SUMMER 2014

MIMS matters

A year of Significant Change in the Management of Medications and their Role in the Economics of Health

2014 saw the funding of Australian healthcare become a water-cooler topic as the new federal government warned of unsustainable healthcare spending. Healthcare currently costs the nation 4.1% of GDP and the projections used by the government predict a rise to 7% if no strategic changes are made.

As a measure to reduce the spiraling spending, the proposed federal budget suggested a controversial $7 co-payment to see a bulk billing doctor, receive X-rays and get blood tests. The measure is planned to save $3.4 billion over five years, however $5 of it will go toward new medical research. Australians would also pay an increased contribution towards the cost of each Pharmaceutical Benefits Scheme (PBS) prescription from July.

The GP co-payment proposal has been criticised by many in the health sector because out-of-pocket costs in Australia are already relatively high by world standards, and there are concerns that the measure will reduce necessary GP visits (for preventive services such as immunisations or cancer screening), particularly in people with lower incomes, who also tend to be in poorer health and are most likely to defer visits to the GP because of cost. At this time there is a chance that some of the healthcare strategies proposed in the budget will never be implemented due to public opposition.

However, the increasing cost of providing healthcare to the nation continues and in 2014 the most significant investment in strategies to more efficiently provide health services was seen in the tertiary and secondary health sectors rather than primary care.

Behind the majority of these projects is the expectation that efficiencies will provide better patient outcomes together with a reduction in overall costs. Key to reducing these costs is the more efficient management of medications.

2014 has seen Melbourne's Cabrini Health invest significantly in an electronic closed-loop medication management (EMM) environment that includes iPads used for prescribing and medication review. Cabrini's EMM is a fundamental foundation for the group's "Cabrini Clinicals" system that underpins their progression towards a paperless electronic medical record (EMR) and operation as a fully integrated digital hospital. Cabrini's system is delivered by CSC and is powered by MIMS integrated drug data and information.

Very few private hospitals in Australia have implemented electronic medication management systems on the same scale as Cabrini, however 2014 saw other private hospitals substantially increase their capability in the electronic management of medications that aim to both reduce risk to patients and deliver efficiencies that reduce costs.

Macquarie University Hospital in Sydney was an early adopter of integrated digital health and for four years has been operating primarily "paperless". 2014 has seen the introduction of their second generation of fully electronic closed-loop medicines management, which is being delivered by InterSystems and deploying MIMS integrated drug data and information.

While the claim to be "Australia's first fully integrated digital hospital" has been made a few times in the past, the 2014 opening of St Stephen's Private Hospital in Hervey Bay in Queensland has clearly set a new level of digital integration for others to strive to achieve.

The hospital has achieved a HIMSS level 6 classification on opening, with a fully electronic medical records and a closed loop medication management system that sees a new level of sophistication in Australia. The system also includes electronic drug cabinets in the wards that provide single-dose blister packs for each drug to be administered to the patient.

This Issue...

A year of Significant Change in the Management of Medications and their Role in the Economics of Health (continued)

2014 also saw significant new electronic medication management programs be commenced in the public hospital sector.

Early 2014 saw the commencement of a tender process in NSW to identify solution providers that will deliver accurate medications information to the state's EMR, allowing a holistic view of a patient's previous, current and future treatment plan. When implemented, the NSW EMM will include Clinical Decision Support (CDS) with drug-to-drug interaction checking and drug-to-allergy checking and may also include drug-to-pathology and drug-to-diagnosis checking. Active clinical decision support includes automatic drug interaction checking and "alerts" while a passive clinical decision support will include in-workflow links to published medicines reference information and links to local policies and procedures.

Western Australia's new Fiona Stanley Hospital opened in late 2014 and while it has not achieved its original goal of being a fully integrated digital hospital on its opening, it is laying the foundations for a paperless EMM environment as the hospital expands towards full acute care admissions in 2015.

June 2014 saw the latest release by Australian Medicines Terminology (AMT version 3) from NEHTA. AMT unambiguously identifies drugs using a common terminology to describe the medication, which is needed to support interoperability between systems used by health workers and health sectors and is perhaps the key enabler that has seen so much EMM activity in 2014.

State health organisations are now looking to establish systems that provide clinicians with a non-ambiguous, medicines management system to support the clinical applications that prescribe, administer and dispense medications. The systems are early examples of real-world use of Australian Medicines Terminology (AMT) for the unambiguous description of medicines approved and stocked for state supply.

The last twelve months have seen many state health systems commence planning and implementation of AMT standards based medication formularies and common drug catalogues with the flexibility and capability to feed electronic medical records and medication systems. For many years Queensland Health has used a common drug catalogue. However in other states typically the individual hospitals or regional health services have been responsible for deciding which drugs are purchased and stocked. In most states and territories there has not been an organizational approach to the supply and management of medications. This uncoordinated approach often results in inefficiency such as wastage due to expiry and overstocking of medications in some hospital pharmacies while others may be ordering the same medication from suppliers to overcome a shortage.

NSW Health's Pharmacy Improvement Program (PIP) is enhancing hospital pharmacy systems and processes to support safer, more efficient and cost effective medication management and patient care in NSW public hospitals. A delivery of the program is a Hospital Pharmacy Product List (HPPL) which is a state-wide list of pharmaceutical products used by NSW public hospital pharmacies. This list will for the first time provide standardised naming and product descriptions across the state, which is essential to allow the state's ambitious electronic medicines management and electronic medical record rollouts to progress.

As has been the case in recent years, 2014 saw no issue more discussed in the eHealth sector than the PCEHR. Its demise was predicted, but at the end of 2014 it was being reported that the national electronic health record had pulled off a billion-dollar comeback and is ready, pending the belated government go-ahead. 2014 has seen each state health system commence large scale delivery of hospital discharge summaries to the PCEHR. NSW EMM will also provide improved medicines information in discharge summaries for transition of care back to primary care providers and to patients.

No review of 2014 eHealth activity would be complete without a mention of Telstra Health. Telstra has become the most significant new entrant into the eHealth industry with several acquisitions and investments over the last few years in eHealth companies including HealthEngine, fred IT, Health Connex, Communicare and Verdi.

2014 saw Telstra's ambitions for not just driving the technology behind eHealth, but rather Telstra Health are now entering the "care" side of the business. In November, Telstra announced their ReadyCare service developed with Swiss eHealth company MedGate, which will enable 24-hour access to GPs, including referrals and online prescription services. Finishing off the year, Telstra announced the acquisition of iCareHealth, who develop aged-care solutions, and a significant investment in Orion Health, a key player in integrated eHealth solutions.

Telstra believes it has solutions that will relieve some pressure to consumers from what the government predicts is unsustainable future healthcare spending. With the high level of activity of 2014 behind us, and the signs of some change and disruption to the business of health from both government and private players in the new year, 2015 certainly looks like an interesting year for the health industry and its consumers.

Visual Outcomes launches with MIMS Integrated to provide safe prescribing and decision support for multidisciplinary healthcare teams

VISUAL OUTCOMES™
CLIENT•CLINIC SOFTWARE

We welcome our new partner Visual Outcomes, an organisation with an ethos that quality healthcare is not only about processes but about relationships. Visual Outcomes is built on relationships,data relationships across the clinic, the clients and the clinicians. Used by a wide range of healthcare practitioners, with screens and reports tailored for each, Visual Outcomes is ideal for multi-specialty clinics and is maintaining over two million patient records for more than 150 practices in Australia and the USA.

Most EHR software can keep track of appointments, visits, payments, prescriptions, lab results and other processes. Visual Outcomes connects it all together and collates data across the whole system. With the power of MIMS Integrated, Visual Outcomes is now also able to provide users with a trusted local medicines database that supports their prescribing and patient care. “Our mission is to support great patient-centered outcomes within a unified healthcare information system that delivers all the processes of different healthcare specialties while empowering clinic-client relationships” said Visual Outcomes CEO, Dr. Sue-Ellen McKelvey PhD.

‘MIMS Supports that mission,” said Dr. McKelvey “and we are working together to ensure we meet the needs of the customers of today and into the future”.

Medication errors are one of the most common causes of harm in Healthcare with 50% considered preventable. The driving force of MIMS is an uncompromising mission to provide the knowledge which can deliver better health outcomes. Through effective implementation of our information we enable safer prescribing, dispensing and administration and help clinicians to avoid potential medication errors.

Our partnership with Visual Outcomes consolidates our position as Australia’s preferred source of medication decision support for the primary and acute care software industry and we look forward to yet another successful partnership.

To find out more about Visual Outcomes visit their website www.visualoutcomes.com, phone +61 2 80657912 or email info@visualoutcomes.com

MIMS – working with partners to support end users

The MIMS Integrated data solutions team works collaboratively with third party software developers and partners to deliver Australian and international projects that provide safe, relevant, comprehensive, and up to date medicines information. This information and knowledge powers applications such as Electronic Medical Records, Electronic Medication Management Solutions, Primary Care and Specialist Clinical Software, Pharmacy Dispensing and Clinical Quality and Safety Solutions. We work proactively with all stakeholders including solution developers, hospital pharmacists and clinicians to deliver effective solutions that promote the reduction of medication errors and increase efficiencies. We value these partnerships and want to take this opportunity to say thank you to all those who work with us to deliver our trusted medicines information and decision support to the point of care.

- Abaki - Medinet
- Access GP
- Advanced Professional Systems
- Alcidion Corporation
- Al-Din Consultancy, Trading as Pillpedia
- Australian Sports Anti-Doping Authority (ASADA)
- Bp Clinical
- Cancer Council Victoria
- Cardio Vascular Service
- CDC Systems
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- Communicare Systems
- CSC - practiX, Medchart and Episoft eAdmissions
- DoctorWare Australia
- DrsDesk Software
- dZine Software
- Episoft
- Equipoise International- Totalcare
- Genie Solutions
- Global Health - MasterCare EMR and Mhagic
- Godbar Software
- Great Southern Managed Health Network
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- NIB Health Funds
- NPS
- ORION Medicines Reconciliation Service (ACT Health)
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- University of NSW Faculty of Medicine
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- Webstercare
- Zedmed
- Z Software

Colorectal (bowel) cancer: prevention, risk factors and faecal occult blood tests

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Discipline of Pharmacology,
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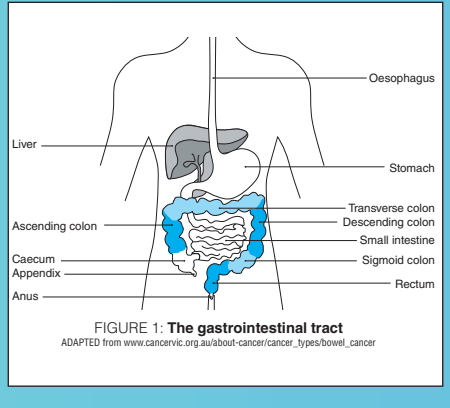

FIGURE 1: **The gastrointestinal tract**
ADAPTED from www.cancervic.org.au/about-cancer/cancer_types/bowel_cancer

AJP AUSTRALIAN JOURNAL OF PHARMACY

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Colorectal cancer, also called bowel cancer, occurs in the colon and the rectum. It is the second most common cancer in Australia (with the exception of non-melanoma skin cancers) and is the second most common cause of cancer-related deaths.[1,2,3] It affects both genders[3,4] and kills more Australians than breast cancer or prostate cancer.[3] One-in-12 Australians will develop colorectal cancer in their lifetime,[4,5,6] and one Australian dies from colorectal cancer approximately every two hours.[3,4,7]

The colon and the rectum are at the lower end of the gastrointestinal tract and together are approximately 1.5 metres long. As shown in Figure 1, the colon is divided into the ascending colon, the transverse colon, the descending colon and the sigmoid colon.[8–10] Colorectal cancers can occur anywhere in the colon or rectum, but the majority occur in the sigmoid colon and the rectum.[11,12]

Risk factors for developing colorectal cancer

The risk of developing colorectal cancer increases over the age of 40, and is greatest for those aged 50 and older.[2,10,13,14,16] Diets high in red meat and/or processed meat have also been reported to be associated with an increased risk of developing colorectal cancer, while diets high in fruit, vegetables and fibre have been reported to be associated with a decreased risk.[2,13–16]

Certain inflammatory bowel diseases e.g. Crohn's disease and ulcerative colitis also increase the risk,[1,5,10,13,16] as does obesity, a sedentary lifestyle, excess alcohol and smoking.[1,2,10,13,14,16,19]

There is good evidence that increasing physical activity reduces the risk of colorectal cancer,[13,14,16,19] and it has been suggested that eating a healthy diet and exercising regularly could prevent 66–75% of cases.[18]

Most colorectal cancers develop from polyps[1,2,5,9,10,12,17–19] which are outgrowths that grow from the wall of the colon or the rectum. Polyps vary in shape and size and sometimes look like a cherry or a mushroom on a stalk.[5,18,20,21] The occurrence of polyps increases as we age[2] and most are benign.[9,10,21] Some, however, may undergo changes and become adenomas and then develop into colorectal cancer.[2,9,18,19,21]

From the time the first abnormal cells start to grow it usually takes many years for them to develop into colorectal cancer, and for the cancer to spread from the bowel to lymph nodes and other body organs.[9,12,14,18,19]

The majority of people who develop colorectal cancer have no family history of the disease, although having a first degree relative (parent, sibling or child) with colorectal cancer does increase a person's risk.[13,16,18] In addition, people with a genetically inherited condition called familial adenomatous polyposis (FAP) have a greatly increased risk of developing colorectal cancer.[10,12–14,19,20] In this condition hundreds of polyps develop in the colon and rectum and although it is responsible for only 1% of cases, without appropriate treatment virtually all people with the condition will develop colorectal cancer by the age of 40 to 50.[13,14,19] Another genetic condition known as hereditary non-polyposis colon cancer (HNPCC), or Lynch syndrome, also increases the risk of developing colorectal cancer.[10,12–14,19]

Signs and symptoms of colorectal cancer

The signs and symptoms of colorectal cancer may include a persistent change in bowel habit, e.g. constipation or diarrhoea; persistent, severe abdominal pain; frequent gas pains, bloating, fullness or cramps; a feeling that the bowel does not empty completely; weight loss for no apparent reason; visible blood in the faeces; feeling very tired (bleeding may cause anaemia).[1,10,12,18,21,22]

However, it is extremely important to realise that these signs and symptoms may only be present in the later stages of the disease, and that in the early stages a person may experience no symptoms at all.[2,18,21,22,28,38]

Stages of colorectal cancer

The stages of colorectal cancer indicate the extent to which the cancer has grown, and whether it has spread to the lymph nodes and other organs in the body. There are a number of staging systems but a common one used in Australia is the Australian Clinico-Pathological Staging (ACPS) system.[1,2,23–25] The stages under this system are:

- Stage A—Cancer is found only in the bowel wall.
- Stage B—Cancer has spread to the outer surface of the bowel wall.
- Stage C—Cancer has spread to the lymph nodes near the bowel.
- Stage D—Cancer has spread beyond the lymph nodes to other areas of the body, such as the liver or lungs.

These stages are sometimes also referred to as Stages I, II, III and IV.[1,25]

As mentioned previously, colorectal cancer tends to grow and spread slowly and if detected early is one of the most curable types of cancer.[5] The estimated five-year survival rates for the different stages are:[1,2]

- Stage A—93%
- Stage B—82%
- Stage C—59%
- Stage D—8%

However, because there are generally no symptoms associated with the early stages of the disease, fewer than 40% of colorectal cancers are detected early,[5,18,38] and the overall five-year survival rate for all Australians diagnosed with colorectal cancer is only 66%[1,3] (the overall five-year survival rate for breast cancer is 89%, and for prostate cancer it is 92%).[3]

Screening for colorectal cancer: faecal occult blood tests

Polyps and the early stages of colorectal cancer may bleed and this blood is present in the faeces, although it is not visible to the naked eye.[2,26–28] This bleeding quite often occurs before any symptoms are noticed and faecal occult blood tests (FOBTs) are designed to detect this bleeding.[2,26–28]

There are basically two types of FOBT. The guaiac FOBT is the oldest and is based on a reaction between the peroxidase-like activity of haem and guaiac. Haem is the iron containing portion of haemoglobin. There are, however, a number of drawbacks with the guaiac FOBT. It is not selective for human blood and some common vegetables can exert peroxidase activity. It also does not distinguish between blood originating in the colon or rectum, and blood originating from other parts of the gastrointestinal tract, e.g. if bleeding occurs in the upper gastrointestinal tract the haemoglobin in the blood will be broken down, but as the haem molecule is stable it will remain intact, travel down the gastrointestinal tract, be excreted in the faeces and may produce a positive result on the guaiac FOBT. Thus, as some medications may produce upper gastrointestinal bleeding, some vegetables contain high peroxidase activity and the test is not specific for human blood, there are dietary and medication restrictions associated with this test,[26,28,44] e.g. taking non-steroidal anti-inflammatory drugs, or eating red meat or vegetables such as broccoli, cauliflower or parsnips may produce a false positive result. High-dose vitamin C may produce a false negative result.[28,44]

The second, and newer type of FOBT, is the immunochemical FOBT which uses antibodies to detect the human haemoglobin molecule, not haem.[29,30–33] It is thus specific for human blood. There are no restrictions on diet or medications with this test,[26,28] and it is less likely to produce false positive results. It is important to remember, however, that bleeding haemorrhoids or menstrual blood may produce a positive result. When compared with the guaiac FOBT the immunochemical FOBT has also been reported to have an increased participation rate, and a higher sensitivity for detecting advanced adenomas and colorectal cancer.[29,30–35,44] In order to distinguish it from the older guaiac FOBT, the immunochemical FOBT is also referred to as the Faecal Immunochemical Test, or FIT.

If a FOBT does give a positive result, the patient should consult their general practitioner for advice regarding further investigation, e.g. a colonoscopy.

As polyps and early stages of colorectal cancer may bleed only intermittently, a negative result with a FOBT does not definitely exclude the presence of cancer.

However, as precancerous polyps and colorectal cancers are slow growing, repeating the test on a regular basis increases the chances of detection. In fact, many studies have now shown that regular annual or biennial screening with FOBTs can significantly reduce colorectal cancer incidence and mortality.[36–41]

The use of FOBTs allows for the detection of the cancer at an earlier stage, when no symptoms may be present and it is far more curable, and for the detection of precancerous adenomas which can be removed.[39,41–43]

Screening in Australia

The current NHMRC Clinical Practice Guidelines recommend that every Australian older than 50 should complete a FOBT at least every two years.[14] Currently the National Bowel Cancer Screening Program (NBCSP), which uses an immunochemical test, invites people turning 50, 55, 60 and 65 to complete a free FOBT.[45,46] Money has also been allocated in the 2014 Federal Budget to expand this program, and when fully implemented in 2020, all Australians aged between 50 and 74 years will be offered a free screening test every two years.[46,47]

It has also been reported that the NBCSP can lead to colorectal cancer being diagnosed at a significantly earlier stage,[42] and it has been estimated that when fully implemented for people aged between 50 and 74 years, the NBCSP will reduce colorectal cancer mortality by 15–25% and prevent 300–500 deaths annually.[37] At present the uptake of the NBCSP is unfortunately quite low, and in 2012–2013 it was only 33.5% (of 964,000 tests mailed out, only 321,000 were completed).[2,48]

The vast majority of people who might benefit from regular screening with FOBTs are not doing so

There are more than 7 million Australians aged 50 and older,[49] and in 2012–2013 only 321,000 of these completed an FOBT as part of the NBCSP.[2,48] Annual FOBT sales of the National Bowelscan Program provided by Rotary through community pharmacies are around 150,000.[50] It thus seems reasonable to conclude that the vast majority of Australians aged 50 and older are not undertaking a FOBT every two years.

People younger than 50, and at present those older than 65, are not included in the NBCSP (people up to the age of 74 will be included when the scheme is fully implemented by 2020). It has been reported, however, that up to 10% of colorectal cancers occur in people younger than 50[11,13,51–53] and, while most recommendations are that regular screening of the population should not commence until the age of 50, the Gut Foundation has suggested that screening should commence at age 40.[52] In addition, it has recently been reported that in healthy individuals FOBT screening up to the age of 86 is beneficial and cost effective, particularly if the person has not previously completed a test.[54]

Remember that if detected early, colorectal cancer is very curable but at present, because it is all too often not diagnosed until a late stage, it kills one Australian approximately every two hours. Increased screening with FOBTs will reduce this toll. FOBTs are not expensive, they are done at home and, depending on the level of cover, there may be a health fund rebate.

> Why should someone die from a cancer which, if detected early, is curable?

Early detection essential

The question must be asked: why should someone die from a cancer which, if detected early, is curable? Several million Australian females regularly have screening mammograms for breast cancer[55] and regularly have screening Pap smears for cervical cancer.[56] Similarly, large numbers of Australian males regularly have screening digital examinations and/or PSA tests for prostate cancer.[57] Figures suggest that far fewer Australians have regular FOBTs for colorectal cancer, yet colorectal cancer kills more people than breast, cervical or prostate cancer.

In order to significantly reduce deaths from colorectal cancer, all healthcare professionals should strive to ensure that all people aged 50 and older have a regular (at least every two years) screening FOBT.

* Professor Carroll has received support from Clinical Genomics to talk on colorectal cancer screening at continuing education conferences.

References are available with the original publication or from http://mims.com.au/content/MimsMatters/References_Colorectal_Cancer.pdf

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Content updated monthly	M	M	M
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*eMIMSDesktop can be used on MAC providing you have Microsoft for MAC installed.

MIMS Proud to be Supporting Pharmacy Interns with Intern of the Year Awards

MIMS has partnered with the Pharmaceutical Society of Australia and the Pharmacy Guild for many years to support interns through their intern year by providing free access to eMIMS.

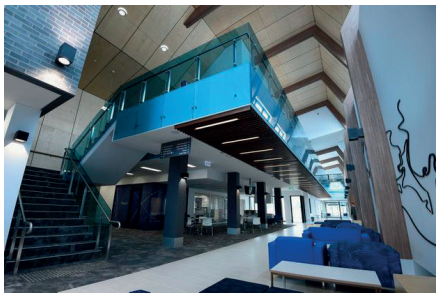
In 2015 we will be proudly providing awards to the best of the best in the world of young pharmacists. Encouraging pharmacy interns to pursue excellence and supporting them through the provision of educational grants is something that has far reaching benefits not only to the pharmacy profession but also the broader Australian community. This is in alignment with the ethos of MIMS, where we look to support the healthcare communities we serve and, through them, the whole community, by providing high quality, relevant knowledge and products.

What is a pharmacy Intern?

Before registering as a pharmacist, graduates are required to fulfil the Pharmacy Board's internship requirement in completing 1824 hours of supervised practice and complete an approved Intern Training Program (ITP) before they can sit the written and oral examinations. The ITP is undertaken in conjunction with supervised practice as an intern. These programs help to develop the necessary skills in applying the knowledge gained in university to the workplace environment - becoming a competent pharmacist.

Interns work across all aspects of pharmacy and contribute hugely to their chosen work place, many developing and running programs in both community and hospital settings. MIMS has partnered with both the PSA and the Pharmacy Guild to reward excellence in this final training year.

UnitingCare's, St Stephens Hospital in Hervey Bay has opened its doors



St Stephen's hospital

The fully-integrated regional digital hospital in Hervey Bay on Queensland's Fraser Coast is a state-of-the-art 'hospital of the future' which has been supported by the Federal Government's Health and Hospitals Fund.

In a statement, UnitingCare Health executive director Richard Royle said the group expects "All medical records, X-ray and pathology results will be accessible by doctors and nurses anywhere in the hospital, whether at the bedside or remotely on tablets, mobile phones, laptops or mobile computers on wheels, as well as at nurses' stations."“The advanced wireless technologies will generate efficiencies, improve safety and clinical outcomes, and create higher levels of patient and clinician satisfaction," he said.

The 96-bed facility has completely digitised record and patient management, including electronically dispensed medications and monitoring patients during surgery.

The Electronic Medical Record and digitisation of the hospital will lead to improved patient safety and clinical outcomes. Factors such as reduced adverse events, decreased length of stay, high levels of patient and clinician satisfaction, reduction in document duplication or time wasted chasing information or equipment will deliver corresponding improvements in efficiency; all of which will eventually flow through to an improved bottom line.

St Stephen's Hospital, Hervey Bay is part of UnitingCare Health, a not-for-profit provider of health services in Queensland, employing more than 3500 people and treating more than 100,000 patients each year.

Its hospitals include St Stephen's, Maryborough; The Wesley Hospital and St Andrew's War Memorial Hospital, Brisbane; and The Sunshine Coast Private Hospital, Buderim.

St Stephens Hospital and all UnitingCare hospitals will be utilising MIMS Medicines Knowledge as a key component of its drug reference and its medicines management process.

GP 14 and Adelaide turned on some great spring weather

What a great conference, busy and buzzy and very well attended, for MIMS this was the first GP conference for a few years. The overarching theme of the conference was the role of GPs as advocates for their profession and for the health and wellbeing of their patients. It was about working together to ensure all Australians have access to GP coordinated primary care and with communities, governments and allied healthcare providers to achieve the best possible patient outcomes.

GPs, students, interns and registrars who came to visit our stand during the conference came from all over Australia, New Zealand and even Malaysia. Of particular interest was MIMS Integrated, which is the MIMS medicines database and evidence based drug interactions integrated into the clinical software doctors use every day.

Some of the MIMS partners were exhibiting at GP14 and it was a great opportunity to talk to them and their users about the way MIMS is integrated into the software. We love feedback, and understanding more about what doctors like and what they feel could be improved in the way MIMS is integrated proved useful for both MIMS and our partners.

We offered a free trial of the new MIMS for Android app to everyone who visited out stand and happily interest was high with many people taking up the offer.

Congratulations to Dr Jess Bunker who won a year's subscription to eMIMSCloud

You can watch and read highlights and presentations on the website **http://www.gpconference.com.au/presentations/**

MIMS matters

MIMS Staff Profile

Emily Naziri
Editor

What do I do?

My role as an editor involves preparing and updating the MIMS database content. Working within the editorial team, I am involved in reviewing and abbreviating the product information for medicines approved by the TGA in Australia. I work closely with other editors to ensure the MIMS databases and publications are accurate, consistent and up to date, and remain a reliable resource for our clients.

What is your background?

I graduated with a pharmacy degree from the University of Sydney and then completed my pharmacist registration in community pharmacy. I then took on the role of a pharmacist in charge in various pharmacies for several years. My background as a pharmacist has provided me with useful skills and the clinical knowledge necessary for a smooth transition into editorial work.

What do you enjoy most about your role?

The best part about working as an editor is being able to broaden the scope of my clinical knowledge. Each day I come across products that I would have never been exposed to in my previous role and I really enjoy learning about them. I enjoy keeping up to date with new medicines which we include in MIMS every month.

When I was working in community pharmacy, I would use eMIMS daily as I found it a very useful and reliable reference tool. Now that I work as an editor I find it very rewarding to be able to contribute towards providing information to others.

I have also had the opportunity to be involved in testing new MIMS applications such as MIMS for Android which was exciting. Being able to work with other teams within MIMS towards achieving the launch of a successful product has been a highlight.

What do you enjoy outside the office?

Outside of work I enjoy catching up with family and friends over a movie or a meal. I am always curious to try new food places that keep cropping up. I also enjoy travelling and going to the beach. Lately I have been learning to rollerblade- I am still learning how to skate with the proper technique however it is a lot of fun!

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