Australian Government
Department of Health and Aged Care

Aged care on-site pharmacist measure

Consultation response template

Instructions

- Please refer to the consultation paper
- Use the below response template as a guide
- Return your feedback by email to agedcarepharmacist@health.gov.au
- The consultation closes on Friday 9 September 2022
- Information on the consultation is available at https://consultations.health.gov.au/aged-care-division/aged-care-on-site-pharmacists/

Funding model for employment of on-site pharmacists	
Question	**Response**
1. Do you believe funding should be provided directly to residential aged care homes or coordinated through Primary Health Networks (PHNs)?	National Aboriginal Community Controlled Health Organisation (NACCHO) recommends that the Department explore a mixed model of funding for this measure to ensure there are adequate funds to cover the costs of delivery in rural and remote locations and to populations with diverse needs.
Why is this your recommended funding model?	The current funding model allows for one full time pharmacist per 250 beds. As a result, smaller services will not receive enough funds to hire a full or part-time pharmacist and will have to pay for pharmacy services on an hourly or visit rate. There are also high costs

	associated with attracting and retaining pharmacists to rural and remote locations. Options to pool funds across services and with other pharmacy programs would provider a great chance of recruiting a fulltime pharmacist. Funds could be distributed though the Aboriginal Community Controlled Health Organisation (ACCHO), Community Pharmacy (CP) and/or Primary Health Network (PHN). Funding can still be provided directly to approved providers operating large metropolitan facilities who will be able to directly recruit pharmacists. A mixed funding model will require effective oversight to ensure the measure is operating effectively across Australia and meeting the needs of all aged care recipients. NACCHO also recommends that the Department consider a base line of 0.2FTE for smaller aged care facilities with a loading per capita. Funding should also consider the costs of travel and accommodation for visiting pharmacists. Funds could be administered via a contracted third party agency such as the Pharmacy Programs Administrator Registration and Claiming (PPA) portal which is currently used by pharmacists for claiming community pharmacy funds. **Case studies:** • Mala'la Health Service Aboriginal Corporation operates a 10 bed National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) service in Maningrida, Northern Territory. Based on the proposed funding formula and an estimated salary of $150,000 (including on-costs), they would receive approximately $6,000 in funding. Given the high costs of travel and accommodation, this funding would only support occasional pharmacy visits. If this ACCHO were able to pool aged care and primary health funds they may be able to delivery a range of pharmacy services to their clients. • ARRCS operates a 25 bed NATSIFAC service in Tennant Creek. Based on the proposed funding they would receive $15,000 in funding. There is a Community Pharmacy (CP) operating in Tennant Creek that may be able to pool aged care and primary health funds to deliver visiting pharmacy services to both the aged care service and ACCHO, and general health clients.

	• Wellington Aboriginal Corporation Health Service (WACHS) in country NSW provides visiting GP services for residents in local Aged Care Facilities, without any additional funding. WACHS has an embedded pharmacist (1 day per week) providing support to the ACCHO patients. Under current Residential Medication Management Review (RMMR) contract arrangements this pharmacist is not able to provide funded support into aged care facilities, although this would be useful particularly at times of transition of care. Under a mixed funding model, the current ACCHO embedded role could extend into the aged care facilities if the ACCHO received the funding directly or indirectly by contract with the ACF. Alternatively, aged care pharmacist services could also be provided by the local CP or external contractor pharmacist, with need determined by the ACCHO, the aged care facility and dependent on local pharmacist workforce availability.
Theme 1: Developing and defining the role of the on-site pharmacist	
Question	**Response**
2. What do you see as the key role and responsibilities for an on-site pharmacist in residential aged care homes? Please consider the role in relation to the Medicines Advisory Committee/residential aged care home clinical governance.	The key responsibilities for an on-site pharmacist caring for Aboriginal and Torres Strait Islander aged residents include: • Consideration of the cultural perspectives of Aboriginal and Torres Strait Islander residents and staff • All services involving ACCHOs and/or a significant number of Aboriginal and Torres Strait Islander residents should be negotiated between the Aged care facility and the pharmacist. This is the spirit of self-determination that underpins the ACCHO model of care where roles are within the pharmacist scope of practice but meet the unique needs of the Aged care facility. • Undertaking cultural awareness training to ensure they are delivering culturally safe care. • Clinical services of a quality consistent with best practice national standards

3. How could residential aged care homes or Primary Health Networks be supported in engagement of pharmacists to work in aged care homes? Do you have a suggested approach to engaging pharmacists in rural and more remote locations to work on-site in residential aged care homes under this measure?	NACCHO recommends that the Department explore a mixed delivery model in rural and remote settings that includes face to face visits with follow up tele-health appointments. Funding through ACCHOs CPs and PHNs would allow them to pool funding and attract pharmacists to work across a range of settings e.g., a community visit might include visit to aged care and primary health clinic. It is vital that pharmacists employed in rural and remote settings have support structures through local health networks and national pharmacy bodies (PSA, AACP or NACCHO) to reduce professional isolation and to ensure quality of services.
4. How could this relatively new role be promoted to pharmacists to encourage uptake?	There are good networks for discussion and promotion of the role through existing pharmacist networks. The barrier to implementing the new role is more likely to be in aged care facilities. It may need to be intensively promoted to the ACCHOs, aged care facilities and the GPs servicing them. NACCHO could have a role in supporting ACCHOs who administer or otherwise support aged care facilities to help them define the role of their pharmacist. NACCHO successfully provided this role to ACCHOs as part of the *Integrating Pharmacists within Aboriginal community controlled health services to improve Chronic disease management* (IPAC) study[1].
5. How can on-site pharmacists best collaborate with the aged care health care teams (including residents and their families, other staff, the local general practitioner and pharmacy) in regard to transitioning between health care settings?	Medicine 'mishaps' occur frequently during transitions between health care settings and is an ongoing source of problems including unexpected readmission to hospital. On-site pharmacists would be able to work with the processes and information systems in the aged care facility to be alerted to residents transitioning between health care settings. They can also develop networks with pharmacists, GPs and discharge co-ordinators in other health care settings to help resolve medicines issues early at this risky transition period.

[1] Medical Srvices Advisory Committee (2022). Public Summary Document: Application No. 1678 – Integrating Pharmacists within Aboriginal Community Controlled Health Services to Improve Chronic Disease Management (IPAC Project). Health. Canberra, Australian Government. Available from http://www.msac.gov.au/internet/msac/publishing.nsf/Content/8FBBD6DC1F003721CA25876D0002CEF5/$File/1678%20-%20Final%20PSD_Mar-Apr2022.pdf

	The IPAC project, conducted in 20 ACCHOs around Australia demonstrated that pharmacists fit well within the health care team in ACCHOs. The management of transitions of care between the primary health care setting and other agencies such as hospitals and aged care facilities was a frequent activity of the pharmacist and was seen as a positive outcome of IPAC. A review of the enablers and barriers of the integrated pharmacist found that patients and their families were overwhelmingly supportive of the pharmacist's role[2]
6. How should continuing professional development, mentoring and networking for on-site pharmacists be supported and maintained?	It is vital that pharmacists, especially those employed in rural and remote settings, have support structures through local health networks and national pharmacy bodies to reduce professional isolation and to ensure quality of services. NACCHO in collaboration with PSA hosts a 'Community of Specialty Interest' that supports pharmacists working in the ACCHO sector which could accommodate those pharmacists working with NATSIFAC facilities and those aged care facilities with significant numbers of Aboriginal and Torres Strait Islander residents.
Theme 2: Training requirements for pharmacists	
Question	**Response**
7. What training currently exists that could be adapted to meet training requirements? Can existing training be upscaled if required?	Pharmacists visiting Aboriginal and Torres Strait Islander clients need to undertake cultural awareness training and be educated about the health issues/barriers facing Aboriginal and Torres Strait Islander people. NACCHO and PSA have co-designed an online training course (Deadly Pharmacists) for pharmacists working in ACCHOs, including a module on the culture and history of Aboriginal and Torres Strait Islander people and culturally safe practice for pharmacists. This may be able to be adapted for the Aged Care context.

[2] Drovandi A, Smith D, Preston R, Morris L, Page P, Swain L, et al (2022). Enablers and barriers to non-dispensing pharmacist integration into the primary health care teams of Aboriginal community-controlled health services. *Res Social Adm Pharm*: 2022.

	Indigenous Allied Health Australia (IAHA) also run cultural awareness training - https://iaha.com.au/iaha-consulting/cultural-responsiveness-training/
8. What should be the model/provider of national oversight of the training to ensure the ongoing quality of the training, consistency of training across all training providers and maintenance of currency of knowledge once training is completed?	If pharmacists will be required to be accredited, AACP or SHPA could be extended to be the accrediting body for aged care pharmacists and for education that qualifies a pharmacist for MMR accreditation. Incentives should be put in place to support and encourage rural and remote pharmacists to upskill. It may be appropriate that an alternate pathway to an 'Aged Care Pharmacist' be developed that deemphasises HMR and focuses on governance, incidental medicines review, and more formal written medicines reviews such as the existing RMMR model. Qualifying 'courses' could be accredited under the Pharmacy Council, PSA or SHPA as is currently the requirement for courses that pharmacists do to qualify for stage one of the HMR/RMMR accreditation.
9. How would accredited pharmacists make the transition into the role of an on-site pharmacist in a residential aged care home?	N/A
Theme 3: Development of health outcome indicators and associated reporting	
Question	**Response**
10. What outcome indicators should be included in addition to the Aged Care Quality Indicators for medication management, e.g. specific indicators on inappropriate antimicrobial use, anticholinergic load reduction?	The existing indicators are appropriate but should be expanded to describe quality of team care and patient focus including culturally safe care for Aboriginal and Torres Strait Islander residents and their families. A simple indicator could be the number of times a pharmacist has contributed to patient care as indicated by entry in clinical record. This is simple to collect from a report from most computer systems, however does not describe the quality of the intervention. This may need further discussion to ensure any 'soft' indicators are easily collected and reported.

11. Are there any barriers to the on-site pharmacist working with the Medicines Advisory Committee, and if so, how can they be addressed?	Many pharmacists already associated with aged care facilities in a quality way, organise and run MACs. There may be logistical and interpersonal barriers that would need to be accommodated but in general, an onsite pharmacist would facilitate an effective MAC.
Theme 4: Transition from services funded under the Seventh Community Pharmacy Agreement Pharmacy Programs	
Question	**Response**
12. What support will residential aged care homes require with this transition, in addition to the on-site pharmacist?	Aged care facilities will require support to ensure that they understand the role of the pharmacist and their scope of practice, but importantly, they need to be supported to co-design the service that most meets their needs. This would be best facilitated by agencies that the facility already know and trust and that have a good understanding of the role and scope of a pharmacist and of the 'onsite pharmacist in aged care measure'. This could be facilitated for NATSIFAC facilities or aged care facilities associated with an ACCHO by the NACCHO medicines team as described in Q4. As noted in Q2, it is vital that ACCHOs and associated aged care facilities determine the roles of the onsite pharmacist.
13. What is the optimum period of time required for this transition, i.e. how long do you think the Residential Medication Management Review and Quality Use of Medicines Program services funded under the 7CPA Pharmacy Programs should continue at residential aged care facilities that have engaged an on-site pharmacist?	Any transition to the new program should ensure there is a period of clinical handover to allow for continuity of care for residents.

Do you have any other comments or feedback?
1. This program should be extended to include providers who deliver residential services under the NATSIFAC Program. The *Aged Care On-site Pharmacists consultation paper* notes that this new measure will replace any current Quality Use of Medicines (QUM) and RMMR program funded services. Following advocacy from NACCHO, the RMMR Program Rules were expanded in December 2020 to include residential services funded under the NATSIFAC Program. NACCHO recommends that the new measure also be expanded to include NATSIFAC services delivering residential services. The expansion of the program into NATSIFAC facilities will ensure that Aboriginal and Torres Strait Islander aged care recipients residing in these facilities have access to the same level of pharmacy services as those in mainstream residential facilities. This also aligns with the recommendations of the Royal Commission into Aged Care Quality and Safety to improve the delivery of aged care to Aboriginal and Torres Strait Islander people. 2. If the RMMR program is to be abandoned, this will leave GPs unfunded as they were previously able to claim MBS item 903 for referral and managing follow up of a RMMR. NACCHO found similar implications for MBS item 900 (Home Medicines Review) in the recent IPAC project where pharmacists were salaried for providing HMR services so couldn't claim. It was noted that even if the pharmacist didn't claim, if all other requirements of HMR were met, then the GP could still claim MBS item 900. This can easily be accommodated since HMR is a widely available service, but may be an issue if all RMMRs are decommissioned. It may be that the facility to allow GPs to claim MBS item 903 on receipt and follow up of a comprehensive review from the pharmacist needs to be accommodated. 3. The use of telehealth and 'fly-in-fly-out' services are important for the flexibility of services in rural and remote areas and should be available where no other services are possible. However, NACCHO supports pharmacist face to face services as the preferred delivery method where possible, so access to adequate travel and accommodation allowances are essential.