



# NACCHO

National Aboriginal Community Controlled Health Organisation

## **QUMAX Programme:**

**Quality use of Medicines Maximised for  
Aboriginal and Torres Strait Islander People  
(2010-2015)**

## **NACCHO Report Back to Member Services**

**March 2016**

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# NACCHO

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NACCHO QUMAX Programme: Report Back to NACCHO Member Services

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## 1. Executive Summary

QUMAX is a collaboration between the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Pharmacy Guild of Australia (PGoA) which is funded by the Commonwealth Department of Health under the Community Pharmacy Agreement. QUMAX is a mature, proven beneficial Programme that optimises quality use of medicines for patients, delivered by Aboriginal Community Controlled Health Organisations (ACCHOs) and community pharmacies. In addition to the delivery of quality health outcomes, the Programme has been received strong support from both ACCHOs and Community Pharmacies.

The QUMAX Programme (2015-2016) currently engages with just over 50% of NACCHO Member Organisations - 75 Aboriginal Community Controlled Health Organisations in every State and Territory, as well as two non-member service providers. A total of 508 community pharmacies have participated.

This is the first ever 'Report Back to NACCHO Member Services'. The processes of preparing, editing and publishing this 'Report Back' have created long-overdue reforms to the Programme's database and improved accountability to NACCHO's Member Services.

The data from the Programme and comments from staff in ACCHOs and Community Pharmacies show that QUMAX is a valued and effective pharmacy service for Aboriginal and Torres Strait Islander people.

QUMAX Programme expenditure is distributed almost evenly across outer regional areas, inner regional areas, and major cities – what are often referred to as “regional, rural, urban” areas.

Funding for QUMAX was capped at \$11.0M for the five years (2010-2015). Although the release of funds has increased each year, it has been insufficient to meet the identified needs of patients requiring support through QUMAX. This, coupled with the financial co-investment independently committed by ACCHOs of nearly \$500,000 across the 2013-2015 financial years, indicates a higher level of funding is needed for Aboriginal and Torres Strait Islander clients in relation to quality use of medicines.

Of the seven support categories eligible to receive QUMAX Programme funding, Dose Administration Aids (DAAs) absorb the highest proportion of QUMAX funding across all five years. Twenty-one percent of funds have been used for transport assistance to clients to acquire medications.

Clients with chronic disease are evenly distributed regardless of location.

The delay in notification of the 6th Community Pharmacy Funding Agreement has caused significant disruption to the 2015-2016 QUMAX time-sensitive Programme Cycle. This has placed an added administrative burden on NACCHO from a national coordination stand- point, as well as imposing service delivery costs on ACCHOs and community pharmacies for months while hoping for reimbursement.

This Report Back to Member Services demonstrates that continued investment in the ongoing sustainability of the QUMAX Programme will maintain a valuable contribution to health outcomes of Aboriginal and Torres Strait Islander peoples in major cities and inner and outer regional areas for whom S100 support is not available. A brief discussion about the S100 medicines supply system compared with the QUMAX Programme has been provided in Section 10 of this Report Back.



## 2. At A Glance

- 81 organisations have participated in the QUMAX Programme from 2010-2015; 63 ACCHOs have always participated in each of the years. In 2010-2011, 68 organisations participated and in subsequent years the number of organisations has been: 70 in 2011-2012; 75 in 2012-2013; 76 in 2013-2014; and again 76 in 2014-2015.
- Nearly 50% of NACCHOs Member Services are eligible to access the QUMAX Programme, all have participated.
- The number of 'candidates'/eligible clients has increased 76% to 218,549 over the period 2010 - 2015.
- ACCHOs are reporting a greater uptake of QUMAX-supported activities to address identified patient need, for which increases in funding have not kept pace.
- 57 ACCHOs co-invested over \$420,000 in FY 2014-2015 alone, mainly on Dose Administration Aids and Transport. These overspends have been necessary due to the lack of adequate QUMAX Programme funding to meet the increased number and needs of QUMAX clients.
- Data reporting protocols need to be upgraded to enable better ongoing monitoring and evaluation of the Programme.
- Participants in the Programme are evenly distributed across major cities and inner and outer regional areas.
- 508 community pharmacies have participated as DAA contracted pharmacies.
- Across the seven categories of support offered by the QUMAX Programme:
  - The highest proportion has been allocated to Dose Administration Aids for complex medications (50%).
  - Asthma masks and spacers, nebulisers and peak flow meters are the most highly used devices for adults and children with over 22,500 being provided.
  - 21% of funds have been used for transport assistance to clients to acquire medications; access to pharmacies is a major factor in medication adherence. It is noted that 80% of contracted pharmacies are over 1km from the ACCHO clinics.
- Community Pharmacists actively participate in improving their own Cultural Awareness for Aboriginal and Torres Strait Islander clients and support for client education on medications, especially in relation to complex medications for chronic disease(s) and after hospitalisation.

### 3. Background

In 2008, as part of the Fourth Community Pharmacy Agreement (4CPA 2006-2010), the PGoA and the NACCHO jointly developed the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples Programme (QUMAX) in consultation with the QUMAX Reference Group (QRG). The Programme commenced as a two-year trial to 30 June 2010.

The success of the QUMAX Trial Programme was highlighted in the Department of Health Evaluation of the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) Program (April 2011). As a result, QUMAX was approved for a transition year beyond the 4CPA, and a further four years under the 5CPA. During 2014-2015, 76 organisations participated in QUMAX, 74 ACCHOs and two Aboriginal Health Services (AHSs), with a population of eligible clients reaching 218,549 Aboriginal and Torres Strait Islander clients<sup>1</sup>. QUMAX continues in the first year of the Sixth Community Pharmacy Agreement (6CPA).

#### 3.1 Aims

The QUMAX Programme aims to improve the health outcomes of Aboriginal and Torres Strait Islander people who attend participating Aboriginal Community Controlled Health Organisations (ACCHOs) in inner and outer regional and major cities, by improving the quality use of medicines through seven support categories. QUMAX is for the benefit of Aboriginal and Torres Strait Islander peoples of any age who present at participating Aboriginal Community Controlled Health Organisations (ACCHOs) or Aboriginal Health Services (AHSs). An assessment conducted by a General Practitioner determines levels of risk, particularly to adverse health outcomes that may result from issues including medication regime, pharmacy access and cultural safety.

#### 3.2 Eligibility

Locality eligibility is determined by the Rural, Remote and Metropolitan Area (RRMA) classification system<sup>2</sup>, of which there are seven categories ranging from 1 = major capital cities to 7 = very remote. ACCHOs located within RRMA 1-5 are eligible<sup>3</sup>. Remote and very remote (RRMA 6-7) ACCHOs are not included because they are eligible for Section 100 Support Allowance Programme implemented in 2002 under the Third Community Pharmacy Agreement (3CPA) and as such do not participate in QUMAX.

Because 50% of NACCHO's Member Organisations are in RRMA 6-7 locations, they cannot participate in the QUMAX Programme but do have access to the S100 Remote Aboriginal Health Services Program (S100 RAHSP).

The QUMAX Programme is intended to benefit Aboriginal or Torres Strait Islander people ('Eligible Client') of any age who present to participating ACCHOs and are assessed by a General Practitioner (prescriber) to be at risk of adverse health outcomes from a failure to adhere with their medicine regime without assistance<sup>4</sup>

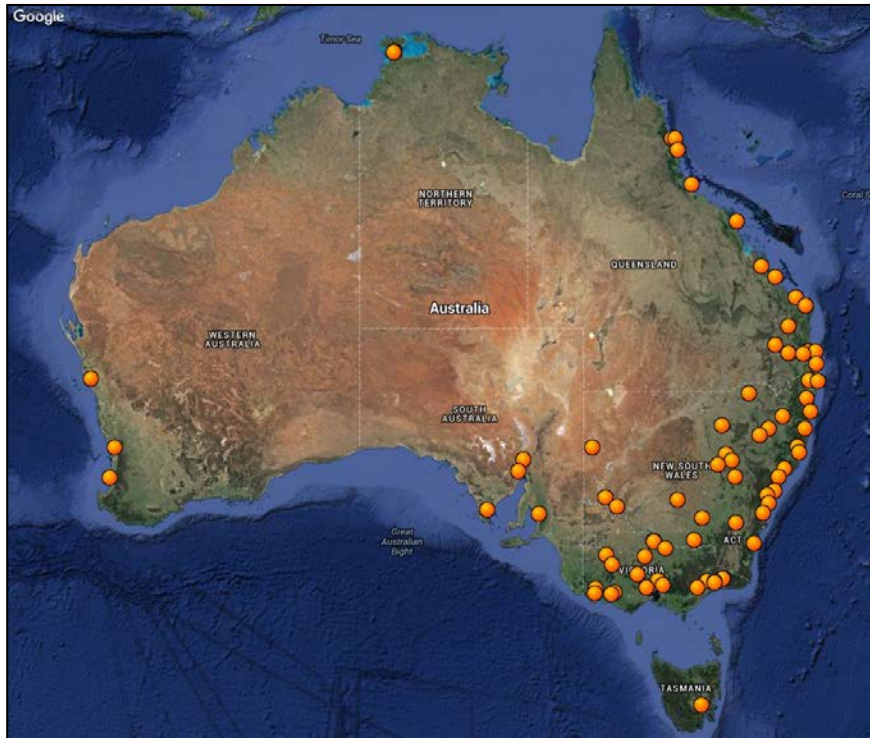
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<sup>1</sup> NACCHO Annual Report 2014-2015

<sup>2</sup> <http://www.aihw.gov.au/rural-health-rrma-classification/>

<sup>3</sup> Quality Use of Medicines for Aboriginal and Torres Strait Islander People (QUMAX) Program Specific Guidelines (Page 6). 6<sup>th</sup>

<sup>4</sup> Ibid.



**Figure 1.** Location of 76 participating ACCHOs (2014-2015).

### 3.3 Governance

The QUMAX Programme Specific Guidelines (PSG) underpin the QUMAX Programme under Community Pharmacy Agreements. The QUMAX Reference Group (QRG) governs any changes to these Guidelines. Final sign off of the QUMAX PSG is by the Commonwealth Minister for Health.

The QUMAX Reference Group (QRG) advises on Programme and resource development and policy issues of the Programme. Membership includes:

- The Pharmacy Guild of Australia (PGoA).
- National Aboriginal Community Controlled Health Organisation (NACCHO).
- The Department of Health (DoH).
- The Pharmaceutical Society of Australia (PSA).

### 3.4 Funding

The QUMAX Programme was originally funded as a two year pilot to 30 June 2010. Due to the success of the Programme it was later approved for a transition year outside the 4CPA and for a further four years under the 5CPA. Funding of up to \$11M was allocated for the period FY 2010-2015.

The 6CPA Framework to support Rural and Urban Aboriginal and Torres Strait Islander Peoples provides one year of funding, for 2015-2016, pending a Review of the Programme to be conducted by the Medical Services Advisory Committee (MSAC) for the Department of Health. The Minister for Health allocated \$2.5M for 2015-2016 for service delivery, the same as for 2014-15.

### 3.5 Categories of Support

1. The support categories are:
  - a) **Dose Administration Aid (DAA) agreement** - Aim: Reduce the financial barriers to access a comprehensive DAA service provided by community pharmacy to improve medication adherence and medication management for ACCHO clients.
  - b) **DAA Flexible Funding** - (Not introduced to QUMAX until 2013-2014).  
Aims: to provide funding to help cover the costs for transient patients.
2. **QUM Pharmacy Support** - Aim: Facilitate additional community pharmacy involvement and support in areas such as QUM planning, policies, protocol development, medicine quality assurance and appropriate Safety Net utilisation.
3. **Home Medicines Review (HMR) models of support** - Aim: Reduce the cultural and logistical barriers to access HMRs by ACCHO clients.
4. **QUM Devices** - Aim: Reduce the financial barriers of access to QUM devices to improve overall delivery of medicines and management of chronic diseases e.g. asthma and diabetes.
5. **QUM Education** - Aim: Reduce financial barriers associated with access to QUM education and health promotion for ACCHO employees and their clients. This category may also help ACCHOs access current medicine resources, promoting suitable, safe and effective medication management for ACCHO clients.
6. **Cultural Awareness** - Aim: Improve access and delivery of cultural awareness resources and training for community pharmacy to promote a culturally aware pharmacy environment.
7. **Transport** - Aim: Reduce barriers of access to medicines and community pharmacy services by providing transport support.



## 4. How QUMAX works

### 4.1 QUMAX Programme Cycle

Steps to the QUMAX annual cycle are below. A number of these steps are time dependent. The current review of programmes and services, including QUMAX, and delays in the negotiation of the 6CPA have meant significant delay in Work Plan development (Step 4) for the 2015-2016 cycle. These delays continue to have significant roll on effects, including the release of funds to ACCHOs and community pharmacies.



**Diagram 1.** The QUMAX Annual Cycle - highlighting the Annual QUMAX timeframes for Registration, developing Work Plans and Progress Reports 1 and 2.

Steps in the QUMAX Annual Cycle are:

1. Registration - Where eligible organisations declare their number of eligible patients (April-May).
2. A total QUMAX Programme budget for the year is provided by the PGoA (typically in May). An Allocation Model is used to provide a budget for each participating organisation.
3. Each organisation prepares a Work Plan (typically in July) with support from NACCHO defining how the allocated funding will be distributed, based on need, for each of the seven QUMAX support categories. A QUMAX Work Plan contains local QUM objectives for each of the seven QUMAX support categories.

Work Plans are approved in three stages:

1. Approval by NACCHO.
2. Approval by the PGoA.
3. Approval by the Department.

Following approval by the Department of Health, the Department notifies the PGoA and the PGoA prepares Contracts to be signed and returned to the PGoA by ACCHOs. Return of the signed contract to the PGoA signals release of the first payment of funds, 50% of the annual Budget, to the participating organisation.

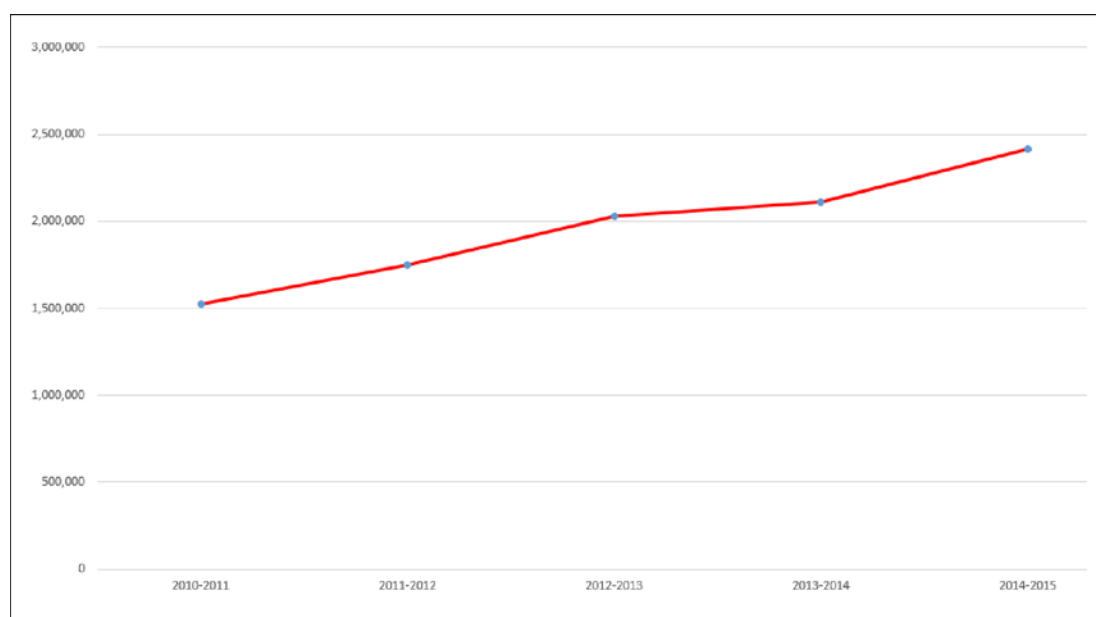
Unapproved Work Plans are returned by the Department to NACCHO via the PGoA for clarification or amendment with the relevant ACCHO. NACCHO works with the ACCHO to revise and re-submit the Work Plan. The Work Plan is then re-submitted to the PGoA and the Department.

Each of the participating organisations provides NACCHO with an implementation Progress Report 1, typically in January. This Report is initially reviewed, approved or approved after clarification by NACCHO and referred to the PGoA for final approval against the Work Plan. Following approval, the remaining 50% of Budget is released by the PGoA to the participating organisation.

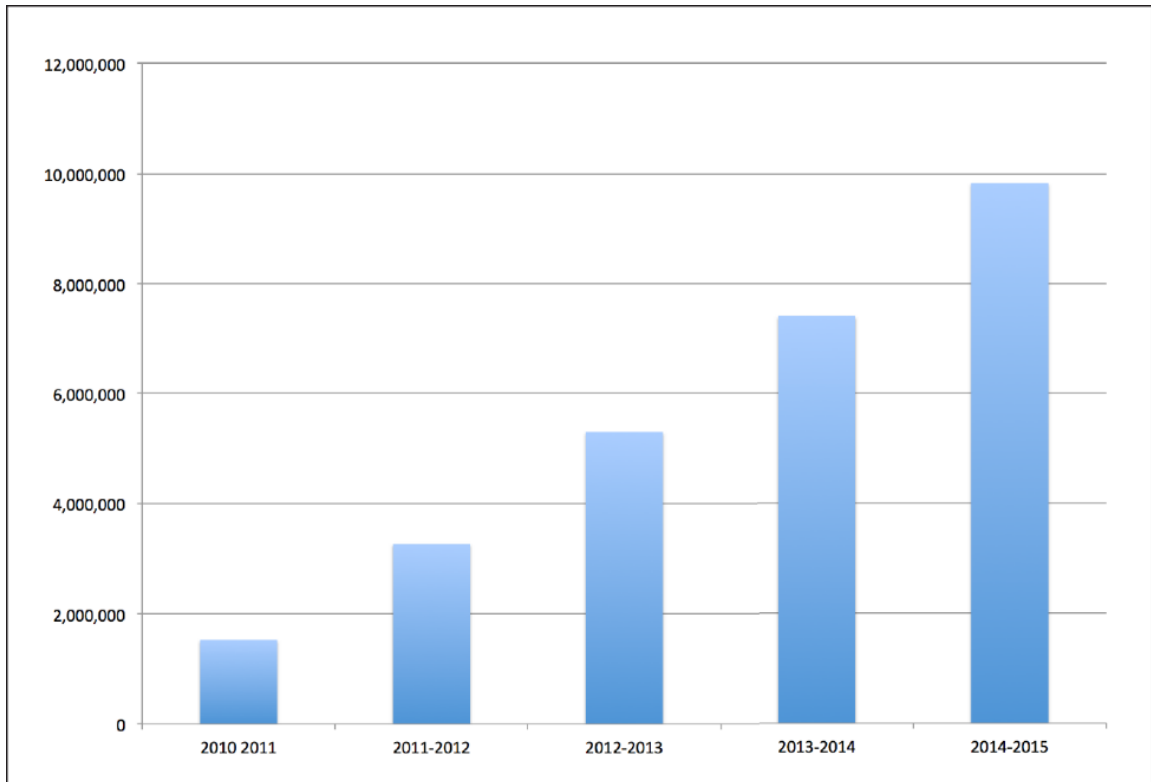
A second Progress Report is submitted in July. After the acceptance of the second Progress Report by NACCHO and PGoA, NACCHO and the PGoA prepare an acquittal for ACCHOs based on both Progress Reports. The ACCHOs review, update as necessary with NACCHO and PGoA and provide an approval of the Acquittal.

## 4.2 Funding per annum

Funding for QUMAX was capped at \$11M over five years. Within this budget there has been a staged release of funds in line with the number of participating ACCHOs and number of eligible clients. Levels of annual funding are shown in *Figure 2*.



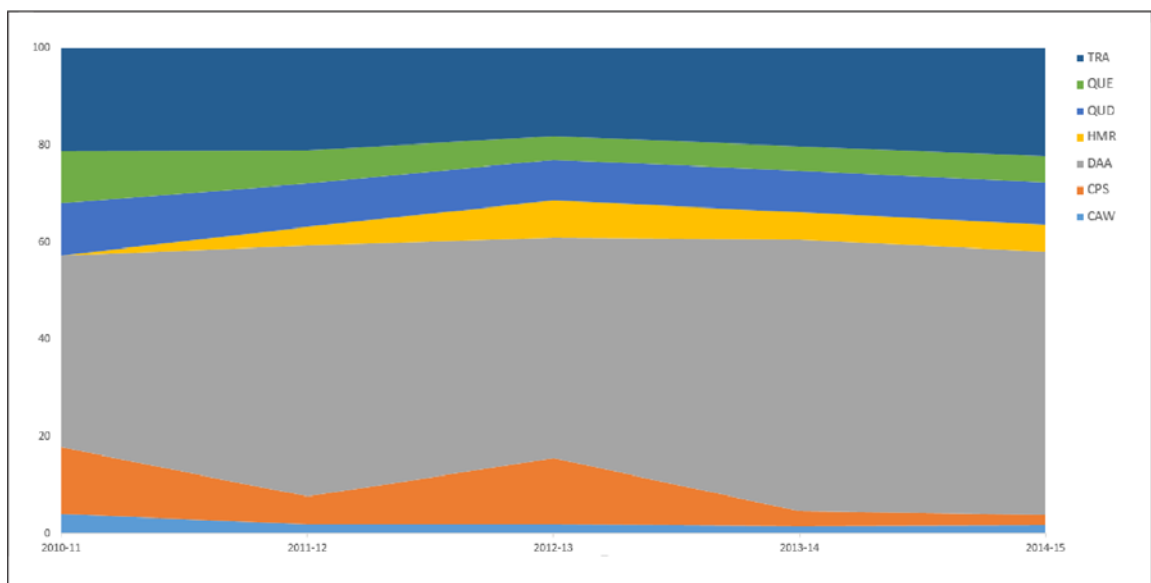
**Figure 2.** Annual funding 2010-2015.



**Figure 2a.** Annual funding on a cumulative basis.

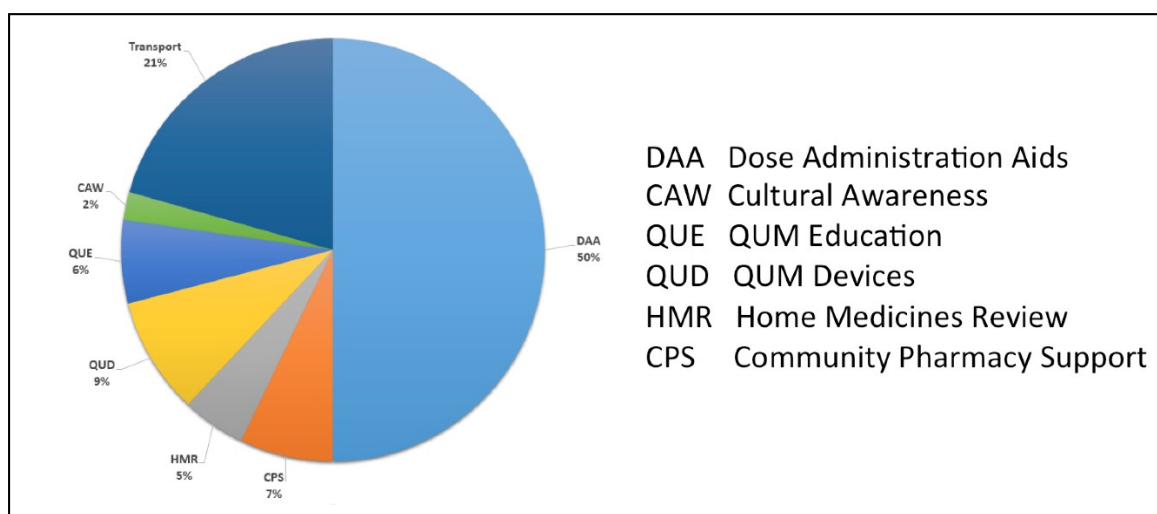
### 4.3 Pattern of Funding 2010-2015

The seven QUMAX Categories of funding shown in *Figure 3* are for (from top to bottom): Transport (TRA), QUMAX Education (QUE), QUMAX Devices (QUD), Home Medication Review (HMR), Dose Administration Aids (DAA), Community Pharmacy Support (CPS) and Cultural Awareness training (CAW).



**Figure 3.** Pattern of annual funding for QUMAX Categories.

## 4.4 Average funding by Category



**Figure 4.** Proportion of funding allocated to each of the QUMAX Categories 2010-2015.

- **Dose Administration Aids (DAA):** DAA is the highest proportion of QUMAX funding across all five years. Clients with chronic disease are evenly spread regardless of outer or inner regional or major cities.
- **Transport:** The second highest proportion of funding indicates that clients' requiring access to a community pharmacy or medication experience barriers to access. Transport under the QUMAX Programme is only for clients accessing a community pharmacy.
- **QUM Devices (QUD):** Proportion of funding allocated is QUM Devices which could indicate that chronic disease clients' are the highest need (third highest funding category).
- **QUM Education (QUE):** QUM Education supports education regarding quality use of and medication interaction delivered by a pharmacist or qualified educator. It targets chronic disease and any client requiring medication.
- **Home Medicines Review (HMR):** HMR is highest in inner regional areas and lowest in cities.

There is a clear and high demand for three of the categories – DAAs, QUM Devices and Transport. This indicates demand for adherence support services to clients for these three categories.

## 4.5 Regional Distribution

There are many different measures to define regions. For the purpose of planning at a national level, the PGoA has developed a composite value allocated to geographic localities (PhARIA). QUMAX uses RRMA and NACCHO uses the current Australian Statistical Geography Standard Remoteness Classification (ASGS-RA).

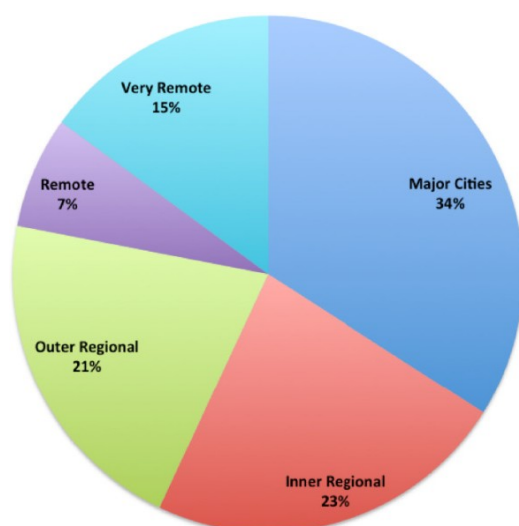
The PhARIA is a composite index which incorporates measurements of general remoteness, as represented by ARIA+ (released in 2000) with a professional isolation component represented by the road distance to the five closest pharmacies. The location of over 13,000 populated localities were used in the development of this index<sup>5</sup>

Eligibility for QUMAX funding is determined by an ACCHO's location in relation to Rural, Remote and Metropolitan Areas (RRMA). The classification was developed in 1994 and is currently under review<sup>6</sup>. Actual dollar allocations to ACCHOs are then determined by client numbers.

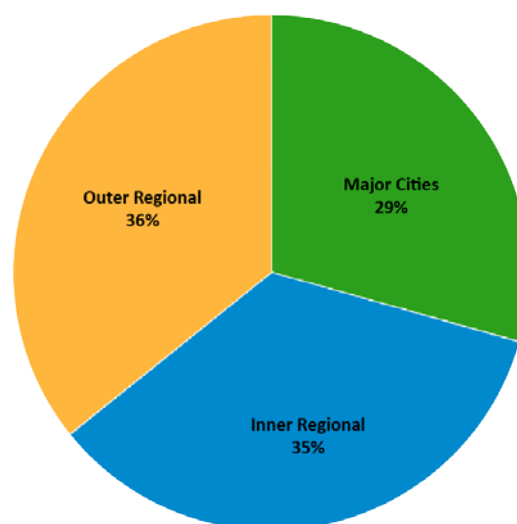
For the purposes this Report Back to Members, the ASGS Remoteness Structure (ASGS-RA) is used. ASGS-RA is used by NACCHO to classify Member Services by remoteness, in line with reports on Indigenous Health published by the Australian Institute of Health and Welfare, Department of Health and the Office of Prime Minister and Cabinet. ACCHOs participating in QUMAX are in three groups: Major cities, inner regional or outer regional<sup>7</sup>.

Figures 5-8 illustrate Indigenous population demographics by ASGS-RA showing that 78% live in three focus RAs for QUMAX (Figure 5) and the proportion living in each of the focus RAs for QUMAX (Figure 6). Figure 7 shows the Indigenous age/gender distribution by RA highlighting the high proportion of Indigenous people aged under 20 compared to the total population shown in Figure 8. It is also noted that the Indigenous population trend is one of decline after those in the 15-19 band, whereas there is an increase in the total population.

The figures are included to show that a “wave” of Indigenous children and young adults will be likely to be placing a sustained and increasing demand on and for programmes such as QUMAX if the well-established pattern of the burden of disease with age amongst Indigenous people continues.



**Figure 5:** Distribution of Aboriginal people All Remoteness Areas (ASGS-RA) 2011 Census.



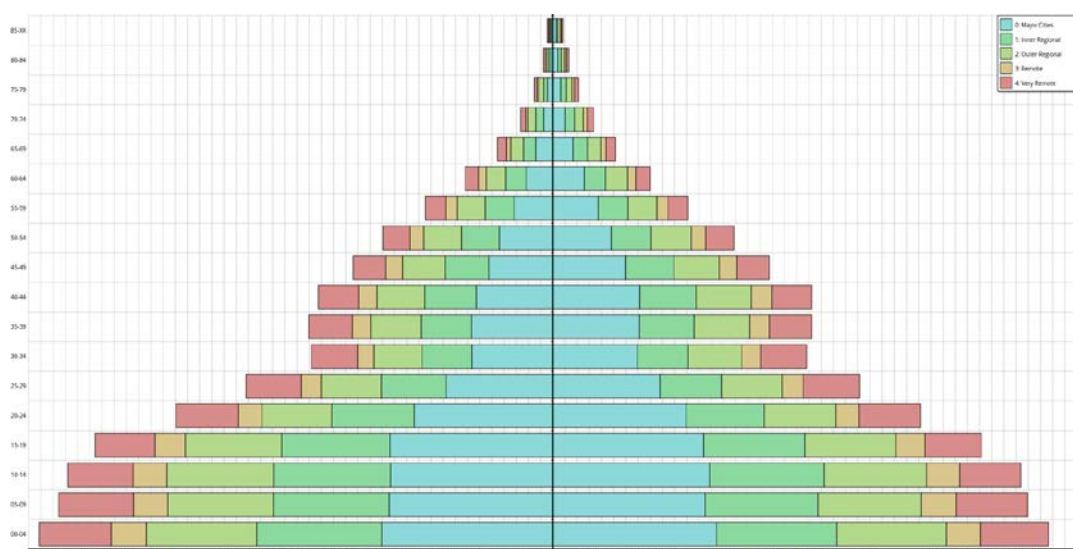
**Figure 6:** Distribution of QUMAX Clients within the three RAs eligible for QUMAX namely Major Cities, Inner Regional and Outer Regional.

<sup>5</sup> [www.adelaide.edu.au/apmrc/research/projects/pharia/pharia-info.html](http://www.adelaide.edu.au/apmrc/research/projects/pharia/pharia-info.html)

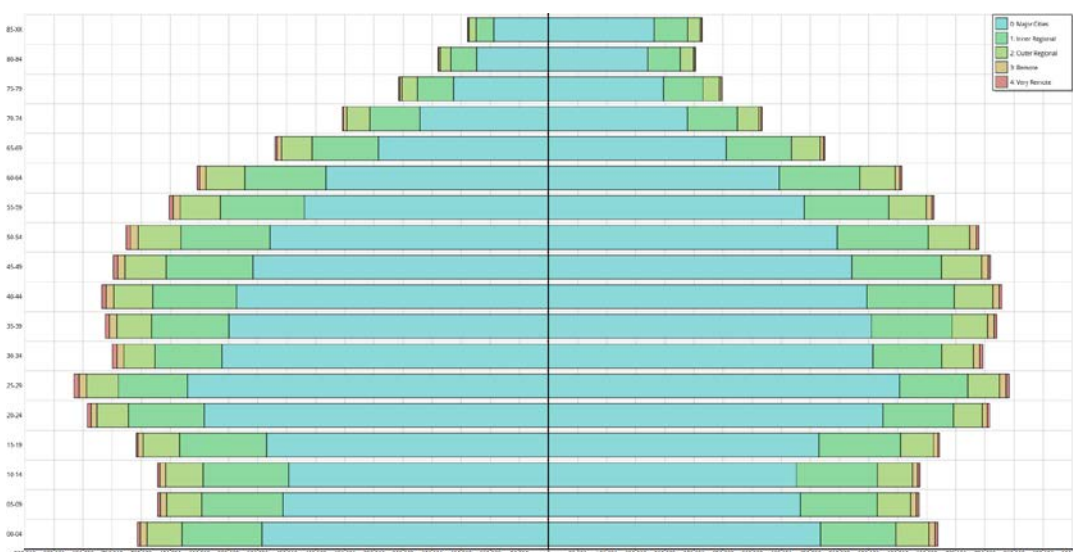
<sup>6</sup> [www.aihw.gov.au/rural-health-rrma-classification/](http://www.aihw.gov.au/rural-health-rrma-classification/)

<sup>7</sup> [www.abs.gov.au/websitedbs/D3310114.nsf/home/remoteness+structure](http://www.abs.gov.au/websitedbs/D3310114.nsf/home/remoteness+structure)





**Figure 7.** Indigenous Age Gender pyramids by Remoteness Area using 2011 Census. Males (left), Females (right) from the centre out Major Cities (blue), Inner Regional (green), Outer Regional (lime), Remote (buff) and Very Remote (faded red).



**Figure 8.** Non-Indigenous Age Gender pyramids by Remoteness Area using 2011 Census. Males (left), Females (right) from the centre out Major Cities (blue), Inner Regional (green), Outer Regional (lime), Remote (buff) and Very Remote (faded red).

## 4.6 Flexible Funding

DAA Flexible Funding as a sub category for support was introduced to the QUMAX Programme in 2013-2014 (See Section 5.1 Category 1b).

This category provides an option for ACCHOs to retain DAA category funding and pay community pharmacies on delivery of an invoice from them, which details the number of clients and DAAs provided. In 2014-2015, a number of ACCHOs began to utilise the funding category 1b Flexible Funding. This category also allows for growth in DAA

clients outside of DAA Contracts each year and clients who prefer to select their own pharmacy.

The advantage of this arrangement for improving data collection is apparent. The ACCHOs which adopt DAA Flexible Funding will have the capacity to report back to NACCHO on actual client numbers, as well as actual DAAs related to their organisation and their annual budget. This is significant for determining performance across ACCHOs in different geographies and enables redistribution of underspends to other QUMAX Categories where needs are identified, following approval from NACCHO.

## 5. Data and Reporting

The QUMAX Programme's online reporting data portal enables lodgement of Registration, annual Work Plans and semi-annual Progress Reports.

During 2011-2012, the QRG (QUMAX Reference Group) agreed to reduce the reporting requirements for ACCHOs. This was implemented in the 2012-2013 financial year.

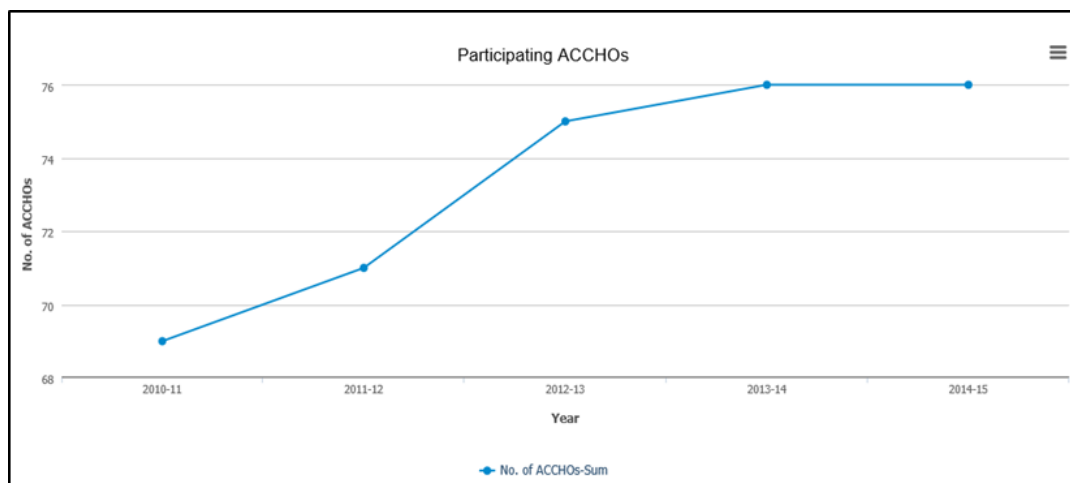
This change affected opportunities for the time series analysis for the full five years of the 5CPA, that is, 2011-2015. As a result, data analysis undertaken for the seven QUMAX Categories has only been possible for the last three years (2013-2015). However, analysis of financial information covers the full five-year period (2011-2015).

## 6. Participation in QUMAX

### 6.1 Introduction

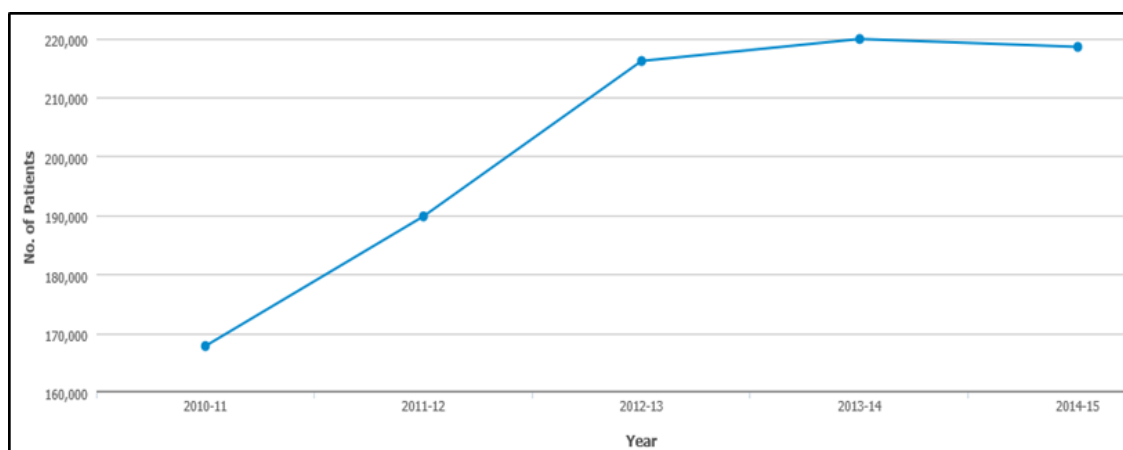
In this section of the Report Back, graphical analysis has been presented for the first time on the highly successful uptake of the QUMAX Programme. Four graphs, (*Figures 9 and 10*), pie chart (*Figure 11*) and a table (*Table 1*) are presented, each of which tracks or provides a trend analysis on key performance measures of the QUMAX Programme.

### 6.2 ACCHOs Participating



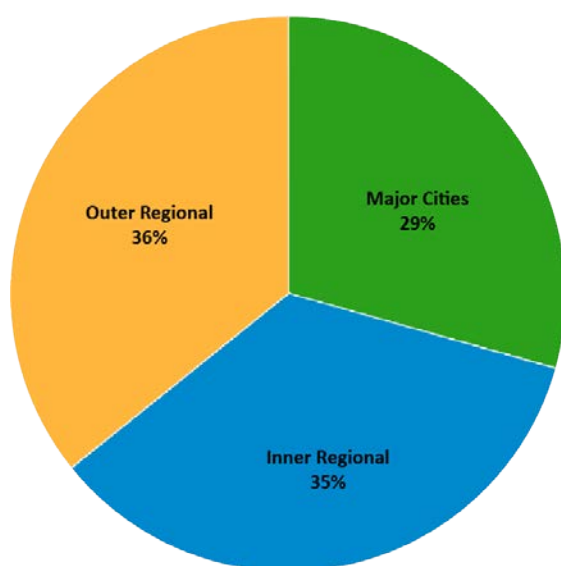
**Figure 9.** Number of ACCHOs participating in QUMAX 2010-2015.

### 6.3 Number of Eligible Clients: Total number of eligible clients



**Figure 10:** Number of Eligible Patients 2010-2015.

## 6.4 Eligible clients by remoteness



**Figure 11:** Proportion of Eligible Patients by Remoteness Area 2010-2015.

## 6.5 Number of participating Pharmacies under contract and distance from ACCHOs

QUMAX has been very effective in improving access to community pharmacies (cp), as the table below indicates:

Number of contracted Community Pharmacies (CP): 508				
	Within 1km	1-10kms	10-50km	50+km
<b>% of (cp) by distance from ACCHO</b>	19%	50%	24%	7%

**Table 1:** Number of contracted community pharmacies and proportion within distance bands from participating ACCHOs.



## 7. ACCHO delivery within the Support Categories

*"The introduction of the QUMAX program has dramatically increased the medication compliance of residence of Cherbourg. Prior to the introduction of the QUMAX Programme no residents were receiving DAAs. The number of residents now receiving DAAs is in excess of 120. This fact alone is evidence of just how important the QUMAX programme has been for the residence of Cherbourg."*

- Curtis Mickan, Community Pharmacist, Murgon, QLD

### 7.1 Dose Administration Aid (DAA)

A DAA Agreement is a three-way Agreement between the 75 ACCHO members of NACCHO and two Aboriginal Health Services (AHS), local community pharmacies and the PGoA. Contracted DAAs are based on a pre-defined number of clients and cost per DAA.

In the order of \$5M worth of DAAs have been subsidised through QUMAX to date. This represents a significant public health intervention that is evidence-based and clearly valued by participating communities and patients.

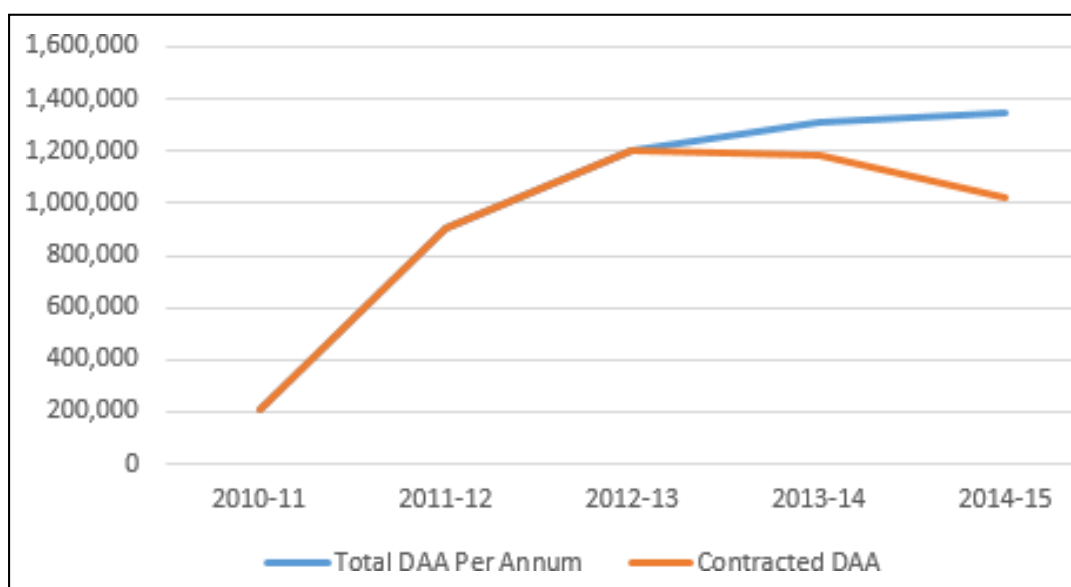
The Flexible DAA Funding support sub-category (mentioned in Section 4.6 above) provides for pharmacies to be paid by the ACCHO on presentation of an invoice for the number of patient presentations and service(s) delivered, rather than payment based on a pre-determined allocation of funding based on the ACCHO's PGOA approved Work Plan.

DAAs are generally provided to clients' requiring complex medications. Funding allocations for DAAs consume the highest proportion of QUMAX funding across all five years.



Figure 12. Example of a Dose Administration Aid (DAA) – Webster/Blister Pack.

The figure below shows the cost (\$) of DAAs per year provided under the QUMAX Programme during the years 2011-2015. Clients receiving DAAs are evenly spread regardless of rural, regional or urban settings.



**Figure 13.** QUMAX Programme cost (\$) of Contracted DAAs 2011-2015 via DAA Agreements showing Flexibly Funded DAAs (blue).

## 7.2 QUM Pharmacy Support

Between 2011-2013, the Community Pharmacy Support category included direct funding for Quality Use of Medicine Support Pharmacists (QUMSP) to be paid to provide advice to ACCHO staff about services available at their QUMAX registered pharmacies.

Since direct funding for the QUMSP role was cut, some ACCHOs have found it beneficial to staff and patients to allocate some QUMAX Programme funding to enable Pharmacists to advise ACCHO staff on the Quality Use of Medicines. Advice is particularly valuable to staff where their patients, on discharge from hospital, have a large range of medications that need to be acquired and managed.



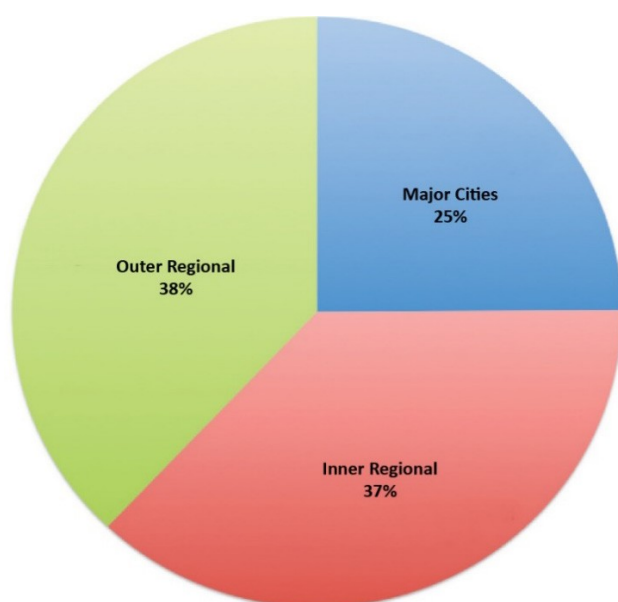
**Figure 14.** Galambila Consultant Pharmacist Client Post Discharge Medications.

### 7.3 Home Medicines Review (HMR)

During 2013-2015, ACCHOs reported that 2,779 HMRs were assisted under the QUMAX Programme. *Figure 15* indicates the breakdown of HMRs assisted under the QUMAX Programme by Inner Regional, Outer Regional and Major Cities.

Outer Regional indicates the highest uptake of HMRs with 1,055 HMRs or 38%. The higher proportions in both Inner Regional (37%) and Outer Regional suggest access to the ACCHO and community pharmacies is a barrier compared to Major Cities (25%) and that pharmacists are conducting more HMRs as a result.

Inner and Outer Regional areas have the highest occurrence of Community Pharmacy Support in the QUMAX Programme, this category may include a Pharmacist engaged as an employee of the ACCHO (see Section 7.2). Community Pharmacy Support Pharmacists are able to build relationships with ACCHO staff such as GPs, nurses and AHWs as well as clients and provide education in relation to HMRs, all of which enhance the uptake of an HMR.



**Figure 15.** Proportion of HMRs provided by Remoteness Area (2010-2015).

*"Through the HMR support category of the QUMAX Programme, Njernda was able to expand our Home Medicine Reviews and increase client uptake from no HMRs to a total of 15 in a six-month timeframe. Under the Programme 'incentive' we were able to provide a fruit and vegetable basket for each client to thank them for the Pharmacist being able to do their medicines review in their home with an Aboriginal Health Worker. Our clients with chronic disease have multiple medications and we have been able to raise awareness of the Home Medicines Review Programme in our Community through QUMAX."*

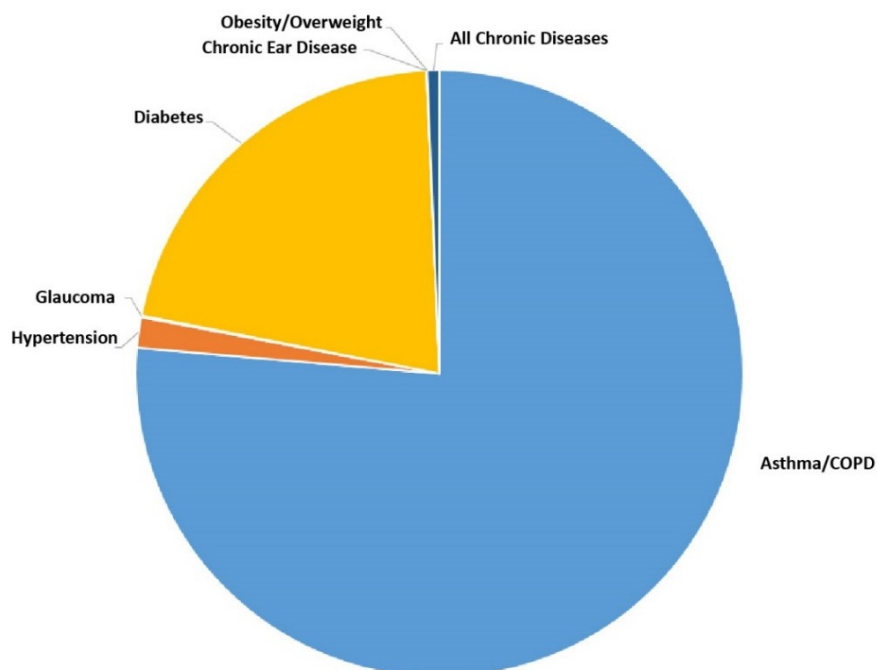


*- Anne Munzel, Practice Manager, Njernda Aboriginal Corporation, Victoria, and member of the NACCHO Lead Clinicians Group  
Curtis Mickan, Community Pharmacist, Murgon, QLD*

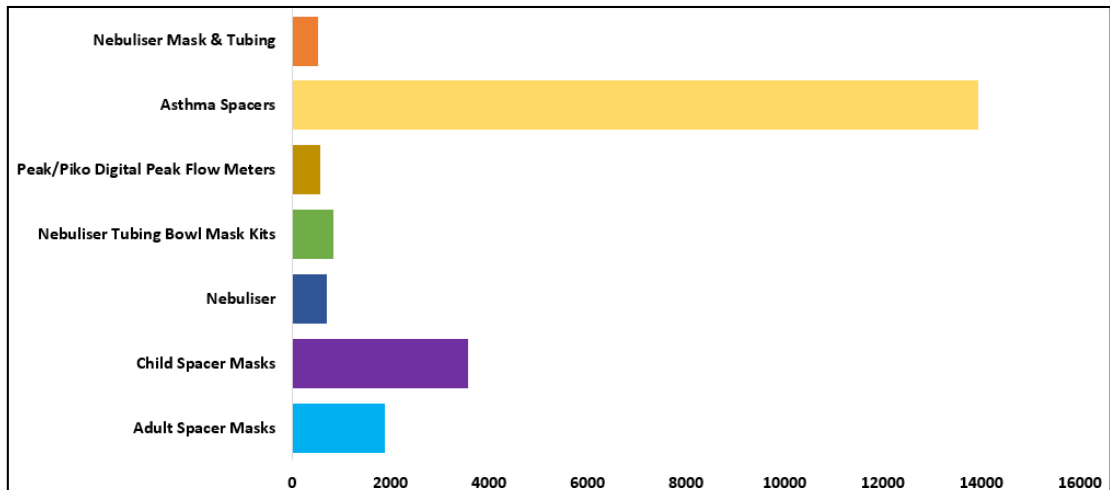
## 7.4 QUM Devices

Assistance under the QUMAX Programme includes funding for an Aboriginal Health Worker to attend the HMR, small incentives for clients such as a Fruit and Vegetable Voucher, as well as HMR Awareness Sessions for ACCHO and AHS clients and staff. Pharmacists are also provided with nominal payments for clients who are unable to keep the appointment, i.e. a no-show fee.

Figure 16 below shows the number of devices classified by the disease(s) with which the devices are most closely associated. The principal use of devices is with those who have airways disease, such as asthma or COPD.



**Figure 16.** QUM Devices by type of disease(s).



**Figure 17.** Types of devices provided to those patients with asthma/COPD, the most prevalent group of diseases.



**Figure 18.** QUM Devices, Asthma Education: Photo provided by Galambila Aboriginal Health Service. Laura Little – Galambila Consultant Pharmacist (pictured right) with Galambila staff and clients.

## 7.5 QUM Education

QUM Education is provided by a Pharmacist or qualified educator, e.g. diabetes educator. This category supports education for patients and staff for quality use of medicine; most education sessions target those either with chronic disease(s) or those involved in supporting patients using medication.

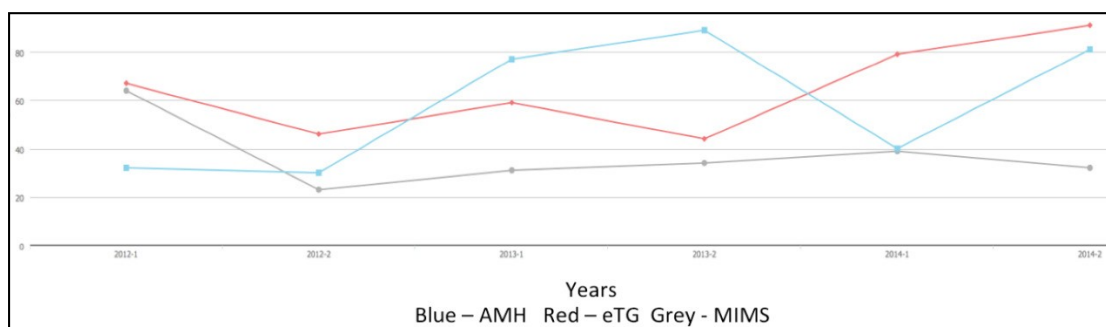


*"The QUMAX program has given me, as an independent consultant Pharmacist, the opportunity to share a unique relationship with my local Aboriginal health service – Galambila in Coffs Harbour.*

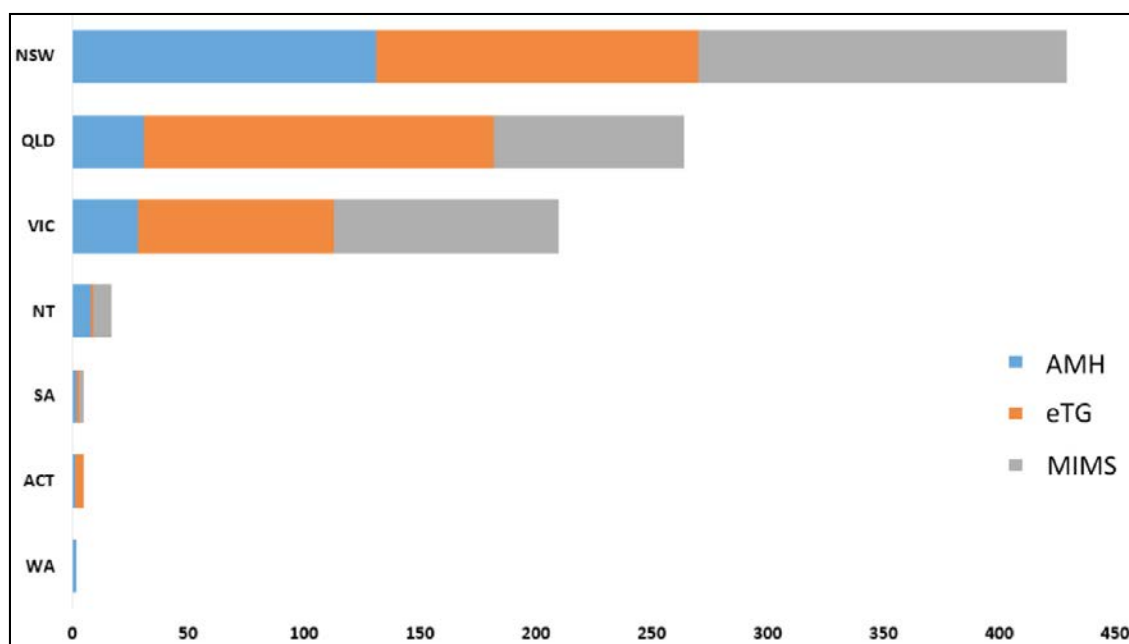
*The Community Pharmacy Support part of QUMAX has been vital for building and maintaining excellent relationships between Galambila and the some 20 local pharmacies that they deal with on a regular basis. Not only has a vastly improved and more effective working relationships been built, but also one of deeper, cultural respect. For example, I have personally been able to introduce both Aboriginal Health Workers and our clients to individual pharmacies, increasing both the trust for our clients and the likelihood of compliance with medications. I know that I have come in handy as I am always asked to explain about medications and prescription issues (e.g. CTG and Safety Net) to my Galambila colleagues and the community. In much the same way, I often get phone calls from pharmacies asking for support and advice when it comes to particular script or client needs. This would not have been possible without the QUMAX programme.*

*The QUMAX QUM Education has allowed me to conduct regular medication education sessions at Galambila, aiming at both the community and clinical staff level. My presentation about skin care and medications at a Galambila Elder's group sparked great interest from the clients and the local pharmacies were able to assist by providing samples to try."*

*- Laura Little, Consultant Pharmacist, Galambila Health Service, NSW*



**Figure 19.** Proportion of QUMAX Education funding allocated to licensed online information resources about medicines used in prescribing, for the years 2010-2015.



**Figure 20.** Number of Resources (licences) purchased at the jurisdictional level.

Figure 20 illustrates the use of the different medicines information resources in the states and territories and clearly illustrates the demand for training in medicines information.

## 7.6 Cultural Awareness

*Under the QUMAX Programme in 2014, Armajun Aboriginal Health Service in Inverell NSW utilised the Quality Use of Medicine Education and Cultural Awareness support categories to engage 30 clients in a Community Information Day focused on quality use of medicines, Home Medicine Reviews (HMR) and managing chronic disease. A local Community Pharmacist attended with their staff and met with clients, under guidance of ACCHO staff for culturally safe engagement.*

*Armajun, via the QUMAX Programme, provided incentives to clients to attend. These incentives included transport and fruit and vegetable vouchers. A significant outcome was the collaboration between the community pharmacy and Armajun working together to support Armajun's clients to ensure medicine compliance in a safe and welcoming environment.*

- NACCHO 2013-2014 Annual Report (p57)

## 7.7 Transport

This funding category is utilised by nearly all participating ACCHOs and AHSs.

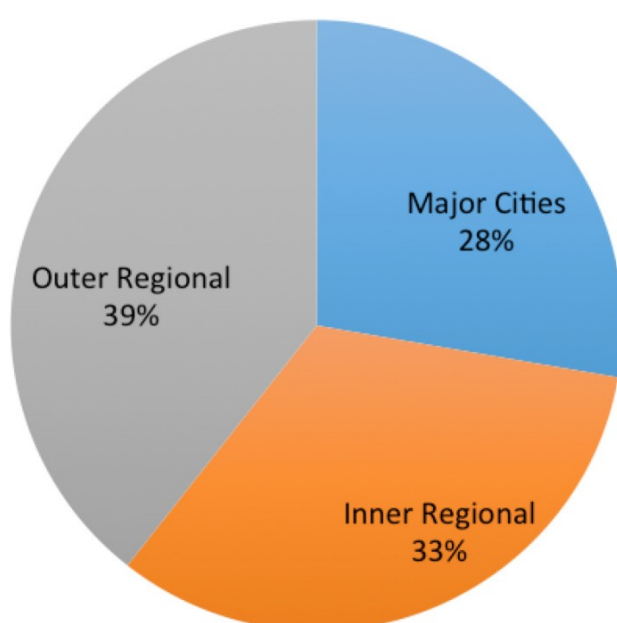
Transport funding support is available via three options:

- **Option 1:** Costing based on a set cost per kilometre (ATO rate) travelled for ACCHOs and AHSs that fund transport for clients to attend consultation at the ACCHO or AHS and then take them to the community pharmacy to have scripts filled or deliver medications and DAAs;

- **Option 2:** Costing based on allocating funds to cover the cost of a transport driver; or
- **Option 3:** Costing based on car running costs, such as registration, insurance and maintenance.

*“Yarrabah’s model of health care is a holistic model of service delivery for our clients. It involves a team approach across all areas and programmes, including social and emotional wellbeing and culturally appropriate health care, programmes targeting men’s, women’s, children’s and youth areas and quality use of medicine. QUMAX supports our model of care, particularly for clients with Chronic Disease - especially DAAs and medication management, most of our funding is used for DAAs. We also apply funding to transport so that our clients can access Yarrabah and Pharmacy support services and the community pharmacy regularly”.*

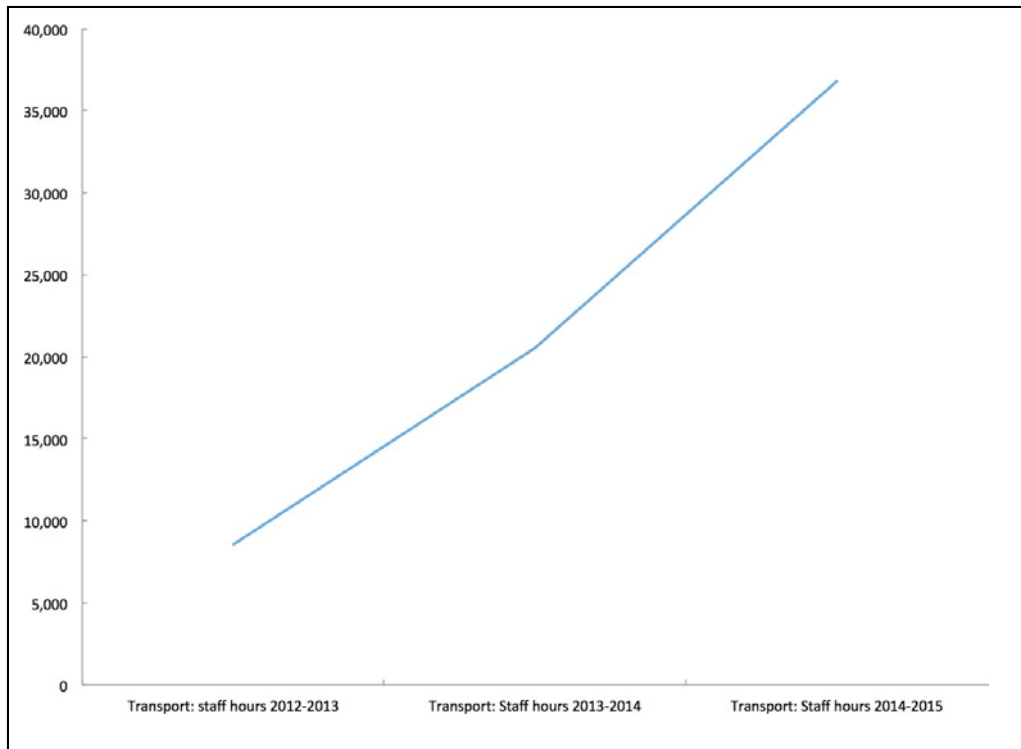
- Paul Munn, Manager Primary Health Care, Gurriny Yealamucka Health Service.



**Figure 21.** Total actual expenditure on transport proportioned by ASGS-RA.

The physical location of health services is a very well established factor that strongly influences client access. QUMAX has had a significant impact on enabling clients to have improved physical access to pharmacies and community demand is growing.

Participating ACCHOs reported the number of kilometres travelled for and staff time spent on transport. The total distance travelled for 2013-2015 is just over 1,000,000 kms with 457,000 of those being undertaken in 2014-2015. The trend in staff hours dedicated to transport has risen significantly during the period 2013-2015 as shown in Figure 22.



**Figure 22.** *Number of Staff Hours dedicated to transport.*

## 8. ACCHOs' Investments – Overspends responding to Budget Limitations

*"QUMAX enables GRAMS' clients to receive Webster Packs supporting their medication management and quality use of medicines. Current QUMAX funding covers 193 of our clients to receive a DAA in the 2015-2016 financial year but the number of clients who need a DAA is 274. While the current funding is a benefit to clients' of GRAMS, growth in funding would ensure our need for 274 clients being met. Without the QUMAX Programme the risk of medication misuse would be an impact for our clients."*

- Deborah Wood, CEO, Geraldton Aboriginal Medical Service, Western Australia.

During 2013-2015, NACCHO collected evidence of higher spends by a large number of participating ACCHOs which had co-invested in the QUMAX Programme Support Categories:

- Due to the positive outcomes being realised by their clients; and
- Due to the inadequacy of the levels of QUMAX Programme funding globally.

However, this voluntary Programme overspend, see *Table 2*, utilising the self-generated funds from MBS claimed income of ACCHOs, is acknowledged by ACCHOs as not being sustainable. It should be seen as an interim measure pending a larger Budget for QUMAX hopefully, following the Programme's Review by the Medical Services Advisory Committee.

	2013-2014	2014-2015
<b>Number of ACCHOs providing additional funding for QUMAX supported Categories.</b>	64	57
<b>Total \$ overspend</b>	\$80,605	\$426,918

**Table 2.** ACCHO Voluntary Overspends



## 9. Improvements to QUMAX indicated by the Review

NACCHO has undertaken this internal review to consolidate the data, knowledge and understanding of the QUMAX Programme to inform NACCHO Member Services. This internal review has already resulted in the implementation of improvements to both processes and systems. The resulting actions have enhanced monitoring and reporting for the NACCHO Programme Manager.

Funding surety and the timing of fund allocations is a persistent issue. The number of ACCHOs and community pharmacies registering and the number of patients eligible to engage with the Programme determine the quantity of QUMAX funds that can be provided for an organisation. Delays in Registration cause delays in allocating funding and development of Work plans.

2015-2016 has been a particularly difficult year due to delays in notification of the funding package for the period because of negotiations in relation to the 6th Community Pharmacy Agreement. However, support from participating organisations has been so strong that the Programme has been continued by ACCHOs and community pharmacies from 2014-2015 into 2015-2016 using their own interim funding, confident that the Programme would be funded.

Consolidation and analysis of the financial activities and processes for the QUMAX Programme over the past five years provide a solid base for considering a number of improvements to the administration of the Programme and to data collection and reporting. These recommended improvements are:

1. Pre-fill on-line forms with values based on previous submissions and performance. This will address a number of concerns raised by participants:
  - i. It will reduce the amount of time taken to submit Registration details, receive feedback for actual funding, and to develop Work Plans;
  - ii. It will improve the efficiency of the processes of the NACCHO and PGoA QUMAX Coordinators.
2. NACCHO will make use of the graphical analysis in this Report to Members, showing funding allocations across the seven elements of QUMAX, to enhance evidence-based discussions about the overall budget needs for the Programme. The more active an ACCHO and a community pharmacy are in promoting access to QUMAX, the smaller the amount of money that is available to each Aboriginal and Torres Strait Islander client. This is an illogical policy whereby success and effectiveness are financially penalised.
3. NACCHO has received feedback that a number of new technologies have become available to patients eligible for QUMAX. These technologies include: blood pressure and sugar level measuring devices; sleep apnoea machines; and apps for smart phones. These devices/technologies have the ability to send patient-specific data to the ACCHOs and community pharmacies which improves their capacity for pro-active wrap-around services. The funding for the QUMAX Programme needs to be adapted to reflect these new technologies.
4. The current Programme reports support accountability and activities to be documented in accordance with the current Programme Guidelines as approved by the Minister for Health. However, NACCHO is aware of deficiencies in the current Programme Guidelines wherein the outcomes of the QUMAX-sponsored interventions are not recorded. What has been measured historically are inputs and activities. This would be a significant

change to “Programme Policy” that NACCHO would have to take forward to its partner, PGoA, and to the Department of Health.

5. QUMAX has established a robust platform of relationships for service delivery around optimum use of medicines. QUMAX has the capacity to be extended for new methods of health education and ‘medications literacy’. It is possible that this platform might be involved in the Pharmacy Trials Programme under 6CPA to help achieve Minister Sussan Ley’s goal of transformative, innovative and flexible patient-centred pharmacy services more firmly embedded into primary health care.

## 10. Other Pharmacy related considerations

The separation of access to medicines based on the application of RRMA classifications has long been a concern to the ACCHOs and their patients.

- QUMAX is available for RRMA urban and rural areas (ASGS-RA Major Cities, Inner Regional and Outer Regional),
- S100 Remote Aboriginal Health Services Program (S100 RAHSP) for RRMA Remote and Very Remote (ASGS-RA Remote and Very Remote), and
- Closing the Gap (CTG) PBS Co-payment Measures, which allow eligible patients access to more affordable PBS medicines.

A summary of the S100 RAHSP and CTG eligibility conditions are outlined below with two recommendations from the NACCO PGoA Joint Position Paper (2015). The paper is entitled, Closing the Gap Pharmaceutical Benefit Scheme Co-Payment Measure (CTG PBS Co-payment) – Improving access to Pharmaceutical Benefits Schedule Medicines for Aboriginal and Torres Strait Islander People, a copy of which is as Appendix 1.

- i. The S100 Remote Aboriginal Health Services Program (S100 RAHSP) for RRMA 6-7 locations. An AHS is defined as: “A State/Territory or Community Controlled organisation which provides primary health care services to Aboriginal and/or Torres Strait Islander people”, i.e. includes ACCHOs. Under the provisions of Section 100 of the National Health Act 1953, clients of approved remote area AHSs are able to receive medicines from the AHS, without the need for a normal PBS prescription form, and without charge. Clients of around 170 remote area AHSs, including Aboriginal community controlled AHSs and remote services operated by the States and Territories, benefit from improved PBS access through these arrangements. An approved AHS could also access S100 PBS medicine supply arrangements for Outreach Clinics, called “Outstations”. These are defined as: “... a remote permanent health service of a primary AHS that participates in the s100 supply arrangements, staffed by at least one permanent healthcare worker, where prescription only (Schedule Four) medicines are stored in compliance with an approval issued by the relevant State/Territory health authority.” Participating AHSs order required PBS pharmaceuticals from pharmacies, which transmit claims to Medicare Australia for reimbursement. There is no need for AHSs to make payments to pharmacies for the majority of medicines obtained under these arrangements.
- ii. The Closing the Gap PBS Co-payment Measures allow patients access to more affordable PBS medicines by attending a registered general practice that participates in the Indigenous Health Incentive (IHI) under the Practice Incentives Program (PIP) or a registered non-remote (major city or regional) Indigenous Health Service. After checking a patient’s eligibility, general practitioners working in Aboriginal Health Services or mainstream general practices participating in the IHI register the patient in the measure. Once a patient is registered, prescribers annotate their prescription by software or hand to indicate that it is to be dispensed with co-payment relief. Upon presenting a correctly annotated prescription to a pharmacy for dispensing, eligible patients who would normally pay the full PBS co-payment will pay the concessional rate. Those who would normally pay the concessional price will receive their PBS medicines without the requirement to pay any PBS co-payment.

NACCHO and the PGoA have proposed comprehensive, practical reforms in a Joint Position Paper [2015]. Example recommendations include:

- Linking eligibility to the Medicare Card would enable residents living in remote locations who access medicines through the S100 Remote Aboriginal Health Services Program (S100 RAHSP) to automatically access CTG prescriptions when travelling in rural and urban locations. This is currently not available and, therefore, limits an individual's ability to travel and or have timely and affordable access to medicines in the event of travel.
- Aboriginal Health Services in remote locations cannot currently provide both CTG prescriptions and medicines under the s100 RAHSP. These services should be able to provide services at their own discretion based on the needs of the patient whether under the S100 RAHSP or the CTG-PBS co-payment measure.

## 11. Acknowledgements

NACCHO acknowledges:

- ❖ The Department of Health for funding QUMAX
- ❖ The Pharmacy Guild of Australia as the funds holder and partner in assuring delivery of the Programme
- ❖ The dedication of ACCHOs to achieve maximum engagement with eligible clients
- ❖ The consistent cooperation and professionalism of the community pharmacies for dispensing medicines but also advice to ACCHO staff and patients.

**Appendix:** NACCHO PGoA Joint Position Paper (2015), Closing the Gap Pharmaceutical Benefit Scheme Co-Payment Measure (CTG PBS Co-payment) – Improving access to Pharmaceutical Benefits Schedule Medicines for Aboriginal and Torres Strait Islander People.