Feedback and queries regarding: Update for stakeholders on implementation of the aged care on-site pharmacist measure

Role of the on-site pharmacist

- It should be made clear that there is separation of supply from the role of the on-site pharmacist.
- To provide some consumer-centred focus, this description should include some part of education to residents and family/caregivers/substitute decision makers about their medications.

1.1 Aged care on-site pharmacist measure – Funding Administration

- We are concerned about the level of independence of the credentialed pharmacist if they are paid via the community pharmacy, which operates as a for-profit business whose activity is derived from the sale of medicines, complementary medicines and other products.
- Deprescribing in older patients is supported by evidence to improve outcomes and reduce polypharmacy and medication-related adverse events, however this funding mechanism may not incentivise deprescribing practices.

1.2 Aged care on-site pharmacist measure – Funding

- Needs to be clear that the community pharmacy should not be allowed to withhold a portion of salary from the on-site pharmacists as a fee for funding administration.
- The credentialed pharmacist should receive the entire amount that is paid by government to the community pharmacy at a minimum, to avoid the current practices observed with HMR and RMMR programs where referrals are held by providers and offered to accredited pharmacists for a significant portion of the medication review service fee.
- We understand the government's view is that it will provide the funding to the community pharmacy based on the number of beds and size of the RACH, and the community pharmacy is then responsible for employing a credentialed pharmacist and engage in salary discussions with them that can lead to the credentialed pharmacist being paid a lesser or higher amount than what the community pharmacy is being paid by the government for the ACOP program.
    - While we accept that this funding pathway is a government decision, the scenario where a credentialed pharmacist could be paid less than what the government is paying community pharmacies to pay the pharmacist, will have grave risks in the engagement of a workforce in shortage and overall success of the program.
    - It would benefit stakeholders to understand the intent and flow of funding if a diagram was produced to represent the department's intent of how the funding pathways will work.
- Funding should not be provided just because a service has been delivered, but provided on the basis that it was also a quality service that meets a minimum standard, possibly achievement of the Quality Indicators that are currently being planned as per Section 1.6.
    - Current medication management programs that have produced service activity that incentives quantity over quality – aided by a lack of governance and oversight of the quality of services delivered – should provide valuable lessons in how to ensure the ACOP program incentivises quality to deliver a return on investment for government and improved health outcomes for RACH residents.

The Society of Hospital Pharmacists of Australia
PO Box 1774 Collingwood Victoria 3066 Australia
(03) 9486 0177 | shpa.org.au | shpa@shpa.org.au | ABN: 54 004 553 806

1.3 Aged care on-site pharmacist measure – Allocation of funding

- No specific comment.

1.4 Aged care on-site pharmacist measure – Participation

- While we understand the difficulties of mandating the ACOP program for RACHs, there should be sufficient incentive for RACHs to participate in the ACOP program which stakeholders anticipate will produce better outcomes for aged care residents than existing programs, such as the RMMR program.
    - Aged care residents have the right to access the highest quality services on offer, and evaluations of the RMMR program thus far have demonstrated limited impact. If it is demonstrated that the ACOP program delivers better outcomes for aged care residents, this should be the preferences as the preferred medication management program for RACHs over RMMRs.
- If the ACOP program is not mandated, and RACHs have the option to continue current arrangements with the RMMR program, this does not address the issues uncovered by the Royal Commission into Aged Care Quality and Safety or implement its recommendations regarding medication management and medication safety.

1.5 Aged care on-site pharmacist measure – Standards, accreditation and training

- Given the impending 30 June 2024 date where currently accredited pharmacists with MRNs will no longer valid to make claims for HMR/RMMR services as interpreted by the statement on PPA Online's website, the government must provide an update on what will occur and what transitional arrangements may occur, such as extending MRN validities again and providing a transitional period for currently accredited pharmacists to achieve credentialling with the new programs.

1.6 Aged care on-site pharmacist measure – Quality indicators, reporting and monitoring

- SHPA publishes the Standard of Practice in Geriatric Medicine for Pharmacy Services which describes the clinical activities a pharmacist in a RACH should undertake in Table 1.
    - These should provide the foundation of quality indicators and reporting.
    - SHPA is well placed to lead or assist in the development of quality indicators.
- Ideally, these quality indicators will be finalised prior to commencement of the program so pharmacists who want to participate in this program have an understanding of what they need to provide for and achieve.
- Governance, compliance and quality improvement should be a collaborative effort by the clinician team at the RACH, and collection of data for quality indicators, reporting and monitoring should be integrated with other existing monitoring and activity reporting undertaken by the RACH. It would be unfortunate and inefficient if the RACH and the credentialled pharmacist are duplicating work or not collaborating effectively.

2.1 Residential Aged Care Homes – Engaging a pharmacist

- We query if the anticipated role of the PHNs has been articulated to them and how they can assist with this program.
- We understand RACHs are able to approach any organisation that has credentialled pharmacists, including public and private hospitals. We would appreciate written confirmation of this in business rules or future stakeholder update.
    - Many hospitals already provide on-site aged care pharmacy services to state-funded residential aged care beds, transitional care beds, mental health residential facilities and other care facilities.

- See comments at Section 1.1.

2.2 Residential Aged Care Homes – Proximity and rural and remote locations

- While we understand the rationale for not implementing proximity rules to preserve existing relationships between pharmacies and RACHs that work well, the business rules should stipulate explicitly that this is an on-site service.
    - We are concerned no location rules could mean a pharmacy in one state is providing the service to a RACH in another state without being present on-site. This should only be permissible in instances of market failure, as well as consideration for telehealth services where there is market failure to provide an on-site service.

2.3 Residential Aged Care Homes – Types of residential aged care homes that are eligible to participate in the measure

- We query if this means RACHs that are not funded by the Commonwealth but are funded by state governments, are also eligible to participate in the ACOP program.

2.4 Residential Aged Care Homes – General practitioners

- This section should mention the RACH, GP and pharmacist should agree on a communication plan that is collaborative and suits everyone's needs and schedules. While understanding the GPs' schedules and preferences is helpful, this understanding should go both ways.
- The pharmacist and GP should be onsite together at least once a month to support collaborative care and case conferencing.

2.5 Residential Aged Care Homes – Electronic National Residential Medication Charts (eNRMC)

- Given pharmacists' experience with implementing electronic charts in hospitals, engaging the pharmacist to be implemented in implementation of eNRMCs can have positive impacts on a smooth implementation, understanding of roles and responsibilities by all clinicians, problem-solving and engaging with clinicians to ensure safety of its use and implementation.

3.1 Community Pharmacy – Funding

- See comments at Section 1.1.

3.2 Community Pharmacy – Communication

- There needs to be flexibility for the credentialed pharmacist to provide services and be contacted when they are required and not just on the designated day of work. For example, if a patient is being titrated on a medicine and is having variable dosing arrangements, it would be reasonable to expect that the pharmacist needs to be contacted regularly during this period even if they are only contracted for one day per week.

3.3 Community Pharmacy – Adjustments to RACH employment arrangements

- We would appreciate confirmation on whether the credentialed pharmacist contracted by the community pharmacy for ACOP program purposes, can also work as a dispensing pharmacist in the same community pharmacy and/or be a business owner of the same community pharmacy? There are potential and perceived conflict of interests to be addressed here.

- The second point implies the ACOP program is a secondary service compared to medicines supply in the event of a workforce shortage, we query the rationale for this and are concerned about the message and confidence the government is projecting about the ACOP program.

4 Primary Health Networks

- We understand the role of the PHNs will be to connect RACHs with credentialed pharmacists in the local area, which can also be assisted by current accredited pharmacist registers, one of which is convened by SHPA. We understand this is already done by PHNs as regular business activity.
    - Thus, we are unclear what type of grant opportunities could arise for PHNs, if only the community pharmacy and RACHs will be able to employ credentialed pharmacists. We understand that PHNs will not be employing credentialed pharmacists.

5.1 Credentialed Pharmacists – Time on site

- This seems reasonable, no further specific comment.

5.2 Credentialed Pharmacists – Leave and salary

- It sounds like the Department has undertaken an analysis of what they envisage the salary to be, it would be beneficial to disclose this figure for stakeholders so they no longer need to make estimates based on Grade 2 salaries across all jurisdictions which have a large variance between lower and upper ends of the scale.
- The salary amount needs to be indexed each year against the Consumer Price Index. The salary in which this is referenced against stems from public sector enterprise agreements which have inbuilt annual increases which have historically ranged from 2% to 5%.
    - Some awards also provide for education and professional development allowances, and allowances for attaining post-graduate qualifications and fellowship of professional associations. These should be considered to ensure the credentialed pharmacist role is competitive in the market.
- If salary advancement with career progression is not possible as stated in the stakeholder update, we are concerned with the message this sends to the potential workforce and whether it provides the right incentives for them to engage in the ACOP program when there are other sectors that do provide more career advancement and development opportunities.

6.1 General Practitioner engagement – Communications

- This section should mention the RACH, GP and pharmacist should agree on a communication plan that is collaborative and suits everyone's needs and schedules. While understanding the GPs' schedules and preferences is helpful, this understanding should go both ways.

6.2 General Practitioner engagement – Funding for GP engagement

- We query whether the funding and incentive payments mentioned in this section make references to the ACOP program, and whether payment to GPs will be dependent on or require consideration of aged care pharmacy services provided under this program.

For more information, please contact Head of Policy and Advocacy, Jerry Yik at jyik@shpa.org.au.