Aged & Community Care Providers Association
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4 April 2024

David Laffan
First Assistant Secretary
Pharmacy Branch
Department of Health and Aged Care
Agedcarepharmacist@health.gov.au

Dear David,

RE: ACCPA Feedback on the Aged Care On-site Pharmacist Measure Implementation Plan

The Aged and Community Care Providers Association (ACCPA) appreciates the opportunity to comment on the proposed implementation plan for the Aged Care On-site Pharmacist (ACOP) measure. This submission has been prepared with input from ACCPA's members and partners.

Summary of Recommendations

R1: Introduce Activity Based Funding for the ACOP program measure to enable external expertise to participate in and support the ACOP initiative.

R2: Include a clear statement that it is not compulsory for a residential aged care facility to take up an on-site pharmacist and that residential aged care facilities can access Residential Medication Management Review (RMMR) and Quality Use of Medicines (QUM) via the 8CPA.

R3: Define on-costs for the ACOP program and allow funding to be used as a wage subsidy to enable the pharmacy or facility to create a career path for the pharmacist.

R4: Introduce the ACOP program in stages to ensure that there is credentialed pharmacist workforce to support the measure.

R5: Provide adequate funding under the 8CPA to support QUM for residents in RACFs.

R6: Clarify requirements for the current accredited pharmacists who have not completed the new accredited training programs to join the ACOP workforce.

R7: Clarify any additional training requirements for pharmacists who are already working as an ACOP.

R8: Remove the requirement that a residential aged care facility must first approach at least one community pharmacy.

R9: Provide clarity about how the ACOP funding will work under the PHN model.

R10: Clarify protocol for both the community pharmacy and residential aged care facility with regard to residents' medication management when an ACOP is on leave, to ensure continuity of quality of care.

R11: Clarify funding arrangements for General Practitioners to participate in the ACOP initiative.

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Overall comment

ACCPA strongly supports the introduction of the ACOP measure, which we believe will improve medication management for residents in residential aged care facilities (RACFs). There is a compelling case for greater medication management expertise in RACFs, with a pilot study in Canberra demonstrating that embedding a pharmacist in RACFs improved medication administration and the reporting of resident allergies, adverse drug reactions, and medication incidents.[1]

However, ACCPA is concerned about several fundamental challenges which may create risks for the sector, limit uptake of the initiative and/or prevent achieving the intended longer-term outcomes.

Notably, the program does not take into account the growing amalgamation of the sector characterised by a significant increase in multi-home providers who require consistency, transparency and optimal risk mitigation.

The specialised field of Residential Medication Management Review (RMMR), Quality Use of Medicines (QUM), and the management of a clinical pharmacist workforce delivering these services, has not previously been the core business of residential aged care. Currently, the RMMR and QUM programs are funded under the 7CPA, and that the RMMR and QUM services are being provided by either independent/contract clinical pharmacists or by clinical pharmacists employed by organisations specialising in RMMR and QUM services, such as Meditrax or WardMM which have responsibility for day-to-day management of their clinical pharmacists.

To do justice to the ACOP measure and optimise the benefits, particularly for multi-home providers, additional support is needed to ensure proper clinical governance and high-quality service delivery. This includes the option of engaging external expertise to support this initiative. We believe that a pure "salary only" funding model does not enable such support to be provided.

ACCPA notes that the 7CPA RMMR and QUM funding arrangements, which are activity based rather than salary based, provide scope for external companies with specific targeted medication management expertise to participate in these programs to the benefit of residents and providers. As such, the 7CPA / 8CPA programs (with appropriate funding support and suggested enhancements moving forward) are far better aligned to the needs of the multi-home aged care providers and would enable external organisations to participate in the program.

ACCPA supports medication management activities in the context of the ACOP measure be captured and costed by the Independent Health and Aged Care Pricing Authority (IHACPA) noting the IHACPA's role[2] within the aged care sector is to provide annual aged care costing and pricing advice to the Australian Minister for Health and Aged Care, who is responsible for determining the price for aged care services.

To this end, we support the introduction of a similar Activity Based Funding for the ACOP measure (or reapportioning some of the funding allocation) that would enable support to be provided by external companies with relevant expertise.

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[1] McDerby N, Kosari S, Bail K, Shield A, Peterson G, Naunton M. Residential aged care pharmacist: An Australian pilot trial exploring the impact on quality use of medicines indicators. Medicines 2020; 7: 20.

[2] IHACPA (2020) IHACPA's role in aged care pricing fact sheet https://www.ihacpa.gov.au/resources/ihacpas-role-aged-care-pricing-fact-sheet

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R1: Introduce Activity Based Funding for the ACOP measure to enable external expertise to participate in and support the ACOP measure.

Comment on specific sections of the ACOP update paper/Implementation Plan

Role of Aged Care On-site Pharmacists

Embedding pharmacists in RACFs is an opportunity to improve medication management for older Australians. However, this opportunity will not be fully achieved unless the current model of service provision is expanded beyond the current predominately resident-level model to an integrated resident- and system-level model. To this end, ACCPA strongly supports the role of Aged Care On-site Pharmacists (ACOP) being as outlined below:

- Being on-site and readily available to aged care staff and residents, building collaboration with the health care team, including local general practitioners, other medical practitioners, other allied health professionals, and community pharmacy.
- Providing continuity in medication management, such as day-to-day monitoring of residents' medication and resolving medication related issues promptly.
- Assisting with medication reconciliation, medication management and communication during transitions of care.
- Undertaking whole-of-facility quality use of medicines activities, such as drug use evaluation and implementation of changes to improve the use of psychotropics, antimicrobials and other high-risk medication.
- Advising, attending, and reporting to the Medicines Advisory Committee (MAC) as part of governance and oversight in the RACF, and helping set up a MAC where one is not established.

While ACCPA notes the role of ACOP as outlined, it is not clear what governance (if any) an RACF would have over the ACOP. An ACOP is an independent worker answerable to the supply pharmacy not to the RACF, which could be problematic given their role of working in the multidisciplinary team.

Furthermore, having a siloed model does not allow for whole of provider reporting and for head offices to understand what is happening from a QUM perspective at the home level, as no global view will be available.

1. Aged care on-site pharmacist measure

1.1 Funding Administration

ACCPA notes funding will be provided to community pharmacies to employ pharmacists to work on-site in RACFs in a clinical role. Where community pharmacies are unable or choose not to provide these services, Primary Health Networks (PHNs) will be able to engage pharmacists on behalf of RACFs to work on-site. It is not compulsory for a RACF to take up an on-site pharmacist.

ACCPA has strongly argued that there should be flexibility for aged care providers in how they source pharmacist/s to work at their facilities. We believe that it is essential that the program enables RACFs to 'employ' credentialed pharmacists via a subcontracted model, and that a clear statement on this issue is needed to ensure RACFs understand that they have this option under the 8th Community Pharmacy Agreement (8CPA).

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R2: Include a clear statement that it is not compulsory for a residential aged care facility to take up an on-site pharmacist and that residential aged care facilities can access RMMR and QUM via the 8CPA.

Importantly, ACCPA notes that pharmacist-led organisations have many years of experience in delivering RMMR and QUM services, providing support oversight of individual pharmacists, and managing recruitment, mandatory compliance, governance and systems for pharmacists to use. We support a funding model that enables such organisations to continue operating and transition from existing 7CPA agreements to new on-site pharmacist agreements, ensuring both a smooth transition of services and maintaining medication management quality within RACFs.

1.2 Funding

The implementation plan notes, "The measure provides funding for the on-site pharmacist's salary, inclusive of on-costs. There are no additional financial incentives for community pharmacies or RACHs to participate in the measure."

The pharmacy or facility must be able to cover overheads to employ an ACOP. Therefore, it is critically important that the definition of 'on-costs' include all ancillary costs such as Clinical Governance at an Organisation Level; Specialist training; Quality review; Recruitment; Onboarding; and Medication Management Applications and Systems (that go beyond the electronic National Residential Medication Charts).

R3: Define on-costs for the ACOP initiative and allow funding to be used as a wage subsidy to enable the pharmacy or facility to create a career path for the pharmacist.

1.3 Allocation of funding

The Implementation Plan notes "Pharmacists will be required to be on-site for a minimum block of a half day at a time." ACCPA believes there is likely to be insufficient credentialled pharmacists in Australia to meet this requirement. Based on the suggested ratio, a 5-7 multiple increases in accredited/credentialled pharmacists may be required than under the current 7CPA funding model. There is a major challenge in resourcing to this level. To this end, a staged approach to implementation of the initiative is recommended.

Importantly, there is currently no clear job description or KPIs attributed to this model, resulting in uncertainty about how consistency will be maintained and where responsibilities will lie. In addition, it is unclear whether each home are expected to negotiate independently as to their requirements.

R4: Introduce the ACOP measure in stages to ensure that there is credentialed pharmacist workforce to support the program.

1.4 Participation

It makes sense not to have RMMR/QUM and the on-site pharmacist operating at the same time. However, if there is not a reliable funding mechanism for a General Practitioner (GP) (current RMMR program), getting GP engagement with proposed medication changes is likely to be unnecessarily difficult (See 6.2).

ACCPA considers it would be a far lower risk approach to enable QUM type of funding in addition to, or as a portion of, the ACOP funding for these reasons. Even if this means less on-site time, the ability to support in other organisation-wide ways will have greater impact.

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With better QUM funding, pharmacists could be onsite more regularly and could provide all those additional services whilst being remunerated rather than for "free".

R5: Provide adequate funding under the 8CPA to support quality use of medicines (QUM) for residents in RACFs.

1.5 Standards, accreditation and training

To enable a commencement date of 1 July, it will be essential to recognise that most currently 'accredited' pharmacists would not have completed one of the new accredited training programs.

ACCPA also notes that the grandfathering for those pharmacists currently accredited has not been decided. It is also unclear whether pharmacists who are already working as an ACOP will need to undertake further training.

Clarification is therefore needed regarding the requirements which must be met, for the current accredited pharmacists who have not completed the new accredited training programs, in order to join the ACOP workforce.

R6: Clarify requirements for current accredited pharmacists who have not completed the new accredited training programs to join the ACOP workforce.

R7: Clarify additional training requirements for pharmacists who are already working as an ACOP.

2. Residential aged care homes

2.1 Engaging a pharmacist

The implementation plan notes that "Although a RACH may have a working relationship with a credentialed pharmacist (for example through the RMMR program), they must first approach at least one community pharmacy. If a community pharmacy is unable or chooses not to participate, then the PHN can assist with engaging a credentialed pharmacist."

ACCPA believes the requirement that a RACF must first approach at least one community pharmacy is unnecessary. If a facility, or group, has an established relationship with a pharmacist who already knows the home, it is contrary to best clinical practice for them to have to approach a different community pharmacy. The reality is that a significant proportion of accredited pharmacists do not work for a community pharmacy – meaning homes will be unnecessarily restricted from working with the most appropriate expertise for their residents.

It is also important to note that it would be difficult for one supply pharmacy to employ pharmacists to work for the larger groups, which means the RACF will have multiple pharmacists working under different operators outside of their control. This will be very problematic from a quality, consistency, and control perspective.

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R8: Remove the requirement that a residential aged care facility must first approach at least one community pharmacy.

3. Community pharmacy

With regards to funding for community pharmacy to employ ACOP, ACCPA members have raised the following questions and concerns:

- Is there a conflict of interest for an accredited pharmacist to be responsible for both the review of medications (particularly reduction in polypharmacy) as well as the supply of medication?
- Would it be difficult to determine/monitor the on-site time of the pharmacist?
- Is there a potential conflict of interest between the person trying to reduce medications by an organisation that receives funding by supplying medications. If so, how can this circumstance be managed?
- Would funding change for pharmacists who are already working as an ACOP?
- If the employed pharmacist into RACF needs to return to the community pharmacy role (either temporarily to fill a gap or permanently), how will this shortfall be managed? Members noted that pharmacists already working in aged care would not engage in a contract that might result in the above scenario.

4. Primary Health Networks

The Implementation Plan notes that "In undertaking their engagement role, PHNs may work with organisations that employ credentialed pharmacists, including other than community pharmacy." However, it is not clear from the statement how this funding will be managed. Will the PHN pay the clinical pharmacy provider directly or will the funds have to go through multiple steps (e.g. PHN to RACF to clinical pharmacy provider)?

More clarity is needed on how the funding will work under the PHNs, and how aged care providers will need to engage with PHNs. As noted above, there are a range of issues with a 'salary only' approach. However, if it allows for an activity-based model or a margin on the labour rate, this will provide flexibility for external providers (who already service RACFs under the 7CPA) to participate in the measure. Otherwise, there is no scope within the ACOP funding model for external providers to participate in the ACOP measure.

R9: Provide clarity about how the ACOP funding will work under the PHN model.

5. Credentialed pharmacists

5.2 Leave and salary

As noted above, there are numerous additional costs that must be included in order for this program to both succeed and avoid unintended risk and harm.

Importantly, clarification is needed with regard to who will cover the ACOP when they are on leave and who the RACF should contact when the community pharmacy does not have the credentials or experience.

In addition, given the current pharmacist workforce shortage, ACCPA believes it will be incredibly challenging to recruit pharmacists into this role without career progression and/or experience-based

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salary scales. Absence of a career progression model will become a substantive issue in retaining pharmacists in aged care under this model.

R10: Clarify protocol for both the community pharmacy and RACF with regard to residents' medication management when an ACOP is on leave to ensure continuity of quality of care.

6. General Practitioner Engagement

6.2 Funding for GP engagement

The paper notes that "The Australian Government is investing $112 million over four years in the General Practice in Aged Care Incentive (GPACI) to support older Australians living in a residential aged care home to receive quality primary care services."

However, the paper does not clarify how GPs will be renumerated for engagement under the ACOP measure. If funding for the pharmacist is no longer available, how does the GP get paid for their engagement?

ACCPA believes it is essential that this program enables GPs to receive a similar income to what they would otherwise have received under an RMMR program. GP/Pharmacists collaboration is beneficial; however, it is important that health professionals are remunerated for their time.

R11: Clarify funding arrangements for GPs to participate in the ACOP initiative.

If you have any further questions or would like to discuss, please contact Dr Moe Mahat at Mohamad.Mahat@accpa.asn.au

Yours sincerely

Roald Versteeg
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Aged & Community Care Providers Association