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)? Why is this your recommended funding model?	The AMA's preferred model is for funding to be provided through PHNs. Firstly, funding through PHNs will ensure independence of pharmacists from aged care providers. Secondly, a PHN model would ensure that all pharmacists in the area are linked together and are able to develop and support communities of learning and practice. Furthermore, PHNs have experience with non-prescribing pharmacists in GP practices. Lessons learned

	from those trials could be applied to this new system.[1] In addition, the PHNs are better placed in terms of establishment of key performance indicators for pharmacists and their outcome measurement. Finally, the PHN model will enable stronger clinical governance, provides commissioning expertise and the ability to job-share across aged care homes. The AMA has concerns in relation to providing funding directly to residential aged care homes, without any specific requirements linked to the funding provided. If funding is provided directly to aged care homes, then they should be expected to provide financial statements as evidence that the funding was actually used to hire on-site pharmacists. Reporting should be itemised by hours worked and hourly pay rate. This is important because there have been instances in the past where funding was provided for a specific purpose (for example 2021 Basic Daily Fee Supplement of $10), where the reporting system used failed to actually demonstrate whether the funding received was used for the specific purpose it was intended for.[2]
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.	In the AMA's view, the pharmacists who work with doctors have an important role in: assisting with medication adherence; improving medication management; and providing education about medication safety to residents, RACF staff, GPs and other health professionals. The AMA maintains that GPs are the key specialists providing medical care for people in aged care and that pharmacists should work in collaboration with GPs. It is the AMA position that pharmacists working in aged care should not be able to prescribe medication,

[1] https://www1.racgp.org.au/ajgp/2018/august/what-can-pharmacists-do-in-general-practice
[2] https://www.health.gov.au/sites/default/files/documents/2022/03/food-and-nutrition-report_0.pdf

	bur rather work in a multidisciplinary team with GPs and aged care homes nursing staff. Any move in the direction of allowing pharmacists to prescribe will be strongly opposed by the AMA. Pharmacists could work with clinical governance structures such as Medicines Advisory Committees (MACs) and GPs to develop and implementing plans to optimise the use of medication, as well as reduce polypharmacy. The AMA recommends that that registered health practitioners should be appointed to the clinical governance and MACs, including medical practitioners, pharmacists, and registered nurses. One role of MACs could be to perform audits of high-risk medication (for example antipsychotics, anticoagulants), monitor their use and implement plans to reduce uptake. The AMA maintains that a resident's usual GP is the key medical practitioner looking after the health of the older person and is a valuable source of advice for medication management and clinical governance.[3]
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?	In the AMA's view, in areas where there are not enough accredited pharmacists to meet the workforce demand (e.g. rural), links to hospital pharmacists in local health networks should be considered, as hospital pharmacists have robust standards for aged care medicines services.[4] Funding arrangements should be such that enable appropriate governance but allow for local adaptability. There should also be recognition that not all pharmacists' work will have to be done on site, and that some flexibility is required. Further to this, if the PHN model is adopted, PHNs could start communities of practice across aged care homes, introduce an aged care home GP liaison officer and multidisciplinary teams.

[3] https://www.ama.com.au/sites/default/files/2021-11/AMA%20Submission%20to%20ACSQHC%20-Updating%20National%20Quality%20Use%20of%20Medicines%20Publications%20-%20DRAFT.pdf
[4] Society of Hospital Pharmacists of Australia (2021), *Geriatric Medicine and Aged Care Clinical Pharmacy Services*.

	The AMA believes that pharmacists should work with GPs who care for patients in aged care, and that recruitment of GPs and other specialists in rural and remote areas has been an issue for a number of years. Therefore, the AMA suggests that improving the recruitment and retention of GPs in rural and remote areas could be one way of ensuring that pharmacists are engaged. A strategy of simply engaging pharmacists without properly collaborating with GPs or expecting pharmacists to mimic the role of GPs is doomed to fail and will likely lead to adverse health outcomes.
4. How could this relatively new role be promoted to pharmacists to encourage uptake?	In the AMA's view, PHNs have strong communication links with pharmacies and can promote this role. Hospitals and university pharmacy departments may also be in a position to effectively promote this role internally.
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?	The AMA supports a model where accredited pharmacists collaborate with GPs in aged care on assisting with medication adherence, improving medication management and providing education about medication safety. This is not a preference, but a condition. This collaboration will be particularly important during the instances of intake of new residents into aged care homes, when any medication reviews are conducted, or when a resident is discharged from hospital and brought back to the aged care home. Furthermore, on-site pharmacists should maintain an ongoing relationship with the GPs providing medical care for residents of aged care homes, discussing residents' health and conducting case conferencing when needed. In the AMA's view, clinical information systems should be easy to use by GPs, pharmacists and other health professionals involved in a residents' care. The AMA has also continuously called for interoperability between the clinical systems used by GPs and those used by the aged care homes, as the best way of facilitating effective communication. In addition, adequate verbal and written communication between GPs and pharmacists will be key to ensuring adequate medical care for older people living in aged care homes.

6. How should continuing professional development, mentoring and networking for on-site pharmacists be supported and maintained?	The AMA suggests that much of the professional development, networking and mentoring could be achieved through the PHN funding model, as explained in the response to question one. Furthermore, working with GP liaison officers would support the recruitment and induction of pharmacists, and provide support as needed to them.
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?	It is the AMA's position that the minimum skill requirement for pharmacists in aged care should be 'consultant pharmacist'. While it is expected that pharmacists would have sufficient training in their field of speciality, it is possible they would need additional training in geriatric pharmacy, or understanding and working with people who have dementia, and similar.
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?	No comment
9. How would accredited pharmacists make the transition into the role of an on-site pharmacist in a residential aged care home?	No comment
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?	Consideration could be given to both general measures and those bespoke to a particular aged care home. Measures for consideration may include: - Quality documentation of medicine - Use of antipsychotics - Use of medication for chemical restraint - Medication review when high risk medication or multiple medication - Antimicrobial use indication - Timely administration of antivirals - Documentation and analysis of errors
11. Are there any barriers to the on-site pharmacist working with the Medicines Advisory Committee, and if so, how can they be addressed?	In the AMA's view, the main barrier will be that not many residential aged care homes have MACs. Furthermore, where MACs do exist, they can significantly differ in structure and functions across different aged care homes. It will therefore be important to find a way to both standardise MACs across the entire aged care setting, as well as to develop clear policies articulating the role of pharmacists in relation to MACs. The AMA also calls for adequate funding to be provided for establishment of MACs across aged care homes. GPs need to be appointed to MACs, along with pharmacists, and those roles must be reimbursed. To achieve this, broader expansion of MACs will be required, along with appropriate funding attached to it, to ensure all RACFs have MACs. Without MACs the role of pharmacists in aged care will not be able to ensure good quality care.
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?	It is essential that residents of aged care homes are supported to continue to access MMRs regardless of whether or not there is an on-site pharmacist. There must be

	safeguards in place that would ensure residents are not denied these important services should the on-site pharmacist not be available or leave the aged care home.
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?	The AMA expects that it would be feasible for the transition to occur within 6 months of the employment of the accredited pharmacist in the individual aged care home, if that is the preferred model selected following the consultation. If the PHN model is selected, then perhaps 12 months would be the more optimal period.
Do you have any other comments or feedback?	
To the AMA these will be the key features of a successful pharmacist model in aged care: - PHN employment model. In this way their independence of aged care providers is ensured. In areas where there are not enough accredited pharmacists to meet the need (e.g. rural), links to public hospital pharmacists in local health networks should be considered. This means that funding arrangements should enable appropriate governance but allow for local flexibility. - Alternatively to the PHN employment model, the AMA suggests that current MBS Item 731 'care plan review'[5] is used to fund pharmacists in aged care, by increasing the number of services, or allocating a specific number of hours for each aged care home resident (similar to nursing hours) per week/month/year. - GPs are the key medical care professionals in aged care, with pharmacists providing essential support on medication issues, but not replacing the role of GPs. Pharmacists must be non-prescribing, and any move in this direction will be strongly opposed by the AMA. - GPs and non-dispensing pharmacists can work collaboratively as part of multidisciplinary teams on medicines safety, but the pharmacists should not overrule GP prescription. - GPs need to be appointed to Medical Advisory Committees, along with pharmacists, and those roles must be reimbursed. To achieve this, broader expansion of MACs will be required, along with appropriate funding attached to it, to ensure all aged care homes have MACs. Without MACs the role of pharmacists in aged care will not be able to ensure good quality care.	

[5] http://www9.health.gov.au/mbs/fullDisplay.cfm?type=item&q=731&qt=item

- The AMA considers the role of GP Liaison Officers an important one for improving medical care of people in aged care homes. GPLO in RACFs and pharmacists in GP practices (link to existing AMA policies).
- Pharmacists need to be appropriately qualified to work in aged care – consulting pharmacist level, qualified to perform MMRs, and need to be appropriately reimbursed. The AMA does not support a model that would see a community pharmacist with no additional accredited training filling this role.
- The Department should be aware that this new model could pose a threat to current pharmacy business viability in some parts of the country. In addition, not all pharmacists' work will have to be done on site, and some flexibility is required.
- The key role of pharmacists in aged care will be working with nurses on medication timing, medicine delivery and with GPs on medication rationalisation.
- Aged care homes should use adequate clinical software that should be interoperable (in the future) with the GP and pharmacy software. In the absence of interoperability, written and verbal communication with the GP will be crucial.
- RMMRs must continue even after the role of pharmacists in aged care is rolled out. RMMRs must be conducted annually, regardless of the new role given to pharmacists. GP reimbursement for RMMRs must be maintained, regardless of whether the pharmacists' fee is rolled into the new funding model.