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Royal Australian College of General Practitioners

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14 September 2022

Mr Michael Lye
Deputy Secretary for Ageing and Aged Care
Department of Health and Aged Care
GPO Box 9848
Canberra ACT 2601

Via: agedcarepharmacist@health.gov.au

Dear Mr Lye,

The Royal Australian College of General Practitioners (RACGP) thanks the Department of Health and Aged Care for the opportunity to provide input into the planned introduction of on-site pharmacists in residential aged care homes.

The RACGP is Australia's largest professional general practice organisation, representing over 43,000 members working in or toward a career in general practice including four out of five general practitioners (GPs) in rural Australia.

The RACGP is supportive of appropriately resourced, fit-for-purpose measures to improve medication management in residential aged care. We acknowledge the importance of the professional relationship between GPs and pharmacists in enhancing patient care and outcomes. As outlined in our submissions to the Royal Commission into Aged Care Quality and Safety, quality care for older people must incorporate expert medication management, rational prescribing and mindfulness of issues such as polypharmacy.

We are supportive of measures to improve medication management and are generally supportive of proposal for onsite pharmacists. However, it is the position of the RACGP that this program should only be implemented with thorough consideration and tailoring to fit in with the current system and account for the system-level issues that are preventing older people from accessing person-centred, continuous care in residential aged care facilities (RACFs). The RACGP would like the Department to also consider other more flexible and localised models that could achieve this purpose with better integration with current care provision, for example, using general practice-based pharmacists to undertake this role.

Please see the detailed feedback below in Appendix 1.

We would welcome the opportunity to meet with you to discuss the contents of this submission further. If you have any queries regarding this submission, please contact Michelle Gonsalvez, National Manager, Policy and Advocacy on (03) 8699 0490 or via Michelle.Gonsalvez@racgp.org.au.

Yours sincerely

Adj Prof Karen Price
RACGP President

Appendix 1: Aged care on-site pharmacist measure - consultation response

1.General comments

GP-led multidisciplinary care is essential to optimal health outcomes for older people, particularly for the high proportion of this group with multimorbidity and complex health needs. However, GPs face a number of barriers to working in RACFs, including fragmented systems, restrictive funding, limited information sharing, general practice workload and capacity issues and inadequate multidisciplinary collaboration.

While the RACGP is supportive of improving medication management under this proposal, we are concerned that this measure could further complicate and fragment care if not implemented wisely.

For this measure to produce positive outcomes for older people in RACFs, it must:

- prioritise integration with general practice and collaboration with the multidisciplinary care team
- be supported by appropriate training requirements and governance arrangements
- be accompanied by additional funding support for GPs to provide coordinated and continuous care to older people
- be flexible in its implementation to build on and not replace successful existing models and programs
- incorporate clear delineation and separation from community pharmacy
- not expand the scope of pharmacists beyond their core competencies.

It is critical this model does more than previous programs to integrate with the GP-led care that is currently provided to older people in RACFs. This model should be robustly trialled and evaluated before rolling out nationally or indefinitely. This could be aligned with trials supporting general practice-based pharmacists.

The model should be flexible to collaborate with and not compete or replicate services where Aboriginal and Community Controlled Health Services have already integrated pharmacists to improve medication management for Aboriginal and Torres Strait Islander communities.

The RACGP believes the proposed implementation timeframe (by 2023) would likely not provide sufficient time for the development and delivery of appropriately robust training to enough pharmacists to support the program. We support staging the implementation of this program over several years to ensure it is fit-for-purpose and responsive to on-the-ground feedback. There should be clear feedback pathways for general practitioners and other participating health professionals to advise on the ongoing implementation and flag any gaps/issues with the program once introduced.

2.Key recommendations

To ensure the successful implementation of this program and optimal patient outcomes, the RACGP recommends:

- introducing additional resourcing to support GPs in aged care, potentially via new funding targeted towards coordination of care and engagement between GPs and other team members
- considering flexible application of the pharmacist model in instances where a RACF based pharmacist might not be the most suitable setting to meet the community needs – including trialling other models such as general practice-based pharmacists
- ensuring funding agreements for the program reflect the following:
    - mandated upskilling of registered pharmacists
    - clear delineation from community pharmacy, ensuring the on-site pharmacist is independent of any dispensing community pharmacy and derives no direct or indirect benefit from additional prescriptions
    - clear oversight of the pharmacist by appropriately trained medical professionals and specific points of engagement with the patient's usual healthcare team
    - mandated information sharing with a patient's usual GP
    - clear and specific roles and responsibilities for participating pharmacists
    - consideration of factors which impact those in a rural or remote setting where availability of a pharmacist might be more limited and/or there is need for more integration with hospitals.

- clearly outlining the roles and responsibilities of the on-site aged care pharmacist according to the reasonable activities outlined in this submission
- conducting a review of the comparative skills and competencies of community pharmacists (recent graduates vs experienced community pharmacists), hospital pharmacists, pharmacists working in general practice and consultant pharmacists to identify gaps
- linking funding to clear performance and outcome measures that ensure the program is effectively improving patient care and is not contributing to fragmentation of care.

3.Accounting for increased workload of GPs

Recommendation: Introduce additional resources to support GPs in aged care to enhance coordination of care and engagement between GPs and other team members.

If meaningfully and successfully implemented, it is likely this measure could contribute significantly to the workload of GPs providing care to people in RACFs. There will be additional time required for care coordination, including case conferencing and liaising with the on-site pharmacist, as well as care activities resulting from any recommendations and advice provided by the on-site pharmacist.

As such, the RACGP recommends government allocate additional resourcing to support GPs in doing this work, potentially via the introduction of new funding targeted towards coordination of care and engagement between GPs and other team members (e.g. for GPs to participate in RACF weekly ward rounds). There should be a focus on ensuring reasonable remuneration for a GP assessment of aged care residents and resulting appropriate prescribing or describing. It also may be valuable to consider how descriptors for RACF MBS item numbers could be broadened to facilitate conversations with team members and adequately remunerate GPs for their portion of the work generated by the aged care pharmacist.

There is a need for broader measures to support and encourage GPs to work in aged care. We know effective GP-led multidisciplinary care is likely to reduce unnecessary hospital transfers and allow greater management within RACFs. As such, government should consider measures to reduce barriers to GPs working in aged care, including issues around insufficient funding, communication between health professionals and services, and education and resources for GPs in this space. Further information is available in RACGP Position Statement on Supporting sustainable GP-led care for older people.

In addition, the introduction of onsite pharmacists must not result in a reduction in support for GPs providing services to people in RACFs. Any funding that is currently provided to GPs to support their involvement in medicine review programs and activities (e.g. MBS Item 903) should be updated to reflect the changes in these programs and to align with the introduction of on-site aged care pharmacists.

4.Alternative models to successfully achieve the intent of measure

Recommendation: Consider flexible application of the on-site aged care pharmacist model, particularly in instances where a RACF based pharmacist might not be the most suitable setting to meet the community needs – including trialling other models such as general practice-based pharmacists.

The RACGP supports the purpose of the proposal put forward but sees benefit in the consideration of other more flexible and localised models that could achieve its purpose with better integration with current care provision.

Too often models of care are implemented in isolation without thorough consideration of the wider health system and existing care arrangements. Aged care is a complex and multidisciplinary area, and there is significant risk of duplication and fragmentation of care under this measure if not carefully implemented. Our members advise that larger RACFs (100+ residents) may be supported by up to 60 different GPs and a huge cohort of allied health staff and other medically trained professionals, with whom pharmacists would need to work collaboratively.

We see that these alternative models could be implemented in place of, or complementary to, the proposal put forward. We recommend that the Department of Health consider flexible application of the on-site aged care

pharmacist model, particularly in instances where a RACF based pharmacist might not be the most suitable setting to meet the community needs.

One model for consideration would be to fund general practice-based pharmacists, who can work collaboratively with GPs and provide care to the RACF patients that GP is already caring for. Support for general practice-based pharmacists would ensure care is patient-centred and coordinated. General practice-based pharmacists would have a pivotal role in supporting RACF patients, and at the same time could use their skills to support the wider general practice patient cohort.

In addition to the benefits this would bring to the patient and system through better coordinated care, this model would also have benefit for pharmacist themselves. The on-site pharmacist model proposed is likely to be a very isolated role. The general practice-based pharmacist model would ensure that pharmacist is formally part of a healthcare team and can learn and share with other healthcare provides as part of a community of care.

Another potential model could be applied that includes hospital-based pharmacists, allowing for a localised approach (e.g. GP, RACF or hospital-based pharmacist) depending on what is most appropriate for the patients and services in that area. This could also utilise already established State-based funding mechanisms.

5.Funding model for employment of on-site pharmacists

The RACGP supports a patient-centred funding model that prioritises the best possible care and outcomes for people in residential aged care.

We note there are unique considerations that would need to be addressed depending on whether funding is provided through RACFs versus Primary Health Networks (PHNS) and our members see benefits and challenges to both options. Feedback from our members has indicated PHNs may be well placed to recognise the gaps in care provision, make sure there is no duplication of services, support flexible program implementation and ensure the pharmacists that do work in RACFs already have professional relationships with the local GPs. They may also be well positioned to provide more independent oversight and feedback pathways for the program. However, we also note that engagement with local GPs and health services varies between PHNs and RACFs.

Recommendation:

The funding agreements put in place for this program must support the delivery of high-quality, patient outcomes-focussed coordinated care. As such, we recommend the funding agreements reflect the following requirements:

- **mandated upskilling of registered pharmacists through the provision of training covering aged care and primary care and Continuing Professional Development (CPD) requirements for participating pharmacists**
- **clear delineation and separation from community pharmacy i.e. there must be no arrangements with preferred medicine suppliers or preferred pharmacies or employing a pharmacist who is also employed in a local retail pharmacy, and the on-site aged care pharmacist must derive no direct or indirect benefit from additional prescriptions**
- **clear oversight of the pharmacist by appropriately trained medical professionals and specific points of engagement with the patient's usual healthcare team**
- **mandated information sharing with a patient's usual GP**
- **clear and specific roles and responsibilities for participating pharmacists, including a requirement that pharmacists are not able to dispense medicines in their assigned aged care facility**
- **consideration of factors which impact those in a rural or remote setting where availability of a pharmacist might be more limited and/or there is need for more integration with hospitals.**

These measures are required to avoid the inherent conflict of interest in retail pharmacy, and to promote patient choice, better health outcomes and equity of access for all.

The funding agreements should be structured so that if these requirements are not met, funding is immediately halted. We also expect that funding will be contingent on participation in regular program reviews to ensure the program is evidence-based, improves patient outcomes and represents value for money.

6.Developing and defining the role of the on-site pharmacist

Recommendation: Clearly outline the roles and responsibilities of the on-site aged care pharmacist according to the reasonable activities outlined in this submission.

Successful implementation of pharmacists in an RACF is associated with physical presence, building of trusted relationships with visiting GPs and RACF staff, and appropriately defined roles and responsibilities. The role of the pharmacist must be defined in terms of value-add and enhanced patient care. There is also a need to avoid an overemphasis on single-disease treatment guidelines given that the RACF population has frailty, multimorbidity and often reduced life expectancy, with a focus on quality of life and person-centred end of life care.

Medication management can be complex, involving a range of health professionals in different roles, including the GP as prescriber and provider of medical care, the community or hospital pharmacist as the supplier and dispenser, and residential aged care staff as the administrators. We see that the addition of a pharmacist to the aged care team is positive, and for this program to be successful there needs to be clarity around the key roles and relationships for the pharmacist and the broader healthcare team.

The role and responsibilities for on-site pharmacists in aged care should be centred around improving patient-centred medication governance and quality use of medicines under the supervision of a patient's usual healthcare team. To prevent fragmentation of care, on-site pharmacists should not act independently without the insight and oversight of a patient's usual healthcare team, in particular the patient's GP.

Reasonable activities may include:

- providing reports and updates to the patient's usual GP regarding medication governance and quality use of medicines
- supporting the facility to make medicine administration processes more efficient
- supporting implementation of palliative care plans and deprescribing plans under the careful direction of the patient's medical team and after agreement with the patient and their family
- attending GP case conferences with families, particularly where there are poly-pharmacy issues

On-site pharmacists should not be undertaking chronic disease management activities or other activities that duplicate services already provided by the patient's GP. These activities should be carried out under the direction of each patient's medical team. While they may make recommendations to a patient's medical team, pharmacists should not be making treatment decisions or implementing changes to a patient's medical plan without appropriate oversight.

The RACGP notes that the role and activities of the pharmacist will need to meet a set of independently accreditation standards to ensure high-quality patient care.

6.1 Collaboration with the multi-disciplinary team

Continuous and coordinated multidisciplinary care is critical for patients transitioning between healthcare settings, which is why it is so important for RACF patients to remain under the care of their regular GP. Research suggests facilitating continuity of GP-led care for new RACF residents is particularly important for preventing inappropriate initiation of psychotropic medications.[1]

Providing collaborative and continuous medical care for RACF residents requires effective and robust systems with transparent arrangements that support GPs and other members of the RACF care team who may work across multiple RACFs. It is essential that systems of care and collaborative arrangements are clearly defined so residents have access to safe and timely comprehensive and quality care.

The introduction of on-site pharmacists should support continuity of care and information sharing with all members of a patient's healthcare team. However, as outlined earlier, to prevent fragmentation of care, on-site pharmacists should not act independently without the insight and oversight of a patient's usual healthcare team, in particular general practitioners.

On-site pharmacists can best collaborate with aged care healthcare teams by:

- participating in regular case-conferencing discussions with a patient's usual general practitioner
- participating in regular multidisciplinary team meetings at respective RACFs

providing regular updates (via secure messaging) to a patient's usual general practitioner
- regularly updating the patient's myHealth record.

The RACGP notes that the rollout of this program should also consider other barriers to continuous and coordinated care that exist in RACFs. These include the current mixed paper/digital approaches to drug charts, prescribing, dispensing, recording of clinical information, recording of blood test results.

The guidelines for this program should address this with clear instructions around paper/digital approaches, with a focus on enabling collaborative care for all patients. Work may also be required to address pharmacist access to medication databases, which can often reside within general practice, with GPs remotely logging into the practice software when visiting RACFs.

Funding of general practice-based pharmacists, as put forward as an option earlier in this submission, could mitigate some of these challenges.

6.2 Rural and remote considerations

The RACGP notes that residential aged care in rural and remote areas face unique challenges in the delivery of coordinated and continuous multidisciplinary care. It may be necessary to tailor the proposed measure to ensure it is suitable for rural and remote populations, including addressing geographical and epidemiological diversity.

We acknowledge in rural and remote areas there may be a need to employ pharmacists to travel between RACFs, and specific supports should be in place to support this arrangement.

Support for the general practice-based pharmacists model is likely to be beneficial in these settings. In this model the pharmacist can provide support for RACF patients as well as utilising their learned skills to support other general practice patients, whilst avoiding conflicts of interest (which may occur if they are also working in retail pharmacies).

Targeted consultation and program development with rural and remote stakeholders should inform the delivery of this program in their local areas.

7.Training requirements for pharmacists

Recommendation: Conduct a review of the comparative skills and competencies of community pharmacists (recent graduates vs experienced community pharmacists), hospital pharmacists, pharmacists working in general practice and consultant pharmacists to identify gaps

The RACGP firmly cautions against introducing on-site aged care pharmacists without additional training and accreditation. Training of pharmacists in aged care, palliative care and primary care is variable, and will need to be addressed through a robust, collaboratively developed training and accreditation program with clearly identified learning outcomes.

The required skills and learning outcomes specific to aged care should be outlined in a publicly available, independently developed set of education standards for training and accreditation. These should be developed in collaboration with key stakeholders and with genuine opportunities for feedback. We would specifically like to see ongoing engagement with RACGP in the development of aged care and primary care pharmacy training/credentialling so that we can ensure alignment with best practice and general practice workflows.

We expect that adherence to the training standards and accreditation guidelines will be a requirement of the ongoing funding agreements with RACFs or PHNs, and as outlined earlier, if these requirements are not met then funding will be immediately halted. We would also expect independent external oversight of compliance with the standards.

The RACGP would suggest that a review of the comparative skills and competencies of community pharmacists (recent graduates vs experienced community pharmacists), hospital pharmacists, pharmacists working in general practice and consultant pharmacists is needed to identify gaps. Once the gaps in knowledge and skills are identified, then learning outcomes should be written to ensure the training will develop the necessary competencies specific to the pharmacist's role in aged care with consideration of variable baseline competencies. It is important to avoid over-emphasis on single-disease treatment as aged care includes a broad range of issues such as frailty, multimorbidity and decreased life expectancy.

The RACGP expects that on-site pharmacists would be required to establish and maintain their skills relevant to the aged care setting through a certified training program and ongoing CPD equivalent to the manner of any other accredited health professional in Australia.

7.1 Terminology and training

We also note the terminology used to refer to pharmacists throughout the consultation paper varies, including:

- Registered pharmacist
- Specialist aged care pharmacist
- Accredited pharmacist
- On-site pharmacist

Given these differing terms can be indicative of various training levels, accreditation and professional development requirements, it is suggested that more consistent and clearly defined set of terms be used moving forward. The definitions of these terms and glossary should include the required training, accreditation, regulatory and professional development requirements. We seek specific clarification on the term 'accredited' pharmacists, as this term can be used to refer to pharmacists, such as consultant pharmacists, that are accredited to deliver Home Medicines Reviews (HMRs) and Medication Management Reviews (MMRs) to community-based individuals (including veterans) and residents of aged care facilities.

8.Development of health outcome indicators and associated reporting

Recommendation: Link funding to clear performance and outcome measures that ensure the program is effectively improving patient care and is not contributing to fragmentation of care.

The RACGP supports the use of the Aged Care Quality Outcome Indicators for medication management, including the percentage of care recipients who were prescribed nine or more medications.

In addition to compliance with standards, funding for this program should be linked to measures that ensure the program is effectively improving patient care and is not contributing to fragmentation of care. We encourage the development of ongoing KPIs for participating pharmacists to ensure their role is having a meaningful impact on patient outcomes.

Program outcome indicators should include measures that cover:

- avoidable hospital admissions and emergency department presentations
- engagement with the patient's usual medical team and adherence collaborative care arrangements
- interventions that lead to deprescribing
- interventions that reveal significant drug interactions
- interventions that lead to additional medication
- reduction in falls
- medication reviews and results
- education events.

We would also suggest consideration of the *Registry of Senior Australians* Outcome Monitoring System Quality and Safety Indicators for any additional indicators that might be of value that are not addressed above. We also note process indicators should also be considered as part of ongoing quality and safety reporting.

9.Transition from services funded under the Seventh Community Pharmacy Agreement Pharmacy Programs

The RACGP position is that government funding should be directed towards evidence-based programs that will improve patient outcomes. As flagged by the Medical Services Advisory Committee in their assessment of several medicine review programs funded under consecutive Community Pharmacy Agreements, there is limited evidence to support the ongoing implementation of some of these programs.[2]

It is important that the proposed measure to embed pharmacists in RACFs is not simply replacing non-evidence-based programs within another model that will have little effect on improving patient outcomes and simply

contribute to fragmentation of care for older people. As identified earlier, it is critical this model does more than previous programs to integrate with the GP-led care that is currently provided to older people in RACFs.

The new model must also build on successful programs and measures that are currently in place.

As flagged earlier, if this program is intended to replace other medicine review programs and activities, then there must be measures in place to ensure there is no reduction in support for GPs providing services to people in RACFs with this new program. Any funding that is currently provided to GPs to support medicine review programs (e.g. MBS Item 903) should be updated to reflect the changes in these programs if necessary.

10. References

[1] Welberry HJ, Jorm LR, Schaffer AL, Barbieri S, Hsu B, Harris MF, Hall J, Brodaty H. Psychotropic medicine prescribing and polypharmacy for people with dementia entering residential aged care: the influence of changing general practitioners. Medical Journal of Australia. 2021 Aug 2;215(3):130-6.
[2] Medical Services Advisory Committee. Minutes from MSAC 69th Meeting, 6-7 April 2017. Canberra, Australia: Australian government; 2017.