



STAKEHOLDER MEETING OUTCOME STATEMENT

Integrating Pharmacists within Aboriginal Community Controlled Health Services to Improve Chronic Disease Management (IPAC Project)

Monday, 10 October, 2022

1. Introduction

Attendees

Meeting attendees included members of the Medical Services Advisory Committee (MSAC); representatives of the applicant from Pharmaceutical Society of Australia, National Aboriginal Community Controlled Health Organisation (NACCHO) and James Cook University; representatives from Aboriginal Health Services (AHS) and Aboriginal Community Controlled Health Services (ACCHS); representatives from Northern Territory (NT) Health department; and representatives from the Australian Government Department of Health and Aged Care.

The Chair opened the meeting at 12.03pm. The Chair advised that the stakeholder meeting was not an MSAC decision making forum but would inform MSAC's future deliberations and advice to the Minister for Health and Aged Care by providing a better understanding of issues raised during its March-April 2022 consideration of Application 1678 - Integrating Pharmacists within Aboriginal Community Controlled Health Services to Improve Chronic Disease Management (IPAC Project). MSAC's subsequent advice would then be considered by the Government.

The Chair reminded participants that this was a confidential discussion, and an Outcome Statement would be published on the MSAC website.

The Chair provided an overview of MSAC's role and membership.

Purpose

The key objectives of the meeting were to allow MSAC to seek input from stakeholders on:

- What are the current funding arrangements for ACCHSs and AHSs?
- What are the barriers and enablers to implementation of IPAC?
- What funding issues might impact current and future arrangements?
- For ACCHSs not involved in the IPAC trial, what benefits/disadvantages/duplication of services?
- What is the preferred model of pharmacist support?

Conflicts of interest

The Chair noted that conflicts of interest had been declared and recorded, but in the context of this meeting conflicts did not need to be managed by exclusion from discussions.

2. Background

The Chair presented the background regarding MSAC's March-April 2022 consideration of Application 1678 which sought public funding of the IPAC Project. At that time, MSAC

deferred providing its advice on the IPAC Project. MSAC considered the model of care examined in the IPAC Project was an excellent example of an integrated, collaborative, patient-centred approach to primary care and has the potential to have a meaningful societal impact by improving equity of health outcomes for Aboriginal and Torres Strait Islander peoples. However, MSAC considered additional information was required to interpret the clinical significance of the biomedical outcomes, assessment of the qualitative feedback, revised economic analysis and presentation of the financial implications in the context of other relevant funding programs.

MSAC requested further advice on current funding arrangements for ACCHSs and how the proposed program would interact with existing initiatives such as the Indigenous Australian Health Programme. MSAC recommended that the Department organise a stakeholder meeting so that ACCHSs could provide input, which could help inform MSAC and provide some necessary context for decision-making. MSAC considered that it was important to better understand the diversity of ACCHSs.

A representative of NACCHO provided a brief introduction on the history, need and role of ACCHSs and the work undertaken by NACCHO to advocate for improved primary health care for Aboriginal and Torres Strait Islander peoples including improving access to medicines, the quality use of medicines and the need for funding integrated pharmacists to support ACCHSs. It was highlighted that Aboriginal and Torres Strait Islander people continue to be at higher risk for many health conditions such as rheumatic heart disease, kidney disease, circulatory disease and low birth weight, demonstrating that improving access to appropriate primary health care for Aboriginal and Torres Strait Islander peoples remains an ongoing priority.

The Department briefly presented the IPAC model proposed for implementation to stimulate discussion of the benefits and advantages of the IPAC Project, the barriers and enablers to implementing the IPAC Project nationally and how the proposed program would interact with existing initiatives.

3. Summary of discussion and outcomes

Benefits of the IPAC

After the Department introduced the IPAC model, the Chair welcomed opening comments from the stakeholders on the IPAC model.

The stakeholders shared their views on the benefits and strengths of the IPAC Project, reiterating that the integrated and collaborative healthcare provided by integrating pharmacists within ACCHSs will provide many benefits contributing toward improving health outcomes for Aboriginal and Torres Strait Islander peoples. One stakeholder reflected that Pharmaceutical Benefits Scheme (PBS) utilisation data showed relatively small amounts spent on Aboriginal and Torres Strait Islander people, reflected in ratios of Indigenous to non-Indigenous expenditure for the PBS and Medicare Benefits Schedule (MBS).¹ The stakeholders commended the IPAC trial for formalising the benefits of integrating pharmacists within ACCHSs and suggested that the trial duration potentially underreported the benefits. The work of the integrated pharmacists in supporting patients, coordinating and linking healthcare services, and undertaking quality use of medicine activities is highly

¹ Australian Institute of Health and Welfare (2022) Aboriginal and Torres Strait Islander Health Performance Framework, Tier 3 – Health System Performance 3.15 Access to prescription medicines.
<https://www.indigenoushpf.gov.au/measures/3-15-access-prescription-medicines>

valuable and can prevent adverse events such as medication errors thereby reducing the rate (and costs) of hospitalisation. This view was supported by pharmacists who are currently integrated in ACCHSs sharing how their collaboration with ACCHS has continued to strengthen and their roles have evolved. The pharmacists shared how the versatility of their role has allowed for the scope of activities and support they provide to be broadened substantially since the IPAC trial commenced to meet the needs of the ACCHS and patients.

The stakeholders also commended the patient and clinician experience video which the stakeholders considered highlighted the cultural safety the patient experienced when participating in the IPAC trial.

Current funding arrangements for ACCHSs and AHSs

The Chair noted there are several funding programs available to ACCHSs and AHSs and sought stakeholder input on how integrated pharmacists are currently funded.

Stakeholders representing the applicant, AHSs, ACCHSs and NT Health agreed in their views that the current funding programs are inadequate to support funding an integrated pharmacist. The stakeholders noted that while the Indigenous Health Services Pharmacy Support (IHSPS) Program provides some funding for a pharmacist to provide a range of quality use of medicines (QUM) activities, this funding is inadequate to support an integrated pharmacist and that an integrated pharmacist would provide a broad range of activities beyond QUM activities. Stakeholders also shared that while other programs exist, such as the Workforce Incentive Program – Practice Stream, Medical Outreach for Indigenous Chronic Disease Program (MOICDP), and Primary Health Networks – Integrated Team Care (ITC) and other local initiatives, these programs are already used to support other allied health professions. As such if these programs were used to fund integrated pharmacists instead, the ACCHSs would not be able to fund other allied health professions to provide services for patients, who may be able to attract Medicare benefits for the services provided and provide a means to supplement funding (pharmacists are not eligible health professionals for the purpose of claiming for MBS services). The ACCHSs also would not be able to fund other initiatives for patients such as fund continuous positive airway pressure (CPAP) machines.

Pharmacists who are currently integrated in ACCHSs reiterated these points and shared their individual experience in how a variety of funding sources and activities (IHSPS, providing vaccinations, academic funding) are used to fund their role (varying from part to full time) and in some cases the remaining funding for the role is supplemented through running costs. For example, integrated pharmacists working in an ACCHS cannot claim the time for conducting a Home Medicines Review (HMR), where an MBS item (item 900) provides for a general practitioner (GP) referral fee to an accredited pharmacist, who is separately paid for conducting the review under the Seventh Community Pharmacy Agreement (7CPA). It was highlighted that using a variety of funding sources is very challenging, creates a lot of administrative burden and can mean an ACCHS runs at a loss for the service provided, making the continued funding of the role highly unreliable.

Barriers and enablers to implementation of IPAC

Participants were advised that the enablers and barriers identified in the IPAC qualitative evaluation, that explored the perceptions of IPAC pharmacists, community pharmacists, healthcare staff, managers, and Aboriginal and Torres Strait Islander patients involved in the

IPAC trial, had recently been published (Drovandi et al. 2022)².

The views of stakeholders that didn't participate in the IPAC Project were sought on the barriers that prevented their participation. A representative from an ACCHS that did not participate in the IPAC trial explained the ACCHS was not eligible to participate as the ACCHS already employed an integrated pharmacist. A representative of the applicant confirmed that only ACCHSs from 3 states/territories (Northern Territory, Queensland and Victoria) were eligible to participate (based on the ethical approval granted) and ACCHS that already employed an integrated pharmacist were excluded from participating in the IPAC trial.

The stakeholders raised and discussed adequate ongoing funding, workforce, and support mechanisms as barriers/enablers for IPAC.

1. Adequate ongoing funding

Stakeholders representing the applicant, AHSs, ACCHSs and NT Health agreed that 'adequate ongoing funding' is an important enabler (or conversely inadequate funding is a barrier) for successful implementation of the IPAC model.

The stakeholders expressed that the knowledge that there would be adequate ongoing funding would have positive effects on successfully integrating pharmacists within ACCHSs. That assurance for the continuity of funding and the longevity of the program would improve the ability to recruit and retain pharmacists (i.e., providing job security). This would have several follow-on benefits including improving GP and patient engagement with the integrated pharmacists (i.e., GPs and patients are more likely to engage with the pharmacist if they know the pharmacist will be there on their next visit and the longer the pharmacist is retained the better the rapport with GPs and patients). The stakeholders also expressed that adequate ongoing funding was important to recruit pharmacists for a minimum term of one year, preferably a minimum of two years. The stakeholders shared that the longer the pharmacist was retained, the more they integrate with the community, learning the language and the cultural environment, which enhances their ability to perform their role as an integrated pharmacist in the ACCHS.

A GP from an ACCHS with an integrated pharmacist shared their experience that while the need for services at their clinic had increased (from one GP to five full time GPs), the funding for the integrated pharmacist had not increased. The stakeholder expressed their view that an integrated pharmacist is highly valuable (supporting both patients and GPs) and concern that there isn't stable ongoing funding for a role that can help decrease GP workload when the current GP and healthcare workforce are experiencing burnout.

2. Workforce

Stakeholders' views were sought on whether workforce issues would be encountered and the impact this may have on implementation.

Stakeholders representing the applicant, AHSs, ACCHSs and NT Health considered that this potential barrier could be overcome by establishing adequate ongoing funding for integrated pharmacists. The stakeholders reiterated that secure dedicated funding would create the opportunity to recruit and retain pharmacists. Further, the stakeholders considered that this

² Drovandi A, et. al. (2022) Enablers and barriers to non-dispensing pharmacist integration into the primary health care teams of Aboriginal community-controlled health services. *Res Social Adm Pharm* 18(10):3766-3774. doi: 10.1016/j.sapharm.2022.05.002

would promote long term retention and grow the workforce. This would create career pathways including for Aboriginal and Torres Strait Islander pharmacists who have the capability, skills and interest to work as integrated pharmacists in the communities being served by the ACCHSs and AHSs.

Representatives of the applicant highlighted that during the IPAC trial, there was high interest from pharmacists in being involved, that the trial was able to implement integrated pharmacists in remote areas and was able to re-recruit during the trial. It was also shared that the training program in the IPAC trial had now been further developed and that over 400 pharmacists have enrolled in the recently released Deadly Pharmacists foundation training program, suggesting that there is a strong interest for this kind of role. It was also noted that most ACCHSs and AHSs are in urban and regional locations, therefore only a small number of integrated pharmacists would be in remote locations.

Pharmacists who are currently integrated in ACCHSs expressed that the role provides them with a high level of job satisfaction and shared that they have encountered several pharmacists who are interested and looking for different career options but that the lack of adequate ongoing funding is a barrier.

3. Support mechanisms

Stakeholders representing the applicant, AHSs, ACCHSs and NT Health highlighted the need to ensure appropriate support mechanisms are in place to facilitate successful integration of the pharmacist and implementation of the program.

Stakeholders' views and experience were sought on the time it takes for a pharmacist to integrate into an ACCHS. Pharmacists who are currently integrated within ACCHSs shared their experience that it took from 3-6 months to integrate, to build rapport with staff and patients and for the value of the role to be realised (i.e., for GPs to fully understand and utilise the support the pharmacists can provide). The pharmacists reported that training, mentoring and networking initiatives created by NACCHO and the support of practice managers were important for helping the pharmacists integrate within the ACCHS. A GP shared their experience that initially it took 3-4 months to fully understand the role of the integrated pharmacist and another 3-4 months to fully appreciate the value the integrated pharmacist can provide. The GP reflected that while there may be some resistance from some GP to engage with the integrated pharmacist, that this is not insurmountable and can be overcome by education and support to realise the value and benefits the role provides.

The stakeholders also highlighted that ACCHSs are by nature a multidisciplinary health service such that GPs and other allied health professionals who work in these clinics take a collaborative patient-centered approach to providing healthcare to Aboriginal and Torres Strait Islander patients. Therefore, the issue is not resistance but the time to develop an understanding of the true value of the role and that once this is achieved there is a catalytic shift.

A representative of the applicant also highlighted that this issue was addressed in the recent publication by Drovandi et al (2022) which also reported how ACCHSs overcame this during the IPAC trial. It was also noted that support for implementation and onboarding is important and that NACCHO currently provides some national support to assist ACCHSs and pharmacists.

Funding issues that might impact current and future arrangements

The Chair sought input from the stakeholders on the issues they consider could impact current and future funding.

The stakeholders discussed potential issues: the diversity of ACCHSs, rural loading, full time employment and whether there is the ability to consolidate funding streams.

4. Diversity of ACCHSs

When MSAC considered the IPAC project in March-April 2022, the committee raised concerns around whether all associated costs had been included and whether the diversity of the ACCHSs had been considered when estimating the costs of the program. For example, the availability of accommodation in very remote regions and whether a proportion of costs may need to be attributed to this issue. Input from participants was sought to help MSAC understand the true costs which in turn can help MSAC form its advice.

A representative of NACCHO agreed that accommodation can be an important issue in some areas but that in collaboration with the Department, a review of infrastructure had been completed recently with some improvements pending. Therefore, it was considered that costs related to accommodation did not need to be included as part of the IPAC program funding.

The stakeholders reflected that it was difficult to advise on how the diversity of ACCHS can be factored in when costing the program without knowing what the funding model would look like (i.e., where part of the integrated pharmacists time would be shared in the community to help cover funding, whether a hub and spoke model would be used, etc.). The stakeholders felt it was important for the funding model to be flexible to allow for evolution of best practice, to allow services to collaborate and to incorporate an approach that allows for recognition of the challenges for rural/remote locations and scaling of funding for rural/remote locations. A representative of NACCHO agreed and highlighted that NACCHO is experienced in applying formulas to account for the difference between ACCHS (e.g., metro ACCHS versus an ACCHS with smaller patient numbers but servicing 15 outreach stations) and can use this experience to work this out carefully with the Department.

5. Rural loading

The stakeholders further elaborated on the challenges for rural/remote locations and how incorporating a rural loading mechanism in the funding program would be important. A representative from NT Health expressed that not all remoteness is equal, especially when you consider the vast remoteness and population size in the Northern Territory. While a location may appear relatively close on a map this doesn't correlate with accessibility. That is, access by car is not always possible and may require travel by boat or plane. A stakeholder noted the WIP includes a sliding scale for remoteness which could be a useful starting point for future discussions between stakeholders and the Department to review and further develop a rural loading mechanism within the IPAC model.

6. Full time equivalent (1.0 FTE) employment

The stakeholders raised that it was important for the funding model to be flexible and adequate in terms of supporting pharmacists to achieve 1.0 FTE employment. It was highlighted that other employment opportunities to supplement and achieve 1.0 FTE employment differ depending on location. For example, an integrated pharmacist working in a rural/remote ACCHS who is funded part time (less than 0.8 FTE) may find it impossible to identify other employment opportunities to supplement and achieve 1.0 FTE employment.

However, an integrated pharmacist working for an urban ACCHS may have more opportunities to supplement and achieve full time equivalent employment.

7. Consolidate funding programs

The views of stakeholders were sought on whether there may be an argument for rationalising the existing funding streams into a consolidated funding program that is flexible and could also be used as a program to fund integrated pharmacists in ACCHSs and AHSs.

Stakeholders acknowledged that a consolidated funding stream could be beneficial (e.g., less administrative burden, easier to navigate than multiple disparate funding streams with different rules) however, the stakeholders also expressed several reservations. The stakeholders reiterated that the current funding amounts under the existing programs is inadequate to support funding an integrated pharmacist. Representatives of NACCHO were opposed to consolidating funding for IPAC with the IHSPS and questioned whether it was appropriate to consolidate funding for an integrated pharmacist in ACCHS/AHS with IHSPS funding as the IHSPS is funded and administered as part of the 7CPA. It was also highlighted that there is a lack of data on the provision of HMRs for Aboriginal and Torres Strait Islander peoples and that there is a risk of unforeseen consequences if the programs are consolidated without such data. The stakeholders also noted that IPAC was trialed alongside these programs. Therefore, the stakeholders felt that clear rules and support for the ACCHSs and AHS to understand how the programs work alongside each other would be more beneficial than consolidating the programs.

8. Equity of access

A representative from NT Health noted that while the IPAC trial was conducted within ACCHSs, Aboriginal and Torres Strait Islander people should not be disadvantaged in communities where health services are delivered by the Government. Therefore, it was advocated for the IPAC program to be available to all AHS regardless of the governance model (i.e., community or government run).

4. Meeting close

The Chair thanked the participants for their valuable insights and closed the meeting at 2.00pm.