2022/23 Australian Government Pre-Budget Submission

Healthy Collective

It's good to be healthy.

Contacts

Nick Tsamaidis BPharm

Managing Director

The Healthy Collective

Nick.tsamaidis@healthyretail.com.au

0403 015 160

Joseph Whitehouse BPharm AACPA

Director

Healthy Care Services

Joseph.whitehouse@healthycareservices.com.au

0418 477 396

Address

The Healthy Living Precinct – Welland

16-20 Hindmarsh Ave

Welland SA 5007

Executive Summary

Healthy Collective is a private membership-based organisation for individuals, primary healthcare practitioners and other care providers. We work together with practitioners in our network to provide coordinated service delivery models for individual consumers and care organisations.

Pharmacy services for aged care facilities is a core business unit and strategic focus; our directors and network practitioners have decades of experience in pharmaceutical supply, medication packing, clinical service provision through Residential Medication Management Review (RMMR) and Quality Use of Medicine (QUM) programs.

In this pre-budget submission, we are proposing a progression of existing programs to encompass the scope of all pharmacy services provided to aged care and enable enhancement of existing clinical service and medication governance funding models to facilitate effective response to critical medication safety issues in aged care, including responding to key recommendations from the Royal Commission into Safety and Quality in Aged Care.

We have undertaken considerable industry consultation regarding these concepts, including with pharmacy peak bodies and key stakeholders. A support letter from the Pharmacy Guild of Australia accompanies our submission, and we will be continuing this engagement with other industry groups in coming months.

Proposed Framework – Key Elements:

Our proposed framework is structured to address the following key elements relating to quality use of medicines in aged care.

While not immediately encompassed in our proposal, we believe these elements can also be expanded to primary care (community-based) settings, supporting consumers in the community with management of their chronic disease in partnership with the primary care team including General Practice.

Our proposed framework includes:

1. Formal and accountable Clinical Governance through the Medication Advisory Committee (MAC) in RACF's linked to an integrated Medication Management Service Level Agreement (SLA)
2. Workforce training and upskilling to support integrated, multi-disciplinary approach to medication management
3. Onsite (in-facility) clinical pharmacy services – the embedded pharmacist model with enhanced and integrated Residential Medication Management Review (RMMR)
4. Funded 24/7 offsite medication access services – via the community pharmacy network
5. Continued use of Pharmacy Program Authority (PPA) structure for payment – including approved providers but introducing, incrementally, site-level accountability for service level delivery from all stakeholders with alignment to Quality Indicators
6. Accountability of procurement and contracting arrangements to ensure they meet client needs and local application of accreditation standards

About – The Healthy Collective

The Healthy Collective brings together for the first-time, citizens, health and wellness practitioners and other stakeholders with a vision to build a healthy community through consistent, transparent, and accessible holistic healthcare options. The Healthy Collective helps citizens, and their providers optimise their care and wellness goals by creating a governed environment that makes working with others easy to access while retaining independence. The Healthy Collective has a network with many health professionals and practices including GP's, pharmacies, and allied health practitioners as well as over 70 aged care and disability providers across Australia.

The role of The Healthy Collective is to work with potential collaborators such as state and federal government departments, insurers, local councils, health, wellbeing and other community and sporting organisations to support the strategic and operational objectives of each organisation.

Citizens can join The Healthy Collective (HC) via direct membership or enrollment into a HC managed health program or through our network of practitioners and providers existing clients base – **Healthy Networks**

We will create optimised care solutions by bringing together health professionals from all disciplines, social enterprises, wellness, and lifestyle providers to create consistent, transparent, and accessible holistic healthcare options under new, shared care models. – **Healthy Ventures**

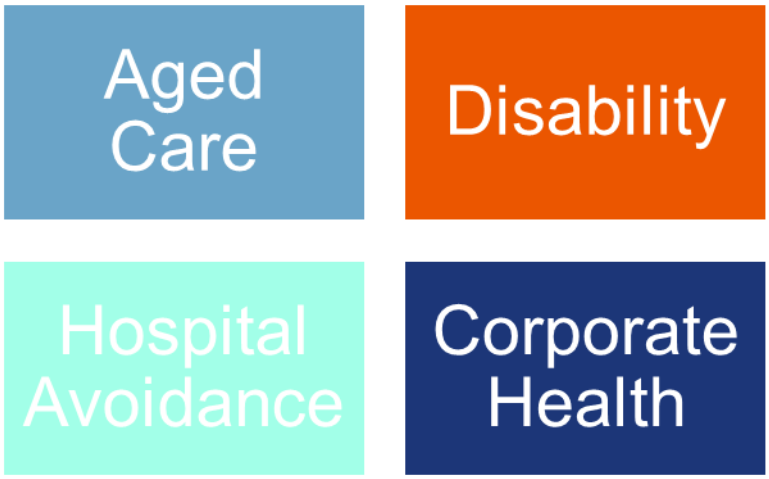
The HC provides better opportunities for integrated rather than siloed care and stronger links and structures to achieve innovative health ventures supported by its internal project management and support services. The HC Executive team and Board ensure operational efficiency, partner communication and corporate/and clinical governance – **Healthy Support**

Our priorities have been developed to achieve our strategic objectives, specifically of our charter:

- *improve consumer outcomes.*
- *improve consumer value through consistent, transparent, and measurable care.*
- *facilitate shared care structures and initiatives.*
- *grow the governance, economic, digital and workforce capabilities of all Parties.*
- *improve integrated service delivery across primary care including aged care and disability.*
- *create primary care initiatives for hospital avoidance, including Hubs of Care*
- *provide procurement support, shared services and business growth opportunities to all affiliates*

About – Healthy Care Services

Healthy Care Services (HCS) is a division of The Healthy Collective with a primary purpose to facilitate coordinated care solutions, clinical governance, and business support in primary care setting, with a particular focus to improve primary healthcare delivery in the home care/community, aged care and disability sectors.



We have many years of expertise in delivering and managing pharmacy services in aged care in particular:

- Medicine supply to 6000+ RACF beds nationally (70+ RACFs) from subcontracted pharmacies
- Provide clinical pharmacy services – Residential Medication Management Reviews and Quality Use of Medicines (RMMR & QUM Program) through collaboration with independent local practitioners
- Our approach is "corporate yet local" – single point of governance for service provision, community engagement, consumer choice and responsive care
- Quality Assurance via the Medication Advisory Committee (MAC) is the cornerstone of our service across multiple providers and care locations to assist in the development, promotion, monitoring, review and evaluation of medication management policies and procedures.
- Providing support across Australia working with multiple community pharmacies and RMMR providers, over 70 Aged Care facilities including small private and larger corporate and not for profit organizations.

National Strategy for Quality Use of Medicines

Australia's National Medicines Policy[1], published in 2000 aims to deliver positive health outcomes for all Australians through their access to and appropriate use of medicines. It is a well-established and universally endorsed framework based on partnerships between consumers and all segments of the medicines sector.

This national strategy and the concepts surrounding the National Medicines Policy have underpinned our thinking and approach to developing our proposed framework.

Essential components of Australia's National Medicine Policy:

- Timely access to medicines
- Medicines meet appropriate standards
- **Quality use of medicines**
- Responsible and viable medicines industry

Principles to the National Strategy for Quality Use of Medicines:

- Primacy of consumers
- Partnership
- Consultative, collaborative, multi-disciplinary activity
- Support for existing activity
- Systems-based approaches

We note that a high level review aimed at identifying any gaps in the National Medicine Policy objectives, partnership approach and accountabilities is currently underway and it would be our intention to ensure our proposed framework and continued service models are consistent with the outcomes of that review.

[1] National Medicines Policy © Commonwealth of Australia 1999 ISBN 0 642 41568 4 https://www1.health.gov.au/internet/main/publishing.nsf/Content/B2FFBF72029EEAC8CA257BF0001BAF3F/$File/NMP2000.pdf

Snapshot of current pharmacy contracting arrangements for RACFs in Australia

Contracting arrangements for pharmacy services for RACFs in Australia require three separate agreements.

I. A service level agreement for medicine supply services – typically encompass the mechanisms and expectations for daily medicine dispensing, packaging, after hours support, service payments, service review and performance indicators.
II. An agreement for provision of Residential Medication Management Review (RMMR) services – using a standard template provided by Pharmacy Program Administrator (PPA), the agency responsible for management of the Community Pharmacy Programs funded under the 7th Community Pharmacy Agreement (7CPA).
III. An agreement for provision of Quality Use of Medicine (QUM) services – using a standard template provided by the PPA.

The following table provides an overview of contracting arrangements.

SLA type:	Medicine Supply	RMMR Service	QUM Service
Type of agreement	**Private arrangement between pharmacy and care organisation.** No standardisation or oversight for quality outcomes.	**Standard agreement aligned to program rules and outcomes.** Multiple service providers can be engaged (non-exclusivity).	**Standard agreement aligned to program rules and outcomes.** Exclusively one provider per RACF.
Service provider	Section 90 (PBS) pharmacy	Must be a registered service provider (including S90 PBS pharmacy) with accredited pharmacist providing the service	Must be a registered service provider (including S90 PBS pharmacy) with accredited pharmacist providing the service
Services provided	PBS dispensing, DAA packing, management of patient profiles, afterhours support, daily deliveries, medicine data access, pharmacy procedures, participation in MAC, etc.	Comprehensive review of medications for individual patients following GP referral. Can now include Follow Up services.	Participation in MAC, clinical education, policy review, DUE services, etc.
Funding	PBS dispensing fee + patient co-payment (same as for community). Excluded from community DAA payment. May be private service fee for DAA packing (minority of cases).	Fee per service from government (PPA).	Rolling quarterly payment from government (PPA) with self-report of providing two 'services' per quarter.
Accountability Measures	Pharmacist accountability for accurate dispensing. PBS rules and private contracts.	Paid per service – no quality measure or accountability for outcomes.	Self reported on activity, not quality of service provided. No accountability measure.

Key points

- To provide services and receive funding for RMMR and/or QUM services for aged care, a pharmacy service provider must be registered with the PPA and abide by the specific program rules.

- The RMMR and QUM service provider can be a section 90 community pharmacy but does not have to be.
- There is no register for medicine supply service level agreements which are typically a private arrangement between the servicing community pharmacy and the care organisation.

Strengths and Weaknesses

The current model for contracting of pharmacy services has both strengths and weaknesses, as summarised in the table below.

Our proposed framework seeks to address many of the weaknesses identified while maintaining or enhancing various strengths.

SLA type:	Medicine Supply	RMMR Service	QUM Service
Strengths	**Nationally available workforce** through established community pharmacy network.	**Funded and established practice.** Person centred, comprehensive clinical review, responsive to clinical need, can be timely on admission to a facility, follow-up services are useful, collaborative with GP and clinical team.	**Funded**. Ability to customise a SLA based on a recommended list of activities (despite being a limited list).
Weaknesses	**No funding for offsite clinical services.** This means that medicine supply related services can be variably provided. Afterhours is not always available. Medicine packing is not standardised. Timeliness of delivery is variable. Responsiveness around clinical need is variable. Data integration and aggregation is variable. "Value-adds" have become expected. **As a result the service outcomes cannot be influenced by government or standards provider, and the system has resulted in accumulation of service contracts by small number of operators who have developed business models around economies of scale and efficiency.**	**No accountability for quality** - service provision has become commoditised. Can be stilted in structure, wait between referral to review, irregular timing of attendance, not easily conducive to case-conferencing, do not enable a clinical service that is integrated with medicine supply and can respond to simple clinical issues, respite residents are excluded. **Workforce dependent.**	**No accountability for quality – self report of a minimum service to meet QUM contract terms** – has lead to commoditisation of service. The current program creates a false separation of the goal of QUM as an overarching approach – QUM should connect **medicine supply**, **RMMR**, **clinical governance**, **quality improvement**, **training** and **workforce development**. The separating of the payments impacts the viability of having an integrated service which could enable a pharmacist with dedicated time in the facility each week if QUM service provider integrated with medicine supply **and** RMMRs.

Proposed Framework

We are aiming to enhance outcomes for residents, their families and the workforce through addressing the following:

1. **Accountability for service quality** – we are looking to introduce a framework for accountability of service providers in meeting quality indicators and outcome measures (evidence based).
2. **Reduce siloing of service providers (RMMR/QUM/medicines supply)** – we are looking to create structures which facilitate collaboration from pharmacy service provider types to enable comprehensive approach to QUM (aligned with the National Medicines Policy) and effective contributions to clinical service teams.
3. **Address commoditisation and imbalance of funding arrangements** – we are looking to rework funding rules to direct remuneration towards providers based on service levels and performance.
4. **Increase access to pharmacists at point of care** – we are looking to enhance the RMMR program to facilitate more meaningful and responsive onsite clinical pharmacist services (workforce dependent).
5. **Empower the care workforce**, so they are better supported to manage medication risks in aged care and optimise patient outcomes.
6. **Adress recommendations from the Royal Commission into Safety and Quality in Aged Care** – through cost-effective and meaningful evolution of existing models.
7. **Facilitate the continuity of services between care settings** (community, residential, hospital) – through expansion of current community pharmacy programs to improve their applicability, cost-effectiveness, and accessibility.
8. **Challenges around having a pharmacist workforce to provide RACF services** – we believe the framework can revitalise the pharmacist workforce and industry expectations relating to holistic quality use of medicine services for aged care.

Improved Patient Experience

The proposed model has a patient centric intention and is designed to improve patient (resident) experiences through:

- Increased presence of pharmacists on site for direct patient contact (counselling, advice, information sharing, etc.)
- Increased involvement of pharmacists in care team to support their safe and optimal prescribing and administration of medicines, especially in relation to transitions of care
- Improved access to pharmaceuticals and responsiveness to clinical needs
- Minimised out of pocket costs to the consumer for medication supply (packing fees, private margins, transport costs, etc.)
- Increased involvement of pharmacists in medication governance, reporting and policy implementation, thereby releasing the clinical staff for more appropriately suited patient-centred activities

Royal Commission – Recommendations Relating To Medication Management

Our proposed framework seeks to address some of the important recommendations from the Royal Commission into Safety and Quality in Aged Care relating to medication management.

Recommendation	How the framework meets the recommendation
#19 – Review of quality standards	Improved implementation of new quality standards by onsite and offsite pharmacists working alongside clinical workforce (nurse, GP, carer). Governance of standards of practice by MAC.
#22,23,24 – Use of Quality Indicators	Increased funding for involvement of pharmacists via MAC, offsite services and onsite (embedded) roles to manage data collection, analysis and quality improvement activities.
#38 – Arrangements with allied health including pharmacists (blended funding).	Provision of point-of-care pharmacist engagement through onsite pharmacist services (component 1b.) who will be available to optimise medication use for individual residents. Blended funding options through flexible contracting arrangements according to needs of local community.
#58 – Access to pharmacists through LHN Multidisciplinary Outreach Services	Improved funding for dedicated onsite and offsite pharmacist resources, leading to improved capacity for information transfer, communication channels and follow up actions in response to outreach services provided by LHNs.
#64 – RMMRs upon entry and annually. Monitor quality & consistency of RMMRs.	RMMR program is enhanced and integrated into the role of the dedicated onsite clinical pharmacy services that review all new admissions, contribute to case conferences and provide regular review and follow up for all medication related matters – for all residents.
#66 – Continuity of medication management at transitions of care.	More efficient and accurate transfer of medication information between RACF and hospital due to increased presence of onsite pharmacists.
#67 – Tracking of PBS usage in RACFs (linking to aged care identifier).	Use of onsite pharmacist who is integrated with local community pharmacy (offsite pharmacists) is ideally suited to implement changes required to adopt an aged care identifier for MBS and PBS utilisation in aged care.

7th Community Pharmacy Agreement (2020-2025)

Our proposed framework has been created with awareness of the intended outcomes of the 7th Community Pharmacy Agreement (7CPA) and as an evolution of the related Community Pharmacy Programs.

Continuing Community Pharmacy Programs include:

- Home Medicines Review
- Residential Medication Management Review
- Quality Use of Medicines in Residential Aged Care Facilities
- MedsCheck
- Diabetes MedsCheck

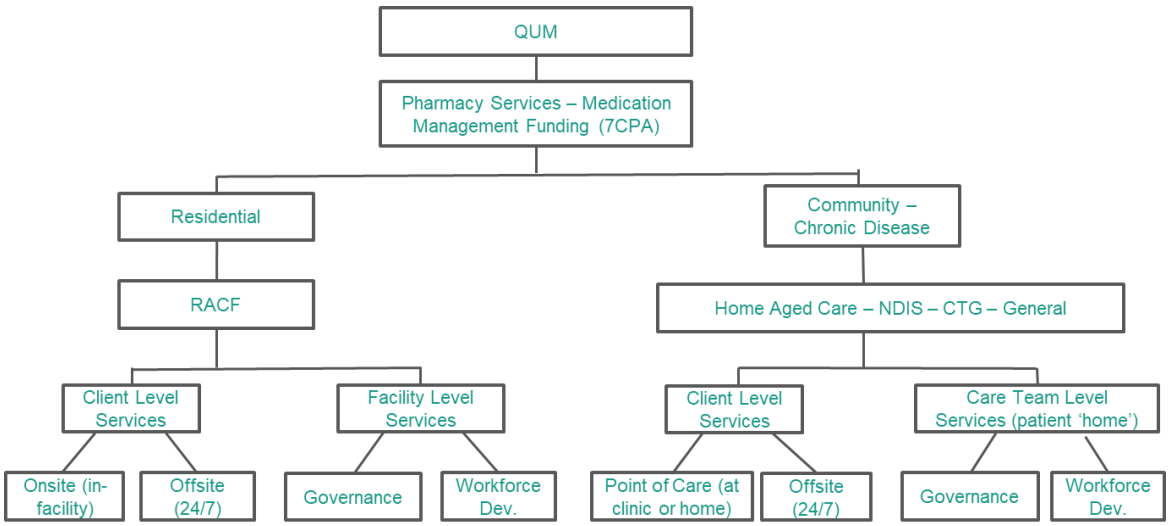
We also note the following points made within the agreement which relate to community pharmacy programs for aged care (section 9.3 of the agreement):

- The CPA programs will be largely unchanged during the first Financial Year;
- It is the intention of the Commonwealth to maintain investment in CPA programs designed to support older Australians and arising from the Royal Commission into Aged Care Quality and Safety.
- The Commonwealth intends to undertake an assessment of the CPA programs which is expected to commence during the second Financial Year.

Proposed Framework – Overarching Approach -:

Taking a holistic view to quality use of medicines in society, we have mapped out key elements for pharmacy services to both residential and community-based settings, particularly in relation to chronic disease.

In both settings there is a need to deliver services at a client level (resident or consumer) and at a care team level (care facility or primary care team), as summarised in the diagram below.



At the client level, the nature of pharmacy services as they relate to medicine management means there are significant activities that are based **outside of the care setting** (in the pharmacy, or 'offsite') and **within the care setting** (at point of care, or 'onsite').

- Offsite services include those pertaining to medication procurement, storage, dispensing, packaging and delivery. With changing care needs in the community and residential settings, the requirement for these services at all times of day and night is increasing.
- Onsite services relate to direct engagement with consumers to optimse their use of medicines, understand the clinical challenges they are facing, and provide advice and guidance to carers and other health profiessionals relating to the impact of medication use and appropriate prescribing, monitoring and review of medicines.

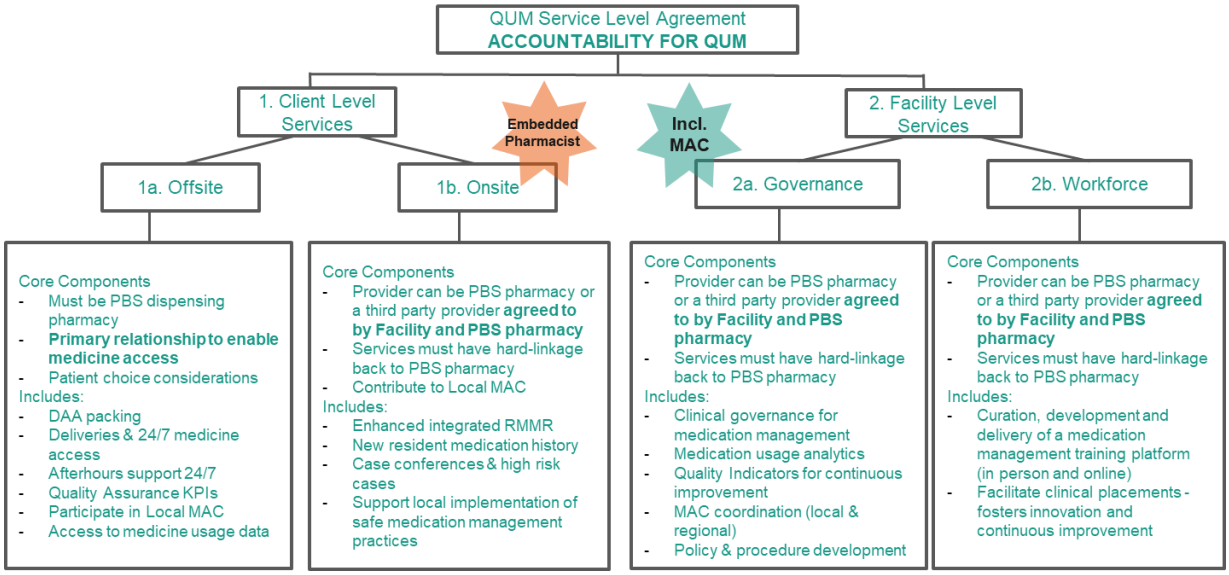
Care team level services by pharmacy are those which optimise clinical systems service delivery by carers and clinicians, through **governance** – including contributing to local policies & practices, reporting and review of medication management incidents and trends, and **workforce development** – including training and support for clinicians at all levels to enable safer and more appropriate medication management.

Proposed Framework –Focus on Aged Care:

Application of our proposed framework for the context of residential aged care.

The following diagram breaks the framework into the specific components and summarises the types of services included in each component.

- **Component 1** relates to Client Level Services including Offsite (**1a**) and Onsite (**1b**) services.
- **Component 2** relates to Facility Level Services including Governance (**2a**) and Workforce Development (**2b**).



Through this framework we believe the following objectives can be effectively and sustainably addressed.

1. Introduction of formal and accountable Clinical Governance through the **Medication Advisory Committee (MAC)** in RACF's linked to an integrated Medication Management Service Level Agreement
2. Workforce **training and upskilling** in medication management
3. Onsite (in-facility) clinical pharmacy services – the **embedded pharmacist model with enhanced & integrated RMMR**
4. Funded 24/7 offsite medication access services – via the **community pharmacy network**
5. **Continued use of Pharmacy Program Authority (PPA)** for program management and funding mechanisms – including approved providers but introducing, incrementally, accountability and sign-off (via MAC) for assurance that services are meeting defined service level performance indicators for all stakeholders
6. **Accountability of service procurement and contracting arrangements** to ensure they meet client needs and MAC standards

Proposed Approach To Contracting For QUM in RACFs

Our proposed framework supports the role of the governance hierarchy within RACFs to engage pharmacy (QUM) service providers of their choice.

This means, each RACF can factor in the needs and capabilities and preferences of their clients, community and local stakeholders, which may be different between RACFs in different settings (e.g. rural and remote settings vs. metropolitan settings and small operators compared to large corporate care organisations).

The following principles are important considerations for how providers should be engaged, considering the primary functional purpose of safe and timely supply of medicines for residents.

Contracting considerations:

1. **Find a 'medicine access provider' – this must be a PBS dispensing S90 community pharmacy (Component 1a)**

Then, with engagement & collaboration with the PBS dispensing pharmacy find and engage:

2. **An onsite clinical provider (Component 1b)**
3. **A QUM governance provider (Component 2a)**
4. **A QUM workforce development provider (Component 2b)**

Notes

- A PBS pharmacy can provide services 1,2,3 & 4 under a comprehensive arrangement. This may be the preference of the RACF organisation, subject to the PBS pharmacy having capability to provide all services.
- Alternatively, one or multiple non-PBS pharmacy organisations (service providers) can provide services 2,3 & 4 in collaboration with the PBS pharmacy. To ensure positive working relationships and collaborative outcomes, their engagement should ideally be agreed to by both Facility and PBS pharmacy
- An alternative option is to engage a QUM governance provider (Component 2a) first, then the pharmacy, clinical provider and workforce development provider are selected

Further Detail – Service Definitions for Each Component

We have further developed a concept for the types of services provided within each Component, and made calculations around the time requirements and expectations for each.

Component 1. Client Level Services

→ 1a. Offsite Clinical Services (Community pharmacy network)

Example based on 100 bed RACF:

24-hour service and support
- 168 hours – 20 hours = 148 hrs per week not covered by onsite pharmacist - includes:

Client medication profile management for DAA packing and QI data
- Approx. 10-12hrs/wk

Daily deliveries and A/H access to medicines
- Approx. 10hrs/wk

Therapeutic advice and policy/procedure system implementation
- Approx. 2-4hrs/wk)

DAA packing processes & consumables
- Compare to community DAA payments ~$6/patient/week)

These services are provided over-and-above current PBS dispensing service expectations for community pharmacy and for residential aged care they are excluded from the Dose Administration Aid (DAA) community pharmacy program.

→ 1b. Onsite Clinical Services (Embedded pharmacist services)

Example based on 100 bed RACF:

New admissions and discharges from hospital – Est. 100 per year
- 2x 3hr per week = 6hrs/wk

Case conferences – Estimate 2 per patient per year (200 per year)
- 4x 2hr per week = 8hrs/wk

Other/adhoc advice, data collection, peer support, practice improvement, etc.
- Approx. 6hrs/wk

Total time commitment approx. 20 hrs per week per 100 beds

These services are based on enhancement of the existing RMMR program to encompass the principles of the 'embedded pharmacist' in aged care. The scope of services could be introduced in a step-wise fashion to accommodate pharmacist workforce availability e.g. tier 1: new admissions & high risk case review, tier 2: case conferences and tier 3: Other/adhoc services.

Component 2. Facility Level Services

→ 2a. QUM Governance (accountability through MAC meetings)

Governance for QUM includes:

- Multidisciplinary approach – GP/medical, nursing, pharmacy, management, consumer
- Management/administrative support for MAC Meetings
    - Local MAC at facility level – quarterly
    - Corporate or Regional MAC at group level or geographical region – at least bi-annually
- Quality assurance to manage quality of medication management and pharmacy services against KPIs
- Aggregation and cleansing of medicine data for Quality Improvement indicators (DUE, analytics & benchmarking)
- Leadership for medication management policies & procedures through clinical governance channels
- Direction for workforce development and training needs analyses

→ 2b. Workforce Development (medication management training)

Upskilling of care workforce to provide safe and optimal medication management (QUM at point of care)

- Content uses principles of Continuing Professional Development (for RN/EN)
- Carer education enables credentialling against agreed best practice standards
- Tailored education relating to current policies & practices in place within the facility
    - Guided and governed by direction from MAC
    - Flexible delivery options
    - Online learning
    - Face to face training
    - Mentor development (Train the Trainer)

Options for Service Provision Based on RACF Size

We have considered options for RACF service provider selection based on different context.

1. Single RACFs – small and large

Provider type		Single facility – small regional	Single facility – large metro
Description		**Single site in country area <50 beds**	**Single site in metro area <90 beds**
CLIENT LEVEL SERVICES	**1.a Offsite clinical service provider (PBS Pharmacy)**	The local pharmacy in the country town is ideally suited to provide local, responsive medicine supply services (offsite clinical services).	The RACF is empowered to identify and select a community pharmacy to provide medicine supply services (offsite clinical services) in a way that meets their unique need.
	1.b Onsite clinical service provider	The local pharmacy is able to be funded to deliver a local onsite clinical service. This is the ideal model for a community focussed, consistent offering.	The RACF can elect to receive services from the community pharmacy or they can engage a third party clinical service provider to deliver the services. Regardless of model, integration and collaboration between service providers is monitored via MAC.
FACILITY LEVEL SERVICES	**2.a QUM Governance provider**	The local pharmacy can provide the QUM Governance, or the RACF can engage a third party QUM Governance Provider which may bring benefits of breadth of input, independent advice and industry awareness.	The local pharmacy can provide the QUM Governance, or the RACF can engage a third party QUM Governance Provider which may bring benefits of breadth of input, independent advice and industry awareness.
	2.b Workforce Development provider	The local pharmacy, if capable, can offer workforce development for RACF staff. However, a more suitable model maybe to engage a third party to provide the workforce development. If the latter, governance for workforce development activities is managed by the QUM Governance Provider via the MAC.	The community pharmacy, if capable, can offer workforce development for RACF staff. However, a more suitable model maybe to engage a third party to provide the workforce development. If the latter, governance for workforce development activities is managed by the QUM Governance Provider via the MAC.

2. Multi-group RACFs – small and large (national)

Provider type		Single facility – small regional	Single facility – large metro
Description		**Single site in country area <50 beds**	**Single site in metro area <90 beds**
CLIENT LEVEL SERVICES	**1.a Offsite clinical service provider (PBS Pharmacy)**	The local pharmacy in the country town is ideally suited to provide local, responsive medicine supply services (offsite clinical services).	The RACF is empowered to identify and select a community pharmacy to provide medicine supply services (offsite clinical services) in a way that meets their unique need.
	1.b Onsite clinical service provider	The local pharmacy is able to be funded to deliver a local onsite clinical service. This is the ideal model for a community focussed, consistent offering.	The RACF can elect to receive services from the community pharmacy or they can engage a third party clinical service provider to deliver the services. Regardless of model, integration and collaboration between service providers is monitored via MAC.
FACILITY LEVEL SERVICES	**2.a QUM Governance provider**	The local pharmacy can provide the QUM Governance, or the RACF can engage a third party QUM Governance Provider which may bring benefits of breadth of input, independent advice and industry awareness.	The local pharmacy can provide the QUM Governance, or the RACF can engage a third party QUM Governance Provider which may bring benefits of breadth of input, independent advice and industry awareness.
	2.b Workforce Development provider	The local pharmacy, if capable, can offer workforce development for RACF staff. However, a more suitable model maybe to engage a third party to provide the workforce development. If the latter, governance for workforce development activities is managed by the QUM Governance Provider via the MAC.	The community pharmacy, if capable, can offer workforce development for RACF staff. However, a more suitable model maybe to engage a third party to provide the workforce development. If the latter, governance for workforce development activities is managed by the QUM Governance Provider via the MAC.

Costings – Proposed programs (estimate)

Component 1 – Client Level Services (100 bed RACF)

- **1a. Offsite**: $10 per 'weekly medication service'
    - = $10 x 100 beds x 50 weeks = **$50,000 pa**
- **1b. Onsite**: 20 hours per week at $50/hr = $50,000 pa
    - = 20 hours x $50 x 50 weeks = **$50,000 pa**

Annually/Nationally (~200,000 beds)

- 1b. Onsite: $50,000 per 100 beds = $100 million per annum
- 1a. Offsite: $50,000 per 100 beds = $100 million per annum

Total $200 million per annum

Note: funding can be introduced incrementally to reflect workforce limitations and upscaling of service deliverables

Component 2 – Facility Level Services (100 bed RACF)

- **2a. QUM Governance**: $50 per patient per year (modelled on current QUM funding)
    - = $50 x 100 beds = $5000 pa
- **2b. Workforce Development**: $50 per patient per year
    - $50 x 100 beds = $5000 pa

Annually/Nationally

- 2a. QUM Governance: $50 x 200,000 beds = $10 million per annum
- 2b. Workforce Development: $50 x 200,000 beds = $10 million per annum

Total $20 million per annum

Grand Total $220 million per annum

Mechanism For Payment

Using the existing PPA paid to approved service providers

- **1a. Offsite** – Weekly Medication Management Service similar to current DAA in community – signed off quarterly by MAC based on reporting of incidents, deliveries, afterhours, accuracy audits and other KPI's are reported to the MAC Committee
- **1b. Onsite** – Embedded (in-facility) clinical services – New Admission and Case Conferences (enhanced RMMR) – signed off quarterly by MAC based on attendance levels and improvements in Quality Indicators - reported to the MAC Committee
- **2a. QUM Governance** – based on operation of MAC meetings (local and regional), medication management policy manual signed and reviewed annually, Training Needs Analysis and medication data collection & reporting as satisfied by facility Clinical Governance Committee/Representative - reported to the MAC Committee
- **2b. Workforce Development** – Training plan submitted, and evidence of training sessions provided for payment – signed off quarterly by MAC Committee

Important Considerations – Q&A

Does the proposed framework incorporate 'embedded pharmacists?

Yes. The 'onsite clinical' component incorporates the role of an embedded pharmacist working alongside the clinical team at the facility.

How does the proposed framework ensure separation of 'medication supply' and 'clinical' services?

The proposed framework is not explicit in how these services are contracted to the RACF. We recognise that the needs and opportunities for pharmacy services into RACFs hare highly varied throughout different settings, especially in regional and remote areas where a holistic community offering is optimal. Therefore the framework must be flexible enough to enable a variety of service models which could include 'supply' and 'clinical' coming from the same party, or from different (independent) parties. Regardless of which model works best in a given setting, the framework ensures that governance for quality and outcomes comes from the multi-stakeholder Medication Advisory Committee (MAC) rather than any single service provider.

How confident are we that the framework can work – is there evidence of success?

The principles presented in the proposed framework are embedded in the models we have in place for servicing 70 RACFs through Healthy Collective. Our centralised contract management arm, Healthy Care Services (HCS) is accountable for pharmacy service provision through contracted terms, with PBS pharmacies being engaged to deliver local medicine packing and supply and independent clinical providers (accredited pharmacists) being engaged to provide RMMR and QUM services. We have built this model through existing relationships with pharmacy and aged care groups, despite current contract frameworks not naturally supporting it. Formalising of the core principles through a rework of the contracting framework (as proposed) is an essential step to enable a multi-stakeholder and comprehensive approach to QUM in aged care.

Does the framework consider all relevant industry stakeholders?

We believe that the framework is flexible enough to resonate with all relevant stakeholders, and consider this as a key priority to facilitate a sustainable and holistic service using existing workforce and commercial models. Community pharmacies, independent pharmacy consultants, larger medication review and training providers are all factored into the framework, which is designed to enable collaboration and partnership of multiple stakeholders around a common goal.

How does the framework support multidisciplinary approaches to provision of care?

The framework presents a structure for funding and contracting of comprehensive pharmacist input into QUM, recognising that effective QUM strategies require multidisciplinary input from all stakeholders involved in medication management – nursing, GP, carers, consumers etc. These stakeholders contribute to overall service governance through participation in the MAC, as well as daily clinical tasks undertaken by the pharmacist.










Healthy Collective

It’s good to be healthy.