Australian Association of Consultant Pharmacy (AACP) comments on the discussion paper on the Review of Pharmacy Remuneration and Regulation

The AACP welcomes the opportunity to provide comments on the discussion paper. Whilst a number of the issues raised in the paper are not related to the AACP and the role of accredited pharmacists, this response provides brief comments on those questions raised in the paper which relate to the role of accredited pharmacists.

About the AACP

The Australian Association of Consultant Pharmacy Pty Ltd (AACP) was established to develop a national approach to the practice of ‘consultant’ pharmacy as an expansion of the professional health role of pharmacists in Australia. The AACP is jointly owned by the Pharmaceutical Society of Australia (PSA) and The Pharmacy Guild of Australia (the Guild).

The AACP is one of only two organisations authorised by the Australian Department of Health to credential pharmacists to conduct medication management reviews.

Accreditation with AACP entitles pharmacists to claim for remuneration for Home Medicines Reviews (HMRS) and Residential Medication Management Reviews (RMMRs).

Both of these Medication Management Review (MMR) programmes are currently funded via the Sixth Community Pharmacy Agreement (6CPA)

Over 2,300 registered pharmacists are currently accredited with a further 350 pharmacists currently in the process of accreditation. This represents approximately 10 percent of all registered pharmacists.

The role of accredited pharmacists

Accredited pharmacists are essential members of the inter-professional healthcare team who work with other health professionals, in particular general practitioners, and exchange information on a regular basis regarding optimum medication use with the aim of achieving better health outcomes for patients.

The Australian Government introduced the HMR programme in October 2001. A Home Medicines Review (HMR) is a comprehensive clinical review of a patient’s medicines in their home by an accredited pharmacist on referral from the patient’s general practitioner (GP). The patient may choose to be referred to their usual community pharmacy or an accredited pharmacist who meets the patient’s needs.

The service involves cooperation between the GP, pharmacist, other health professionals and their patient (and, where appropriate, their carer). A HMR service improves the patient’s and health professionals’ knowledge and understanding about medicines, facilitates cooperative working relationships between members of the health care team in the interests of patient health and
wellbeing and provides medication information to the patient and other health care providers involved in the patient’s care.

Since their introduction, approximately 690,000 HMRs have been conducted by accredited pharmacists. This program promotes collaboration among GPs, pharmacists and other health care professionals with the aim of improving patient health and well-being.

The HMR provides the opportunity for patients to have a general practitioner and a pharmacist collaboratively review their use of medications, leading to development of an agreed Medication Management Plan. The HMR normally involves a visit by an accredited pharmacist to the patient’s home.

Through the provision of medication management review services, accredited pharmacists:

- Take responsibility for their patients’ medication-related needs
- Ensure that their patients’ medications are the most appropriate, the safest possible and are used correctly
- Identify, resolve and prevent medication-related problems that may interfere with the goals of therapy.
- Review and provide solutions to medicines adherence issues
- Address patient concerns about their medicines and provide education to patients about the optimum use of their medicines.

Current guidelines dictate that a HMR can be provided no more than once every two years or when the patient’s GP deems that a subsequent review is clinically for example when there have been significant change to the patient’s condition or medication regimen.

**Residential Medication Management Reviews** have been designed to enhance the quality use of medicines for consumers in approved Australian Government funded aged care facilities (ACFs), by assisting consumers and their carers to better manage their medicines.

The programme also supports activities that are designed to improve quality use of medicines across approved Australian Government funded aged care facilities through the Quality Use of Medicines (QUM) component of the programme.

As part of their work in aged care facilities accredited pharmacists:

In particular, they:

- Contribute to the safe, appropriate and effective use of medicines by identifying and addressing medication-related problems and therefore improve patient outcomes
- Collaborate with and provide recommendations and information to prescribers and staff
- Review drug regimens

The **QUM service** is a separate service provided by a Registered or Accredited Pharmacist and focuses on improving practices and procedures as they relate to the quality use of medicines in a Facility.

QUM activities include (but are not limited to) participation in Medication Advisory Activities, the provision of advice to members of the healthcare team on a range of issues, including storage, administration, dose forms, compatibilities, therapeutic and adverse effects and compliance, and provision of education sessions for nursing staff and carers or residents on medication therapy, disease state management or prescribing trend issues.
Accredited pharmacists provide RMMRs to 2,800 aged care facilities (approximately 188,000 beds).

Accredited pharmacists have the necessary skills and to contribute to improved health outcomes as members of multidisciplinary teams.

**Where do they work?**

Accredited pharmacists work in diverse environments.

Some are based in in community pharmacy.

Others work independently, setting up business structures to support their practice.

Some accredited pharmacists combine their work conducting medicines reviews with employment in the hospital sector and others combine it with roles in research and academia.

**Remuneration for Accredited Pharmacists for the conduct of HMRs and RMMRs**

Accredited pharmacists are currently remunerated for the conduct of HMRs and RMMRs via the 6CPA.

Programme Specific Guidelines govern the conduct of both programmes which are parts of the suite of Medication Management Programmes funded under the 6CPA to support quality use of medicines services that are designed to reduce adverse events and associated hospital admissions or medical presentations.

Current remuneration

Home Medicines Review (HMR) – $213.67
Residential Medication Management Review (RMMR) – $108.05

QUM service $240.00 per annum plus $24.00 per bed

**Questions posed by the discussion paper of relevance to the AACP and accredited pharmacists**

**Regulatory Landscape Question 7**

Community pharmacy programs within the CPA include some professional services that could be delivered by non-dispensing pharmacists.

*Should the CPA be limited to dispensing and professional programs provided by community pharmacy only? If so, how can contestability and effectiveness be ensured in professional programs? If not, why not?*

HMR and RMMRs may be conducted by accredited pharmacists either linked with or working in community pharmacies and by independent accredited pharmacists.

Both programmes are well entrenched in pharmacy and the aged care sector (RMMRS)

The AACP considers that it may be an option for funding of HMR and RMMR/QUM programmes to be at least partially removed from the CPA.

GPs have control over the HMR and RMMR programmes via a referral system. The referral of HMRs and RMMRs by GPs are uncapped MBS items (GP Items 900 and 903 respectively). Creating an MBS item number for pharmacists for the pharmacist Portion of both programmes would seem to be a logical and appropriate step.
Accredited pharmacists can only initiate a HMR or RMMR in response to a GP’s referral.

As both programmes may be delivered outside the community pharmacy network, fully funding both services from within the Community Pharmacy Agreement budget could be considered to be somewhat unreasonable by the community pharmacy sector.

Removal or part-removal of the MMR services from the CPA may allow for expansion and greater promotion to consumers of both services.

However, the provision of medication reviews through community pharmacy utilising CPA funds should be encouraged to improve consumer access to both programs.

For the HMR service, this would potentially allow for the service to be provided in more areas of need rather than being hampered by the 20 per month service cap.

The cap on the number of HMRs that can be conducted per service provider to 20 per month has been a source of frustration to a number of accredited pharmacists. This cap potentially limits the availability of the service to patients residing in rural and remote locations with limited access to accredited pharmacists. It also has the potential to affect the timeliness of HMRs for patients who may need to wait until the next month, after the providers cap has been reached for the previous month. GPs will refer patients for HMRs as per clinical need, meaning that often a large number may be referred one month and then fewer the next, creating challenges for the accredited pharmacists deciding which reviews should be prioritised.

At present some concern exists that increased promotion of the availability of both programmes, and HMRs in particular, would lead to greater pressure on the CPA budget.

This conjecture, while probably valid, would seem to be contrary to the end-goal of assisting patients with complex medication-related issues, improving health outcomes and reducing hospital admissions.

The AACP does not support the removal of funds from the CPA for MMRs, but instead would support additional sources of external funding to increase the availability of both services.

Concerns that a number of reviews are potentially being conducted for no clear reason could be addressed with a focus on eligibility criteria, with an aim to better target those patients identified as having clinical need, i.e. defined reason for referral with an associated end-goal in mind.

In suggesting a shift or partial shift of the funding of the MMR programmes to the MBS, options for consideration would include:

- Research has shown that a HMR conducted with 5-8 days of discharge from hospital may prevent repeat hospital admissions. A small trial of this option was conducted but results have not been published as yet. The benefit to the hospital system may well be sufficient to justify this style of HMR being funded under the MBS. From a budget perspective the numbers of patients being re-admitted with medication related issues within a few weeks of hospital discharge is reasonably well understood and could provide the underlying budget/justification for the MBS inclusion.

- Another relatively well understood datum is the number of first-time admissions to Aged Care Facilities. The first RMMR on admission being funded under the MBS would seem to be a reasonable focus for the RMMR programme in terms of potential benefits to the patient and the facility. The majority of RMMR providers are not directly linked with community pharmacy and as such MBS funding would seem to be potentially reasonable.
The role of pharmacists Question 25

Currently, the 6CPA funds pharmacists to deliver a range of professional programs and services subject to evaluation of their cost-effectiveness.

As medicine specialists, what are the professional programs and services that pharmacists should or could be providing to consumers in order to best serve the consumers?

The AACP supports expanded roles for all pharmacists, including accredited pharmacists.

Professional programs and services to be considered to best service consumers include the following:

- Medication reviews including HMRs and RMMRs
- MedsChecks/Diabetes MedsChecks – both allow for medication reconciliation and appear appropriate tools for considering or suggesting referral to the more comprehensive HMR and/or medication adherence programmes such as Dose Administration Aids
- Chronic disease management services, to include services for those with, for example diabetes, asthma COPD, arthritis. Two 4CPA funded-programs were the Diabetes Medication Assistance Service (DMAS) and the Pharmacy Asthma Management Service
- Education to improve healthy literacy
- Preventive health programs in community pharmacy such as smoking cessation, immunisation and weight management

In addition the AACP supports the integration of accredited pharmacists into multidisciplinary care teams and primary health care settings.

This has the potential to contribute to optimum medicines management and improved health outcomes.

Accredited pharmacists have the skills and knowledge to make a valuable contribution to the healthcare teams that will be responsible for the ongoing co-ordination, management and support of a patient’s care in the recently announced Australian Government primary care package to be trialled through creating ‘Health Care Homes’.

A medicines review (funded outside the CPA) with appropriate follow up and collaboration with the patient’s community pharmacy should form part of the package. A review should be embedded in the package, rather than provided in its current form as a one-off HMR every two years or according to clinical need.

Opportunities exist for accredited pharmacists to enhance their collaborative working relationships, in addition to their work conducting HMRs and RMMRs, with formal integration within GP practices.

Collaborative practice of accredited pharmacists working in this setting already exists in this country and has been championed by several trailblazers in this field who have published on their experiences. 1-3

Opportunities such as this provide flexibility to accredited pharmacists who can combine work several sessions per week in a GP practice with either community pharmacy practice or medicines reviews. Such arrangements provide exciting career paths for accredited pharmacists, but are not currently formally funded in any way.

The Australian Medical Association (AMA) supports the role of non-dispensing pharmacists in general practice, proposing that they can be a key part of the future general practice health care team, supporting GPs to deliver high quality care for their patients. 4
Their proposal calls on the Commonwealth to establish a separate funding program external to the CPA to support general practices to employ pharmacists - the Pharmacist in General Practice Incentive Program (PGPIP).4

Potential roles for pharmacists in general practice include:

- Medication management reviews
- Medicines reconciliation
- Patient education to improve compliance and understanding of medicines
- To support GP prescribing
- Liaison and coordination of information at transitions of care to avoid medication misadventure
- Provision of education to GPs, nursing and allied health personnel
- Drug utilisation reviews

A Monash University study, led by Edwin Tan from the Centre for Medicine Use and Safety, explored the experiences of general practitioners, pharmacists and patients with the integration of pharmacists into general practice clinics in Australia.3

The study published in the journal, *BMJ Open*, found the co-location of pharmacists with Australian GPs in primary healthcare clinics optimised the safety and provision of medication used by patients.

A final important role for pharmacists is in the management of medicines in Residential Aged Care Facilities. RMMRs and associated QUM activities are important contributors to optimum medication use.

Confusion exists however with the RMMR rules over their timing. A RMMR can be referred yearly by a GP but the rules for pharmacists’ state that a review of a resident in an ACF can only be conducted once every two years (or more frequently according to clinical need). The health of residents will usually decline during this time frame with average life expectancy of 155 weeks in residential aged care. More frequent review of these frail and vulnerable patients is often required.

RMMRs conducted by accredited pharmacists can reduce prescribing of sedative and anticholinergic drugs in older people.5 There is also evidence that they can identify and resolve medication-related problems and improve medication appropriateness.6

Another concern relating to RMMRs includes the lack of choice the resident and/or GP has for choosing which pharmacist provides clinical services, including RMMRs. Currently only one service provider is permitted per facility, and the service agreement is with the facility and not the GP nor the resident.

Research has shown that collaboration between the GP and the accredited pharmacist conducting the review increases the implementation rates of recommendations.7 It may therefore be appropriate for consideration to be given to allow for increased flexibility in the provision of RMMR services.
Question 34

How should government design the provision and remuneration of new programs that are offered through community pharmacy to ensure robust provision, value for taxpayers and appropriate supply for patients in need? For instance, should all patients be entitled to an annual HMR? Should HMRs be linked to a health event, such as following hospital discharge? Should they only occur following referral from a medical practitioner?

All existing and new programs should be underpinned by a robust evidence gathering and review system.

This is essential to ensure that the health system is funding a service appropriately.

Currently the lack of appropriate evidence being gathered, stored and assessed has led to the need for a cost benefit review of the MMR programs. An appropriate data collection system would allow for ongoing justification and funding of the MMR services.

This would then allow the programs to be better targeted to those in need.

An appropriate reporting system would take a considerable amount of time and effort to develop but the expense would then be justified in outcomes data being available for review when required.

A routine annual HMR for all patients would appear to be counterproductive as most patients would not need the service annually. Yet some patients who have a significant change in clinical condition or hospitalisation with many medicine changes may benefit from a medication review within 12 months.

In fact there many patients with complex care needs who would benefit from a series of follow-up visits from an accredited pharmacist. These follow up visits (not necessarily a full HMR) would allow for long term review of patient progress and additional assistance with medicine management as required with the aim of preventing hospital admissions that are so frequent in this group.

It would be useful to refer to the research conducted in the 5CPA to inform discussion on the determination of a set of valid and robust criteria for HMR eligibility. 8

It is also worth noting that evidence exists to support post discharge HMRs conducted with a set time frame. Research conducted in the 4CPA concluded that the conduct of reasonably timely post-discharge HMRs can occur when GPs are made aware of their urgency, patients have been identified as being at ‘high’ risk of medication misadventure by the hospital home team and GPs are supported by a liaison pharmacist.9

The 5CPA ran a small trial but no data has been published.

Collaboration between the patient, pharmacist and all their health care providers is vital and thus referral from a medical practitioner is supported.

However there are patients who are cared for predominantly by medical specialists or other prescribers thus referral points for both programmes could be improved by allowing referrals by others such as specialist medical practitioners, nurse practitioners at ACFs and Aboriginal and Torres Strait Islander (ATSI) health workers.
Accountability and Regulation Questions 92, 93 and 95

What data is already available in pharmacy and other parts of the health system that could be used to inform the monitoring and assessment of standards of delivery and health outcomes? How might a patient’s existing My Health Record be used to support this?

Access to the My Health Record for accredited pharmacists conducting MMRs would be valuable as it would provide access to relevant patient information that is often not provided by the GP with the referral. Access for such information would avoid the need for accredited pharmacist to contact GP practices to obtain missing information as is so often the case at the present time.

It would also allow for timely and convenient upload, access and review by GPs. Likewise GP medication management plans could be uploaded for access by the reviewing accredited pharmacist.

This information would then be available for all relevant health professionals involved in the care of the patient. Access to a current medication list (included in the MMR report) is vital in emergency situations and is essential information for ambulance officers.

Is there a role for pharmacists to work with patients and other health professionals, possibly relating to individual medicines or specific conditions, to better create the data to analyse the health outcomes for that particular patient or group of patients, including through the use of a patient’s existing My Health Record?

A potential role exists for collaboration between accredited pharmacists conducting medication reviews to collect and share data for quality assurance and research projects to improve practice.

Data sharing between relevant stakeholders would facilitate research and evaluation of the programmes, including for cost effectiveness.

The conduct of drug utilisation reviews as part of the role of accredited pharmacists to inform practice would be assisted with access to My Health Record.

Are consumers aware of what programs and general pharmacy services they are entitled to? Is there enough information available regarding the services for which they are eligible?

The AACP considers that consumers may not be fully aware of the HMR and RMMR programs currently funded under the 6CPA for eligible patients.

HMRs and RMMRs are currently conducted on the basis of GP referral. The value of the MMR services for eligible patients should be more widely promoted to GPs and their staff and patients.

Community pharmacies can assist in identifying eligible patients and providing them with information to discuss with their GP on follow up visits.

Patients, their families and carers can also identify the need for a medication review.

The role of accredited pharmacists and value of HMRs and RMMRs should be promoted more widely via Primary Health Care organisations and patient support groups such as Alzheimer’s Australia, Parkinson’s Australia and others.
References


