

Pharmacy Trial Program Tranche 2

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

## ***Pharmacist Recruitment***

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The financial assistance provided by the Australian Government must not be taken as endorsement of the contents of this report. The trials are undertaken by independent researchers and therefore the views, hypotheses and subsequent findings of the research are not necessarily those of the Australian Government Department of Health.

## Abbreviations

ASGS-RA	Australian Statistical Geography Standard Remoteness Area 2016
AACP	Australian Association of Consultant Pharmacy
ACCHS	Aboriginal Community Controlled Health Service
AHS	Aboriginal Health Service
AHW / ATSIHP	Aboriginal Health Workers/Aboriginal and Torres Strait Islander Health Practitioners
CEO	Chief Executive Officer
FTE	Full Time Equivalent
HMR	Home Medicines Review
HTA	Health Technology Assessment
IPAC	Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve Chronic Disease Management
JCU	James Cook University
MBS	Medicare Benefits Schedule
MMM	Monash Modified Method
NACCHO	National Aboriginal Community Controlled Health Organisation
NT	Northern Territory
PBS	Pharmaceutical Benefits Scheme
PGA	Pharmacy Guild of Australia
PSA	Pharmaceutical Society of Australia
QLD	Queensland
QUMAX	Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People
S100 RAAHS	Section 100 Remote Area Aboriginal Health Services Program
VIC	Victoria
6CPA	Sixth Community Pharmacy Agreement

# Executive Summary

## Introduction

The Integrating Pharmacists within Aboriginal Community Controlled Health Services (ACCHSs) to improve Chronic Disease Management (IPAC) project aimed to improve quality of care outcomes for Aboriginal and/or Torres Strait Islander adult patients with chronic disease by integrating a practice pharmacist within the primary health care team of ACCHSs. The Pharmaceutical Society of Australia (PSA) was responsible for recruiting suitably skilled pharmacists to integrate within all participating ACCHSs across Queensland, Victoria and the Northern Territory to deliver the required services in a culturally-responsive manner and to capture relevant data for evaluation of the intervention.

## Method

Once ACCHS sites were recruited for the project, PSA worked with NACCHO and participating ACCHSs to ensure the respective needs and priorities were met. PSA Coordinators invited local community pharmacies, identified by participating ACCHSs as those with whom they worked, to nominate suitable pharmacist candidates to work in the project. Concurrent to this approach, an open call for expressions of interest was conducted by PSA Coordinators to generate a database of potential pharmacists interested in working within Aboriginal Community Controlled Health Services. This was done via PSA and Australian Association of Consultant Pharmacy (AACP) newsletters, social media channels, the NACCHO/PSA ACCHS Leadership Group and throughout the ACCHS network via NACCHO. Finally, where these two methods of recruitment were not successful, advertising through mainstream online job seeking platforms was utilised along with active, direct scoping of candidates through informal pharmacy networks, hospital pharmacy departments and a publicly available list of accredited pharmacists coordinated by the AACP. Respecting the principles of self-determination, each ACCHS was responsible for making the final decision on the appointment of the pharmacist to their service.

## Results

Recruitment of 23 pharmacists enabled initial implementation of the project at all 20 participating ACCHSs. A total of 12.5 pharmacist Full Time Equivalent (FTE) was distributed across individual ACCHSs, who were each apportioned pharmacist time between 0.2 and 1.4 FTE according to patient numbers, capacity and priorities of both the pharmacists and health service. Re-recruitment and reallocation of FTE throughout the project, necessary due to pharmacist turnover and site attrition, enabled an overall delivery of 12.3 FTE to 18 ACCHSs. A total of 26 pharmacists participated as integrated pharmacists throughout the intervention. In all sites where community pharmacy nominated a candidate for the role, a community pharmacy nominated candidate was appointed. Seven pharmacists were employed under subcontract with community pharmacy, with the remaining 19 pharmacists employed directly by PSA.

## **Conclusion**

Through a proactive and multi modal approach to recruitment, the IPAC project identified significant interest from pharmacists from a range of pharmacy sectors to work within the ACCHS settings. Maintenance of a register of pharmacists interested in undertaking integrated roles within an ACCHS may assist future efforts to recruit pharmacists for similar positions.

Community pharmacies who have well developed and respectful relationships with ACCHSs are well placed to identify pharmacists to perform integrated roles.

The IPAC project assisted with the refinement of a position description for pharmacists working within ACCHSs, acknowledging the importance of providing culturally safe and acceptable services to Aboriginal people and Torres Strait Islanders within the holistic primary health care setting.

Regardless of the funding mechanism for future program role out, models of recruitment and employment must be flexible and underpinned by ACCHSs' right to self-determination. Funding mechanisms will need to factor in pharmacist recruitment, salary and retention, as well as the increased costs of program delivery in remote locations.

The successful completion of the implementation phase in 18 ACCHSs located across all geographic regions, including very remote locations, demonstrates that integration of pharmacists within ACCHSs is achievable across the entirety of Australia

## **Recommendations**

1. Regardless of funding mechanisms, methods used to employ integrated pharmacists must recognise the principles of self-determination for ACCHSs. Recruitment should be flexible and be led by ACCHSs to enable selection of pharmacists with the 'right organisational fit'.
2. Develop proactive and multimodal strategies to assist future recruitment, encompassing engagement with community pharmacy and other pharmacy sectors. Program support enabling maintenance of a register of pharmacists interested in working within the ACCHS sector, and creation of generic templates for position descriptions guided by the core roles of the IPAC project, will assist all ACCHSs to access a suitable pharmacist.
3. Legislative barriers that inhibit an integrated pharmacist from practicing to their full scope of practice within an ACCHS should be identified and overcome.

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## 1. Introduction

The Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve Chronic Disease Management (IPAC) project is a tripartite project with the aim of improving quality of care outcomes for Aboriginal and/or Torres Strait Islander adult patients with chronic disease by integrating a practice pharmacist within the primary health care team of ACCHSs.

The IPAC project is a partnership between the Pharmaceutical Society of Australia (PSA), NACCHO, and James Cook University (JCU) College of Medicine and Dentistry.

The PSA, as the lead agency, was responsible for managing the Head Agreement with the Australian Government Department of Health, and service agreements with partners and ACCHSs. PSA coordinated the appointment of practice pharmacists including their recruitment, selection, placement, training, mentoring and performance. Pharmacists delivered ten core roles in participating ACCHSs across Queensland, Victoria and the Northern Territory to deliver the required services in a culturally-responsive manner and to capture relevant data for evaluation. NACCHO provided Aboriginal governance leadership for the project and coordinated all communication with ACCHSs, Affiliates and the NACCHO Board. JCU has undertaken the project evaluation, having developed the research methodology based around a pragmatic, community-based participatory research model.

## 2. Methods

PSA was responsible for coordinating the recruitment, selection, placement, training and ongoing performance management of the integrated pharmacists.

### Pharmacist eligibility criteria

The IPAC Protocol<sup>1</sup> outlined the criteria for pharmacists to be considered for an integrated pharmacist position within the ACCHS selected to participate in the project. These included:

- current registration with the Australian Health Practitioners Regulation Agency (AHPRA) as a pharmacist;
- more than 2 years post registration experience;
- post-graduate clinical qualifications or demonstrated clinical experience (eg. hospitals or HMRs)

A position description (Appendix 1) for the role was developed by PSA and endorsed by the IPAC Steering Committee and defined the selection criteria, qualifications and requirements to fulfil the core roles and key responsibilities of the IPAC roles. PSA and staff from the individual ACCHS would consider this position description when appointing pharmacists to the positions.

Along with appropriate clinical experience, selection criteria required pharmacists to have a demonstrated understanding and awareness of Aboriginal cultures, including acceptance of the principles of community control and self-determination. There was a preference for pharmacists who were accredited to undertake medication management reviews, however this was not considered mandatory due to concerns related to an adequate supply of accredited pharmacists in all participating ACCHS locations.

It was deemed essential that pharmacists have excellent communication skills, have well developed organisational skills and the ability to work with minimal supervision.

## **Recruitment of pharmacists**

Once ACCHS selection for the project was finalised NACCHO also sought information from each ACCHS to identify the community pharmacy (ies) with whom services had existing relationship(s). PSA engaged with these local community pharmacies and invited them to nominate suitable pharmacist candidates for all sites. In addition to approaching community pharmacy, an open call for expressions of interest was conducted by PSA Coordinators to generate a database of potential pharmacists interested in working within Aboriginal Community Controlled Health Services. This was done via PSA and AACP newsletters, social media channels, the NACCHO/PSA ACCHS Leadership group and throughout the ACCHS network via NACCHO. Where these avenues of recruitment were not successful, advertising through mainstream online job seeking platforms was utilised along with active, direct scoping of candidates through known networks, hospital departments and publicly available accredited pharmacist lists.

## **Interviewing and appointing pharmacists.**

Applicants were screened by PSA Coordinators by reviewing information provided via the nomination process and/or direct contact with the pharmacists. An IPAC Project Recruitment – Screening checklist (Appendix 2) was utilised to standardise the process.

This process enabled preparation of a shortlist of candidates for each ACCHS, after which representatives of the ACCHSs were invited to review applications, select candidates for interview and participate in the interviewing process. In addition to the PSA Coordinators, participants from the ACCHSs involved in the interview process included CEOs, Senior Medical Officers, Clinic Managers, Aboriginal Health Practitioners, Aboriginal Health Workers and Practice Nurses. Standardised interview questions (Appendix 3) were prepared by PSA Coordinators and guided the interview process however each ACCHS was able to modify or add questions specific to their setting.

Following the screening and interviewing process, respecting the principles of self-determination, each ACCHS was responsible for making the final decision on the appointment of their pharmacist. Pharmacists were engaged either via a subcontract through community pharmacy or under an employment contract with the PSA.

PSA undertook checks on pharmacists' registration status and ensured that appropriate police clearance or working with children checks (as per state specific requirements) were sighted.

The following algorithm outlines the pharmacist recruitment process undertaken through the IPAC project. The process was endorsed by the IPAC Steering Committee, prior to the appointment of any pharmacist.

Figure 1. Pharmacist recruitment process

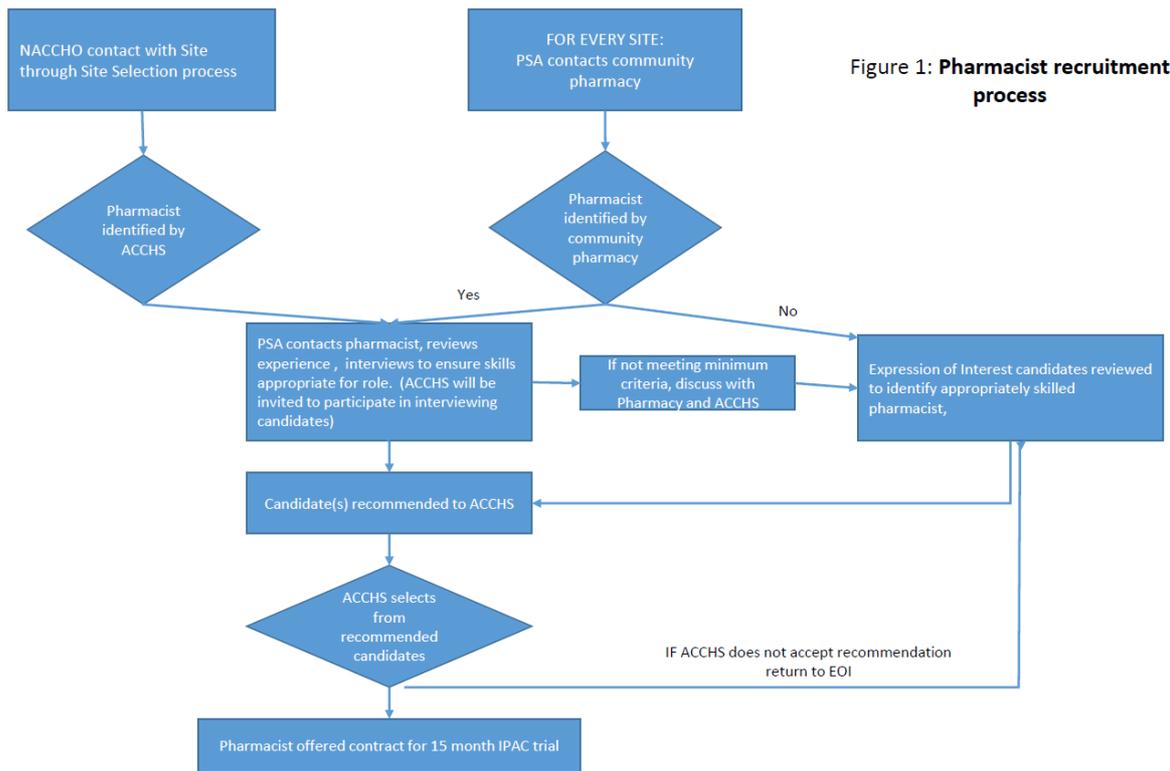


Figure 1: Pharmacist recruitment process

## Induction

PSA-employed pharmacists undertook an induction process upon becoming an employee of the PSA, while community pharmacies retained their usual induction practices for their pharmacists participating in the project. Site specific workplace inductions were provided by the ACCHS upon commencement of the pharmacist. Pharmacists were expected to comply with site specific Work health and safety requirements at the ACCHS, as per the PSA ACCHS site agreement.

Induction training of the pharmacists by PSA Coordinators encompassed the lines of communication required for clinical, project, conflict resolution and human resources support<sup>2</sup>. Despite being employed either by community pharmacy or PSA, pharmacists were expected to seek permission from the ACCHS prior to taking leave and to notify the health service if personal leave was required, in addition to notifying either PSA or the community pharmacy.

## Performance Management

PSA was responsible for the performance management of the pharmacists directly employed by PSA, and was also responsible for overseeing the delivery of the subcontracting arrangements through community pharmacy. NACCHO had undertaken a Needs Assessment with each ACCHS at the commencement of the project<sup>3</sup> to identify ACCHS priority areas from the range of core role activities expected to be undertaken by the pharmacists. The Needs Assessment informed a Pharmacist Activity Workplan that was provided to each pharmacist to guide their activity within the ACCHS. PSA utilised regular communication with pharmacists and community pharmacy owners via phone calls and emails to provide updates regarding their activity. NACCHO retained responsibility for liaising with the ACCHS managers regarding performance of the project. Site visits conducted by PSA Coordinators provided an opportunity to undertake a face to face review of pharmacist performance and offer additional support to optimise project delivery.<sup>4</sup>

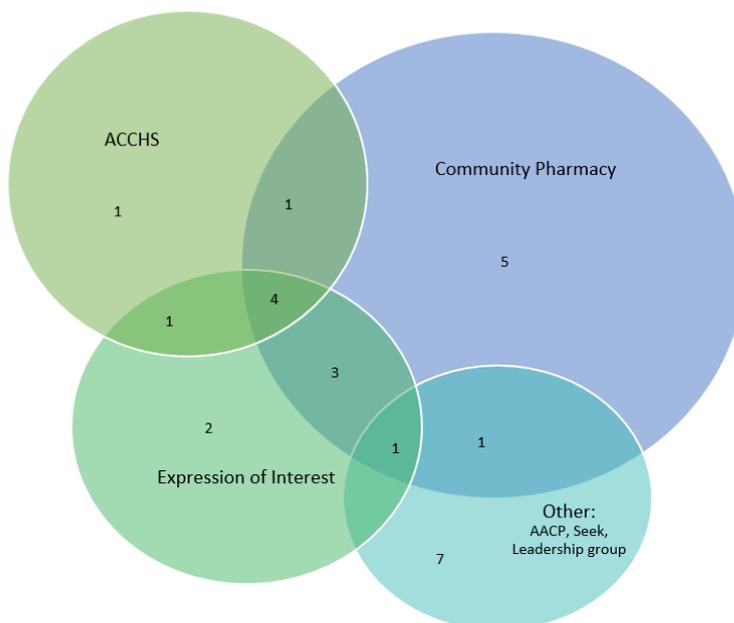
### 3. Results

#### Pharmacist recruitment

Pharmacists were nominated via a multimodal approach including community pharmacy, ACCHSs, an open expression of interest and other sources which are outlined below.

Figure 2 illustrates the number of pharmacists participating in the project according to the source of their nomination. Many pharmacists were identified through multiple processes, with community pharmacists assisting in the identification of 15 of the 26 integrated pharmacists ultimately employed within ACCHSs.

Figure 2 Integrated Pharmacist nomination sources



## ACCHS Nomination

Through their site selection process, NACCHO requested participating ACCHSs to nominate the community pharmacy with whom they identified as having an existing relationship. At the time of receiving these nominations, 22 ACCHSs had identified interest in the project. Of the 22 ACCHS, 17 identified either one or multiple community pharmacies with whom they had a relationship. In one instance an ACCHS indicated they would only participate in the project if the community pharmacy with whom they had an existing relationship was involved with the project. These nominations were provided to PSA to assist in prioritising which community pharmacies to seek pharmacist nominations from.

In addition, some ACCHS had developed relationships with accredited pharmacists who undertook Home Medicines Reviews (HMR) with their clients. NACCHO provided PSA with the details of these pharmacists to consider through the recruitment process.

## Community Pharmacy Nominations

For every site, local community pharmacies were approached to determine if they had any pharmacists who were interested in nominating to participate as the ACCHS integrated pharmacist for the duration of the project. Following input from the Pharmacy Guild of Australia (PGA), a subcontract was developed that enabled the pharmacist to remain employed by the community pharmacy.

Once the recruitment process had been endorsed by the Steering Committee, PSA communicated via direct phone call or emailed letters to 50 community pharmacies inviting them to nominate pharmacists who might be interested in the integrated pharmacist positions. The list of pharmacies was compiled with input from the PGA, ACCHSs, NACCHO and PSA. Each pharmacy involved in supplying medications via Section 100 Remote Area Health Service program (S100 RAAHS) and providing services via the Section 100 Support Allowance Program, had already been contacted by the PSA Project Coordinators to gauge their interest and capacity to participate in the project. The recruitment process generated pharmacist nominations from 11 community pharmacies interested in participating in the project within 11 ACCHS.

In the time between receipt of nominations and finalising the recruitment process, 5 of the community pharmacies withdrew their interest in being subcontracted to participate in the trial;

- For one of the ACCHSs the pharmacist nomination was made by a manager of the community pharmacy rather than the owner of the pharmacy. The owner subsequently advised that their current priority was to direct the pharmacist to alternate community pharmacy based activities, and withdrew their nomination.
- At another ACCHS, the nominated pharmacist was offered a position through a subcontract with community pharmacy however the community pharmacy owner declined the subcontracting arrangement. They did not provide a specific reason for this decision, however the pharmacist remained partially employed by the community pharmacy while undertaking the IPAC trial part-time as a PSA employee, and maintained this employment relationship with the community pharmacy for the duration of the project.
- At one site the community pharmacy initially expressed interest to nominate a pharmacist for the project but then withdrew their nomination.

PSA Coordinators proceeded to advertise externally for a pharmacist for this position through SEEK®, with a community pharmacy employee of the same pharmacy applying for the role. PSA re-offered a subcontract to the community pharmacy owner, however they declined and gave approval for PSA Coordinators to proceed with offering their pharmacist a direct employment arrangement with PSA.

- Two community pharmacies withdrew their nominations when they were advised that the ACCHS, which had multiple clinics, wanted the pharmacist to work at a specific clinic located between 80 and 300km away from the pharmacies.

Respect for the principles of self-determination was fundamental to the recruitment process. At one ACCHS, both the health service and community pharmacy nominated the same pharmacist to conduct the IPAC role. The pharmacist was not a direct employee of the community pharmacy at the time of being nominated, and had historically provided HMRs and limited consulting services to the ACCHS. The ACCHS requested that the pharmacist be employed directly by PSA throughout the project. The Steering Committee, respecting the principles of self-determination, endorsed this arrangement.

Two ACCHSs, on the basis of being associated with multiple community pharmacy providers of services under QUMAX, declared they did not want to have a pharmacist employed under a community pharmacy subcontract delivering the IPAC project; they did not want to be seen to prefer one community pharmacy over another, or to deal with any perceptions of conflicts of interest on the part of the community pharmacies. At one of these ACCHSs, pharmacists were nominated by two community pharmacies. A short listing and interview process was conducted, with two of the pharmacists nominated via community pharmacy being offered the roles. The community pharmacist who nominated the pharmacists was understanding of the request from the health service and supported PSA being the direct employer. The other ACCHS who had indicated their desire to not have a single community pharmacy provider received no nominations of pharmacists from their community pharmacy providers.

Despite a community pharmacy owner initially expressing interest in participating in the IPAC project, the community pharmacy did not nominate pharmacists for the 2 ACCHSs they had contracts to supply to during the recruitment phase. There was understandably some reluctance due to the initial lack of project funding available to support costs associated with recruiting and retaining pharmacists in remote locations eg initial relocation costs, housing costs, allowances to enable access to vehicles, professional development support. An open recruitment process including external advertising resulted in a candidate being offered one of the roles, however the candidate withdrew their interest after training but prior to commencement at the site due to another job offer. Following this withdrawal there were further discussions with the community pharmacy to address and overcome barriers to participating in the project, which resulted in the community pharmacy agreeing to be the subcontracted provider of pharmacists to 2 ACCHSs with whom they had a relationship.

There were another 2 pharmacists who, through the recruitment process, were identified as having ownership interests in community pharmacies. They were both offered employment under a subcontract arrangement, however chose to be employed directly by the PSA. Some community pharmacies contacted throughout the recruitment process did not have the capacity to participate themselves, however did provide contact details of pharmacists whom they identified as potential candidates.

Community pharmacy subcontracting arrangements saw the successful implementation of the project at 5 ACCHS, utilising a total of 7 pharmacists. Of these community pharmacies, all were existing suppliers of medications under S100 RAAHS and S100 Support Allowance Program providers. Two of the integrated pharmacists involved in delivering the IPAC project under community pharmacy subcontracts had ownership interests in the community pharmacy.

In summary, excluding sites where community pharmacy withdrew their nomination to participate, in all sites where community pharmacy nominated a candidate, a community pharmacy nominated candidate was appointed to the role. The employment arrangement was either via a subcontract with the community pharmacy or directly with PSA as per the preference of the community pharmacy owner or, in keeping with principles of self-determination, at the request of the health service.

## **Open Expression of Interest**

PSA undertook an open expression of interest process via Survey Monkey to generate a database of pharmacists interested in working within Aboriginal Community Controlled Health Services and participating in the IPAC project. The expression of interest survey was circulated via PSA and AACP newsletters, social media channels, the NACCHO/PSA ACCHS Leadership group and via the ACCHS network via NACCHO. The aim of the Expression of Interest was to gauge broad interest in the roles and was run concurrently with the NACCHO process to identify sites to participate in the project. A total of 69 responses from pharmacists was received.

Following initial ACCHS selection, further correspondence was sent to the pharmacists who had registered their interest. This correspondence was to ensure the pharmacists who had indicated interest understood that the recruitment process prioritised community pharmacy nominations and to determine if they remained interested and willing to be considered for the project, once specific locations were known. This communication was circulated in early May 2018; 42 responses were received.

Some of the nominating pharmacists either owned or were employed by community pharmacies interested in participating in the project.

Of the 26 pharmacists ultimately employed to participate in the project, 11 had completed the original expression of interest. This validated the expression of interest process as a means of broadly identifying potential pharmacists for the role.

## Advertising and alternate methods of identifying potential candidates

An active approach to recruitment was required in sites where no community pharmacy nomination was received and no alternate pharmacist had been identified via the open expression of interest process. Separate and prior to the IPAC Project, PSA had identified a number of pharmacists interested in working within general practice (GP-Pharmacist Connect); this list was also used to identify potential candidates for the IPAC Project. Pharmacists who were listed on AACP accredited pharmacist list within the vicinity of participating ACCHSs were contacted to determine if these roles were of interest; this approach resulted in 3 successful appointments. The NACCHO/PSA ACCHS Pharmacist Leadership group was notified of sites that did not yet have a candidate identified, and through this network another ACCHS had a pharmacist successfully appointed. Seek® was the platform used when external advertising was required. Advertisements were placed for positions at 4 ACCHSs, successfully identifying 2 pharmacists who proceeded to participate in the project.

A total of 26 pharmacists were employed over the duration of the IPAC project, including 21 female and 5 male pharmacists. At the time of being appointed to the role, 19 of the pharmacists were accredited to conduct medication management reviews, with another pharmacist gaining accreditation during the project. An additional 2 pharmacists have completed their accreditation since the end of the project, while a further 2 pharmacists who were not accredited have commenced studies to become Credentialed Diabetes Educators.

## FTE Allocation

The initial project anticipated 0.57 FTE pharmacists aggregated across 22 participating sites, the equivalent of 12.54 FTE in total. ACCHSs were identified via a selection process coordinated by NACCHO<sup>5</sup>.

The number of active patients attending each ACCHS was variable, with as few as 600 active patients at some sites and over 10,000 active patients over multiple clinic locations at other ACCHSs. As it was not equitable to apply the 0.57 pharmacist FTE universally to each site, a modified allocation of a 0.2 FTE baseline plus a ratio of the remaining FTE was allocated across all the ACCHS based on active patient numbers, as reported by the ACCHS to NACCHO. Initial pharmacist recruitment commenced for 22 ACCHS with an FTE allocation ranging from 0.2 FTE for smaller ACCHSs up to 1.2 FTE for larger ACCHS, effectively allowing an ACCHS with multiple clinic locations to have more than one pharmacist participating in the project. Prior to finalising pharmacist recruitment, 2 ACCHSs withdrew from the project prior to the implementation phase; the total 1.2 FTE originally allocated to those ACCHSs was redistributed across the remaining 20 ACCHS to optimise project delivery. As such, implementation was achieved in 20 ACCHS, with the FTE allocation per ACCHS ranging from 0.2 – 1.4 FTE (see Table 2). Some ACCHSs had limited consulting room availability, which also influenced the FTE that could be allocated (which are described in the NACCHO ACCHS support report)<sup>6</sup>.

It was evident that participating ACCHSs in very remote locations (ASGS-RA 5, MMM 7) would require some flexibility in how the FTE delivery was accomplished. Blocks of pharmacist activity were permitted to ensure that a pragmatic and practical approach to the trial was adopted, enabling inclusion of very remote sites.

Throughout the project, one ACCHS withdrew and another ACCHS opted to discontinue the implementation phase due to resignation of the integrated pharmacist for personal reasons. Low patient numbers at that site made continuation unfeasible. Pharmacist FTE originally allocated to these services were redistributed throughout the project to maximise FTE allocation. Reallocations involved a process of engaging with the ACCHSs and pharmacists to determine if health services had space and time to accommodate additional pharmacist presence, and if the pharmacists had the capacity to undertake more hours for the project. A final FTE of 12.3 was achieved. The FTE allocation at varying stages throughout the project are outlined in Table 1.

Community pharmacy subcontracts delivered 7,461 hours of activity within the project, which was 89% of the hours anticipated to be delivered through these contracts.

Table 1 - Number of ACCHSs per geographic location and total FTE per State and Territory

No of ACCHS per geographic location, and total FTE per state and territory						
		Urban	Regional	Remote	Total	FTE
Proposed (project protocol)	NT		1	5	6	3.42
	Qld	3	3	2	8	4.56
	Vic	5	3	0	8	4.56
	Total	8	7	7	22	12.54
Initial allocation (upon site selection)	NT	0	1	6	7	4.9
	Qld	3	2	2	7	4.4
	Vic	4	4	0	8	3.2
	Total	7	7	8	22	12.5
At implementation	NT	0	1	5	6	4.9
	Qld	3	2	2	7	4.8
	Vic	3	4	0	7	2.8
	Total	6	7	7	20	12.5
Project End	NT	0	1	4	5	4.6
	Qld	3	2	2	7	5.1
	Vic	2	4	0	6	2.6
	Total	5	7	6	18	12.3

Table 2 - Final distribution of pharmacist FTE per ACCHS

FTE Allocation	ACCHS
0.2	1
0.4	6
0.6	3
0.7	1
0.8	2
1.0	3
1.2	1 (0.5 + 0.7 FTE)
1.4	1 (0.4 + 1.0 FTE)

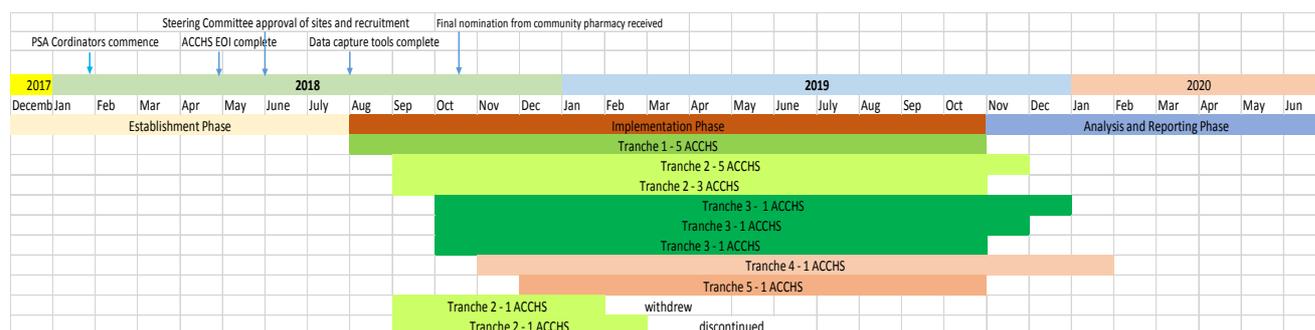
In some sites where pharmacists commenced in later tranches of the implementation phase, efforts to optimise project delivery within the data capture period were achieved by increasing the FTE allocation over a reduced period of time (ie 0.6 FTE over 15 months became a 0.8 FTE contract over 12 months). In instances where the pharmacist was recruited to a full time position and their contracted time could not be completed prior to the end of the data capture period, the project honoured the agreement made with the ACCHS and pharmacist to retain their services beyond the data capture cut off of 31<sup>st</sup> October 2019.

The trial funded pharmacist's salaries for a 15 month equivalent timeframe which included a provision for leave ie approximately 25 days per FTE. A pharmacist took maternity leave near the end of the project at a point in time where replacing them for a short time was not feasible. The PSA encouraged pharmacists scheduled to finish at the end of October, to have their leave entitlement paid at the end of the project, maximising pharmacist activity within the data capture period.

## Timelines

The final timeline indicates the months of activity delivered across the project, and differs slightly from the original timeline which reflected a project commencing in December 2017. The head contract was signed late December 2017, commencement of Project Coordinators for PSA in late January 2018, Project Coordinators for NACCHO in late February 2018 and the contract for JCU research staff in mid-March 2018. The Steering Committee endorsed the ACCHS selection and pharmacist recruitment process at the end of May 2018. Data capture tools were finalised in July 2018 ready for the commencement of training in late July 2018. The final nomination of pharmacists from community pharmacy, to complete full project implementation, was received mid October 2018.

Figure 3. Final project timeline relating to recruitment.



## Salary and additional costs

The budgeted salary for the pharmacist roles was \$50 per hour plus on-costs. Normal recruitment processes were followed where pharmacists had the opportunity to negotiate conditions upon commencement in the project. In some instances due to the nature of the roles (eg. ‘block’ work of 2 weeks at a time), a casual rate was applied. Allowances were negotiated in relation to travel and leave entitlements.

Community pharmacy subcontracting arrangements were paid on the basis of \$50 per hour plus 17% on costs, regardless of the salary the community pharmacy paid the pharmacist, plus negotiated allowances to cover housing and travel for delivery of services in remote areas.

Additional resources either in kind or funded were provided by ACCHSs and community pharmacies to enable delivery of the project. Examples of support provided by ACCHSs included covering the cost of travelling to remote clinics eg. charter flights, accommodation when in remote locations away from the pharmacist’s home base, computer access and office provisions. Community pharmacy provided support with contributions towards salaries, time and housing. In one instance where block activity was provided, the community pharmacist owner did not charge the IPAC project for their time spent transiting to the remote clinic; if they were employing someone to undertake the same role, this could end up being a significant additional cost to deliver the service.

## Re-recruitment

Pharmacist turnover within the implementation phase was minimal, with 17 of the pharmacists remaining in their positions until the end of the project. Reasons for turnover included ill health, relocation overseas for a partner’s job, relocation to another regional centre for an alternate managerial role and the need to cover maternity leave at their community pharmacy.

Re-recruitment for 3 ACCHSs was undertaken proactively, with positions filled from either community pharmacy recommendations or the existing pool of participating trained integrated pharmacists.

A total of 26 pharmacists participated as integrated pharmacists throughout the intervention. Seven pharmacists were employed under subcontract with community pharmacy, with the remaining 19 pharmacists employed directly by PSA (Table 3).

Table 1 - Total number of pharmacists throughout the IPAC trial, by jurisdiction and employer

State	PSA employed pharmacists	Community pharmacy subcontracted pharmacists
Northern Territory	3	5
Queensland	7	2
Victoria	9	0
<b>TOTAL</b>	<b>19</b>	<b>7</b>

## 4. Discussion

A very active recruitment program was undertaken by PSA Coordinators to ensure that project implementation was achieved across all geographic locations. A multimodal approach was used to identify and engage pharmacists for the integrated roles with pharmacists identified through community pharmacy, by the ACCHS, an expression of interest process, the AACP register of pharmacists and other known networks. The full implementation successfully achieved demonstrates the translatability of the project across all Australian ACCHS regardless of remoteness.

Coordination and scheduling of interviews was a time consuming process, at times delaying the ability to finalise recruitment, however it was important that ACCHSs approve every pharmacist appointment.

Community pharmacies successfully delivered the project in 5 ACCHSs across the NT and QLD. Victoria was the only state that did not have a community pharmacist take up the offer of a subcontract in the project, despite being offered the opportunity. One ACCHS reported to the PSA Coordinator that they only became involved in the project at the request of the community pharmacy who supplied medications under the S100 RAAHS program.

Some challenges experienced by community pharmacy in delivering their subcontracted hours included competing interests in ensuring community pharmacies remained adequately staffed, difficulties associated with travel during wet season and times of ill health. In recognition of the need for pharmacists to build rapport and trust with ACCHS clients and to integrate effectively into the primary healthcare team, the subcontracts specified participation by individual pharmacists rather than a service that could be delivered by any pharmacist employed within the community pharmacy. This restricted the community pharmacy from covering times of pharmacist absence with another staff member. Some of the participating pharmacists were long term employees of community pharmacy, and as such backfilling them with replacement staff required additional effort from the community pharmacy owner to maintain their core operation. Despite these challenges community pharmacy participants were able to deliver 89% of their contracted hours, demonstrating their ongoing commitment to the project. Community pharmacies who have well developed and respectful relationships with ACCHSs are well placed to provide pharmacists to perform integrated roles.

Ultimately, funding mechanisms may drive the employment structure of pharmacists providing services to ACCHS however underpinning any program rules and regardless of the funding sources there must be acknowledgement of the needs and preferences of individual ACCHSs. ACCHSs are founded on the mantra of “Aboriginal Health in Aboriginal hands”<sup>7</sup>. Upholding the principles of self-determination is necessary to enable a culturally acceptable mode of delivering effective and sustainable primary health care services to Aboriginal peoples and Torres Strait Islanders. The project identified situations where participating ACCHSs had a preference for a particular employment model, highlighting the necessity for this consideration in future programs.

The recruitment process demonstrated significant interest from pharmacists looking to work within ACCHSs, with 69 expressions of interest received from pharmacists for positions in QLD, Victoria and the NT. While there are documented concerns relating to alternate models of practice reducing the supply of pharmacists in regional and remote areas<sup>8</sup> the experience within the IPAC Project suggests this is not necessarily the case. The project identified a cohort of pharmacists who are seeking alternate career pathways, and willing to relocate to regional and remote locations for these positions. Rather than perceiving these roles as a drain on stretched staffing models, they could instead represent opportunities for more pharmacists to be employed within discrete geographical locations, thereby increasing opportunities for professional support, collaboration and additional workforce capacity to staff pharmacies “after hours” evenings and weekends. Indeed, some of the pharmacists who worked full time hours within the IPAC project elected to work additional hours within community pharmacies where they were located. In multiple locations, community pharmacies who did not have capacity to provide pharmacists to undertake the roles advised PSA Coordinators that they could offer hours of employment to supplement the integrated pharmacist’s role.

The mechanisms of recruitment and employment used in the project achieved the ultimate goal of identifying pharmacists deemed by individual ACCHSs to be a good ‘fit’ for their community, while enabling full implementation and consistent employment of pharmacists for the duration of the intervention. The maintenance of a register of pharmacists interested in undertaking integrated roles within an ACCHS may assist future efforts to recruit pharmacists for similar positions. In supporting their members’ efforts to recruit integrated pharmacists, ACCHS representative bodies at both the national (NACCHO) and state (Affiliate) level need to be made aware of the range of targeted strategies which may be used to identify potential pharmacist candidates. Such strategies may include engagement with community pharmacy and hospital pharmacy departments, as well as with connection to a PSA Aboriginal Health Service pharmacist register, AACP accredited pharmacist list, and the Society of Hospital Pharmacists of Australia (SHPA) jobs page.

Demonstrated sound clinical knowledge, good communication skills and a demonstrated understanding and awareness of Aboriginal cultures and healthcare, including acceptance of the principles of community control and self-determination were appropriate key selection criteria for the pharmacists. A position description has been created using the template from the IPAC project and is now available for use by ACCHSs looking to employ an integrated pharmacist. The template has removed the research specific components from the IPAC project (Appendix 4). The PSA Pharmacists in 2023 Roles and Remuneration report<sup>9</sup> has also documented the key roles of an Aboriginal Health Service (AHS) Pharmacist encompassing patient based activities, clinical governance tasks and education and training. This document assists in standardising language used to define the roles and therefore the qualifications and attributes of pharmacists performing these roles. The position description assists ACCHSs to understand the scope of practice of integrated pharmacists and also assists pharmacists in identifying the role as a distinct career pathway. While the scope of practice of an ACCHS pharmacist may have similarities to the General Practice Pharmacist, there is a uniqueness involved in delivering services within ACCHSs in a way that is culturally acceptable and consistent with the holistic care model.

Pharmacists' ability to work to their full scope of practice within an ACCHS can be limited by legislative barriers at a State or Territory level. An example of these legislative barriers identified through the IPAC project included pharmacists in the Northern Territory being able to provide an immunisation service when working within the community pharmacy however being unable to immunise when working as a pharmacist (employed by the community pharmacy) within the ACCHS. Ongoing efforts will need to be undertaken by peak bodies such as PSA to identify and advocate for changes to legislation to enable pharmacists to work to their full scope of practice within an ACCHS.

The FTE allocation undertaken with a base of 0.2 per ACCHS and a subsequent distribution of the remaining FTE based on active client numbers, provided an equitable distribution of pharmacists across sites of varying size. A pilot scheme of pharmacists working within general practices in the United Kingdom recommended that pharmacists be employed at least 2 days a week, with a preference for 3 days or more, to assist with successful integration.<sup>10</sup> Congruent with this recommendation, it was observed in the IPAC Project that the one site allocated a 0.2 FTE pharmacist was the location hardest to keep staffed, with 3 different pharmacists employed over the period of the intervention. Another pharmacist who was employed 0.4 FTE elected to deliver their hours over 3 days, instead of 2, to provide a presence in the clinic on more days each week. This pharmacist reported feeling more part of the team and more likely to receive patient referrals once moving to 3 days of activity.

The UK study<sup>11</sup> which reported this preference for minimum FTE allocation also suggested the time to realise the benefits of a pharmacist within a general practice may take longer in smaller practices. Given that 7 of the ACCHSs participating in the IPAC project had an allocation of less than 0.6 FTE, a timeframe of 15 months may not have allowed sufficient time to demonstrate the full benefit that can be achieved by having an integrated pharmacist as part of the team.

To accommodate challenges involved in delivering part time roles in remote locations in the IPAC Project, blocks of activity were conducted in 6 ACCHSs. At one ACCHS, a pharmacist appointed to a 0.4 FTE position delivered a 2 week block of activity at regular intervals, rather than 2 days per week, while in another setting the pharmacist spent 2 week blocks at one of the clinics that involved charter flights for clinic access. Based upon this experience, blocks of activity should be considered in future programs as an appropriate method of delivering integrated pharmacist services to ensure that smaller and more remote ACCHS are not excluded. The IPAC Project did not evaluate pharmacist activity versus FTE.

Availability of space to conduct patient consultations was a limiting factor at times throughout the project, and restricted some opportunities to increase pharmacist FTE allocation. GPs and allied health staff, with the ability to generate income through Medicare billing, were at times prioritised at sites with a limited number of consulting rooms. Future uptake of integrated pharmacists by ACCHSs could be influenced by the prioritisation of consulting space to professionals who can increase billing through Medicare funding. Noting that pharmacists currently have no ability to claim fees related to chronic disease management via Medicare in the primary care setting, specific pharmacist program funding may be required to overcome this barrier.

A salary of \$50 per hour was budgeted for the integrated pharmacist roles throughout the project. For some pharmacists this rate was an increase on what they had been receiving prior to IPAC, while for others the rate was lower than the pay rate in their role immediately prior to IPAC. Hourly rates for employment within community pharmacy vary significantly depending on the market forces in place for specific geographic areas. Pay conditions of public health systems can influence pay conditions within ACCHS in the same jurisdictions. Comparative rates within the public hospital system of the NT at the time of the project were \$45 - \$59/hour with 6 weeks' annual leave provisions<sup>12</sup>. These comparative rates highlight that pharmacists' goodwill in the project's aims and objectives, rather than high levels of remuneration, was a factor in reaching full implementation.

Salary is only one component of the remuneration required to support integrated pharmacists. Adequate funding to support the known additional costs of delivering programs in rural and remote locations is essential. The Workforce Incentive Program incorporates rural loadings of between 20-50% to incentive payments to practices located in MMM 3-7, with the greater loading skewed to more remote locations<sup>13</sup>. In the IPAC Project, integrated pharmacists would not have commenced within some remote ACCHSs without the additional funding sourced from the project budget, ACCHSs in-kind support and community pharmacy contributions towards travel, housing and allowances.

## **5. Conclusion**

Through a proactive and multi modal approach to recruitment, the IPAC project identified significant interest from pharmacists from a range of backgrounds to work within the ACCHS settings. Pharmacists were recruited from the community pharmacy, hospital pharmacy, primary care and consulting sectors. Maintenance of a register of pharmacists interested in undertaking integrated roles within an ACCHS may assist future efforts to recruit pharmacists for similar positions. Community pharmacies who have well developed and respectful relationships with ACCHSs are well placed to identify pharmacists to perform integrated roles.

The role of an integrated pharmacist within an ACCHS is unique, with similarities to other areas of practice however components which set it apart from all others. The IPAC project assisted with the refinement of a position description for pharmacists working within ACCHSs, acknowledging the importance of providing culturally safe and acceptable services to Aboriginal people and Torres Strait Islanders within the holistic primary health care setting.

Regardless of the funding mechanism for future program role out, models of recruitment and employment must be underpinned by ACCHSs' right to self-determination. Flexibility also needs to be incorporated to ensure that options for regular weekly work schedules and/ or blocks of activity can be delivered depending on pharmacist availability and health service capacity. Funding mechanisms will need to factor in pharmacist recruitment, salary and retention, as well as the increased costs of program delivery in remote locations.

The successful completion of the implementation phase in 18 ACCHSs located across all geographic regions, including very remote locations, demonstrates that integration of pharmacists within ACCHSs is achievable across the entirety of Australia.

## **6. Recommendations**

1. Regardless of funding mechanisms, methods used to employ integrated pharmacists must recognise the principles of self-determination for ACCHSs. Recruitment should be flexible and be led by ACCHSs so that pharmacists have the 'right organisational fit.
  2. Develop proactive and multimodal strategies to assist future recruitment, encompassing engagement with community pharmacy and other pharmacy sectors. Program support enabling maintenance of a register of pharmacists interested in working within the ACCHS sector and creation of generic templates for position descriptions, guided by the ten core roles of the IPAC project, will assist all ACCHSs to access a suitable pharmacist.
  3. Legislative barriers that inhibit an integrated pharmacist from practicing to their full scope of practice within an ACCHS should be identified and overcome.
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## Appendices

### Appendix 1: Position Description approved for use with the IPAC project.

#### Aboriginal Health Service Practice Pharmacist

##### Key responsibilities/core roles

The role of the Aboriginal Community Controlled Health Service (ACCHS) Practice Pharmacist may differ between sites and should be adapted to the needs of the ACCHS setting through collaborative agreement. The main purpose of the position is to contribute to activities of the primary health care team to improve medication management for patients of the health service.

In performing the role of the ACCHS Practice Pharmacist, activities may include:

- Provide medication advice and education services to the clients of the health service according to the policies and cultural practices of the health service.
- Contribute to existing programs of chronic disease management in the health service to expand the capacity of patients to manage their own conditions through quality use of medicines.
- Provide expert professional support and advice to the multidisciplinary team.
- Undertake and/or facilitate medication management reviews for Aboriginal and Torres Strait Islander peoples
- Liaise with other agencies as appropriate to ensure optimal outcomes for the patients of the health service.
- Participate in initiatives to improve medication management quality through the development and review of clinical and procedural policies and protocols.
- Participate in activities identified as essential to the final evaluation of the IPAC project while being respectful to patient needs and wishes.
- Conduct all activities and services in accordance with professional, legislative and ethical standards and with respect for the culture of the clients and staff of the health service.

##### Work Plan

The pharmacist will work collaboratively with the health service to identify and document tasks in the early stages of the pharmacist's employment. These tasks will form the basis of a structured work plan based on the following 10 core roles of the IPAC project:

<b>SUMMARY OF PRACTICE PHARMACISTS CORE ROLES</b>			
<b>Patient Level activities are expected to be 75% of the pharmacist's time.</b>			
<b>Practice level activities are expected to be 25% of the pharmacist's time</b>			
	<b>Focus</b>	<b>Theme</b>	<b>Core activity examples</b>

1	Patient	Medication Management Reviews	Pharmacist reviews the medication the patient is taking. The pharmacist initiates and facilitates a medication management review- which may be a Home Medicines Review (HMR) or a non-HMR (medication management review not conducted in the patient's home)
2	Patient and practice	Team-based collaboration	Pharmacist participates in clinic activities that support team-based chronic disease care plans, and cardiovascular (CV) risk assessment
3	Patient	Medication adherence assessment & support	Pharmacist assesses the medication adherence of a patient while undertaking a consultation and provides support to improve adherence if necessary.
4	Patient and Practice	Medication appropriateness audit	Pharmacist assesses 'medication appropriateness and underutilisation of medicines' <u>as an audit of a sample of patients with chronic disease.</u>
5	Patient and practice	Preventative health care	Pharmacist provides preventive interventions to patients eg smoking cessation interactions.
6	Practice	Drug Utilisation Evaluation	Pharmacist conducts a DUE to undertake a systematic review of medication usage collaborating with the multidisciplinary team.
7	Practice	Education and training	Pharmacist conducts education sessions at the service
8	Practice	Medicines information service	Pharmacist provides medicines related information to staff within the service and responds to clinician medicines enquiries.
9	Practice	Medicines stakeholder liaison	Pharmacist develops a written <u>stakeholder liaison plan</u> supporting engagement with community pharmacy and other key organisation/business/individuals that provide medication related services to the site or its patients.
10	Patient and Practice	Transitional care	Pharmacist facilitates care coordination with relevant hospitals; residential aged care facilities, etc.

### Qualifications and requirements

The selection criteria, qualifications and requirements to fulfil the core roles and key responsibilities of an Aboriginal Health Service Pharmacist will include:

- Tertiary qualification in pharmacy with current registration as a pharmacist with the Australian Health Practitioner Regulation Agency (AHPRA);
- Minimum of two years post-registration experience in pharmacy (hospital, community or primary care);
- Demonstrated understanding and awareness of Aboriginal cultures and healthcare, including acceptance of the principles of community control and self-determination;
- Ability to work in <<identified ACCHS location>>
- Preferably hold or be working toward accreditation for the delivery of Medication Management Reviews
- Demonstrated sound clinical knowledge;
- Abide by PSA's Privacy Policy and all relevant ACCHS policies
- Provision of a recent police check and Working with Vulnerable People card. (or equivalent for the state/territory of employment)
- May hold other certificates or be working toward other relevant qualifications. Examples may include but are not limited to postgraduate clinical pharmacy, diabetes educator, asthma educator.

#### **Key attributes**

- Excellent interpersonal and communication skills including the ability to influence and facilitate change and to work with a diverse range of colleagues and clients;
- Proven ability to provide medication educational sessions with clients, community members and other stakeholders
- The ability and the enthusiasm to work independently and as part of a team;
- Well-developed organisational skills including time management. The ability to work in an environment with minimal supervision;

#### **Desirable:**

- Knowledge of the health issues faced by Aboriginal Communities
- Experience in health promotion and the delivery of health education strategies
- Demonstrated experience in operating as part of the primary health care team, supporting chronic disease care, including prevention and management.
- Post graduate qualification in clinical pharmacy.

## Appendix 2: Recruitment screening checklist



### IPAC Project Recruitment – Screening checklist

PSA Project Co-Ordinator completing checklist: \_\_\_\_\_

<b>Project Pharmacist's name</b>			
<b>Nominated by</b>	<b>Community Pharmacy</b>	<b>ACCHS</b>	<b>EOI</b>
<b>ACCHS of interest</b>			
<b>FTE allocated to this site</b>			
<b>Pharmacist's preferred FTE</b>			
<b>Date available to commence work</b>			

Criteria	Met /Not met	Demonstrated via	Comments
AHPRA registered		Check via AHPRA website	
2 years experience	<2 2-5 >5	Resume/interview/ referee check/other interaction	
Aboriginal cultures		Resume/interview/ referee	

understanding and awareness including principles of community control and self determination		check/other interaction	
Further comments			
Ability to work at location		Resume/interview/ referee check/other interaction	
Further comments			
HMR accredited		Resume/interview/ referee check/other interaction	
Demonstrated sound clinical knowledge		Resume/interview/ referee check/other interaction	
Further comments			

Interpersonal skills		Resume/interview/ referee check/other interaction	
Further comments			
Education skills		Resume/interview/ referee check/other interaction	
Further comments			
Work independently		Resume/interview/ referee check/other interaction	
Further comments			

Organisation skills – time management		Resume/interview/ referee check/other interaction	
Further comments			
<b>Desirable</b>			
Knowledge of health issues in Aboriginal Communities		Resume/interview/ referee check/other interaction	
Further comments			
Health promotion activities		Resume/interview/ referee check/other interaction	
Further comments			
Experience as part of primary health care team		Resume/interview/ referee check/other interaction	

Further comments			
Post graduate qualifications		Resume/interview/ referee check/other interaction	
Further comments			

	Candidate appropriate for role (Yes or No)	Comment
PSA Recommendation		
ACCHS Recommendation		

## Appendix 3. IPAC Project Pharmacist Recruitment – Interview Questions

### Introduction

- What interests you most about the IPAC Project?
- Noting that we have received your CV, is there anything about your work history to date you would like to draw particular attention to?

### Cultural (these questions or similar may be asked by a representative from the ACCHS)

- How would you describe your knowledge and experience of Aboriginal cultures & the health issues faced by Aboriginal communities?
- Please explain your understanding of community control in relation to Aboriginal Health Services, & the principles of self-determination...
- Do you currently provide a pharmacy-related service to \_\_\_\_\_ (ACCHS)? If so, please describe...
- Have you previously undertaken any cultural awareness training? If so please describe...

### Clinical

- Please describe your clinical experience to date, particularly in relation to Aboriginal or Torres Strait Islander patients (eg accredited to conduct HMRs, hospital experience, public health)
- How would you describe your current knowledge surrounding chronic disease management, in particular cardiovascular disease, diabetes & chronic kidney disease?
- Have you participated in (or delivered) health promotion programs, or provided education to others (either consumers or health professionals)? Please describe...
- Please describe a situation in which you have been involved in clinical decision making
- Noting that the IPAC Project is a trial, do you have any previous experience with research projects or data capture & evaluation?

### Availability

- You have expressed an interest in working with the \_\_\_\_\_ (ACCHS), which has been allocated a pharmacist FTE of \_\_\_\_\_. How do you see that this would fit with your other work commitments (if applicable)?
- When would you be available to commence work at the ACCHS?
- Which IPAC Project Pharmacists' Training session would you be able to attend? (end of July or end of August 2018)
- Do you have any existing leave/holiday plans?

## Appendix 4: Generic position description

### Aboriginal Health Service Practice Pharmacist

#### Key responsibilities/core roles

The role of the Aboriginal Community Controlled Health Service (ACCHS) Practice Pharmacist may differ between sites and should be adapted to the needs of the ACCHS setting through collaborative agreement. The main purpose of the position is to contribute to activities of the primary health care team to improve medication management for patients of the health service.

In performing the role of the ACCHS Practice Pharmacist, activities may include:

- Provide medication advice and education services to the clients of the health service according to the policies and cultural practices of the health service.
- Contribute to existing programs of chronic disease management in the health service to expand the capacity of patients to manage their own conditions through quality use of medicines.
- Provide expert professional support and advice to the multidisciplinary team.
- Undertake and/or facilitate medication management reviews for Aboriginal and Torres Strait Islander peoples
- Liaise with other agencies as appropriate to ensure optimal outcomes for the patients of the health service.
- Participate in initiatives to improve medication management quality through the development and review of clinical and procedural policies and protocols.
- Conduct all activities and services in accordance with professional, legislative and ethical standards and with respect for the culture of the clients and staff of the health service.

#### Qualifications and requirements

The selection criteria, qualifications and requirements to fulfil the core roles and key responsibilities of an Aboriginal Health Service Pharmacist will include:

- Tertiary qualification in pharmacy with current registration as a pharmacist with the Australian Health Practitioner Regulation Agency (AHPRA);
- Minimum of two years post-registration experience in pharmacy (hospital, community or primary care);
- Demonstrated understanding and awareness of Aboriginal cultures and healthcare, including acceptance of the principles of community control and self-determination;
- Ability to work in <<identified ACCHS location>>
- Preferably hold or be working toward accreditation for the delivery of Medication Management Reviews
- Demonstrated sound clinical knowledge;
- Provision of a recent police check and Working with Vulnerable People card. (or equivalent for the state/territory of employment)

- May hold other certificates or be working toward other relevant qualifications. Examples may include but are not limited to postgraduate clinical pharmacy, diabetes educator, asthma educator.

**Key attributes**

- Excellent interpersonal and communication skills including the ability to influence and facilitate change and to work with a diverse range of colleagues and clients;
- Proven ability to provide medication educational sessions with clients, community members and other stakeholders
- The ability and the enthusiasm to work independently and as part of a team;
- Well-developed organisational skills including time management. The ability to work in an environment with minimal supervision;

**Desirable:**

- Knowledge of the health issues faced by Aboriginal Communities
- Experience in health promotion and the delivery of health education strategies
- Demonstrated experience in operating as part of the primary health care team, supporting chronic disease care, including prevention and management.
- Post graduate qualification in clinical pharmacy.

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