



NACCHO

National Aboriginal Community Controlled Health Organisation

NACCHO Report IPAC Project ACCHS Support

May 2020

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In presenting this IPAC Project ACCHS Support Report, NACCHO wishes to acknowledge the contributions of Aboriginal and Torres Strait Islander peoples who participated in the project. We would like to thank the Aboriginal and Torres Strait Islander people for their cooperation and assistance as consented patients for the research information that was essential for this project. We wish to acknowledge and pay respect to Elders, both past and present and all generations of Aboriginal and Torres Strait Islander peoples now and into the future as the Traditional Owners of this land.

1. Executive summary

Background:

The burden of chronic disease is higher for Aboriginal and Torres Strait Islander people compared to other Australians. Moreover, access to medicines and pharmacist services for Aboriginal and Torres Strait Islander people is inequitably low, especially considering the greater need for such services owing to the higher burden of disease. The *Integrating Pharmacists within Aboriginal Community Controlled Health Services (ACCHSs) to improve Chronic disease management (IPAC) Project*^a aims to integrate pharmacists into ACCHSs to deliver services to patients, staff and the ACCHS organisation to improve chronic disease outcomes. ACCHS organisational needs and priorities may be differentiated from other Australian primary care providers, for example by focussing on prevention, early intervention and comprehensive care and reducing barriers to access and racism.(1)

To fulfil the Project's aim, three partner organisations were involved including the Pharmaceutical Society of Australia (PSA), James Cook University (JCU) and National Community Controlled Health Organisations (NACCHO). Each partner organisation acted in a specific role to ensure the Project was designed, implemented and evaluated effectively. These roles reflected the organisations' distinct competencies and sector representation. The PSA was the lead organisation and contracted JCU and NACCHO to undertake specific Project activities based on objectives and aims outlined in the Project protocol and respective agreed service contracts.(2) PSA was also responsible for pharmacist recruitment, training and support, while JCU led the research component of the Project.

Aim:

NACCHO's primary aim as a Project partner was to provide input, representation and support for the ACCHS sector throughout the entire Project lifecycle.

NACCHO's Project objectives, which are expanded from the primary aim above and reflected in the Project protocol, are:

- To design the Project to be acceptable and effective for ACCHSs
- Oversee recruitment of ACCHSs into the Project
- Assist in collecting research information from ACCHSs
- Provide support for participating ACCHSs and receive ACCHSs' feedback
- Provide input into Project oversight and governance
- Provide input into other Project related activities where needed and appropriate

Methods:

Related to NACCHO's primary aim and its objectives, 6 key activities were developed in collaboration with the Project partners. The 6 key activities are described below:

- a. Develop and manage an effective and acceptable process for Project ACCHS expressions of interest (EOI) and site recruitment
- b. Manage and conduct ACCHS scheduled site visits; including conducting research, education and support activities whilst visiting ACCHSs
- c. Manage and administer the IPAC Project Reference Group (PRG)
- d. Manage Affiliates' Project activities
- e. Commission, develop and contribute to Project resources and materials
- f. Coordinate ACCHSs' feedback, communication and support

^a The IPAC Project is known as "the Project" from here onward

Operationally, these 6 key activities were delivered by dedicated IPAC Project Coordinators, who were central to ensuring that NACCHO's primary aim and Project objectives were achieved.

Results:

NACCHO executed all activities as planned and was therefore able to meet its primary aim to provide input, representation and support for the ACCHS sector throughout the entire Project. NACCHO Coordinators were fundamental in managing and conducting the 6 key activities in a way that was acceptable, culturally safe and effective for ACCHSs. NACCHO Coordinators managed the EOI and ACCHS recruitment processes to recruit 20 ACCHSs into the Project (inclusive of clinic 24 sites), distributed across intended jurisdictions and remoteness. Coordinators visited each ACCHS at least 2 times, as planned, and conducted all planned on-site research and communication activities during these visits. NACCHO established and managed the IPAC Project Reference Group, which provided ongoing Aboriginal and Torres Strait Islander Project governance and feedback to the Project team throughout the Project. NACCHO also managed the Project activities and service delivery of state and territory Affiliates, who delivered tailored regional expertise and activities to suit their respective jurisdictions. NACCHO commissioned, developed or provided input into several key Project resources and documents including the ACCHS Pharmacist Needs Assessment, ACCHS Health Systems Assessment, Project presentations and Project promotion material for ACCHSs. Throughout the Project, Coordinators were able to provide ongoing, flexible support for ACCHSs. Feedback received from ACCHSs was consistently positive across Coordinator activities, which was corroborated by low site attrition. The Coordinators aided in research data collection Project oversight and governance when needed and acted expeditiously to address any issues that may have risked ongoing participation.

Discussion:

NACCHO fulfilling its primary aim and Project objectives throughout the entire Project life cycle validated the 6 key ACCHS support activities developed by partners and demonstrated that the Project Coordinators delivered services related to the 6 activities effectively in a way that was acceptable to ACCHSs. These operational activities augmented NACCHO's general governance-related objective to ensure Aboriginal and Torres Strait Islander representation and oversight at all levels of the Project.

Some limitations and challenges were identified in ACCHS support activities. These included maintaining effective communication and engagement with a small number of ACCHSs and Affiliates within the governance structures defined by the Project; and managing communication and delivery of Project activities between several stakeholders involved in supporting pharmacists and ACCHSs, including Affiliates, PSA and others.

Ultimately, the effectiveness of this model and the delivery of the key activities was supported empirically by extremely low patient attrition, low site attrition, positive results in the Project's Qualitative Evaluation Report and feedback from the PRG and individual ACCHSs and Affiliates throughout the Project.

ACCHSs found the Project intervention acceptable and effective. Such results strongly support implementation of a national program that integrates pharmacists into ACCHSs, adapted from the IPAC model. Furthermore, any such national program must incorporate ACCHS support modelled on support provided in the IPAC Project. This national integrated pharmacist program should be implemented immediately to help reduce the gross health and medicines-related inequities faced by Aboriginal and Torres Strait Islander people compared to other Australians.

2. Recommendations

The following recommendations are related to findings from this report and based on delivery of the 6 key activities and in consideration of NACCHO's participation in Project evaluation, implementation and governance.

1. The Australian Government Department of Health should immediately implement an ongoing national ACCHS-integrated pharmacist program adapted from the IPAC Project's model and incorporating the 4 overarching goals (accessibility, safety, equality and efficiency) of ACCHS pharmacists as identified by NACCHO, to address health and medicines related disparities between Aboriginal and Torres Strait Islander populations compared to other Australians.
2. The national ACCHS-integrated pharmacist program must include adequate support for both ACCHSs and pharmacists. This support for ACCHSs should be adapted from the 6 key activities delivered in the IPAC Project including dedicated program coordinator/s, an Aboriginal and Torres Strait Islander governance group, support for pharmacist recruitment and training, and culturally appropriate program resources.
3. Community-control and self-determination must remain central to the national program, to allow ACCHSs to employ pharmacist/s of their choice in a way that is adequately flexible and relevant to their specific needs.
4. Specific challenges related to remoteness must be considered in the national program. Pharmacists working in remote ACCHSs require a higher level of funding to account for additional implementation costs, as well as salary loading for travel and accommodation.
5. The national program must be patient-focussed, but also synergistic with other related pharmacy activities and medicines programs. Specifically, the program must be complementary to relevant community pharmacy and health programs and activities as demonstrated in the IPAC Project. This includes Home Medication Review, Quality Use of Medication MAXimised for Aboriginal people and Torres Strait Islanders (QUMAX), s100 Support Allowance, Workforce Incentive Payment and more.

3. Introduction, aims and objectives

The burden of chronic disease is higher for Aboriginal and Torres Strait Islander people compared to other Australians. Moreover, access to medicines and pharmacist services for Aboriginal and Torres Strait Islander people is inequitably low, especially considering the greater need for such services owing to the increased burden of disease. The *Integrating Pharmacists within ACCHSs to improve Chronic disease management* (IPAC) Project^b aimed to integrate pharmacists into ACCHSs to deliver services to patients, staff and the ACCHS organisation to improve chronic disease outcomes.

NACCHO Project objectives and activities

To fulfil the Project's aim, three partner organisations were involved, including the Pharmaceutical Society of Australia (PSA), James Cook University (JCU) College of Medicine and Dentistry, and NACCHO. Each partner organisation undertook specific roles to ensure the Project was designed, implemented and evaluated effectively. The PSA was the lead organisation and contracted JCU and NACCHO to undertake specific duties. PSA was also responsible for pharmacist recruitment, training and support while JCU led the evaluation of the Project. NACCHO's primary aim as a Project partner was to provide input, representation and support for the ACCHS sector throughout the entire Project life cycle.

This document outlines NACCHO's key activities in achieving this aim. NACCHO acted to fulfil its primary aim through several activities developed with the Project partners. NACCHO's key activities outlined in this document relate to specific objectives which are based on the primary aim.

These objectives are:

- To provide input into Project design to be acceptable and effective for ACCHSs
- Oversee recruitment of ACCHSs into the Project
- Assist in collecting research information from ACCHS
- Provide support for participating ACCHSs and receive ACCHSs' feedback
- Provide input into Project oversight and governance
- Provide input into other Project related activities where needed and appropriate

In consultation with Project partners and through a Project Activity Workplan, NACCHO has acted on these objectives through undertaking several activities. These activities are outlined in the following document and summarised in the Summary section above.

NACCHO IPAC Project Coordinators

NACCHO employed two National IPAC Project Coordinators with a combined Full-Time Equivalent (FTE) of 1.0. The aim of the role was to manage and coordinate ACCHS-related Project activities and operations. The Project Coordinators were central to addressing objectives related to the NACCHO's Project aim. The Coordinators managed and coordinated the following 6 key Project activities:

a. ACCHS expressions of interest and site recruitment

The aim of the Project's site recruitment process was to identify and recruit the required number of ACCHSs that met Project site eligibility criteria, in a way that was effective and acceptable to the ACCHS sector.

b. Coordinator ACCHS site visits

The aim of the Project Coordinators' ACCHS site visits was to build rapport with ACCHSs, conduct service needs and health systems assessments and to provide resources and ongoing support.

^b The IPAC Project is known as "the Project" from here onward

c. Project Reference Group

The Project Reference Group's (PRG) aim was to be the primary governance body that represented participating Aboriginal and Torres Strait Islander organisations, leaders and patients and to provide oversight and feedback to Project partners. Specifically, the PRG objectives and functions included:

- Provide Aboriginal and Torres Strait Islander oversight and input into the Project
- Report on IPAC cultural safety and effectiveness to ACCHSs and Aboriginal people at all levels
- Synthesize themes and provide recommendations to the Steering Committee to improve the effectiveness and appropriateness of the Project for ACCHSs and Aboriginal clients as needed, throughout the lifespan of the Project.
- Advise on Project risk mitigation strategies, as necessary.
- Endorse the nomination of three sites for site visits for the qualitative evaluation

d. State and territory Affiliate involvement

There are significant variations in ACCHS practice, legislation, geography and governance amongst states and territories in Australia. State and territory Affiliates of NACCHO have knowledge and networks to navigate and advise on Project issues at this level. Therefore, the Project engaged the assistance of the relevant Affiliates, coordinated by NACCHO. The primary aim of Affiliates in the Project was to provide knowledge, oversight and support for participating ACCHSs in their respective state or territory. Affiliates also provided jurisdictional input and subject matter expertise through the Project's evaluation processes and PRG.

e. Resources and materials

Within the Project protocol a need was identified for NACCHO input into key Project research resources, and administration of some of these resources to participating ACCHSs. Resources identified included the ACCHS's pharmacist Needs Assessment, Health System Assessment and others.

A need was also identified by Project partners for several Project promotional materials to be developed for use during Project establishment and implementation. Primary aims of these resources included:

1. Improve consistency and communication between NACCHO and ACCHSs
2. Promote the Project to patients and enhance patient and ACCHS participation

f. Ongoing communication, feedback and support for participating ACCHSs

The Project team proposed that to make the Project acceptable for participating ACCHS, it was necessary to have a support person or organisation to work consistently and responsively for each ACCHS to ensure the Project met their needs in a culturally responsive way, consistent with the NACCHO's primary aim to support ACCHS. This role was undertaken by the NACCHO Project Coordinators under the supervision and guidance of NACCHO.

4. Methods

NACCHO Project Coordinators

The Coordinators were employed to deliver services throughout the entire Project (see Appendix 1 for Coordinator Position Description). The role of the Project Coordinators is captured in their key duties below:

- Work with Project partners; the Pharmaceutical Society of Australia, James Cook University and NACCHO leadership to ensure effective and culturally safe project establishment, implementation, development and evaluation.
- Maintain engagement and coordinate communications with all participating ACCHSs and Affiliates, through:
 - Establishing and managing the IPAC Project Reference Group (PRG)
 - Visiting participating ACCHS sites, to conduct ACCHS needs and health systems assessments, provide induction presentations,
 - Other ongoing formal and informal communication and support, as required
- Coordinate the expressions of interest, invitation and enrolment of ACCHSs to participate in the Project
- Work with relevant state and territory Affiliates and NACCHO's participating Member ACCHSs to ensure that the Project is acceptable and meets Members' needs and expectations
- Consult with and assist Project Partners to develop resources and documents related to the Project's establishment, implementation and evaluation in collaboration with ACCHOs, Affiliates and consumers ensuring appropriate cultural protocols are followed.
- Provide support to ACCHSs in assessing and developing their pharmacy service needs, in collaboration with relevant Project partner representatives
- Report on activities to NACCHO executive and Project contractor – PSA

An overview of the role and activities of the NACCHO project coordinator is shown in the ACCHS Consultation and Information Flow Diagram from the project protocol (Appendix 2). The methods of delivery of specific Coordinator activities are explained below. These activities were overseen and supported by the NACCHO management, Executive and Board as necessary.

a. ACCHS expressions of interest and site recruitment

NACCHO conducted a two-phase Expression of Interest (EOI) site recruitment strategy for the IPAC Project which was managed by the NACCHO Project Coordinators. Phase 1 of the EOI process involved communication through two media releases, general emails to ACCHSs and stakeholders, and direct correspondence with individual sites across each of the participating jurisdictions. Input into EOI delivery and recruitment was garnered from the following stakeholders and informants: Affiliate representatives, QUMAX Coordinator, Evaluation team, PSA, NACCHO Communications and Members Services teams.

Health service inclusion criteria (Appendix 3) were used to select sites after reviewing the responses to the advertised EOI. The Project protocol outlined the proposed distribution of ACCHSs in urban, regional and remote locations across 3 jurisdictions, the Northern Territory, Queensland and Victoria. The proposed allocation of pharmacist hours for each of the 22 proposed sites was aggregated and equivalent to 0.57 Full time equivalent (FTE) pharmacists.

The proposed site distribution plan reflected the diversity in geographical location required for this Project and is shown in Figure 1.

Figure 1. Proposed site distribution plan from Project Protocol

	Urban	Regional	Remote	Total
Northern Territory		1	5	6
Queensland	3	3	2	8
Victoria	5	3	0	8
Total	8	7	7	22

The protocol specified that the IPAC Project Operational Team review the expressions of interest and decide if a temporary panel made up of Affiliate representatives was necessary to select the most suitable sites to participate in the Project.

NACCHO was responsible for preparing a report detailing the proposed allocation of FTE to each of the suggested list of 22 sites for endorsement by the Steering Committee.

Once services were endorsed by the Steering Committee, Phase 2 of the EOI process was conducted. Phase 2 involved further in-depth discussions between representatives from proposed sites and the NACCHO Coordinator/s, including their chronic disease patient numbers, existing services from a pharmacist and/or community pharmacy, practical considerations such as consulting room space within the ACCHS and available accommodation for pharmacists in remote sites, and expectations of what a pharmacist could add to the workplace.

After discussion with the Project team and Steering Committee, each ACCHS was formally invited to apply to participate in the project. Participation required a formal agreement between the ACCHS and PSA as the head contractor outlining the requirements of each party to the agreement, participation consent of the ACCHS in the IPAC Project and consent to install the GRHANITE™ software to enable extraction of deidentified patient specific data.

b. Coordinator ACCHS Site Visits

As part of the Project design, the NACCHO Coordinators' role was to undertake two site visits to each participating ACCHS. First, at the commencement of the Project (start of the Implementation phase) and again at the end of the implementation phase (the final site visit). The purpose of these visits was to:

- Conduct the IPAC ACCHS Health Systems Assessment (HSA).
- Conduct the IPAC ACCHS Needs Assessment during the first visit. (Appendix 4)
- Meet and provide information about the Project to ACCHS managers and staff, including provision of Project information, presentations to staff meetings, provision of the formal site participation brief (Appendix 9), ensure contracts and consent forms were complete. (Appendix 5)

Health Systems Assessment

The Health Systems Assessment (HSA) was a survey conducted to identify health system-related covariates. Each participating ACCHS was visited twice to enable capture of any changes in health services over the period of the project that may have confounded the measured results of the IPAC project.

- 1st HSA: At the time of, or just prior to the appointment of the pharmacist during the first site visit, to obtain baseline data
- 2nd HSA: Towards the end of the implementation phase at the final site visit during months 12-15, to identify any changes

The HSA sourced information about service size and function within the ACCHS, how many staff (and types) were employed within the ACCHS, the total service population, the total service budget, Aboriginal governance structures, health services on offer, Continuing Quality Improvement (CQI) processes, models of care such as outreach, if home medicines reviews were conducted and how, type of CIS used, recall systems in place, the features of existing communication with the hospital, and community pharmacy/s, medicines access information, use of point of care testing and regional services available such as specialist and allied health visits. The detail of the HSA is described in other reports (3).

Needs Assessment

The Needs Assessment aimed to elicit the type of support needed by the ACCHS so that the pharmacist may best be integrated within the service. The elements of the Needs Assessment were based on the Needs Assessment for pharmacists embedded into GP practices (4) and the 10 core roles of the IPAC pharmacist. Examples of suggested contributions by a pharmacist were provided and the ACCHS representatives estimated on a scale of 1 to 3, with 1 the most important, how important those functions were to the ACCHS. There were also opportunities to describe and plan how the role of the IPAC pharmacist would integrate with existing services from community pharmacies and consultant pharmacists. A more detailed description of the Needs Assessment is provided in the published protocol for the Project. (2)

From this Needs Assessment, a structured workplan was developed for the pharmacist/s in each individual service. This was provided to the health service, IPAC pharmacist, contracted community pharmacy where applicable, PSA and NACCHO Project team members. This plan was reviewed after 3 months for continuing applicability. The purpose of the work plan was to:

1. Clarify the specific role of the pharmacist within the health service according to identified need
2. Clarify the work requirements for the Project evaluation
3. Allow review of the performance of the pharmacist in meeting the needs of the health service and the aims of the Project
4. Identify learning needs of the integrated pharmacist

Project Information and Induction Presentation

The first site visit also allowed discussion of the ACCHSs preferred system for referring patients to the pharmacist and for seeking patient consent. The visit ensured that the pharmacist had approved access to the CIS, had a private space to consult with patients and was provided with a uniform, if available, to indicate the pharmacist was part of the team. Opportunities to ask questions about the Project were also provided to as many available ACCHSS staff as possible. The NACCHO coordinator also arranged a nominated ACCHS staff member to act as a 'go to' person for the IPAC pharmacist to assist in their orientation to the service.

An induction presentation (using PowerPoint software) was developed and presented to available staff at the first site visit. This is available at Appendix 6.

This presentation covered a variety of topics to guide further discussion with ACCHSs to assist with implementation such as:

- Background on why the Project was developed
- Information on the Project partners and ethics approvals
- Governance structure
- Evaluation methods
- Information on services the ACCHS would receive

- Information on “what a pharmacist can do for you”
- 10 core roles for IPAC pharmacists
- Information on consent process and establishment of the Project

c. Project Reference Group

The Project protocol specified the requirement for NACCHO to establish and manage the IPAC Project Reference Group (PRG), which reported to the NACCHO Board and the IPAC Steering Committee.

Membership consisted of:

- Deputy CEO of NACCHO and Chair of Operations Team (Chair initially held by NACCHO Senior Member Services Officer)
- Representatives of the participating Aboriginal Community Controlled Health Services
- Representative of the Victorian Aboriginal Community Controlled Health Organisation
- Representative of the Queensland Aboriginal and Islander Health Council
- Representative of the Aboriginal Medical Services Alliance Northern Territory
- Director of Medicines Policy and Programs (NACCHO)
- NACCHO National Project Coordinators
- NACCHO-invited guests to participate or observe

Group meeting mode and frequency

The PRG communication and discussion was designed to be responsive to members’ needs and was planned to be conducted in several ways including:

- Approximately 3 monthly teleconferences hosted by NACCHO
- Forums at NACCHO national conferences 2018 and 2019
- Bi-monthly electronic newsletter
- Ad hoc correspondence with NACCHO Project Coordinators via phone or email

d. State and territory Affiliate activities

The three NACCHO Affiliates involved in the Project were:

- Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
- Queensland Aboriginal and Islander Health Council (QAIHC)
- Aboriginal Medical Services Alliance Northern Territory (AMSANT)

Affiliates appointed a designated staff member (0.2-0.4 FTE) to liaise with the NACCHO Project team and with ACCHSs participating in the IPAC Project. Affiliates were able to choose how to allocate funds towards salary and associated staff costs, and travel as was appropriate, to meet their deliverables outlined in a workplan. A workplan template was provided to Affiliates based on roles specified in the Project protocol.

The Affiliate staff members developed a workplan according to the needs of their members, which was included in a formal agreement between Affiliates and NACCHO. The basis of these agreements was that Affiliates would have operational responsibilities within their jurisdiction and a role within the evaluation and governance of the Project. Affiliates were responsible for state-based service support to participating ACCHS; for providing input into Project implementation and establishment; and providing guidance to the Project as members of the evaluation team.

The Affiliates were provided the following roles to consider including in their agreed workplan, tailored to the needs of their respective jurisdiction:

- 1) Work with Partners to ensure that the Project is acceptable and culturally safe for ACCHS members at all stages
- 2) Provide input and collaborate with Partners during Project's establishment and implementation, including:
 - a) Provide input into the Project expressions of interest (EOI) process
 - b) Contribute to providing support to ACCHSs during EOI, and establishment and implementation phases as required, including site visits as needed
 - c) Contribute to the identification and selection of suitable sites in consideration of site inclusion criteria in the Protocol
 - d) Provide input to Partners to ensure that pharmacist training and service delivery meets ACCHS needs
 - e) Contribute to the NACCHO and PSA led health service assessment and concurrent pharmacist recruitment as negotiated with participating ACCHSs
 - f) Participate in regular communication between ACCHS, NACCHO and Partners to ensure that operational problems are identified and managed in a timely way
 - g) Provide assistance and support to ACCHSs who are at risk of withdrawing from the Project
- 3) Actively participate in the Project Reference Group - meeting at least quarterly by teleconference or other web-based platforms of communication
- 4) Provide input into Project governance
- 5) Actively participate in governance groups outlined in the Protocol:
 - a) Evaluation Team - meeting at least 3-monthly for teleconference, and face-face meetings required during the evaluation phase of the Project
 - b) Project Reference Group
- 6) Provide input into evaluation of the Project
- 7) Contribute to Project-related advocacy and to policy work, to ensure that the findings from this research are used to support integration of pharmacists into Aboriginal primary health care.
- 8) Ensure that the Project's establishment and implementation are delivered between ACCHSs and jurisdiction consistently and aligned with the Protocol
- 9) Provide a workplan to NACCHO for the Project with a simple budget outlining the proposed costs and deliverables.

e. Resources and materials

NACCHO led the development of promotional materials, the Needs Assessment tool and Pharmacist Workplan template. NACCHO was also responsible for managing or providing input into the development of several Project resources and materials that were developed to be used throughout the administration of the Project either by participants or Partners. These included the ACCHS participations agreement document between ACCHSs and PSA, presentations for PSA training modules, Adherence tools, project documentation and the Health Systems Assessment (HSA).

Needs assessment tool

The Needs Assessment aimed to elicit the type of support needed by the ACCHS so that the practice pharmacist may best be integrated within the service. A Needs Assessment was required by the project protocol, and for consistency across ACCHSs, a tool for helping ACCHSs identify the needs of the

health services and their patients was developed by the NACCHO Project Coordinators. The Needs Assessment tool developed by NACCHO for the IPAC project is available at Appendix 4

Workplan template

A structured workplan template that could be adapted to the needs as identified on the Needs Assessment and which was consistent with the 10 core roles of the project was also developed. Although led by the NACCHO team, these were developed in consultation with the project team. A more detailed description of the workplan is provided in the Project protocol.

Health Systems Assessment

NACCHO worked with Partners to contribute to the development of the HSA to be delivered by NACCHO Project Coordinators during Project implementation. This involved considering the ONE21Seventy CQI tool and looking at health systems assessments used in the Kanyini Project and assessing them as not specific enough for the Project or not culturally appropriate. This led to the development of the IPAC HSA tool described in detail elsewhere. (1)

Promotional materials

A need was identified by partners to develop promotional materials to assist patient recruitment and increase acceptability of the Project. NACCHO led the development and distribution of these materials. These materials included:

1. A poster for display in ACCHS waiting rooms
2. A brochure to explain the project to patients and in particular to patients with low English literacy
3. Promotional videos to air on audio-visual systems in waiting rooms in participating ACCHSs, including on the Aboriginal Health Television (AHTV) network

f. ACCHSs ongoing communication, feedback and support

NACCHO established several methods to allow Project-related feedback from ACCHSs to the Project team. The methods identified any difficulties with the project so they could be addressed in a timely manner and in a culturally sensitive way. In particular, the methods were designed to capture feedback from ACCHSs about the conduct of the Project, research methods and future usefulness and opportunities to embed a pharmacist into ACCHS. Communication modes for ACCHSs included:

- Establishment of a Project Reference Group (PRG) that could advise on the appropriate conduct of the Project and the research requirements of the Project as it impacted on individual health services.
- Establishment of a relationship between a specific NACCHO Project Coordinator and a main ACCHS contact/s from each site (also known as the “go-to” person/people). The Project Coordinator allocated to each particular ACCHSs remained constant throughout the Project.
- Regular (at least monthly) communication between the NACCHO Project Coordinators and ACCHS contact person by phone or email, outside of PRG activities.
- Seeking of specific feedback by NACCHO Project officers from ACCHS managers and staff at the second site visit
- Feedback from Affiliates, obtained during their communications with participating ACCHSs

5. Results

Project Coordinators

The project coordinators achieved all planned activities as shown in the Consultation and Information Flow Diagram (Appendix 2) and described in the methods. NACCHO's primary aim as a Project partner to provide input, representation and support for the ACCHS sector throughout the entire Project was achieved.

NACCHO had at least one representative at all Operational Team discussions and Steering Committee meetings. NACCHO coordinators conducted the planned activities to ensure the Project was acceptable and effective for ACCHSs, to oversee recruitment of ACCHSs into the Project and to provide ongoing support for ACCHSs throughout the project. The role of ensuring continuity and acceptability of the project for ACCHSs through assisting in research data collection, providing Project oversight and governance and immediately addressing any issues that may have risked ongoing participation was very successful. This was demonstrated by most of the ACCHSs completing the project.

a. ACCHS expressions of interest and site recruitment

Expression of interest (EOI)

The EOI process was conducted between 20th March 2018 and 11th April 2018. After the first phase of the EOI had been executed, 33 responses in total were received. After excluding sites due to duplicate EOIs (2) and inability to meet inclusion criteria (1 from NSW, 5 with Medical Director software, 1 with PCIS software and 2 without a full-time GP), there were 24 sites. One ACCHS was allocated the status of 2 sites as it had locations in separate regional towns, using 2 standalone clinical information systems (CIS) and thus 2 separate CIS extraction software (GRHANITE™) licenses would be required.

A temporary panel as referenced in the Project protocol was not required. After considering the inclusion criteria and proposed site distribution, the number of sites who met the criteria was equal to the required number of sites required for the project.

In some cases, ACCHSs made suggested amendments to proposed pharmacist FTE allocation. For example, a reduction in FTE where the ACCHS felt they could only accommodate a pharmacist a certain number of days per week because of space allocations, or where the calculated FTE was more than 1 and the ACCHS was in a remote area with proven difficulties in recruiting staff, especially a full-time plus part-time pharmacist or 2 part-time pharmacists. Discussion and negotiation between the ACCHS and the NACCHO project Coordinator/s was required to ensure the needs of the ACCHS were accommodated where possible.

Studies suggest there are economies of scale in larger health services with the price per capita of services decreasing with larger numbers of patients (5), therefore it was identified that a model that distributes pharmacist time only by a per capita basis unfairly disadvantaged smaller health services. On consideration of the number of patients managed by the range of sites, it was proposed to allocate FTE according to a baseline allocation plus a formula based on patient numbers. Large multi-location sites were therefore eligible to receive more than 1 FTE pharmacist. NACCHO prepared a report detailing the proposed allocation of FTE to each of the 24 sites for endorsement by the Steering Committee.

Contacts from proposed sites were invited to discuss the Project with the NACCHO Coordinators in greater depth including their chronic disease patient numbers, existing services from a pharmacist and/or community pharmacy, practical considerations such as consulting room space within the ACCHS and

available accommodation for pharmacists in remote sites, and expectations of what a pharmacist could add to the workplace. NACCHO provided ongoing communication with ACCHSs regarding their eligibility.

ACCHS recruitment

A report was prepared for the Project Steering Committee's consideration in May 2018. Issues that were considered when finalising site selection included willingness to commit to installing the GRHANITE™ data extraction tool and ability to meet inclusion criteria. (Appendix 3)

The ACCHS inclusion criteria excluded ACCHSs which already employed an integrated non-dispensing practice pharmacist. Three health services identified an arrangement with a pharmacist that required further consideration in relation to that exclusion. On further investigation by NACCHO project officers, it was recommended to and supported by the Steering Committee, that the services could participate in the project as the pharmacists were employed primarily for a governance role. The particulars of the pharmacist activity prior involvement were captured in the HSA and are discussed elsewhere (3). The protocol proposed a mix of urban, rural and remote locations as defined by the Australian Statistical Geography Standard-Remoteness Area (ASGS-RA) (6). The sites selected were as close as possible to the proposed distribution as shown in Figure 2. Client numbers of the ACCHS were considered to ensure there was an adequate pool of active clients to recruit from during the project. These numbers were obtained verbally in interview with the main ACCHS contact and were then used to guide pharmacist FTE allocation.

Of the 24 ACCHSs initially invited to participate, two ACCHSs decided not to proceed and withdrew their EOI. Two other ACCHSs that had not responded to the initial EOI, but which had since contacted the NACCHO Project Coordinators expressing interest were then invited to apply. Both declined. The extra available pharmacist FTE caused by ACCHS withdrawal was then reallocated to two ACCHSs that had more than one physical location and these were considered dual "sites" for the purposes of pharmacist allocation, while remaining a single "participating ACCHS". One ACCHS had two sites in different towns, each with a standalone CIS and therefore a unique GRHANITE™ license. One ACCHS chose to withdraw from the project and the project was discontinued early at another ACCHS. Thus, the final site and ACCHS count by the end of the intervention was 22 sites over 18 different ACCHSs. This report refers in general to ACCHS as, for communication and support purposes, ACCHSs with more than one site were administered centrally and thus communication by NACCHO project coordinators could be done through common managers and go-to people.

PSA and NACCHO provided the Project contracts to ACCHS, who commenced the Project once the contracts had been signed and pharmacists had been recruited.

Site distribution

The final geographical distribution of urban, remote and regional ACCHSs recruited to the Project was acceptably aligned to the proposed distribution outlined in the Project protocol (Fig 1). This distribution was endorsed by the Steering Committee as achieving the aims outlined in the protocol and referenced in the agreement with the funding body. Figure 2 shows the revised IPAC site distribution plan at the start of the Project.

Compared to the original distribution table, the number of sites in Queensland was reduced by 1 because there were only 7 sites who expressed interest who were eligible. This was primarily due to the CIS-related inclusion criterion that excluded some Queensland ACCHS applicants. Although the number of sites in Victoria was allocated as planned, the total FTE for Victoria was reduced as most of the Victorian sites had smaller numbers of patients, as declared in the EOI process. The number of sites in NT was accordingly

increased by 1 and the total FTE increased which was to enable the project to accommodate the large numbers patients attending ACCHSs in the NT.

Figure 2 The Revised IPAC site distribution plan at start of the Project

	Urban	Regional	Remote	Total	FTE
Northern Territory		1	6	7	4.9
Queensland	3	2	2	7	4.4
Victoria	4	4	0	8	3.2
Total	7	7	8	22	12.5

When an adjustment was made from the proposed 0.57FTE per site, to a formula allocation based on patient load, with some consideration of expected difficulty to recruit in remote areas and other individual ACCHS requirements, the total FTE load across states as proposed initially and as proposed in this revision is shown below in Figure 3.

Figure 3 The revised FTE distribution by state compared with initial projections

	initial FTE proposed	revised FTE
NT	3.42	4.9
Qld	4.56	4.4
Vic	4.56	3.2
Total	12.54	12.5

Project progress - ACCHS retention and attrition

One ACCHS withdrew within 3 months for several cited reasons, one being the unexpected workload placed on other staff due to the pharmacist's recommendations and activities, in an already busy period where staff shortages were ongoing.

Another ACCHS chose to discontinue the intervention after 6 months of activity, when their pharmacist resigned for personal reasons. There were also very low patient numbers at the ACCHS which made re-recruitment unfeasible for the remaining project duration.

The majority of pharmacist FTE allocation from these two sites was redistributed to existing large participating ACCHSs that had multiple locations, which enabled services to meet the needs of a broad range of eligible patients. A total pharmacist FTE of 12.3 was maintained throughout the project. Figure 4 shows the final number of ACCHSs involved in the Project at the end of the intervention phase was 18.

Figure 4 ACCHS distribution at the end of the project

	Urban	Regional	Remote	Total	FTE
Northern Territory		1	4	5	4.6
Queensland	3	2	2	7	5.1
Victoria	2	4	0	6	2.6
Total	5	7	6	18	12.3

b. Coordinator ACCHS site visits

NACCHO Project Coordinators conducted at least two site visits for each ACCHS completing the Project as per the IPAC protocol. Two ACCHSs were visited a 3rd time to address operational issues identified through ongoing communication with the ACCHS and Project partners. Two other ACCHSs received an additional site visit when the NACCHO Project Coordinator was at the ACCHS location for other business enabling opportunistic support for the ACCHS and pharmacist to be provided in person rather than my phone or email, reinforcing the support from NACCHO.

First Site Visits

The first site visits were conducted to 20 participating ACCHSs between and 12th June 2018 and 13th September 2018. These were divided equally between the two NACCHO Project Coordinators with one Coordinator visiting Victorian and southern Queensland ACCHSs and the other coordinator visiting the Northern Territory and Northern Queensland ACCHSs. Visits took 1-2 days depending on travel schedules and needs of the ACCHS.

Feedback from local community pharmacies towards IPAC was observed to be very positive by NACCHO Project Coordinators. During initial site visits, the Project Coordinators met most of the relevant community pharmacists and were able to explain the Project's processes and aims. Subcontracting arrangements enabled the participation of community pharmacies to deliver the IPAC project by providing pharmacists to work in 5 ACCHSs. At each of these ACCHSs the community pharmacy had an existing relationship by providing s100 supply and s100 Support Services to the ACCHS. Some challenges with this arrangement were noted including initial uncertainty from ACCHSs regarding who would undertake management duties for the pharmacist (i.e. PSA or the pharmacy). These issues were largely overcome, with community pharmacy owners invited to participate in communication between the project partners related to service delivery by their sub-contracted pharmacists.

Conducting Needs Assessment

Needs Assessments were conducted by the NACCHO Coordinators at all ACCHSs in the Project at the same time as the above initial visits. Participants included managers and senior clinical staff. In eight ACCHSs, the site visits were conducted around the time of commencement of the pharmacist, or once they had been recruited but had not commenced. Thus, pharmacists were able to contribute extra discussion of the role of the pharmacist in terms of their own skills and experience. At other ACCHSs the Needs Assessments were conducted before recruitment of the pharmacist. After explaining the 10 core roles of the IPAC pharmacists and general discussions around what a pharmacist could do, ACCHSs were asked to prioritise individual ACCHS's preferences relating to pharmacists' duties. This formed the basis of the pharmacist's workplan.

The contribution of an existing service contract with a community pharmacy was captured in the Needs Assessment, with an extra column for the services that the ACCHS felt they regularly received. The community pharmacist also had an opportunity to describe the services provided under their s100 or QUMAX agreement in an extra section taken from the HSA but added to the Needs Assessment. The community pharmacists were asked to sign the needs analysis where possible to demonstrate their participation in the planning of services. The NACCHO Coordinators visited or consulted with a total of 18 community pharmacies at 15 locations to gather information on services provided for the Needs Assessment. Only one of six community pharmacies providing s100 support services opted to supply a copy of their s100 Support Allowance Agreement; confidentiality of a commercial arrangement was cited as the main reason for not providing these agreements. ACCHSs also declined to provide copies of the agreements without the other party's consent. Despite the project team not having copies of all the s100

Support Allowance agreements, 5 of the 6 remote ACCHSs had their IPAC pharmacist supplied by their s100 supplying pharmacy under a sub-contract agreement with PSA. The sixth ACCHS had an existing agreement for an onsite pharmacist service focused on supply/dispensing 2 days a week which continued throughout the IPAC project. This close collaboration with community pharmacies providing the Section 100 supply and support services assisted to ensure activities were not duplicated. It also ensured that the ACCHS continued to receive the support outlined via existing s100 workplans.

The Needs Assessment and workplan template forms are shown in Appendix 4

Pharmacist Workplans^c

All pharmacists had workplans developed at the beginning of the Project. These were distributed to the ACCHS CEO and go-to person, the IPAC pharmacist and to the owner of community pharmacies which entered into a sub-contract with PSA to supply the pharmacist.

The workplans were reviewed approximately 3 months after the date of the initial workplan. This provided an opportunity for both pharmacists and ACCHSs to revise items in their workplan. At this point, it had become apparent to the Project team that the total Project target patient number was unachievably high, and this was an opportunity to revise the target number down. It was acknowledged this revised target remained challenging for some pharmacists to achieve in consideration of the pragmatic Project design and ACCHSs' specific needs and priorities. Other amendments were made to workplans on review, for example clarification of the numbers of previous HMR provided to the ACCHS. Reviewed plans were likewise distributed to ACCHS, pharmacists and relevant community pharmacy contractors.

Project Information and Induction Presentation

The induction presentation (using PowerPoint software) (Appendix 6) was delivered at a whole of service team meeting (six ACCHS) or opportunistically with members who were available (14 times). It was also made available to the IPAC pharmacists to use as needed in the event of staff turn-over at the ACCHS. It was delivered multiple times at four ACCHSs. At ACCHSs where the presentation was not delivered, information about the project was provided verbally using the site participation brief and a discussion of the 10 core roles.

Final Site Visits

The final site visits were conducted to 18 ACCHSs by the same NACCHO project coordinator that initially visited, between 6th September 2019 and 22nd October 2019. Follow up visits were not required for the two ACCHSs which did not complete the intervention, these were both small ACCHSs representing a total of 0.5 FTE pharmacists (4% of total FTE)

This site visit involved a repeat of the HSA to identify any confounding changes to health services, particularly as it may affect the parameters measured in the IPAC project. Eleven of eighteen (61%) of these HSAs were conducted at the end of the project with at least one of the same ACCHS representatives as participated in the initial HSA. Any large discrepancies in responses from the initial and repeat HSA were checked and verified.

The final visit also provided an opportunity for the project Coordinator to proactively seek feedback from ACCHSs representatives involved in the Project on the conduct of the Project as well as their experience of having a pharmacist as part of the team. Information was provided by the Project Coordinator about possible sources of ad-hoc funding to continue access to a pharmacist beyond the project. ACCHS

^c for more information, refer to PSA reporting on pharmacist recruitment

managers and go-to people were very positive in most cases about the value of having a pharmacist and urged NACCHO to continue to support a national program with dedicated funding for pharmacists integrated into ACCHS. Most thought they would not be able to identify sufficient existing funds to support a pharmacist.

Coordinators experienced a turnover of some ACCHS' go-to people, with nine of the ACCHSs having a different go-to person at the end of the project compared to the beginning. In two cases, there were multiple changes of the key contact throughout the Project. Communication was noted to be challenging with some ACCHSs and occasionally NACCHO was not informed of a change in the go-to person. Coordinators endeavoured to use regular communication and considered and revised the most appropriate method of communication for the needs of each ACCHS.

c. Project Reference Group

The PRG generally fulfilled its aim to deliver Aboriginal and Torres Strait Islander oversight, communication and discussion in a way that was responsive to ACCHS' needs. The PRG also fulfilled the core of its stated functions including capturing themes and concerns from ACCHSs, which were taken to the Operational Team and the Steering Committee to improve the effectiveness and appropriateness of the Project. The PRG also advised generally on Project risk mitigation strategies as necessary and specifically endorsed the nomination of three appropriate ACCHSs for site-visits for the qualitative evaluation.

All ACCHSs and Affiliates were asked to nominate representatives to participate in the PRG. These staff included clinic managers, practice nurses, Aboriginal and Torres Strait Islander Health Workers and GPs. Teleconference groups were hosted by NACCHO approximately 3 monthly; forums were held at NACCHO national conferences in 2018 and 2019; electronic updates were circulated, but at lower frequency than planned, in response to Pharmacy Trial Program publication and communication requirements and ACCHS' needs; and innumerable instances of ad hoc correspondence occurred between NACCHO and PRG members via phone or email.

The first Project Reference Group (PRG) meeting was held on 8th June 2018 at which the Terms of Reference were ratified. Early feedback from PRG members was that they did not want regular meetings scheduled, communication and meetings were seen as only required as issues arose. Attendance at PRG meetings was also reflective of ACCHS' preferences to maintain direct contact with NACCHO Coordinators, rather than participate in formal meetings. IPAC Updates to ACCHSs were produced in September 2018, April 2019, and September 2019.

The first forum was facilitated at the National NACCHO conference in Brisbane on 1st November 2018 in which feedback was requested on the implementation of the IPAC Project in ACCHS. This was open to all conference participants. A follow up meeting by teleconference was held on 16th November 2018 to consider and add to the feedback from the conference forum. Both feedback sessions were recorded and summarised separately to the meeting minutes. General feedback through PRG was overwhelmingly supportive of the pharmacist's roles.

The PRG held a teleconference on 22nd February 2019 and discussed the qualitative evaluation plan, language used in surveys and planning for site visits. The three sites recommended from those who nominated for evaluation visits were discussed and the selection endorsed by the PRG.

Another PRG teleconference was held on 5th September 2019. ACCHSs expressed their desire to retain pharmacists after the IPAC project and NACCHO led the discussion of potential ongoing funding options.

The second Project Reference Group forum was conducted at the NACCHO annual conference on 6th November 2019. Again, response to the Project was positive and supportive of future funding to support integration of pharmacists within ACCHSs. At this meeting, there was a request for feedback of a summary of Project activity to individual ACCHS' results on a service-level. This was to enable ACCHSs to use this data for their CQI process. NACCHO prepared these reports using data collected up to the end of September (1 month before the final data close off). These reports were emailed to individual ACCHSs on 29th November 2019 and 9th December 2019, with a covering email suggesting they contact NACCHO if they required a final complete report to the end of October (or any other data).

d. State and territory Affiliates

Each Affiliate contributed in different ways based on the needs of members within their individual negotiated workplans. Affiliate officers also provide some Project oversight and planning, including providing input into the initial development of the Project protocol and HREC submissions. In general, Affiliate workplans were executed effectively. This was demonstrated through Affiliate reporting, Project Qualitative evaluation, feedback from participating ACCHSs and through the generally effective Project implementation overall. Affiliate logos were used on IPAC project documents and resources to show recognition and endorsement of the Project.

Affiliate representatives often acted in a contingency or problem-solving role. When specific unforeseeable issues arose during the Project, workplans allowed them to respond flexibly including ad hoc site visits or increased staff time to manage and troubleshoot acute problems. For example, VACCHO assisted in negotiating appropriate technology changes in ACCHSs to allow the GRHANITE™ data software to operate. Some Affiliates had more involvement at an operational level, depending on the needs of the services in their jurisdiction.

The Affiliates were requested to provide NACCHO with final reports on their involvement in the IPAC project.^d Key activities and themes from reports and feedback received throughout the Project are summarised below.

Expressions of interest

Affiliates assisted in coordinating the Project EOI to respective member ACCHS as needed. This included working with the NACCHO Coordinator, having input into the EOI documents provided to ACCHSs and working with ACCHSs in completing and submitting the EOI. Affiliates also advised NACCHO Project Coordinators of ACCHSs that needed to be approached directly to ensure more complete reach of the call for EOI as a "second round" process. However, no further sites were able to be recruited from this second-round contact.

ACCHS support during Project implementation

Once sites were endorsed by the Project Steering Committee as outlined in the protocol, Affiliates liaised with individual ACCHSs when required regarding site agreement concerns or questions. Affiliates maintained regular contact with ACCHSs during the Project and ensured ACCHSs knew they could contact their Affiliate representative to discuss progress with the Project on site.

Attending site visits allowed Affiliate representatives to become more familiar with the Project. Where Affiliate representatives had existing relationships with ACCHSs, this improved the uptake and acceptability of the project. One ACCHS representative stated that they were not happy with the amount of data

^d These have not been attached in full to avoid ACCHS level identification

proposed to be extracted by CIS extraction software (GRHANITE™) and would not have signed up to the project without the involvement of an Affiliate representative known to them from previous research.

Affiliates participated in regular communication between ACCHSs, NACCHO and Project partners to ensure that any operational problems for ACCHSs were identified and managed in a timely way. This included providing assistance and support to ACCHSs who were at risk of withdrawing from the Project.

Project Reference Group

Affiliate representatives participated productively in the Project Reference Group (PRG) managed by NACCHO. The role and activities of the PRG are described in their specific section of this report.

Evaluation Team

Affiliate representatives participated effectively in the Evaluation Team throughout the project. This was facilitated with three evaluation team meetings including one face to face meeting at the beginning of the Project to establish details of Project methodology within the parameters of the agreed Project protocol.

Individual Affiliate Engagement Summary

As well as the agreed functions that all Affiliate representatives participated in, there were unique activities that each Affiliate undertook to support their members.

Examples are provided below from reports received by NACCHO from Affiliate representatives to illustrate some key activities undertaken by Affiliates.

VACCHO:

- Discussions regarding funding for GRHANITE™ data extraction tool as additional IT costs occurred at ACCHSs where it needed to be hosted in a cloud environment. Costs were covered by the Project or by VACCHO on production of invoices.
- Accompanied NACCHO Project Coordinator on majority of initial IPAC site visits. After discussion and by mutual agreement, NACCHO conducted follow up visits without VACCHO participation due to strong NACCHO relationship with sites.
- The VACCHO officer had experience with Continuous Quality Improvement projects which assisted in the information gathering process for the Health System Assessment
- Discussion regarding pharmacist turn over at some ACCHSs
- Involvement with decision to complete intervention early at a Victorian ACCHS due to pharmacist resignation for personal reasons, and very low patient numbers at the ACCHS making re-recruitment not feasible for the remaining Project time.

AMSANT:

- Appointment of a pharmacist 0.2FTE to support the ACCHS participating in the Project in the NT including contact with pharmacists in negotiation with PSA project coordinators.
- Recurring update meetings were scheduled between NACCHO, PSA and AMSANT to discuss strategies to support all ACCHSs in the Project.
- Significant discussion and information about Health Care Homes and its impact on the IPAC Project
- Presentation by AMSANT to a member teleconference about the IPAC Project including follow up discussion

QAIHC:

- Assistance with identifying potential sites during the EOI process when proposed numbers of eligible Queensland sites were not reached after the first call for EOI.
- Involvement in selection of sites to be included in the Project qualitative evaluation
- Notification that no specific site level issues have been raised.
- Promotion of the project in QAIHC quarterly magazine.

e. Resources and materials

NACCHO Project Coordinators worked consistently with the Project team to contribute to the development of the Health Systems Assessment (HSA), Needs Assessment, workplan template, the application by pharmacists of the Medication Appropriate Index, the Adherence Assessment Tool and the education resources for pharmacists developed by PSA. The Needs Assessment tool was developed with assistance from the Project Operational Team and tabled at the Steering Committee on 13th July 2018. There was an amendment required to add a section to elicit information about existing s100 RAAHS^e services from the pharmacist concerned. This was done and re-sent to the committee out of session. The Needs Assessment tool largely fulfilled its aim to elicit the type of support needed by the ACCHS so that the practice pharmacist may best be integrated within the service. ACCHSs effectively described and planned how the role of the IPAC pharmacist would integrate with existing services from community pharmacies and consultant pharmacists. Some ACCHS staff suggested the process itself was also important in their understanding of the role of a pharmacist.

Promotional materials

ACCHS Pharmacist Poster

A poster using two Aboriginal designs as well as specific medication graphics was commissioned from an Alice Spring artist to promote the IPAC pharmacist. These posters were a colourful design and were individualized with the pharmacist's photo. These were printed by NACCHO and distributed directly to ACCHSs by a major office supplies and logistics company. A sample of both posters are shown at Appendix 7.

Brochure

A brochure describing the Project was also designed to assist in explaining the Project when seeking consent from patients. This was distributed electronically for printing in the ACCHS if required. This allowed local adjustment to the brochure if required and to reduce freight and handling costs. A sample of this brochure is shown at Appendix 9).

Letterhead:

An IPAC letterhead for general Project purposes was developed incorporating a variation on the NACCHO ribbon and distributed to Project partners.

Film:

Pharmacists and staff at a participating ACCHS were filmed discussing the Project and its benefits. This content was coordinated by NACCHO, filmed and edited by JCU, then supplied to Tonic Health Media to play on the Aboriginal Health Television (AHTV) network across Australia. It ran for 7 months from March

^e Section 100 Remote Area Aboriginal Health Service Measure of the National Health Act

to September 2019 inclusive. Initially there were only 3 participating ACCHSs equipped with the televisions, but this was extended as more ACCHSs could access this network. The short videos were also available on the NACCHO website.

Radio:

NACCHO coordinated a Radio National interview that aired on Life Matters on 22nd August 2019^f. This involved one IPAC pharmacist and described the role of the IPAC pharmacist.

Several other materials and resources were developed by or with other external organisations to provide information and research translation for the Project. These included local radio broadcasts by individual IPAC pharmacists as part of the ACCHS health promotional activity and another series of films that were co-ordinated by NACCHO Project Coordinators and filmed and edited by JCU. Unfortunately, the stringent communication requirements enforced by the Pharmacy Trial Program (PTP) limited the research translation activities and engagement with the sector.

f. ACCHS' ongoing communication, feedback and support

The NACCHO Project Coordinators established working relationships with all nominated ACCHS contacts, including the go-to person/s. The 2 Project Coordinators liaised regularly with each of their allocated ACCHSs and remained the primary ACCHS contact throughout the entire Project.

In addition to the formal PRG meetings, regular communication between the NACCHO Project Coordinators and ACCHS go-to person by phone or email was maintained. This was generally around fortnightly or more frequently if there was an issue identified that the Coordinator could help address.

In some cases, communication was initiated by the IPAC pharmacist. The NACCHO Coordinators participated in each of the induction training workshops conducted by PSA Coordinators and met pharmacists recruited for the Project. In some cases, the Coordinator developed a relationship with the pharmacist on initial site visits. Thus, communication from the integrated pharmacists became an informal method of support for pharmacists, but also provided insight into issues that may have needed support for ACCHSs.

There were both formal and informal requests for feedback from ACCHSs. In general, comments at the PRG were extremely positive, with many ACCHSs providing examples of how the IPAC pharmacists had transformed medicines services in their workplace. Feedback from Affiliates was also generally positive, but also provided valuable insight into how things could be improved, such as enhancing support for remote areas, tailoring Project resources to local language and literacy (e.g. the Project consent form), reconsideration of patient recruitment numbers and ensuring adequate remuneration for future programs.

At the end of the Project, there was an almost unanimous preference from the ACCHS sector for continuation of a program akin to IPAC supporting an integrated pharmacist model in their health service.

ACCHS Feedback

The ACCHS feedback summarised below has been grouped into themes in the context of further research or implementation of an IPAC-related integrated pharmacist program more generally.

^f See <https://www.abc.net.au/radionational/programs/lifematters/tackling-aboriginal-chronic-disease-through-grass-roots-pharmacy/11435412>

Positive support for having a pharmacist

Feedback through the PRG, informal communications with ACCHS staff and at the site visits conducted by NACCHO project Coordinators at the end of the project were generally positive. This was also supported by the qualitative evaluation report. (7)

Clients and community engagement indicated that the project has been seen to add value. Many ACCHSs reported that their pharmacist had become a valuable member of the health team in the ACCHS. When pharmacists wore the ACCHS' uniform it was seen to be highly beneficial in terms of patient and staff acceptance.

“The pharmacist has been amazing resource. Liaison with community pharmacy, hospital and other services. Assisting with onsite medication processes.” PRG, Nov 2018

“..pharmacists have case managed difficult patients, strengthened relationships with community pharmacies who now use the pharmacists as a conduit to GPs, contributed to procedures around medicines onsite, being there every day and wearing a uniform helped them become part of the team” PRG, Nov 2019

Doctors expressed how valuable the pharmacists were in assisting them to manage patient medications. Other clinical and program staff also found them to be helpful and knowledgeable about medicines and ready to help patients work through various health providers, including community pharmacies, diabetes educators and renal units.

“All Drs [sic] are now enthusiastic about using pharmacists, only 2 Drs were previously referring for HMR” PRG, Nov 2018

NACCHO observed that pharmacists were generally proactive in finding patients that may have needed help with their medicines, and ACCHS staff reported stories of patients who became advocates for the pharmacist services in the community after receiving education about their medicines and support that they had not had access to before.

“After a slow start, great to have extra input for people about their medicines and people very receptive even reminding staff it is time for their review” PRG, Nov 2018

At the end of the Project, on the second site visits, the Project Coordinators provided information on potential sources of ongoing funding for an integrated pharmacist. All ACCHSs expressed a wish to continue employing an integrated pharmacist, depending on adequate funding and availability of an appropriate pharmacist. One ACCHS manager stated that she “didn't know how much we needed a pharmacist until we had one”. There was overwhelming support for the extension of such a program.

Feedback from research Project implementation

Despite some initial concerns relating to the implementation of the project, the concerns were not insurmountable, as evidenced by the very low patient and site attrition observed. A number of managers and go-to people stated they were not sure of the role of the pharmacist at the beginning of the project.

The NACCHO project Coordinators endeavoured to address implementation and some research related concerns throughout the Project. For example, ACCHSs were asked to include pharmacists in staff meetings, to provide the pharmacist a uniform and to incorporate them fully into the ACCHS clinical team. Subsequently, feedback at the end of the project was more positive with most managers saying the pharmacists had done a great job, worked well as part of the team and that the ACCHS would be investigating how to maintain pharmacist services.

Because the Project did not include loadings or subsidy for remote service delivery, travel or accommodation, the Project Coordinators worked with PSA and assisted ACCHSs and pharmacists to ensure optimal service delivery and patient recruitment. In some cases, the pharmacist was required to travel between different locations within their ACCHS as part of their role, requiring access to a vehicle, accommodation at the alternate site and living away from home allowance. These issues were addressed through by a combination of resources. For example, ACCHSs' in-kind use of facilities, such as staff accommodation and vehicles, extra support from Project funds for accommodation for the pharmacist supplied by PSA or from direct or in-kind contributions by contracted community pharmacies. NACCHO Coordinators observed seven ACCHSs receiving additional support, beyond Project methods, to ensure they could participate effectively in the project.

Other implementation issues for ACCHSs observed by Coordinators related to the research component of the Project included GRHANITE™ data extraction software operability, concerns with having double data entry (once in the CIS, and again in the pharmacists logbook), and the consent process from patients before providing services. These were generally understood as being related to research methodology, though they were a regular reason for communication with Project Coordinators as the Project was implemented. However, when an issue was identified by either party, ACCHSs were very responsive to resolving the issues and continuing participation in the Project.

The initial ease of implementation of the IPAC Project varied between the participating services. One Affiliate representative felt that "it seemed to depend significantly on the 'readiness' of the service for the IPAC Project and the pharmacist role. A lead in period enabling the pharmacist and services to familiarise themselves with the proposed model and role would have been beneficial". ACCHSs with an existing relationship with the pharmacist prior to the Project were observed to implement the project more rapidly and efficiently. However, even these ACCHSs could have benefited from a lead-in period.

6. Discussion

NACCHO fulfilled its primary aim to provide input, representation and support for the ACCHSs participating in the Project throughout the entire Project life cycle. NACCHO satisfied its Project objectives within this aim by successfully completing the 6 key Project activities, including developing and managing an effective and acceptable Project ACCHS expressions of interest and site recruitment process; managing and conducting ACCHS scheduled site visits, including conducting research, education and support activities; managing and administering the Project Reference Group (PRG); contracting and coordinating Affiliates; providing input and developing Project resources and materials; and providing communication and support for participating ACCHS. These operational activities augmented NACCHO's general governance-related objective to ensure Aboriginal and Torres Strait Islander representation and oversight at all levels of the Project. The effectiveness in delivery of the 6 key activities is corroborated through extremely low patient attrition, low site attrition, positive results in the Project's Qualitative Evaluation Report and feedback from the PRG and individual ACCHSs and Affiliates throughout the Project.

NACCHO Project Coordinators

The NACCHO Project Coordinators were central to successfully delivering the 6 key Project activities, which provided the necessary support for ACCHSs to participate in the IPAC project. Their ongoing engagement with all participating ACCHSs and Affiliates through the PRG, site visits and other ongoing formal and informal communication and support as required, allowed the Project to run in a culturally responsive and effective way. The effectiveness of their work illustrates the importance of consistent personnel and communication from Coordinators with experience working in the ACCHS sector. The Coordinators' clinical experience and technical understanding of the integrated pharmacist role augmented their effectiveness in this position.

The Coordinators' skills, qualifications and knowledge related to clinical pharmacy and the ACCHS sector allowed them to provide technically detailed communication and reporting both verbally and in writing to NACCHO executive and Project partners throughout the Project. The Coordinators' consistent and active participation in Project governance meetings and reporting also provided valuable direct operational insight and input the oversight of the Project.

a. Expressions of interest and site recruitment

The EOI and site recruitment process was demonstrably successful in identifying and recruiting a sufficient number and distribution of ACCHSs to fulfil the criteria in the Project's protocol. This was attributable to consultative and comprehensive methods and governance applied to these activities. The skills and experience of the NACCHO Project Coordinators and Affiliate representatives facilitated Project activities to be delivered in a culturally responsive and acceptable way. Support and sector knowledge from both other Project partner organisations further enhanced the effectiveness and acceptability of the EOI and site recruitment.

While the EOI and recruitment process was observed to be effective and acceptable to the ACCHS sector, some minor limitations in the process were identified by NACCHO. These limitations primarily related to the requirements of the funding body or research processes generally. For example, the ACCHS inclusion criterion for research software compatibility excluded several ACCHSs who expressed interest, who were otherwise eligible. Such issues are unlikely to be a factor for inclusion if the Project model were to be adapted into a national ongoing program.

The capacity to adapt the allocation of pharmacist time (i.e FTE per ACCHS) in the recruitment stage and then throughout the Project as needed to meet the needs of individual ACCHSs was valuable. The dynamic nature of support from Project partners and Coordinators exemplified by this allocation process was one reason for the sustainability of the intervention activity and workforce over the life of the Project. Aboriginal Community Controlled Health Services across Australia are not homogenous, and it is vital that they are assisted to tailor a pharmacist service to their own needs and that of their community.

The support of ACCHSs for recruiting and establishing pharmacists' activities, as well as the ongoing assistance throughout the project by NACCHO Project Coordinators was an important part of the success of the model and should be incorporated into any future proposal for expansion of the model to other ACCHS and Aboriginal Health Services.

b. ACCHS Site Visits

Through site visits, ACCHSs were supported to conduct Project research activities (e.g. conduct the Health Systems Assessment). The NACCHO Project Coordinators received feedback from participating ACCHSs that these visits were useful and appreciated.

The Project Coordinators found that site visits were a valuable opportunity to meet the appropriate staff at the ACCHS, understand the ACCHS' operations, determine what kind of support was most relevant and likely to be needed and to provide information to as many staff as feasible and necessary.

Coordinators noted the high importance and impact of direct face to face communication. The volume of information, quality and nature of face to face communication was not substitutable by any form of phone or online correspondence. The ability to build rapport and trust with key ACCHSs representatives during the site visits allowed the Project to be established and delivered effectively.

ACCHSs reported the site visits to be an opportunity to meet the Coordinator and discuss any possible specific barriers and concerns related to participation in the project. These dynamic interactions allowed ACCHSs to consider how their individual needs for pharmacist services could fit into the 10 core roles of the IPAC project. For example, ACCHS representatives and Coordinators frequently discussed how the IPAC pharmacist could support medicines governance for the ACCHS' specific needs and local environment and legislation. Further to this, ACCHSs expressed uncertainty regarding how IPAC pharmacists could use their pharmacist to assist in developing and documenting medicines management guidelines, imprest lists and policies and processes to meet accreditation standards. The Project Coordinator was able to demonstrate how this was applicable under the 10 core pharmacist roles of the Project with around 25% of workload proposed to support non-patient related activities and 75% to patient related activities.

Needs Assessment

After the partners developed the Needs Assessment template, Project Coordinators found the content and application of the template to be generally suitable and effective for ACCHSs. The inherent flexibility in conducting the assessment to adapt to each individual ACCHS's requirements and ability to revise over time was useful and consistent with ACCHS self-determination and the community participatory research model.

Coordinators and ACCHSs generally perceived the core requirement of the funding body that demanded 75% of pharmacist workload to be for patient-related activities was a barrier to effective and appropriate service delivery. Some ACCHSs identified the need for a greater percentage of allocation towards health service directed activity during the Assessment. This may have been due to strict definitions in the project

protocol of what was defined as patient related activity. NACCHO observed that in practice, many activities had a significant overlap in relating to a patient or to the service. The pharmacists also conducted some activities for patients who declined to give consent to participate in the project, in accordance with the pragmatic project design.

The criteria for the research and requirement to recruit specific volumes of patients was understandably not always consistent with ACCHSs' needs and preferences, but Coordinators were able to liaise with ACCHSs and Project partners to address such challenges as they arose. This was particularly important as target patient numbers were revised twice during the Project's implementation phase.

Most participating pharmacists were new to working in the ACCHS sector. Most ACCHSs had little or no experience with an integrated pharmacist role prior to the project. This meant that establishing their workflow and role in the ACCHS team took time and careful coordination. Pharmacists also cited challenges in the time it took to obtain informed consent for the research purposes and recording all activity in a data collection logbook. NACCHO Coordinators helped support pharmacists and ACCHSs in addressing these issues, which are unlikely to exist to the same extent in any similar national program or research.

NACCHO also observed the positive response and input from community pharmacy during the initial site visits, which supported the effective implementation and sustainability of the Project across ACCHS.

Final Visit

The final visit allowed Coordinators to conduct final research activities (i.e. HSA), to respond to feedback from both ACCHS representatives and pharmacists and to consider what planning may be needed for after the Project. Coordinators found these visits productive and noted positive feedback from most parties.

Coordinators were satisfied with the consistency in how the repeat HSA was conducted and verified, which provided the evaluation team with confidence of the reliability and validity of the health systems data. Furthermore, the consistency in NACCHO Coordinators for the entire Project allowed uniform and reliable data capture across ACCHSs for all Project activities. The turnover of ACCHSs go-to people was addressed dynamically by NACCHO Coordinators and therefore this did not manifestly affect the Project's communication and implementation. Staff turnover is sometimes referenced as a challenge for the rural and remote health sector.(8, 9) This highlights the importance of maintaining regular contact through dedicated coordinator positions to ensure programs are sustainable in these settings.

c. Project Reference Group

The Project Reference Group generally fulfilled its aim to capture feedback and oversight from ACCHS and Aboriginal and Torres Strait Islander representatives throughout the duration of the Project, especially when the format and approach of ACCHS support was adapted based on PRG feedback. The successful activities of the members of the PRG tended to be captured in personal communication. Consistent communication was maintained with all ACCHSs on an individual basis. The face to face meetings were considered valuable and especially well-attended at the first meeting at the NACCHO annual conference in 2018.

The practical challenges related to participation, structure and the format of communication were addressed by NACCHO in several ways but did persist in some ways throughout the Project. Early in the Project, ACCHS representatives requested ad hoc meetings at key times of the Project rather than regularly scheduled meetings, which NACCHO responded to. Interpreting the reasons for low participation in some meetings was challenging. ACCHS and Affiliate feedback did not find any specific criticism of the meeting format or methods. It could be considered that low participation in meetings indicated a satisfaction with

the Project's progress and feedback through Coordinators, and therefore there was no need to express concerns or challenges through a formal meeting. The pragmatic project design enabled IPAC to be compatible with existing operational activities of the ACCHSs. For a busy ACCHS representative participating in a project reference group, this participation may sometimes be considered a low priority, especially if they are confident that the Project is running acceptably. For future projects, involving Affiliates and potential sites earlier in the design of governance processes may help with establishment and format of a PRG or similar.

d. Affiliate Involvement

Though results from the involvement of the Affiliates were varied, their participation was considered to have had a positive impact on the implementation and acceptability of the Project across all jurisdictions. This was attributable to the flexibility of the Affiliates' workplans, their detailed knowledge of local issues and ACCHSs and ongoing dynamic communication with NACCHO; all of which allowed adaptable delivery of services throughout the Project depending on jurisdictional considerations and local needs of individual ACCHSs. Affiliates work with ACCHSs on more grass roots projects than NACCHO, such as Continuous Quality Improvement projects and local advocacy. This was ultimately useful to improve ACCHS engagement and sustainability of the Project. The professional relationships formed between Affiliate representatives and ACCHS staff in previous roles were also supportive for Project implementation. Affiliates had different levels of engagement with the project, this could be interpreted as less input being required in that state.

NACCHO and PSA project officers were all pharmacists and had significant experience and relationships developed from previous work with ACCHSs. This may have meant that less Affiliate involvement was required for the IPAC project than initially anticipated. One Affiliate report states:

"[Affiliate staff] had less ongoing regular contact with ...ACCHS services once in [the] project than expected, most likely due to good relationship between NACCHO project officer and sites, and the feeling that duplication of communication by [Affiliate staff] would be an unnecessary burden on ACCHSs"

If an integrated pharmacist program is to be implemented nationally, local level support from Affiliates could be considered. Affiliates may have a role in promoting such a program to individual ACCHSs and specifically the type of work pharmacists may deliver for ACCHSs. Affiliates could assist in receiving and collating feedback from ACCHSs to provide to a national program manager, such as NACCHO. Affiliates can support pharmacists to work in culturally appropriate ways, responsive to local and jurisdictional issues, and to have a good understanding of the way ACCHSs work in their respective states and territories. They could help navigate local healthcare systems and legislation to determine where the skills of pharmacists fit best amongst the diverse range of programs and services provided in ACCHS.

e. Resources

The production of Project resources, including tools such as the Needs Assessment and workplan template, was effective in developing a structured approach for the pharmacist services and for providing information and discussion on the role of the pharmacist at the beginning of the project. Therefore, these resources' benefits could be considered as two-fold in delivering both research outputs and ACCHSs strategic outputs. The adaptability of resources for ongoing use by ACCHSs and pharmacists was useful and aligned with community-based participatory research principles.

Robust discussion and collaborative development of resources involving perspectives from NACCHO, PSA and JCU was useful in ensuring the resources were well-considered, validated and suitable for use in the Project. Furthermore, the subject matter expertise from each of the Project partners was invaluable in the development of these resources.

Administration and delivery of resources by NACCHO Coordinators (e.g. the HSA) utilised the expertise and knowledge of practitioners with experience in the ACCHS sector. This was highly advantageous in ensuring that the resources had maximum value and were administered consistently and appropriately.

The consistently positive feedback from ACCHSs regarding the promotional materials was supported by findings in the Project Qualitative Evaluation Report (7). In particular, ACCHSs reported that the inclusion of the photo of the pharmacist on the poster displayed in the waiting area was useful for acceptance by patients of the pharmacist as part of the primary health care team. These results may be generalisable to other settings, such as where other novel health practitioners are beginning work at an ACCHS.

f. Communication, feedback and support for participating ACCHSs

The ongoing communication, feedback and support for ACCHSs throughout the Project was an integral component of NACCHO's role and was important in allowing NACCHO to achieve its primary aim. The flexibility and range of methods used were important to allow ACCHSs to communicate and receive support in a format and frequency that suited their organisation's needs. This was especially important considering the preference from some ACCHSs to not participate in all PRG meetings. Direct professional relationships with Coordinators, and sometimes Affiliates, was an important component of this support. Ultimately, the almost unanimous ACCHS support for an ongoing integrated pharmacist program validated the support methods and communication approach taken.

The ACCHS staff uncertainty regarding the role of the pharmacist was considered primarily due to the pharmacist role being novel for ACCHSs. Traditionally, the pharmacist's role had been perceived by some as limited to medicines supply, such as dispensing medication, which was specifically excluded from the IPAC pharmacists' roles. There was no lead-in time prior to commencement of the Project for pharmacists to build relationships before beginning to undertake recruitment of patients. This was compounded by the pharmacist employment arrangements, involving employment contracts with PSA and sometimes the community pharmacy under sub-contract with PSA. There was a perception from some ACCHSs that they may not have adequate influence on their pharmacist's activities because the pharmacist was not employed by the ACCHS. A model involving direct pharmacist employment by ACCHSs removes this concern.

Themes from ACCHS feedback provided to NACCHO and direct quotes illustrate the effectiveness of the Project in meeting ACCHSs' needs, including the competency and value of pharmacists and engagement from ACCHS staff. The acceptability of a culturally competent pharmacist and the ability to involve pharmacists with existing relationships to ACCHSs is an important aspect of community control and success of the project. The specific duties defined with the 10 core roles were adequately flexible and did not impede ACCHSs' ability to receive the type of pharmacist services that they had prioritised.

We propose that the challenges identified throughout the Project should be considered in the context of the requirements of the funding body and general research methods that must be applied to capture data and information. These challenges were especially relevant for the complex pharmacist employment arrangements and pharmacist data entry and extraction processes. Generally, ACCHSs and Affiliates were

accepting that research projects have inherent additional requirements beyond a healthcare program or subsidy measure. ACCHSs and pharmacists were generally accommodating of these challenges for this reason. However, we recommend that a future integrated pharmacist program should seek to streamline reporting arrangements for ACCHSs and pharmacist; remove all inclusion criteria and components that are related to research; and retain a community-controlled approach, including allowing ACCHSs to employ pharmacists of their choice directly. Funding for pharmacists should also consider remoteness and apply loading to facilitate equitable uptake and sustainability across Australia. A support program to ensure that implementation is executed optimally will assist with the 'readiness' of ACCHSs for pharmacist services and the execution of an impactful health program. NACCHO well placed to manage and oversee all elements of national integrated ACCHS pharmacist support program in a culturally acceptable manner under principles of community control.

g. Further considerations for an ongoing national program

After extensive sector consultation, including a national NACCHO Integrated Pharmacist Workshop in May 2019, NACCHO has developed 4 primary Goals of ACCHS pharmacists, which we propose are applied to future ACCHS pharmacist programs. These are:

- **Accessibility:** Facilitating medicines supply; supporting access to pharmacies, medicines services and medication
- **Safety:** Safe prescribing and identification of drug related problems; safe use and storage of medications for patients; safe transitions of care between hospital and community
- **Quality:** Quality prescribing and use of medications; enhancing chronic disease care
- **Efficiency:** Improving systems and processes within services; supporting accreditation, legal and guideline adherence

7. Conclusion

The establishment and implementation of the IPAC Project was successful in integrating pharmacists into ACCHSs. The IPAC pharmacists' activities and ACCHS engagement and participation were sustained effectively throughout the Project across a range of ACCHSs in heterogeneous settings, locations and levels of remoteness. Project reports have demonstrated positive results in quality of care outcomes for Aboriginal and Torres Strait Islander adults with chronic disease.

Some of this success is attributable to the effective ACCHS support and communication provided by NACCHO. Acceptability and effectiveness of NACCHO ACCHS support is clearly evidenced in several ways, including through the Project's Qualitative Evaluation report, the successful recruitment and retention of 22 sites, extremely low participant attrition and low site attrition, positive feedback from ACCHSs and Affiliates across a range of methods and uptake and effectiveness of Project resources and materials.

We recommend a national program that supports pharmacists integrated into ACCHSs. Furthermore, any such national program must incorporate ACCHS support modelled on support provided by NACCHO in the IPAC Project. Without appropriate ACCHS support for the relatively novel intervention, there is a significant risk of low uptake, poor sustainability and ineffective program delivery. This program should be implemented immediately to help reduce the gross health and medicines-related inequities faced by Aboriginal and Torres Strait Islander people compared to other Australians.

8. References

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9. Appendices

Appendix 1 – NACCHO IPAC Project Coordinator position description

NATIONAL ABORIGINAL COMMUNITY CONTROLLED HEALTH ORGANISATION (NACCHO)

Position Statement

National Project Coordinator – Integrating Pharmacists into Aboriginal Community Controlled Health Services Project

Background and position summary

The Pharmacy Project Program is delivered through the 6th Community Pharmacy Agreement to project new and expanded community pharmacy programs which seek to improve clinical outcomes for consumers and extend the role of pharmacists in the delivery of health services through community pharmacy. The 'Integrating Pharmacists into Aboriginal Community Controlled Health Services Project' (the 'Project') is funded through Tranche 2 of this program and is a joint Project between the Pharmaceutical Society of Australia, NACCHO and James Cook University. This Project will determine if including a practice pharmacist in the primary health care team within Aboriginal community controlled health organisations (ACCHOs) leads to improvements in the quality of the care received by Aboriginal and Torres Strait Islander peoples. The National Project Coordinator will work with partners, Commonwealth Department of Health, relevant State and Territory Affiliates and around 22 of NACCHO's Member ACCHOs across Queensland, Northern Territory and Victoria. The position involves Project management, communication and oversight to ensure that NACCHO's responsibilities in administering the project are met.

Position title:

National Project Coordinator – Integrating Pharmacists into Aboriginal Community Controlled Health Services Project ("National Project Coordinator")

Salary

TBC – indication: ~\$100,000 pa including salary packaging, plus 15% superannuation

Position type:

Fulltime (1.0 FTE), 2-year contract, could consider multiple part-time appointments

Apply by:

December 2017

Support:

NACCHO National Medicines Policy Manager (Mike Stephens) and NACCHO national secretariat support, Canberra, ACT

The person filling the position of National Project Coordinator agrees that behaviour needs to reflect the values of NACCHO

Position objective:

The National Project Coordinator will NACCHO's duties relating to the national 'Integrating Pharmacists into Aboriginal Community Controlled Health Services Project' and its arrangements for Aboriginal Community Controlled Health Organisations (ACCHOs) across Australia from Feb 2018 to Jan 2020.

Primary responsibilities

The primary responsibilities of the National Project Coordinator are to:

- Oversee NACCHO's contractual requirements of the Project
- Work with Project partners; the Pharmaceutical Society of Australia, James Cook University and NACCHO secretariat to ensure effective project establishment, implementation, development and evaluation.
- Work with relevant State and Territory Affiliates – AMSANT, QAIHC and VACCHO – and NACCHO's participating Member ACCHOs to ensure that the Project is acceptable and meets Members' needs and expectations
- Work with Affiliates to oversee and support ACCHO's Project deliverables and reporting
- Assist the Project team to support the community-based participatory research design.
- Support the Project evaluation by working with ACCHOs, Affiliates and Project partners to acquire appropriate levels of consent, agreements and other requirements
- Support the development and maintenance of communication and governance protocols

- Provide support to ACCHOs in assessing and developing their pharmacy service needs, in collaboration with relevant Project partner representatives
- Liaise with ACCHOs and Affiliates regarding the development of materials and/or resources for pharmacists, consumers and participating Aboriginal Community Controlled Health Services (ACCHO) as required
- Deliver reports regarding the Project to NACCHO executive, secretariat and Board, as required
- Support and liaise regarding data collection and monitoring during Project delivery
- Any other duties to facilitate the implementation and delivery of the Project.

Reporting requirements

The National Project Coordinator is to report to the following:

NACCHO National Medicines Policy Manager (Mike Stephens)

NACCHO Deputy CEO (Dawn Casey)

Selection Criteria - Qualifications

The following qualifications are required or desirable for this National Project Coordinator:

- Tertiary qualifications, preferably in health research and/or pharmacy (although not essential)
-Bachelor of Pharmacy University of Sydney

Selection Criteria - Experience

Experience in the following areas would be advantageous for the National Project Coordinator:

- A demonstrated understanding of and support for the philosophy of Aboriginal community control in health and sensitivity to cultural issues and protocols in contemporary Aboriginal society
- Knowledge and experience in conducting research relating to Aboriginal health and community controlled health services, including Community-Based Participatory Research (CBPR)
- High level written and verbal communication skills
- High level liaison and negotiation skills and experience in communicating sensitively and effectively with Aboriginal people
- High level program and task management skills
- Proven ability, initiative and experience in leading team Projects, particularly in the health setting
- Demonstrated experience in working with ACCHOs or excellent knowledge of ACCHOs
- Demonstrated experience in working with state and territory Affiliates or excellent knowledge of Affiliates
- Excellent knowledge of the Australian health care system
- Knowledge of program evaluation in the health setting
- Sound IT, electronic health record systems, database and health systems understanding
- The ability to work closely with research partners, stakeholder groups and other health organisations

People of Aboriginal and Torres Strait Islander descent are encouraged to apply

We are looking for an outstanding candidate and will consider out-posting this position. Candidates from all over Australia are encouraged to apply.

For further information please contact:

Mike Stephens, NACCHO National Medicines Policy Manager, Mike.Stephens@naccho.org.au

0408278204

OR

Dawn Casey, NACCHO Chief Operations Officer, Dawn.Casey@naccho.org.au,

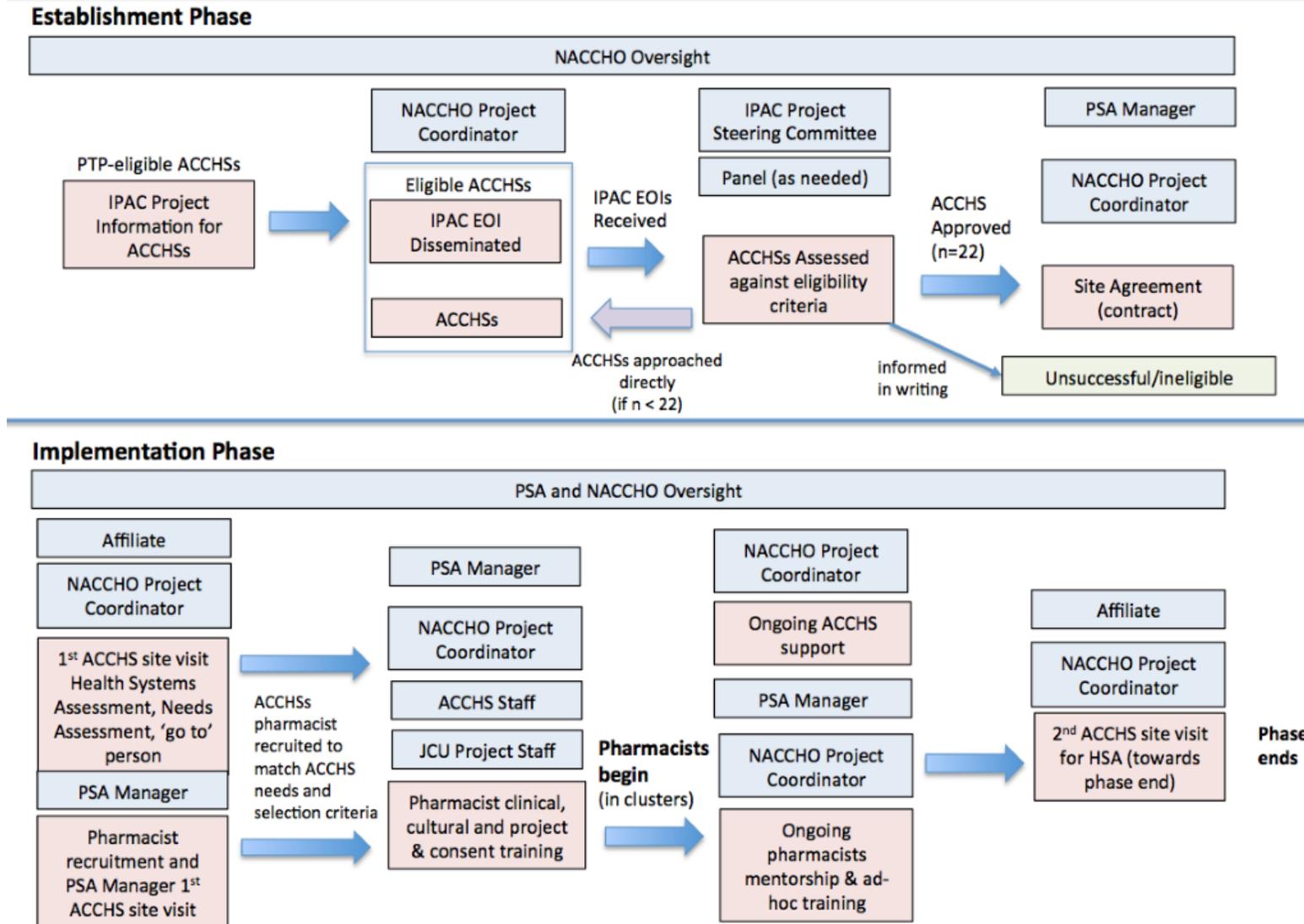
02 6246 9345

About NACCHO

NACCHO is a national organisation representing the health aspirations of Aboriginal peoples through 142 ACCHOs. The Secretariat was established in February 1997 and has responsibility for the advocacy, coordination and development of health policies and programs under the direction of the NACCHO Board of Directors. To find out more information about NACCHO visit; <http://www.naccho.org.au>

IPAC Project: ACCHS Consultation and Information Flow

Appendix 2^g:



^g NB: This model is presented as an extract from the project protocol. There was some variation to this model in that PSA conducted site visits after recruitment, training and commencement of pharmacists, rather than at the same time as the NACCHO project coordinator. The role and activities of the NACCHO project coordinators remained as per this flow chart.

Appendix 3 - Site inclusion criteria:

To be involved in IPAC services needed to meet the following conditions:

- The health service must be an “ACCHS”. This means an Aboriginal Community Controlled Health Organisation funded by the Australian Government Department of Health for the provision of primary health care services to Aboriginal and Torres Strait Islander peoples.
- The ACCHS is located in Victoria, Queensland, and the Northern Territory.
- The ACCHS employs at least one (1) full-time- equivalent (FTE) general practitioner per clinic who is able to prescribe medicines to clients of that organisation.
- The ACCHS does not currently employ a non-dispensing practice pharmacist at the participating clinic.
- The ACCHS uses a clinical information system such as Communicare, Best Practice, and Medical Director.
- The ACCHS has participated in continuing quality improvement and reporting on the national Key Performance Indicators for at least 24 months through the use of electronic data extraction tools.
- The ACCHS is participating in the *Quality Assurance for Aboriginal and Torres Strait Islander Medical Services (QAAMS)* program, if it is conducting ‘point of care’ testing.
- The ACCHS agrees to download the GRHANITE data extraction tool into one computer within the practice, adhere to program business rules/protocol and guidelines, data provision requirements, and patient/service consent requirements for the evaluation of the program.
- The ACCHS can provide the practice pharmacist access to a private consulting room on the clinic premises that has access to the clinical information system used by the practice.
- The ACCHS can allocate a staff member who will act as a ‘go to’ person to assist the practice to obtain informed patient consent.
- The ACCHS is a member of NACCHO, and the relevant NACCHO State/Territory Affiliate.
- The ACCHS is an accredited practice in accordance with the RACGP Practice Standards.
- In non-remote locations, the ACCHS must be participating or eligible to participate in the PBS co-payment measure (practice incentive program).
- In remote locations, the ACCHS must be eligible to participate in the remote Section 100 arrangements for the supply of pharmaceutical benefits



INTEGRATING PHARMACISTS WITHIN ACCHS TO IMPROVE CHRONIC DISEASE MANAGEMENT

ACCHS Pharmacist Needs Assessment

This document has been developed as a tool to guide collaborative practice between a pharmacist and the multidisciplinary team colocated in the ACCHS. The purpose of the tool is to clearly articulate the role of the pharmacist to the primary health care team and provide a means for identifying and rating the importance of a particular service to the ACCHS. It also aims to provide the foundation for the service agreement between the health service and the pharmacist as well as a tool for ongoing evaluation.

This form should be read with the “**Role of the IPAC pharmacist**” document which explains the potential role of a non-dispensing pharmacist in an Aboriginal Health Service. This document should be provided with the pharmacist’s completed self-assessments if possible, prior to the meeting to ensure ACCHS staff have time to reflect on their priorities.

The suggested process for conducting a Needs Assessment in the ACCHS is:

1. **Pharmacist** self-assesses against the items described as Confident (C) or not yet confident (NYC). If the pharmacist recruitment is not finalised by the date of completion of this process, leave the column blank.
2. **Meeting with key team members:** Identify the members of the interprofessional team who should be involved with developing the service agreement and arrange a suitable time to meet. This should include the pharmacist, if available, and the lead General Practitioner (GP). Consider inclusion of the Health Service Manager, other GPs currently employed in the practice, and other relevant Health Professionals. The NACCHO Project Coordinator can facilitate this meeting at their first site visit.
3. **Review needs of the service:** Each of the services available should be assessed with consideration given to the capacity of the pharmacist to deliver these services effectively to patients within the pharmacist’s employment hours. Use the results of this assessment to work from services with the highest priority to the lowest to define the pharmacist’s scope of practice. Additional services not already considered in this document may be added provided if it is within the scope of the 10 core roles of the IPAC Project. Activities should be allocated as around 75% patient directed services and 25% staff-related or liaison activities.
4. **Review Existing Agreements with Pharmacy: See attachment below.** NACCHO coordinator to contact Community Pharmacy where an S100 or QUMAX agreement is in place to confirm that the proposed services do not duplicate existing arrangements.
5. **Develop the Pharmacist work plan:** After discussion and completion, this document can be used to develop the **pharmacist’s work plan**. This is transferred to the provided template and measurable outcomes developed. This process will be facilitated by the NACCHO Project Coordinator and a copy provided to both pharmacist and health service management. The original Needs Assessment should be retained for records. This document will then provide the basis for the service evaluation.

	Pharmacist self assessment Confident (C) /not yet confident (NYC)	Practice Priority Rate priority to AHS (1-3) 1 = essential 3= nice but not essential	Agreed Yes/ No Comments ?	Community pharmacy comment: Tick if provided
Patient directed services (75% of workload)				
HMR				Number per month?
Non-HMR				
Review patient files to identify people who may benefit from a HMR/non-HMR				
Identify patients recently discharged from hospital, collect discharge summary, review changes to medicines, advise GP and patient if follow up is required.				
Brief interview with patients before doctor's appointment, with/without AHW to get accurate medication history and provide preliminary counselling (and consent for IPAC)				N/A
Medication adherence assessment & support NMARS				
Follow up consultations with patients after HMR/non-HMR and GP management plan				N/A
Opportunistic counselling on prescribed medicines (new or complex meds or those requiring specific administration techniques)				N/A
Provide medication profile to patients on request or as part of follow up interview				
Provide culturally appropriate written medication information if required				
Participate in case conferences and team care arrangement				

	Pharmacist self assessment Confident (C) /not yet confident (NYC)	Practice Priority Rate priority to AHS (1-3) 1 = essential 3= nice but not essential	Agreed Yes/ No Comments ?	Community pharmacy comment: Tick if provided
Liaison with community pharmacy on patient specific matters according to privacy policy of the ACCHS				
Medication reconciliation – receive/provide documentation to relevant health care professionals eg hospital on admission RCF, community pharmacy,				
Participate in (or manage) chronic disease clinics				
Participation in preventive health programs with other staff				
Other:				
Staff directed services (25% of Workload)				
Develop structured education plan based on assessment of practice staff needs.				
Provision of education sessions in professional specific or interprofessional formats as identified in education plan.				
Ad hoc response to drug information queries by staff				
Provide drug utilisation reviews in response to practice specific issues.				
Orientation of new staff to medication management services				
Response to queries about access to medicines eg high cost drugs, SAS medicines.				

	Pharmacist self assessment Confident (C) /not yet confident (NYC)	Practice Priority Rate priority to AHS (1-3) 1 = essential 3= nice but not essential	Agreed Yes/ No Comments ?	Community pharmacy comment: Tick if provided
Support for training for Aboriginal staff as pharmacy assistants in ACCHS (formal or informal)				
Assist trainee health workers with medication education				
Liaison with other agencies re supply management issues eg RCF, community pharmacy				N/A
Liaise with community pharmacy re s100 or QUMAX work plan to ensure activities meet ACCHO's needs				
Communicate with community pharmacy re quality of services provided under s100 or QUMAX agreement.				
Other:				

Attachment to point 4: Review Existing Agreements with Pharmacy: To be completed by IPAC coordinator with community pharmacy representative for S100 sites or QUMAX sites with formal agreements. This will not be appropriate for sites engaging with multiple pharmacies. This initial information can be used at a later time to form part of a stakeholder liaison plan, especially if discrepancies between perceived services provided are identified.

Pharmacy name:

Contact name:

S100 or QUMAX workplan: requested, provided, attached?

Services provided as per question 91 of the Health System Assessment

Service (tick if occurring)	ACCHO response	Pharmacy Response	Comment
Dose administration aids			
Dispensing of medicines			
Home medicines reviews			
Response to queries about medications			
Educational sessions to staff within the clinic			
Educational sessions to community groups/your patients			
Home delivery of medicines to patients			
Delivery of medicines to the clinic			
Quality control of medicines stock onsite			
Assistance with script collection			
Other. Please specify. For Example: 1. Non patient contact med reviews 2. Medication and/or script audits 3. Medschecks/diabetes medschecks			

Further Comments:

Names of people participating in Needs Assessment:

.....

.....

Signed..... Date.....
Manager, ACCHS

Signed..... Date.....
NACCHO IPAC Project Officer

Signed..... Date.....
IPAC pharmacist

Signed..... Date.....
Representative of community Pharmacy (if subcontract)

INTEGRATING PHARMACISTS INTO ACCHS TO IMPROVE CHRONIC DISEASE MANAGEMENT (IPAC)

PHARMACIST WORK PLAN

Date completed: 1/11/18

The following work plan has been developed in consultation between the Project pharmacist- <> and the health service, with facilitation by NACCHO representative Alice Nugent. This plan was developed after an assessment of the needs of the health service, existing pharmacy support through S100 or QUMAX and with consideration of the skills of the pharmacist. The 10 core roles of the IPAC Project form the basis of this work plan. The specific needs of the Project evaluation has been incorporated into the work plan which may seem to be extra to the normal role of a pharmacist. It is recommended that an initial review be done 3 months into the Project and the plan revised as necessary. A report against the work plan will form part of the final evaluation. Key Actions need to be SMART.

S- Be **Specific** about what you want to achieve.

M- Ensure your result is **Measurable**. Have a clearly defined outcome and ensure this is measureable (KPIs).

A- Make sure it is **Achievable**.

R- Check that its **Realistic**, it must be possible taking account of time, ability and finances.

T- Make sure it is **Time** restricted, an achievable time frame, deadlines and milestones to check progress.

This plan will be developed with input from the pharmacist (or contracted community pharmacy) and the health service. Copies will be provided to the health service, pharmacist (or contracted community pharmacy), PSA and the NACCHO Project team members.

The purpose of the work plan are to:

- a. Clarify the specific role of the pharmacist within the health service according to identified need.
- b. Clarify the work requirements of the Project evaluation
- c. Allow review of the performance of the pharmacist in meeting the needs of the health service and the goals of the Project.
- d. Identify learning needs of the Project pharmacist

Key Action Steps	Timeline	Expected Outcome	Data Source and Evaluation Methodology	Resource needs	Comments
<i>Define each action step on its own row. Define as many action steps as necessary by adding rows to the table.</i>	<i>An expected completion date (month and year) must be defined for each action step.</i>	<i>An expected outcome must be defined for each action step.</i>	<i>An evaluative measure must be defined for each action step.</i>	<i>Resources needed to enable actions and outcomes eg learning needs, equipment, software,</i>	<i>Comments are optional.</i>
Core Role 1: Medication Management Reviews					
Provision of or facilitation of HMR	Throughout Project	Completed HMR including Item 900 claim	No of Item 900 claims - MBS	Contact with local HMR accredited pharmacists. Clinical mentoring as required	HMR high priority for funding. May need to be outside Project time to meet patient numbers.
Provision of non-HMR	Throughout Project	Completed non-HMR including GP follow up	No of non-HMR recorded - log book No of related MBS items by AHW	Clinical mentoring as required	
Core Role 2: Team-based collaboration					
Refinement of a process of obtaining patient consent	<Agreed process within 1 month start of pharmacist>	>80% of patients receiving services have provided consent for collection of data	No of enrolled patients - log book.	Consent forms & process	Development of a process for obtaining consent to be commenced by NACCHO Project Coordinator. However, review may be necessary if this is found to less than optimal
Enrolment of patients in	Average 4 new patients/day in	Participation consent	No of enrolled patients as %		

Key Action Steps	Timeline	Expected Outcome	Data Source and Evaluation Methodology	Resource needs	Comments
Project and obtaining informed consent	first half of Project Average 4 encounters/day by end of Project	obtained from [640/FTE=] patients for Project	of target - logbook		
Participation on team clinical meetings	Throughout Project	Pharmacists participates in all relevant clinical team meetings	No of case conferences attended - MBS No of non-claimable clinical team meetings attended – logbook	MBS claiming rules for these items numbers	
Core Role 3: Medication adherence assessment & support					
Conduct N-MARS on all patients at least twice during the Project	Phase 1: 9 months Phase 2: 15 month	All patients enrolled for Project evaluation have had at least 2 nMARS	No of nMARS recorded in Log Book. nMARS flagged in CIS		It is expect some patients will be lost to follow up, aim for No of patients with 3 nMARS to exceed No with 1.
Core Role 4: Medication appropriateness audit, and Assessment of Underutilisation					
Provide MAI and AOU assessment on [30 patients per FTE] pharmacist, twice during the Project and selected at random	Phase 1: 3 months Phase 2: 12-15 month	All randomized <add target quantity for site> patients have had 2 MAI and AOU assessments	No of randomised patients for whom 1 or 2 MAI and AOU have been recorded in Log Book MAI flagged in CIS	Access and familiarity with references in MAI and AOU	

Key Action Steps	Timeline	Expected Outcome	Data Source and Evaluation Methodology	Resource needs	Comments
Core Role 5: Preventative health care					
Participate in concurrent preventive health programs offered by the AHS with other staff	Throughout Project	Significant and relevant contribution to the ACCHS's preventive health programs	No of activities participated in and recorded in log book (in Education & training)	Education materials, education in public health principles	
Core Role 6: Drug Utilisation Review					
Provide at least 1 drug utilisation review in response to practice specific issues.	15 months	At least one DUR performed, documented and fed back to staff	No of DUR Details of DUR from log book	Education on the design & implementation of DUR	
Core Role 7: Education and training					
Develop a structured education plan based on assessment of practice staff needs and revised as necessary	Plan:3 months Review: 7 months	Education plan developed	Review of education plan – pdf in logbook	Access to existing programs NPS, GP synergy, AHW training etc, Knowledge and assessment of other programs service and staff are already doing	
Provide group education sessions	Throughout Project	Education plan achieved	No of activities for staff education; PDF of education materials and evaluations - log book	Training in group education	

Key Action Steps	Timeline	Expected Outcome	Data Source and Evaluation Methodology	Resource needs	Comments
Mentor training for Aboriginal 'Medicines Workers' involved in onsite supply	Throughout Project	Medicines workers more confident and competent in medicines supply activities	Certificate of achievement Qualitative feedback from clinic staff	Contact with available trainers; copies of educational material	Only relevant where onsite supply of meds

Core Role 8: Medicines information service

Ad hoc response to drug information queries by staff	Throughout Project	Staff obtain a timely response to all drug information queries	No and type of staff drug info queries - log book	Access to online literature database AMH, TG, complementary medicines reference, contact with other drug info services such as Mothersafe phoneline	
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Core Role 9: Medicines stakeholder liaison

Liase with stakeholders and document plan for ongoing interaction. Priority should be based on need.	In first 3 months for regular stakeholders, then as required	Stakeholder plan has been developed that meets the needs of both parties	Liaison Plan and Outcomes documents - logbook		
Liase with community pharmacy re dispensing and supply services	As required	Service from community pharmacy meets the needs of the health service	No of service related contacts with pharmacy and outcome of contact - log book	Knowledge of s100/QUMAX business rules. Awareness of ACHHS work plan	

Core Role 10: Transitional care

Communicate with other agencies re clinical or supply management issues eg RCF, hospital, community pharmacy	Throughout Project	Continuity of Care to and from other agencies is facilitated	No of patient-related interagency contacts - log book		
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Signed..... Date.....
Date.....

Manager, ACCHS

Signed.....

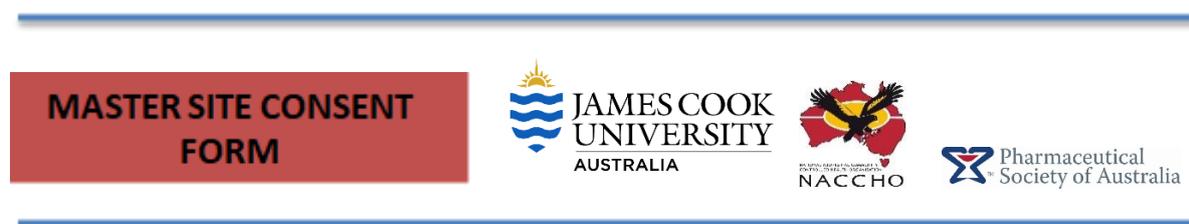
NACCHO IPAC Project Officer

Signed..... Date.....

IPAC pharmacist applicable)

Signed..... Date.....

Contracted community pharmacist (if applicable)



Name of Project: *Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve Chronic Disease Management (IPAC) Project*

Name of Aboriginal Community Controlled Health Organisation: insert name of ACCHS

Project Leaders: Ms Dawn Casey, Mr Mike Stephens (NACCHO), Associate Professor Sophia Couzou (JCU), Ms Shelley Crowther (PSA)

Evaluation Organisation: Evaluation Team led by the College of Medicine and Dentistry, JCU.

Project Sponsor: James Cook University (JCU)

I,can confirm that the

(insert name of Aboriginal Community Controlled Health Service) gives its consent to the above project, subject to the following conditions:

We have the right to withdraw our consent and cease any further involvement in this Project at any time without any penalty and without giving any reasons.

The purpose of the Project, as outlined in the attached Site Participation Brief has been explained, and we have had the opportunity to ask questions about the project. We have received satisfactory answers to our questions and have been given adequate time to consider the appropriateness of the project.

The Project Partners will need to obtain additional consent if there are any changes to the overall design of this Project.

The Practice Pharmacist, who will work within our service, will receive off-site and on-site training by a visiting facilitator from the PSA in consultation with NACCHO. This will be conducted in consultation with your nominated staff, and your Affiliate.

The Practice Pharmacist will be able use our clinical information system and access the information contained within it to allow them to undertake their clinical duties, and to support the data collection required for this Project including completing their Pharmacist Log Book.

Our ACCHS will receive at least two on-site support visits to assist our service to integrate the Practice Pharmacist into our health service team, and to collect data about our health service.

We agree to allow data to be extracted from our clinical information system using the GRHANITE™ Data Extraction Tool, for the purpose of evaluating this Project. This will occur only for individual participants who have consented for this to occur and be de-identified.

Our ACCHS will assist the Practice Pharmacist to set up appropriate systems within our ACCHS to obtain the written consent of individual participants in this Project. This includes nominating a dedicated 'go to' ACCHS staff member to assist in obtaining consent.

Data collected from our ACCHS, in its raw and unanalysed form, is owned by our ACCHS. It will be stored and managed by the Data Custodian at the College of Medicine and Dentistry (JCU) and adhere to all ethical requirements.

Any results from this Project that are published by the Project Partners will acknowledge the ACCHSs ownership of this data.

Any information that identifies this ACCHS or the Aboriginal and Torres Strait Islander community that it serves will not be used nor published without the written permission of the Board or CEO of this ACCHS.

This Project will not proceed until all required negotiation has occurred to the satisfaction of this ACCHS. This will include a legal Agreement with the PSA, described in the attached Site Participation Brief.

The ethical provisions relating to the health of Aboriginal and Torres Strait Islander peoples, as set out in NHMRC publications, will be complied with and this Project will not proceed until the St Vincent’s Hospital Melbourne Human Research Ethics Committee has endorsed the Project.

We understand that if we have any complaints or questions concerning this Project we can contact any of the key contacts mentioned in the Site Participation Brief. This includes the St Vincent’s Hospital Melbourne Human Research Ethics Committee with contact details as follows: Executive Office of Research, St Vincent’s Hospital Melbourne, Tel: 03 9231 2394, or email: research.ethics@svhm.org.au

We understand we will receive a signed copy of this document and the Site Participation Brief to keep.

Signed on behalf of (_____ insert name of ACCHS _____)

Signature

Position in the organisation (Board Chair or CEO)

Date

Witnessed by Date

As the Contractor (PSA) and in this Project and on behalf of the Project Partners, I acknowledge the conditions set out above:

Name:

Signature..... Date

The Project Partners, and Project Operational Team for the *Integrating Pharmacists within ACCHSs to improve Chronic Disease Management Project (IPAC)* include: The National Aboriginal Community Controlled Health Organisation (NACCHO); Pharmaceutical Society of Australia, and the College of Medicine and Dentistry, James Cook University. *Evaluation Team* members include the Project Partners, and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO); Queensland Aboriginal and Islander Health Council (QAIHC); and the Aboriginal Medical Services Alliance in the NT (AMSANT). The Project Reference Group includes representatives of NACCHO, Affiliates and ACCHSs.

Witnessed by Date

Appendix 6: Presentation prepared for ACCHS information at first site visit

The IPAC Project
Integrating Pharmacists within ACCHSs to Improve Chronic Disease

A joint project between NACCHO | JCU | PSA

1

Introduction: Health and medicines use

Aboriginal and Torres Strait Islander peoples experience a much higher burden of chronic disease due to

- cardiovascular disease,
- diabetes, and
- other health problems,

...Yet have poorer access to medicines and associated services

Adverse health outcomes from these illnesses are preventable if

- prescribing quality is improved, and
- patients are better supported with medicines use

2

What is IPAC?

- Will investigate if including a non-dispensing 'practice pharmacist' as part of the primary health care team within ACCHSs leads to improvements in the health of Aboriginal people

Number of Indigenous clients for ACCHS and Indigenous population distribution, 2011

- Funded by the Aus Government
 - Through Pharmacy Trials Program
 - 6th Community Pharmacy Agreement
- Involves 22 ACCHS sites
- NT, Qld and Vic

3

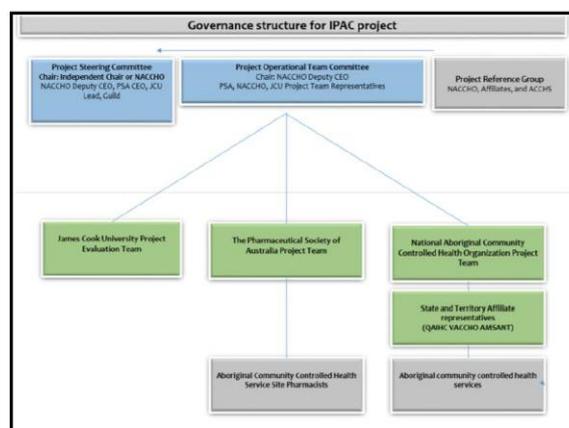
Project Partners Ethics Approvals

- Pharmaceutical Society of Australia (PSA)
- James Cook University
- NACCHO and Affiliates
- St Vincent's Public Hospital HREC (Victoria)
- James Cook University HREC (QLD)
- Menzies School of Health Research HREC (NT)
- Central Australia HREC (NT)

4

Project Partners			
Funding	Project oversight	Project staff	Project sites
Australian Government Department of Health	NACCHO Board of Directors	NACCHO Team (Executive and Project Coordinator)	Aboriginal community controlled health services (22 sites: urban, rural, remote)
	Pharmaceutical Society of Australia Board of Directors	PSA Team (Executive and Project Manager)	
	Human Research Ethics Committees	JCU Research Team (Project Evaluation Lead, Project Manager, Biostatistician)	Pharmacists per site (Aggregated 0.57 FTE for 15 months)
		Affiliates VACCHO, GAHC, AMSANT	

5



6



How will IPAC help?

- Non-dispensing practice pharmacists can improve prescriber and patient medicines knowledge and the use of medicines
- There is extensive global evidence that practice pharmacists co-located within general practice clinics can
 - enhance chronic disease management and
 - improve quality use of medicines
- IPAC is modeled on pharmacists roles in these studies



7



How will IPAC help? Cont.

- Benefit the ACCHS sector by providing the evidence-base to better support quality use of medicines through integrated care models.
- The pharmacist will provide education and shared decision making for patients and staff on appropriate medicines for people with chronic conditions.
- Having a culturally responsive pharmacist integrated into ACCHSs should enable the building of relationships and trust between pharmacists, patients, ACCHS staff and the community.
- **Therefore** improved medicines use and health for ACCHS patients who agree to be part of this project.



8



What is the aim of IPAC?

Improve quality of care outcomes for Aboriginal and/or Torres Strait Islander adult patients with chronic disease.

The Project will investigate:

- Improvements in health measures of those patients who have been receiving support from a pharmacist and who agree to participate in the Project;
- Improvements in:
 - prescribing so that medicines patients are taking are appropriate for them and their individual healthcare needs;
 - patient adherence to medicines;
 - health service utilisation of Medicare;
 - relationships with and perceptions of stakeholders (ACCHSs staff; community pharmacies; pharmacists);
- The cost-effectiveness of the intervention



9



What's included for ACCHSs?

- ✓ Fully subsidised non-dispensing pharmacist to be embedded into ACCHS's teams for 15 months (~0.57 FTE)
- ✓ ACCHSs can choose their pharmacist
 - From the pharmacists who express interest or
 - From local community pharmacies with capacity
- PSA and NACCHO will provide comprehensive support during recruitment and employment
- ✓ The pharmacist delivers a range of services based on a thorough ACCHS's needs-assessment
- ✓ The pharmacist will receive clinical, cultural and project training to ensure their readiness and suitability
- ✓ NACCHO and Affiliates have dedicated officers to provide communication and support for the life of IPAC
- ✓ The pharmacist will complement other pharmacy services



10



What can a Pharmacist do for you?

- Medication management reviews conducted within the ACCHS and HMRs have the potential to increase patients' medication knowledge and medication adherence when these are delivered in a culturally appropriate way
- Medication reconciliation: The pharmacist reviews all medicines people say they use as well as documentation in the ACCHS records, letters from specialists, hospitals or others. They can help sort this out and record actual therapy in the patient's file and may recommend medication changes in line with recommendations by the transferring agency eg after discharge from hospital.



11



What can a pharmacist do for you...

- Drug Utilisation Review (DUE) is a structured review program to ensure quality of medications prescribing and systems management. It involves identification or suspicion of a problem with respect to medicines, investigation of that problem through a review of case files and reporting back results to staff to allow improvement in systems or quality of care
- Staff education in medication management and assistance with health worker training
- Liaison with community pharmacy



12



What can a pharmacist do continued

- Provide culturally appropriate education to patients to address adherence. N-MARS
- Assessment of prescribing MAI and Under utilization
- Preventative healthcare: reduce smoking through education and provision of nicotine replacement therapy; a campaign to improve inhaler technique for people with asthma and chronic lung disease or referral to nutrition and exercise programs in conjunction with the chronic disease team.



13



Consent Process

- Pharmacists can see any patient in ACCHS
- Data will only be gathered from consented patients, in a deidentified manner.
- Consent form and project brief have ethics approval
- Patients can withdraw consent at anytime
- Can staff please help refer patients
- Which staff will be trained to gather consent?



14

**This clinic has
a PHARMACIST
to TALK WITH YOU
about your medicines**

Are you having trouble with your medicines?
Do you wonder what they are all for?

Ask to make
an appointment
with our
PHARMACIST:

Name

Our clinic is supporting the pharmacist in a project.
You will need to sign that you want to take part. Privacy and confidentiality are ensured.



IPAC is funded by the Australian Government Department of Health under the Sixth Community Pharmacy Agreement

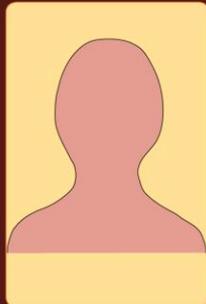


Are you having trouble with your medicines?
Do you wonder what they are all for?

This clinic has a **PHARMACIST** to
TALK WITH YOU
about your medicines

Illustration by: Julie A Taylor © JAT Illustrations

Ask to make
an appointment
with our
PHARMACIST:



Name

Our clinic is supporting the pharmacist in a project.
You will need to sign that you want to take part. Privacy and confidentiality are ensured.



IPAC is funded by the Australian Government Department of Health under the Sixth Community Pharmacy Agreement

Appendix 8: IPAC Brochure



There is a pharmacist available in this clinic to answer questions about your medicines.



You can do this in the clinic . . . or at home . . . whichever suits you.
You might need to make an appointment.

Integrating Pharmacists Within ACCHSs To Improve Chronic Disease Management (IPAC)
 This project is running 2018-2019. For further information talk to the clinic staff or contact the project team:
ipac@naccho.org.au or ipac@psa.org.au

Name

Your appointment to talk with the pharmacist is on :

Day, Date

Time

Pharmacist

Where

If you can't make this time, please ring the clinic on:

Need help with your MEDICINES?



You can talk with our PHARMACIST















Funded by the Australian Government under the 6th Community Pharmacy Agreement

Do you want to know more about your medicines?

What are they for?



Do your medicines make you feel sick?



Could you be having side effects?

Do they go together?



Do you think you take too many medicines?



What will happen if you don't take them?



Are these brands all the same?



When you talk with the pharmacist about your medicines, your clinic will make sure that it is done in a safe way.

The pharmacist is working as part of the IPAC project. You will be asked to sign a consent form to say its ok for the story about your health and your medicines to be used in the project. Many people's stories will be collected but we will not know their names.



A report will be written about whether having a pharmacist working in the clinic has helped people understand their medicines better. You don't have to sign a consent to talk with a pharmacist. If you do sign, you can change your mind later.

When you consent to this project, the pharmacist will work with you and the clinic staff so that you are OK with your medicines.

Illustrations by: Julie A Taylor © 2017 Illustrations

Appendix 9: Master site participation brief



Title	<i>Integrating Pharmacists within Aboriginal Community Controlled Health Service (ACCHSs) to improve Chronic Disease Management Project (IPAC)</i>
Short Title	<i>Putting Pharmacists into ACCHSs</i>
Project Sponsor	<i>James Cook University</i>
Coordinating Investigators	<i>Associate Professor Sophia Couzos (JCU), Ms Shelley Crowther (PSA), Mr Mike Stephens (NACCHO), Ms Dawn Casey (NACCHO)</i>
Evaluation Team	<i>Prof Rhondda Jones (JCU), Dr Emily Callander (JCU), Dr Erik Biroz (JCU), Dr Deborah Smith (JCU), Prof Bev Glass (JCU), Dr Robyn Preston (JCU), Ms Priscilla Page (JCU), Mr Donald Whaleboat (JCU), Assoc Prof Michelle Bellingren (JCU), Ms Nicole Bates (JCU), Dr Nadia Lusic (VACCHO), Dr Elizabeth Moore (AMSANT), Mr Roderick Wright (QAIHC), Dr Katie Panaretto, Dr Douglas Boyle (UniMelb).</i>
Location	<i>Wathaurong Aboriginal Co-operative Health Service</i>

What is the IPAC Project?

IPAC stands for 'Integrating Pharmacists within Aboriginal Community Controlled Health Service (ACCHSs) to improve Chronic Disease Management' Project. This project will explore if including a registered non-dispensing practice pharmacist as part of the primary health care team within Aboriginal community controlled health services (ACCHSs) leads to improvements in the quality of the care received by Aboriginal and Torres Strait Islander peoples. The project will explore improvements in prescribing by doctors, if patients are more likely to take their medicines, and if indicators of their health are improving over time, by measuring these factors before and after the pharmacist is appointed. Practice pharmacists will work with the doctors and other health staff in each ACCHS for a period of 15 months per service, in Vic, Qld and the NT.

Practice pharmacists will provide relevant healthcare activities within their scope of practice to patients. They will also provide education and training to existing staff within the services (as appropriate), improve relations with community pharmacies to overcome barriers that patients may face in accessing

medicines, and assist in managing medications at transitions of care (such as discharge from hospital). This project will also explore the cost-effectiveness of pharmacist integration within ACCHSs.

How did this Project come about?

The Project was developed at the request of the National Aboriginal Community Controlled Health Organisation (NACCHO, representing ACCHSs across Australia) and the Pharmaceutical Society of Australia (PSA, representing pharmacists). The Project is a tripartite partnership between NACCHO, PSA and James Cook University (JCU). Participants include Affiliates of NACCHO in Vic, Qld, and the NT, up to 22 ACCHSs in these jurisdictions, practice pharmacists, and patients who will receive healthcare support from a pharmacist.

Community-based participatory research principles and methods are used to make sure there is appropriate Aboriginal governance over this Project.

Why is this Project important?

Aboriginal and Torres Strait Islander peoples experience a much higher burden of chronic disease due to cardiovascular, diabetes, and other health problems, and yet have poorer access to needed medicines.ⁱⁱⁱ Adverse health outcomes from these illnesses are preventable if prescribing quality is improved, and patients are better supported with medicines use, which is a key health equity issue.

This project is necessary, as non-dispensing pharmacists are not currently funded consistently or reliably to work within primary health care settings in the public health sector in Australia. Reasons for this are mainly related to funding access as Australian pharmacists are located almost exclusively within community pharmacies and hospitals. Despite this, several ACCHSs across Australia have sourced adhoc funding to employ pharmacists in non-dispensing roles. This project is modelled on these pharmacists' roles and on international research evidence. There is extensive global evidence that practice pharmacists co-located within general practice clinics can enhance chronic disease management and quality use of medicines.ⁱⁱⁱ

The NACCHO and the PSA have promoted the need for this project for many years. The project will help the Australian Government make decisions about future funding and the role practice pharmacists may play as members of primary health care teams within ACCHSs and potentially other settings in Australia.

What is the aim of this project?

This project aims 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. This means the Project will investigate:

- Improvements in health measures of those patients who have been receiving support from a pharmacist and who agree to participate in the Project;
- Improvements in:
 - prescribing so that medicines patients are taking are appropriate for them and their individual healthcare needs;
 - patient adherence to medicines;
 - health service utilisation of Medicare;
 - relationships with and perceptions of stakeholders (ACCHSs staff; community pharmacies; pharmacists);
- The cost-effectiveness of the intervention, which will investigate the costs of the pharmacist service and measures of effectiveness such as increased Medicare utilisation (as a marker of increased patient access to healthcare services towards equity).

Does this project have ethics approval?

Ethics approval has been received from a Victorian Human Research Ethics Committee (HREC). This is the St Vincent's Public Hospital HREC in Melbourne. This HREC participates in National Mutual Acceptance of ethics. This means that the review of this committee in Victoria may be acceptable to other HRECs. Acknowledgement from JCU has also been received. This Project will also seek ethics review from two other HRECs in the Northern Territory. These are the:

- Menzies School of Health Research HREC
- Central Australian HREC

As this project is to be run in Qld, Victoria and the NT, ethics review is required from all these jurisdictions.

How is the Project funded?

The Australian Government under the Pharmacy Trials Program of the 6th Community Pharmacy Agreement has funded the project for 29 months.

Governance

The Project Partners and the Project Operational Team Committee

This project is a partnership between the PSA, NACCHO, and JCU (College of Medicine and Dentistry), guided by a Memorandum of Understanding that outlines communication and governance processes.

The PSA, as the lead agency, is responsible for managing the Head Agreement with the Department of Health, and service agreements with partners and ACCHSs, and will coordinate the appointment of practice pharmacists, their recruitment, selection, placement, and training. The NACCHO will provide Aboriginal governance leadership for the project and coordinate all communication with ACCHSs, Affiliates and the NACCHO Board. JCU will undertake the project evaluation, having developed the research methodology based around a pragmatic, community-based participatory research model.

The Project Operational Team Committee is made up of the project partners and is Chaired by the Deputy CEO of NACCHO, Ms Dawn Casey.

Steering Committee

The Operational Team Committee will report to this group as this is made up of representatives of the Project partners, the Department of Health, the Pharmacy Guild of Australia and external experts.

Members of the Evaluation Team

The Project Partners are members of the evaluation team as are other Aboriginal community representative bodies. These are the Victorian Aboriginal Community Controlled Health Organisation (VACCHO); the Queensland Aboriginal and Islander Health Council (QAIHC), and the Aboriginal Medical Services Alliance in the NT (AMSANT). These organisations are NACCHO Affiliates and will be responsible for state-based service support to registered ACCHSs, and provide guidance to the project as members of the evaluation team.

Project Reference Group

State and Territory Affiliates of NACCHO (QAIHC, VACCHO and AMSANT) will be members of the Project Reference Group. Participating ACCHSs will also be invited to be members of the Project Reference Group managed by NACCHO. The Chair of the Project Reference Group will be a nominated member of the NACCHO Board of Directors. This group will meet by teleconference or web-based platforms.

Aboriginal governance and leadership

The way in which these groups communicate and link with each other is shown in Figure 1 and 2. The Project respects and acknowledges Aboriginal governance principles, and ACCHS sector leadership and involvement.

Figure 1. Governance and partnership structure of the IPAC project

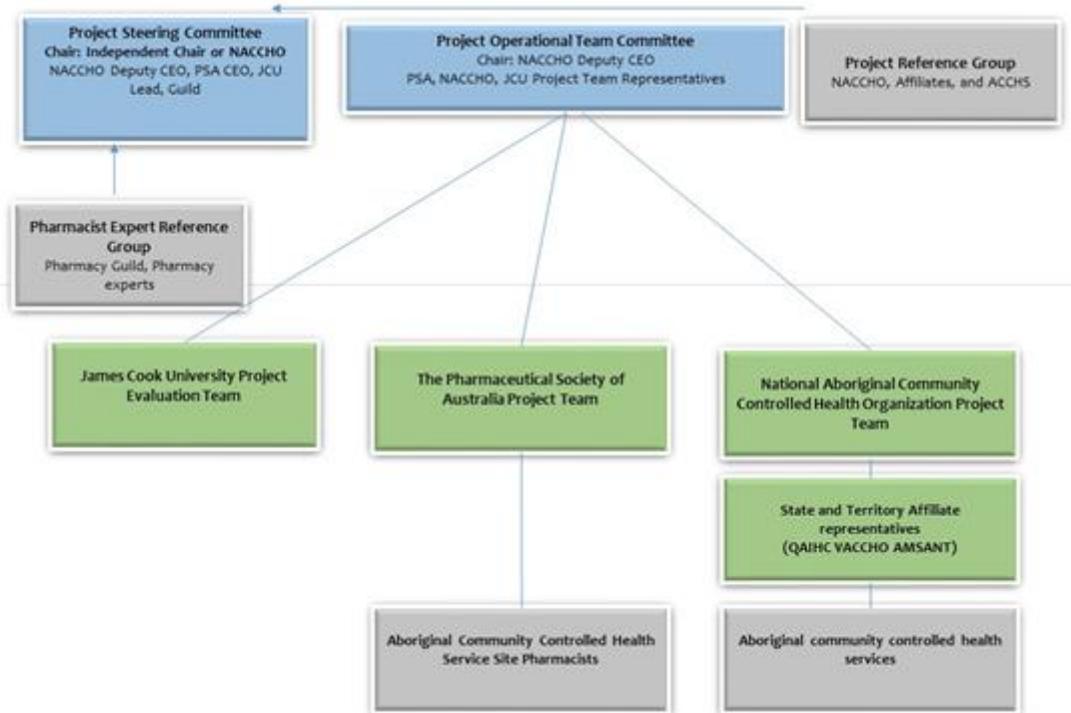
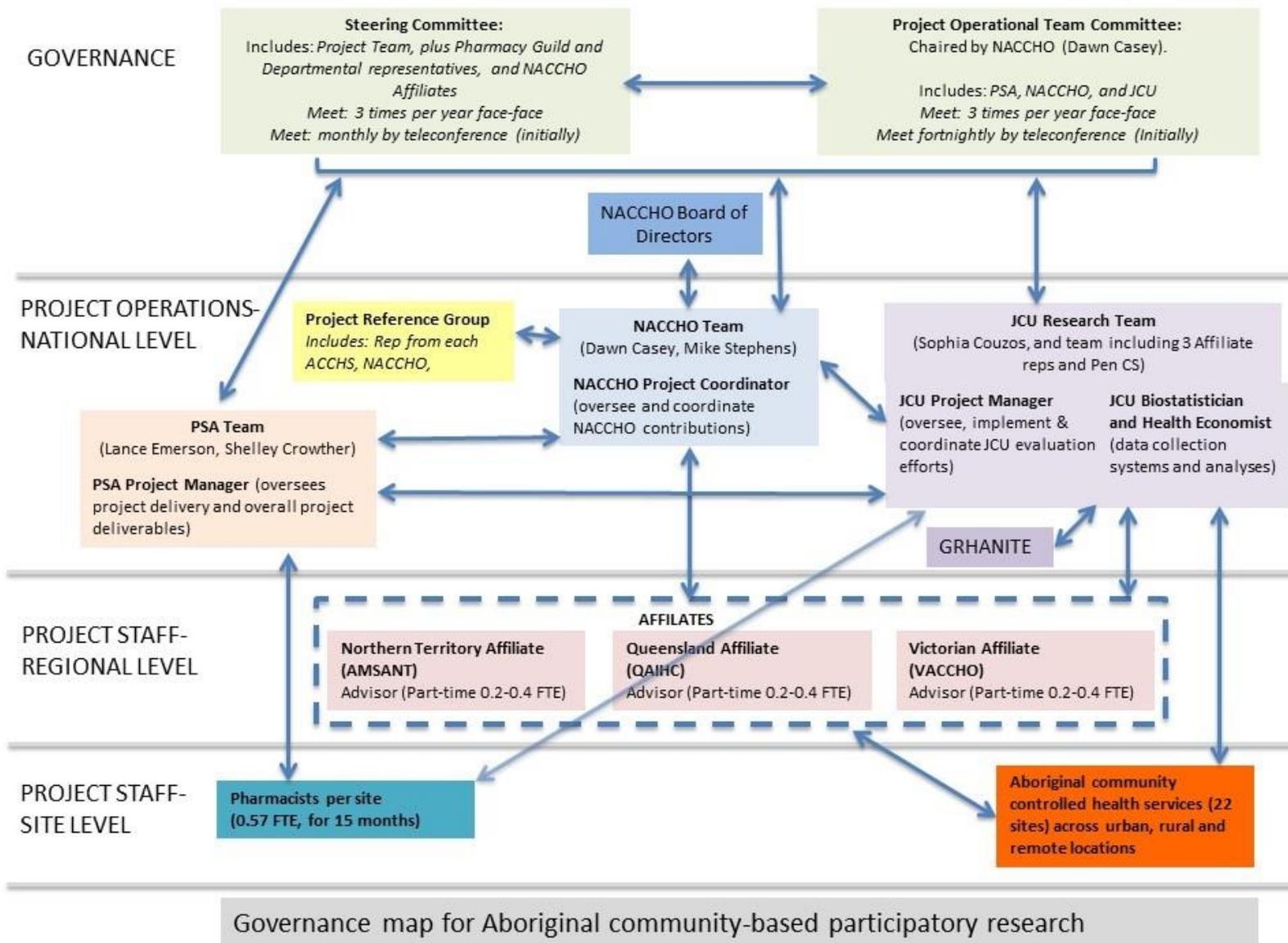


Figure 2. Governance map for the IPAC project.



What is the design of this project?

The project partners are committed to undertaking the Project to ensure clear benefits to ACCHSs, and to ensure acceptability and sustainability of the intervention within ACCHSs.

The project is a pre and post study where the pharmacist intervention will be added to standard primary health care practice within ACCHSs. Information will be collected from the time the pharmacist starts until they finish, and this will be compared with information from 12 months before the pharmacist started.

The parts of the project

There are three project phases over a 29 month project duration: Phase 1: Establishment (4 months); Phase 2: Implementation/intervention (19 months); Phase 3: Analysis and Reporting (6 months). The project is scheduled to be completed by April 2020. ACCHSs will be invited in stages (tranches) and will therefore be staggered. This is so that the project can give time to each service to get them ready for the project.

The selection of project sites

The project is inviting ACCHSs in geographically diverse settings in Vic, Qld, and NT. Up to 22 ACCHSs will be able to participate. ACCHSs need to meet certain eligibility criteria to participate as project sites.

The eligibility criteria for ACCHSs is:

- The ACCHS employs at least one (1) full-time- equivalent (FTE) general practitioner per clinic who is able to prescribe medicines to clients of that organisation.
- The ACCHS does not currently employ a non-dispensing practice pharmacist at the participating clinic.
- The ACCHS uses a clinical information system such as Communicare, Best Practice, and Medical Director.
- The ACCHS has participated in continuing quality improvement and reporting on the national Key Performance Indicators for at least 24 months through the use of electronic data extraction tools.
- The ACCHS is participating in the *Quality Assurance for Aboriginal and Torres Strait Islander Medical Services (QAAMS)* program, if it is conducting 'point of care' testing.
- The ACCHS agrees to download the GRHANITE data extraction tool into one computer within the practice, adhere to program business rules/protocol and guidelines, data provision requirements, and patient/service consent requirements for the evaluation of the program.
- The ACCHS can provide the practice pharmacist access to a private consulting room on the clinic premises that has access to the clinical information system used by the practice.
- The ACCHS can allocate a staff member who will act as a 'go to' person to assist the practice to obtain informed patient consent.
- The ACCHS is a member of NACCHO, and the relevant NACCHO State/Territory Affiliate.
- The ACCHS is an accredited practice in accordance with the RACGP Practice Standards.
- In non-remote locations, the ACCHS must be participating or eligible to participate in the PBS co-payment measure (practice incentive program).
- In remote locations, the ACCHS must be eligible to participate in the remote Section 100 arrangements for the supply of pharmaceutical benefits

These criteria have been developed with Affiliate input to suit most ACCHSs in Qld, Vic, and the NT, and to make the project as 'real life' as possible. It is important that ACCHSs have clinical information systems (CIS) that the pharmacist can use like other health staff. Only the listed clinical information systems can work with the GRHANITE™ tool to collect information. (GRHANITE is explained later in this document).

The project will recognise the diversity of Aboriginal peoples and Torres Strait Islanders and models of care across Australia, and will select ACCHSs in urban, regional and remote areas. This is so that the project can understand the many ways that ACCHSs may utilise the pharmacist in their clinic.

How will ACCHSs be invited to take part?

ACCHSs will be invited to participate in the project by NACCHO and Affiliates through an 'expression of interest' process. The 'expression of interest' process will explain to ACCHS the process that will be used for site selection.

The Operational Team Committee, Chaired by the NACCHO Deputy CEO will review the expressions of interest and decide if a temporary Panel made up of Affiliate representatives is necessary to select the most suitable sites to participate in the project. As the recruitment process for sites will be staggered, this process will be repeated.

When NACCHO receives an expression of interest from an ACCHS, and the ACCHS is agreed to being a suitable site, the NACCHO Project Coordinator will contact the ACCHS and explain the project further to provide instructions on the process required to establish the site participation.

Formal participation of ACCHSs

After this consultation, a Site Agreement, Site Consent form, and Site Participation Brief (*this document*) will be provided to the ACCHS. Once this is signed and agreed, the project officers will arrange for practice pharmacist recruitment and placement within the ACCHS.

A visit to the ACCHS will be arranged to undertake a 'Needs Assessment' and a 'Health Systems Assessment' just before, or at the time that the practice pharmacist commences (these are explained later in this document).

How will each ACCHS benefit from this project?

Each service will be offered a practice pharmacist (aggregated 0.57 FTE across 22 sites each for 15 months duration) under a service agreement with the PSA. This will enhance the medicines-related workforce capacity of the ACCHS. Practice pharmacists are registered to work within their scope of practice and will have a non-dispensing role. The appointments will include salary, training, and the provision of supportive resources.

In the short-term, Medicare claims for medications-related, preventive care and chronic disease care may increase. The practice pharmacist will support other staff with quality prescribing and medicines use. The relationship with community pharmacies in the local area may improve if pharmacies' are helped to provide more appropriate services to the local community. Relationships between the ACCHS, local hospitals and other care providers may improve with communication between care providers when it pertains to the medicines that patients are taking.

These short-term benefits have potential for long-term gains for the sector as a whole. The project will provide the Australian Government with the evidence-base (biomedical, process, and economic evaluations) for the development of national health policies to potentially support on-going resourcing for practice pharmacists integrated within ACCHSs.

What is the role of the Affiliates in this Project?

NACCHO is a project partner and will maintain Aboriginal governance over this project. Affiliates are also participants in this project. They will be providing support to ACCHSs through funded project officer positions (0.2-0.4 FTE). The ACCHS will be notified of the name and contact details of the Affiliate staff to contact if and when the service needs to.

What is the pharmacist's role in the ACCHS?

The pharmacist employed within the ACCHS will deliver medication advice and education to patients and staff. They will work to improve patient medication adherence, improve prescribing, tailor medications to best suit the patient in collaboration with the prescriber, and assist with/oversee medication management processes. They may provide health promotion, disease prevention, and assist patients with chronic disease self-management and more judicious use of medicines.

The pharmacist will be required to respond to medication enquiries from patients and health professionals such as general practitioners and Aboriginal and Torres Strait Islander Health Workers/Practitioners, conduct staff education, review prescribing, mentor new prescribers, participate in case conferences, liaise across health sectors, undertake medication management reviews, and evaluate drug utilisation to ensure optimal therapy. As part of their collaborative work, an important element of the practice pharmacist's role is liaison with local community pharmacists to ensure continuity of care, and assist in medication management with transitions of care (such as when the patient is discharged from hospital).

Overall, there are 10 core roles targeting *patients, and health professionals and health systems*. These roles are all non-dispensing, for which practice pharmacists are registered to deliver. This is summarised in Table 1.

Whilst the project has developed these core roles for evaluation purposes, each participating ACCHS has the flexibility to utilise the services of the pharmacist according to service and client priorities. Practice pharmacists will be supported to adapt to cultural ways of delivering primary health care within each service. The project will aim to document the diversity in pharmacist core roles and in the patient journey. This will be possible through qualitative evaluation, but also through pre-post Health Systems Assessments (this is explained later in this document). The practice pharmacist will be supported to adapt to their role as directed by the staff and CEO.

Most of the practice pharmacist's activity must be devoted to providing supportive clinical care to patients who are participants in this project.

Table 1. Summary of practice pharmacists core roles

SUMMARY OF PRACTICE PHARMACISTS CORE ROLES

Core		
Role #	Theme	Core activity
1 (a)	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)
1 (b)		Pharmacist reviews the patient who had a HMR after 12 months and a Non-HMR after 3-6 months.
1 (c)		Pharmacist ensures the MMR is claimed by the practice when completed (as a DMMR item 900 or RMMR item 903)
2	Team-based collaboration	Pharmacist participates in clinic activities that support team-based chronic disease care plans, and cardiovascular (CV) risk assessment
3 (a)	Medication adherence assessment & support	Pharmacist assesses the medication adherence of the patient being seen
3 (b)		Pharmacist improves the patient's experience with their medicines

4	Medication appropriateness audit	Pharmacist assesses 'medication appropriateness and underutilisation of medicines' <u>as an audit of a sample</u> of patients with chronic disease.
5	Preventative health care	Pharmacist provides preventive interventions to patients
6	Drug Utilisation Review	Pharmacist conducts a DUR to audit and improve a priority issue at the service
7	Education and training	Pharmacist conducts education sessions at the service
8	Medicines information service	Pharmacist provides medicines related information to staff within the service and responds to clinician medicines enquiries.
9	Medicines stakeholder liaison	Pharmacist develops a written <u>stakeholder liaison plan</u> supporting engagement with community pharmacies.
10	Transitional care	Pharmacist facilitates care coordination with relevant hospitals; residential aged care facilities, etc.

Pharmacist's qualifications

Pharmacist's who will be able to work in ACCHSs will be required to have:

- current registration with the Australian Health Practitioners Regulation Agency (AHPRA) as a pharmacist;
- more than 2 years post-registration experience;
- medication review accreditation such as from the Australia Association of Consultant Pharmacy (AACP) or Society of Hospital Pharmacists of Australia (SHPA) or working towards accreditation;
- post-graduate clinical qualifications or demonstrated clinical experience (e.g. hospital or HMRs).

The need for post-graduate qualifications or accreditation will be dependent on ACCHSs preference regarding the applicant and an adequate supply of accredited and experienced pharmacist applicants.

The PSA confirms that the proposed activities are consistent with the existing scope of practice of pharmacists as defined by the PSA Competency Standards endorsed by the Australian Health Practitioner Registration Agency.

Training the pharmacist at the ACCHS

The PSA will deliver the training to practice pharmacists in partnership with NACCHO. Some of the training will be off-site (before the pharmacist starts) and some will be on-site (at the start of their placement in the ACCHS). The NACCHO Coordinator and PSA training facilitator will arrange a training time with the practice pharmacist and with the nominated ACCHS, so that on-site training can best suit the ACCHS.

To follow up training, pharmacists will also have access to structured pharmacist mentor program that will link them with a dedicated mentor pharmacist with experience in the ACCH sector and to the other practice pharmacists within the project.

What patients' are eligible to be participants in this project?

If the patient is aged 18 years of age and over and has the following conditions, then they are eligible to be a participant in this project:

- Cardiovascular disease (coronary heart disease, stroke, hypertension, dyslipidaemia and any other CV disease)
- Type 2 diabetes mellitus,

- Chronic kidney disease,
- Other chronic conditions that mean a patient is at high risk of developing medication-related problems (e.g. polypharmacy).

These conditions are selected because *most* of the mortality gap for Aboriginal and Torres Strait Islanders is due to these chronic diseases. Optimizing medicines for people with these conditions can make an important impact on their health.

The consent of the patient will be required to participate in this project. Most of the patients attending ACCHSs are of Aboriginal and Torres Strait Islander origin (81%).^{iv} Therefore, we expect most of the patients involved in this project will be of Aboriginal and Torres Strait Islander origin.

Patients who are regular patients of the service should be prioritised as pharmacists will make sure they follow-up these patients over time.

If a patient consents to be a participant, how may they benefit from this project?

These participants will have immediate access to an on-site pharmacist at no charge. The Pharmacist will check their medicines and make sure they are right for them. Some recommendations may require the prescriber to change medicines or their dose, or cease a medication, or start a necessary medication.

The pharmacist will help resolve problems the participant may have with taking medicines, storing them, and will assess for adverse effects. Participants will be offered medication review in the clinic, or at home, or a place that best suits them. Just like the doctors and other staff, the pharmacist will record the encounter and recommendations in the CIS so that the doctor and health team can read them and make any agreed prescribing changes. The pharmacist also has more time to spend on supporting participants with medications than the doctor has.

The Pharmacist will see participants again to provide them with ongoing support. The pharmacist may follow-up with other members of the primary healthcare team, including with community pharmacy, and depending on the participants needs, with the hospital for discharge medications. This intensive support may help to improve the health of the participant.

There are no other expectations on participants in this project. Personal details of participants are not collected at all, and the data being extracted for the project is completely de-identified. A *Participant Consent Form* and *Participant Information Brief* is available for the ACCHS and practice pharmacist to seek patient consent. Patient participation in this project is voluntary. If consent is not given, this will not affect the patient's routine treatment, or their relationship the clinic, and the patient will still be able to be referred to the Pharmacist.

If a patient consents to be a participant, how may this benefit the ACCHS?

If patients agree to be participants, this enables the ACCHS to collect information for the purpose of the project. The participation of the patient will assist the ACCHS to collect information to determine the clinical and cost-effectiveness of the practice pharmacist, and will support the clinic activity overall (with Medicare and staff education). The information will inform on whether the health of participants improves over time, compared to their health before they received the services of the pharmacist. The ACCHS may receive a site-specific report if they wish. If patient consent is not given, information cannot be extracted from the CIS for this project. Patient consent is therefore vital to assess the value of the practice pharmacist within ACCHSs.

How will patients be referred to the pharmacist in the ACCHS?

The staff within the ACCHS will need to be briefed about this project and the role of the practice pharmacist. The project will also seek the consent of general practitioners in the clinic and provide them with an *information brief*. This *Site Participation Brief* can assist the ACCHS with informing other staff.

Patients attending the ACCHSs doctor, health worker or other healthcare provider will be invited to talk to a practice pharmacist. These staff can refer the patient to the practice pharmacist. NACCHO and the PSA will prepare some simple promotional material to help health staff with this referral, so that patients who are most in need and meet the inclusion criteria are offered the services of the pharmacist.

The practice pharmacist or a designated staff member will tell the patient about this Project (and provide the patient with the *participant information brief*) and ask them if they want to take part. They will then be asked to *sign a participant consent form*. They may see the Pharmacist straight away or an appointment may need to be made for a later time.

The practice pharmacists (with assistance from trained ACCHS staff) may also directly approach patients attending the clinic who meet the individual participant criteria. The process for participant recruitment will be flexible according to the preferred process recommended by the ACCHS. This can be arranged during the first site visit to the ACCHS (see later in this document).

How will our ACCHS seek patient consent?

A suggested process for seeking individual patient consent has been developed in consultation with NACCHO Affiliates on the Evaluation Team. The process respects the systems that ACCHSs may wish and choose to adopt.

The practice pharmacist will be trained to seek the participant's consent. Training for seeking participant consent will also be provided to other staff who may be designated by the ACCHS to seek the participant's consent for cultural appropriateness reasons.

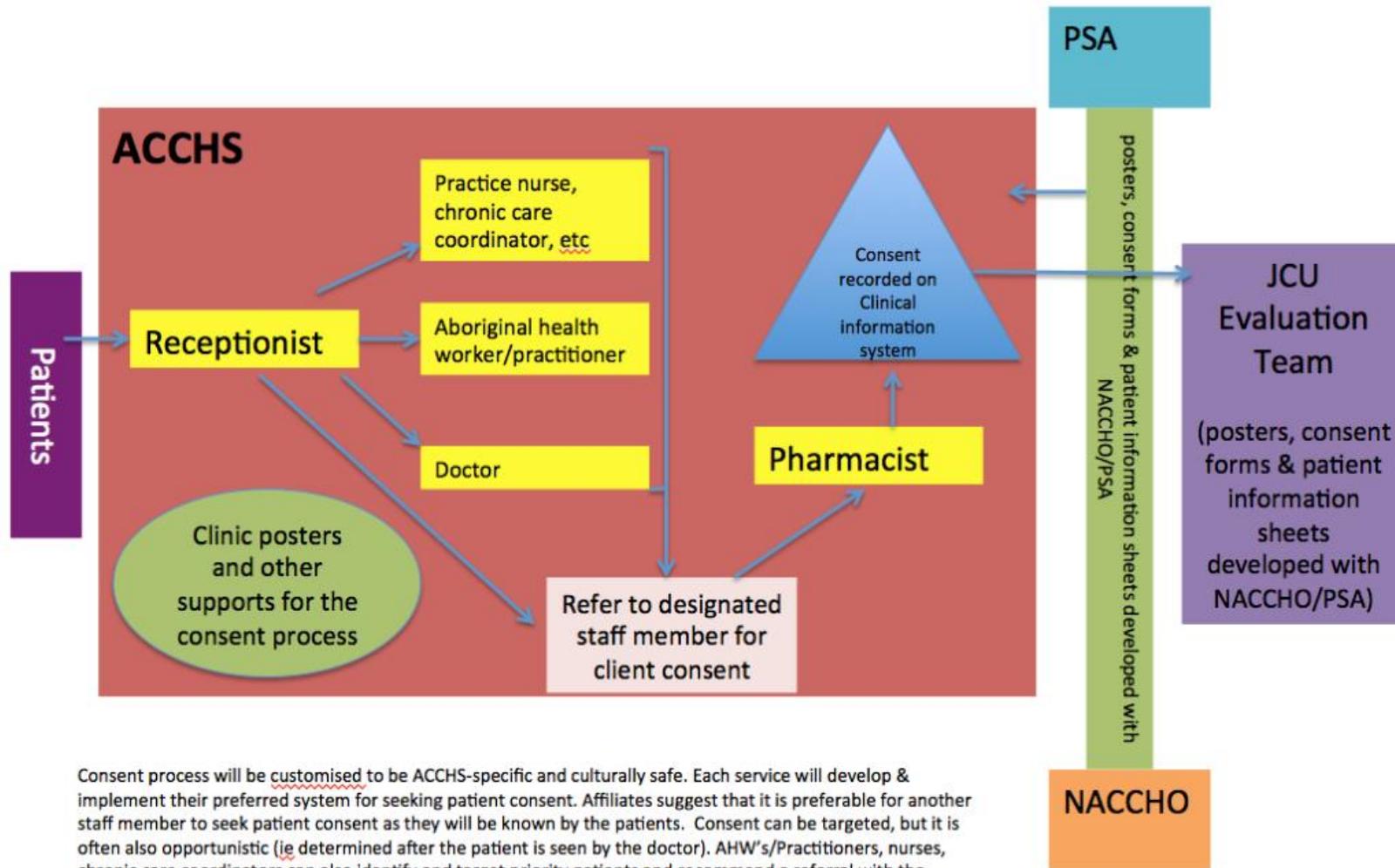
The participants consent form will then be signed and dated by the patient, a witness, and the designated staff member seeking patient consent. The consent form will be stored in a locked briefcase by the practice pharmacist until posted by registered post. It may be transmitted electronically to JCU after scanning. A written copy of the verbal information will be provided to the patient, including advice on how they may ask questions or make complaints about the project.

Consent will then be recorded on the clinical information system (CIS) by the practice pharmacist and GRHANITE will extract information only from consented patients. This suggested process is summarised in Figure 4.

Figure 4. A suggested process to seek patient consent.

DRAFT SCHEMA FOR PATIENT CONSENT-PTP TRIAL

JCU, PTP Tranche 2 Trial



Consent process will be customised to be ACCHS-specific and culturally safe. Each service will develop & implement their preferred system for seeking patient consent. Affiliates suggest that it is preferable for another staff member to seek patient consent as they will be known by the patients. Consent can be targeted, but it is often also opportunistic (ie determined after the patient is seen by the doctor). AHW's/Practitioners, nurses, chronic care coordinators can also identify and target priority patients and recommend a referral with the consent process referred to the designated staff member. Refusal to give consent should not preclude a patient from receiving pharmacist services. Patients who give consent will be noted on the clinical information system. This schema is a draft guide.

How will participants be followed-up?

Practice Pharmacists will aim to follow-up participants using the usual clinic processes. Pharmacists will work with the existing staff in the ACCHS to follow-up participants in the same way used for all patients. Participants will need to be reviewed according to clinical needs and Medicare rules, and may include 3-monthly, 6-monthly or an annual review or more frequent review by the pharmacist.

The pharmacist will need to use the CIS within the ACCHS to record follow-up clinical details like other healthcare staff. The pharmacist will also record follow-up details in the pharmacist log-book as is appropriate for the type of review being conducted (such as medication appropriateness index measurements).

How many patients will ACCHS be asking to participate?

It is estimated that the practice pharmacist and the ACCHS may seek consent from about 350 people to be part of this Project and to see the Pharmacist over 15 months. This may vary considerably from service to service.

It is important for the ACCHS to encourage patients to be referred to the pharmacist early in the project. This is so that enough time is available to follow-up patients during the 15 months the pharmacist is employed in the project.

Are there any risks or benefits to patients from taking part?

The Pharmacist is a qualified and registered health professional who will be trained to work in this ACCHS. The risks to patients are no different to seeing a Pharmacist in a Pharmacy, except that patients will be seeing Pharmacists in this clinic. The Pharmacists will not be prescribing or dispensing medicines as they would in a Pharmacy. They will be working with the primary health care team in the ACCHS.

How will information for the project be collected?

The project has been designed to be acceptable and feasible to ACCHSs and practice pharmacists, by making most of the data collection a 'by-product' of service delivery. There are three main types of information that will be collected with the help of ACCHSs. Information will be collected from clinical information systems (CIS), pharmacist log-books (managed by the pharmacist), and from site visits to ACCHSs.

1. Deidentified information about patients who have consented (participants) will be collected from services clinical information systems (CIS), using an electronic data extraction tool known as **GRHANITE™**. ACCHSs will be supported to have the GRHANITE data extraction software installed in one personal computer in the clinic. This software will be installed in one workstation to minimise practice impact. When GRHANITE runs, it does so at a scheduled time and queries data from the practice database server. This is the only time GRHANITE communicates with the practice server. GRHANITE will extract weekly data from the CIS to the secure JCU repository. The ACCHS does not need to do anything to maintain that this program is working.
2. Practice pharmacists will also collect information about what they do through an **electronic log-book**. This system will be an online secure database requiring practice pharmacist secure log-in. It will be used by practice pharmacists to record deidentified daily activity. Each electronic log-book entry will be able to be interrogated by the JCU data custodian. The daily-recorded activity will refer to 6 core pharmacist roles. The electronic interface will be user-friendly to minimise the reporting burden of practice pharmacists.

3. **Health systems assessment, qualitative data, and cost-effectiveness analysis** data will be collected during visits to the ACCHS. Mainly the NACCHO Project Coordinator, will undertake visits to the ACCHS. A qualitative researcher will visit only three ACCHSs if they are invited by the service. The costs related to the employment of pharmacists will be sourced mainly from the PSA.

How does GRHANITE work and how secure is it?

GRHANITE™ strictly conforms to extract only data that is approved. It provides ethical and secure mechanisms for the provision of data from the CIS. If an individual gives their permission to be involved in a project, GRHANITE can read this consent information if it is recorded in the clinical notes. Patients who have not consented will not have their data interrogated, even if deidentified. This is an ‘opt-in’ consent process. Patient names, dates of birth, address or other identifying information are not extracted.

The data extraction from the CIS within the ACCHS will only extract deidentified data and then transmit it securely to the secure repository at JCU. The exported data is encrypted, and can only be decrypted at its final destination. This ensures transmission security. Data is deidentified as patients are assigned a unique patient ID. It is not possible for the project partners to reidentify any patient.

GRHANITE software will not operate if copied or moved from one computer to another. All installations require a unique authorising license. It is a nationally recognised tool as over 1000 health services across Australia have used/are using this for quality improvement and for research activity.

JCU will be the repository body responsible for the protection of data from loss, misuse and unauthorised access. A data custodian will be appointed (the biostatistician investigator). JCU will comply with the Code for the Responsible Conduct of Research (JCU) [This Code has been adapted from the Australian Code for the Responsible Conduct of Research [“the National Code”], developed jointly by the National Health and Medical Research Council, Australian Research Council and Universities Australia, and published in 2007.]

What type of information will be collected by GRHANITE?

The information will be deidentified and only from consented patients (participants). The information will refer to periods 12 months before, and the periods after the pharmacist first provided support to the participants. This is summarised in Table 2.

Table 2. Deidentified patient information that will be extracted from clinical information systems (CIS) in the ACCHS

Measure	Detail
Patient characteristics	age, year of birth, sex, height and weight (for BMI), condition (diabetes, hypertension, dyslipidaemia, CHD, PAD, CVA, CKD, plus other disease (<i>in patients who fit the inclusion criteria with polypharmacy</i>), smoking status (history details: start/stop year), postcode, CTG status, ethnicity, Aboriginal and Torres Strait Islander status, DVA status, pension/concessional status, year of death.
Encounter/contact indices & other demographic measures	contacts with staff (different job roles), episodes of care (date of visit, reason for visit, duration, visit type), patient status/record status (active), created and updated dates and user who created and updated the record; consented patients; patients ID/MRN/UR number/chart No/record No

Biometric indices	Diastolic and systolic BP, HbA1c, lipids (HDL, LDL, TG's, and TC), CV absolute risk assessment (levels and risk), ACR, e-GFR,
Prescribing indices	All medications (including PBS drug code); all information contained within prescriptions (route, strength, formulation, quantity); date of the script being generated, including ceased/delete date; deleted flag (if any) and reason for delete or ceased; created and updated dates, and user (job role) who created and updated the record. This information is for both current medications and past medications.
Dispensing indices	All medications (including PBS drug code); all information contained within prescriptions (route, strength, formulation, quantity); date of the medicine being supplied and dispensed; user (job role) who created and updated the record. This information is for both current medications and past medications.
Measures of health service utilisation:	
Medicare Benefits Schedule indices	900 (DMMR or HMR), 903 (residential aged care DMMR or HMR), 721 (GPMP), 732 (GPMP review 3 months later), 715 (Health Check); record status, created and updated dates, and user (job role) who created and updated the record, item billing amount.
Non-HMR data (out-of home interviews)	non-HMR flagged in CIS will link this to the above variables <i>(to be recorded by the pharmacist)</i> .
Measures of medication adherence	<ul style="list-style-type: none"> • Electronic measures of medication adherence <i>(to be calculated by the evaluators)</i> • Medication Adherence <i>(to be recorded by the pharmacist)</i>

ACR= albumin-creatinine ratio; BP= blood pressure; CIS= clinical information systems; CKD= chronic kidney disease; CTG= Close The Gap; CV= cardiovascular; CVA= cerebrovascular disease; DET= data extraction tool (GRHANITE); DMMR= Domiciliary Medication Management Review; DVA: Dept of Veterans Affairs; e-GFR= electronic glomerular filtration rate; GPMP= General Practice Management Plan; HDL= high density lipoprotein; HMR= Home Medications Review; LDL= low density lipoprotein; MAI= Medication Appropriateness Index; PAD= peripheral artery disease; TC= total cholesterol; TG= triglyceride

What type of information will be collected by the pharmacist in the log-book?

The pharmacist will record their daily activity in the log-book. This will include information about education sessions they provided to staff, adhoc advice provided and any evidence this led to an outcome, the development of any resources for patients or the ACCHS, whether the pharmacist developed a plan to liaise with community pharmacy (and details of that plan), and the number of medicines reconciliations from stakeholders like hospitals.

In particular, the pharmacists log-book will enable practice pharmacists to record the results of medication assessments for each of 30 participants. Of the participants seen by a practice pharmacist, 30 participants per site will have their medications intensively appraised as part of the medication management review.

No personal information about participants is contained in the logbook. The participant does not need to be present for the medication assessment as it is an audit of the participants medications held in the CIS.

The pharmacist will only record the unique 'patient ID' to enable matching of the medication assessment audit of 30 participants to the participant data extracted through GRHANITE.

The practice pharmacist will communicate the findings of the medication assessment for the participant to the prescribing team within the ACCHS so that appropriate clinical action is taken. Practice pharmacists will ensure that the assessment takes account of additional clinical information such as an assessment of the participant's absolute cardiovascular risk when assessing their medications.

Practice Pharmacists will follow-up participants as per usual clinic processes. These follow-up mechanisms may vary from service to service (see above).

What type of information will be collected during the site visits?

Every participating ACCHS site will be visited at least twice during the project.

1. The 'needs assessment' visit (see '*what will happen during the first visit*').
2. To conduct a 'health systems assessment' (HSA):
 - at the time of, or just prior to the appointment of the pharmacist, and
 - repeated towards the end of the implementation phase (month 12-15).

The NACCHO Project Coordinator will conduct visits and assessment with assistance from Affiliate staff. The needs assessment and health systems assessment will be conducted at the first visit.

The '*needs assessment*' will collect information about what the ACCHS may need to support the practice pharmacist to work in that clinic. This will be used to help the pharmacist to get started.

The '*health systems assessment*' will source information about the ACCHS. Each ACCHS is different in many ways. The project needs to understand how many staff (and types) are employed within the ACCHS, the total service population, the total service budget, Aboriginal governance structures, health services on offer, quality improvement processes, models of care such as outreach, if home medicines reviews are conducted and how, type of CIS used, recall systems in place, the adequacy of existing communication with the hospital, and community pharmacy/ies, medicines access information, use of point of care testing, regional services available such as specialist and allied health visits, and how the ACCHS will implement and define the core roles of practice pharmacists.

A meeting with key informant staff in a focus group setting will be needed to undertake the health systems assessment. This information will be collated in a summary report for the ACCHS to use for any quality assurance activity.

What type of information will be collected for qualitative analysis?

Three ACCHSs will be invited to participate in a qualitative evaluation of the Project in mid-late 2019. ACCHSs will be asked if they will support focus group discussions with certain patients, Aboriginal health workers/practitioners, and with the pharmacist on site. These meetings will be fully catered and will be conducted in ways to minimize clinic disruption. ACCHSs will be contacted closer to that time to explain what that might involve.

What will happen during the first visit to the ACCHS?

The 'needs assessment' visit to the ACCHS will elicit the type of support needed by the ACCHS so that the practice pharmacist may best be integrated within the service. The visit will also assist the ACCHS to establish their preferred system to seek patient consent, and ensure the pharmacist can use the CIS, has a space to consult with patients, and the CIS is set to accept the 'job-role' for the pharmacist (this is necessary for the GRHANITE data extraction). A 'health systems assessment' may also be undertaken at this visit (see above).

The NACCHO Project Coordinator will make contact at this visit with the nominated ACCHS staff member who will act as a 'go to' person. Together with the nominated 'go to' person/s and relevant ACCHS staff, a project consent pathway and process that is responsive to the local ACCHS' model of care will be planned. A second 'go to' person may also need to be identified by the ACCHS and Coordinator as contingency for leave, resignation or movement between clinics or roles.

The NACCHO Project Coordinator will ensure that the service has adequate promotional material and strategies to engage both ACCHS staff and clients.

Who owns the GRHANITE information?

The raw (unanalysed) data collected from the GRHANITE data extraction is owned by the ACCHS even though it will be used, analysed and stored safely by JCU. Details regarding this is included in the service agreement with the ACCHS for this project.

Intellectual Property

Details regarding Intellectual Property of the Project will be included in the Service Agreement with the PSA.

Use of information collected by the Project

The information collected from this project will be used to prepare reports to the Australian Government on 'quality of care' outcomes (the project objective) that arise from integrating a practice pharmacist within ACCHSs. The reports will assess change in the:

- quality of prescribing,
- quality of medicines support through indicators of health service utilization,
- quality of the patient, service and stakeholder experience, and
- ultimately an effect of these improvements on biometric indices as a measure of health outcome.

The reports will also assess the cost-effectiveness of the practice pharmacist within ACCHSs.

The data analysis will also be able to provide ACCHSs and Affiliates with local level and aggregated data. Most analyses at this level would not be meaningful because the number of participants will be too small. However, the information will be aggregated at a national level for the NACCHO, Affiliates, ACCHSs, and the PSA, as well as the Australian Government. This will inform the development of health policy about practice pharmacists and the role they can play supporting Aboriginal and Torres Strait Islander peoples with chronic disease in Australian primary health care settings.

Health systems assessment summaries will also be able to be provided to ACCHSs for their use.

Security of information collected by the Project

As the leading research organisation, JCU (the repository body) will be responsible for the protection of data from loss, misuse and unauthorised access. The Data Custodian (Biostatistician: Erik Biros) will be responsible for this role.

Further, the Project Operational Team Committee, Chaired by the Deputy CEO of NACCHO, will be consulted in all matters brought to its attention with regard to concerns about data security.

How will the collected information be transported to JCU?

Completed Site Consent Forms will be collected by the NACCHO Project Coordinator, scanned and sent electronically to the data custodian. Participant consent forms will be scanned by the practice pharmacist and electronically transmitted to the data custodian. The forms will be stored electronically in a secure computer under the management of the data custodian on the property of College of Medicine and Dentistry, James Cook University. Information extracted using GRHANITE and from the Pharmacist log-book will be transmitted electronically and stored on password-protected internal server on JCU premises. Data accessed during the analysis phase will be stored in JCU-supported database applications only.

Health Systems Assessment (HSA) and Needs Assessment information collected from site visits, will be collected on paper-based forms, (or in electronic format) collected by the NACCHO Project Coordinator and will be transported in a locked briefcase, scanned and stored in electronic format in a secure computer under the management of the data custodian.

Where and for how long is the information going to be kept?

Data will be kept for a minimum period of 7 years from the end of the year of publication of the last refereed publication or other form of public release to an audience external to JCU.

Electronic data will be stored on password-secured databases only. Any paper-based documents will be scanned and stored electronically, and the paper documents stored in a locked cabinet in a secure room at JCU. The data custodian (Biostatistician- Erik Biros) will be responsible for data storage consistent with the JCU *Code for the Responsible Conduct of Research*.

After the minimum period of storage, the data may be considered for disposal if there is a written request to the Evaluation Lead, from both the NACCHO and the PSA for the disposal of the data. As the raw unanalyzed data extracted by GRHANITE is owned by the ACCHSs, JCU will seek instruction from NACCHO and each ACCHS as to the ongoing use or destruction of this data. The Evaluation Lead will authorize the data custodian to delete the data if this is instructed by NACCHO, in accordance with the JCU *Code*.

Who will be able to access this information?

Data will be accessible only to members of the Evaluation Team who will have a role in handling this information. From time to time, one member of the evaluation team (the University of Melbourne HaBIC Research Information Technology Unit) may need access to the data-landing server at JCU to provide technical support services.

ACCHSs may request access to de-identified information from their service. These requests can be made to the Project Operational Team Committee or its members, or directly through the NACCHO Affiliate or Project Officers involved in this project. The request must also include documentation of intended data use and must align with project objectives (the individual consent provided by each participant). Requests to access the data that *does not align* with the project objectives will need HREC approval. Similarly, Affiliates may request access to data at their jurisdictional level. This request must be in writing and align with the project objectives.

External requests from other organizations and research agencies not participating in this project to access data from this project will need to be submitted to the Project Operational Team Committee. NACCHO will recommend that external agencies seek approval from Affiliates and from participating ACCHSs relevant to the request. Approval will not be granted for the release of data if it is not approved by NACCHO. There may be a need to seek approval from the Department of Health if this is a condition in the Head Agreement for this project. All external requests will need to have HREC approval prior to the release of this data.

What can we do if we have concerns about data security, research misconduct or complaints?

ACCHSs can report any breaches in data security or research misconduct or complaints to:

- project partners/staff,
- Affiliates,
- NACCHO directly, and/or
- Designated HREC representative.

Reports received by project staff will be forwarded to the Operational Team Committee and the Deputy CEO of NACCHO.

What is the role of ACCHSs in this project?

The ACCHS will host the practice pharmacist who will be providing health services to the patients in the community. The pharmacist will effectively be an employee of the PSA, who will provide all employment support. This will minimise the administrative burden on the ACCHS so that the pharmacist and ACCHS can focus on effective service delivery from the start. NACCHO and respective Affiliates will have the capacity to liaise closely with PSA, ACCHS and the pharmacist to ensure that the pharmacist's roles are understood clearly by both parties.

The Head Agreement between the PSA and the Department of Health will influence the service agreement between the PSA and the ACCHS. The Service Agreement with the ACCHS will document the terms of participation including: Health Service Responsibilities and Financial Arrangements.

ACCHSs will be provided with a *Site Consent Form* that will need to be signed if the ACCHS agrees to be a participant in this project.

The NACCHO Project Coordinator will be available to ACCHSs to assist in understanding and delivering on their roles within the project. They may also work with their Affiliate representative to assist ACCHSs.

The following is a summary of the ACCHSs role as a participant in this project that will be negotiated with each ACCHS to be most appropriate for that service.

The role of the ACCHS is:

- To nominate a 'go to' person to be a point of contact for the project staff.
- To support the practice pharmacist to use the CIS within the practice, and access the patient's clinical records in order to support patient care and make medicines-related recommendations to other health staff.
- To enable the CIS to recognise the practice pharmacist in their 'job role'. (The ACCHS will be assisted with this. This is so that the information can be collected about the work the pharmacist has done).
- To support the pharmacist to access a private consulting room to meet with patients.
- To support the practice pharmacist to have time to record their work and findings in the pharmacist log-book.
- To assist the practice pharmacist to work with other members of the health care team by sharing information about the project with other members of the team.

- To assist the pharmacist to prepare a workplan that best suits the model of care of the ACCHS.
- To host information for patients attending the practice by using posters and other health promotion material to promote patients to be participants in this project.
- To develop a participant consent process that is approved by the ACCHS involving the practice pharmacist and/or other staff in the ACCHS.
- To support site visits and support a focus group with relevant staff for 'health systems assessment' and 'needs assessment'.
- To support site visits and support focus groups with relevant staff for the qualitative evaluation if the ACCHS wishes to volunteer as a case study site (further information about this will be provided to ACCHS to make a decision in 2019).
- Any other matters that are relevant to the work of the practice pharmacist that the ACCHS may wish to consider. (Examples include mechanisms for home medicines review, or use of point of care testing, etc).

What support will ACCHSs receive in this project?

Each ACCHS that participates in the project will receive:

- The services of an on-site registered practice pharmacist for a 15-month duration.
- Administration of pharmacist employment and contract to be provided by PSA.
- The opportunity to select their preferred practice pharmacist.
- A 'Needs Assessment' site visit to ascertain any specific needs of ACCHS.
- A facilitated 'training' on-site visit to support and prepare the practice pharmacist within the primary healthcare team.
- Resources to support the practice pharmacist, such as medication management guides.
- A supportive mentor for the practice pharmacist (that will be managed by NACCHO and the PSA).
- Installation of the GRHANITE data extraction tool in the CIS and licence for its use for 15 months.
- Two site visits to explore Health Systems Assessment (one of these will be at the same time as the needs assessment visit).
- A Health Systems Assessment Report for ACCHS use for CQI.
- Involvement of a nominated staff member to be a member of the Project Reference Group in the project.
- Support from a nominated Affiliate officer involved in this project.
- Support from the NACCHO Project Coordinator during site visits and contact by email and phone.
- An opportunity to review project findings and provide feedback through ACCHS membership of the Project Reference Group.
- Customised reports specific to the participating ACCHS (if requested and if the data analysis is meaningful due to limitations with small participant numbers).

Each Affiliate that participates in the project will receive:

- Remuneration to participate in the project. This can be used to employ a part-time project officer (or to back-fill existing staff).
- Involvement of nominated staff as members of the Evaluation Team in the project.
- An opportunity to review project findings and provide feedback (through membership of the evaluation team and Project reference group).
- Customised reports specific to the jurisdiction (if requested).

How will ACCHSs find out the results of the Project?

ACCHSs will receive information about the Project through NACCHO communication mechanisms. The Project will finish at ACCHSs in late 2019. The ACCHSs will know the results in 2020. Other ways in which ACCHSs will be informed include:

- Through the Project Reference Group which will be provided with updates on progress with the project and extracts of reports arising from the project.
- Summary results to individual ACCHSs (pertaining to their own data) may be provided upon request to the Operational Team Committee, although these may not be meaningful due to small participant numbers and the inability to undertake data analysis.
- Extracts of reports arising from this project will be summarized in plain language and disseminated according to usual NACCHO communication mechanisms, such as email, the NACCHO News, and NACCHO website, including communication with any relevant special interest groups supported by NACCHO.
- Presentations detailing progress and results will be communicated at NACCHO and/or Affiliate Conferences and Annual Meetings.

The findings of the project will also be reported for publication in articles and journals relevant to this project. There may also be presentations at conferences.

Reports will also be provided to the Australian Government, Department of Health, and through communication mechanisms used by the Pharmaceutical Society of Australia. NACCHO (as a project partner) will check this information before it is released.

Can ACCHSs decide to withdraw from this project?

ACCHSs and Affiliates that are participants reserve the right to withdraw their participation in the project in accordance with their service agreements. If an ACCHS site withdraws, the ACCHS will be asked to provide a written reason for the withdrawal to the PSA (for the contract) and the Project Operational Team Committee. The ACCHS will be asked whether they agree to the continued use of the data collected in this Project prior to their withdrawal of Site Consent. The withdrawal of the Site from the project will mean the withdrawal of the site support specified in the service agreement (and explained above). The withdrawal of the Site will be reported to all relevant HRECs when the Project's annual report is due.

Who can the ACCHS contact for more information or to make a complaint?

The ACCHS can contact the NACCHO Project Lead: Mike Stephens, Tel: 02 6246 9300; Email: mike.stephens@naccho.org.au. Other Project staff to contact include: Shelley Crowther from the Pharmaceutical Society of Australia: Tel: 03 9389 4004; Email: Shelley.Crowther@psa.org.au. You can also contact the NACCHO Deputy Chief Executive Officer: Ms Dawn Casey at dawn.casey@naccho.org.au.

The Human Research Ethics Committees will continue to provide oversight as the project progresses. You can contact the Ethics Committee with any concerns about the safety and fairness of the Project at: Executive Office of Research, St Vincent's Hospital Melbourne, Tel: 03 9231 2394, or email: research.ethics@svhm.org.au

Thank you on behalf of the IPAC Project Team.

The *IPAC Project* is the *Integrating Pharmacists within ACCHSs to improve Chronic Disease Management Project (IPAC)*. The Project Partners and Project Operational Team Committee for the *IPAC Project* include: The National Aboriginal Community Controlled Health Organisation (NACCHO); Pharmaceutical Society of Australia, and the College of Medicine and Dentistry, James Cook University. *Evaluation Team* members include the Project Partners, and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO); Queensland Aboriginal and Islander Health Council (QAIHC); and the Aboriginal Medical Services Alliance in the NT (AMSANT). The Project Reference Group includes representatives of NACCHO, Affiliates and ACCHSs.