QAIHC
Queensland Aboriginal and Islander Health Council

QAIHC SUBMISSION TO THE

Australian Government Department of Health

SUBMISSION

Aboriginal Health Services Quality Use of Medicines and Pharmacy Support – Discussion Paper

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About Queensland Aboriginal and Islander Health Council (QAIHC):

The Queensland Aboriginal and Islander Health Council (QAIHC) was established in 1990 by dedicated and committed Aboriginal and Torres Strait Islander leaders within the community-controlled health Sector (the Sector). From our first meeting 30 years ago, we have grown to become a national leader in Aboriginal and Torres Strait Islander health, and as a voice for our 26 members, the Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHOs) in Queensland, two regional bodies, 14 Associate Members and one Affiliate Member.

Like our ATSICCHOs, we embody self-determination; we are governed by an Aboriginal and Torres Strait Islander board that is elected by our Members.

QAIHC Members work tirelessly to provide culturally appropriate, comprehensive, primary health care services to local Aboriginal and Torres Strait Islander communities in Queensland. Collectively they have established more than 60 clinics across the state to service the population. Our two regional bodies – the Institute for Urban Indigenous Health (IUIH) and Northern Aboriginal and Torres Strait Islander Health Alliance (NATSIHA) also provide support to our Members.

Our Members provide more than just holistic Primary Health Care models, they help the whole community and regional economies by encouraging whole of community wellbeing, thus creating local jobs and ensuring local design of services.

Nationally, we represent ATSICCHOs through our affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO) and are regarded as an expert in our field.

QAIHC, as the peak of ATSICCHOs in Queensland, wishes to express the collective views on behalf of our Members into the discussion paper on the Aboriginal Health Services Quality Use of Medicines (QUM) Program.

QAIHC would like to acknowledge the Australian Government for seeking feedback from the wider stakeholders and the community. QAIHC welcomes the opportunity to provide collective views into the discussion paper.

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Opening Statement

QAIHC believes that all Aboriginal and Torres Strait Islander peoples in Queensland should have timely and affordable access to essential medicines no matter their geographic location or socio-economic status, in line with the Australia's National Medicines Policy.[1] Yet, Aboriginal and Torres Strait Islander peoples do not presently have the same level of access to quality medicines as other Australians.[2]

It is evident that the age-adjusted rate of potentially preventable hospitalisations (PPH) for Aboriginal and Torres Strait Islander peoples is almost three times the rate of other Australians.[3] Quality use of medicines has an important role in alleviating these differences.[4] Evidence also indicates the need to strengthen current collaboration between community Pharmacists and health service providers, particularly with the ATSICCHO Sector, and to ensure services are culturally appropriate to meet community needs.

There is no doubt that the ATSICCHO Sector plays a substantial role in improving access to medicines for Aboriginal and Torres Strait Islander patients, and are continually working to eliminate disparity through addressing systemic barriers. The ATSICCHOs' evidence-based integrated Model of Care[5] is the true reflection of Aboriginal and Torres Strait Islander people's self-determination and the Sector's collective goal of delivering high quality comprehensive primary health care for our people, by our people. The Model of Care further incorporates the holistic concept of Aboriginal and Torres Strait Islander peoples' health and wellbeing. ATSICCHOs' are often the first point of contact for Aboriginal and Torres Strait Islander peoples and it is for this reason that ATSICCHOs' must be engaged in the co-design, co-development, co-implementation and co-evaluation of health promotion initiatives.

Participating in QUMAX program, ATSICCHOs' have successfully trialled a number of mechanisms to address the barriers to accessing Pharmaceutical Benefits Scheme (PBS) medications in remote, rural and urban Aboriginal and Torres Strait Islander communities.[6]

QAIHC and its Members acknowledge the Department of Health's intention of improving the effectiveness of the QUMAX and s100 Pharmacy Support Allowance Program through their amalgamation and redesign into a single Quality Use of Medicines (QUM) program. However, we recommend that the redesign process should consider retaining and refining the majority of the programs' components that have been proven to successfully meet the needs of Aboriginal and Torres Strait Islander communities and the health organisations that represent them, in consultation with the ATSICCHO Sector, rather than trialling new components. The redesign should adhere to the principles of the National Agreement on Closing the Gap; and actively involve Aboriginal and Torres Strait Islander peoples, and their representatives, at each level of the decision-making process.

This brief submission addresses the key consultation questions that were put forward by the Department of Health in the discussion paper. QAIHC is strongly committed to, and interested in, being part of the solution to ensure Aboriginal and Torres Strait Islander peoples are able to access and use the QUM program and would welcome opportunity to provide further input.

Please note that QAIHC have also contributed to and support the National Aboriginal and Community Controlled Health Organisation's (NACCHO's) submission.

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[1] Australian Department of Health. National Medicines Policy. Updated 29 Apr 2019. (Viewed 22/12/2020)

[2] Sophie Couzos, Vicki Sheedy and Dea Delaney Thiele. Improving Aboriginal and Torres Strait Islander people's access to medicines — the QUMAX program. eMJA Rapid Online Publication 21June 2011

[3] Australian Institute of Health and Welfare 2020. Disparities in potentially preventable hospitalisations across Australia, 2012–13 to 2017–18. Canberra: AIHW.

[4] Johnston J, Longman J, Ewald D, et al. Study of potentially preventable hospitalisations (PPH) for chronic conditions: what proportion are preventable and what factors are associated with preventable PPH? BMJ Open 2020;10:e038415. doi:10.1136/ bmjopen-2020-038415

[5] Queensland Aboriginal and Torres Strait Islander Community Controlled Health Organisations' Model of Care (QAIHC), November 2019. https://www.qaihc.com.au/media/37570/modelofcare_19082019_hr.pdf

[6] Evaluation of the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) Program

QAIHC and its Members response

Based on the consultation questions, QAIHC provides the following recommendations for consideration.

1. Are the current QUM support categories appropriate?

Should additional support categories be included or any current categories be amended or removed?

QAIHC notes that the QUM support categories are broad and cover the majority of the issues that Queensland ATSICCHOs are currently dealing with in relation to the pharmacy support program. However, to ensure the program meets the needs of Aboriginal and Torres Strait Islander peoples effectively and efficiently, QAIHC and its Members recommend that the categories should *only serve as a guide* and provide local ATSICCHOs the flexibility to define different categories that align with the QUM principles to meet the needs of the local community. The categories should incorporate, but not be limited to, the following additional points:

1. **Pharmacist Support:** This definition could be expanded as it does not fully cover the range of services that non-dispensing pharmacists can provide to Aboriginal and Torres Strait Islander clients accessing services through the ATSICCHOs. As stated in the discussion paper, QAIHC notes that the Pharmacist Support aims to facilitate pharmacist involvement and support in activities that promote the QUM, such as education, medication advice, and continuous improvement activities.

   QAIHC recommend the following additional activities be incorporated as part of the Pharmacist Support category:

   - utilising the medical records of the ATSICCHOs to optimise patient care;
   - identifying barriers and implementing strategies to support the medication adherence of patients;
   - providing medicines information to patients;
   - supporting the use of dose administration aids;
   - undertaking activity to support the transfer of care of patients including hospital discharges and medicines reconciliation after hospital discharge;
   - undertaking medication reviews outside the patient's home to meet the needs of the patient;
   - supporting medication access and supply;
   - maintaining the medical records systems so that medication lists are current and accurate; and
   - including a range of other clinical services deemed necessary by the ATSICCHOs, which may include the administration of vaccinations.

2. **QUM Devices:** This aims to reduce financial barriers for Aboriginal and Torres Strait Islander patients to access QUM Devices, which should improve the overall delivery of medicines and the management of chronic disease. Under the currently available National Diabetes Services Scheme (NDSS), lancets and glucometers continue to incur gaps; the cost of staff time to order and dispense these items and then report expenditure is not compensated which limits the usefulness of this category. This issue should be addressed under the proposed QUM.

3. **Home Medicine Reviews**: In our experience this remains an essential component, however the overall budget had little impact.

4. **QUM Education:** We support this as an essential component of the program. However, Aboriginal and Torres Strait Islander communities, and their needs, are diverse across Australia. As such, we recommend the QUM should acknowledge the diverse perspectives and needs of Aboriginal and Torres Strait Islander peoples and promote location-specific educational activities that meet local community needs.
5. **Cultural Awareness:** QAIHC and its Members recognise cultural competency as vital for practicing community pharmacists to establish trust and open communication with patients. We recommend cultural awareness should not be limited to pharmacist only; it should be extended to pharmacy assistants as well. Also, ensuring the cultural competency of the practicing community pharmacists should be the responsibility of Pharmaceutical Society of Australia (PSA), the Pharmacy Guild of Australia and the Society of Hospital Pharmacists of Australia (SHPA).

The Dose Administration Aids (DAAs) support under current QUMAX program has been identified as a critical component of the program and dominates QUMAX expenditure. We support the Australian Government's initiation of developing and implementing a specific DAA program for Aboriginal and Torres Strait Islander people. However, our recommendation is that the program should ensure there is no gap payment for patients to access DAAs. This will address financial barriers that may potentially lead to patients not accessing their required medications.

2. What models of Pharmacy Support would be appropriate:

a) Registered Pharmacist working in AHS
b) Aboriginal Health Worker engaged by AHS to work in a community pharmacy
c) Telepharmacy
d) Other models?

In QAIHC's view, all the proposed models of Pharmacy Support would support Aboriginal and Torres Strait Islander peoples to improve access to the QUM program. Specific feedback received from our Members on the different models includes:

1. **Registered Pharmacist working in AHS:** We recommend that every ATSICCHOs should have at least one fulltime registered non-dispensing Pharmacist attached to the practice. This Pharmacist should be allowed to manage the QUM program and perform an unlimited number of Seventh Community Pharmacy Agreement (7CPA) subsidised medication reviews. Pharmacists are essential at every stage where medicines are managed, including primary care.
2. **Aboriginal Health Worker engaged by AHS to work in a community pharmacy:** All trained Aboriginal and Torres Strait Islander Health Workers/Practitioners (ATSIHW/Ps) should rotate through community pharmacies for at least one module throughout their training. This would improve the cultural competence of the pharmacy.
3. For long term benefit, the program should aim to support and train Aboriginal and Torres Strait Islander people to be Pharmacists and Pharmacy Assistants.
4. **Tele-pharmacy**: This module is difficult to make effective as the most disadvantaged patients (particularly those in rural and remote locations) are less likely to have access to the internet and suitable telecommunications equipment. A risk associated with tele-pharmacy is that it becomes corporatised and the Pharmacist delivering the service does not understand local

client needs and conditions. This could potentially limit the impact/effectiveness of the service the patient receives. The solution to this could be a requirement for the Pharmacist delivering tele-pharmacy to have local knowledge and culturally competency; and/or an existing relationship with the client.

Despite benefits that can be seen from all four models, **the most appropriate and best suited model of Pharmacy Support for ATSICCHOs is the provision of a registered non-dispensing Pharmacist working within the ATSICCHO.** QAIHC's recommendation is based on the findings of the large study 'Integrating Pharmacists into Aboriginal Community Controlled Health Services (IPAC)' that investigated the integration of registered Pharmacists within 18 Aboriginal Community Controlled Health Services in Queensland, Victoria, and the Northern Territory and explored clinical and service outcomes for Aboriginal and Torres Strait Islander adults with chronic disease (n= 1,456).[7] Moreover, global systematic reviews have also supported the positive role of non-dispensing Pharmacists within primary health care settings.[8, 9]

3. Should all Pharmacists providing Pharmacy Support to AHSs be required to undertake cultural awareness training?

a) Is there any Cultural awareness training available that would be appropriate?

b) If not, is there an organisation / organisation which would be most appropriate to develop it?

QAIHC's position is that cultural safety must be embraced at all levels of health care planning and delivery (programs, services, policies and strategies) in order to provide the best possible health care for Aboriginal and Torres Strait Islander peoples. Cultural safety is about respecting the cultural rights, values, beliefs and expectations of Aboriginal and Torres Strait Islander peoples while providing services that meet their need.[10] Cultural safety is distinguished from cultural 'awareness' as it relates to embedding culturally sound practices into all elements of delivery, rather than merely recognising that cultural differences exist.

All Pharmacists and pharmacy assistants providing pharmacy support should undertake cultural safety training, and this should be provided by the local community where possible. In addition, Pharmacists and Pharmacy Assistants should also undertake additional training in the delivery of core roles as outlined for pharmacy support which has been developed and delivered by the PSA as part of the IPAC project. This aligns with priority reform three of the National Agreement on Closing the Gap whereby governments will "support mainstream agencies and institutions to embed transformation elements, and monitoring their progress". Transformation elements include "embedding and practicing meaningful cultural safety".[11]

[7] Integrating pharmacists into Aboriginal Community Controlled Health Services (IPAC). Full report Submission to the Australian Government, Medical Services Advisory Committee, June 2020

[8] Newman TV, San-Juan-Rodriguez A, Parekh N, Swart ECS, Klein-Fedyshin M, Shrank WH, Hernandez I. Impact of community pharmacist-led interventions in chronic disease management on clinical, utilization, and economic outcomes: An umbrella review. Res Social Admin Pharm. 2020. [In Press] https://doi.org/10.1016/j.sapharm.2019.12.016

[9] Shaw C, Couzos S, Integration of non-dispensing pharmacists into primary healthcare services: an umbrella review and narrative synthesis of the effect on patient outcomes. Australian Journal of General Practice- In Press

[10] Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice

[11] National Agreement on Closing the Gap

We recommend this training model be integrated into the QUM program. ATSICCHOs should play an important role in making this training module adaptable to the local community needs.

4. What sort of additional support would be required for approved RAAHS that are required to stock and supply PBS medicines directly to clients?

In QAIHC's view, additional support should be provided to all ATSICCHOs regardless of their location as outlined above with regard to the program categories and support (please refer to QAIHC's response to question 1).

Under the current RAAHS Pharmacist support system, Pharmacists can vary the degree of integration and support activities provided. The IPAC trial involved ATSICCHOs across all regions: rural, remote (and very remote) and urban settings. The IPAC trial learnings are applicable to the setting of RAAHS with regard to the activities that non-dispensing Pharmacists could undertake as part of the proposed new QUM program.

Also, there is a need for specific training for ATSIHW/Ps to enable them to administer or supply medications and provide education to patients in line with the *Health (Drugs and Poisons) Regulation 1996* which provides the authorities for Aboriginal and Torres Strait Islander Health Practitioners o use scheduled medicines, and specifies the circumstances and conditions for use.[12]

5. Are Pharmacy Support Services provided by non-dispensing Pharmacists supported, or do you believe service provision should be restricted to community pharmacies? Please provide insights into your views in this respect.

As outlined above, the best and most effective model of Pharmacist support as proven by research is the integration of a Pharmacist within the ATSICCHO. This model is supported by QAIHC, NACCHO, and other Affiliates across Australia and is the preferred model of Pharmacist support for Aboriginal and Torres Strait Islander peoples.

Community pharmacies play an important role in continuing a dispensing relationship with the ATSICCHOs, whereupon the integrated Pharmacist can facilitate a stronger partnership between community pharmacy and the ATSICCHO for supply of medicines and of dose-administration aids as well as other supports. In fact, the current model of embedding non-dispensing Pharmacist in our ATSICCHOs has demonstrated improved collaboration with community pharmacies. Evidence also shows that there can be opportunities for community pharmacies to engage in models of care with the ATSICCHO to provide integrated Pharmacists, who can then work for the ATSICCHOs on a pro-rata basis.

[12] Queensland Government. Using medicines as an Aboriginal and Torres Strait Islander Health Practitioner

6. Is there any reason why Pharmacy Support to RAAHS could not be provided by the nearest pharmacy or non-dispensing Pharmacist instead of the supplying pharmacy??

QAIHC and its Members' experience is that the RAAHS is best placed to make decisions about where their preferred QUM Pharmacist support service should be sourced from. This means that a non-dispensing Pharmacist may be the preferred pharmacy support provider for that service, or this may be the supplying pharmacy. Either model is conducive to supporting and fostering better relationships and collaboration between ATSICCHOs and a community pharmacy.

7. Should Pharmacists providing Pharmacy Support to RAAHS be required to liaise with a RAAHS a minimum number of times a year? This could be done be teleconference or site visits?

There should be a regularity to the provision of pharmacy support. This is particularly important in the delivery of QUM to patients. Options for locally-designed methods of support are required, with options for mixed methods of support to be incorporated based on local need. QAIHC strongly suggest the first visit should be planned through consultation with the respective ATSICCHO and ideally include a physical visit, with future teleconference options available for trialling. If this doesn't prove suitable, ATSICCHO visits need to occur. Regarding the extent of regulation and frequency for this, QAIHC recommend further consultation is undertaken with the ATSICCHO Sector.

The enhanced model of Pharmacist support means that integration is the preferred approach and this can mean integration as part of the healthcare team (and this may not require visits as the Pharmacist is on-site), or an enhanced frequency of service provision so that the Pharmacist is integrated within the ATSICCHO at known intervals, or is able to provide services from a distance where appropriate.

8. Are there any other QUM devices that should be included in the standard list (excluding devices that are subsidised through other Government programs, e.g. National Diabetes Services Scheme)?

QAIHC's recommendation is that QUM devices should not be limited to a pre-defined list as suggested in the discussion paper. We support NACCHO position with this regard and suggest expanding NDSS device lists to meet patient needs.

9. Are there any other QUM education resources that should be included in the standard list (excluding resources that can be downloaded for free)?

QAIHC support NACCHO's response for this question. In addition, we recommend to:

1. Consult PSA to acquire expert advice on the IPAC trail training resources that has been developed and delivered by them;
2. Include Queensland Health's Choice and Medication© Printable Leaflets for the Consumer
3. Include information for mental health medicines; and
4. Include patient flow charts and an explanation of the process when taking the medication, when the patient misses a dose, and the outcome if the patient doesn't take the medication correctly etc.

10. Is there anything else that should be considered when implementing the program changes?

QAIHC recommend that the Department:

1. Contact NACCHO for more information on the outcomes of IPAC trial model of care; and
2. Review: *Couzos S, Smith D, Stephens M, et al. Integrating Pharmacists into Aboriginal Community Controlled Health Services (IPAC project): Protocol for an interventional, non-randomised study to improve chronic disease outcomes. Res Social Adm Pharm. 2020;16(10):1431-1441. doi:10.1016/j.sapharm.2019.12.022*

Furthermore, our experience is that:

3. The overall budget allocations are too small to achieve significant and sustainable impacts; and
4. Reporting obligations are too onerous and are disproportionate to the overall funding pool.

11. Any comments, other key issues or concerns regarding the program categories or associated issues that you would like to raise that aren't addressed in the questions above?

QAIHC has nothing to add.

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