Part C of the circulated discussion paper summarises findings from examination of the literature associated with the supply arrangements of Pharmaceutical Benefits Scheme (PBS) medicines in Residential Aged Care Facilities (RACFs), and the outcomes of consultations with the key stakeholders. The stakeholders have identified issues which, in their opinion, impact on their sectors of practice. They have also presented a number of potential options which they consider may address these issues.

C.1 Factors and Issues Related to the Supply Arrangements of PBS Medicines in RACFs

On reviewing the presented literature on current practice and requirements for prescribing and supply to Residential Aged Care Facility (RACF) residents APHS notes a number of disparities in comparison to actual practice and expectations/guidelines.

‘Resident is not required to pay for medication every time a medicine is provided’

An agreement is usually established between the RACF, on behalf of its residents, and the pharmacy for monthly billing in arrears. Factors such as dose changes, time delays in receiving prescriptions, and the disconnect between quantities supplied per month and PBS quantities, often results in inconsistent and highly confusing accounts. This can be a cause of great anxiety and financial burden for elderly residents, and a further compelling reason for a prescription-less system.

‘RACF assumes responsibility for providing pharmacy with a valid PBS prescription’

This is not the usual scenario. The majority of service agreements between RACFs and pharmacies specifically state that all PBS and script matters are the responsibility of the pharmacy. With the recruitment challenges faced by all RACFs and a move to non-qualified/professional care staff, this aspect of pharmacy service is not within the scope of practice and professional knowledge of facility staff.

‘The basic steps in the supply of PBS medicines to a resident in a RACF’

The outlined process of GP charting, supplying PBS script, gaining authority approval in a timely manner at the time of prescribing, supply after receipt of Rx and packing into DAA does not accurately reflect current practice. The current supply requirements fall far from the reality of the necessary procedures and agreements required to ensure the timely administration of medications. In most pharmacies, it is standard practice to dispense medications from the residents medication chart, and to then request PBS prescriptions from medical practitioners within the 7 day timeframe allowed under emergency supply regulations. Obtaining prescriptions within a 7 day window is extremely difficult, and this not only exposes the pharmacy to PBS non compliance, but severely affects pharmacy cashflow.

The effectiveness of the working relationship between GP and pharmacist is often compromised as a direct result of this administrative burden. Safety/quality concerns often arise when there are disparities between the PBS script and the medication chart, an inevitable consequence of the current requirement for document duplication.
1. Prescription Timing

The primary concerns / causative factors experienced by APHS as a barrier to feasible turnaround and timely supply of prescriptions include:

- No prescription pads (standard and authority) or prescribing software available to GPs at RACFs
- Lack of IT access at facilities for the Pharmacies and GPs – ‘facility owned and facility operated’
- Lack of secure links between prescribing software, RACF management systems, and dispensing software
- Focus on Aged Care Funding Instrument (ACFI) recording and reporting, rather than medication management records in any available facility programs
- Inability to access detailed patient records and prescribing history for authority approval etc
- Reliance by GPs on current prescribing software to determine PBS quantities and repeats
- Reliance on prescribing software for authority indications and recording impacting on the timeframe for receipt of PBS prescriptions at the supplying pharmacy, leading to increased risk of non-administration of essential treatment. Streamlining authority arrangements of certain prescription medication has certainly assisted with the continued supply of these items in the aged care environment, without increased prescribing (or government spend) of these medications. In the review of the streamlining process some consideration should be given to additional, geriatric-specific streamlining codes to facilitate ease of supply.
- Unreliable postal service – increasing fear of ‘losing’ prescriptions
- Once weekly provision of PBS prescriptions from GPs – allocated timeframe for Rx writing - highlighting the unfeasible expectations of a 7 days prescription turnaround, and an overlay of 48 hour state legislative requirement for the Schedule 8 medications.
- Time, money and resource invested into increasingly complicated prescription reporting request for GPs
- Lack of consistency in PBS quantities leading to multiple monthly dispensing and subsequent patient account queries and dissatisfaction
- Current barriers to e-prescribing and electronic transfer of confidential information
- The residential aged care population are becoming increasingly older, frailer and having the need for higher levels of both physical and medical intervention. This can lead to multiple issues including unavoidable polypharmacy and increasing difficulty in managing the medication supply and administration requirements.
- Monthly invoicing of residents requires numerous resources (technology and personnel) and can lead to delay in payment as well as confusion to our clients. Account confusion results from disparity between monthly supply quantities and PBS quantities, and if an item is supplied prior to receipt of a prescription where the charge to the resident will not/cannot be entered until receipt and processing of the actual prescription. This can also result in RACF staff time being taken to explain processes (that they do not always find easy to understand), leading to compounding frustration.
- Complexity arising from the all too common situation of the deceased resident with outstanding prescriptions. Many patients require increased quantities of medications (particularly schedule 8) at end of life, and the window between dispensing and prescription receipt of any deceased patients often results in either the revenue loss being absorbed by the pharmacy, or the recently bereaved relatives being asked to pay private prices for the final medications supplied.
The potential for error through medication misadventure has increased significantly since the emergence of non-professional RACF care staff coinciding with more complex medication regimens, new drugs and wide-ranging availability of trade and generic brands. Further professional responsibility is placed on the pharmacy to achieve safe, quality use of medicines.

Significant resources and costs are associated with complying with PBS requirements for supply and receipt of prescriptions from GP, which can have a significant impact on the financial performance/viability of the aged care pharmacy provider.

2. Resident Transition between RACF and Hospital

The aging Australian population combined with capacity constraints in both public and private hospitals, has resulted in residential aged care clients being ‘frequent-flyers’ between multiple healthcare facilities. The transfer process between RACFs and hospitals has always proven to be an area of significant risk and a logistical nightmare for the patient, the care staff, the GP and the pharmacy.

Causative factors to increased risk – hospital to RACF:

- Poor or inappropriate discharge planning by the hospital
- Lack of communication between hospital and the facility (and resident) regarding the time and date of discharge
- Discharge prior to the preparation of an approved discharge medication summary
- Timing of GP visits to facility in relation to patient return resulting in lack of medication administration documentation to enable legal administration of medication by facility staff
- Lack of supply of newly prescribed medications, or supply in a format not complying with facility policy, leading to increased wastage and increased patient cost
- Hospital prescribed medications may not be PBS listed requiring changing by patients GP
- Hospital alters medications to comply with their standard drug list, creating major difficulties on discharge
- GP not in agreement with medical officer (MO) decisions – multiple supply and charging for resident which can lead to multiple medications being held at facility in turn increasing the risk of duplication or misadministration
- Timing of new regimen being supplied to pharmacy to allow DAAs to be prepared and delivered for administration, potentially leading to treatment delay

Causative factors to increased risk – RACF to hospital:

- Reliance on RACF staff to supply hospital with appropriate medical records
- Variation in quality and safety of medication charts and administration records
- Non-recognition or transferability of DAA by the hospital to ensure continuity of medication administration

Various trials have been conducted in an attempt to circumvent these issues and ensure the highest standard of medication information sharing without compromising confidentiality, as well as focussing on maintaining the most appropriate level of patient care possible.
The Qld Health Safe Medication Practice Unit conducted one such trial at the Royal Brisbane and Women’s Hospital. It involved the provision of a pharmacy prepared medication discharge summary in the form of an interim medication chart, with regimen alterations noted and explained. This was faxed to the GP for approval and sign-off, forwarded to the supply pharmacy and RACF, and could be used by nursing and care staff at the aged care facility as a record of administration, prior to a GP visit. The pharmacy could then prepare the patients medications ideally in time for the patients arrival back at the RACF. This trial has proven to be extremely popular with all concerned, reducing the pressures for the GP, the pharmacy and ultimately providing a continuum of care. Outcomes would be expected to improve further with the introduction of electronic communication initiatives.

Obviously both of these projects rely very heavily on excellent communication and a dedicated hospital team with an efficient discharge planning program, and the timely provision of prescription or medication charts by the hospital MOs. This may be facilitated through use of a pharmacist ‘certified’ copy of the current patient medication profile (PMP - government funded instrument) if considered as a valid authorisation of the GPs and/or MOs orders. This would mirror the pharmacist collaborative prescribing experience in the UK and other countries utilising the clinical skills and expert drug knowledge of the pharmacy profession, which has reduced costs to government, increased patient consultation time and reduced the stress on GP clinics. The recognition of the necessary changes and the progress that can be made through adopting well-proven practices, should only be the first step towards a more effective and multi-disciplinary, interactive professional healthcare service.

3. Use of Dose Administration Aids

The value of DAAs has been extolled by GPs and care staff alike, general comments including:

- Ideal compliance aid for regular medications
- Agency/transient/casual staff are able to administer the medications safely and efficiently, with minimal amount of training/orientation
- Administration errors and risk to patient minimised
- Patient personal and care time maximised
- Additional packing can be added to the standard weekly packs (in some cases) minimising waste
- Ability to inform GPs of the weekly packing schedule to minimise confusion (and hence patient risk) through supply of multiple weekly DAAs for individual patients to the facility
- Ability of the GP to recognise the need to consider the costs and wastage associated with multiple changes – no similar provision is available in the community setting.
- Maintenance of an electronic patient medication regimen has led to innovative software development, for example the ‘virtual pill box’, reporting functionality etc

The weaknesses of DAAs have been highlighted by pharmacies, care staff and GPs, for example:

- Time and resource required for preparation with limited to no remuneration available
- Unsuitable for all medications to be supplied in aids (i.e. topical, inhalers, eye drops etc) – leads to multiple training and certification of competencies for non-nursing staff
• Stability issues prevent certain medications from being packaged – as above with increased training and knowledge requirements for unskilled staff.

• Medication change process can result in a delay in the patient receiving their new medications due to repackaging of the DAA (only in some of the older systems)

• Changes can increase wastage and incur additional costs to the resident if managed as above.

• Increased expectations from clients regarding personally supplied medications (e.g. complimentary products)

• Increased numbers of prescriptions required when repackaging of DAAs is required – not well received by GPs

• Repackaged medications remain a major issue and frustration to both GPs and residents in relation to the use of DAAs. To minimise this many supply pharmacies have incorporated new functionality into their medication charts which contain valuable information on the packing schedule which is readily available to the GP at every patient consultation. The next available packing date can alert the GP to the start day of the new medication if they consider the patients medication change as non-urgent – the majority of the cases in the residential care setting. This process has received positive feedback from the GP, reducing the stress of supply on the pharmacy and decreasing the potential confusion amongst the care staff. The residents also benefit by a reduction in prescription costs associated with the increased dispensing associated with repackaging.

• Consideration needs to be given to the type and process of packaging DAAs. Roberts et al 19 (The Effectiveness and Cost Effectiveness of DAAs – Final Report Nov 2004) concluded the quality of DAA services currently provided by pharmacies is inconsistent and does not conform to all Pharmaceutical Society of Australia (PSA) Guidelines and PSA/Quality Care Pharmacy Program (QCPP) standards. It suggested that the majority of pharmacies were inconsistent in performing many of the functions related to DAA provision. A study by Carruthers et al 20, published in 2007 in the MJA, conducted in the Hunter Valley region of NSW looked at DAAs and error rates. Using the older technology of manually packed aids 297 incidents were detected from 6972 packs for 2480 residents, equating to an incident rate of 4.3% of packs and 12% of residents from 42 participating RACFs.

The reasons for these recorded incidents included:

• Medications missing from a pack (99 occasions),
• Wrong medication dispensed (12),
• Supply of the wrong strength (32),
• Incorrect labelling (7),
• Pharmacies supplying medication that had been ceased by the GP (37),
• Incorrect dosage instructions (32).

Many leading aged care supply pharmacies now employ GMP standard production policies and procedures, in full compliance with the Code of Good Manufacturing Practice and the PSA Guidelines, utilising state of the art, automated compliance packaging technology. Fully labelled, tamper evident compliance packets are produced at up to 52 packets a minute, each packet displaying vital patient and drug information together with dosage strength and administration times. New advances in packaging format now allow for Barcodes, batch numbers, bed and ward numbers to be printed.

The design and layout of DAAs achieved through sachet packaging technology meets every requirement detailed in the PSA Guidelines for DAAs, some having advanced as far as to comply with the specific APAC recommendation regarding dose administration aids, “The labelling should enable identification of individual medications”, providing a clear description of the dosage form on the sachet itself. Automation comes at a significant financial burden to the pharmacy. Training of staff, compliance with manufacturing guidelines, ensuring stability and
compatibility of the packaged products, validating and maintaining adequate IT platforms to allow secure transfer of information between dispensing systems and packaging systems all have a significant impact on the operating costs of a pharmacy.

The HMA Discussion Paper raised the issue that “the use of automated packaging of DAAs also creates concerns over the residents’ right to choose generic or non generic medicines”. APHS was surprised by this statement. All packaging technology that APHS is familiar with has the capability to supply any brand of a medication.

The choice by the pharmacy operator of the technology to calibrate machine canisters to provide their preferred generic brand in the fastest and most accurate manner possible is no different to every other community pharmacy choosing to stock a preferred generic range or brand of a particular molecule. If a patient or prescriber wishes to have a particular brand specified and supplied as per existing PBS legislation then APHS would have no trouble meeting this need through their current automated technology and could not see how doing so would be any more difficult for any other provider, whether they were using automated or manual processes for packing their DAAs.

While the many benefits of DAAs are not in dispute and allow for the multiple medications required for administration to be incorporated into one system (PBS subsidised can be packed with non-PBS medications, complimentary medications and authority items, all having different dosage requirement, packs sizes or durations of treatment) there remain many hurdles to a smooth and effective supply system.

4. Information Technology Infrastructure

“Across Australia there is a groundswell of support for a better, more connected healthcare system. More than 80 percent of Australians are in favour of electronic health records and are increasingly aware of the safety and quality benefits that e-health can deliver” (National e-Health Transition Authority or NeHTA).

The underutilisation of information technology by RACFs hinders clinical best practice with the lack of electronic communications and records adding to the substantial workload of the GP and facility personnel. This further impacts the pharmacy service due to delayed information receipt regarding medication changes and relay of patient status information.

The following issues reflect the primary concerns experienced by APHS:

- Inadequate security to facilitate ‘sharing’ of information
- Lack of computer access and hardware at RACF
- Lack of access by attending GPs to RACF IT
- Inabilities and unfamiliarity of RACF staff to utilise available IT
- Insufficient focus on medication management systems when IT is available
Secure electronic messaging is available now, e.g. Medical Objects and Queensland Division of General Practice collaboration. GP Partners (North Brisbane Division of General Practice) has demonstrated the value of a shared electronic record (in their case, Health Record Exchange) through 2 coordinated care trials and subsequently through Team Care Gold and Team Care Private programs. Over the past few years the advent of complex electronic medication management systems has proven to be of benefit to the larger, well-funded aged care organisations, but requires considerable investment. Companies such as iCare have worked in conjunction with key aged care industry stakeholders to produce a documentation system to support and simplify the complicated ACFI report requirements, as well as incorporating a detailed electronic medication management and recording module. It will only be through open negotiations and a collaborative healthcare approach that meaningful progress can be made in this field, and recognition of this through professional bodies and panels would provide essential leverage to make this reality.

5. Right of Choice

APHS is committed to providing a best practice medication management service to all clients, whether in residential care or at home, and consistent with APAC guidelines, does not limit the right of choice over which pharmacy will dispense prescriptions or whether generic or brand medications are provided.

The resident’s right of choice to choose which pharmacy provides their medications is always respected, but it should be acknowledged that considerable difficulties can be experienced by RACFs because of the ensuing multiple medication systems. This right must be sensibly balanced by the RACFs Duty of Care, with the primary objective of meeting Accreditation Standard 2.7 - Residents’ medication is managed safely and correctly.

An example of the challenge this balance can present was recently seen in a SE Queensland regional centre, where a local service provider ceased their supply to a large facility, opening up the services to multiple local providers. The result left nursing staff expected to administer medications from 5 different medication management systems, use 5 different charting and recording tools, have detailed knowledge of each patient’s pharmacy provider for after-hours supply (further complicated by the unavailability of 3 of these suppliers after 5pm each day). Subsequently the medication incident rate at this facility significantly increased, with the facility staff reporting increased stress. This was also a nightmare scenario for GPs.

The RACF environment certainly lends itself to an increased use of generics versus branded products and APHS considers this outcome to be absolutely consistent with Australian Government policy. Cost reduction through generic supply has contributed significantly to reducing PBS expenditure, particularly in this area with much higher substitution rates than the wider community.

In summary the resident’s right of choice is not compromised when receiving a DAA from a contracted pharmacy. As with community practice (and unlike the majority of public hospital situations where a standard drug list or the preferred hospital contracted medications are provided) the resident has the final say on what medications they are supplied (with the GPs agreement), and wherever possible in the context of Duty of Care, delivered by the pharmacy of their choice as well.
6. Administrative Arrangements

Contractual agreements between the RACF and the pharmacy are an important part of ensuring standards of supply, as well as providing guidance and stipulating service level expectations for both parties.

The HMA discussion paper raises the following issues:

- “Failure to recognise the right of choice of patient”
- “Inability to ensure integrity of the medication supplied”

A comprehensive agreement between a RACF and a pharmacy provider, and the implementation of appropriate communication and management systems, address these issues. The critical consideration for RACFs in entering into a Service Level Agreement (SLA) with a pharmacy provider is to achieve a uniform medication system to meet Accreditation Standard 2.7 - Residents’ medication is managed safely and correctly. An SLA provides a default choice of pharmacy provider without compromising resident choice.

From the HMA document and the perceived ‘issues’ with such agreements it can be deduced that these agreements can vary greatly in content and workability between supplier and facility, bringing with it an aspect of uncertainty regarding the professionalism of some of the current operators – no doubt in the minority of the Australian Pharmacy Industry, but having significant impact on the majority of the providers.

The second issue is one of the pharmacy and facility ensuring the integrity of the medications delivered to the RACF. The strict quality control practices employed by APHS ensure that the integrity of medicines is maintained in all instances. Given the focus that all aged care providers have on delivery of medications, and the contractual obligations that are put in place with the majority of the supply agreements, this risk to the aged care client is minimal. However, APHS would support any initiative that enhanced the integrity of the medication supply chain through the packaging and delivery phases.

C.2 Other Factors for Consideration – APAC Guidelines

Recommendation 2: Medication Charts

The APAC guidelines on medication management in residential aged care facilities have added a greater degree of control on processes for aged care managers and staff, as well as ensuring a focus on best practice from the GPs.

As mentioned in the previous sections many aged care pharmacy suppliers have demonstrated their commitment to this APAC recommendation by investing a substantial amount of time and money into developing a medication chart that best meets the needs of both the aged care staff and the GPs, with continual improvement designed to achieve quality use of medicines. Clear instructions, medications grouped into dosage times, and the ability to advise on potential medication-related issues at a glance all assist in the provision of a safe and efficient medication management process. APHS has incorporated the principal elements of the National Medication Chart in designing its chart.
The success of PBS and Medicare Online embraced by GPs and pharmacists, in reducing the administrative burden on the healthcare system, is a strong indicator that GPs and pharmacists would embrace an electronic chart as part of a shared electronic health record. NeHTA research demonstrates that more than 80 percent of Australians are in favour of electronic health records and are increasingly aware of the safety and quality benefits that e-health can deliver.

C.2 Other Factors for Consideration – APAC Guidelines

Recommendation 3: Medication Review

The benefits of comprehensive medication management reviews have been demonstrated in several trials and well documented.

To enable the healthcare profession to work as a group and focus on ensuring the right medications are available to the right patient at the right time in a manner they can tolerate, funding of medication review throughout hospitalisation or directly post-discharge (with or without GP authorisation) should be considered. Clinical pharmacists within the acute-care setting are ideally placed to review current regimens and advise the treating MO (in person in some instances – the most effective approach to collaborative management) of potential alterations in medications and/or formulations to increase effectiveness and reduce risk of adverse reactions or inappropriate management. This initiative would also facilitate seamless transition from acute to chronic care.

C.2 Other Factors for Consideration – APAC Guidelines

Recommendation 9: Dose Administration Aids

The use of dose administration aids within the residential aged care setting brings with it all the benefits discussed previously, as well as providing a time-efficient solution to the nursing and care staff for their medication administration rounds.

In 1997 when the APAC guidelines were published, the nursing workforce shortfall was not as acute as it is today. The significant undersupply of registered nurses to meet the future health needs of the Australian community, particularly considering the ageing of the nursing workforce and the rapidly ageing population of Australians in the next three decades, has been well documented. Increasing use of non-professional staff conducting medication rounds is a fact of life in modern aged care. Subsequently, the provision of all medications within a dose administration aid can now be regarded as an essential requisite of the pharmacy service agreement for aged care supply.

Care staff and nurses alike are focused on the entire healthcare needs of their clients, which include the aspect of medication management. Given their broad-ranging care duties the assistance from the medication supply ‘specialists’ (i.e. the pharmacy providers who takes the responsibility of packaging the medications within DAAs) should be viewed as a significant benefit and time-efficient solution to their daily operational duties as well as having a great impact on the reduction of risk to their clients and themselves.
C.2 Other Factors for Consideration – APAC Guidelines

Recommendation 14: Emergency Supplies of Medication

As with standing orders the collaborative approach through bodies such as Medication Advisory Committees (MACs) are essential to approve setup, ensure appropriate supply is held and manageable processes are implemented. State/Territory legislative requirements for emergency supply to RACFs can vary significantly.

This approach also ensures that all relevant healthcare personnel are informed and instructed on the correct use of the emergency supply facilities from initiation of service. With all necessary documentation completed and supplied to ensure ongoing requirements of the facility are met, and remuneration to the pharmacy either through facility invoicing, or PBS prescription supply, there is no reason to view this service as potentially problematic with any future review of aged care supply services.

The expertise brought to the RACF by the pharmacy supplier, as well as their ability to provide a high standard of staff training to ensure competency in the appropriate management of the emergency service, should be viewed as an additional benefit to the healthcare management of the age care client. Working within our professional guidelines to ensure a safe, effective medication management system the pharmacy provider can and will ensure that the supply of a minimum range of appropriate medications to meet after emergency hours use does not get abused and is maintained in conjunction with state laws.

C.2 Other Factors for Consideration – RACGP Guidelines

RACGP guidelines support collaborative healthcare partnerships and team approaches to medication management in the aged care setting, as well as in community practice. Working collaboratively as a multidisciplinary care team, facilitates a more effective approach to caring for our ageing Australian population. This submission strives to firmly stress that the regulatory and administrative burden of the PBS in RACF supply is a significant barrier to this multidisciplinary, collaborative ideal.
C.3 Proposed Options to Enhance PBS Supply in RACFs

Option 1: Prescription-less System using current PBS Structure

**APHS unequivocally supports this option.**

APHS is firmly of the view that the introduction of a prescription-less PBS model in residential aged care is an absolutely critical reform. Adoption of this model is also aligned with National Medicines Policy “access processes are made as simple and streamlined as possible, so that subsidisation of medicines is timely, mechanisms are understood, and unnecessary administrative barriers and expenses are avoided”.

A prescription-less system will:

- Reduce the risk of medication misadventure resulting from misinterpretation or erroneous transcribing of duplicated medication orders in the form of PBS prescriptions
- Reduce the workload of medical practitioners generated by the current “double-entry” system
- Ameliorate the financial burden to pharmacies caused by the untimely turnaround of PBS prescriptions and resultant cashflow problems
- Reduce confusion and resultant anxiety from resident accounts
- Reduce attrition rates of GPs from aged care

**Additional Considerations**

In addition to the above, the current PBS arrangements also require the patient or their agent (in the RACF this can be viewed as a nurse or carer) to endorse receipt of supply of the PBS item. Given the previously outlined disconnect that exists between supply on a 7 day cycle rather than at full PBS quantity this requirement is not only administratively burdensome but also provide no tangible positive outcome in the audit process. To fully demonstrate this point, the nurse/carer effectively endorses receipt of a PBS benefit every time they sign that a dose is administered on the medication chart.

C.3 Proposed Options to Enhance PBS Supply in RACFs

Option 2: Authority Applications by Pharmacist for Approved Indications

**APHS supports this option.**

The majority of residents of RACFs have long-term therapy for chronic conditions. Medications for cardiovascular, diabetes, dementia, musculoskeletal, and mental health require regular ongoing supply for the elderly patient.

Application of authority prescriptions by pharmacists for approved indications, through a streamlined authority process under the principles of medication continuance, would not only improve the timeliness of medication supply but also eliminate the risk of missed doses.
C.3 Proposed Options to Enhance PBS Supply in RACFs

Option 3: Authority Applications by Pharmacist for Increased Quantity

APH supports this Option.

In the aging population, whether the patient remains in the community or is under the care of a residential facility, medication needs increase with age and increasing frailty. Medication regimens become more complex, and the workload on medical practitioners can be significant.

The approval for increased quantities of authority prescriptions by pharmacists would have a positive impact on medical practitioner workload, availability and timeliness of supply to RACF residents.

In the RACF setting, information required for authority applications including indication and if appropriate, pathology data, is readily accessible to pharmacists.

Additional Considerations

One of the major areas where this authorisation approval could be applied is for the palliative patients. Palliative patients routinely require special care and have increasing need for pain and symptom management. The standard PBS quantities for appropriate analgesics (S8s included) are insufficient to maintain the level of care of the palliative resident. The recognition of increasing quantities for these patients, and the ability of the pharmacists to gain approval for these items, would facilitate more effective terminal pain control, in a fully auditable environment.

C.3 Proposed Options to Enhance PBS Supply in RACFs

Option 4: Collaborative Prescribing - Pharmacist

APH supports this option.

APH strongly endorses the Pharmacy Guild’s stated position that a more appropriate term is medication continuance in this setting. APH does not propose or support pharmacist prescribing outside of medication continuance. Experience in the UK and other countries has clearly demonstrated the benefit of greater utilisation of the skillset of the pharmacist in the multidisciplinary team.

When a resident’s medication regime has been established and reviewed, the ability of the pharmacist to ‘prescribe’ ongoing supply of these medications would be of significant benefit to all the aged care healthcare team. Timeliness of supply, clarity of medication orders and a reduced administrative workload for medical practitioners would be some of the positive impacts seen in RACFs.

An additional benefit to this proposal would be to facilitate the safe and efficient transition of the RACF resident between acute and residential care facilities by improving communication and continuity of care.
Option 5: Collaborative Prescribing – Nurse Practitioners

APHS does not have a position on this option.

The option would allow nurse practitioners, within their scope of clinical practice, to initiate medication orders onto the medication chart, which would then become the prescription for medication supply. APHS is not in a position to comment on the level of clinical expertise of clinical nurse practitioners required to perform this model of collaborative prescribing. The continuing attrition in the number of Registered Nurse Practitioners in the RACF setting, may make implementation of such an option impractical.

Option 6: Funding of Cognitive Services

APHS supports this Option.

The provision of a Patient Medication Profile (PMP) and Dose Administration Aids (DAAs) reduces the risk of medication mismanagement in the community, as well as reducing the burden on the health service through reducing hospital admissions. In addition, the benefits seen by patients through the provision of patient medication information and counseling can greatly reduce or prevent misuse and/or abuse.

APHS fully supports the proposal to recognise and fund defined cognitive services provided by the pharmacy to their aged care facilities and clients.

Such services can include assisting in the provision of:

- Dose administration aids
- Patient medication profiles
- Comprehensive medication information as well as DAAs to patients on discharge/transfer from hospital
- Charting tools and administration records to the facility and GP in line with quality and safety initiatives
- Participation and attendance in medication management committees
- Education and training
C.3 Proposed Options To Enhance PBS Supply in RACFs
Option 7: Contracts with General Practices

APHS conditionally supports this option.

The establishment of service level agreements between the RACF and a General Practice, has the potential to improve communication with prescribers, increase understanding of the pharmacy and patient requirements as well as increase the patient benefits realised from a joint approach to residential aged care practice and medication management.

Additional Considerations

Issues surrounding the patient’s right of choice must be considered, although there are definitely positives that such a SLA can bring, which must be seen as an advantage. The improved level of service available to these clients, provides sufficient incentive to the resident or their relatives to consider transfer to the care of the contracted GP.
Supporting Paper: The GP Perspective

There are numerous barriers faced by General Practitioners (GPs) who care for patients in residential aged care facilities (RACFs). These barriers have led to a situation where fewer GPs are prepared to visit facilities, causing a critical shortage of GP services within some facilities.

Dr Wayne Herdy is a general practitioner on Queensland’s Sunshine Coast, with over 30 years clinical experience and a wealth of experience in residential aged care. He has a law degree and has accrued nearly a decade of experience as an AMA Councillor at State and Federal levels. As Vice-Chair of a Division of General Practice, he guided a successful Aged Care Panel through projects including prescription management. Dr Herdy has also been a member of the AMA Care of the Older Person Committee.

Following is a detailed insight into some of the difficulties in aged practice for today’s GP, provided by Dr Herdy.

Dr Wayne Herdy currently juggles his practice between his surgery and his aged care patients, and states that GPs are continuously challenged by (and often forced to bend) the rules in providing an efficient aged care service under the current legislative requirements pertaining to prescription timing.

There is a distinct disconnect between the requirements and the physical practice of aged care prescribing, a fact that practising aged care GPs are hoping to be revised in the very near future. The practice of handwriting prescriptions at the facility at the time of charting new or altered medications is no longer supported in view of the increased risk of error and interpretation difficulties.

Many processes and systems have been put into place in conjunction with Divisions of General Practice to reduce workload and increase the GP’s time-efficiency in supplying prescriptions as required. The aged care GP workforce is also ageing, with limited IT and change management skills, which limits the effectiveness of these initiatives.

When comparing age care general practice to the standard surgery-based practice, there are numerous factors impacting on the GP’s time and efficiency that discourage GP participation in aged care.

- Surgery consultations are all time based and charged at the time of the visit. With RACF clients GPs base their charges per visit or patient numbers reviewed – although the actual time spent with individual clients can be significantly longer than any standard GP consultation due to the nature of illness (e.g. palliative patients) and the complexity of geriatric medication management.
- The GP (or their managers) have to then submit Medicare claims post RACF visit, delaying payment or risking non-payment.
- The additional time taken for scripting (normally completed during surgery hours in general practice) adds to the frustrations faced and is a significant contributor to GP attrition from aged care.

GP remuneration is based on face-to-face interaction with the resident, a fact that is often overlooked. Non-contact time can be significant. GPs spend time on the road to reach the facility, access the facility (surprisingly not always an easy task at all sites!), find the patient, access the care staff, gain an update on medical and physical status, locate previous records (if available on site) prior to commencing the face-to-face consultation.
Dr Herdy describes aspects of his ‘normal’ working week undertaking aged care practice:

- Visits at least weekly to 130 aged care residential patients, spread across 9 facilities
- Travel time never less than 1 - 2 hours per week (non contact, unremunerated)
- RACFs supplied by 6-7 different pharmacies, all having different dispensing/reporting/charting systems and varying expectations from the one GP
- A typical week involves consultations with around 100 patients
- The frailty and increasing complications of patients, especially palliative patients, can result in a huge variation in consultation times
- Often the room that is allocated, if at all, to the GP is uninviting and uncomfortable, without necessary equipment and standard items required to conduct minor procedures etc
- Currently returns to his practice to enter handwritten notes from each individual consultation into his prescribing and patient record system
- The majority of consultations result in scripting requirements:
  - Leading to around 3 hours of prescription writing to supply between 200 – 300 prescriptions (non contact, unremunerated work)
  - Prescription writing often needs to be undertaken in his own time in the evening
  - He must handwrite controlled drug scripts (viewed as an outdated requirement by GPs given the controlled managed environment of a RACF)
  - He must collate information required for PBS authority applications as well as have appropriate script pads at hand. This process can lead to residents going without essential authority items for a period of up to 10 days
  - Contact Medicare Australia for any authority items required for continuous, essential, long-term treatment
  - Once all of the requested and required prescriptions are processed he must then sign, bundle into each individual facility grouping, deliver to the facility on his next visit which may not be until the following week (reliance on postal system has dwindled in view of multiple failed deliveries) or fortnight. These prescriptions are then collected from the facility and delivered to the pharmacy – all undertaken by courier and at an additional non-recoverable cost to the pharmacy. This delivery and return process can result in a delay in the receipt of a prescription by the pharmacy through collection (or even post) often being up to 14 days from initial prescribing, 7 days outside the current requirements

The workload of the current aged care practicing GP is constantly increasing with the increasing number and acuity of age care patients and the decreasing incentives for GPs to undertake this work. The above timeframes are an accurate reflection on current aged care practice and as such highlight with extreme clarity the unfeasible expectations of a 7 days prescription turnaround, not to mention the impossible 48 hour requirement for the Schedule 8 medications.

Dr Herdy also highlighted an area on contention and frustration caused by the current PBS standards and expectations. With the time-lag between receiving an order for supply and when the GP can finally write the prescription then return to the pharmacy via the facility then a courier, the ‘prescription request report’ from pharmacy can become out of date and hence is viewed as inaccurate by the prescriber. The perceived and reported error rate of these reports can vary between a typical 10% error rate (accurate report) to an overwhelming 80% error rate. With the time taken to review every individual prescription request, advise the pharmacy of the error and return to the patient notes it is no wonder that some GPs refuse to supply outstanding prescriptions to the supply pharmacy, further complicating the PBS reconciliation and payment process.
A further source of frustration for these GPs is that some pharmacies insist on waiting until there is no prescription and no stock before requesting another prescription from the GP. This has the potential for significant impact on the supply to the resident and reimbursement process for the pharmacy. The production of ‘predictive’ prescription requests (a request for a regular medication is generated once the final repeat of the medication has been supplied with a date required listed) are well received from all aged care GPs and this allows them to manage their prescription timing and workload more efficiently and goes a long way to ensure the continuity of a high standard of patient care.

The introduction of electronic medication charts at RACFs and patient histories being available on various electronic medication management systems (currently limited to larger organisations due to cost) means many GPs can access up-to-date information from any location. However with the inability to link prescribing software with these systems, numerous programs and entries for charting and prescribing are still required – again further impacting on the timely supply of prescriptions and the ability of the GP to comply with legislative requirements. GPs report that although RACFs may have IT infrastructure, this is not readily accessible by external healthcare workers. If they are fortunate enough to be able to access the facility hardware and/or software the functionality that is available is often less than ideal for efficient patient records and prescribing purposes.

Aged care patients, the major users of anti-depressive, dementia and Alzheimer-specific therapies are prescribed these medications on a long-term basis. A similar situation exists for Schedule 8 medications for pain relief and palliative care management, which requires higher than average dosages, hence using increased PBS quantities. Options should be explored that aim to simplify the authority process without compromising patient care, or blowing healthcare budgets, and alleviate the workload of all staff involved in medication management and supply.

Dr Herdy is aware of reports of the Medicare call centre for authority applications being perceived as ‘less efficient’ in recent times for various reasons, including having to contend with a linguistically diverse medical workforce with limited knowledge of the PBS system. A GP is hesitant to risk delays in contacting this service by post. Delayed or lost prescriptions in the postal system further impacts on the timing of the prescription being made available to the pharmacy, and in view of the legislation, an even lengthier delay before the patient receives their medication.

With PBS quantities not meeting monthly requirements and ongoing therapy meaning increased prescription requests, deteriorating patients frequently changing medications and the continuous demands on their time by both facility and pharmacy staff, GPs have been quoted as feeling undervalued – the time spent in supplying valid prescriptions becomes an annoyance and claims of ‘not getting paid to write prescriptions’ is a constant quote to pharmacy after yet another request for timely supply. With these pressures facing both the GP and the pharmacy, relationships can become strained, resulting in a less than ideal healthcare partnership to achieve quality use of medicines.

The transition between RACF to and from hospital can be classified as one of the greatest areas of risk to the aged care patient. On transfer back to aged care facility the patient may have undergone multiple medication changes to achieve the most appropriate treatment regimen. If the GP does not receive an explanation for the change, further communication between GP, MO and/or pharmacy is necessitated. At this time in Queensland the average quantity of medications given to a patient on discharge from a Qld Health hospital is 3 days, some sites choosing to opt out of the supply at all, which can have an even bigger impact on the continuum of care of the patient, and increase the burden of the GP. With the possible delay of a GP in visiting a facility sometimes being as much as 7 days the prospect of an elderly patient, recently having been discharged from an acute-care setting going without essential medications is significantly increased.
The adoption of Dosage Administration Aids into the RACFs has been welcomed by aged care GPs, although it is apparent that the major issue and frustration to both GPs and residents in relation to the use of DAAs is when repacks have been requested. The next available packing date being highlighted on medication summaries can alert the GP to the start day of the new medication if they consider the patients medication change as non-urgent – the majority of cases in the residential care setting. In the elderly the alteration of their anti-hypertensive medication, changing doses of their lipid-lowering agents or an adjustment in their diabetic medication can be delayed for a couple of days and commence in the next packing cycle. This process has received positive feedback from GPs, reducing the stress of supply on the pharmacy and decreasing the potential confusion amongst the care staff.

Why do GPs like Dr Herdy continue in aged care practice? “Being able to make the transition at a patient’s end of life as smooth, comfortable and painless as possible” is his response. He also has a fondness for achieving some benefits for the patient particularly when they are approaching the end of their life. In addition Dr Herdy’s focus and commitment to reducing risk and promotion of patient safety throughout his practice is paramount.

Between 1997 and 2005, the number of general practitioners declined from 108 to 98 FTE per 100,000 population\(^1\). Australia’s population is projected to grow and continue to age over the next 40 years with the fastest rates of growth in the numbers of people aged 65 and over. 25 per cent of the population is projected to be aged 65 and over by 2047.

Every effort must be made to ensure that the barriers to aged care general practice be removed to reverse the attrition of GPs such as Dr Herdy from aged care. As described in considerable detail in this supporting paper, the introduction of a prescription-less PBS model in residential aged care is an absolutely critical reform.