SARRAH

Services for Australian Rural and Remote Allied Health

21 December 2021

Attention: **Health and Medication Safety team**

Australian Commission on Safety and Quality in Health Care
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Services for Australian Rural and Remote Allied Health (SARRAH) Submission:
Review and update of Guiding principles to achieve continuity in medication management.

Thank you for the opportunity to provide feedback on the current review and update of the ***Guiding principles to achieve continuity in medication management***.

Services for Australian Rural and Remote Allied Health (SARRAH) is the peak body representing rural and remote allied health professionals (AHPs) working in the public, private and community sectors, across primary and other health settings, disability, aged care, and other service systems. SARRAH was established in 1995 by and as a network of rurally based allied health professionals and continues to advocate on behalf of rural and remote communities to improve access to allied health services and support equitable and sustainable health and well-being. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians. SARRAH members include pharmacists and a range of other allied health professionals for whom the guiding principles are an important consideration in the clinical care they provide and in their roles as members of multidisciplinary, patient-centred health professionals.

As a general comment, the proposed approach to the review, as described in the consultation, is coherent and should deliver improved safety and quality for Australians who require health and related services. We would generally support all of the Recommendations listed in the consultation paper.

We particularly note and support the increased emphasis on ensuring the specific needs of people in rural and remote Australia and of groups identified as being at relatively greater risk of negative medications related impacts. Many people may be considered at risk under several of the identified categories, and for them the risk and potential for adverse impacts are heightened. For this, and other reasons, SARRAH strongly supports the shift in emphasis described under Guiding Principle 10, to introduce and embed reflective questioning as part of the revised guiding principles.

While we support the Recommendations, SARRAH believes there re points that warrant stronger emphasis and/or deeper exploration of the rationale for their inclusion. These are highlighted in the following comments.

SARRAH strongly supports the cross-cutting emphasis on:

- Interdisciplinary collaboration between health care professionals;
- person-centred care and ensuring clinicians and members of the healthcare team involve patients in every step of their transition of care; and
- Inclusion of the additional guiding principle and the Recommendation, relating to *Identification and risk mitigation strategies related to medication management*.
    - Consistent with the focus on patient-centred enablement/engagement reflective practice, risk assessment and mitigation strategies should entail, more frequently, include assessment by members of the health care team, beyond the medical, pharmacy and nursing team members and include other allied health therapists etc.

From page 13 of the consultation paper: with regard to the AMAs position of inclusion of *GP representation within individual hospital management structures, (e.g. Quality and Safety and Clinical Governance committees) to ensure general practice issues are regularly discussed and to allow for concerns of local GPs in their dealings with hospitals to be raised and addressed in an appropriate forum.* ***This same principle could be applied to other disciplines, such as encouraging primary care or allied health representation on hospital management structures and vice versa***. (SARRAH supports this important inclusion).

Recommendation - GP1. Strongly supported.

Recommendation - GP2. Supported, and especially note the potential benefits of Sub-point 3: *regular measurement of culture (e.g., validated measures of organisational culture) and an approach to quality improvement, which applies both within and across sectors*.

Recommendation - GP3 – supported.

Recommendation - GP4 – supported.

Recommendation - GP5 – strongly supported, noting:
A comprehensive medication review is a systematic and collaborative assessment of medication management for an individual person that aims ***to optimise the patient's medicines and outcomes of therapy*** *by providing a recommendation or making a change. It includes the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste.*

- As described in the consultation paper, a person-centred medication review should include an objective and informed assessment of the therapeutic value of the medication, alongside consideration of other therapies/treatments that may be beneficial and efficacious in conjunction with medications or potentially as an alternative to medications.
- This point relates to several areas of risk, such as the overuse/over-reliance on medications as has been identified by the Aged Care Royal Commission among others and is apparent in the findings of the ACSQHCs atlas of Health Care Variation.
- A related risk, that SARRAH believes may be associated with the point above, is that the severe shortage / mal-distribution of allied health professionals in rural and remote Australia (more severe than for GPs) is likely contributing to these risks as practitioners manage patient care as best they can in the circumstances (including, for examples, where a physiotherapists or mental health counsellor/behavioural therapist may not be available).
- A further risk is the extent to which health practitioners are aware of and inclined to seek out alternative treatments and health professional advice. For instance, as recent

publication by the New Zealand Institute of Economic Research (on behalf of Allied Health Aotearoa New Zealand (AHANZ)) found that the workload pressures on GPs and factors, such as limited understanding of allied health professionals expertise and capacity constrained appropriate referral activity, and presumably consideration of treatment options by the GP and the patient.[1] Clearly, similar issues may also be of concern in Australia.

As stated in the consultation paper:

> *"Each clinician involved in a person's care has the responsibility to use their specific knowledge, skills and expertise to ensure the safe and quality use of medicines by all consumers in their care. If risks with medicine use are identified early, it may prevent unnecessary escalation in care or hospital admission. Two-way ongoing communication should be maintained between the healthcare professional and the consumer/carer throughout the medication review process. Whilst a comprehensive medication review by a pharmacist is ideal, there may be situations where other clinicians need to consider and review the appropriateness of a medicine, suitability of its formulation, or a change in a consumer's situation or condition that prompts an 'ad hoc' review of their medicines. It is possible that this would prompt referral to their GP or contact with the consumer's pharmacist for advice and/or review."*

Recommendation GP6 – This is an important Recommendation.

- *A coordinated collaborative case conference involving the medical practitioner, the pharmacist conducting the review and other health professionals may be required for addressing complex issues.*
- *Noting,* sub-point 4: *That GP 6 be broadened to integrate principles of a medication management plan in the community and hospital sector and reflect contemporary practice standards and guidelines.*

SARRAH notes the risk that collaborative case conferencing across sectors, and especially as they relate to allied health practitioners working in private, community and NFP sectors (especially) are unlikely to be supported (paid or otherwise enabled) to participate in such case conferences.

- This is not to suggest the standard should be set at a lower level, but points to a very real and practical issue that inhibits the participation of all members of the multi-disciplinary team to be part of such case conferences.
- It is noteworthy that the recent Commonwealth initiative to extend MS payments for allied health to participate in a limited number of case conferences for patients under a chronic disease management plan as determined by the treating GP is a welcome development. Until now, treating allied health professionals have not been funded for this work. This exemplifies the practical issues faced in enabling case conferencing and should be considered and highlighted by this process, although should not erode the quality of the standard set.

Recommendation - GP7: Again, supported, however, we note
"*there is a need to use technology to provide better medicines information to patients, so that they are better equipped to be shared decision makers in their medication management".*

[1] Hidden in Plain Sight - https://nzier.org.nz/publication/hidden-in-plain-sight-optimising-the-allied-health-professions-for-better-more-sustainable-integrated-care (see page iv, for example). June 2021

- In the main, allied health practitioners are not supported to access or maintain digital health record systems in the same way that GPs and some others may be. This inhibits their involvement.

Recommendation - GP8 (page 22)

- *As a result of the movement restrictions imposed during the COVID-19 pandemic, challenges to ongoing access to medicines in the Australian community were experienced. For instance, vulnerable and older people with chronic and complex conditions may not have been able to attend consultations with their health practitioner or visit their community pharmacy to have medicines prescribed and dispensed prompting an expansion of tele-health arrangements. However, there is a need to assess an individual's digital health literacy prior to consultation.*
- It is worth noting that COVID also restricted access for people (often exacerbated inappropriately and against official health official advice by police and other authorities) to other ongoing treatments/therapies, which may have added to otherwise avoidable demand for medications etc etc.

Recommendation -GP9 (page 24)

- *Optimal care is provided when health disciplines do not act in isolation but in concert with each other, facilitated by the existence of digital solutions with adequate interoperability between sectors and different health professions.*
- The points raised above identify some of the practical risk to optimal care under current arrangements.

Recommendation – GP 10: Strongly supported.

If you would like to discuss issues raised in our submission or require further information, please contact Allan Groth at allan@sarrah.org.au.

Yours sincerely,

for

Cath Maloney

Chief Executive Officer