4. Phase Two: Stakeholder Consultations

This chapter presents the key findings from the stakeholder consultations phase. Interviews were conducted with a range of stakeholder organisations by senior CR&C consultants, Dr Leanne Rowe and Stephen Campbell, in December 2007 and January 2008. (See Table 1 for a List of Stakeholder Organisations and Appendix 4 for Lines of Enquiry for Stakeholders.)

Overall, the stakeholder consultations found that the HMR Program was highly valued by stakeholders as an effective tool with the *potential* for meeting its objectives. There was a high level of awareness of the HMR Program from stakeholders representing health professionals involved in delivery of the program (GPs, pharmacists and pharmacies). Although 'top of mind' awareness of the detailed objectives was low, when prompted, most professional stakeholders were familiar with the specifics. Stakeholders representing consumers, on the other hand, had low levels of awareness of the program but immediately identified the program as valuable for their constituencies.

All stakeholders felt that the HMR Program could be strengthened, and have provided a number of suggestions for how this could be achieved.

Stakeholders felt there was strong anecdotal evidence to suggest the HMR Program was meeting a number of its objectives, including maximising a consumer's benefit from their medication, but stakeholders representing professionals noted that there was a lack of hard evidence to show that the current HMR model improves consumer outcomes significantly - particularly in relation to reducing medication error and hospitalisation.

Stakeholders tended to agree that the HMR Program improved patient education and compliance, reduced confusion - especially around generic medications - and facilitated relationships between GPs and pharmacists. Most stakeholders believed participation in the program by health professionals was being inhibited by the current HMR model, and that it could be more effective if the HMR processes were implemented consistently and the feedback loops completed.

While the interviews with stakeholders were generally positive about HMRs, some medical organisations reported that many GPs believe the accredited pharmacist usually makes only minor recommendations, which are often not clinically relevant. The quality of some of the accredited pharmacist reports also contributed to a perception amongst GPs that HMR recommendations could be immaterial or inappropriate. Those representing pharmacists, on the other hand, identified a reluctance of GPs to involve pharmacists in the HMR Program as a barrier to participation.

Most stakeholders believed that an increased uptake of the HMR Program would have much greater potential to reduce medication misadventure and hospitalisation, particularly within the first ten days after discharge from hospital. This view was often based on the research evidence of studies undertaken by the Quality Use of Medicines and Pharmacy Research Centre, University of South Australia.[9] One stakeholder noted that the current HMR model bears little resemblance to the model evaluated in the original research study (however the detail of the technical differences in models would be best provided directly by those involved in the original research study).

Stakeholders were able to identify recent changes to the HMR Program which were generally considered to be improvements. These included:

➢ Better remuneration including compensation for training, accreditation, and rural loading

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[9] This material was provided by the Quality Use of Medicines and Pharmacy Research Centre as part of the Call for Submissions.

CR&C

> ➢ Better promotion to consumers with television advertising in some states
> ➢ The GP champions program.

Many stakeholders also commented that a number of initial difficulties with the HMR Program had now been resolved.

It was noted that a number of new medication initiatives and research projects were due to commence. Stakeholders believed these would further add to the understanding and the uptake of medication review.[10] The Department of Veterans' Affairs (DVA), was seen as a '*whole of health payer*', holding complete patient data (except for data relating to Accident and Emergency presentations and GP consultations), and some stakeholders noted that this potentially put DVA in a position to measure the impact of HMR on hospital admission.

Based on qualitative evidence reported by stakeholders representing professional associations, the HMR Program was seen to be meeting its stated objectives but most stakeholders believed that the program had the potential to achieve greater patient outcomes. However, all stakeholders agreed that the program should undergo an evaluation to measure what was referred to as '*patient outcomes*'. The outcomes identified included the number of medication problems identified and the number of accredited pharmacist recommendations acted on by GPs and patients.

During the course of the consultation, stakeholders identified ways that their organisations could further support the HMR Program in its existing form. For example, many consumer groups and health foundations suggested that it would be helpful if they promote HMR more actively through their websites and newsletters. Medical organisations were able to identify practical ways to encourage GP uptake of the HMR Program.

4.1   Barriers and enablers to participation by health professionals in the HMR Program

The lines of enquiry and initial framework for analysis explored the barriers and enablers to the HMR Program identified by stakeholders along with issues around access to HMRs and ways in which the Program could potentially be strengthened.

4.1.1   Enablers of health professionals participation in the HMR Program

In general, stakeholders had difficulty in specifically identifying the enablers for participation by health professionals in the HMR Program, yet they were able to identify that where the HMR Program was working well:

> ➢ GPs had positive experiences of the Program
> ➢ there was no shortage of accredited pharmacists
> ➢ relationships between the community pharmacist, accredited pharmacist and GP were based on mutual respect
> ➢ the general practice managers set up systems to identify eligible, at risk patients
> ➢ there was a strong network of support from Divisions and Facilitators.

A number of enablers that emerged throughout the consultations are considered in more detail below.

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[10] Quality Use of Medicines and Pharmacy Research Centre in University of South Australia is currently working on a major research project identifying high risk patients (the preliminary results show a 4-5 fold increase in uptake of HMR).

Remuneration

The remuneration for GPs and pharmacists was generally described as adequate. The increase in remuneration in March 2006 was considered, by most stakeholders, to have taken the amount to an adequate level, where it was believed to have previously been unreasonably low. The introduction of remuneration for accredited pharmacists who attend training was also identified as an enabling factor.

Network of support between Divisions, Facilitators, pharmacists, GPs and other health professionals

> *The team is important, where there's good governance, mutual respect and face to face contact, where there has been relationship development between the Royal District Nursing Service, GP divisions and hospitals, it works.* (Other health organisation)

The network of support between Divisions, Facilitators, pharmacists, and GPs was viewed very favourably by most stakeholders. The HMR Program tended to work better when there were mutually respectful relationships between professionals. Professional stakeholders described the initial governance of the Facilitator program as complex and a barrier to encouraging participation. However, those stakeholders reported that these issues were now settled.

The Facilitators are seen to have adopted a more streamlined approach to reporting, work across different Divisions to share information about HMR and to support each other. Medication Management Review (MMR) Facilitators sometimes have multiple roles in GP Divisions including working with the National Prescribing Service (NPS) and Residential Medication Management Review (RMMR) programs. Stakeholders reported that the multiple roles of Facilitators are helpful in the coordination of medication management programs.

Divisions actively promote the HMR Program to GPs and a number run HMR training for GPs. Practical information on the HMR Program is available to GPs through the Australian General Practice Network website. Practice managers receive training and support from Divisions, particularly around systemic identification of eligible patients.

Stakeholders reported that most pharmacists and GPs are now aware of the HMR Program through Facilitator and Division promotion and support. Stakeholders representing pharmacists are reporting a greater level of professional satisfaction from being involved in HMR and being recognised as a professional.

> *HMR recognises the counselling role of the pharmacist.* (Pharmacist organisation)

It is clear from the consultations that good relationships between the GPs and pharmacists are essential to the success of the HMR Program - and that a collaborative approach is critical. GP feedback to the reviewing pharmacist has been identified as one of the most valuable parts of the HMR process, however, stakeholders reported that GP feedback rarely occurs.

Accredited pharmacist training

The Australian Association of Consultant Pharmacists (AACP) is owned by the Pharmaceutical Society of Australia and the Guild. The AACP is responsible for the training of accredited pharmacists and has addressed many of the issues related to accreditation training. While the training has been described by some stakeholders as onerous, the clinical content of training and the quality of HMR reports were generally recognised as important enablers of the HMR Program.

However, stakeholders representing GPs noted that the quality of some reports provided by accredited pharmacists were not clinically useful. The length of the reports, the manner in which the material was presented and their wordy, lengthy nature were identified as problematic. These negative experiences were identified as a barrier to GP participation in the HMR Program.

Positive patient feedback and outcomes

Stakeholders representing GPs reported that they (the GPs) were more likely to participate in HMRs if their patients reported positive experiences of the Program. For example: although the home visit for the HMR can be time-consuming, stakeholders identified that patient feedback indicated they (the patients) prefer the relaxed environment where they feel they have the time to ask questions about their medicines.

Although community pharmacists receive very little remuneration, they recognise the positive benefits of HMR for the patients and recognise HMR as a *'consumer loyalty'* program.

GP champions

In 2003, a GP champions program was implemented through the Australian General Practice Network to encourage GP uptake of the HMR Program. Formal and informal GP champions are seen as very important in leading the professions' opinions about HMR. Some stakeholders reported that HMR uptake was less in areas where GP opinion leaders had a negative view of HMR. Participation of an opinion leader was reported as having a huge impact on difference in uptake of HMR between regions.

Other stakeholders cautioned against recruiting champions from different professions. For example, a pharmacist would not be able to act as a champion in a GP audience.

Systematic identification of eligible patients

GPs who identified eligible patients systematically initiated a higher number of HMRs. In most cases, it was reported that systematic identification was facilitated by the practice manager and practice nurse. Stakeholders noted that medical software could also be used to assist with the identification of patients who were taking over five medications.

> *There could be alerts on prescribing software for patients who are at risk <and> who would benefit from an HMR.* (Research organisation)

Where hospitals notified GPs immediately on the discharge of their patients, it was possible for GPs to refer patients for an HMR immediately. However, stakeholders indicated that this rarely happened.

The Quality Use of Medicines and Pharmacy Research Centre reported a study that found GPs rarely used this opportunity unless they were contacted by the hospital directly or unless the practice nurse or practice manager was involved.

Promotion

The HMR Program was considered by professional stakeholders to have been effectively promoted to pharmacists and GPs. However stakeholders believed that very few carers and consumers are aware of the HMR Program or its benefits. The *Margaret Fulton* campaign was mentioned by many, but criticised as limited. TV advertisements in ACT and Tasmania were mentioned as positive.

Consumer stakeholders representing high risk groups (those with HIV, Alzheimer's, mental health issues) identified value in promoting the HMR to their constituents. Promotion of the HMR was identified as facilitating professional participation through consumer demand. However, others believed promotion directly to consumers could have a negative effect by attracting *'low risk'* people to the Program or by overloading an already overworked health system.

Most stakeholders believed it would be more beneficial to target high risk groups in the promotion of the Program and provided examples where this method had worked well. For example, the DVA MATES program (See section 3.6.1) contacts veterans with a personal letter informing them of the

benefits of HMR and encourages them to visit their Local Medical Officer (LMO)[11]. DVA has conducted a broad awareness campaign including distribution of a brochure promoting medication reviews (Department of Veterans' Affairs, 2008). The MATES program alerts LMOs where veterans may be at risk of medication misadventure and encourages the use of HMRs (Department of Veterans' Affairs, 2008). Representatives from DVA reported that the MATES program has resulted in a significantly higher uptake of HMR amongst veterans.

4.1.2   Barriers to participation by health professionals

The barriers limiting successful uptake of the HMR Program are complex. Stakeholders identified a number of barriers which have been grouped into five main categories relating to:

  ➢ the complexity of the HMR Program
  ➢ medical and pharmacy workforce issues
  ➢ communication and collaboration between GPs, pharmacists and other health professions
  ➢ remuneration
  ➢ access and participation of consumers and carers.

Each of these five categories is explored in further detail in the following sections.

Complexity of the HMR Program

Stakeholders reported that there are some problems with reporting lines for HMR Facilitators. This is regarded as a complex governance arrangement. For example, in Victoria, Facilitators report to individual GP divisions, the state Facilitator (Pharmacy Guild) and General Practice Divisions Victoria.

Stakeholders were also concerned at the complexity of training for accredited pharmacists and considered this to be a significant barrier limiting participation in the HMR Program.

The main complexity of the HMR Program identified as a point of concern was the number of steps involved in the HMR process.

Complex requirements for payment were also identified as an issue, particularly for GPs.

### Steps of the HMR process

Stakeholders identified seven steps that are involved in a single HMR (these steps are summarised in (Figure 4):

  1.   Patient visits GP
  2.   GP refers eligible patient to community pharmacy
  3.   Community pharmacy contacts accredited pharmacist
  4.   Accredited pharmacist contacts patient and visits at home
  5.   Accredited pharmacist reports to GP and community pharmacist
  6.   Patient returns to visit GP
  7.   GP writes plan for patient and discusses with community pharmacist.

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[11] LMO is usually the GP

Figure 4:   **Steps to the HMR process (as identified by stakeholders)**
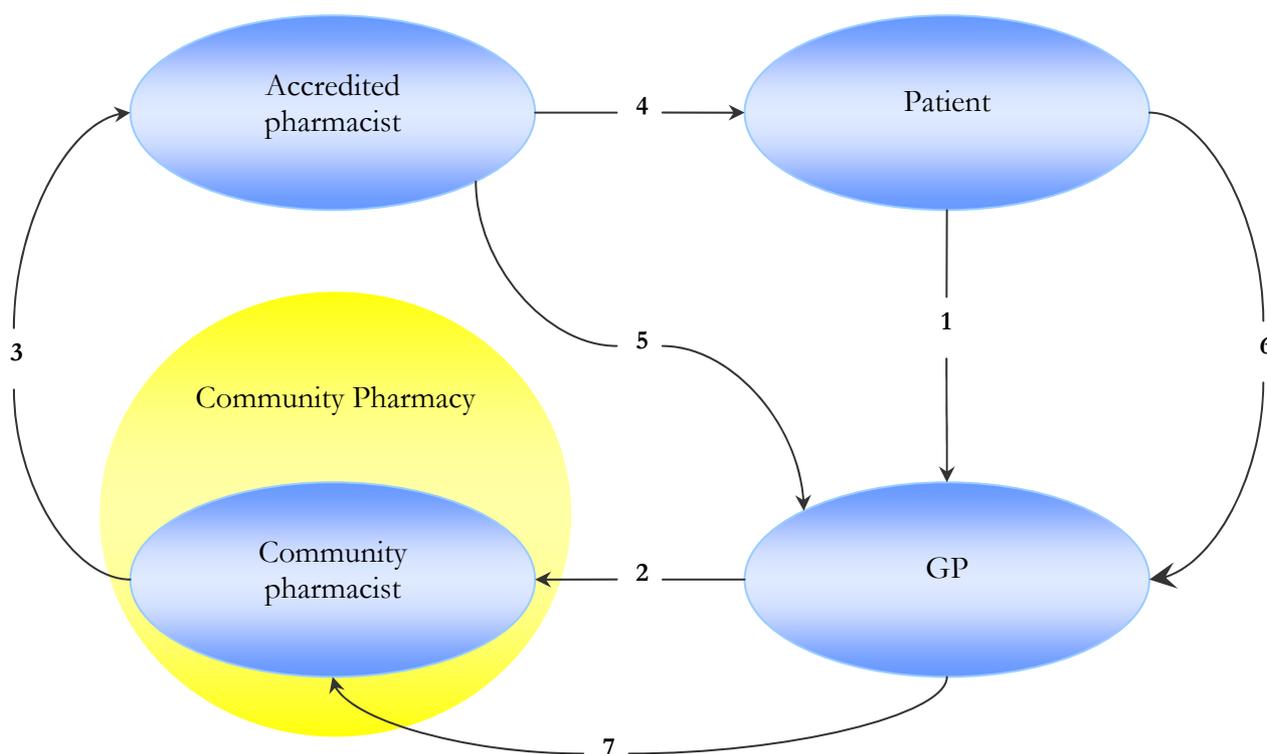
HMRs are a complicated process for all parties involved (the GP, the community pharmacist, the accredited pharmacist and the patient). The HMR guidelines prepared for GPs by the Department outline twelve steps to the process, incorporating:

➢ Identification of an eligible consumer and their community pharmacy

➢ Discussing appropriateness with the consumer

➢ Obtaining consumer consent

➢ Notification of the accredited pharmacist by the community pharmacy to the GP

➢ Discussion of the pharmacist report between the GP and reviewing pharmacist

➢ Agreement of medication management plan between consumer and GP

➢ Implementation of agreed actions and appropriate follow up and monitoring.

Barriers identified during the stakeholder consultations to take up of the HMRs were associated with the complexity of the HMR process and include:

➢ GPs tend to identify patients opportunistically rather than systematically. This is not efficient as GPs can find it difficult to remember the patient guidelines for HMR. GPs have a myriad of Medicare items to understand, all with different eligibility criteria or guidelines.

➢ The HMR tools (referral forms, management plans) usually appear in a different section of medical software from other Medicare items such as care planning and case conferencing. This means that the GP may not be automatically prompted to order a HMR when reviewing a patient with a complex disorder.

➢ To initiate a HMR, the GP is required to assess the patient and to refer the patient to the community pharmacy, during their consultation for another matter. At this initial stage, the GP does not receive payment for this service stage and may never receive

payment unless all the steps of the HMR are undertaken. The pharmacists and the patient determine whether the other steps are completed. The complexity of the payment process was identified as resulting in under–reporting, as well as a barrier to GP participation.

➢ On average, stakeholders reported a wait of about ten days between the GP referral and the visit by the accredited pharmacist to the patient. Some indicated that even longer delays were not uncommon. Many stakeholders believed that even a ten-day delay was unacceptable for a patient at risk of medication misadventure. The delay is particularly detrimental for patients after hospital discharge, as most medication misadventure occurs in the first ten days post hospital discharge.

➢ The feedback loop often does not happen. Stakeholders attributed this to the patient not understanding the significance of returning to the GP, and the GP not communicating with the accredited pharmacist by telephone as required by the HMR guidelines. It is not a requirement of the HMR Program for the GP to communicate with the community pharmacy, which is seen as a negative by community pharmacists who are providing the ongoing care to the patient.

➢ Most stakeholders agreed that overall remuneration was adequate, particularly since the rural loading and payment for accreditation training have been introduced, but some identified circumstances when it was less than adequate. Views expressed that remuneration may not be adequate for GPs who are unable to charge the Medicare Benefits Scheme item unless all HMR steps are completed. Others identified that generally community pharmacies receive very little remuneration as they pass most of the payment to accredited pharmacists. Remuneration for accredited pharmacists in rural areas may not be adequate if there are long distances involved in travel to patient homes.

➢ If a GP initiates a case conference with the pharmacist and another health professional, the pharmacist does not receive any remuneration.

Some stakeholders reported that the initial involvement of the community pharmacy may unnecessarily complicate the HMR steps. GPs preferred referring to a known accredited pharmacist and felt there would be more benefit in communicating with the community pharmacy after the HMR. Community pharmacies, run by those who see themselves as business people, were reported as sometimes reluctant to become involved in complex training and accreditation requirements for HMR. Some stakeholders, including those representing pharmacists, suggested that direct referral and payment to the accredited pharmacist without the community pharmacies involvement, could be considered. Others noted that the community pharmacy was an important point of contact for consumers.

Situations where consumers have multiple GPs or multiple pharmacists were seen to increase the complexity of governance arrangements.

Lack of systematic identification of appropriate eligible patients

Despite the complexity of the HMR steps, many professional stakeholders reported the success of HMR was largely a function of how individual GPs manage their practices. These stakeholders suggested that GPs need assistance with structure around HMRs. Related to this concern was the perception that GPs do not know how to identify appropriate patients, and some have difficulty following the HMR guidelines. Stakeholders reported that it was even more difficult to identify the most at-risk groups systematically as they were a very diverse group. Overall these views demonstrated support for a highly selective approach to HMRs.

> We need to identify who is … at risk and which patients benefit and whether much value is added in a HMR. It may be better to do less of them, but to fund them better. There could be a reinvestment of funds

> *or a remodelling of items where you use less for more money, but there's no evidence to back it up.* (Medical organisation)

Some stakeholders felt that a HMR should be mandatory after discharge from hospital, and also for anyone who has reached the Medicare Safety Net. In theory, it should be easy to identify these patients.

> *HMR is difficult to do within the first week post-discharge because you can't get an appointment with the GP and it involves having the patient drop in the referral to the pharmacist. They physically can't do it post-discharge.* (Medical organisation)

Although HMR guidelines are similar to that for other Medicare items like care planning and case conferencing, diabetes annual cycle of review, asthma management plans, and mental health care plans; it sits in isolation rather than in parallel. Stakeholders noted that these Medicare items compete for the GP's attention and look and feel different.

Medical and pharmacy workforce issues

The GP and pharmacist workforce shortages limit the uptake of HMRs, particularly in rural areas. Stakeholders mainly identified the lack of availability of accredited pharmacists. HMR was not seen as being high on the list of priorities for GPs due to the competing demands for GP time. There is also limited time for communication between GPs and pharmacists.

In rural areas, the availability of accredited pharmacists was identified as a barrier to participation in the Program by pharmacists, particularly those who could not leave their practice. The low uptake in the Northern Territory was attributed to workforce issues. Together, the high workforce turnover, difficulty in recruitment, high workloads, and the perceived inappropriateness of the HMR for Indigenous Australians was reported to result in very few HMRs being claimed in the Territory.

Stakeholders from medical organisations stated that growth in HMR needs to be commensurate with the medical workforce. Other stakeholders believed that recruiting more pharmacists as Facilitators may contribute further to the pharmacist workforce shortage, and questioned whether this role could be undertaken by another health professional group.

> *If there were more HMRs there may be more accredited pharmacists as the model suits some pharmacists and requires volume. For example, pharmacists who are young mums may enjoy being accredited pharmacists.* (Pharmacist organisation)

It was suggested that a small number of pharmacists are developing a practice around medication reviews, including reviews in residential aged care facilities. The emerging workforce is relatively small, estimated to be about 200 – 300 nationally, and developed primarily around provision of RMMRs. The business model for such an enterprise is still developing. Payment through community pharmacies for HMRs was identified as problematic for this group because of delays in receiving payment.

Stakeholders highlighted that there are fewer accredited pharmacists in rural areas, and therefore lower participation in the HMR Program in rural areas and amongst Indigenous communities. Poor compliance with medication was seen as particularly problematic in rural and remote areas.

Despite the workforce shortage, many stakeholders believed that the uptake of HMR would improve with increased promotion of the Program and a greater understanding of the real barriers limiting the participation in the HMR Program. The following quotes reflect some of the lack of awareness and negative attitudes about the HMR Program:

> *There are different levels of awareness – GPs are aware of HMR, but they don't know which patients benefit or how to do them. They are not 'aware' of HMR when a patient at risk is sitting in front of them.* (Medical organisation)

Most pharmacists are aware of HMR but when asked why they don't do it, many community pharmacists say they don't know. (Pharmacist organisation)

Providers have new program wariness – fancy names come and go and they are cynical whether or not this <HMR> will make a difference. (Research organisation)

Doctors will say that red tape, money and workforce are the barriers, but these are often not seen as a problem when a program is seen as of value. For example, the team care arrangement also has an issue with red tape, but there are obvious benefits of being able to fund allied health professionals. (Medical organisation)

Communication and collaboration between GPs, pharmacists and other health professions

Communication and collaboration were identified as crucial to the success of HMR by stakeholders. Stakeholders identified issues with inconsistent quality of reporting between GPs and pharmacists, clinically inappropriate pharmacist reports, and poor communication from GPs about the HMR plan as particular barriers to effective communication and collaboration. To complicate the HMR process further, the patient may visit multiple GPs and community pharmacies. Although it is a stated objective of the HMR Program to improve collaboration between different professions and the Program's business rules state that other health professionals can be involved although no payment is allocated, other professionals are largely excluded by the HMR process (e.g. nurses and medical specialists). A number of stakeholders believed that inclusion of such groups could improve HMR uptake and assist with identification of eligible patients.

Different reporting systems and inconsistency in quality of reporting

Stakeholders representing GPs highlighted inconsistencies in the level of reporting by the accredited pharmacists. From a GP perspective, a HMR could be problematic if the pharmacist did not understand the clinical context of prescriptions, or where pharmacist suggestions may 'interfere' with the GP's management of the patient's medication. Others indicated that the communications training for accredited pharmacists could be improved to overcome these shortcomings.

Building relationships between the accredited pharmacist and the GP was considered to be an enabler to participation by medical stakeholders. Direct referral was considered to be more in line with the usual referral relationships used by GPs and other health providers including specialists and allied health providers.

The required 'conversation' between GP and pharmacist on completion of the HMR was not always possible. An electronic communication strategy has been suggested as a way of overcoming this barrier.

GP and pharmacist relationship

HMR is very much dependent on the relationship between the GP and the pharmacists, particularly the accredited pharmacists. If the relationship is not working, the HMR will not work. The quality of the relationships between GPs and pharmacists was identified as a reason for the variability of uptake in HMR in different areas. The inter-professional relationships will be a primary focus of the grassroots qualitative research.

From a pharmacists' point of view, the HMR initiative is a new professional challenge. The GP sometimes sees it as further encroaching of others into their (the GP's) space. Protection of professional territory was identified as a barrier to participation by pharmacy stakeholders.

Stakeholders reported that some GPs are resistant to the idea that pharmacists can contribute to medical management. Some stakeholders representing GPs noted that historically, GPs and pharmacists have not communicated well and the two professions have worked in silos. A more

negative view expressed by medically focussed stakeholders is that the patient perceives the GP to be responsible for their overall care, while pharmacists are currently perceived as shop-keepers.

Broadening the referral base

A number of stakeholders suggested the HMR could be strengthened by broadening the referral base to include medical specialists, hospital-based doctors, nurses (particularly district nurses who visit patient's homes) and carers. This list is slightly broader than what is recommended in the literature, which recommends nurses but not carers. There was an indication from some stakeholders that health professionals other than GPs are in a position to identify a need for HMR and would like to be involved yet, at present, they cannot participate in the HMR Program.

Limited access for those who are marginalised and at high risk

Stakeholders representing professionals who worked with marginal consumers argued that many people who are marginalised have a need for HMRs, but have limited access due to their limited access to GP services. Homeless people, recent migrants, people with mental illness and Indigenous Australians were identified as groups who may not have a regular GP or pharmacist, yet have complex medical needs including multiple medications. Such people may use hospital emergency departments as their main source of medical care. Concerns around the difficulty or lack of access to HMR for those with complex needs were also a feature of findings from the Literature Review conducted for this research project. See section 3.2

The impact of HMR on use of emergency services was identified as an area that required further research to identify the extent of the issue and this was not an area in scope for this research project.

Home carers who attend older patients, or those living with a disability in their homes, were identified by stakeholders representing community-based services as persons who could observe problems with medication management. However, the lower skill levels of these workers was recognised and their inclusion in the referral process was recognised as complex and requiring review by trained workers before it would be appropriate to make onwards referrals to a GP.

Concerns for those at high risk of medication mismanagement were prevalent among stakeholders (and later, also among submitters and health professionals interviewed for this project) and these concerns echoed those found in the literature review. There was however disagreement from one stakeholder.

> *The high risk, and low risk assumptions about medication management need to be challenged because medication error is everywhere.* (Other health organisation)

Multiple HMRs

A single HMR visit was seen by a number of stakeholders as not always addressing the complete range of medications issues for patients with complex conditions, particularly where medications and circumstances are changing. Monitoring was considered to be important and a number of stakeholders felt this role could also be taken on by a nurse to some extent, particularly in situations where the patient had a chronic condition(s). While more than one HMR in a 12 month period is understood by the authors to be permissible in certain specified circumstances, stakeholder views reveal that this is clearly not well recognised and not part of the way HMRs are currently conducted. This lack of awareness of the option for multiple HMRs within a year, also emerged throughout the remaining phases of this research.

Remuneration

It was noted above that stakeholders representing GPs and pharmacists identified the increase in remuneration to what was widely regarded as an 'adequate' level as an enabler of participation in HMRs. Development of the workforce of accredited pharmacists was also facilitated by remuneration

incentives for training, although the financial return for accredited pharmacists was not sufficient to support pharmacists through HMRs alone. The emergence of medication review specialists was seen, by some stakeholders representing pharmacists, to enhance the role of pharmacy in the health system. However, these stakeholders also noted that the current business rules did not support an attractive business case to encourage pharmacists to work in the area of HMRs as a full-time or part-time proposition. (Issues and options around remuneration are explored in subsequent phases of this research project.)

In the context of perceived workforce shortages, (noting that DoHA quantitative data analysis provided for this research, found no clear link between the presence and availability of accredited pharmacists and uptake of HMRs) stakeholders felt that with the complexity of the model and competition for demand for health professionals' time, 'adequate' remuneration is unlikely to develop the momentum of participation, support a continued development of a workforce of accredited pharmacists, or establish the Program as a priority for GPs and community pharmacists.

The key remuneration issues that were seen by stakeholders to act as a barrier to participation, based on the range of stakeholder consultations undertaken for this project are:

> Community pharmacies were considered to be currently making a loss when conducting HMRs (Note that stakeholders did not provide detailed calculations to support their views, as the consultations were specifically aimed at seeking their views and perceptions of the Program, rather than seeking the financial data.) The loss was reported by stakeholders to be a function of the time-intensive nature of the steps involved in an HMR, whether or not it included outsourcing the conduct of the HMR.

> The complexity of the processes for GPs where there is a risk of no remuneration for the first consultation if the patient does not return, or the claim is not made at the second consultation

> Travel is not sufficiently remunerated in both rural and metropolitan regions.

Stakeholders noted that the GP had to perform too many steps and wait a considerable amount of time before Medicare Benefits Schedule Item 900[12] could be charged. This delay was considered a barrier. In addition, the way in which community pharmacies were remunerated was also seen as a barrier with most of the payment being passed on to accredited pharmacists. While this was based on the accredited pharmacist requiring an average of about three hours to complete an HMR, the amount of effort for little return has been identified as a barrier to participation by community pharmacies. Pharmacist payment is now supplemented by a loading in rural areas, which was acknowledged as an enabler.

4.1.3   *Access and participation of consumers and carers*

It was generally agreed by all stakeholders that consumers and carers had received very limited information about HMR. Stakeholder organisations representing consumers had a low level of awareness of the HMRs but, when provided with a summary of the Program, immediately saw the usefulness and were able to identify how they could promote the Program among their constituents.

Marketing campaigns were mentioned in the stakeholder consultation but were considered to have been limited until now. Recall of specific campaigns was not high and limited to comments such as *'the Margaret Fulton campaign was not the right message. It is not about cooking'*.

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[12]   Payments to GPs for HMR services are made through Item 900 of the Medicare Benefits Schedule (MBS).

However, some stakeholders expressed concerns that a broad public awareness campaign may result in a huge demand for HMR from people who did not require the service. This issue will be investigated in the grassroots qualitative research with consumers and professionals.

Furthermore, some at-risk communities were expected to not be responsive to the promotion, because a home visit may be viewed as inappropriate by cultural norms (for example, Indigenous communities or Vietnamese communities).

In general, consumers expected to benefit most from a HMR are those who take more than five medications on a regular basis, patients taking multiple generic medications and patients who have recently been discharged from hospital. Stakeholders, including those representing key consumer groups, reported that HMR has not been effective at targeting high risk groups including:

> ➢ homeless consumers
> ➢ patients with disability (such as hearing loss or a visual disability)
> ➢ people with Alzheimer's disease (who may experience difficulties with compliance, poor social inclusion, co-morbid disorders and multiple medications, interactions and side effects, poor access to health treatments and late diagnosis)
> ➢ people with asthma, diabetes and co-morbid disorders
> ➢ children with newly diagnosed chronic diseases including diabetes
> ➢ people living with HIV (HMR could be used to improve access for medication in their community).

Note that the literature review revealed considerable expectation that HMRs had the *potential* to assist some of these high-risk groups but little evidence to confirm outcomes and effectiveness in doing so.

Stakeholders noted that consumer attitudes can sometimes limit the uptake of HMR. Consumers may have a perception that they are managing their medication well or do not want to upset their carer. They may not understand the importance of the follow-up appointment with the GP after the pharmacist visit. Some GP attitudes contribute to this confusion. A number of stakeholders believed GPs were overconfident of their own prescribing habits and that others may feel threatened by HMR. These attitudes were then conveyed to their patients who did not want to upset their GP.

One GP who saw many HIV patients suggested that persons living with HIV would not want their community pharmacy to be aware they had HIV. They can often obtain HIV drugs from a specialised service who may not have the expertise to review other medications. The combination of privacy concerns and specialist expertise was said to make HMRs difficult to implement.

4.2 Strengthening the HMR Program

Stakeholders identified a number of ways to strengthen HMRs by:

> ➢ streamlining the HMR process
> ➢ increasing the number of accredited pharmacists
> ➢ improving collaboration and communication
> ➢ increasing consumer and carer awareness
> ➢ communicating the positive benefits of HMR to consumers, carers, GPs and pharmacists.

These suggestions for improving the HMR Program are explored in further detail below.

4.2.1 Streamline the HMR process

Anything that can be done to simplify HMR would help. (Research organisation)

Stakeholders identified a number of ways to streamline the HMR process. The main strategies included systematic identification of eligible consumers and at risk groups, reducing the number of steps in the HMR process, improving electronic communication between GPs and pharmacists, and involving other health professionals. Stakeholders also suggested a number of practical ways to streamline the process.

Streamlining through systematic identification of patients was also identified as providing opportunities for improving GP participation and while it was known to be occurring in some instances, for the most part, identification of patients by GPs was regarded by some stakeholders as being 'ad hoc', while others considered it to be due to the GP's preference for a highly selective approach.   Suggestions included community pharmacists identifying eligible patients and sending a list to GPs on a monthly basis. Practice managers or nurses could also use the GP medical software functions to create lists of patients, who are taking five or more medications, have chronic conditions or have recently been discharged from hospital. The practice manager or nurse could then place a flag on the patients' files to prompt the GP to consider HMR at the next consultation.

Routine flagging of patients at specific events was considered an opportunity for streamlining the HMR process. Examples were at:
> ➢ the 75+ health assessment
> ➢ an assessment for a patient with intellectual disability, care plan or case conference
> ➢ at the time of other enhanced primary care item (mental health care plan, asthma management plan and diabetes cycle of care).

The practice manager or nurse could also set up a recall system to ensure patients regularly receive HMR, by sending reminders (similar to the identification system used by the DVA MATES program).

Some stakeholders – not all - believed that all patients on multiple medications, not just those determined to be at high risk, should be required to have a HMR following hospital discharge, yet the consultations also uncovered potential logistical impediments to this for some patients. A small number of other stakeholders believed that all patients who reached the Medicare Safety Net could be encouraged to have HMR.

Some stakeholders supported GPs, hospitals, the Royal District Nursing Service and perhaps consumers and carers themselves, referring directly to an accredited pharmacist on a list within the Division. If a particular accredited pharmacist is not available, another pharmacist on the list may undertake the HMR. However, some stakeholders believed that these changes may alienate community pharmacies and some GPs. It should be noted that referrals by consumers and carers directly was not widely supported by stakeholders.

Divisions could be funded to coordinate '*flying pharmacy locum services'* in remote areas of Australia. It was suggested that in some areas, where there were severe shortages of accredited pharmacists, non-accredited pharmacists could be permitted to undertake HMRs. Note, current business rules do allow non-accredited community pharmacists to conduct the interviews for the HMR in the consumer's home, and then liaise with an accredited pharmacist remotely. It is known that this approach is already occurring in a number of regions.

Some stakeholders stated that it should be the responsibility of the accredited pharmacist to communicate with the GP and the community pharmacist (rather than the current step that requires the GP to contact the accredited pharmacist), before payment is claimed by the accredited pharmacist. This step is one of the most important parts of the HMR process but seems to be the one most likely to be omitted.

Most stakeholders noted that the Guild 'insisted' that GPs refer to community pharmacies as a first step of the HMR process. However, most stakeholders also believed that this step hindered the uptake of HMR, as many community pharmacies did not want to be involved in the program. For example, an

eligible patient may be identified and referred to the community pharmacy, but if the community pharmacy did not offer HMRs then the HMR did not proceed or it proceeded after much delay while other arrangements were made – either way significantly reducing the timeliness and effectiveness of the HMR, even if was able to eventually occur. This is frustrating for both the GP and patient. Some stakeholders believed that the National Prescribing Service should take over the governance of the HMR Program, as the Service is an independent organisation which could work across all stakeholder groups.

Some stakeholders suggested nurses could be trained to perform HMRs. The inclusion of nurses in the HMR Program may have several advantages. Not only may nurses be able to offer HMR on a more timely basis, but they may also be able to offer HMRs more regularly to those at-risk patients who require ongoing monitoring. The Royal District Nursing Service often undertakes a medication review within the first week of hospital discharge, and has developed a medication assessment tool for this purpose. It could be argued that in some cases HMR is an unnecessary duplication of what the Royal District Nursing Service are already providing. Some stakeholders believed that nurses may not have the skills to provide HMR, while others believed that nurses were very capable of encouraging compliance, reviewing patient medication lists, checking for duplication of generics and disposing of old medicines. It was noted that since the HMR Program commenced in 2001, practice nurses have become much more involved in general practice, though their role in HMR has largely been ignored.

The Quality Use of Medicines and Pharmacy Research Centre at the University of South Australia has trialled a program where 'heart failure' nurses work with hospitals and GPs to identify patients with heart failure who would benefit from HMR on discharge from hospital. They reported that this program has been very successful and felt its application to other chronic disease should be explored further.

Most stakeholders believed that the home visit was necessary for the success of HMR as it allowed the patient to ask questions in a comfortable, unrushed environment and for all medicine bottles and packages to be checked, including complementary medicines. However, there were a smaller number of stakeholders who believed that the home visit was time-consuming, probably limited the uptake of HMR, was not cost-effective and had not been objectively evaluated. It should be noted that there are complementary programs delivered in-pharmacy that provide medication management services such as Dose Administration Aids and Patient Medication Profiling. Whilst not as comprehensive as a formalised HMR, these programs help patients to better manage their medicines.

Although most stakeholders believed remuneration for pharmacists and GPs was adequate, a number commented that the GPs should be able to charge a Medicare item for the initial assessment and referral for HMR. On balance however this did not emerge as a major issue. Some stakeholders believed that pharmacists in community pharmacies should receive payment for case conferencing, however this too did not emerge as central to the discussion on the barriers to HMRs.

Patients who require case conferencing or care planning are usually also eligible for HMR. A number of stakeholders suggested that medical software should set up close links between the templates for other Medicare items to help prompt GPs to refer patients for HMR. Currently all the Medicare items for chronic disease management look and feel different and it would help to minimise some of the differences between the items.

4.2.2 *Increase the number of accredited pharmacists*

The limited number of accredited pharmacists who are undertaking substantial numbers of HMRs is seen by stakeholders as limiting participation by GPs and access by consumers to HMRs, particularly in rural areas. Often there will be no accredited pharmacist available across a very large geographic region so the GP would need to work around these issues if they wanted to take part. Access by consumers was also seen to be limited by these factors. Some stakeholders felt there would never be enough accredited pharmacists to respond to community need for HMR.

To recruit more accredited pharmacists, pharmacists needed to be convinced about the business case for HMR. Many believed that if there were more HMR referrals, there would be more accredited pharmacists - as accreditation would then be 'worth their while'.

Stakeholders also felt that it would be helpful if the Program was promoted as an opportunity for professional development and greater professional satisfaction, yet this is already occurring in many regions and has been a component of the Guild's promotion.

A number of stakeholders believed that HMR affirmed the counselling role of pharmacists.

While a number of stakeholders described accredited pharmacist training as onerous, many agreed that it was important for accredited pharmacists to receive training to improve HMR reporting to GPs. If pharmacists are equipped with training in specific disease states, there is an improvement in the quality of HMR. The Quality Use of Medicines and Pharmacy Research Centre at the University of South Australia has developed a number of tools to assist the accredited pharmacist with particular chronic diseases – the heart failure checklist, the diabetes check list, the ischaemic heart disease check list and the arthritis check list were seen as worthy of further exploration as they assist the pharmacist remember important clinically relevant information.

Certain groups of pharmacists were identified as more likely to consider becoming an accredited pharmacist. Young pharmacists were more likely to consider training as a career opportunity. Pharmacists with young families were believed to be more likely to appreciate the flexibility of the work.

It was acknowledged by a number of stakeholders that the AACP had resolved many of the initial barriers working against accreditation. While pharmacists undertaking accreditation were required to become a member of AACP (or SHPA), this did not prove to be a barrier. Some stakeholders believed that the AACP could work more closely with the National Prescribing Service to improve training for accredited pharmacists to the National Prescribing Service standards.

Facilitators were also considered to have worked constructively to promote accreditation for HMR to pharmacists and to assist GPs understand the HMR process including referrals. There was strong stakeholder support for the continuation of the Facilitator program.

4.2.3   *Improved collaboration and communication*

While many stakeholders agreed that the HMR Program had increased the collaboration and communication between GPs and pharmacists, it was acknowledged the HMR process excluded other professions because no payment was involved for their participation.

Stakeholders believed that pharmacy and medical workforce shortages were a problem, they considered a team-based approach including other professions as crucial. As the required telephone call to the reviewing pharmacist by the GP was often omitted, stakeholders suggested that this step could be replaced with a case conference where necessary.

To improve communication between health professions, an electronic communication strategy should be developed. Currently the HMR process is largely a paper-based exercise, which is not viewed as reliable. The community pharmacy could also be contacted electronically by the accredited pharmacist as a part of the HMR and by the GP after the plan is finalised. Other health professions such as the Royal District Nursing Service could also receive electronic communication about their clients. While this was suggested by stakeholders, subsequent phases of this research revealed that electronic communication concerns were not the major barrier to effective uptake and conduct of HMRs, even though improvements could be made and would be of some value.

It was seen of benefit if the Facilitator in the GP Division coordinated the HMR, National Prescribing Service and Aged care programs (RMMR). In this case, the pharmacist worked well across many other professions and with general practice.

Stakeholders agreed there could be more promotion of the HMR Program to practice nurses to encourage better identification of eligible patients. The practice managers often needed to be convinced about the financial model of HMR before they would become involved. Most stakeholders agreed it was important to involve other practice staff to take the burden away from the GP.

The Quality Use of Medicines and Pharmacy Research Centre at the University of South Australia indicate their research has confirmed the benefits of a collaborative approach for community care and team care in promoting the uptake and the outcomes of HMR. All stakeholders confirmed that the team-based approach to the management of patients with special needs and chronic disease was essential for good patient care.

4.2.4   Increased consumer and carer awareness

All stakeholders agreed that the HMR Program should be promoted more to consumers and carers. They noted that the *Margaret Fulton* campaign was limited but that TV advertising has now commenced in some States.

Stakeholders suggested a number of innovative ways to target at-risk groups. For example, one stakeholder suggested promoting HMR in places where older people meet, such as libraries. Another example is where consumers in high risk groups received personal letters promoting the benefits of HMR and encouraging them to visit their GP (similar to the DVA MATES program). Consumer organisations and health foundations were willing to assist by promoting HMR on their websites and in newsletters.

Other consumer organisations enlisted the support of peer educators to assist with information about HMR. This was a particularly important strategy for people from culturally and linguistically diverse backgrounds. This strategy has worked in older Vietnamese and Chinese communities. The use of ethnic radio stations is also helpful in promoting the HMR Program to people from culturally and linguistically diverse backgrounds.

Aboriginal Health Workers were considered to be crucial in the implementation of HMR in Indigenous communities. Stakeholders agreed that HMR had very limited uptake in Indigenous communities - not only because of the lack of acceptance of the home visit, but because compliance was an enormous problem linked to the inability to pay the co-payment. These issues will be further investigated in the next phase of this project.

4.2.5   Communicate the positive benefits of HMR to consumers, carers, GPs and pharmacists

While stakeholders confirmed anecdotal evidence of positive patient outcomes with HMR, most agreed that the positive benefits needed to be quantified to convince consumers, GPs and pharmacists of their value. Stakeholders suggested a number of ways to achieve this through case discussion, audits of pharmacy reports and GP plans, and measuring the impact of HMR on preventing hospital admission.

Stakeholders acknowledged the GP champions program and believed that both formal and informal GP champions increased the uptake of HMR by GPs. Stakeholders believed that there could be greater promotion of the benefits of HMR by Facilitators to practice nurses.

Many GPs were impressed by the National Prescribing Service newsletter and believed that this organisation could highlight the HMR Program in articles and case presentations. The HMR Program could be specifically promoted to GP registrars and international medical graduates, who were likely to find the Program useful.

Above all, it was noted that if patients reported positive experiences of the HMR Program, it was more likely to be embraced by GPs and pharmacists. Carers were also a very important, but often overlooked group, who could also encourage HMR uptake.