6. Phase Four: Qualitative Research with Health Professionals

The objective of the qualitative research with grassroots health professionals was to provide in-depth analysis of gaps in access to the HMR Program, and to determine what drives HMR participation amongst health professionals and the factors involved in non-participation. Specifically, the qualitative research stage aimed to provide grassroots views on existing practice and identify options for the future directions of the HMR Program.

Issues for exploration in this phase were formulated from findings of the earlier three phases of this research: the Literature Review; the Stakeholder Consultations and the Call for Submissions.

6.1 Health professionals' perceptions of the program

Overall, stakeholders perceived the HMR Program as 'a good idea' but also as a program that was not working well. Most stakeholders identified opportunities for improvement. Dominant themes included the complexity of the business rules, delays between initiation and completion of HMRs associated with the many professionals involved and communication difficulty. These issues were embedded in a perception that reviewing medicines was something that GPs, pharmacies and pharmacists did anyway as part of their everyday work. The additional training and accreditation was not always seen as necessary.

While many perceptions were negative, there was a consistent view expressed about the value of medication review and the importance of reducing adverse events associated with pharmacy use. Nearly all stakeholders identified room for improvement. Many expressed concern at the lack of a solid evidence base of outcomes, in the form of reduced adverse drug related events directly associated with HMRs.

Many health professionals are not participating in the Program because they don't find it valuable or don't consider it to be a priority. As a result, consumers are not getting access to the Program.

In the following section, a wide range of barriers for grassroots professionals are outlined, together with the strong positive suggestions for improvement. Different issues for each health professional – GP, community pharmacy, accredited pharmacist and other health professionals, are dealt with. Across the board it is the ambivalence of health professionals exacerbated by some negative experiences that is limiting participation.

The views of the grassroots professionals were often inconsistent with those of their professional stakeholder organisations.

6.1.1 Perceptions of the Program - GPs

GP attitudes towards HMRs were most commonly ambivalent. Some were positive and a number of respondents were clearly negative, considering the program a waste of money.

Positive GPs, usually those with a higher number of referrals, believe the HMR program is beneficial for both patients and health professionals. These GPs emphasised the importance of a team approach to healthcare, and cited the quality assurance that comes from having an independent person reviewing medication and a second opinion on patient care. They are also strong believers in the value of HMRs and find that they provide educative, psychosocial and health benefits to participants, practice review and learning opportunities for GPs, as well as financial savings to the health system.

> *The HMRs provide a psychological boost to the patient, showing that you are interested in their welfare, that something is being done. They provide a big boost. They sometimes pick up some interactions and you*

can cut down on one or two medications and if so, the patient will feel that they are healthier… It is useful to have my practices reviewed. I find it a learning process and make use of it because it is available. (Rural HMR GP)

Most GPs were **ambivalent** about the HMR Program, and while they did not criticise the HMR Program outright, they rarely referred patients. In general, they wanted to see further evidence of clinical health outcomes and effectiveness. Some were also concerned with the work that could be generated when they had to explain their clinical practice decisions to the pharmacists.

Often the pharmacist isn't telling us anything new, but sometimes you get real gems. 60% probably confirming what we did already know. 5-10% causing grief and about 25% coming up with gems … and we will make changes and have new information. (Rural/Remote HMR GP)

A small number of **negative** GPs did not view the HMR Program as at all effective in improving health outcomes for their patients and generally saw HMRs as a misuse of time and *a waste of government money (Rural Non-HMR GP).*

I do think the Government should spend their money on something else instead, like public hospitals. (Regional Non-HMR GP)

It is important to note that often these GPs present very clearly as giving considerable time to their patients, being committed to the patient's wellbeing and having a strong commitment to collaborative care. Despite the negative characterisations sometimes put forward to explain GP resistance to HMRs, these did not appear to be valid for many non-referring GPs, nor even for many of those referring in low numbers.

6.1.2 Perceptions of the HMR program compared with other healthcare initiatives

GPs frequently made comparisons between HMRs and the various other Government primary healthcare initiatives of recent years. Overall, GP Management Plans, Enhanced Primary Care Initiatives for diabetes and for asthma, as well as over 75 health assessments received considerable and obvious support. By comparison, HMRs were viewed as either less valuable or a lower priority. The other programs tend to be perceived as more closely tied to the GP's role.

HMRs tended to be seen as the primary healthcare initiative that could be 'dropped' without any negative impacts for their patients.

While the level of need for HMRs may always be very small in comparison with some of the other primary healthcare initiatives, HMRs do not seem to come close to the other programs in terms of their consideration by the GP.

With the Diabetes and Asthma Care Plans, they are given good prioritisation by the GPs because they can clearly show hard clinical outcomes. Also, all of these plans do cover all of those issues around medications, so sometimes there is a sense of overlap. (Rural Former practice manager, HMR GP clinic)

There was one GP however, who said that he found the HMRs to be a more valuable program than GP Management Plans.

When I had used them <in previous practice> they definitely helped the patient and me as well. They can help bring to your attention some problems that you were not aware of … <they>may be more of a help than a GP Management Plan. (Rural non HMR GP, as HMR not available in current location)

Some GPs resisted HMRs due to concerns it could leave them vulnerable if a routine Medicare audit found that they had not adhered to the required HMR patient eligibility and billing requirements.

In one Division, HMR referrals were reduced by half as soon as a Medicare audit was announced.

Referrals dried up by 50% when Medicare advertised that they were auditing GPs in relation to HMRs. (Rural/Remote CPBOM).

For some GPs, concern about the Medicare audit came through when they expressed they must *'get it right'*, when selecting patients for HMRs. For others, the concern about Medicare audits was obvious in the GP's refusal to do HMRs if he/she had to 'get around the system' to make it work. The requirement for a phone call to the accredited pharmacist was taken literally by some GPs who were not confident about 'working around' a Medicare requirement. In contrast, other GPs simply treated this communication as an option and were happy to be flexible.

> *The difficulty is that there is so much paperwork in what you do … that one more thing to fill out when you're trying to get through all the other sort of EPCs, primary care, GP Management Plans and so on. I find it hard enough to understand who's appropriate for what, much less add in a medication review, but I really do think they're valuable.* (Regional HMR GP)

6.1.3 Factors in GP participation and factors in non-participation

HMR Program participation drivers for GPs varied, but their approach to HMR tended to fall into the following categories: entrepreneurial; selective approach; healthcare team approach; reluctant; frustrated; traditionalist.

The **entrepreneurial** GP was driven by business opportunities associated with the HMR Program. Remuneration was a key driver and this type of GP was more likely to advocate for universal triggers (e.g. all patients over 75 years of age). They typically had efficient organisation systems in place to record and track all patients fitting the HMR referral criteria.

GPs with a **selective** approach to their HMR referrals assessed HMR eligibility on an individual patient basis, rather than advocating blanket referrals for all their patients who met the HMR criteria. They were concerned that some GPs ordered HMRs for business rather than patient care reasons.

The typical **healthcare team** GP was driven to participate as HMR was compatible with their approach to patient care; alleviated their workload; and provided an additional quality assurance. This type of GP was usually involved in other government primary healthcare initiatives such as GP Management Plans, Enhanced Primary Care Initiatives for diabetes and asthma and the over 75 health assessments.

> *The chemist also gives me ideas …not just to reduce medication, also to look at other issues because there is just so much involved in looking after patients … unfortunately I can't deal with every little thing. I tend to deal with big issues and it's all that fine tuning that other staff help with … it's just working as a team.* (Metropolitan HMR GP)

The **reluctant** GP describes those who were encouraged to participate in the HMR Program by others, for example: the Division Facilitator suggesting the GP find appropriate patients to increase uptake; the local community pharmacy recommending a patient; or the patient requesting the review. This type of GP had typically only referred three or four HMRs over the last three years.

The **frustrated** GP had tried to participate and had come up against barriers, or had previously participated and since lost interest in the Program, due to negative experiences.

The **traditionalist** GP tended to show reluctance towards having pharmacists review their prescribing practices (*I don't need anyone checking up on my work*). They felt that medication review was the domain of the medical practitioner. These GPs were more likely to also hold reservations about other Government healthcare initiatives.

> *Like the GP Management Plans, I think these types of programs are only useful if they're done by a doctor.* (Regional Non-HMR GP)

> *I don't know how receptive our [local] doctor would be. He doesn't like being told what to do and is not really abreast of modern health programs … I guess there are some doctors that have big egos, and he is one and he likes it be known that he is the doctor and he is in charge.* (Rural/Remote Clinic Nurse Manager)

For the traditionalist GP, 'trialling' a new healthcare program was often done in quite a limited way, before the GP then made a judgement about the value or otherwise of the program. When one GP was asked how many HMRs he had referred in total since the Program began, the reply was *'maybe six'* despite the fact he had said he had done *'quite a few'*. Another GP, who'd been a GP for 40 years, expressed support for HMRs, saying '*you're too close to it yourself, it can be handy to have a dispassionate view*' yet he had referred only one patient in five years.

Traditionalist GPs took the view that healthcare programs such as HMRs should be used sparingly, to ensure suitable use of Government funds and considered HMRs to be one of many different healthcare programs they had seen come and go over the years.

> *With some people they [HMRs] are a waste of time. I feel with my patients, it isn't necessary … Most of my patients have grown up with me and the elderly patients do tend to be prepared to do whatever you tell them.* (Regional Non-HMR GP)

6.1.4 Perceptions of the Program – community pharmacy business owners/managers

The views of community pharmacy business owners/managers tended to fall into four categories: enthusiastic; indifferent; indignant; or; negative. Overall, pharmacists tend to be in the indifferent camp.

Some community pharmacy business owners/managers were **enthusiastic** about the HMR Program. They believed that medication reviews are core to the pharmacist's role, and that the HMR Program gave official recognition to an enhanced role of pharmacists with consumers and GPs. They tended to be involved in other government initiated preventative health programs, and were proactive in establishing relationships with local GPs.

Overall, community pharmacy business owner/managers were **indifferent** in their views of the HMR Program. They did not place HMR referrals as a priority for day-to-day business in their pharmacy. They could take weeks, or even months, to act on referrals. The HMR process was perceived as a burden. Even some who had become accredited to conduct HMRs held this indifferent view of the Program.

> *I don't exactly go seeking them out.* (Regional HMR CPBOM and accredited pharmacist)

The indifferent pharmacists tended to see a limited role for HMRs, and a need to be selective in its use.

> *I think they're a good idea but the ones I've done and the suggestions I've made seem to get ignored by the GP and the issues are not big enough to worry about. I've seen perhaps 3-4 that were useful.* (Rural HMR CPBOM and accredited pharmacist)

Indifferent pharmacists sometimes did not consider the home visit to be essential.

> *The home component is not that important – it should only be a home option. They should be able to be done in the shop.* (Rural HMR CPBOM and accredited pharmacist)

Others in community pharmacies felt that the HMR Program was a good initiative with positive benefits for the consumer, but were **indignant** about the additional training in order to become accredited. They believed that medication review is already a core pharmacist skill.

> *Every pharmacist can do a review … no point to do further training. I review everything. <I am> already very thorough. My question is why? Don't get me wrong, it's good, but it needs to recognise the base skill set of community pharmacists.* (Metropolitan CPBOM)

A small number of community pharmacy business owners/managers had a clearly **negative** view of HMRs. These respondents expressed outright scepticism but also thought HMRs should remain an option available to the pharmacist.

I'm not so sure it's necessary. Probably only 5-10% are really worthwhile. They should be redirected to higher need patients, there should be fewer of them. (Rural HMR CPBOM and accredited pharmacist)

At a pharmacy I was at, there was a big push just to get the numbers up on HMRs so the study would look good, so I'd be wary of the areas of very high uptake of HMRs. If you do have to have it pushed by a facilitator then something's not right – it means doctors are not seeing a need for them. (Rural HMR CPBOM and accredited pharmacist)

6.1.5 Factors in community pharmacy participation and non-participation

HMR Program participation drivers for community pharmacy business owners or managers tended to fall into the following categories: core professional role; customer loyalty; healthcare team approach; low priority; wary.

Core professional role community pharmacy business owners/managers were driven by the perceived health benefits for their customers, and felt rewarded by the positive responses they received from customers who had received a HMR. The primary driver for their participation was the centrality of the medication review and education as core elements in the professional role of pharmacists. They felt that community pharmacy had become too supply-orientated; and that HMR assisted to shift the focus back to providing advice.

HMR ensures that pharmacists get reimbursed for their advice and it encourages pharmacists to offer extra services. (Metropolitan CPBOM)

Most rural towns visited for this research had one (or no) pharmacy, so customer loyalty was not a driving factor for the pharmacies participating in HMR. Those who participated in the Program (to one extent or another) did so for the benefits of their consumers.

Customer loyalty community pharmacies saw HMR as good for business. This group of pharmacists could also be driven to participate in HMR by the perceived customer health benefits and a genuine belief in the Program.

The **healthcare team** group were generally proactive campaigners for the HMR Program and likely to have approached local GPs to find solutions to get the HMR Program working efficiently in their area. This group strongly believed in the value and benefits of the HMR Program and may have undergone accreditation training and conducted HMRs themselves. In some cases, these individuals also held representative positions with the Guild.

We always do them. Never refuse. (Metropolitan CPBOM)

Certainly with HMRs, we can improve compliance; improve knowledge; provide reassurance; demystify the health of the patient; and the GP realises they can use us for advice more than in the past. (Regional CPBOM and Guild advocate)

Some community pharmacy business owner/managers were only mildly interested in HMRs and despite thinking 'HMRs seemed like a good idea', due to time and the costs of becoming accredited, the Program was a very **low priority** (below other initiatives such as diabetes monitoring/testing etc).

Others were disinterested and would process HMR referrals and pass them on to a consultant accredited pharmacist, but considered them also to be a low priority. They did not perceive the Program to be any great asset to their pharmacy and they had no real interest in learning from the reports.

The **wary** community pharmacy business owners were very protective of their customer base and reluctant to use consultant accredited pharmacists as they were wary of losing customers. This type typically preferred to delay HMR referrals than employ a consultant accredited pharmacist.

Financial gain was rarely seen to be a driver for participation, particularly due to the perceived low margins on HMRs.

> Drivers for participation amongst community pharmacy owners included the belief that medication management and education is a core component of the pharmacist's role, the benefits of developing and improving relationships between pharmacists and GPs, benefits for their customers, and improved customer relations. Remuneration was a less common driver.

6.1.6 Perceptions of the Program - consultant accredited pharmacists

The consultant accredited pharmacists interviewed for this research were generally positive in their views of the HMR Program, although most felt there was room for improvement in its effectiveness. Some were concerned that most patients referred for HMRs were not what the consultant viewed as being 'high need' for a HMR.

> *I am sure that I don't see enough of the people that desperately need one, no. They are probably quite infrequent really.* (Regional consultant accredited pharmacist)

There were a small number who preferred to put their energy towards the Residential Medication Management Review (RMMR) Program instead. For this group, RMMRs provided a higher volume of consistent work with less output required on the part of the consultant pharmacist to generate work.

Some accredited pharmacists felt that a HMR was much more comprehensive and a higher quality process than that of an RMMR, particularly because many RMMRs involve no contact with the consumer whatsoever. From a business model perspective however, there was no comparison - accredited pharmacists could make a profit from RMMRs but not from HMRs.

One consultant accredited pharmacist interviewed held a divergent and negative view about the HMR Program. Despite being accredited and stating that home interviews were rewarding and enjoyable to conduct and well received by patients, this pharmacist felt that: the HMR Program was not an effective use of government money and putting effort into those whose health has already deteriorated (*'…shutting the gate when the horse has bolted'*).The pharmacists felt that the government should be putting more money and effort into preventative healthcare initiatives and education, rather than '*wasting mon*ey' on those who the pharmacists perceived as being beyond help (*'Don't drive around without oil and then get the car fixed'*).

Most consultant accredited pharmacists reported getting involved in the HMR Program because they saw it as a potential **business model**, especially for some who were new parents and others who were semi-retired. However, many found that it took a substantial amount of time (in some cases, years) before they received financial rewards from the HMR Program. Consultant accredited pharmacists reported that it was a belief in the health benefits from HMRs that kept them participating in the HMR Program during this period.

Whilst the majority of consultant accredited pharmacists preferred the process of HMRs, many had to rely on the RMMR Program for a consistent income flow.

Many consultant accredited pharmacists were only conducting HMRs for the **benefit of the patient** and the belief in the service, as it served no purpose in generating a profit for their business. In general, these pharmacists relied on RMMRs for the financial reward but found the HMRs more personally and professionally rewarding. Some of these pharmacists also conducted HMRs due to a sense of obligation, as they may have been the only accredited pharmacist in the area and continued to receive requests. They did not wish to decline requests for HMRs where they knew they would deprive the patient of a HMR.

It is not for financial reasons at all that I occasionally do HMRs, it is as service to the patient only. It is a service we should be offering. Those who don't provide the service limit the level of care their customers are receiving. (Regional CPBOM and accredited pharmacist)

6.2 Health professionals' perceptions of the effectiveness of HMRs

6.2.1 Education and prevention or clinical benefits

The primary purpose of the HMR Program was debated among the 'HMR professionals'. Is it first and foremost a tool of education and long-term prevention, or is it a program for reducing adverse events associated with polypharmacy and the achievement of health outcomes? Some respondents felt that the HMR Program can do both well. Many emphasised the patient education function and identified outcomes associated with improved and appropriate medication use.

Discussions with the GPs and pharmacists involved in this research led to the clear impression that HMRs, as they currently stand, mostly tend to: come up with very little of direct significance to the patient's health, from a clinical perspective, that is, they generally do not uncover instances of imminent harm from medication misadventure, such as accidental double-dosing or under-dosing. There is also a clear sense that they have little bearing on hospital admission or re-admission and have very few health outcomes that could be immediately measured from a clinical perspective.

I could not see in the ones I did that it actually made any difference to them at all; they were still on all their medicines. (Rural HMR CPBOM and accredited pharmacist)

There were isolated cases of clearly defined health outcomes as a result of HMRs:

This month I had a 90 year old on Warfarin and he was also put on Tramadol and on a combination of meds commonly known as a cause of renal failure. I reported this to the doctor and he changed two drugs and that was essential, as the patient could have gone into renal failure as a result. I have another one this month which will be an important one. The HMR is being done because the patient has put on 10 kgs in a month. These things can be insidious … Probably in about 90% of HMRs, you provide the GP with some really relevant information and 10% are quite serious medical dilemmas. (Regional CAP and former AACP Board member)

Even accredited pharmacists (whether consultant or working in a community pharmacy) typically struggled to think of many, if any, direct and immediate significant health outcomes as a result of HMRs, even though they could recount good examples of the program being of assistance.

The examples of outcomes included:

- A patient who had multiple bruises from incorrect technique in administering daily injections for insulin and was at risk of ceasing her treatment as a result. As a result of the HMR, the patient was able to adjust her technique, prevent the bruising and thereby be once again fully compliant with the injection regime
- Improving technique for use of puffers and nebulisers
- Shifting timing of medication dosages to ward off side-effects of nausea, nightmares
- Enabling the patient to drop a secondary and non-prescription medicine
- Sorting out confusion that may have arisen with generic names of common drugs
- Encouraging the patient to be more compliant/adherent with critical medications to prevent future life-threatening deterioration
- Make some patients feel that they are indeed 'doing better' than they thought, and feel some pride in managing their own 'systems'
- Some GPs noted that their patients 'felt healthier' as a result of the HMR as it confirmed they were on track and doing quite well with their own healthcare

- Carers were often relieved to have had the chance to be briefed fully on the medications of the person for whom they provided care, particularly where that person's GP did not allow the carer to come in to the appointments.

Instead of generating immediate clinical health or pharmacological outcomes, HMRs were reported to be serving a much stronger role in providing reassurance to the patient; educating the patient on the importance of a medication and the possible side-effects; and providing advice on symptoms that might relate to the medication.

A small number of consultant accredited pharmacists and several GPs believed that HMRs resulted in significant health improvements for patients.

> *I would say 98% of the reviews I do there is something of significance to report.* (Metropolitan CAP)

Most health professionals however stated that the HMR Program influenced prevention and education rather than producing immediate clinical outcomes.

Impact on hospital admissions for adverse medication events was expected, by some respondents, to be a longer term outcome.

> *There might not be a shift in hospitalisation numbers now, but further down the track there probably will be … Patients are not coming in with those obvious adverse reactions … <HMRs are> helping to stop it getting to those phases.* (Rural/Remote HMR Accredited CPBOM)

Clarification of the focus on immediate clinical outcomes versus longer term prevention and education would be helpful.

6.2.2 Impact of delays

The researchers found that it was common for delays of up to three months to occur between the time a HMR was referred by the GP and the time the HMR actually took place. Further delays would subsequently occur in the time it took for the patient to make the return visit to the GP.

Health professionals referred to a number of consequences arising for the patient, the GP, and the accredited pharmacist as a result of delays in conduct of HMRs, including: the point of the initial referral is often lost over time; the health concern that may have prompted the initial referral can have changed; a new referral comment is often required from the GP; pathology tests often accompany a HMR – new tests may be needed; the patient may have been in and out of hospital since the initial referral; the GP often finds the HMR less useful due to the delay.

The delay caused by the current HMR model, where a hospital has to recommend to a GP that a HMR referral take place, was widely seen as a barrier to access to timely HMRs for post discharge consumers.

> *If I want to send a patient out of hospital, the turnover is really fast, because we have 98.5% occupancy rates. What would be really, really good is if we could get a medication review done by two weeks after discharge…We make recommendations on our discharge that they do that, however then the patient has to then make an appointment with their GP, then take it to a community pharmacy, who have then got to find somebody, then go back to the GP. It's incredibly convoluted for someone who is just out of hospital and isn't feeling terribly well.* (Regional Hospital Director of Pharmacy)

6.3 Gaps in access

CR&C has used the definition of access established by the National Health Performance Committee in 2001 as:

> *The ability of people to access healthcare services at the right place and time, irrespective of income, physical location or cultural background.*[13]

Access was largely driven by participation in the HMR program, or lack thereof, by the range of health professionals. This participation by health professionals is largely driven by the confidence the health professionals have in the effectiveness of the HMR program. At times it is also a result of the restrictions of the business model.

Health professionals identified a number of areas where a HMR **could** be effective but at present these consumers are not typically receiving a HMR. The consumers identified by respondents as having the **greatest** gaps in their access to HMRs were those patients at **highest** risk of medication misadventure, including:

- patients post hospital discharge
- Indigenous consumers
- consumers in remote locations
- CALD consumers
- palliative care patients
- non-compliant consumers
- consumers who are transient or homeless

The reasons for gaps were often believed to be systemic, including inadequate communication between state health services and community health professionals, a lack of consultation with health professionals who service at-risk communities (such as CALD community health workers); or that the Program model was not suited to some consumers (namely, Indigenous consumers). For post discharge patients, a different set of reasons applied.

Inadequate identification of appropriate patients by individual health professionals was also reported to be a common reason for gaps in consumer access. Some respondents questioned whether the referral criteria were suitably designed to target those at highest risk of medication misadventure.

Most respondents reported that HMRs were only reaching patients who were at low or minimum risk.

> *I am sure that I don't see enough of the people that desperately need one, no. They are probably quite infrequent really.* (Regional CAP)

> *The doctors using the Program are good doctors, so HMRs are just tidying up.* (Metropolitan CAP)

One community pharmacy business owner/manager in a rural area however, reported that '*100% of the people getting HMRs were high need*' as the GP only referred those in most need, due to limited availability of resources and time.

6.3.1 Post hospital discharge patients

For most respondents, the greatest gap in access to the HMR Program was in reaching patients immediately following discharge from hospital.

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[13] National Health Performance Committee, 2001.

Hospital pharmacist respondents were anxious to see HMRs used to help reduce the number of patients who are readmitted to hospital soon after discharge due to medication confusion. Hospital pharmacists presented as the health professionals most deeply concerned at the failure of the HMR Program to reach patients they believed to be in great need of the service.

> *Maybe 10% of our readmissions are due to confusion over medications …This is an extremely busy hospital and we are trying to get an additional ten pharmacists … onto the Emergency Department Floor just to achieve medication reviews on the spot for patients … We have quite a lot of kidney transplants here arising from diabetes complications and the side-effects of the drugs they take. HMRs can definitely be valuable once they go home. Having someone come in to the home and help sort things out in the first week is most important.* (Regional Hospital Director of Pharmacy)

> *We have just gone through Easter and so we provided 10 days of medication on discharge … two Webster packs were issued. The patient had the notion that they should be used sequentially, however, they were to be used concurrently and so the patient did not get any of their steroid for that period of time and so they have bounced back into hospital.* (Regional hospital senior clinical pharmacist)

GPs often highlighted long-standing concerns with hospitals changing medications, or prescribing new medications, without communicating these changes to the patient's regular GP. Concern with hospital prescriptions related mainly to hospitals prescribing a different brand of medication, with consequent concerns that this could cause confusion for patients, as different brands were usually of a different colour, shape and size, and could even have slightly different dosages.

> *The patient will come out of hospital and even without any change in the actual medication, they will be on medication that appears to be completely different, due to different brands.* (Regional Hospital pharmacist)

The largest gap in HMRs was for consumers on multiple medications in the immediate period post hospital discharge. There is a strong consensus that HMRs do not reach such patients in the necessary timeframe.

6.3.2 Indigenous consumers

A number of senior staff at Aboriginal Health Services in Rockhampton, Townsville and Geraldton (Capricornia, Townsville and Midwest Divisions) were interviewed for this research along with a number of other health professionals who worked with Indigenous consumers in remote locations. Professionals consulted ranged from CEOs who provided an overall operational focus; to GPs, Aboriginal Health Workers (AHW) and nurses, who provided more of a patient-centred perspective on medication issues.

The overwhelming issues identified for Indigenous Australians related to adverse events arising from not adhering to medication regimes. Patient education provided in culturally appropriate ways was seen as essential.

Assisting Indigenous consumers with medication management was seen to be very difficult but also a high priority. Hospitalisations of Indigenous patients were reported to be high as a direct result of medication non-adherence. One manager of an AHS which operated in a remote area reported that, within his service area, hospitalisations for complications of diabetes/hypertension and non-compliance/adherence with medications were approximately three to four times higher among the Indigenous community than non–Indigenous Australians.

> *The hospitalisations are high … and are related to <non-adherence with medications leading to> complications from diabetes and hypertension.* (Remote AHS Manager)

Non-compliance can make our job very difficult here. (Regional Non-HMR GP working in an AHS)

The management of the multitude of Indigenous health issues was acknowledged by respondents to be much broader and more complex than the Home Medicines Review Program, however, they saw a clear role for the Program in assisting Indigenous consumers to better manage their health.

Health professionals from Aboriginal Health Services reported that non-adherence to medication regimes was a chronic and ongoing problem among the communities that they service. They reported that the medication issues included imminent and current risk of adverse events, including hospitalisation, arising from inappropriate medicine use. While clear steps forward had been made in relation to screening for diseases, there was often a lack of understanding in taking the prescribed medication for the diagnosed disease.

> *The co-morbidities because of the lack of adherence to medications are very significant. We see high rates of infection and the patients don't want to go to hospital or discharge themselves from hospital.* (Regional Non-HMR GP working in an AHS)

Financial disadvantage or hardship impacted significantly on Indigenous Australians' ability to purchase medication, with respondents reporting cost as one of the most significant barriers to adherence among this group of Australians but was also seen to be compounded by lack of understanding of consequences.

> *With diabetic patients, non-compliance is often due to not having the money to buy the medications, but also not fully understanding the consequences.* (Regional Non-HMR GP working in an AHS)

> *In the time I have, I try to explain that they need to take the medication, but they will often say 'we understand but we don't have the money'. The consequences we then see are in the eyes, the feet, the kidneys. They cannot see these consequences and don't necessarily understand that they will eventually see these things if they don't control their condition by simply taking the medications. I then see the patients with the later stages of cardiovascular disease; chronic kidney disease; loss of vision; amputations of the foot.* (Regional Non-HMR GP working in an AHS)

Some respondents reported progress in relation to non-adherence; nevertheless, it is still a major issue. Continuous reassurance and education were seen as important components of the solution and this is where an adapted HMR Program was seen to have the potential to play a role in future.

> *A good percentage are compliant, some are not, a lot of the time if they come from big families, or something else, money goes on other things and a lot of them think, if you take tablets for a while and things settle down you don't need them anymore. It's got to go through education. We need to emphasise that you need to take all medications that are prescribed to keep you at optimum health.* (Remote Aboriginal Health Worker)

It was noted that it was easier among health workers to gauge levels of adherence in areas that operated under the provisions of the Section 100 scheme.

> *<In towns operating under the Section 100 scheme> what we have been doing is going and reviewing the packs, so of course we know what's being used so if they have not used a pack we don't re-issue a new one. Where of course the problem in town here is people just get re-issued another script. They come in and say 'I need a new script' and they might have a heap of stuff at home and that is a problem.* (Remote AHS CEO)

A number of those interviewed reported that there were several different types of consumers within the Indigenous community.

The first type of Indigenous consumer was well educated, working and generally adherent with their medications. Another lived in remote areas and traditional bush medicine and tucker make up a large component of day-to-day life. Western styles of medication and attitudes towards disease are viewed by

these Indigenous Australians as belonging to the 'White Fella'. It was reported that a lot of education is undertaken with this group and that a HMR could be a useful adjunct in this process, if done well.

> *Education is important but socio-economics are a big issue too. They do have a strong attitude of wanting to ignore their illnesses and being resigned to it. Even with education, the message is very hard to get through, but it is still important.* (Regional Non-HMR GP working in an AHS)

> *There is no use in doing a medication review if a person does not have medication to review.* (Remote AHS Manager)

The research identified that the current business model for HMRs was not appropriate for Indigenous Australians in remote and rural regions. Alternative strategies being used or suggested generally involved a location other than the consumer's home as most appropriate for medication reviews. Solutions proposed include funding positions in Aboriginal Health Services specifically devoted to medication review and consumer education by a pharmacist; ensuring that, in remote communities, pharmacists are properly oriented and introduced into the community before attempting health education work.

6.3.3 Consumers in remote locations

Indigenous consumers in remote areas were clearly a high risk group, however, respondents noted that they were not the only population in remote areas for whom difficulties exist.

> *What you find in remote areas are the lifestyles are similar, so Indigenous health and non-Indigenous health are very similar.* (Remote AHS CEO)

These areas often have no doctor or dispensing pharmacist available to them and are serviced by means of a 'fly-in, fly–out' service, often on a fortnightly to monthly basis.

> *You look at the PBS in those areas and it's just so hugely down on other areas. Why is that? Because people can't get to see a doctor, they can't get a script written.* (Remote AHS CEO)

> *What we do is we do a monthly run, so we just do chronic disease … that's about it. We can't do the acute, we can't do much primary care, we can't do much health promotion, we can't do the basic stuff because we are there for only 3 hours, 5 hours a month, and that is a problem.* (Remote AHS CEO)

The difficulty of obtaining accessible healthcare is a substantial and ongoing problem for remote communities. Respondents reported that the lack of availability of any service, coupled with illness and a general reluctance to adhere to medication regimes, was having an enormous impact on the type of service they could provide.

Example

One AHS servicing a remote town had a doctor available but no pharmacy supply. The service attempted to manage this gap with innovative means, reporting that patients would fax the script to a chemist 200 kms away and then medication would be sent to the patient via post. This method of obtaining medication provided limited success, with patients residing outside the town often picking the medication up from the post office – sometimes 50 km away. As a result, many did not return to collect their medication.

6.3.4 CALD consumers

CALD community health workers from Dandenong, Bayside and Bankstown Divisions (covering large areas of metropolitan Melbourne and Sydney) were interviewed for this research. Perceptions of HMR and CALD communities were consistent across all three metropolitan Divisions – despite the fact that Dandenong and Bankstown were areas with a much higher proportion of residents from CALD backgrounds than Bayside.

CALD community health workers reported that CALD consumers with a regular doctor and pharmacy were just as likely to receive a HMR as patients from English speaking backgrounds. However, this type of CALD consumer was more likely to have been in Australia for a long period of time, allowing them to have established regular relationships with their doctors and pharmacies. Also, they were more likely to have family members that speak English and assist them in their dealings with health professionals.

CALD community health workers reported a gap in reaching the broader CALD population and identified that many of their clients were potentially at high risk of medication misadventure. Patients who do not speak English are often isolated, especially if they are in an area where they don't have access to health professionals speaking their language. For example, one CALD worker stated that there were bigger health issues for Greek and Turkish patients in the Bayside area than for the local Indian or Chinese population, as there were many GPs from the latter nationalities practicing in near by locations. Furthermore, CALD health workers reported that despite the option to have access to interpreters when visiting health professionals, some were reluctant to use this service.

Other high risk characteristics of many CALD consumers identified by community health workers included:

- high levels of confusion about their medication

  Some of them will say 'I am on this blue medication … but I don't know why.' (CALD community health worker)
- a tendency amongst some CALD patients to see their medication as valuable and not something to be thrown away, often keeping medication well past its use by date
- certain cultural beliefs that could hinder appropriate use of medication, such as different beliefs among certain cultures that cancer is a curse rather than a disease that can be treated with western medication and myths about medications.

  There is a lot of misinformation going around about medications and probably western medicine in general I suppose, that they get from the cultural group, their friends and family and things like that, that stops them adhering to what their doctors has prescribed … I had a man yesterday … that was on diabetes medication and he was told not to take his diabetes medication as it would make him impotent. I had to explain to him, 'it's actually the opposite, if you don't take it you might become impotent'. (CALD community health worker)
- the children of non-English speaking parents often had to take on the responsibility of ensuring that their elderly parents were taking their medication correctly
- as community centres only reach a certain proportion of the high risk CALD population, many high risk individuals amongst this group are receiving no help.

While there were issues raised in earlier phases of this research about certain cultures having a reluctance for strangers to visit the home, most CALD workers disagreed, believing there were no differences here to mainstream Australia. That is, if the HMR visit is introduced correctly by the patient's regular doctor or pharmacist, then there is no issue.

> *Depends who it is coming from. They trust the GP, if coming from them, they trust their word.* (CALD community health worker)

One HMR GP, whose patients were predominantly refugees, migrants and asylum seekers, noted that newly arrived refugees tended to be particularly familiar with home visits by a whole range of health and other professionals, as it is part of the process for refugee settlement.

CALD community health workers felt that there was definitely a role for community health workers in reducing the access gap for their clients around the HMR Program.

Community health workers run regular groups conducting health promotion with CALD populations, and often run partner programs with groups such as Diabetes Australia. They often educate groups on the importance of having regular doctors and pharmacists.

One of the core goals of the community health workers is to assist the elderly to remain living independently and they saw the HMR Program as having the potential to help with this. Case workers routinely conduct home visits and see those at risk first-hand.

However, community health workers qualified their potential to assist with HMRs by stating that they did not have enough resources to cater for everyone in need.

> *There is definitely a role, but we don't have enough staff to cover everyone.* (CALD community health worker)

> *There is a need for communication to community health centres. Information exchange is what is ideal … and inform us about new programs and we can tell our clients. <We need> a way of identifying and screening more at risk people, because a lot of the time they are very hidden it's not until they have an acute episode … that you know that something is going wrong.* (CALD community health worker)

There is a need for the HMR system to incorporate CALD workers and community centres if the Program is to effectively target this high-risk group. Their current exclusion is a barrier, creating gaps in access for CALD consumers. Health workers run regular health information sessions and case workers conduct regular home visits.

6.3.5 Palliative care patients

A number of respondents with specialist expertise in palliative care outlined the role that HMRs could play for palliative care patients. They spoke about the potential value of HMRs in enabling a review for patients who are in the terminal phase, as well as for patients who are in the dying phase. In each phase, one of the key issues is to review and recommend the reduction and elimination of medications which were no longer relevant. For example, patients suffering side-effects from continuing to take medications related to kidney function and diabetes may benefit from reducing such medications, as the patients were beyond the point where the medications served a purpose.

In the dying phase, palliative care practitioners identified that there is a need for an urgent HMR so that every medication not directly related to providing end-of-life comfort and pain relief is reviewed and unnecessary medications discontinued.

6.3.6 Non-compliant consumers

All respondents agreed that the most non-compliant patients were not receiving HMRs, and most felt that the Program was not effective in targeting these patients. Some respondents felt that these patients would remain non-compliant regardless of access to HMRs or any other government initiative health program, while others held a counter view.

> *There is a certain element of compliance involved in a lot of this, and unfortunately a lot of high risk patients are not compliant.* (Regional/rural Non-HMR GP)

Some respondents expressed strong opinions that it was not appropriate to refer non-compliant patients for HMRs, because a HMR was unlikely to make a difference for this type of patient. Some respondents (including some Facilitators) tended to actively support measures designed to focus on long-term prevention and younger, less complex patients rather than those seen as 'too far gone'.

One GP provided the following example of a highly non-compliant patient:

> *If he was still alive he would be 70 years of age … he saw a number of practitioners, consulted a number of practitioners on his walks around the area, for the purpose of having his blood pressure checked and determining what blood pressure medications he fancied taking. Every time I saw him his medication was awful. Every time I asked him 'what are you taking now?'… it was very rare that his blood pressure was normal … At the end he got a massive cerebral haemorrhage and passed away. It was coming; it was a long time coming. He was setting himself up for disaster for about 12 years. There was nothing you could do, he was the sort of guy that would show you the door [if you suggested a HMR].* (Metropolitan Non HMR GP)

Others felt the opposite was true – that non-compliant patients were precisely the type of patients who should be targeted by a more intensive and deliberate approach to the HMR Program. These respondents emphasised that even small adjustments to medication for patients with highly complex illnesses could make a real difference to their quality of life and survival.

> *There is a lot of non-compliance, but some of it is wise <because of side-effects>, some of it is mistaken, some of it is accidental.* (Regional consultant accredited pharmacist)

> *We are doing HMRs for patients at medium risk, because they are the type <of patients> that are happy to have the HMR. It is harder to get those who are non-compliant.* (Rural/remote HMR GP)

Overall, there was little evidence of HMRs being recommended and used for highly non-compliant patients. There is considerable evidence of it being very difficult to reach such patients to provide a HMR service to them, based on the current model.

6.3.7 Consumers who are transient or homeless

Transient or homeless consumers are recognised by many health professionals as suffering from high levels of medication misadventure. These consumers are very difficult to reach and tend to fall through a range of 'safety nets' designed to assist them in their healthcare. They may attend emergency departments in hospitals or a series of GPs. The HMR Program is seen by respondents as being difficult to apply to these consumers, but also as a service which could be beneficial to these consumers.

6.3.8 Consumers living with a mental illness

The qualitative research with health professionals did allow an opportunity for this issue to be canvassed in the study to some extent. Despite comments and findings by some stakeholders and within elements of the literature review, indicating that there was a gap in HMR access for consumers living with a mental illness, CR&C found that overall, GPs did not consider HMRs to be a suitable approach for most of their patients with a mental illness, particularly because not all such patients were on multiple medications, therefore interactions were not necessarily an issue. In addition, the home visit component was not necessarily considered suitable if the patient was exhibiting signs of being unstable anyway. Furthermore, several GPs interviewed for this research who had a higher proportion of patients with a mental illness, expressed a belief in maintaining the one-on-one GP relationship with

such patients, as a key element in achieving best possible outcomes in terms of compliance with medication. An additional complicating factor was that consumers living with mental illnesses were often younger and therefore shared some of the issues which related to younger consumers and HMRs, discussed in the following section 6.3.9

6.3.9 HMRs considered less appropriate for younger consumers

Younger patients with chronic disease and high medication use are typically not being reached within the HMR Program, however most respondents were not concerned about this, as they considered that HMRs were generally not appropriate for a younger age group. Subsequent consumer research also indicated that the Program in its current form is not as appropriate for younger consumers, who tend to have a negative reaction to the prospect of a home visit, as they see it as something that is only necessary for older people. They also felt strongly that they 'still had their faculties' and so this service would not be necessary for them.

There is a need to decide whether the HMR Program is an appropriate healthcare tool for younger patients.

6.4 The need for a more flexible model

The need for a flexible HMR Program model was a raised by respondents across all Divisions visited for this research. Even where the HMR Program was working well, with strong relationships and good communication channels between health professionals, there was still consensus that the HMR model needs to be flexible to account for differing circumstances.

6.4.1 Working around the system

In many of the cases where HMRs were occurring more frequently, this was enabled by 'working around the system'.

As the researchers moved from Division to Division, they became aware that individuals were often going to considerable lengths to adapt the designated processes, so that they could make the Program viable and enable HMRs for local patients.

Where HMR participation and access worked well, it was commonly found that the reason it was working was due to the diligent efforts of individual health professionals, who had found innovative solutions to make HMRs work for them and their patients in their particular setting.

It became clear that, ideally, the HMR Program needs to reflect the reality of how the system works best 'on the ground' by allowing for a flexible model. In some cases, the guidelines could be interpreted as allowing for the modifications currently being made, however there is often uncertainty on this among the health professionals or GPs who are involved and they prefer not to have to find 'loopholes' when it comes to a Medicare claim item.

> Where the HMR Program works well, it tends to work in spite of the system and not because of the system. A flexible model is needed to reflect the practical aspects of the Program.

The need for flexibility was especially evident in rural and remote locations, where health resources were often more limited than in metropolitan areas.

> *Have to adapt the model to make it work here.* (Rural/Remote CPBOM)

In one rural/remote town with only a single pharmacy and single solo practice GP, a practice nurse identified eligible HMR patients whilst undertaking health assessment visits for those over 75. The nurse conducted the HMR visit for these patients.

There were a number of rural and remote community pharmacy business owners/managers (who were not accredited), going out to conduct the home review and sending all data off to a consultant accredited pharmacist electronically for them to confirm the HMR report. This occurred even though there were locally available accredited pharmacists, however they were employed or had a regular working relationship with another community pharmacy, so were not asked to do the HMR. In these instances, a pharmacy was 'working around the system' in order to protect the business interests of its franchise.

In one rural town, the community pharmacy owner, who was also an accredited pharmacist, arranged for those referred for HMRs to come to his pharmacy (as long as they were physically able) because he did not see any need for the home visit component in many instances. He stated that home visits should be only an option and not a requirement. In several cases, this pharmacist's HMR recipients were also interviewed for this research. They lived only two or three town blocks from the community pharmacy so distance had not been a barrier at all in these instances.

One modification that was being made in almost every HMR discussed with GPs or accredited pharmacists as part of this research was the elimination of a phone call between the GP and the accredited pharmacist. This rarely occurred as most communication was by paper, fax or email, yet it is a modification which, while outside the guidelines, did not appear to be having any detectable detrimental effect.

In some cases, modifications are minor and relate to simple, practical considerations and adjustments to the designated process which are made to reflect local realities. These examples offer an insight into what may well be more appropriate approaches for particular communities.

In order to cater to the specific needs of some rural and remote patients (in particular for Indigenous communities) medication reviews were taking place either in the pharmacy, or at a public safe place suitable for both the pharmacist and patient. In one instance, Indigenous consumers would have the HMR consultation near the pharmacy. This was considered to be an appropriate and culturally acceptable way of providing the service.

> *[The pharmacist] is great. He does them on the bench outside the pharmacy if he has to.* (Rural/Remote HMR Facilitator)

It was rare for the HMR Program to be working efficiently without some level of modification.

Some health professionals in rural and remote areas had not yet found a way to modify the HMR model to fit their circumstances, so were not participating in the Program. Respondents with circumstances that did not fit the HMR model included:

- dispensing GPs in towns where there was no local community pharmacy at all
- GPs who offered fly in/fly out services to remote consumers
- rural hospital physicians and nurses with no authority to initiate a HMR referral; and
- towns where one health professional (either GP or pharmacist) was simply not interested in HMRs, leaving the other unable to utilise the Program for their patients/customers.

Whilst some respondents did not explicitly state the need to modify the model, it was apparent they were in fact modifying the HMR Program model to fit their needs.

The most common example of modification related to the GP - accredited pharmacist communication step in the process. In reality, verbal communication between the GP and accredited pharmacist rarely occurred. A phone call was also considered unnecessary by most GPs and outside the scope of usual

GP-provider interaction. Most GPs were not aware that verbal communication with the accredited pharmacist was required.

> The need for a flexible HMR Program model to account for differing circumstances was a consistent finding across all Divisions, even when the Program was working well and strong relationships were established between health professionals.

> At present, the range of barriers and inflexibility of the model mean that HMRs are unlikely to happen in an ideal timeframe.

A number of respondents reported that the reality of participating in the HMR Program had led them to realise that the Program 'red tape' was not the issue they thought it would have been.

> *It appears hard when you don't do it. But it is not that difficult when you do actually start doing them.* (Metropolitan HMR GP)

In some instances, particularly in rural areas, the association of HMR with excessive red tape was not eased until relationships were formed and the model adapted to fit local circumstances.

> *Once the process was started, things started to fall into place. But it was the initial 'how do we do this?'* (Rural/Remote Accredited CPBOM)

The perception of difficulty and red tape reduces as health professionals become familiar with the HMR process and streamline it to fit their individual business needs.

6.4.2 Flexibility in meeting the needs of Indigenous consumers

Respondents from two of the largest regional Aboriginal Health Services in Australia (Townsville and Rockhampton) felt strongly that offering HMRs to Indigenous patients in their clinic would be a very valuable service, and would also alleviate some of the extreme time pressures on GPs and practice nurses. One of these clinics had some 10,000 Indigenous patients on its books, with up to 1,000 of those suffering from diabetes. The other regional clinic had some 7,000 Indigenous patients on its books, with upwards of 800 diabetic patients.

> *If we had a pharmacist here that we could refer patients to, so they could speak to them for some time, perhaps meet with them fortnightly or monthly initially, it would definitely help – educating them a little each time. The diabetes educators could also alert the GPs to the patients who should be referred to the pharmacist. It's a very personal service here. The staff in reception are Indigenous themselves and so they encourage the patients to take the advice, attend the appointments.*
>
> *They would come and they would listen, because we do a pick-up service. They like the staff here, they like the doctors here, so they are happy to come. If they're not, they don't come back.*
>
> *If you can change one thing, it is better than no things.*
>
> *It's all practical you know. Some of the education, even in the younger ones, is not as good as a lot of others, a lot of them don't read and write particularly well, so if you can get the message across … in a nice way, and if they keep coming back to see you, then you know that you're on the right track. Because as I said, if you change one thing and then gradually change more, that's the way to go.* (Regional AHS Practice Nurse)

The practice nurses and GPs in the large regional Aboriginal Health Services visited for this research emphasised that they are accustomed to working in a collaborative healthcare setting, and constantly refer to other in-house resources, including podiatrists, diabetic educators, hearing specialists, eye specialists and others who provide sesssional support at the clinic. Providing a service for HMRs in a similar manner would therefore be more familiar, and palatable, for the patients and the clinic.

Based on findings of this qualitative phase, it is likely that this type of service may be best provided as an option to Aboriginal Health Services – as some believe it would be highly beneficial, whereas others do not see the need for it in their area.

Aboriginal Health Workers in one service felt that for a HMR to work effectively, there was a need to collaborate with local health professionals and to utilise local community pharmacies to undertake reviews with the assistance of Aboriginal Health Workers. They preferred this approach rather than having a pharmacist under the direct employment of the AHS. This model was currently working with one very proactive community pharmacy in the Midwest Division.

> *Getting on my country high horse, if there is a pharmacy in the town we should all be supporting that pharmacy to make it a viable business so it is there for everyone.* (Remote AHS CEO)

6.4.3 Section 100

Some respondents were employed in areas that operated under Section 100 provisions whereby they provide a range of QUM and medication management services, including education materials and training, to support approved remote area AHS that participate in the special supply arrangements for PBS medicines under Section 100 of the National Health Act 1953. Links between HMRs and Section 100 provisions were seen as mildly successful in improving both the uptake of medication and assisting with adherence.

> *' … the drugs we hold: they are mainly diabetic, hypertensive, renal disease and antibiotics that we hold. We hold those really because even though we have got a pharmacy that is just 100 metres down the road we found that we could get better uptake of medications if we held them, dish them out here, Aboriginal person to Aboriginal person.* (Remote AHS Manager)

Most Aboriginal Health Workers saw that while Section 100 (s100) had benefits and assisted in leading to clear improvements in the health of Indigenous patients, there is still a place for HMRs both within s100 and in non-s100 regions. There was consensus that the current goal of an enhanced primary model would incorporate HMRs, and that the educational component of a HMR would be a core element within the HMR model for Indigenous Australians.

Flexibility in the model was viewed as vital to the success of a HMR Program for Indigenous consumers.

> *You can't have a one size fits all model - it is not going to work.* (Remote AHS CEO)

6.5 Workforce issues

A range of respondents reported that limited resources and workforce shortages in the health sector were a barrier to health professional participation in the HMR Program. Shortages were a problem in a variety of geographic locations, with shortages of accredited pharmacists being one of the concerns.

6.5.1 Rural and remote areas

Many community pharmacy business owners/managers in rural and remote areas reported that it was difficult to get through HMR referrals in a timely fashion due to the large general workload.

Time was also a barrier for those rural/remote community pharmacy business/owners operating a modified version of the HMR model (where they would undertake the interview themselves and send the data to an accredited pharmacist). Many were working in states where pharmacy legislation required

the pharmacist to remain in the shop for at least 5.5 days per week. They were usually forced to conduct HMRs out of working hours and this was a barrier to increased participation.

> *I find it very difficult to take so much time out of the pharmacy.* (Rural/Remote CPBOM)

Arranging for locum pharmacists is a great expense for rural/remote pharmacies. Costs include the locum's salary, their travel and accommodation costs, as well as a finder's fee for the pharmacy recruitment agency. One (remote location) business owner reported that the contracting of a locum to be available for a 12 month contract included a $10,000 finder's fee, taking the projected cost to over $100,000 for a 12 month contract.

Pharmacy and workforce shortages, coupled with the lack of accredited pharmacists in rural and remote areas, led to a resistance to HMR by some community pharmacies.

> *The pharmacists aren't keen. They're a major stumbling block.* (Rural/Remote Non-HMR GP)

6.5.2 Time as a barrier

The perennial problem of enormous time pressures on GPs is a barrier for HMRs – just as it is for many other health programs that place demands on GP time. The difference, however, appeared to be that the HMR Program was one of the most likely programs to be abandoned as a result of time pressures.

It is essential that HMRs impact a GP's time as little as possible in order to overcome the barrier of time.

Many GPs interviewed reported being extremely overloaded. Most had closed their books to new patients and were working long hours. Some were seeing well over 100 patients a day. For these time pressured GPs, incorporating government health program initiatives like HMRs into their busy daily practice was seen as too difficult.

A number of solo GPs perceived themselves as being especially pressed for time. They reported that being in a solo practice hindered participation in the HMR process. These GPs felt that larger practices have better resources, including practice nurses and administration staff, to do the required follow up on HMR referrals (such as chasing reports and tracking follow up appointments). HMRs seemed *like a good idea* for the time pressured solo practitioner GP, but they just did not have the time or resources to participate. Often they '*had not really thought about*' the HMR Program before being contacted to participate in this research.

There were however a number of solo practitioners who regularly participated in the HMR Program and had found ways to incorporate HMR referrals into their practice.

GP shortages were especially evident in rural areas. Many rural and remote towns had only one practicing GP. Often this GP would not reside in the town, splitting their time between their metropolitan or regional base and the remote town. These GPs had very little time available to undertake 'new government health initiatives.'

Some remote locations had no permanent GPs, with the community only having access to healthcare via fly in/fly out doctor services (such as the Royal Flying Doctor Service and private providers). GPs who offered fly in/fly out services reported that it was not possible to offer HMRs to their remote patients because it was too difficult (and costly) to get pharmacists to go to these areas.

> *We only do HMRs for our [town] patients. I mean you have got to take the pharmacist with you, it's just not worth it for them – unless there is a special incentive for remote area patients. I mean, there are high risk patients out there who are very crook with all sorts of problems but … pharmacists are not keen to go there, not private pharmacists ….They're making more money in their own little shop.* (Rural/Remote HMR GP)

6.5.3 High rotation of doctors in rural and remote areas

Rural and remote respondents frequently raised issues relating to the high rotation of hospital doctors and GPs in rural/remote areas. Many respondents reported that that due to a GP workforce shortage in rural areas, it was often overseas trained doctors who were enticed to work in remote locations. Most respondents were not criticising the fact that these doctors were overseas trained, rather that they were hired to work for local health services on short-term contracts. The frequent rotation of doctors hindered relationship building and acted as a barrier to the HMR Program.

Example

One overseas trained doctor had recently been transferred to operate a general practice out of a local hospital in a small rural town. This GP had previously worked in a different rural area where he had worked closely with the local pharmacy to participate in the HMR Program. This GP was keen to be involved in HMR in his new location and had attempted to refer patients for a HMR to the local pharmacist. However, he discovered that the local pharmacist was not accredited and was not participating in the HMR Program. The local Division had since initiated a program where an accredited pharmacist would come from the nearest metropolitan city once a year to conduct reviews for the pharmacy. However, the GP did not view this as an adequate arrangement of capturing those most at risk of problems with their medications, essentially rendering HMRs ineffective in this region. This was a very frustrating process for the GP.

6.6 Referral pathways

6.6.1 Direct referral to consultant accredited pharmacists

The suggestion that direct referral to consultant accredited pharmacists should be introduced as an option in the HMR process model produced two streams of opinion among respondents. Any consideration of this option emphasised the importance of maintaining involvement of the community pharmacy. The suggestions were to include an **alternative option** to enhance participation and improve access for consumers. It was **not to replace** the existing model.

Some GPs interviewed for this study already refer directly to accredited pharmacists and prefer to do so as it is in line with their usual approach and they trust the health professional involved. Other GPs not currently referring to accredited pharmacists felt that there was merit in the option of direct referral. GPs in rural and remote areas who did not have access to consultant pharmacists (as there were none operating out of their area) were strongly in favour of the option being made available, with some suggesting that the Division MMR Facilitator would be in a position to coordinate this process.

All GPs in favour of direct referral strongly emphasised the importance of keeping the local community pharmacy in the loop.

> *I think it is simpler now because we can refer to [name of accredited pharmacist] directly now so it became less complicated…even though it took only one step out of the equation.* (Regional HMR GP)

> *I've had GPs refer directly to me and I have had to say 'No you can't do that'.* (Regional CAP)

Some community pharmacy owners interviewed for this research did not have any concerns about direct referral, as long as they were kept in the loop. They felt that the current model for referral should always be the preferred model and the first path taken. However, they stated that community pharmacy business owners/managers needed to take responsibility and respond to HMR requests in a timely

manner, and that GPs should be able to refer to a consultant pharmacist if the community pharmacy did not provide a timely response to their request.

Other community pharmacy business owners/managers reluctantly acknowledged the potential need for a direct referral option to consultant pharmacists, however some in metropolitan regions felt that direct referral would only be appropriate for rural or remote areas, where they believed there would be a shortage of community pharmacies. Some in rural and remote regions felt that direct referral would only be appropriate for metropolitan areas, where they believed that consumers would be less likely to have developed relationships with their community pharmacy. In other words, '*direct referral is a good idea but don't think about implementing that in my region'*.

The option of direct referral to a consultant accredited pharmacist is well supported by many health professionals.

All consultant accredited pharmacists interviewed were in favour of the option of direct referral to an accredited pharmacist.

The introduction of direct referral to consultant accredited pharmacists produced two streams of opinion among health professionals – where it would act as a barrier or enabler to participation.

A number of respondents firmly believed that direct referral to a consultant accredited pharmacist should not be allowed, even as an alternative when the standard referral pathway was not working.

This position was primarily argued by some community pharmacy business owners/managers who felt that direct referral would exclude the community pharmacy. In doing so, they believed the HMR process would lose access to relevant patient medication history. These pharmacy owners were concerned that a pharmacist unknown to the patient contacting them about their medications would risk offending, upsetting or confusing patients/customers.

> *As a former community pharmacy manager, I would hate to see GPs and accredited pharmacists set up these super clinics. You need to enable the community pharmacy to be the information collector.* (Regional MMR Facilitator)

Other community pharmacy business owners/managers currently participating in the HMR Program were concerned that consultant accredited pharmacists would not be protected by the *'same umbrella of protection'* or safety-net that a community pharmacy has if the patient suffered complications from medications after receiving a HMR and making changes.

Strategies to manage business risk, quality control and insurances for Consultant Accredited Pharmacists working independently of community pharmacies may need to be considered if direct referral is to occur.

For others, the resistance to direct referrals to consultant accredited pharmacists was related directly to the protection of established customer relationships. Even when the pharmacy would hit 'peak times' creating a delay with HMRs, they would never consider hiring a consultant to undertake HMR referrals.

A number of GPs were also concerned about direct referral to a consultant accredited pharmacist. For these GPs, concerns primarily related to the patient relationship and referring their patient to a

pharmacist who did not have an established relationship and who would not have firsthand knowledge of the patient's medical history.

> *I think the best person to do the HMR is the patient's pharmacist, whether they are accredited or not. Because they know the patient … I mean the stuff that they are giving us back is not rocket science, and if these guys have got their pharmacy degree … If you have a patient within a community and he has got his pharmacist and you're talking about getting his medical or pharmacy profile assessed by some stranger outside the community: a) you're going to alienate the patient; b) you're going to insult the pharmacist; and c) you are going to get mixed results which are of variable use to the GP.* (Rural/Remote HMR GP)

For other GPs, concern about direct referral to a consultant pharmacist stemmed from a wariness of 'career HMR pharmacists'. Such GPs felt that consultant accredited pharmacists were undertaking HMRs for monetary reasons rather than having a genuine interest in continued patient care. One GP stated that his negative perception of consultant accredited pharmacists was enhanced by the increased numbers of RMMRs occurring, and the fact that RMMRs '*fall on your desk'* without the GP initiating the referral, and that the RMMR process was tedious for GPs and could work as a disincentive to participation on HMRs.

6.6.2 Alternative referral pathways for post hospital discharge

Of all the interviews conducted for this phase of the research, the respondents most anxious to see the HMR Program working well were the hospital pharmacists, who were seeing the daily effects of medication misadventure leading to hospital admissions and readmissions (or 'bounce backs').

The respondents who expressed great concern about the lack of access to HMRs in the post discharge period, believed that the Program could be integrated easily into the hospital discharge planning process. They suggested that referrals made by hospital doctors and hospital pharmacists directly to a consultant accredited pharmacist or a community pharmacy.

> *There needs to be a comprehensive handover back to community care … it is getting primary care activity, primary care resources being deployed in those areas. If the report came back to us as well … <and> we know these are repeat offenders, we are highly likely to have these patients come back to us and we could then monitor how effective it had been for the patient to have the HMR.* (Regional Hospital Director of Pharmacy)

6.6.3 Referral and other roles for nurses in HMRs

One strategy is for practice nurses to be actively involved, with some support for practice nurses being granted referral rights for HMRs in certain circumstances.

> *We're very very busy here as we are also hospital GPs and work in A & E as well. So we are very much time-pressured. Doctors here are therefore mainly treating acute illnesses and while education and prevention is important, we have limited resources for that. So this is a role we are asking of the practice nurse. It is otherwise all a competition for our time.* (Regional HMR GP)

In small towns with limited healthcare services, nurses were often the most stable health professionals, and were regularly required to act above and beyond the usual nursing role.

Example

One remote town visited for this research had a stable population of 1,400 residents (swelling to 10,000 in peak holiday seasons). A solo GP practice serviced the town four days per week. There were no resident doctors employed at the town's health centre, which was staffed by state-funded nurses. These nurses are considered to be the town's primary healthcare providers, with strong relationships with the local GP and pharmacist.

Local nurses felt they could play a vital role in health programs including HMR, as they were often the connection between doctors, pharmacy and patients - and the first point of call for patient care.

Nurses had the opportunity assist with identifying and tracking eligible patients. In some instances, rural practice nurses are already doing the home visit aspect of the HMR. In order for HMRs to be possible under an adapted model in some rural areas of Australia, it is often a case of having a practice nurse involved. The alternative may be having no HMRs take place at all or not for three-four months.

Community nurses interviewed in metropolitan divisions felt that they were also in a prime position to identify high risk patients for HMRs. Community nurses see patients post discharge from hospital, and part of their routine visit is to ask about medication. Some community nurses interviewed had not heard about HMRs, and were surprised at this. They believed that they were in a unique position to connect high risk patients to their pharmacists and GPs. They did however caution that there are certain types of GPs who were not receptive to nurses' recommendations, and that in these instances there would be blockages.

Metropolitan community nurses also mentioned that it would be very useful to have a list of accredited pharmacists in the area to contact in these circumstances for referral to the HMR Program.

Respondents also suggested that it is appropriate for palliative care nurse practitioners to be authorised to refer directly to an accredited pharmacist for HMRs, and that up to three could be allowed within the terminal and dying phases, unrestricted by timelines (given the unpredictability of such phases).

The palliative care nurse practitioner is already authorised to prescribe medication. Changes to allow the nurse to refer for HMRs, with a requirement to keep the GP and community pharmacy informed, were seen as minimal but necessary.

Consideration could be given to providing a referral role on HMRs for practice nurses, community nurses and district nurses, in certain circumstances.

Palliative care nurse practitioners appear to be ideally placed to refer for HMRs.

6.7 Accreditation issues

Substantial evidence emerged that pharmacists perceived the accreditation and re-accreditation process to be difficult and onerous. The accreditation process was presented as a barrier to participation, particularly in rural and remote regions. Negativity towards the accreditation process was widespread –

across all regions and types of pharmacists, including those with substantial experience as well as recent graduates.

> *50% of barrier to entry is the fact that the examination for becoming accredited is overly onerous, for something that even the new graduates are coming out with a 4year degree, but you're saying they can't do it, they have just finished their degree in … patient care, pharmaceutical patient care, and then you're saying 'well, no you can't actually do that – we want you to do another test'. I just think that the association of consultant pharmacists are just trying to make themselves elitists in all honesty.* (Rural CPBOM)

In one case, a consultant accredited pharmacist who had completed around 1,000 HMRs found the re-accreditation exam onerous. Another pharmacist had decided not to promote their accreditation to GPs because she was 'ashamed' at being told she 'nearly failed' her HMR accreditation exam - this person reported they had always received the highest marks while undertaking their pharmacy degree six years earlier.

> *The complex and difficult five hour re-accreditation exam is a big barrier to me being re-accredited. I run a seven day pharmacy. I have been accredited for three years and am now facing the re-accreditation. They need to make re-accreditation less daunting. 75% of those questions are more suited to a hospital setting so I don't think it is so suited to a home setting. For me it is the re-accreditation process that is too daunting and yet I was awarded the Guild medal when I completed my degree. I can only do the exam when I have another pharmacist available and I cannot be interrupted when doing the online exam. So I just don't think it is realistic.* (Regional CPBOM)

Several reports emerged of pharmacists who had been stuck halfway through the accreditation process for up to three years, unable to find the time and energy to complete the process. The small number of potential referrals of HMRs in many areas meant that individuals were particularly reluctant to spend many hours – and considerable sums of money - to become accredited.

> *I did about 150 HMRs through my previous pharmacy in Adelaide, as we had referrals coming through all the time, but here I have only seen one referral in a year here.* (Rural CPBOM)

For rural and remote pharmacists, cost was a substantial barrier to accreditation.

> *Accreditation and re-accreditation costs too much as well, even though the incentives helped.* (Rural CPBOM and accredited pharmacist)

In some cases, large regional cities had been reduced to one or two accredited pharmacists and had lost the services of several highly experienced accredited pharmacists, primarily because of the accreditation process.

The intensive accreditation process was not considered to improve the perception of HMRs by GPs.

> *I don't think that the GPs are put off by HMRs because they think that we are not academic enough. I certainly don't think that they want reams and reams of academia.* (Regional MMR Facilitator)

One community pharmacy business owner had a different view, even though he admitted finding it almost impossible to find a consultant accredited pharmacist.

> *I hear a lot of people find it <accreditation> a bit onerous but I don't have a lot of sympathy for that attitude. It is not acceptable to be second-best and a certain level of skill assessment is necessary.* (Rural HMR CPBOM, non-accredited, senior Guild representative)

The views on the accreditation process by accredited pharmacists and community pharmacy business owners/managers were expressed consistently and frequently but not unanimously.

6.7.1 GP views on accreditation

As the issues around accreditation were raised frequently, the researchers canvassed the issue at different levels. GPs were probed about what they knew of the accredited pharmacists' skills and

training, and what they thought of the accreditation process. Feedback was sought on whether the process was onerous. Did accreditation have at least a positive flow-on effect to the GPs, perhaps increasing their willingness to refer? Perhaps it increased the trust in the HMR process?

GPs knew very little about the accreditation process for the accredited pharmacists and generally cared even less about what that process was. A few had made a number of assumptions such as '*well I think they probably go through some skills training*', but others made comments such as '*I don't know that they should need to go through any additional training should they? Don't they do this sort of thing every day in their pharmacies? I am not even sure that it absolutely needs to be a pharmacist does it? I think it could be done just as well by a practice nurse.'*

When asked if GPs were aware of the level of training involved in pharmacists becoming accredited to conduct HMRs, one GP said:

> *Do they care?* (Metropolitan HMR GP)

Accreditation training seems to be making little, if any difference, to the perceptions of pharmacists amongst GPs or to the uptake of HMRs by GPs.

6.7.2 Drivers for accreditation

Reasons given by community pharmacy business owners/managers for becoming accredited included being a career community pharmacy manager, but not wanting to (or having the opportunity to) own their own business. These pharmacists saw accreditation as a professional development option, to gain '*professional depth'*.

> *I don't want to own my own business, but I would like to be more fulfilled professionally. So I thought, well, HMR is just a good way to go … one thing that I will say with the accreditation process is [that] I thought 'wow' there was a lot that I don't know … when you see prescriptions come through now you think, 'oh, I know why that is happening'.* (Rural/Remote CPBOM)

Other community pharmacy business owners/managers reported that they had become accredited after receiving requests from their local GP to conduct HMRs. In these instances, it was the relationship with the GP and the customer that drove the pharmacist to undertake accreditation training, rather than a personal belief in the benefits of the Program or for personal development.

Community pharmacy owners/mangers in rural and remote locations reported a number of barriers to obtaining HMR accreditation specifically related to their rural or remote area location. The most prominent of these barriers related to time, costs and a pharmacy workforce shortage in rural/remote areas.

> *We have to spend a couple of thousand dollars to go to Perth for a course and take a few days off work to do it. That's actually an unrealistic expectation … I have not had a holiday for two years because I can't get a locum. How am I going to get a locum <so I can> do a course?* (Rural/Remote CPBOM)

> *I don't believe that it is necessary to jump through this enormous number of hoops and pay all these fees to become accredited. It's ridiculous and that's our barrier to entry.* (Rural/Remote CPBOM)

Some rural/remote community pharmacy business owners/managers had explored the option of completing the first stage of accreditation training online to overcome the time and cost burdens associated with obtaining accreditation. However, one pharmacist stated that he was deterred from taking up the online option by the increased fee for the online training component.

There was a substantial financial disincentive to attending accreditation training for rural community pharmacy business managers/owners.

6.8 Perspectives on remuneration

6.8.1 Remuneration for GPs

While there are financial and payment issues to be addressed with the HMR Program, overall, the problems with the Program do not appear to be primarily a matter of money. There does not appear to be any need for an increase in payment on the GP side.

GP reimbursement was widely regarded as adequate and even generous, with many positive references and descriptions when asked how much the reimbursement was and what they thought of that reimbursement. Comments included: *stacks; heaps; not sure, but I know it is plenty.*

Most GPs had no idea what the actual amount of reimbursement was and no idea of the fact that it was lowered and was then increased. Even when the GP admitted freely to some consideration of financial issues with a number of other government primary healthcare initiatives, money did not appear to be a motivating factor or disincentive on HMRs.

Entrepreneurial GPs were the exception on the matter of payment. Where they referred for HMRs, it was typically in quite large numbers and was routinely applied to all patients in certain 'categories', such as those having an over 75 health assessment. There was evidence that they tended to use the same blanket approach for a number of other Government funded programs and tests.

It is important to note that even when a GP, or clinic of GPs, is widely described as being 'money oriented', the GPs in that clinic are not necessarily doing many, if any, HMRs.

For most GPs, financial reward does not appear to have any effect on their uptake of HMRs.

Community pharmacy business owners/managers who are actively involved in advocating HMRs expressed strong feelings about GP payment for HMRs.

> *There is one part that is well remunerated and that is the GP…The remuneration for the pharmacy and the accredited pharmacist needs to be higher in order to generate more accredited pharmacists. This is absolutely critical. Money is the root of practical and viable programs. For example, the introduction of PBS online and the incentivising of pharmacies to participate [made a major difference]. This [HMR] will work when the model is right.* (Rural CPBOM and senior representative of the Guild)

When asked why the remuneration for GPs was not triggering the greater involvement of GPs in HMRs, the respondent replied:

> *Not sure, I think a lot of GPs have not analysed what is in it for them. Maybe they are just trying to survive a busy practice.* (Rural CPBOM and senior representative of the Guild)

6.8.2 Remuneration for pharmacy side

As mentioned in a number of sections of this report, the general consensus among community pharmacy business owners/managers and consultant accredited pharmacists is that HMRs are not profitable.

The increase in the amount of remuneration to $220, as advocated by the Guild at the national level (in its submission), was consistently reported by pharmacists as a fair and appropriate minimum remuneration for the time required for conducting HMRs. Those pharmacists who were familiar with the Guild campaign for an increase to $220, volunteered this figure as the level at which HMRs would be a reasonable proposition financially. There were one or two respondents who suggested the figure should be closer to $250.

Some of the many comments by pharmacy respondents included:

> *At the moment, it's a love job.* (Regional CPBOM and accredited pharmacist)
>
> *It used to be a loss-making proposition before the increase, now you probably come out even but you don't make anything on it.* (Regional CPBOM and accredited pharmacist)
>
> *The Pharmacy Guild say… 'pharmacists can make a lot of money out of medication reviews,' I reckon that is a load of rubbish……they look at it purely as a service I think.* (Regional consultant accredited pharmacist)

Despite the perception that HMRs are not sufficiently well-remunerated for community pharmacies and CAPs, pharmacists agree the main barrier to take-up is at the GP end and is not related primarily to remuneration.

The very low referral numbers for HMRs combined with an unprofitable payment level act as a disincentive for most community pharmacies.

For many CAPs, distance has severe cost implications in relation to HMRs, adding another layer of difficulty and deepening the extent to which cost is a barrier overall.

Throughout the course of this study, varying views emerged about the remuneration levels for the main participants in the HMR process, that is: the GP; the community pharmacy and the accredited pharmacist. There was consistency about the remuneration for GPs, with agreement that it was adequate.

(See Section 3.4.2 and section 4.1.1 and section 5.1.6 and section 5.2 for additional perspectives on remuneration elsewhere in this report)

Despite the information in the literature review suggesting that HMR remuneration for the pharmacy side is now 'about right', the qualitative research with health professionals in several phases of this study, including Stakeholder Consultations, Call for Submissions and this phase, the Qualitative Research with Health Professionals, uncovered information which could support the case for an increase in the fee for the 'pharmacy side'.

The debate about whether the remuneration for accredited pharmacists is adequate is influenced by the wide range of settings and circumstances in which HMRs occur. There was ample supporting material provided by submitters as well as through fieldwork interviews with health professionals, to indicate that remuneration is often inadequate, particularly for those accredited pharmacists disadvantaged financially by travel costs, yet ineligible to apply for any allowances.

The complex pathways involved in the HMR process and the lack of economies of scale are among the additional contributors to the financial impact on many community pharmacies and accredited pharmacists.

The accreditation incentives, while mentioned in the literature review as making the remuneration 'about right' now (see Section 3.4.2) are not considered by a pharmacist or business owner when looking at the rebate and therefore, while appreciated, they do not tend to influence the accredited pharmacists' response to the adequacy or otherwise of the rebate, because they are related to accreditation and not to reimbursement for professional time spent providing the service.

Overall findings from this study indicate that increased remuneration for the 'pharmacy side' would **not** be expected to make a significant difference to the uptake of HMRs or to the provision of the service to those at high risk of medication misadventure.

6.8.3 Remuneration for consultant accredited pharmacists

Processing payment through the relevant community pharmacy is a substantial payment barrier for some consultant accredited pharmacists.

Late payments from community pharmacies were common, and were seen as reflecting a lack of professional respect and little faith in the Program by community pharmacy owners/managers.

> *It has got to change. . . I am owed so much money. It has to be able to go directly to me. I shouldn't have to spend that time chasing up $160.* (Metropolitan CAP)

Some community pharmacies feel that they should not receive any additional payments – some firmly believe that the consultant accredited pharmacist is doing the hard work, and some believe that the amount they receive (varying from $25-$40 depending on the amount pharmacy decides to retain) for simply filling in forms is quite generous.

It is important to note that many community pharmacies had no problem whatsoever with direct billing by CAPs, and commented that *it made sense to them* – with the proviso that they must keep the community pharmacy in the loop.

Overall, there is a high level of demand for accredited pharmacists to be able to bill directly.

6.8.4 PhARIA travel allowances

There is a widespread consensus that Pharmacy Access Remoteness Index of Australia (PhARIA) allowances are very often inadequate in relation to HMRs. While the proponent for inadequate reimbursement mostly relates to rural and remote areas, sometimes this inadequacy can also apply within a large city, where the CAP has to travel upwards of 20kms each way to conduct a HMR. Respondents argued that it would be more appropriate to provide allowances based on the distances travelled by the CAP.

> *When I go to <name of small town>, I travel a few hundred kilometres to get there as they have no local accredited pharmacists, but the patients all live within a few kilometres of the pharmacy and although it's a PhARIA 3 pharmacy, it is only if I have to travel more than 10 kms from the pharmacy that I receive an allowance and then only $30 or so, whereas it would cost $50-$60 to get there alone. To try to make it more economical, I usually do 6 in a day, which means there is a long delay before I have 6 that I can do.* (Regional CAP)

The problems with travel allowances have a direct impact on the timely delivery of HMR services in some parts of Australia, as CAPs typically need to accumulate a number of referrals in order to make a trip worthwhile. This may take up to four months, as they may need to accumulate up to eight HMRs to make the trip more financially manageable. Typically, they will still make no profit on these types of HMR trips, so it is a considerable disincentive.

In other cases, the accredited pharmacist asks the patient to come to the pharmacy or GP's clinic and the HMR is routinely conducted there rather than in the home, as this is the only way to overcome cost barriers.

Travel allowance was not a major issue in all rural areas, as HMRs were only performed within the vicinity of the town or within a short distance in a regional city and were being performed by the local pharmacist.

> Inadequate travel allowances are having a direct impact on delivery of HMRs in many areas.

6.8.5 Newly established practices

There were many newly established medical practices in one metropolitan Division. Being newly established meant that GPs in the region were in a good position to create new financial and administrative systems and structures to incorporate new government health initiatives such as the HMR Program. Pharmacists in the area reported that local GPs were generally well aware of the Program and this was of considerable benefit in the uptake of HMR. The Division where this scenario applied was one of the higher uptake Divisions explored for this research phase.

6.9 Relationships between health professionals

The quality of relationships between health professionals is a key factor influencing participation by health professionals in the HMR Program. Good relationships often acted as an enabler to participation, whereas poor relationships often acted as a barrier.

Where there were good and communicative relationships, the HMR process was reported to be easy, efficient and effective. Good relationships assisted health professionals to modify the HMR model to fit their circumstances. However, even where these positive relationships existed, HMRs were still not occurring systematically and were not always targeting those in most need of assistance. Good relationships alone were not sufficient to overcome other limitations.

Rural and remote respondents also reported that changes to relationships in small towns could be disruptive to the HMR process. Some rural and remote participants reported that the frequent rotation of overseas trained doctors disrupted established HMR relationships.

> *…it is difficult, he's not very communicative with me … very rarely would he communicate with me.* (Rural/Remote CPBOM)

6.9.1 Electronic communication solutions

A lack of electronic communication was not reported to be a significant barrier to uptake or involvement in the HMR Program by those interviewed for this project. However some respondents believed that electronic communication would reduce some of the perceptions of red tape and burdensome administration, as electronic communication was standard practice for many GPs and pharmacists.

> *The paper trial is a pain in the neck, you know electronic and just being able to do it by secure email is really important.* (Metropolitan HMR GP)

One HMR facilitator in a rural remote Division reported that they were partnering with two other Divisions in a trial to implement secure electronic transfer between GPs and pharmacists in their region.

Developing measures to encourage electronic communication between GPs and pharmacists was suggested as a potential enabler to assist health professional participation in the Program.

6.9.2 Quality of referrals and HMR reports

Many accredited pharmacists reported that the quality of their final HMR report was related in part to the quality of the initial GP referral.

Concerns about the variable quality of pharmacists' reports were repeatedly reported by HMR GPs. A common complaint from these GPs was that accredited pharmacists often produce large volumes of information, sometimes with detailed academic references, and the GP considered the detail to be irrelevant. Invariably GPs preferred short and concise reports, usually not more than one page. In this way, the GP's preference appeared to mirror their preference for reports back from specialists.

Where the doctor had a good, communicative relationship with the pharmacy, they tended to provide feedback about reports, and pharmacists would tailor their reporting style to the doctor's preferences.

In cases where GPs had repeatedly referred directly to their preferred accredited pharmacist (whether a consultant or in a pharmacy), they tended to be quite satisfied with the quality, style and content of the reports they received.

6.10 Strategies to improve access and uptake

6.10.1 GPs' role critical

The point at which the Program's uptake is most affected is with the GPs as it is the GP who will refer patients for HMRs. Without this referral, neither community pharmacies nor accredited pharmacists have a role. The central focus of reporting and involvement is the GP. The consumer component of the qualitative research has shown that it is the decision of the GP that is the most important factor for the consumer to participate in a HMR - and for the final decision in changing medications and to follow through on treatment.

It was apparent from the qualitative research that many GPs are not referring for the Program at all and it would appear that they may be unlikely to ever be interested, given their expressed reluctance. Another segment of GPs only occasionally and sporadically refer for a HMR, while a very small minority refer reasonably frequently. This overview is based on the experience on the ground while conducting fieldwork rather than a data analysis.

> Whatever actions are taken to address program uptake, without a change in the level of interest in the Program by GPs, the uptake of the Program will remain low.

6.10.2 Blanket screening or a targeted approach?

Most GPs were wary of the blanket screening approach for HMR referral, stating that HMRs were not appropriate for every patient that fitted the referral criteria. These GPs considered that referral should be selective, and decided on a case-by-case basis. They believed that doctors should have a clear objective for a patient when referring for a HMR, and should specify the reason for the review on the HMR referral form.

> *The criteria for referral is flexible enough that you could do a large number if you wanted to. But you need to be selective in referring. Some patients have been very complex and these are the ones that have the most benefits.* (Metropolitan HMR GP)

> *Using polypharmacy and health assessment as indicators for a HMR [is OK], but the doctor still needs to make an individual assessment as to whether or not a HMR is required. [We] simply would not have the resources for the luxury of blanket referrals.* (Rural Hospital GP)

It was not only GPs who saw a need for a selective approach. A number of community pharmacy business owners/managers and a number of accredited pharmacists interviewed, expressed a similar view. These respondents felt that generating a referral based on the number of medications alone was not going to generate HMRs that provided significant health improvements.

> *They should be reserved for the high risk patients, for example those who have just been released from a big public hospital on multiple medications.* (Rural HMR CPBOM and accredited pharmacist)

Only a small number of GPs (predominantly in metropolitan regions) were in favour of a blanket screening approach to link HMR referrals to all patients requiring an over 75 health assessment. They combined the administration and reminders for the home health assessment program with those for the HMR, utilising the practice nurses for administration. These GPs tended to be entrepreneurial in their style.

Most consultant accredited pharmacists were reasonably likely to support the notion of blanket screening and promote the benefits of linking HMR into other health programs.

Overall, the researchers did not find evidence to support blanket screenings for HMRs.

6.10.3 The role of Facilitators

While evaluation of the role of the MMR Facilitators was not a component of this project, information and observations on the Facilitators inevitably arose from the fieldwork.

The extent of impact by Facilitators appeared to vary considerably and opinions about their role ranged from great respect and regard for the Facilitator, to outright and vehement disdain for their alleged ineffectiveness; including extreme comments such as *'the person is … a waste of money.'*

Many respondents were ambivalent about the Facilitators and made only mild comments about them, whether positive or negative. Some tended to think it was a good idea to have them there.

There is some resentment among those HMR community pharmacy business owners/managers who are active in the Guild, that resources are unnecessarily going to the Facilitator program. In their view, Facilitators were making very little difference, while the pharmacists themselves were struggling to make this Program pay its way. For some community pharmacy owners/managers, the concern about HMR Program expenditure on Facilitators was great, and they advocated the need to look at re-direction of Facilitator funds.

> *I'm not averse to the removal of the Facilitator function.* (Regional CPBOM and active Guild member)

GPs did not have strong views about the role of the Facilitators but most GPs reported that they preferred to teach themselves about health programs and initiatives. This tendency toward self learning by GPs meant that much of the information and action coming from Facilitators was not seen as particularly useful.

One region had been comparatively successful in generating reasonable uptake of HMRs, but this was only while the Facilitator role was filled jointly by two accredited pharmacists who were able to directly promote the service to GPs. Those GPs then directly referred to those accredited pharmacists who liaised with community pharmacies.

It was clear that without a Facilitator, some Divisions would have almost no uptake of HMRs. Nevertheless, these Divisions did not necessarily have a very high or sustainable level of HMRs and once there was a change in the Facilitator role, the gains appeared to be lost[14].

Through the inclusion of the Sunshine Coast in the list of Divisional areas covered for this research, it was also possible to assess activities in an area where there has never been a Facilitator. In comparison with other Divisions included in this study, Sunshine Coast did not appear to suffer any negative side-effects from the absence of a Facilitator.

Based on information gathered in the qualitative research, the Sunshine Coast has a comparatively high number of GPs who refer for HMRs, and a comparatively high number of HMRs overall.

In the Sunshine Coast, a consultant accredited pharmacist was reported to have been receiving referrals from some 35 GPs. In an area of comparable size elsewhere (visited during this research), only four to five GPs, at most, would be doing regular and high numbers of referrals.

One new Facilitator stated that there was a strong GP mindset that HMRs are about checking up on the GP, and are not for the patient.

In another Division, the Facilitator felt that it was important to clearly demonstrate how GPs could make a good profit from HMRs by combining them with other related Medicare item numbers (such as care plans). However, follow-up discussions with the region's GPs reported being so busy that they appeared to be quite unconcerned about obtaining financial rewards from HMRs. These GPs were more concerned about measures that would remove some of the time pressures, including the post-HMR phone call to the accredited pharmacist.

6.10.4 The effect of a highly proactive pharmacy

The qualitative research phase provided an opportunity to observe the effect of a number of highly proactive HMR community pharmacies. Despite an extreme amount of activity, the numbers of HMRs referred were still low, given the number of patients who would have been eligible 'on paper'.

[14] The variability of uptake over time makes the use of cumulative indicators inappropriate as a Performance Indicator.

Example

In one case, the respondent owned six community pharmacies in one city. The pharmacies had their own in-house full-time HMR accredited pharmacists, who also provided clinical pharmacy services to local private hospitals. These community pharmacies took a highly proactive approach to generation of HMRs. The pharmacy owners and managers had a very strong commitment to the value of the HMR Program and a commitment to the philosophy of HMRs dating back many years. The owner continues to be an active Guild advocate for the HMR Program. These HMR pharmacies, their managers and pharmacists, take every possible opportunity to generate HMRs for the patients they believe would benefit. Yet even with all of this activity, they are still conducting only about 150 a year and find this number of HMRs means they are at only at a break-level financially. Based on eligibility guidelines, the owner and manager of this series of pharmacies would expect to be seeing *about 20 times as many* HMRs.

In another example, the respondent was a community pharmacy business owner, in addition to holding a senior role with the Pharmacy Guild - this respondent was strongly committed to HMRs as an educational and preventive tool, yet his pharmacy is processing only about six per year (outsourced to consultant accredited pharmacists).

> *I try to support them because I really believe, from the instances I've seen, that they enable a lot more people to manage their medications much better, but it is difficult for me to personally deliver on HMRs. It is hard to find accredited pharmacists and I have not been able to find the time to be accredited, having been on the Board of the Guild for 12 years. I haven't had anything but positive responses from GPs, though marketing it to them is hard.* (Rural CPBOM & senior representative of the Pharmacy Guild)

6.10.5 HMR uptake tracing back to a single 'source'

Where there are higher numbers of HMRs, they often appear to be very strongly related to a 'single source' or perhaps two or three sources. While this is generally the case, there were exceptions, including the Dandenong Division.

Where the 'single source' was a GP, that GP did not appear to have necessarily become effective as an unofficial 'GP champion' influencing others to take up the Program. Indeed, it was common to find that a proactive HMR GP's own immediate GP colleagues rarely took up HMRs.

Typically the 'single source' was either a GP who was highly interested in and active on HMR referrals; a community pharmacy which was extremely proactive (including 'reverse referral' activity with GPs); a Facilitator at the Division who was an accredited pharmacist and could provide a reasonably 'seamless' service for the GPs. (A number of other Facilitators considered this a conflict of interest.)

The striking nature of the 'single source' effect on the HMR Program came through repeatedly, but was particularly apparent in certain Divisions. It did not necessarily present as an ideal approach to best practice and appropriate use of HMRs, though that may have been the case in many instances.

In one Division with a population of 150,000 people – and a very low HMR uptake, the researcher could find no 'on the ground' evidence of any HMR referrals that were referred other than by a single GP. The identified GP is also on the Division's Quality Use of Medicines Committee. Of the 12

health professional interviews and three consumer interviews undertaken in this area, seven were traced directly back to this single source.

Example

In one practice, Dr K refers around 250 HMRs a year. He is in a practice where there are eight GPs, but his colleagues are not known to refer more than five or six a year.

6.10.6 Promotion through link to NPS

Facilitators would often use the National Prescribing Service as a stepping stone to discussing HMRs with doctors. For those who held Divisional roles relating to MMRs and NPS programs (and many did), they would set up routine visits to discuss NPS, and would then follow on to discuss HMRs because they could not secure appointments under the HMR heading.

In addition to the connection with setting up interviews, Facilitators tended to find other ways of linking HMR with NPS Programs. Again this was in order to gain the interest of GPs and the credibility that came with the NPS Program. Examples included references by Facilitators to links with the NPS focus on osteoporosis for a portion of 2008, to be followed by an NPS focus on diabetes. Several Facilitators actively promoted these links.

The NPS appears to be more respected and appreciated by GPs.

> *We're now trying to link the NPS case studies with HMR. The current one is on osteoporosis. We will explain to GPs the range of drugs, interactions and other issues associated with medication for treatment of osteoporosis. I will be suggesting that GPs use this as a trigger for a HMR. The next NPS topic is diabetes and we will have the practice nurses in special training for that, so I will also use that as link to HMR.* (Rural Divisional Facilitator).

This Facilitator also stated that she believed the NPS QUM Program has more definitive goals than the HMR Program, and that HMR should have some similarly clear key performance indicators.

The fact that many Facilitators would use NPS as a direct link to the HMR Program is reflective of GP perceptions of the HMR Program compared with NPS.

6.10.7 Systems and organisation

Respondents from all health professions reported that having efficient systems and the resources in place to manage referrals was key to streamlining the HMR process.

Most GPs interviewed reported that additional support staff and organisation structures were needed for HMRs to be conducted efficiently and effectively. Where practices were managing HMRs in a systematic way, they tended to rely heavily on practice nurses for assistance with the administration.

> *It's harder in a smaller surgery if you're not systems driven, and do not have a process to do it, it can drop off.* (Metropolitan HMR GP)

For community pharmacy business owners/managers, having the right systems in place ensured that referrals were handled in a timely and appropriate manner, and that patient records were easily accessed to provide the required background information for the accredited pharmacist.

For some GPs and community pharmacy business owners/managers, not having the organisational infrastructure to manage HMRs systematically was a barrier to continued participation in the Program.

Some GPs working in remote areas reported that the appropriate systems did not exist at a health administration level to allow for new doctors (overseas trained or otherwise) to be aware of available health programs such as HMR. One respondent suggested that the administrative staff at the health service should adopt measures to include the HMR Program into induction training.

In areas with a high rotation of doctors, the appropriate systems need to be put in place at an administrative level to inform health professionals about the HMR Program.

6.11 Other issues

6.11.1 Grassroots views different from those of stakeholder organisations

The prelude to the qualitative research involved input primarily from stakeholder organisations and peak bodies, while the qualitative phase involved grassroots interviews with individuals who, for the most part, had little or no involvement in their representative body.

Substantial differences emerged between views put forward by the stakeholder organisations and representative bodies, and the views provided directly from individuals in small town, large city or outer suburban pharmacies and doctor's surgeries around the country. In many cases, there was just no correlation whatsoever between the views of the organisation and the views put forward at the grassroots level.

There was some disquiet at the role of the Guild in promoting HMRs:

> *The Guild has been flogging this dead horse for 5 years now. They're good lobbyists. I would like to still see them out there as an option, but generally I don't know whether it's money well spent.* (Rural HMR CPBOM and accredited pharmacist)
>
> *I am concerned and angry about the Guild's attitude.* (Rural HMR CPBOM and accredited pharmacist)

Many community pharmacy business owners/managers had no problem at all with direct payment to consultant accredited pharmacists.

The funding agreement barely rated a mention from community pharmacy business owners/managers who were not active in the Guild or a similar representative organisation. A high proportion of community pharmacy business owners/managers were disinterested in HMRs. Disinterested pharmacies seemed to incur the wrath of those respondents who were active in their representative organisation.

Promotion to eligible consumers was reasonably strongly backed by some stakeholder respondents in earlier phases. However on the ground, there appeared to be very little reference to this and little support for such promotion. One of the few categories of respondents who did refer to a need for promotion was the Facilitator. While several respondents did propose that there be direct promotion to consumers on HMRs, others had tried it and found it to be ineffective.

In addition to direct promotion, some community pharmacy and accredited pharmacist respondents even suggested that consumers be able to self-refer for HMRs - a concept also raised in some submissions for this research - but little evidence was found in the grassroots fieldwork, to support the value or appropriateness of this concept.

> There are at times, more similarities between the views of community pharmacy business owners/managers and the views of some GPs, than between the community pharmacy business owners/managers and their representative bodies.

6.11.2 'That is our money' – the funding agreement

The 'average' community pharmacy business owner did not express strong views about the funding agreement - indeed, it did not rate a mention. Where pharmacy owners were active in the Guild however, they made it clear that '*this is our money'* and that they would '*resist any change that attempted to take any of it away from Section 90 pharmacies'; 'while ever the payment is coming out of our pocket'* due to the changes linked to the funding agreements, '*I will argue against [direct referral to CAPs]'*.

Resistance to certain changes, including referral relationships, was so closely argued by community pharmacy owners who were Guild advocates, in relation to the funding agreement, that the interviewer had to request several respondents to consider the issue beyond the framework of the funding agreement - as it was not the subject of this research.

Other health professionals were able to see a different side of the equation.

> *If no one claims the money because the process is convoluted, the Pharmacy Guild members lose out the same as everyone else does, so I'm not really sure it's protecting their interests either.* (Regional hospital pharmacist and former CAP)

6.12 Summary of findings from qualitative research with health professionals

GPs with no involvement or interest in HMRs tended to refuse all attempts to elicit participation. The overview presented in this report should therefore be seen to be '*as good as it gets'* because it is predominantly a reporting of the views of those who are more positive about HMRs.

Based on the findings of the qualitative research with health professionals, it is clear that at present, HMRs have little or no connection to immediate prevention of hospital admission due to medication misadventure.

The consumers identified by respondents as having the **greatest** gaps in their access to HMRs were those patients at **highest** risk of medication misadventure, including:

- patients post hospital discharge
- Indigenous consumers
- consumers in remote locations
- CALD consumers
- palliative care patients
- non-compliant consumers
- consumers who are transient or homeless.

The largest gap in HMRs was for consumers on multiple medications in the immediate period post hospital discharge. There is a strong consensus that HMRs rarely reach such patients at all, let alone in the necessary timeframe.

There were very few respondents who felt that the HMR Program was unnecessary or worthless. Most positive views of the Program did however come with the qualification '*it is a good thing, but there are areas for improvement'* or '*but I have not found it to be valuable/effective*'.

While HMRs appear to be a potentially valuable tool in meeting the objectives of preventing hospital readmission and adverse drug events, at present they predominantly serve as a valuable tool of:

- reassurance
- information provision
- encouragement of continued compliance
- positive feedback
- de-mystification of the reason for medication

It was rare for the HMR Program to be working efficiently without some level of modification. Some health professionals in rural and remote areas had not yet found a way to modify the HMR model to fit their circumstances, so were not participating in the Program.

Respondents from two of the largest regional Aboriginal Health Services in Australia (Townsville and Rockhampton) felt strongly that offering HMRs to Indigenous patients in their clinic would be a very valuable service. One of these clinics had some 10,000 Indigenous patients on its books, with up to 1,000 of those suffering from diabetes. The other regional clinic had some 7,000 Indigenous patients on its books, with upwards of 800 diabetic patients.

Support was also expressed for adaptation to the HMR model so that it could be of assistance to Indigenous consumers in remote communities.

Where the HMR Program works well, it tends to work in spite of the system and not because of the system. A flexible model is needed to support the practical adaptation needed to make the Program work in some areas.

The option of direct referral to a consultant accredited pharmacist is well supported by many health professionals. Overall, there is a high level of demand for accredited pharmacists to be able to bill directly.

Consideration could be given to providing a referral role on HMRs for practice nurses, community nurses and district nurses, in certain circumstances. Palliative care nurse practitioners appear to be ideally placed to refer for HMRs.

Overall, the researchers did not find evidence to support blanket screenings for HMRs.

Inadequate travel allowances are having a direct impact on delivery of HMRs in many areas.

Whatever actions are taken to address program uptake, without a change in the level of interest in the Program by GPs, the uptake of the Program will remain low. For most GPs, financial reward does not appear to have any effect on their uptake of HMRs.

The primary purpose of the HMR Program is a matter for debate among the 'HMR professionals'. Is it first and foremost a tool of education and long-term prevention, or is it more appropriate to reserve it for the achievement of pharmacological and immediate health outcomes?

There are at times, more similarities between the views of community pharmacy business owners/managers and the views of some GPs, than between the community pharmacy business owners/managers and their representative bodies.

6.13 Summaries of access gaps, barriers, and strategies

Respondents identified a number of gaps in consumer access to HMRs, the reasons for these gaps and some proposed strategies for how these gaps could be addressed (Table 7).

Table 7: Access, Gaps and Strategies

Access: The ability of people to access healthcare services at the right place and time irrespective of income, physical location and cultural background

Gaps in Access	Reasons for Gaps	Strategies to Address Gaps
Post hospital discharge patients	Inadequate referral pathways. Lack of timely response for these consumers. No effective link between hospital and community health.	Modification of HMR referral pathway model to allow hospital discharge doctors or hospital pharmacists to refer directly for HMRs (with strict requirements for patient's GP and community pharmacy to be kept fully informed).
Indigenous patients	Current model is unsuitable. Community pharmacy link for referral is inappropriate for a large majority of Indigenous communities. Inadequate and irrelevant travel allowances for those in remote communities.	HMR Program must offer different models to assist Indigenous consumers. HMR Program to work collaboratively with Aboriginal health services. Provide pooled funding for up to three HMRs a year for those on chronic disease registers in Aboriginal communities. Provide the option of an in-clinic service where a consultant accredited pharmacist is available on a regular basis. Consider link with Section 100 to address travel payment issues.
Remote (and some rural) consumers	Limited resources and workforce availability in remote areas. Barriers to accreditation are accentuated for those in rural areas.	Allowing for a wider range of flexible models of HMR. Reducing barriers to accreditation. Addressing inadequacies in travel allowances. Many remote communities are Indigenous, and gaps for these consumers are addressed above.

Table 7: Access, Gaps and Strategies

Access: The ability of people to access healthcare services at the right place and time irrespective of income, physical location and cultural background

Gaps in Access	Reasons for Gaps	Strategies to Address Gaps
CALD consumers	HMR Program model has not effectively introduced to health professionals who service CALD communities. Lack of awareness by GPs of the cultural behaviours that can affect correct medication management. Isolation, with limited access to health professionals who speak their language. Lack of free interpreting services for direct use by CAPs.	Incorporate community health centres into the HMR Program model. Communication campaigns targeting CALD media. Provide the option of free interpreting services for CALD patients.
Palliative care patients	Unpredictable and short time periods between terminal and dying phases mean GP referral model can be inadequate.	Palliative care nurse practitioners be authorised to refer directly to a CAP. Allow up to three HMRs for palliative care patients, with no time limit, due to the need for rapid response to changing phases.
Non-compliant patients	These patients are very difficult to reach using the current HMR model.	Many respondents felt that the HMR Program was not the right program for targeting many in this group, particularly where there were younger consumers with mental health issues. Highly selective referrals, with more intensive support for these consumers.
Consumers who are homeless or transient	More time-consuming to reach and difficult to arrange referral. May require GP or visiting nurse follow-up to gain agreement for appointment. May be homeless or transient.	Refocus the HMR model to focus time and resources on providing a highly responsive service to target hard-to-reach patients. Provide an 'intensive HMR' approach which may entail higher reimbursement amounts and a series of HMRs, rather than just one.
Younger patients with chronic disease or high medication use	HMRs are generally not seen as appropriate for this younger age group, especially from the view of the consumer themselves.	Decision to be made about whether there should be a continued expectation of the involvement of younger patients.

Table 8: Participation: Barriers, Drivers and Strategies

Participation: The incidence of health professionals providing, or willing to provide, a HMR. Full participation occurs when GP, community pharmacy business owners/managers and accredited pharmacists are providing a service to consumers

Drivers	Barriers	Level of Barrier	Enablers (Strategies to Promote Drivers)
Improving patient care	HMRs not targeting those who really need them.	System	(System) Refine the HMR model to target those in most need. (System) Business rules to widen referral opportunities. (Organisation) Improved patient management systems in general practice – IT and nurses. (Individual) Improving focus of GP referrals.
	HMR Program model acted as a barrier in areas where resources were limited (rural & remote).	System	(System) The need for a flexible HMR Program model, to count for differing circumstances, and to include participation amongst other health professional groups - especially in rural and remote areas.
	GPs not convinced that HMRs can be effective in improving health outcomes for patients. No clinical evidence that HMRs improve patient outcomes.	Individual (GP; CAP; CPBOM)	(System) Establish measures for short and long term patient outcomes.
Remuneration	Not a barrier for GPs who generally believe current remuneration for HMRs is adequate.	Individual (GP)	Not applicable for GPs.
	Payment arrangements for consultant accredited pharmacists.	Individual (CAP) Team (CAP & CPBOM)	(System) Option to be made available for consultant accredited pharmacists to bill directly for HMRs. (System)
	HMR remuneration not profitable for community pharmacy business owners/managers.	Individual (CPBOM & CAP)	(System) Consider increase in the pharmacy component for the HMR payment. (System) Provide option for direct referral to consultant accredited pharmacists.
	HMR remuneration not reflective of time taken to complete HMRs.	Individual (CAP & CPBOM)	(System) Consider increase in the pharmacy component for the HMR payment.

Table 8: Participation: Barriers, Drivers and Strategies

Participation: The incidence of health professionals providing, or willing to provide, a HMR. Full participation occurs when GP, community pharmacy business owners/managers and accredited pharmacists are providing a service to consumers

Drivers	Barriers	Level of Barrier	Enablers (Strategies to Promote Drivers)
	Current PHARIA travel allowance for pharmacists is inadequate.	Individual (CAP & CPBOM)	(System) Proposed solution to provide allowances based on actual distances travelled by the accredited pharmacists to conduct HMRs.
Inter-professional communication / Effective communication	HMR GPs are not championing the HMR Program to other GPs.	Individual (GP)	(System) Support GP champion Program (after evidence base is established).
	Verbal communication component between GPs and accredited pharmacists does not occur.	Team	(System) Amend the verbal requirement to allow for electronic or faxed feedback forms.
	Poor quality reports from accredited pharmacists.	Individual Team	(System) Include a business communication module in accredited training program. (System/Organisation) Conduct quality clinical audits to improve reporting processes, similar to measures run by NPS.
	Poor relationships between health professionals	Team	(Team) Develop good relationships and communication channels between health professionals. (Team) Protocols for quality improvement to assist all health professionals to adjust the model to work for their circumstances.
Team based approach to healthcare/ Quality Assurance	Protection of professional territories: - GPs reluctant to work with pharmacists in a healthcare team based approach. - The influence of the Guild on community pharmacy business owners/managers 'it's our money'. - Community pharmacy business owners/managers reluctance to work with consultant accredited pharmacists.	Individual (GP)	

Table 8: Participation: Barriers, Drivers and Strategies

Participation: The incidence of health professionals providing, or willing to provide, a HMR. Full participation occurs when GP, community pharmacy business owners/managers and accredited pharmacists are providing a service to consumers

Drivers	Barriers	Level of Barrier	Enablers (Strategies to Promote Drivers)
Efficient delivery of Service	Not having the systems or organisational infrastructure to manage HMRs systematically.	Individual (GP); CPBOM)/Team	(Team/Organisation) Good systems, organisation and utilisation of support staff.
	GP time constraints; perception that the HMR Program has too much red tape.	Individual Team System	(Organisation/Team) Active learning – demonstrations of the simple process of generating referrals using medical software.
	Indifference from community pharmacy end; HMRs not completed on time; HMR referrals ignored	Team Individual	(System) Education targeted at community pharmacy business owners/managers on the benefits of HMR. (System) Option for GP to refer direct to accredited pharmacists when community pharmacy is acting as a barrier to an efficient HMR process.
Professional development	No business case for supporting consultant pharmacist workforce.	Individual	Increase funding.
	No official option in the HMR model allowing direct referral to consultant accredited pharmacists.	Team Individual	(System) Modification to allow option for direct referral by GPs to consultant accredited pharmacists, with the provision that consultant liaise with the patient's community pharmacy.
	Accreditation and re-accreditation process for pharmacists overly onerous.	Individual	(System) Provide recognition for experienced pharmacists; prior learning (especially for hospital pharmacists). (System) Re-evaluate the format of accreditation processes.
	Medication review is part of GP role.	Individual	(Organisation - Divisions) Promote improved workload resulting from team approach.
	Medication review is what pharmacists do everyday.	Individual	(Organisation - Divisions) Promote access to laboratory results and GP relationship as an opportunity to enhance pharmacists' role.
Division facilitation	GPs' low level of interest in the HMR Program.	Team	(Organisation) Incorporate HMR with NPS visits. (Organisation) MMR Facilitators to conduct NPS work.

Table 8: Participation: Barriers, Drivers and Strategies

Participation: The incidence of health professionals providing, or willing to provide, a HMR. Full participation occurs when GP, community pharmacy business owners/managers and accredited pharmacists are providing a service to consumers

Drivers	Barriers	Level of Barrier	Enablers (Strategies to Promote Drivers)
Improved pharmacy customer relations	Community pharmacies are concerned that broadening referral will detract from improving customer relations.	Team	All of the suggestions for broadening referral base identified the inclusion of community pharmacy as essential. Active promotion of community pharmacist role in QUM.
Preventative healthcare approach	Limit of HMR to one visit.	System	Ensure GPs and APs communicate findings relevant to long-term care. Provide for up to three HMRs for those at high risk.
Effective collaboration between hospital and community on discharge	HMR model not conducive to the short turnaround of HMRs.	System	Direct referral pathways from hospital upon discharge. Innovation arising from change to HMR model.
Effective relationships with CALD workers	Lack of awareness among many CALD workers. Lack of direct avenues for accredited pharmacists to access interpreting services.	Team Organisation	Promote the HMR Program and its appropriateness for CALD patients, directly to CALD workers. Provide for use of free interpreting services directly through accredited pharmacists.
Indigenous specific	HMR model inappropriate for this group.	Organisation	Provide alternative HMR models appropriate for Indigenous consumers.