8. Project Conclusions

The HMR Program was introduced as a preventative health care measure in 2003 to address the adverse medication events associated with polypharmacy. Initial take up of the program was slower than expected although participation, as measured by pharmacy claims under the Community Pharmacy Agreement and GP claims made under Medicare Benefits Schedule Item 900, has been steadily increasing. There were 46,768 pharmacy claims, and 36,020 GP claims made in 2007/08. However, participation by health professionals has been patchy at best. Even now, after five years of implementation, less than 10% of GPs are participating in the HMR Program (submitting a Medicare claim for Item 900).

The research commissioned by the Department and which is the subject of this report, explored barriers to participation. This research has identified that the existing model is not focused on ensuring access by those consumers who could benefit most from the HMR Program, including patients recently discharged from hospital, Indigenous Australians, CALD consumers, patients receiving palliative care, and consumers who did not have an existing relationship with a GP or community pharmacy.

For some consumers, HMR is a signal that their independence is under threat and they consider HMR to be a '*good idea … but for someone else … not for me*'.

The research has revealed in principle support for the concept of the HMR Program but with very little support for the current approach to implementation. This is particularly the case for GPs and owners and managers of community pharmacies. Consultant accredited pharmacists are supportive of the Program but consider the current business model is preventing them from being able to respond effectively. Participation of GPs is essential. Without GP involvement, consumers are highly unlikely to consider participating. This study confirmed that GPs are ultimately trusted over other health professionals when it comes to medication advice, so it is clearly appropriate to retain their role as the primary source of referrals.

The research has found that, at best, GPs are ambivalent about the HMR Program, with very few GPs actively supporting the Program and many considering it a waste of time and Government resources.

The primary barrier for GPs was the lack of convincing evidence from either the research literature or their own experience, that HMRs were effective. In addition, GPs find the Program complex; at odds with the normal referral relationships they develop with medical professionals; and have often experienced poor-quality HMR reports that are voluminous but provide little value. Other negative experiences for GPs included instances of the GP having to spend time explaining the history of medication strategies to the accredited pharmacist. While the occasions of such instances may be infrequent, they emerged in the grassroots qualitative research as establishing the GP mindset of indifference or antipathy to HMRs. One or two difficult experiences were sufficient to relegate the priority of the HMR Program for GPs, particularly if they felt they already reviewed medication use as part of maintaining a quality practice.

Complex business rules and delays in implementing the many stages of each HMR reinforce the argument that participation, when it does occur, is less than enthusiastic and conducted with little sense or urgency, by either the GP or the community pharmacy or consultant accredited pharmacist. This has resulted in substantial delays at different stages after the initial referral: from community pharmacy to accredited pharmacist; from accredited pharmacist to consumer; from HMR visit to the provision of the report to the GP; and ultimately for the consumer to return to the GP; and the GP to make any necessary changes. The cascading series of delays has a substantial impact upon the perceptions and effectiveness of the Program.

The delays described at the grassroots level were supported through individual case examples put forward by the GP, the accredited pharmacist, the community pharmacy and often, the HMR consumer themselves. In all locations where fieldwork was conducted there was agreement that HMRs could rarely be conducted in the optimal timeframe. It is worth noting that the practical on-the-ground delays in conduct of HMRs contrasted with the perceptions gathered in Stakeholder Consultations, as many were apparently unaware of the extent of delays. The reality and ramifications of delays were however supported fully and backed by considerable justification, in a large proportion of the submissions received in Phase 3 of this study. Indeed, this study has uncovered a vast array of evidence to support concerns regarding delays.

Significantly, while many barriers were identified, the level of remuneration for GPs was not found to be a factor limiting GP participation as the level of remuneration was considered by the GPs to be adequate. Some practices, particularly those which could be described as more entrepreneurial in their approach, have incorporated the HMR Program into everyday routine. However, integration of the Program was the exception and not the rule.

Remuneration was however an issue for community pharmacies and accredited pharmacists. Owners and managers of community pharmacies tended to be ambivalent about the HMR Program, partly due to the remuneration arrangements. In addition, HMR was seen to compete for the pharmacist's time with other programs.

The importance of established relationships between consumers and their community pharmacy was confirmed in the qualitative research with consumers. The HMR Program was not identified as central in maintaining those relationships as they were widely acknowledged as being well established anyway.

Accredited pharmacists had a much more positive view of the Program's effectiveness and value to the consumer. However they expressed concern that the existing business model was complex and restrictive. A particularly strong criticism from consultant accredited pharmacists was the requirement for referral through the community pharmacy. They were also concerned about the level of payment and mechanisms for receiving payment, through the community pharmacy. The lack of priority given to the HMR Program by community pharmacies was reflected in the considerable delays in processing referrals, with a lapse of two months and more a common occurrence.

Over and over again, throughout the five phases of this study, timeliness emerged as a key issue, with delays having a major impact on many factors including the ultimate effectiveness of the HMR itself.

One of the ways in which change is also sought, relates to the involvement of The Guild.

Many submitters expressed strong views that the role of the Guild had led to an over-representation of the interests of pharmacy businesses rather than a balance between the interests of consumers, accredited pharmacists, GPs and community pharmacies.

The role of the Guild in the HMR Program was seen by a number of respondents as presenting a conflict of interest, and an inappropriate monopoly over the process. Both of these factors were thought to negatively impact the ultimate goal of the HMR Program: the appropriate and effective use of medicines in the community.

> *Currently the Pharmacy Guild is the chief negotiator for HMRs … <and given> equity of health care access is Government policy, the prime, and indeed only, consideration should be delivery of the service to those most likely to need and benefit. It is not about returning dollars to community pharmacy owners. The monopoly that has been created does not allow models to meet the needs of individuals.* (Consultant accredited pharmacist, Qld and peak body representative)

8.1.1 Strategies for improvement

There was widespread recognition of the potentially positive role for HMRs. Some advocates argued the need for a consumer awareness campaign to encourage consumer driven demand. The findings of this research study do not support the argument for a broad brush consumer marketing campaign because of the strong set of indications of the need for much tighter targeting of HMRs to those at higher risk of medication misadventure. Despite the fact that a revised national advertising campaign for consumers was suggested by almost half of those who contributed submissions for this research, the consumer awareness campaign is likely to generate demand among those at low risk of medication misadventure. Reviewing the overall findings for this research leads to a conclusion that consumers who are regarded as the most receptive to HMRs appear to be the very consumers who are least likely to need HMRs.

The consumer based component of the research did not identify a high level of consumer demand for HMRs, even when it was explained fully. Consumers demonstrated little understanding of the effectiveness of HMRs, even after experiencing one, receiving some additional advice and finding the consultant pharmacist very helpful.

Both those consumers who had experienced HMRs and those who were eligible ideal candidates and exhibited a number of risk factors but had not participated in the Program, saw the prospect of a HMR as possibly indicating they were not in control of their medications and this at times threatened their sense of independence. For many, self-reliance was highly valued and appeared to be a key mechanism for coping with their multiple illnesses and serious health conditions.

The loyalty of consumers to both their community pharmacy and their GP emerged clearly, although the GP relationship was paramount. Consumers clearly relied on their ongoing relationship with these health professionals, but particularly their GP, to inform their medication strategies. The research with consumers demonstrated just how strong this bond was, in particular, for persons with complex chronic conditions requiring polypharmacy.

This study confirmed that increased participation can only be directly driven by GPs (other than adoption of an additional model involving other referral sources, specifically, hospitals).

The principal strategies identified for improved participation were: to streamline the existing business rules to enable more flexibility in implementation of HMRs while maintaining the role of the four key participants – the GP, the community pharmacy, the accredited pharmacist and the consumer.

The research did not find evidence to support blanket screenings or universal triggers for HMRs. Indeed, the findings support a highly selective approach adapted to reach those in greatest need of the service, with flexibility in order to achieve this, rather than flexibility that could be used to increase uptake of HMRs without reaching those in greatest need of the service.

Alternative referral processes were identified as important to increase participation of GPs. Consultant accredited pharmacists suggested that allowing GPs to refer directly to them would be a strong incentive for them to promote the program to GPs and enable them to develop relationships with practices. The current business rules were described by these professionals as restrictive, limiting the opportunity for consultant accredited pharmacists to advocate for HMRs directly to GPs. It is important to note that all respondents who supported direct referral were recommending it as an *option*, not as a replacement of the existing referral framework.

One of the greatest concerns arising from this research was that there is no strategic, program-wide concerted effort being made to address the gaps that inevitably allow high risk patients to fall through the cracks in the HMR system when they are likely to be in most danger: that is, in the period following hospital discharge. Referral by discharging hospital medical officers and hospital pharmacists, was identified as extremely important to enable access by consumers seen to be among those at highest risk

of medication misadventure. Inclusion of options for direct referral to an accredited pharmacist by hospital medical officers, are regarded as critical to manage the need for short turnaround times on post discharge HMRs. All proponents stress the need for this process to include clear protocols for provision of information to the patient's treating GP and regular community pharmacy.

It is noted that the area of responsibility between hospitals and primary health care delivery is complex. However, this research strongly suggests that implementing a model based on best practice for at-risk post-hospital patients would have considerable benefits through improving patient care, integrating primary health providers with hospitals, and potentially reducing the number of adverse events associated with medication misadventure, at a point when patients are most vulnerable. **The CR&C team is of the strong view that this is the single most important recommendation for improving participation in and access to HMRs.**

The logic of requiring the community pharmacy to be the sole referral pathway was criticised by both GPs and pharmacists (including many grass roots community pharmacists) as an impediment to the effective and efficient implementation of the program. The importance of maintaining the relationship between the consumer and the community pharmacy was widely acknowledged but it was felt that this could be achieved even with direct referral as an option. Direct referral was also seen to free the community pharmacy from the task of processing the HMR payments.

Submissions strongly held that the fact the GP cannot refer to an accredited pharmacist of their choice (a model much closer to their current familiar and longstanding arrangements of referrals to specialists) can be a barrier to GP participation. Reference to this as a barrier emerged throughout each of the first three phases of research conducted for this project, and this was further explored and confirmed in the qualitative research amongst health professionals at the coalface of HMRs. It should be noted however that the current absence of a direct referral pathway is not the only, nor is it the primary reason for GP ambivalence about HMRs.

Despite the degree of support found for increased remuneration for the pharmacy side in the qualitative stage of this research study, overall findings indicate that higher levels of remuneration on the pharmacy side would **not** be expected to make a significant difference to the provision of HMRs to consumers at high risk of medication misadventure.

All professional stakeholders, but particularly the accredited pharmacists, identified problems with delays in the different steps for referral. These problems were considered to reduce the efficacy of the HMR Program.

Within the existing model, provision of HMRs in rural regions was reported to be achieved through taking a highly flexible approach to the application of the rules – often going beyond the 'letter' of the rules - despite the fact that in some towns, strong professional relationships mean that HMRs work well and more efficiently than some metropolitan settings. Workforce shortages, high cost of travel and licensing requirements for pharmacists to be in attendance at the pharmacy contribute to the difficulty of providing HMRs in many rural and particularly in remote regions. Strategies used included involvement of practice nurses and remote review of information by accredited pharmacists in metropolitan areas. The importance of reimbursement of the high cost of travel in rural (and indeed in some metropolitan) regions was also identified as an important issue. HMRs in remote areas are almost impossible to achieve cost effectively at present, while metropolitan settings can also include substantial travel costs with no provision for travel allowances.

Indigenous Australians, in remote areas as well as in large regional cities, are the most likely of all Australians to miss out on any effective access to HMRs at present, despite having the highest rates of hospitalisation due to medication misadventure. Strategies for providing alternative models of HMR aimed at reaching Indigenous consumers are outlined in this report. Specific models for major overhaul of this aspect of the HMR Program were put forward by submitters (and later explored to some extent

in the qualitative research with grassroots health professionals in Phase Four). However, further research specifically focusing on Indigenous communities and/or a pilot program would be valuable as an adjunct to this research.

In summary, while the current model of HMRs was widely criticised, nearly all stakeholders identified strategies for improvement. These strategies included major structural changes based around referrals, with the most critical of these: referral directly from hospital upon a patient's discharge; and the inclusion of an **option** for direct referral to a consultant accredited pharmacist (either from a GP or a hospital medical officer or hospital pharmacist). Another key area requiring urgent consideration is the introduction of a far more appropriate model for Indigenous Australians, in both remote areas and major regional cities.

Without substantial changes in the way the Program is delivered, the HMR Program is unlikely to meet its objectives.

9. References

Ajdukovic, M., M. Crook, et al. (2007). "Pharmacist elicited medication histories in the Emergency Department: Identifying patient groups at risk of medication misadventure." Pharmacy Practice Research 5(4): 162.

Annabel, B. (2006). "HMRs: Get with it." Aust J Pharmacy 87(May): 38-39.

Australian Council For Safety And Quality In Health Care (2002). Second National Report on Patient Safety: Improving Medication Safety July 2002. , Australian Council For Safety And Quality In Health Care, Canberra.

Australian Institute of Health and Welfare (2005). Australian Hospital Statistics 2003-2004. Canberra: AIHW. AIHW cat. no. HSE 37: 47.

Australian Institute of Health and Welfare (2006). Australian Hospital Statistics 2004-2005. . Canberra. AIHW cat. no. HSE 41.: 56.

Australian Institute of Health and Welfare (2007). Australian Hospital Statistics 2005-2006. Canberra: AIHW. AIHW cat. no. HSE 50: 48.

Baldock, M. S., J. Kaufman, et al. (2006). "Home medication reviews: what do people in the Australian Riverland think of them?" Rural and Remote Health (Online) 6(1): 546.

Bates, D. W., R. Scott Evans, et al. (2003). "Detecting Adverse Events Using Information Technology " JAMIA 10: 115-128.

Beck, D. E. and D. P. Rodman (1995). "Pharmacokinetics Involves Lifelong Learning: The PILL Program " AM J Pharm Ed 59(1): 66-72.

Bell, J. S., P. Whitehead, et al. (2006). "Drug-related problems in the community setting: pharmacists' findings and recommendations for people with mental illnesses." Clin Drug Investig 26(7): 415-425.

Blennerhassett, J. D., B. M. Cusack, et al. (2006). "A Novel Medicines Management Pathway." J Pharm Practice Research 36(3): 175-179.

Brown, E. L., P. J. Raue, et al. (2006). "Transition to Home Care: Quality of Mental Health Pharmacy and Medical History Information." Int J Psychiatry Med 36(3): 339-349.

Burkiewicz, J. and B. L. Sweeney (2006). "Medication reviews in senior community housing centers." Consult Pharm 21(9): 715-718.

Cameron, K. A. (2005). "Comment on medication management models and other pharmacist interventions: implications for policy and practice." Home Health Care Serv Q 24(1-2): 73-85.

Cannon, K. T., M. M. Choi, et al. (2006). "Potentially inappropriate medication use in elderly patients receiving home health care: a retrospective data analysis." Am J Geriatr Pharmacother 4(2): 134-143.

Chan, M., F. Nicklason, et al. (2001). "Adverse drug events as a cause of hospital admission in the elderly." Intern Med J 31(4): 199-205.

Clarke, R. B. (2001). Australian patient safety survey. Department of Health and Ageing, Commonwealth Department of Health and Ageing, Canberra.

Clifopoulos, C. (2007). "Effective use of HMRs in General Practice (Item 900). What do we gain from a HMR report?" from Retrieved January, 2008, from http://www.nevdgp.org.au/?content=33.

Consumer Health Forum (2001). "Consumer Evaluation of Domiciliary Medication Management Reviews." Unpublished.

Department of Health and Ageing. (2008). "Medication Management Reviews." Retrieved January, 2008, from http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-epc-dmmrqa.htm.

Department of Veterans Affairs. (2008). "Veterans' Medicines Advice and Therapeutics Education Services." Retrieved January, 2008, from Veterans' Medicines Advice and Therapeutics Education Services.

Doucette, W. R., R. P. McDonough, et al. (2005). "Comprehensive medication therapy management: identifying and resolving drug-related issues in a community pharmacy." Clin Ther 27(7): 1104-1111.

E-PillPal. (2008). "e-Pill Pillpal Medication Reminder 1.1." Retrieved January, 2008, from http://downloads.zdnet.co.uk/0,1000000375,39059640s,00.htm?r=1.

Fejzic, J. B. and S. E. Tett (2004). "Medication management reviews for people from the former Yugoslavia now resident in Australia." Pharm World Sci 26(5): 271-276.

Foust, J. B., M. D. Naylor, et al. (2005). "Opportunities for improving post-hospital home medication management among older adults." Home Health Care Serv Q 24(1-2): 101-122.

Freedman, A. (2005). "A service opportunity begging for professional involvement." Aust J Pharm 86(May): 324-325.

Gowan, J. (2005a). "Diversity in Health: How can HMRs Help?" Austr J Pharm 86(December): 981-982.

Gowan, J. (2005b). "Men's Health - Implications of HMRs." Aust J Pharm 86(October): 830-831.

Gowan, J. (2007). "Women's Health and Medication Reviews." Aust J Pharm 88(August): 69.

Gurwitz, J. H., T. S. Field, et al. (2003). "Incidence and preventability of adverse drug events among older persons in the ambulatory setting." JAMA 289: 1107-16.

Hicks, N. (2008). "Evidence-based Health Care." Retrieved February, 2008, from http://www.jr2.ox.ac.uk/bandolier/band39/b39-9.html.

Holland, R., J. Desborough, et al. (2008). "Does pharmacist-led medication review help to reduce hospital admissions and deaths in older people? A systematic review and meta-analysis." Br J Clin Pharmacol. 65(3): 303-316.

Holland, R., E. Lenaghan, et al. (2005). "Does home based medication review keep older people out of hospital? The HOMER randomised controlled trial." BMJ 330(7486): 293.

Hughes, C. F. (2008). "Medication errors in hospitals: what can be done? (Editorial)." MJA 188(5): 267-268.

Institute for Safe Medication Practices. (2008). "About ISMP." Retrieved January, 2008, from http://www.ismp.org/about/Default.asp.

Kaushal, R., K. N. Barker, et al. (2001). "How can information technology improve patient safety and reduce medication errors in children's health care?" Arch Pediatr Adolesc Med 155(9): 1002-1007.

Kelly, B. (2007a). "New studies highlight the need for our own research." Aust J Pharm 88(May): 30-31.

Kelly, B. (2007b). "UK study identifies familiar implementation issues for medication reviews." Aust J Pharm 88(July): 34-35.

Kovner, C., J. Menezes, et al. (2005). "Examining nurses' decision process for medication management in home care." Jt Comm J Qual Patient Saf 31(7): 379-385.

Kyle, G. and L. M. Nissen (2006). "A community nurse referral system for HMRs: Can it work?" Australian Pharmacist 25(4): 326-331.

Lenaghan, E., R. Holland, et al. (2007). "Home-based medication review in a high risk elderly population in primary care--the POLYMED randomised controlled trial." Age Ageing 36(3): 292-297.

Lesar, T., A. Mattis, et al. (2003). "Using the ISMP Medication Safety Self-Assessment to improve medication use processes." Jt Comm J Qual Saf 29(5): 211-226.

Maidment, I. D., P. Lelliott, et al. (2006). "Medication errors in mental healthcare: a systematic review." Qual Saf Health Care 15(6): 409-413.

Martin, K. (2006). "Join the Team and Gain on Pain." Aust J Pharm 87(November): 44.

Medicare Rights Centre (2007). "Making medication therapy management a cornerstone of community-based care for people with Alzheimer's disease and other forms of dementia." Care Manag J 8(2): 87-95.

Miller, G. C., H. C. Britt, et al. (2006a). "Adverse drug events in general practice patients in Australia." MJA 184(7): 321-324.

Miller, G. C., H. C. Britt, et al. (2006b). "Adverse drug events: counting is not enough, action is needed (Letter)." MJA 184(12): 646.

Moore, C., J. Wisnivesky, et al. (2003). "Medical errors related to discontinuity of care from an inpatient to an outpatient setting." J Gen Intern Med 18: 646-651.

Morris, C. (2007). "Home Medicine Reviews - Why Aren't More Being Conducted?" Unpublished.

Nathan, A., L. Goodyer, et al. (1999). "'Brown bag' medication reviews as a means of optimizing patients' use of medication and of identifying potential clinical problems." Fam Pract 16(3): 278-282.

National Health Performance Committee (2001). "National Report on Health Sector Performance Indicators 200." Queensland Health, Brisban.

Nguyen, A., K. Yu, et al. (2007). "Classification of findings in the home medicines reviews of post-discharge patients at risk of medication misadventure." J Pharm Practice Research 37(2): 111-114.

Pacini, M., R. D. Smith, et al. (2007). "Home-based medication review in older people: is it cost effective?" Pharmacoeconomics 25(2): 171-180.

Peterson, G. M., S. L. Jackson, et al. (2006). "Home medicines review in the elderly: most effective if performed and reported in a timely manner (Editorial) " Aust Pharmacist 25(11): 860-863.

Pharmaceutical Society of Australia (2002). Domicilliary medication management review. Australian Pharmaceutical Formulary and Handbook, Pharmaceutical Society of Australia, Canberra.

Pharmacy Guild of Australia. (2008). "Patient Medication Profiling " Retrieved January, 2008, from http://www.guild.org.au/pps/content.asp?id=1426.

Pirmohamed, M., S. James, et al. (2004). "Adverse drug reactions as cause of admission to hospital: prospective analysis of 18,820 patients." BMJ 329(7456): 15-19.

Ponniah, A., B. Anderson, et al. (2007). "Pharmacists' role in the post-discharge management of patients with heart failure: a literature review." J Clin Pharm Ther 32(4): 343-352.

Ponniah, A., S. Shakib, et al. (2008). "Post-discharge medication reviews for patients with heart failure: a pilot study." Pharm World Sci 30(6): 810-815.

Quirke, J., B. Wheatland, et al. (2006). "Home medicines reviews - do they change prescribing and patient/pharmacist acceptance?" Aust Fam Physician 35(4): -267266.

Rigby, D. (2007). "Communication skills in medication management reviews." Aust J Pharm 88(August): 34-35.

Roberts, A. S., S. I. Benrimoj, et al. (2005). "Implementation of Home Medicines Review (HMR) in Community Pharmacy." Aust Pharmacist 24(10): 808-813.

Roberts, S. (2006). "Customer loyalty and home medicines reviews." Pharmacy News October: 8.

Roughead, E. (2006). "Adverse Drug Events - Counting is not enough." Australian Medical Journal 184(7): 315-319.

Roughead, E. (2007). "Improving Medication Safety: Influence of Patient Specific Prescriber Feedback Program on Rate of Medication Reviews Performed by Australian General Medical Practitioners." Pharmicoepidemiology and Drug Safety 16: 797.

Roughead, E. E. and J. Lexchin (2006). "Adverse drug events: counting is not enough: action is needed (Editorial)." MJA 184(7): 315-316.

Royal District Nursing Service. (2008). "Hospital in the Home." Retrieved January, 2008, from http://www.rdns.com.au/Services/Hospital+in+the+Home.htm.

Royal District Nursing Service. (2008). "Palliative Care and Bereavement Support " Retrieved January, 2008, from http://www.rdns.com.au/Services/Palliative+care+and+bereavement+support.htm.

Runciman, W. B., E. E. Roughead, et al. (2003). "Adverse drug events and medication errors in Australia." Int J Qual Health Care 15(Suppl 1): i49-59.

Scott, A., M. Tinelli, et al. (2007). "Costs of a community pharmacist-led medicines management service for patients with coronary heart disease in England: healthcare system and patient perspectives." Pharmacoeconomics 25(5): 397-411.

Smith, C. (2004). "Facilitating professional felicity and home medicines review implementation." Australian Journal of Pharmacy 85: 864-865.

Sorensen, L., M. A. King, et al. (2004). "In-home medication reviews for war veterans: Early experience in Australia." J Pharm Practice Research 34(2): 122-124.

Sorensen, L., J. A. Stokes, et al. (2005). "Medication management at home: medication-related risk factors associated with poor health outcomes." Age Ageing 34(6): 626-632.

Tatham, P. (2007). "The HMR Model: Success or Mediocrity." Aust Pharmacist 26(4): 330-331.

The Cochrane Collaboration. (2008). "Glossary of Cochrane Collaboration and research terms." Retrieved February, 2008, from http://www.cochrane.org/resources/glossary.htm.

University of Tasmania (2006). "Use of Telepharmacy in Medication Reviews." Unpublished.

Urbis Keys Young (2005). Evaluation of the Home Medicines Review Program (Pharmacy Component). P. G. o. Australia. Canberra, Australia.

Victorian Government Department of Human Services. (2008). "Agency for Healthcare Research and Quality " Retrieved May, 2008, from (http://nrcpicker.com/adx/aspx/adxGetMedia.aspx?DocID=1328,1327,574,1,Documents&MediaID=3005&Filename=HCAHPS_Chartbook.pdf.

Victorian Government Health Information. (2008). "HARP - Chronic Disease Management." Retrieved June, 2008, from http://www.health.vic.gov.au/harp-cdm/index.htm.

Vowles, E. (2007). "Medication management at the hospital-community interface." Aust J Pharm 88: 56-58.

Yu, K., A. Nguyen, et al. (2007). "Enhancing Continuity of Care: Development of a post-discharge Home Medicines Review Model." J Pharm Practice Research 37(1): 22-26.

Appendix 1:
Terminology used in this Report

Appendix 1: Terminology used in this report	
Access	The ability of people to obtain healthcare services at the right place and the time irrespective of income, physical location and cultural background (National Health Performance Committee 2001).
Accredited Pharmacists	To be able to conduct a Home Medicines Review, pharmacists must be an accredited pharmacist. Accreditation can be obtained from either the Australian Association of Consultant Pharmacy or the Society of Hospital Pharmacists of Australia[16] Accredited pharmacists may be community pharmacy business owners/managers, community pharmacy permanent employees, or may work in a consultant capacity (as a consultant accredited pharmacist)
Adverse Drug Event	An adverse outcome that occurs during or after the use of a drug intervention but is not necessarily caused by it. (adapted from Cochrane 2008)
Community Pharmacy business owners/ managers	Consumers' preferred pharmacist operating in the community
Consultant Accredited Pharmacists	Accredited pharmacist working in a consultant capacity, as an individual contractor. Consultant accredited pharmacist can not bill directly for HMRs – Medicare reimbursement must be co-ordinated through the community pharmacy through which they have been contracted to conduct the HMR
Descriptive study	A study that describes characteristics of a sample of individuals. Unlike an experimental study, the investigators do not actively intervene to test a hypothesis, but merely describe the health status or characteristics of a sample from a defined population. (The Cochrane Collaboration 2008)
Eligible Consumer	A consumer who is eligible for referral to HMR but has not received HMR, who is at risk of medical misadventure.
Evidence based health care	Evidence based health care takes place when decisions that affect the care of patients are taken with due weight accorded to all valid, relevant information. (Hicks 2008)
GP Champion	The GP Champion program is a 'Train the Trainer' initiative developed by the Australian General Practice Network. The objective of the GP Champions program is to provide HMR training for GPs by their peers, to ensure that HMR works for the patient, GP and pharmacist.[17]
HMR/MMR Facilitator	There is an MMR Facilitator in most divisions of General Practice. Their role

[16] (Source: http://www.guild.org.au/mmr/content)

[17] (Source: http://www.guild.org.au/mmr/content.asp?id=421 and http://www.guild.org.au/mmr/content)

Appendix 1: Terminology used in this report	
	is to assist GPs, pharmacies and accredited pharmacists to increase the uptake of Home Medicines Reviews in local areas[18]. Facilitators can assist with developing local networks, organise educational events and generally increase awareness of the HMR service to all stakeholder groups. Facilitators can provide assistance and information and more importantly, help pharmacists get started as an accredited pharmacist.
Participation in the HMR Program	The incidence of a consumer receiving, or health professional providing, a HMR. Full participation is flagged by payments made to both GP and the community pharmacy.
Qualitative research	Qualitative research entails in-depth examination of attitude, perception or event to identify the range of characteristics in the context of every-day life. Qualitative research can be idiosyncratic.
Quantitative research	Quantitative research measures the extent to which an attitude, perception or event occurs in a population. Sample surveys are the most common form of quantitative social research. Quantitative research is always nomothetic.
Randomised control trial	An experiment in which two or more interventions, possibly including a control intervention or no intervention, are compared by being randomly allocated to participants. In most trials one intervention is assigned to each individual but sometimes assignment is to defined groups of individuals (e.g. in a household) or interventions are assigned within individuals (e.g. in different orders or to different parts of the body). (The Cochrane Collaboration 2008)
Stakeholders	Stakeholders interviewed in this stakeholder consultation component of the research were selected if they were identified as the person in the organisation representing the interests of GPs (medical stakeholders), pharmacists (pharmacy stakeholders) and consumers (consumer stakeholders). The term professional stakeholders is used to refer to '*stakeholders representing professionals involved in the HMR Program*'.

[18] (Source: http://www.guild.org.au/mmr/content)

Appendix 2:
Acronyms and Abbreviations

Appendix 2: Acronyms and abbreviations used in this report	
AACP	Australian Association of Consultant Pharmacists
ADE/ADR	Adverse drug event/ reaction
AHS	Aboriginal Health Services used to refer to both Aboriginal Community Controlled Health Services (ACCHS) and Remote Area Aboriginal Health Services (RAAHS)
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
ANPA	Australian Nurse Practitioners Association
CALD	Culturally and Linguistically Diverse
CAP	Consultant Accredited Pharmacists
CPBOM	Community Pharmacy Business Owners and Managers
CR&C	Campbell Research & Consulting
DDI	Dangerous Drug Interaction
Division	Division of General Practice
DVA	Department of Veterans' Affairs
Facilitator	Division MMR/HMR Facilitators
GP	General Practitioner
HARP	The Hospital Admission Risk Program
HBC	Home Based Care
HITH	Hospital in the Home
HMR	Home Medicines Review
ISMP	Institute for Safe Medication Practices
MATES	Medicines Advice and Therapeutics Education Service
MBS	Medicare Benefits Schedule
MMR	Medication Management Review
MRP	Medication Related Problems
NDSS	National Diabetes Services Scheme
NPS	National Prescribing Service
PhARIA	Pharmacy Access/Remoteness Index of Australia
PILL	Pharmacokinetics Involves Lifelong Learning
PIM	Potentially Inappropriate Medication
RFDS	Royal Flying Doctor Service
RMMR	Residential Medication Management Review
RN	Registered Nurse
The Department	The Australian Government Department of Health and Ageing
The Guild	The Pharmacy Guild of Australia

Appendix 3:
List of Submitters

Appendix 3: List of Submitters		
Name	**Occupation**	**Organisation/Location**
Yvonne Allinson	CEO	The Society of Hospital Pharmacists of Australia, Federal Secretariat, ACT
Lisa Atkins	Consultant accredited pharmacist	NT and other locations (inc remote Indigenous communities)
Jenny Blennerhassett	Accredited pharmacist and community liaison pharmacist	Prince of Wales Hospital and Community Health Services, Sydney NSW
Assoc Prof Chris Bonner	Faculty of Medicine and consultant accredited pharmacist	Bond University QLD
Helen Brown	QUM Program Manager	Kwinana DGP
Wendy Campbell	QUM coordinator	Alliance of NSW Divisions
Stephen Carbonara	Consultant accredited pharmacist	Dapto, NSW
Assoc Prof Andrew Cashin	President	Australian Nurse Practitioner Association and Justice Health Nursing Professional Unit, University of Technology, NSW.
Prof Colin Chapman	Faculty of Pharmacy	Monash University, VIC
Andrew Clayton	Consultant accredited pharmacist	Launching Place, VIC
Jenny Cole	Consultant accredited pharmacist	No further information
Debra Cottrell	CEO	Goulburn Valley DGP
Deirdre Criddle Pradeep Jayasuriya	Consultant accredited pharmacist GP	Dianella, WA
Lisa Crisp	Consultant accredited pharmacist	No further information
Kerry Deans	CEO	Pharmaceutical Society of Australia, Curtin, ACT
Christine Donaldson	Accredited Pharmacist	No further information
Michael Dooley	Director of Pharmacy	Bayside Health, VIC
Patricia Downes	Pharmacy Project Officer	Western Melbourne DGP
Michael Driscol	HMR Facilitator	Mid North Coast DGP
Sue Edwards	Pharmacist	Southern DGP (SA)
Timothy Chen	Senior Lecturer in Pharmacy Practice (Young pharmacist of the Year 2001)	Faculty of Pharmacy – University of Sydney
Linda Fitzgerald Renata Schindler	HMR Program Manager Program Officer	Toowoomba & District DGP, QLD
Gail Forlonge	Quality Use of Medicines and Cancer Support Program	Southern Highlands DGP
Robert Forsythe	Director of Pharmacy	Rockhampton Hospital, QLD

Appendix 3: List of Submitters

Name	Occupation	Organisation/Location
Alan Freedman	Victorian MMR Facilitator	Pharmacy Guild of Australia VIC
Michael Furey	Manager MMR Program	Blood and Pharmaceutical Programs DHS, NSW
Markus Gebauer	Pharmacist/owner	Strathalbyn Pharmacies
Jenny Gowan	MMR Facilitator and consultant accredited pharmacist	North East Valley DGP/ Northern D GP/ MediCom, Gowan & Associates (3 submissions)
Georgina Green	Acting Manager, Corporate Public Affairs and Marketing	National Prescribing Service
Graham Greenhill	Consultant Clinical Pharmacist	Medication Management
Marc Grimer	Hospital pharmacist	John Hunter Hospital
Julie Grint	Consultant accredited pharmacist	Victoria
Paul Gysslink	Professional Issues and Research Officer	Pharmacists Division of APESMA
Paul Hannan	General Manager	Manrex Pty Ltd - Webstercare
Patrick Hayden	Pharmacist	IGA Superpharm Zillmere
Jill Hayward	MMR Facilitator	Gold Coast & Tweed Valley DGP
Tim Hewitt	Community pharmacy business owner	Albion Park Pharmacy. NSW
Alison Hilet	Pharmacist	Echuca Regional Health, VIC
Sheila Holcombe	CEO	Blue Mountains DGP
Jay Hooper	Consultant accredited pharmacist	Sunshine Coast, and Former National President, Pharmaceutical Society of Australia
Roslyn Hosking	Pharmacist	NW DGP QUM Advisory Committee
Karen Huxhagen	Pharmacist	Mackay QLD
Suzanne Jacobs	Consultant accredited pharmacist	East Fremantle, WA
Shirley James	Pharmacist	Bendigo & District DGP
Stefanie Johnston	Pharmacist/QUM PM	Osborne GP Network
Noelene Karlson	Consultant accredited/ hospital pharmacist / community pharmacist	Medowie, NSW
Bill Kelly	CEO	Australian Association of Consultant Pharmacy ACT
Greg Kyle	PhD Candidate	School of Pharmacy University of QLD
Sue Leitch		Pharmacy Guild of Australia TAS
Gavin Lockcock	Pharmacist	No further information
Karen Luetsch	QUM Program Manager	Health Workforce QLD
Greg Luke	Consultant accredited pharmacist	Mt Evelyn VIC
Rollo Manning	Consultant accredited pharmacist	RWM Consultancy, NT
Grant Martin		Pharmaceutical Society of Australia

Appendix 3: List of Submitters

Name	Occupation	Organisation/Location
Geoff McCurdy	Director of Pharmacy	Ballarat Health Services, VIC
Jenny McGill	Pharmacist	No further information
Tanja McLeish	MMR Facilitator	North West Slopes DGP
Andrew McPherson	CEO	Ballarat & District DGP
Bill Newton	CEO	GP Network Victoria
Debbie Norton	QUM Program Pharmacist	West Victorian DGP
Brendan O'Loughlin	Pharmacist	No further information
Matt Pettit	Accredited pharmacist/ MMR Facilitator	Goldfields-Esperance GP network
Neil Petrie John Morgan Angela Clucas	Consultant accredited pharmacists	Business owners
Vijay Ramanathan	Medication Management Review Facilitator	Central Sydney GP Network
Vijay Ramanathan	MMR Facilitator	Sydney South West GP Network Ltd, NSW
Debbie Rigby	Consultant accredited pharmacist	Australian Assoc of Consultant Pharmacy Board Member
Andrew Roberts	Locum pharmacist	Ngaanyatjarra Aboriginal Health Service, remote desert communities, WA
Joanne Rolland	Director of Pharmacy	Bass Coast Regional Health, VIC
Lee Sadler	MMR Facilitator	Pharmacy Guild of Australia SA
Sue Scott	Consultant Accredited Pharmacist	No further information
Shivon Singh	No further information	Sydney South West Area Health Service, NSW
Carlene Smith	Manager MMR Program NSW	Pharmacy Guild NSW Branch
Andrew Stafford	Ph.D Candidate and Research Assistant, School of Pharmacy	University of Tasmania
Pam Stanford	Pharmacist	No further information
Cameron Stewart	HMR Facilitator	Sutherland DGP
Keli Symons	Pharmacist	No further information
Anne Todd	QUM Liaison Officer	DGP North, submitting on behalf of General Practice Tasmania
Fran Vaughan	Consultant accredited Pharmacist/ Lecturer	Faculty of Education, Health and Science (EHS), Centre for Remote Health Charles Darwin University, Alice Springs, NT
Marcus Weidinger	Consultant Accredited Pharmacist	Perth, WA
Neil Wildman	National Program Manager	Pharmacy Guild of Australia National Office

Appendix 3: List of Submitters		
Name	**Occupation**	**Organisation/Location**
Alice Windle	Continuing Professional Development and QUM Program Officer	Adelaide Hills DGP, Mt Barker SA
Christine Wise	Consultant accredited pharmacist	Toowoomba DGP and University of Queensland School of Medicine QLD

Appendix 4:
Lines of Enquiry for Stakeholder Consultations

HMR Qualitative Research Lines of Inquiry **Stakeholder Consultations**	
Topic	**Points to cover**
INTRODUCTION & RULES	CR&C has been commissioned by the Department of Health and Ageing to conduct qualitative research to identify options for enhancing the HMR Program, including identifying gaps in access and understanding factors that influence participation amongst consumers and health professionals (confirm PAL. Resend if necessary). Explain approach (show diagram) and note opportunity for further input at the time of Call for Submission. Interviews confidential … Record for CR&C internal purpose … recording destroyed on completion of project … not provided to the Department. Get permission for recording. Reporting will not identify views expressed by an individual or organisation unless specifically requested (list of stakeholders will be included). A short summary of findings will be provided to all participants at the conclusion of the research.
RESPONDENT AND THE ORGANISATION	Can you tell me about yourself and your role in the organisation? ➢ How **you** have been involved in HMRs? ➢ … *probe for* policy/ research / practice / funding negotiations involvement ➢ And how has <*organisation name*> been involved in the HMR Program?
THE CURRENT HMR PROGRAM IN AUSTRALIA	How would you describe the HMR Program as it stands today? ➢ What do you see the overall objective of the HMR Program to be? – What are the factors influencing the achievement of these objectives? *Probe for* – Factors enhancing and inhibiting achievement? ➢ What factors influence the take up of HMRs? *Probe for* – Circumstances in which it is working and/or not working – Geographic/workforce/cultural/gender

HMR Qualitative Research Lines of Inquiry Stakeholder Consultations	
Topic	**Points to cover**
	➢ How does the program identify consumers who are suitable for review? What is the evidence for that? ➢ Would you say that the Program is effective in targeting at-risk groups? *Probe for* – Groups that are effectively targeted; – Groups that have limited access but would benefit from HMRs. P*robe for* Cultural/socio-economic/geographic/ Indigenous Australians. ➢ How widespread is awareness of the HMR Program? *Probe for*: – Organisations (General practices/pharmacies) – Individual professionals (GPs/pharmacists and others)? – Consumers/Carer's?
SYSTEM LEVEL	Which aspects of the HMR **policy framework** have influenced up-take by: GPs, pharmacists, pharmacies and consumers? *Probe for* ➢ specific factors enhancing and inhibiting ➢ suggested enhancements/ improvements
ORGANISATIONAL LEVEL	There are a number of different individuals and organisations involved in supporting HMRs. How would you describe their roles? *Probe for* ➢ Divisions/Facilitators/general practices/ pharmacies and others. ➢ How do they influence uptake? Participation? Effectiveness? Usefulness? – How could their involvement be enhanced? ➢ What other organisation are important? Why is that? *Probe for* – ACATS, hospitals and others
TEAM LEVEL	How would you describe the ways that GPs and pharmacies/pharmacists work together to conduct HMRs? *Probe for* ➢ Examples of where and why they work together well ➢ Examples of where and why collaboration could be improved ➢ What specific factors enable/inhibit a collaborative team approach in the conduct of HMRs to promote uptake, effectiveness and

HMR Qualitative Research Lines of Inquiry Stakeholder Consultations	
Topic	**Points to cover**
	usefulness? *Probe for evidence*
INDIVIDUAL LEVEL	(*In turn*) what motivates GPs and pharmacies/pharmacists to get involved in the program? *Probe for* ➢ Financial, professional, health outcome and personal motivators? Patient wishes? Other parties? What are the factors influencing ongoing participation in the program for GPs and pharmacies/pharmacists? *Probe for* ➢ Financial, professional, health outcome and personal, benefits/disincentives? Patient wishes?
FOR PHARMACISTS/PHARMACIES	How does the accreditation process for pharmacists influence uptake and conduct of HMRs? *Probe for* ➢ Impact of the accreditation incentive ➢ Specific enablers/barriers. How does the training provided to pharmacists promote quality in the conduct of HMRs? *Probe for* ➢ Sufficiency, quality and targeting of training. ➢ How would the proposed HMR mentoring program enhance participation? *Explore impact of payment to pharmacies*
FOR GPS/GENERAL PRACTICES	➢ What support or specific training to enhance participation in HMRs? ➢ What is the role of a practice nurse?
CONSUMER LEVEL	➢ What are the major benefits of participation in an HMR for consumers/Carer's? ➢ In general; are HMRs an effective tool for improving medication management? Why is that? What is the evidence for improved outcomes for consumers? ➢ Is the current model the best way to conduct HMRs from a consumer's/Carer's perspective? ➢ What other ways could this be done?
COMPARATIVE MODELS	What other mechanisms exist for improving medication management? *Probe for* ➢ Alternatives that are: efficient, effective, appropriate. ➢ Does the HMR provide a medication management model that is applicable across Australia (i.e. rural settings)? Why or Why not?

HMR Qualitative Research Lines of Inquiry Stakeholder Consultations	
Topic	**Points to cover**
	How does the HMR compare with other medication review models? *Probe for:* ➢ Residential MMR ➢ MATES (DVA) ➢ Hospital-initiated home medicines reviews? ➢ Overseas experience ➢ Any others? How do the services provided under HMR complement these other approaches to medicine management?
FUTURE DIRECTIONS	Overall, how do feel about the HMR Program? ➢ What are its strengths and weaknesses? ➢ How could the HMR Program be improved? What is the best way of achieving this? ➢ Do you have any other comments or suggestions about HMRs that we have not already covered?
FINISH UP	➢ Identify specific details of any literature mentioned in the interview or probe for availability of evidence based material; ➢ Mention Call for Submissions and ask if there are newsletters or other ways to communicate the Call to interested parties? ➢ Anything else that is important that we have not covered? Thank you for your time.

ISSUES IDENTIFIED FROM LITERATURE

The following are specific issues identified from previous literature. They do not need to be directly related to the interviewee, but need to be borne in mind throughout the consultation.

Amongst pharmacists:

- The majority of community pharmacies in Australia (nearly 80%) are currently registered as DMMR Service Providers. However, substantial numbers of pharmacists regard the $183.60 currently payable to community pharmacies for each HMR as inadequate.
- Low number of accredited pharmacists has been identified as a problem.
- Distance to be travelled to conduct the HMR especially in rural and remote locations.
- The need to invest time in learning and using the HMR process.

GPs

- Poor relationship between the pharmacist and the GP.

HMR Qualitative Research Lines of Inquiry Stakeholder Consultations	
Topic	**Points to cover**
	➢ Conflict with nursing home reviews. ➢ GP reluctance to lose control of the patient / GP relationship. ➢ Lack of knowledge of the HMR process. ➢ Time constraints of GPs and pharmacists. ➢ The need to invest time in learning and using the HMR process. ➢ Lack of conviction, belief or confidence in the HMR process. ➢ GPs feeling they already provide a quality medicine review process. ➢ Fear of 'big brother' intruding into the practice. ➢ Concerns over the influence of the pharmacist over the patient care. ➢ The time required to produce referral documents, especially when the practice is not fully IT-enabled. ➢ The uneven quality of accredited pharmacists' HMR reports - not set out in a form that the GP finds convenient and useful. ➢ Concern about pharmacists undertaking the kinds of work traditionally seen as being in the domain of the medical profession (such views were said to be held by older GPs in particular). ➢ The large number of recently introduced Australian Government initiatives targeted at general practice and competing for GPs' attention. ➢ The low level of support that was available to 'early adopter' GPs, some of whom became disillusioned with the HMR Program.

Appendix 5:
Recruitment Screener for Health Professionals

Client	Campbell Research & Consulting
End Client	Australian Government Department of Health and Ageing
Number of interviews	109
Location of interviews	Melbourne (Central Bayside, Dandenong) Sydney (Bankstown) South Australia (Mid North) Western Australia (Mid West, Wheatbelt District) Queensland (Capricornia, Townsville, Sunshine Coast) Tasmania (Northern)
Number of participants per interview	1
Dates	February and March 2008

Recruitment Questionnaire

General Practitioners and Practice Nurses

Good morning / afternoon / evening. My name is <insert name> from Campbell Research & Consulting calling on behalf of the Australian Government Department of Health and Ageing. May I please speak to the practice manager?

1. Yes (Continue-S1)
2. Person not available now (Arrange call-back appointment)
3. Refused (Terminate)

RE-INTRODUCE, IF NECESSARY

S1 The Australian Government, through the Department of Health and Ageing, is currently conducting a project looking at the Home Medicines Review program.

The aim of this research is to obtain information and feedback regarding health professionals' experience and views of the HMR program.

<Provide further explanation of the HMR program if necessary: see information overview sheet>

The Department is inviting GPs and other health professionals who participate, or choose not to participate in the HMR program, to be involved in one-on-one research interviews.

I am calling you today because we would like to arrange a time for one of our senior consultants <Cathy Somerville or Evylyn Campbell> to come and meet with a doctor in your practice.

GPs who participate will be given $200 to compensate for their time, and the interview would be scheduled at a venue convenient for the doctor.

Participation is completely voluntary and anonymity is assured. (EXPLAIN AS REQUIRED).

Would I be able to speak with the doctor about participating in this research project?

1. Yes (Continue)
2. No / Unsure/ Requests further information
(ARRANGE TO SEND INFORMATION SHEET THROUGH FOR DOCTOR'S INFORMATION)

S2 As we are speaking with GPs who have participated in the HMR Program, as well as those who have not, can you please confirm whether <doctor has/ you have> has referred a patient for a HMR in the past year? This can include starting the referral and HMR process but not submitting a Medicare claim

1 Yes (check against quota before continuing – go to N1 if quota full)

a. How long have you been undertaking HMRs/ or participating in the HMR program for?

2 No (check against quota before continuing – go to N1 if quota full)

S3 Our consultant <Cathy Somerville or Evylyn Campbell> will be in your area on <insert day/date>. The discussion would take around ½ an hour.

<Is doctor/ Are you> available on these dates for <Cathy or Evylyn> to meet with <doctor/ you> at the practice ?

1. Yes (Continue) Confirm practice address/ email and telephone number
2. No / Unsure (A1)

Demographic Profile

S4 Can you please confirm how many doctors are working at your practice?

S5 Does your practice service any specific ethnic or socio-economically disadvantaged populations?

Alternative Interview Options Section <if unavailable during scheduled interview times>

A1 Would there be a more convenient time that we could arrange for <Evylyn or Cathy> to call <doctor /you>, to conduct the interview via telephone instead?

1. Yes (Continue)
2. No / Unsure (Continue)

A2 Arrange time and date for tele-interview. Make arrangements for incentive to be paid electronically. (Only pursue this option if alternative interviewees are unavailable or if this contact is particularly important for the research.)

Nurses and Practice Managers Section

N1 We would also like to speak with practice nurses who do or do not currently have involvement in the HMR program. Is there a nurse working in your practice who participates in any aspect of the HMR program?

1. Yes (Continue)
2. No / Unsure (N1)

N2 Would I be able to speak to your nurse?

1. Yea

(Continue)

2. Person not available now (Arrange call-back appointment)
4. Refused (Terminate)

N3 – Repeat S1-S3 for nurses. Differences are that nurses will be paid $150 and we only wish to speak to nurses where their practice or role has a direct relevance to populations with high numbers of potentially eligible HMR consumers.

Confirmation

C1 I will arrange for an email/letter to be sent out to you (today / tomorrow) confirming all of these arrangements. Could I confirm that I have your correct contact details? (CONFIRM EMAIL ADDRESS/ & STREET ADDRESS FOR PRACTICE)

Termination

"Thank you for your help. Just in case you missed it, my name is <insert name> from Campbell Research & Consulting."

IF VALIDATION REQUESTED, REFER TO EITHER

CR&C: Evylyn Campbell or Cathy Somerville on 1300 368 113. Or the Department: Marita Kenrick on (02) 9263 3548

Pharmacists (HMR accredited and non-HMR accredited)

NOTE: RECRUITMENT LISTS WILL IDENTIFY IF THE PHARMACIST IS HMR ACCREDITED OR NOT.

Introduction

Good morning / afternoon / evening. My name is <insert name> from Campbell Research & Consulting calling on behalf of the Australian Government Department of Health and Ageing. May I please speak to <insert name >?

1. Yes (Continue-S1)
2. Person not available now (Arrange call-back appointment)
4. Refused (Terminate)

RE-INTRODUCE, IF NECESSARY

(OFFER TO SEND INFORMATION SHEET IF NECESSARY)

S1 The Australian Government, through the Department of Health and Ageing, is currently conducting a project looking at the Home Medicines Review Program.

The aim of this research is to gather information about your experience and views of the HMR program.

The Department is inviting a number of pharmacists and other health professionals who participate, or choose not to participate, in the HMR program in your area, to take part in one-on-one interviews.

I am calling you today because we would like to arrange a time for one of our senior consultants <Cathy Somerville or Evylyn Campbell> to come and meet with you.

If you participate you will be given $150 to compensate for your time, and the interview would be scheduled at a time and location convenient to you.

Participation is completely voluntary and your anonymity is assured. (EXPLAIN AS REQUIRED).

Are you interested in participating in this research project? (OFFER TO SEND INFORMATION SHEET)

1. Yes (Continue)
2. No / Unsure (Terminate)

S2 Can I just confirm that you have undertaken medication review accreditation training/education?

Record details

S2A And you long have you been conducting HMRs for?

Record details

S3 Our consultant <Cathy Somerville or Evylyn Campbell> will be in your area on <insert day/date>. The discussion would take around 45 minutes of your time.

Are you available on these dates for <Cathy or Evylyn> to meet with you?

1. Yes (Continue)
2. No / Unsure (A1)

S4 Where would be the most convenient location for <Cathy or Evylyn> to meet with you? (NOTE: Where relevant, prefer the pharmacy office, or a central location.)

1. Record details. (Continue)

Alternative Interview Options Section <if unavailable during scheduled interview times>

A1 Would there be a more convenient time that we could arrange for <Evylyn or Cathy> to call you, to conduct the interview via telephone instead?

1. Yes (Continue)
2. No / Unsure (Continue)

A2 Arrange time and date for tele-interview. Make arrangements for incentive to be paid electronically.

HMR Consumer interviews

H1 As part of this research project, we are also conducting consultations with HMR consumers. We would like to speak with patients who have participated in a HMR.

Consumers' experience and perspectives of the HMR program are integral parts of this project. Are you able to assist us with this process by helping us to get in touch with one of your HMR patients?

1. Yes (Continue)
2. No / Unsure (N1)

H2 List opt-in process and offer to send through opt-in information sheet [See HMR Consumer Recruitment Specifications for further detail]

Confirmation

C1 I will arrange for an email/letter to be sent out to you (today / tomorrow) confirming all of these arrangements. Could I confirm that I have your correct contact details? (CONFIRM EMAIL ADDRESS/ ADDRESS OF INTERVIEW LOCATION)

Termination

"Thank you for your help. Just in case you missed it, my name is <insert name> from Campbell Research & Consulting."

IF VALIDATION REQUESTED, REFER TO EITHER

CR&C: Evylyn Campbell or Cathy Somerville on 1300 368 113. Or the Department: Marita Kenrick on (02) 9263 3548

Business owners of Community Pharmacies

Good morning / afternoon / evening. My name is <insert name> from Campbell Research & Consulting calling on behalf of the Australian Government Department of Health and Ageing. May I please speak to <insert name >?

1. Yes (Continue-S1)
2. Person not available now (Arrange call-back appointment)
4. Refused (Terminate)

RE-INTRODUCE, IF NECESSARY

OFFER TO SEND INFORMATION SHEET IF NECESSARY

S1 The Australian Government, through the Department of Health and Ageing, is currently conducting a project looking at the Home Medicines Review Program.

The aim of this research is to gather information on your experience and views of the HMR program.

The Department is inviting a number of pharmacy owners and other health professionals who participate, or choose not to participate, in the HMR program to take part in one-on-one interviews.

S2 Are you the person responsible for making business decisions for your pharmacy?

1. Yes (continue)
2. No (ask to be transferred to business decision maker and repeat introduction and S1)

S2a Is your pharmacy an independent pharmacy or part of a pharmacy chain?

Record response – aim for a mix of independent and chains

S3 I am calling you today because we would like to arrange a time for one of our senior consultants <Cathy Somerville or Evylyn Campbell> to come and meet with you.

Community pharmacy business owners who participate will be given $150 to compensate for your time, and the interview would be scheduled at a venue convenient for you.

Participation is completely voluntary and your anonymity is assured. (EXPLAIN AS REQUIRED).

Are you interested in participating in this research project? (OFFER TO SEND INFORMATION SHEET)

1. Yes (Continue)
2. No / Unsure (Terminate)

S4 Our consultant <Cathy Somerville or Evylyn Campbell> will be in your area on <insert day/date>. The discussion would take around 45 minutes of your time.

Are you available on these dates for <Cathy or Evylyn> to meet with you at your consulting rooms?

1. Yes (Continue)
2. No / Unsure (A1)

Alternative Interview Options Section <if unavailable during scheduled interview times>

A1 Would there be a more convenient time that we could arrange for <Evylyn or Cathy> to call you, to conduct the interview via telephone instead? (ONLY IF NECESSARY, otherwise seek alternative interviewee.)

1. Yes (Continue)
2. No / Unsure (Continue)

Confirmation

C1 I will arrange for an email/letter to be sent out to you (today / tomorrow) confirming all of these arrangements. Could I confirm that I have your correct contact details? (CONFIRM EMAIL ADDRESS.)

Termination

"Thank you for your help. Just in case you missed it, my name is <insert name> from Campbell Research & Consulting."

IF VALIDATION REQUESTED, REFER TO EITHER

CR&C: Evylyn Campbell or Cathy Sommerville on 1300 368 113. Or the Department: Marita Kenrick on (02) 9263 3548

Appendix 6:
Discussion Guide for Interviews with Health Professionals

HMR Qualitative Research Discussion Guide Interviews with Health Professionals (GPs)		
Topic	**Points to cover**	**Duration (Mins)**
INTRODUCTION and Rules	Introduction about the nature of the interview. Confidentiality, privacy, recording, non-identifiable.	(0:00) 2 min
OVERVIEW OF THEIR PRACTICE	Tell me something about your practice: ➢ Location, geography, services in the area; ➢ Demographics; ➢ Social and economic setting; ➢ Home visits; ➢ Practice nurse. Overall, how would you describe the majority of your patients/clients: ➢ Ageing; ➢ High levels of unemployment; ➢ Young families; ➢ Single and professional; ➢ Low levels of English; ➢ Indigenous; ➢ Transient or lived in the area a long time. What are the relationships like between your practice and: ➢ Local pharmacies; ➢ Nursing Services; ➢ Hospitals. How would you describe the level of IT 'literacy' and usage within this practice: ➢ How much of the prescribing is done through electronic systems direct from the doctors' offices; ➢ What electronic linkages do you have with other major IT support systems for medical practitioners? Pharmacies? (Etc).	(0:02) 7 min
EXPERIENCE OF HMR /PERCEPTIONS	Are you familiar with Home Medicines Reviews? What experience have you had with these in this practice or in	(0:09)

HMR Qualitative Research Discussion Guide Interviews with Health Professionals (GPs)		
Topic	**Points to cover**	**Duration (Mins)**
	other settings where you may have worked recently; What would be the level of understanding of medicines among most of your older patients/clients; What is your overall view of the Home Medicines Review program; Can you describe any examples you can recall of: ➢ Referring patients for HMRs. What process did you follow in those instances; ➢ Being asked to refer patients but deciding against it. What sort of factors did you consider in making that decision? What sorts of responses do you see from patients when the possibility of a HMR comes up: ➢ Receptive; ➢ Resistant; ➢ Confused; ➢ Overwhelmed. What differences do you see between patients when you discuss HMRs with them: ➢ The characteristics of those who are more or less inclined to accept your recommendations? (Eg. Those over 75 compared with younger patients; or patients with little English compared with those without language barriers.) The general health of those patients for whom you have recommended a HMR. Would you say they were at a medium or high risk of ill-effects from factors relating to their medications?	10 min
WHAT WORKS AND WHAT DOES N'T	I'd now like to discuss your experience of what works well with HMRs and what does not work so well, based on your experience in this practice: ➢ Firstly, what works well for the patient; ➢ Then, what works well for you as a healthcare professional: – Financial arrangements; – Process – steps involved; – Information flow and quality; – Hospital discharge;	(0:19) 10 min

HMR Qualitative Research Discussion Guide Interviews with Health Professionals (GPs)		
Topic	**Points to cover**	**Duration (Mins)**
	– Frustrations; – Work capacity/workforce shortages. When it works well, what does it look like? What is different?	
BENEFITS	Explore potential and actual benefits for: ➢ Your patients: – For those with high needs; – For those of all ages. ➢ You as a health professional. Explore why these benefits have been cited, and what examples they have seen of these. How important do you think HMRs are for the clinical care of the patient? Do you see any benefits in terms of preventing hospitalisation? Do they help prevent it at all? What about when patients come out of hospital? In the early discharge phase? Re-admission levels and any connection to HMR?	(0:29) 5 min
VISION FOR THE PROGRAM SUGGESTED ENHANCEMENTS	In an ideal world, how should the Home Medicines Review program work? What changes or enhancements would you like to suggest for the Home Medicines Review: ➢ For the patients; ➢ For you as a health professional. Here are some examples of ways in which others have suggested that the HMR Program might work differently. I would like you to tell me your response to these: ➢ Provision for GPs to refer HMRs directly to an accredited pharmacist and not necessarily to a community pharmacy in the first instance: ➢ Would you feel more comfortable if you could refer directly to someone you had an established professional relationship with?	(0:34) 7 min
CONCLUSION	Anything else you'd like to mention? Thank you for your time. The results of this series of interviews will be very valuable in providing feedback to the Department on the HMR Program.	(0:41 pm) 4 min
End		(0:45)

Appendix 7:
Discussion Guide for HMR Consumer Interviews

HMR Qualitative Research Discussion Guide Interviews with HMR Consumers		
Topic	**Points to cover**	**Duration (Mins)**
INTRODUCTION	Introduction about the nature of the interview. Confidentiality, privacy, recording, non-identifiable.	(0:00) 2 min
ACKGROUND INFORMATION	Tell me something about yourself: ➢ Live alone/with others; ➢ How long have you lived in the area; ➢ Your own background; ➢ Home visits from any carers; ➢ Family carers? Relatives nearby. Tell me something about your health issues and the reasons you are on a large number of medications. . How do you feel about: ➢ Your GP (one or more than one): – Frequency of visits/Home visits; – Length of time seeing this doctor.	(0:02) 5 min
	➢ Local pharmacy (one or more than one): – How did you select this pharmacy? – How long has this been your regular pharmacy for? – Do you use other pharmacies as well? ➢ Local hospital – Have you been admitted to hospital? – Do you go to an emergency department instead of seeing your regular doctor?	5 min

HMR Qualitative Research Discussion Guide Interviews with HMR Consumers		
Topic	**Points to cover**	**Duration (Mins)**
EXPERIENCE OF HMR /PERCEPTIONS	Do you recall someone coming to your home to talk to you about your medicines? What can you tell me about the visit? How did it come about? When did it take place? (Approx): ➢ How did you feel when the idea first came up? Was this from your GP or from the pharmacist or someone else? ➢ How did you feel about someone visiting you at home to talk about your medicines? ➢ Was it your regular pharmacist who came to your home, or somebody you had not met before? – If it was somebody you had not met before, did that concern you at all? ➢ Did you have any concerns about why your GP was suggesting the visit? ➢ Do you know what this visit was called? ➢ Have you had more than one of these visits? ***Before the visit*** How would you describe your general approach to your medicines before the visit? Had you ever experienced any side-effects or bad reactions to prescription medicines? Had you ever needed to go to hospital, either to a clinic or to be admitted, because of problems with medicines?	(0:12) 5 min 5 min

HMR Qualitative Research Discussion Guide Interviews with HMR Consumers		
Topic	**Points to cover**	**Duration (Mins)**
FOLLOW-ON FROM HMR	***Explore any changes that arose as a result of visit*** ➢ Do you think the visit helped you with your medicines? How did it do that? ➢ Once you had the pharmacist come to visit and talk to you about your medicines, did you change anything? ➢ Do you recall talking to your GP about the home visit after it had taken place? ➢ Did you have to make a special appointment to speak to your doctor about the visit? ➢ Was making a second appointment to see your doctor easy for you? ➢ Did the visit leave you feeling confused about your medications at all? ➢ E.g., did the pharmacist make suggestions that seemed to be different from what your Doctor had said?	(0:22) 7 min
EXPLORE WISHLIST	Are there any things about the review visit that you would like to change? What would you suggest and why? ➢ Changes relating to the way you were asked about the visit? ➢ Changes relating to the visit itself and the pharmacist? ➢ Changes in the follow-up period, after the visit *[Other points to note could include changes to the number of people involved; the length of time it took for the visit to be completed etc]*	(0:29) 7 min
CONCLUSION	Anything else you'd like to mention? Thank you for your time. The results of this series of interviews will be very valuable in providing feedback to the Government.	(0:36) 4 min
		(0:40)

Appendix 8:
Eligible Consumer Screening Questions

Appendix 8: HMR Eligible Consumer Screening Questions
1. In the last 6 months, approximately how many times have you consulted a. A GP? Specify (ONCE A MONTH OR MORE INDICATES A HIGH RISK CONSUMER) b. A specialist? Specify (2 OR MORE INDICATES A HIGH RISK CONSUMER) c. An Emergency Department or Outpatients' Clinic at a hospital? Specify (ONCE A MONTH OR MORE INDICATES A HIGH RISK CONSUMER)
2. Are you currently taking (or meant to be taking) any prescription medications? (If necessary, prescription medications are medications that are prescribed by your doctor or specialist that you buy from a pharmacy). a. YES (If YES)
3. About how many prescription medicines are you taking each day? Specify (High risk users to be taking **five or more prescription medications** on a daily basis. Note this relates to different medicines, rather than doses of the same medication) a. If taking less than 5 medications, go to Q5 b. NO Go to Q5
4. Are you providing assistance to a close relative or friend who is in need of daily care and who may be taking **five or prescription medications** each day? (Not in a professional employment capacity). a. YES. Continue – GO TO CARERS' STREAM, see below. b. NO. Terminate. "Unfortunately, you are not one of the people we need to speak to for this study, but thank you very much for being prepared to participate."
5. Are you currently or have you been in the past, working as a medical doctor, a nurse or in another medical profession? a. NO Continue b. YES Terminate. "Sorry, unfortunately for this research, we need to talk to people who do not have health training. Thank you for your time"

Appendix 9:
Moderators' Guide for Eligible Consumer Focus Groups

HMR Qualitative Research Discussion Guide Focus Groups with Eligible Consumers		
Topic	**Points to cover**	**Duration (Mins)**
INTRODUCTION	*Introduction about the nature of the discussions. Confidentiality, privacy, recording, non-identifiable.* We are a company based in Melbourne specialising in social research for government and business. We have been commissioned by the Australian Government Department of Health and Ageing to conduct a study about use of medicines in the home. The format of the group is open and free flowing. There are no right or wrong answers. However, we do ask that: ➢ You don't all talk at once, as it means we might not catch something important, or something that someone else in the group might want to comment on. ➢ Everyone joins in and offers their opinion, everyone's view is important. – You don't talk among yourselves but address yourselves to the group – otherwise it can be disruptive for the group and people can miss what others have to say. ➢ CR&C is bound by the Market and Social Research privacy code. Please be assured that the information and opinions you provide today will be used only for research purposes, and only for this project. ➢ Our report will present the overall findings from the research. No individual will be identified. If you agree, I would like to record this discussion. This is only to help us write our report. The tape is not provided to anyone and will only be accessed by those people working within the company, who are assisting on this project. The tape and all notes that may identify you will be deleted at completion of the project. (NB respondents will have been advised of recording at the time of recruitment).	(0:00) 3 mins
INTRODUCTION	Some of the topics for discussion may be sensitive, and if you	

HMR Qualitative Research Discussion Guide Focus Groups with Eligible Consumers		
Topic	**Points to cover**	**Duration (Mins)**
AND RULES	feel uneasy you do not need to talk or answer any questions if you do not want to. You may also leave the discussion at any point should you wish. We also have a number that you can call if you need more information about tonight's discussion, or this research project. This number will put you through to our offices in Melbourne where one of our staff members can help you with any questions you might have about the research or our company. If anyone would like to write down this number, it is 1300 300 979. Tonight we have a number of observers here, from both the Department and Campbell Research. They are simply here to observe the proceedings and won't be involved in the discussion in any way. Did you have any questions at this stage? You'll see that we have some refreshments available so please help yourself to these at any time.	
ABOUT THE PARTICIPANTS	➢ Firstly, could everyone introduce themselves, and tell the group a little bit about: ➢ Who you are ➢ Where you live ➢ Perhaps what you like to do with your time ➢ You might want to mention whether you live with anyone else If you are here as a carer, please let us know that as well. This is just so we can learn a little about each of you.	(00:03) 8 mins
OVERVIEW OF DISCUSSIONS	To give you an idea about tonight's discussion, I would like to talk to you ***generally*** about use of medicines in the home and other issues. Then I would like to talk about any personal experience you have in relation to your approach to your own healthcare.	(00:11) 2 min
RELATIONSHIP WITH: THEIR GP SPECIALISTS COMMUNITY PHARMACIES	**GPs** I'd like to start by asking you to tell me something about your visits to your doctor – and in this case, we are mainly thinking of GPs: *Consumer Behaviour (frequency of visits; doctor shopping)* ➢ Where do you go? How long have you been	(00:13) 10 min

HMR Qualitative Research Discussion Guide Focus Groups with Eligible Consumers		
Topic	**Points to cover**	**Duration (Mins)**
	going to this doctor? ➢ Do you always go to the same doctor/practice? Any difficulty in getting to see the doctor? ➢ Bulk bill or not? Home visits? ➢ When was the last time you went to see your GP? ➢ Do you ever visit a hospital emergency department or clinic rather than seeing a GP? *Relationship with GP (level of trust* Overall, how would you describe your relationship with your GP? ➢ Level of trust? ➢ Would you ever raise questions with your GP about any aspect of his/her advice? **Specialists** No doubt many of you see specialists as well from time to time. Would you say you have more involvement with your GP or with your specialists? (thinking of your current situation) **Pharmacies** When you need prescriptions, do you always visit the same local pharmacy? Or a number of different pharmacies? How do you choose which one to go to? Do you feel you know the pharmacist quite well in your local pharmacy?	
EXPERIENCE OF: CARE IN THE HOME HOSPITAL VISITS AND ADMISSIONS	**In-home care** Do you receive regular assistance because of health problems you might be facing? Have you received care from any health workers in your own home? Perhaps from a district nurse? When visiting you, has a nurse ever discussed your medicines with you? ➢ Hospital visits Discuss their hospital experience, reason for admission, and what happened with their medicines when in hospital and in the days after they left.	(00:23) 5 mins

HMR Qualitative Research Discussion Guide Focus Groups with Eligible Consumers		
Topic	**Points to cover**	**Duration (Mins)**
UNDERSTANDING OF THEIR MEDICINES ADVERSE REACTIONS KNOWLEDGE AND UNDERSTANDING GENERICS PHARMACIST LIAISON	Most of you who are here this evening have quite a few medicines to take each day. I'd just like to talk with you now about how you feel about your medicines. Can you describe any examples you can recall of: *Adverse Reactions* ➢ Having a bad reaction to a medicine? What happened? Did you need to visit or be admitted to hospital as a result? ➢ Feeling that you were at risk from ill-effects relating to your medicines? *Knowledge and Understanding* ➢ Feeling confused about why you were taking a medicine or perhaps the dose? ➢ What do you know about how your different medicines work? *Generic Medications* ➢ Generics/different names for familiar medicines – does this make it any more confusing for you? *Pharmacist Liaison* ➢ Do you ever discuss any of these issues with the pharmacist when you pick up your medicines?	(00:28) 15 min
STRENGTH OF GP RECOMMENDATIONS FOR PHARMACIST VISIT: RELUCTANCE	*Strength of GP Recommendations:* If your doctor suggested that it would be helpful for you to have a pharmacist come to visit you at your home to discuss your medicines, how would you feel about this? Explore range of responses: ➢ Receptive/Resistant/Confused/Overwhelmed/ Not a problem *Reluctance Towards Home Visits* For those of you who have concerns, or who are resistant, what are the reasons for these responses? Explore range of responses: ➢ Personal safety?/Unfamiliar concept?/Would not feel comfortable/Unnecessary/Can discuss at the pharmacy – no need to visit my	(00:43) 5 min

HMR Qualitative Research Discussion Guide Focus Groups with Eligible Consumers		
Topic	**Points to cover**	**Duration (Mins)**
	home/Would make me feel like they did not trust me/Too hard to understand/Can't be bothered/ Don't like to think about my medicines (Note the characteristics of those in the group who are more or less inclined to be concerned or resistant. E.g. Are they older or younger? Patients with a lower level of English? Other factors?)	
ROLE OF THE CARER IN DECISION MAKING AROUND MEDICINES	Who can you turn to if you need to talk about your health? ➢ Relatives? Friends? ➢ Visiting health workers or carers? Are you the only person involved in making decisions about your healthcare – or does another person assist you with this? If this person suggested you ask your GP for a review of your medicines, including a visit to your home by a pharmacist, would you speak to your GP about this? ➢ If not, what are some of the reasons? Concern that it would offend? Show a lack of trust? Not needed? He/she's too busy for that… (Exploring level of willingness to take a proactive stance with their GP – and note different characteristics of those willing and not so willing.)	(00:48) 10 mins
AWARENESS OF HMR PROGRAM AND ACCESS	*Awareness of HMR Program* Has anyone heard of a service where the Government pays for a pharmacist to visit your home and advise you on your use of medicines? ➢ If so, can anyone tell me the name of that service? ➢ For those who have heard of this type of service, where and when did you first hear of it? ➢ Do you recall your pharmacist or GP making a suggestion for this kind of service at any time? *Experience with Access:* ➢ Have you tried to access this service? Do you know of anyone who has had one of these visits? Perhaps a relative or friend or someone you have met in a group activity?	(00:58) 10 mins

HMR Qualitative Research Discussion Guide Focus Groups with Eligible Consumers		
Topic	**Points to cover**	**Duration (Mins)**
	➢ If so, how did that person feel about the Home Medicines Review service? Do you know whether the visit happened soon after they left hospital? Or whether it had anything to with a hospital stay that they may have had? (Aiming to uncover if it was a visit by a hospital outreach pharmacist or a HMR.) Would you like your GP to give you the opportunity for a visit of this kind? *Perceptions of Access* ➢ Do you feel that you could access this service if you wanted to?	
EXPLORE ANY PREFERENCES	Is there anything you can think of which you feel would help you with your use of medicines?	(1:08) 5 min
CONCLUSION	Are there any other questions or comments? We have been commissioned by the Department of Health and Ageing to carry out this study. The Government will use the results of the study to inform their future work. As I stated at the start of the group, if you would like any further information about tonight's discussion or this research project, please call 1300 300 979 Thank you and close.	(1:13) 3 min
End		(1:16)