

Options for Consideration

Context

A number of options for consideration for changing the HMR Program model have been suggested, drawing from the findings of all stages of the qualitative research project.

Three types of options have been identified:

1. **Major structural changes** including suggestions, made by stakeholders and drawn from the research findings, which are aimed at refocusing the HMR Program to: increase access by patients who are considered to be of most need but not currently receiving HMRs; encourage marketing and promotion by consultant accredited pharmacists; and to improve efficiencies to focus on outputs that can improve outcomes for patients and enhance the contribution to general practice management of patients.
2. **Minor adjustments to rules** that would provide incentives for pharmacists, reduce some cumbersome requirements, and reduce areas of dissatisfaction that are currently contributing to non-participation by health professionals in the HMR Program.
3. **Considerations for data collection** including performance monitoring, review of key elements and future research.

The options suggested for consideration indicate a major overhaul of the structure of the HMR Program. Consideration should be given to identifying the extent to which the original model (suggested in the early South Australian trials) differed from the current implementation and what, if any, lessons can be learned from the translation of the early trials into practice at the wider community level. In some instances, where major changes may be considered, it is strongly suggested that pilot programs be established with a built-in structure for evaluation to provide convincing evidence, or otherwise to encourage participation in the Program.

It is noted that, apart from GPs providing HMR type functions within already overburdened general practices, no other programs were identified that would substitute for the HMR Program.

Options for major structural changes

Option 1. Develop a strategy for a highly selective and targeted approach to HMR

Overall views and evidence gathered through the course of this research project, demonstrate the need for a highly selective and targeted approach to HMRs - amendments or redirection of the HMR Program need to take account of these concerns if high-risk consumers are to benefit.

Rationale

We need to identify who is ... at risk and which patients benefit and whether much value is added in a HMR. It may be better to do less of them, but to fund them better. (Stakeholder - Medical organisation)

Concerns that consumers who are the most in need of a HMR are currently missing out on the service, were prevalent throughout the 84 submissions received for this research. These concerns were backed up in detail throughout the Qualitative Research with Health Professionals component of this research.

Option 2. Allow direct referrals to accredited pharmacists

The option to allow direct referrals to consultant accredited pharmacists was identified *in addition to* the current referral system. Direct referral can facilitate access where patients do not have a relationship with a single community pharmacy, where community pharmacies do not participate or are indifferent



to participation in the HMR Program, or where the GP strongly prefers a direct referral relationship. In rural areas where there was a dearth of health professionals, direct referrals were identified as a solution to overcome barriers to access resulting from workforce shortages.

Rationale

While referral from the GP to the community pharmacy is the ideal model, it does not always work. Currently, the sole reliance on this referral pathway is a barrier where:

- a patient does not regularly attend a community pharmacy (particularly the case for marginal consumers)
- the community pharmacy has a negative or ambivalent response to HMRs and is disinclined to participate or will delay referrals
- the consumer's GP has a strong preference for a direct referral relationship.

Support for a direct referral option was widely supported throughout the various phases of the research, specifically including Stakeholder Consultations, Public Call for Submissions and the Qualitative Research with Health Professionals.

Qualification/consideration

Direct referral processes must ensure participation of, and payment (of a component of the rebate) to, community pharmacies. All stakeholders identified the important role of community pharmacies in continuity of medication advice and continuing education of the patient, as well as quality assurance on dispensing. This is particularly the case where consumers have established relationships with community pharmacies.

Option 3. Allow accredited pharmacists to claim fees directly for services

Rationale

Consultant accredited pharmacists argued that direct referrals together with direct claim for services provided would allow for development of a viable business proposition. It would also address barriers at the community pharmacy level (such as the delay in referral and delay in claiming for payment).

Delays and erratic payment by community pharmacies were seen as a significant disincentive and led a large number of accredited pharmacists to call for payment to be made directly to them. Indeed, this was one of the strongest arguments presented across many submissions, including from some peak bodies. The administrative burden of sending reminders and 'chasing up' community pharmacies was also highlighted. A compromise payment scheme was also proposed, whereby the fee could be split between the community pharmacy business owner/managers and the accredited pharmacist.

Qualification/consideration

A separate payment would be required for work undertaken by the community pharmacy therefore the suggestion is for a 'split payment'.

Submissions by consultant accredited pharmacists argued for this group to be eligible for a Medicare provider number to facilitate direct payment.

Many community pharmacies were openly supportive of the option to allow accredited pharmacists to invoice directly and receive direct referrals.

Option 4. Broaden the referral base – hospital discharge

Develop structures for hospital medical officers and senior hospital pharmacists to refer patients for a HMR, either through a community pharmacy, or direct to a consultant accredited pharmacist.

Rationale

When a patient comes out of hospital, the referral pathway is even longer than the usual HMR referral pathway, precisely when it needs to be the most streamlined and occur most urgently.

Stakeholders consistently identified the value of a HMR within approximately 10 days of hospital discharge, preferably earlier. This is not happening with the current model due to delayed referral by GPs, by community pharmacies and the variable linkages between hospitals and GPs. Direct referral will enhance appropriateness and access to HMRs for a group of consumers who are clearly seen as being at imminent risk of medication misadventure, and possible hospital readmission due to medication problems.

Implementation could commence with a pilot in a number of different regions to test approaches, develop performance reporting (including process outputs such as measuring changes made to medications, education advice given, and follow-on outputs – informed GPs, inclusion of community pharmacies, long-term measurement of adverse events and hospital readmission due to medication issues).

Facilitating access to HMRs immediately on discharge was widely supported by all stakeholders. However, direct referral was not supported in the submission by the Guild national representative.

Planning for HMRs was widely considered to be an element which could be incorporated into the broader discharge planning process.

Qualification/consideration

It is essential to note that it is *not* proposed that all patients of a certain age leaving hospital on multiple medications would require a HMR. Instead, the Program would be used selectively, and be aimed at targeting those patients who were assessed as being at high risk of medication misadventure or confusion in the post discharge period. The approach would be used on a case-by-case basis, similarly to many other post discharge processes that are assessed in this way as part of discharge planning.

Consider introducing pilot programs to thoroughly test implementation.

Aspects of the Medicare Act may be an impediment if payment is to be made to acute hospitals for the work undertaken in preparing a referral.

If the referral is made directly from the hospital to consultant accredited pharmacists, mechanisms for inclusion of the GP and community pharmacist will be necessary.

Option 5. Broaden the referral base – palliative care nurse practitioners, community nurses

Develop structures for a small number of other health professionals, including palliative care nurse practitioners, health professionals making home visits, Aboriginal Health Workers and others, to refer patients for a HMR either through a community pharmacy or direct to a consultant accredited pharmacist.

Rationale

There are a range of health professionals who come into contact with patients who may benefit from a HMR, where formal mechanisms could be established to refer patients to a GP. Medical specialists and palliative care nurses in particular were identified for this broader referral role.

In other cases, a regular GP or community pharmacy may not be involved in the HMR referral. For example, those in Indigenous communities, persons receiving treatment for HIV/AIDS who did not want their community pharmacy to know about their condition, or people living a marginal existence who do not have access to a GP or regular community pharmacy (perhaps relying on Emergency Departments for their primary medical care).

Where HMRs currently assist some of the highest need consumer groups, it is typically through adaptation of the model to include some of these other health professionals as a core component.

Qualification/consideration

Payment arrangements become a consideration where other health professionals are to be substantially involved in HMRs.

There is a need for a clear definition under which health professionals could refer, and under what circumstances.

The GP and, wherever possible, the community pharmacy must be informed of the referral and its outcomes.

Option 6. Nurses to undertake home visits where alternative unavailable

Rationale

Where consultant accredited pharmacists are unavailable in the local area, allow practice nurses to conduct the home visit component of HMRs, followed by later consultation (by email of a draft report) with a HMR accredited pharmacist.

Qualification/consideration

While this is a departure from the primary model, a number of stakeholders and professionals identified this approach as the only way the service could be delivered to some remote communities. In some areas this adapted model is already being used, as it is the only viable service delivery.

In numerous cases, this is the only way HMRs occur in these areas at present – as part of an adapted model.

Workforce issues and availability of appropriately trained nurses (nurse practitioners) will limit implementation.

Consider limiting practice nurse involvement to those areas where consultant accredited pharmacists are not available.

Option 7. Indigenous – Explore alternative mechanisms for medication review services within Indigenous communities

Rationale

There has been very little use of HMRs among Australia's Indigenous population, where the incidence of medication non-compliance and misuse is known to be significant. (Consultant accredited pharmacist, NSW)



Referrals to a 'community retail pharmacy' via a GP are so impossible for this population. Indigenous clients who use an Aboriginal Health Service (AHS) generally do not ever set foot into a community pharmacy. They receive all of their medications directly from the AHS. (Consultant accredited pharmacist, NT)

In short, HMRs are unsuited to many Indigenous communities on two key criteria: they have to link in with a community pharmacy and they are meant to occur in the consumer's home.

HMRs for Indigenous Australians are not being undertaken, and a range of alternative approaches have been suggested, not least of all, alternatives which do not have to take place in a house (given that this is in itself problematic in some communities) and which take a shape and form much more in line with other health services provided in Indigenous communities.

Some city/town based Aboriginal and Islander Health Services supported the option of an accredited pharmacist conducting medication reviews at the health service premises, in line with similar services that Indigenous patients are familiar with (such as podiatry, dieticians, diabetes educators).

Other suggestions include enabling automatic HMR referral for all those on the community's chronic disease register; and allowing up to three HMRs a year as standard to allow maximum flexibility to respond to need.

Qualification/consideration

Development of HMR services for remote Indigenous communities requires a different approach, including funding for travel substantially beyond the current parameters.

One-off services were identified as inappropriate for many Indigenous Australians.

Minor modifications

Option 8. Modify requirement for GP telephone communication with accredited pharmacist on HMR completion

Rationale

Telephone communication between the accredited pharmacist and the GP post HMR is considered inconvenient and does not achieve its goals. At present, it rarely happens and when it does occur the communication is not necessarily effective. Scheduling the call at a time appropriate for the GP and accredited pharmacist is difficult.

Qualification/consideration

Effective written communication, preferably using e-health communication, would be more effective for GPs and pharmacists. Information would continue to be provided to community pharmacists as well.

Option 9. Allow more than one HMR in a year

Rationale

Hospital pharmacists identified the need for more than one HMR to take place after hospital discharge for high-need, high-risk patients. This provision would be used only sparingly, but the follow-up effect was thought to be ideal for teaching and the reinforcement of medication patterns.

Pharmacists working with Indigenous populations identified multiple visits as appropriate for providing an education function and continual building of knowledge and understanding of medications.



Qualification/consideration

Protocols specifying criteria for multiple visits would be required.

Provide maximum flexibility around the timing of the second and/or third visits, so that they can be of most direct benefit to the patient (e.g. a palliative care patient moving from the terminal phase to the dying phase, where timeframes are unpredictable).

Where multiple visits are required for consumer education, a different model focused on education may be appropriate.

Option 10. Review remuneration for accredited pharmacists and participating community pharmacies

Review remuneration for the 'pharmacy side' including likely impact on HMR provision if there is an increase in remuneration.

Rationale

There was widespread agreement that the remuneration for work undertaken by pharmacists and community pharmacies was often insufficient to cover costs.

Some community pharmacies chose to pass the full HMR payment amount on to the accredited pharmacist.

Qualification / consideration

Generally stakeholders and respondents identified \$220 as the minimum level of reimbursement for both accredited and community pharmacists. This amount was considered to cover both the community pharmacy component and the accredited pharmacist component.

It was suggested at times during the qualitative phase that a payment of approximately \$40 to the community pharmacy would be a reasonable amount, if it becomes necessary to define a stand-alone payment for the community pharmacy's involvement.

Option 11. Change travel allowance arrangements

Rationale

The cost incurred by accredited pharmacists to travel to patient's homes in Rural, Remote and some Metropolitan areas is not covered by current travel allowances. It is suggested that reimbursement of travel needs to be based on the actual distances required to conduct a HMR, rather than the distance of the patient from the community pharmacy. Reviewing these travel allowances is an important measure to address cost burdens that are limiting access. PhARIA regions associate the location of a community pharmacy in relation to a patient, but not the location of the accredited pharmacist, so may not be an appropriate reference point.

Qualification/consideration

The cost of addressing travel allowance concerns is considered minor because of the small numbers involved. Substantially higher costs would be incurred for rural and remote communities.

If an accredited pharmacist is available locally, consider a requirement that this service be accessed to prevent costs associated with travel from another city.

Option 12. Address issues involving ready availability of interpreting services

Rationale

The issue of access to free interpreters arose repeatedly in the study, at different phases of the research. While such services may be available, they are either not widely known or cannot be easily accessed or to do so requires time-consuming arrangements involving the GP (in some states/territories). It is clear that there is variation among states but that this is an issue of concern for many consultant accredited pharmacists.

Considerations for data collection

Option 13. Establish minimum data set to provide performance monitoring

Rationale

A lack of evidence of the value of HMRs was identified as barrier to participation in the Program. A structured system of identifying inputs (reason for referral), processes (time taken for each of the six stages), outputs (changes made to medication, education advice provided) and outcomes (immediate health benefits, risks avoided, hospital admissions avoided) is required. The introduction of a minimum data set could be undertaken with all stakeholders to ensure relevance and value and to identify appropriate reporting mechanisms.

Qualification/consideration

Any minimum data set would be used to collect only the information which is clinically useful, will minimise administrative burden for professionals and can be used in reporting.

Facilitators could assume the role of managing reporting with support from appropriate organisations.

Option 14. Review MMR accreditation

Rationale

Pharmacists consulted throughout the project consistently put forward a strong case that the requirements for accreditation and re-accreditation were substantial barriers, particularly when the demand for HMRs from local GPs was low. The accreditation training did not impact GPs' views of the HMR Program.

GPs identified concern about competencies of pharmacists to provide useful reporting that informs the GP's practice in a clinically meaningful way. A 'communications' module in training has been identified as an option for improvement.

The recognition of prior learning was identified as an issue requiring change.

Qualification/consideration

Review of medication management accreditation to be undertaken by pharmacy educator of standing and informed by general practice outcomes.

The number of accredited pharmacists has been shown to increasing. Qualitative research identified that a number of experienced accredited pharmacists expressed intention not to re-accredit, or had already allowed accreditation to lapse due to the training barriers. (Qualitative research identified this emerging trend but did not quantify the extent of the issue.)

Consideration of RMMR requirements is important.



Option 15. Encourage further research

Rationale

Participation by GPs would be enhanced if there is strong evidence for the effectiveness of the Program.

Qualification/consideration

Research would be a long term proposition and should be based on an implementation which is timely (especially in referral and feedback times) and with an established team to reduced the effect of team establishment as a confounding factor. Most importantly, any research should be transferable to real life practice.
