Health Workforce
Queensland
Supporting Primary Health Care in Rural Communities

Medication Management Review Facilitator Program

Consortium Report June 2005

*THIS FINAL MMRFP REPORT
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SOUTHERN QUEENSLAND RURAL DIVISION, FAR NORTH QUEENSLAND RURAL DIVISION, WIDE BAY DIVISION, NORTH WEST QUEENSLAND PRIMARY HEALTH CARE DIVISION, BARWON DIVISION OF GENERAL PRACTICE (NSW)*

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Report Recommendations:

- ***Consideration needs to be given to increase funding to rural Divisions of General Practice to conduct adequate Joint Information Sessions in the future**. Joint Information Sessions conducted by Health Workforce Queensland have been very effective in achieving good communication channels between professions. More sessions need to be conducted to ensure adequate accessibility and coverage for all relevant health professionals in rural areas. Unfortunately, distances and expense of travel between rural towns limits accessibility and attendance.*

- ***It is suggested that Medication Management Action Plans be discussed at a national level and strategies developed, introduced and/or piloted to improve provision to community pharmacist in the future.** Medication Management Action Plans are not always sent to the community pharmacy at the completion of the Home Medicines Review (HMR) cycle to provide feedback to, and assist the community pharmacist monitor their patients' medications and use of their medical devices.*

- ***Consider establishing a "National Rural Divisions MMR Working Party" with rural MMR Facilitator representatives.** Its purpose; to address all matters pertaining to the Home Medicines Review (HMR) and Residential Medication Management Review (RMMR) programs for rural Divisions nationally.*

- ***Consider establishing a "National MMR Advisory Group" with general practitioner, community pharmacist and other interested health professional representatives from each State.** Its purpose; to address nationally strategic issues around the MMRFP. Representative members from the Department of Health and Ageing (DoHA), Pharmacy Guild of Australia and other relevant authorities should be also be represented on this Advisory Group. General practitioner and community pharmacist members should be selected from the established "Program Advisory Groups" in participating Divisions to ensure continuity and consistency of messages.*

- ***Minutes of all meetings, e.g. National Advisory Groups, National Working Parties, etc be disseminated to all MMR Facilitators and other relevant groups.***

- ***All MMR Facilitators be provided with adequate and similar resources, to ensure that the same key messages are delivered to relevant health professionals nationally. The resources should also be provided in a timely manner.***

- ***Similar to the "General Practitioner HMR Champions" concept, nominate very active and enthusiastic "Community Pharmacist HMR Champions".** Their role would be to network with community pharmacists and other relevant health professionals. This should raise awareness of the HMR program with the aim to increase the uptake of HMRs and simultaneously raise the profile of community pharmacy in general.*

- ***Introduce an incentive, financial or otherwise to ensure that the HMR reports are completed and returned to the referring general practitioner in a timely manner.** It is suggested for example, that a bonus be paid to the community pharmacy if the HMR claims are submitted to HIC within 1 month of referral or similar.*

- ***Modify the HMR model to address rurality issues.** It is suggested that other models be investigated and piloted during the next phase of funding. This should include addressing the provision and accessibility to HMR services for Indigenous communities and people from non-English speaking backgrounds.*

- ***If the next round of MMRFP funding is more outcomes focused; based on the numbers of HMRs conducted, then Item 900 claiming will be critical to Divisions ongoing funding. It will be essential therefore, that correct HMR claiming by general practitioners also be encouraged at a national level through general practitioner and practice manager journals etc.** Charts 1, 2 and 3 (page 22) demonstrate the disparity of claiming between general practitioners (Item 900) and community pharmacies in the consortium catchment between September 2002 and March 2005. Despite best efforts, this continues to be a challenge for Health Workforce Queensland. Information gleaned from a number of general practitioners indicate that they are not claiming in all circumstances and some are claiming the Item 23 instead at the completion of the cycle. In the meantime, Health Workforce Queensland and its participating Divisions will continue to inform general practice.*

- ***Integrate the MMR (HMR and RMMR) programs into the Quality Use of Medicines activities including NPS and EDQUM within Divisions of General Practice.** Having complementary roles involving a package of widely accepted programs should improve credibility and acceptance by general practice.*

Summary:

As a Rural Workforce Agency primarily responsible for the recruitment and retention of doctors in rural Queensland, the MMRFP consortium activity as part of the Quality use of Medicines program has been very effective for Health Workforce Queensland in many ways. It has given Health Workforce Queensland the opportunity to:

- *expand its Quality Use of Medicines provision to include the pharmacy profession;*
- *forge new and or/closer collaborations with many other health professions and organisations; for example:*
  - *Provincial and urban Divisions of General Practice,*
  - *Pharmacy Guild of Australia, both State and National,*
  - *Pharmaceutical Society of Australia*
  - *Australian Divisions of General Practice,*
  - *Queensland Divisions of General Practice*,
  - *Australian Association of Consultant Pharmacy,*
  - *Community Pharmacists,*
  - *Practice Staff, and*
  - *Hospital Pharmacy and Discharge Staff.*
- *work more closely with its participating Rural and Provincial Divisions of General Practice; through:*
  - *Educational activities (Joint Information Sessions, Practice Staff Information Sessions, various teleconferences etc),*
  - *Weekly telephone contact by MMR Coordinator with MMR Project Officers in Divisions,*
  - *Fortnightly MMR Newsletters to MMR Project Officers in Divisions, and*
  - *Opportunistically meet with MMR Project Officers in Divisions during QUM Clinical Facilitator visits.*

Health Workforce Queensland has found that most rural general practitioners are supportive of the HMR concept and many rural community pharmacists support the program. However, many barriers exist which prevent optimal implementation of the Program as highlighted further in this report and in the "Cause, Effect and Result Table" Table 6 (page 25). Some solutions to overcome barriers have been identified and successfully implemented with the "HMR Pilot Project in SQRDGP" in the South Burnett area as detailed below.

Our Successes

Health Workforce Queensland's Developed Resources
Many of Health Workforce Queensland's' developed resources have been well received by other MMR Facilitators and re-developed by the Pharmacy Guild of Australia and introduced nationally.

Supplementary Provisions for Rural Loading
Health Workforce Queensland submitted a paper in November 2003 to the Pharmacy Guild of Australia, which formed the basis for the introduction of "Supplementary Provisions for Rural Loading". This approach was officially approved by the Health Minister and introduced in early 2005.

HMR Pilot Project in SQRDGP
One of Health Workforce Queensland's major achievements has been the "HMR Pilot Project in SQRDGP", which is and continues to be a great success. Since the beginning of 2005, Health Workforce Queensland's contracted accredited pharmacist has conducted 76 HMRs in the South Burnett Region (Murgon, Kingaroy, Nanango and surrounding towns). The success of this pilot demonstrates that good outcomes can be achieved when all pre-existing barriers to the process are overcome. With a well co-ordinated, collaborative, quality system in place to conduct HMRs, all parties, including the general practitioners, community pharmacists and their patients benefited.

General practitioners see that their patients are provided with a valuable review of their medications; the general practitioners receive valuable information regarding their patients and are financially rewarded for their efforts. The community pharmacist can make a significant contribution to the quality use of medicines for their patients and is financially rewarded for their efforts.

Although this is a pilot project, there have now been three visits to this community and it is the community's wish that it continue into the future. However, this project is only possible where there are

limited travel expenses. It would need an injection of funding to provide the same level of activity in other communities, which have to be accessed by air.

Joint Information Sessions
Soon after each Joint Information Session conducted with both rural general practitioners and community pharmacists there is normally an increase in the number of HMR referrals to the rural community pharmacies in the particular area. Unfortunately, after approximately 3 – 6 months following each Session, referrals start to decline or stop altogether. This is demonstrated in the Charts (page 22). For example, Chart 3 for BDGP shows, following the Session conducted in the June 2003 quarter, referrals spiked and then reverted to zero in the following quarter. Unless Health Workforce Queensland QUM Clinical Facilitators meet with both general practitioners and pharmacists in all areas continually, the momentum seems slow or worse still, stop. Health Workforce Queensland found many reasons for this, which are covered in Table 6, page 25 (Cause, Effect and Result Table). However, in most cases the one paramount positive achievement from these sessions is that they provide a good medium for both professions to network and get to know each other. Break down barriers!

Our Disappointments

Low take up rate of HMRs Across the Consortium Divisions
Despite our best efforts, as can be seen from the Charts 1, 2 and 3 (page 22), the uptake of HMRs across the 3 rural Divisions has been low.

Turnaround Time for HMR Reports
In Health Workforce Queensland's experience, the time taken by some community pharmacists to complete the HMR reports is of real concern for the longevity of the Program. In some instances community pharmacists have not returned the HMR reports to the referring general practitioner for up to 5 months from the date of referral.

In another instance, a patient complained to the referring general practitioner because the community pharmacist had not conducted the home visit in a reasonable timeframe. This was not only a frustration for this general practitioner, from a process perspective, but also reflected badly from a professional standpoint with the patient. As a result the general practitioner ceased referring.

Communication between General Practitioner and Community Pharmacist
Communication channels between general practitioners and community pharmacy need to be further improved. In some instances the community pharmacist has not advised the general practitioner that there may be a delay with particular referrals. Although Health Workforce Queensland has discussed this matter with community pharmacists and sent a number of MMR Rural Newsletters addressing this issue to all community pharmacists in its catchment, this matter still remains a problem.

Attendance on Focus Group Teleconferences
As can be seen at Table 2 (page 13), since the introduction of the Program, Health Workforce Queensland has offered all community pharmacists in the consortium catchment the opportunity to attend Focus Group Teleconferences. The topics for the Teleconferences have included the NPS topics, HMR case studies, and Complimentary Medicines discussion with Geraldine Moses, etc. However, the take up rate for these teleconferences has been disappointing. The average attendance has been 10 from a population of approximately 300 pharmacists across the 3 participating Divisions.

Strategy:
This matter was raised with the QUMAG committee members and a strategy suggested was that the teleconferences be conducted at the beginning of the topic delivery with general practitioners. This concept has already been adopted and will continue during the next phase of funding and monitored for effectiveness.

Health Workforce Queensland
Supporting Primary Health Care in Rural Communities

Quality Use of Medicines Activity at Health Workforce Queensland.

Background

Health Workforce Queensland is part of a network of Rural Workforce Agencies within Australia and is funded by the Australian Government Department of Health and Ageing. Its responsibilities are to:

- *Improve access for rural and remote communities to primary medical services through the attraction, recruitment and retention of general practitioners in rural and remote communities.*
- *Improve the supply and distribution of general practitioners to rural and remote communities, ensuring equitable access based on priority of need.*

Main core programs of Health Workforce Queensland are: Recruitment and Retention, Locum Services, Data Research and Evaluation and Medical Education and Training.

The Quality Use of Medicines (QUM) program was born!

In 1999, the then Queensland Rural Medical Support Agency (QRMSA), now known as Health Workforce Queensland, was successful in obtaining funding from the National Prescribing Service (NPS) to provide clinical education visits to general practitioners in its rural Divisions of General Practice. The Quality Use of Medicines (QUM) program was now incepted at Health Workforce Queensland! Since that time, other sources of funding have seen the QUM activities develop into a sound and well-regarded retention strategy for rural general practice as an integral part of the organisation's essential services.

Some of the QUM activities at Health Workforce Queensland:

- *Academic detailing and small group education;*
- *Regular email and fax newsletters allow ongoing contact with isolated professionals;*
- *Focus Group Teleconferences;*
- *Quality Use of Medicines Advisory Group (QUMAG;) and*
- *Provision of QUM information.*

Expansion of QUM Program including the Medication Management Review Facilitator Program (MMRFP):

The QUM Program expanded in 2002 to include coordination and facilitation of the Medications Management Review Facilitator Program (MMRFP), Enhanced Divisional Quality Use of Medicine (EDQUM) Program and the Career in Pharmacy Program for a consortium of rural and provincial Divisions in both Queensland and New South Wales. The Queensland Health Quality Improvement and Enhancement Program funding has further allowed for the extension of the service to hospital-based staff. The implementation of the EDQUM program also provided an opportunity to weave pharmacoeconomic considerations into Health Workforce Queensland's QUM interventions.

Proudly, the Health Workforce Queensland QUM Program with the incorporation of its other auxiliary programs (including the MMRFP) now offers a more holistic service, providing information and education on QUM issues to general practitioners; hospital based medical practitioners, pharmacists, nurses and hospital management teams.

Key reasons for success of the QUM Program at Health Workforce Queensland:

The most important benefits of the QUM Program are that it meets the individual needs of the rural doctor and that it recognises local differences. As such, rural doctors are more likely to implement QUM in their practice as the advice given is practical and applies to their circumstances. Under the auspices of Health Workforce Queensland, the Program builds relationships between doctors and the facilitators to be maintained across large distances, reducing the professional isolation of the rural doctors. The rural QUM Program is highly valued and represents a setting where clinical pharmacists are utilising their unique professional skills to collaborate with other health professionals in rural areas to promote quality use of medicines. It has become an established program with high level of engagement with appreciation and enthusiasm. The program uses highly efficient and evidence-based education interventions to change prescribing behaviour.

Medication Management Review Facilitator Program (MMRFP)

Why is a Rural Workforce Agency Involved in the MMRFP?

Health Workforce Queensland immediately recognised that the MMRFP initiative was a perfect opportunity to improve communication and linkages between general practitioners, community pharmacists and other health professionals in rural areas. As Heath Workforce Queensland already had:

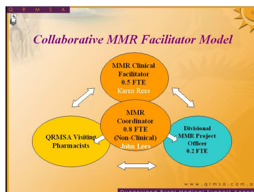
- *established networks with rural and remote communities throughout Queensland;*
- *established rapport with its consortium Divisions, general practitioners and local pharmacists;*
- *excellent communication links such as a comprehensive interactive website, newsletters, face to face meetings, teleconferencing; and*
- *accredited pharmacists employed and available to provide clinical expertise*

it was therefore a good opportunity to expand its QUM role to include the Home Medicines Review (HMR) activity.

Consortium Application:

Over a period of 2 months, Health Workforce Queensland collaborated with all its rural Divisions and some interested provincial Divisions to develop a model for the MMRFP delivery. A "Collaborative MMR Facilitator Model" emerged and was presented to the Divisions. It was agreed that Health Workforce Queensland be the lead agency for 4 Divisions of General Practice to rollout the Home Medicines Review activity. In December 2001, Health Workforce Queensland applied to the Pharmacy Guild of Australia for a collaborative model including the 4 Divisions. The MMRFP application was approved in-principle in early January 2002.

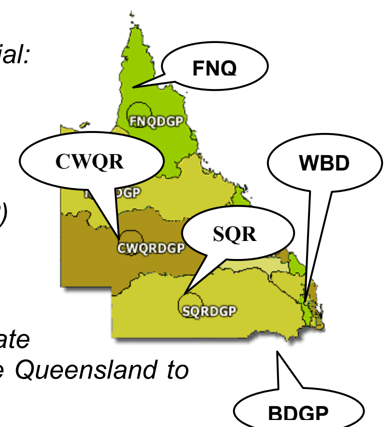
The Collaborative MMR Facilitator Model:



The Model places a MMR Clinical Facilitator (.5 FTE) and MMR Coordinator (.8 FTE) in the Health Workforce Queensland office and a MMR Project Officer (. 2 FTE) in each of the consortium Divisions. The collaborative model was the first and largest model in Australia and the only Model lead by a Rural Workforce Agency. All QUM Clinical Facilitators at Health Workforce Queensland provided support to the MMR Clinical Facilitator and Coordinator and promoted the Program during their visits to the rural Consortia catchment. ***(Refer to Attachment 1 – Collaborative MMR Facilitator Model and PowerPoint Presentation)***

Participants in the MMRFP with Health Workforce Queensland:

Initially there were 5 Divisions of General Practice (4) rural and (1) provincial: These were:



- *Far North Queensland Rural Division of General Practice (FNQRDGP)*
- *Southern Queensland Rural Division of General Practice (SQRDGP)*
- *Central West Queensland Rural Division of General Practice (CWQRDGP)*
- *Wide Bay Division of General Practice (WBDGP)*
- **Barwon Division of General Practice (BDGP) in NSW (a Rural Division)*

**In November 2002, the Barwon Division of General Practice applied for separate funding from the Pharmacy Guild of Australia and approached Health Workforce Queensland to rollout the program on their behalf.*

On 1 July 2003, the CWQRDGP amalgamated to form part of North West Queensland Primary Health Care (NWQPHC Division) and acquired separate funding from the Pharmacy Guild of Australia. In July 2004, the WBDGP also obtained separate funding from the Pharmacy Guild of Australia. An accredited pharmacist contracted to many of pharmacies in the Bundaberg Region was well placed to take on the MMR Facilitator role for the Division. Their Division and Health Workforce Queensland saw this as a natural progression and well supported by both organisations.

Consortium Contract with National Pharmacy Guild of Australia:
A formal contract between the Health Workforce Queensland and the Pharmacy Guild of Australia was approved on 23 May 2002. The Medication Management Review Facilitator program was launched on 1 May 2002 with all consortium Divisions outlined above except the BDGP in NSW, which joined in December 2002.

Contracts with Consortium Divisions:
Individual contracts were drawn up and are currently in place with each of the 3 consortium Divisions.

Staff involved in the Program at Health Workforce Queensland since inception:
MMR Clinical Facilitator: ***Karen Rees*** *(Nov 2001 - Nov 2004) Accredited Pharmacist*
QUM Clinical Facilitator: ***Chris Cutts*** *(QUM Manager, Nov 2001 - Jul 2003)*
QUM Clinical Facilitator: ***Adam La Caze*** *(QUM Manager, Jul 2003 - Mar 2004)*
QUM Clinical Facilitator: ***Howard Punchard*** *(Nov 2001 – to date) Accredited Pharmacist*
QUM Clinical Facilitator: ***Kieran Behan*** *(Oct 2002 - Jun 2004)*
QUM Clinical Facilitator: ***Elaine Lum*** *(Oct 2002 - Aug 2003)*
QUM Clinical Facilitator: ***Dr Karen Luetsch*** *(QUM Manager, May 2004 - to date) Accredited Pharmacist*
MMR Clinical Facilitator: ***Judith Burrows*** *(Nov 04 – to-date)*
MMR Coordinator: ***John Lees*** *(Nov 2001 - to date)*

Staff involved in Consortium Divisions of General Practice since inception:
MMR Project Officers: ***Isabel Mazgay*** *(Nov 2001 – to date) FNQDGP*
Trish Nicholas *(Nov 2001 – to date) SQRDGP*
Louise Houlahan *(Jan 2002 -to date) BDGP*
Kay Harper *(Nov 2001 – 31 Dec 2002) CWQRDGP*
Kate McLeod *(early 2003 – Jun 2003) CWQRDGP*
Lynn Clarke *(Nov 2001 – 30 June 2004) WBDGP*

“The Final MMRFP Report”

Report Concept
This Report has been compiled in accordance with specific requirements of Schedule 1 and 3 of the Contract “Agreement between the Pharmacy Guild of Australia and the Queensland Rural Medical Support Agency (QRMSA)”, now known as Health Workforce Queensland. The Report will address specific obligations by Health Workforce Queensland with regards to its contracts with the Pharmacy Guild of Australia and its participating consortium Division of General Practice.

For the purposes of the Report:
The following Divisions of General Practice are reflected in this report i.e.

- *Far North Queensland Rural Division of General Practice (FNQRDGP);*
- *Southern Queensland Rural Division of General Practice (SQRDGP);*
- *Barwon Division of General Practice (BDGP);*
- ** Central West Queensland Rural Division of General Practice (CQRDGP); and*
- ** Wide Bay Division of General Practice (WBDGP).*

Please note:
- *The BDGP has a direct contract with the Pharmacy Guild of Australia. As lead agency for the rollout of the Program on behalf of BDGP, Health Workforce Queensland has completed their report, which is detailed below. However, they will provide an audited financial statement to the Pharmacy Guild of Australia separately.*
- ** The CQRDGP amalgamated with the North West Queensland Primary Health Care (NWQPHC Division) on 1 July 2003. As they received separate funding from the Pharmacy Guild of Australia at that time, Health Workforce Queensland will report for the period from 1 May 2002 to 30 June 2003 only.*
- ** The WBDGP will report separately for the period 1 July 2004 to 30 June 2005 as their contract with Health Workforce Queensland concluded on 30 June 2004. Health Workforce Queensland will report for the period from 1 May 2002 to 30 June 2004 only.*
- *All references to “QRMSA” in the Contract will be replaced with “Health Workforce Queensland” in this report.*
- *Health Workforce Queensland clinical pharmacists will be referred to as QUM Clinical Facilitators.*

Prior to the Rollout of the MMRFP
Health Workforce Queensland obtained MMRFP application approval in principal in January 2002. Although funding was to commence from 1 July 2002, Health Workforce Queensland and the participating Divisions agreed with an early launch date of 1 May 2002. The Divisions and Health Workforce Queensland agreed to:
- *employ MMRFP staff at Health Workforce Queensland and in the Divisions;*
- *arrange funding, reporting and contractual processes;*
- *develop an MMRFP Operational Plan and forward to Pharmacy Guild of Australia;*
- *develop a comprehensive database of relevant health professionals;*
- *set-up relevant MMRFP Committees;*
- *develop agreed protocols; and*
- *develop and/or obtain the necessary resources to promote the program to rural general practitioners, rural community pharmacists and other health professionals.*

Health Workforce Queensland developed a comprehensive database of all health professionals, general practitioners and pharmacists in the consortium catchment. The database maintains all contacts with these health professionals. Once this was established, a short survey was forwarded to all general practitioners and pharmacists to obtain base line information and stored on the database. The database has since been re-developed to encompass all aspects of the Quality use of Medicines activities.

Strategies were developed to ensure that during visits to health professionals, various resources are used in an efficient and targeted approach with each professional. With the assistance of the consortium Divisions, HMR Information Kits were forwarded to all general practitioners in the consortium catchment.

The Rollout

Refer Schedule 1 – Sub-Contractors Obligations, Clause 4 Program Advisory Group (PAG)

4.1 Health Workforce Queensland is required to establish a PAG within 2 months of signing a MMR Facilitator Contract with the Guild composed of equal number of representatives of community pharmacists and general practitioners including at least one local representative of the Guild.

4.2 The PAG may be an existing structure or newly established specifically for the MMR Facilitator Program. The main responsibilities of the PAG will be to have input into the development of the role and function of the MMR Facilitator.

4.3 Consortia will nominate one PAG to be responsible for all member Participating Divisions. Membership of a consortium PAG will consist of representatives of the participating Divisions while complying with the constituent requirements mentioned in 4.1.

Health Workforce Queensland established 2 Advisory Groups at the commencement of the Program rollout. These were:

- *A Program Steering Committee (PSC) established in May 2002 and December 2002 for BDGP and comprised general practitioners, community pharmacists, the State Guild MMR Queensland Facilitator (Ms Debbie Rigby) and MMR Facilitators from Health Workforce Queensland. Nominations were sought from the 5 consortium Divisions. The PSC's were conducted by bi-monthly teleconference for approximately 1 hour and Health Workforce Queensland's QUM Program Manager chaired these meetings. Minutes of every meeting were recorded and forwarded to all Committee members.*

- *A Divisional Program Advisory Group (DPAG) was established for each Division in May 2002 and December 2002 for BDGP and comprised local area general practitioners, community pharmacists and the relevant Divisional MMR Project Officers. Nominations were sought from each of the 5 consortium Divisions. The DPAG's were conducted by bi-monthly teleconference or face-to-face in the Division where possible for approximately 1 hour. The Health Workforce Queensland's MMR Coordinator or the QUM Clinical Facilitator chaired these meetings.*

Health Workforce Queensland met the requirements of the Contract and both the PSC and DPAG were established prior to the rollout on 1 May 2002. Bi-monthly PSC and DPAG teleconference meetings were held on a regular basis from May 2001 to June 2003.

In the early stages of the Program rollout, the Committees provided a good medium for the implementation, strategic development and continued direction and at the same time gain local area knowledge. However, these meetings were ceased after June 2003 because it was felt they derived insufficient benefits. This matter was passed to the Pharmacy Guild of Australia and it was understood to be an issue for many MMRFP Divisions in Australia.

As can be seen from the Operational Plan, although the PAG and DPAG committees were still in place but not active, one of the objectives of Health Workforce Queensland in 2004/2005 was to look at resurrecting a PAG in accordance with the Contract, but include all aspects of the Quality Use of Medicines Program. Health Workforce Queensland approached the consortium Divisions and floated the idea of creating a Quality Use of Medicines Advisory Group (QUMAG). The concept received overwhelming support.

Health Workforce Queensland, with the support from the consortium Divisions, contacted all existing committee members, advertised for both general practitioner and community pharmacist/accredited pharmacist members and established the new committee in February/March 2005. A Purpose Statement for the committee was developed and sent under cover letter to all members prior to the first QUMAG teleconference held in May 2005. The teleconference received a good response from the consortium Divisions and committee members. ***(Refer to Attachment 2 – List of QUMAG Committee Members and Purpose Statement)***

Clause 5. The Health Workforce Queensland must employ or contract a MMR Facilitator to fill the requirement of this agreement.

Prior to the rollout of the Program, Health Workforce Queensland and its participating consortium Divisions advertised for or re-directed resources to meet this requirement. Health Workforce Queensland appointed an accredited pharmacist to the position of MMR Clinical Facilitator (.5FTE) and a project officer to the position of MMR Coordinator (.8FTE). All consortium Divisions appointed MMR Project Officers (.2) in their respective Divisions.

Refer Schedule 3 – Core Services

Clause 2 Provision of MMR Facilitator Program
The Health Workforce Queensland must ensure that the participating Divisions have a responsibility to ensure that MMR Facilitator carries out the following tasks:

a) ***Support the implementation of medication management reviews;***
b) ***Facilitate effective communication processes between Pharmacists and General Practitioners;***

General Practitioners
Since the inception of the Program, all general practitioners have been invited to attend one-on-one meetings with the QUM Clinical Facilitators from Health Workforce Queensland and at the same time discuss the HMR Program and its processes. All general practitioners visited by the QUM Clinical Facilitators have been provided with relevant information about the Program. Resources were also left with them at the conclusion of their visits.

Between 1 May 2002 and 30 June 2005, a total of 1,115 one-on-one visits have been conducted with general practitioners across the 5 Divisions. To illustrate the actual visits conducted with general practitioners in the Divisions refer to Table 1 below.

Table 1 – QUM Clinical Facilitator Visits to General Practitioners

Division	***# of general practitioners in Division***	***Total # of Visits***	***Had at least one visit***	***% Coverage***
SQRDGP	*154 (approx)*	*530*	*114*	*74%*
FNQRDGP	*86 (approx)*	*300*	*86*	*100%*
BDGP	*43 (approx)*	*127*	*43*	*100%*
CQRDGP	*9 (approx) to 30 Jun 03*	*17*	*8*	*89%*
WBDGP	*170(approx) to 30 Jun 04*	*141*	*99*	*58%*
Totals	***462 (approx)***	***1,115***	***350***	***76%***

As can be seen from Table 1 above, overall, most general practitioners have been visited at least once during the period of this contract.

Community Pharmacists
All community pharmacies have had at least 2 face-to-face visits each year by the QUM Clinical Facilitators. During these visits, pharmacists are provided with the relevant information and resources relevant to the Program.

Telephone Contacts to Pharmacists
Another very useful strategy introduced by Health Workforce Queensland at the commencement of the rollout was telephone contacts with community pharmacists. All community pharmacists are contacted by telephone by the MMR Coordinator once every 4 – 6 months. This strategy provides another level of support and information gathering between the face-to-face visits by the QUM Clinical Facilitators.

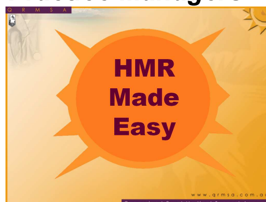
Focus Group Teleconferences
One of the most effective strategies has been the Focus Group Teleconferences initiative. Initially the Focus Group Teleconference concept was to support rural community pharmacists with the HMR activity but has been a very effective medium to impart information to rural community pharmacists, accredited pharmacists and general practitioners.

A number of these teleconferences have been conducted since May 2002 and are listed in Table 2 below. They run for approximately 1 hour in the early evening. All of the teleconferences have been evaluated following the event and have been very well received.

Table 2 – Focus Group Teleconferences Conducted

Topic	*Date Conducted*	*No of Attendees*
Introduction – HMR Situation	*September 2002*	*9 pharmacists*
Dyslipidaemia	*December 2002*	*11 pharmacists*
HMR Case Study	*April 2003*	*13 pharmacists*
Getting to know Complementary Medicines	*August 2003*	*10 pharmacists and 8 general practitioners*
Antibiotics	*November 2003*	*12 pharmacists*
Optimising Use of Proton Pump Inhibitors	*October 2004*	*4 pharmacists*
Antithrombotic Therapy in General Practice	*March 2005*	*10 pharmacists*
Improving Drug Use in Heart Failure	*June 2005*	*10 pharmacists*

Practice Managers



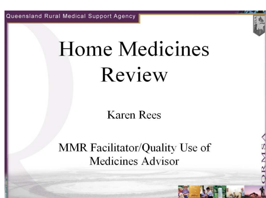
Health Workforce Queensland has always considered the practice manager to be integral to the uptake of HMRs and has developed resources for these purposes, which are detailed further in this report.

Health Workforce Queensland has looked for opportunities to speak with practice managers apart from meeting with them during the QUM Clinical Facilitator visits. As such, Health Workforce Queensland has been invited to speak at a number of practice managers or combined general practitioner and practice manager workshops in the SQRDGP and BDGP area catchments. A PowerPoint Presentation was developed for this purpose. Table 3 below illustrates which towns have been visited and the number of attendees.

Table 3 – Practice Manager Presentations Conducted

Division	***Town***	***Type of Session***	***No of Practice Managers***
SQRDGP	*Toowoomba*	*Practice Manager Workshop*	*43*
	Roma	*Joint Practice Manager and general practitioner*	*30*
	Warwick	*Joint Practice Manager and general practitioner*	*7*
BDGP	*Moree*	*Practice Nurses Meeting*	*11*

HMR Joint Information Sessions/Home Interview/Information Sessions



Shortly after the launch of the Program, Health Workforce Queensland began arranging and conducting HMR Information Sessions with both general practitioners and community pharmacists in selected communities. Table 4 below illustrates the Joint Information Sessions conducted over the 3 consortium Divisions since the inception of the Program. A PowerPoint Presentation was developed for this purpose. The "Home Medicine Review Joint Information Sessions" received accreditation from both the RACGP and ACRRM colleges and participants receive 2 points per hour (4 points for 2 hours) from RACGP and 1 point per hour from ACRRM.

The MMR Pharmacy Guild Facilitator (Ms Debbie Rigby) assisted Health Workforce Queensland with the early stages of the rollout of the Joint Information Sessions and had introduced Home Interview Sessions with pharmacists in many Divisions in Queensland. Debbie offered to conduct these workshops in selected towns and communities in the consortium catchment. Health Workforce Queensland invited all pharmacists in the FNQRDGP to attend a workshop in Cairns and received a good response; 15 FNQRDGP pharmacists attended. Another similar workshop was held in Goondiwindi, SQRDGP and also received a good response, 5 pharmacists attended from the surrounding area. Since that workshop Health Workforce Queensland has continued to provide support to a Stage 2 community pharmacist in Goondiwindi, who is conducting HMR home interviews.

Table 4 – Information Sessions Conducted

Division	Town	Type of Session	No of general practitioners	No of Pharmacists
SQRDGP	*Beaudesert*	*Joint Information Session*	*9*	*8*
	Warwick	*Joint Information Session*	*8*	*7*
	Goondiwindi	*Home Interview Session*	*Not applicable*	*5*
	Roma	*Joint Information Session*	*5*	*3*
	Murgon	*Group Info Session with general practitioners*	*6*	*Not applicable*
	Dalby	*Group Info Session with general practitioners*	*15*	*Not applicable*
FNQRDGP	*Port Douglas*	*Joint Information Session*	*7*	*9*
	Mareeba	*Joint Information Session*	*7*	*15*
	Innisfail	*Joint Information Session*	*5*	*4*
	Cairns	*Home Interview Session*	*Not applicable*	*15*
BDGP	*Gunnedah*	*Joint Information Session*	*6*	*5*
	Moree	*Joint Information Session*	*9*	*4*
	Narrabri	*Joint Information Session*	*2*	*3*
WBDGP	*Bundaberg*	*Joint Information Session*	*6*	*10*
	Maryborough	*Joint Information Session*	*5*	*9*
	Hervey Bay	*Joint Information Session*	*8*	*7*
CWQRDGP	*Longreach*	*Information Session*	*2*	*Not applicable*

All sessions have been evaluated and in general, all session participants were either satisfied or very satisfied with the content, information and style of these sessions.

c) Assist pharmacists, medical practitioners and other health professionals to identify patients who would most benefit from the service, including the development of processes to support medication management reviews;

Various Tools, Strategies and Pilot Projects

Detailing Cards

Various tools and resources have been developed by Health Workforce Queensland to assist health professionals in identifying patients who may benefit from an HMR and to simplify the process.

HMR Detailing Cards

To assist Health Workforce Queensland's QUM Clinical Facilitators explain the process in a succinct and efficient way with general practitioners and pharmacists during their visits, a HMR detailing card was developed. Two versions of the card were developed, one specifically labelled for "General Practitioners" and other for "Pharmacists". At the completion of the QUM Clinical Facilitator visit a copy of the card is left with them. The Cards proved to be a very useful resource during the initial rollout of the program. ***(Refer to Attachment 3 – "HMR Detailing Card")***

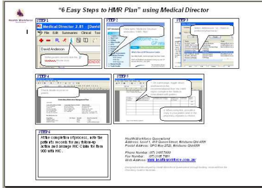
HMR Made Easy

In mid 2003 feedback from general practitioners and practice staff revealed that there was some confusion with the HMR process and there needed to be a resource that would de-mystify and simplify the program. The "HMR Made Easy" card emerged, designed and developed by Health Workforce Queensland. Its sole purpose was to demonstrate how easily health professionals can be involved and who can be involved. On the reverse side of the card is more general information including the "Risk Factors" to generate a referral for an HMR. ***(Refer to Attachment 4 – "HMR Made Easy" Information Card)***

The Pharmacy Guild of Australia (QLD) and the Australian Division of General Practice (ADGP) recognised the benefits of these resources and with Health Workforce Queensland approval, re-produced the HMR Made Easy and the HMR Detailing Cards. They were made available to MMR Facilitators nationally. These cards are still in use today. Health

Workforce Queensland was acknowledged for their design and development.

Medical Director Instruction Card:



One of the difficulties some doctors have with referring patients for an HMR is their understanding of how to generate HMRs using their Medical Software. As approximately 85% of general practitioners across the 3 consortium Divisions are utilising Medical Director software, Health Workforce Queensland designed a visual instruction card for their use in late 2004. It is now included in the General Practitioner Resource Folder. MMR Facilitators have received very positive comments from general practitioners who have used the card to date. The card was presented at the recent MMR Facilitator Workshop in Queensland and the National Pharmacy Guild is going to reproduce it for National distribution. ***(Refer to Attachment 5 – HMR Medical Director Instruction Card)***

Pharmacy Resource Kit:

In late 2004, Health Workforce Queensland developed a "Pharmacy Resource Kit". The Kit has now been utilised on 2 occasions during visits to the SQRDGP community pharmacists and has been a success. Prior to these visits, Health Workforce Queensland contacted the community pharmacists and arranged a venue (normally hosted by one pharmacy) and invited other community pharmacists from the surrounding areas. The Kit contains an HMR Case Study, which the participants work through together and outlines valuable resources i.e. texts, journals, web links, on-line databases and drug information. It is preferred that the hosting pharmacy has Internet access. A glossary of terms in Evidence-Based Medicine and a 2 page "Useful Resources for Pharmacists" is also included. It is intended to provide guidance for the meaning of EBM terms.

This Kit will now be utilised by all Health Workforce Queensland QUM Clinical Facilitators during community pharmacy visits in future.

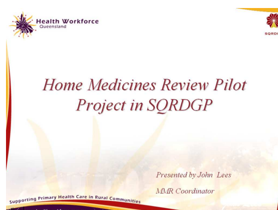
MMR Rural News Newsletter:

Since the launch of the program in May 2002, Health Workforce Queensland introduced the MMR Rural News newsletter (fax) to both pharmacists and general practitioners. The newsletter resulted from a Program Steering Committee meeting. It was requested by members that health professionals be kept informed about the HMR activity through a succinct one-page fax. So as not to overburden both professions, Health Workforce Queensland keeps these newsletters to a minimum and only sends them when there is important information to distribute. The newsletter has been very successful in getting important information out to health professionals. Over the period of the Contract, 46 newsletters have been forwarded to general practitioners and community pharmacists. ***(Refer example at Attachment 6 –" MMR Rural News" newsletter)***

Rural HMR Remote Model

In 2003, Health Workforce Queensland conducted a one-off pilot project "Rural HMR Remote Model". A rural accredited pharmacist from Central Queensland was contracted to undertake a number of HMRs in rural communities of SQRDGP. This was a coordinated approach between the general partitioners and pharmacists in 5 rural towns; Augathella, Cunnamulla, Charleville and Roma. Twenty (20) HMRs were conducted over a period of 4 days in August 2003. The MMR Clinical Facilitator for Health Workforce Queensland presented the findings of this project at the MMR Facilitator Conference in Sydney, October 2003.

Home Medicines Review Pilot Project in SQRDGP



During visits to general practitioners and pharmacists by the QUM Clinical Facilitator to the South Burnett area of SQRDGP in late 2004 it became obvious that many general practitioners were keen to start HMRs but there are no current accredited pharmacists available to do HMRs. The towns included Kingaroy, Murgon, Nanango, Wondai and Yarraman.

A pilot project was suggested and received support from most of the general practitioners and all community pharmacists in the area. A memorandum of understanding (MoU) developed by Health Workforce Queensland was entered into by all 8-community pharmacies in the region. Health Workforce Queensland contracted an accredited pharmacist from Brisbane who visited

the general practitioners and community pharmacists in January 2005 to introduce himself and provide any support or resources they may require.

Approximately 9 general practitioners began referring their patients for an HMR immediately to their community pharmacies. In a coordinated approach, Health Workforce Queensland contacted all patients and arranged suitable visit times and ensured that all patients were aware of the HMR.

The first road trip was conducted in February 2005 to 20 patients over 4 days and the second trip conducted in April 2005 to 17 patients over 3 days. HMR reports were forwarded to the referring general practitioners within 2 weeks of the patient interview. All participants, including HMR patients were asked to complete a survey and results of the survey are detailed in Tables 5, 6 and 7 below. The MMR Coordinator was invited to the SQRDGP Kingaroy Impact Workshop in April 2005 and provided general practitioners with an overview and major results from the evaluation. There was an overwhelming response from the attending general practitioners that the pilot continues. Another visit is scheduled in June 2005. A pharmacist from Kingaroy went on Community Radio promoting the HMR program during Pharmacy Week.

Table 5 - General Practitioners Comments re Home Medicines Review Pilot Project in SQRDGP

Major Results from the Evaluation by General Practitioners - 6 of 9 responded
General Practitioners: • *were satisfied or very satisfied with the HMR delivery and reports* • *thought the review recommendations were appropriate and thought about changes to medications* • *would like the HMR program to continue*

Table 6 - Community Pharmacists Comments re Home Medicines Review Pilot Project in SQRDGP

Major Results from the Evaluation by Community Pharmacists - 3 of 7 responded
Community Pharmacists: • *were satisfied with the support they received* • *having an accredited pharmacist working for them encouraged participation in the pilot.*

Table 7 - HMR Patients Comments re Home Medicines Review Pilot Project in SQRDGP

Major Results from the Evaluation by HMR Patients - 20 of 37 responded
HMR Patients: • *felt the HMR visit was of value to them* *Some Patient Comments:* • *"I now realise what some of the medications I'm on can do to my health long term"* • *"More positive about taking the correct medicines in view of the various name changes…."* • *"A useful program that should be maintained on a regular basis"*

.

d) Develop local area medication management review networks for pharmacists and/or general practitioners;

Health Workforce Queensland has introduced a number of strategies to develop area networks for pharmacists and general practitioners. Some of these strategies are listed below:

- *MMRFP Collaborative Model with local area MMR Project Officers situated in each of the Divisions;*
- *MMR Coordinator in the lead agency to facilitate and maintain networks with the local Divisions of General Practice;*
- *Weekly communication with Divisional MMR Project Officer to obtain any local area information;*
- *MMR Fortnightly (Email) Newsletter to MMR Project Officers and cc to QUM Clinical Facilitators at Health Workforce Queensland;*
- *Four (4- 6) monthly telephone calls to all community pharmacies across the 3 consortium Divisions;*
- *Development and maintenance of comprehensive QUM Database of all general practitioners, pharmacists and accredited pharmacists and all contacts made during the course of the program rollout;*
- *Introduction of Focus Group Teleconferences to pharmacists mainly and general practitioners where appropriate. (Refer Table 2 above); and*

- *MMR Rural News newsletters to pharmacists and general practitioners.*

e) ***Interface with existing pharmacist/general practitioner programs at a local level where synergistic or complementary support can be provided;***

f) ***Organise educational events which address, but are not limited to, MMR framework and process;***

Health Workforce Queensland has looked for opportunities to conduct educational activities in a synergistic way with its consortium Divisions. When and where appropriate or convenient for the consortium Divisions of General Practice, Health Workforce Queensland has sought to interface with the Division to conduct its MMRFP support activities. For example, a number of Joint Information Sessions for both general practitioners and pharmacists were conducted during local Divisional Liaison Meetings in SQRDGP. During the rollout of the Enhanced Divisional Quality Use of Medicines (EDQUM) Health Workforce Queensland conducted a joint EDQUM and HMR Evening in Innisfail, FNQRDGP. The expanded role of the Program Advisory Group (QUMAG) is a good opportunity to even improve synergies with these Divisions and their other educational and program activities.

g) ***Promote and provide information on the program to health professionals including local hospitals and community to facilitate timely uptake of the service;***

As mentioned above, Health Workforce Queensland has promoted the HMR program to general practitioners, community pharmacists and other health professionals. This has also included visits to community nursing groups, local hospital pharmacies and discharge staff at the hospitals. QUM Clinical Facilitators and the MMR Coordinator have also conducted consumer talks. However, due to the low number of accredited pharmacists in the rural consortium catchment, this activity has been kept to a minimum or conducted only where resources are available to handle referrals.

h) ***Contribute to the Medication Management Review evaluation process;***

In accordance with Clause 11.1 KPI (a) dot point 2, "Satisfaction established via questionnaire of local pharmacists and general practitioners in the participating Divisions with the role of MMR Facilitator", Health Workforce Queensland sent a questionnaire to all its general practitioners and pharmacists in the consortium catchments during August 2003. All participants were asked to forward their responses to the National Pharmacy Guild of Australia. Results of the questionnaire were presented at the MMR Facilitator Workshop in 2004. The Pharmacy Guild of Australia advised in late 2004 that this was no longer a requirement under the current MMRFP Contract.

i) ***Facilitate pharmacy access to accredited pharmacists within Divisions;***

Health Workforce Queensland has undertaken a number of processes to ensure that all community pharmacists across the 3 Divisions have access to an accredited pharmacist. These processes are listed below:

- *The State MMR Facilitators for Queensland and NSW provide regular lists of Australian Association of Consultant Pharmacists (AACP) accredited pharmacists available to conduct HMRs for community pharmacy. These lists are faxed to community pharmacists as soon as possible upon receipt.*
- *As the AACP list only lists those accredited pharmacists who have given consent to have their name and contact details available, Health Workforce Queensland has also compiled a list of accredited pharmacists on its database who are available to conduct HMRs. During visits by the QUM Clinical Facilitators, the local community pharmacy is provided with available accredited pharmacists to do the HMRs.*
- *Joint Information Sessions are an opportunity for the general practitioner and the community pharmacists to become more familiar with the accredited pharmacists in the community or who is available to do the reviews remotely. (Refer to Table 2 above)*
- *The MMR Rural News newsletter is another medium to promote available accredited pharmacists.*

j) Convene a Program Advisory Group by utilising an existing structure or establish a new structure specifically for the MMR Facilitator Scheme;

Refer Section 5 above.

k) Participate in bi-monthly teleconferences facilitated by the Guild State Branch MMR Facilitator;

Since the beginning of the rollout of the Program in May 2002, Health Workforce Queensland has participated in all bi-monthly teleconferences with the Guild State MMR Facilitator and other MMR Facilitators in Queensland. Health Workforce Queensland has also participated in and or attended all State MMR Facilitator Workshops held in Queensland and when and where appropriate in NSW.

l) Prepare reports as required.

In accordance with the requirement of the Contract, Health Workforce Queensland has prepared and presented all reports for the MMRFP to the National Pharmacy Guild and its consortium Divisions of General Practice in a timely manner since the inception of the Program.

In accordance with Clause 7.4 June Annual Reports and Final Reports, 7.4.1(b) "Any difficulties experiences in performing the Project during the reporting period" and 7.4.1(c) "Action or proposed action undertaken to overcome the difficulties", Health Workforce Queensland presents the following:

Overview and Barriers or Challenges:
The MMR Facilitator's role is to document the findings, provide support, address concerns and develop strategies to overcome the barriers and challenges that both general practitioners and pharmacists are experiencing. Practice visits to rural general practitioners have allowed Health Workforce Queensland QUM Clinical Facilitators to visit each pharmacy personally and obtain an insight into the barriers or challenges that they may be faced with providing an HMR service.

Most general practitioners are very positive about the concept of the HMR program and feel that many of their patients would benefit. Some general practitioners feel that the process is time consuming and unable to be incorporated into their already busy day. Very few general practitioners reported poor relationships with their local pharmacist. The following list of barriers or challenges has been formulated from information received over the period of the contract and our strategies or solutions for each.

Barriers or Challenges for Health Workforce Queensland re Rural General Practitioners:
- ***the process is time consuming and hard to incorporate into their already busy day;***
- ***already rolling out other Government initiatives;***
- ***aware of extra workload and time constraints placed upon their community pharmacists;***
- ***prepared to wait until the local pharmacist becomes accredited;***
- ***their local pharmacists report a lack of time to conduct HMRs;***
- ***HMRs are taking too long and***
- ***remuneration perceived as inadequate.***

Solutions to Overcome the Barriers and Challenges for Rural General Practitioners

The process is time consuming and hard to incorporate into their already busy day:
The Joint Information Sessions have been a good opportunity to meet with both general practitioners and community pharmacists in rural communities and explain the process in a clinical and non-clinical un-biased way. It is an opportunity to demonstrate how easy HMR can fit into general practice activities and at the same time benefit specific patients. General practitioners get to know who can do the reviews in their community. However, attendance at the Joint Information Sessions has not been exceptional. For both professions, travel distances are sometimes a barrier. Therefore it has been essential for QUM Clinical Facilitators to impart sufficient information to general practitioner and community pharmacists about the HMR activity.

The QUM Clinical Facilitators and MMR Coordinator at Health Workforce Queensland have looked at various strategies to demystify the process and simplify the information for health professionals during their visits. The information needs to be succinct, easily understood but comprehensive. Various

resources were designed and developed for this purpose. For example, the fist resource developed by Health Workforce Queensland was the HMR Detailing Card (General Practitioner and Pharmacist) as shown above.

The various detailing and instruction cards e.g. nine (9) step "HMR Made Easy" and 2 sided "HMR Referral and Plan Instruction Card" discussed earlier in this report became essential elements for informing general practitioners, pharmacists and other health professionals about the HMR Program. These Cards have been utilised by the QUM Clinical Facilitators with good success and have been well received by the Pharmacy Guild of Australia.

Already rolling out other Government Initiatives:
The HMR Made Easy detailing card gives a complete overview of the Program and how it could be integrated into other Government initiatives like the Enhanced Primary Care (EPC) items and the Asthma 3+ program.

Since the inception of the program, Health Workforce Queensland has held many Focus Group Teleconferences with both general practitioners and pharmacists. Initially the Focus Group Teleconference concept was introduced to assist in communicating with community pharmacists regarding the HMR activity. However, this has been expanded to include rural general practitioners on a couple of occasions with good success.

Aware of extra workload and time constraints placed upon their community pharmacists:
Prepared to wait until the local pharmacist becomes accredited:
Their local pharmacists report a lack of time to conduct HMRs:
Over the period of the contract, these comments have come up on many occasions. In many rural communities visited by the QUM Clinical Facilitator, the local general practitioner has been cognisant of the work pressures on their rural community pharmacist. They have mentioned that their pharmacist does not always have the time to do anything other than look after the pharmacy. This is especially the case in many remote and/or sole pharmacy towns. In these situations, the QUM Clinical facilitator has continued to provide information, offered support and/or assistance when and where possible.

HMRs are taking too long:
Health Workforce Queensland considers the time taken from referral to receipt of the HMR report by the referring general practitioner a matter of concern to the longevity of HMRs in rural areas. A number of general practitioners have raised this matter with QUM Clinical Facilitators during the period of the contact. This is a national issue and instructions have been forwarded to all rural community pharmacists and accredited pharmacists on their duty of care. Health Workforce Queensland QUM Clinical Facilitators continue to inform community pharmacists about the importance of this matter through a number of mediums, i.e. newsletters, face-to-face visits etc. General practitioners become frustrated and do not continue to refer in some instances.

Barriers or Challenges for Health Workforce Queensland re Rural Community Pharmacists:

- ***lack of time to conduct HMRs;***
- ***lack of time to become accredited;***
- ***financial burden to become accredited;***
- ***lack of remuneration (primarily to support employing another pharmacist or locum);***
- ***no financial recognition/reward for distances pharmacists need to travel to do HMRs in the bush;***
- ***sole-practising pharmacist inability to leave the pharmacy during working hours;***
- ***sole-practising pharmacist has no support from other pharmacists;***
- ***very few pharmacists in the rural consortium Divisions are currently accredited and available to provide the service.***

Solutions to Overcome the Barriers and Challenges for Rural Community Pharmacists

Lack of time to conduct HMRs:
Since the commencement of the Program rollout, there has been considerable comment from community pharmacy regarding the lack of time predominately, and the lack of accredited pharmacists available in their communities. To try to overcome some of these issues Health Workforce Queensland has introduced a number of resources to assist pharmacists, i.e. the various detailing cards, forms and Resource Kits and lists of accredited pharmacists. However, with regards to relieving other pressures to facilitate HMR by community pharmacy is a very difficult challenge and is outside the scope for Facilitators. However, the HMR model does allow the patient interview to be conducted at the pharmacy.

Whilst it is not the preferred option it may be the only feasible option for some pharmacies in the more rural and remote towns although most pharmacists who were given this suggestion by the MMR Clinical Facilitators reported that they would find it difficult to interview a patient without interruptions in the pharmacy.

HMR Home Interview Conducted by Non-Accredited Pharmacist:
The HMR model also allows a non-accredited pharmacist to conduct the patient interview. The information gathered at this interview together with clinical information provided by the general practitioner can be forwarded to a contracted accredited pharmacist. Discussion of the report between the general practitioner and the accredited pharmacist can be done in person or via the telephone. Although this is an option for rural and remote pharmacy, many rural pharmacies do not take up this option. There can be a number of reasons for this:

- *accredited pharmacist requires comprehensive information from the interviewing pharmacist;*
- *leaves the accredited pharmacist vulnerable if general practitioner questions the interview information;*
- *time taken to get the report back to the general practitioner can be lengthier in these situations;*
- *more administration, coordination and financial split arrangements between both parties (contracts etc) can be a deterrent;*
- *the general practitioner is not always aware of who is carrying out the review of their patient.*

Contracted Accredited Pharmacists to do Interview and Report:
There are some accredited pharmacists available to travel to rural towns as a consultant accredited pharmacists and conduct the interview in addition to writing the report. However distance, time and financial feasibility need to be taken into consideration. In some areas this may be possible particularly with good communication and planning between the local community pharmacists and the general practitioners within the towns to ensure maximum number of visits organised and determined carefully to ensure financial viability.

In a number of areas of the consortium catchment, Health Workforce Queensland has been successful in arranging for an accredited pharmacist to service nearby communities. However, this is very reliant on whether the accredited pharmacist remains in the community.

Lack of time to become accredited:
Financial burden to become accredited:
Lack of remuneration (primarily to support employing another pharmacist or locum):
Lack of time to become accredited, inability to leave the pharmacy during working hours, lack of remuneration (primarily to support employing another pharmacist or locum) and no financial recognition/reward for distances pharmacists need to travel to do HMRs in the bush are often raised by community pharmacists. These matters continue to be challenges for all QUM Clinical Facilitators. Many other rural MMR Facilitators, including Health Workforce Queensland, have repeatedly raised these matters at many forums over the period of the contract. We understand that some of these matters are to be addressed by the Pharmacy Guild of Australia and the Australian Association of Consultant Pharmacy (AACP) in the future.

No financial recognition/reward for distances pharmacists need to travel to do HMRs in the bush:

Proposal for Extra HMR Payments to Rural Pharmacists based on PHARIA Index

As a rural workforce agency, Health Workforce Queensland is well placed to inform on strategies to address many rural issues for general practice recruitment and retention. Based on a current Government strategy to retain general practice workforce in Australia, Health Workforce Queensland identified the opportunity to introduce a similar approach for rural community pharmacy travel. Health Workforce Queensland recognised that rural travel payments could be made through the HIC by way of the PHARIA remoteness index. A paper was drafted and forwarded to the National MMR Program Manager and QLD State MMR Guild Facilitator in November 2003. We understand that this paper formed the bases for the introduction of the Rural Payments (Supplementary Provisions for Rural Loading) recently introduced by the Minister. ***(Refer Paper at Attachment 7 – "Rural Payments Based on Pharia Index" paper)***

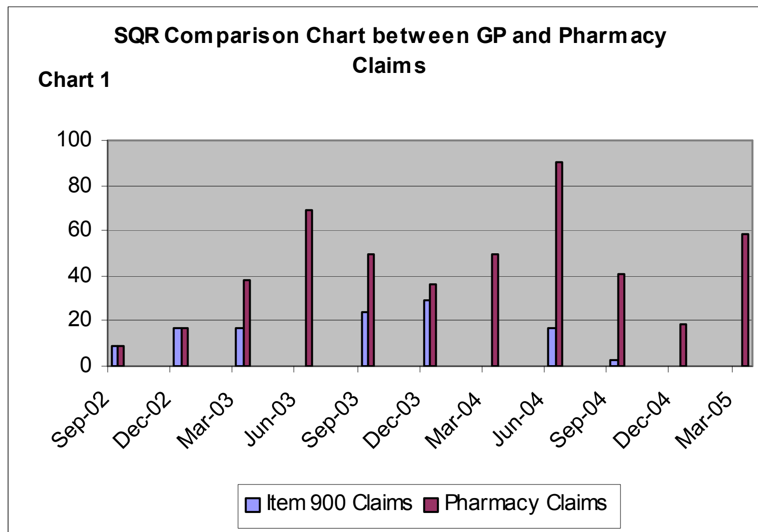
Sole-practising pharmacist inability to leave the pharmacy during working hours:
Sole-practising pharmacist has no support from other pharmacists:
Those who are sole practitioners within the community report that they already work long hours, find it difficult to get a locum to cover holidays, unlikely to find a locum or a pharmacist to assist with HMRs and are unable to leave the shop due to the Pharmacy Board legislation. In many rural communities, sole practicing pharmacists do not have a support network with other rural pharmacies. Although most pharmacists in this situation feel that the service would be worthwhile and rewarding for their patients they unfortunately are not in a position to conduct an HMR.

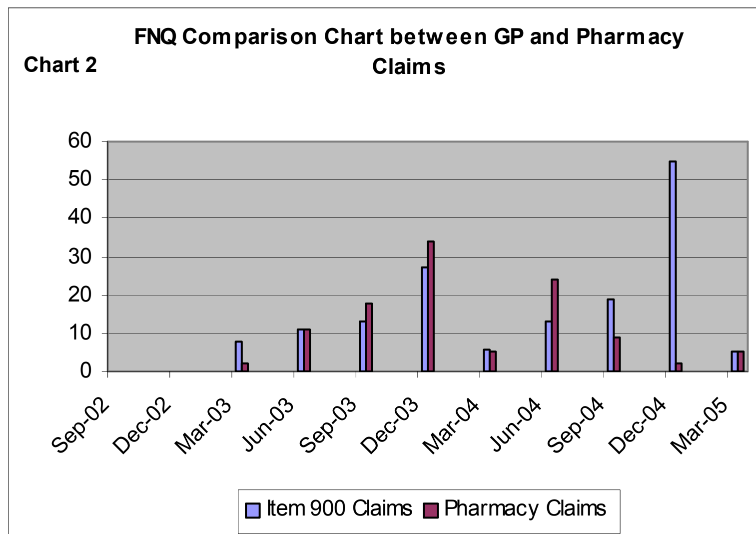
Very few pharmacists in the rural consortium Divisions are currently accredited and available to provide the service:
This is a major challenge for Health Workforce Queensland and has been since the inception of the program. There are insufficient accredited pharmacists available to conduct HMRs in the bush. Table 5 below demonstrates the number of accredited pharmacists in each of the consortium Divisions, numbers who have completed Stage 1 and those at Stage 2 as at 30 June 2005.

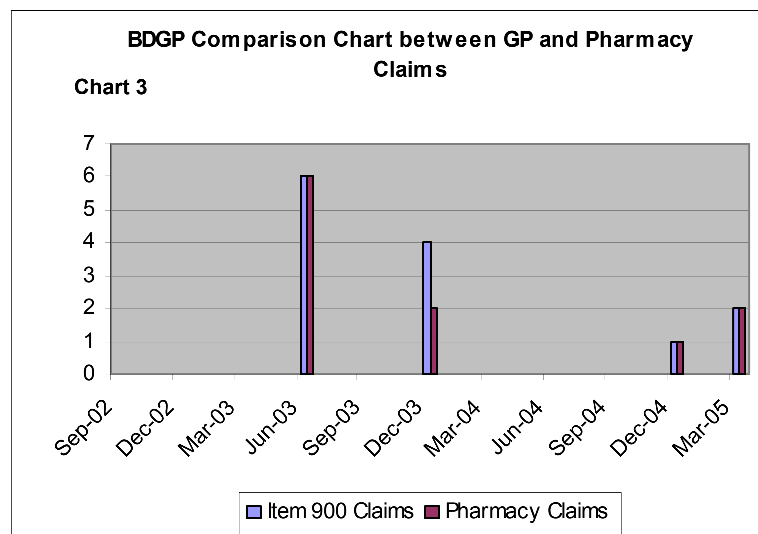
As can be seen from the table below, there are a number of pharmacists who have completed Stage 1 (Weekend Workshop), but not started Stage 2 (Case Studies). Many who have started their case studies have made minimal effort and not shown any real determination to become accredited. Some have been at Stage 2 for the past 2 – 4 years. Many say that there are just not enough financial rewards or incentives for becoming accredited and maintaining their accreditation. Some just do not have the time. Despite our best efforts, some in fact have let their accreditation lapse and some have put them on hold. In fact, one accredited pharmacist in the BDGP forwarded her case studies and failed. She lost all hope and said she was not willing to try again saying, "It's all too much effort and not enough gain". Just recently in the FNQRDGP an accredited pharmacist has decided to let her accreditation lapse as the financial rewards were insufficient and the effort was not worth the impact on her family life. As mentioned above, the Pharmacy Guild of Australia and the AACP are looking at strategies to improve or remedy this situation in the future.

Table 5 – Accredited Pharmacists Across the current 3 participating Divisions

Division	*# of Accredited Pharmacists*	*# of Stage 1 Pharmacists*	*# of Stage 2 Pharmacists*	*Let Lapse or On hold*
SQRDGP	*13*	*15*	*10*	*2 let lapse*
FNQRDGP	*5*	*10*	*5*	*1 let lapse*
BDGP	*3*	*6*	*3*	*1*

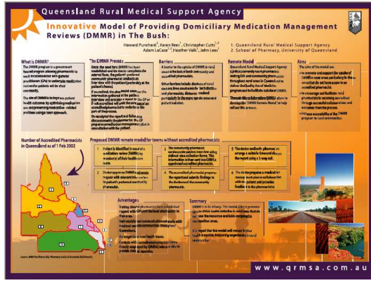

SQR Comparison Chart between GP and Pharmacy Claims
Chart 1
100
80
60
40
20
0
Sep-02
Dec-02
Mar-03
Jun-03
Sep-03
Dec-03
Mar-04
Jun-04
Sep-04
Dec-04
Mar-05
Item 900 Claims
Pharmacy Claims


FNQ Comparison Chart between GP and Pharmacy Claims
Chart 2
60
50
40
30
20
10
0
Sep-02
Dec-02
Mar-03
Jun-03
Sep-03
Dec-03
Mar-04
Jun-04
Sep-04
Dec-04
Mar-05
Item 900 Claims
Pharmacy Claims


BDGP Comparison Chart between GP and Pharmacy Claims
Chart 3
7
6
5
4
3
2
1
0
Sep-02
Dec-02
Mar-03
Jun-03
Sep-03
Dec-03
Mar-04
Jun-04
Sep-04
Dec-04
Mar-05
Item 900 Claims
Pharmacy Claims

Other Key Achievements of Health Workforce Queensland:

Poster: "Innovative Model of Providing Medication Management Reviews (HMRs) in the Bush"

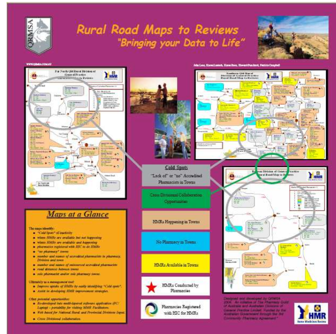


(Refer to Attachment 8 – "Innovative Model of Providing Medication Management Reviews (HMRs) in the Bush" Poster)

Poster: "The Practice Staff"

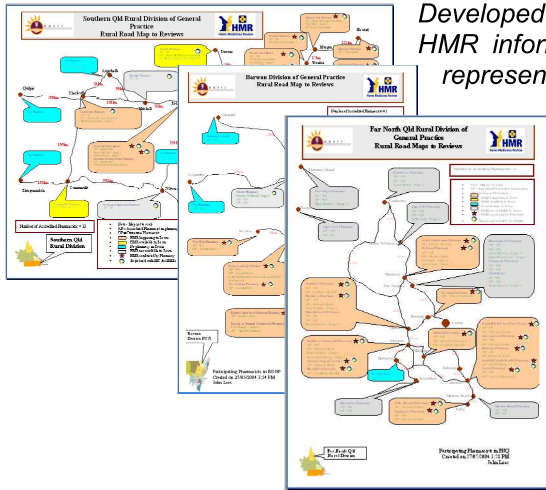
Shortly after the development of the HMR Made Easy Card, Health Workforce Queensland developed "The Practice Staff" poster. Two versions were developed and are pictured here. The intention was that it be sent to all Practices in the consortium catchment. This was a collaborative effort with the Queensland MMR Guild Facilitator (Ms Debbie Rigby) and Health Workforce Queensland. Unfortunately due to cost implications, the poster was not produced.
(Refer to Attachment 9 – "The Practice Staff" Poster)

Poster: "Rural Road Maps to Reviews"



Poster developed and presented at the MMR Facilitator Conference, Melbourne, and October 2004 at the Australian Divisions of General Practice Conference in Adelaide, November 2004. ***(Refer to Attachment 10 –"Rural Road Maps to Reviews" Poster)***

Divisional HMR Maps

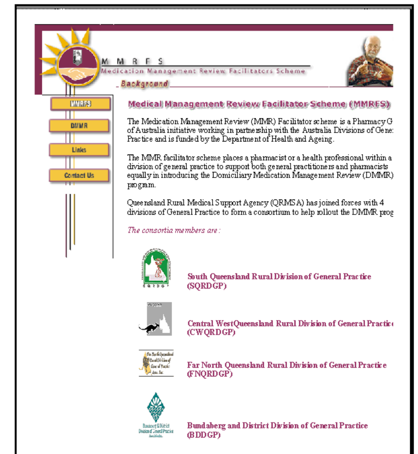


Developed and introduced Maps of Divisions incorporating specific HMR information – Brings data to life in a visual way. The Maps represent in a visual way which pharmacies:

- *are conducting HMRs;*
- *are registered with HIC to conduct HMRs*
- *HMRs are available*
- *HMRs available but not happening*
- *HMRs not happening at all*
- *name of accredited pharmacist*
- *current # of Accredited Pharmacists in Division*

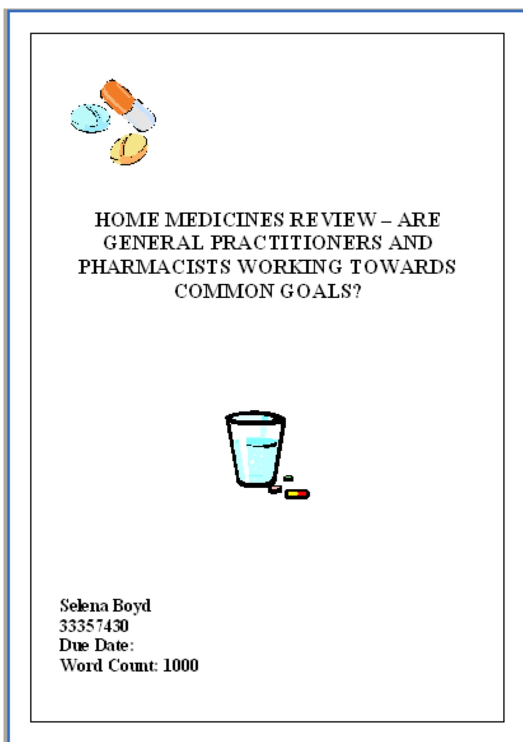
(Refer to Attachment 11 – "Rural Road Maps to Reviews" Maps)

Health Workforce Queensland MMRFP Website



At the commencement of the Program rollout in 2002, Health Workforce Queensland developed a website for health professionals to obtain information about the HMR activity. It also contained various forms and links to other relevant pharmacy websites. As more and more websites began to appear, Health Workforce Queensland did not continue to maintain the site and was removed in late 2003. ***(Refer to Attachment 12 – Front Page of MMRFS Website)***

Study: "HMR – Are General Practitioners and Pharmacists Working Towards Common Goals?"



HOME MEDICINES REVIEW – ARE GENERAL PRACTITIONERS AND PHARMACISTS WORKING TOWARDS COMMON GOALS?

Selena Boyd
33357430
Due Date:
Word Count: 1000

The aims of this study were to determine if there was a difference between what pharmacists perceive doctors want from an HMR and what doctors expect from the pharmacist. Surveys were sent to 390 general practitioners and 190 pharmacists. ***(Refer to Attachment 13 – "HMR – Are General Practitioners and Pharmacists Working Towards Common Goals?")***

Table 6

Cause, Effect and Result Table

Reasons for HMR Momentum to Decline or Stop in Rural Areas

Cause	***Possible Effects and Result. These are not exhaustive; they are examples only of how the HMR activity can decline or stop especially in rural areas. The end result being that the patient misses out!***					
GP unsure about the benefits of HMR activity	_GP doesn't refer_	_Pharmacist cannot see the benefits of becoming accredited or maintaining accreditation_	_Pharmacist losses interest in HMRs_	_Pharmacist puts accreditation on hold or lets it lapse_	***Patients in community miss out on HMR***	
GP doesn't provide feedback and/ or medication plan to pharmacist	_Pharmacists unsure whether GP is satisfied with report_	_Pharmacist may become apprehensive_	_Pharmacists may not consider identifying patients for HMR again_	_Pharmacists may not consider becoming accredited or if accredited, lets it lapse of puts on hold_	***Patients in community miss out on HMR*** ***Refer to Report Recommendations***	
Pharmacists unsure about HMR activity	_Patients unsure of the benefits of HMR_	_Patients may become confused and refuse HMR_	_GP concerned about patient_	_GP becomes frustrated_	_GP may stop referring_	***Patients in community miss out on HMR***
Pharmacists in sole pharmacy towns do not have the time	_GP concerned about workload of local pharmacist (burden)_	_GP may not refer_	***Patients in community miss out on HMR***			
	Nothing happens by pharmacist- HMR referrals sit with the referred community pharmacy too long	_GP concerned about patient_	_GP becomes frustrated_	_GP may stop referring_	***Patients in community miss out on HMR***	
Pharmacist does not have time to become accredited	_GP may become frustrated, not refer or stop referring_	_Pharmacist looses interest in HMR activity_	***Patients in community miss out on HMR***			
Pharmacist finds cost of accreditation and re-accreditation and issue	_Pharmacists don't bother becoming accredited_	_Pharmacists don't bother re-accrediting_	_Pharmacists lose interest in HMRs_	_Pharmacist puts accreditation on hold or lets it lapse_	_GP may become frustrated and stop referring_	***Patients in community miss out on HMR***
Pharmacist does not communicate with GP when there is a backlog of referrals	_GP becomes frustrated_	_GP concerned about patient/s_	_May create animosity between professions_	_GP may stop referring_	***Patients in community may miss out on HMR***	

Cause	***Possible Effects and Result. These are not exhaustive; they are examples only of how the HMR activity can decline or stop especially in rural areas. The end result being that the patient misses out!***					
Insufficient accredited pharmacists in the community	*GP doesn't refer*	*No seen advantages for community pharmacist to engage remote accredited pharmacist*	*Too much trouble and pharmacist losses interest in HMRs*	***Patients in community miss out on HMR***		
Accredited pharmacists too busy running own business	*Insufficient time to conduct HMRs. HMR referrals sit too long*	*GP concerned about patient*	*GP becomes frustrated and may stop referring*	*Pharmacist cannot see the benefits of becoming accredited or maintaining accreditation*	*Pharmacist puts accreditation on hold or lets it lapse*	***Patients in community miss out on HMR***
Pharmacist finds HMR too time consuming	*Insufficient time to conduct HMRs. HMR referrals sit too long*	*GP concerned about patient*	*GP becomes frustrated and may stop referring*	*Pharmacist cannot see the benefits of becoming accredited or maintaining accreditation*	*Pharmacist puts accreditation on hold or lets it lapse*	***Patients in community miss out on HMR***
Pharmacist finds HMR activity not financially rewarding	*Pharmacists lose interest in HMRs activity*	*Pharmacist puts accreditation on hold or lets it lapse*	*GP becomes frustrated and may stop referring*	*Pharmacist cannot see the benefits of becoming accredited or maintaining accreditation*	*Pharmacist puts accreditation on hold or lets it lapse*	***Patients in community miss out on HMR***
Pharmacist does not provide a satisfactory report to GP	*GP may not call patient in for 2nd appointment*	*GP does not claim for HMR*	*GP becomes frustrated*	*GP may stop referring*	*Pharmacist losses interest in HMRs*	***Patients in community miss out on HMRs***
Pharmacy sits on HMR referrals for too long	*GP becomes concerned about patient*	*GP becomes frustrated*	*GP may stop referring*	*Pharmacist cannot see the benefits of becoming accredited or maintaining accreditation*	*Pharmacist puts accreditation on hold or lets it lapse*	***Patients in community miss out on HMR*** ***Refer to Report Recommendations***