1.   Introduction

1.1   Background

In October, 2001 the Australian Government through the Department of Health and Ageing (the Department) introduced the Home Medicines Review (HMR) Program. The HMR Program is designed to help those people living at home to maximise the benefits of their medication regimen and prevent the harmful consequences of medication misuse. The objectives of the HMR Program are to:

➢ achieve safe, effective and appropriate use of medications by detecting and addressing medication-related problems that interfere with desired health outcomes

➢ improve the consumer's quality of life and health outcomes using a best practice approach, that involves cooperation between the general practitioner, pharmacist and other relevant health professionals and the consumer (and where appropriate, their carer)

➢ improve the consumer's and health professional's knowledge and understanding about medications and

➢ facilitate cooperative working relationships between members of the healthcare team in the interests of consumer health and wellbeing.

The HMR Program encourages general practitioner (GP) and pharmacist cooperation with the aim of providing a 'comprehensive review' of an individual's medication regimen via a home visit made by an accredited pharmacist and is 'central in the development and implementation of an agreed medication management plan.'[1]

During the HMR visit the HMR accredited pharmacist will assess patient use of medication in his/her environment as well as review issues such as medicine storage practices, discuss medicine regimes with the individual and provide feedback to the GP with the ultimate aim of improving compliance and/or modifying the treatment regime. The steps in the HMR process are:

➢ a GP assesses the consumer's need for a HMR in an initial consultation and asks the consumer to nominate their preferred community pharmacy. The GP then provides the pharmacy with relevant clinical information

➢ the community pharmacy then arranges for a home interview to be conducted by an appropriately qualified pharmacist to assess how the consumer is using his or her medicines in their own environment. This also provides an opportunity for the pharmacist to assess the consumer's medicine storage practices

➢ the accredited pharmacist will prepare a written report based on the home interview and discuss the findings and any suggested management strategies with the consumer's GP

➢ the GP will then develop a medication management plan for the consumer, taking into account any relevant findings from the home assessment. The GP will then discuss the findings with the consumer and make any necessary changes to the consumer's medicines or dosages

➢ the GP will ensure that the consumer understands the reasons for any changes to their medicine regimen and that they are comfortable with these changes

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[1]   Department of Health and Ageing, Home Medicines Review Program Research Brief, 27 September 2007

> ➤ the GP, pharmacist and consumer implement the new medication plan with follow up and monitoring.

The HMR Program is only available to people living at home in the community setting. It does not apply to in-patients of a hospital, day hospital facility, or care recipients in residential aged care facilities, or those who have received a HMR in the past 12 months (unless their treatment regime has been significantly altered or their condition has changed).

Consumers most likely to benefit from an HMR are those for whom quality use of medicines may be an issue, or who are at risk of medication-related problems. Risk factors known to predispose people to medication-related problems include:

> ➤ taking five or more regular medications or more than 12 doses of medication per day
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> ➤ significant changes in medication treatment regimen during the previous three months;
>
> ➤ taking medication with a narrow therapeutic index and/or requiring therapeutic monitoring (e.g. warfarin or digoxin)
>
> ➤ symptoms suggestive of an adverse drug reaction
>
> ➤ sub-optimal response to treatment with medicines
>
> ➤ suspected non-compliance or inability to manage medication-related therapeutic devices
>
> ➤ literacy or language difficulties, dexterity problems, impaired sight, confusion/dementia or other cognitive difficulties
>
> ➤ attending a number of different doctors, both GPs and specialists
>
> ➤ recent discharge from a facility or hospital (in the last four weeks).

Both pharmacists and GPs are incentivised to participate in the scheme. The HMR Program operates under Business Rules developed in conjunction with the Pharmacy Guild of Australia and Medicare Australia. Payments to GPs and pharmacists for their involvement in the conduct of a HMR are facilitated through two separate mechanisms:

1. payments to GPs are made through Item 900 of the Medicare Benefits Schedule (MBS). The fee is indexed annually and from 1 November 2006 the fee was $134.10 per service. This fee is only payable on completion of a medication management plan following receipt of the report from the Accredited Pharmacist

2. payments are made to pharmacies via provisions in the *Fourth Community Pharmacy Agreement* (2005-2010). Please note, while HMRs are conducted by accredited pharmacists[2] only appropriately registered community pharmacies[3] are eligible to receive payments under the HMR Program. Payments can not be made directly to accredited pharmacists. This fee is indexed on 1 July each year and at the commencement of research was set at $183.60 per review, which covers costs relating to the community pharmacy's role and the services of the accredited pharmacist who conducts the review.

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[2] An accredited pharmacist is an experienced pharmacist who has undertaken specified education programs or examinations, as approved by the Australian Association of Consultant Pharmacy or the Society of Hospital Pharmacists of Australia, and undertakes specified continuing professional education and re-accreditation.

[3] Registered community pharmacies are established under Section 90 of the *National Health Act 1953* and also approved to provide HMR services.

1.2   Research

A number of evaluations of the HMR Program have already been undertaken and some of the issues raised by these have since been addressed and the Program enhanced in these areas. The evaluations were:

> ➢ *The Evaluation of the Home Medicines Review Program – Pharmacy Component*, prepared for the Pharmacy Guild of Australia (funded by the Department) in 2005

> ➢ The Evaluation of the GP Component of the Home Medicines Review Program, prepared for the Department by Urbis Keys Young in December 2004.

However, the Department required further research to complement existing knowledge (and inform future policy) in relation to the HMR Program, in particular to:

1. identify the appropriate target population(s) that would most benefit from the Program

2. identify gaps in access for people and the reasons for these gaps in access, considering but not limited to, gender, cultural/ethnicity, geographic location and workforce issues

3. determine what drives participation in the program, including identifying barriers and enablers relative to different target groups and geographic locations across Australia.

Two separate (but complementary) research projects have been undertaken to address these objectives, consisting of an internal data analysis and a qualitative research program. The findings of the quantitative research, as detailed below, addressed objective one while the qualitative research undertaken by Campbell Research & Consulting (CR&C) addressed the second and third research objectives and is reported herein.

The quantitative analysis by the Department of HMR service data (i.e., claims against MBS 900 and pharmacy service payments) and investigation of leading Australian summary studies indicated that those at greatest risk of medication misadventure are consumers of multiple medications aged 65 or over. On this basis, estimated per capita service provision to the over 65 population was used to compare HMR uptake across Divisions of General Practice (Divisions).

The quantitative analysis by the Department was used to inform the selection of Divisions for the qualitative research.

To make the qualitative sample broadly representative, Divisions were selected to represent a range of states, geographical regions (according to the rural, remote and metropolitan areas <RRMA> classifications system) and HMR service levels. Based on the estimate the Divisions were ranked and divided into 20 percentile bands.

In order to investigate variations in HMR service levels, pairs of Divisions that differed by service level were selected. These pairs were also selected so that they had:

> ➢ the same RRMA classification; and

> ➢ similar socio-economic (SE) ratings, and similar CALD or indigenous presence, as reflected in measures applied and reported by the Public Health Information Development Unit (PHIDU).

After analysing the list of Divisions with these considerations in mind, three pairs of Divisions and four single Divisions were recommended for intensive investigation during the qualitative research. These included three from Queensland, two each from Western Australia and Victoria, and one each from New South Wales, Tasmania and South Australia. In terms of RRMA classifications, four were metropolitan Divisions, four were rural and two were rural/remote. The Divisions selected as pairs were:

> ➢ *Dandenong* and *Bankstown*, located in Melbourne and Sydney respectively. Both are RRMA metropolitan Divisions with a low socio-economic rating and a high CALD

       presence. In terms of HMR service provision to those aged 65 and over, Dandenong ranked as very high and Bankstown at the lower end of medium

> *Capricornia* and *Townsville,* both of which are Divisions that include rural North Queensland cities. These Divisions have a similar socio-economic rating and a relatively high indigenous presence. Comparative analysis of HMR service provision to the over 65 population indicated Capricornia ranked as high and Townsville as very low

> *Mid West* and *Central Wheatbelt,* both of which are rural/remote WA Divisions. Both have a similar socio-economic rating and a relatively high indigenous presence. They differ in service levels with Mid West having very high levels and Central Wheatbelt very low.

In each of the first two pairs above, the Division with a higher uptake of HMR had a significantly lower presence of accredited pharmacists (per capita for the 65+ age group) than the Division with lower HMR uptake.

Four single Divisions were also selected:

> *Mid North* was included to represent low service levels, as well as rural Divisions and South Australian

> *Central Bayside,* a Victorian Division was included to investigate an urban/metropolitan upper socio-economic Division with very high HMR service levels. Other urban Divisions with a high socio-economic rating tend to provide low levels of HRM services

> *GP North,* a Tasmanian rural Division was included to represent Tasmanian Divisions and/or those with medium service levels

> *Sunshine Coast,* a rural Queensland Division was included to allow close investigation of the factors that enabled high levels of service provision without the use of a Medication Management Review (MMR) Facilitator.

1.3   This report

This report presents the findings from the HMR Program qualitative research project conducted by CR&C. It is based on a series of qualitative interviews with representatives from peak bodies and stakeholder organisations; a review of available literature on medication management programs; submissions received via a public call for submission process; a series of in-depth interviews with grass roots health professionals; together with focus groups and in-depth interviews with consumers.

The report is structured to present findings from each phase of research separately and sequentially, although the overall findings of this research are based on the balanced assessment of views sourced throughout the entire project.

Qualitative research deals with relatively small numbers of people and is used to gain in-depth insight into people's attitudes, behaviours, feelings, concerns, motivations and value systems. Qualitative approaches to data collection involve direct interaction with individuals on a one to one basis or in a group setting. The exchange of views and experiences is relatively open and free flowing, and as a result provides rich data that is broadly characteristic of the range of views held by the population of interest. The findings are not analysed with statistical techniques, and while indicative of the population's views, they cannot be assigned to a proportion of the population. Rather, qualitative findings are interpretive in nature.

Appendices 1 and 2 provide details of the acronyms, abbreviations and terminology used in this report.

1.4 Disclaimer

Please note that, in accordance with our Company's policy, we are obliged to advise that neither the Company nor any member nor employee undertakes responsibility in any way whatsoever to any person or organisation (other than the Australian Government Department of Health and Ageing) in respect of information set out in this report, including any errors or omissions therein, arising through negligence or otherwise however caused.

2. Methodology Overview

In collaboration, CR&C and the Department developed a multi-faceted methodology to access a wide range of views, from peak bodies and stakeholder organisations through to grass roots health professionals and consumers. This approach sought to maintain the independence of the research, ensuring that no single group or stakeholder had any significant influence on those recruited to participate, or on the research findings. The key research stages (Figure 1) included:

> ➢ a review of available literature since 2005 on medication management and the HMR Program (the Literature Review)

> ➢ consultations with stakeholder organisations and peak bodies (the Stakeholder Consultations)

> ➢ a publicly advertised invited call for submission (the Call for Submissions)

> ➢ qualitative research with grass roots health professionals and consumers (the Qualitative Research).

The earlier stages of the project were used to inform subsequent stages and provide hypotheses to be tested.

Figure 1:   Key stages for the project