PHARMACY GUILD MMR PROGRAM FACILITATOR'S WORKSHOP
SUMMARY OF PROGRAM / PROCESS ANALYSIS
WEDNESDAY JUNE 13 2007

| ISSUE LEVEL | OPPORTUNITY | THREAT | STRENGTH | WEAKNESS |
|---|---|---|---|---|
| NATIONAL | ▪ PPSAC with HMR facilitator on committee<br>▪ Remove GP barriers – time, money, referral process, paperwork<br>▪ Broaden referral base e.g. to medical specialists<br>▪ Ride on success so far<br>▪ Integration of HMR program with other program areas in the divisions<br>▪ Consumer campaign (3) – where is Margaret on the TV?<br>▪ Understanding of pharmacy as an industry<br>▪ National Prescribing Service (NPS)<br>▪ Enhanced item numbers – not 'siloed', holistic approach<br>▪ Facilitators in the divisions | ▪ HMR model versus GP referral normally – to known and trusted healthcare colleagues (2)<br>▪ Bureaucratic problems – dual pharmacy approvals<br>▪ Competition between item numbers<br>▪ Flawed statistics model<br>▪ Return to 'silos'<br>▪ Accredited pharmacist disenchantment<br>▪ Government intervention<br>▪ Poor quality of reviews<br>▪ Loss of government support money to realistically fund HMRs for pharmacies (2)<br>▪ Government 'deafness' | ▪ HMR dovetails with other items e.g. EPC / chronic disease items and other divisional programs<br>▪ Preventative healthcare for the patient<br>▪ Commitment by all stakeholders<br>▪ Health outcomes<br>▪ Professional services for pharmacy<br>▪ Consumer support, acceptance, desire<br>▪ DVA and NPS support | ▪ What we are measuring – number of HMRs only?, measuring quantity not quality<br>▪ Inability to measure preventative healthcare outcomes<br>▪ Need for pharmacy 'approval' for HMR provision<br>▪ Lack of forward planning nationally<br>▪ Remuneration for GPs, pharmacist, pharmacy, consultant pharmacist (3)<br>▪ GPs cannot refer directly to a preferred accredited pharmacist<br>▪ Meaningless reporting<br>▪ Pharmacist re-accreditation process |

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| STATE | ▪ More accredited pharmacists available<br>▪ HMR on discharge (2)<br>▪ Interact with other programs at GPDV<br>▪ Ride on success so far<br>▪ State Guild to encourage community pharmacists / pharmacy owners | ▪ Lack of community pharmacy participation<br>▪ Facilitator fatigue / disenchantment | ▪ HMR dovetails with other programs<br>▪ More accredited pharmacists available<br>▪ HMR facilitator network (3) ("facilitator mafia")<br>▪ The value of HMR for patients | ▪ Timeliness of referrals and payment<br>▪ Guild support for the programme – driving the community pharmacy / pharmacist involvement |
| LOCAL | ▪ 'Collaborative programs' in the division<br>▪ Integration of the HMR program into other divisional program areas<br>▪ Facilitators based in division give the program credibility – see the 'big picture'<br>▪ Practice nurses and practice managers<br>▪ Engagement with Quality Care Pharmacy Program (QCPP)<br>▪ Overseas trained doctors, new GPs to an area, GP registrars<br>▪ Ride on the successes so far<br>▪ Medical Specialist awareness | ▪ GPs wanting to do the reviews themselves – they have their own idea of what a review is<br>▪ Negative attitudes between GPs and Pharmacies<br>▪ Poor quality of reviews<br>▪ Lack of community pharmacy participation (2)<br>▪ Facilitator 'fatigue', 'disenchantment', 'frustration', 'boredom' | ▪ Consumer acceptance<br>▪ Facilitator passion<br>▪ GP divisions credibility<br>▪ Collaboration between other professions, divisional staff and divisional programs<br>▪ Collaboration and communication between GPs and pharmacists<br>▪ Patient satisfaction<br>▪ Division-based facilitators able to 'get in the door' at practices<br>▪ Information gained for the GP and the patient on medication management | ▪ Engaging the ATSI community<br>▪ Travel costs in rural / remote areas<br>▪ Poor uptake by community pharmacy<br>▪ Lack of personnel – workforce issues (GP, pharmacist)<br>▪ Access to interpreters in pharmacy<br>▪ Quality of reports<br>▪ Engaging the CALD community<br>▪ Timeliness of referrals and payment |