Research Report: Qualitative Findings from Pharmacy Owner and Manager Group Discussions Promise III

August 2009
Prepared for: Professor Greg Peterson and Dr Peter Tenni
Promise III Lead investigators
Unit for Medication Outcomes Research and Education
School of Pharmacy
University of Tasmania
CONTENTS

1 EXECUTIVE SUMMARY ................................................................................................................................. 6

2 CONCLUSIONS .................................................................................................................................................. 7
  2.1 Documentation of clinical interventions .................................................................................................... 7
  2.1.1 Barriers .................................................................................................................................................... 7
  2.1.2 Drivers .................................................................................................................................................... 7
  2.2 Remuneration for documentation ................................................................................................................ 8
  2.2.1 Remuneration key elements .................................................................................................................... 8
  2.2.2 Component preferences ........................................................................................................................ 10
  2.2.3 Remuneration magnitude ....................................................................................................................... 11
  2.3 Additional program features ....................................................................................................................... 11
  2.4 Ongoing support .......................................................................................................................................... 12
  2.5 Next steps ................................................................................................................................................... 13

3 BACKGROUND ................................................................................................................................................ 14

4 PROJECT OBJECTIVES ................................................................................................................................ 14
  4.1 Overall objective .......................................................................................................................................... 14
  4.2 Research objectives .................................................................................................................................... 15

5 RESEARCH APPROACH ............................................................................................................................... 15
  5.1 Methodology .............................................................................................................................................. 15
  5.2 Sample ........................................................................................................................................................ 16
  5.2.1 Sample selection ...................................................................................................................................... 16
  5.2.2 Sample structure .................................................................................................................................... 16
  5.3 Research constraints ................................................................................................................................... 17

6 RESULTS .......................................................................................................................................................... 18
6.6.3 Quality Care Practice Program (QCPP) points

6.7 Ongoing resource support

7 APPENDICES

7.1 Appendix A - Discussion Guide - Focus Group – Managers and Pharmacy Owners

EXHIBITS

Exhibit 1: Sample structure

Exhibit 2: Acceptance of comparative intervention reports

Exhibit 3: Acceptance of blended model – set up and intervention payment

Exhibit 4: Acceptance of set up, continued participation and per intervention payments

Exhibit 5: Acceptance of payment per intervention

Exhibit 6: Acceptance of payments based on a percentage of expected health cost savings

Exhibit 7: Practice incentive for interventions during specific times of year

Exhibit 8: Acceptance of a tiered payment system based on health benefits

Exhibit 9: Acceptance for documentation linked to payment initiation

Exhibit 10: Acceptance of payment for specific targeted interventions

Exhibit 11: Acceptance of payment for only significant interventions

Exhibit 12: Acceptance of different payment options
Exhibit 13: Acceptance of different payment levels ........................................................................................................... 39
Exhibit 14: Acceptance of payment frequencies .................................................................................................................... 40
Exhibit 15: Acceptance of different levels of practice payments ............................................................................................ 41
Exhibit 16: Acceptance of various practice payments ........................................................................................................... 42
Exhibit 17: Acceptance of data to drive professional education .............................................................................................. 43
Exhibit 18: Acceptance of reports for pharmacist re-registration ............................................................................................ 44
Exhibit 19: Acceptance of intervention reports used for QCPP accreditation ............................................................................ 45
1 EXECUTIVE SUMMARY

This report represents one stage of a larger program designed to develop an electronic documentation system for clinical interventions that will be accepted and used by community pharmacies across Australia.

The outputs are based on the findings from 5 focus groups conducted in NSW (2), Tasmania (1) and Victoria (1) with 30 pharmacists participating in the Promise III trial.

The key conclusions arising from this qualitative stage of the research program are:

- The Promise DOCUMENT software module was easy to use and was well accepted as a documentation system for clinical interventions.
- There are a number of practice and logistical barriers which will need to be overcome for a successful implementation of a system for the documentation of clinical interventions in Australian pharmacies.
- An accepted remuneration system for the documentation of clinical interventions is likely to be one that, is simple to administer, remunerates all documentations, and pays for start up costs and ongoing participation.
- Other features can be used to stimulate interest and level of intervention documentation in community pharmacy. These include: additional payments for specific interventions at various times of the year, the use of data to drive professional education, credits or points for employee pharmacists to use for re-registration or CPE purposes and credits for pharmacies participating in a Quality Care Practice Program (QCPP).

These attributes of a proposed documentation and remuneration system need to be tested quantitatively for ranked preferences using a representative sample.
2 CONCLUSIONS

2.1 Documentation of clinical interventions

The documentation of clinical interventions is not undertaken routinely in Australian pharmacies. Most pharmacists use established procedures to minimise mistakes when supplying medications on prescription. These procedures are well entrenched in dispensing routines, meaning that any changes to incorporate intervention documentation will require time and specific forms of assistance.

2.1.1 Barriers

There are a number of barriers that hinder the documentation of clinical interventions in pharmacies:

- **Entrenched practices**: Pharmacists have difficulty incorporating the documentation of clinical interventions into the current workflow of pharmacies as it requires a change to their current dispensing routine;

- **Intervention recognition**: Often interventions are performed routinely but are not recognised as interventions by pharmacists;

- **Remembering to document**: Pharmacists are often too busy to document immediately following interventions and then forget documentation or do not have opportunities to do so later;

- **Time to document**: Many pharmacies do not have time to document interventions within the current staffing and workflow of pharmacies;

- **Intervention recall**: Pharmacists who delay documenting interventions may not recall the intervention detail later, when they do have time to document.

2.1.2 Drivers

The following drivers were considered important in increasing the level of documentation in pharmacies:

- **Remuneration**: Adequate payment would increase the level of intervention and documentation;

- **Improved clinical training**: Pharmacist training on recognising interventions will increase the level of interventions and subsequent documentations;
Change to practices or computer terminal access: The availability of forward dispensing terminals\(^1\) to improve computer access or a change to dispensary practices that encourage pharmacists to spend more time face to face with patients, should increase the level of intervention and documentation;

Incentives to dispensary staff: Employee pharmacists often dispense a large percentage of the prescription workload. Incentives for these employees in the form of re-registration points or CPE points for documenting clinical interventions will increase interest in interventions and documentation within pharmacies.

Adequate staffing levels: Pharmacists with a high prescription workload have less opportunity to perform and document interventions. Thus adequate staffing levels in dispensaries will increase the potential for intervention and documentation.

Computer functionality: Easy to use software, intervention prompts and the ability to enter draft documentation all work to increase the chances of intervention documentation.

2.2 Remuneration for documentation

2.2.1 Remuneration key elements

Based on the focus group discussions the following conclusions can be made:

- There was a strong preference for a simple remuneration system. The perception was that a simple system would also be attractive to Government as it would be easier to administer.

- Somewhat minor clinical interventions can prevent major complications in patients’ health. Thus all interventions are regarded as important in the overall care of patients.

\(^1\) Forward dispensing terminal – A computer terminal linked to dispensing software available at the point of counselling/prescription receipt
To selectively remunerate some interventions was not considered desirable:

- Pharmacists may focus on paid interventions to the detriment of non paid interventions;
- Selective payment may not encourage pharmacists to document interventions in all cases or increase the average intervention rate;
- The identification of interventions is a core function of pharmacy practice and should be part of routine dispensing. For many, documentation should follow all interventions as part of quality pharmacy practice and should not be optional.
- Any collection of data by Government for education and to drive public health care initiatives will require documentation of most interventions to produce a complete picture of drug related problems in all groups of drugs;
- Selective payment assumes knowledge of the more important drug related problems and under all circumstances. This knowledge may not be available or achievable.
- For pharmacy to fully adopt documentation as a routine practice it needs to occur following all interventions. Pharmacists do not want to deal with the complexity of deciding what or not to document.

It was concluded within the focus groups that the uptake of any documentation process will be facilitated by payment for all documented interventions. This should also drive the establishment of intervention documentation in community pharmacy.

- While payment for all documentation is a preference and a recommendation from the focus group, it was indicated that the payment does not have to be a large amount. Pharmacists seem willing to accept a reasonable fee per documentation if calculations were based on the following:
  - The final calculation for remuneration for an average intervention should be at least greater than cost to perform that intervention;
  - Any loss in revenue from a decreased mark-up on PBS prescriptions is offset by gains from documentation payments.

- Some funding arrangements for pharmacy services do not require ongoing participation after upfront fees are paid to pharmacies. Thus the upfront payments are collected and in some cases used as revenue rather than towards increasing pharmacy services. A participation fee has the benefit of rewarding those pharmacies continuing to perform the service. If the payment was relatively easy to achieve and perhaps based on an intervention rate quota, the participation payment has the benefit of reminding pharmacists of documentation and both stimulating intervention and documentation rates.
The identification of clinical interventions is a major issue for pharmacy: currently many interventions are conducted without recognition by pharmacists. Adequate training, conducted by the Pharmacy Society of Australia as part of CPE lectures, together with online training using case histories would improve pharmacists’ performance in the recognition of clinical interventions.

Pharmacists expect Government to have the ‘right of audit’ if intervention documentation was remunerated;

It was envisioned that intervention data would be electronically transmitted to Government at the completion of an intervention recording.

The following were not acceptable as core or stand-alone components of a remuneration system because they do not encourage documentation of clinical interventions:

- Thresholds where payment for intervention documentation did not occur until a quota was reached
- Payments for stand alone specific targeted interventions. These payments however could be acceptable for specific health issues as decided by government and remunerated additionally;
- Payments for only significant interventions
- Time based payments for interventions and documentation.
- Any opt in program for remuneration where pharmacies would elect to participate.

2.2.2 Component preferences

The components of an ‘acceptable’ documentation remuneration package would best comprise a selection of the following payment approaches:

- Payment per documented intervention (set fee for all documentations, payments as a percentage of health cost savings or tiered payments based on the severity of intervention) paid weekly or fortnightly to pharmacies;
- Practice payments that would be split between:
  - Upfront payment to each pharmacy to offset costs of training and capital expenditure (additional computer terminals and shop layout changes);
Quarterly payments for continued participation which would remind pharmacists to maintain a level of documentation.

2.2.3 Remuneration magnitude

Shrinking margins from dispensing PBS prescriptions means pharmacists cannot afford to provide additional services to consumers free of charge and they expect payment for any additional activities. Pharmacists want a fair level of remuneration for the documentation of clinical interventions.

- **Intervention remuneration**: The expectation was that the level of remuneration for each intervention would have to be at least more than 10% of the time cost to intervene and document. It was not acceptable to provide a service for cost or less than cost. The final value would have to be calculated by health economists based on remuneration criteria and any loss in mark-up suffered by going to a fee for service model.

- **Practice payments**: The accepted level for practice payments (upfront and for continuing participation) varied in the range from $3000 to $5000\(^2\). Some groups discussed that this could be split between an upfront payment of $2000 to $3000 for training and capital equipment (computers etc) and $1000 to $2000 for continued documentation paid in quarterly instalments should intervention rates exceed a target level.

It is important to note that these ranges are derived from qualitative research and are indicative only. They will need to be tested quantitatively with a representative sample.

2.3 Additional program features

The research identified some additional program features which were attractive to pharmacists. These features, listed below, could be usefully incorporated into a remuneration model for clinical intervention documentation:

\[^2\] Derived from qualitative research and is provided to indicate an expectation of magnitude that can be used in subsequent quantitative analyses.
- **Specific interventions**: Additional payments for interventions performed and documented on specific health issues. The nature of these interventions would be decided by Government and would run for a specified time. These interventions could be linked to extra pharmacist training and specific pop up reminders (if applicable).

- **Data to drive professional education**: Pharmacists would strongly support the use of data captured from interventions to drive pharmacy and medical education.

- **Training**: Both face to face training (lectures etc) and online training will be important to ensure a smooth adoption of a remuneration system for clinical interventions.

- **Employee pharmacist incentives**: Credits or points could be available from certified reports for pharmacists’ re-registration or Continuing Professional Education (if possible). Comparative data could be available online or with payment notifications to stimulate interest in the documentation of clinical interventions.

- **Quality Care Practice Program**: Certification as a QCPP pharmacy could include a target intervention rate as one measure of the evaluation process.

### 2.4 Ongoing support

Some feedback on the type of ongoing support for performing and documenting clinical interventions suggested by participants included:

- Ongoing online training using case histories and how to classify interventions;
- Clinical (to verify an intervention meets criteria) and IT support (for software support) accessed by an 1800 number\(^3\). May only need to be provided in first year of system establishment;

\(^3\) Pharmacists can then be redirected using automatic answering capability
Feedback information using comparative reports on other pharmacies intervention rates by geographical region and newsletters with case histories with resultant estimated health cost savings;

The provision (selected by National Prescribing Service Ltd &/or Department of Health and Aging) of pop ups linked to public health initiatives.

2.5 Next steps

This report outlines the qualitative findings from focus group discussions with 30 pharmacists participating in the Promise III program. The report identifies acceptable components of a remuneration system for the documentation of clinical interventions. The next steps are to test quantitatively the preferences and weightings of the entire Promise III participants with a Choice based conjoint exercise. Then the findings will be used to test these preferences in Computer assisted telephone interviews on a National sample of community pharmacists.
3 BACKGROUND

In November 2008, the Pharmacy Guild of Australia commissioned a trial (PROMISe III) to refine and extend the outcomes of previously funded projects - PROMISe I and II. The previous projects developed and piloted an electronic documentation and communication system designed to record the resolution of drug related issues by pharmacists, commonly referred to as pharmacy clinical interventions.

The aim of Promise III is to develop an electronic documentation system that will be accepted and used by community pharmacies across Australia. To date the emphasis of the project has been to refine the electronic software module so that it is functional, easy to use and allow communication with outside parties.

However for any documentation system to be adopted *nationally* it will need to cut through current practice routines where very few interventions are documented. One of the key drivers for national acceptance of a documentation system will be to have Government remunerate pharmacies for performing and documenting clinical interventions.

This report examines the functional issues related to day to day documentation of clinical interventions, the remuneration components that will be acceptable to pharmacists and the level of support required by pharmacies to ensure ongoing documentation.

4 PROJECT OBJECTIVES

4.1 Overall objective

The overall objectives of this qualitative research were to:

- Determine the barriers and drivers for the documentation of clinical interventions in pharmacy;
- Develop acceptable models that will encourage pharmacists to perform and document clinical interventions;
• Ascertain pharmacists’ long term requirements for participation in a national program to document clinical interventions.

4.2 Research objectives

In order to achieve these overall objectives, a range of research objectives were addressed. Specifically, to determine the:

] Barriers and facilitators for the identification of clinical interventions and subsequent documentation;

] Resources required for effective documentation of clinical interventions;

] Support services for the implementation of a documentation system;

] Level of financial incentives required to facilitate the documentation of clinical interventions;

] Accepted remuneration models for undertaking and recording clinical interventions;

] Preferences for remuneration models.

5 RESEARCH APPROACH

5.1 Methodology

Thirty owner or manager pharmacists participating in the Promise III trial were asked by telephone or email to attend focus groups held in their local capital city to discuss possible remuneration options for the documentation of clinical interventions. Each group discussion was recorded and subsequently analysed. Participants were also asked to rate some remuneration options in order to demonstrate their preferences. The results are also included in this report.
5.2 Sample

5.2.1 Sample selection

A convenience sample of owners and managers was taken from a list of ‘active participant pharmacies’ in the Promise III trial.

5.2.2 Sample structure

The structure of the final sample is shown in the following Exhibit 1.

Exhibit 1: Sample structure

<table>
<thead>
<tr>
<th>State</th>
<th>Respondent Job Title</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Owner</td>
<td>Manager</td>
</tr>
<tr>
<td>NSW</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Victoria</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Hobart</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>7</td>
</tr>
</tbody>
</table>
5.3 Research constraints

This project was conducted by selecting a sample of respondents from lists of Promise III pharmacists participating in the trial. Because the focus groups were conducted in Melbourne, Sydney and Hobart, rural respondents were unable to attend. Therefore the findings may not be representative of the rural community pharmacy experience.

This is also a qualitative study and as such is indicative of attitudes and does not attempt to quantify issues.
6 RESULTS

6.1 Intervention and documentation

6.1.1 Software

The overall experience with the DOCUMENT software was positive. Functionality was considered to be good with no major issues uncovered. The software was easy to navigate with little training. Several suggestions for improvement were made, these included:

- Documentation notes should be listed in the drug history and not the alternate history,
- A ‘radio’ button on the main dispensing screen should enable the activation of the DOCUMENT software without the need to use particular key strokes and
- A more prominent prompt to remind dispensers of incomplete intervention documentation.

“It is a good clean program”

“A draft button should be on the main screen so the intervention can be logged during dispensing so it (draft) should be available at any time during dispensing.”

“There is not much wrong with the software it is pretty ironed out.”
6.1.2 Barriers to performing and documenting clinical interventions

There were some reoccurring barriers mentioned which limited the rate of intervention and documentation:

**Entrenched dispensing routines:** Respondents failed to document interventions as they had forgotten to enter the details into the computer software. This was the greatest cause of low documentation rates. Many pharmacists described entrenched workflow practices, established over many years based on training they had received in their Under-Graduate years. Unless respondents were able to modify their dispensing routines to include documentation, then the documentation was often forgotten.

**Focus on dispensing:** Pharmacies are remunerated for professional efforts largely through the dispensing of prescriptions. Hence most pharmacies focus on processing the greatest number of prescriptions possible. This focus lessens pharmacists’ ability to identify and document clinical interventions.

**Intervention identification:** Many instances, particularly of what could be called ‘minor drug related problems’, often were not recognised as interventions by pharmacists as intervening is second nature to most pharmacists. Training, especially with case histories and experience, was seen as the way to overcome the problem of non-recognition of interventions.

**Low consumer contact:** Pharmacists who spent little time with consumers had a reduced chance of identifying drug related problems. One way to overcome this and to drive an increase in the level of interventions would be to encourage pharmacists to always counsel consumers when handing out prescriptions.

**Classification of interventions:** Difficulties with the classification of interventions was mentioned by some. In cases where the pharmacist struggled to classify interventions there was a tendency to delete the intervention rather than to spend time on its categorisation:

**Time to document:** Some pharmacies were so busy in some periods that there was no time to document immediately after an intervention occurred;

**Intervention recall:** Some reported although drug related problems were identified, interventions conducted and a draft documentation entered into the patient’s history, it was sometimes difficult to recall the precise details of the intervention at the end of the day.
“It is getting into the habit of documentation.”

“I have been in both Promise II and now Promise III so I have a good idea what an intervention is, but it is remembering to document it.”

“I’ve done the intervention but I’ve not recorded anything on Promise quite a few times.”

“If I am still not sure how to classify an intervention, I just cancel out of it.”

“You don’t even register what you are doing. This is the first point of acknowledgement of interventions.”

6.1.3 Drivers of documentation

Participating pharmacists identified a number of strategies to increase the rate of documentation. The key drivers of clinical intervention documentation were:

**Remuneration:** An accepted remuneration system for pharmacies should increase the level of documentation:

**Computer functionality:** The introduction of a software module to easily record clinical interventions would increase the level of documentation and focus on clinical interventions in Australian pharmacy practice. There was differing opinion on the use of ‘pop up’ prompts. Some thought they were useful in identifying possible drug related problems. However others were annoyed by them, especially if pop ups appeared when:

- A patient had been counselled at a previous dispensing on the same issue or
- The dispensary was busy and the drug related problems identified were minor and frequently displayed.

Most respondents wanted control over the appearance of pop ups. Some suggestions were:

- the ability to turn them off and/or;
- restrict ‘pop ups’ to a dispenser’s initials;
- restrict ‘pop ups’ to certain public health events or times of the year
All saw the benefit of having ‘pop ups’ coordinated with public health initiatives eg diabetes week, heart disease etc

**Pharmacy layout:** The physical layout of a pharmacy dispensary was seen as a possible facilitator of documentation. When forward dispensing terminals were available, then in some circumstances, it was easier to record the intervention into a patient's history at the forward terminal. Only a few pharmacies in the sample had terminals at the receiving point for dispensed prescriptions so there was potential to improve the level of documentation with additional computer terminals.

**Routine change:** Pharmacists in the sample had been using their dispensing procedures for many years. In the same way as the introduction of ‘bar code scanning’ during dispensing, the adoption of a new procedure took time to establish into a dispensary workflow. Many pharmacists in the sample had consequently made changes to their dispensing workflow to include intervention documentation. They had also adopted some strategies to ensure that intervention documentation was completed. Suggested modifications to workflow were to:

- save a empty draft in a patient's history as a reminder to later document or
- have a highlighted tag system so dispensing assistants can initiate a draft in a patient's history for the pharmacist to complete at a later time,
- making notes in a writing pad with the patients name,

**Training:** The identification and subsequent recording of interventions relied on pharmacists recognising and responding to possible drug related problems. Both face to face and online training were important to drive improvements to pharmacists’ skills in this area. Case histories were an acceptable and welcome means of training, especially when the history included the classification and likely outcome should an intervention not occur. Including the documentation of clinical interventions into undergraduate training was considered to be important if documentation was to become commonplace.

**Dispensary staff incentives:** The target of any incentives for completing clinical interventions was an issue. While it was expected that pharmacies would receive payments for documented interventions, at the same time there was a need to reward employee pharmacists to ensure that documentation of clinical interventions was carried out. To resolve this, suggestions were made that focussed on pharmacist dispensers potentially receiving continuing professional development points or points which could be used to support pharmacy re-registration.

**Adequate staffing levels:** Some pharmacy dispensaries were known to have workloads above the recommended 150 prescriptions per day per dispenser. If some pharmacies employed more dispensary staff this would facilitate time spent on interventions and subsequent documentation.
**Professional satisfaction:** The act of documentation provided some pharmacists a sense of personal satisfaction: they had intervened on a drug related issue and there was a record of that action. The recording of the intervention was a confirmation of its importance and this perceived importance would induce some pharmacists to conduct and record more interventions. Many believed that better recording should be part of quality pharmacy practice and not optional.

**Comparative reports:** As depicted in Exhibit 2, the majority wanted to determine how their pharmacy was performing against pharmacies in other areas/regions (postcode, state and national). The issue of internal comparisons was also discussed, with the potential for competitions within pharmacies for the greatest number of interventions.

“A tag that comes back into the dispensary reminds us to save a draft …”

“I really like the comparison thing as I like to see how I am going in relation to others.”

“If you are doing 500 to 600 prescriptions a day the last thing they will want to do is document clinical interventions." “It would be good to have it as the first point of training…It is like scanning as that was hard to get used to.”

“We’ve got enough computers too….We’ve got them on the front, we’ve got one on each bench, and then one in the consulting rooms as well, so it doesn’t matter, you’ve got to take like 5 steps and you’re on a computer, it makes it easy.”

“If you are 21 and you are just out of uni and they expect you to do 200 scripts by yourself in a day it doesn’t matter how keen you are, you won’t even think about it (document interventions).”

“I found it pretty rewarding as it reminds you of the job you are actually doing. All the things you can take for granted you are actually documenting.”

Exhibit 2: Acceptance of comparative intervention reports

<table>
<thead>
<tr>
<th>Acceptance</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>1</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>7</td>
</tr>
<tr>
<td>HIGH</td>
<td>22</td>
</tr>
</tbody>
</table>

N = 30   Mean acceptance score = 6.3

4 Graphs - Individual scores were transformed into 0 to 3 = Low acceptance, 4 to 6 = Medium acceptance and 7 to 10 = High acceptance
“I’ve seen some very clever pop ups … you’ve got somebody on diabetic medication and it does a check and sees if they’re on aspirin, ..., and then you go out and say ‘are you on aspirin’ and then you do that until you’ve done it to death, and you go in and switch it off and say ‘I’ve had enough of that pop up’ you know, and you’ve got a function in there that you can actually turn it off, and then next month you might get another one and you can have a go at...”

“‘We have 4 dispensing terminals and it certainly helps us....’

“I suppose, If it coincided with Asthma Week or Heart Disease Week or whatever it might be, but it might not have to do that either, but there are some really clever little pop ups out there that just say, you know ‘this might suit this occasion.’

“A lot of places are working on (a basis of) staff turnover but we need to think of staff to workload in the dispensary. There needs to be adequate dispensary staff to enable adequate staff to customer contact.”

6.2 Resource requirements

In order to facilitate the documentation of clinical interventions the following resources would be needed within pharmacies:

**Additional terminal at point of prescription collection:** The availability of a computer terminal linked to dispensing software at the point of prescription collection would enable some interventions to be entered while counselling. This would save time, encourage documentation as well as support the concept of forward dispensing.

**Training:** Training was considered to be an imperative for the introduction of any scheme to facilitate the documentation of clinical interventions. It was difficult for many to recognise clinical interventions as the process occurred at almost an instinctive level. Training would be needed to assist pharmacists to identify specific components in their dispensing and counselling routines. Pharmacists expressed a preference for both initial face to face and online training. Online case histories were considered to be a good way for pharmacists to learn how to identify and manage drug related problems.

Some early discussions on training speculated that pharmacists may need to up skill’ and achieve a higher certification, enabling them to intervene in drug related problems in a same way that accredited pharmacists are approved to conduct Home Medication Management Reviews. This concept was however
discounted in latter discussions as being counterproductive to increasing the number of clinical interventions because it would have the undesirable effect of increasing the level of complexity of the documentation system. Clinical interventions were conducted by all pharmacists and it was a part of pharmacy practice: to have additional certification to undertake interventions was deemed by most to be inappropriate.

“It might mean you’ve got another computer out the front somewhere that allows you to document interventions in the front of shop rather than in the dispensary”

6.3 Government requirements of a documentation and remuneration system

Participants were asked to contemplate what Government would want in return for documentation payments if remuneration was to be introduced.

**Documentation:** Pharmacies would have to supply documentation records to Government in a similar way to that prescription claims are made now. There was also an expectation this would be an electronic communication over the internet. The information would be sent on the completion of the documentation.

**Ability to conduct audits:** There was agreement that Government would want to have the ability to audit any documented claim for clinical interventions. This was expected as it was equivalent to the current agreements pharmacies had with Government for the supply and reimbursement of Pharmaceutical Benefits.

**Simple system:** Government will require an uncomplicated system to administer, similar to the other reimbursement schemes in place for professional health services.

**Health cost savings and better health care:** Government will want to see either health cost savings or better health care in return for a payment for clinical interventions and data.

“Need to stop those pharmacists who will just put in 50 interventions per day for the money.”

“It’s would be surprising if they don’t (audit)”. 
"When you click on send on recording the intervention, it could send it through PBS online."

6.4 Remuneration structure

All participants asserted that pharmacists have provided counselling and advice on drug related problems without adequate payment. For some, any remuneration would be welcomed.

For many participants, payment for the documentation of clinical interventions was recognition of the professional services pharmacy provided to the community. This was particularly important as PBS prescription gross margins had steadily over eroded the past 10 years so there were fewer funds available to provide professional services.

Added to this there was an increasing focus on prescription volume due to the way pharmacies were paid for dispensed items. Thus remuneration of clinical interventions could change the focus of some pharmacies towards taking a more advisory and clinical role in the community

“If the focus is paid per script then the focus will be on script volume.”

“The Government is going to reduce the margins (on prescriptions) then we will be virtually doing it (dispensing) for not much at all.”

“If you pick up an intervention and you don’t dispense a script at the moment you don’t get paid.”

“Any payment would be good.”

6.4.1 Acceptance of remuneration options

Participants in each group were asked to propose suitable remuneration components for performing and documenting clinical interventions. Once each group had exhausted new suggestions then a number of possible options for remuneration were presented to them and discussed. At the end of this session each participant was asked to score the possible options out of ten for acceptability. The outputs from these discussions and ratings are reported in the following sections. The graphs show the ‘mean acceptability scores’ which are averages across all group participants.
6.4.2 Blended models

a) **Payment for set up and payment per intervention:**

Under this model, payments are made to pharmacies for (i) participating in “the program” with an upfront payment as well as for (ii) documenting each intervention. This model was strongly supported by participants (n=30, mean score 8.9).

The advantages of the model were:

- The upfront payment could pay for training, extra terminals and/or rearrangement of shop layout if required;
- Payments were proportional to any additional effort made to intervene and record, so extra effort was rewarded;
- Payment for documented interventions would encourage pharmacies to increase their intervention activity.

The main disadvantages were:

- The model allowed pharmacies to sign up for the program and receive an upfront fee. However depending on the payment provided by the Government for each documentation this per intervention amount may be insufficient to encourage pharmacies to continue documenting interventions.
- There was no expected performance level that would encourage pharmacists to document more interventions.

“It might mean you’ve got another computer out the front somewhere that allows you to document interventions in the front of shop rather than in the dispensary.”

*There needs to be an aspect of it (remuneration model) that actually promotes interventions.*

“I want to see the more professional pharmacies paid more. So they can employ the staff they need.”

---

Exhibit 3: Acceptance of blended model – set up and intervention payment

<table>
<thead>
<tr>
<th>Acceptance</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>0</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>5</td>
</tr>
<tr>
<td>HIGH</td>
<td>25</td>
</tr>
</tbody>
</table>

N = 30  Mean acceptance score = 8.9
b) **Payment for set up, continued participation and per intervention**

Payment is made to pharmacies for (i) Once off initial payment for set up (ii) a quarterly payment for continued participation based on (achievable) intervention quota and (iii) documenting each intervention.

The development of this model represents an option suggested by one of the focus groups when asked to suggest options for a remuneration model. It was not rated by all participants because the option did not emerge until the third group.

Many participants indicated they would prefer a lower upfront payment if they were to receive regular payments throughout the year for continued participation, measured by monthly or quarterly quotas.

This model’s perceived advantages were:

- Any practice payments would be split between an upfront payment for training and set up (software charges, additional terminals etc) and a quarterly payment for continued participation (based on a *quota* set by the Government). This was in addition to a payment for each documented intervention. If the quotas were achievable it would lessen the chances pharmacies opting in to the program and not documenting.

- Payment for documented interventions would encourage pharmacies to increase intervention activity;

- Missing quarterly payments for underperformance would remind pharmacists to document

“A practice payment every three months acts as a carrot to continue.”

“That there be a quarterly payment that would cover the, you know, the time and the resources to actually manage the whole thing.”

“As long as you are documenting then you get an ongoing practice payment.”

“I do not want people to opt in and not do any documentation. All they have is $600 for the Christmas party.”
“It works against those who want to just pump out prescriptions.”

6.4.3 Payment per intervention

Payment for each documented intervention was supported by many as a fair means of documentation reimbursement.

Those against this model generally scored the blended model with the addition of ongoing participation and upfront payments highly. Thus the issue was not payment per intervention but was a lack of upfront payment and ongoing participation payments.

The advantages of this model were:

- It would stimulate intervention documentation rates (more interventions documented then a greater payment and driver of documentation);
- It was fair to make payments based on the effort taken;
- The model supports the concept that all interventions are important and thus documentation of those interventions should all be remunerated.

However there were disadvantages expressed:

- No reimbursement for any investment in equipment or pharmacy layout changes.

“That would really encourage the practice (of documentation of interventions) throughout the profession”
6.4.4 Payment per percentage of expected health cost savings

Many participants were supportive of sharing any cost savings with the Government but were unable to make suggestions on how this could be implemented.

The concept was thought to be unwieldy for Government to administer. It was also considered to have potential for abuse: less honest pharmacists could classify interventions to maximise their payments. Another problem was that the model may cause pharmacists to focus on the more serious and disregard the less severe interventions. In balance this model was considered neither simple to manage nor working to encourage documentation of all interventions.

The strengths of this model were:

- Large health cost savings in dollar terms would mean payments to pharmacy may also be large;
- Both the Government and pharmacy practice would share in any cost savings so if there were no health cost savings there would be no payments to pharmacy and any savings are shared. Therefore the Government is not paying for poor outcomes.

The weaknesses were:

- Difficult to administer: Health cost savings for all interventions could be hard to set and any possible savings may need to be reassessed frequently;
- Open to abuse: Some pharmacists could try to optimise their income by selecting the more heavily remunerated options.

"A percentage of health cost savings would be good as the savings would be huge. But would it make the system to cumbersome to manage."

"If the focus is on severity that is too much splitting and the focus is then on the more serious interventions when all interventions are important."
Targeted interventions would be good as an add-on.”

“Specific interventions would not work, as people would only do those interventions.”

“We are using the part of Promise which has the pop ups for Nexium 40mg and it is not really doing anything. I think we have had one change of therapy.

We talk to people and it is ‘I can’t drop down, I can’t drop down.”

“I’m not comfortable with it, I’m worried about some pharmacists may feel some interventions aren’t worth their time and they’re just going for the bigger ones.”

6.4.5 Practice incentive for interventions performed during specific times of year

In this model pharmacies would be paid for documented interventions during specific times of the year where Government could drive the focus and type of Interventions covered by the program. Any payments would be in addition to the regular remuneration for the documentation of clinical interventions.

There was no clear pattern of acceptance of this model, with equal numbers rejecting it as there were accepting it. Some respondents clearly preferred a simpler approach where each intervention received equal remuneration. In addition without payment differentiation to pharmacy then there could be no bias in the direction of pharmacy activity.

Some however saw the benefit of specific health initiatives supported by practice incentives as a way to encourage pharmacists to focus on specific interventions. Indeed this was the suggestion made by respondents when considering option 6.4.9 Payment for only significant interventions.

Exhibit 7: Practice incentive for interventions during specific times of year.

n = 30  Mean acceptance level = 6.3
6.4.6 Tiered scale payment dependent on health benefits

This tiered scale model was presented as involving 3 tiers of payment based on possible health benefits. While (9) participants liked the concept, more found it unacceptable (14).

As with the model based on a percentage of cost savings, there were no suggestions on how a tiered payment model could work in practice.

By basing payments on the associated expected health benefits, the model would require a greater level of complexity. Another criticism was that the model may be open to abuse if it was to rely on pharmacists’ classification of interventions.

"Tiered seems fair as it is likely to save the government more money."

Tiered payment system “I don’t think it would work”

“I don’t think it the government would be happy with it. They are more likely to go with a simple approach.”

“I like the tiered scale but I don’t know how it would work.”

“A tiered payment system is open to fraud”

“But the government, will the government accept our judgement call as to what level of intervention we’ve decided on?”

Exhibit 8: Acceptance of a tiered payment system based on health benefits

N = 30  Mean acceptance score = 5.9
6.4.7 Threshold for documentation linked to payment initiation

In this model any payments for documented clinical interventions would commence only once a certain number of interventions had been documented.

The reasoning behind this model was that clinical interventions are a professional responsibility and form part of pharmacists’ normal role. Therefore any payments received should be only for ‘over performance’.

Participants were divided in their support for this model. Overall it received a low acceptance score of 5.7. Some participants were of the opinion that all interventions were important and as such all should be remunerated and there should be no thresholds. Others supported the concept as the model would drive respondents to conduct more clinical interventions and document the outcomes in order to receive documentation payments.

The strength of this model was that it:

- May encourage documentation of interventions if the threshold was relatively low

The weaknesses were that:

- Thresholds may discourage documentation because pharmacists are undertaking an activity for Government without payment until they reach a certain level;
- The number of potential interventions may differ substantially between geographical areas so setting thresholds may disadvantage some pharmacies and advantage others;

“*If you are really good you have pretty much ironed out many of the problems. So the threshold system for small pharmacies that are on top of things may be where they are victims of their own success.*”
6.4.8 Payment per specific/targeted interventions

Many participants (15) had low acceptance of targeted interventions. All interventions were regarded as important, not only interventions associated with specific public health targets such as heart disease and asthma. Many routine interventions were considered critical as they prevented significant complications. The concept of payment only for targeted inventions was rejected as it was seen to be nonsensical to limit payments only to specific interventions.

The strengths of this model were that:

- Allows Government to target specific public health problems to minimise the overall health costs;

The weaknesses identified were that:

- Only the targeted interventions would be documented by pharmacists and therefore there would be less focus on other interventions. Many participants preferred payment for all documented interventions to prevent any imbalance of effort.
- It could disadvantage pharmacies in some areas where the targeted interventions would be rare as an outcome of the demographics of the area. If previous work had been successfully conducted by pharmacy staff to manage drug related problems, again there would be minimal need to conduct interventions in the specific health care issue;
- Targeting specific interventions would not force pharmacy to document all interventions; other documentation could become a forgotten task. If all interventions are documented then it becomes part of the dispensing process.

This model was preferred to be used an additional payment for specific interventions at various times of the year dependent on Government health strategies. Most thought that this option could be used very effectively with overall public health care initiatives as it would be better than handing out brochures, having diabetes or asthma booths erected in the pharmacy for patients as it much more proactive approach.

<table>
<thead>
<tr>
<th>Acceptance</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>15</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>9</td>
</tr>
<tr>
<td>HIGH</td>
<td>6</td>
</tr>
</tbody>
</table>

Exhibit 10: Acceptance of payment for specific targeted interventions

N = 30    Mean acceptance score = 5.2
“They (pharmacists) would only pick and choose, if only the important ones are remunerated. It discourages intervening in the smaller interventions where all interventions are important.”

“Documentation has to be all the time it can’t be for a few months of the year as you won’t remember it.”

“And you want to get people doing the whole thing properly, and even if they do a few, it’ll build, whereas if you’re targeting such a small area, it’ll just stay in a rut.”

6.4.9 Payment for only significant interventions

This model involves payment only for interventions with a greater than certain health cost savings. This model was viewed to be similar to the previous model which targeted specific interventions. This model was unacceptable to most participants (22) as a stand alone option. The reason for this was that all interventions were important therefore all documentation should be reimbursed. This model could however be used in addition to a remuneration per documented intervention model for issues selected by the Government. Significant health savings could be made with an intensive effort by community pharmacy.

The strengths were:

- It could be used at certain times of the year as in addition to regular intervention remuneration to focus effort on particular public health issues;
- Government may receive the best return on investment from funding such a system.

The disadvantages were:

- It would be difficult for Government to manage the system as it requires a regular assessment of the health costs for broad classifications of interventions;

Exhibit 11: Acceptance of payment for only significant interventions

N = 30  Mean acceptance level = 4.0
Pharmacists may only document those interventions which may be funded. Any payment model which was not inclusive of remuneration for all interventions would require pharmacists to make a decision on whether to document.

Pharmacists need to include documentation of interventions into their normal dispensing practice: selective documentation does not reinforce documentation into routine pharmacy practice.
6.4.10 Payment options in summary

The blended models, where documentation payments for set up and per intervention (with or without participation payments (mean = 8.9 and 8.5 respectively)) had the highest acceptance for the participants.

Payments for each intervention (mean = 7.7) was the next most acceptable option.

The remaining payment options were less acceptable to participants.
6.4.11 Options considered but largely rejected or with no conclusion

Several remuneration options were considered but were eventually rejected during the focus groups.

] **Time based payments**: were discussed by all groups. The results were:

- The consensus was that a payment procedure based on the time spent to intervene and document was too difficult to administer;
- Some pharmacists may take a long time on a specific intervention and others may be quicker if presented with the same drug related issue;
- There was no consensus on timing method as often pharmacists only completed full documentation at the end of the day or when they were not busy;
- If signatures were required from patients to verify clinical interventions then the time taken would increase. Gaining patient signatures would be a significant problem in residential aged care facilities when signatures are difficult to obtain;
- In addition if pharmacists were left to indicate how long an intervention and documentation took to complete the participants considered this could introduce abuse potential as well as issues around accuracy and units of measurement

“So I guess it would be good, but how can you be honest, we’d all be clicking on (the) 20 minutes (button).”

“Sometimes an intervention may take half an hour so maybe we could have short and long interventions. But it may take one pharmacist longer to do the intervention than others (pharmacists). So that means we should be paying for each documentation.”

] **Payment per prescription**: Some groups discussed a set fee for each prescription. The conclusions were that this represented the status quo and it did not encourage documentation of clinical interventions. A new system should stimulate and remunerate the activity of clinical interventions.

] **Pharmacy opt-in scheme**: Discussions of whether all pharmacies should be included in a remuneration scheme for documentation of clinical interventions were dominated by two main arguments
o For - There were those who thought that if owners wanted to run a discount pharmacy business with a focus on prescription throughput, then these owners should not have to document clinical interventions.

o Against - Others reasoned that as clinical interventions were part of pharmacy practice all pharmacies should document their clinical interventions. It is a core activity of good professional practice. To do otherwise was to create a two-tier community pharmacy system: an unhealthy development for the pharmacy profession.

“I don’t like the idea of getting a varied scale of pharmacies, Australia has always been a place of a proud history of providing quality if you are city or bush, or whether it is north south or east west. Once you start doing these things as having some pharmacies are doing this and some are quality care and some pharmacies aren’t…. the only way you are going to get the Government interested if it is done as an industry or profession.”

“It should not be a negotiated thing.”

“It is core business for us.”

“We’ve been poor recorders of our clinical interventions within the pharmacy, I mean we’ve never really done it, so the fact that we need to record it and show that we’re doing it and be remunerated for it is important. I think that’s going to differentiate pharmacies in the future as to whether you’re just a supply pharmacy helping out low cost PBS items or whether you’re actually providing additional clinical value.”

6.5 Payment options for intervention documentation

6.5.1 Payment levels for documentation

Participants were asked if various payment levels for interventions were considered acceptable. Often these discussions centred around what would be fair and
reasonable for Government and community pharmacy. Most thought it was time for pharmacy to receive some recognition for the counselling and advice currently provided for no payment.

Not surprisingly there was a direct relationship between the overall acceptance score and increased levels of remuneration.

However most pharmacists were aware there was an advice and counselling component in the current PBS mark up Thus remuneration discussions often reverted to debate on a potential drop in the PBS mark up in future Pharmacy Agreements and the level of funds received from Government. There was strong feeling that any documentation payments should exceed any loss suffered in a diminished mark up. So if Government was to drop a fee per prescription in favour of a fee for service model any overall reduction in remuneration should be more than offset with remuneration for documentation as now pharmacists were not only providing advice and counselling but documenting it as well. Participants were clear that they did not want to continue to provide services for inadequate remuneration.

“There is no way anyone does work for nothing and it is taking us time…we want to do the right thing by the community and the Government. I really believe that these things are going to be the things that make pharmacy relevant to the community. But there is no way we can do things under cost as we have been doing it for such a long time with dosettes and all that community based stuff… We used to be able to do it when we had fat in the system but we don’t have that fat anymore and even doing it as cost it not possible to run all the things the Government wants us to run so it is not possible at cost.”

“At a minimum there has to be an incentive so it has to be something that gives us a margin of greater than 10%”

“The kindness is going out of pharmacy as there is no fat to supply other services.”
“It is not greedy it is very reasonable.”

“The payments need to be structured so with any reduction of mark up, overall the intervention payment will still be attractive.

“And that (the current gross margin) is where some of the funding will come from, and so it will be that will move us potentially from just doing supply and being paid purely on supply. This will be the sort of system where you are paid for your interventions. So for your big budget pharmacies, who just want to do supply then they will get a lower dispensing fee but the pharmacies who are actually putting the time and effort into services are going to be remunerated through interventions.”

6.5.2 Frequency of payment

There was a preference for either weekly or monthly (mean scores = 8.9 & 7.4 respectively) payments for the documentation of clinical interventions. All thought a payment process could easily work with PBS prescription payments where payments are made to pharmacies for PBS supply every 7 to 14 days.

“It would be nice to be paid every week …like they do with the scripts.”

“I want to see the more professional pharmacies paid more so they can employ the staff they need.”
6.5.3 Levels of practice payments

Practice payments can be paid to pharmacies either as stand alone remuneration for documentation or in addition to any fee for service model.

As with the payment levels for documentation in 6.5.1 there was a direct relationship between the magnitude of the practice payment and the level of acceptance by participants. While this was the case on overall acceptance, the data collected indicated that there was minimal acceptance difference between a $4000 practice payment and an $8000 payment (See Exhibit 16: Acceptance of various practice payments). This indicates that a total practice payment of around $4000 may be acceptable to pharmacists based on this small sample.

Practice payments can also be split into an upfront component and an ongoing payment subject to ongoing participation based on achievement of a set quota. (See section 6.4.2).

The feedback from the groups indicated an upfront payment of around $2000 to $3000 with an ongoing payment of $2000 (split quarterly) for ongoing participation would be acceptable to pharmacists.
Exhibit 16: Acceptance of various practice payments

- **Practice payment of $500**
  - LOW: 29
  - MEDIUM: 1
  - HIGH: 0

- **Practice payment of $1000**
  - LOW: 15, 14
  - MEDIUM: 1
  - HIGH: 1

- **Practice payment of $2000**
  - LOW: 5
  - MEDIUM: 14
  - HIGH: 11

- **Practice payment of $4000**
  - LOW: 1
  - MEDIUM: 6
  - HIGH: 23

- **Practice payment of $8000**
  - LOW: 3
  - MEDIUM: 6
  - HIGH: 21
6.6 Additional features of a documentation system

Respondents were asked to consider possible incentives which could ensure high uptake and ongoing participation to facilitate the national adoption of the clinical intervention documentation process. Scoring on acceptance was completed on each option at the end of the discussion. The results are included graphically (where appropriate) to the right of each section.

6.6.1 Drive education direction

There was very strong support for aggregated documentation data to be used to drive the direction taken by professional education (mean score 9.3). It was thought that the National Prescribing Service and Pharmaceutical Society of Australia could use the data to address any gaps in profession education.

Another benefit would be having some coordination with pharmacy and medical professional education.

“Driving education is good.”

“I really like that idea of bringing it all together…having pharmacists and doctors on the same page regarding education.”

“With education, it is all about health outcomes and that is really important.”

Exhibit 17: Acceptance of data to drive professional education

N = 30   Mean acceptance score = 9.3
6.6.2 Reports for pharmacy re-registration

Some participants argued that any process to remunerate pharmacists for clinical interventions would require incentives for employee pharmacists if the process was to be fully embraced.

A report that could be used to assist pharmacists to re-register each year was supported by the majority of group participants. This capability, if available, should motivate employee pharmacists to consider documenting clinical interventions performed while dispensing. Otherwise, aside from professional satisfaction and a professional shop culture, there was little to entice employee pharmacists to document their clinical interventions.

“I think it helps from the Government’s point of view that if everyone needs this to reregister then it gives the perception of high quality practice.”

Exhibit 18: Acceptance of reports for pharmacist re-registration

<table>
<thead>
<tr>
<th>Acceptance</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>3</td>
</tr>
<tr>
<td>Medium</td>
<td>8</td>
</tr>
<tr>
<td>High</td>
<td>19</td>
</tr>
</tbody>
</table>

N = 30  Mean acceptance score = 8.2
6.6.3 Quality Care Practice Program (QCPP) points

Providing a high level of professional services (such as clinical interventions) within pharmacies was compatible with the Quality Care Practice Program. Many participants argued that recognition of the documentation of interventions should be included in the assessment of pharmacies for QCPP.

Not all pharmacies participate in the QCPP and this could account for some of the low acceptance scores.

---

**Exhibit 19: Acceptance of intervention reports used for QCPP accreditation**

- **Count**
  - LOW: 2
  - MEDIUM: 9
  - HIGH: 19

**N = 30**  Mean acceptance score = 6.9
6.7 Ongoing resource support

When time permitted at the end of each group, participants were asked what they would need as ongoing support if a remuneration system were established. A collection of the findings were:

- **Training** – education, available online was considered a good means of training pharmacists on clinical interventions. Case histories with how the consumer presented, the intervention carried out, any outcome, its classification were valuable resources for pharmacists learning to document clinical interventions.

- **Feedback information** –
  - **Benchmarking** - The ability to benchmark against other pharmacies was a way to see how other pharmacies were performing with respect to clinical interventions.
  - **Newsletters** – Newsletters should contain case histories of interventions and the possible cost savings gained. They could also contain sample interventions on which a pharmacy could focus on for the next month. This information could also be made available online.
  - **Payment reports** – A summary of the payment reports could have the pharmacies intervention rate listed against the national figure. This could also be available on the dispensing screen or when the dispensing software was opened each morning.

- **Pop ups linked to public health initiatives** – It would be useful for pop ups to be coordinated with public health initiatives where possible.

- **Intervention flow diagram** – The intervention flow diagram developed for Promise III was very useful in guiding pharmacists through the intervention steps.

- **Same as Promise III** – “What the Promise guys have been doing is good.”

Re newsletters: “They could have a section on an intervention that you could focus on for the following week.”

“It is important to know how you are going in relation to others.”
7 APPENDICES

7.1 Appendix A - Discussion Guide - Focus Group – Managers and Pharmacy Owners

PROMISe III
Focus Group – Managers and Pharmacy Owners
Discussion Guide

Introduction

Thank you: Thank the respondents for attending the focus group.

Explain the reason for using a group discussion.

“Often data is collected by questionnaire or one to one discussions. However in this case this discussion is being used to better understand something where you may share ideas. A group has other advantages as it can generate interesting, unexpected and insightful opinions that will be very helpful to this research.

Purpose of research: Explain the purpose of the research:

As they will know the aim of PROMISe III is to develop a community pharmacy medication incident and reporting system that will encourage the documentation of clinical interventions.

You have been invited here tonight as you all have experiences and views that will enable us to achieve our objectives.

Purpose of the Focus Group: Explain that tonight we are going to:

• Gather your thoughts on the barriers and facilitators in conducting and documenting clinical interventions based on your experience over the past few weeks;

• Develop an acceptable remuneration model where pharmacists will be encouraged to undertake and document clinical interventions;

• Better understand the likelihood that pharmacies will identify and undertake more clinical interventions with a national rollout of the software including what could be facilitators.

Confidentiality and anonymity: (VIC and NSW) Explain that this session will be videoed and recorded but this is for our research purposes only. The tapes will be destroyed once the final report has been
completed and any personal information will be kept private and not revealed to anyone not directly involved in the market research project.

**Observation:** Reassure participants that there is no one observing the group from behind the one way mirror.

**Explain moderator role:**

“My role is to help guide the discussion so that we cover the topics of interest, but overall I intend to play a minor role and instead listen to your responses as you talk to one another, so please don’t feel as you need my permission to speak. If you want to respond to someone’s comments go right ahead. Of if you want to ask some questions or query someone. You don’t have to talk to me. Just direct your comment to the person you are interested in talking to.”

1. **Respondent Background (Brief):**
   Ask the respondents to introduce themselves and provide some background information re:
   - Their first name;
   - Background in community pharmacy;
   - Current pharmacies worked and number of staff.

2. **Trial feedback (Brief):**
   Encourage respondents to briefly discuss their experiences with the trial thus far from the perspective of any difficulties with identification or documentation of clinical interventions.

   [Note: Designed to get any issues with the trial/software from participants and remind them of one of the main objectives being the facilitation of clinical interventions before we move to remuneration discussions.]

   **2.1 Specific Barriers (Brief)***
   - What have they found to be barriers to documentation;
   - Workflow changes/ issues
     - Remembering to document
     - If and how they overcame any barriers;
   - Comments on the functionality of the documentation software.
   - Ease of use
2.2 Facilitators (Brief):

Remind respondents that in Promise III one goal was to develop a system that would increase the number of documented clinical interventions.

Encourage respondents to think of ways how clinical interventions and documentation could be increased within their pharmacy. [Here the expectation is for respondents to suggest a remuneration package for clinical interventions]

] Unprompted: Specifically what would enable them to increase the number of clinical interventions?

] Prompted: if not covered consider:

- Remuneration (a given);
- Pop ups on possible drug related problems (rotated or linked to specific times of year)
- Influence of a practice payment for pharmacies to participate in the scheme;
- Software functionality improvements;
- Communication with GPs (direct comms with GPs so recommendation is acted on);
- Feedback of pharmacy performance with clinical interventions;

3. Remuneration and perceived Government expectations

Explain that any system where money is paid there is often a requirement on the recipient to provide something in return.

Explore participants’ thoughts on the perceived expectations of Government if clinical interventions were funded

] Unprompted – Specifically what components of a remuneration system would the government want in return if pharmacy clinical interventions were remunerated?

Then,

] Prompted:

Evidence of intervention through documentation to justify payment;
Right to audit documentation.
Communication of intervention data for analysis;
Health care cost savings (given);
Better patient health;
4. Components of Remuneration Models

Based on the background above, ask the group to suggest some remuneration model components which they would find acceptable in a remuneration package.

[Note: remind participants that models should an increase in the identification of clinical interventions, and ongoing documentation will be the major outputs]

] Unprompted

[Encourage suggestions for participants and write on white board]

] Prompted

Explain that the Promise III team and the Guild have come up with some suggestions and that we would like to have their comment.

Show the attributes (displayed for all in group to see) on Table 1 and encourage respondents to discuss each.

5. Detection of opinion difference

5.1 Attribute or component scoring

Provide each respondent with a prepared scoring sheet

IF ANY MODELS OR COMPONENTS FORMULATED BY THE GROUP ARE NOT INCLUDED ON THE SCORE SHEETS HAVE GROUP MEMBERS ADD THE ADDITIONAL COMPONENT/MODEL TO THE BOTTOM OF THE SHEET SO IT CAN BE RATED.

Ask each work on their own and to give a score out of ten to illustrate the ACCEPTABILITY to each of the items where 10 means a high score, 0 is a low score and 5 means neutral.

5.2 Sharing of scores

On some butchers paper previously prepared record the scores for each respondent. Have the group discuss any large difference in scores and reasons why.

6. Summary: models for remuneration of clinical interventions

6.1 Summary:

Have the group conclude with their preferred options for remuneration of clinical interventions. [List on butcher’s paper] Aim to reach a list of preferred options which are acceptable to the group.
6.2 Discussion:

Determine if the ‘acceptable’ models for remuneration are likely to meet the following criteria:

(1) Encourage pharmacists to identify more clinical interventions?
(2) Encourage documentation?
(3) Assist in the national acceptance of a clinical intervention system?

Thank the respondents for their participation.

Terminate the group.

Pay voucher incentives and have respondents sign their receipt.
Table 1

Mode of payment

1. **Payment per intervention** – fee for each intervention documented

2. **Payment per specific/targeted interventions** (e.g. asthma, heart disease decided by Government)

3. **Payment per percentage of expected health cost savings** – Payments calculated based on the intervention classification and expected cost savings to health system

4. **Blended model**: Payment to pharmacies (i) for participating in “the program” as well as (ii) documenting each intervention. I.e. a payment for participation as well as a fee for intervention model

5. **Tiered scale of payment** for interventions depending on overall health benefits for different tiers of interventions ($ and health outcomes).

---

1. **Payment initiation linked to number of interventions**: once a certain number of interventions have been documented, payments commence.

2. **Minimum # of interventions linked to QCPP accreditation** (Quality Control Practice program). Pharmacy receives a performance tick once a certain number of interventions are documented.

3. **Threshold for only significant interventions**: Payment for only those interventions with greater than certain health cost savings

4. **Practice incentive** for interventions performed during specific times of year (may have prompt “pop up” in system) Asthma week, diabetes week, etc

---

**Shared** - Information is shared with Medicare and/or DoHA (online)

**Reports for re-registration or QCPP** - Pharmacists can prepare reports on clinical interventions from website

**Comparative reports** - Pharmacists can compare own pharmacy’s clinical intervention rate to others by grouped locations. E.g. State, postcode

**Education input** – Data received from interventions is pooled and drives educational direction eg PSA or NPS use data to target specific areas of GP and/or pharmacy education.

**Comparative reports** - Pharmacists can compare own pharmacy’s clinical intervention rate to others by grouped locations. E.g. State, postcode

**Education input** – Data received from interventions is pooled and drives educational direction eg PSA or NPS use data to target specific areas of GP and/or pharmacy education.
### Sheet 1 - Clinical interventions – Method of remuneration

Please score each out of 10 where 0 is a low score of ACCEPTABILITY and 10 is a high score

<table>
<thead>
<tr>
<th>Option</th>
<th>Component</th>
<th>Score out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Payment per intervention – fee for each intervention documented</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Payment per specific/targeted interventions (e.g. asthma, heart disease decided by Government)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Payment per percentage of expected health cost savings – Payments calculated based on the intervention classification and expected cost savings to health system (fees developed by health economists etc)</td>
<td></td>
</tr>
</tbody>
</table>
| 4      | Blended model: Payment to pharmacies for  
|        | (i) participating in “the program” as well as  
|        | (ii) documenting each intervention.  
I.e. a payment for participation as well as a fee for intervention model |                 |
| 5      | Tiered scale of payment for interventions depending on overall health benefits ($ and health outcomes). |                 |
| 6      | Blended model (version 2): Payment to pharmacies for  
|        | (i) Once off initial payment for set up  
|        | (ii) Quarterly payment for continued participation based on (achievable) intervention quota,  
|        | (iii) documenting each intervention |                 |
Sheet 2 - Clinical interventions – Payment options

Please score each out of 10 where 0 is a low score of ACCEPTABILITY and 10 is a high score

<table>
<thead>
<tr>
<th>Option</th>
<th>Additional Component</th>
<th>Score out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Payment for documented intervention is at less than cost</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Payment for documented intervention at cost (around $5 to $7 for a 10 min intervention)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Payment for documented intervention at cost plus 10%</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Payment for documented intervention at cost plus more than 10%</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Payment weekly – Payment for interventions weekly</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Payment Monthly - Payment for interventions is monthly</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Payment Quarterly - Payment for interventions is quarterly</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Payment Greater than quarterly - Payment for interventions is greater than quarterly</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Practice payment of $500</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Practice payment of $1000</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Practice payment of $2000</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Practice payment of $4000</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Practice payment of $8000</td>
<td></td>
</tr>
</tbody>
</table>
# Sheet 3 - Clinical interventions – Additional features

Please score each out of 10 where 0 is a low score of ACCEPTABILITY and 10 is a high score

<table>
<thead>
<tr>
<th>Option</th>
<th>Additional Component</th>
<th>Score out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Threshold for interventions linked to payment initiation</strong>: once a certain number of interventions have been conducted and documented payments commence. Reasoning clinical interventions are a professional responsibility and payment is for over performance.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Threshold for interventions linked to QCPP</strong> (Quality Care Practice program). Pharmacy receives a performance tick once a certain number of interventions are documented.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Threshold for only significant interventions</strong>: Payment for only those interventions with greater than certain health cost savings</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Practice incentive</strong> for interventions performed during specific times of year (may have prompt 'pop up' in system) Asthma week, NPS programs, etc</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Sheet 4 - Clinical interventions – Additional features

Please score each out of 10 where 0 is a low score of ACCEPTABILITY and 10 is a high score

<table>
<thead>
<tr>
<th>Option</th>
<th>Additional Component</th>
<th>Score out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Reports for re-registration</strong> - Pharmacists can prepare reports on clinical interventions from website that can be used for Pharmacy re-registration</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>Reports for QCPP</strong> - Pharmacists can prepare reports on their clinical interventions from website that can be used for Pharmacy QCPP accreditation and payment</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Comparative reports</strong> - Pharmacists can compare own pharmacy's clinical intervention rate to other pharmacies by grouped locations. E.g. State, postcode</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>Education input</strong> – Data received from interventions is pooled and drives educational direction eg PSA or NPS use data to target specific areas of GP and/or pharmacy education.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>