Final Report on the Evaluation of the
Quality Care Pharmacy Program*

February 2005

*An industry-specific quality assurance program developed by the Pharmacy Guild of Australia
with the assistance of other industry stakeholders

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Foreword

A Quality and Standards accreditation scheme should have the same commitment to evaluation and improvement of itself as it recommends to its target market.

The Pharmacy Guild of Australia (PGoA) and its partner in the development of the Quality Care Pharmacy Program (QCPP), the Pharmaceutical Society of Australia (PSA), are committed to ensure that this program remains at the forefront of pharmacy quality initiatives worldwide and have demonstrated this by the commissioning of this independent evaluation. The PGoA and the PSA welcome the positive findings of the report, and will seek opportunities to implement as many of the recommendations as possible. The evaluation was funded by the Australian Government Department of Health and Ageing as part of the Third Community Pharmacy Agreement Research and Development Grants Program.

The QCPP Division is committed to delivering a program that is robust, yet user-friendly, that enables pharmacy owners to operate safely, efficiently and economically viable while delivering cost-effective, quality health outcomes to their customers. QCPP has indeed, had a significant positive impact on community pharmacies and the service they provide to their customers, and will continue to be responsive to these needs. The recommendations of this evaluation will inform the QCPP review, which is the next stage of program improvement.

Many people involved with the profession of pharmacy have contributed to the development of the QCPP. It would perhaps be timely for me to acknowledge some individuals who were instrumental to the progress of the program to date, such as Kos Sclavos, Jay Hooper, John Bronger and Graham Bridge.

Finally, I would like to acknowledge the efforts of the evaluation team that has culminated in this comprehensive report, and the assistance provided to them by the Director and staff of the QCPP Division.

Tim Logan

Chair, QCPP Division, Pharmacy Guild of Australia
Community Pharmacist & proud owner of a QCP-accredited pharmacy
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### 16. Appendix J: Standards Relating to QUM and Outcome and Economic Benefit

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# Glossary of Names and Terms

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<th>A</th>
<th>Australian College of Pharmacy Practice &amp; Management Ltd</th>
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<tbody>
<tr>
<td>AIPM</td>
<td>Australian Institute of Pharmacy Management Ltd</td>
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<td>APP</td>
<td>Australian Pharmacy Professional Conference</td>
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<tr>
<td>BAS</td>
<td>Business Activity Statement</td>
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<td>C</td>
<td>Continuing professional education</td>
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<td>CPE</td>
<td>CPE Continuing professional education</td>
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<td>CQI</td>
<td>Continuous quality improvement</td>
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<td>D</td>
<td>Dose administration aid</td>
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<td>DAA</td>
<td>DAA Dose administration aid</td>
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<td>DMMR</td>
<td>DMMR Domiciliary medication management review</td>
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<td>DSM</td>
<td>DSM Disease state management</td>
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<td>G</td>
<td>General linear model</td>
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<td>GP</td>
<td>GP General Practitioners</td>
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<td>H</td>
<td>Health Insurance Commission</td>
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<td>MMR</td>
<td>MMR Medication management review</td>
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<td>P</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PhARIA</td>
<td>PhARIA Pharmacy remoteness accessibility index of Australia</td>
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<td>POM</td>
<td>POM Pharmacist/pharmacy only medicines</td>
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<td>PSA</td>
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<td>QA</td>
<td>Quality assurance</td>
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<td>Q</td>
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<td>QCPP</td>
<td>Quality Care Pharmacy Program</td>
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<td>QCPSC</td>
<td>Quality Care Pharmacy Program Support Centre</td>
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<tr>
<td>QUM</td>
<td>QUM Quality use of medicines</td>
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<td>SMA</td>
<td>Standards maintenance assessment</td>
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<td>SOP</td>
<td>SOP Standard operating procedure/s</td>
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<td>T</td>
<td>Total quality management</td>
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<td>TQM</td>
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<td>U</td>
<td>Universal resource locator</td>
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ABBREVIATIONS USED IN STANDARDS NAMES

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ACC</td>
<td>Consumer access</td>
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<tr>
<td>APP</td>
<td>Pharmacy image and appearance</td>
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<tr>
<td>BUB</td>
<td>Building up business</td>
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<tr>
<td>CFP</td>
<td>Cash flow and profit</td>
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<tr>
<td>COL</td>
<td>Maintaining the cold chain</td>
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<tr>
<td>MTP</td>
<td>Managing the pharmacy</td>
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<tr>
<td>PDE</td>
<td>Pharmacy design and environment</td>
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<td>POP</td>
<td>Pharmacist-Only and Pharmacy medicines</td>
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<td>PPS</td>
<td>Professional Practice Standards</td>
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<td>SAF</td>
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<td>SER</td>
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<td>Security</td>
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<td>STA</td>
<td>Staffing and staff performance</td>
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<td>STO</td>
<td>Making stock easy to purchase</td>
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PREFACE

This is the Final Report of the project ‘Evaluation of the QCP Program’. This Report is provided as required by the Deed of Grant between the Pharmacy Guild of Australia and the Australian Institute of Pharmacy Management Limited (now the Australian College of Pharmacy Practice and Management Limited), (the Service Provider). The Australian Institute of Pharmacy Management has, in turn, subcontracted the services of Quality Medication Care Pty Ltd, which, in its turn conducts collaborative studies with staff at the University of Queensland.

This Report deals with the data collected over the three years of the project. Data not previously covered in the Interim Reports and relied on in this Final Report is presented in detail in the appendices. Data presented in detail in the interim reports (2002 and 2003) is presented in a more condensed format in Chapter 4.

Whist the essence of the Report is to be found in the Executive Summary and Recommendations, a clearer understanding of the issues will be facilitated by considering Chapters 3 and 5, referring where necessary to the data in Chapter 4 and the appendices.

We acknowledge the valued assistance of the consortium associates in carrying out the quite complex tasks associated with this Evaluation: Mr David Wright, Dr John Aloizos AM, Mr Tony Wade, Mr Bruce Annabel, Mr Frank Sirianni Dr Elaine Beller and Mr Malcolm Mearns.

The principal researchers also acknowledge the work done by Dr Julie Stokes in the project overall, but specifically in the areas of data design and management, analysis and integration.

We further acknowledge the dedication and efforts of the key individuals prominent in these first years of the program, specifically:

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Canberra and Brisbane
February 2005
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RECOMMENDATIONS IN BRIEF

1. QCPP should be continued as the pivotal quality program in Australian community pharmacy.

2. The program should retain the focus on improving functional and technical quality in community pharmacy and the teamwork approach to implementation in pharmacies.

3. The program should continue in its efforts to assist government policy which facilitates improved consumer outcomes such as the QUM policy.

4. Progress made to date in the integration of practice and business management standards should be acknowledged and built upon.

5. The case for an efficient business platform based in CQI should be actively promoted to pharmacy.

6. Consideration should be given to the establishment of centralised data collection protocols and processes for pharmacy to measure performance within a pharmacy and across the QCP program.

7. Whilst overall management of the program implementation has been well conducted, future implementation needs to be more flexible and diversified.

8. The program needs to maintain its ‘can do’ philosophy and style and, in turn, instil this into pharmacies.

9. The QCPP Division should be more adequately resourced.

10. A charter defining visions and values for the program, the sought-after benefits for the community, for pharmacy and addressing stakeholder needs should be developed by pharmacy peak bodies.

11. Governance of QCPP should move progressively towards a more inclusive model to manage and oversee the program.

12. A strategic plan should be developed with stakeholder input to move to a program focused on and responding to desired outcomes and the wider environment.

13. The program structure, content and processes need to be further developed to build in CQI and to meet the developing needs of pharmacies and other stakeholders recognising pharmacies’ capacity to implement change.

14. The introduction of CQI to the program structure, content and processes should be gradual and supported by appropriate resources.
15. The operational development of QCPP should also be more CQI based. The Division should seek external accreditation of QCPP from an appropriate body such as ISQua, and should also implement more comprehensive quality monitoring of its own processes and the performance of the pharmacies in the program.

16. The structure and content of the standards should be revised.

17. The assessment process should be revised.

18. There should be a major consumer campaign promoting the program and the improved consumer satisfaction with accredited pharmacies.

19. A future assessment of QCPP should re-examine its cost-effectiveness in relation to pharmacy productivity, health outcomes and government outlays as the program matures.

20. Financial incentives for pharmacies should be retained to meet the costs of maintaining the program where these incentives are structured so as to incentivise quality improvement and disincentivise its absence.
EXECUTIVE SUMMARY

The Quality Care Pharmacy Program (QCPP) was established in 1998 and is a ‘quality assurance’1 self-regulation program for Australian community pharmacy that consists of an integrated system of performance standards, supporting tools and processes. The program process is one of accreditation by independent assessors against the performance standards.

This report arises from an evaluation of QCPP commissioned as part of the Third Community Pharmacy Agreement through the Third Community Pharmacy Agreement Research and Development Grants (CPA R&D Grants) Program managed by the Pharmacy Guild of Australia.

AIM OF THE EVALUATION

The overall aim of this evaluation was to measure how QCPP impacted on community pharmacy, consumers, other health professionals and government.

The report addresses the following specific issues related to this aim:

Design and implementation issues
- How well the program objectives were met. This required consideration of:
  - The conceptual underpinnings of the program.
  - The vision of the program derived from these underpinnings and used to market the program to participants and stakeholders.
  - The extent to which the program is one of quality assurance (QA)1 or continuous quality improvement (CQI)2.
- A comparison between QCPP and similar quality programs in the health including issues of program governance.
- How QCPP supports the Quality Use of Medicines (QUM) policy.
- Measuring and monitoring quality in community pharmacy.
- Quality and monitoring of the QCPP program.

Process measures
- What worked and may not have worked in relation to initial roll out.
- What is working well now and what could be improved.
- Whether there are any gaps in program material and resources or in the standards.
- Whether the assessment process, the self assessment process and the period for re-accreditation are in need of review.
- Whether the QCPP objectives for implementation were met.

---

1 Quality assurance is generally achieved by accreditation, defined as ‘a public recognition by a national healthcare accreditation body of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation’s level of performance in relation to the standards (Shaw, 2004)

2 Continuous quality improvement has been defined as ‘ongoing response to quality assessment data about a service in ways that improve the processes by which services are provided to clients’ (International Society for Quality in Health Care, 2004). The emphasis is therefore on both measurement of service efficacy and then responding to perceived deficiencies.
The objectives for QCPP relating to implementation were to:
- Encourage all pharmacies to become accredited through the program.
- Encourage the maintenance of standards and continuous improvement of quality of care in accredited pharmacies as specified through the QCPP standards.
- Encourage accredited pharmacies to maintain their quality care and practice standards through re-accreditation processes.
- Reward and acknowledge community pharmacies that rapidly seek and then attain accredited status as well as those that have already attained accreditation.

Outcome measures
- Improvement in the level of community pharmacy services (professional and management).
- Improvement in consumer satisfaction with services.
- Improvement in health outcomes as a result of improved services.
- Benefits to the proprietor in terms of business efficiency and profitability.
- Benefits to the government in relation to Pharmaceutical Benefits Scheme (PBS) costs and total health budget outlays.
- Improvements in QUM.

APPROACH
The evaluation was designed to encompass a literature review and an evaluation of secondary source data e.g. QCPP administrative files and material, as well as process and outcome evaluations, recognising the various stakeholder perspectives (Figure 1). The overall study design was approved by an overarching Expert Advisory Group (involving major organisational stakeholders), the Princess Alexandra Hospital Research Ethics Committee and the University of Queensland’s Human Ethics Committee - as were individual data collection instruments (including information and consent forms) used in each phase of the evaluation.

Figure 1 Scope of evaluation
The overall evaluation involved:

- An examination of the files from the QCPP Division of the Pharmacy Guild of Australia
- Interviews with major stakeholders including representatives of the Department of Health and Aged Care, the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia
- A review of relevant pharmacy, health, quality and business literature
- A census of community pharmacy yielding 4085 usable responses from 4859 Australian pharmacies in 2002
- Focus groups with 36 pharmacists and other stakeholders in 2002
- 517 usable responses from 1183 (43.7%) pharmacy surveys (proprietor/manager) and 1372 usable responses from 4612 (30%) pharmacy staff surveys
- An administrative audit of accredited pharmacy files (notional sample size 300 randomly selected pharmacies with 75 each in the early, middle, late and last groups. Timing issues meant that pharmacies in the late and last groups were underrepresented with 45 and 16 pharmacies in each group for a total of 202 pharmacies)
- Survey of 2732 consumers yielding 1902 usable responses (69.62%)
- Focus groups with 16 community pharmacists and 20 QCPP assessors in 2003
- Survey of 743 general practitioners yielding 193 usable responses (26%)
- An analysis of Standards Maintenance Assessment data from 293 pharmacies
- Assessor reports on performance in 80 pharmacies at time of reaccreditation
- An second audit of QCPP Division records including electronic records of 1750 assessments between October 2003 and September 2004, lapsed accreditations and the self-assessment reports from 30 randomly-selected pharmacies
- 113 usable pharmacy financial surveys from a sample of 1183 pharmacies
- A synthesis and interpretation of findings.

RESULTS FROM DATA COLLECTED

QCPP has had an overall positive effect on some areas of community pharmacy performance over the six and a half years since its introduction. Almost 4300 pharmacies have been accredited against the QCPP minimum standards. Many, however, have only recently been accredited so that the overall impact of the program cannot be fully appreciated at this time. Further, implementing systems to meet standards across all practice areas is likely to have a diffuse effect so that higher order outcomes are likely to be delayed.

**Form of program:** The original QCPP concept was to improve the quality of retail service in community pharmacy but was later extended to incorporate standards for professional pharmacy services. The focus on professional standards and consequent impact on health outcomes is now the dominant theme, with the retail service and business management standards acting to underpin the professional service delivery platform. The program was based on specified standards being reached through quality assurance based on accreditation in a self-regulatory environment. Consistent with the program evolving over time, an ‘introductory’ CQI component was added.

**Uptake:** Ninety-eight percent of pharmacies are registered for the program with 4242 (86%) accredited as at 15 December 2004 (down from 88% as at 29 October 2004). Enthusiasm to attain accreditation has been driven by different incentives for different pharmacies with the early adopters being motivated by internal pharmacy culture...
issues which allowed them to more easily discern the business and professional opportunities offered by the program and the mid, late and last adopters apparently progressively more driven by financial incentives and a ‘threat’ mentality.

**Program materials:** The program materials overall were judged useful and appropriate by pharmacists, with some reservations about the volume of material, though this reflected more of a lack of understanding of quality programs rather than a deficit of this program.

**Promotion:** Pharmacies were encouraged to attain and maintain accreditation by various means (e.g. self-assessment, QCPP Pharmacy of the Year competition), but the program was not promoted to any extent to other health professionals or to the public.

**Standards:** Whilst the standards against which pharmacies are accredited are comprehensive and detailed, appropriate consolidation with an emphasis on pharmacy as a health service provider and CQI is warranted at this stage of program development.

**Census:** The census informed the sample stratification and selection methodology. It also provided underpinning insights into the structure and culture (including value sets) of community pharmacy, together with initial evidence of QCPP effectiveness.

**Audit:** Two audits of the QCP Division records were conducted. Whilst pharmacies generally performed well against the standards, inter-assessor variability, the self-assessment process and improvements in data management by the Division need to be addressed.

**Focus Groups:** In the focus groups, both positive and negative comments were reported. The main concerns related to process and pharmacy implementation issues. Other comments suggested areas where the program overall might be improved (increased promotion, effective self-assessment and use of CQI).

**Pharmacy proprietor and staff surveys:** Pharmacies reported that a number of perceived benefits arose from the adoption of QCPP particularly as regards staff empowerment, both from the team approach usually adopted for implementation and from the role and responsibility clarity arising from job definition and description. These surveys confirmed the existence of a value set related to an organic and innovative/developing organisational culture, where a participative management style enables attention to innovation, service quality and improvement which is at odds with the more traditional views of the pharmacy role with a dispensing and retail product focus, rather than health care service provision. Important hindrances to QCPP implementation by pharmacies included variation in this value set between pharmacies (such that only some pharmacies were able to easily accept and adopt proposed changes), and difficulties encountered by smaller pharmacies relating to resource issues, usually revolving around manpower.

**Standards Maintenance Assessment visits:** An analysis of pharmacies within our sample who had also received one or more SMA visits was performed. This analysis showed that performance against pharmacy professional practice standards improved over time. While early adopters of QCPP outperformed the later adopters, the difference in performance has decreased over time.
Assessor reaccreditation survey: The views of assessors in respect of pharmacies undergoing reaccreditation suggest that standards have improved over time. However, pharmacies noted difficulties in moving to CQI.

Consumer survey: The consumer survey showed that the technical and functional quality of services provided by accredited pharmacies was superior to non-accredited pharmacies in terms of counselling given, consumer perceptions of quality and satisfaction, and intention to return. Consumers, however, had low recognition of QCPP.

Survey of General Practitioners (GPs): Awareness of the program amongst GPs was low. GPs associated with accredited pharmacies, however, were more likely to agree that the pharmacy contributed to their practice and care of patients than GPs associated with non-accredited pharmacies.

Survey of consumers with asthma or diabetes: It was not possible to relate patient outcomes to QCPP accreditation. The preliminary findings suggest that the rate of disease specific services offered by pharmacies is low and is not affected, as yet, by QCPP – but it does offer a platform for the future delivery of services.

Financial survey of pharmacies: Pharmacists were generally unable or unwilling to provide sufficient financial data to an independent third party to allow to analyse change in business performance in a meaningful way.

DESIGN AND IMPLEMENTATION ISSUES

Question 1: How well were the program objectives met, where the program objectives themselves depend on (i) the conceptual underpinnings of the program, (ii) the vision of the program, derived from these underpinnings and used to market the program to participants and stakeholders, and (iii) the extent to which the program is one of quality assurance (QA) or continuous quality improvement (CQI)?

Conceptual framework and vision. We were unable to discover a clear, single statement of the program objectives that had been jointly issued by the program stakeholders at the commencement of or during the program. There is a descriptive statement on the QCPP website but we understand that this was placed on the site at about the time the QCPP Division was developing its own mission statement. Accordingly, conceptual program objectives were synthesised by the evaluators from various documents and presentations, interviews with stakeholders at various levels and concepts raised in focus groups. This synthesis took account of the conceptual underpinnings and the vision(s) used to market the program as revealed by these sources.

Program style – QA or CQI. Whether the program is (or should be) one of quality assurance or continuous quality improvement is dependent in part on the meaning given to ‘quality’. Evidence from the literature and our observations of the ‘value set related to an organic and innovative/developing organisational culture’ suggest that the program needs to move progressively towards a CQI-based culture as opposed to the present QA structure.

The synthesised objectives and outcomes were:
1. Halt or reverse the decline in pharmacy’s ‘retail’ business by enhancing and standardising the consumer experience - partially met.
2. Improve the quality of professional practice and thereby improve health outcomes - **partially met**.

3. Enhance pharmacy’s image in general and in particular with government by using the program as evidence of pharmacy’s desire to improve – **met**.

4. By taking the initiative, pharmacy would retain a greater measure of control over the process than if a quality regimen was imposed – **met**.

5. Improve pharmacy ‘in-store’- processes as regards retail and management processes - **partially met**.

**Question 2:** How does QCPP compare with similar quality programs in the health sector in Australia and overseas, including issues of program governance?

QCPP generally compares favourably with both Australian and international programs where comparison is possible, particularly in the domains of approach to accreditation, resources used at accreditation and fees for accreditation but differs in respect of program governance, particularly in the areas of transparency and stakeholder involvement. A progressive move towards a more inclusive ownership and governance structure should be investigated with an emphasis on transparency and stakeholder (including consumer) participation.

The programs examined included: Australia (the Aged Care Standards; the Australian Quality Awards; the Australian Council of Healthcare Services (ACHS) and Australian GP Accreditation Ltd (AGPAL) and overseas (the United States of America (JCAHO), the United Kingdom (HAP), Canada (CCHASA) and New Zealand (QHNZ)).

**Question 3:** How does QCPP support the QUM policy?

QCPP has created 31 QCPP standards which can be directly mapped to the QUM policy developed by the Commonwealth.

**Question 4:** Is quality in community pharmacy appropriately measured and monitored?

Not as well as might be possible. A set of indicators to measure the quality of performance by community pharmacies could be developed from the QCPP standards.

**Question 5:** Is QCPP itself appropriately accredited and monitored?

No. Accreditation of QCPP by an appropriate external accrediting body (like ISQua) would provide external validation of the processes and outcomes of the program. QCPP Division itself should be more self-monitoring, and follow a similar CQI process to that being applied to pharmacies. The administrative audit and SMA analysis identified a number of areas for possible CQI.

**PROCESS MEASURES**

**Question 1:** What worked and may not have worked in relation to initial roll out?

The broad processes associated with the launch and implementation of QCPP were effective although more consideration should have been given to how smaller business would implement the program.

**Question 2:** What is working well now?

Most of the QCPP initiatives (aspects of the program structure, content and processes) are working well:
- QCPP modules for professional services, retail skills, business management and loss prevention were all found to be helpful. The support materials, workshops and video were important tools for successful implementation.

The following processes worked well:
- Uptake of the program by large pharmacies.
- The SMA visits were effective.
- The administration of the program by the QCPP Division.
- Implementation of program at individual pharmacy level.

Even in those areas working well, improvement is possible.

**Question 3: What could be improved?** Addressing the following would improve aspects of the program:
- Clarity and consistency in QCPP goals and desired outcomes
- Resourcing of the QCPP Division, especially in data management, data interrogation capabilities, internal quality control and the monitoring of the quality of responses
- Using change management strategies to move pharmacy to embrace an underlying culture of quality
- Marketing of the program to the wider community.

**Question 4: Whether there are any gaps in program material and resources?**
Generally no. The program materials were generally well-received although the volume of materials and updates created problems for some pharmacies.

**Question 5: Whether there are any gaps in the standards?**
Generally no. Rather than gaps in the standards, the issues relate to relative emphasis or priority, and measurement of indicators. Given the professional nature of pharmacy’s role, the actual construction of the program should make it clear that the business and retail elements are there to support and underpin the core role of professional care. Measurement of quality, both what (indicators) and how to measure (a scale rather than yes or no) remains an issue. Indicators could be developed to reflect functional areas, performance and outcomes, and to support better CQI.

**Question 6: Whether the assessment process, the self assessment process and the period for re-accreditation are in need of review?**
Yes. The administrative audits exposed a number of weaknesses including incomplete or inaccurate data from assessors, inter-assessor variation and matters of overview of the assessors themselves. The non-mandatory self-assessment process was not felt to be very effective in maintaining standards or in implementing CQI. Even where pharmacies attempted to engage in self-assessment and made suggestions for improvement, they often failed to re-visit these areas to see if improvement had, in fact, occurred. The period for re-accreditation is consistent with comparable national and international programs, and was appropriate initially. With greater program maturity, the accreditation period should be reviewed.

**Question 7: Were all pharmacies encouraged to become accredited through the program?**
Yes. Both the financial incentives and the general promotional activity to pharmacy including awards such as the Pharmacy of the Year sponsored by Pfizer, were effective in driving accreditation and awareness respectively.
Question 8: Was the maintenance of standards and continuous improvement of quality of care in accredited pharmacies as specified through the QCPP standards encouraged? Partly. The program encouraged standards maintenance through SMA visits, the monitoring tools provided as part of the program materials, and a requirement for annual self-assessments. Unfortunately, maintenance of CQI was less effectively encouraged resulting in a poor understanding of this concept and subsequent poor implementation due in part to the non-mandatory nature of the CQI process.

Question 9: Were accredited pharmacies encouraged to maintain their quality care and practice standards through re-accreditation processes? Partly. Encouragement was provided but it was not always effective given that the disincentive (the cost and work involved) may outweigh the incentives as re-accreditation was difficult for some pharmacies where program maintenance was low or ignored until re-accreditation was due. There is a small but increasing rate of lapses from the program.

Question 10: Were community pharmacies that rapidly seek and then attain accredited status, as well as those that have already attained accreditation, rewarded and acknowledged? Yes, within the community pharmacy sector and by government through payment of incentives, but less widely in other health sectors or with the public.

OUTCOMES AND IMPLICATIONS

The key hypotheses addressed and our findings are as follows:

Hypothesis 1: That QCPP improves the functional and technical quality of services provided by community pharmacy.

Finding: The functional quality of community pharmacy services (which refers to how the service is perceived by the consumer) is high generally. QCPP has improved functional quality. Accredited pharmacies performed better in meeting consumer service needs than non-accredited pharmacies (from the modified SERVPERF scale) and consumer intention-to-return was higher for accredited pharmacies than for non-accredited pharmacies with this result remaining stronger for early adopters and declining through to last adopters. Encouraging high functional quality is an important part of the program, particularly those aspects dealing with consumer service and the pharmacy environment.

QCPP has improved technical quality (which refers to the ‘correctness’ or ‘accuracy’ of the service or product provided) in a number of areas, with physical aspects of the pharmacy such as cold chain and privacy requirements (vaccine refrigerators and shredders respectively) being most obvious. Accredited pharmacies have a higher frequency of clinical and monitoring services than non-accredited pharmacies and an increased focus on the professional role, leading to higher levels of transactional counselling and directive guidance. Whilst the time frame of the evaluation was not suited to examining higher-order outcomes from this improvement in technical quality, the literature supports the flow-on effect into health outcomes.

High functional quality can be seen in the consumer survey and in the literature in the face of relatively low technical quality. There is capacity for improvement in technical
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Consortium: ACPPM, QMC, UQTRU

February 2005

quality, particularly as regards the provision of written information to patients, monitoring of patient adherence and adverse drug events and disease state management intervention. It is important to encourage and monitor both technical and functional quality.

**Hypothesis 2:** That QCPP improves productivity to deliver the same or superior outcomes for the same or lesser cost.

**Finding:** The evaluation has not found improved productivity but has shown that the pre-disposing factors for productivity gain (higher staff skill levels, staff empowerment, role re-engineering) are more often present in accredited than in non-accredited pharmacies. Accredited pharmacies employ a greater proportion of non-pharmacist staff with higher training qualifications and employ more dispensary assistants, even after adjusting for business size. Accredited pharmacies generally promote and practise staff empowerment more than non-accredited pharmacies and this improves delegation and role responsibility. Improvement in these areas tends to lead towards a capacity to deal with patient health issues in-store (where appropriate). Inherent pharmacist productivity is already quite high and further gains in productivity in the dispensing process may rely on role re-engineering within the dispensary. QCPP accreditation status is unlikely to affect the level of generic substitution at this stage of the program.

**Hypothesis 3:** That QCPP allows cost-effective services to be delivered by community pharmacies adopting the program.

**Finding:** A full economic analysis of QCPP was not possible as many positive effects are likely to occur in the future as a result of changes made now by community pharmacies (such as improvements in technical and functional quality) referable to QCPP. From a government perspective, QCPP has the potential to be cost-effective, but the full impacts of the program cannot be determined as yet.

**Hypothesis 4:** That QCPP improves consumer satisfaction with community pharmacy services.

**Finding:** Consumer satisfaction with community pharmacy services is high but consumers of accredited pharmacies are more satisfied as evidenced by (1) greater consumer satisfaction with pharmacy services both on the day of service, (2) greater satisfaction in the longer term (reflected by functional quality), (3) greater consumer intention-to-return and (4) GP agreement that a specific pharmacy contributes to their practice and patient care. Consumers remembered the receipt and nature of information provided, both on the day of service and over time (directive guidance). As the level of information provided increased, so to did transactional satisfaction and longer term satisfaction (functional quality, a perception that the pharmacy meets the consumer's service needs). Since consumer intention-to-return is also linked to technical quality, attention to these service components could increase consumer loyalty further.

**Hypothesis 5:** That QCPP accredited pharmacies leads to positive societal health outcomes.

**Finding:** QCPP supports QUM policies and accredited pharmacies outperform non-accredited pharmacies in areas either shown to improve health outcomes or which
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could reasonably be expected to improve health outcomes. As noted above, accredited pharmacies display higher technical quality in professional services generally, have more professional services and tend to employ these in-store to a greater extent than non-accredited pharmacies. These characteristics appear grounded in a dynamic mix of innovation, role re-engineering and training, supported by the infrastructure and system improvements encouraged by the program.

**Hypothesis 6:** That QCPP minimises Government budget outlays.

**Finding:** Changes in government budget outlays are a higher-order change, the full assessment of which has proven to beyond the resources and time frame available to this evaluation. Accredited pharmacies have more actively encouraged role re-engineering resulting in a greater utilisation of dispensary assistants and the higher levels of training shown by non-pharmacist staff in accredited pharmacies assist in the greater resolution of health enquiries in-store, rather than by ‘automatic’ referral to medical services. This latter characteristic and activities that support improved health outcomes through QUM have the capacity to address downstream health system costs.

**Hypothesis 7:** That QCPP improves overall management processes, specifically: Human resource management; financial management; risk management; strategic and operational planning; asset management.

**Finding:** The evaluation has shown that whilst the program has resulted in changes to human resource management in areas such as staff empowerment, induction and training, there are as yet no detectable differences in staff or proprietor satisfaction between accredited and non-accredited pharmacies. In other aspects of management, accredited pharmacies tended to have a more participative culture and a higher level of congruence between staff and proprietor views in respect of many business values than for non-accredited pharmacies. Further to be accredited pharmacies had to have addressed the business management and loss prevention standards that included measuring and monitoring financial indicators and having and measuring performance against a business plan. Having a discernible business strategy is a first measure of risk management and risk minimisation, particularly where this strategy is formalised within a planning process. Proprietors of accredited pharmacies were more likely than those of non-accredited pharmacies to have a competitive business strategy, to value business planning and to have quality systems in place.

**OVERALL CONCLUSIONS**

QCPP has introduced a standardised quality assurance system to approximately 5000 independent entities over about six years with almost a complete uptake. The effective program design, enrolment of pharmacies, program implementation and accreditation of this large number of independent pharmacies is an outstanding achievement. Indeed, many pharmacy owners attest to improved performance of the pharmacy team and a consistently high level of service to pharmacy consumers, to increased staff empowerment and higher levels of productivity, to an improvement in business management from moving to properly-documented processes, and to higher levels of consumer satisfaction.
However, the program has had some difficulties and has been limited by being overly pharmacy-centric. Some smaller pharmacies, in particular, have struggled with the volume of paperwork associated with the program, the time taken to implement and a myriad of other concerns which reflect both the reality of their perceptions day-to-day and their lack of understanding of the nature of quality processes. The notion of measuring performance is central to quality processes, yet many community pharmacists are reluctant to capture or monitor data that could be of benefit to them both at an enterprise and an industry level. There is now an opportunity to further develop the program recognising the role the consumer and government to a greater extent in the ongoing improvement of the program, to consider the program impact on other health professionals and to build in a data framework for ongoing program monitoring.

The program has also had some very positive outcomes including improved technical and physical improvements in community pharmacies, better human resource management and business planning, facilitation of formalised professional standards, and been a change agent so that pharmacies better meet evolving consumer needs. Indeed, a higher consumer satisfaction was found for pharmacies achieving these outcomes.

**RECOMMENDATIONS**

1. **The Quality Care Pharmacy Program (QCPP) should be continued as the pivotal quality program in Australian community pharmacy.** QCPP underpins many future practice initiatives and provides a QA or monitoring framework for these future practice developments. It is an industry-specific quality assurance program that recognises pharmacy as the only health profession operating in the readily accessible retail channel and so addresses quality in both the professional and business domains. The majority of Australian community pharmacies have been successfully accredited against these minimum standards. (see sections 5.2, 5.3)

2. **The program should retain its focus on improving functional and technical quality in community pharmacy and on the teamwork approach to implementation of quality in community pharmacy** built into the program, both successful aspects of QCPP. (see sections 5.4.1, 5.4.7)

3. **In addition, the program should continue in its efforts to assist government policy** which facilitates improved consumer outcomes, such as the **Quality Use of Medicines (QUM)** policy. Thirty-one QCPP standards can be directly mapped to the Commonwealth’s QUM policy. Accredited pharmacies provide a greater number of monitoring and clinical services and a greater level of directive guidance. (see sections 5.2.5, 5.4.1.2)

4. **Progress made to date in the integration of professional practice and business management standards should be** acknowledged and **built upon.** Both PSA and the Guild are to be congratulated in managing the fusion of quite distinct approaches to standards-setting into a workable model which recognises the need for an efficient ‘business platform’ in the delivery of quality professional services. (see section 5.2.1)
5. The case for an efficient business platform based in Continuous Quality Improvement (CQI) should be actively promoted to pharmacy. This case should re-emphasise the need to collect data both for internal management purposes and for aggregate use. (see section 5.2.2.4)

6. Consideration should be given to the establishment of centralised data collection protocols and processes for pharmacy to measure performance within a pharmacy and across the QCP program. The data framework should deal with quality indicators generally, and be implemented in a way that the independence and integrity of the processes is acknowledged by pharmacy. Such systematically collected data will enable both quality improvement within the program and a means of determining the effects of QCPP as the program matures. (see sections 4.8, 8.1.2.3, 8.4.3)

7. The overall management of the program implementation by the QCPP Division has, in general, been well conducted. However, future implementation needs to be more flexible and diversified to better involve the various types of community pharmacies. In particular, change management strategies should recognise the needs and capacities of smaller, less developed and more conservative pharmacies. (see sections 4.2.5, 4.3.1)

8. The program needs to maintain and develop its ‘can-do’ philosophy and style which has been instilled by the Guild National Council and the Division. This ‘can-do’ attitude to change ought itself be instilled into pharmacists to assist in program development. Change management strategies might assist pharmacists to think outside the ‘four walls’. (see sections 3.2.5, 3.2.6, 4.4.1.1)

9. The QCPP Division should be more adequately resourced irrespective of the future nature of the Program. The Division has performed well in meeting the timeframe set for achieving accreditation of the majority of pharmacies, given the limited resources available to it. Many of the administrative shortcomings noted in the evaluation are, in our view, referable to under-resourcing. (see section 5.3.2)

10. A charter defining the visions and the values of QCPP should be developed by pharmacy peak bodies - in consultation with community pharmacists, government and consumers. These visions and values should define the sought-after benefits for the community and for pharmacy, should meet stakeholder needs and expound the visions of the organisations involved. Charter development should be inclusive and have active stakeholder consultation (i.e. involving “grass roots” community pharmacy, consumers and government). The charter should be explicit about, and prioritise, the desired outcomes of the program. (see sections 5.2.1, 5.2.4.3)

11. Governance of QCPP should move progressively towards a more inclusive model to manage and oversee the program, involving representation from all stakeholders and greater transparency in all facets of the program. This more inclusive management model should be a first step in a progressive transfer of full governance to an independent body with wider stakeholder representation. The timetable for this transfer should allow for the necessary organisational, educational and attitudinal adjustments recognised in the literature. Progressive changes to the governance model might assist in allowing an integrated approach to professional standards,
service quality, health outcomes and regulatory requirements facilitated by an
overarching commitment to CQI within pharmacy generally. Our perception of the
current environment is that it remains unintentionally fragmented.

A workable timetable with realistic milestones for this transfer should be developed and
this timetable should be widely promulgated. (see section 5.2.4)

12. A strategic plan for QCPP to move to a program focussed clearly articulated
desired outcomes and responding to a changing wider environment should be
developed. This plan should articulate the charter and involve wide stakeholder
input. This plan should also be explicit (e.g. timetable for change and milestones),
clear and consistent, and should be widely disseminated to the community pharmacy
sector and other stakeholders. Performance of the program should be monitored
against this plan. (see section 5.2.1)

13. The program structure, content and processes need to be further developed
to build in continuous quality improvement (CQI) and to meet the developing
needs of pharmacies (particularly smaller pharmacies) and other stakeholders
(e.g. more informed consumers will have different service expectations). Development
should focus on emphasising and enhancing values supportive of quality and a
capacity to implement any changes. (see section 5.2.2)

14. The introduction of CQI to the program structure, content and processes (i.e.
what must be done by accredited pharmacies) should be gradual and supported
by appropriate resources. This implementation effort should be largely educational,
and structured to address the learning needs and styles of pharmacy proprietors and
staff. It should be iterative, with an achievable timeline and monitoring milestones. (see
section 5)

15. The operational development of QCPP should also be more CQI based. The
Division should seek external accreditation of QCPP through an appropriate
accrediting body (e.g. ISQua, section 5.2.7). The QCPP Division should also
implement more comprehensive quality monitoring of its own processes and the
performance of the pharmacies in the program, so QCPP itself can be continually
monitored and continually improve. The Division should be adequately resourced to
undertake these developments. (see section 4.2.5)

16. The structure and content of the standards should be revised to (1) be
integrated and consolidated, and support the development of ‘quality’ values and the
desired outcomes of the program, (2) develop better indicators that reflect functional
areas and outcomes, and that can be measured on a more continuous scale, and (3)
reframe the standards so that the business components support professional service
delivery. Higher technical quality is associated with higher satisfaction, functional
quality and consumer loyalty but the business infrastructure must be efficient and
effective to support technical quality. (see Chapter 5)

17. As part of changes to the nature of the QCPP, the assessment process should
be revised with changes so that (1) external assessment is better monitored, (2) self-
assessment becomes more self-monitoring, (3) the practice areas audited by the SMA
program are expanded, and (4) continuous improvement and high quality performance by pharmacies is incentivised or rewarded. (see section 5.3.6)

18. There should be a major consumer campaign promoting both the program and the improved consumer satisfaction with accredited pharmacies. Such a campaign would add a consumer ‘pull’ to the organisational ‘push’ for quality improvement, and would reward accreditation and provide an incentive for reaccreditation. (see section 4.4.2.1.3 and 11.4)

19. A future assessment of QCPPP should examine its cost-effectiveness in relation to pharmacy productivity, health outcomes and government outlays as the program matures. To facilitate this future work, indicators and processes should be developed and put into place as soon as possible, building into the program the ability to collect data to inform the future assessment. (see section 5.4.3)

20. Financial support for pharmacies should be retained to meet the costs of maintaining the program. This support should be structured so as to provide incentives for the monitoring and improvement of outcomes generally and disincentives if this monitoring and improvement is absent. Data so collected should be used to evaluate the cost effectiveness of quality changes at both an individual pharmacy and program level. (see Chapter 5)