

Appendix 5.2 – Consumer and carer ideal pharmacy service

This is the pre-print (pre-refereeing) version of the following paper:

McMillan SS, Sav A Kelly F, King MA Whitty JA, Wheeler AJ. Is the pharmacy profession innovative enough? Meeting the needs of Australian residents with chronic conditions and their carers using the nominal group technique. *BMC Health Services Research* (revisions submitted 15th August 2014).

McMillan SS, Sav A, Kelly F, King MA, Whitty JA, Wheeler AJ. *Is the pharmacy profession innovative enough? Meeting the needs of Australian residents with chronic conditions and their carers using the nominal group technique.* BMC Health Services Research (submitted 12 March 2014, under review)

Is the pharmacy profession innovative enough? Meeting the needs of Australian residents with chronic conditions and their carers using the nominal group technique

Sara S McMillan (BPharm, PhD Candidate),¹ Adem Sav (PhD, Senior Research Assistant),¹ Fiona Kelly (PhD, Research Fellow),^{1,2} Michelle A King (PhD, Senior Lecturer),³ Jennifer A Whitty (PhD, Associate Professor),^{1,4} and Amanda J Wheeler (PhD, Professor).^{1,2}

¹Griffith Health Institute, Griffith University, University Drive, Meadowbrook, Queensland, 4131, Australia

²School of Pharmacy, Faculty of Medical and Health Sciences, University of Auckland, New Zealand

³School of Pharmacy, Griffith Health Institute, Griffith University, Gold Coast Campus, Parklands Drive, Southport, Queensland, 4215, Australia

⁴School of Pharmacy, University of Queensland, Cornwall Street, Woolloongabba, Queensland, 4102, Australia.

Corresponding Author

Sara S McMillan

Population and Social Health Research Program, Griffith Health Institute, Room 2.15, Building L08, Griffith University, University drive, Meadowbrook, Australia, 4131

Telephone: +61 (0)7 338 21571

Fax: +61 (0)7 338 21041

Email: s.mcmillan@griffith.edu.au

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Abstract

Background: Community pharmacies are ideally located as a source of support for people with chronic conditions. Yet, we have limited insight into what innovative pharmacy services would support this consumer group to manage their condition(s). The aim of this study was to identify what innovations people with chronic conditions and their carers want from their ideal community pharmacy, and compare with what pharmacists and pharmacy support staff think consumers want.

Methods: We elicited ideas using the nominal group technique. Participants included people with chronic conditions, unpaid carers, pharmacists and pharmacy support staff, in four regions of Australia. Themes were identified via thematic analysis using the constant comparison method.

Results: Fifteen consumer/carers, four pharmacist and two pharmacy support staff groups were conducted. Two overarching themes were identified: extended scope of practice for the pharmacist and new or improved pharmacy services. The most innovative role for Australian pharmacists was medication continuance, within a limited time-frame. Consumers and carers wanted improved access to pharmacists, but this did not necessarily align with a faster or automated dispensing service. Other ideas included streamlined access to prescriptions via medication reminders, electronic prescriptions and a chronic illness card.

Conclusions: This study provides further support for extending the pharmacist's role in medication continuance, particularly as it represents the consumer's voice. How this is done, or the methods used, needs to optimise patient safety. A range of innovative strategies were

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- 26 proposed and Australian community pharmacies should advocate for and implement
27 innovative approaches to improve access and ensure continuity of care.
- 28 **Keywords:** pharmacies, nominal group technique, prescribing, innovation, chronic disease,
29 Australia

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30 **Background**

31 Similar to other countries, chronic conditions present an increasing burden in Australia [1].
32 As medication is generally needed to treat chronic conditions, pharmacists can provide
33 further support in this area. Certainly, the Pharmaceutical Society of Australia's (PSA) '*Call
34 to Action on Chronic Disease*' [2] comes at a most opportune time. The call is for
35 pharmacists to expand their scope of services, thus realising their full potential to assist
36 people with chronic conditions. While the provision of professional pharmacy services in
37 Australia has increased, more needs to be done in preventative care, and to improve the
38 health of people with a chronic condition [2].

39
40 Unpaid carers play an integral role in supporting people with chronic conditions. There are
41 over 2.7 million carers in Australia, representing approximately 11.9% of the population [3].
42 This role could include managing the medication of the person they care for [4], hence carers
43 are likely to interact with community pharmacy staff. Further insight is needed as to how
44 community pharmacy can support carers, and subsequently, better assist the care receiver.

45
46 In order to be effective, healthcare services need to be of value to the end user; therefore,
47 people with chronic conditions need to have more prominence in research [5]. Professional
48 pharmacy services appear to be designed with limited input from target users, with many
49 pharmacy research evaluating programs implemented and planned by researchers [6-8]. This
50 raises the question as to what pharmacy services do people want from community pharmacy
51 to support them in managing their chronic condition/s.

52

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53 This is a particularly important question with respect to innovative pharmacy services, i.e. the
54 introduction of a new service or approach in pharmacy [9]. In the context of this study,
55 innovation was further defined to include the extension of the community pharmacist's
56 current role/s or services. Internationally, there have been significant changes to the
57 pharmacist's role and the services that community pharmacies can provide. This includes the
58 provision of public health services [10], minor ailments schemes [11], pharmacist-
59 administered vaccinations [12] and prescribing [13]. While there has been significant
60 dialogue about extending the roles of Australian pharmacists [14], this has not eventuated
61 into practice. There has been, however, research as to whether Australian residents actually
62 want the types of services described above. Hoti *et al.* conducted one of two studies that
63 explored the public's view of pharmacist prescribing [15, 16], with the majority of
64 participants accepting this expanded role within the community pharmacy setting. Although
65 many study participants used more than one medication and were regular pharmacy users, it
66 is unclear as to what proportion of participants had a chronic condition or were unpaid carers
67 [15]. This is important to distinguish, as people with chronic conditions are likely to have
68 different experiences and needs to those who are carers or general consumers.

69

70 Furthermore, is innovation at the community pharmacy level driven by a clear understanding
71 by pharmacy staff, i.e. pharmacists and pharmacy support staff, of what consumers/carers
72 want? There is a need to explore this further; there is limited knowledge as to what
73 community pharmacy staff believe people with chronic conditions and their carers want
74 pharmacy to provide. If there are incongruent views between consumers, carers and
75 pharmacy staff, differences will need to be explored further to ensure that pharmacy staff
76 meet their consumers' needs. This study aims to identify what innovations people with

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chronic conditions and their carers want from their ideal community pharmacy, and compare this with what pharmacy staff think consumers want community pharmacy to provide.

Methods

Study participants

Consumer participants with one or more chronic condition(s), or an unpaid carer for such a person, were purposively sampled [17], from four Australian regions; Mount Isa and Logan-Beaudesert (Queensland), Northern Rivers (New South Wales) and Perth (Western Australia). These areas vary in terms of accessibility to pharmacies, i.e. from being highly accessible in Perth, to modestly or remotely accessible in Mount Isa [18]. Participation included individuals from culturally and linguistically diverse populations (CALD) and Aboriginal or Torres Strait Islander people (IND).

The health professional groups consisted of either pharmacists or pharmacy support staff; pharmacy assistants were included as they are generally the first point of contact for consumers [19, 20]. It was preferable that pharmacists were currently employed, or had recent experience in the community pharmacy setting. This ensured that pharmacists had up to date knowledge of community pharmacy practice, and were therefore better placed to answer the research question. Recruitment for all participants involved snowball sampling [17] and dissemination of information to consumer health groups, professional organisations, and community pharmacies located within the study areas.

Procedure

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100 The nominal group technique [21, 22], a highly structured process which facilitates the
101 generation, discussion and ranking of participant ideas [23] (Figure 1), was used to elicit and
102 compare opinions and priorities between consumers, carers and pharmacy staff [23, 24].
103 Participants were asked to *imagine their local pharmacy several years into the future: what*
104 *services could they offer to help them to meet their individual health goals, or to best support*
105 *them in their role as a carer?* To enable a direct comparison with the priorities of people with
106 chronic conditions and their carers, pharmacy staff were directed to reflect on what they think
107 their consumers would want, not what they would personally want.

108

109 Groups were conducted between December 2012 and April 2013, audio-recorded and
110 transcribed verbatim. A University Human Ethics Committee (PHM/12/11/HREC) provided
111 study approval.

112

113 [Insert Figure 1 here]

114

115 *Data analysis*

116 A ranked list of priorities, i.e. ideas, generated from the ranking/discussion stage of each
117 group (Figure 1) was reviewed to develop an initial analysis framework. This framework was
118 discussed between four researchers who primarily facilitated the groups, with 23 themes
119 condensed into 12 over-arching themes (McMillan S.S. *et al* unpublished manuscript). This
120 final framework was then used to assist both qualitative and quantitative analysis, of which
121 the latter process is detailed elsewhere (McMillan S.S. *et al* unpublished manuscript). All
122 transcripts were analysed, via the framework, using the constant comparison method [25] and

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123 NVIVO.® This paper reports the qualitative data relevant to *innovative services and roles*,
124 one of the 12 themes identified.

125

126 **Results**

127 Individuals participated in 15 consumer/carer groups ($n=103$), two pharmacy support staff
128 and four pharmacist groups ($n=35$; Table 1). Two over-arching themes were identified in
129 relation to innovation; extended scope of practice for the pharmacist, i.e. new roles, and
130 providing new or improved existing pharmacy services, i.e. increased access to the
131 pharmacist and other healthcare professionals, medications, and information (Table 2).
132 Additional quotes are provided in Table 3.

133

134 [Insert Tables 1 & 2 here]

135

136 Extended scope of practice for pharmacists

137 Medication continuance was the most novel pharmacist role generated by all groups
138 (consumer, carer, pharmacist and support staff), with an emphasis on renewing medications,
139 i.e. repeat, not new medication. This role was expressed by some participants as being able to
140 ‘make,’ or ‘renew’ or ‘prescribe’ medication:

141 *Be able to prescribe medicine without a doctor's prescription...* (Consumer_1040;

142 Group_6)

143 This was deemed useful for people taking medications regularly, at a consistent dosage, with
144 the proviso of a limited time-frame, generally up to twelve months from the doctor’s initial
145 prescription:

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146 ...pharmacists should be able to renew prescriptions for people who are on the same
147 medication year in, year out, for at least 12 months to take the pressure off doctors.
148 (Carer_1068; Group_17)

149
150 A reason for wanting pharmacists to have this extended role of medication continuance was
151 to reduce the burden placed on GPs. Frustration about current practice was evident from
152 consumer and carer groups, mostly from the inconvenience of making and attending GP
153 appointments and their associated cost. Some non-urban participants described being charged
154 a 'prescription service' to obtain ongoing (repeat) prescriptions when a GP was unavailable.
155 Pharmacists were also frustrated with the administrative procedures associated when
156 consumers ran out of their medication, and some consumers and carers did not understand
157 why certain pharmacies provided an urgent supply of medication and others did not. This was
158 particularly discussed by CALD participants; some did not understand why the pharmacist
159 could not provide their medication when they had no prescription, particularly when the
160 pharmacist was aware of their medication history. This resulted in additional stress:

161 ...I was very sick and then the chemist they said no way [not supplying medication
162 without a prescription]. And sometime[s] you ring the doctor and they told you, next
163 day, or one week... (CALD_Consumer/Carer_1207; Group_13)

164
165 The types of medication suggested for continued supply were mostly those being used long
166 term, such as blood pressure, insulin and cholesterol medication. Others, mostly pharmacy
167 assistants, commented about the pharmacist being able to prescribe antibiotics or medication
168 for simple ailments, thus alleviating the need to see the GP. This was viewed as a way to
169 facilitate continuity of care for the consumer and reduce the burden on an already busy

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170 healthcare system. To enable this extended role, some consumers commented on having an
171 agreed treatment plan with the GP. Carers particularly stressed the need for GP follow up or
172 collaboration between GPs and pharmacists:

173 ... there can be a danger if they [pharmacist] just constantly renew it and you're not
174 seeing your doctor. (Carer_1013; Group_13)

175

176 One CALD consumer emphasised that pharmacists needed further 'professional freedom' to
177 be able to do their job more effectively, i.e. to fully utilise their medication knowledge. This
178 included the ability to change medication if there was a side effect, or to alter doses. The
179 provision of "point of care diagnostics" (Pharmacist_2066; Group_23) was also mentioned
180 by consumers and pharmacists, particularly for the monitoring of warfarin, blood glucose,
181 cholesterol and blood pressure:

182 ... [pharmacists] should know who is a diabetic and who has blood pressure and have
183 it automatically tested when they go to pick up their prescription...
184 (IND_Consumer_1106; Group_4)

185

186 New or improved existing pharmacy services

187 *Increased access to pharmacist or other healthcare professionals*

188 Consumer and carer groups showed interest in pharmacy as part of a 'one stop shop,' where
189 the pharmacists "work very closely in this health hub, or wherever they're situated, with the
190 other [healthcare] providers..." (Carer_1217; Group_15). This carer also described having a
191 more specialised, medical focused pharmacy in Australia, one that did not sell non-health
192 related products. However, a pharmacist group thought their consumers would want a doctor
193 located within a pharmacy, either physically or virtually. Consumer groups had a similar idea

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194 involving virtual access, but in relation to pharmacy staff. This involved something like
195 Skype, and was seen as a way to improve privacy and reduce waiting time, allowing people
196 who can't, or don't want to, physically enter the pharmacy to still access care:

197 *... rather than having to go and stand and telling my story in front of everybody else in*
198 *the shop, I'd like to have a virtual one where you can have somebody talk to you on*
199 *the line and you can just have a face-to-face. (Consumer/Carer_1118; Group_13)*

200

201 It was evident that consumers, carers and pharmacy support staff wanted increased access to
202 other healthcare professionals in the pharmacy, such as nurse practitioners, physiotherapists
203 and dieticians, to provide additional services:

204 *...instead of trying to train a pharmacist...you've got a nurse practitioner...and*
205 *they've gone a little bit higher to get the betterment of qualification to give you the*
206 *injection... (Consumer/Carer_1214; Group_13)*

207 Conversely, pharmacists diverged slightly from this view in relation to nurse-administered
208 vaccinations, with discussion of the pharmacist conducting this role.

209

210 Home visits and utilising indigenous community health workers were discussed by an
211 Aboriginal or Torres Strait Islander group. This involved monitoring a person's healthcare
212 and medication usage via community follow ups, having a yarn and getting to know the
213 person, hence, assisting to 'close the gap,' i.e. improve the health of Aboriginal or Torres
214 Strait Islander people:

215 *If they see people aren't coming to the chemist... they [pharmacist] should make it*
216 *their business to go out to their house. (IND_Consumer_1191; Group_3)*

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217 Increasing the opportunity to speak to a pharmacist was discussed in different ways via a
218 consumer group, i.e. increasing pharmacist numbers in a pharmacy, a pharmacy assistant
219 group, i.e. using checking technicians to relieve the pharmacist's dispensing duties, and a
220 pharmacist group, i.e. working predominantly outside the dispensary (forward dispensing)
221 and offering a 'Rolls Royce service,' at a price, to consumers:

222 *... you always get to talk to your pharmacist and your scripts are always ready for you*
223 *so you jump the queue essentially... and you pay for that.* (Pharmacist_2000;
224 Group_10)

225 Obtaining specialist referrals from the community pharmacist was also viewed as a way to
226 improve healthcare access.

227

228 *Increased access to medications and information*

229 Improving health care access was discussed in relation to medications and information.
230 Pharmacists considered consumer and carers would want dispensing or 'script in' machines,
231 enabling more counselling time with the pharmacist and providing a faster service:

232 *This is quite controversial, but I think some people would want automatic*
233 *dispensing... they'd have a computer, they'd type in their name and scan the*
234 *prescription or something and it just dispenses to you.* (Pharmacist_2068; Group_23)

235 However, rapid dispensing was not discussed by the majority of consumers and carers. Only
236 one participant wanted to be able to dispense their own medication, another wanted to fast-
237 track the dispensing process with a system similar to photo processing booths. Instead, most
238 consumers and carers wanted e-prescribing, or to be able to request their prescriptions online.
239 This was emphasised as a way to reduce pharmacy queues and associated prescription
240 paperwork, and help people with a physical disability to easily access their medication:

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241 ... online prescriptions. So when the doctor types it out, why can't it... go straight to the
242 chemist, and then hey you haven't got... papers to carry around... you can either go
243 online [to order it]...or by phone... (Consumer_1037; Group_8)

244

245 A chronic illness card was acknowledged as a tool to facilitate easier access to medication,
246 without 'the third degree,' i.e. being asked multiple questions by pharmacy staff:

247 ... a chronic illness card... so that it says you have a chronic condition... so that the
248 pharmacist knows... (Consumer/Carer_1206; Group_9)

249 This idea was also raised by an Aboriginal or Torres Strait Islander group, with participants
250 describing what the card would incorporate, including their photo and medical history, known
251 allergies, doctor/s details, and to be linked to preventative articles and information about their
252 condition/s. These participants also thought it would be particularly useful for elders,
253 especially when they travel or go 'walkabout.' Another participant wanted to have the
254 medication indication listed on the prescription.

255

256 A prescription reminder system such as receiving an automatic alert when a new prescription
257 was due or when their medication was running out, was another extended service suggestion:

258 ... before the due date... get an alert... Because a lot of elderly people forget...
259 (CALD_Consumer/Carer_1133; Group_7)

260 A pick-up and home delivery service was also mentioned by some consumers. However, a
261 pharmacist group perceived that consumers would want an extended service of being able to
262 obtain medication at any time, day or night, if needed. While consumer and carer groups did
263 not request this much access, some did suggest a drive through service:

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264 *You can just drive through with your ID and... here you go.* (Consumer/Carer_1118;
265 Group_13)

266

267 Pharmacy support staff thought that consumers would want a simple service directory that
268 provided information and contact details of healthcare and support organisations. However,
269 having a case-coordinator to provide this information was discussed by consumers and carers:

270 *... accommodate my ideal case coordinator. Because the pharmacy isn't as intense as,*
271 *say, even going to your GP or going to your specialist... house this person who would*
272 *then have enough room to bring in guest speakers... have all the resources there, all*
273 *the pamphlets we're needing and information...* (Consumer_1014; Group_15)

274 Extended services in the form of information evenings were also seen to be important:

275 *... the more interest and the more education you get into the pharmacies the better.*
276 *Because a lot of people are using the pharmacist instead of their GP.*
277 (Consumer_1116; Group_9)

278 [Insert Table 3 here]

279

280 **Discussion**

281 This study strengthens support for Australian pharmacists to expand their scope of practice to
282 include continued supply of repeat prescriptions. This was described in numerous ways by
283 participants, with terminology including prescription renewal and prescribing. However,
284 regardless of the terminology used, the end result was the same, i.e. that consumers and
285 carers wanted to obtain a continual supply of the medication they regularly use, from their
286 pharmacy, without having to go back to the doctor for a repeat prescription. Furthermore,

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pharmacist support staff and pharmacist groups also thought that consumers and carers would want this extended pharmacist role; they were correct in their assumptions.

Currently, when an Australian runs out of their prescription medication, a pharmacist can assist in the following ways by [26]:

- (i) Contacting the prescriber and obtaining an ‘oral or faxed prescription.’ The prescriber sends the prescription to the pharmacist;
- (ii) Providing three days (non-government subsidised) treatment, known as an ‘emergency supply.’ A follow-up prescription is not required; and
- (iii) ‘Continued dispensing’ for one standard pack of statins and oral contraceptive pills only (e.g. 28 day supply). This is a relatively new arrangement in some Australian states and territories.

However, despite the above provisions, this study suggests that people with chronic conditions and carers are still having problems obtaining their prescription medication/s. This issue is linked with the inconsistencies in quantity and repeat prescription allowances for medicines for chronic conditions, i.e. 28 to 200 days’ supply, and zero to eleven repeats. Consequently, consumers can have difficulty synchronising their medications in terms of needing a new supply or prescription, particularly if they are taking numerous medications with different quantities and repeats. Furthermore, a pharmacist group described that, because of the limited GP appointments available in their rural area, consumers were being charged for a new (repeat) prescription without seeing their GP. Consumer and carers were frustrated with being unable to get a GP appointment in time, or being charged a fee just to pick up new prescriptions. While this study did not explore the experiences of our participants during their GP consultations, it is evident that consumers and carers wanted a more convenient system

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311 by involving the community pharmacist in prescription reminders and in the continual supply
312 of their medication.

313

314 Groups also raised the issue of supplying medication without a prescription (owing
315 prescriptions). Although the provision of medication in this way is illegal, our findings
316 indicate that this happens in practice to ensure continuity of care. Indeed, some consumers
317 and carers expected their pharmacists to provide an owing prescription, and did not
318 understand why they were refused when the pharmacist was aware of their history and need
319 for it. Ultimately, the prescription supply system could be made safer and more accessible to
320 people via enhancing the continued dispensing legislation for pharmacists. This would
321 remove the practice of ‘owing prescriptions,’ protect pharmacists from potential indemnity
322 claims, and align with Australia’s National Medicines Policy for more timely access to
323 medicines [27]. Continued medication supply, if conducted appropriately, and collaboratively
324 with GPs, could allow for more consumer contact with the pharmacist; something that
325 participants wanted in this study.

326

327 This study cannot provide details with respect to ‘how’ pharmacists could provide a
328 continued supply of medication to people with chronic conditions. However, an example of
329 pharmacists working collaboratively with doctors to assist with medication continuance, and
330 improve patient convenience, is demonstrated by the Pharmacy Anti-coagulation
331 Management Services in New Zealand [28]. Pharmacists can monitor therapy, review results
332 and provide dose changes under a GP standing order; prescribing rights are retained by the
333 GP [29]. Healthcare policy makers and professional pharmacy bodies should consider two
334 recent Australian reports documenting the movement towards ‘non-medical prescribing’ for

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pharmacists [30, 31], a move seen internationally with supplementary prescribing [32, 33]. Our findings align with aspects of supplementary prescribing, i.e. that a pharmacist prescribes in accordance to a clinical management plan, by continuing medication that has been approved by the patient's medical prescriber [33].

There were differences in opinions between consumer, carer and health professional groups. Pharmacy staff overvalued the importance of rapid dispensing; consumer and carer groups did not want innovative dispensing machines. They wanted improved access to the pharmacist via online, virtual pharmacy consultations and home visits, and streamlined prescription access via medication reminders, electronic prescriptions and a chronic illness card containing their medical history. Consumers and carers also wanted easier access to a range of other healthcare professionals, with some commenting on having a 'one-stop shop,' similar to a medical hub. However, this was described as more for the purposes of convenience [34]. Pharmacy assistants, not pharmacists, were more forthcoming with this idea.

Strengths and limitations

This paper relies on self-reported data and does not present the quantitative (i.e. priority lists) results from the nominal groups. The majority of groups were conducted during working hours and may not be representative of people who work or have caring commitments in the day, e.g. parents. No specific information about the characteristics of the pharmacy that participants either used or worked in was sought. However, the nominal group method did allow people to talk about their experiences, giving participants an equal say in terms of

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responding to the question. Furthermore, this technique allows for the generation of more than one single idea, i.e. ideas are maximised and exhausted in each group.

Conclusion

Consumer and carers supported extending the role of the community pharmacist to include continued medication supply. Furthermore, this was one idea where views between the different groups, i.e. consumer, carer and pharmacy staff, were aligned. Continued medication supply could be via repeat prescribing or other management services, whichever method optimises patient safety. Pharmacists need to be aware that their consumers do not necessarily want a speedier, automated dispensing service, but seek greater access to them as a healthcare professional. Consequently, Australian community pharmacists and the pharmacy profession should consider these findings, given that they are what people with chronic conditions and carers want from their ideal pharmacy.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

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382 FK, MK, JW and AJ participated in the design of the main study, SM, AS and FK were
383 involved in designing and facilitating the nominal groups, SM, AS, FK analysed the data, SM
384 drafted the manuscript and all authors provided editorial comments. All authors read and
385 approved the final manuscript.

386

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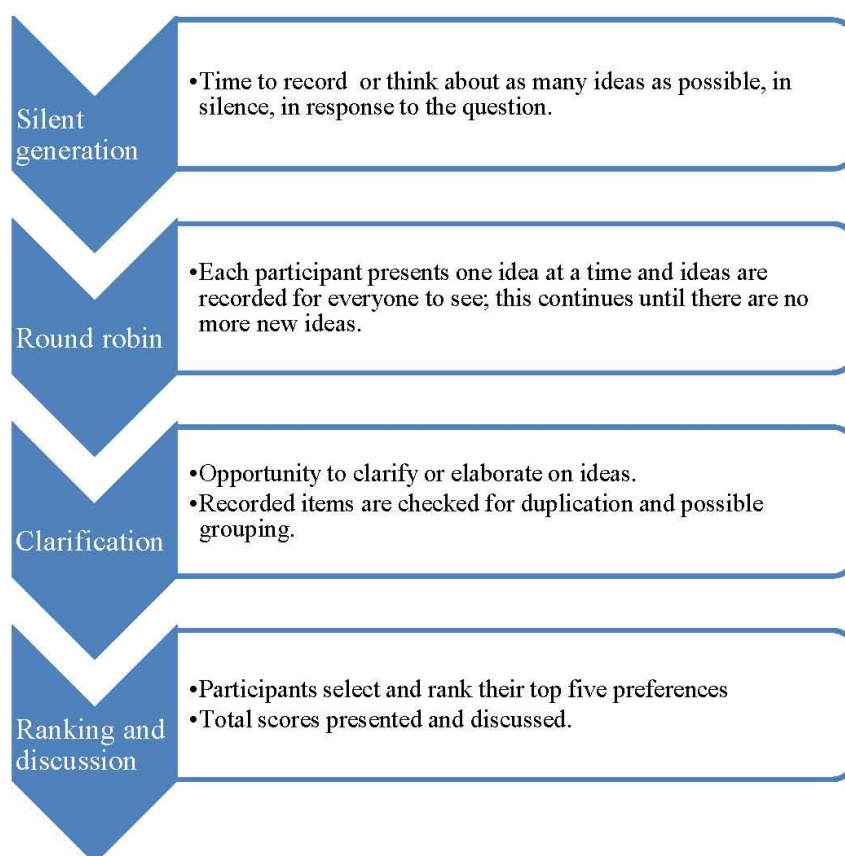


Figure 1. Adapted version of Nominal Group Technique that is relevant to this study

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Table 1: Participant data

	Participants						
	Pharmacists	Pharmacy support staff	Consumers	Carers	Mixed Consumer/Carer	Aboriginal or Torres Strait Islander	CALD
Location	Groups						
Logan/Beaudesert (QLD)	1	1	2	1	2	1	1
Mt Isa (QLD)	1	0	1	1	1	1	0
Northern Rivers (NSW)	1	0	2	1	1	1	1
Perth (WA)	1	1	2 [#]	0	1 [*]	1	0
Total	4	2	7	3	5	4	2
n	22	13	54	17	32	35	17

n = total number of participants per group type

* 4 CALD participants participated in mixed consumer/carer group

2 CALD participants participated in one of the consumer groups

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Table 2. Innovation themes generated from nominal group participants

EXTENDED SCOPE OF PRACTICE FOR THE PHARMACIST
<ul style="list-style-type: none"> • Repeat prescribing (Continuing supply of repeat medication) • Minor ailments scheme (e.g. for antibiotics, urinary tract infections) • Medication adjustments (e.g. dosing, side-effect concerns) • Point of care testing (e.g. blood cholesterol, glucose testing) • Pharmacist-administered vaccinations
NEW OR IMPROVED PHARMACY SERVICES
<ul style="list-style-type: none"> • <i>Increased access to pharmacist or other healthcare professionals</i> (co-location with other healthcare professionals, one-stop shop, virtual pharmacy consultations, home visits/community health workers, increased number of pharmacists in the pharmacy/checking technicians/forward pharmacy/Rolls Royce Service, direct referrals to specialists from pharmacists) • <i>Increased access to medications and information</i> (prompt dispensing and ordering, e.g. online and dispensing terminals, chronic illness card, medication indication on prescriptions, prescription reminder service, home delivery, drive thru service, health promotion and service directory, case-coordinator and information sessions)

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Table 3: Additional quotes illustrating themes

Extended scope of practice for pharmacists
Repeat prescribing (Continuing supply)
<i>Yeah, the pharmacist should be able to make prescriptions. (Consumer_1208; Group_13)</i>
<i>... they [pharmacists] should be able to renew them but I think perhaps they should collaborate with the doctor...sometimes medication has changed... (Carer_1149; Group_17)</i>
<i>Pharmacist needs to be able to prescribe medication, at least one that's been already prescribed, ongoing medication, like contraception pill, or blood pressure medication. (Pharmacy Assistant_2025; Group_11)</i>
<i>... pharmacists able to supply repeat therapies where appropriate. (Pharmacist_2048; Group_18)</i>
<i>... why should I have to spend \$60 going to see the doctor...every time I need a new script? It's daft. (Consumer_1115; Group_8)</i>
<i>... I think the pharmacist profession is... much limited by legislation... if there is a side-effect for our medication...he [pharmacist] should be able to replace this medication for you. (Consumer_1208; Group_13)</i>
<i>... they [pharmacists] can probably do that [prescribe] and free up maybe the system a little bit better... (Pharmacy support staff_2042; Group_14)</i>
<i>Maybe a two month supply [of medication]. Because out here [rural setting] we have... a lot of compliance issues because people run out of their scripts... (Pharmacist_2048; Group_18)</i>
Medication adjustments
<i>Pharmacist reviews with the ability to adjust meds [medication] (Pharmacist_2049; Group_18)</i>
New or extended pharmacy services
Increased access to pharmacist
<i>...they should have an extra chemist on the floor to explain all these things... (IND_Consumer_1106; Group_4)</i>
Co-location with other health care professionals and one-stop shop
<i>... a doctor within the pharmacy, so they come in, we can't do anything about it, straight in to the doctor" (Pharmacist_2068) "Taking that one step further, have an in-pharmacy setup for [a] virtual doctor... " (Pharmacist_2062; Group_23)</i>
<i>... go from door to door and see all their health professionals in a one stop shop... (Pharmacy Support Staff_2024; Group_11)</i>
<i>... have the pharmacy A type class, which is what we have now, and pharmacy B which is the specialist pharmacy who probably is in a health hub, and that's all they do. They don't sell sunglasses and they don't sell body stockings, they just dispense and they are highly trained and you probably pay a bit more... (Carer_1217; Group_15)</i>

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Table 3: Additional quotes illustrating themes contd.

Direct pharmacist referrals to health professionals

...refer to professionals and get me into professionals in a timely manner...
(Consumer/Carer_1179; Group_Pilot2)

Community health workers

...indigenous health workers out in the community, follow up the scripts... (IND_Consumer_2; Group_3)

Prompt dispensing and ordering (online and dispensing terminals)

...a USB script transmitter... some sort of system like a machine at the front or something that you could access, and bang, bang, bang, this is the script and it goes through to them [pharmacy staff] with a private password or key... it issues a script, and it will give you an estimated time when you can come back or it would be ready... (Consumer/Carer_1041; Group_7)

Chronic Illness Card

...a lot of the elders... travel a long way to go to funerals... That card would be priceless if they had that. So if they went a long distance, go the chemist, zap it and do whatever they do and the information is right there for them. Because we all do travel... (IND_Consumer_1158; Group_12)

Prescription Reminder Service

...this is your last repeat, they [pharmacies] should give me a warning...
(CALD_Consumer_1231; Group_21)

Health promotion, information and service directory

Information nights run by pharmacists and doctors for specific health conditions.
(Pharmacist_2053; Group_22)

Appendix 5.3 – Consumers and carers versus pharmacy staff nominal groups

This is the pre-print (pre-refereeing) version of the following paper, which is under review:

McMillan SS, Sav A, Kelly F, King MA, Whitty JA, Kendall E, Wheeler AJ. Consumers and carers versus pharmacy staff nominal groups: do their community pharmacy priorities align? Submitted to *The Patient* 22.07.14.

McMillan S.S, Kelly F, Sav A, Kendall E, King M.A, Whitty J.A & Wheeler AJ. Consumers and carers versus pharmacy staff: do their priorities for pharmacy services align? *The Patient: Patient Centred Outcomes Research* (submitted 22 July 2014; under review).

Consumers and carers versus pharmacy staff: do their priorities for pharmacy services align?

Sara S McMillan,¹ Fiona Kelly,^{1,2} Adem Sav,¹ Elizabeth Kendall,¹ Michelle A King³ Jennifer A Whitty^{1,4} and Amanda J Wheeler.^{1,2}

¹Griffith Health Institute, Griffith University, University Drive, Meadowbrook, Queensland, 4131, Australia

²School of Pharmacy, Faculty of Medical and Health Sciences, University of Auckland, New Zealand

³School of Pharmacy, Griffith Health Institute, Griffith University, Gold Coast Campus, Parklands Drive, Southport, Queensland, 4215, Australia

⁴School of Pharmacy, University of Queensland, Cornwall Street, Woolloongabba, Queensland, 4102, Australia.

Corresponding Author

Sara S McMillan

Population and Social Health Research Program, Griffith Health Institute, Room 2.15, Building L08, Griffith University, University drive, Meadowbrook, Australia, 4131

Telephone: +61 (0)7 338 21571

Fax: +61 (0)7 338 21041

Email: s.mcmillan@griffith.edu.au

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Consumers and carers versus pharmacy staff: do their priorities for pharmacy services align?

Abstract

Background: Health professionals, including pharmacists, are encouraged to meet the needs of their consumers in an efficient and patient centred manner. Yet, there is limited information as to what consumers with chronic conditions need from pharmacy as a healthcare destination, or how well pharmacy staff understand these needs.

Objective: To identify service user priorities for ideal community pharmacy services for consumers with chronic conditions and carers, and compare these priorities with what pharmacy staff think they want.

Methods: The Nominal Group Technique was undertaken with pharmacist, pharmacy support staff, consumer and carer groups, in four Australian regions, between December 2012-April 2013. Participant ideas and priorities for new or improved services were identified, and contextual insight was obtained by thematic analysis.

Results: Twenty-one nominal groups were conducted, including 15 consumer and carer, four pharmacist and two pharmacy support staff groups. Pharmacy staff views generally aligned with consumer priorities, such as access, affordability, patient centred care and continuity and coordinated care, yet diverged with respect to consumer information. Fundamentally, consumers and carers sought streamlined access to information and medication, in a coordinated, patient centred approach. Alleviating financial burden was a key consumer priority, with a call for the continuation and extension of medication subsidies.

Conclusion: Overall, pharmacy staff had a reasonable understanding of what consumers would prioritise, but further emphasis on the importance, delivery, or both, of consumer

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information, is needed. Greater consideration is needed from policy makers as to the financial barriers to accessing medication for consumers with chronic conditions.

Key points for decision makers

- Consumers highly valued information or education; it is imperative for pharmacy staff, especially pharmacists, to provide medication information, in a patient centred way.
- Financial burden is a key issue for medication users; further advocacy is needed to reduce barriers to medication access.

58 **1 Introduction**

59 The burden associated with living with, managing, and treating chronic conditions, alongside
60 the increasing prevalence of long term conditions, has led to countries proposing or initiating
61 numerous health reforms. Health professionals are encouraged by governments and consumer
62 groups to meet the needs of their consumers in an efficient and patient centred manner [1-3].
63 Pharmacists have not been excluded from this directive, particularly as people with chronic
64 conditions are likely to be using medication, and hence, regularly visit a community
65 pharmacy. The pharmacy profession has responded by providing recommendations on how
66 pharmacists can provide further assistance in this area [4-7].

67 In Australia, the pharmacy profession has emphasised the need for pharmacists to be
68 more effectively utilised to improve care for people with chronic conditions [7]. To achieve
69 this, pharmacists must be well informed about the current experiences and needs of
70 consumers with chronic conditions in an increasingly complex health system. In-depth
71 knowledge about what patients prioritise from primary health services, such as pharmacy,
72 will inform recommendations for new or extended pharmacy services that improve consumer
73 experiences and outcomes.

74 The need to involve consumers in healthcare research is well recognised [8],
75 particularly since adults with chronic conditions, especially co-morbidities, are more likely to
76 report unmet healthcare needs [9]. For example, a recent Australian study identified that
77 consumers with chronic conditions experienced financial hardship and valued continuity of
78 care [10], which was verified by health professionals in a follow up study [11]. However,
79 only consumers with specific conditions were included and the research was not specific to
80 community pharmacy services [10]. A study exploring the service priorities of people, with a

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variety of chronic conditions or co-morbidities, and unpaid carers, is timely within the Australian pharmacy context.

This study will identify ‘what’ consumers with chronic conditions prioritise, in terms of service provision, from community pharmacy in the future. Further insight into the role/s for pharmacists could support additional funding and expansion of professional services. Given the evolution of community pharmacy practice, the study findings are an important addition to knowledge in this field. Finally, how well pharmacy staff, i.e. pharmacists and support staff, understand what their consumers would want from them in terms of service provision was also relevant to explore; any disparities would need to be addressed in order for pharmacy staff to provide optimal care. Subsequently, the study aimed to identify the priorities for ideal pharmacy services from the perspective of consumers with chronic conditions and carers, and compare their overall priorities with what pharmacy staff think they want.

2 Methods

The nominal group technique was used to investigate priorities around ideal community pharmacy services. This approach has been used in pharmacy practice research [12], and to explore differences in opinions, e.g. between consumers and pharmacy staff [13]. The nominal group technique offers a platform whereby participants are encouraged to share their ideas and vote on their priorities. The groups participated in four key stages (Table 1); further details of which are described elsewhere [14].

2.1 Study design

Consumer participants were required to have a chronic condition or be an unpaid carer for someone that did (e.g. a family member), as well as live or access care in one of the

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following Australian regions: two urban (areas 1 and 2), one semi-rural and one remote area. Locations are not specified as they could compromise the identity of participants in some areas. To help identify different views, separate groups were held consisting of pharmacists, pharmacy staff, and consumers. Consumers were further stratified into Aboriginal and Torres Strait Islander, carers, and culturally and linguistically diverse groups.

This study modified an approach by Bissell *et al.*, who asked experts to consider the views of other stakeholders, in addition to their own perspectives [15]. Pharmacy staff were asked the same question as consumers and carers, but were directed to consider what their consumers would prioritise as ideal pharmacy services.

2.2 Procedure

Ethics approval was obtained from a University Ethics Committee. Two pilot groups were conducted in November-December 2012 to finalise the facilitator framework (Table 1), and for the four facilitators to familiarise themselves with the technique [14]. There were three facilitators for most groups: a primary facilitator, a scribe for the round-robin and clarification phases, and a note taker who recorded ideas electronically using Microsoft Office® Excel (v14) and calculated the final scores.

A purposive and snowball sampling approach was used for recruitment [16], with assistance provided by community pharmacies, general practices and consumer organisations. It was anticipated that 16 consumer and carer groups (four in each site), and six pharmacy staff groups would be needed to obtain a broad range of participants and ideas.

2.3 Data collection

Nominal groups were undertaken between December 2012 and April 2013, in numerous locations within the four project areas, including community and healthcare centres,

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universities and community pharmacies. Written and verbal consent was obtained prior to audio-recording sessions, which were then transcribed verbatim.

2.4 Data analysis

Both quantitative (original ideas and ranking scores) and qualitative (group transcripts) data were obtained from each group. Thematic analysis of the original group ideas was undertaken by two researchers, and reviewed and discussed by two other researchers for reliability purposes. The thematic framework was validated by the entire research team, resulting in 12 over-arching themes. The overall priorities (i.e. over-arching themes) for the entire data set for consumers, carers, and pharmacy staff were obtained using a technique by Van Breda [17]. This method combined the average score with how often themes appeared in the top five for groups and frequency of themes across groups [17]. The top five priorities per group were identified for between-group comparisons. This analysis method used a relative importance score which considered the total value placed on a theme by each group, even when individuals prioritised different aspects of that theme (e.g. extended opening hours vs. delivery both relate to access) [14]. Using QSR NVIVO 9[®], the qualitative data were coded according to the 12 over-arching themes, thus providing further insight into the group priorities.

3 Results

Twenty-one nominal groups were conducted with 138 participants in 15 consumer and carer ($n=103$), four pharmacist ($n=22$), and two pharmacy support staff groups ($n=13$). Twelve groups were conducted in two urban areas, four groups in a remote area and five in a semi-rural area. There was a range of two to fourteen participants per group, with an average of six to seven members.

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152 The overall top five priorities for consumer and carer groups' ideal pharmacy services
153 are presented (Table 2) and explored further in relation to individual group location and
154 composition (Table 3). Results are compared to the views of pharmacy staff to identify how
155 well they understood the priorities of this consumer group (Table 2).

156 Overall, information or education was the most highly valued pharmacy service for
157 consumers and carers, with twelve groups nominating this theme in their top five priority list.
158 However, pharmacy staff views did not align with this; they perceived that consumers would
159 want innovative services e.g. continued medication supply (Table 2). Otherwise, apart from
160 slight differences in the ranking order of the top priorities, there was alignment in views for
161 other themes.

162 3.1 Consumer information or education

163 Medication related information was a key focus for consumers and carers, with an emphasis
164 on what medication is used for, how to use it, potential side effects, and treatment and
165 monitoring updates. The importance of safeguarding against drug interactions and advising
166 consumers of this was emphasised:

167 *... I take so many [medications] I want to know that they're compatible with each other*
168 Aboriginal and Torres Strait Islander Consumer (Urban 2).

169 Nine out of 15 consumer and carer groups sought further explanation about generic
170 (bio-equivalent) medications, including how they differed from the original brand, who
171 benefited most from their use, and the reason/s for price differences. Pharmacists agreed that
172 generic confusion could be minimised by more consumer information:

173 *I think that generics are still an issue so less confusion, more patient counselling.*
174 Pharmacist (Urban 2).

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175 Consumers and carers wanted pharmacists to proactively and consistently offer verbal
176 and written medication information, and spend time explaining this in a meaningful, patient
177 centred way:

178 ... if you need to use jargon explain what it is... you don't want to feel like you're being
179 treated like you're stupid but at the same time... Consumer (Urban 2).

180 Consumers and carers also sought greater awareness of the existence, or availability, of
181 pharmacy services and medication entitlements.

182 Only pharmacists in the semi-rural region prioritised consumer information in their
183 top five list. Both pharmacy support staff groups thought that consumers would want more
184 time with the pharmacist, expressing a preference for taking on technical tasks to free up
185 pharmacists to do this. Due to concerns over the training or qualifications of pharmacy
186 assistants to provide counselling, consumer and carer groups preferred pharmacists to provide
187 information. Pharmacy support staff suggested the use of badges to highlight their skills to
188 consumers.

189 3.2 Access

190 There was a strong desire for continued or better access to quality medication, equipment and
191 pharmacy services, with further discussion on the *factors* that influenced access, i.e. the
192 pharmacy environment, and *how* to increase this access, i.e. longer opening hours.
193 Ultimately, access was considered important to improve convenience and consequently,
194 relieve some of the burden associated with managing a chronic condition/s or being a carer.
195 Frustration was evident when medication was not in stock, resulting in multiple trips back to
196 the pharmacy:

197 ... they [pharmacy staff] should know that he's on it [the medication] and how long it's
198 going to last and have it there. Consumer/Carer (Rural).

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199 Although there was an appreciation of the reasons why a pharmacy may not have adequate
200 stock of medication, this was of little comfort to rural participants who, compared to their
201 urban counterparts, could not visit another pharmacy as easily:

202 *... better supply of medications in rural areas, because you don't have the choice you*
203 *have in the city...* Consumer (Rural).

204 Conversely, rural and semi-rural pharmacists perceived that their clients would want greater
205 access to pharmacy services, such as simplification of the Home Medication Review¹ process
206 and increased dispensing efficiency.

207 A pharmacy environment conducive to healthcare access was also important for
208 consumers and carers, and further verified by pharmacy staff. This included a clean and
209 comfortable environment, increased privacy, and time with the pharmacist, e.g. more or
210 better utilisation of pharmacy staff and technology. Access to a pharmacist's advice online or
211 via the phone was particularly convenient for people who had physical difficulty visiting a
212 pharmacy:

213 *... we should have like a Pharmacy direct, where you can actually ring and there are*
214 *pharmacists manning phones constantly...* Carer (Urban 2).

215 Longer opening hours or a way to access medication outside of normal trading hours
216 was also discussed by consumer and carers, particularly in the more rural/semi-rural areas.
217 Beyond increased access to the pharmacist, only half of the pharmacy staff groups believed
218 their consumers would want extended opening hours or seven-day pharmacy trading.

219 3.3 Affordability

¹ An accredited pharmacist reviews a person's medication at their home, and reports back to the GP with any medication recommendations.

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220 Affordability was the top priority for three consumer groups and a top five priority in eleven
221 groups, yet not considered as high a priority by pharmacy staff. Although consumers and
222 carers were appreciative of Government initiatives to facilitate equitable medication access,
223 affordability arose as their third (overall) priority. This appeared to be influenced by the
224 cultural background or geographical location of participants. Ideas included free or further
225 subsidised medication, devices, or services, more price consistencies between, and payment
226 options in, community pharmacies.

227 Medication was deemed particularly expensive if a consumer was ineligible for
228 Government subsidies; ultimately, consumers were stuck between ‘a rock and a hard place,’
229 by wanting employment but feeling punished for working. Some consumers experienced
230 treatment delays as they could not afford their medication. Although pharmacy groups
231 confirmed that consumers and carers would want cheaper or free medication, concerns were
232 raised:

233 *... if someone pays nothing for it they don't value it...*Pharmacist (Semi-Rural).

234 While pharmacies were acknowledged within the context of a business, urban
235 participants wanted greater pricing consistency, and rural participants sought better cost
236 alignment with urban areas. No annual increase to the Pharmaceutical Benefits Scheme
237 Safety Net threshold² was requested by some consumers and carers, with rural pharmacists
238 verifying that some consumers who should be eligible, do not reach this threshold as they use
239 various pharmacies and do not maintain a proper medication record.

240 Contrary to other groups, affordable medication was less of a priority for Aboriginal
241 and Torres Strait Islander participants, which was attributable to the Closing the Gap

² Australian's who spend a certain threshold on medications are entitled to either reduced (co-pay), or free, medication supply, for the rest of the calendar year.

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242 initiative.³ Instead, these groups sought greater pharmacy staff awareness of Closing the Gap,
243 and to offer consumer accounts or flexible payment systems, e.g. direct medication payments
244 through Centrelink, an Australian Government welfare organisation:

245 *... if you don't have any money for the medication they have those Centrepay forms*
246 *that you can fill out and it comes out of your pay from Centrelink...* Aboriginal and
247 Torres Strait Islander Carer (Rural).

248 3.4 Patient Centred Care

249
250 Consumers and carers wanted care that encompassed friendly, approachable pharmacy staff
251 who took time to listen, and provided personalised service that recognised and respected their
252 individual needs. This was clearly an important component of any pharmacy service, which
253 reflected a spectrum from personalised service through to care incorporating one or more
254 attributes of patient centred care [18]. At a minimum, people wanted pharmacy staff to smile,
255 be friendly, attentive, and know their names. This also needed to occur within a professional
256 context:

257 *... I don't want them to be my mates. I want them to be my pharmacist.* Aboriginal and
258 Torres Strait Islander Consumer (Urban 2).

259 In contrast, only one pharmacist and pharmacy support staff group believed patients would
260 prioritise patient centred care. Nevertheless, their ideas did align with some consumer
261 suggestions; providing care that was honest and trustworthy, effective communication and the
262 development of a consumer-pharmacist relationship:

263 *I think they'd like to see a pharmacist they know, someone that they've got a*
264 *relationship with.* Pharmacist (Urban 2).

³ Aboriginal and Torres Strait Islanders who have a chronic condition/s may be eligible for subsidised, or free, medications.

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265 Respect was a collective need for consumers and carers when interacting with
266 pharmacy staff. This included maintaining privacy and confidentiality, respecting brand or
267 medication preferences and avoiding a patronising tone during consultations. Respectful care
268 was emphasised by Aboriginal and Torres Strait Islanders, particularly within the context of
269 anti-discrimination and men and women's business:

270 *... having a man come up to me to talk about is really, is like a no. You don't do*
271 *that... Disrespectful.* Aboriginal and Torres Strait Islander Consumer (Urban 2).

272 Culturally appropriate care was a high priority for Aboriginal and Torres Strait
273 Islander peoples; patient centred care was the top priority for three of the four groups.
274 Although patient centred care was less of a priority for culturally and linguistically diverse
275 participants, they did express a desire for culturally appropriate care and good interpersonal
276 communication skills. Use of interpreters was suggested to facilitate the transmission of
277 information and education. Conversely, cultural awareness was not discussed among
278 pharmacy staff groups as something they thought their clients would prioritise.

279 3.5 Continuity and coordinated care 280 281

282 This theme was emphasised by urban consumer and carer groups, with ideas including: co-
283 location and coordination of services or health professionals, healthcare records and follow
284 ups. Group differences were also identified, for example, healthcare records were
285 predominantly discussed by Aboriginal and Torres Strait Islander and carer groups, compared
286 to a referral/triage role by mixed consumer/carers groups.

287 The co-location of health professionals was discussed by consumers and carers as
288 involving either: a 'one stop shop' with all health professionals, pharmacy staff situated
289 within the medical centre, or other health professionals working in the pharmacy. Urban 2

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290 pharmacy support staff thought consumers would want familiar faces in the pharmacy, as
291 well as health professionals to be located there, e.g. online access to a GP, or co-located in a
292 one stop shop:

293 *I think they could have a one stop shop and literally go from door to door and see all*
294 *their health professionals... Pharmacy support staff (Urban 2).*

295 The pharmacy was also viewed by some consumers as an ideal setting for someone,
296 i.e. a pharmacist or other health professional, to provide individualised information, support
297 and to refer them to other services:

298 *Have links/info [information] to all my other health professionals, medications,*
299 *complementary medications and other lifestyle choices, to enable the pharmacist and*
300 *their assistants to offer me the best service and medications and referrals to my needs*
301 *Consumer/Carer (Urban 1).*

302 Extending the pharmacist's role to refer consumers directly to another health professional or
303 service was also viewed by pharmacists as an aspect of continuity of care that consumers
304 would want. Alternatively, a pharmacy support staff group discussed this in the form of a
305 local information directory/portal accessible to consumers.

306 Consumers and carers desired the use of an electronic medication and health record,
307 in the form of a chronic illness card/chip or a national online database, which they and their
308 health providers could access. These records were described as having multiple purposes; to
309 act as a portable record to streamline medication supply, provide individualised information,
310 and prompt pharmacists to remind consumers when check-ups were due or if they were
311 eligible for relevant pharmacy services:

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312 ...if you walk into another pharmacy, they just type in your name and everything
313 comes up...So you don't have to constantly tell everyone the same story... Carer
314 (Urban 2).

315 Pharmacy staff believed that consumers would want streamlined care, with all
316 pharmacist groups emphasising the importance of consistent healthcare records. Open
317 dialogue, e.g. dynamic feedback between pharmacists and GPs regarding a consumer's
318 progress, was also thought to be important to consumers:

319 ...collaboration between the pharmacist and the patient's other healthcare
320 professionals to improve their outcomes...the patient would feel like they had a whole
321 team trying to work for them to improve their health... Pharmacist (Urban 1).

322 **4 Discussion**

323 This study asked consumers with chronic conditions and carers to propose and prioritise their
324 ideas for ideal pharmacy services, and explored how well pharmacy staff understand what
325 these consumers want. Fundamentally, consumers and carers sought streamlined access to
326 information and medication, in a coordinated, patient centred manner. Overall, pharmacy
327 staff had a reasonable understanding of what consumers would prioritise, such as access,
328 affordability, patient centred care and continuity and coordinated care. However, consumers
329 placed greater emphasis on information, underscoring the importance of pharmacy staff
330 optimising counselling procedures in their everyday practice.

331 Only one pharmacist group included consumer information in their top five priorities.
332 It is plausible that the other pharmacists perceived this subgroup of consumers to be 'experts'
333 in managing their chronic conditions, and therefore, less likely to need information.
334 Alternatively, pharmacists would strongly identify with this role given it is a professional
335 practice standard [19], and may have considered counselling as something they routinely do

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336 as a non-negotiable aspect of any pharmacy service. Although rural pharmacists did not raise
337 any specific ideas pertaining to information or education, this is likely influenced by the
338 small number of participants per group. Furthermore, ideas were related to improving
339 healthcare access, aligning with the needs of a rural/remote context.

340 Pharmacy support staff were more in-tune with consumer preferences than
341 pharmacists, which reflect their key customer interaction role [20] as the first person that
342 consumers usually speak to. Ultimately, information needs to be tailored to the specific needs
343 of the consumer [21], in a manner that consumers understand and makes them feel ‘safe’ and
344 respected. Consumers and carers also wanted pharmacists to be more proactive and consistent
345 in offering medication information. While the need for a patient centred approach towards
346 pharmacy counselling has been previously highlighted [22], more work is needed to optimise
347 this. For example, increased tertiary training on interpersonal communication skills is
348 recommended to assist pharmacists to develop consumer relationships [23].

349 Confusion over generic medications is a long established concern, and this study
350 further confirms this issue. Pharmacy staff need to reduce this knowledge gap; optimising
351 consumers’ understanding of generics is likely to promote patient choice, medication safety,
352 and some, if minimal, cost savings for them [24].

353 Patient centred care was the fourth priority overall for consumer and carer groups, and
354 this supports calls for greater adoption of this approach in the pharmacy setting [25, 26]. Only
355 one pharmacist and one pharmacy support staff group voted this theme as a top five priority
356 for consumers and carers. While this result could reflect an assumption that patient centred
357 care is already part of pharmacy services, it would be in the best interest of pharmacies to
358 look towards actively recruiting or training their workforce to address patient centred
359 priorities. Also, research exploring the application of patient centred care within a pharmacy

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360 context is limited. While a recent systematic review proposed that having a relationship with
361 one's clinician can result in a small, but statistically significant improvement in health
362 outcomes [27], further research is needed to determine how patient centred care can be
363 effectively implemented, particularly across different pharmacy settings, and the subsequent
364 pharmacy and consumer outcomes.

365 Cultural awareness and respect was a particular focus for Aboriginal and Torres Strait
366 Islander groups. Strategies to improve care within the context of community pharmacy
367 included enhanced multicultural training for pharmacy staff [28], and supporting
368 opportunities for Aboriginal and Torres Strait Islander peoples to work in pharmacies [29].
369 While there is currently a Government funded program to promote cultural awareness and
370 collaboration between pharmacies and Aboriginal Health Centres [30], the current study
371 suggests that further uptake or promotion of this initiative is needed. Given the limited
372 enrolments of Aboriginal and Torres Strait Islander peoples in vocational and university
373 based pharmacy programs in previous years [31], and the call for more Aboriginal and Torres
374 Strait Islander pharmacists to optimise care for their people [32], the continuation and
375 expansion of programs supporting Aboriginal and Torres Strait Islanders to enter the
376 pharmacy workforce is relevant [32, 33]. This is even more important when, compared to
377 other Australians, Aboriginal and Torres Strait Islander people have poorer health outcomes
378 [34].

379 This study clearly identified that affordability is still a key concern of consumers with
380 a chronic condition/s and their carers, particularly for those ineligible for Government
381 subsidies. Pharmacy staff appeared to have some understanding of financial burden for these
382 consumers, with agreement that they would want 'cheaper' or 'free' medication.
383 Unfortunately, the Australian Government's 2014 budget proposals indicate that medication

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384 prices and Safety Net thresholds for consumers are set to rise [35]. Cost impacts on
385 medication adherence [36]: increased medication co-payments result in reduced medication
386 utilisation and thus, non-adherence [37, 38], and full medication subsidy increases adherence
387 [39]. It is concerning that this population, who need medication the most, may experience
388 delays in treatment because of financial burden. The pharmacy profession and consumer
389 health organisations should advocate for the removal of barriers to medication access, thus
390 improving the Quality Use of Medicines. At a grass-roots level, community pharmacy staff
391 should also raise awareness of the Safety Net Scheme to ensure that all eligible consumers
392 can access cheaper medication; and consider providing additional payment options as
393 discussed by consumer and carer groups, e.g. payment plans or direct payment from welfare
394 agencies.

395 The rollout of patient controlled electronic health records is continuing. Community
396 pharmacists should consider utilising this technology as it has the potential to address
397 consumer and carer needs, i.e. streamlined care. Consumers and carers also identified the
398 community pharmacy as a plausible setting for care coordination to occur. Subsequently, the
399 concept of the community pharmacy becoming a health hub destination [40] becomes more
400 tangible.

401

402 **5 Limitations**

403 This study focused on consumers who have a chronic condition or are carers, a subgroup of
404 the Australian population. The extent to which they can be generalised to other groups, for
405 example to other health jurisdictions, is an empirical question. By agreeing to participate,
406 both consumers and pharmacy staff were likely to be proactive and interested in healthcare
407 improvements, thus potentially influencing their responses. However, these participants were

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408 regular health service users, and thus their viewpoints are particularly relevant. While only
409 four areas were included in the study sample, these were diverse in nature and comprised
410 rural and urban living. Apart from cultural diversity and geographical location, the results
411 were not analysed with respect to other participant demographics, e.g. age, chronic
412 condition/s, medication usage, or, for pharmacy staff, work employment history. It is
413 plausible that these other factors influenced what participants considered to be important with
414 respect to ideal pharmacy services. Although researchers re-coded the original nominal group
415 ideas to themes to allow for group comparisons, bias was limited through research validation,
416 quality checking and use of a consumer researcher. Finally, pharmacy staff were asked to
417 consider what they thought their clients would prioritise in terms of pharmacy services; it is
418 possible that some of their own ideas reflected what they wanted as a health professional.

419

420 **6 Conclusion**

421 Pharmacy staff generally understood consumer and carer needs. However, consumers valued
422 information or education the most; a theme lacking from pharmacy staff responses. It is
423 imperative for pharmacy staff, especially pharmacists, to provide medication information, in
424 a patient centred way. Financial burden emerged as a key issue for medication users, in
425 contrast with Australian Government intentions to increase medication costs. Therefore,
426 greater consideration is needed from policy makers as to the financial barriers for consumers
427 with chronic conditions to access medication.

428

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429 **Conflict of interest**

430 None.

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436

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440

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Table 1: Nominal Group framework for facilitators

Stages	Process	Time (min)
<i>Introduction</i>	To provide an overview of the study and objectives of the group. Confirm/obtain participant consent.	10
<i>Initial brainstorm</i>	Participants are asked the following question: <i>What would you describe as your most positive experience with a health care service or from seeking care within the Australian healthcare system?</i> Sets the scene and facilitate discussion about the positive aspects of healthcare experiences that can be translated into future solutions.	15
<i>Silent generation</i>	Participants are instructed to record as many ideas down as possible in silence in response to this question: <i>Imagine your local pharmacy several years into the future, what services could they offer to help you to meet your individual health goals?</i>	10
<i>Round Robin</i>	Each participant presents one idea, this continues until ideas are exhausted. This is recorded on a whiteboard.	15
<i>Clarification</i>	An opportunity to clarify/elaborate ideas on the board. Items checked for duplication and possible grouping.	25
<i>Voting/ Ranking</i>	Participants select their top FIVE preferences and then rank them (i.e. 5= most important item, 1=least important).	10
<i>Discussion</i>	Total scores presented and discussed with group.	20

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Table 2: Top five priorities for consumer and carer groups

	Final Rank (Overall Priority)	Frequency the theme was in the top priority list (for all groups)		Frequency the theme was the top priority (for all groups)	
Consumers, carers or both (n=15)		(n)	(%)	(n)	(%)
Consumer information or education	26.50	12	80.0	1	6.7
Access	25.50	10	66.7	2	13.3
Affordability	25.00	11	73.3	3	20.0
Patient centred care	24.50	8	53.3	3	20.0
Continuity/coordinated care	24.00	9	60.0	2	13.3
Pharmacy staff (n=6)		(n)	(%)	(n)	(%)
Innovative services and roles	27.00	6	100.0	2	33.3
Continuity/coordinated care	26.00	4	66.7	1	16.7
Access	23.00	5	83.3	2	33.3
Affordability	22.00	4	66.7	0	0
Patient centred care	18.00	2	33.3	1	16.7

Table 3 Consumer, Carer and Pharmacy Staff Priorities for Ideal Pharmacy Services

Aboriginal and Torres Strait Islander (Consumer) Priorities								
	Urban area 1 Group 3 (n=14)	%	Rural Group 20 (n=6)	%	Semi-Rural Group 4 (n=8)	%	Urban area 2 Group 12 (n=7)	%
One	Patient centred care	40.5	Access	44.4	Patient centred care	30.0	Patient centred care	62.9
Two	Continuity & coordinated care	23.3	Patient centred care	25.6	Health promotion	19.2	Continuity & coordinated care	16.2
Three	Affordability	12.9	Affordability	16.7	Continuity & coordinated care	15.0	Health promotion	11.4
Four	Consumer information or education	10.5	Consumer information or education	7.8	Quality of service delivery	15.0	Access	4.8
Five	Access	5.7	Quality of service delivery	4.4	Access	10.0	Consumer information or education	1.9
Consumer Priorities								
	Urban area 1 Group 6 (n=6)	%	Rural Group 16 (n=4)	%	Semi-Rural Group 8 (n=10)	%	Urban area 2 Group 09 (n=5)	%
One	Access	28.9	Affordability	21.7	Innovative services & roles	41.3	Affordability	30.7
Two	Affordability	24.4	Consumer information or education	21.7	Consumer information and education	32.7	Patient centred care	16.0
Three	Innovative services & roles	21.1	Supply related service	21.7	Quality of service delivery	12.0	Consumer information or education	16.0
Four	Consumer information or education	14.4	Access	15.0	Affordability	10.0	Quality of service delivery	10.7
Five	Medication management	11.1	Innovative services & roles	15.0	Patient centred care	4.0	Government initiative/legislative change	10.7

Mixed Group Priorities								
	Urban area 1 Group 2 (n=6)	%	Rural Group 5 (n=6)	%	Semi-rural Group 15 (n=8)	%	Urban area 2 Group 13 (n=6)	%
One	Continuity and coordinated care	33.3	Affordability	28.9	Innovative services and roles	20.8	Innovative services and roles	31.1
Two	Access	23.3	Consumer information or education	18.9	Consumer information or education	20.0	Consumer information or education	16.7
Three	Quality of service delivery	17.8	Access	11.1	Supply related services	16.7	Access	16.7
Four	Consumer information or education	15.6	Continuity and coordinated care	10.0	Continuity and coordinated care	12.5	Continuity and coordinated care	13.3
Five	Affordability	8.9	Innovative services and roles	10.0	Patient centred care	7.5	Health promotion	8.9
Carer Group Priorities								
	Urban area 1 Group 7 (n=7)	%	Rural Group 17 (n=5)	%	Semi-rural Group 21 (n=5)	%		
One	Continuity and coordinated care	25.7	Medication management	24.0	Supply related service	21.3		
Two	Medication management	24.8	Affordability	21.3	Consumer information or education	17.3		
Three	Affordability	22.9	Innovative services and roles	18.7	Affordability	17.3		
Four	Government initiative/legislative changes	17.1	Patient centred care	17.3	Access	14.7		
Five	Quality of service delivery	8.6	Continuity and coordinated care	13.3	Quality of service delivery	12.0		

Pharmacist Group Priorities								
	Urban area 1 Group 23 (n=7)	%	Rural Group 18 (n=2)	%	Semi-rural Group 22 (n=7)	%	Urban area 2 Group 10 (n=6)	%
One	Continuity & coordinated care	48.6	Innovative services & roles	43.3	Access	41.9	Patient centred care	36.7
Two	Access	21	Affordability	30	Affordability	28.6	Innovative services & roles	13.3
Three	Affordability	16.2	Access	16.7	Innovative service & roles	21	Continuity & coordinated care	11.1
Four	Innovative services & roles	8.6	Continuity & coordinated care	10	Consumer information or education	5.7	Access	10
Five	Health promotion	5.7	-*		Government initiative / legislative changes	2.9	Government initiatives /legislative changes & Health promotion	8.9
Pharmacy Support Group Priorities								
	Urban area 1 Group 14 (n=4)	%					Urban area 2 Group 11 (n=9)	%
One	Innovative services and roles	36.7					Access	40.7
Two	Quality of service delivery	21.7					Continuity & coordinated care	20.7
Three	Patient centred care	15					Affordability	11.9
Four	Consumer information or education	15					Consumer information or education	8.1
Five	Supply related service	8.3					Innovative services & roles	5.2

*Only four priorities were identified for this group.

Appendix 5.4 – Facilitator Information Sheet on Nominal Group Process

Nominal Group Technique: information guide for facilitators

What is it?

The Nominal Group Technique (NGT) is a technique used to elicit people's priorities about a topic. For the Chronic Illness study, the aim is to explore what people with chronic conditions and carers want from community pharmacy, i.e. what would their ideal pharmacy look like? We will also explore their views on what their ideal health care service would look like.

It is a highly structured process that involves the generation of individual ideas which are then discussed as a group and individually voted on. It involves three main phases: (i) silent generation of ideas, (ii) round-robin and clarification and (iii) voting. Three facilitators are required to assist in this process: the facilitator who guides the group processes (facilitator 1), a person to take notes for the participants and record group ideas on the white board (facilitator 2) and a third person who records the ideas, keeps time and confirms the final voting (facilitator 3).

It is important for the group facilitator to direct the whole process as this will minimise participant confusion and help to maintain their focus. For this to work, there should be minimal interruption/direction from the other two facilitators i.e. their roles are primarily supportive.

Participant details

A range of NGTs will be conducted involving these specific groups: consumers, carers, people from culturally and linguistically diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander background, pharmacy support staff, pharmacists, allied health professionals and general practitioners (GPs). The target participation number is 6 to 10 people per group. Each participant will be provided with background information on the project and the questions to expect at the session prior to attending the NGT (**Appendix 1**).

The process

A guide for the NGT process has been attached. This is a run sheet so that Facilitator 3 can keep an eye on the time (**Appendix 2**).

1. Introduction [Facilitator 1]

- Welcome and introduction (include the aims of NGT session)
- Confirm consent and ethical obligations
- In the event that participant demographic information is missing, Facilitator 1 will follow this up with individuals as they arrive / delegate to another facilitator.

Important points: The group facilitator should emphasise the importance of their individual participation for the NGT to work and that it is structured in a way that enables everyone to have their say, i.e. because everyone has great ideas, we are using this structure to ensure that all ideas are heard.

2. Icebreaker [Facilitator 1]

- Participants are asked to share their most positive experience with a health care service or from seeking care within the Australian healthcare system. This will help participants to adopt a positive approach to problem solving, with the aim to encourage them to think about more creative solutions for the future.

Important points: The facilitator needs to keep participants focused on positive experiences. An example could be: *Thank you for your story. Whilst we acknowledge that many of you may have negative health care experiences, we would like to try and focus on positive experiences instead. This will help you to think about what your ideal health care service looks like, which is what we will focus on in this session.*

If this is challenging, an alternative question could be: *what are some of the things you value most in a health care service? Or, what are some of the things that you have liked about health professionals?*

3. Nominal Group Question 1

Imagine an ideal healthcare service several years into the future, what should this service look like?

Silent Generation Phase [Facilitator 1]

- Participants will be provided with the following written question: *Imagine an ideal healthcare service several years into the future, what should this service look like?*
- Participants are instructed to record as many ideas down as possible in silence. Encourage people to write down whatever they think of and emphasise that all ideas are important.

Round Robin Phase [Facilitator 1]

- Each participant presents one idea at a time, this is kept going until there are no more new ideas

Important points: Participants should be advised that everyone takes turns, i.e. if they want to add another idea then they should wait their turn. This way everyone gets a say. This stage should not involve any discussion of what the ideas mean. Advise people that if they think of a new idea whilst someone else is talking, they can write it down or just share it with the group when they have their next turn.

[Facilitator 2]

- Needs to record all participant ideas on a whiteboard

Important point: It is important for the points on the board to be recorded as accurately (verbatim) as possible, i.e. the facilitator should not clarify or reword participant responses. The facilitator can always confirm what they have written with the participant to ensure accuracy.

[Facilitator 3]

- Needs to record all participant ideas verbatim on an ExcelL document (**see Appendix 4 for template**)

Discussion/Clarification Phase [Facilitator 1]

- This is an opportunity to clarify/elaborate ideas. Each item is read out to ensure that the group understands its meaning and to provide opportunity for further discussion of that idea.
- Items checked for duplication to allow for removal of duplicates and possible grouping of similar ideas.

Important points: The participant that offered the idea does not necessarily have to clarify it; this can be done by any participant in the group. All items must be given equal time for clarification, therefore timing is important. Participants should be instructed that grouping is for similar ideas only and that they need to agree on this – there should be no/minimal instruction from the group facilitator [and all other facilitators] for this process. The group facilitator can always ask: *Are there any similar ideas on the board?*

[Facilitator 2]

- Should re-group ideas if needed on a separate section of the whiteboard, or alternatively on butchers paper. This will help participants to vote on ideas.

Important points: This should end up with a more structured list of ideas; however, items do not need to be grouped if they are all different. An example of what this could look like is below If the list contained the following points:

Original list (Round robin phase)	Second list (Clarification phase)
Free prescription medications	A. Efficient health care <ul style="list-style-type: none"> • No waiting times • Easier access to test results • More services and resources in regional areas
No waiting times	B. Affordability <ul style="list-style-type: none"> • Free prescription medications • Free counselling services
Free counselling services	C. Empathic and caring professionals
Empathic and caring health professionals	D.
More services and resources in regional areas	E.
Easier access to test results	F.

[Facilitator 3]

- Needs to record the clarification list on an Excel document and keep timing of process

Scoring [Facilitator 1]

- Participants select their top FIVE preferences.
- They then score their preferences (i.e., 5 most important item, 1 least important)

Important points: The facilitator should explain that although all items are important and will be used, participants are required to individually choose what the most important items are for them. They should choose their top five items first and place in any order under the 'Letter' column (see fig. below using previous example). Emphasise that first they just choose the five ideas that they consider most important.

Participants can choose to provide further comments about their choices. (The fig. below shows this for item B.)

Participants are then asked to score their five preferences. The facilitator needs to explain that their number one choice should be awarded the highest score of 5 points, their second choice 4 points and so on. Please use the word 'score' rather than 'rank' as when participants are asked to rank they may rank their most important item as 1. Alternatively, if participants are confused then the facilitator can describe it the following way: Select your top priority or choice from your list and award it 5 points. Then select your lowest priority or choice and award it one point. Now choose the top priority from the letters remaining and award it 4 points and so on...

<u>LETTER</u>	<u>Additional Comments</u>	<u>SCORE</u>
C		3
A		1
B	Referring to free prescription medications	5
F		2
D		4

[Facilitator 2]

- Should watch to see that everyone understands the scoring process and provide guidance if necessary.
- Collect the ranking sheets when participants have finished scoring and give to Facilitator 3.

[Facilitator 3]

- Using Excel spreadsheet, scores should be totalled to identify the top 5 scores (see fig. below). **(see Appendix 4 for template)**

	A	B	C	D	E	F	G	H	I	J
1	Item #	Item Description	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6	Total Points	
2	A	Efficient health care		5	2				7	
3	B	Affordability	3	4	5				12	
4	C	Empathic and caring professionals	5		4				9	
5	D		4	2	1				7	
6	E		2	3	3				8	
7	F		1	1					2	
8										
9										
10										

Conclusion of Nominal Group 1

[Facilitator 3]

- To let participants know the final top 5 scored items.

[Facilitator 1]

- If time allows, to facilitate discussion of the above findings.

Important points: This part of the group can reveal quite important insights into the reasoning behind peoples' scoring. If people are slow to talk you can start the conversation by asking whether people were surprised by the top priorities / why they think that those priorities were at the top and others were at the bottom.

3. Nominal Group Question 2 (see Appendix 3 for participant sheets)

The above process for Nominal Group technique 1 is followed for the following question:

Now imagine your local pharmacy several years into the future, what services could they offer to help you to meet your individual health goals?

4. Concluding Session [Facilitator 1]

Important Point: For pharmacy staff groups, if there is time the facilitator may pose another question to participants for general discussion: **What would pharmacy staff like to see change so that they can provide these services / care?**

- Thank everyone for their time
- Seek further recruitment for Stage 3
- Provide gift vouchers

5. Debrief of session between facilitators

If there is time, a quick debrief would be appreciated for feedback/quality assurance purposes.

Appendix 5.5 – Facilitator Run Sheet on Nominal Group Process

(Report - Section 3.2, Nominal groups to explore priorities of health consumers and carers, pg. 38)

	Step 1: Introduction & general discussion	Timing
	<ul style="list-style-type: none"> Overview of project Overview of today – test a process, get their views on healthcare & pharmacy, feedback This stage sets the scene and facilitates discussion about the positive aspects of healthcare experiences that can be translated into future solutions. <p>What would you describe as your most positive experience with a healthcare service or from seeking care within the Australian healthcare system?</p> <p>What are some of the things that you value most in a healthcare service?</p>	15
	Step 2: Nominal group – What should health care be ideally?	
	<p>Imagine an ideal healthcare service several years into the future, what should this service look like? This could include any of the following:</p> <ul style="list-style-type: none"> What the service is Where it is How it is delivered Who delivers it / Who is in it 	
1	An overview of the NGT is provided – importance of their ideas and then we decide what is most important. We'll take you through this step by step. Group is given this question and asked to consider how they would respond with respect to ideas or solutions or strategies.	
2	Silent generation - Participants instructed to record as many ideas as possible in silence.	10
3	Round robin - each participant presents one idea, keep going until there are no more new ideas	15
4	Discussion / clarification of solutions - this section is an opportunity to clarify any of the ideas and elaborate on them if we need to. We also need to look for duplication and whether items should be grouped together.	25
5	Participants select their top FIVE preferences	
6	Score - Rank preferences by allocating 5 to most important down to 1 (the least important).	10
	Break (20 minutes) Participants will be asked to consider what else community pharmacy could offer them as they go into the break so informal discussions can take place.	
	Step 3: Nominal group – How can we better use the resource of community pharmacy?	
	Now imagine your local pharmacy several years into the future, what services could they offer to help you to meet your individual health goals?	
1	Participants are reminded this is the same process as before the break. Group is given this question and asked to consider how they would respond with respect to ideas or solutions or strategies.	
2	Silent generation - Participants are instructed to record as many ideas down as possible in silence.	10
3	Round robin - each participant presents one idea, keep going until there are no more new ideas	15
4	Discussion / clarification of solutions - this section is an opportunity to clarify any of the ideas and elaborate on them if we need to. We also need to look for duplication and whether items should be grouped together.	25
5	Participants select their top FIVE preferences	
6	Score - Rank preferences by allocating 5 to the most important down to 1 to (least important).	10
7	Group discussion of votes – we present the total scores for both sections here and have a brief discussion which is audio taped.	25

Appendix 5.6 – Letter about the Nominal Group Process for Consumer & Carers



Dealing with and ongoing condition
or caring for someone who does?

How can we improve healthcare?



Ongoing (chronic and long term) health conditions (e.g. asthma, diabetes) can have a significant impact on the people who experience them, on those who care for them (carers) and on other family members. This impact can include the negative effect of symptoms like pain or restriction of daily activities, or the workload created by the treatment(s) that are required to manage these conditions (e.g. multiple medical appointments, medication side effects). This impact is also known as 'treatment burden' and can include the time taken to do the daily tasks that must be performed by people in order to monitor their illness, the financial burden of treatment, or the burden associated with accessing and using healthcare services (e.g. hospital waiting lists).

When changes are made to improve healthcare, people who use healthcare are not always consulted about what is important to them. People want their concerns to be heard. They want their healthcare experiences and priorities to be valued. People value caring healthcare professionals, who take time to listen to their patients, get to know them, treat them as an individual, consider their overall situation as well as their specific health condition(s) and respect their opinions.

One healthcare professional who can offer a range of healthcare services is your local pharmacist. However, pharmacies are often only used to purchase medicines. Your local (community) pharmacy has trained health professionals (pharmacists and assistants) who can provide advice or healthcare services whenever you need them. In the last ten years, pharmacies have offered new services in addition to medication supply, and the profession is looking to extend its role(s) in the future. Although not all pharmacies offer all of these services, they might offer some of the services below.

Standard Services

Services that most pharmacies offer

- **Medication supply:** Medication on prescription, without prescription, herbal medication, home deliveries. Pharmacists check medication safety before supply, provide medication and health care advice.
- **Medication returns:** Unwanted medication can also be returned to the pharmacy.
- **Dose Administration Aids (e.g. Webster -pak®):** Condensing medication(s) into a weekly pack.
- **Home Medication Reviews:** A specially trained pharmacist will discuss all of your medications and medication needs with you at home to ensure that you get optimal, safe and effective use of medication(s).
- **Additional services or programs:** Some pharmacies offer advice/programs for diabetes, weight management, smoking cessation, opioid cessation, health checks and immunisations.

New Services

Services that some pharmacies offer

- **Health promotion:** Improve health care awareness via information to prevent ongoing health conditions.
- **Screening and risk assessment:** Identify people undiagnosed and raise awareness of risk factors.
- **Condition monitoring:** Provide monitoring, information and self-management advice.
- **MedsCheck:** A pharmacist will discuss all of your medications and health goals in the pharmacy. There is also a similar service for Type 2 diabetes (Diabetes MedsCheck).
- *Please note that these services are often for ongoing health conditions like diabetes, mental health, etc.*

Future Services

Potential role(s) for Australian pharmacists in the future

- **Continuing medicine supply:** Trained pharmacists continue a person's normal medications (i.e. provide repeat prescriptions).
- **Medication prescribing:** Specially trained pharmacists can prescribe medication(s) for a specific range of conditions (i.e. provide a prescription for a new medication).
- **Outreach services:** Pharmacists provide health care medication advice to communities with no pharmacy access.
- **Immunisation providers:** Specially trained pharmacists administer a variety of vaccinations.

If you would like to take part in the Chronic Illness Project or to find out more,
please Free call 1800 600 687 or visit www.chronicillnessproject.com.au

Appendix 5.7 – Participant Nominal Group Worksheets

(Report - Section 3.2, Nominal groups to explore priorities of health consumers and carers, pg. 38)

Step 2: What should healthcare be ideally?

Imagine an ideal healthcare service several years into the future, what should this service look like?

Please record your responses to this question below. Your individual ideas are important and they can be as broad or specific as you like.

2. Healthcare Service

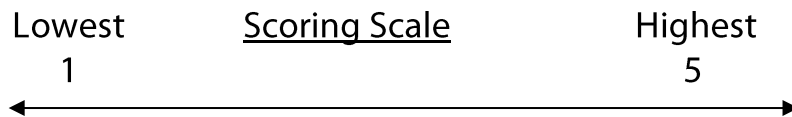
Step 1.

Of all the options up on the board please select 5 which you feel are most important and in the first column place the assigned letters (eg. D, A, F, G, etc.) of these preferences.

Step 2.

Of your selected options, please assign these options a score from '5' to '1' in the second column.

5 being the highest score (what you feel is most important to you) and 1 being least important.



<u>LETTER</u>	<u>Additional Comments</u>	<u>SCORE</u>

Step 3: How can we better use the resource of community pharmacy?

Considering your ideal healthcare service:

Now imagine your local pharmacy several years into the future, what services could they offer to help you to meet your individual health goals?

Please record your responses to this question below. Your individual ideas are important and they can be as broad or specific as you like.

3. Community Pharmacy

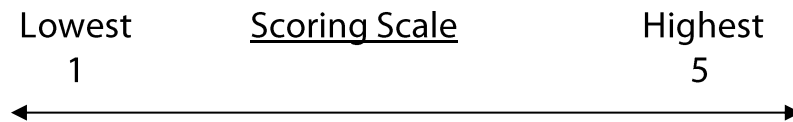
Step 1.

Of all the options up on the board please select 5 which you feel are most important and in the first column place the assigned letters (eg. D, A, F, G, etc.) of these preferences.

Step 2.

Of your selected options, please assign these options a score from '5' to '1' in the second column.

5 being the highest score (what you feel is most important to you) and 1 being least important.



<u>LETTE</u>	<u>Additional Comments</u>	<u>SCORE</u>

Appendix 5.8 – Nominal Group Themes for Ideal Pharmacy

1. **Access:** Any references to accessing care and can include examples such as 24 hour access, limited access due to location, etc.
 - **Environment:** References to environment that care is delivered in, physical space of the pharmacy (e.g. privacy, stocked products).
2. **Affordability:** Any reference to costs or affordability of care e.g. free or subsidised medical tests or services (i.e. increased Medicare rebates for other services such as dental care, medical testing/equipment, Webster packs/dose administration aids, deliveries, prescription repeats to be sent to the pharmacy so GP fee is by-passed); free or consistent or subsidised medication (i.e. reduced medication costs, non-prescription medications are similar prices for all pharmacies, consistent pricing for generic/original medication brands); accounts (i.e. to have an account system so people can pay when they can).
3. **Consumer education/information:** anything in relation to providing the consumer more medication (i.e. about medications such as side effects, benefits, how to use them correctly) or services information.
 - **Pharmacy Marketing:** Marketing of the pharmacists' roles and services they offer to the community.
4. **Continuity and coordinated care**
 - **One-stop shop:** Having all health professionals/services under the one roof/centre.
 - **Continuity of care:** Anything to do with maintaining care (e.g. providing medical records, having the same staff on to develop relationships).
 - **Collaboration /coordinated care:** Any reference to coordinated care or collaborative care between health care professionals, or between health care professionals and consumers. Also refers to better relationships between pharmacy staff and other health care professionals.
 - **Healthcare records:** References to healthcare records (e.g. medication records, e-health/portable information (USBs), access to medical records, better co-ordination of patient information between health professionals, more comprehensive recording).
5. **Quality of Service Delivery**
 - **Professional competency (HCP):** Anything in relation to pharmacy staff members providing a quality service, following or improving professional standards, duty of care etc. (i.e. a need to improve pharmacy assistant or pharmacist training to become more competent).
 - **Quality assurance and improvement:** Any reference to improving the availability and delivery of services that is not specific to staff training (e.g. bigger medication labels).
6. **Innovative services and roles:** Anything in relation to new pharmacy or health service roles (i.e. ability to prescribe medication).
7. **Health promotion:** This focuses on preventative health and health promotion (i.e. lifestyle or non-medication related services such as smoking cessation and other innovative services (i.e. walking groups).
 - **Screening and monitoring:** Anything in relation to diagnostic tests to check patient progress (i.e. blood pressure, blood glucose readings, INR testing).

8. **Medication management:** Anything in relation to pharmacy staff helping consumers to manage their medications (i.e. dose administration aids, medicine use reviews, organising repeats/new prescriptions via the doctor).
9. **PCC:** references to the four attributes of PCC, or when this type of care was lacking:
 - **Empowering:** anything to do with assisting consumers to become more proactive/expert in their condition. Encourages autonomy, self-confidence and self-determination, facilitates a person's participation in decision making which requires effective communication and negotiation.
 - **Holistic:** recognises and values the whole person, including social, psychological, emotional and spiritual factors. Not just focusing on the disease itself, person not seen as a number, can relate to them.
 - **Individualised:** considers the individuals unique needs, personal situation (i.e. preferences, beliefs, culture), and specific health concern.
 - **Respectful:** recognises individuals as active health consumers. Respects consumer choices. Anything to do with listening and appropriate communication skills (this could also be coded under individualised care). Also, any comment relating to the person knowing more about their conditions than the doctor, or the doctor [not] acknowledging the person's strengths and abilities.
 - **Interpersonal relationships (health professional):** References to the type of interaction that they would like or desired qualities in a healthcare professional (i.e. approachability, efficiency, promptness, ethical and trusting).
 - **Gender awareness:** any reference to respecting gender-specific needs (i.e. men's business).
 - **Culturally appropriate:** Improving healthcare through culturally appropriate services (e.g. awareness of closing the gap, assisting consumers who have limited English via interpreters, cultural awareness, and no discrimination/racism).
10. **Supply related service:** Services related to medicine supply (i.e. delivery and return of medicines). Does not include innovative medication services.
 - **Labelling and repeats (medication):** Any references towards labelling of products/medication, the number of repeats available, how easy the information is to read/understand etc.
11. **Government initiative/legislative changes:** Macro-level changes within the health system (i.e. easier access to new medication, how to navigate the health system etc.) Also changes within the pharmacy structure (i.e. how repeats are managed, pricing differences).
12. **Carer:** Anything to do in relation to a carer (i.e. their needs, experiences, ideal care).

Appendix 5.9 – Consumer, Carer and Health Professional Priorities for Ideal Pharmacy

Mixed Group Priorities								
Aboriginal and Torres Strait Islander (Consumer) Priorities								
	Logan/Beaudesert	%	Mt Isa	%	Northern Rivers	%	Perth	%
	Group 3 (n=14)		Group 20 (n=6)		Group 4 (n=8)		Group 12 (n=7)	
One	Patient centred care	40.5	Access	44.4	Patient centred care	30.0	Patient centred care	62.9
Two	Continuity & coordinated care	23.3	Patient centred care	25.6	Health promotion	19.2	Continuity & coordinated care	16.2
Three	Affordability	12.9	Affordability	16.7	Continuity & coordinated care	15.0	Health promotion	11.4
Four	Consumer information or education	10.5	Consumer information or education	7.8	Quality of service delivery	15.0	Access	4.8
Five	Access	5.7	Quality of service delivery	4.4	Access	10.0	Consumer information or education	1.9
Consumer Priorities								
	Logan/Beaudesert	%	Mt Isa	%	Northern Rivers	%	Perth	%
	Group 6 (n=6)		Group 16 (n=4)		Group 8 (n=10)		Group 09 (n=5)	
One	Access	28.9	Affordability	21.7	Innovative services & roles	41.3	Affordability	30.7
Two	Affordability	24.4	Consumer information or education	21.7	Consumer information and education	32.7	Patient centred care	16.0
Three	Innovative services & roles	21.1	Supply related service	21.7	Quality of service delivery	12.0	Consumer information or education	16.0
Four	Consumer information or education	14.4	Access	15.0	Affordability	10.0	Quality of service delivery	10.7
Five	Medication management	11.1	Innovative services & roles	15.0	Patient centred care	4.0	Government initiative/legislative change	10.7

Pharmacist Group Priorities								
	Logan Beaudesert Group 23 (n=7)	%	Mt Isa Group 18 (n=2)	%	Northern Rivers Group 22 (n=7)	%	Perth Group 10 (n=6)	%
One	Continuity & coordinated care	48.6	Innovative services & roles	43.3	Access	41.9	PCC	36.7
Two	Access	21	Affordability	30	Affordability	28.6	Innovative services & roles	13.3
Three	Affordability	16.2	Access	16.7	Innovative service & roles	21	Continuity & coordinated care	11.1
Four	Innovative services & roles	8.6	Continuity & coordinated care	10	Consumer information or education	5.7	Access	10
Five	Health promotion	5.7	-		Government initiative / legislative changes	2.9	Government initiatives /legislative changes & Health promotion	8.9
Pharmacy Assistant Group Priorities								
	Logan Beaudesert Group 14 (n=4)	%					Perth Group 11 (n=9)	%
One	Innovative services and roles	36.7					Access	40.7
Two	Quality of service delivery	21.7					Continuity & coordinated care	20.7
Three	PCC	15					Affordability	11.9
Four	Consumer information or education	15					Consumer information or education	8.1
Five	Supply related service	8.3					Innovative services & roles	5.2

GP Group Priorities						
	Logan Beaudesert Group 24 (n=4)	%	Brisbane Group 25 (n=3)	%	Brisbane Group 27 (n=3)	%
One	Medication management	38.3	Quality of service delivery	37.8	Consumer education / information	37.8
Two	Quality of service delivery	28.3	Consumer education / information	35.6	Affordability	30
Three	PCC	23.3	Continuity & coordinated care	13.3	Access	23.3
Four	Innovative services and roles	8.3	Affordability	8.9	Medication management	6.7
Five	Continuity & coordinated care	1.7	Innovative services and roles	4.4	Continuity & coordinated care	2.2
Allied Health Professional Priorities						
	Logan Beaudesert Group 26 (n=9)	%	Mt Isa Group 19 (n=4)			
One	PCC	27.4			Medication management	25
Two	Continuity & coordinated care	25.9			Access	23.3
Three	Quality of service delivery	19.3			Continuity & coordinated care	21.7
Four	Affordability	16.3			Consumer information and education	20
Five	Health promotion	11.1			Quality of service delivery	10

N.B. Red emphasises themes that were prioritised across all groups for that particular sub-group (e.g. Aboriginal and Torres Strait Islander Consumers, Consumers, Mixed, Carers, Pharmacist, Pharmacy Assistant, GP and Allied HealthCare Professionals).