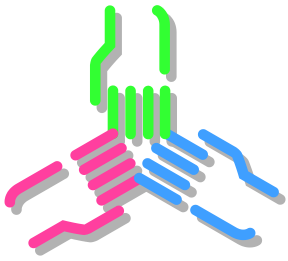
Central Bayside
Division of General Practice Ltd.

Pharmacy and General Practice Disease Management Collaboration



Final Report

April 2003

Central Bayside Division of General Practice Ltd
193 Bluff Road
SANDRINGHAM, VIC 3191
Tel: 03 9521 6755 Fax: 03 9521 6855
www.centralbayside.com.au
info@centralbayside.com.au

For further information contact Roy Batterham
roy.batterham@centralbayside.com.au

Acknowledgements

This project was funded by the Commonwealth Department of Health and Ageing as part of the Third Community Pharmacy Agreement under the Research and Development Grants Program. The authors wish to thank the staff of the Pharmacy Guild of Australia for their unflagging interest in, and support of, this project. We also thank the staff of the Pharmaceutical Society of Australia for their input and their assistance locating relevant literature. A special mention also goes to the staff at Central Bayside Division of General Practice who provided such great support over the life of the project, it has been much appreciated.

Mostly we wish to thank all the local consumers, GPs and pharmacists who participated in focus groups and have been enthusiastic in taking on the project, their input and feedback has been invaluable.

Project Team

Roy Batterham	Chief Investigator
Margaret Lawson	Project Manager
Reitai Minogue	Consultant Pharmacist

Steering Committee

Frank Fisher	Consumer
Denise Seely	Consumer
Kathryn De Garis	GP
Rod Trevena	GP
Susan Kloot	GP
Michael Best	GP
Gerald Galatis	Pharmacist
Neil Petrie	Pharmacist
Alicja Najbar-Kazkiel	NPS Facilitator

Table of contents

Table of tables

Table of figures

Glossary and Abbreviations

Glossary

CARE PLAN	In the context of this project a care plan refers to a document produced by a GP in consultation with a patient and involving two other providers that meets the requirements of the Commonwealths 'care planning' item numbers.
DOMICILIARY MEDICATION MANAGEMENT REVIEW	A review of medication that is: a) requested by a GP b) conducted by an accredited pharmacist c) in the presence of a patient (frequently in their home) d) that meets Commonwealth content requirements, and e) attracts a payment to both the referring GP and the pharmacist.
ENHANCED PRIMARY CARE	A Commonwealth Government strategy to improve primary care. It involves a number of initiatives and components, most relevantly a range of new item numbers and incentives to assist GPs work collaboratively with other providers.
HOME MEDICATION REVIEW	See Domiciliary Medication Management Review above.
INTEGRATED CARE PROJECT	A project currently being undertaken by CBDGP that involves development and testing of a decision support system for GPs to use in the management of patients with asthma. The PGP DMC project is expected to inform the ICP in relation to GP-pharmacist collaboration in the management of asthma.
SELF EFFICACY	The belief that one has the power and ability to implement desired practices or make desired changes effectively. ('Chronic disease self efficacy' refers to the belief that one can manage one's own illness effectively)
SHARED CARE PLAN	A template for the GP and pharmacist to contribute to the development of a care plan and monitor its implementation. The template meets the requirements of both a care plan and DMMR. Copies are retained by the GP, patient and pharmacist. This tool was developed as part of this project.

Abbreviations

CBDGP	Central Bayside Division of General Practice
CMF	Consumer Medication Fact-sheet
DMMR	Domiciliary Medication Management Review
EPC	Enhanced Primary Care
HMR	Home Medicines Review
HIC	Health Insurance Commission
ICP	Integrated Care Project
OTCs	Over-the-counter medications
PGA	Pharmacy Guild of Australia
PGP DMC	Pharmacy and General Practice Disease Management Collaboration
PSA	Pharmaceutical Society of Australia
QUM	Quality Use of Medicines
RACGP	Royal Australian College of General Practitioners
SCP	Shared care plan

Executive summary

Purpose and aims

The Pharmacy and General Practice Disease Management Collaboration project was a 12-month project funded by the Commonwealth Department of Health and Ageing as part of the Third Community Pharmacy Agreement under the Research and Development Grants Program. The main purpose was to develop and test a model of increased GP-pharmacist collaboration in the care of people with chronic illnesses.

At the time that the program commenced a number of other initiatives were also commencing focusing on possibilities for collaboration. The most notable was the introduction of Domiciliary Medication Management Reviews (DMMR)[1] an initiative where GPs could request pharmacists to visit a patients home to assess how they were handling and using medication. There was some evidence however, that both GPs and pharmacists were uncomfortable with having their potential collaboration considered solely in terms of medication review—many GPs felt that review programs involved pharmacists "checking up on them" while pharmacists felt that the programs underestimated their potential contribution to patient management.

In the context of these concerns it was important that the project also sought to inform debates about:

- How can pharmacists contribute to the management of people with chronic illnesses beyond just medication review?
- How can better communication between the GP and the pharmacist add value to and enhance the care provided to patients and, ultimately, the outcomes of that care?
- Is there value in pharmacists contributing to a multidisciplinary care plan and if so what form of contribution is beneficial?

The contracted aims of the project, which form the rationale for undertaking the project, were, to achieve:

1. Enhanced structured communication between pharmacists and GPs in relation to the management of patients with complex health care needs
2. A transferable model of disease management that reflects the skills and strengths of community pharmacy and general practice
3. A long-term reduction in health care costs for participating patients through better patient management.

Methods

The sequence of development proceeded through a number of stages. Initially a brief scan of the literature and informal discussions with a number of stakeholders helped define the potential value of collaboration between GPs and pharmacists and led to the development of questions to be explored more formally through the focus groups. This stage can be viewed as a scoping exercise.

[1] Now more commonly referred to as Home Medicines Review (HMR).

Two focus groups were then conducted, one with consumers and one with GPs and pharmacists together. The focus groups had two main purposes:

a) to identify ways in which improved collaboration between GPs and pharmacists might potentially lead to benefits to patients
b) to identify criteria that any model for collaboration (and any tools or instruments used to implement it) must meet.

The next step involved the development of a draft 'Shared Care Plan' as a tool for collaboration. This was informed by input from Division staff, the project's pharmacy adviser and two member GPs. The draft tool was then presented to another meeting of GPs, pharmacists and patients including most of those who had attended the first two meetings. This group was asked:

a) whether the tool met the requirements they had identified;
b) for any other suggestions or improvements.

In concluding the group identified the following key requirements for any model to improve collaboration

- Pharmacists need to know reason for medication so can better inform patient
- Pharmacists want to provide patient with information / education regarding their medication
- Pharmacists want to know result when patient is referred back to GP
- GPs need to know what the patient is taking other than on prescription i.e. Over The Counter drugs (OTCs)
- GPs and Pharmacists need to know about medication compliance
- GPs want patient referred back as necessary.

Principles and requirements emerging from consultation process

One of the key points of discussion for both groups was how the patient could be effectively engaged as a manager and coordinator of their own care. This led to an expanded model of partnership involving the patient, GP and pharmacist (hence the project logo with the three hands). A second major requirement was that model and tools would need to meet the requirements for both a Care Plan (GP funding item) and a Domiciliary Medication Management Review (GP and pharmacy funding item).

The Shared Care Plan was developed to meet the requirements of the three project participants, GPs, Pharmacists and patients. As such the data and format incorporates information regarding:

- Patient and provider demographics
- Diagnosis / condition / medication
- Adverse events
- Problem list
- Action plans and request
- Issues that may influence medication use or effectiveness and
- Contact log.

The Shared Care Tool that was developed not only satisfied care planning requirements but also those for a Medication Management Review. This provided some efficiencies in data collection and usage.

Evaluation

Data collection primarily involved questionnaires for patients (pre, and post), and focus groups with all stakeholders.

Questionnaires were used to collect data on patients and involved pre and post assessment of current management including self-management behaviours and confidence about managing their illness/es. Standardised tests were used for some aspects of this data collection (see Section 5.3.1).

Focus Groups were used:

- Before the pilot focus groups with GPs and pharmacists to develop the requirements for the model and assess the acceptability and feasibility of the proposed model
- After the pilot focus groups to identify patients perceptions of the value of the contribution of GPs and pharmacists and of having them act collaboratively. Additional groups with GPs and pharmacists will assess how the model can be improved and made sustainable.

Communications between pharmacist and GPs regarding the patient management plan were logged on the shared care plan in some cases.

An issues log was kept noting any issues raised through the course of the trial by patients, GPs or pharmacists.

Results

Beyond medication review?'

The collated experiences of GPs and pharmacists in the project make it clear that there many important contributions that pharmacists can make to the implementation of a GP's plan of care. It was equally clear, however, that most GPs have no overall understanding of these contributions and that the prompts in the shared care plan were insufficient to stimulate GPs to identify potential contributions. Increased awareness was achieved among participating GPs; but this came about through the experience of interacting with pharmacists in relation to particular patients rather than as a result of using the shared care plan proforma.

The pharmacist roles that were valued by GPs and patients were:

- Home Medications review
- Notification of the GP that the patient was on medications of which the GP was unaware

- Assistance dealing with the practicalities of medication use, particularly scheduling. (This was an issue for single medications but was even more of an issue where the patient was on many medications.)
- Helping patients to deal appropriately with side-effects
- Monitoring conditions where numerous repeat medications are the norm (eg hypertension, asthma)
- Advising about natural and over the counter medications.

For pharmacists the things that were considered most important in helping them fulfil these roles were:

- Obtaining a full list of the medications that a GP believed a patient was on
- Reasons for prescription indicated on scripts
- Highlighting changes in medication or dosage and comments on the reason for changes
- Greater personal knowledge of the GP and feeling comfortable to ring them
- Lists of active medical conditions
- Specific requests for pharmacy intervention (pharmacists indicated that such requests could be very useful but that during the project few specific requests were made despite the dedicated section of the shared care plan tool).

Summary of conclusions

C1. The utilisation of a shared care plan between GPs and pharmacists gives some patients a greater sense that the pharmacist is a legitimate health care provider and that they are being cared for by a team of providers. This belief, along with the process of doing the care plan and the document itself, gives patients increased confidence about their ability to access the help they need to care for their health. These effects were demonstrated both quantitatively and qualitatively. While statistical significance was achieved with only a few variables positive trends were seen for nearly all items and many of these could be expected to achieve significance with greater numbers. Care plans were highly valued by patients.

C2. The project achieved greater mutual understanding between GPs and pharmacists and a greater appreciation by GPs of the contribution that pharmacists can make to patient care. This was considered to be more a result of getting to know each other than of the tools and processes that were involved in the project.

C3. The GP care plan and a Home Medicines Review can be used in an effective, complementary manner but this occurred in relatively few cases. The main barriers to more uniformly effective use of the shared care plan appeared to be:

a. Poor understanding by GPs of the contribution that pharmacists can make with a consequent difficulty making specific requests
b. Generally poor understanding of what care planning involves as evidenced by a lack of specific objectives in all but a few care plans
c. The amount of time that a care plan takes to undertake

d. The number of new initiatives that GPs were seeking to take on board during the trial period
e. Possibly a reluctance to include text in computer generated documents (the GP who used the hard copy tools included many more details about the care plan and requests to pharmacists).

In addition the extra burden involved in explaining the research project and obtaining consent hindered the utilisation of the shared care plan[2].

Recommendations

R1. The Department of Health and Ageing should acknowledge the appropriateness of pharmacists as participants in care plans and should actively encourage GPs to involve pharmacists.

R2. The Pharmacy Guild should develop an education strategy (including a brochure) to inform GPs about the potential contribution of pharmacists to patient care in terms of:

a. Dealing with the practicalities of medication usage (eg: scheduling, dose management devices, technique, working around side-effects and lifestyle issues)
b. Medication review (including both HMR and less formal reviews that may lead to pharmacists notifying GPs of medications that the patient is using of which they are not aware)
c. Disease management for priority conditions including diabetes, asthma and hypertension

The strategy should also inform GPs of the value of providing pharmacists with full current medication lists, reasons for prescription and, where possible highlighting and explaining changes in medication.

R3. There should be continued exploration of mechanisms to reimburse pharmacists for the above contributions (R2) and for participating in the development and implementation of a patient care plan.

R4. Divisions should encourage and create opportunities for members to develop personal relationships with local pharmacists (eg: joint educational activities, HMR).

R5. A standard for communication between GPs and pharmacists should be defined and a realistic change management strategy for achieving that standard should be developed (eg: simplifying and prompting the recording of reasons for prescription, automating the production of medication change summaries).

R6. The developers of clinical software packages should consider the following enhancements to their products:

a. Developing a modular tool for producing care plans with optional modules applicable to certain professions
b. Introducing a flag to highlight on the prescription printout when there has been a change in a patient's prescribed medications, e.g. when the dosage / frequency of a current medication has been changed or when a current medication has been substituted with something similar.

[2] While GPs reported that this was the case the fact that they consented at least 106 patients but then went on to complete Shared Care Plans on less than half suggests that the process of scheduling and completing the care plan was, in fact, the greater barrier.

c. Encouraging the inclusion of patient's nominated pharmacist's name and contact phone number in the patient record and bringing it up when GP recalls patient demographic details.

R7. Central Bayside Division of General Practice should modify the computerised Shared Care Plan template in line with suggestions and continue to make it available to members and encourage its use. Utilisation should be monitored in the absence of the extra burden of the research project. The Division should review and implement the suggestions for sustainability listed in section 6.2 above.

R8. The Department of Health and Ageing, Divisions and the Divisions program need to continue to support care planning in relation to:

a. Clarifying the purposes and essential features of care plans
b. Increasing the ability of GPs to formulate specific medium-term, goals, objectives and planned actions
c. Increasing the understanding of GPs about the potential contribution of health providers (including pharmacists) to the assessment and medium to long term management of patients with complex health problems
d. Helping practices developed streamlined and efficient processes for conducting care plans.

R9. While the assessment of intermediate level patient outcomes such as self-efficacy, confidence, anxiety, and self-management behaviours creates logistical difficulties for researchers, they are critical to the achievement of health benefits and more intervention trials should consider assessing them.