Reviewer's report

Title: "Medication reviews are useful, but the model needs to be changed": Perspectives of Aboriginal Health Service health professionals on Home Medicines Reviews.

Version: 3 Date: 3 June 2015

Reviewer: Sophia Couzos

Reviewer's report:

This descriptive qualitative study explores an important program- the HMR program and the receptiveness of the program for AHSs. This is an important area of research and can help to inform future program development. The authors are to be commended for instigating this research.

These comments are a mixture of major compulsory revisions and minor essential revisions.

1. Some grammar errors and inconsistent use of abbreviations. Ie HMR is mostly abbreviated and sometimes not abbreviated. Careful proof reading necessary.

2. Line 73: Medicare Benefits Schedule.

3. Line 83-85: “The 24 month rule appears to have been applied due to budgetary restrictions of the program rather than as a result of any data that determines that this is an appropriate timeline for maximising medication management.”

Given that the program rules permit a HMR within the 24 month window if “HMR is specifically necessary due to significant changes to patient’s condition or medication regimen”, then a 24 month rule as a program requirement seems appropriate to prevent overservicing (see also comments below).

4. Line 86: “…are also restrictive for pharmacists”. Evidence for this statement?

5. Line 91-94: “Rules state that an HMR interview must occur in the patient’s home unless prior approval has been obtained. This prior approval has to be sought by the pharmacist on a case to case basis, giving full patient details, at least 10 days prior to the proposed interview date”.

The authors should elaborate- giving full patient details to who? Prior approval from whom?


7. Line 110-111: What rules in particular impeded HMR use according to Aboriginal patients? (in relation to reference 7). More clarity on this would assist the reader to understand the findings of the study that is referenced.
8. Line 123: Site selection. The authors will need to explain how the 11 AHS sites were selected. Was an invitation sent to all AHSSs and only 11 replied? Were these services specifically approached and if so, what circumstances led the researchers to approach these specific services?

9. Line 127: Consent from services and participants. How was consent from services obtained from the Boards and management? Was this verbal with an agreement in writing, or did it take another form? What did the participants consent to? Were services compensated for their time in taking part? How long were each of the interviews? Note that the consent form used by participants should also be made available as an appendix.

10. Intellectual property: Who owns the data and did the agreement with services involve agreement on this issue and use of the information collected for purposes other than what was agreed?

11. The discussion could be improved by more careful consideration of financing issues. For example, the authors could more explicitly outline the current financing structure for HMRs and then relate suggested reforms to that. I.e. the HMR program finances pharmacists development of a HMR through the 5th CPA and the GP who requests and actions the HMR (through item 900 MBS for a DMMR). The authors could explain that the pharmacist payment through the 5th CPA is much higher than the MBS payment to the GP, and that the CPA allows for additional funding to contribute to pharmacist travel costs incurred under the HMR Rural Loading Allowance. However, these allowances might have changed under the 6th CPA and this information might need updating.

12. There are a number of assumptions in the HMR program- that is, that MBS rebate compensates practices for the administration costs incurred in facilitating HMRs by pharmacists. The authors could reference research that might have explored this issue. If the MBS rebate is sufficient to cover these costs, then the suggestion for additional payment to AHSSs for their staff time in coordinating patient participation in the program might not be substantiated.

13. Given the important role of the GP to assess if there is a clinical need for a HMR, the GP will need to be the instigator of HMR. However, the MBS descriptor could be relaxed to permit AHWs to assist in the conduct of the HMR and assist in referral to pharmacy /accredited pharmacists and assist with obtaining patient consent. However, a case could be made for an MBS rebate payable for AHWs participating in DMMR with the HMR program.

14. Care needs to be taken in promoting the view that “it is unnecessary for GPs to be involved in the process” as this has not been demonstrated in this and other research, and suggests there is no need for the MBS rebate 900. Rather, the focus group perspective was mixed, and where such a perspective exists suggests a need for more GP education as to their core role in managing medication adherence and quality use of medicines than the implication for task substitution.
15. The authors have not provided sufficient information to make the statement that: “For complex patients with multiple medications, regular pharmacist interactions to reinforce medication messages is needed”. On the contrary, the response of focus groups participants was that medication management was the core duty of GPs and HMR risked overburdening patients with different service providers.

16. The DMMR claim can be payable every 12 months if needed. The authors could explain how MBS financing for GP services relates to the 24 month rule of the HMR program under the 5th CPA.

17. The authors also write that ‘recent changes to the HMR program rules…have exacerbated issue of medication management” and this statement is related to [presumably] the 24 month rule and other program rules. The authors infer (inappropriately) that this has affected Aboriginal populations, however, reference 4 provides no evidence of this. Such a statement also contradicts the authors statements that HMRs are underutilized by AHSS largely because of a poor history of client-pharmacists relationships and professional networks.

18. The authors could refer to the NACCHO recommendations regarding employment of pharmacists within ACCHSs to support their conclusion that “embedding a pharmacist with AHS is a solution which addresses many of the barriers to HMRs”. The models adopted and promoted by ACCHSs should be supported.

National Aboriginal Community Controlled Health Organisation (NACCHO) submission to the Senate Inquiry-Community Affairs References Committee: Inquiry into the effectiveness of the special arrangements for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to Remote Area Aboriginal Health Services (RAAHSs)

19. The authors could also refer to the outcomes of the ongoing QUMAX program funded under the 4th-6th CPAs, which found that relationships between pharmacists and ACCHSs and cultural training of pharmacists, and HMR uptake had expanded as a result of that program. Using the lessons in the QUMAX program as ways to overcome the barriers to HMR uptake identified in this descriptive study will avoid cross-purposes and ensure a consistent message for reform involving the AHS sector.

The Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) Program Evaluation (Urbis)

20. Another key message from the QUMAX program is the need to foster and encourage support from AHS Boards and governing structures towards programs that encourage QUM. This was one of the program strengths and is vital to overcome some of the attitudes expressed by some focus group participants. This may require more information to Boards of the financing benefits from item
900 claims, reforms to enhance pharmacy employment within AHSs, and support for embedding uptake of HMR/DMMR in quality improvement cycles at the service level.

21. Participating services should be given a copy of the final report as feedback and the opportunity to discuss the findings and approve the final draft for publication.

22. I also recommend the authors include an acknowledgement to the health services and Boards that supported the research.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being published

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests