Submission

in response to the Department of Health and Ageing Discussion Paper:

Implementation of a hospital referral pathway to enable urgent Home Medicines Reviews (HMR)

2 February 2012

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.
Submission in response to Department of Health and Ageing Discussion Paper:

*Implementation of a hospital referral pathway to enable urgent Home Medicines Reviews (HMR)*

About the National Rural Health Alliance

The Alliance is comprised of 33 Member Bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, educators, researchers and Indigenous health organisations (see Attachment). The vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia, and it has the particular goal of equal health for all Australians by 2020.

Introduction

More than seven million people (one third of Australia’s population) live in rural and remote areas of Australia. These Australians have poorer health outcomes and access to health services, an older age profile, higher levels of health risks and higher rates of chronic conditions than those living in major cities. It is essential that health programs such as the hospital-initiated Home Medicines Review (HMR) are tailored so that the needs of people living in those areas are met as well as the needs of those living in major cities.

The Alliance supports the intent of the hospital-initiated HMR to complement GP-initiated HMRs and other programs where patients at high risk of medicines misadventure following discharge from hospital would benefit from an urgent review of medications soon after their return home. However, there are likely to be considerable challenges in ensuring that patients in many rural and remote areas are able to benefit from medications support through the hospital-initiated HMR program. Accordingly the Alliance welcomes the opportunity to comment on the Department of Health and Ageing discussion paper: *Implementation of a hospital referral pathway to enable urgent Home Medicines Reviews (HMR).*

People who live in rural and remote communities are particularly vulnerable immediately following hospital discharge, especially if the hospital was beyond their local community. They generally face added difficulties in accessing primary care; it may be a considerable time before a local clinic is held; and/or they may need to seek help with travel arrangements and face up to challenging journeys to obtain follow-up primary care while their health is still vulnerable. Further, they may want to avoid the risk of being sent again so soon from home and back to a regional or city hospital.

In addition, the best efforts of local health practitioners to coordinate immediate post-hospital care for patients are fraught with challenges in getting even the most basic information, such as the hospital discharge plan, in a timely manner.

The principal and over-riding barrier to the success of the hospital-initiated urgent HMR is that there are not sufficient accredited pharmacists available in rural and remote areas to provide HMRs, whatever the referral path. A hospital referral will not result in an urgent HMR in many instances as there will simply not be an accredited pharmacist near enough to visit the patient’s home to undertake it within the suggested 10-day timeframe.

Another key concern is that many of the possible solutions to facilitate better delivery of hospital-initiated HMRs in urgent situations, such as referral to ‘outside’ pharmacists, place an additional step between the patient’s discharge from hospital and the involvement of local health professionals in appropriate coordination of the patient’s ongoing care.

Although there are many places in rural and remote Australia without the staff to either initiate or carry out an HMR, this submission does include responses to questions in the Department’s discussion paper about issues where there is the capacity to provide HMRs.

Great flexibility will be needed in the hospital-initiated urgent HMR program to accommodate the diversity of rural care pathways. However, it would be frustrating to see another pharmacy support program introduced that is barely available to people who live outside major cities. Accordingly, further policy levers are suggested in this paper that would make both the hospital-initiated and GP-referred HMR programs more readily available to rural people.

Recognise rural care pathways in hospital-initiated HMR implementation

Recognise frontline rural health care professionals

The discussion paper specifies that an HMR hospital referral pathway must be implemented to be consistent with clinical and professional best practice, as set out in:

- National Medicines Policy 2000;
- Guiding principles for medication management in the community;
- Guiding principles to achieve continuity in medication management;
- National Competency Standards Framework for Pharmacists in Australia;
- Good Medical Practice: a Code of Conduct for Doctors in Australia; and
- Professional Practice Standards.

The Alliance notes the very important roles that Remote Area Nurses, nurse practitioners and Aboriginal Health Workers play in rural and remote healthcare. These professionals are ideally suited to refer patients for an HMR, but the HMR itself must be conducted by a pharmacist accredited to do such work.

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2 Nurses are the best distributed of all health professionals across rural and remote communities and play critical parts in the primary care and community support of many of the vulnerable people likely to be targeted by the hospital-initiated HMR program.
In addition, the number of nurse practitioners in rural and remote areas is slowly increasing and they will play a growing role - within their area of competency - in medication management in the community.

So in rural and remote areas it is critical that the hospital referral pathway takes into account the wider range of health professionals who are frontline members of the primary care team. This should include consultation about the program with these professional groups, recognition of their codes of conduct, competencies and standards, and the provision of follow-up information and support for their involvement in the program as it is implemented.

**Make the links with aged care and Multi-Purpose Services**

In the planning and implementation of a hospital-initiated HMR program it will be important to involve aged care professionals and the sector in which they work. There is little if any reference to the aged care sector in the current document, with residential medication management reviews being among the important issues on which it is silent.

Some elderly patients from rural and remote communities will be discharged to residential aged care in rural, if not remote, communities or to a city location that is far from their home and regular health care providers. Admission to a residential aged care facility may also be the only ‘step down’ care available for younger people in rural areas following discharge from hospital or rehabilitation services, such as following sudden onset brain injury through stroke or accident.

Although rural areas have a slightly older population profile than major cities, the balance in rural areas between residential aged care and community aged care packages favours the latter. In planning medication support for older rural people discharged from hospital, links with the community aged care system are therefore critical.

Multi-Purpose Services (MPSs) in small towns must also be considered. Using pooled funding arrangements between the Commonwealth and States, MPSs provide a mix of acute, aged and primary care, including facilities for visiting health professionals. Nurses, GPs, specialists and Aboriginal Health Workers should be able to organise HMR referrals for patients in or on discharge from a Multi-Purpose Service.

**Respect the potential role of local hospitals within their capacity**

Multi-Purpose Services and indeed many smaller rural hospitals, or even larger private hospitals such as those of the charitable institutions that provide significant hospital services in some regional centres, may not have a pharmacist on site. The ‘on duty’ clinical team may include various combinations of local GPs on a sessional basis, rotations of medical officers with various levels of experience, locums and nursing staff. The continuity of the nursing staff and their role in liaising with the medical staff and off-site pharmacy mean that nursing staff need to play a more significant role in hospital-initiated HMR referrals in rural areas.

In summary, the Alliance is concerned to ensure that the hospital referral pathway for HMRs takes into account the health professionals available locally when discharging high risk patients back to their rural and remote communities. This includes those working in local hospitals, primary care and aged care – often with overlapping roles. While in larger centres a patient’s usual GP and community pharmacist are likely to be central members of the primary care team, outside the major cities the team may or may not include those two, and
may or may not include small numbers of other health professionals. The hospital referral pathway needs to accommodate this varied situation.

**Patient eligibility criteria**

The discussion paper proposes that patients must meet all of the following criteria:

- patient is at risk of significant morbidity or death due to medication misadventure and requires urgent review within 10 days of discharge;
- patient’s condition cannot be managed within a hospital as an in-patient or outpatient, particularly through the medication reconciliation process (pre-discharge) and pharmacist counselling;
- patient’s condition cannot be managed by their GP or their other primary care provider within the timeframe set out above; and
- patient’s condition cannot be managed within the community pharmacy as part of a PPE or MedsCheck/Diabetes MedsCheck or managed through a non-urgent HMR.

The first dot point rightly places a duty of care on the hospital discharge team to identify that the patient is at risk and a medication review needs to occur within 10 days. The following three dot points provide relevant guidance to the discharge team on alternative arrangements that should be considered ahead of invoking a hospital-initiated HMR.

As discussed above, the capacity of smaller rural and remote hospitals to become a part of the discharge pathway and/or to provide a hospital referral for HMR is relevant to patient eligibility considerations (dot point 2). Considering all avenues of primary and aged care, the actual health professionals available locally, not just a GP or community pharmacist, and the range of support programs available locally is critical when discharging patients who are returning to rural and remote communities (dot points 3 and 4).

There is a view that all patients on multiple medications and new medications would benefit from an HMR. However, the discussion paper proposes that the patient would be expected to present with two or more of the following indicators:

- the patient is cognitively impaired and manages their own medicines;
- the patient was started on medication with a narrow therapeutic index during admission;
- the patient has had recurrent admissions to hospital (eg 2 within 6 months); and/or
- the patient has changes made to a regular drug regimen upon admission to hospital, with the potential for confusion (excluding short-term courses under 14 days).

The Alliance proposes a fifth indicator for patient eligibility which, if accompanied by one of the four indicators listed above, would be sufficient for eligibility:

- the patient is an Indigenous person living in rural or remote communities and/or on low income.

This fifth indicator is consistent with the national health reform objective for social inclusion and Indigenous health and the desired outcome: “that Indigenous Australians and those living in rural and remote areas or on low incomes achieve health outcomes comparable to the broader population.”
For the community controlled health sector it is a priority that local health professionals coordinate the HMR and ongoing medication management process, as well as all post-hospital needs. Unless this happens, hospital-referred HMRs may place an unnecessary and potentially problematic step between a patient’s discharge from hospital and their local primary care.

The Alliance supports the general tenor of the first four indicators proposed, but makes the following observations that are particularly relevant to rural people.

- In determining recurrent hospitalisation, all hospital-type admissions should be considered, including a local hospital and an MPS.
- In determining changes to drug regimens, short term courses under 14 days should not automatically be excluded. Hospitalisation for short term courses is part of the risk management consideration for people living in rural and remote communities who might safely spend their recovery time at home if they lived in urban areas.\(^3\)

**Timeframe for HMR to be conducted**

The discussion paper notes that existing research suggests patients at high risk require medication review services within 10 days of discharge. Stakeholder input is requested on what aspects of the HMR should be completed within the 10-day period:

- organising the HMR referral;
- completing an HMR interview and providing counselling on medication usage to the consumer;
- completing the HMR report and providing the information to the patient’s GP and community pharmacy; and/or
- completion of a Medication Management Plan by the GP that identifies ongoing actions for the patient, community pharmacy and GP to improve quality use of medicines.

Feedback from Alliance networks indicates that, under present arrangements for an HMR, little more than organising the HMR referral is likely to be achievable within 10 days in many rural and remote communities, whether the patient is referred by a GP or a hospital. This is due in part to the limited supply and sparse distribution of accredited pharmacists.

However rural health care providers welcome the opportunity for early identification (upon discharge) by the hospital of patients at high risk of medication misadventure. The early involvement of local health professionals in planning for ongoing medication management is highly valued.

Recent changes to the HMR rural allowance mean that it is often not cost effective to conduct only one HMR in a remote setting. From the rural patient’s perspective, it would seem that completing an HMR and providing medication counselling to the consumer in their home within 10 days would be critical in managing the identified medication risks, so long as this was acceptable to the consumer.

\(^3\) For example, admission to a regional hospital for an Aboriginal child from a remote community to ensure administration of a full course of life saving antibiotics, or admission to a small rural hospital for an elderly patient with a chest infection who lives out of town to provide support during a course of antibiotics may be accepted initially, but these patients or their families (on their behalf) may elect to return home before the 14 days of treatment is up, and a hospital-initiated HMR should not automatically be excluded.
However an off-site professional may need to be involved by teleconference or videoconference to meet the timeframe, and would need to be working with the local GP, pharmacist or other primary care providers to put in place effective monitoring and management plans. Alliance networks suggest that the results of trials of HMR by videoconference that are underway should be considered before such options are widely adopted.

Overall, rural and remote health care providers and consumers would like to see the early involvement of local health professionals in the HMR and ongoing medication management process. It is suggested that local health professionals are informed of the high risk and need for an HMR before the patient is discharged and given first option on making the arrangements. If the local health professionals are not able to act within the timeframe, their buy-in will still be critical to the success of the intervention. Thus they would need to receive the HMR report as soon as possible, most likely within the 10-day timeframe, as the home visit to review medications is only the first step in managing medication risk.

One of the premises for the extension of the HMR program to include hospital referral is the possibility that, for one reason or another, the patient may not see the GP within the allocated timeframe. It would seem to be counterintuitive to require the GP to complete a Medication Management Plan based on the hospital-initiated HMR within the 10-day timeframe.

**Coordination**

As discussed above, the Alliance sees value in a hospital-initiated HMR program as complementary to the GP referred HMR program. The guidelines should be sufficiently flexible to allow the most relevant health professional or health care team in a rural or remote hospital to identify patients and organise the referral.

In order to fulfill its duty of care, the discharging hospital must bear responsibility for liaison with the most appropriate and available service in the patient’s home area and ensure that the relevant local health care providers were involved. This will require someone in the major hospital understanding the context of the primary care available to the patient on discharge to their home in a rural or remote community. They must also be responsible for liaising with the relevant local hospital to establish whether the care needed may be available there as an inpatient or as an outpatient, and make the links with the GP or other relevant primary health care provider and the local pharmacist - if there is one.

This could result in an immediate transfer of responsibility to the GP or local hospital if they have the capacity – and they would receive the payments for the ongoing arrangements, such as the GP’s Medicare payment due for referral for HMR. (Currently this MBS item can only be claimed after the medication management plan is completed by the GP; the payment would remain with the GP regardless of who made the referral.)

If these tasks cannot be discharged by a responsible party at the major hospital within the timeframe for urgent referral, hospital protocols (to meet national standards) would need to outline alternative pathways to ensure that a timely and effective arrangement for medication review is offered to the patient.

If the Commonwealth is not funding a GP through Medicare to coordinate the initial HMR referral, some alternative means of funding it may be justified for rural patients who are being
discharged to a setting beyond the reach of the hospital’s outreach and outpatient programs. Whoever it is, the person writing the referral for a rural and remote patient for an HMR in such circumstances will have quite a complex set of information, networking and decision tasks and there should be a new funding stream to cover this.

**General Practitioner involvement**

As discussed above, the GP and most relevant local primary care providers must be involved in hospital-referred HMRs as soon as possible. It would seem appropriate to recommend GP referral wherever possible but, should this not be possible, the hospital should retain the responsibility to seek out the most relevant local health care provider such as a Remote Area Nurse or Aboriginal Health Worker and liaise with and support them in the establishment of appropriate mechanisms for the initiation of a hospital-referred HMR. Collaboration with an appropriate GP should be established and maintained throughout the arrangements and in the final development of the ongoing Medication Management Plan.

**Particular patient characteristics that may impact on effective referral and service provision**

The discussion paper describes a number of patient characteristics that may impact on effective referral and service provision. These include Aboriginal and Torres Strait Islander people, people with chronic and complex conditions, patients without a usual GP, and other circumstances relating to their status in the hospital (inpatient, short stay, outpatient).

The Alliance supports consideration of these groups and, as discussed above, proposes the inclusion of an additional criterion for the hospital-referred HMR for Aboriginal people, people living in rural and remote communities or on low income, coupled with any one of the other proposed inclusion criteria.

In part this is because people living in rural and remote communities have higher risk factors for and poorer health outcomes from a number of chronic and complex conditions. Their rates of hospitalisation are also higher, due in part to poorer access to primary care compared with people in major cities.4 The healthcare pathways for rural people are also more complex, given the need for them to be referred to regional or city centres for tertiary care and a range of specialist services.

**Pharmacy involvement**

Wherever possible, local pharmacy involvement should be maintained throughout the hospital-initiated HMR process. However there will be settings in rural and remote Australia that do not have good access to local pharmacies and others where the pharmacy does not conduct HMRs. There might be issues when the local pharmacist is unable to meet the 10-day timeframe about whether the referral can be usefully passed to the next-nearest accredited HMR pharmacist, who might be some distance away.

Despite the current oversupply of pharmacy graduates, there are still shortages in rural and remote areas. Many rural pharmacies have a dedicated person undertaking HMRs and, given the overall supply situation, there may be additional opportunities in future for pharmacists relating particularly to HMRs.

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Direct referral to an accredited HMR pharmacist who is willing and able to work remotely is often the best model for remote communities, but city-based pharmacists will continue to need special training and support for effective HMR work in rural and remote areas. HMRs could be conducted by a hospital pharmacist if this was the only pharmacist available to undertake the task. To avoid ‘double dipping’ they would need to conduct the review in their own time if they were claiming the MBS item number.

Other means for the supply of medicines include the Section 100 arrangements for supply to Aboriginal and Torres Strait Islander communities, where pharmacy services are in very short supply. Where medicines are supplied under Section 100, patients often have little or no access to a pharmacist and therefore services such as HMRs are even more important.

**Different hospital settings**

The discussion paper notes the different hospital referral pathways that need to be considered, including public hospitals, private hospitals, large tertiary hospitals, metropolitan area hospitals, rural and remote hospitals (with different campuses and outposts), small hospitals and the transition between public and private health systems.

The Alliance has flagged additional considerations for rural and remote areas throughout this submission, including Multi-Purpose Services in small rural towns and the relationship with the aged care system, Aboriginal Health Services and Remote Area Nursing services. Flexibility is needed to ensure that protocols can be put in place for the professional staff who are present in small hospitals and rural and remote areas.

**Training and support**

The Alliance would be pleased to work with the Department and other stakeholders in developing and promoting the availability of training and support information. This information needs to be available to the full range of health and aged care providers in rural and remote communities. Information for patients about how the program fits in with their usual healthcare and other medication support programs will also be particularly important for people who live in rural and remote communities.

**Evaluation**

Like many programs, the GP-referred HMR program has taken many years to become an accepted part of practice for a substantial proportion of health care providers. Changes to the program, including the introduction of hospital-referrals, will take a long time to be effective, as awareness is raised, confidence in using the program established, and targeting refined.

It is therefore important that sufficient time be allowed for evaluation of the program, including early feedback to improve and support implementation and longer term monitoring over several years. While initial evaluation may have a stronger focus on process issues that need to be sorted out for optimal use of the program, it is important that the evaluation includes longer-term outcome measures such as reduction in adverse medication events and avoidable readmissions to hospital, as well as improved patient understanding and use of medications following hospital discharge.

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## Member Bodies of the National Rural Health Alliance

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<th>Acronym</th>
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<td>ACHSM</td>
<td>Australasian College of Health Service Management</td>
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<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
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<td>Australian General Practice Network</td>
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