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

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Urbis Pty Ltd acknowledge the program evaluation methodology recommended in the joint submission from the Pharmacy Guild of Australia and the National Aboriginal Community Controlled Health Organisation (NACCHO) to the Department of Health and Ageing ‘Program of the improved Access of Aboriginal and Torres Strait Islanders to the PBS (2008) under the Fourth Community Pharmacy Agreement. This submission was used to inform the evaluation methodology adopted and described in this report.

We would like to thank the QUMAX Reference Group who provided valuable input and advice throughout the evaluation.

We would like to thank the Pharmacy Guild, NACCHO and the Pharmaceutical Society of Australia for their advice on draft versions of the evaluation framework and research instruments, and who also facilitated the collection of data from their respective sectors. We would especially like to thank the QUMAX Program Managers from the Guild and NACCHO.

Considerable cooperation and assistance was received from ACCHSs, participating pharmacists, QUMSPs and NACCHO Affiliates – who gave up valuable time in their busy daily schedules to contribute to the evaluation. We thank them also.

Finally, we would also like to express our gratitude to all Departmental personnel with whom we have worked over the last three years, who have been exceedingly well-informed and focussed on achieving a quality evaluation of this important Program.
Executive Summary

This evaluation

The Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) Program aims to improve the health outcomes of Aboriginal and Torres Strait Islander people that attend participating ACCHSs in rural and urban Australia, by trialling interventions that aim to:

- improve Quality Use of Medicines (QUM) and medication compliance, and
- support improved access to medicines under the Pharmaceutical Benefits Scheme (PBS) by addressing cultural, transport and financial barriers.

QUMAX was devised jointly by the Pharmacy Guild of Australia and the National Aboriginal Community Controlled Health Organisation (NACCHO) over 2005-06. It operated with a budget of $10.9 million from 2008-2010, as part of the Fourth Community Pharmacy Agreement between the Australian Government and the Pharmacy Guild of Australia. Services were limited in the proportion of funds that could be allocated to medicine co-payments. Approximately $2 million per year was available to meet the co-payments for PBS medicines.

In December 2007, Urbis was contracted by the Australian Government Department of Health and Ageing (the Department) to conduct an evaluation of QUMAX Program. This is the final report on the evaluation of the Program.

The objectives of the evaluation were to:

- assess whether the QUMAX Program had met its objectives;
- assess the interventions used to help meet the Program’s objectives and the relative impact and effectiveness of each of these interventions on the Program’s outcomes;
- monitor the Program during its implementation to assist the members of the QUMAX Program Reference Group (QUMAX PRG), in particular the Department, the Guild, and NACCHO to identify any potential Program implementation issues as they arise; and
- inform the Commonwealth on the development of future policies and programs that support improved QUM and access to PBS medicines for Aboriginal and Torres Strait Islander people in rural and urban areas of Australia.

Evaluation outcomes are based on numerous research activities conducted throughout the implementation of the Program. Analysis and ongoing reporting of this research has provided opportunities for adjustments to the Program throughout its implementation. Key research activities over the last three years included:

- in-depth telephone interviews with 23 Aboriginal Community Controlled Health Services (ACCHSs) and 24 participating community pharmacies;
- 12 case study field visits to participating ACCHSs and community pharmacies providing opportunities for in-depth face-to-face discussions with Program stakeholders, including patients;
- In-depth interviews with NACCHO Affiliates and Quality Use of Medicines Support Pharmacists (QUMSPs);
- an online survey of participating ACCHSs;
- an online survey of participating community pharmacies;
- analysis of PBS utilisation data;
- analysis of 4CPA IT data; and
- participation in, and presentations at, national QUMAX workshops and related conferences.
Key outcomes

The QUMAX Program represents a new model for partnerships and collaborations that work towards improved health outcomes for Aboriginal and Torres Strait Islander peoples. The Program has been successful both in terms of achieving key Program objectives and demonstrating the value and further potential of the model.

The QUMAX Program has been successful in trialling a number of mechanisms to address the known barriers to accessing PBS medications in non-remote Aboriginal and Torres Strait Islander communities. The provision of financial assistance to individual ACCHSs for the purchase of medications has been the most significant focus of the Program, with the majority of services (85%) allocating the largest proportion of their available funds to financial assistance for medicine co-payments.

The key finding of the evaluation is that, since the introduction of QUMAX, there has been increased access to the PBS for clients of ACCHSs – the main aim of the Program. Compared with the baseline year (12 months period prior to the Program) over the November 2009 to April 2010 period, there was a 14% increase in PBS utilisation for ACCHSs clients. This increased PBS utilisation far outstripped that for all Australians (3%) and for recipients of medicines under s100 arrangements (ie Aboriginal and Torres Strait Islander people living in remote areas – where the comparable figure was less than 2% over the same period). Given that the methodology utilised to calculate this figure was conservative, it is highly possible – indeed likely- that the actual increase in PBS utilisation is higher than 14%.

Notably, the increase was higher still for non-concessional or general patients (18% increase) which adds weight to the argument that the financial barrier for many non-concession patients has been significant. The increase in PBS utilisation was most pronounced for clients of ACCHSs in Queensland and in Western Australia, and in relation to lipid-lowering medications, anti-hypertensive and asthma medications.

Over the course of the Program to June 2010:

- nearly 34,000 ACCHSs clients across all States and Territories had been registered to receive financial assistance in the form of a Medication Access and Assistance Package (MAAP); and
- direct assistance had been provided to clients in the form of relief from PBS co-payments (271,226 PBS medicines dispensed) and subsidised or free Dose Administration Aids (DAAs) (74,122).

Doctors, pharmacists and clients surveyed and interviewed for the evaluation consistently report that QUMAX has:

- led to an increase in the regularity and quality of contact between ACCHSs and their clients;
- increased patients’ understanding and self-management of their own conditions; and
- led to an improvement in patients’ health, such as lowered HbA1c, reduced blood pressure, blood glucose or cholesterol.

PBS Safety Net entitlements had been a focus across some ACCHSs and their participating community pharmacies. Participating services, patients and community pharmacies all acknowledged the various benefits of enhanced monitoring of safety net entitlements. Increased communication between services, patients and community pharmacies as a result of QUMAX had greatly contributed to a reported increase in monitoring across some locations.

Hard data (ie Medicare claims data) to measure the use of Home Medicine Reviews (HMRs) by participating services was not available to the evaluators. However, the survey research and consultation with participating services (as well as an analysis of QUMAX work plans) strongly suggest that HMR has been given a strong focus by participating services. The evidence obtained suggests that there is a strong likelihood that Medicare claims made by General Practitioners of participating services for the HMR referrals would have risen significantly over the life of the QUMAX Program.

It was common for services to have integrated Aboriginal and Torres Strait Islander Health Assessments or the development of care plans as part of the QUMAX process. Services reported that
these items provided a useful benchmark for both ACCHS staff and patients of clinical indicators, such as blood pressure prior to participation in the Program.

The above results are impressive given the relatively short time the Program has been operating and the fact that QUMAX funding was capped at what could be considered a relatively modest level.

The key success factors in QUMAX can be found in the Program structure, and design and implementation at a Program and local level.

At a **Program structure** level QUMAX:
- was well-designed and conceived, with considerable research and forethought;
- had a strong and effective governance and advisory structure (the QUMAX PRG) and a sound set of Business Rules and Guidelines;
- was well-managed by the QUMAX Project Managers at the Guild and at NACCHO;
- enjoyed an open and collaborative approach from partnership stakeholders, combined with a high level of commitment to progress Program objectives;
- achieved almost universal participation by eligible ACCHSs (69 out of 70 eligible services) and strong participation by community pharmacies (541) and consumers; and
- built in excellent communications and practice-sharing mechanisms, particularly via websites, national workshops and conferences.

At a **Program design** level, critical factors that facilitated positive outcomes included:
- funding for the provision of transport assistance to attend medical appointments and/or collect medication;
- flexibility within the Program guidelines to enable ACCHSs to focus on local issues and needs; and
- the inclusion of regional support mechanisms via QUMSPs and NACCHO Affiliates.

At a **local** level, QUMAX progressed most successfully where:
- ACCHSs received ‘top down’ support from the Board and the CEO and there was organisational stability;
- a person or committee was appointed to ‘champion’ Program implementation internally;
- there was effective internal communication about QUMAX;
- there was regular contact between ACCHSs and QUMSPs;
- there were prior positive relationships and/or regular contact between ACCHSs and local community pharmacies; and
- good communication and support was received from regional Program stakeholders and management.

The QUMAX Program struggled locally where the above factors were absent, and where there appeared to be limited investment in, or capability to focus on, QUMAX by ACCHS and/or community pharmacies.

The report concludes with a number of recommendations arising from the evidence as to the effectiveness of the QUMAX Program.
## Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACCHSs</td>
<td>Aboriginal Community Controlled Health Services</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>ASOS</td>
<td>Asthma Spacer Ordering Scheme</td>
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<tr>
<td>ATC</td>
<td>Anatomical Therapeutic Classes</td>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<td>CTG</td>
<td>Closing the Gap scheme</td>
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<td>DAAs</td>
<td>Dose Administration Aids</td>
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<tr>
<td>DEC</td>
<td>Departmental Ethics Committee</td>
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<td>HMR</td>
<td>Home Medicines Review</td>
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<td>ICDP</td>
<td>Indigenous Chronic Disease Package</td>
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<td>IHI</td>
<td>Indigenous Health Incentive</td>
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<td>IHS</td>
<td>Indigenous Health Services</td>
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<td>MAAPs</td>
<td>Medication Access and Assistance Packages</td>
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<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<td>NDSS</td>
<td>National Diabetes Services Scheme</td>
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<td>NPS</td>
<td>National Prescribing Service</td>
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<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PhARIA</td>
<td>Pharmacy Access/Remoteness Index of Australia</td>
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<td>PIP</td>
<td>Practice Incentives Program</td>
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<td>PIRS</td>
<td>Patient Information Recall System</td>
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<td>PMP</td>
<td>Potent Medication Practicing</td>
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<tr>
<td>PPSAC</td>
<td>Professional and Programs Services Advisory Committee</td>
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<td>PSA</td>
<td>Pharmaceutical Society of Australia</td>
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<td>QUM</td>
<td>Quality Use of Medicines</td>
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<tr>
<td>QUMAX PRG</td>
<td>QUMAX Program Reference Group</td>
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<tr>
<td>QUMAX</td>
<td>Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples Program</td>
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<tr>
<td>QUMSPs</td>
<td>Quality Use of Medicines Support Pharmacists</td>
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<tr>
<td>S100</td>
<td>Section 100 Pharmacy Support Allowance</td>
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<tr>
<td>SIP</td>
<td>Service Incentive Payments</td>
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1 Introduction and background

The Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples Program (QUMAX) is an initiative of the joint partnership between the Pharmacy Guild of Australia (Guild) and the National Aboriginal Community Controlled Health Organisation (NACCHO) as a Program within the Fourth Community Pharmacy Agreement. The concept for the Program was agreed after a joint meeting of both organisations in August 2005.

The Program for the Improved Access of Aboriginal Peoples and Torres Strait Islanders to the PBS (as it was originally named) was developed over 2006 and improved through a collaborative relationship with the Department of Health and Aging, until approved by the Professional and Programs Services Advisory Committee (PPSAC) and the Federal Health Minister in March 2007.

The Joint NACCHO-Guild evaluation methodology was formative and was to be undertaken by an independent agency. In December 2007, Urbis was contracted by the Australian Government Department of Health and Ageing (the Department) to conduct an evaluation of the QUMAX Program. This report presents are findings from the evaluation.

1.1 The QUMAX Program

The introduction of arrangements to supply medicines to Aboriginal and Torres Strait Islander peoples in remote Australian communities under s100 of the National Health Act has worked to address barriers to accessing PBS medications in remote areas of the country. Evidence suggests however that Aboriginal and Torres Strait Islander people in non-remote areas also face geographical, financial, cultural, health and other barriers to accessing the PBS. The QUMAX Program was developed in response to these known barriers to access and to improve the quality use of medicines (QUM) in non-remote Aboriginal and Torres Strait Islander communities.

The primary aim of the QUMAX Program was to improve the health outcomes of Aboriginal and Torres Strait Islander peoples attending Aboriginal Community Controlled Health Services (ACCHSSs) in urban and rural areas through the provision of Medicine Access and Assistance Packages (MAAPs) for PBS co-payments, dose administration aids (DAAs) and transport. The Program also aimed to provide structured support for QUM in ACCHSSs and cultural awareness development in community pharmacies, through the implementation of service-level QUM work plans over a period of up to two years (these are discussed further below).

Funding for the QUMAX Program was approved as part of the Fourth Community Pharmacy Agreement between the Guild and the Commonwealth Government, as represented by the Department of Health and Ageing. The funding agreement provided $10.9 million for the implementation of the Program over the life of the Agreement.

The Project Reference Group (PRG) was established to oversee the development and implementation of the QUMAX Program. The PRG was to:

- provide advice to the Guild and NACCHO regarding Program development and implementation;
- advise the Department and the independent Program Evaluator on the development, management and conduct of the Program evaluation;
- advise and report to the Professional Program and Services Advisory Committee (PPSAC) as established under the Fourth Community Pharmacy Agreement, through the PPSAC Rural and Indigenous Steering Committee, on Program development and implementation; and
- develop and review key materials relating to the Project in accordance with the requirements set out in the funding agreement between the Guild and the Commonwealth. Membership of the PRG is detailed at Appendix A.

1 PGoA, NACCHO. 'Program for the Improved Access of Aboriginal Peoples and Torres Strait Islanders to the PBS'. Joint submission to the PPSAC, 2006
1.2 The state of Aboriginal and Torres Strait Islander health

The state of Aboriginal and Torres Strait Islander peoples’ health in Australia continues to be at lower levels than other sectors of the population. Indigenous people remain the least healthy sub-population in Australia.² The reasons for this are complex, but represent a combination of factors including education, employment, income and socioeconomic status.³

Available data indicate that the life expectancy at birth for Aboriginal and Torres Strait Islander people is much lower than for non-Indigenous Australians. Recently, the Australian Bureau of Statistics (ABS) reviewed their method of estimating life expectancy of Aboriginal and Torres Strait Islander people and concluded the difference in life expectancy for Indigenous Australians is 12 years lower for males and 10 years lower for females compared to the Australian average⁴. The new method suggests there is less of a gap in life expectancy compared to previous estimates, which put the mortality gap at about 17 years lower for Aboriginal and Torres Strait Islander people than the Australian average. It should be noted that that the use of this new method for calculating the life expectancy at birth for Aboriginal and Torres Strait Islander people has been somewhat contentious and is currently the subject of vigorous debate.

The most recent AIHW report on Australia’s Health 2010, explains that two thirds of the Indigenous health gap was due to mortality, and one third to disability. In particular, chronic (non-communicable) illnesses such as cardiovascular disease, diabetes, mental disorders and chronic respiratory diseases are responsible for 70% of the observed health gap.⁵

A recent ‘Overview of Australian Indigenous health status, April 2010’ by the Australian Indigenous Health Infonet also acknowledges diabetes as a health problem among Indigenous people. They cite diabetes as a major contributor to Indigenous mortality, responsible for almost 8% of deaths among Indigenous people living in Queensland, Western Australia and the Northern Territory between 2002 and 2006.⁶

There is evidence that Aboriginal and Torres Strait Islander peoples’ experience of chronic disease is preventable with education, information regarding nutrition and lifestyle, access to good food, and availability of health services⁷. The role of the social determinants of health is now widely recognised and governments are putting in place strategies to address those structural issues which contribute to the continuing poor health outcomes for Indigenous Australians. The availability of services to respond to chronic disease has clear implications for the quality of life of citizens of those communities who require on-going treatment and management for their condition. Addressing chronic disease also has intergenerational implications for the health, well-being and care of children in these communities whose parents are affected by disease.

1.3 Policy context

1.3.1 Fourth Community Pharmacy Agreement

The QUMAX Program was one of four Aboriginal and Torres Strait Islander programs and services funded under the Fourth Community Pharmacy Agreement. The other programs and services included:

⁴ 3302.055.002 Discussion Paper: Assessment of Methods for Developing Life Tables for Aboriginal and Torres Strait Islander Australians, 2006
• Section 100 (S100) Pharmacy Support Allowance;
• Aboriginal and Torres Strait Islander Pharmacy Scholarship Scheme; and
• Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme.\(^8\)

The priority of these programs was to:

• recognise the cultural preferences of Aboriginal and Torres Strait Islander peoples in community pharmacy health care delivery;
• provide ongoing funding through the community pharmacy Section 100 support allowances to improve QUM by clients of eligible remote area Aboriginal Health Services;
• improve quality use of PBS medicines for Aboriginal and Torres Strait Islander peoples through the community pharmacy network in rural and urban Australia; and
• improve participation by Aboriginal and Torres Strait Islander people in the pharmacy workforce.

1.3.2 National Medicines Policy

The National Medicines Policy (1999) sets out a number of overarching objectives for improving the health outcomes of all Australians through providing enhanced access to, and encouraging the wise use of medicines. One of the central strategies of the National Medicines Policy is the National Strategy for the Quality Use of Medicines. QUM is defined in the strategy as:\(^9\)

• Selecting management options wisely by:
  – considering the place of medicines in treating illness and maintaining health; and
  – recognising that there may be better ways than medicines to manage many disorders.

• Choosing suitable medicines if a medicine is considered necessary so that the best available option is selected by taking into account:
  – the individual;
  – the clinical condition;
  – risks and benefits;
  – dosage and length of treatment;
  – any co-existing conditions;
  – other therapies;
  – monitoring considerations; and
  – costs for the individual, the community and the health system as a whole.

• Using medicines safely and effectively to get the best possible results by:
  – monitoring outcomes;
  – minimising misuse, over-use and under-use; and
  – improving people’s ability to solve problems related to medication, such as negative effects or managing multiple medications.

All participants in the cycle of health care have a role to play in enhancing QUM – consumers, prescribers, pharmacists, government, community-based organisations, medical professional associations, healthcare facilities, pharmaceutical manufacturers and the media.

\(^8\) Department of Health and Ageing, ‘Programs and Services for Aboriginal and Torres Strait Islander People Fact Sheet’, http://www.health.gov.au/internet/main/publishing.nsf/Content/C8914699C0CDAC18CA2572B9001F33FC/$File/IndigenousPr ogamsFactSheetOct08-PDF.pdf

\(^9\) National Medicines Policy, Commonwealth of Australia, 2000
The Quality Use of Medicines Strategy is being fulfilled through a range of activities undertaken by many individuals and organisations. QUM principles are increasingly being reflected in (or by):

- policy documentation and legislation at all levels of government;
- professional and practice standards;
- professional development activities for health professionals;
- educational activities aimed at consumers, health professionals and others;
- information on medicines (for consumers and health professionals) based on sound evidence and objectively presented; and
- data collection, research and evaluation activity across the health sector.

1.4 This evaluation

1.4.1 Objectives of the evaluation

The objectives of the three year evaluation were to:

- assess whether the Program had met its objectives;
- assess the interventions used to help meet the Program’s objectives and the relative impact and effectiveness of each of these interventions on the Program’s outcomes;
- monitor the Program during its implementation to assist the Department, PGA, and the QUMAX PRG to identify any potential Program implementation issues as they arise; and
- inform the Commonwealth on the development of future policies and programs that support improved QUM and access to Pharmaceutical Benefits Scheme (PBS) medicines for Aboriginal and Torres Strait Islander people in rural and urban areas of Australia.

This Evaluation has been informed from the joint Guild and NACCHO submission to the Department under the Fourth Community Pharmacy Agreement: the 'Program for the Improved Access of Aboriginal People and Torres Strait Islanders to the PBS' (2006)

The NACCHO-Guild proposal (2006) to the PPSAC stated:

"It is proposed that an independent Evaluation consultancy be commissioned by the PPSAC Evaluation Committee through a select tender process. The Evaluators will be required to develop the evaluation methodology as outlined in this submission in partnership with NACCHO and the Guild, and under general direction of the Evaluation Reference Group. The partnership with NACCHO in the development of the methodology is to ensure that ACCHSs find the evaluation process acceptable and feasible which are of critical importance in achieving the Program outcomes. In addition, the development of this methodology is intricately linked with the implementation of the Program. For example, in the development of individual service contracts, these must specify the evaluation requirements for each ACCHSs. Thus, the framework for the evaluation needs to be established at the same time as the Program infrastructure."

This Report comprises the outcome of that formative evaluation as guided by the QUMAX Program Reference Group (see Appendix B for Terms of Reference and membership).

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1.4.2 Structure of this report

The structure of this report is as follows:

Chapter 1: Introduction
Chapter 2: Methodology
Chapter 3: Program overview and the transition to the Closing the Gap Co-payment budgetary measure
Chapter 4: PBS utilisation data and analysis
Chapter 5: QUMAX participation and implementation
Chapter 6: Service improvements under QUMAX
Chapter 7: Patient outcomes under QUMAX
Chapter 8: Conclusions and recommendations
2 Methodology

The methodology for the evaluation included the following components as outlined in the QUMAX Evaluation Framework and incorporated in the consultancy contract between Urbis and the Department. Each section provides details on activities undertaken for the evaluation.

2.1 Development of the evaluation framework and program methodology

2.1.1 Review of Program information

A review of existing Program data and documentation provided by the Department was undertaken to develop a profile of key issues, funding arrangements and operational activities across QUMAX.

The review allowed for:

- investigation of strategic issues and context for the evaluation;
- identification of key issues emerging from associated initiatives, evaluations and work undertaken to date in connection with the Program;
- identification of existing data collections (including health outcome data) and opportunities for making use of this data; and
- analysis of relevant methodologies that have been tested to measure the impact of QUM activities and interventions to inform the development of the evaluation framework.

The review considered:

- the initial Program proposal formulated by NACCHO and the PGA;
- Program business rules and other documentation;
- early Program registration data; and
- information relating to other initiatives, for instance the Healthy for Life Program evaluation framework, guidelines, toolkits, background documentation and other relevant information.

2.1.2 Initial stakeholder consultations

A series key informant interviews were undertaken to explore key Program and evaluation issues. This included scoping of context, key practice and policy issues, relevant research and identification of additional sources of related data. These interviews were also used as a means of providing critical feedback on strategic priorities for the evaluation and to inform an initial ‘snapshot’ of emerging issues to be tested during consultations. Information gained was also used in the development of the evaluation framework.

Representatives from the following organisations participated in phone or face to face interviews as part of the initial consultations:

- the PGA;
- NACCHO;
- the PSA;
- the Department of Health and Ageing;
- National Prescribing Service (NPS);

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2.1.3 Development of the evaluation framework

An evaluation framework was developed in consultation with the QUMAX PRG and informed by the initial Guild/NACCHO submission. This framework was based on a program logic model, devised to evaluate the assumptions or evidence used to design each stage of the Program. This program logic was operationalised through a Hierarchy of Outcomes, otherwise explained as a cause and effect sequence of activities and outputs.

The evaluation framework allowed for analysis of a range of factors that contributed to Program outcomes, as well as a complex mapping of the relationships between Program activities and outcomes in relation to effectiveness, efficiency, quality, and key learnings. This also included measures or indicators used in the evaluation, the research methods used to collect relevant data, the risks or limitations associated with measurement of the Program outcomes, and any ethical issues to be considered.

The evaluation framework has served as a useful tool of reference throughout the course of the evaluation.

2.2 Ethics approval process

Ethics approval for the evaluation was sought from the Departmental Ethics Committee (DEC) and from relevant State and Territory ethics bodies with the assistance of NACCHO.

In order to comply with ethics requirements, particular care was given to the development of data collection mechanisms with reference to:

- developing culturally sensitive instruments and tools for use in the evaluation; and
- developing appropriate liaison procedures and processes for obtaining client consent and for communication with ACCHSs.

2.2.1 Departmental Ethics Committee (DEC) approval

A comprehensive ethics submission was provided to the DEC. Approval was provided by the DEC after seeking independent advice on the privacy implications of the planned PBS data extraction process (see Chapter 2.4).

2.2.2 State and Territory ethics approval

Separate ethics applications were submitted to seven State and Territory NACCHO Affiliate ethics committees. Approval was provided by all States and Territories except for Western Australia, where approval was denied on the basis that, due to confidentiality provisions of its contract with DoHA, Urbis was unable to provide regular reports to Western Australia on the Program evaluation. This meant that no field visits could be conducted in Western Australia.

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12 PGoA, NACCHO. ‘Program for the Improved Access of Aboriginal Peoples and Torres Strait Islanders to the PBS’. Joint submission to the PPSAC, 2006
2.3 Development of a communications strategy

A Communications Strategy was developed in consultation with the Department and QUMAX PRG, with the purpose of:

- informing the sector about the evaluation aims, objectives and methodology;
- describing the processes and protocols for the evaluation;
- introducing the evaluation team;
- providing contact details for the evaluation team; and
- providing any other relevant information about the evaluation.

2.3.1 Communication provided through the QUMAX website

With regards to communicating with ACCHSs, it was decided that the NACCHO QUMAX website was the most effective instrument for communication. This website was used by Program administrators and participating ACCHSs for all communication and the development and submission of work plans.

2.3.2 Participation in Program workshops and other Program activities

Program workshops/conferences

Updates on the progress of the evaluation were provided to the sector by the evaluation team at three national Program workshops/conferences.

These three workshops occurred: at the commencement of the Program in April 2008, one year into the Program in March 2009, and towards the conclusion of the QUMAX in March 2010.

At the first QUMAX (orientation) workshop in Canberra in 2008, the evaluation aims and objectives were presented, and the evaluation team were introduced to the workshop participants. The second workshop in Canberra in 2009 presented some early outcomes on QUMAX data. The third workshop in Melbourne in 2010 discussed emerging themes from the evaluation to date, with particular focus on findings from site visits and telephone interviews with ACCHSs and participating pharmacies.

Other Program activities

The evaluation team also took part in a number of additional activities to keep up to date with and contribute to, the progress of the Program and its Evaluation. These allowed for ongoing updates to the sector and QUMAX PRG. They included the following:

- attendance at QUMAX orientation sessions, including presentation of the evaluation framework to the sector in both NSW (October 2008) and South Australia (November 2008);
- contribution to the specification for the 4CPAIT QUMAX module, as well as ongoing negotiations with the IT developer;
- attendance at PBS data analysis workshop and 4CPAIT workshops in, 2008; and
- presentation of evaluation findings to Quality Use of Medicines Support Pharmacists (QUMSPs) and State Affiliates in Melbourne, 2010.

2.4 Extraction and analysis of PBS utilisation data

PBS utilisation data were extracted and analysed for clients of participating ACCHSs for six monthly intervals over the life of the Program. These data were compared with data extracts for:

- a benchmark period for clients of participating ACCHSs – the 12 months prior to the implementation of the program;
- PBS utilisation data for all Australians over the same time periods; and
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- supply of medicines to clients of remote area Indigenous Health Services under s100 arrangements over the same periods.

PBS utilisation data was stratified by major therapeutic drug classes (anti-hypertensives, diabetes medicines, lipid therapy, asthma medications, antibiotics and Indigenous-specific PBS items).

A process for extracting PBS records relating to clients of participating ACCHSs was developed and agreed between the evaluators, the Department, Medicare Australia and the QUMAX PRG. This process and further details of the analysis – along with the results - can be found in Chapter 4 of this report.

2.5 Data collection throughout the evaluation period

Qualitative and quantitative data were collected throughout the evaluation period relating to all activities associated with the Program. This was done at an individual ACCHS level, and also included aggregated data nationally.

Data was collected through monthly data reports on 4CPAIT data via the Program’s web-based claiming system (developed by the Guild), a survey of both ACCHSs and participating community pharmacies, and ongoing consultations with ACCHSs, participating pharmacies, QUMPSs and NACCHO Affiliates. This is discussed further in the sections below. These mechanisms were decided upon in consultation with both the Department and the QUMAX PRG.

Aggregated data collected on a national scale included:

- Medication Access and Assistance Packages (MAAPs) – that is, provision of transport assistance, on-call pharmacist dispensing and medicines advice, audits of PBS safety net entitlements, financial assistance to individual ACCHS clients, and Dose Administration Aids (DAAs);
- cultural education and training for community pharmacies;
- training in QUM for staff in ACCHSs;
- support and assistance provided to ACCHSs by QUM Support Pharmacists (QUMSPs); and
- enrolment in the National Diabetes Services Scheme, the Asthma Spacer Ordering Scheme, and the Home Medicines Review Service.

In acknowledging existing demands on ACCHSs, the evaluation sought to minimise the data collection and reporting requirements of participating services. In this context, all evaluation activities were as flexible and as timely as possible.

2.5.1 Monthly data reports

Monthly 4CPAIT data reports were provided to the Department and QUMAX PRG for the period of July 2009 to June 2010.

Data collated for these monthly reports included:

- monthly ACCHS and pharmacy activity on client type, general MAAP and co-pay allocations, brand premiums, DAAs and safety net reporting;
- co-payment and DAA budget progress (cumulative);
- co-payment expenditure by Anatomical Therapeutic Classes (ATC) groupings; and
- expenditure by Indigenous PBS items.

Results from these reports are discussed in relation to other findings from the evaluation in the body of this report.
2.5.2 Survey of ACCHSs

A survey was developed in conjunction with the Department and the QUMAX PRG, and emailed in online format to all participating ACCHSs in April 2010 for completion. A copy of the survey is attached at Appendix C. The purpose of this survey was to facilitate reporting on Program progress and achievements to date. It was facilitated by the fact that progress reporting was a requirement under the funding agreement between ACCHSs and the Pharmacy Guild.

The survey was hosted independently by an online survey scripting and data processing company. It was originally envisaged that the survey would be distributed three times over the course of the evaluation, however the evaluators and the Department were concerned that this would overburden services, and cause duplication in reporting. As such, services were asked to complete one online survey only.

The survey with ACCHSs requested data on the following:

- progress of QUM implementation and financial assistance given prior to QUMAX;
- QUMAX eligibility criteria – for both patients and medication;
- QUMAX activities to date, including:
  - QUM activities such as cultural awareness and safety training for community and/or Home Medicines Review (HMR) pharmacists (note that it was not a contractual obligation to conduct cultural awareness and safety training for pharmacists, and limited funding to subsidise the provision of training was not available until the final year of the Program).
  - transport;
  - PBS Safety Net entitlements;
  - on call pharmacy services; and
  - access to the Medicare Benefits Schedule (MBS) and Service Incentive Payments (SIP);
- the Program’s impact and outcomes to date; and
- experiences in implementing QUMAX to date (for instance satisfaction with particular aspects of QUMAX such as IT systems, contact and support provided by QUMSPs, implementation of QUM activities).

In addition, the survey allowed the evaluators an opportunity to invite services to provide any health outcome data relating to QUMAX patients, for instance improvements in cholesterol or Glycosylated Haemoglobin Test HbA1c levels. ACCHSs could nominate whether they were willing to share this data. Services that were willing to provide data were then followed up by telephone and email. Their feedback is presented in case study format in Chapter 7.

Forty-four of the 69 ACCHSs participated in the survey – a 65% response rate.

Survey results are discussed in the body of this report.

2.5.3 Survey with participating community pharmacies

All participating community pharmacies were asked to complete an online survey regarding their involvement with the Program. A copy of the survey is attached at Appendix D. The survey questionnaire was developed in consultation with the Department and the Guild, and was emailed in online format to all participating pharmacists in April 2010 for completion. As with the ACCHS survey, the pharmacy survey was hosted independently by an online survey scripting and data processing company.

In total, 160 participating pharmacies completed the survey. This represented a third (33%) of the 486 pharmacies dispensing general MAAPs in April 2010.

The survey with community pharmacies asked questions about the following:
• pharmacies’ profile (for instance Pharmacy Access/Remoteness Index of Australia (PhARIA) location, ownership, number of scripts dispensed);
• initial processes in relation to QUMAX;
• cultural awareness and safety training;
• relationships and protocols with ACCHSs;
• Program impacts and outcomes;
• experience in implementing QUMAX to date;
• QUM activities;
• PBS Safety Net reporting; and
• on call pharmacy service.

Survey results are discussed in following chapters of this report.

2.5.4 Ongoing consultations with ACCHSs and participating pharmacies

Data were also collected at periodic intervals throughout the evaluation during site visits and telephone consultations with ACCHSs and participating pharmacies, as well as in-depth interviews with QUMSPs and NACCHO Affiliates. This is discussed further in Chapters 2.6 and 2.7, and findings are presented in the body of this report.

2.6 Telephone consultations with ACCHSs and participating pharmacies

A series of three telephone consultation rounds were undertaken at six monthly intervals during the course of the evaluation. Originally there were to be four consultation rounds, however it was agreed by Urbis and the Department that due to delays at the beginning of the Program, only three consultations would be conducted.

Eight ACCHSs and their corresponding participating pharmacists were interviewed during each consultation round. Only the ‘main’ or principal participating pharmacy for each ACCHS was consulted. Altogether, 23 ACCHSs and 24 participating pharmacies were consulted. Data from these consultations was provided in each of the three progress reports to the Department and QUMAX PRG in July 2009, January 2010 and May 2010.

The aim of the telephone consultations was to complement site visits to services (discussed below) in further developing an in-depth understanding of how QUMAX was operating in various ACCHSs and pharmacies. A copy of the interview guides for the consultations are attached at Appendix E. Effort was made to ensure a good cross-section of sites across States and Territories, metropolitan and regional locations, and size of ACCHSs were included.

Locations were selected according to:
• whether they had participated in site visits or previous consultations, with priority given to those ACCHS who to date have not been involved in any consultation;
• ACCHSs or pharmacies that had been identified as having had particularly positive experiences in implementing the Program; and
• ACCHSs or pharmacies that had been identified as having encountered a number of challenges or obstacles in the implementation of the Program to date.

13 Except for the second round of telephone consults where only seven ACCHSs were interviewed due to scheduling problems and ACCHS staff turnover. All efforts were made to make up numbers for the missing interview in the final consultation round, however we were unsuccessful.
Interviews with ACCHSs were conducted with the QUMAX Program managers. Consultations were semi-structured and followed discussion guides developed in consultation with QUMAX Program partners.

Interviews explored ACCHSs perspectives on:

- degree of consultation and clarity about the objectives of the Program and the local QUM workplan, developed by the ACCHS and funded under the Program on medicine access and compliance issues for Aboriginal and Torres Strait Islander peoples;

- patient health outcomes;

- responding to barriers for regular access to medical care and medication compliance for Aboriginal and Torres Strait Islander peoples;

- the nature of the contact between community pharmacists and ACCHSs both before and after the introduction of the Program;

- the quality of cultural awareness education materials developed;

- the Program activities, their strengths and weaknesses;

- degree and quality of Program supports (eg QUMSPs);

- improvements made to data collection and sharing practices; and

- financial implications of participating in the Program.

A discussion of findings from these consultations can be found in the body of this report.

2.7 Case study field visits

A total of 12 case study field visits were undertaken during the course of the evaluation. The purpose of these case studies was to gain a greater understanding of how the Program had progressed in a variety of different settings and contexts, and to obtain face-to-face qualitative data from a range of Program stakeholders.

The visits were conducted between November 2009 and March 2010. Field visits took place over a one to three day period depending on the availability of ACCHS staff. During the course of each visit, one-on-one interviews and small group discussions were conducted with:

- ACCHS staff – including (where applicable) the CEO of the service, the practice manager, doctors and medical officers using QUMAX, Aboriginal health workers, nursing staff, administrative staff;

- QUMAX clients; and

- participating pharmacists.

Copies of the research instruments used in the fieldwork consultations are attached at Appendix F. Assistance of ACCHSs was sought in recruiting patients on the evaluation team’s behalf, and patients understood prior to interview that they would receive an information sheet explaining the evaluation, and would be required to complete a consent form (a copy of the patient consent form is attached at Appendix G). Strict adherence was given to protocols set out by the ethics bodies from which we obtained approval in terms of client privacy and consent.

ACCHSs that were requested to participate in the case studies were selected in consultation with the Department and QUMAX PRG, and according to recommendations from NACCHO and QUMSPs. Criteria used for the selection of sites was based on the following:

- sites with varying performance of QUMAX activity;

- single and multi-service sites;

- the size of organisations;

- characteristics of local communities (size, service infrastructure, etc);
▪ the nature and range of QUMAX activities undertaken by organisations; and
▪ the nature of the relationship with community pharmacists.

Findings from the field visits are discussed in depth in the body of this report.

2.8 Reporting

Regular reports were provided to the QUMAX PRG and the PPSAC Evaluation Steering Committee via the Department throughout the course of the evaluation, under the Governance structure developed by the Department detailed below.

Figure 1 – Program for Improved QUM and PBS Access by Indigenous Australians in Non-Remote Locations Governance Structure

The ongoing monitoring, evaluation and reporting activities throughout the implementation of the Program allowed the Department to respond to arising issues and make adjustments to the Program as needed. These were provided in various ways as outlined below.
2.8.1 Monthly data reports

As noted above in Chapter 2.5.1, monthly data reports were provided to the Department on 4CPA IT data via the Program’s web-based claiming system developed by the Guild. Altogether, 12 monthly reports were submitted during the period of July 2009 and June 2010.

2.8.2 Progress reports

Four progress reports were submitted to the Department for the period of December 2008 to May 2010 as follows:

- First progress report – December 2008;
- Second progress report – July 2009;
- Third progress report – January 2010; and

These progress reports provided the following:

- progress made against the evaluation framework and Project timeframes;
- any Program or evaluation issues encountered, actions taken and/or recommended steps to address these issues as required; and
- a comprehensive analysis of key data sets and qualitative information as identified in the evaluation framework, PBS benchmarking and analysis, general data collection mechanisms, Program workshops, telephone consultations, and case study field visits.

2.8.3 Interim, draft and final reports

Interim, draft and a final report were prepared, the final report required to:

- comprehensively address the evaluation aims in accordance with the evaluation framework;
- include a rigorous assessment of whether the Program has met its objectives, and an analysis of the relative impact of each Program activity or intervention on achieving the Program’s objectives; and
- provide advice to the Commonwealth on options for future interventions that aim to improve QUM and access to PBS medicines by Aboriginal and Torres Strait Islander people in rural and urban areas of Australia.
3 Program overview and the transition to the Closing the Gap (CTG) Co-payment budgetary measure

3.1 The genesis of QUMAX

The QUMAX Program is the result of a unique collaboration between key stakeholders involved in the design and delivery of the Program. In 2006, a Joint Submission was made by the Pharmacy Guild of Australia (the Guild) and NACCHO to the Fourth Community Pharmacy Agreement entitled ‘Program for the Improved Access of Aboriginal and Torres Strait Islanders to the PBS’. The Joint Submission had been developed by a team of people including representatives from the Guild, NACCHO, ACCHSs and James Cook University. A full list of the people involved in developing the Joint Submission is attached at Appendix H.

This Joint Submission was successful and the funding of $10.9 million was provided for the implementation of the Program over the life of the Agreement.

The QUMAX funded model represents a ‘first’ in that it involves a partnership between the Guild and NACCHO to manage and implement the Program in close consultation and collaboration with one another and other key stakeholders. To facilitate this, a QUMAX Program Manager was appointed to the Guild, and also to NACCHO. (The holders of these positions over the life of the Program are listed at Appendix I.)

3.2 QUMAX processes

3.2.1 The QUMAX Business Rules and Guidelines

The Business Rules and Guidelines for the Quality Use of Medicines Maximised for Aboriginal and Torres Straight Islander Peoples (QUMAX) Program developed by the QUMAX PRG and the Department provided parameters to govern the implementation and management of the QUMAX Program. A copy of the Business Rules are attached at Appendix J.

Specifically, these rules included:14

- a description of the respective roles of and the relationships between key Program participants with respect to how the Program will operate;
- eligibility arrangements for Program enrolment and payment of funds under the QUMAX Program;
- a description of the key processes to be followed by participants in the administration of the Program; and
- rules that will govern the payment of funds based on claims from community pharmacies. The Program Evaluators are responsible for consulting with the PRG in the development of the evaluation framework and reporting back to the PRG on the outcomes of the Program.

The Business Rules and Guidelines were updated in May 2010.

The following section is largely taken from the Program aims, objectives and key roles of stakeholders outlined in the Business Rules and Guidelines.

14 QUMAX Business Rules and Guidelines, updated May 2010
3.2.2 Key stakeholders and their roles

**The Pharmacy Guild of Australia**

The QUMAX Program was developed and implemented in partnership with the Pharmacy Guild of Australia. The key responsibility of the Guild was overall management of the Program. This was done in close consultation and collaboration with NACCHO.

The Guild’s responsibilities throughout the Program were to:

- coordinate the QUMSP role via Memorandums of Understandings (MOUs) between the Guild’s National Secretariat and each State and Territory branch;
- inform community pharmacies about the Program and invite expressions of interest to participate;
- act as the key contact point for QUMSPs and community pharmacies participating in the Program;
- disburse funds to key participants under the terms of its Funding Agreement with the Commonwealth, including the management of claims from community pharmacies for reimbursement costs following the provision of MAAP components to individual ACCHS clients (explained further below);
- administer funds to cover administrative costs and the cost of MAAP components under QUM work plans (via individual contracts established between the Guild and participating ACCHSs) ; and
- develop and host the QUMAX IT claims system (discussed further below).

**NACCHO**

The QUMAX Program was developed and implemented in partnership with the NACCHO. NACCHO was responsible for working with the Guild in all aspects of the Program, and with the assistance of its State Affiliates, provided information to and recruited eligible ACCHSs into the Program.

NACCHO was the key contact point for NACCHO State Affiliates and ACCHSs eligible for and/or enrolled in the Program, regarding any aspect of the Program including guidance on the development of QUM work plans. NACCHO developed the online communication and work plan management system for the QUMAX Program and also contributed to the development and conduct of annual QUMAX education conferences for services, QUMPs, and pharmacists.

NACCHO was also responsible for the disbursement of funds to their State Affiliates to cover administrative costs associated with activities carried out by the Affiliates. An administrative arrangement between each party was formed for the provision of these funds.

NACCHO State Affiliates worked with the QUMSPs and NACCHO to:

- assist in developing the ACCHS QUM work plan;
- provide advice to ACCHSs in the development of key policies and processes required for successful integration of the QUMAX Program in current processes;
- provide advice to individual ACCHSs on the application of guidelines for overall MAAPs eligibility;
- review QUM work plans to ensure QUM opportunities were maximised at a State and Territory level; and
- assist NACCHO with problem solving, feedback and monitoring of the Program by engaging with individual ACCHSs.

In the event where State Affiliates were unable to participate, NACCHO engaged alternative providers from the sector to fulfil these State-wide services.

The Information kit for ACCHS and State Affiliates provided parameters to govern the State-based agreements between NACCHO and its State Affiliates and provided advice by way of examples to
services in completing their QUM work plans. This was updated yearly and submitted and approved by the PRG\textsuperscript{15}.

**ACCHSs**

ACCHSs were responsible for carrying out the QUMAX Program with eligible clients. QUMAX was implemented by ACCHSs through development and use of a QUM work plan which was developed in consultation with their QUMSPs, and with support from their NACCHO State Affiliate.

ACCHSs were required to complete a registration form which was available online at the NACCHO website.

The process for ACCHSs in establishing service level contracts with the Guild was as follows. Services were invited by NACCHO to register for the program on the QUMAX online management system. The PRG approved ACCHS workplans based on the recommendation of the NACCHO and Guild program managers. After approval of the QUM work plan by NACCHO, the Guild and the PRG, a standard contract approved by the Department was provided to the ACCHS by the Guild. This Contract included a fixed budget and detailed the budget allocations for each of the MAAP components as set out in the approved ACCHS QUMP work plan. The contract was to run for a one year period from 1 July 2010 to 30 June 2011.

**QUM Support Pharmacists (QUMSPs)**

QUMSPs worked with each ACCHS and local participating pharmacies to:

- provide information, advice and support for staff in participating ACCHSs and to community pharmacists regarding the Program;
- broker assistance to establish, continue and strengthen the relationship between participating ACCHSs and local community pharmacies;
- provide assistance to participating ACCHSs in implementing, monitoring and reviewing Year 3 QUM work plans with State Affiliates where necessary;
- provide ongoing education on medicine use and QUM to ACCHS staff;
- provide assistance to the ACCHS in coordinating QUM services to clients and staff;
- deliver peer education produced by the PSA to local community pharmacies to increase awareness of cultural safety and communication issues for Aboriginal and Torres Strait Islander peoples presenting at community pharmacies;
- provide assistance to ACCHSs and their clients in accessing other community pharmacy programs as required (for instance diabetes and asthma subsidy programs and Home Medicines Reviews);
- provide quarterly progress reports to the National Secretariat of the Guild with assistance from the Branch Director; and
- participate in education activities relevant to the QUMAX Program.

QUMSPs were required to dedicate 10 days per year to each service. At least two to three of those days were spent visiting the service and assisting with QUM work plan development and providing QUM training. The remaining time was spent assisting with documenting QUM work plan activities and working with local participating community pharmacies.

Community pharmacies were able to be contracted to deliver this service if, for example, distances were too great or in cases where there was a single obvious provider preferred by the ACCHS. In cases where a branch was unable to recruit a qualified pharmacist to fill the role of QUMSP, a person was able to be appointed who had adequate experience and qualifications that fulfilled the job description criteria.

\textsuperscript{15} Sheedy V, Couzos S. NACCHO Information Kit for ACCHSs and State Affiliates. NACCHO, 2010
Participating community pharmacies

Community pharmacies participating in the Program provided patient focussed and culturally appropriate services to ACCHSs and their clients. This included the following:

- liaising with ACCHSs and QUMSPs to assist in implementing QUM work plans;
- ensuring eligible clients’ PBS safety net records were up to date, to ensure full entitlements were paid;
- streamlining medicines transport arrangements with ACCHSs and/or clients;
- provision of a range of medication compliance improvement interventions including the provision of DAAs where appropriate;
- working with ACCHS staff on systems to reduce financial barriers to medicine access for disadvantaged clients;
- assisting with enrolling diabetic clients in the National Diabetes Services Scheme (NDSS) and informing ACCHS of the Asthma Spacer Ordering Scheme (ASOS); and
- working with medical practitioners in ACCHS to provide HMRs for clients where appropriate.

Under the QUMAX Program, community pharmacists may also be involved with QUM training activities within an ACCHS and in raising awareness about other professional pharmacy programs such as HMRs, Diabetes Medication Assistance Scheme (DMAS), and Patient Medication Profiling (PMP).  

3.2.3 Eligibility

Eligibility criteria were developed by the NACCHO, Pharmacy Guild and Department as part of the initial program development.

Clients

The criteria are extracted here from the QUMAX Program Business Rules. The Program’s target group was registered clients of participating ACCHSs who had identified themselves as an Aboriginal or Torres Strait Islander person, or a member of that Aboriginal or Torres Strait Islander person’s family group.

Client eligibility was assessed by the prescriber within the ACCHS on an individual and per consultation basis, and was restricted to clients where:

- a clinical decision to prescribe a PBS medicine for the person had been made by a registered medical practitioner;
- it was the view of the prescriber that significant adverse health outcomes may result from the failure of the person to take the prescribed medicine, and the person was unlikely to comply with their medication regime without assistance;
- the person was currently holding a concessional entitlement card for PBS benefits or was eligible to receive such benefits;
- or the person was not currently holding a concessional entitlement card for PBS benefits and was not eligible to receive such benefits, but the clinical consultation with a prescriber indicates one of the following sub-criteria are met:
  - a history of evidence of foregoing medicines;
  - evidence that health was failing because of non-compliance with medicines;
  - social and/or legal obligations for a large family including guardianship of children; and
  - existence of co-morbidities and need for three or more prescribed medicines.

Clients needs were to be assessed by the prescriber at each consultation, and financial assistance was not to be carried over from one consultation to the next. Prescribers within ACCHSs were also guided by the priorities of the governing Aboriginal Board.

**ACCHSs**

ACCHSs located in rural and urban areas were eligible to participate in the Program, so long as they met the following criteria:

- they were located in a RRMA classification (1991 Census Edition) of 1 to 5 (i.e. were in a non-remote area);
- they were not currently eligible to participate in the remote Section 100 arrangements for supply of pharmaceutical benefits;
- they provide consent for the release of prescriber PBS data from Medicare Australia to the Program Evaluator; and
- they adhere to the Program Business Rules and Guidelines and the service-level QUM work plan.

**Community pharmacies**

The sole criterion for community pharmacy involvement in the Program was agreement of the community pharmacy to adhere to the Program Business Rules and Guidelines.

**3.2.4 Budget allocations**

The QUMAX Program operated with a capped budget. Given this constraint, the Guild and NACCHO were responsible for determining the overall MAAPs budget allocation for ACCHS based on the following budget algorithm (in this case for ACCHSs participating in the third year of QUMAX). This algorithm was designed to ensure that the entire budget allocated for ACCHSs was distributed entirely regardless of the number of services who chose to participate. It is important to note that it was not possible to determine the number of eligible patients in advance in order to allocate funds per patient. Therefore, the limited capped budget needed to be distributed equitably and it was agreed that the algorithm best achieved that given these constraints:

\[
\text{MAAPS Budget per ACCHS for Year Three of Program} = 10,000 + \left\lfloor \frac{a}{b} \times (1,573,250 - c) \right\rfloor
\]

where:

- \(a\) = number of registered clients in the ACCHS (i.e. total number of clients who have attended the ACCHS in the previous 12 months)
- \(b\) = total number of registered clients across participating ACCHSs
- \(c\) = number of ACCHSs registered to participate in the QUMAX Program.

The budget algorithm was reviewed after both the first and second years of operation of the Program by the PRG. Any particular DAA MAAP funds allocated to individual ACCHSs which remained unspent at the end of Year 2 of the Program were rolled over for use in Year 3 (in addition to funds allocated for Year 3 of the Program).

From 1 July 2010, PBS co-payment relief was assumed under a new uncapped funding measure (PBS Co-Payment Measure) under the provisions of the Indigenous Chronic Disease Package (Council of Australian Governments National Indigenous Reform Agreement to Close the Gap). The QUMAX capped Budget was extended from 1 July 2010 to 30 June 2011 to provide DAA's, transport and education for ACCHSs, State Affiliates and QUMPs support to ACCHSs.
3.2.5 QUM work plans

An online work plan was completed by each participating ACCHS following registration with the NACCHO online management system and budget allocation. This was done by ACCHSs in consultation with their QUMSP and with the assistance of NACCHO and its State Affiliates. The NACCHO online management system was designed to facilitate collaboration and communication at a distance.

The QUM work plan template was divided into the following sections (although some adjustments were made to the 2009 template):

- policy and protocol development;
- QUMSP and pharmacist support;
- QUM devices;
- provision of Dose Administration Aids (DAAs);
- QUM education;
- cultural awareness training; and
- transport support.

The MAAPs components of the QUM work plan template were as follows:

- financial assistance (through the payment of prescription co-payments) to eligible clients with medicine requirements, for whom financial or personal hardship prevents them obtaining their medicines;
- provision of DAAs for eligible clients who are at high risk of unintentional medicine non-concordance;
- transport support for the delivery of prescriptions or medicines between the ACCHS and a local community pharmacy, client transport to a local community pharmacy or transport of an accredited pharmacist to a community in order to undertake HMRs;
- improved recording of PBS safety-net entitlements of ACCHS clients and their families;
- Aboriginal Health Workers will work with Community Pharmacists to raise awareness of the Safety Net Scheme and create lists of eligible family members to be linked together; and
- on-call pharmacy/pharmacist assistance to the ACCHS for urgent medicine queries or after hours dispensing of medicines.

Each ACCHS was to document activity to be undertaken in each section of the QUM work plan template and for each of the MAAP components.

These work plans were submitted by each ACCHS Chief Executive Officer, along with the budget allocations for each MAAP component, to the Guild and NACCHO through the NACCHO QUMAX website to be assessed and approved by the NACCHO and Guild National Program Managers.

Following the execution of the contract, the ACCHS, QUMSP, State Affiliate and community pharmacy were required to implement the QUM work plan. The Guild and NACCHO Program Managers monitored overall progress made under the work plans on a quarterly basis and referred any issues of concern to the QUMAX PRG for advice.

3.2.6 QUMAX in practice with consumers

During each consultation the doctor determined whether a patient required assistance under the Program’s MAAPs, in accordance with the service’s policies and the QUMAX Program Business Rules.

If the doctor assessed that the patient required assistance, he or she would make an entry in the on-line QUMAX Claims IT system. The aim of this process was to be efficient and to not interrupt normal workflow.
The doctor would then prescribe the medicines and Dose Administration Aids in the normal manner, and stamp the prescription with a QUMAX Program number, generated by the QUMAX Claims IT system.

The patient would then take their prescription to a participating community pharmacy who would validate the annotated script through the QUMAX IT system and the medicine would be dispensed by the pharmacist as usual. If the patient was eligible to receive assistance under the Program, they would not need to pay for their medicine. In some instances the Service or the pharmacy would provide transport assistance for the urgent supply of medicines to needy patients.

**The role of doctors**

Doctors who consented to the QUMAX Program could participate. These doctors were required to sign a consent form to allow the Program Evaluator to access information on their prescriber PBS data (linked to the Provider number) (A copy of the consent form is attached at Appendix K).

If doctors left the service or withdrew from the Program, or if additional doctors joined after service registration in the Program, services were required to inform the NACCHO QUMAX Program Manager and update this information in the QUMAX pharmacy IT claims system. Any new doctors were then provided with a system login and password and the capacity to prescribe under the QUMAX Program.

### 3.3 IT support systems

#### 3.3.1 NACCHO registration and QUM work plan site

The online NACCHO work plan and communication system provided for:

- ACCHS registration at the commencement of and throughout the Program;
- the exchange of ideas between ACCHSs, QUMSPs and State Affiliates on QUM work plans;
- the development of QUM work plans; and
- a general communication tool for the ACCHS sector, State Affiliates and QUMSPs:
  - collaboration and a conjoint development of work plans by ACCHS staff, QUMSPs, and NACCHO;
  - simplification of reporting arrangements; and
  - access to a range of resources through the virtual library.

#### 3.3.2 QUMAX IT system

The QUMAX IT system provided a mechanism for a number of functions including:

- registration and maintenance of pharmacy participant details and patient participation details;
- the enrolment and maintenance of ACCHS participant details;
- the maintenance of registration forms for ACCHSs uploaded from the NACCHO website;
- allocation of funding to the participating ACCHS including total funding allocation per ACCHS, and funding allocation at ACCHS level to each MAAP component;
- allocation of MAAP components to patients by each participating ACCHS using a unique identifier;
- entry of MAAP authorisation number (for patients) for verification by participating pharmacies;
- collation of end of period claim documents for participating pharmacies and ACCHSs on a quarterly basis;
- reporting results of end of period claim payments to participating pharmacies;
- reporting MAAPs expenditure to each ACCHS; and
Program progress reports to stakeholders.

3.4 Reporting requirements

3.4.1 ACCHSs

As part of their contractual requirements with the Guild, ACCHSs were required to report against their approved budget allocation for each MAAP component of their QUM work plan. Variations to these budget allocations of 10% or more had to be submitted by the ACCHS to the Guild with reasons, for approval.

The QUMAX IT system, which managed the movement of funds under the Program, had the capacity to report on MAAP budget allocations and expenditure and was able to be used by ACCHSs, the Guild and NACCHO in monitoring the Program.

3.4.2 QUMSPs and community pharmacy reporting requirements

QUMSPs provided input into reports from the Guild State/Territory branch on a four monthly basis. Where necessary, community pharmacies were also asked to provide feedback to assist QUMSPs in their reporting to the Guild.

3.5 Transition to the Closing the Gap (CTG) Measure

3.5.1 Closing the Gap (CTG) PBS Co-payment Measure

The Closing the Gap or ‘CTG’ PBS Co-payment Measure commenced on 1 July 2010, as part of the Council of Australian Governments (COAG) $1.6 billion National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation.

The measure is one of 14 elements of the Indigenous Chronic Disease Package (ICDP) and was also established to reduce the cost of PBS medicines for all eligible Aboriginal and Torres Strait Islander people living with, or at risk of, chronic disease. The PBS Co-payment Measure was modelled on the QUMAX Program but extended to include private general practices and other service providers to the Aboriginal and Torres Strait Islander population. The measure was not extended to PBS prescribing in the public hospital system.

Patients will be registered to take part in the measure at rural and urban Indigenous Health Services (IHS) and at general practices that participate in the Indigenous Health Incentive (IHI) under the Practice Incentives Program (PIP).

The measure was designed to benefit Aboriginal and Torres Strait Islander people of any age who present with an existing chronic disease or are at risk of chronic disease. Eligibility is determined according to whether the patient:

- would experience setbacks in the prevention or ongoing management of chronic disease if the person did not take the prescribed medicine; and

- would be unlikely to adhere to their medicines regime without assistance through the measure.

3.5.2 QUMAX going forward\textsuperscript{18,19}

In March 2010, changes were announced regarding the future of the QUMAX Program and the introduction of the CTG PBS Co-payment Measure. These changes to QUMAX reflected the activity outlined in a proposal developed by NACCHO to assist services to transition to the new CTG arrangements and to continue to provide the other QUM elements within QUMAX. The NACCHO submission was endorsed by the Guild and the Department\textsuperscript{20}.

Changes for QUMAX included an extension of the Program with regards to:

- QUMAX scripts written before 1 July 2010, which are valid until 30 June 2011; and
- QUM activities until 30 June 2011.

The aim of the extension of the co-payments was to ensure that there was no gap between QUMAX co-payment relief ceasing, and the commencement of the COAG Closing the Gap PBS Co-payment Measure on 1 July 2010. Co-payments for PBS medicines issued with a MAAP number prior to 1 July and associated repeats would continue to be honoured by the Guild for 12 months until 30 June 2011.

Commencement of the CTG PBS Co-payment Measure included the following changes and additional factors:

- management of the reimbursements for the co-payments for medicines by Medicare Australia rather than the Guild;
- restriction of co-payment relief to only Aboriginal and Torres Strait Islander clients with chronic disease and those who are at risk of chronic disease, with eligible general patients to pay a reduced co-payment for their medicines and eligible concession patients to receive their medicines free of charge;
- annotation of PBS scripts with ‘CTG’ (Closing the Gap) by prescribers at general practices and specialists as well as ACCHSs;
- PBS prescriptions to be annotated by the prescriber (either with prescribing software or manually) without the need for a validation number to cross reference between the service and the pharmacy;
- the Guild and NACCHO to continue to manage other QUM components of QUMAX to June 2011, and the Guild to process claims to pharmacies;
- allocation of QUMAX funds (non Co-payment) and variation to contracts with ACCHS to be linked to approved ACCHS QUM work plans for 2010 to 2011;
- NACCHO to continue to engage with State Affiliates to provide State-based QUMAX support to ACCHSs;
- the Guild to continue to engage/subcontract with state branches of the Guild for QUM services;
- NACCHO to maintain and extend the QUMAX website for work plan management and communication system;
- the QUMAX hotline to continue for DAAs and other components of QUMAX;
- CTG PBS Co-payment measure queries to be managed by the Department of Health and Ageing; and
- only the DAA component of the Pharmacy Programs QUMAX website to be visible.

\textsuperscript{18} NACCHO. QUMAX: Transitioning Quality Use of Medicine Support and Co-pay Relief for ACCHSs. Submission to the Department of Health and Ageing. October 2009.

\textsuperscript{19} Information provided in the Guild and NACCHO’s QUMP Support Pharmacists Checklist handed out at the QUMAX conference in Melbourne March 2010.

\textsuperscript{20} NACCHO. QUMAX: Transitioning Quality Use of Medicine Support and Co-pay Relief for ACCHSs. Submission to the Department of Health and Ageing. October 2009
4 PBS utilisation data and analysis

4.1 Summary of the chapter

This chapter presents an analysis of PBS utilisation data in relation to the clients of participating ACCHSs.

The analysis shows that there was an increase in PBS utilisation for ACCHS clients of 14% between the baseline period (12 month period prior to the Program) and the period November 2009 to April 2010. The comparable figure for all Australians was 3%. The comparable figure for s100 recipients (clients of remote Aboriginal and Torres Strait Islander health services) was less than 2%. This result clearly demonstrates a sizeable impact of the QUMAX Program on access to PBS medicines by clients of ACCHSs.

The increase in PBS utilisation was most pronounced for clients of ACCHSs in Queensland and Western Australia, for general (ie non-concession) patients and for clients of particular services where very large increases were seen. There were especially large increases in access to Indigenous-specific PBS items and for lipid therapies, asthma drugs and anti-hypertensives.

4.2 The data extraction and analysis process

A core aim of the QUMAX Program was to reduce or overcome the financial barriers to access to the PBS amongst clients of ACCHSs. From the outset, the Program was designed to test the hypothesis that targeted financial assistance could help to increase use of PBS medicines amongst clients of ACCHSs. The evaluation of the impact of QUMAX on PBS utilisation is a crucial element of the overall evaluation.

Based on the joint NACCHO-Guild proposal of 2006, the planned approach was to compare PBS utilisation of ACCHS clients over the life of the Program to the baseline of the previous 12 months and also to the trend evident in the PBS utilisation data for all Australians. It is important to note that the ACCHS sector had recognised a financial barrier to clients accessing the PBS and had instituted a range of measures to subsidise access prior to QUMAX, including providing relief for PBS copayments from their operating budgets. The baseline used as a comparison would reflect these pre-QUMAX activities. The observed trends were also to be compared to trends evident in the bulk supply of medicines to clients of Aboriginal and Torres Strait Islander Health Services in remote areas through s100 arrangements. It is important to note that the PBS data set does not include medicines dispensed at a price under PBS copayment levels. The analysis relates only to medicines that were subsidised by the PBS.

Measuring any change in PBS utilisation for clients of participating ACCHSs is by no means straightforward. The constraints of the PBS data set, the ACCHS prescribing environment and the need to protect the privacy of individuals meant that a complex process was required to extract relevant PBS records to allow for the required analysis. ACCHSs developed and used client consent forms as part of the registration process for QUMAX. This permitted the extraction and use of data for the purposes of evaluation as was mandated in the Business Rules (item 16). The QUMAX Business Rules provided further confidentiality and privacy guidelines (section 18), including that the NACCHO Data Protocols be followed by all parties in the management and evaluation of the Program.

A process for extracting data was required that:

- allowed for PBS dispense records to be extracted only where medicines were prescribed by a doctor working in a participating ACCHS.

It is important to note that PBS unit record data does not identify the service or practice where a prescription originated. Records only identify the prescriber number of the prescribing doctor, the Medicare number of the patient and the date of prescription and details of the dispensing event. The complexity arises from the fact that doctors may divide their time between an ACCHS, a private practice...
or other prescribing environment but use the same prescriber number regardless of where the prescription is written.

A process was developed and agreed through discussions between Urbis, the Department and Medicare Australia. This process was endorsed by the QUMAX PRG and the Departmental Ethics Committee. The agreed process was as follows:

- obtain the consent of participating doctors to use their location-specific provider number as a link to relevant PBS records;
- extract MBS claims records associated with those provider numbers generated during set time periods;
- match MBS records to PBS records using the Medicare client identifier and date, along with the prescriber number associated with the MBS provider number; and
- extract and aggregate relevant PBS records at an individual ACCHS level and as a total for all participating services.

This process had few if any precedents. It required special authorisation under Subsection 135AA(5)(e) of the National Health Act 1953, by the Secretary of the Department to authorise linkage between MBS and PBS data.

Doctors were required, as part of their participation in the QUMAX Program, to provide their consent to use their provider number to extract PBS data in this manner. Furthermore, ACCHSs were asked to supply the provider numbers of non-participating doctors as well as doctors who worked in the service for the 12 months prior to the commencement of QUMAX. Participating ACCHSs were required to provide this information when registering for the Program and doctors could not generate MAAPs unless they had registered, provided their consent and recorded their provider number via the 4CPA IT. The on-line survey of ACCHSs asked services to validate the supplied provider numbers.

A list of some 766 provider numbers was generated; this list was provided to the Department in order to perform the data extraction. Using these numbers, a total of 929,592 MBS records were identified as having been generated between 1 November 2007 and 30 April 2010. Of these, a total of 266,214 were able to be matched with a PBS record, equating to a ‘match rate’ of 28.6%. This match rate increased slightly over time, from 27.8% in the baseline period to 29.9% during the final period of the Program (November 2009 to April 2010). Assuming that the matching process found all associated PBS records, these figures can be interpreted as the proportions of MBS consultations which were associated with the dispensing of at least one PBS medicine.

Although every effort was made to obtain the provider numbers for all doctors working in participating services during the periods of interest, there is no guarantee that the final list of provider numbers was complete. In fact, it is almost certain that the final lists of provider number numbers were incomplete to some degree. The data to be extracted was thus likely to represent most, but not all, of the PBS medicines prescribed to clients of participating ACCHSs. Importantly, the portion of dispensed PBS medicines captured by the data extraction process is also likely to be different for the different time periods used for the analysis, causing potential for error when comparing PBS utilisation over time. For example, it is likely that the list of provider numbers was more complete for recent time periods than for the baseline time period (it is fair to assume that ACCHSs will have had more difficulty in accurately reporting the provider numbers of doctors who worked in the service during a set of dates in the past). The implication of this is that any apparent increase in PBS utilisation could be due to under-reporting in the baseline period rather than to increased access.

To account for this, the extracted data were weighted, using the number of MBS records identified via the data extraction process. Effectively, this accounts not only for the above potential source of error, but also for any expansion or contraction within individual ACCHS and the sector generally. It allows for a significantly more reliable expression of the increase in PBS utilisation to be provided, and in a way that is more closely attributable to the QUMAX Program. A similar weighting process was used with the comparator data set for all PBS recipients. The weighting matrix applied was as follows:
Table 1 – Weighting factors applied to PBS utilisation data (ACCHS clients vs all Australians)

<table>
<thead>
<tr>
<th></th>
<th>Baseline NOV 07 – OCT 08 (12 months)</th>
<th>NOV 08 – APR 09 (6 months)</th>
<th>MAY 09 – OCT 09 (6 months)</th>
<th>NOV 09 – APR 10 (6 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCHS clients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Medicare services</td>
<td>321,869</td>
<td>180,202</td>
<td>215,869</td>
<td>211,652</td>
</tr>
<tr>
<td>Weight factor applied</td>
<td>1</td>
<td>0.893</td>
<td>0.746</td>
<td>0.760</td>
</tr>
<tr>
<td><strong>All PBS recipients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Medicare services**</td>
<td>115,603,237</td>
<td>56,890,040</td>
<td>63,785,193</td>
<td>60,518,595</td>
</tr>
<tr>
<td>Weight factor applied</td>
<td>1</td>
<td>1.016</td>
<td>0.966</td>
<td>0.955</td>
</tr>
</tbody>
</table>

* Refers to the number of MBS records identified using the provider numbers supplied by ACCHSs
** Total of un-referred attendances generating an MBS payment, processed by Medicare Australia during the specified time periods. Data sourced from Medicare Australia website.

As Table 1 shows, the discrepancy in the numbers of MBS records identified for ACCHSs across time periods was much greater than for all Medicare services nationally. This is, in all likelihood, due to the under-reporting of provider number numbers, particularly for the baseline time period. It demonstrates the need to adjust the extracted PBS data to account for this before undertaking the analysis.

The weighting factors were determined by dividing the occasions of service in each time period by the occasions of service in the baseline period. For example, the weighting factor for the November 08-April 09 period was calculated by dividing 180,202 X2 (for annualised number of MBS claims) by 321,869 (for the baseline period). The PBS utilisation is then reduced by this ratio to reflect the lower occasions of service captured compared to the baseline.

The effect of weighting was to assess PBS utilisation over time as if the number of Medicare services generated by ACCHSs across time periods was the same as that at baseline.

Table 1 shows that on average, the proportion of Medicare services generated over time within ACCHSs needed to be reduced by a factor of 20.03% to be equivalent to the number of services generated at baseline.

Whilst this might account for the bias in under-reported provider numbers at baseline, it has the effect of underestimating occasions of service if there was underreporting in subsequent time periods as well. Moreover, weighting has the effect of negating the impact of increased client demand for ACCHS services that have reportedly been brought about by the QUMAX program (as described in this report).

The overall effect is for weighting to underestimate changes in PBS utilisation over time, when the comparison is with the baseline year.

However, comparisons with PBS utilisation for all Australians and s100, are not likely to be underestimates as weighting applied over the same time periods imposed the same effect (comparison of PBS utilisation as if the number of Medicare services had stayed the same as the baseline year).
4.3 Change in PBS utilisation

4.3.1 Change in PBS utilisation across all participating ACCHSs

The data analysis showed that there was an increase in PBS utilisation for ACCHS clients that outstripped the increased PBS utilisation of all Australians. The data are presented in Table 2 below. Note that the volumetric data for the three six monthly time periods have been annualised (ie multiplied by two) to allow ready comparisons to be made. Both weighted and unweighted figures are provided.

Table 2 – Trend in total PBS utilisation (ACCHS clients vs all Australians)

<table>
<thead>
<tr>
<th>Total number of PBS items dispensed</th>
<th>NOV 07 – OCT 08 (annualised)</th>
<th>NOV 08 – APR 09 (annualised)</th>
<th>MAY 09 – OCT 09 (annualised)</th>
<th>NOV 09 – APR 10 (annualised)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCHS clients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unweighted</td>
<td>324,486</td>
<td>386,800</td>
<td>458,004</td>
<td>484,746</td>
</tr>
<tr>
<td>Weighted</td>
<td>324,486</td>
<td>345,412</td>
<td>341,671</td>
<td>368,407</td>
</tr>
<tr>
<td><strong>All PBS recipients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unweighted</td>
<td>173,268,006</td>
<td>186,246,044</td>
<td>178,791,106</td>
<td>187,187,262</td>
</tr>
<tr>
<td>Weighted</td>
<td>173,268,006</td>
<td>189,225,981</td>
<td>172,712,208</td>
<td>178,763,835</td>
</tr>
</tbody>
</table>

Based on weighted data, the annualised PBS utilisation of ACCHS clients during the November 2009-April 2010 period (ie the final six-month period under the original arrangements of the program), represented an increase of 14% compared to the 12 month benchmark period of November 2007-October 2008. The corresponding increase for all recipients of PBS benefits was 3%. This result should be interpreted as being the ‘bottom end’ estimate of the impact of the QUMAX Program on PBS utilisation in ACCHSs. Using unweighted data, the increase in PBS utilisation for ACCHS clients is 49% compared with 8% for all Australians. This can be regarded as the ‘top end’ estimate of the impact of the program on PBS utilisation.

If a linear trend line is applied to the (weighted) data generated during the operation of QUMAX (the three data points between November 2008 and April 2010), using the baseline period as the origin (y-intercept) the annual rate of increase in PBS utilisation for ACCHS clients is 8.2% compared with an annual rate of increase of 2.6% for all Australians.

4.3.2 Changes within individual ACCHS and at a State/Territory level

Sufficient PBS records were identified for 61 of the participating services, allowing for an analysis of change in PBS utilisation at an individual ACCHS level. It should be noted that the results for individual ACCHS cannot be included in this report for privacy reasons.

Using unweighted data, it appears that there was an increase in PBS utilisation for all participating ACCHSs. However, at an individual ACCHS level, the impact of any possible under-reporting of provider numbers for the baseline period is high although it was not possible to confirm the existence of underreporting. Based on this assumption, weighting was applied to the data. Individual weightings were applied for each participating ACCHS, again based on the numbers of MBS records identified for each ACCHS in each time period. The result of this weighting process was that, for some ACCHSs at least, the data was subject to large adjustments. This makes the resultant figures for changing PBS utilisation somewhat unreliable and unsuitable for further breakdown. However, the analysis of weighted data showed that of the 61 ACCHSs:

- 74% demonstrated an increase in PBS utilisation for their clients;
- Approximately one third of ACCHSs (31%) demonstrated an increase of more than 25%; and
One QLD-based ACCHS showed an increased PBS utilisation of more than 200% and another QLD-based ACCHS showed an increase of more than 100%.

The change in PBS utilisation was also analysed geographically. Analysis by State/Territory is set out in Table 3 below, and shows that there were larger increases in PBS utilisation for clients of ACCHS in Queensland and Western Australia than in other States/Territories. The changes in PBS utilisation were similar for clients of ACCHS in urban areas (14%) and in rural areas (16%).

Table 3 – Trend in PBS utilisation (by State/Territory)

<table>
<thead>
<tr>
<th></th>
<th>Total number of PBS items dispensed (weighted)</th>
<th>% increase – final period vs benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOV 07 – OCT 08 (annualised)</td>
<td>NOV 08 – APR 09 (annualised)</td>
</tr>
<tr>
<td>NSW/ACT</td>
<td>141,413</td>
<td>142,665</td>
</tr>
<tr>
<td>QLD</td>
<td>77,760</td>
<td>84,779</td>
</tr>
<tr>
<td>SA/NT</td>
<td>20,094</td>
<td>22,415</td>
</tr>
<tr>
<td>VIC/TAS</td>
<td>58,849</td>
<td>64,079</td>
</tr>
<tr>
<td>WA</td>
<td>26,370</td>
<td>28,534</td>
</tr>
</tbody>
</table>

Note that the figures for the ACT, Tasmania and the Northern Territory have been combined with other States as there was only one participating service in each of these States/Territories and there is a need to protect the confidentiality of information for individual services.

4.3.3 Comparison with s100 recipients

While the increase in PBS utilisation was greater for ACCHS clients than for all Australians, it is also of interest to compare this client group with another ‘control’ group composed predominantly of Aboriginal and Torres Strait Islander peoples. Under s100 arrangements for bulk supply of medicines to Aboriginal and Torres Strait Islander Health Services in remote areas, the supply of medicines has risen at an almost linear rate of 5% from 1,159,381 medicine items in 2005/06 to 1,370,840 items in 2009/10. It is important to note here that the data for supply of medicines under s100 and the supply of PBS medicines are not directly comparable. While PBS supply data represents supply (ie dispensing) to patients, s100 supply data represents supply to Aboriginal Health Services, which occurs via bulk orders. The data for the supply of s100 medicines between 2005/06 and 2009/10 – expressed in quantity terms – is set out in Figure 2 below.
The data shows an average annual increase in the bulk supply of s100 medicines of 5%. However, between 2007/08 and 2009/10, the annual increase was only 1.8%. The comparable figure of 14% for clients of ACCHSs clearly outstrips these figures.

The PBS utilisation data clearly show that there has been a relative increase in access to PBS medicines amongst clients of participating ACCHSs, beyond the increase that might be expected in the absence of the support provided via the QUMAX Program. The observed utilisation of PBS medicines, particularly in the latter stages of the Program, was greater than it was in the 12 months prior to the Program, by a factor that exceeded all available benchmarks. The results provide strong evidence that the QUMAX Program has helped to overcome the financial barrier to accessing PBS medicines in non-remote areas.

### 4.4 Further trends in PBS utilisation

The larger increase in PBS utilisation was evident for both concession and general patient clients of ACCHSs. Table 4 sets out the data for both concession card holders and general patients for ACCHS clients and all Australians.

**Table 4 – Trend in PBS utilisation (concession vs general patients)**

<table>
<thead>
<tr>
<th></th>
<th>Total number of PBS items dispensed (weighted)</th>
<th>% increase – final period vs benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOV 07 – OCT 08</td>
<td>NOV 08 – APR 09 (annualised)</td>
</tr>
<tr>
<td>ACCHS clients (concession)</td>
<td>300,701</td>
<td>320,680</td>
</tr>
<tr>
<td>ACCHS clients (general)</td>
<td>23,785</td>
<td>24,733</td>
</tr>
<tr>
<td>All PBS recipients (concession)</td>
<td>148,017,503</td>
<td>160,468,820</td>
</tr>
<tr>
<td>All PBS recipients (general)</td>
<td>24,905,484</td>
<td>28,377,575</td>
</tr>
</tbody>
</table>
The PBS utilisation data was disaggregated by medicine category (using Anatomical Therapeutic Classes) in order to focus on some specific classes of medicines. Groupings included medicines used to treat chronic conditions and infectious diseases that are disproportionately prevalent in Indigenous communities.

The analysis – presented in Table 5 – shows a relatively high increase in utilisation across all the key medicine groups for ACCHS clients vs all Australians. The relative increase in the use of lipid therapies, asthma drugs and anti-hypertensive was particularly noticeable. There was no increase in the use of antibiotics by clients of ACCHSs, but this is in contrast to a 7% reduction among all Australians.

Table 5 – Trend in PBS utilisation (by major Anatomical therapeutic Classes (ATC) groupings)

<table>
<thead>
<tr>
<th></th>
<th>Total number of PBS items dispensed (weighted)</th>
<th>% increase – final period vs benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOV 07 – OCT 08</td>
<td>NOV 08 – APR 09 (annualised)</td>
</tr>
<tr>
<td>Lipid therapy (ATC C10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCHS clients</td>
<td>34,402</td>
<td>38,445</td>
</tr>
<tr>
<td>All Australians</td>
<td>20,954,490</td>
<td>23,259,004</td>
</tr>
<tr>
<td>Diabetes drugs (ATC A10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCHS clients</td>
<td>23,854</td>
<td>24,847</td>
</tr>
<tr>
<td>All Australians</td>
<td>6,208,987</td>
<td>7,032,526</td>
</tr>
<tr>
<td>Asthma drugs (ATC R03)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCHS clients</td>
<td>26,486</td>
<td>27,099</td>
</tr>
<tr>
<td>All Australians</td>
<td>9,164,147</td>
<td>9,564,053</td>
</tr>
<tr>
<td>Antibiotics (ATC J01)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCHS clients</td>
<td>34,530</td>
<td>33,120</td>
</tr>
<tr>
<td>All Australians</td>
<td>11,510,944</td>
<td>11,576,727</td>
</tr>
<tr>
<td>Anti-hypertensives (ATC C02)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCHS clients</td>
<td>1,047</td>
<td>1,263</td>
</tr>
<tr>
<td>All Australians</td>
<td>797,708</td>
<td>919,580</td>
</tr>
</tbody>
</table>

These results provide a further indication that the extracted data provides evidence of improved access to PBS medicines. It provides further evidence that the QUMAX Program was effective in reducing barriers to access to medicines for key chronic conditions and infectious diseases. The trends in PBS utilisation shown in Table 7 also reflect the impact of budget rationing on the choices prescribers made. The capped budget allocated to PBS co-payment relief imposed significant restrictions on ACCHSs as to which patients could be assisted and which could not. Table 7 shows that ACCHSs tended to ration co-payment relief to those with chronic disease. This may reflect the higher costs of medicines to clients with chronic disease.
Table 6 below sets out the PBS data for Indigenous-specific PBS items – medicines made available via PBS arrangements specifically for Aboriginal and Torres Strait Islander people. The table shows the large and growing difference in utilisation between ACCHS clients and others. These results again suggest that QUMAX has been associated with improved access to these medicines.

Table 6 – Trend in PBS utilisation (by Indigenous-specific PBS items)

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Generic</th>
<th>Total number of PBS items dispensed (weighted)</th>
<th>% increase – final period vs benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NOV 07 – OCT 08</td>
<td>NOV 08 – APR 09</td>
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<tr>
<td>All other Aboriginal and Torres Strait Islander people</td>
<td>TOTAL</td>
<td>4,061</td>
<td>6,919</td>
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* The restricted listing for ciprofloxacin and terbinafine was extended to all Australians (up to the age 18 years) in November 2009 without changing the item code for this medicine. This will have the minor effect of slightly inflating the total figures for ‘All other Aboriginal and Torres Strait Islander people’ by including the number of ciprofloxacin and terbinafine scripts dispensed to non-Aboriginal people. It will also lead to a slight under-estimate of the proportionate increase in access to these items for ACCHS clients.
5 QUMAX participation and implementation

5.1 Summary of the chapter

This chapter presents an analysis of data collected during site visits, telephone interviews and online surveys with participating ACCHSs and community pharmacies. This chapter aims to contextualise the settings in which the Program was implemented.

The chapter has four sections:

- Service activities prior to QUMAX - This section outlines the reported activities undertaken by participating services prior to QUMAX to help overcome the known barriers to access to medicines and compliance with treatment by Aboriginal and Torres Strait Islander people.

- QUMAX Program design and structure - This section outlines the experience and views of services and community pharmacies regarding key components of the Program’s design and structure.

- Implementing QUMAX at the site level – This section provides a snapshot of the different contexts in which QUMAX was implemented locally, and examples of various strategies and issues encountered.

- Structural factors affecting participation - This final section considers the structural factors that have enabled or limited the successful implementation of the Program by both participating ACCHSs and community pharmacies.

Overall the chapter identifies a range of enabling and limiting factors that have impacted on the experience of Program stakeholders throughout the implementation of the Program across four levels –

- Organisational –support from the CEO or Board for the Program has been a significant enabling factor.

- Staffing and resourcing –the Program has significant administrative resource implications for ACCHSs. Services that have been able to identify a staff member to champion QUMAX within their organisation have found the process much easier.

- Communication and engagement – the history and quality of relationships between the ACCHS and community pharmacies can greatly impact on the experience of both ACCHSs and community pharmacies in implementing the Program.

- Quality and availability of support – the level of support provided to ACCHSs and community pharmacies by the Quality Use of Medicines Support Pharmacists (QUMSPs), NACCHO and the Guild can greatly impact on the experience of both ACCHSs and community pharmacies in implementing the Program.

5.2 Service activities prior to QUMAX

It is important to acknowledge that ACCHSs have historically implemented their own local initiatives to help overcome the known barriers of access to medicines and compliance with treatment regimes by Aboriginal and Torres Strait Islander people. All of the services involved in the evaluation had prior to QUMAX been involved, to some degree, in the implementation of initiatives to maximise access to medicines and medical treatment by Indigenous patients.

While some services reported these initiatives to have had some success, these were limited by the availability of resources and funding. For example, while many services reported providing some degree of financial assistance for the purchase of medications prior to QUMAX, this was mostly only for emergency situations or not for regular treatment regimes.

This section outlines the reported activities undertaken by participating services prior to QUMAX to help overcome the known barriers of patient access to medicines and compliance with treatment regimes across four areas:
 provision of financial assistance for the purchase of medications;
 provision of transport assistance;
 relationships with community pharmacies; and
 involvement in QUM activities.

5.2.1 Financial assistance for the purchase of medications

Many of the services involved in the evaluation had established processes to provide financial assistance to patients for the purchase of medications. This included:

- providing patients with a voucher or authority to purchase medications on a one-off basis;
- providing loans to patients and developing payment plans for the return of funds;
- encouraging patients to establish personal saving plans, either by providing authority for Centrelink to deduct sums from support payments or by giving a nominated community pharmacy funds on a fortnightly basis to build up credit; and
- establishing an imprest dispensary as part of the service (one service only).

While estimating the cost of providing financial assistance for the purchase of medications prior to QUMAX was difficult, throughout consultations this cost was estimated to be $14,000 - $25,000 per annum. One service reported spending up to $60,000 per annum. Services did not report detailed information to the evaluators regarding the provision of financial assistance and it is therefore unclear as to the number of incidents in which financial assistance was provided annually.

While the reported criteria for the provision of financial assistance varied between services, funding was generally used flexibly for the purchase of both medicines under the PBS and of non-PBS items (such as contraceptives, head lice treatments, paracetamol and vitamins).

It was reported that services often relied on doctors or other practice staff to determine on a case-by-case basis the extent of financial assistance that would be provided.

5.2.2 Provision of transport assistance

The provision of transport was and continues to be considered a great barrier to regular access to medical services and medications particularly for services that have patients across large geographical areas and/or that do not have a community pharmacy within close proximity.

A number of services anecdotally reported that although there was no specific funding available for the transport of patients or their medications prior to QUMAX, this was provided at great difficulty by staff such as health workers or transport officers who were employed for other purposes (such as the delivery of food). Services reported also relying on arrangements with community pharmacies for the delivery of medications to either the service, or their patients’ homes.

5.2.3 Relationships with community pharmacies

It was common for services to report having had existing relationships with local community pharmacies prior to QUMAX. This was particularly the case for services that had prior to QUMAX, provided financial assistance for the purchase of medications.

Most services reported that the local community pharmacist with whom they had a prior relationship was now participating in QUMAX. Their involvement in the Program was considered to be a natural extension of a positive and ongoing relationship.

A number of services however reported that QUMAX had helped the service develop new relationships with additional community pharmacies.
5.2.4 Involvement in QUM activities

As part of the ACCHSs survey, services were asked to describe their implementation of QUM activities and systems prior to QUMAX. Analysis of these responses noted that 55% (24 services) reported that prior to QUMAX their QUM activities and systems were either at a fairly early stage or underdeveloped.

Other responses noted that:
- 20% (9 services) of respondents believed their QUM activities and systems to be reasonably well established; and
- 18% (8 services) of respondents believed their QUM activities and systems to be progressing.

5.3 Program design and structure

The vast majority of those consulted were of the view that the QUMAX Program design and structure was sound.

The flexibility afforded to services in developing local criteria for patients to access the Program, for example, different treatment options for medical conditions which reflected local priorities, was considered to be one of the Program strengths. Whilst the program defined eligibility criteria, services refined that to best prioritise needy patient groups within the constraints of their limited capped budget.

The need to develop work plans guided by the Program Business Rules, and the opportunity to review these and the associated financial allocations for activities, was also considered to be a Program strength.

This section outlines the experience and views of services and community pharmacies regarding key components of the Program’s design and structure, mainly:
- Program reach;
- registration and initial work plan development;
- Program Business Rules;
- Program supports mechanisms; and
- development of work plans, eligibility criteria and allocating available funding.

5.3.1 Program reach

For services

The Program uptake was almost universal across all eligible services. The only exception was a Northern Territory service which preferred to delay their participation until the Program funding and structure was recurrent.

All services consulted had recognised the cultural, transport and financial barriers for Indigenous access to medications prior to QUMAX. In reflecting on their rationale for Program participation, all services consulted believed that QUMAX would respond to these known barriers, problems and gaps in the system.

For community pharmacies

In regards to community pharmacy involvement, the majority of services reported no problems in engaging community pharmacies for participation.

Many services had good working relationships with local pharmacies prior to QUMAX and these had been extended as part of the Program. All community pharmacies consulted had recognised the business and financial incentives of involvement, and this had been a significant factor in their participation.
Only one service reported problems in engaging community pharmacies for participation. In this instance, pharmacies had cited a lack of anticipated patient numbers to warrant the investment in the registration process, while other local community pharmacies were reported to have stated that they preferred not to encourage Aboriginal or Torres Strait Islander clients.

5.3.2 Registration and initial work plan development

For services

It was clear from the consultations that some services found the registration and initial work plan development process relatively straightforward while others found QUMAX more challenging.

While some services, for example, reported being provided with a work plan template or example that was largely used in that form with only a few minor modifications, others reported that the templates provided to them were unhelpful and vague.

One service for example commented that “[QUMAX] pretty much slotted in with the work we were already doing, and assisted in reducing the need to buy medicines out of our own general budget”.

Another service noted that the time taken and effort expended on the application process was “on par with the [Program] funding received”.

Other services however noted that they found the application and registration process to be complex, with one service stating that the process was “massive, it was very difficult”.

Another service reported that they felt that the sample work plans provided were vague, and that it had been a case of “just submitting their work plan and hoping they were going in the right direction”.

As part of the ACCHSs survey, respondents were asked to rate their level of satisfaction with a number of aspects of QUMAX including their satisfaction with the support provided in developing work plans and the funding application process. In both of these cases, 91% of respondents (40 services) expressed a degree of satisfaction with the funding and work plan development process.

Generally, the following factors influenced the experience of services during the initial registration and work plan development process:

- QUMAX champion: services that were able to nominate a ‘champion’ to lead the application process internally found the planning phase easier.
- Previous experience: services that had structured processes in place, for example providing financial assistance, found the planning phase more straightforward than did services which were doing it for the first time.
- Internal support provided: the level of internal support provided impacted on the experience of services. For example, some services established internal working groups to inform the application and registration process.
- Stability of organisation: ACCHSs that were generally considered by its staff to be dysfunctional or that had vacancies in its executive leadership (such as a CEO position) generally found the application process harder.
- External support provided: there was great disparity in the levels of external support received by services, for example from QUMSPs. This had a significant impact on the experience of services through application process.

Further discussion regarding the development of work plans is included in Chapter 5.3.6 of this chapter.

For community pharmacies

Community pharmacies generally had mixed views about their experiences in preparing for QUMAX. While some pharmacists found the process of registering for QUMAX straightforward others expressed concern regarding the potential financial and administrative burden the Program may have on the pharmacy and its staff.
A number of pharmacies reported receiving QUMAX prescriptions prior to their registration, or in more extreme cases, prior to them being aware of the Program’s existence. In these situations, pharmacists expressed dissatisfaction with the coordination of the Program’s rollout locally and their unpreparedness for the Program’s commencement. This may have been the result of the decision to not widely or publicly communicate the launch of the program.

As part of the Community Pharmacy Survey, respondents were asked to rate their level of satisfaction with a number of aspects of QUMAX including their satisfaction with the initial registration process. Overall, 88% of respondents (160 community pharmacies) expressed a degree of satisfaction with the registration process.

Generally, the following factors influenced the experience of community pharmacies during the initial registration process:

- Prior relationship with local ACCHSs: community pharmacies that had regular contact with local ACCHSs found the planning phase easier. In these situations community pharmacies had been informed of the Program in advance and had held discussions with the service regarding their proposed involvement.
- Level of contact with support networks: community pharmacies that had approached or been approached by the Guild or QUMSP to discuss their potential involvement found the planning phase easier.

5.3.3 Business Rules and Guidelines

The Program Business Rules were widely distributed to ACCHSs to support them throughout the implementation of the Program.

The Business Rules aimed to:

- provide a description of all Program stakeholders and their relationships;
- outline eligibility arrangements and processes for payment of funds;
- provide guidance to individual ACCHSs on the administration of the Program locally; and
- outline rules that govern the payment of funds based on claims from participating community pharmacies.

The original Business Rules specified a minimum and maximum percentage of Program funding that had to be allocated to specific Program priorities. For example, the work plans prepared for the first year of the Program included, on average, an allocation of only 1% of available funds to on-call pharmacy. Commonly, services allocated only a notional amount to ensure that their work plans were compliant with the Business Rules.

For the second round of work plans (completed by June 2009), the Business Rules were adjusted to allow for a ‘flexible MAAPs’ allocation rather than specifying a requirement to allocate funds. The flexible MAAP allocations included on-call pharmacy among a range of other potential activities. Services reported that various other activities were pursued through the ‘flexible MAAPs’ category, beyond on-call pharmacy arrangements. They included:

- the purchase of QUM resources such as subscription to therapeutic guidelines services and the purchase of various manuals;
- the development and delivery of QUM-related health promotion activities, for example, workshops with particular target groups such as diabetic patients, new mothers;
- activities to promote Home Medication Reviews;
- purchase of asthma spacers, nebulisers, glucometers etc;
- further QUM training for staff;
- ‘safe use of medicines’ workshops for clients;
provision of cultural awareness training to community pharmacists;
- enhancement of record keeping procedures and patient information management;
- community events, for example a barbeque for clients to allow them to meet community pharmacists and for information to be provided on HMR, the PBS Safety Net and general QUM issues; and
- to pay for external speakers with expertise on chronic disease management, such as QUM, HMR, PBS Safety Net.

It was clear that the ‘flexible MAAP’ category was a well-received change to the Business Rules, allowing for a range of activities that were not funded under the prior arrangements but still within the spirit of the Program’s objectives.

Some 86% (38 services) of respondents to the ACCHSs survey, and 68% (109 community pharmacies) of respondents to the Community Pharmacy survey expressed some satisfaction with the Business Rules (both surveys provided a scale of very satisfied, somewhat satisfied, somewhat dissatisfied, very dissatisfied, not sure/can’t say).

5.3.4 Program support mechanisms for ACCHSs

The consultations confirmed that there were variable degrees of support provided by QUMSPs and NACCHO State Affiliates to services. Equally there were varying degrees of service access and familiarity with other Program support mechanisms such as the QUMAX hotline, State workshops or conferences. Generally speaking however, there was overall service satisfaction with the Program’s support mechanisms.

The ACCHSs survey asked respondents to rate their level of satisfaction with a number of aspects of QUMAX (ratings options included very satisfied, somewhat satisfied, somewhat dissatisfied, very dissatisfied, not sure/can’t say). Results show that services were largely satisfied with many of these aspects – in particular:

- the QUMAX hotline - 87% (38 services) either very or somewhat satisfied;
- the support provided by QUMSPs - 87% (38 services) either very or somewhat satisfied;
- the level and nature of support provided by NACCHO - 87% (38 services) either very or somewhat satisfied;
- the NACCHO IT system for submitting work plans, accessing information, communicating with others - 86% (38 services) either very or somewhat satisfied;
- the Business Rules and Guidelines - 86% (38 services) either very or somewhat satisfied;
- the level and nature of support provided by NACCHO State Affiliate - 77% (34 services) either very or somewhat satisfied;
- the QUMAX annual conference - 77% (34 services) either very or somewhat satisfied; and
- the QUMAX orientation conference - 68% (30 services) either very or somewhat satisfied.

During consultations it was common for services to note the value of State workshops convened by NACCHO State Affiliates in providing the impetus for developing work plans, understanding Program requirements and generating ideas. Equally, the QUMAX annual conferences were valued for the opportunities they presented for networking, information sharing, overcoming common Program obstacles and promoting good practice. It was common for services to report that they had reviewed their work plans or participation eligibility criteria as a result of discussions with other services during the annual conferences.

It was also common for those consulted to praise the level and quality of support provided by the QUMAX National Program Managers and the QUMSPs. One service for example noted that:

“As the QUMAX coordinator I have had the pleasure of working with [NACCHO] and [QUMSP]. They are dedicated to their work and dedicated to seeing QUMAX develop into a program that will
be sustainable for Indigenous people and will provide better health outcomes. I have also been able to develop a working relationship with staff from the Guild who have been extremely helpful”

QUM Support Pharmacists (QUMSPs)

As has been previously discussed, the QUMSPs have been a critical factor to the success and quality of experience of services in implementing the Program. An important role set down for the QUMSPs was to broker stronger relationships between ACCHSs and community pharmacies in developing and implementing the ACCHS workplans. In some instances, it was clear that participation in QUMAX had given cause for community pharmacies and ACCHSs to work more closely. For example, a number of community pharmacists reported that they had visited the ACCHS for the first time in order to discuss the QUMAX program and this had been a valuable professional experience that led to stronger working relationships. QUMSPs often played a role in bringing community pharmacists and ACCHSs together for these purposes.

A number of services in one jurisdiction for example noted that the QUMSP had a significant impact on the success of the Program regionally.

Case study – QUMSP good practice

One QUMSP was reported to have kept in regular contact with services, and held quarterly meetings with some services (together as a group) to discuss concerns about QUMAX and to stimulate ideas for best practice. The QUMSP also developed a fortnightly newsletter on general information on PBS medicines which was distributed to services to keep them up to date. The QUMSP was sometimes present on the first day that QUMAX-stamped prescriptions were provided. This physical presence reportedly helped greatly in understanding what was required by the IT system and in bedding down the QUMAX process within the ACCHS.

Overall, consulted services reported that QUMSPs had been instrumental in: providing support during the initial registration and work plan development process, educating service stakeholders about the Program, assisting the development of QUM frameworks/activities, and providing general trouble shooting support as needed.

Data collected as part of the ACCHSs survey further supported the focus of activities undertaken by QUMSP as reported during consultations:

- 88% of services (38 services) reported that they had received in-service education from their QUMSP; and
- 84% (36 services) reported that they had received assistance from their QUMSP in developing their work plans.

Of particular interest to the QUM focus of the Program is that 83% of ACCHS survey respondents reported that their QUMSP had an impact on the development of QUM frameworks within their service. Of these, over half of respondents (59%) reported that QUMSPs had a substantial impact.

Responses to the ACCHSs survey showed that the majority of services (73%) have contact with their QUMSP at least on a monthly basis (see Figure 3).
There was however some reported disparity in the levels of support provided by QUMSPs. While services generally reported high satisfaction and regularity of contact with their QUMSP, some services were critical of their assigned QUMSP for being unresponsive and lacking knowledge of the sector.

One service for example commented that “[The QUMSP] is paid to visit us a few times a year but doesn’t…it would be good for [the QUMSP] to be more involved, to ensure we are on top of our plan and heading in the right direction, provide overall support and maybe some training as needed”.

Another service commented that whilst their QUMSP had been helpful, given the size of their geographic area of responsibility, it was difficult to contact them and to meet on a regular basis.

A number of services specifically commented on difficulties encountered where their QUMSP was, or had a personal relationship with, their local participating community pharmacy or pharmacist. In these situations services felt that their ability to negotiate with the community pharmacy on issues such as pricing, or to resolve concerns, was limited. For example, one particular service located in a metropolitan location reported only using two community pharmacies, both owned by the same person, who was also the QUMSP. The pharmacies are not within close proximity to the service or easily accessible by patients, as one service respondent stated, “[the pharmacy] is in the middle of white middle class [city]…not a great location.” The location of the community pharmacy has reportedly put significant pressure on the transport assistance provided by the service, which is often required to deliver medications to patient homes as a result of the distance between the participating pharmacy and the service. The service would like to expand the number of community pharmacies involved in the Program but is unsure of how this will impact on the relationship with the QUMSP.

There were also some cases of ‘role confusion’ where community pharmacists played the role of QUMSP as well as being a participant in the program. It appeared, in some cases, that playing the role of QUMSP required a separate set of commitments to those required of simply being a participating pharmacy.

**Case study – monitoring the implementation of work plan activities**

A particular service is working with a number of community pharmacies which are all owned by a single person. The QUMSP was an employee of the community pharmacy but left the position without notifying the ACCHS. The community pharmacy is planning to replace the QUMSP role but some months have passed and the position remains vacant. The community pharmacy has not fulfilled commitments as part of QUMAX. The ACCHS is frustrated with the increase in business the community pharmacy is receiving despite an unwillingness to meet other program commitments. There is significant tension between service staff and the community pharmacy.
It was also often reported by ACCHSs that, as small business owners, community pharmacists are often time poor and not always supported by the availability of relieving pharmacists. This sometimes made it very difficult for them to meet commitments made to perform the role of a QUMSP, for example, by attending planning meetings during business hours or travelling to other locations to support an ACCHS.

5.3.5 Program support mechanisms for community pharmacies

With few exceptions, pharmacies reported that they had found the Program support mechanisms satisfactory, particularly the support provided by the QUMSP and the QUMAX hotline.

The majority of pharmacies reported being approached by a QUMSP or the Guild to introduce the Program. While the support provided by the QUMSP had been important in the early stages of the Program, it was often reported that there had been limited contact since. In this context pharmacies reported that once established, the Program was relatively simple to implement and there was no need for ongoing support. A number of pharmacies however relied on the QUMAX hotline to provide on-call assistance and trouble shooting advice.

Of pharmacies surveyed (160 community pharmacies) as part of the Community Pharmacy Survey:
- half (52%) had used the QUMAX Business Rules and Guidelines and of these 83% had found them to be helpful;
- two thirds (66%) had used the QUMAX hotline and 97% of these had found it to be helpful;
- just over two thirds (69%) had accessed the Pharmacy Guild of Australia website and 89% had found it to be helpful;
- one in three (31%) had accessed their QUM Support Pharmacist (QUMSP) and 98% had found it to be helpful; and
- one in twenty (5%) had not used, attended or accessed any of the above.

5.3.6 Development of work plans, eligibility criteria and allocating available funding

Development of work plans

The processes adopted by individual ACCHSs to develop their work plans varied greatly, and as previously mentioned were impacted by the levels of internal support received (such as from senior management), external support received (such as from the QUMSP) and the availability of staff to allocate sufficient time to complete the work plan (such as having a QUMAX ‘champion’ within the organisation to lead the process). As has been previously discussed, while some ACCHSs reported that the work plan development process was difficult and time consuming, overall, the majority of ACCHSs reported that the process had been relatively straightforward.

It is important to note that ACCHSs consulted after the development of their second work plan reported that the experience was much easier for a number of reasons, namely:
- After an initial period of implementation ACCHSs better understood the Program, what was expected and what would work in their organisation.
- After an initial period of implementation ACCHSs better understood the actual cost of implementing activities, patient demand for different supports/activities and were able to estimate their funding expenditure more accurately (for example to allow for greater use of DAAs).
- After participating in information sharing activities (such as annual conferences) in which common problems, solutions, activities and good practice were discussed, ACCHSs were more confident in the types of work plan activities prioritised.

Generally there was commonality across the key work plan activities identified by services, namely:
- issuing co-payments;
- improving medication compliance through patient education or through the provision of DAAs;
- transport assistance (of patients to service and pharmacies and/or of medications to patients);
- QUM education sessions for staff;
- cultural training and awareness;
- conducting Home Medicine Reviews (HMRs);
- safety-net monitoring; and
- on-call pharmacy.

Only a small number of ACCHSs reported consulting with their local community pharmacy in the development of their work plan. For example, some ACCHSs had convened working groups to inform the development of their work plan and monitor the implementation of the Program more broadly; the participating community pharmacist was part of the working group.

It was clear that a great deal of work and thinking had gone into the development of most work plans. There were a number of work plans that were similar from one service to the next, reflecting the support role often played by QUMSPs in helping services to assemble their work plans.

Functionality was added to the NACCHO work plan website to allow ACCHS staff to make annotations to their work plans. This allowed services to mark off tasks as completed or to otherwise make notes about progress.

**Allocating available funding**

Amongst the services consulted, there were different approaches to allocating available funds reflecting the varying work plan priorities. As previously noted, ACCHSs reported that allocating available funding in the second work plan was much easier as services had a better understanding of the likely demand and cost for different work plan activities. Further more, changes to the Program Business Rules as previously outlined allowed for far greater flexibility.

The focus of the majority of work plans (and allocation of available funding) was on the provision of co-payments, DAAs and transport assistance.

The work plan process required ACCHSs to allocate funds – according to their own criteria – to the various kinds of direct financial and other assistance to be offered to clients. The allocations made are somewhat telling in terms of the needs of clients as perceived by the ACCHSs. For example, the vast majority of services (85%) allocated the largest portion of their available funds to financial assistance for medicine co-payments.

Figure 4 below sets out average funding allocations made in both 2008 and 2009 to the various categories.
The results above show that services in general chose to continue allocating significant funds to meet the medicine co-payments for clients into 2009/10. However, allocations were made in 2009 for a range of other activities allowed for under the new ‘flexible MAAPs’ category, coming at the expense of allocations made for medicines and DAAs.

There was considerable variation in the allocations made by many individual ACCHSs from 2008 to 2009. It was common for services, for example, to significantly reduce their allocations for co-payments but increase their allocations for transport or DAAs, or vice versa. As the figure above shows, there was not a lot of net effect across all services but it was clear that the 2008 experience led to adjustments within nearly all services in the allocations made for the different MAAP categories.

Throughout consultations, stakeholders expressed two funding related concerns:

- Some ACCHSs perceived a lack of transparency in how Program funding is allocated across services. This particularly related to the second year of funding in which a number of ACCHSs reported a reduction in funding without sufficient explanation by either their QUMSP or the Department.
- ACCHSs and community pharmacists expressed concern that the Program funding structure did not consider the significant in-kind support provided by them in relation to the administration of the Program generally, and participation in activities such as training. As previously noted, a small number of community pharmacies were charging services patient set up fees to recover some of the costs associated with the administrative related tasks they had to undertake as part of the Program.

**Establishing the eligibility criteria**

Whilst some services adopted the MAAPs eligibility criteria set out in the Program Business Rules, other services applied additional criteria to ensure that funds were used at the appropriate rate and that those in most need received assistance.

Services limited access to financial assistance on a number of bases, often reflecting local health priorities, including:

- concession card holders only;
- only Aboriginal and Torres Strait Islander patients;
- only people with chronic conditions;
- only people with *specific* chronic conditions;
- only people who use specific chronic illness medications;
- multiple medication users;
- no benzodiazepines;
- on condition that patients made return visits to the ACCHS;
- on condition that patients participated in health checks, care planning activities and HMRs;
- for a limited number of medications or repeats only;
- co-payment, requiring the patient to pay for some of the medications;
- contraception, obstetrics and mental health medications;
- smoking cessation treatments;
- medication for children under 16 years of age;
- medication for infectious diseases;
- any patient with financial difficulties;
- all patients on DAAs who have a concession card;
- all children aged under 16 years; and
- all patients on three or more medications.

Eighteen of the forty four services (41%) that responded to the ACCHSs survey reported that QUMAX financial assistance was only available to patients with chronic disease, while fifteen services (34%) provided other criteria for the allocation of financial assistance such as those outlined above.

Services varied on the criteria they placed on patients in accessing QUMAX with regards to financial circumstances. Nineteen services (43%) reported that *assessment of financial need is made on an individual basis*; 17 services (39%) reported that *all patients regardless of financial circumstance can access QUMAX*. Eight services (18%) said that *only concession card holders can access QUMAX*.

Small numbers of services surveyed reported that they, as a matter of course, limited access to Medication Access and Assistance Packages (MAAPs) in either the *number of medications* (5 services; 10%); or the *number of prescription repeats* (13 services; 20%).

**Enforcing the eligibility criteria**

Enforcing the eligibility criteria is a significant challenge faced by many ACCHSs, particularly in ensuring that financial assistance is only made available to Aboriginal and/or Torres Strait Islander patients, and to those in financial hardship.

It was noted that there was a degree of discomfort on the part of doctors and others in assessing either financial need or the Aboriginal or Torres Strait background of patients. Some very different practices were described – from assumptions being made about a patient’s financial needs to requesting documentation from patients to prove that a need existed.

One service reported that it was hard to determine whether patients were being truthful about their financial situation, and in this context it was difficult for doctors to determine who was eligible for QUMAX. The service reported that this was an awkward position for doctors to be in, as on one hand doctors were offering QUMAX to patients who they thought were in need but who took offense at the offer of QUMAX, and on the other hand doctors were being “bullied into stamping a QUMAX script” when it was known amongst the staff that the patient was not in financial need. In this sense, QUMAX was sometimes perceived to be a burden for doctors who felt it was not their place, nor within their skill, to determine financial eligibility.
In this context one ACCHSs staff member stated:

“The doctors found virtually every patient difficult in determining eligibility. In the opinion of the doctors, all Aboriginal and Torres Strait Islander patients and their family members were eligible. The social contexts of each patient was too complex to determine eligibility. Time restraints on the GP meant that it was generally easier and more convenient to make the person eligible than it was to sit there and discuss the subject.”

Similarly a doctor stated that “…It is not the doctors role to ask questions about personal finances…. [the] approach is to give it to everyone until it [QUMAX funding] runs out”.

Another doctor stated that she simply asked the patient ‘will you be able to pick up that medicine today?’ and that if there was any doubt, a financial barrier was assumed and a MAAP was generated.

It is important to note that despite the reported problems in defining and enforcing criteria related to financial disadvantage, many services reported that their patients understood the eligibility criteria and were using it responsibly. ACCHSs noted many instances in which patients would state that they did not need the financial assistance and that they understood the importance of funding going to those in most need.

When asked whether they had experienced any difficulties or issues in determining financial need and eligibility for QUMAX assistance, 84% (37 services) of respondents to the ACCHSs survey replied that they had not and the remaining 15% (7 services) replied that they had. Such difficulties detailed by the 7 services, included:

- difficulties in coming to a consensus at the service regarding a definition of ‘financial disadvantage’;
- including all ‘financial disadvantaged’ clients within the QUMAX budget;
- the patient not disclosing details on financial hardship; and
- health care card information not being readily available.

A number of ACCHSs expressed concern that as a result of increased patient numbers (due to QUMAX), patients with no history in the service or apparent connection to local Aboriginal or Torres Strait Islander communities were requesting Program assistance. In this context ACCHSs felt that it was difficult to either prove, or disprove, a patient’s claim for Program assistance.

One service for example reported that “All sorts [of people] saying yes I am, and because there is no regulation it is hard to prove it”.

As is the case with establishing financial need, ACCHSs, and in particular doctors, did not feel it was their role to test the validity of patients’ claims regarding their background. In this context doctors preferred to approve Program assistance rather than engage in debates with patients.

**Reviewing the eligibility criteria**

A number of services noted that the eligibility criteria had shifted since the commencement of the Program based on how they were tracking against their funding. For instance, if too much funding had been expended, the eligibility criteria were tightened; if the service felt the budget would allow for more, the criteria were expanded. Some services also reported reviews to the criteria based on a reduction in their funding in the second year of the Program.

One service for example reported that after a few months of implementation it was decided that funding would be sufficient to include all Aboriginal and Torres Strait Islander community members, and that there was no need to discriminate based on the severity of medical conditions.

Another service on the other hand initially included all classes of drugs, however had to limit this to chronic disease as they were running out of funds.

Some 50% (22 services) of respondents to the ACCHSs survey for example reported that there has been no change to the eligibility criteria since implementing QUMAX. Around one in three (36%; 15
services) reported that the eligibility criteria have been changed to increase access of patients to QUMAX.

Case study – reviewing eligibility criteria on a monthly basis

A particular service is implementing a ‘weighting’ model of funding to ensure the allocation lasts the required twelve months. In this context the service expands or contracts the eligibility criteria depending on whether the allocated monthly funding is likely to be sufficient or expended. At the time of the field visit for example, the Program was “on hold for two months”. This meant that unless it was deemed an emergency situation, no MAAPs were issued. Doctors in the ACCHSs noted that “people are cutting down on their medication now that QUMAX has temporarily ceased…it doesn’t look good at all to say we’ve finished the funding and we don’t know when it is coming back”. It is important to note that staff in this particular service had struggled to enforce the eligibility criteria, and in this context, QUMAX was being accessed by any patient. In explaining the frustration in enforcing the eligibility criteria and why the Program should be available to all patients, a health worker stated, “how do you say no to one and yes to another?”

5.4 Implementing QUMAX at the site level

Further to case studies outlined earlier in this chapter, this section provides a snapshot of the different contexts in which QUMAX was implemented locally, and provides examples of various strategies and issues encountered by participating ACCHSs and community pharmacists to further contextualise the evaluation. Please note that specific discussion and analysis of ACCHSs service improvements and Program outcomes can be found in Chapters 6 and 7.

5.4.1 The QUMAX process locally

Organisational structures and local Program management

As has been previously discussed there was significant difference in the organisational context in which QUMAX was implemented across ACCHSs.

Within many ACCHSs, internal committees were established in the early stages of the Program (for example prior to the work plan development), and included a range of stakeholders such as: Public Health Medical Officers, GPs, Senior Medical Officers, Clinic Managers, representatives from the Aboriginal Health Council, Health Workers, organisational executives such as the CEO, QUMSPs, and participating community pharmacists. The committees aimed to consider the requirements of the Program and how it could be best adapted to the needs of the local patient population. The committees lead the formulation of work plans and activities, and continued to meet regularly to address issues and monitor progress.

One factor which was shown to be important was the existence of at least one person within the service to be a ‘champion’ for QUMAX and to coordinate the planning and implementation effort (as noted previously in this report). Local circumstances determined who this person was - in some services, the Program was advanced by an administrative officer while in others it was a doctor, nurse or Aboriginal Health Worker.

In contrast, other services had far less structured processes and more ad hoc responses to Program requirements such as the development of work plans.

Managing MAAPs

As expected, the issuing and management of MAAPs was both from a financial allocation and an administrative perspective, one of the most significant focuses of the Program across ACCHSs. This required ACCHSs to develop processes to guide the issuing of MAAPs as per their eligibility criteria, and to liaise with participating community pharmacies in the dispensing of medications.
Operationally, the Program and role of internal stakeholders in the management of MAAPs differed across services, in accordance with the direction provided by ACCHS CEOs. While in some services GPs performed all associated tasks and issued the MAAP during the consultation, in others, this task was delegated to other staff members. In a number of more extreme scenarios, GPs were so removed from the process that they were unaware of whether MAAPs were issued to their patients.

Overall, the internal managing of MAAPs included the following scenarios:

- GP determines patient eligibility, issues QUMAX script, and enters MAAP number into QUMAX IT system as part of the consultation.
- GP determines eligibility and issues QUMAX script, reception staff or health worker enter MAAP number in QUMAX IT system.
- Health care worker determines if patient is eligible for QUMAX and flags this with the GP. The GP issues the script and enters the MAAP number into the QUMAX IT system as part of the consultation.
- GP issues regular PBS script, health service staff determines whether patient is eligible for QUMAX, stamps the script and enters MAAP number in QUMAX IT system.

Registration of patients

There was some frustration expressed about the need to manually enter patient details, including Medicare numbers in order to generate the first MAAP for an individual patient. Doctors were particularly likely to express frustration and it was often suggested that an IT link be established between the Patient Information Recall System (PIRS) and the QUMAX IT system that allowed automatic population of fields to greatly minimise this administrative impact.

In response, ACCHSs had implemented a variety of workflow practices in order to minimise administrative impacts. These included:

- ‘bulk’ registration of all potentially eligible patients (leaving the consent obtained box unchecked), usually performed by someone other than a doctor;
- assessment of eligibility and registration of patients immediately prior to the GP consultation, again performed by a nurse, health workers or other person;
- doctor assessment of eligibility and QUMAX stamping of a prescription, with all data entry performed subsequently by an administrative officer; and
- placing a QUMAX flag in a free text field of the PIRS to indicate whether a patient had been registered (and to allow easier management of records).

Establishing partnerships with community pharmacies

One of the objectives of the QUMAX program was to address cross-cultural barriers to access to community pharmacies by ACCHS clients. Generally QUMAX represented an opportunity for increased collaboration between ACCHSs and local community pharmacies. Overall, ACCHSs and community pharmacies reported positive experiences in working together as part of the Program.

While many ACCHSs reported that QUMAX had provided an opportunity for the development of new partnerships with local community pharmacies, the experience of ACCHSs in engaging with community pharmacies was dependent on the following:

- The type of support provided by the QUMSP and their association to a particular community pharmacy (as discussed in Chapter 5.3.3): While some QUMSPs actively promoted the involvement of local community pharmacies in the Program, others left it to the service to initiate these discussions. In a number of scenarios in which the QUMSP was related to a local community pharmacist, or was a local community pharmacist, ACCHSs felt inhibited and unable to encourage other local community pharmacists to participate in the Program.
- The ACCHSs history in working with specific local community pharmacies: Many ACCHSs had prior and good working relationships with local community pharmacists. While QUMAX allowed for the
development of new partnerships, many ACCHSs relied on existing partnerships with local community pharmacies.

- The geographic proximity of the ACCHSs to community pharmacies: A number of ACCHSs only had one or two local community pharmacies within reasonable geographic proximity.

Analysis of Program data to June 2010 noted that there were 541 pharmacies actively dispensing MAAPs (that is, dispensing medications or DAAs as part of QUMAX). The minimum number of MAAPs dispensed by participating community pharmacies was 1 and the maximum, emphasising the significant financial incentive for participation, was 4,553 over the course of the Program.

**Case study – issuing medications despite MAAP errors**

*It is common for community pharmacies to report that they receive MAAPs with minor errors. Once issued, MAAPs cannot be changed, requiring the ACCHSs to effectively cancel it and reissue a new one. This can be a time consuming process as the community pharmacist needs to contact the ACCHS and the contact person within the ACCHS needs to be available to reissue the MAAP. A majority of community pharmacists reported that given their familiarity and good working relationship with the ACCHS, they often dispense medications even though MAAPs are incorrect and trust that the a new MAAP will be reissused in the future. This is a generous gesture as it does not delay patients in receiving medications, but does delay the community pharmacy’s ability to submit a funding claim for the medications that have been dispensed.*

**Case study – problems in engaging community pharmacies**

*One particular ACCHS in a metropolitan location reported that they had ongoing issues in engaging community pharmacies to participate in the Program. Although the ACCHS and QUMSP had made a number of attempts to expand the number of local community pharmacies involved in the Program, these had been unsuccessful. The ACCHS reported that community pharmacies did not feel the Program would attract enough patients to warrant the perceived investment in time/training. A number of local community pharmacies also stated that they don’t want to encourage Indigenous patronage.*

**Case study – community pharmacy approaching the ACCHS**

*While in the majority of cases either the ACCHS or QUMSP approached local community pharmacies to become involved in the Program, in a number of instances it was the community pharmacy that approached the ACCHS. In one particular case, a community pharmacy owner who did not have a pre-existing relationship with the ACCHS approached them directly to express interest in being a participating pharmacy. The community pharmacist reported that QUMAX “makes good business sense” and he was actively approaching a number of ACCHSs to establish arrangements under the Program.*
Case study – overcoming geographical distance

A number of ACCHSs reported processes to ensure that isolated locations could still participate in the Program. This included for example relying on the QUMAX hotline to issue MAAP numbers in services that do not have regular internet access and therefore cannot access the QUMAX IT system. In another example, the ACCHSs fax through scripts to a community pharmacy that is 45 minutes away. While the ACCHS transport officer could collect medications from the pharmacy, the pharmacist prefers to travel to the service to dispense the medications. The pharmacy reports that face-to-face dispensing allows them to meet patients on a regular basis, answer questions and monitor compliance.

5.4.2 Common Program obstacles

Confusion during the initial stage of implementation

There were some common obstacles experienced by participating ACCHSs and community pharmacists during the initial stage of implementation. These particularly related to difficulties in interpreting the requirements of the various fields included on the 'Issue MAAP' function of the IT system.

While these initial obstacles were reported to the Department and QUMAX PRG throughout the early progress reports, more recent stakeholder consultations reveal that these initial obstacles have now been overcome. A brief summary of these is outlined below:

- The implication of selecting (or not selecting) the concession status was not well understood. In some instances, doctors (or others in the ACCHS) ticked the concession card box when the patient did not in fact have one. The result of this action is that the pharmacist could not dispense the medicine or else ended up out of pocket. Conversely, if the concession status box was left unchecked when the patient in fact had a concession card, the implication is that the non-concession copayment amount would be deducted from the ACCHS budget unnecessarily (and mainstream PBS funds would not be accessed in full).

- Similarly, there was reported confusion about the brand price premium box. The terminology was reportedly not well understood by doctors and some had taken the advice of community pharmacists (and QUMSPs) to always tick the box in case the medicine attracted the premium, so as to avoid the need to reissue the MAAP. Again, the budgetary implications of this had not always been thought through. Where the box remained un-tick ed but the prescribed medicine attracted the premium, pharmacists were left unsure as whether to substitute a cheaper brand or seek to have the MAAP reissued.

It is important to note that no formal training package was produced to support ACCHSs or pharmacists in using the QUMAX module of the 4CPA IT system.

Limitation of repeats

Several of those consulted spoke of the difficulties caused by the limitation of QUMAX assistance to four repeats.

The objection often related to the change to the normal workflow and the need to change the PIRS default (from six to four).

Although it was acknowledged that it was desirable to encourage more frequent GP visits by QUMAX patients, the frustration was still evident across ACCHSs and community pharmacies.
Management of DAAs and monitoring compliance

An ongoing problem reported by ACCHSs was that it was difficult to monitor medication compliance and ensure that patients received their medications when they needed them, particularly relating to repeats. It was regularly reported that to ensure patients have continuous access to their medications, community pharmacies automatically dispensed medications (as long as repeats were valid) when their systems alerted them that the patient was running low. In this context the pharmacy systems calculated the difference between the amount the medication was dispensed for and the prescribed dose. For calculation purposes the systems assumed 100% medication compliance.

While ACCHSs report that this was an extremely helpful mechanism, it meant that some ACCHSs often had large stock piles of medications that were delivered by their community pharmacy, but that were unclaimed by patients.

There were a number of reported reasons why patients did not collect their medications, namely:

- Patients were not compliant all of the time so it took longer to finish their medications courses.
- Patients were in hospital.
- Patients were travelling out of the area (which was common) and receiving their medications via another ACCHS.
- Medications were being delivered to homes automatically – when a delivery driver realised that patients still had unopened medications, they would return them to the ACCHS for storage.

Given that DAAs are individually prepared, in most instances it was not possible to return the unclaimed medications to the community pharmacy.

While ACCHSs acknowledged the problems in this process they did not have the resources to monitor compliance and contact all their patients prior to the dispensing of repeats. Further, ACCHSs were concerned that unless medications were automatically dispensed, patients would not collect their repeats regularly and medication compliance would be compromised.

5.5 Structural factors affecting participation

This chapter has considered the experience of participating ACCHSs and community pharmacies throughout the implementation of the Program.

Through the analysis of data collected from site visits, telephone interviews and online surveys, the chapter has provided narratives and case studies to contextualise the implementation of the Program.

Based on the information presented throughout this chapter, this final section considers the structural factors that have enabled or limited the successful implementation of the Program by both participating ACCHSs and community pharmacies. The enabling and limiting factors are presented in Table 7.
Table 7 – Enabling and limiting factors that affect participation

<table>
<thead>
<tr>
<th>Enabling factors</th>
<th>Limiting factors</th>
</tr>
</thead>
</table>
| **Organisational** | ‘Top down’ support from Board and CEO  
Organisational stability | Limited or no support from Board and/or CEO due to vacant positions, organisational dysfunction or other reasons |
| **Staffing and resourcing** | Appointment of a QUMAX coordinator to ‘champion’ the implementation of the Program  
Establishment of an internal working group with diverse organisational representation to lead and monitor the implementation of the Program  
Establishment and implementation of Program procedures, guidelines and eligibility criteria | Lack of QUMAX Program leadership within the organisation  
Requiring that an already busy staff member lead QUMAX in addition to existing demands  
Minimal investment in Program resource development  
Lack of internal stakeholder interest in the Program |
| **Communication and engagement** | Effective internal communication about QUMAX  
Regular contact with QUMSP  
Prior positive relationships between ACCHS and local community pharmacies  
Regular contact between ACCHS and participating community pharmacies | Failure to inform and engage service staff regarding the Program  
ACCHS experiencing difficulties engaging local community pharmacies  
Lack of regular communication between ACCHS and QUMSP  
Lack of regular communication between ACCHS and participating community pharmacies |
| **Quality and availability of support** | Good communication and support from Program stakeholders such as NACCHO, the Guild and QUMSP | Poor communication and support from Program stakeholders such as NACCHO, the Guild and QUMSP  
Concern regarding the independence of the QUMSP (for example, when they are both the QUMSP and participating community pharmacy) |
6 Service improvements under QUMAX

6.1 Summary of the chapter

This chapter presents an analysis of data collected during site visits, telephone interviews and online surveys with participating ACCHSs and community pharmacies. Discussed, are overall service improvements for participating ACCHSs and community pharmacies under the key Program categories of:

- Overcoming cultural, transport and financial barriers to accessing medications:
  - allocation of MAAPs;
  - provision of financial assistance to individual ACCHS patients for the purchase of medications (co-payments);
  - provision of financial assistance to individual ACCHS patients for the purchase of DAAs;
  - transport assistance;
  - implementation of cultural awareness and safety training activities for community pharmacies; and
  - PBS safety net entitlements.

- Improved QUM:
  - training in QUM for staff in ACCHSs;
  - provision of on-call pharmacist dispensing and medicines advice;
  - enrolment in the National Diabetes Services Scheme, the Asthma Spacer Ordering Scheme, and the Home Medicines Review Program; and
  - diabetes or asthma cycle of care consultations and Aboriginal and Torres Strait Islander Health Checks/Development of care plans.

Overall the chapter presents evidence to support the claim that QUMAX has had a significant impact on overcoming known barriers to Indigenous access to medications, medication compliance and medical services.

In this context the chapter also highlights that some parts of the Program, such as the provision of financial assistance for the purchase of medications or the provision of transport, have been of far greater focus across ACCHSs than other aspects, such as QUM training and cultural awareness and safety training.

6.2 Overcoming cultural, transport and financial barriers to accessing medications

6.2.1 Allocation of MAAPs

A note regarding terminology

As explained in earlier chapters of this report, MAAPs are the Program instrument used to allocate funding to various Program components such as the provision of financial assistance, transport and safety net monitoring.

For the purpose of this chapter, particularly the forthcoming Chapters 6.3.2 and 6.3.3, the term MAAPs has been used to refer to the number of MAAPs allocated by ACCHSs. In this context Program terminology refers to instances in which an ACCHS issues a MAAP number for the provision of financial assistance to either purchase medications or DAAs.
Overall analysis of MAAP allocations

The number of monthly MAAP allocations for the period of 1 July 2009 to 30 June 2010 is shown in Figure 5 below, and highlights as expected, a general upward trend in the monthly allocation of MAAPs from 268 in July 2009 to 14,504 in June 2010.

Figure 5 – Monthly number of MAAPs allocated

The following comments can be made about this data:

- The number of MAAP allocations, as expected, rose steadily in the first six months of the Program as services came on board and became more familiar with QUMAX processes.
- Allocations reached a plateau in August and September 2009 as services settled with their imposed budgets.
- Allocations rose sharply in February 2010, and again in March and June 2010 as services became more certain of the extension of QUMAX to 30 June 2010, and the commencement of the COAG Closing the Gap PBS Co-payment Measure on 1 July 2010.

6.2.2 Provision of financial assistance to individual ACCHS patients for the purchase of medications (co-payments)

The provision of financial assistance to individual ACCHS patients for the purchase of medications has been the most significant focus of the Program across ACCHSs. Financial barriers are one of the most well known obstacles to Indigenous patient compliance with medication regimes.

All ACCHSs who participated in either the field visits or telephone consultations reported that the Program’s ability to provide financial assistance for the purchase of medications has been at the core of its success.

As previously discussed in Chapter 5, a number of ACCHSs reported that they had provided financial assistance to patients prior to QUMAX. In this context QUMAX funding for the provision of financial assistance is noted to have alleviated financial pressures on ACCHSs. Some services reported that QUMAX funding is insufficient and thus they have continued to provide additional funding for the purchase of PBS and non-PBS items.

As previously discussed in Chapter 5, ACCHSs have developed eligibility criteria to manage the allocation of financial assistance. These criteria, and their enforcement, vary greatly across services.
Overcoming individual financial barriers

During consultations, ACCHSs staff and patients regularly reported on the obstacles they used to face in purchasing their medications regularly prior to QUMAX.

One service for example reported that [as a result of QUMAX] children were more likely to get their medicine straight away “rather than after the groceries or rent were paid for” and were taking a full course of antibiotics resulting in less recurring infections, as “in the past, patients were taking antibiotics until they felt they were better then keeping the remainder of the pills until they felt they needed them again in order to save money”.

Another service reported that while their patients had always known that without medicines they were sicker, when purchasing medications patients often had to choose whether to purchase them or food (in some cases for their family) – as noted, “one prescription is three loaves of bread”.

It was common for services to compliment the Australian Government for their provision of funding to reduce the financial burden of medications. As will be discussed in the following chapter, ACCHSs staff particularly, often attributed much of the success of the Program in improving health outcomes to the provision of financial assistance for the purchase of medications.

Analysis of co-payment allocations

As reported in Chapter 5, the work plan process required ACCHSs to allocate funds – according to their own criteria – to the various kinds of direct financial and other assistance to be offered to clients. The vast majority of services (85%) allocated the largest portion of their available funds to financial assistance for medicine copayments.

As indicated in Table 8 below, by June 2010 there were a total of 33,924 Program clients who had been allocated a total of 578,691 co-payment incidents (that is, incidents in which financial assistance was provided for the purchase of their medications).

Table 8 – ACCHS and Pharmacy Activity to June 30, 2010

<table>
<thead>
<tr>
<th></th>
<th>Total Clients</th>
<th>Concession Clients</th>
<th>MAAPs Allocated</th>
<th>Co-Pay allocated</th>
<th>Copay dispensed</th>
<th>Brand Premium Allowed</th>
<th>DAA allocated</th>
<th>DAA dispensed</th>
<th>Safety Net reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW/ACT</td>
<td>13,626</td>
<td>9,981</td>
<td>37,438</td>
<td>202,033</td>
<td>93,749</td>
<td>8,276</td>
<td>42,993</td>
<td>19,781</td>
<td>296</td>
</tr>
<tr>
<td>QLD</td>
<td>9,793</td>
<td>5,954</td>
<td>28,037</td>
<td>153,930</td>
<td>75,250</td>
<td>1,231</td>
<td>35,588</td>
<td>14,885</td>
<td>335</td>
</tr>
<tr>
<td>SA</td>
<td>875</td>
<td>611</td>
<td>4,496</td>
<td>25,910</td>
<td>16,637</td>
<td>1,099</td>
<td>27,158</td>
<td>16,274</td>
<td>93</td>
</tr>
<tr>
<td>VIC/TAS</td>
<td>7,312</td>
<td>5,699</td>
<td>35,606</td>
<td>150,921</td>
<td>66,811</td>
<td>165</td>
<td>35,275</td>
<td>17,156</td>
<td>246</td>
</tr>
<tr>
<td>WA</td>
<td>2,194</td>
<td>1,728</td>
<td>6,456</td>
<td>43,971</td>
<td>18,043</td>
<td>856</td>
<td>10,519</td>
<td>5,418</td>
<td>176</td>
</tr>
<tr>
<td>NT</td>
<td>124</td>
<td>104</td>
<td>313</td>
<td>1,926</td>
<td>736</td>
<td>2</td>
<td>724</td>
<td>608</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>33,924</td>
<td>24,077</td>
<td>112,346</td>
<td>578,691</td>
<td>271,226</td>
<td>11,629</td>
<td>152,257</td>
<td>74,122</td>
<td>1,146</td>
</tr>
</tbody>
</table>

21 For the provision of financial assistance to purchase medications or DAAs
22 Note that figures provided here reflect the incidence of the ‘Brand Price Premium’ field being checked by the prescriber. It does not necessarily reflect the number of brand price premium medicines actually dispensed.
Co-payment expenditure by ATC groupings and Indigenous PBS items

Data were tracked monthly for expenditure on co-payments by ATC groupings. This included: diabetes drugs (A10), anti-hypertensives (C02), lipid therapy (C10), asthma drugs (R03), antibiotics (J01), and other Indigenous PBS items.

Table 9 below provides comparative data for the months of July 2009 and June 2010 (at the beginning and conclusion of this data tracking exercise). The comparative data clearly indicates a significant increase over the course of the tracking period in the numbers of clients, numbers of co-payments and related expenditure.

<table>
<thead>
<tr>
<th>ATC</th>
<th>Expenditure on copayments</th>
<th># of copayments covered</th>
<th># of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>July '09</td>
<td>June '10</td>
<td>July '09</td>
</tr>
<tr>
<td>A10 – Diabetes drugs</td>
<td>$47,729</td>
<td>$288,834</td>
<td>4,940</td>
</tr>
<tr>
<td>C01-C09 – Anti-hypertensives etc (to 17 July 2010)</td>
<td>$645,329</td>
<td>63,219</td>
<td>21,565</td>
</tr>
<tr>
<td>C10 – Lipid therapy</td>
<td>$62,027</td>
<td>$367,171</td>
<td>4,878</td>
</tr>
<tr>
<td>R03 – Asthma drugs</td>
<td>$34,747</td>
<td>$186,553</td>
<td>3,939</td>
</tr>
<tr>
<td>J01 – Antibiotics</td>
<td>$38,982</td>
<td>$214,690</td>
<td>4,934</td>
</tr>
<tr>
<td>Indigenous PBS items</td>
<td>$2,331</td>
<td>$28,105</td>
<td>246</td>
</tr>
</tbody>
</table>

6.2.3 Provision of financial assistance to individual ACCHS patients for the purchase of Dose Administration Aids (DAAs)

During consultations, ACCHSs and community pharmacists regularly reported that DAAs had been a very effective instrument in increasing medication compliance and ensuring patient QUM.

It was common for services to report that while they were aware of the potential benefits of DAAs prior to QUMAX, the additional costs charged by community pharmacies for dispensing them made DAAs highly prohibitive.

The use of DAAs had significantly increased, however, as a result of QUMAX. For example, 84% (37 services) of ACCHS Survey respondents believed that the Program had led to an increase in their use.

The number of DAAs dispensed as the Program progressed also significantly increased. As information presented in Figure 6 indicates, 13,489 DAAs had been dispensed by July 2009 as part of QUMAX. Less than twelve months later, by June 2010, this number had increased to a total of 74,122.
Management of DAAs

It was common for ACCHSs to develop criteria for the use of DAAs. The criteria to access DAAs were often related to:

- the number of medications being prescribed for example, some services provided DAAs to patients with 4 or more medications; and
- the patient’s history with QUM and compliances. For example some patients had a history of hospitalisation due to mismanaging their medication and/or the correct dose.

It is important to note that it was difficult for ACCHSs to manage and monitor expenditure on DAAs. When a doctor prescribed a DAA using QUMAX funds, typically this entailed 12 weeks of, say, Webster packs. Upon generating a MAAP in the 4CPA IT, 12 weeks of DAA were deducted from the ACCHS ‘on hold’ budget at the notional rate of $5 per week. When a community pharmacy provided the DAA to the patient, one week was deducted from the ACCHS ‘used’ budget at a cost determined by the pharmacy, usually though not always through negotiation with the ACCHS. Pharmacists charged a variety of fees for providing DAAs, often up to $10 per week. The remaining funds from the original allocation remained in the ACCHS ‘on hold’ budget. Under these circumstances, it was very difficult for ACCHS to determine whether their capped budget for DAAs would last for the entire year.

Allocation of funding

While inconsistent, substantial Program funds were allocated in both 2008/09 and 2009/10 by individual ACCHSs for the purchase of DAAs. Some services allocated a large portion of their funds (up to 45%), while others allocated very little (less than 1%).

Despite the reported positive impact of DAAs, it is important to note that by June 2010 only 32% of the budget allocated by ACCHSs for DAAs had been used.

As information presented in Table 12 indicates, overall there was $1,033,672 allocated for the purchase of DAAs, of which $333,203 had been used by June 2010. It is important to note that some of the discrepancy between the allocated sum and the actual amount used, relates to the number of DAA repeats that have been allocated (152,257 by June 2010) but at this stage are to be dispensed. As previously mentioned 74,122 DAAs had been dispensed by June 2010.
Table 10 – DAA budget progress – to June 2010 (includes 2008/09 and 2009/10 budget allocations)

<table>
<thead>
<tr>
<th></th>
<th>Total Budget</th>
<th>Used</th>
<th>Used %</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW/ACT</td>
<td>$363,513</td>
<td>$112,343</td>
<td>31%</td>
</tr>
<tr>
<td>QLD</td>
<td>$216,011</td>
<td>$75,852</td>
<td>35%</td>
</tr>
<tr>
<td>SA</td>
<td>$122,267</td>
<td>$35,997</td>
<td>29%</td>
</tr>
<tr>
<td>VIC/TAS</td>
<td>$245,781</td>
<td>$83,393</td>
<td>34%</td>
</tr>
<tr>
<td>WA</td>
<td>$69,600</td>
<td>$22,882</td>
<td>33%</td>
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<tr>
<td>NT</td>
<td>$16,500</td>
<td>$2,736</td>
<td>17%</td>
</tr>
<tr>
<td>Total</td>
<td>$1,033,672</td>
<td>$333,203</td>
<td>32%</td>
</tr>
</tbody>
</table>

Overall impact of provision of financial assistance to individual ACCHS patients for the purchase of DAAs

It was common for services to report that despite their known benefits, the use of DAAs prior to QUMAX was limited by their cost.

It was common for many services to report an increase use of DAAs as part of QUMAX, particularly for patients with multiple medications.

DAAs were reported by participating services, community pharmacies and patients as having greatly assisted QUM and medication compliance.

6.2.4 Transport assistance

The provision of transport assistance has been regularly identified by participating ACCHSs as a significant factor in the success of the Program. As one respondent stated, “Transport is a major part of the system”. As per information presented in Chapter 5.3.6, on average, ‘transport assistance’ represented the second largest financial allocation made by ACCHSs with Program funding, had only by the provision of financial assistance for the purchase of medicines or DAAs.

Service’s noted that transport (particularly because of geographical distances between communities, the ACCHS, and community pharmacies) has been a known barrier to regular medical care and medication compliance. While services reported variably on the number of transport incidents that had been delivered or the numbers of kilometres travelled as part of the Program, a number of services reported anecdotally as many as 1800 incidents of transport assistance per annum (around 150 incidents per month), or travel exceeding 32,000 kilometres per annum (around 2,700 kilometres per month).

Overall, services reported providing transport assistance across three areas:

- transport to deliver medications to the patient’s home;
- transport for patients to collect their medications from their QUMAX community pharmacy; and
- transport for patients to attend the service.

As noted in Figure 7 below, 84% (36 services) of respondents to the ACCHS survey reported that QUMAX funding had been used to expand existing transport services. This is consistent with consultation data in which many ACCHSs reported that they already had in place transport related infrastructure prior to QUMAX (such as vehicles and staff) for other purposes such as the delivery of food. In these instances however they did not have sufficient funding to extend the assistance to include transport of either patients or their medications.
Drivers as outreach workers

It was common for ACCHSs to report during consultations that transport drivers, in addition to the transport assistance itself, were playing an important outreach role in the implementation of the Program.

In this context it was reported that:

- Given many drivers’ familiarity with the local Indigenous community they had personal relationships with patients and maximised these by informally by reminding patients of upcoming appointments or encouraging them to attend the ACCHSs regularly.

- When delivering medications many drivers were actively asking patients about their recent medication compliance, and if they found the patient for example to have a number of unused boxes of medications, they would not deliver the latest batch and report it to the ACCHSs.

- Many drivers were accompanying patients inside the community pharmacy to collect their medications. This was a service that many patients liked as they did not feel comfortable attending the community pharmacy on their own either for cultural reasons or concern that they would not accurately understand/remember the instructions given to them regarding their medications.

The importance of face-to-face contact with community pharmacists

Many community pharmacists noted that the provision of transport assistance has allowed them for the first time to develop regular relationships with their Aboriginal and Torres Strait Islander clients.

In this context community pharmacists reported that the provision of patient transport particularly for patients to attend the community pharmacy (rather than for home deliveries) had:

- Allowed the community pharmacist to meet patients for whom they had been dispensing medications (via the ACCHS) for many years.

- Provided an opportunity for the community pharmacy to give QUM education by discussing with patients face-to-face the importance of compliance, or for example, appropriate storage of certain medications.
Increased cultural competence across community pharmacies as they now had for the first time regular contact with Indigenous clients.

Greatly assisted in safety net monitoring, as community pharmacies had a better understanding of relations between clients.

**Overall impact of transport within ACCHS**

The provision of transport assistance was found to have contributed to:

- the regularity of patients attending the ACCHSs;
- the regularity of patients collecting their repeats; and
- the development of positive relationships between patients and their local community pharmacist.

In addition, as noted in Chapter 5 a number of services reported that prior to QUMAX the service had provided limited transport assistance. In these services, the transport assistance had either diverted ACCHS staff from their core roles (such as health workers), or increased demand on an already resource-poor service (such as drivers employed for the delivery of food). In these services, the provision of transport assistance by QUMAX had:

- Allowed staff (such as health workers) to focus on their core work priorities rather than spend valuable time transporting patients or medicines.
- Supported the expansion of existing transport services; this was a time efficient and cost effective approach as many services reported that they already had the vehicles to provide transport assistance but insufficient funding to extend their use.

**6.2.5 Implementation of cultural awareness and safety training activities for community pharmacies**

The implementation of cultural awareness and safety training was intended to be an important component of the Program in ensuring that participating community pharmacies were able to provide a culturally appropriate level of service. The elements of such training included:

- An *Introduction to Cultural Orientation for Participating Pharmacists* manual (the manual) was developed by the Pharmaceutical Society of Australia and distributed to all participating community pharmacists.

- Staff from participating community pharmacists were encouraged to review the manual and to also undertake additional training opportunities.

- Services were encouraged to provide opportunities, either formally or informally, for cultural awareness and safety training with their participating community pharmacists. It is noted however that providing cultural awareness and safety training was not a formal requirement of ACCHSs.

The PSA advocated a more expansive suite of cultural awareness materials and training but the available budget did not allow for this.

Despite the important role of cultural awareness and safety training, with few exceptions, the implementation of training had not been a Program priority for community pharmacists or ACCHSs, for a number of reasons:

- Many community pharmacies noted the administrative impact of Program participation and did not feel that in this context training was a priority.
- Many community pharmacies reported that they had an established Indigenous clientele and a good relationship with the ACCHS and therefore they did not feel training was relevant.
- There were mixed views, by both community pharmacists and ACCHSs, regarding the quality of the cultural awareness and safety training manual.
The provision of cultural awareness and safety training was not a formal requirement or responsibility of participating ACCHSs.

The importance of culturally appropriate service delivery

Throughout consultations, it was common for ACCHSs to comment on the importance of cultural awareness and safety training. A small proportion of ACCHSs reported that, despite the training provided, a small number of community pharmacies had made inappropriate comments, (for example, one community pharmacist had referred to the Program as a ‘welfare hand out’. While the majority of pharmacists interviewed indicated their commitment to providing a culturally appropriate service to ACCHS clients, and to taking up training opportunities to further improve the service, there were a small number of examples that suggested an ongoing effort is required.

The cultural awareness and safety training manual

As previously reported, An Introduction to Cultural Orientation for Participating Pharmacists manual developed by the PSA was intended to be an important component of the cultural awareness and safety training resources provided to participating community pharmacies. There were mixed views regarding the quality of the cultural awareness and safety training manual and its use by community pharmacists.

In response to the Community Pharmacy survey, for example, it was noted that:

- Only 46% (74 respondents) had read the PSA cultural and training manual. In only 5% of instances all staff employed at the community pharmacy had read the training manual, as had been the original expectation of participating community pharmacies.
- Of the 74 respondents who had read the manual, few said that they referred to the manual regularly. Some 35% of respondents noted that they referred to the manual now and then and as many as 45% of respondents noted that they never refer to the manual. It should be noted here that the manual provided references and resources for pharmacists to refer to as needed rather than it being a manual that would be referred to on an ongoing basis.
- Some 59% of the respondents who had made use of the manual reported that they had found it useful.
- The large majority (94%) of survey respondents had not engaged in other cultural awareness and safety training and/or activities through QUMAX.

Reported participation in other cultural awareness and safety training activities

Throughout consultations, some community pharmacies reported participation in a range of additional cultural awareness and safety training activities, including:

- training provided by the ACCHS, such as information evenings;
- training provided by Universities, such as Schools of Rural Health;
- training provided by the Pharmaceutical Society of Australia;
- training provided by QUMSPs; and
- training through the National Prescribing Service (NPS).

It was also common for community pharmacists to note that some of the most effective cultural awareness and safety training activities had been relatively informal and developed organically based on practical experience in providing services to Indigenous patients and in working closely with ACCHSs.
Case study – training provided by ACCHSs

One ACCHS developed a full day cultural awareness and safety training and required community pharmacists to complete it before they would be ‘allowed’ to participate in QUMAX. Effectively the ACCHSs would only refer patients to participating community pharmacies that had completed the training. The training included a visit to the ACCHSs. It was noted that many community pharmacists had not previously visited the ACCHS and the aim of the visit was to increase their understanding of the services offered, its operation, staff and patients. The training was reportedly very well received by pharmacists.

Case study – training provided by ACCHSs

One ACCHS developed cultural awareness and safety training requiring attendance over various sessions. The focus of these sessions was different and provided opportunities to:

- introduce all participating community pharmacists, HMR pharmacists, doctors and health workers;
- guide community pharmacists through a museum on Indigenous history and art to increase their understanding of Indigenous culture; and
- invite community pharmacists to attend community event such as NAIDOC Day to further their cultural understanding.

Overall impact of cultural awareness and safety training

Mixed reports were given by community pharmacists regarding participation in cultural awareness and safety training activities.

While some community pharmacists reported participation in training activities, overall, the reach and breadth of this training across all staff employed by participating community pharmacists, was significantly less than initially anticipated.

Community pharmacists and ACCHSs staff also reported varying satisfaction with the quality of the cultural awareness and safety training manual.

While the delivery of cultural awareness and safety training was not a formal requirement of participating ACCHSs, it was common for services to report involvement in this regard. Many ACCHSs considered training to be an essential component of the Program and believed their contribution to these activities to be important.

6.2.6 PBS safety net entitlements

Monitoring PBS safety net entitlements had been a focus across some ACCHSs and their participating community pharmacies.

As with other components of the Program that did not directly relate to the provision of financial assistance or transport, the safety net focus was limited. For example, only 68% (30 services) of respondents to the ACCHS Survey believed that QUMAX had led to an increase in the use of PBS safety net entitlements. Similarly, 54% of respondents to the Community Pharmacy Survey felt that the Program had little to no improvement in the monitoring of the PBS safety net entitlements.

Services and pharmacies involved in safety net monitoring as part of the Program noted the following:

- Services felt that prior to QUMAX poor medication compliance made it difficult for patients to reach their safety net, thus safety net monitoring had not been a priority.
Given the irregularity of communication between ACCHSs, their patients, and community pharmacies prior to QUMAX, it was difficult for community pharmacies to know which patients should be under the same safety net.

Services were aware of the benefit to their Program budgets in monitoring the safety nets of their patients. That is, once a QUMAX patient reached their safety net the cost of providing the medication was no longer paid for by the ACCHSs’ Program budget.

Given the significantly increased medication compliance and the appropriate identification of people who should be under the same safety net, it was common for patients to meet the safety net threshold as part of the Program.

**Focus of safety net activities**

The overall focus of safety net activities was on education of patients and ACCHS staff, and enhancing communication between the ACCHS and community pharmacies. This included:

- the production of consumer leaflets on how to take advantage of the safety net;
- pharmacist-provided education to patients at point of sale;
- processes for data sharing between community pharmacies;
- ACCHSs providing updates on family structures to community pharmacies;
- changes to ACCHS record keeping to identify clients who should have reached the safety net threshold;
- Aboriginal Health Workers taking a case-based approach to ensuring families receive safety net benefits;
- ACCHS staff education on the workings of the PBS safety net; and
- pharmacy and ACCHS staff workshops to identify better mechanisms for safety net monitoring.

**Overall impact of PBS safety net entitlements monitoring**

Monitoring PBS safety net entitlements had been a focus across some ACCHSs and their participating community pharmacies.

Participating services, patients and community pharmacies all acknowledged the various benefits of enhanced monitoring of safety net entitlements. However, it was hard to determine whether safety net activities were successful in increasing awareness of the PBS safety net.

Increased communication between services, patients and community pharmacies as a result of QUMAX had greatly contributed to a reported increase in monitoring across some locations.

**6.3 Improved Quality Use of Medicines (QUM)**

**6.3.1 Training in QUM for staff in ACCHSs**

While QUM training is an important component of the Program, services provided variable feedback on participation in QUM training activities.

It was common for services to report that QUM training had taken a “back seat” to other Program components such as financial and transport assistance. In this context ACCHS staff often noted the administrative resource implications of the Program and the subsequent limited time available to participate in formal training activities.

However 84% (37 services) of respondents to the ACCHS survey reported that they had received QUM in-service education and training for staff since participating in QUMAX.
Of these 37 services:

- 51% (19 services) reported that all GPs had received QUM training;
- 41% (15 services) reported that all nurses, and all Aboriginal and Torres Strait Islander Health Workers had received QUM training; and
- 35% (13 services) reported that administrative staff had received no QUM training.

Respondents reported that QUMSPs were most likely to have been involved in preparing and delivering this QUM education and training (76%, 28 services), followed by ACCHS staff (48%, 21 services), and participating community pharmacies (35%, 13 services).

The analysis of the ACCHS survey also noted that:

- 75% (33 services) believed that staff knowledge and understanding of QUM had improved as a result of the Program;
- 76% (34 services) believed that QUMAX had led to an improvement in prescribing practice; and
- 82% (36 services) believed that QUMAX had led to an improvement in QUM systems and practice within their service.

**Experiential learning**

It is important to note that while many services did not report participation in formal QUM training activities, many stakeholders reported QUM-related service improvements as a result of their participation in QUMAX. In this context participation and familiarity with the Program has naturally required the development of QUM skills, knowledge and processes irrespective of whether formal training was delivered.

One of the most regular QUM service enhancements reported by ACCHSs relates to the improved relationship and regularity of contact between local community pharmacists and ACCHSs. Many ACCHSs report that despite having had accounts with local community pharmacies for decades, they did not know the staff or had never engaged with them beyond providing prescriptions. Equally, many community pharmacists reported that prior to QUMAX they had never visited the ACCHS, and did not know who to contact if they had a query.

Following implementation of QUMAX, it is now common for participating ACCHSs and community pharmacists to discuss patient medication regimes and jointly monitor compliance to ensure the safe use of medicines. Many community pharmacists and ACCHSs staff reported to have regular contact and positive working relations.

**Case study – QUM in action**

*One pharmacy reported QUMAX had facilitated a general improvement of processes associated with quality use of medicines. For instance they had developed a process of regularly updating patient profiles in consultation with the ACCHS. In this instance, the GP sends a ‘medical summary’ of the patient with the prescription to the pharmacy which the pharmacy then adds to the patient’s record. The pharmacy then faxes back an update of medications dispensed to the service so they can track whether patients were presenting and collecting their scripts. The pharmacy reported that this process has been of great benefit in monitoring QUMAX patients, as it ensures both the pharmacy and service have an accurate record of their patients’ medical history alongside the medications that have been dispensed.*

**Overall impact of training in QUM for ACCHSs**

While participation in QUM training activities was reported to be inconsistent across participating ACCHSs, those who did report participation found it lead to improvements across their service. In these
cases, however, QUM training was mostly contained to key service staff such as GPs and health workers.

It is important to note that a majority of improvements in QUM practice developed naturally across services as a result of their involvement in the Program, irrespective of whether they participated in training. Increased communication between ACCHSs and community pharmacists was a common example of this improved practice.

### 6.3.2 Provision of on-call pharmacist dispensing and medicines advice

The provision of on-call pharmacist dispensing and medicines advice was not a priority for participating ACCHSs.

Throughout consultations, ACCHSs and community pharmacists indicated that other Program areas had been of focus. A review of ACCHSs’ work plans noted that on average only 1% of the ACCHSs’ Program budget was allocated to the provision of on-call pharmacy related services.

The original Business Rules for the QUMAX Program required ACCHSs to allocate some funds to making arrangements for on-call pharmacy, that is, for community pharmacists to respond to the needs of ACCHS clients outside of normal operating hours or at the ACCHS rather than the pharmacy.

The work plans prepared for the first year of the program included, on average, an allocation of only 1% of available funds. Commonly, services allocated only a notional amount to ensure that their work plans were compliant with the Business Rules. Only seven services allocated an amount of $1,000 or more and only one service allocated funds to a community pharmacy rather than to the service itself.

Services reported a reluctance to allocate funds to on-call pharmacy on the basis that adequate arrangements were already in place (ie that pharmacies already provided an on-call service as required). It was also commonly noted that ACCHS clients had access to hospital pharmacy services. Some services also noted that no after hours medical service was offered by the ACCHS and there was therefore little need for after hours dispensing of medications.

For the second round of work plans (completed by June 2009), the Business Rules were adjusted to allow for a ‘flexible MAAPs’ allocation rather than specifying a requirement to allocate funds to on-call pharmacy. Nearly 10% of all funds were allocated to this category, representing a total of $327,000.

Most (96%) of these funds were allocated to the ACCHS. One service allocated 35% of all available funds to this category. Only one ACCHS made an allocation for on-call pharmacy – funds were allocated to a community pharmacy in a relatively isolated community to offer extended trading hours. One other ACCHS allocated significant funds to pay the salary of a pharmacist, seconded from a community pharmacy to work at the ACCHS for one day per week.

As part of the ACCHS survey respondents were asked whether there had been any changes in arrangements for ensuring that the service and its clients have access to after hours on-call pharmacists.

Only one service reported that on-call arrangements had been put in place as a result of their Program participation; 46% (20 services) reported that arrangements had always been in place and congruent with consultation anecdotal data, the majority of services (52%, 23 services) reported that no arrangements were in place.

Similarly, respondents to the Community Pharmacy survey reported that only 17% (27 pharmacies) had put in place new arrangements for providing on-call pharmacy services while 83% (139 pharmacies) reported that no on-call pharmacy arrangements have been established.

### Overall impact of on-call pharmacist dispensing

The provision of on-call pharmacist arrangements has not been a priority for participating ACCHSs.

It was common for participating ACCHSs to report that either adequate arrangements were already in place or that these services were not required by the ACCHSs.
6.3.3 Enrolment in the National Diabetes Services Scheme, use of the Asthma Spacer Ordering Scheme, and conduct of Home Medicines Reviews.

National Diabetes Services Scheme (NDSS)

One of the aims of the QUMAX Program was to enhance access to mainstream health programs, including the NDSS, through promotion of the benefits of the schemes to ACCHS staff and clients. Data provided by Diabetes Australia shows that there has been an increase in NDSS registrations by Aboriginal and Torres Strait Islander people that is greater than the national average increase in registrations. Table 11 sets out some recent registration data which, according to Diabetes Australia, provides a relatively reliable reflection of the growth in registrations.

Table 11 – Trend in NDSS registrations (Indigenous vs non-Indigenous peoples)

<table>
<thead>
<tr>
<th></th>
<th>All registrants</th>
<th>Aboriginal and Torres Strait Islander registrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-09</td>
<td>925,054</td>
<td>14,789</td>
</tr>
<tr>
<td>Jan-10</td>
<td>927,782</td>
<td>14,882</td>
</tr>
<tr>
<td>Feb-10</td>
<td>935,131</td>
<td>15,142</td>
</tr>
<tr>
<td>Mar-10</td>
<td>939,143</td>
<td>15,313</td>
</tr>
<tr>
<td>Apr-10</td>
<td>945,328</td>
<td>15,489</td>
</tr>
<tr>
<td>May-10</td>
<td>951,821</td>
<td>15,640</td>
</tr>
<tr>
<td>Jun-10</td>
<td>957,338</td>
<td>15,782</td>
</tr>
<tr>
<td>Jul-10</td>
<td>963,440</td>
<td>15,922</td>
</tr>
<tr>
<td>Aug-10</td>
<td>970,602</td>
<td>16,133</td>
</tr>
<tr>
<td>Annual rate of increase</td>
<td>7.50%</td>
<td>13.80%</td>
</tr>
</tbody>
</table>

Of course, this observed increase cannot be solely attributed to the QUMAX Program. Diabetes Australia has, in recent times, employed a range of strategies to boost NDSS registration among Aboriginal and Torres Strait Islander people. These initiatives have included, for example, the training of Aboriginal Health Workers, promotional activities in Aboriginal and Torres Strait Islander Health services and the employment of Aboriginal and Torres Strait Islander people as diabetes educators.

Nonetheless, it is likely that the QUMAX Program has made some contribution to the increase in NDSS registrations seen in the NDSS data. The analysis of the ACCHS Survey data showed that 50% of respondents (22 services) believed that the Program had led to an increase in client registrations with the National Diabetes Services Scheme (NDSS) within their Service.

Asthma Spacer Ordering Scheme (ASOS)

Again, the QUMAX Program sought to encourage participating services to make use of the Asthma Spacer Ordering Scheme. Data provided by the Asthma Foundation of Australia shows that there is a spike in ASOS orders made by Indigenous Health Services each year between May and October, particularly just prior to the end of the financial year. The data also shows that this ‘spike’ was particularly pronounced for QUMAX-participating services in May-October 2009, although the overall trend in making orders from ASOS is similar to that for non-participating services. The data suggests that the QUMAX Program may have encouraged participating services to make better use of the asthma equipment available via ASOS.
The analysis of the ACCHS Survey data showed that 41% of respondents (18 services) believed that the Program had led to an increase in client access to the Asthma Spacer Ordering Scheme (ASOS).

**Home Medicines Review Program (HMRs)**

Unfortunately hard data to indicate the use of HMRs by participating services (ie Medicare claims data) was not available to the evaluators. However, the survey research and consultation with participating services (as well as an analysis of QUMAX work plans) strongly suggest that HMR has been given a strong focus by participating services. The evidence obtained suggests that there is a strong likelihood that Medicare claims made by participating services for referring patients to an accredited HMR pharmacist would have risen significantly over the life of the QUMAX Program.

The conduct of HMRs was reported differently by ACCHSs across consultations.

In this context:
- Some services reported that HMRs had not been a priority for the ACCHSs, although in many instances it had been an action initially identified in their work plans.
- Some services reported that they were unable to refer clients for HMRs as they did not have an accredited HMR pharmacist in their local area.
- Some services had been referring patients to community pharmacies for HMRs prior to QUMAX.
- Some services had been referring patients for HMRs as a result of their participation in QUMAX.

The following approaches to the use of HMRs across ACCHSs were noted:
- Incorporating HMRs into a QUM framework: Some services had incorporated HMRs as a component of their QUM framework. In this context, a patient’s eligibility for QUMAX for example triggers referral for an HMR. Some 68% (30 services) that responded to the ACCHS Survey noted this to be the case in their organisation. In other services however, HMRs were considered on a more ad-hoc basis and were highly dependent on the GPs understanding of them.
Overcoming cultural obstacles: Many services reported that HMRs could be problematic as patients were not comfortable with a pharmacist visiting their home. To overcome patient concerns services either asked patients to bring in all their medications to the service (so that these could be reviewed by the HMR pharmacist at the service) or the HMR pharmacists was accompanied to the patient’s home by a service staff member who was familiar with the patient.

Integrating HMR pharmacists into the ACCHSs: Some services invited their HMR pharmacist to staff meetings or patient events such as information sessions. This provided an introduction for the HMR pharmacist and raised awareness of their role. On the other hand, some HMR pharmacists were so integrated into the operations of the ACCHSs that they had their own ‘pigeon hole’ in the ACCHS or an ACCHS email address.

Post HMR follow up: It was common for services to report that they had follow up sessions with HMR pharmacists to discuss the review’s recommendations, and review their implementation.

### Case study – Home Medicines Review debriefings

One service has been holding four hour meetings each week with their main participating pharmacy since the middle of 2009 to discuss and follow up on HMRs conducted. It was reported by both the ACCHSs and pharmacy that this was an excellent way of improving the quality care of clients as it ensured HMR recommendations were well communicated and implemented. These sessions are also used to discuss updates from the National Prescribing Service (NPS), cultural awareness issues and also to talk about any other particular Program issues to date. The collaborative relationship between the ACCHSs and the pharmacist is a direct result of participation in QUMAX.

### Case study – Funding to action Home Medicines Review recommendations

One service has made additional funding available (not from QUMAX) to implement HMR recommendations. For example, if the HMR pharmacist finds that certain medications need to be stored in the fridge, and the patient does not have one – the service will purchase it.

### 6.3.4 Diabetes or asthma cycle of care consultations and Aboriginal and Torres Strait Islander Health Checks/Development of care plans

#### Diabetes or asthma cycle of care consultations

Some 64% of respondents to the ACCHS survey reported that determining eligibility for QUMAX triggered a Diabetes or Asthma Cycle of Care consultation.

As per Figure 9 below services reported that few Asthma Cycle of Care consultations took place that attracted a $100 Service Incentive Payments (SIP) payment.

In this context:

- 57% (25 services) of respondents reported that there were less than five consultation per week that would attract a $100 Service Incentive Payments (SIP) payment; and
- 39% (17 services) said that there were no consultations what would attract a $100 Service Incentive Payments (SIP) payment.

These are highlighted in the figure below.
Figure 9 – How often do asthma cycle of care consultations take place in this service that attract a $100 SIP payment (MBS rebate 2546, 2552, 2558)? (select one response only) N=44

- Less than 5 per week: 57%
- 11-20 per week: 2%
- 5-10 per week: 2%
- None: 39%

As per Figure 10 below, a similar number of services (27 services, 61%) indicated that they conducted less than five Diabetes Cycle of Care consultations that attracted a $40 SIP payment per week. Some 18% (8 services) of respondents indicated that 5 to 10 Diabetes Cycle of Care consultations took place per week.

Figure 10 – How often do diabetes cycle of care consultations take place in this service that attract a $40 SIP payment (MBS rebate 2517, 2521, 2525)? (select one response only) N=44

- Less than 5 per week: 61%
- 5-10 per week: 18%
- More than 20 per week: 5%
- 11-20 per week: 2%
- None: 14%
Aboriginal and Torres Strait Islander Health Assessments / development of care plans

It was common for services to have integrated Aboriginal and Torres Strait Islander Health Assessments or the development of care plans as part of the QUMAX process. Some 80% (35 services) of ACCHS Survey respondents for example reported that an Aboriginal and Torres Strait Islander Health Assessments/Development of a care plan was triggered as part of Program participation.

Services reported that these items provided a useful benchmark for both ACCHS staff and patients of clinical indicators, such as blood pressure prior to participation in the Program.

Consultations noted two common experiences by ACCHSs who were implementing Aboriginal and Torres Strait Islander Health Assessments or the development of care plans as part of QUMAX as outlined below:

- Duplicating assessments: While it was common for services to report an increase in active patient numbers as a result of QUMAX, it was also common for services to report that some patients considered the service to be “free medication dispensers”. In these instances patients would only attend the ACCHSs to access QUMAX and continued to seek treatment for other matters from private clinics with whom they had a long established relationship.

  It was not uncommon for ACCHSs to conduct Aboriginal and Torres Strait Islander Health Assessments or to develop care plans for new QUMAX patients and to frustratingly find out at the point of submitting their MBS rebates that these assessments had already been conducted by another practice.

  In addition to the inability to claim a payment for this work, ACCHSs expressed concern at the lack of uncoordinated care that eventuates when one patient has sought for example, treatment from separate clinics. In these instances ACCHSs noted that patient confidentiality was a great obstacle to the sharing of information across practices for the patients’ benefit.

- Maximising revenue potential: ACCHSs reported an increase in revenue as a result of an increase in MBS claims due to the conduct of Aboriginal and Torres Strait Islander Health Assessments or the development care plans.

  One service, for example, reported that due to the revenue generated by the increase in the conduct Aboriginal and Torres Strait Islander Health Assessments they were able to fund one additional registered nurse.
7 Patient outcomes under QUMAX

7.1 Summary of the chapter

This chapter outlines the impact of QUMAX on patient health outcomes. Overall, it notes that QUMAX has had a positive impact on patient across three areas:

- an increase in the regularity and quality of contact between ACCHSs and their patients;
- an increase the patients’ self-management of their own conditions; and
- an increase in patients’ positive health outcomes.

As with previous chapters, the conclusions of this chapter are based on information provided to the researchers by participating ACCHSs and their patients. Much of this information is qualitative in nature.

The concluding section of this chapter considers clinical information. The extent and reliability of the clinical information obtained to support the view that QUMAX has led to positive health outcomes is very limited. Adding this evidence to the highly consistent anecdotal information provided by ACCHSs, pharmacists and patients provides some additional confidence in what has been reported.

7.2 Patient and service contact

One of the most commonly reported outcomes of QUMAX by participating ACCHSs was that the Program had increased the regularity and quality of interactions between services and its patients. ACCHSs noted that the Program’s provision of financial and transport assistance had removed long standing barriers to patient access to regular medical care and treatment.

The provision of financial assistance was particularly attributed to removing the embarrassment of patients in seeing a doctor and having to report that they had not been taking their medications. As one health worker stated, “You wouldn’t want to see your doctor if you were going to get into trouble”.

In this context QUMAX greatly enhanced the regularity with which patients visit the service, and this regularity had a significant impact in the quality of care doctors were able to provide. As one doctor stated, “They [patients] come in at first symptoms because there is no shame and they know they can get their tablets”.

7.2.1 Regularity of patient and service contact

As previously mentioned, it was common for ACCHSs to anecdotally report a significant increase in the regularity of contact between services and patients, particularly patient attendance to appointments. One service for example noted that “They [patients] are coming in more regularly, before [prior to QUMAX] we had to send recalls and chase them up”. Supporting anecdotal reports, 91% (40 services) of respondents to the ACCHS survey reported that the Program had led to an increase in patient attendance at appointments.

The increased regularity of patient attendance to the services can be attributed to one or a combination of the following factors:

- service specific Program requirements such as those requiring that patients attend the service at least once every three months for a check up;
- the positive impact of financial and/or transport assistance;
- increased patient understanding and self management of their medical conditions; and
- increased patient familiarity and confidence in the service and staff.
7.2.2 Quality of patient and service contact

The regularity of contact between patients and services has greatly assisted in the quality and type of care that ACCHSs are able to provide, as one respondent stated, “QUMAX has allowed consistency in care”.

It was common for services to report that regularity of patient contact had provided opportunities for doctors to develop relationships with their patients and as part of this to:

- engage in regular discussions regarding medications and in particular why it was important to take medications to achieve positive health outcomes;
- conduct health check-ups and assessments more regularly; and
- discuss with patients, changes in their clinical indicators (such as blood pressure), how they are tracking, which medications were working for them, how they could improve, and most importantly what factors were affecting their health (such as smoking).

A number of ACCHS doctors also reported that the improvements in patient monitoring and medication compliance allowed them to confidently assess and review treatment regimes. For example, prior to QUMAX it was difficult to establish whether a treatment was not working because of poor medication compliance, or because the medication or the dose prescribed needed to be reviewed. Similarly, the time lapse between the original diagnosis and a subsequent appointment to review this was also too great.

Supporting anecdotal accounts, 80% (35 services) of respondents to the ACCHS survey reported that they believed the Program had increased their services’ level of engagement with patients around the management of their health.

7.3 Patient self-management

An increase in the regularity of communication between ACCHSs and their patients has also led to a significant improvement in patients’ understanding of their health conditions and management. This was reported anecdotally by ACCHS involved in consultations and in the ACCHS survey, and was also self-reported by patients throughout consultations.

It was common for services to note an increase in the numbers of patients “walking in off the street [without appointments]” not to see a doctor, but rather, for the registered nurse to take their blood pressure or monitor their glucose levels. Similarly, doctors reported that their patients were far more engaged and interested in their health management, often actively seeking information on changes to their clinical indicators such as a blood pressure. As one health worker stated, “All of a sudden we’re seeing people keen to go into case planning and talk about their illness”.

Another service stated, “As part of the chronic disease team I have noticed that clients seem to be more active in their management of their disease. They appear to be more compliant with taking their medications and more interested in why they take them.”

Supporting anecdotal accounts, 71% (31 services) of respondents to the ACCHS survey for example noted that in their assessment patient confidence in disease self-management had increased as a result of QUMAX. Some 82% (36 services) of respondents also believed that QUMAX had increased the frequency of patient visits to the service.

7.3.1 As reported by patients

Throughout site visits, the researchers engaged with a small number of QUMAX patients and sought to understand the Program’s impact on the management of their health, as well as their views on changes to their health.

In this context it was common for patients to emphasise the significant financial and transport barriers to regular access to medical treatment and medications prior to QUMAX. Patients would emphasise how
grateful they were, and how important the Program had been in helping them achieve better health outcomes by overcoming these barriers.

It was common for patients to note that even with a healthcare card, given the many various medications they needed on a daily basis; the co-payment was far too great. Many patients reported needing 15-30 different tablets a day, and spending prior to QUMAX around $70 per week on these. In this context prior to QUMAX, patients relied on the ACCHSs for financial assistance or their families. Many patients noted that their own families were under significant financial pressure and therefore their ability to provide financial assistance was very limited.

It was also common for example for patients to note that they understood the importance of medication compliance, but that the financial barriers prior to QUMAX had been too great. As one patient stated, “Without medicines, we were sicker, but if it is between eating and medicines, you go without your tablets”. Another patient stated, “…You feed the kids first and put yourself last”.

All patients involved in consultations noted the Program’s positive impact on their health. Many patients also noted health improvements among their family and friends. In speaking about her family and friends one patient noted, “we are all feeling better, we are happier and healthier”.

The use of DAAs was commonly praised among patients with multiple medications as greatly assisting their compliance. Patients noted that prior to QUMAX it had been very difficult for them to understand and administer the various doses they had to take at different times of the day. In this context it had been common for patients to stop taking their medications because it was “just too hard”. One patient noted that, “DAAs are really good, before, the doctor used to give you the medicine and you would forget to take it. Now it sits there in the Webster pack and you remember”.

It was also common for patients to note that to achieve improved health outcomes they had to be committed to the ongoing management of their conditions. In this context, patients discussed the importance of attending the service regularly, and noted the ease of doing this given that transport assistance is provided across so many ACCHSs. As one patient stated, “you are responsible for your own health, you need to turn up here”. Another patient noted that “[although] I live miles away, it is easy to turn up because of the transport…I don’t mind coming in every three months”.

Confirming anecdotes from ACCHS staff, a number of patients reported that they frequently drop-in at the service so that their blood pressure and glucose level can be monitored and recorded by the registered nurse.

Overall it was common for patients to express gratitude for their involvement in the Program and attribute significant health improvements in their own health and that of their family or friends as a direct result of their participation in QUMAX.

As one patient stated, “The Program is a God send, it makes your life better and helps you live longer”.

Case study – the impact of medication compliance

One patient with a diagnosed mental illness reported to have been unemployed for many years as a result of her inability to purchase the required medications on a regular basis. The patient noted that prior to QUMAX she was “in and out of the psych ward” and often requiring sedation by ambulance staff. The patient reported that since QUMAX she has been able to access the required antipsychotic medications on a regular basis and now manages her own medication regime independently. The patient reported that as a result of the improved management of her health, she is employed for the first time in many years.
7.4 Patient health improvements as reported by ACCHSs

Perhaps the most exciting outcome of the Program was the almost universal reporting by participating ACCHSs that QUMAX had impacted positively on patient health outcomes. As one service staff stated, “These are the sorts of things that will end up closing the gap”.

Anecdotally ACCHSs reported that many patients were experiencing much better health because of the more consistent treatment of conditions. These health improvements were noted across Indigenous people from different ages; for example, one GP believed that there were far fewer cases of complications from untreated infections, particularly among children. In this case the GP was on the Board of a local school and he believed that school attendance had improved as a result of medications being available to treat acute conditions, such as ear infections, quickly.

It was also common for services to anecdotally report improvements in their patients’ health indicators for blood pressure, diabetes and cholesterol. One service, for example reported that many hypertensive patients had been able to lower their medication due to improvements in their health.

7.4.1 Evidence of health outcomes reported by ACCHSs

Services were asked to provide details of any positive health outcomes, or indicators thereof, associated with their participation in the QUMAX Program and the financial and other assistance that they were able to extend to their clients. A small number of services provided the evaluation team with some information, based on clinical data, to support their view – and the more widespread view – that good health outcomes were flowing from the program.

It should be noted that services were not required to monitor or provide this information as part of their participation in the Program. It should also be noted that it was not a straightforward task to extract and analyse clinical information in relation to people who had received QUMAX assistance and to make comparisons with some control groups. For most services, Patient Information Recall Systems do not readily allow this type of analysis.

However, some services undertook this analysis independently to ascertain whether QUMAX had led to positive outcomes for their clients. Some others undertook this analysis in response to the request made by the evaluators. The following services should be acknowledged and thanked for the information offered as a contribution to the evaluation:

- Njernda Aboriginal Women’s & Children’s Health, Echuca;
- Pius X Aboriginal Corporation, Moree;
- Maari Ma Health Aboriginal Corporation, Broken Hill;
- Carbal Health Service, Toowoomba; and
- Aboriginal & Torres Strait Islander Community Health Service, Brisbane

The evidence of positive health outcomes is presented here in the form of a series of de-identified case studies. Four of the five services reported that their analysis demonstrated some health improvements. One of the services provided some quite reliable information to this effect.
Case study 1

Service A with around 800 clients on its books allocated around $27,000 to meeting the cost of PBS medicines, $5,000 to DAAs and $6,500 to transport in its 2009 workplan.

Over the life of the Program, the service registered nearly 700 people (a large proportion of its patients). Nearly 9,000 medicines were paid for with QUMAX funds at a cost of over $87,500. Some 1,900 DAAs were prescribed to patients at a cost of over $9,500.

The service reported to the evaluation team that HbA1c readings were taken on a monthly basis for diabetes patients who had received QUMAX assistance. The service reported that their records showed that HbA1c had been lowered in 85% of cases.

Note that while the service reported these findings from their analysis, data was not provided to the evaluation team.

Case study 2

Service B focused heavily on providing financial assistance for medicines – the allocations made in the work plan for DAAs, transport and other categories were relatively small. In 2009, however, a relatively large allocation was made under the flexible MAAPs category for the provision of cultural awareness training for HMR pharmacists and for Aboriginal Health Workers to accompany HMR pharmacists to people’s homes.

Just over 1,900 of the service’s 7,400 clients were registered for the program. Over the course of the program (to end June 2010), nearly 21,000 medicines were prescribed with QUMAX assistance (at a cost of $340,000) and over 1,600 DAAs (at a cost of just over $8,000).

The service extracted clinical records for 24 patients with a chronic disease risk factor, who participated in a chronic disease self management program and who had received QUMAX assistance. The analysis showed that of the 24 people, 15 had reduced blood pressure, blood glucose, total cholesterol and weight over the life of the QUMAX program.

The provision of financial assistance for medicines or DAAs was one component of the assistance provided to these people – the voluntary self management program also focused on diet, exercise, spiritual and cultural well-being. Nonetheless, the service claimed that the assistance provided by QUMAX was an important ingredient in the positive outcomes observed for these people.
Case study 3

Service C placed a strong focus on the use of DAAs when allocating funds via the QUMAX work plan. Over the life of the program, expenditure was approximately the same for DAAs as it was for medicines. By the end of June 2010, nearly $19,000 had been provided for medicines and nearly $23,000 for DAAs. The service policy was to provide a MAAP for a DAA and/or medicines for patients on three or more medicines and who were judged to be at risk of non compliance. To the end of June 2010, the service had registered 124 patients from a total Aboriginal and Torres Strait Islander patient population of just over 1,200. In this time, the service provided financial assistance for 3,828 medicine copayments and 4,009 DAAs.

Between June 2008 and January 2010, the number of the service’s patients who were prescribed a DAA rose from 24 to 65 (an increase of 270%).

Analysis was conducted of the most recent recorded blood pressure of patients who had received financial assistance via QUMAX versus those who had not. The analysis found that, for QUMAX patients, 59% had a blood pressure at or below target (≤130/80mmHg) compared with only 35% of non-QUMAX patients.

Analysis also found that, on average, QUMAX patients had 20% lower LDL (low density lipoprotein – indicating risk of cardio-vascular events) than did non-QUMAX patients. They also had 9% lower total cholesterol levels. Further analysis showed that QUMAX patients on lipid-lowering medications were much more likely than non-QUMAX patients on lipid therapy to have an LDL reading at or below target (77.5% vs 53%) as well as at-or-below target levels of total cholesterol (52% vs 32%). These results strongly indicate greater adherence among QUMAX patients.

The service estimated (using Australian guidelines for risk assessment) that QUMAX patients had a reduced cardiovascular risk of between 5% and 25%.

Analysis was also conducted based on Aboriginal and Torres Strait Islander patients with a diagnosis of hypertension, diabetes, ischemic heart disease, cerebrovascular disease or hyperlipidaemia. For QUMAX patients, 31.3% had at-or-below target levels of LDL, total cholesterol and blood pressure. The figure for non-QUMAX patients was 7.5%.

Case study 4

Service D allocated significant funds to medicines, DAAs and transport. Emphasis was given in the service’s work plan to conducting HMRs for people at risk of non-concordance and a large portion of the transport budget was allocated to meeting the travel costs of HMR pharmacists to allow them to travel to more remote locations with the catchment of the service. Since the beginning of the Program, the service obtained the consent of 165 clients from a total client population of nearly 5,500.

Since the beginning of the Program, QUMAX funds were used to meet the costs of over 5,000 copayments (at a cost of about $47,000) and over 4,000 DAAs (at a cost of just over $20,000).

The service reported that it had extracted clinical information from its Patient Information Recall System which showed that for all QUMAX patients with diagnosed diabetes, HbA1c levels had, on average, decreased over the life of the Program. The analysis also showed that blood pressure readings for hypertensive patients on QUMAX had also come down.

Note that while the service reported these findings from their analysis, data was not provided to the evaluation team.
Case study 5

Service E was contracted to participate in QUMAX by December 2008. To the end of the first contract period, the service provided less than 850 medicines to clients using QUMAX funds. The majority (87%) of the 2008 budget for medicines was rolled over to the 2009 funding period. During 2009-10, nearly 13,000 copayments were funded for clients via QUMAX. A similar pattern was observed for the provision of DAAs – by the end of June 2010, over 2,000 DAAs had been provided.

Although the service had budget to provide medicines and DAAs for clients, it was reported to the evaluators that there was some hesitancy in doing so because it was thought patients might not value medicines if they were provided for free. However, the service reported that there was a change of view once the benefit were observed in terms of improved adherence and better health outcomes. By the end of June 2010, over 900 clients (of a total client base of 3,500) were registered to participate in the Program.

Data was extracted by the service, to test the hypothesis that the average blood pressure of hypertensive clients of the service (limited to Aboriginal and Torres Strait Islander people currently prescribed an antihypertensive) would have been reduced over the life of the program. However, the analysis found no such reduction. The results of the analysis were as follows:

- 01 Mar 2006 – 01 Mar 2008 average 114/70mmHg
- 01 Mar 2008 – 01 Mar 2009 average 117/75mmHg
- 01 Mar 2009 – 01 Mar 2010 average 117/76mmHg

This analysis was somewhat ‘blunt’ in that it included all hypertensive patients, not just those to have received QUMAX assistance.
8 Conclusions and recommendations

8.1 Conclusions

The QUMAX Program represents a new model for partnerships and collaborations that work towards improved health outcomes for Aboriginal and Torres Strait Islander peoples. The Program has been successful both in terms of achieving key Program objectives and demonstrating the value and further potential of the model.

The QUMAX Program has been demonstrated to have been successful in trialling a number of mechanisms to address the known barriers to accessing PBS medications in non-remote Aboriginal and Torres Strait Islander communities. The provision of financial assistance to individual ACCHSs for the purchase of medications has been the most significant focus of the Program, with the majority of services (85%) allocating the largest proportion of their available funds to financial assistance for medicine co-payments.

The key finding of the evaluation is that since the introduction of QUMAX, there has been increased access to the PBS for clients of ACCHSs – the main aim of the Program. Compared with the baseline year (12 months period prior to the Program) over the November 2009 to April 2010 period, there was a 14% increase in PBS utilisation for ACCHS clients. This increased PBS utilisation far outstripped that for all Australians (3%) and for recipients of medicines under s100 arrangements (ie Aboriginal and Torres Strait Islander people living in remote areas – where the comparable figure was less than 2% over the same period). Given that the methodology utilised to calculate this figure was conservative, it is highly possible – indeed likely- that the actual increase in PBS utilisation is higher than 14%.

Notably, the increase was higher for non-concession or general patients (18% increase) which adds weight to the argument that the financial barrier for many non-concession patients has been significant. The increase in PBS utilisation was most pronounced for clients of ACCHSs in Queensland and in Western Australia, and in relation to lipid-lowering medications, anti-hypertensive and asthma medications.

Over the course of the Program to June 2010:

- nearly 34,000 ACCHSs clients across all States and Territories had been registered to receive financial assistance in the form of a MAAP; and
- direct assistance had been provided to clients in the form of relief from PBS co-payments (271,226 PBS medicines dispensed) and subsidised or free DAAs (74,122).

Doctors, pharmacists and clients surveyed and interviewed for the evaluation consistently report that QUMAX has:

- led to an increase in the regularity and quality of contact between ACCHSs and their clients;
- increased patients’ understanding and self-management of their own conditions; and
- led to an improvement in patients’ health, such as lowered HbA1c, reduced blood pressure, blood glucose or cholesterol.

PBS Safety Net entitlements had been a focus across some ACCHSs and their participating community pharmacies. Participating services, patients and community pharmacies all acknowledged the various benefits of enhanced monitoring of safety net entitlements. Increased communication between services, patients and community pharmacies as a result of QUMAX had greatly contributed to a reported increase in monitoring across some locations.

Hard data (ie Medicare claims data) to measure the use of Home Medicine Reviews (HMRs) by participating services was not available to the evaluators. However, the survey research and consultation with participating services (as well as an analysis of QUMAX work plans) strongly suggest that HMR has been given a strong focus by participating services. The evidence obtained suggests that there is a strong likelihood that Medicare claims made by General Practitioners of participating services for the HMR referrals would have risen significantly over the life of the QUMAX Program.
It was common for services to have integrated Aboriginal and Torres Strait Islander Health Assessments or the development of care plans as part of the QUMAX process. Services reported that these items provided a useful benchmark for both ACCHS staff and patients of clinical indicators, such as blood pressure prior to participation in the Program.

The above results are impressive given the relatively short-time the Program has been operating and the fact that QUMAX funding was capped at what could be considered a relatively modest level. The key success factors in QUMAX can be found in the Program design, structure and implementation at a Program and local level.

At a Program structure level QUMAX:

- was well-designed and conceived, with considerable research and forethought;
- had a strong and effective governance and advisory structure (the QUMAX PRG) and a sound set of Business Rules and Guidelines;
- was well-managed by the QUMAX Project Managers at the Guild and at NACCHO;
- enjoyed an open and collaborative approach from partnership stakeholders, combined with a high level of commitment to progress Program objectives;
- achieved almost universal participation by eligible ACCHSs, (69 out of 70 eligible services) and strong participation by community pharmacies (541) and by consumers; and
- built in excellent communications and practice-sharing mechanisms, particularly via websites, national workshops and conferences.

At a Program design level, critical factors that facilitated positive outcomes included:

- funding for the provision of transport assistance to attend medical appointments and/or collect medication;
- flexibility within the Program guidelines to enable ACCHSs to focus on local issues and needs; and
- the inclusion of regional support mechanisms via QUSMPs and NACCHO Affiliates.

At a local level, QUMAX progressed most successfully where:

- ACCHSs received ‘top down’ support from the Board and the CEO and there was organisational stability;
- a person or committee was appointed to ‘champion’ Program implementation internally;
- there was effective internal communication about QUMAX;
- there was regular contact between ACCHSs and QUMSPs;
- there were prior positive relationships and/or regular contact between ACCHSs and local community pharmacies; and
- good communication and support was received from regional Program stakeholders and management.

The QUMAX Program struggled locally where the above factors were absent, and where there appeared to be limited investment in, or capability to focus on, QUMAX by ACCHSs and/or community pharmacies.

From an administrative point of view, the Program was reasonably straightforward for both ACCHSs and community pharmacies. Some adjustments to workflows were required and participants generally found a process for allocating MAAPS that worked from an administrative and ethical point of view. One of the main problems faced by doctors and ACCHSs was in having to determine patient eligibility, both according to the business rules and any additional criteria set by the ACCHS. In particular, it being the doctor’s role to determine financial need was problematic. Many services also saw that they needed to apply eligibility criteria as a means of managing the capped MAAP budget and it was common for these criteria to be changed in response to a faster or slower than expected expenditure. This reportedly caused some confusion on the part of clients but was thought to be preferable to using the entire
budget and not being able to provide assistance to anyone. The capped funding arrangement for QUMAX probably meant that ACCHS were judicious rather than generous in the way they provided financial assistance and some ACCHSs were hesitant about providing financial assistance when there was no certainty about the future arrangements for QUMAX.

From the pharmacy perspective, the administrative burden of the required data entry to generate claims was modest but still a complaint for some. It was clear that some critical mass in terms of patient numbers was required to allow efficient participation. Some pharmacists also complained about the need to sometimes manually resolve problems where the MAAP had been generated incorrectly (eg without concession status marked) or the prescription form stamped incorrectly. Generally speaking pharmacists were happy to perform the required tasks in order to see improved medication compliance. There were however a couple of reports of less-than-ideal dealings with QUMAX patients, that were not within the spirit of the program and which undermined the efforts of an ACCHS to address barriers to medicines access.

The role of the QUMSPs and NACCHO State Affiliates also had a strong influence on the effectiveness of the Program. It was clear that for the most part, ACCHS valued the support provided and the job done by some QUMSPs in driving change and supporting ACCHS and pharmacies was reportedly remarkable. There was however some inconsistency in the quality of the support provided – a lack of attention was sometimes reported. It was clear that the performance and commitment of individuals was important, as well as the availability to provide the level of support needed.

8.2 Recommendations

1. It is likely that the new CTG arrangements for providing co-payment relief to Aboriginal and Torres Strait Islander people will generate further improvements in terms of PBS access through ACCHSs. However, some financial barriers will remain, along with geographical (ie transport) barriers, cultural and systemic barriers. The results of this evaluation support a continuation of the QUMAX Program, working in parallel with the PBS co-payment measure, in order to address these barriers.

2. The provision of DAAs as provided under QUMAX should continue to be supported through ACCHSs and community pharmacies. Consideration should be given to providing support for other devices (eg glucometers).

3. The provision of transport support as provided under QUMAX should continue through ACCHSs and community pharmacies.

4. The QUMAX Program was associated with increased uptake of HMRs (anecdotally) and certainly with enhanced promotion of the value of HMRs. Exploring ways to make HMR more useful to ACCHSs in the management of chronic disease clients should be supported.

5. Further development of models for the provision of cultural awareness training to community pharmacists should be pursued. In particular, mechanisms should be considered for equipping ACCHS to provide this training in a local context.

6. The QUM, administrative and practical support offered to ACCHSs by the NACCHO and Guild Program Managers and by QUMSPs and State Affiliates should not be undervalued. There is a clear role for ongoing support and for individuals who can drive change and help ACCHSs and their clients strive for better QUM. People with these skills and abilities – and the time to dedicate to the task – are rare and significant effort should be directed towards employing the right people for the job.

7. The approach of providing flexibility to ACCHS in developing work plans around QUM initiatives was generally effective. The process needs to be positioned as a fundamental part of improving QUM rather than as an administrative requirement. Some examples of work plans would be useful for services to use as a guide, but support (and funds) are often needed to tailor a work plan to address local priorities.
8. The QUMAX partnership model, which featured national management by key stakeholders, is potentially adaptable to a range of health programs involving partnerships between stakeholders such as NACCHO and the Guild. Consideration should be given to adapting the QUMAX governance model to a range of health programs designed for the benefit of the Aboriginal and Torres Strait Islander population.

9. Future program funds should support the development and maintenance of an online information management system, allowing for active work plan management, formative program monitoring and communication across participating organisations. Similarly, program funds should be allocated to the conduct of regular national and/or State-based workshops and conferences to allow for the sharing of good practice.
Appendix A  Membership of the QUMAX Program Reference Group
Membership of the QUMAX Program Reference Group

Mr Ian Todd (Pharmacy Guild)- Chair
Ms Fiona Mitchell (Pharmacy Guild)
Ms Vicki Sheedy (NACCHO)
Ms Karalyn Huxhagan (Pharmaceutical Society of Australia)
Mr Grant Martin (Pharmaceutical Society of Australia)
Ms Michelle Quester (Pharmacy Guild)
Mr Frank Vincent (NACCHO)

Department of Health and Ageing:
Mr David Pearson, Ms Brenda White, Ms Liz Pugh, Mr Robert Nichols

Observers: Ms Dea Thiele (NACCHO), Dr Sophie Couzos (NACCHO).
Appendix B  Project Reference Group
Terms of Reference

Evaluation of the QUMAX Program Final Report
Committee Name: Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) Program Reference Group (PRG)

Terms of Reference and Operating Guidelines

Type of Committee
Technical advisory committee to oversee the development and implementation of the QUMAX Program.

Background, aims and objectives of QUMAX Program
The Program aims to improve the health outcomes of Aboriginal and Torres Strait Islander people that attend participating Aboriginal Community Controlled Health Services in rural and urban Australia, by trialling interventions that aim to:

a. improve Quality Use of Medicines (‘QUM’) and medication compliance; and
b. support improved access to medicines under the Pharmaceutical Benefits Scheme (‘PBS’) by addressing cultural, transport and financial barriers to access.

The Program was developed jointly by the Pharmacy Guild of Australia (the Guild) and the National Aboriginal Community Controlled Health Organisation (NACCHO). The Guild is being funded by the Commonwealth under the Fourth Community Pharmacy Agreement to undertake the Project, which is the development, implementation and management of the Program. The Guild is required, under the funding agreement with the Commonwealth, to engage the NACCHO as a subcontractor and key partner in the Project.

Purpose of the Program Reference Group
The purpose of the PRG is to:

a. provide advice to the Guild and the NACCHO regarding Program development and implementation;

b. advise the Department and the independent Program Evaluator(s) on the development, management and conduct of the Program evaluation;

c. advise and report to the Professional Programs and Services Advisory Committee (PPSAC) as established under the Fourth Community Pharmacy Agreement, through the PPSAC Rural and Indigenous Steering Committee, on Program development and implementation; and

d. develop and review key materials relating to the Project in accordance with the requirements set out in the funding agreement between the Guild and the Commonwealth.

The Guild aims to use the PRG to monitor and review the operation of the QUMAX program to enable the Group to provide appropriate support and direction.
Membership
The PRG will comprise members from:

- The Guild (1)
- The NACCHO (1)
- The Office of Aboriginal and Torres Strait Islander Health, Department of Health and Ageing (1)
- The Community Pharmacy Branch (CPB), Pharmaceutical Benefits Division, Department of Health and Ageing (1)
- The Pharmaceutical Society of Australia (PSA) (1)

Each organisation must nominate a member and may also nominate a proxy, to attend in place of the substantive member.

As agreed at the roundtable meeting held on 3 May 2007, the Guild will chair each meeting of the group with the NACCHO recognised as a key partner based on its integral role in jointly devising, developing and implementing the Program.

Meetings will also be attended by the QUMAX Program Managers (2) and the QUMAX Project Officer (1) from the CPB of the Department.

The Chair will issue a standing invitation to the Chief Executive Officer and the Public Health Officer of the NACCHO, and the Divisional Manager of the Guild’s Rural and Professional Services Division to attend any meeting.

The Program Evaluator(s) may attend PRG meetings as required, and through its contract arrangements with the Commonwealth, will be required to provide regular and ongoing feedback to the group. This includes the provision of advance copies of any reports to the PPSAC or the PPSAC Evaluation Steering Committee for comment and advice by the PRG.

Expert advisers may be invited by the Chair to attend meetings as required.

Quorum and Voting
At least one Member from the Guild, the NACCHO, and the Department must be present in order for a meeting to proceed. Any conflicts arising at a meeting should be resolved by consensus with voting by members only if necessary.

Role of the Chair
The Chair will be responsible for convening meetings of the PRG and for representing, or arranging representation of the PRG as required, such as to the PPSAC or the PPSAC Rural and Indigenous Steering Committee.

Meeting agendas
The Guild and NACCHO Program Managers will draft a list of agenda items for each meeting. Additional items may be put forward by any Member. The Chair, in consultation with the Program Managers and the Secretariat, will be responsible for finalising the agenda for each meeting. New papers are not to be tabled at meetings unless agreed to by the Chair and only in exceptional circumstances.
**Frequency and location of meetings**
The PRG will meet monthly for the first six months, followed by quarterly for the duration of the Project. Meetings may be held by teleconference or face to face, with at least two meetings per financial year being face to face.

**Secretariat support**
Secretariat support will be provided by the Guild in consultation with the NACCHO Program Manager. Agenda papers will be distributed to all Members at least three (preferably five) working days prior to each meeting.

The Guild and NACCHO Program Managers will manage the business of the PRG between meetings and will be responsible for following up action items.

**Arrangements for non-Departmental Member travel and expenses**
The Secretariat will be responsible for arranging venue and catering for all PRG meetings and for booking teleconferences. Travel and accommodation (when necessary) will be arranged by the Secretariat for non-Departmental Members and invited experts only.

**Record of meetings**
Brief outcomes/action items coming out of each meeting will be recorded and provided to the Chair within one week of the meeting, and to Members for ratification within two weeks of the meeting.

**Confidentiality**
In accordance with the relevant Funding Agreement and Sub-Contracts all Members must agree not to disclose to any person other than the Commonwealth any Confidential Information in relation to the QUMAX Program without prior approval in writing from the Commonwealth. Invited attendees (not including those with standing invitations) will be required sign a Confidentiality Statement when attending individual meetings.

All PRG agendas, agenda papers, reports and resolutions are confidential to persons and organisations represented at PRG meetings, unless all Members agree that a particular paper or document should be released, and to whom.

**Conflict of interest**
If, during the period of the Members’ engagement with the PRG, a conflict of interest arises, whether actual, potential or apparent, or appears to arise, the Member must notify the Chair immediately and take such steps as the Chair may reasonably require to resolve or to otherwise deal with the conflict. Members will declare any conflicts of interest which pertain to the agenda at the start of each meeting.
**4th Community Pharmacy Agreement Joint submission (Pharmacy Guild and NACCHO) - ‘Program for the Improved Access of Aboriginal and Torres Strait Islanders to the PBS’ (2006)**

<table>
<thead>
<tr>
<th>Developed by:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Lance Emerson</td>
<td>Pharmacy Guild of Australia</td>
</tr>
<tr>
<td>Dr Sophie Couzos</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>Mr Ian Todd</td>
<td>Pharmacy Guild</td>
</tr>
<tr>
<td>Ms Fiona Mitchell</td>
<td>Pharmacy Guild</td>
</tr>
<tr>
<td>Mr Frank Vincent</td>
<td>AMS Western Sydney</td>
</tr>
<tr>
<td>Dr John Daniels</td>
<td>AMS Redfern</td>
</tr>
<tr>
<td>Ms Dea Thiele</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
</tr>
<tr>
<td>Professor Richard Murray</td>
<td>James Cook University</td>
</tr>
<tr>
<td>Dr Naomi Mayers</td>
<td>AMS Redfern</td>
</tr>
</tbody>
</table>

**NACCHO QUMAX Program Manager**

Ms Vicki Sheedy

**Pharmacy Guild QUMAX Program Manager**

Ms Anne Develin (2008-9), Katherine Baeverstock (2009-10), Marsha Gomez (2010-11), Angela Corcoran (Current)

**Membership of the QUMAX Program Reference Group**

| Mr Ian Todd             | Pharmacy Guild of Australia (Chair)                                                  |
| Ms Fiona Mitchell      | Pharmacy Guild of Australia                                                          |
| Ms Vicki Sheedy        | National Aboriginal Community Controlled Health Organisation                          |
| Ms Karalyn Huxhagen    | The Pharmaceutical Society of Australia (PSA) (Member)                                |
| Ms Michelle QUester    | Pharmacy Guild of Australia                                                          |
| Mr Frank Vincent       | National Aboriginal Community Controlled Health Organisation                          |
| Mr David Pearson       | Department of Health and Ageing                                                       |
| Ms Brenda White        | Department of Health and Ageing                                                       |
| Ms Liz Pugh            | Department of Health and Ageing                                                       |
| Mr Robert Nichols      | Department of Health and Ageing                                                       |

**Observers**

| Ms Dea Thiele          | National Aboriginal Community Controlled Health Organisation                          |
| Dr Sophie Couzos      | National Aboriginal Community Controlled Health Organisation                          |
Appendix C  ACCHSs Survey
INTRO PAGE

This survey is for services who are participating in QUMAX. In completing this survey you may need to consult with other stakeholders in your service who were involved in the QUMAX application process, and/or who are involved in its implementation. You will be able to save your response and come back to this survey at any time during the next 10 days that it is open by [VIEW TO INSERT INSTRUCTIONS HERE].

Please answer as many questions as possible.
Part A – Your service

A1  Prior to QUMAX, how would you describe your service’s implementation of Quality Use of Medicines (QUM)\textsuperscript{23} activities and systems? \textit{(select one response only)}
- 5  Reasonably well established
- 4  Progressing
- 3  At a fairly early stage
- 2  Undeveloped
- 1  Not sure/can’t say

A6  Prior to QUMAX, which of the following was true of your service? \textit{(select one response only)}
- 4  No financial assistance was provided to clients for medications
- 3  Some financial assistance was provided for medications, but only in ‘emergency’ situations
- 2  A modest amount of financial assistance was provided for medications
- 1  A significant amount of financial assistance was provided for medications

\textsuperscript{23} Quality Use of Medicines as defined in the QUMAX Business Rules and Guidelines refers to selecting management options wisely, choosing suitable medicines if a medicine is considered necessary and using medicines safely and effectively.
### Part B – QUMAX eligibility criteria

**B1** Which is the following is true of this service? *(select one response only)*

1. ☐ Only Aboriginal and Torres Strait Islander patients can access QUMAX
2. ☐ Aboriginal and Torres Strait Islander patients and their family members can access QUMAX
3. ☐ All patients (Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander) of the service can access QUMAX
4. ☐ Not sure/can’t say

**B2** Which of the following is true of this service? *(select one response only)*

1. ☐ All patients regardless of financial circumstance can access QUMAX
2. ☐ Only concession card holders can access QUMAX
3. ☐ Assessment of financial need is made on an individual basis
4. ☐ Not sure/can’t say

**B3** Has this service experienced any difficulties or issues in determining financial need and eligibility for QUMAX assistance?

1. ☐ Yes *(please describe any issues)*
2. ☐ No

**B4** Which of the following is true of this service? *(select one response only)*

1. ☐ QUMAX financial assistance is only available to patients with chronic disease
2. ☐ QUMAX financial assistance is available only to patients with specific illnesses or conditions *(please specify which ones)*
3. ☐ QUMAX financial assistance is available only for particular medicines *(please specify which ones)*
4. ☐ Other *(please specify)*

**B4.1** Are there any types of medicines that this service will not offer financial assistance for via QUMAX?

1. ☐ No
2. ☐ Yes *(please specify which medicines)*

**B5** Are there any other criteria that are applied in determining eligibility for QUMAX financial assistance?

1. ☐ No
2. ☐ Yes *(please specify criteria)*

**B6** Does this service, as a matter of course, limit access to Medication Access and Assistance Packages (MAAPs) in either of the following terms: *(select all that apply)*

1. ☐ The number of medications
2. ☐ The number of prescription repeats
3. ☐ Neither of these *(IF SELECT NEITHER CANCEL OUT RESPONSES FOR ABOVE)*
B7  **Does determining eligibility for QUMAX ever trigger:** *(please provide a response for each item)*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A Home Medicines Review</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Aboriginal and Torres Strait Islander Health Check/Development of a care plan</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes or asthma cycle of care consultations</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>Other (please specify)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

B8  **Have there been changes to your QUMAX eligibility criteria since the Program started?** *(select one response only)*

1. ☐ There has been no change to the eligibility criteria **SKIP TO C1**
2. ☐ The eligibility criteria have been changed to increase access
3. ☐ The eligibility criteria have been changed to limit access
4. ☐ The eligibility criteria have been changed for other reasons *(please specify)*

B8.1  **If there has been a change to the eligibility criteria, why has this happened?** *(select one response only)*

1. ☐ To reduce budget expenditure
2. ☐ To increase budget expenditure
3. ☐ Other reasons *(please specify)*
Part C – QUMAX activities

The aim of the following questions is to build a profile of the range and type of QUMAX activities and products.

Quality Use of Medicines (QUM) Activities

C1 Since participating in QUMAX, has your service received any QUM in–service education and training for staff on Quality Use of Medicines issues?

1 □ Yes
2 □ No SKIP TO QUESTION C2

C1.1 IF YES, How many of the following kinds of staff in this service have received significant training on QUM issues? (please provide a response for each type of staff member)

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Most</th>
<th>Some</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Health Workers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Nurses</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Administrative staff</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

C1.2 IF YES, Approximately how many staff in total have attended QUM training of some kind since QUMAX commenced? (please type in your response)

ENTER NUMBER ________

C1.3 IF YES, Who has been involved in preparing or delivering the QUM education or training? (select all that apply)

1 □ QUMAX participating pharmacy or pharmacist
2 □ Quality Use of Medicines Support Pharmacist (QUMSP)
3 □ ACCHSs staff
4 □ Other (please specify)

C2 Since participating in QUMAX, have any of the following been undertaken by your service? (please provide a response for each item)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Developed QUM training resources and materials suitable for use in your service</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2 Developed any new QUM protocols, policies or procedures</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3 Purchased or subscribed to QUM resources (eg Australian Medicines Handbook, Therapeutic Guidelines, RADAR)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4 Sought advice, input or services relating to QUM from other organisations (eg NPS, Division of General Practice, ACCRM)</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

C3 Has your service conducted QUM group information sessions for patients?

1 □ Yes
2 □ No SKIP TO QUESTION C4

C3.1 IF YES, approximately how many people have participated? (please type in your response)

ENTER NUMBER ________
Cultural awareness and safety training for community and/or HMR pharmacists

C4 Have you seen the cultural training and safety resources developed for community pharmacists?
1. Yes
2. No SKIP TO QUESTION C5

C4.1 IF YES, To what extent do you do you feel the cultural training and safety resources available for community pharmacists are adequate? (select one response only)
1. More than adequate
2. Somewhat adequate
3. Not at all adequate
4. Not sure/can’t say

C5 Has your service conducted cultural awareness and safety training for pharmacists?24?
1. Yes
2. No SKIP TO QUESTION C6

C5.1 IF YES, who has attended? (select all that apply)
1. Community pharmacists involved in QUMAX
2. Other staff of pharmacies involved in QUMAX
3. HMR pharmacists
4. Others (please specify)

C5.2 IF YES, How many pharmacists in total have attended? (please type in your response)
ENTER NUMBER _________

Transport

C6 Please detail what transport assistance your service provides for patients? (please provide a response for each item)

1. Transport is provided for patients to attend the service
2. Transport is provided for patients to collect their medications from their QUMAX community pharmacy
3. Transport is provided to deliver medications to the patient’s home
4. Transport is provided for other reasons (please specify)
5. No transport assistance provided SKIP TO QUESTION C7

C6.1 IF YES, How have QUMAX funds been used to provide this transport assistance? (select all that apply)
1. Employed new driver(s)
2. Resourced existing driver(s)
3. Purchased new vehicle
4. Contracted transport provider
5. Reimbursed community pharmacists for delivering medicines

24 Please note this was not a contractual obligation.
C6.2 We are keen to get a picture of how much transport has been provided as a result of QUMAX funding. Please estimate the amount of transport that is provided by this service using QUMAX funds in ONE of the following ways: (your best estimate) [IVIEW only one response allowed]

- _______ km per month
- _______ number of trips per month
- _______ number of clients provided with transport assistance per month
- _______ number of driver hours per month

☐ Not sure/can’t say

PBS Safety net entitlements

C7 Has your service participated in PBS safety net group information sessions for patients?

1. ☐ Yes
2. ☐ No SKIP TO QUESTION C8

C7.1 IF YES, Who was involved in delivering the PBS safety net group information sessions for patients? (please provide a response for each item)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>QUMAX participating pharmacy or pharmacist</td>
<td>☐</td>
</tr>
<tr>
<td>2</td>
<td>Quality Use of Medicines Support Pharmacist (QUMSP)</td>
<td>☐</td>
</tr>
<tr>
<td>3</td>
<td>ACCHSs staff</td>
<td>☐</td>
</tr>
<tr>
<td>4</td>
<td>Other (Please specify)</td>
<td>☐</td>
</tr>
</tbody>
</table>

C7.2 IF YES, How many patients have participated in these PBS safety net group information sessions (your best estimate)? (please type in your response)

ENTER NUMBER ________

C8 Does your service undertake any other activities to ensure that clients receive their safety net entitlements?

1. ☐ Yes (please specify)
2. ☐ No

On call pharmacy

C9 Since participating in QUMAX, have there been any changes in arrangements for ensuring that the service and its clients have access to after hours or on-call pharmacists?

1. ☐ Yes - new arrangements have been put in place
2. ☐ No - arrangements have always been in place SKIP TO QUESTION C10
3. ☐ No – arrangements are not yet in place SKIP TO QUESTION C10

C9.2 IF YES, Approximately how many on-call pharmacist ‘events’ take place on a monthly basis due to these new arrangements (your best estimate)? (please type in your response)

ENTER NUMBER ________
Access to MBS and SIP

C10  How often do asthma cycle of care consultations take place in this service that attract a $100 SIP payment (MBS rebate 2546, 2552, 2558)? *(select one response only)*

1  Less than 5 per week
2  5-10 per week
3  11-20 per week
4  More than 20 per week
5  None

C11  How often do diabetes cycle of care consultations take place in this service that attract a $40 SIP payment (MBS rebate 2517, 2521, 2525)? *(select one response only)*

1  Less than 5 per week
2  5-10 per week
3  11-20 per week
4  More than 20 per week
5  None
Part D – Program impact and outcomes

D1  To what extent do you think QUMAX has led to an increase in each of the following?  
(select one response per row)

<table>
<thead>
<tr>
<th></th>
<th>Substantial increase</th>
<th>Some increase</th>
<th>Little increase</th>
<th>No increase</th>
<th>Not sure/can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Patient access to PBS medicines</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>ii. Use of the PBS safety net entitlements</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>iii. Number of HMRs conducted</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>iv. Use of Dose Administration Aids (DAAs)</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>v. Client access to the Asthma Spacer Ordering Scheme (ASOS)</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>vi. Client registration with the National Diabetes Services Scheme (NDSS)</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
</tbody>
</table>

D2  To what extent do you think QUMAX has led to an improvement in each of the following?  
(select one response per row)

<table>
<thead>
<tr>
<th></th>
<th>Substantial improvement</th>
<th>Some improvement</th>
<th>Little improvement</th>
<th>No improvement</th>
<th>Not sure/can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Medication adherence</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>ii. Patient health outcomes</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>iii. Your service’s relationships with community pharmacies</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>iv. Patient attendance at appointments</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>v.</td>
<td>Frequency of patient visits</td>
<td>Substantial improvement</td>
<td>Some improvement</td>
<td>Little improvement</td>
<td>No improvement</td>
</tr>
<tr>
<td>----</td>
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</tr>
<tr>
<td>vi.</td>
<td>Your assessment of the patient’s wellbeing or level of satisfaction</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>vii.</td>
<td>Your assessment of patient confidence in disease self-management</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>viii.</td>
<td>The level of engagement with clients around the management of their health</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>ix.</td>
<td>Staff knowledge and understanding of QUM</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>x.</td>
<td>QUM systems and practice within the service</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>xi.</td>
<td>Prescribing practice</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>xii.</td>
<td>Community pharmacies’ engagement with Aboriginal and Torres Strait Islander clients</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>xiii.</td>
<td>Your service’s access to MBS items (eg adult and child health checks; GP management plans (care plans); follow-up MBS</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Substantial improvement</td>
<td>Some improvement</td>
<td>Little improvement</td>
<td>No improvement</td>
<td>Not sure/can’t say</td>
</tr>
<tr>
<td>---</td>
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<td>---------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>rebate for health checks and care plans; allied health referrals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>xiv.</td>
<td>Your service’s claiming of QUM related PIP and SIP incentive payments (e.g. quality prescribing incentives)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>xv.</td>
<td>Your service’s claiming of enhanced primary care PIP and SIP incentive payments (e.g. cervical screening, asthma, diabetes incentives)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

D3 Are there any other major impacts our outcomes (positive or negative) that have resulted from QUMAX?
1 ☐ Yes *(please describe these)*
2 ☐ No **SKIP TO QUESTION D4**

D4 We are particularly keen to be able to provide evidence of improving health outcomes for patients who have been assisted by QUMAX (for example, lowering cholesterol or HbA1c across the QUMAX patient cohort).

Is there potential that this service can provide evidence of this kind? If so would you be willing to discuss arrangements for accessing data?
1 ☐ Yes, we can potentially provide some evidence and we would be happy to discuss
2 ☐ No, we are not in a position to make this information available
## Part E – Services experience in implementing QUMAX

### E1 How satisfied has your service been with the following aspects of QUMAX? *(select one response per row)*

<table>
<thead>
<tr>
<th></th>
<th>Very satisfied</th>
<th>Somewhat satisfied</th>
<th>Somewhat dissatisfied</th>
<th>Very dissatisfied</th>
<th>Not sure/can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Funding application process</td>
<td>4 □</td>
<td>3 □</td>
<td>2 □</td>
<td>1 □</td>
<td>99 □</td>
</tr>
<tr>
<td>ii. QUMAX orientation conference</td>
<td>4 □</td>
<td>3 □</td>
<td>2 □</td>
<td>1 □</td>
<td>99 □</td>
</tr>
<tr>
<td>iii. Pharmacy Guild QUMAX IT system (or generating MAAPs)</td>
<td>4 □</td>
<td>3 □</td>
<td>2 □</td>
<td>1 □</td>
<td>99 □</td>
</tr>
<tr>
<td>iv. NACCHO IT system for submitting workplans, accessing information, communicating with others</td>
<td>4 □</td>
<td>3 □</td>
<td>2 □</td>
<td>1 □</td>
<td>99 □</td>
</tr>
<tr>
<td>v. QUMAX Hotline</td>
<td>4 □</td>
<td>3 □</td>
<td>2 □</td>
<td>1 □</td>
<td>99 □</td>
</tr>
<tr>
<td>vi. The support provided by your Quality Use of Medicines Support Pharmacist (QUMSP)</td>
<td>4 □</td>
<td>3 □</td>
<td>2 □</td>
<td>1 □</td>
<td>99 □</td>
</tr>
<tr>
<td>vii. Business rules and guidelines</td>
<td>4 □</td>
<td>3 □</td>
<td>2 □</td>
<td>1 □</td>
<td>99 □</td>
</tr>
<tr>
<td>viii. QUMAX annual conference</td>
<td>4 □</td>
<td>3 □</td>
<td>2 □</td>
<td>1 □</td>
<td>99 □</td>
</tr>
</tbody>
</table>
### APPENDICES

**E2** Did your QUM Support Pharmacist (QUMSP) provide assistance with any of the following? *(please provide a response for each item)*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
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1. Workplan development support
2. In service education
3. Support in establishing safety-net monitoring arrangement
4. Support in developing internal policies and protocols
5. None of the above **SKIP TO E3**

**E2.1** How often are you in contact with your QUM Support Pharmacist (QUMSP)? *(select one only)*

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1. At least fortnightly
2. About once per month
3. About once every 3 months
4. About once every 6 months
5. Rarely
6. I’ve never been in contact with my QUM Support Pharmacist (QUMSP)

**E2.2** What impact did the QUM Support Pharmacist (QUMSP) have on the development of a QUM framework in your service? *(select one only)*

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1. Substantial impact
2. Some impact
3. Little or no impact
4. Hard to say
E3 Which of the following is most true of your involvement with QUMAX to date? (please select all that apply)

1. It has allowed this service to pursue QUM activities that it has previously been unable to pursue
2. It has allowed this service to continue to pursue QUM activities, but in a more sustainable way
3. Not sure/can’t say [IF SELECT NOT SURE CANCEL OUT RESPONSES FOR ABOVE]

E5 Do you have any other comments you would like to make, or any stories you would like to tell, about the benefits of QUMAX to patients? (Please type in your response)

F1 As part of the QUMAX evaluation, Urbis will be conducting analysis of PBS data to determine what overall impact QUMAX has had on access to PBS medicines amongst clients of Aboriginal Community Controlled Health Services. To conduct this accurately, it is important that we obtain a complete list of doctors (prescribers) who have worked in this service since 1 OCTOBER, 2007. We need to know the details of ALL doctors who have worked in the service during this time at all locations where QUMAX operates, including locums and sessional GPs, and including those who may not have been involved with QUMAX.

Below is a list of doctors we understand have worked in your service since 1 October 2007. Please review this list carefully and add the details that are missing.

If you have any questions about this requirement, please contact Murray Benton from Urbis – mbenton@urbis.com.au

INSERT ACCHS SPECIFIC LIST OF PROVIDER NUMBERS

Dr name Medicare provider number (please include leading zeros) [FIELD REQUIRES 8 DIGITS]

That is the end of the survey - thank you very much for your participation.
Appendix D Participating Pharmacies Survey
INTRO PAGE

This survey is for pharmacies who are participating in QUMAX. Whilst the survey does not take long to complete, you will be able to save your response and come back to finish the survey at any time during the next 10 days that it is open [VIEW TO INSERT INSTRUCTIONS HERE].

Please answer as many questions as possible.
Part A – Community Pharmacy Profile

A1  ASK ALL What is your role in the community pharmacy? (please select all that apply)
   1  □  Owner
   2  □  Senior Pharmacist
   3  □  Pharmacist
   4  □  Assistant
   5  □  Other (please specify)

A2  ASK ALL In which PhARIA is this pharmacy located? (please select one response only)
   1  □  1
   2  □  2
   3  □  3
   4  □  4
   5  □  5
   6  □  6
   7  □  Not sure/can’t say

A3  ASK ALL Which of the following best describes this pharmacy? (please select one response only)
   1  □  Independent, sole pharmacy
   2  □  Small pharmacy group (independent)
   3  □  Chain/franchise
   4  □  Other (please specify)

A4  ASK ALL Which of the following represents the average number of prescriptions dispensed per day in this pharmacy? (please select one response only)
   1  □  Less than 150
   2  □  151-250
   3  □  251-350
   4  □  More than 350
   5  □  Prefer not to say
Part B – Orientation to QUMAX

B1  ASK ALL Which of the following did you attend, use or access? *(please select all that apply)*

1  ☐ QUMAX business rules and guidelines (sent to you by post)
2  ☐ Pharmacy Guild of Australia website
3  ☐ QUMAX hotline
4  ☐ QUM Support Pharmacist (QUMSP)
6  ☐ None  **SKIP TO QUESTION C1**

B2  SHOW ALL SELECTED IN B1 ABOVE How helpful were each the following in orienting you to QUMAX? *(Select one response per row)*

<table>
<thead>
<tr>
<th></th>
<th>Very helpful</th>
<th>Somewhat helpful</th>
<th>Not very helpful</th>
<th>Not at all helpful</th>
<th>Hard to say</th>
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</thead>
<tbody>
<tr>
<td>xvi. QUMAX business rules and guidelines</td>
<td>4 ☐</td>
<td>3 ☐</td>
<td>2 ☐</td>
<td>1 ☐</td>
<td>98 ☐</td>
</tr>
<tr>
<td>xvii. Pharmacy Guild of Australia website</td>
<td>4 ☐</td>
<td>3 ☐</td>
<td>2 ☐</td>
<td>1 ☐</td>
<td>98 ☐</td>
</tr>
<tr>
<td>xviii. QUMAX Hotline</td>
<td>4 ☐</td>
<td>3 ☐</td>
<td>2 ☐</td>
<td>1 ☐</td>
<td>98 ☐</td>
</tr>
<tr>
<td>xix. QUM Support Pharmacist (QUMSP) LIST RESPONSE HERE FROM B1</td>
<td>4 ☐</td>
<td>3 ☐</td>
<td>2 ☐</td>
<td>1 ☐</td>
<td>98 ☐</td>
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</tbody>
</table>
Part C – Cultural awareness and safety

C1  ASK ALL Have you read the *An Introduction to Cultural Orientation for Participating Pharmacists* manual (PSA cultural awareness and training manual)?

1  ☐ Yes  SKIP TO QUESTION C8
2  ☐ No

C2  Besides yourself, who in your pharmacy has read the PSA cultural awareness and training manual? (please select all that apply)

1  ☐ All other staff
2  ☐ Some but not all staff
3  ☐ No one else
4  ☐ Not sure/can’t say

C3  How often do you refer to the PSA cultural awareness and training manual? (select one response only)

1  ☐ Frequently
2  ☐ Occasionally
3  ☐ Now and then
4  ☐ Never
5  ☐ Not sure/can’t say

C4  Have you or other pharmacy staff discussed the content of the PSA cultural awareness and training manual (for example at a staff meeting)?

1  ☐ Yes
2  ☐ No

C5  How useful did you find the PSA manual in helping you or the pharmacy staff to engage effectively with Aboriginal and Torres Strait Islander customers? (select one response only)

1  ☐ Very useful
2  ☐ Somewhat useful
3  ☐ Not very useful
4  ☐ Not sure/can’t say

C6  Do you feel the PSA cultural awareness and training manual was adequate in assisting you or your staff to engage appropriately with Aboriginal and Torres Strait Islander customers? (select one response only)

1  ☐ More than adequate
2  ☐ Adequate
3  ☐ Inadequate
4  ☐ Not sure/can’t say

C7  For you, how important was it to have cultural awareness and safety training resources as part of the QUMAX program? (select one response only)

1  ☐ Very important
2  ☐ Somewhat important
3  ☐ Not very important
4  ☐ Not sure/can’t say
**C8**  ASK ALL  Have you engaged in any *other* cultural awareness and safety training and/or activities through QUMAX (e.g. through the local Aboriginal Community Controlled Health Service)?

1. Yes *(please specify)*
2. No

**C9**  ASK ALL  Since participating in QUMAX, how much knowledge have you gained in each of the following areas? *(select one response per row)*

<table>
<thead>
<tr>
<th></th>
<th>Gained a lot of knowledge</th>
<th>Gained some knowledge</th>
<th>Gained no further knowledge</th>
<th>Not sure/can’t say</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. The cultural beliefs and attitudes of Aboriginal and Torres Strait Islander peoples as they relate to health</td>
<td>3</td>
<td>2</td>
<td>1</td>
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</tr>
<tr>
<td>ii. The barriers that some Aboriginal and Torres Strait Islander people face in visiting a pharmacy</td>
<td>3</td>
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<td>1</td>
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</tr>
<tr>
<td>iii. The cultural factors that can affect communication with Aboriginal and Torres Strait Islander customers</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>iv. The effective delivery of pharmacy services to assist with medication management for Aboriginal and Torres Strait Islander customers</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>99</td>
</tr>
</tbody>
</table>
### APPENDICES

<table>
<thead>
<tr>
<th>v.</th>
<th>The effective delivery of Consumer Medicine Information (CMI) to Aboriginal and Torres Strait Islander customers</th>
<th>Gained a lot of knowledge</th>
<th>Gained some knowledge</th>
<th>Gained no further knowledge</th>
<th>Not sure/can’t say</th>
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<table>
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<th>vi.</th>
<th>The nature of the services provided by Aboriginal Community Controlled Health Services</th>
<th>Gained a lot of knowledge</th>
<th>Gained some knowledge</th>
<th>Gained no further knowledge</th>
<th>Not sure/can’t say</th>
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**C12** **ASK ALL** Which of the following were most helpful in developing your understanding of cultural awareness and safety? *(please select all that apply)*

1. [ ] PSA cultural awareness and training manual
2. [ ] Assistance provided by the Aboriginal Community Controlled Health Service
3. [ ] Assistance provided by the QUM Support Pharmacist (QUMSP)
4. [ ] Other *(please specify)*
5. [ ] None of the above **IF SELECT NONE DELETE ANSWERS FOR ABOVE OPTIONS**
Part D – Relationships and protocols with the ACCHSs

D1  ASK ALL Since participating in QUMAX, have any new arrangements been put in place for providing on-call pharmacy services and medicines advice for clients of the Aboriginal and Community Controlled Health Service?

1 □ Yes
2 □ No **SKIP TO QUESTION D2**

D1.1 IF YES, Please describe what new arrangements have been put in place *(please type in your response)*

D1.2 IF YES, How satisfied are you with these new arrangements? *(please select one only and provide an explanation)*

1 □ Very satisfied *(please describe why)*
2 □ Somewhat satisfied *(please describe why)*
3 □ Somewhat dissatisfied *(please describe why)*
4 □ Very dissatisfied *(please describe why)*

D2  ASK ALL What, if any, QUM support has your pharmacy provided to the Aboriginal Community Controlled Health Service? *(please select all that apply)*

1 □ General training and support around quality use of medicines
2 □ Advice on cost effective access to PBS medicines
3 □ Advice on the benefits of Home Medication Reviews
4 □ Advice and assistance on maximizing patient entitlements under the PBS Safety Net
5 □ Delivery of medicines to Aboriginal Community Controlled Health Services and/or patient homes
6 □ Provision of Dose Administration Aids (e.g. Webster packs) for patients
7 □ Other *(please specify)*
8 □ None
**APPENDICES**

**Part E – Program impact and outcomes**

**E1**  
ASK ALL To what extent do you think QUMAX has led to any increase in the following? *(select one response per row)*

<table>
<thead>
<tr>
<th></th>
<th>Substantial increase</th>
<th>Some increase</th>
<th>Little increase</th>
<th>No increase</th>
<th>Hard to say</th>
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<tr>
<td>vii. Patient access to medicines</td>
<td>4 3 2 1 99</td>
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<tr>
<td>viii. Patient access to repeat prescriptions</td>
<td>4 3 2 1 99</td>
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<td>ix. Patient access to over the counter medications</td>
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<tr>
<td>x. Aboriginal and Torres Strait Islander customers to your pharmacy</td>
<td>4 3 2 1 99</td>
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<td>xi. Use of the PBS safety net entitlements</td>
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<td>xii. Number of HMRs conducted</td>
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<tr>
<td>xiii. Use of Dose Administration Aids (e.g. Webster packs)</td>
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**E2**  
ASK ALL To what extent do you think QUMAX has led to any improvement in the following? *(Select one response per row)*

<table>
<thead>
<tr>
<th></th>
<th>Substantial improvement</th>
<th>Some improvement</th>
<th>Little or no improvement</th>
<th>No improvement</th>
<th>Hard to say</th>
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<tbody>
<tr>
<td>i. Medication compliance</td>
<td>4 3 2 1 99</td>
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<tr>
<td>ii. Your pharmacy’s relationship with the Aboriginal Community Controlled Health Service</td>
<td>4 3 2 1 99</td>
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<tr>
<td>iii. Aboriginal Community Controlled Health Service staff knowledge and</td>
<td>4 3 2 1 99</td>
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<tr>
<td>iv. Establishment of QUM systems and practice within the local Aboriginal Community Controlled Health Service</td>
<td>Substantial improvement</td>
<td>Some improvement</td>
<td>Little or no improvement</td>
<td>No improvement</td>
<td>Hard to say</td>
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<th>v. Your pharmacy’s engagement with Aboriginal and Torres Strait Islander customers</th>
<th>Substantial improvement</th>
<th>Some improvement</th>
<th>Little or no improvement</th>
<th>No improvement</th>
<th>Hard to say</th>
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<tr>
<th>vi. Your pharmacy’s monitoring of the PBS safety net entitlements</th>
<th>Substantial improvement</th>
<th>Some improvement</th>
<th>Little or no improvement</th>
<th>No improvement</th>
<th>Hard to say</th>
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**E3** ASK ALL Are there any other major impacts or outcomes (positive or negative) that have resulted from QUMAX?

1. Yes
2. No **SKIP TO QUESTION F1**

**E3.1** IF YES, please specify *(please type in your response)*
Part F – Your pharmacy’s experience in implementing QUMAX

F1  ASK ALL How satisfied has this pharmacy been with various aspects of the QUMAX program and its implementation? (select one response per row)

<table>
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<tr>
<th></th>
<th>Very satisfied</th>
<th>Somewhat satisfied</th>
<th>Somewhat dissatisfied</th>
<th>Very dissatisfied</th>
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<td>xiii. Registering process</td>
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<td>xiv. QUMAX IT system (or generating MAAPs)</td>
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<td>xv. Process for entering MAAPs</td>
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<td>xvi. Process for claiming payments</td>
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<td>xvii. Website</td>
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<td>xviii. QUMAX business rules or guidelines</td>
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<tr>
<td>xix. Relationship with local Aboriginal Community Controlled Health Service</td>
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<tr>
<td>xx. Support provided by the QUM Support Pharmacist (QUMSP)</td>
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F2  ASK ALL Do you have any other comments you would like to make about your involvement in the QUMAX program? (please type in your response)

That is the end of the survey - thank you very much for your participation.
Appendix E  Interview Guides
QUMAX Evaluation
ACCHS Interview Guide
(for interviews with CEOs, Medical Officer, Aboriginal Health Workers and admin staff)

Introduction

NOTE THAT MANY OF THESE DETAILS CAN BE DERIVED FROM QUMAX REGISTRATION FORM – CONFIRM DETAILS AS NECESSARY THROUGH CONSULTATIONS

Can we start with some brief questions about your service:

1) How long has your service been operating? What geographic area do you cover? Do you operate from one locality or do you have outreach clinics? How many staff do you employ and on what basis.

2) What other health professionals does this service have a relationship with? What services are provided by external organisations/practitioners? On what basis?

3) How many patients are registered with your service? How would you describe your patient population - in terms of residential stability, health status, etc?

4) What other health programs does this service participate in?

5) Prior to QUMAX, did your service fund the purchase of medicines or DAAs for your patients? If so, what did you fund and how much did you spend on this annually?

6) What has been your relationship with [local pharmacy]? Have you historically worked on any collaborative projects? Have you been to the pharmacy? Have you been involved in transporting medicines to clients of the pharmacy?

7) What are some of the barriers to ACCHS clients accessing pharmacy services? What challenges have you faced? How well equipped are local pharmacies to provide culturally appropriate services to ACCHS clients?

8) How long have you been operating QUMAX? What stage are you at in implementing the program?

Applying and planning for QUMAX

9) How did you first hear about the QUMAX program? What were you initial thoughts? What, if any concerns did you have? What benefits did you see? What did you think would be required of you?

10) Why did your service decide to seek QUMAX funding?

11) How satisfied have you been with the process for applying for QUMAX funding? Why is that?

12) What contact have you had with local pharmacies in making preparations for QUMAX? What has this been like from your perspective?

13) What are the key activities in your QUMAX work plan (NOTE THAT THIS INFORMATION IS AVAILABLE ON THE WORK PLAN)? - Why did you decide to focus on these activities? Please describe the process through which your service formulated its work plan.

14) How helpful or useful were the NACCHO and Guild program managers, your State Affiliate, the QUMP in assisting you to develop your work plan? What was of most assistance to you? Was
there any assistance that you needed that you weren’t able to get? How could the support structures have better assisted you?

15) How helpful and user friendly have you found the program supports and resources eg the NACCHO website, the Pharmacy Guild website, the program guidelines, the orientation workshop, the National Workshop?

16) What is the process for driving or managing QUMAX within your service? What are the internal governance/management arrangements for the program? Why have you decided to do it this way? What is your particular role /responsibility for QUMAX?

17) What eligibility criteria have you developed for QUMAX eg particular patients or classes of drug? What factors did you take into consideration in deciding to limit QUMAX to these people/circumstances? DISCUSS IN DETAIL

18) To date, have these criteria resulted in any difficulties or unintended outcomes for clients, GPs or pharmacists? DISCUSS IN DETAIL

Implementing QUMAX

19) What are the key QUMAX activities that you have been focusing on in the early stages of the program?

20) What activities are progressing well? Why is that?

21) Are there any activities where progress is slower than hoped or anticipated? Why is that?

22) Are there any particular challenges (internal or external) that you are facing in the early implementation phase of QUMAX? If so, what are these and how they being addressed? Are there any areas where the program guidelines/business rules do not cater for the structure/nature of your service?

23) Have different people in the service responded differently to the requirements of QUMAX? How so?

24) How has the service adapted to using the QUMAX IT system? Is it easy to use? Have you run into any particular problems? How have these been overcome? What impact has using the IT system had on work flows? What would help?

25) How does QUMAX compare with other programs in terms of administrative requirements?

26) What mechanisms have been put in place with local pharmacies to streamline the provision of financial assistance for medicines and DAAs, safety net monitoring, conducting HMRs, transport assistance, on-call pharmacy etc?

27) What other things have you had to do to prepare for QUMAX in your service eg changes to workflow practices, IT changes, communication protocols with pharmacists, communication with clients. What if any wider benefits have these changes brought to the service? Has there been any cost to the service?

Early outcomes

28) Do you have any evidence of early outcomes from QUMAX? For example:
   - Increased patient access to medicines (please refer to data, anecdotes, case studies)
   - Increased use of the PBS safety net
   - Increased medication adherence
• Increased quality use of medicines? (judicious use, appropriate, safe, etc)
• Increased patient access to HMRs, NDSS, ASOS
• Improved relationships with community pharmacies
• Better cultural awareness in community pharmacy
• Increased staff access to QUM material and training resources
• Development of new protocols, policies or procedures leading to improved quality of care
• Other?

29) What will some of the longer term benefits of QUMAX be for clients of this service?

30) Are there any other comments that you would like to make about the progress of QUMAX thus far?
Discussion guide for QUMAX clients

Your experience prior to QUMAX...

We would like to begin by asking you some questions about how easy/difficult it has been to get the medicines you and your family needed in the past...

- How long have you/your family been coming to this service?
- Do you or some people in your family need a lot of medicine?
- How easy was it to get the medicine you/your family need in the past?
- What sorts of problems did you have in getting medicines in the past?
- What happened when you didn’t get them? Got them too late?
- How did you use to get your medicines in the past (e.g. from the health service, delivered to home, travel to the pharmacy)?
- Did you ever go to your local pharmacy? What was that like? Is there a pharmacy you like to go to? Have you avoided going to the pharmacy before?
- Have you had problems in knowing what medicines to take at the right time?

Your experience after being involved in QUMAX...

We would like to ask you some questions about your experience recently....

- In the last year or so, has it been easier to get medicines? How do you get them? What difference does that make to you and your family?
- Do you take your medicines differently from before (e.g. do you take them everyday, do you go back for repeats)? Has that made a difference to you and your family’s health? How?
- How easy or difficult is it to remember to take your medicine? What sort of things help in remembering to take your medicines (e.g. does the pharmacist provide helpful tips/information, Webster packs)?
- How do you usually get your medicines (e.g. from the health service, delivered to home, travel to the pharmacy)?
- In the last year or so, have you gone to your local pharmacy? If yes - How did you get there? What was that like? Does the pharmacy provide you with tips/information/explain the medicines you are taking? If so, is this useful? Why? Has a pharmacist been to your home? Was that helpful?
- Any other comments...?
Discussion guide for QUMAX clients

Your experience prior to QUMAX…

We would like to begin by asking you some questions about how easy/difficult it has been to get the medicines you and your family needed in the past…

- How long have you/your family been coming to this service?
- Do you or some people in your family need a lot of medicine?
- How easy was it to get the medicine you/your family need in the past?
- What sorts of problems did you have in getting medicines in the past?
- What happened when you didn’t get them? Got them too late?
- How did you use to get your medicines in the past (e.g. from the health service, delivered to home, travel to the pharmacy)?
- Did you ever go to your local pharmacy? What was that like? Is there a pharmacy you like to go to? Have you avoided going to the pharmacy before?
- Have you had problems in knowing what medicines to take at the right time?

Your experience after being involved in QUMAX…

We would like to ask you some questions about your experience recently….

- In the last year or so, has it been easier to get medicines? How do you get them? What difference does that make to you and your family?
- Do you take your medicines differently from before (e.g. do you take them everyday, do you go back for repeats)? Has that made a difference to you and your family’s health? How?
- How easy or difficult is it to remember to take your medicine? What sort of things help in remembering to take your medicines (e.g. does the pharmacist provide helpful tips/information, Webster packs)?
- How do you usually get your medicines (e.g. from the health service, delivered to home, travel to the pharmacy)?
- In the last year or so, have you gone to your local pharmacy? If yes - How did you get there? What was that like? Does the pharmacy provide you with tips/information/explain the medicines you are taking? If so, is this useful? Why? Has a pharmacist been to your home? Was that helpful?
- Any other comments…?
QUMAX Evaluation
QUMPS Interview Guide

Introduction

1) How long have you been contracted to work on QUMAX?
2) How many services do you work with?
3) What work do you normally engage in? What particular skills or aptitudes do you bring to the QUMP role?
4) What, if any, previous experience have you had working with ACCHSs or in Aboriginal health?
5) Why were you interested in becoming a QUMP?
6) Have you any comments to make on the effectiveness or efficiency of the QUMP appointment process? Of your satisfaction with the support and assistance (eg guidelines, training, workshops, contact with the Pharmacy Guild) you have been given to assist you perform your QUMP role?

QUMP role and activities

7) What do you see as your key role in relation to QUMAX?
8) What have been the key activities that you have been involved since you became involved in QUMAX?
9) What do you think have been the key challenges in the early implementation phase of QUMAX objectives
   ▪ from your perspective
   ▪ the perspective of the ACCHSs
   ▪ the perspective of State Affiliates
   ▪ the perspectives of the community pharmacists?
10) How much, and what sort of engagement, have you had with the ACCHSs? The State Affiliates? How easy or difficult has it been to engage with the services and sector?
11) What have been the main areas in which ACCHSs have needed assistance from you? Have some services needed more or different types of assistance than others? If so, what and why is that?
12) Where do you think you have been of most assistance to ACCHSs? (Examples)
13) Are there services or areas where you feel it has been more challenging for you to provide support? Why is that?
QUMAX progress

14) What have been the main achievements of QUMAX to date? What data, examples or case studies can you provide to illustrate this? (MURRAY PROMPTS? WHAT CONTACT POST WORKPLAN?)

15) In your opinion, are some ACCHSs progressing better than others in implementing QUMAX? Which services are progressing well and why is that? Which ones appear to be struggling, and why?

16) Are there any areas of QUMAX that you think are working less well/proving to be challenging for ACCHSs, QUMPS, community pharmacies? Why is that and how do you think this might be addressed?

17) Are there any other comments that you would like to make about the early implementation stage of QUMAX
Appendix F  Research Instruments
QUMAX Evaluation
ACCHS Site Visits Interview Guide
(For interviews with CEOs, participating Medical Officers, Aboriginal Health Workers, and admin staff)

Introduction (5 mins)

1) Can you tell me about your service (size, number of clients, etc)?
2) What has been your role in the establishment and implementation of QUMAX?
3) Prior to QUMAX, did your service fund the purchase of medicines or DAAs for your patients? If so, what did you fund and how much did you spend on this annually?
4) Overall - what has been your experience in participating in QUMAX? Has this been a positive or negative experience? What are the strengths and weaknesses of the program? What do you see as the key challenges for the program into the future?

Applying for QUMAX (5 mins)

5) Why did your service decide to seek QUMAX funding?
6) How satisfied were you with the process for applying for QUMAX funding? Why is that?
7) What contact did you have with local pharmacies in making preparations for QUMAX? Did they have input into your application?
8) How helpful or useful were the NACCHO and Guild program managers, your State Affiliate, the QUMP in assisting you to develop your work plan? What was of most assistance to you? Was there any assistance that you needed that you weren’t able to get? How could the support structures have better assisted you?
9) How helpful and user friendly did you find the program supports and resources eg the NACCHO website, the Pharmacy Guild website, the program guidelines, the orientation workshop, the National Workshop? Could these be improved in any way?

QUMAX first steps...(15 mins)

10) What is the process for driving or managing QUMAX within your service? What are the internal governance/management arrangements for the program? Why have you decided to do it this way? How were these processes negotiated and established? What have been the positive/negatives of your approach?
11) How did you develop your workplan and program guidelines? Did you consult with your participating pharmacies or other stakeholders in developing these? Why did you decide to focus on these activities?
12) What eligibility criteria have you developed for QUMAX eg particular patients or classes of drug? What factors did you take into consideration in deciding to limit QUMAX to these people/circumstances? Have these criteria changed since implementation commenced? If so, why?
13) To date, have these criteria resulted in any difficulties or unintended outcomes for clients, GPs or pharmacists?
14) What mechanisms have been put in place with participating pharmacies to streamline the provision of financial assistance for medicines and DAAs, safety net monitoring, conducting HMRs, transport assistance, on-call pharmacy etc? How were these negotiated and developed?
**Implementing QUMAX (20 mins)**

15) Has the work plan changed or been reviewed since it was initially developed?

16) **Please describe the activities you have or are in the processes of implementing** (e.g. enhanced QUM, financial assistance, training, transport)? Which of these are progressing well? Why is that? Are there any activities where progress is slower than hoped or anticipated? Why is that?

17) **Are there any particular challenges (internal or external) that you are facing in implementing the Program?** If so, what are these and how are they being addressed? Are there any areas where the program guidelines/business rules do not cater for the structure/nature of your service?

18) Have different people in the service responded differently to the requirements of QUMAX? How so? What has been the response of consumers?

19) How has the service adapted to using the QUMAX IT system? Is it easy to use? Have you run into any particular problems? How have these been overcome? What impact has using the IT system had on work flows? What would help?

20) What other things have you had to implement in your service as a result of QUMAX (e.g. changes to workflow practices, IT changes, communication protocols with pharmacists, communication with clients)? What if any wider benefits have these changes brought to the service? Has there been any cost to the service?

21) **What if anything would you do differently if you were implementing the program ‘from scratch’?**

**Outcomes (15 mins)**

22) Do you have any evidence of positive outcomes from QUMAX? For example:

- Increased patient access to medicines (please refer to data, anecdotes, case studies)
- Increased use of the PBS safety net
- Increased medication adherence
- Increased quality use of medicines (judicious use, appropriate, safe, etc)
- Increased patient access to HMRs, NDSS, ASOS
- Improved relationships with community pharmacies
- Improved prescribing practice
- Better cultural awareness in community pharmacy
- Increased staff access to QUM material and training resources
- Development of new protocols, policies or procedures leading to improved quality of care, other?

22) **Have there been any unintended negative outcomes that have occurred as a result of QUMAX?**

23) Do you think there will be any longer term benefits of QUMAX for clients of this service?

24) Are there any other comments that you would like to make about the QUMAX program?
QUMAX Evaluation - Pharmacy Site Visits Interview Guide

Introduction (5 mins)

1) How long have you been working in/managing this pharmacy? What geographic area do you cover?
2) Please describe your patient profile. What proportion of your clients is from an Aboriginal or Torres Strait Islander background?
3) How many staff are employed in the pharmacy? What is the approximate average script volume of this pharmacy?
4) What has been your relationship with [ACCHS] prior to QUMAX? Have you historically provided any services to the ACCHS or worked on any collaborative projects?
5) What has been your experience in providing pharmacy services to ACCHS clients? What are some of the barriers to ACCHS clients accessing your services? What challenges have you faced?

Participating in QUMAX (15 mins)

6) Overall - what has been your experience in participating in QUMAX? Has this been a positive or negative experience? What are the strengths and weaknesses of the program? What do you see as the key challenges for the program into the future?
7) How did you first hear about the QUMAX program? Why did you decide to become involved?
8) How easy or difficult was it to become a QUMAX participating pharmacy?
9) What was good about the orientation process? What if anything could be done better next time?
10) What has participation entailed for your pharmacy?

Implementing QUMAX (25 mins)

11) How does it work – describe the process of providing access to free medicines to clients.
12) What mechanisms have been put in place with the local ACCHS to streamline the provision of financial assistance for medicines and DAAs, safety net monitoring, conducting HMRs, transport assistance, on-call pharmacy etc? Are these mechanisms working?
13) Were you involved in the development of the work plan? How well did that process work? Overall, how satisfied are you with the new arrangements? What’s worked well? Less well? Why is that? What could be done differently next time?
14) How has the pharmacy adapted to using the QUMAX IT system?
15) What other things have you had to do to prepare for QUMAX in this pharmacy?
16) Have you had any contact with the Guild, NACCHO or the QUM Support Pharmacist? How helpful was that support? What could have been done better?
17) Have you or others in the pharmacy undertaken any Aboriginal and Torres Strait Islander cultural awareness training? How helpful or useful was that? How (if at all) has that changed the way your or your staff communicate with Aboriginal customers or the ACCHS? What impact is that having? Can you provide some example.
18) Have you been involved in any activities to improve quality prescribing/quality use of medicines by clients of ACCHSs (e.g. providing QUM training to ACCHS staff)?

19) What if anything would have helped you to better prepare for QUMAX?

**Outcomes (15 mins)**

20) Do you have any evidence of positive outcomes from QUMAX? Please provide details.

21) Have there been any unintended outcomes?

22) **Would you recommend this Program to other community pharmacists? Why/why not? Would you become involved again?**

23) Are there ways in which the program rules/ regulations/guidelines and its implementation could be improved to better meet the needs of community pharmacies?

24) Are there any other comments that you would like to make about the QUMAX program?
QUMAX Evaluation - Patient Site Visit Interview Guide

**Your experience prior to QUMAX…**

We would like to begin by asking you some questions about how easy/difficult it has been to get the medicines you and your family needed in the past…

- How long have you/your family been coming to this service?
- Do you or some people in your family need a lot of medicine?
- How easy was it to get the medicine you/your family need in the past?
- What sorts of problems did you have in getting medicines in the past?
- What happened when you didn’t get them? Got them too late?
- How did you use to get your medicines in the past (e.g. from the health service, delivered to home, travel to the pharmacy)?
- Did you ever go to your local pharmacy? What was that like? Is there a pharmacy you like to go to? Have you avoided going to the pharmacy before?
- Have you had problems in knowing what medicines to take at the right time?

**Your experience after being involved in QUMAX…**

We would like to ask you some questions about your experience recently…

- In the last year or so, has it been easier to get medicines? How do you get them? What difference does that make to you and your family?
- Do you take your medicines differently from before (e.g. do you take them everyday, do you go back for repeats)? Has that made a difference to you and your family’s health? How?
- How easy or difficult is it to remember to take your medicine? What sort of things help in remembering to take your medicines (e.g. does the pharmacist provide helpful tips/information, Webster packs)?
- How do you usually get your medicines (e.g. from the health service, delivered to home, travel to the pharmacy)?
- In the last year or so, have you gone to your local pharmacy? If yes - How did you get there? What was that like? Does the pharmacy provide you with tips/information/explain the medicines you are taking? If so, is this useful? Why? Has a pharmacist been to your home? Was that helpful?
- Any other comments…?
Discussion guide for ACCHS – summary

Thank you for agreeing to participate in a discussion about the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) program.

Urbis (a leading independent social research firm) are conducting an evaluation of QUMAX on behalf of the Australian Government Department of Health and Ageing.

The evaluation runs for three years (2007 to 2010) and aims to document the experience and impact of various aspects of QUMAX on participating Aboriginal Community Controlled Health Services (ACCHSs), community pharmacies and patients.

The evaluation involves a range of consultation strategies, including site visits to participating ACCHSs and community pharmacies.

We have included a list of topics we would like to discuss during our interview.

Should you have any further questions about the project, please contact Tomas Lopata, at Urbis on (02) 8233 9958 or tlopata@urbis.com.au.

Your comments will remain confidential to our team at Urbis, and will not be directly attributed to you in our reporting without your permission.

Introduction/background

- Overview of your service – core services provided, how long you have been established, your catchment area and community, total staff employed, relationship with other health services etc.
- Your role in QUMAX and familiarity with the Program.
- Prior to QUMAX –
  - Did your service fund medicines or DAAs?
  - Nature of relationship with local pharmacy
  - Barriers to clients accessing pharmacy services

What shape has QUMAX taken for you?

- Your main reason(s) for applying for QUMAX funding; any barriers or enablers to participating
- Applying for QUMAX – are you satisfied with the application process? What support was provided by Program stakeholders in the application process (Pharmacy, NACCHO and Affiliates, Guild, QUMP)?
- Key areas of activity in your work plan – how were these selected? Who was consulted in their development? Have these changed?
- Who/what has driven or championed QUMAX within your service?

Your experience in implementing QUMAX

- Overall - what has been your experience in participating in QUMAX? Has this been a positive or negative experience? What are the strengths and weaknesses of the program? What do you see as the key challenges for the program into the future?
- Describe the activities you are implementing.
- How does it work – describe the process of providing access to free medicines to clients.
- Local pharmacies – how does the service manage the implementation of the Program with your participating pharmacies? (e.g. provision of free medicines and DAAs, repeats, safety net monitoring, on-call pharmacy, transport, conduct of HMRs)? Any problems?
- Challenges - which activities/aspects of the Program are working and which are not? Why?
- QUMAX instruments – how have you adapted to using the QUMAX IT system? Any problems? have you had to make any internal changes to support the implementation of the Program (e.g. changes to workflow practices, IT training, communication protocols with pharmacies)?

What has been achieved to date?

- Your service’s main achievements arising out QUMAX (e.g. increased client access to medicines and compliance, increased client access to HMRs, new/improved systems in your service, strategies or partnerships; improved relationships with local pharmacies, increased cultural awareness in local pharmacies).
- The key factors that have contributed to these achievements.
- Any challenges you faced in implementing or progressing QUMAX in your service.

Final comments

- Anything you might do differently if you were starting QUMAX ‘from scratch’.
- Have there been any unintended negative outcomes that have occurred as a result of QUMAX?
- Any other comments about the QUMAX program.
QUMAX Evaluation – Community Pharmacy Site Visits Interview Guide

Thank you for agreeing to participate in a discussion about the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) program.

Urbis (a leading independent social research firm) are conducting an evaluation of QUMAX on behalf of the Australian Government Department of Health and Ageing.

The evaluation runs for three years (2007 to 2010) and aims to document the experience and impact of various aspects of QUMAX on participating Aboriginal Community Controlled Health Services (ACCHSs), community pharmacies and patients.

The evaluation involves a range of consultation strategies, including site visits to participating ACCHSs and community pharmacies.

We have included a list of topics we would like to discuss during our interview.

Should you have any further questions about the project, please contact Tomas Lopata, at Urbis on (02) 8233 9958 or tlopata@urbis.com.au.

Your comments will remain confidential to our team at Urbis, and will not be directly attributed to you in our reporting without your permission.

Introduction

1) How long have you been working in/managing this pharmacy? What geographic area do you cover?
2) Please describe your patient profile. What proportion of your clients is from an Aboriginal or Torres Strait Islander background?
3) How many staff are employed in the pharmacy? What is the approximate average script volume of this pharmacy?
4) What has been your relationship with [ACCHS] prior to QUMAX? Have you historically provided any services to the ACCHS or worked on any collaborative projects?
5) What has been your experience in providing pharmacy services to ACCHS clients? What are some of the barriers to ACCHS clients accessing your services? What challenges have you faced?

Participating in QUMAX

6) Overall - what has been your experience in participating in QUMAX? Has this been a positive or negative experience? What are the strengths and weaknesses of the program? What do you see as the key challenges for the program into the future?
7) How did you first hear about the QUMAX program? Why did you decide to become involved?
8) How easy or difficult was it to become a QUMAX participating pharmacy?
9) What was good about the orientation process? What if anything could be done better next time?
10) What has participation entailed for your pharmacy?

Implementing QUMAX

11) How does it work – describe the process of providing access to free medicines to clients.
12) What mechanisms have been put in place with the local ACCHS to streamline the provision of financial assistance for medicines and DAAs, safety net monitoring, conducting HMRs, transport assistance, on-call pharmacy etc? Are these mechanisms working?

13) Were you involved in the development of the work plan? How well did that process work? Overall, how satisfied are you with the new arrangements? What's worked well? Less well? Why is that? What could be done differently next time?

14) How has the pharmacy adapted to using the QUMAX IT system?

15) What other things have you had to do to prepare for QUMAX in this pharmacy?

16) Have you had any contact with the Guild, NACCHO or the QUM Support Pharmacist? How helpful was that support? What could have been done better?

17) Have you or others in the pharmacy undertaken any Aboriginal and Torres Strait Islander cultural awareness training? How helpful or useful was that? How (if at all) has that changed the way your or your staff communicate with Aboriginal customers or the ACCHS? What impact is that having? Can you provide some example.

18) Have you been involved in any activities to improve quality prescribing/quality use of medicines by clients of ACCHSs (e.g. providing QUM training to ACCHS staff)?

19) What if anything would have helped you to better prepare for QUMAX?

Outcomes

20) Do you have any evidence of positive outcomes from QUMAX? Please provide details.

21) Have there been any unintended outcomes?

22) Would you recommend this Program to other community pharmacists? Why/why not? Would you become involved again?

23) Are there ways in which the program rules/ regulations/guidelines and its implementation could be improved to better meet the needs of community pharmacies?

24) Are there any other comments that you would like to make about the QUMAX program?
Appendix G  Participant Consent Form
Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples

Information and Consent Form

Thank you for talking with us today. You are invited to take part in a discussion about the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) program. Below are some details about the study, and a consent form for you to sign if you are happy to participate in our discussions about the program.

What is the study about?

The aim of this study is to find out how the QUMAX program is working to make medicines under the pharmaceutical benefits scheme (PBS) more accessible to Aboriginal and Torres Strait Islander people. QUMAX is the program under which you have been receiving access to free medicines in the last year or so. Urbis (a leading independent social research firm) are conducting this study on behalf of the Australian Government Department of Health and Ageing.

Our study runs for three years (2007 to 2010) and has involved many activities so far. We are currently visiting a number of Aboriginal Community Controlled Health Organisations and pharmacies around the country to talk with service staff and patients who have participated in QUMAX – which is why we are here today.

How can I participate in the study?

You have been selected to participate in this voluntary study because of your involvement in QUMAX as a patient.

We are inviting you to take part in a discussion about QUMAX, either by yourself or in a small group with others who are also participating in the program.

This discussion is voluntary, and you should not feel forced to take part. Your participation will have no effect on your involvement in the program or the medical assistance you are currently receiving. We will be taking notes of our discussion however you will not be identified in any of our reports to Government or the public.

Things that we will be talking about include:

- Your past experiences in getting medicine for you and your
- Your past experiences in knowing which and when to take medicines
- Your experience in the last year or so, has it been easier to get medicines? what difference does that make to you and your family? do you take your medicines differently from before?

What would I have to do if I agree to take part in the study?

You will be asked to sign the attached consent form which says that you agree to take part in the study. You can keep this information sheet for your reference.

What will happen to the information collected?

Information from our discussion will be compared with information from other discussions taking place around Australia. Again, no information which could identify you will be reported on and your privacy will be protected.

If you have any questions following the discussion, you can contact the study Project Manager, Tomas Lopata on (02) 8233 9958 or email tlopata@urbis.com.au
**Consent Form for Participants**

I have read the attached Information Sheet for participants in the QUMAX program.

I understand this will involve taking part in a discussion with consultants from Urbis either by myself, with family or in a small group.

I understand any information I provide is confidential.

I understand my participation will not affect the medical assistance I receive.

I understand that taking part in the study is voluntary and that I am free to withdraw my consent from the study at any time. Deciding to withdraw from the study will not affect the medical assistance I receive.

*I agree to take part in a confidential discussion either by myself, with family or in a small group, led by a member of the study team.*

Your full name (please print): ____________________________________________________  
Mr/Ms  First Name  Family Name

Your signature and the date: ______________________________________________________
Signature  Date

**If required:**

Name of Guardian (please print): _________________________________________________  
Mr/Ms  First Name  Family Name

Signature and the date: __________________________________________________________
Appendix H  Developers of the Joint Submission to the Fourth Community Pharmacy Agreement
4th Community Pharmacy Agreement Joint submission (Pharmacy Guild and NACCHO)-
‘Program for the Improved Access of Aboriginal and Torres Strait Islanders to the PBS’ (2006)

Developed by:

Mr Lance Emerson (Pharmacy Guild of Australia)
Dr Sophie Couzos (National Aboriginal Community Controlled Health Organisation)
Mr Ian Todd ((Pharmacy Guild)
Ms Fiona Mitchell (Pharmacy Guild)
Mr Frank Vincent (AMS Western Sydney)
Dr John Daniels (AMS Redfern)
Ms Dea Thiele (NACCHO)
Professor Richard Murray (James Cook University)
Dr Naomi Mayers (AMS Redfern)
Appendix I  QUMAX Program Managers
APPENDICES

NACCHO QUMAX Program Manager
Ms Vicki Sheedy

Pharmacy Guild QUMAX Program Manager
Ms Anne Develin (2008-9), Katherine Baverstock (2009-10), Marsha Gomez (2010-11) Angela Corcoran (2011-)
Appendix J  QUMAX Program Business Rules
QUALITY USE OF MEDICINES MAXIMISED FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE (QUMAX) PROGRAM

BUSINESS RULES AND GUIDELINES

Updated May 2010

1. INTRODUCTION AND BACKGROUND

This document, Business Rules and Guidelines for the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) Program, sets out the parameters that will govern the implementation and management of the QUMAX Program.

Specifically these rules will include:

a) a description of the respective roles of and the relationships between key Program participants with respect to how the Program will operate;

b) eligibility arrangements for Program enrolment and payment of funds under the QUMAX Program;

c) a description of the key processes to be followed by participants in the administration of the Program; and

d) rules that will govern the payment of funds based on claims from community pharmacies.

The QUMAX Program was developed jointly by the Pharmacy Guild of Australia (the Guild) and the National Aboriginal Community Controlled Health Organisation (NACCHO). The Guild is being funded by the Commonwealth to develop, continue, implement and manage the Program. The Guild has engaged NACCHO as a key partner in the Program.

The QUMAX Program was initially funded under the Fourth Community Pharmacy Agreement to run over a 2 year period to 30 June 2010. NACCHO and the Guild submitted a joint proposal to the Department of Health and Ageing (Department) to have the program extended past this end date. In late 2009, the Department approved the proposal and further funding was received for Year 3 of the Program which will run from 1 July 2010 until 30 June 2011.

These Rules are intended to provide consistency and certainty in respect of the administration of the Program but it should be noted that they are not legally binding on the Guild, NACCHO or the Department. The Guild and/or NACCHO may depart from these Rules in individual situations when circumstances warrant and will receive written approval from the Department before making a decision to depart from these Rules.

These Rules may be revised from time to time. The Rules are administrative and reflect the intention of the Guild, NACCHO and the Department as to how the Program is to be
administered. Neither the Guild, NACCHO nor the Department will accept liability for any loss or damage incurred by a person in expectation of any benefit to be derived from the Program.

Without limiting its rights at law or otherwise, the Guild reserves the right at any time to suspend, amend or vary the Rules, in consultation with NACCHO and with approval by the Department.

Payments to participants under the Program will be made according to the provisions set out in these rules.

In the event that a dispute arises between any of the participants in relation to the application of these Business Rules, the matter should initially be referred to the Pharmacy Guild National Program Manager who will work toward a resolution in consultation with the appropriate contact. The Department will be the final arbitrator in any dispute, should this be required.

2. **DEFINITIONS**

<table>
<thead>
<tr>
<th><strong>ACCHS</strong></th>
<th>an Aboriginal Community Controlled Health Organisation which is funded by the OATSIH for the provision of primary health care services to Aboriginal and Torres Strait Islander peoples, and that employs general practitioners able to prescribe medicines to clients of that organisation</th>
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<tr>
<td><strong>ASOS</strong></td>
<td>Asthma Spacer Ordering Scheme</td>
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<tr>
<td><strong>Budget Algorithm</strong></td>
<td>The formula used to calculate funds available to ACCHSs for allocation to MAAPS</td>
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<tr>
<td><strong>Community Pharmacy</strong></td>
<td>A pharmacy which holds an approval under Section 90 of the <em>National Health Act 1953</em> to dispense medicines under the Pharmaceutical Benefits Scheme</td>
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<tr>
<td><strong>CEO</strong></td>
<td>Chief Executive Officer or equivalent</td>
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<td><strong>DoHA or Department</strong></td>
<td>Department of Health and Ageing</td>
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<td><strong>Dose Administration Aid or DAA</strong></td>
<td>an adherence device which divides patient medications into individual doses and arranges them according to the dosage schedule throughout the day</td>
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<td><strong>Fourth Community Pharmacy Agreement or 4CPA</strong></td>
<td>means the agreement between the Commonwealth and the Pharmacy Guild of Australia executed on 16 November 2005</td>
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<td><strong>Funding Agreement</strong></td>
<td>means the primary Agreement between the Commonwealth of Australia as represented by the Department of Health and Ageing and The Pharmacy Guild of Australia to undertake the QUMAX Project</td>
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<td><strong>Latest Approved Version</strong></td>
<td>means the most recent version of a document Approved by the Commonwealth under the terms of the Funding</td>
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<td><strong>Term</strong></td>
<td><strong>Definition</strong></td>
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<td>Agreement</td>
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<td>MAAPS</td>
<td>Medication Access and Assistance Packages</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation and is the national peak body representing the Aboriginal community controlled health sector</td>
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<tr>
<td>NACCHO State Affiliate</td>
<td>the peak bodies representing the Aboriginal community controlled health sector at the State/Territory level for the relevant State/Territory and which are represented as such on the NACCHO Board</td>
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<tr>
<td>NDSS</td>
<td>National Diabetes Services Scheme</td>
</tr>
<tr>
<td>OATSIH</td>
<td>the Department’s Office for Aboriginal and Torres Strait Islander Health</td>
</tr>
<tr>
<td>Pharmaceutical Benefits Scheme or PBS</td>
<td>the Commonwealth medicines subsidy scheme to subsidise medicines used in the community setting established under Part VII of the <em>National Health Act 1953</em> together with the <em>National Health (Pharmaceutical Benefits) Regulations 1960</em> made under the Act</td>
</tr>
<tr>
<td>Program</td>
<td>the program for Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People developed as part of the Fourth Community Pharmacy Agreement</td>
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<tr>
<td>Program Reference Group or PRG</td>
<td>the technical advisory group established to oversee the development and implementation of the Program</td>
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<tr>
<td>PSA</td>
<td>the Pharmaceutical Society of Australia</td>
</tr>
<tr>
<td>QUM</td>
<td>Quality Use of Medicines:</td>
</tr>
<tr>
<td></td>
<td>- Selecting management options wisely</td>
</tr>
<tr>
<td></td>
<td>- Choosing suitable medicines if a medicine is considered necessary</td>
</tr>
<tr>
<td></td>
<td>- Using medicines safely and effectively</td>
</tr>
<tr>
<td>QUM Support Pharmacists or QUMSPs</td>
<td>Quality Use of Medicines Support Pharmacists – pharmacists employed by the State and Territory branches of the Guild to provide support to ACCHSs and community pharmacies in their participation in the Program</td>
</tr>
<tr>
<td><strong>QUM Work Plan</strong></td>
<td>A work plan developed by ACCHSs in consultation with QUMSPs and assistance from NACCHO State Affiliates to set out the key Program activities to be carried out at the ACCHS on a yearly basis under the Program</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td><strong>QUM Work Plan Template</strong></td>
<td>The approved template to be used as the basis for developing the QUM Work Plan.</td>
</tr>
<tr>
<td><strong>RAPS Division</strong></td>
<td>Rural and Professional Services Division of the Guild</td>
</tr>
<tr>
<td><strong>RCTI</strong></td>
<td>Recipient Created Tax Invoice</td>
</tr>
</tbody>
</table>

### 3. QUMAX PROGRAM AIMS AND OBJECTIVES

The QUMAX Program aims to improve the health outcomes of Aboriginal and Torres Strait Islander people that attend participating ACCHSs in rural and urban Australia, by supporting interventions that aim to:

- a) improve Quality Use of Medicines (QUM) and medication compliance; and
- b) support improved access to medicines under the Pharmaceutical Benefits Scheme (PBS) by addressing cultural and transport.

The Program will provide structured support for QUM in ACCHSs via community pharmacies, through the implementation of service-level QUM work plans for the period of the project which is 1 July 2010 to 30 June 2011.

### 4. ROLES OF AND RELATIONSHIPS BETWEEN KEY PARTICIPANTS

#### 4.1 Guild

The Guild is responsible for the overall management of the Program and is required to do this in close consultation and partnership with NACCHO.

The Guild will subcontract NACCHO to assist with the development, continuation and implementation of the Program.

The Guild is required to ensure, through its State and Territory branches that QUMSPs are recruited to participate in the Program. This will occur via MOUs between the Guild's National Secretariat and each State/Territory branch.

The Guild is required to inform community pharmacies about the program and invite expressions of interest from them to participate. Written information or online materials are to be provided to those pharmacies wishing to participate.

The Guild along with its State/Territory branches is the key contact point for QUMSPs and community pharmacies that are eligible to register and/or are participating in the Program.
The Guild is responsible for the disbursement of funds to key participants under the terms of its Funding Agreement with the Commonwealth. This includes the management of claims from community pharmacies for reimbursement of costs following the provision of MAAPS to individual ACCHS clients.

Funds allocated to ACCHSs to cover the cost of MAAPS under QUM Work Plans, will be administered by the Guild. Individual contracts between the Guild and each participating ACCHS will be set up and monitored by the Guild.

The Guild is responsible for the hosting and maintenance of the QUMAX IT System (refer to section 12).

4.2 QUM Support Pharmacists/Persons

QUMSPs will be engaged by each State/Territory branch of the Guild to provide but not limited to the following services under the Program:

- Provide information, advice and support for staff in participating Aboriginal Community Controlled Health Organisations (ACCHSs) and to community pharmacists regarding the QUMAX Program;
- Brokerage of assistance to establish, continue and strengthen the relationship between participating ACCHSs and local community pharmacies;
- Provide assistance to participating ACCHSs in implementing, monitoring and reviewing Year 3 QUM Work Plan with State Affiliate if necessary;
- Provide ongoing education on medicine use and QUM to ACCHS staff;
- Provide assistance to the ACCHS in co-ordinating QUM services to clients and staff;
- Deliver peer education produced by the Pharmaceutical Society of Australia (PSA) to local community pharmacies to increase awareness of cultural safety and communication issues for Aboriginal and Torres Strait islander peoples presenting at community pharmacies;
- Provide assistance to ACCHSs and their clients in accessing other community pharmacy programs as required (eg diabetes and asthma subsidy programs and Home Medicines Reviews);
- Provide quarterly progress reports to the National Secretariat of the Pharmacy Guild with assistance from the Branch Director; and
- Participate in education activities relevant to the QUMAX Program.

QUMSPs will provide up to 10 days per year in support services to each participating ACCHS (including approximately 2-3 visitations per year as required).

Community pharmacies may be contracted to deliver this service if, for example, distances are too great or in cases where there is a single obvious provider preferred by the ACCHS.

In the event that a branch is unable to recruit a qualified pharmacist to fill the role of QUMSP, they may appoint a person who has adequate experience/qualifications that fulfils the job
description criteria. In the event that this occurs, the QUM person should seek input from a qualified pharmacist when necessary, for example in delivering education on medicines use.

4.3 Community Pharmacies

Community pharmacies participating in the Program will provide more patient focussed and culturally appropriate services for ACCHSs and their clients, which will include the following:

a) liaising with the ACCHS and the QUM Support Pharmacist to assist in implementing the QUM work plan;

b) ensuring eligible clients' PBS safety net records are up to date, to ensure full entitlements are paid;

c) streamlining medicines transport arrangements with ACCHSs and/or clients;

d) provision of a range of medication compliance improvement interventions including the provision of DAAs where appropriate;

e) working with ACCHS staff on systems to reduce financial barriers to medicine access for disadvantaged clients;

f) assisting in enrolling diabetic clients in the National Diabetes Services Scheme (NDSS) and informing the ACCHS of the Asthma Spacer Ordering Scheme (ASOS); and

g) working with medical practitioners in the ACCHS to provide Home Medicines Reviews for clients where appropriate.

4.4 NACCHO

NACCHO is responsible for working with the Guild in all aspects of the Program.

With the assistance of its State Affiliates, NACCHO will provide information to and recruit eligible ACCHSs into the Program.

NACCHO will maintain the online QUMAX communication, registration and workplan management system and will develop and enhance this system by incorporating a searchable cultural training inventory.

NACCHO is the key contact point for NACCHO State Affiliates and ACCHSs eligible for and/or enrolled in the Program, regarding any aspect of the Program including guidance on the development of QUM Work Plans.

NACCHO is responsible for the disbursement of funds to their State Affiliates to cover administrative costs associated with activities carried out by the Affiliates. An administrative arrangement between each party will form the basis for the provision of these funds.

4.5 NACCHO State Affiliates

NACCHO State Affiliates will assist NACCHO at a local level within ACCHSs to disseminate information on the Program and provide guidance to ACCHSs in the implementation of the Program.
The State Affiliate will work with the QUMSP and NACCHO to:

a) assist in developing the ACCHS QUM Work Plan;

b) provide advice to ACCHSs in the development of key policies and processes required for successful integration of the QUMAX Program in current processes;

c) review QUM Work Plans to ensure QUM opportunities are maximised at a state level; and

d) assist NACCHO with problem solving, feedback and monitoring of the Program by engaging with individual ACCHSs.

e) Provide advice regarding Cultural Training Activity and update CST Inventory

In the event that a State Affiliate is unable to participate, NACCHO will engage an alternate provider from the sector to fulfil these state-wide services.

4.6 ACCHSs

ACCHSs registered to participate in the Program will be responsible for working with their QUMSPs and State Affiliate to develop QUM Work Plans. Sections 9 and 10 respectively outline the process to be followed in developing QUM Work Plans and entering into a contract with the Guild.

The ACCHS will then work with the QUMSP, State Affiliate and participating community pharmacies to implement the activities included in the Work Plan.

5. ELIGIBILITY

5.1 ACCHSs

ACCHSs located in rural and urban areas are eligible to participate in the Program, if they meet the following criteria:

a) Previously registered in QUMAX program for Year 1 and/or Year 2

b) adhere to these Program Business Rules and Guidelines and the service-level QUM work plan.

5.2 Pharmacies

The sole criterion for community pharmacy involvement in the Program is agreement of the community pharmacy to adhere to the Program Business Rules and Guidelines.

5.3 ACCHS Clients

The Program's target group is registered clients of participating ACCHSs who identify themselves as an Aboriginal or Torres Strait Islander person, or a member of that Aboriginal or Torres Strait Islander person's family group.
Client eligibility for financial assistance under MAAPs:

This will be assessed by the prescriber within the ACCHS on an individual and per consultation basis, and must be restricted to clients where:

a) a clinical decision to prescribe a PBS medicine for the person has been made by a registered medical practitioner;

b) it is the view of the prescriber that significant adverse health outcomes may result from the failure of the person to take the prescribed medicine, and the person is unlikely to comply with their medicines regime without assistance;

And

c) either
   i. the person is currently holding a concessional entitlement card for PBS benefits, or is eligible to receive such benefits;

Or
   ii. the person is not currently holding a concessional entitlement card for PBS benefits, and is not eligible to receive such benefits, but the clinical consultation with a prescriber indicates one of the following sub-criterion are met:
       - a history of evidence of foregoing medicines;
       - evidence that health is failing because of non-compliance with medicines;
       - social and/or legal obligations for a large family including guardianship of children; or
       - existence of co-morbidities and need for three or more prescribed medicines.

Note that the requirement for financial assistance cannot be carried over from one consultation to the next. The client's need must be assessed by the prescriber at each consultation.

6. ACCHS PROGRAM REGISTRATION PROCESS

The ACCHS is required to complete a registration form which is available online at www.naccho.org.au. The registration form must be fully completed by designated ACCHS staff and authorised by the CEO of the ACCHS.

7. BUDGET ALLOCATION

Once the ACCHS registration form is completed, the Guild and NACCHO Program Managers will determine the MAAPS budget allocation for that ACCHS based on the following Budget algorithm:

\[
\text{MAAPS Budget per ACCHS} = \$10,000 + \left\lfloor \frac{a}{b} \times (\$1,573,250 - \frac{c}{10,000}) \right\rfloor
\]

where:

a = number of registered clients in the ACCHS i.e. total number clients who have attended the ACCHS in previous 12 months

b = total number of registered clients across participating ACCHSs
c = number of ACCHSs registered to participate in the QUMAX Program

Note: Any DAA MAAP funds allocated to individual ACCHs which remain unspent at the end of Year 2 of the Program will be rolled over into the DAA budget for those ACCHs for use in Year 3. This will be in addition to funds to be allocated for Year 3 of the Program.

The NACCHO QUMAX Program Manager will notify the ACCHS of its overall annual budget for participation in the Program. The budget allocation will be dedicated entirely to the MAAPS component of the QUM Work Plan.

8. QUM WORK PLANS

A customised package of interventions will be developed within each ACCHS under Quality Use of Medicines (QUM) work plans.

Following registration and Budget allocation, each ACCHS will complete its QUM Work Plan in consultation with its QUMSP and assistance from the NACCHO State Affiliate contact person.

The QUM Work Plan template is divided into the following sections:
  a) Policy and protocol development
  b) QUM Support Pharmacist and Pharmacy support
  c) QUM Devices
  d) Provision of Dose Administration Aids (DAAs)
  e) QUM education
  f) Cultural awareness training
  g) Transport support

The Medication Access and Assistance Packages (MAAPs) components of the QUM Work Plan template are as follows:
  • QUM Devices – Asthma Spacers, Nebulizers etc
  • Provision of Dose Administration Aids (DAAs) to eligible clients
  • QUM Education – educational initiatives to be supported in the ACCHs
  • Transport Support – transport arrangements to ensure QUM uptake by patients.

Each ACCHS must document activity to be undertaken:
  a) in each section of the QUM Work Plan template; and
  b) for each of the MAAPs components.

QUM Work Plan approval process

Each ACCHS QUM Work Plan, including the budget allocations for each of the MAAPs components, must then be submitted to the Guild and NACCHO through the NACCHO QUMAX website. They will be assessed and approved by the NACCHO and Guild National Program Managers.

9. PROCESS FOR ACCHS IN ESTABLISHING SERVICE LEVEL CONTRACTS WITH THE GUILD

Following approval of the QUM Work Plan, a standard Contract which has been approved by the Department, will be provided to the ACCHS by the Guild. The Contract will include a fixed budget, and will detail the budget allocations for each of the MAAPs components as set out in
the approved ACCHS QUM Work Plan. The contract will run for a one year period from 1 July 2010 to 30 June 2011.

The CEO of the ACCHS and Executive Director of the Guild will be required to sign the contract with a copy to be kept by each party.

10. IT SUPPORT SYSTEMS

NACCHO registration and QUM Work Plan site

The online NACCHO System will provide a mechanism for:
   a) ACCHS registration at the commencement and throughout the Program;
   b) the exchange of ideas between ACCHSs, QUMSPs and State Affiliates on QUM Work Plans;
   c) the development of QUM Work Plans; and
   d) a general communication tool for the ACCHS sector, State Affiliates and QUMSPs.

QUMAX IT System

The QUMAX IT System will provide a mechanism for:
   a) registration and maintenance of pharmacy participant details and patient participation details;
   b) the maintenance of ACCHS participant details;
   c) allocation of funding to the participating ACCHS including total funding allocation per ACCHS, and funding allocation at ACCHS level to each MAAP component;
   d) allocation of DAA MAAP components to patients by each participating ACCHS, using a unique identifier;
   e) entry of MAAP authorisation number (for patients) for verification by participating pharmacies;
   f) collation of end of period claim documents for participating pharmacies, verification and approval of end of period claims by the Guild;
   g) reporting results of end of period claim payments to participating pharmacies;
   h) reporting MAAPs expenditure to each ACCHS
   i) program progress reports to stakeholders;

A QUMAX IT System user manual will be available for reference by participants.

11. IMPLEMENTING AND MONITORING QUM WORK PLANS

Following the execution of the contract, the ACCHS, QUMSP, State Affiliate and community pharmacy will be required to implement the QUM Work Plan.

The Guild and NACCHO Program Managers will monitor overall progress made under the QUM Work Plans of all participating ACCHSs on a quarterly basis and will refer any issues of concern to the Program Reference Group for advice.

12. PROCESS FOR ISSUING MAAPS TO CLIENTS FROM 1 JULY 2010

The prescriber considers the patient’s requirements for financial assistance at the specific consultation and, if appropriate, authorises a MAAP for the patient. This may include a combination of some of the MAAP components as described in Part 8 above ie DAA and/or travel.
The prescriber will annotate the prescription by use of a blue DAA MAAP rubber stamp (on original and duplicate) indicating that a DAA is required. This provides the pharmacist with a visual request when presented with the prescription.

The detail of the DAA MAAP authorised is entered onto the QUMAX IT system by trained staff within the ACCHS and a QUMAX DAA MAAP approval number is issued to identify the detail of the DAA MAAP. The remaining funds available in the ACCHS’s DAA MAAPS funding allocation is adjusted within the QUMAX IT system for the ACCHS accordingly.

In the event that financial assistance for multiple DAs MAAPs has been authorised, the total number of supply episodes authorised for all DAs MAAPs for which the patient will receive financial assistance will also be entered into the QUMAX IT system by the ACCHS staff.

The approval number issued is transcribed onto the original and duplicate section of the prescription by the prescriber or designated staff member, so that the pharmacy can locate the DAA MAAP details within the QUMAX IT System. Accessing this number will reveal the content detail of the MAAP authorised and be used in the pharmacy claiming process.

Full details on how to issue a DAA MAAP for a patient will be set out in the QUMAX IT System user manual.

Co-payment for PBS medicines issued with a MAAP number prior to 30 June 2010 and associated repeats will be honoured in full and claimed through the 4CPA IT system for the life of the life of the prescription – until 30 June 2011 (these will continue to present with a Red MAAP stamp).

13. PHARMACY DISPENSING PROCESSES UNDER THE QUMAX PROGRAM

Dispensing processes are to be followed as per normal procedure with the pharmacy providing any requested MAAP components including PBS Safety Net entitlement monitoring and provision of a DAA at the point of dispensing.

The pharmacy is required to enter the MAAP number into the QUMAX IT system to reconcile the services provided so as to ensure that MAAPs budget recorded in the QUMAX IT system for the ACCHS is kept up to date.

14. PAYMENTS TO PHARMACIES AND ACCHSs FOR PROGRAM ACTIVITIES

Participating community pharmacies are required to make claims to the Guild for reimbursement of costs relating to the provision of MAAPS. Full instructions will be included in the QUMAX IT System user manual.

Claims relating to DAs will be made on a per supply basis, while payments for on-call allowances and transport assistance are made on a one-off basis.

Payments to community pharmacies will be processed by the Guild via the QUMAX IT system.

When transport assistance, QUM Education and QUM devices are provided by the ACCHS as opposed to the pharmacy, one-off payment/s to the ACCHS will be made based on an RCTI from the Guild.
Full instructions on how to make claims under the Program will be available in the QUMAX IT system user manual.

15. REPORTING REQUIREMENTS

15.1 Guild reporting requirements

In accordance with its contractual obligations under its Funding Agreement, the Guild will supply the Department with progress reports according to the contractual obligations. The provision of these reports will rely heavily on other participants meeting their reporting requirements to the Guild under the terms of their respective contract/administrative arrangement.

15.2 NACCHO reporting requirements

In accordance with its contractual obligations, NACCHO will provide the Guild with progress reports on the Program.

15.3 NACCHO State Affiliate reporting requirements

NACCHO State Affiliates will be required to report to NACCHO according to the terms set out in their administrative agreement with NACCHO. Informal verbal and written feedback may also be provided to assist NACCHO in meeting its reporting requirements to the Guild.

15.4 QUMSP reporting requirements

Under the terms of the MOU with the Executive Director of the Guild, QUMSPs will provide input into reports from the Guild State/Territory branch as per contractual arrangements.

15.5 Community pharmacies reporting requirements

Community pharmacies may be asked to provide feedback to the QUMSPs to assist them in reporting to the Guild.

15.6 ACCHSs reporting requirements

ACCHSs will be required to work within their approved budget allocation for each MAAPS component of their QUM Work Plan.

The QUMAX IT system, which will manage the movement of funds under the Program, will have the capacity to report on MAAPS budget allocations and expenditure and may be used by ACCHSs, the Guild and NACCHO in monitoring the Program.

16. CONFIDENTIALITY AND PRIVACY PROVISIONS

All parties are bound by the confidentiality and privacy requirements set out in the Funding Agreement and respective contracts.

Patient identifiable data is only available within the relevant ACCHS. De-identified patient and prescriber data will be available to the Department, NACCHO and the Guild for the purpose of carrying out their duties under the Program.
Signed written informed consent by prescribers and clients to allow the use of
de-identified data in the administration of the Program must be provided prior to participation
in the Program. Consent to participate in the Program can be withdrawn at any time, and if
this occurs then the automatic withdrawal from participation in the Program will apply.

The NACCHO Data Protocols¹ will be followed by all parties in the management and
evaluation of the Program.

17. GOVERNANCE ARRANGEMENTS

A Program Reference Group (PRG) with membership from the Department (Community
Pharmacy Branch and OATSIH), the Guild, NACCHO and the PSA is responsible for
overseeing the development and implementation of the Program.

¹National Data Protocols for the Routine Collection of Standardised Data on Aboriginal & Torres Strait Islander
Health, National Aboriginal Community Controlled Health Organisation, October 1997
Appendix K  Doctors Consent Form
CONSENT FORM FOR ACCHS PRESCRIBERS PARTICIPATING IN THE QUALITY USE OF MEDICINES MAXIMISED FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES (QUMAX) PROGRAM

Participation as a prescriber in the QUMAX Program is contingent on consent being provided for the Program administrators (employed by the Pharmacy Guild of Australia and by NACCHO) and the Program evaluators (Urbis Pty Ltd) to have access to two de-identified datasets:

- PBS data for patients of doctors participating in the QUMAX Program; and
- Prescribing and dispensing event data collected by the QUMAX IT system.

PBS Data
A major component of the QUMAX Program evaluation will be an analysis of the impact of the QUMAX Program on the utilisation of medicines under the Pharmaceutical Benefits Scheme (PBS). This analysis depends on access to PBS dispensing data linked to prescribers who are participating in the QUMAX Program.

A process for data extraction will be used whereby the relevant PBS records are selected by matching PBS records with Medicare Benefits Schedule (MBS) records, using a combination of provider number and consultation date as the link. In order to utilise this data linking process, authorisation under the National Health Act 1953 (the Act), by the Secretary of the Department of Health and Ageing must be obtained. The Program evaluators will be bound by the secrecy provisions of the Act. The data linking process will be carried out by the Department of Health and Ageing. Data will be extracted for the 12 month period prior to the implementation of the Program (to provide baseline information) and at six monthly intervals throughout the life of the Program.

Aggregated PBS data at the ACCHS level will be provided to the Program evaluators by the Department in a way that does not directly identify individual prescribers.

QUMAX IT system
The QUMAX IT system will be managed by the Pharmacy Guild of Australia. It will log the details of Medication Access and Assistance Packages (MAAPs) provided to patients of participating ACCHSs. The Program administrators (the Pharmacy Guild and NACCHO) and the Program evaluators will have access to de-identified data on the QUMAX IT system.

General
The Program evaluators will report the findings of all analyses in a way that does not directly or indirectly identify individual prescribers or ACCHSs to any third party.

The NACCHO Data Protocols\(^\text{\textsuperscript{*}}\) will be followed by all parties in the management and evaluation of the Program.

Further information on the data extraction and analysis process can be obtained via the Program administrators.

\(^\text{\textsuperscript{*}}\) National Data Protocols for the Routine Collection of Standardised Data on Aboriginal & Torres Strait Islander Health, National Aboriginal Community Controlled Health Organisation, October 1997
PRESCRIBER CONSENT FORM

I, Dr. ..........................................................................................................................

with 8-digit Provider Number............................................................................and employed by

........................................................................................................................ACCHS provide consent for the

Department of Health and Ageing to link my PBS prescribing records with MBS (Medicare Benefits

Schedule) records through the use of my provider number and consultation date, for the purpose of the evaluation of the QUMAX Program.

I also provide consent for the Program evaluators of the QUMAX Program to access de-identified aggregated PBS prescribing data, obtained through this linking process, for the purpose of evaluating the QUMAX Program.

I also provide consent for the Program evaluators, and Program administrators employed by the Pharmacy Guild of Australia and by NACCHO, to access de-identified data through the QUMAX IT System for the purpose of evaluating and administering the QUMAX Program.

I acknowledge my right to withdraw from participating in the QUMAX Program at any time, and that this must be done in writing. I understand that such written withdrawal would automatically rescind these consents.

Signed.....................................................................................................................

Print Name.............................................................................................................

Date.........................................................................................................................