Evaluation of the Medication Review Accreditation Incentives Program

Report

Prepared for

Australian Government
Department of Health and Ageing
GPO Box 9848
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June 2010
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Please note that, in accordance with our Company’s policy, we are obliged to advise that neither the Company nor any member nor employee undertakes responsibility in any way whatsoever to any person or organisation (other than the Department of Health and Ageing) in respect of information set out in this report, including any errors or omissions therein, arising through negligence or otherwise however caused.
Table 1: Acronyms and abbreviations used in this report

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>AACP</td>
<td>Australian Association of Consultant Pharmacy</td>
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<tr>
<td>AP</td>
<td>Accredited Pharmacist</td>
</tr>
<tr>
<td>ACH</td>
<td>Aged Care Home</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HMR</td>
<td>Home Medicines Review</td>
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<tr>
<td>MCQ</td>
<td>Multiple Choice Question</td>
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<tr>
<td>MMR</td>
<td>Medication Management Review</td>
</tr>
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<td>MRAI</td>
<td>Medication Review Accreditation Incentives</td>
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<tr>
<td>PhARIA</td>
<td>Pharmacy Access/Remoteness Index of Australia</td>
</tr>
<tr>
<td>QUM</td>
<td>Quality Use of Medicines</td>
</tr>
<tr>
<td>SHPA</td>
<td>Society of Hospital Pharmacists of Australia</td>
</tr>
<tr>
<td>RMMR</td>
<td>Residential Medication Management Review</td>
</tr>
<tr>
<td>The Department</td>
<td>The Australian Government Department of Health and Ageing</td>
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<tr>
<td>The Guild</td>
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Executive Summary

The Medication Review Accreditation Incentives (MRAI) Program was introduced in 2006 under the Fourth Community Pharmacy Agreement to encourage development of the workforce of Accredited Pharmacists who can undertake Medication Management Reviews (MMRs).

The Residential Medication Management Review (RMMR) Program provides funding for MMRs to be conducted for permanent residents of Australian Government funded Aged Care Homes. The Home Medicines Review (HMR) Program provides funding for MMRs to be conducted for people living in the broader community.

Both the RMMR and the HMR Programs require that the MMRs are undertaken by a registered pharmacist who has been assessed as meeting profession-based competency standards to undertake MMRs. These pharmacists are referred to as Accredited Pharmacists. Accreditation can be attained through either the Australian Association of Consultant Pharmacy (AACP) or the Society of Hospital Pharmacists of Australia (SHPA). Nearly all Accredited Pharmacists have gained accreditation through the AACP.

The MRAI Program comprises two types of incentive payments to individual pharmacists:

- a payment of $1,500 for obtaining initial accreditation
- a payment of $750 for undertaking an annual re-accreditation.

Expenditure on incentives has been $7,376,250 up until March 2010: $3,442,500 in initial accreditation payments, $3,933,750 in re-accreditation payments. In addition to the MRAI Program, funding of $1.32 million has been allocated to the AACP to maintain and enhance the credibility and robustness of the accreditation process managed by the AACP.

This report presents the findings of an Evaluation of the MRAI Program and funding to the AACP. The evaluation was conducted in 2009 by Campbell Research & Consulting (Campbell Research) on behalf of the Department of Health and Ageing (the Department). Campbell Research conducted this evaluation concurrently with the evaluation of the Residential Medication Management Review Program.

The evaluation comprised consultation with key stakeholders, organisations, in-depth interviews with Accredited and non-Accredited Pharmacists, analysis of de-identified data from the Department for Incentive claims, online surveys of Accredited Pharmacists and non-Accredited Pharmacists and case studies of non-Accredited Pharmacists from rural and remote regions.

Key Findings

1. Accreditation Incentives have had a modest influence in increasing the Accredited Pharmacists workforce.

The stakeholder consultation, in-depth case studies and surveys identified that the fiscal incentives offered under the MRAI Program have been an enabling factor and have been associated with an initial marked increase in the Accredited Pharmacist workforce. Re-accreditation incentives feature as an important element in workforce retention, particularly in rural and remote areas.
The incentives, while influencing the take-up of accreditation, have not been the primary driver or motivation for becoming accredited. The main drivers for becoming accredited as reported by pharmacists were a commitment to professional service and an interest in clinical pharmacy. Owners of pharmacies reported that being accredited to conduct medication reviews helped their business.

Most (82%) Accredited Pharmacists indicated that they would have become accredited without the incentive. Fewer (61%) indicated they would maintain their accreditation without the incentive payment.

The number of pharmacists accredited by the AACP increased from 1,600, before the Program was introduced, to 1,833 in October 2007. The numbers declined to 1,792 in April 2009 but have been increasing since then to 1,871 as at March 2010. There has been a net increase in workforce of 271 Accredited Pharmacists over the duration of the MRAI Program.

Consultation with stakeholders did not identify similar incentives in place for other health professionals to undertake competency based training.

2. There has been a higher utilisation of incentives (particularly for re-accreditation) outside the PhARIA 1 regions.

Pharmacists in rural/remote areas identified different barriers to becoming accredited than did their metropolitan colleagues. Locum and travel support were particular issues for non-metropolitan pharmacists.

There was a higher proportion of expenditure on initial accreditation payments by Accredited Pharmacists in more rural and remote regions (PhARIA 4 – 6) compared to the distribution of pharmacies. There was a lower proportion of initial accreditation payments in PhARIA regions 2 and 3. Accredited Pharmacists outside PhARIA 1 were more likely to have received re-accreditation payments. Payment of incentives reflected the distribution of the population of states and territories.

3 Providing an incentive in part addresses some of the barriers to accreditation and providing medication reviews.

A key element in the decision to become accredited is the opportunity for a pharmacist to become a RMMR Provider. There were pharmacists who had become accredited but did few or no RMMRs, often because that they were unable to secure the opportunity to provide RMMRs because major RMMR Providers were servicing their areas and they worked independently of these RMMR Providers.

It was found that accreditation incentives typically did not cover the cost of becoming accredited, although it was understood that it was not intended to cover all such costs. Lack of time and perceived lack of business opportunities (following accreditation) were barriers that are not addressed by the incentive payment. Pharmacists were generally willing to pay for some of the costs associated with accreditation because they were committed to the development of their own clinical pharmacy skills.
Accredited Pharmacists appreciated having the incentive to help neutralise costs; especially pharmacists working in remote regions who had additional expenses related to travelling costs to attend training and high costs of obtaining locum pharmacists to cover their absence (this was especially relevant for pharmacy owners and solo pharmacists). The amount of the incentive was identified as a barrier to accreditation by just over one third of non-Accredited Pharmacists. Some pharmacists were unable to cover the extra costs themselves and were deterred from completing accreditation.

4. **Funding of the AACP has enabled improvements to the Accreditation Program, particularly in regard to the development of training and assessment.**

The second component of this evaluation related to the funding of $1.32 million allocated to the AACP to support the Accreditation Program under the Fourth Community Pharmacy Agreement. The funding has made it possible for a number of improvements to be made to the delivery of the Accreditation Program:

- A substantial upgrade of the rigour and integrity of the process through the funding of the development of additional questions for the Multiple Choice Question (MCQ) bank
- The development of 50 new case studies
- An upgrade of the Information Technology system which supports the MCQ component of the process.

In addition, support for Accredited Pharmacists, and those wishing to become accredited, has been provided through the AACP website, e-mails and newsletters. Education sessions have been provided at professional conferences, material has been made available to support the Quality Use Medicines component of the RMMR program in aged care homes, and other work has been conducted with the National Prescribing Service and the Pharmacy Guild to develop material to inform Medication Management of diabetes and asthma.
1. **Background**

The Australian Government and the Pharmacy Guild of Australia have entered into agreements known as Community Pharmacy Agreements since 1990. These agreements have been developed to include the provision of professional pharmacy programs and services.

Medication Management Reviews (MMRs) undertaken by pharmacists have been developed in Australia to improve the safety and quality use of medicines for consumers. MMRs aim to enhance the Quality Use of Medicines, reduce the number of adverse drug events experienced by the elderly and others using multiple medicines, and assist consumers to manage their medicines.

Funding has been provided under the Community Pharmacy Agreements for MMRs. The Residential Medication Management Review (RMMR) Program provides funding for MMRs to be conducted for permanent residents of Australian Government funded Aged Care Homes. The Home Medicines Review (HMR) Program provides funding for MMRs to be conducted for people living in the broader community.

Both the RMMR and the HMR Programs require that the MMRs be undertaken by a registered pharmacist who has been assessed as meeting profession-based competency standards to undertake MMRs. These pharmacists are referred to as Accredited Pharmacists. Accreditation can be attained through either Australian Association of Consultant Pharmacy (AACP) or Society of Hospital Pharmacists of Australia (SHPA) after assessment of competence following a prescribed course of study. The accreditation pathway and costs of accreditation differ depending on whether a registered pharmacist decides to undertake accreditation through the AACP or SHPA. Detailed information on the different pathways and associated costs is at Appendix A.

Experienced registered pharmacists undertaking the accreditation process through the AACP will initially participate in a preparatory course. The assessment process incorporates three case studies and 50 multiple-choice questions (MCQs) to test the underlying clinical knowledge required to conduct MMRs. The process can take up to 12 months. Costs payable to AACP total approximately $1,000. Additional costs of up to $1,200 can be incurred undertaking a preparatory course offered by a number of providers.

Accreditation through SHPA requires the pharmacist to have two years of pharmacy experience, be participating in a continuing professional development program and complete relevant competency based assessment. The competency based assessments are programs conducted from the United States of America, which require payment of approximately $US1,850. SHPA accreditation fee is $220 for SHPA members and $330 for non-members.

Nearly all pharmacists have gained accreditation through the AACP.

The Australian Government has supported the accreditation of pharmacists through the Medication Review Accreditation Incentives (MRAI) Program. The MRAI Program commenced on 1 December 2006 under the Fourth Community Pharmacy Agreement for accreditation and re-accreditation from 1 April 2006.
There are two types of incentives under the MRAI Program: an initial payment of $1,500 for pharmacists being accredited for the first time and an annual payment of $750 for pharmacists who maintain their accreditation.

1.1 MRAI objectives

The primary objective of the MRAI Program is to increase the number of Accredited Pharmacists and thus improve consumer and Aged Care Home resident access to MMR services throughout Australia.

1.2 Evaluation objectives

The objectives of this evaluation were to:

- gain an understanding of the MRAI Program and the Funding to the AACP – with a particular focus on gathering information on accreditation processes and how accreditation influences the uptake of the Home Medicines Review and Residential Medication Management Review Programs
- inform barriers and enablers to these initiatives – with a particular focus on what encourages or discourages participation and areas for improvement
- review the current funding model for these initiatives – with a particular focus on the Program inputs and outputs and informing future directions; and
- inform the benefits of these initiatives – with a particular focus on identifying what the key benefits are, who benefits most, what are the potential gaps and what are the potential barriers to achieving these benefits.

In order to meet these objectives Campbell Research designed an evaluation framework and methodology that was focussed on identifying the perspectives of key stakeholder representatives, the views of pharmacists in community pharmacies (who may or may not have been accredited) as well as those who work as independent Accredited Pharmacists.

1.3 Key evaluation questions

The specific questions addressed included:

- What difference do incentives for accreditation make to the workforce?
- Has the number of Accredited Pharmacists increased since the beginning of the MRAI Program?
- What is the distribution of Accredited Pharmacists throughout Australia?
- How many Accredited Pharmacists actually perform reviews and how many do they perform?
- Does the incentive cover the costs of accreditation?
- Does providing an incentive address the barriers to accreditation and providing medication reviews?
- Are accreditation incentives the best way to encourage pharmacists to attain accreditation and conduct medication reviews?
What impact does funding provided to AACP have on the credibility and robustness of the accreditation process?

1.4 The context for this evaluation

The MRAI Program commenced in December 2006 for accreditation and re-accreditation from 1 April 2006. The Program provides incentives for pharmacists to become accredited and to remain accredited.

There are two types of incentives under the MRAI Program:

- an initial payment of $1,500 for pharmacists being accredited for the first time – described throughout this report as the ‘initial accreditation payment’
- an annual payment of $750 for pharmacists who maintain their accreditation – described throughout this report as the ‘re-accreditation payment’.

The MRAI Program aims to increase the number of Accredited Pharmacists and thus to improve access of consumers to MMR services throughout Australia.

The Department of Health and Ageing (the Department) commissioned Campbell Research & Consulting (Campbell Research) to undertake an evaluation of the MRAI program including consideration of the role of funding to the AACP to support accreditation of pharmacists to conduct MMRs.
2. Methodology overview

Campbell Research designed an evaluation framework and methodology focused on identifying the perspectives of key stakeholder representatives, the views of pharmacists and an analysis of the trends in the number and distribution of Accredited Pharmacists. Detail of the methodology is found in Appendix B.

Stakeholder consultation was conducted with peak bodies and professional associations including the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia, the Australian Association of Consultant Pharmacy and the Society of Hospital Pharmacists of Australia as well as representatives from Medicare Australia.

In-depth interviews were conducted with a total of 34 Accredited Pharmacists and non-Accredited Pharmacists in various parts of Australia covering PhARIA regions 1 to 6. A number of these interviews were conducted in parallel to fieldwork conducted for an evaluation of the RMMR Program.

The Department provided de-identified data for claims by pharmacists for payment under the Program which was analysed in a number of ways including by PhARIA region.

An online survey of 338 Accredited Pharmacists was conducted in conjunction with the survey undertaken for the RMMR Program evaluation. A module was included in that survey for Accredited Pharmacists, addressing the objectives of the MRAI Evaluation. The survey was distributed through the AACP. The survey included questions relating to:

- The pharmacist's role in the pharmacy sector including years of experience, position
- Whether the Pharmacist was accredited to conduct Medication Reviews
- Awareness of the availability of incentives for accreditation and re-accreditation
- Perceptions of the sufficiency of the incentives to cover costs associated with accreditation (for those currently accredited)
- Quantity of MMRs conducted (for those currently accredited)
- Intention to become accredited and conduct MMRs in the future (for those not currently accredited).

An online survey of 260 non-Accredited Pharmacists was conducted to identify motivators and barriers to accreditation and the extent to which the incentives under the MRAI Program are sufficient to overcome the barriers. This survey was distributed through both the AACP (to its associate member base) and the Guild.

A series of five case studies was also conducted with pharmacists in rural and remote PhARIA regions (4, 5 and 6) who were not accredited.
3. Findings

3.1 Impact of incentives for the workforce of Accredited Pharmacists

Most (82%) Accredited Pharmacists indicated that they would have become accredited without the incentive. Fewer (61%) indicated they would maintain their accreditation without the incentive payment.

The majority (82%) of Accredited Pharmacists who had claimed the initial accreditation payment indicated that they would have become accredited without this payment (Figure 1).

**Figure 1: Impact of payments on initial and re-accreditation**

A small proportion of Accredited Pharmacists, just under one in five (18%), indicated they would not have become accredited without the incentive payment (7%) or were not sure if they would have become accredited (11%)  

The impact of the incentive on maintaining accreditation was more substantive. Close to two in five said they would not (16%) or were not sure (24%) if they would become reaccredited without the incentive payment.

Consultation with stakeholders did not identify similar incentives in place for other health professionals to undertake competency based training.
3.2 Increased numbers of Accredited Pharmacists

There was a substantial increase in the number of Accredited Pharmacists following the introduction of the MRAI Program in 2006. The initial increase was sustained until 2008, when the number of Accredited Pharmacists in Australia reached a plateau. There has been a net increase of 271 Accredited Pharmacists since the MRAI Program commenced.

In March 2010 there were 1,898 Accredited Pharmacists in Australia (Figure 2). Nearly all (1,871) were accredited by the AACP and 27 were accredited by the SHPA.

Figure 2: Number of Accredited Pharmacists in Australia

The number of Accredited Pharmacists accredited by the AACP increased markedly during two key time periods: during the early years of the accreditation program, and immediately following the introduction of the MRAI Program.
The varying rate of increase identified in Figure 2 comprises:

1. The number of Pharmacists accredited by AACP in Australia increased steadily from April 2002 (1,048) to April 2004 (1,596)
2. Following this period of relatively rapid increase, growth in the number of Pharmacists accredited by AACP rose more slowly from 1,560 in July 2004 to approximately 1,600 in January 2006
3. Incentives under the MRAI Program were announced in April 2006. The introduction of the MRAI Program was followed by a brief increase in the growth of pharmacists accredited by AACP in Australia from approximately 1,600 in April 2006 to 1,833 in October 2007
4. After the initial increase following the introduction of the MRAI Program, the number of Pharmacists accredited by AACP declined slightly from 1,833 in October 2007 to 1,792 in April 2009
5. The numbers have been steadily increasing since April 2009.

3.2.1 MRAI claims 2007-2010

In total 7,540 MRAI payments have been made up until March 2010 (Figure 3). 2,295 payments were made to pharmacists for initial accreditation, 5,245 for re-accreditation.

There was an initial backlog of 2,749 payments processed in February and March, 2007. These comprised 1,575 initial accreditation payments and 1,174 re-accreditation payments.

These payments represent a total expenditure of $7,376,250 up until March 2010: $3,442,500 in initial accreditation payments $3,933,750 in re-accreditation payments.

The number of incentive payments made to pharmacists each quarter varied between April 2007 and March 2010 (Figure 3).

There was an overall trend toward sustained growth in the number of re-accreditation payments during the period from April 2007 to March 2010, with payments rising from a low of 226 between July-September 2007 to a peak of 435 during April-June 2009 (Figure 3). This upward trend was briefly reversed for July-September (to 351), but then began a slow climb to 397 in January-March 2010.
3.3 Distribution MRAI claims

Based on analysis of claims data provided by the Department, the distribution of Accredited Pharmacists is similar to that of the Australian population in terms of both state, territory and PhARIA Region.

3.3.1 MRAI claims by state and territory

The analyses by state and territory are drawn from a de-identified dataset provided by the Department, for the period of January 2008 to May 2009. The data included information on the state or territory in which the pharmacist was located.

The number of claims made between January 2008 and May 2009 in each state and territory largely reflected the population of each state and territory (Figure 4). The exception is in Victoria where there is a lower proportion of accreditation claims (17%) and re-accreditation...
claims (22%) compared to the population of pharmacists\(^1\). Western Australia and South Australia had higher proportions of initial accreditation.

**Figure 4: Claims by State and Territory**

<table>
<thead>
<tr>
<th>State/Region</th>
<th>Initial Accrediation</th>
<th>Re-accreditation</th>
<th>Population</th>
</tr>
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<tbody>
<tr>
<td>NSW</td>
<td>35%</td>
<td>33%</td>
<td>31%</td>
</tr>
<tr>
<td>VIC</td>
<td>22%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>QLD</td>
<td>18%</td>
<td>19%</td>
<td>14%</td>
</tr>
<tr>
<td>SA</td>
<td>14%</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>WA</td>
<td>11%</td>
<td>7%</td>
<td>7%</td>
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<td>TAS</td>
<td>4%</td>
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<td>ACT</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
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<tr>
<td>NT</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
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Source: MRAI claim data provided by the Department, January 2008 – May 2009

Total: 1,949 claims for Accredited Pharmacists

270 claims for initial accreditation

15,367 Pharmacists in Australia

### 3.3.2 MRAI claims by PhARIA region

The number of claims made in each PhARIA region between January 2008 and May 2009 reflected the population of each region (Figure 5).

\(^1\) Population of pharmacist by state sourced from ABS Population Census cited in Human Capital Alliance *Pharmacy Workforce Study* (2008)
Expenditure on initial accreditation payments (Table 2) showed a higher proportion of initial accreditation by Accredited Pharmacists in more rural and remote regions (PhARIA 4 – 6) compared with the distribution of pharmacies. There was a lower proportion of initial accreditation payments in PhARIA regions 2 and 3.

Accredited pharmacists outside PhARIA 1 were more likely to have received re-accreditation payments.
### Table 2: Funding Allocation by PhARIA region January 2008 to May 2009

<table>
<thead>
<tr>
<th>Region</th>
<th>Initial accreditation payments</th>
<th>Re-accreditation payments</th>
<th>Total</th>
<th>Distribution of pharmacies²</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhARIA 1</td>
<td>82%</td>
<td>76%</td>
<td>77%</td>
<td>81%</td>
</tr>
<tr>
<td>PhARIA 2-3</td>
<td>11%</td>
<td>15%</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>PhARIA 4 - 6</td>
<td>7%</td>
<td>8%</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$402,000</strong></td>
<td><strong>$1,443,000</strong></td>
<td><strong>$1,845,000</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: MRAI claims made between January 2008 and May 2009

Note: Cases where the PhARIA region was not recorded have been excluded from the analysis by PhARIA and thus the total funding allocation does not match that of other analyses for this data set in this report.

### 3.4 Reviews conducted by Accredited Pharmacists

Six in ten Accredited Pharmacists conducted RMMRs in the last year. The number of RMMRs per pharmacist varies widely from 1 to 501. Half of Accredited Pharmacists reported conducting less than 100 RMMRs per year.

The survey of Accredited Pharmacists found that six in ten (60%) Accredited Pharmacists had conducted a RMMR in the last 12 months. The remaining 40%, whilst maintaining accreditation, had not conducted any RMMRs.

The number of RMMRs conducted by the 60% of Accredited Pharmacists who had done any in the last 12 months varied widely (Figure 6). As few as one RMMR had been conducted, whilst 17% of Accredited Pharmacists reported that they had conducted more than 500 reviews.

Close to a third (33%) of those Accredited Pharmacists who did reviews reported doing one RMMR a week or less (less than 50 RMMRs in a year).

On the other hand one in three (34%) reported doing upwards of 5 RMMRs a week, 250 or more a year (Figure 6).

---

Q11. In the last 12 months, approximately how many RMMRs did you conduct?
Base: Accredited Pharmacists who have conducted an RMMR in the last 12 months and provided a response n=203

### 3.5 Does the incentive cover the costs of accreditation?

From the Accredited Pharmacists point of view, the MRAI payment was stated to ‘neutralise’ the cost of becoming accredited, while not necessarily covering all costs of accreditation.

Costs associated with accreditation do act as a deterrent to accreditation for some non-Accredited Pharmacists. Approximately one third of non-Accredited Pharmacists who do not intend to become accredited state that they are dissuaded by the high cost and low incentive associated with accreditation.

Case studies and qualitative research revealed while the main driver in becoming accredited was not directly linked to the incentive, the MRAI payment helped to ‘neutralise’ the cost of accreditation.

Qualitative research with non-Accredited Pharmacists revealed that in general the incentive was viewed as adequate to cover costs incurred by the accreditation process for pharmacists.
working in metropolitan areas. However, this was not the case for pharmacists working in more remote areas. Pharmacists in rural areas reported that travel costs exceeded the amount of the incentive. Extra costs could also be incurred by missing out on days at work, or in the case of pharmacy owners in remote areas, paying for a locum to take their place.

From the survey of non-Accredited Pharmacists, it is known that some pharmacists perceive the accreditation process to be prohibitively expensive, and the MRAI incentive to be insufficient. Specifically, for non-Accredited Pharmacists who do not intend to become accredited:

- 35% stated that the incentive is insufficient to cover the costs of accreditation, thus dissuading them from seeking accreditation
- 30% stated that the accreditation process is too expensive in general.

### 3.6 Barriers to accreditation and provision of medication reviews?

The MRAI incentive goes some way to addressing some of the barriers to accreditation. However, Pharmacists identified that a lack of time was the most significant barrier to becoming accredited. Incentive schemes such as MRAI have limited capacity to address this barrier.

The cost of becoming accredited was the second most commonly identified barrier. Pharmacists identified that the MRAI incentives went some way to overcoming the costs associated with accreditation.

#### 3.6.1 Time, Money and Demand

The reason given most often by pharmacists for not being accredited currently was the lack of time for study and exams (54%). This was followed by insufficient incentive (35%) and accreditation being too expensive (30%) (Figure 7).

One quarter (25%) of the non-Accredited Pharmacists surveyed said they were currently in the process of becoming accredited (Figure 7).

Many pharmacists indicated they worked long hours and found it difficult to commit to the extra time required to become accredited. Some pharmacists said they would need to take time off work in order to complete the accreditation course. Loss of income was identified as a barrier. Some pharmacists interviewed in the qualitative research commented they did not see the incentive as being adequate financial compensation. There were others who thought they could fit in their study outside of work hours and not lose this extra income.
Figure 7: Reasons for not being accredited

Q7. What are the main reasons why you are not currently accredited?
Multiple response allowed
*Unprompted response
Base: Non-Accredited Pharmacists n=260

Lack of time was the main barrier to accreditation, mentioned by 47% of those intending to become accredited and 63% of those not intending to do so. For those who had made the decision to become accredited, cost and business opportunities were less important while the lack of time still stood out as the main barrier. Non-Accredited Pharmacists who did not intend to become accredited in the next 12 months were significantly more likely to identify insufficient incentive, the expense and lack of increased revenue as their reasons for not becoming accredited in the future (Table 3).
Table 3: Reasons for not being accredited by Intentions to become accredited in future

<table>
<thead>
<tr>
<th>Q7. What are the main reasons why you are not currently accredited?</th>
<th>Q8. Do you intend to become accredited in the future? …</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>Accredited Within Next 12 Months</td>
</tr>
<tr>
<td>(260)</td>
<td>(157)</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>No time for study / exams</td>
<td>54</td>
</tr>
<tr>
<td>Incentive is not sufficient</td>
<td>35</td>
</tr>
<tr>
<td>Too expensive</td>
<td>30</td>
</tr>
<tr>
<td>Not lead to increased revenue</td>
<td>17</td>
</tr>
</tbody>
</table>

Base: Non-Accredited Pharmacists n=260
Respondents answering ‘Don’t know’ to this question (n=22) have been excluded from this table

3.6.2 Barrier – limited awareness of incentives for non-Accredited Pharmacists

Most (76%) of the non-Accredited Pharmacists were aware that there is a financial incentive available for pharmacists who attain accreditation. However, fewer were aware (54%) that there is a financial incentive for pharmacists who renew their accreditation each year (Figure 8). However, close to a quarter (24%) of non-accredited pharmacists were either not aware (14%) or not sure (10%) about the availability of the incentives.
Figure 8: Awareness of Accreditation Financial Incentives

Q9. Were you aware that a financial incentive is available for pharmacists who attain accreditation?
Q10. Were you aware that a financial incentive is available for pharmacists who renew their accreditation each year?
Base: Non-Accredited Pharmacists n=260

Most (84%) of the non-Accredited Pharmacists who intend to become accredited in the next 12 months were aware of the financial incentive available for pharmacists who attain accreditation compared to 65% of those not intending to be accredited within 12 months.

3.6.3 Barrier—Limited ability to conduct RMMRs

Most (87%) of the non-Accredited Pharmacists had never conducted RMMRs. The reasons given most often for not conducting RMMRs were that other pharmacists hold the contracts as RMMR Providers (35%) and a lack of time (29%) (Figure 9).

It was common for one RMMR Provider to hold all the RMMR contracts for Aged Care Homes in particular areas. This was especially pertinent in more rural and remote areas due to the limited number of Aged Care Homes. RMMR work for new pharmacists looking to become accredited was seen to be difficult to find as a contract with an Aged Care Home needed to become available.

However, Accredited Pharmacists servicing multiple areas reported they felt overstretched at times and would appreciate the presence of other Accredited Pharmacists to share their workload. The Accredited Pharmacists desiring assistance tended to work as independent contractors or to work for smaller RMMR Providers.
Q23. Why is it that you have not conducted RMMRs?

Multiple response allowed

* Unprompted response

Base: Non-Accredited Pharmacists who have never conducted RMMRs n=227

Lack of time to conduct RMMRs should they be available was another important factor in not becoming accredited. Pharmacists working full time indicated they often work long hours and finding additional time to conduct RMMRs was viewed as too difficult, as well as spending the extra time on becoming accredited. Pharmacy owners who ran small businesses found it particularly difficult to imagine having the time to conduct RMMRs. Starting a business to conduct RMMRs would often involve hiring a new staff member to cover the extra workload and this did not always seem like a sound business decision in the instance where the pharmacy would not be guaranteed enough RMMRs to cover this cost.
3.7 Influence of incentives

Pharmacists identified that financial incentives do play a role in encouraging them to attain accreditation. However, financial incentives were not the primary motivator, suggesting the possibility of alternative strategies to encourage accreditation. Other strategies to encourage accreditation could include raising awareness of the availability of the incentives and promoting the value of accreditation to Pharmacists professional work.

3.7.1 Influence of incentives on accreditation for non-Accredited Pharmacists

Most (76%) of the non-Accredited Pharmacists said that the financial incentive would make it more likely they would apply for accreditation in the future — 32% a lot more likely, 44% a little more likely (Figure 10). One-fifth (21%) said that the incentives would have no influence on their decision regarding accreditation.

Figure 10: Influence of financial incentive on accreditation

Q11. Does the availability of these incentives make it more likely that you will apply for accreditation in the future?

Base: Non-Accredited Pharmacists n=260
Those planning to become accredited within 12 months were more likely to be influenced by the financial incentive than those not planning to be (Table 4).

<table>
<thead>
<tr>
<th>Table 4: Influence of financial incentive on accreditation by Intentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q11. Does the availability of these incentives make it more likely that you will apply for accreditation?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Total (260)</th>
<th>Accredited Within Next 12 Months (157)</th>
<th>Won’t be Accredited Next 12 Months (81)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot more likely</td>
<td>32%</td>
<td>43%</td>
<td>17%</td>
</tr>
<tr>
<td>A little more likely</td>
<td>44%</td>
<td>43%</td>
<td>42%</td>
</tr>
<tr>
<td>No effect</td>
<td>21%</td>
<td>14%</td>
<td>37%</td>
</tr>
</tbody>
</table>

Base: Non-Accredited Pharmacists n=260
Respondents answering ‘Don’t know’ to this question (n=22) have been excluded from this table

3.7.2 Influence of incentives on accreditation for Accredited Pharmacists

Accredited Pharmacists were also surveyed on their views of the incentive payments. The initial accreditation payment to become accredited did not have a significant influence on pharmacists in their decision to become accredited. However the re-accreditation payment was more often noted to have influenced their decision to remain accredited (Figure 11).
Seven in ten (70%) Accredited Pharmacists indicated that the initial payment did not influence their decision to become accredited although a minority (10%) reported it influenced them a lot. Over half (55%) of Accredited Pharmacists indicated that the re-accreditation payment influenced their decision to remain accredited - 23% were influenced a lot and 32% were influenced a little.

A number of Accredited Pharmacists expressed a different view in the course of the qualitative research. These pharmacists indicating that the incentives were unnecessary because medication reviews were a viable business option:

If you’ve got a structure that’s attractive as an alternative careers path, which this is… it’s an extremely attractive career path… why would you have to pay people to want to do it? You don’t pay physicians to become physicians. They’re physicians because they know that it’s an extremely attractive remuneration and very satisfying.

  Accredited Pharmacist

Asked if there was any instance when the incentive was important, the Accredited Pharmacist indicated that he did not believe so.

No, not really. I just reckon it’s wrong, it sends the wrong message…

  Accredited Pharmacist
I think it’s a waste of money.  

Accredited Pharmacist

Others indicated that the incentives were helpful but their focus was on the value of becoming accredited and not on the motivation provided by an incentive.

Accreditation gives you an extra cap. With pharmacy you do a degree and then that is it. Accreditation appeals because it makes the brain tick over. 

Case Study 1

3.7.3 Other factors affecting the decision to become accredited

Non-Accredited Pharmacists were asked about factors that would encourage them to become accredited and start conducting MMRs. The responses (Figure 12) mentioned most often were that a contract would need to become available for them to become a RMMR Provider (46%), the RMMR payment would have to increase (35%) and they would need more time (26%).

![Figure 12: Changes needed for non-Accredited Pharmacists to conduct RMMRs](image)

Q25. What would have to change in order for you to start conducting RMMRs?

Multiple response allowed

Base: Non-Accredited Pharmacists who would like to conduct RMMRs in the next 12 months n=147

Over half (57%) of the non-Accredited Pharmacists who were not intending to become accredited in the next 12 months said the RMMR payment would have to increase for them to start conducting RMMRs. This compares to 29% of those who were intending to be accredited within 12 months.
Almost half (46%) of those not intending to become accredited said they would need to source a replacement pharmacist to keep the pharmacy open compared to 11% of those who are intending accreditation within 12 months.

### 3.8 Impact of funding provided to AACP

Over the life of the Fourth Community Pharmacy Agreement (2005-2010), $1.32 million is allocated to the AACP through the HMR Program to help maintain and enhance the credibility and robustness of the accreditation process.

The intended project outcomes were:

- Maintenance and enhancement of the various elements of the assessment (e.g. multiple choice questions (MCQ) bank, case studies bank and other assessment modalities)
- Maintenance, development and monitoring of the quality assurance relating to the assessment marking and evaluation processes
- Maintenance, development and monitoring of the quality assurance relating to the accreditation of preparatory training Providers (stage 1)
- Ongoing provision and enhancement of a secure online capability to deliver the various aspects (MCQs, cases) of the MMR Credential
- Accreditation and re-accreditation supporting projects encompassing the development of specific resources e.g. AACP Procedures and Resources manual, MCQ Examination and Case Study Assessment guides, to assist pharmacists in becoming and remaining accredited
- Supporting administration, Program management including financial management, and communication and promotion.

The evaluation explored the extent to which the funding had enabled the outcomes to be met.

A number of interviews were conducted with representatives of the AACP. The AACP reported accreditation fees to be the primary means of funding internal operations of the AACP and this therefore limited the scope of what could be achieved in support of the accreditation process.

The accreditation process involves several components. The extent to which a candidate is required to complete the various processes varies according to whether they are becoming accredited for the first time or it is some time since they were initially accredited. In short, the requirements are more extensive upon initial accreditation and once again after a three year period, when a more detailed re-accreditation process must be undertaken. In the intervening first and second year of re-accreditation, there is a minimal requirement for Continuing Professional Development.

The AACP reported that the additional funding had enabled achievement of a range of improvements, specifically including:

3 State and territory legislation requires pharmacies to be open for specific hours. These regulations vary by state and territory.
• A substantial upgrade of the rigour and integrity of the process through the funding of the development of additional questions for the Multiple Choice Question (MCQ) bank.

• The development of 50 new case studies.

• An upgrade of the IT system which supports the MCQ component of the process.

The AACP confirmed that these improvements would not necessarily have been possible without the provision of the $1.32 million from the Fourth Community Pharmacy Agreement.

It would have been very difficult to afford this range of improvements without the additional funding from the Department. For example, we would not have been able to fund the costs of development of 50 new case studies.

AACP

Information was also provided to Campbell Research on the reasons why these improvements were of importance for the accreditation process.

The case study library needs to be quite extensive as we need to avoid collaboration between candidates. We had to remove a large number of case study scenarios from the library over the last year. In total, we like to have 25 case studies available for HMR and 50 for RMMR. It is also important that we have an up-to-date library which reflects best practice and the latest information. The case studies become out of date very quickly. The new case studies are much more relevant.

AACP

Without the additional funding, IT upgrades would be very limited. We have now been able to upgrade the marking process and we have taken the objectivity out of the marking system. Once we did that we were able to have the marking brought into line with the IT.

AACP

It was reported that the $1.32 million had been a valuable component in addition to the funding provided to the organisation for the Mentor Support Program – funded separately and not the subject of this evaluation. The two funding streams were seen as being complementary and bringing about a substantial improvement overall in the accreditation process.

The funding for the upgraded case studies and MCQ bank is considered valuable and enabling an enhancement of the robustness and credibility of the accreditation process. The increased relevance of case studies will engender a higher level of confidence in the value of accreditation.

3.8.1 AACP and QUM

The AACP also specifically commented on the important role played in terms of provision of QUM education and resources. AACP activities include:

• Providing case studies for assessment of pharmacists based on principles of QUM and candidates’ responses assessed on basis of QUM
- The maintenance of the AACP website containing information relating to QUM available to those seeking accreditation, conducting reviews and other interested parties

- The assessment of Stage 1 courses for accreditation which are submitted to the AACP for approval which must address principles of QUM

- The distribution of Email newsletters and a bi-monthly newsletter that contain QUM information and promote relevant QUM activities to Accredited Pharmacists

- The provision of educational sessions including two forums at Pharmacy Australia Congress and Australian Pharmacy Professional Conference and an annual conference ConPharm which are QUM activities involving lectures and workshops. Feedback and evaluation of these sessions is provided by participants and this contributes to planning for future events

- Involvement in the Pharmacy Guild Professional programs which is aimed at improving QUM in patients with diabetes and asthma

- Activity specifically under the RMMR Program where AACP provides information to Accredited Pharmacists relating to the provision of QUM activities in aged care facilities

- Promotion of the work of the National Prescribing Service as a Provider of QUM related activities to both consumers and health professionals and continues to work closely with the organisation to provide QUM related events to Accredited Pharmacists
4. Sample characteristics

This section presents the results of the two surveys: the survey of non-Accredited Pharmacists and the survey of Accredited Pharmacists.

4.1 Demographic and professional characteristics of survey respondents

Accredited Pharmacists had substantial experience in the pharmacy sector with the majority (73%) having at least ten years experience and one in five (19%) having more than 30 years experience. Only one in ten (13%) were recent graduates who had been in the industry for 1 to 5 years.

The Accredited Pharmacists tended to have more limited experience in the pharmacy sector. Four in ten (39%) of all the non-Accredited Pharmacists had only been working in the sector for one to five years (Figure 13).

Figure 13: Non-Accredited Pharmacists: Time in the pharmacy sector

Q2. How long have you been working in the pharmacy sector?
Base: Non-accredited Pharmacists n=260
Accredited Pharmacists n=338
The non-Accredited Pharmacists surveyed came from throughout Australia, most predominantly from New South Wales (32%), Victoria (23%) and Queensland (23%). The remainder were located in Western Australia (8%), South Australia (7%), and Tasmania (6%), 2% from the ACT and under 1% from the Northern Territory.

4.1.1 Location of pharmacy

Almost six in ten Accredited Pharmacists who responded to the survey, worked in Victoria (30%) or New South Wales (27%). Only a minority came from the Territories (Figure 14).

Figure 14: State of pharmacy

Q4. In what state or territory is your main office or pharmacy?
Base: Accredited Pharmacists n=338
Non-Accredited Pharmacists n=260

Metropolitan and non-metropolitan locations have all been represented throughout Australia (Figure 15):

- Almost six in ten (56%) Accredited Pharmacists were from a metropolitan area
- Two in ten (23%) were from a regional centre
- Two in ten (20%) were from a rural area
- A minority (2%) of Accredited Pharmacists worked in a remote area.
Q5. Is this office or pharmacy located in a metropolitan, regional centre, rural or remote area?
Base: Accredited Pharmacists n=338
        Non-Accredited Pharmacists n=260

Compared with those who intended to become accredited, non-Accredited Pharmacists who did not intend to become accredited in the next 12 months were more likely to be a pharmacy owner, have been in the industry for over 10 years and to have been accredited in the past. (Table 5). Pharmacists who had previously been accredited were more likely not to become accredited in the following 12 months.
Table 5: Profile of non-Accredited Pharmacists and their Intentions to become accredited

<table>
<thead>
<tr>
<th>Q3. Which of the following best describes your role as a pharmacist?</th>
<th>Total (260)</th>
<th>Accredited Within Next 12 Months (157)</th>
<th>Won’t be Accredited Next 12 Months (81)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Pharmacy Owner</td>
<td>29</td>
<td>13</td>
<td>57</td>
</tr>
<tr>
<td>Pharmacy Employee</td>
<td>49</td>
<td>58</td>
<td>32</td>
</tr>
<tr>
<td>Hospital Pharmacist</td>
<td>14</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td>Other/not currently in pharmacy</td>
<td>8</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Length of Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>39</td>
<td>53</td>
<td>17</td>
</tr>
<tr>
<td>6-10 years</td>
<td>14</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Over 10 years</td>
<td>47</td>
<td>30</td>
<td>72</td>
</tr>
<tr>
<td>Ever Been Accredited</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>No</td>
<td>95</td>
<td>99</td>
<td>90</td>
</tr>
</tbody>
</table>

Base: Non-Accredited Pharmacists n=260

4.1.2 Non-Accredited Pharmacists: Pharmacy location

Half (51%) of the non-Accredited Pharmacists surveyed worked in metropolitan pharmacies, a quarter (26%) in regional pharmacies, 21% in rural pharmacies and 2% in remote area pharmacies. Demographic and professional characteristics of Accredited Pharmacists
4.1.3 Year of accreditation

The year in which pharmacists became accredited to do medication reviews also demonstrates the breadth of experience of responding pharmacists (Figure 16):

- A quarter (26%) of pharmacists had been accredited for 1 to 3 years, that is between 2007 and 2009
- A quarter (26%) had been accredited for 4 to 7 years
- A quarter (26%) had been accredited for 8 to 10 years
- A fifth (22%) had been accredited for more than 10 years.

Q3. What year did you become accredited to do medication reviews?
Base: Accredited Pharmacists n=338
Non-Accredited Pharmacists n=260
4.1.4 **Intention to become accredited in the future**

Three in five (60%) of the non-Accredited Pharmacists surveyed said they intended to become accredited in the next 12 months (Figure 17). One in ten (12%) said they had no intention of becoming accredited.

**Figure 17: Intentions to become accredited in the future**

Q8. Do you intend to become accredited in the future?
Base: Non-accredited Pharmacists n=260
5. **Detailed Findings: Case Studies**

Five non-Accredited Pharmacists were interviewed to establish the factors that most influence pharmacists in becoming accredited, as well as the barriers that stood in their way, and the impact the accreditation incentive had on their decisions. The pharmacists all worked in remote locations (PhARIA regions 3-6) and faced more challenges regarding access to both training courses as well as RMMR contracts compared with their metropolitan colleagues.

Each case study presents a unique perspective on how becoming accredited may affect their professional role. Despite the fact that all these pharmacists worked in remote locations, their circumstances varied greatly and this affected their motivations to become accredited. The pharmacists ranged in age from early 20s to 60 years of age and experience in pharmacy from 1 to 40 years. The states and territories covered in these case studies were Queensland, Victoria, South Australia, Tasmania and the Northern Territory.

5.1.1 **Case Study 1**

Peter* has been working as a pharmacist for more than 5 years. He trained in his home state and worked for two years in a major city in another state before returning home, where he was employed in a hospital for one year before working in a community pharmacy. He has been working as a locum in a remote town, 50km from the nearest small regional centre, with a population of several thousand people.

Peter is in the last stage of completing his accreditation. He has been working on becoming accredited for a year and a half and says the biggest difficulty is finding time to complete his study. For over a year he has been working six days a week and setting aside a couple of hours each week to study. Peter finds study time consuming in addition to his heavy workload. He had aimed to become accredited by March but this has not been feasible (it is now November). Working as a locum in a small town which does not have the population to support employment of permanent pharmacists, he must continue working the long hours and spend less time on study.

Despite the lack of time available to Peter, he is dedicated to becoming accredited. He feels this is the next step he needs to take in becoming a good pharmacist.

> Accreditation gives you an extra cap. With pharmacy you do a degree and then that is it. Accreditation appeals because it makes the brain tick over.

Money does not motivate Peter’s interests in becoming accredited.

> Even if there was no money involved I would still want to do it.

Peter is concerned with providing a good service to his customers. He claimed that it is even more critical now to become involved with providing RMMRs and HMRs because the population is ageing and there will be no shortage of customers needing his skills. In addition, he thinks

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* All names and some details have been changed to protect confidentiality.
GPs are too busy to keep up with what they are prescribing to patients and that it is therefore important for pharmacists to become involved in medication reviews.

GPs are too busy, [They] find it too difficult to keep up with the changes in the medications they prescribe.

There is no Aged Care Home in the town where Peter works but there are homes in surrounding communities. Peter is fairly confident he would be able to find work in the surrounding areas, despite the fact that he knows a few Accredited Pharmacists are already providing RMMRs to the Aged Care Homes in these locations.

One pharmacist I know has a lot of contracts but he is palming these off and asking for help.

Peter believes that it would be especially easy to find work in providing HMRs as he finds it easy to establish good relationships with the local GPs and knows most of those working in the local communities.

We know each other, or each other’s friends. It makes life easier.

Peter is aware of the incentive payment to become accredited, although he would still become accredited without it, as he is confident that the resulting RMMR work would cover the costs of achieving accreditation. However, he believes the incentive does neutralise the cost of the course and makes managing his funds easier. Peter thinks that having the incentive is especially important for pharmacists with children and mortgages, even though this is not an issue for him as he works long hours to earn more money and has relatively low living costs as a single person in rented accommodation.

5.1.2 Case Study 2

Con* has been a pharmacist for 20 years, working in both hospitals and in community pharmacies. He has spent the last ten years as a community pharmacist in a small mining town, located 60 km away from the nearest regional centre. He is the only pharmacist in his town. The town has a population of a few thousand people and has no Aged Care Home, but two Aged Care Homes are located within 60 km in other regional communities.

Con has never been accredited and although he did start the accreditation course in 2001 he never completed the course as he claimed it took too much money and time. Studying Stage 1 of the accreditation course involved travelling a long distance in order to attend a training seminar. This involved shutting the pharmacy for the weekend, which not only cost him money but also inconvenienced the community. He did consider hiring a locum to allow for the pharmacy to remain open however this would have involved a fly in/fly out arrangement which would not have been economically feasible.

It was very difficult. A big effort [to attend the two day Stage 1 course].

Con had his pharmacy registered as an RMMR Provider but only received requests for five reviews. He considered it to be more viable to hire an accredited locum to conduct these reviews rather than go through the process and costs of personal accreditation as he felt there to be insufficient demand in the area to make accreditation worthwhile.
He also felt it was not viable to become accredited for HMRs. The town had been surviving on locum GPs for 18 months. None of these GPs were aware of patient history to the extent that they would order HMRs. They were busy, and were paying little attention to patient histories.

Con had previously tried to establish a branch of his pharmacy in a neighbouring community, which had an Aged Care Home. If this had been successful, it might have made becoming accredited and trying to conduct RMMRs worthwhile. It had been his intention to work in his second pharmacy for a couple of days per week providing community pharmacy services and potentially RMMRs to the local residents. However his business only survived in the community for three months due to unforeseen troubles he encountered in the town.

Con was unaware of the incentive offered to Accredited Pharmacists. He said it had not been offered when he considered accreditation. While it made the process of becoming accredited more appealing, it was not enough to motivate him to do so as there would not be enough work to sustain him. Things would be different if he had more access to Aged Care Home residents but this time the Aged Care Home would need to be in his own town as he was not willing to risk repeating his previous experience in his neighbouring town.

5.1.3 Case Study 3

Faye* is a pharmacist in her twenties, who has only been working in the industry for two years as a community pharmacist. She works in a country town several hundred kilometres away from the state’s capital city. The town where Faye lives has a population of fewer than 20,000. Due to the relatively large size of the town, there are plenty of pharmacists who share the work with Faye, meaning her longest working hours are 38 per week.

Faye is employed at a community pharmacy which supplies medications to the few Aged Care Homes in the area. Faye is not accredited nor are there Accredited Pharmacists in the pharmacy where she works. Faye is considering becoming accredited in the next two years.

Faye is interested in becoming accredited because she wants to conduct RMMRs one day, but she specifically does not wish to perform HMRs. She is interested in furthering her knowledge about medications and wants to work with GPs and nurses as she is interested in how they perform their roles. She would like to see the way things work in an Aged Care Home. She has had some experience in conducting HMRs whilst training to become a registered pharmacist, however, she was uncomfortable with the process as she did not like the concept of visiting patients in their homes.

I feel insecure going to a patient’s house alone.

Faye is not sure that she would be able to get enough work conducting RMMRs to make it worth her while becoming accredited. Currently only one pharmacist, who works as an independent RMMR Provider, services all four Aged Care Homes. The workload would have to be shared and she is unsure whether the independent pharmacist would be willing to do this as this is his main source of income. She does think it is a possibility though.

He is really busy so he might consider me.

Faye is unaware that an incentive for accreditation exists. The money however, is not important to her as she thinks the cost of accreditation is reasonable and easy to pay. She has very little
idea about the process of accreditation or the time involved. The actual process of accreditation is not much of a concern for her—her main motivator is being able to conduct RMMRs.

The main reason Faye is not considering accreditation within the next two years is because she feels fairly inexperienced in pharmacy. She wishes to gain more skills before embarking on what she perceives to be the next developmental challenge.

I want to work on my team skills and get used to the business a bit more, I'm not ready to become accredited.

5.1.4 Case Study 4

George* has been a pharmacist for 40 years, working both overseas and in Australia. He has spent the last 30 years working in Australia and has worked as a locum for the previous three years. He is currently employed as a locum in a town of just over 2,000 people, located 150km from the nearest large city. George works three days a week and has never owned a pharmacy.

George was last interested in becoming accredited four years ago. He started two training courses but never completed accreditation, finding the process too expensive and arduous. George dislikes that the cost of becoming accredited exceeds the cost of registering to be a pharmacist with the Pharmacy Board. He also resents that he would have to follow a similar process for reaccreditation annually. He is of the opinion that he should be able to sit a test once, pay once, and that this should allow him to remain accredited while he was a registered pharmacist.

There were so many hurdles and the expense was ridiculous.

The pharmacist George works for employs an Accredited Pharmacist from the closest city, on a contract basis to come down to conduct reviews at the one Aged Care Home in the area. The owner is too busy to think about becoming accredited himself or encouraging George to become accredited.

When describing the accreditation process as too expensive, George was unaware of the accreditation incentive. He became more enthusiastic about accreditation when he learnt of it.

An incentive makes a big difference, seems to throw off the financial hurdles. I will now reconsider becoming accredited as I was always interested in doing RMMRs.

George is also satisfied with the incentive being paid once accreditation is completed rather than upfront. He reasons that at least he would not end up out of pocket if he did not manage to get enough work in RMMRs once he became accredited.

George believes it would be relatively easy to obtain work providing RMMRs locally. He believes that he would be able to completely take over the contract from the visiting city-based Accredited Pharmacist, so he would be guaranteed a minimum number of RMMRs per year, which would make accreditation worthwhile.

Despite an increase in enthusiasm after hearing about the incentive, George remains rather cynical about the processes involved in conducting RMMRs and obtaining accreditation. He does not like the idea that RMMRs are paid to the RMMR Provider, which would be the
pharmacy owner in George’s case, rather than to the Accredited Pharmacist completing the reviews.

George believes that it is unnecessary to re-sit exams regularly.

Is it necessary to become reaccredited every twelve months? I don’t think these procedures help the health of consumers at all.

Despite his misgivings however, George is willing to consider accreditation as a result of the incentive being offered.

5.1.5 Case Study 5

Rob* is in his early twenties and has been working as a pharmacist for one year. He studied in a regional town in another state, and moved to work in a remote location with a medium-sized regional population. Rob currently divides his time between two pharmacies and works between 45 to 60 hours a week.

Rob moved to this regional location because the pay was higher than in a metropolitan location or in other states. The town he works in has a fairly large supply of pharmacists, with at least 10 others working in community pharmacy, and another 10 working at the local hospital. However, Rob chooses to work long hours to earn more income. He says that money is a primary motivating factor for him and as such, Rob is not currently considering becoming accredited because he can earn more in his current role.

With Rob’s long work hours, he feels he would lose a lot of profitable time by completing the accreditation course. His distance from a large city further complicates matters as he would need extra time to travel to the two day Stage 1 part of the course. Travelling for this, considering the availability of flights, could mean he would miss out on up to four days of work, which is very costly.

The dollar is the bottom line for me.

Rob is aware of the accreditation incentive, though he originally thought it was $600. He thinks that $1,500 is a good amount of money for people in metropolitan areas who earn less, as it neutralises their costs to become accredited. However, it is not enough to cover his costs, and warrant him missing out on four days of work. He would prefer the incentive to be on par with the amount of money he would earn if he didn’t have to take time off work.

The travel time wipes out the effects of the incentive.

In addition, when it comes to conducting RMMRs, Rob feels the pay per RMMR is very poor. If he worked in a metropolitan area and was paid less as a community pharmacist, he might consider providing RMMRs.

I earn three times the amount of an RMMR per hour. It would only be worth my while if I could conduct RMMRs quickly, and I’d want to do it properly so that would more likely take a while.

There are at least three Aged Care Homes in Rob’s area, and three pharmacists conduct the reviews for these homes. Only one of these pharmacists works in community pharmacy working
one day per week in this environment. The pharmacists who conduct RMMRs are managing very high workloads and they are currently looking to hire a fourth pharmacist to help them. Rob is certain there would be enough work in RMMRs, but he lacks the interest to sacrifice his pay in order to become a RMMR Provider.
6. Detailed Findings: MRAI Claims Data Analysis

Analyses presented in this section are based on de-identified data provided by the Department for the period January 2008-May 2009. Note that this detailed analysis is based on different data to that previously presented in this report which included claims made between April 2007 to December 2009 (see Figure 3).

In total, 2,219 MRAI claims were made between January 2008 and May 2009. 1,949 of these claims were made for the re-accreditation payments (Payment 2); the remaining 270 claims were made by pharmacists who had attained initial accreditation (Payment 1).

These claims represent a total spend of $1,866,750 over the period; $1,461,750 in maintaining accreditation, $405,000 in increasing the accreditation workforce. A tabulation of expenditure by state and territory is provided below (Table 6).

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Re-Accreditation</th>
<th>Initial Accreditation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>$486,750</td>
<td>$141,000</td>
<td>$627,750</td>
</tr>
<tr>
<td>VIC</td>
<td>$327,000</td>
<td>$69,000</td>
<td>$396,000</td>
</tr>
<tr>
<td>QLD</td>
<td>$269,250</td>
<td>$70,500</td>
<td>$339,750</td>
</tr>
<tr>
<td>SA</td>
<td>$174,750</td>
<td>$57,000</td>
<td>$231,750</td>
</tr>
<tr>
<td>WA</td>
<td>$98,250</td>
<td>$45,000</td>
<td>$143,250</td>
</tr>
<tr>
<td>TAS</td>
<td>$61,500</td>
<td>$12,000</td>
<td>$73,500</td>
</tr>
<tr>
<td>ACT</td>
<td>$34,500</td>
<td>$7,500</td>
<td>$42,000</td>
</tr>
<tr>
<td>NT</td>
<td>$9,750</td>
<td>$3,000</td>
<td>$12,750</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,461,750</strong></td>
<td><strong>$405,000</strong></td>
<td><strong>$1,866,750</strong></td>
</tr>
</tbody>
</table>

Source: MRAI claims made between January 2008 and May 2009
Appendix A: Pathways to accreditation and associated costs

The AACP accreditation process involves the following steps:

- **Stage 1 Preparatory Course**
- **Portfolio of experience – 200 points**
- **Release of 50 questions from the Multiple Choice Question bank. A 75% pass mark is required. The questions are completed in five sets of 10 questions**
- **Then two RMMR case studies and one HMR case study are required to be completed**
- **The candidate has 12 months to complete the initial accreditation process**
- **The incentive for becoming accredited is able to be claimed as soon as the pharmacist receives a certificate of accreditation.**

The re-accreditation process is a triennium. In Years 1 and 2, the pharmacist must achieve at least 40 points of recognised learning specific to medication reviews as part of a program of Continuing Professional Development. In the third year, they must also achieve 40 points for recognised learning – for a total of 120 over the three years. However in the third year they must also undergo additional testing.

The costs involved in the AACP accreditation process include:

- $585.75 for the assessment fee
- $412.50 which includes the Certificate of Accreditation, as well as membership fees for the AACP (all Accredited Pharmacists must also be members of the AACP)

There are further costs associated with Stage 1 Preparatory Course and these can range up to $1,200.

There is currently no charge for the MCQ question bank component of the testing.

Pharmacists may also become accredited through the SHPA. SHPA accreditation is based on evidence of registration, at least two years practice and participation in a continuing professional development program.

SHPA accreditation fee is $220 for SHPA members and $330 for non-members. Indicative cost for the CGP are $US998, and then examination application fee of $US600 and certificate fee of $US250 which provides certification for five years. SHPA reaccreditation costs are $110 to SHPA members and to non-members for $220

For accreditation through SHPA pharmacists must provide evidence of successful completion of competency based assessment. Presently these are:

- Certification as a Geriatric Pharmacy Specialist by the Commission for Certification in Geriatric Pharmacy (CGP).
• Certification as a Pharmacotherapy Specialist by the US Board of Pharmaceutical Specialties.

The CGP entails passing a multiple choice examination administered by the Commission for Certification in Geriatric Pharmacy in the USA. The cost to a pharmacist comprises fees charged by SHPA and fees for the certification.

The Certification as a Pharmacotherapy Specialist entails assessment using a multiple choice examination. The costs include an application fee of $US600, an exam fee of $400 and an annual fee of $100. Certification is for seven years.
Appendix B: Methodology

Stakeholder consultation

High-level input

Consultations for the evaluation of the MRAI program were undertaken in association with the evaluation of the RMMR program. Stakeholders included: Medicare Australia, the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia, the Australian Association of Consultant Pharmacy, the Society of Hospital Pharmacists of Australia.

Additional consultations were specifically scheduled for the MRAI evaluation, with:
- AACP experts who provide input to enhance the robustness and credibility of the accreditation process
- Australian Medical Association in regards to their comparable professional accreditation processes

Field visits

In-depth interviews with Accredited Pharmacists and non-Accredited Pharmacists were conducted as face-to-face interviews in association with the field work to be undertaken for the RMMR evaluation. An additional ten pharmacists were recruited specifically for the MRAI evaluation. The consultations focussed on identifying specific issues relating to motivations for accreditation and barriers to achieving and maintaining accreditation.

Campbell Research conducted face-to-face consultations with pharmacists in six locations across Australia. A small number of consultations were conducted via telephone to facilitate participation of all relevant parties.

Across all field visits, 34 in-depth qualitative interviews were conducted, comprising:
- nineteen Accredited Pharmacists
- five pharmacists at Aged Care Home supply pharmacies or RMMR Provider companies
- ten non-Accredited Pharmacists

The recruitment achieved a broad range of views and experiences across the range of PhARIA regions (Table 7) and states. Including:
- six states
- metropolitan, rural and remote regions
- regions characterised by high and low socio-economic status.
Table 7: Pharmacists interviewed by PhARIA Region

<table>
<thead>
<tr>
<th>PhARIA Region</th>
<th>Non-Accredited Pharmacists</th>
<th>Accredited Pharmacists</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhARIA 1</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>PhARIA 2-4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>PhARIA 5-6</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

* most Accredited Pharmacists interviewed from PhARIA 1 also provided services to other regions including Regions 5 and 6.

Analysis of the qualitative data from consultations with health professionals and consumers followed a systematic process. Notes and recordings from all interviews were reviewed, summarised and collated. A thematic analysis approach was applied.

A summary of the locations selected for the RMMR consultation (and thus the sites for consultation on MRAI) is provided below (Table 8). Around 4-5 MRAI-related consultations were conducted in each location.

Table 8: Field visit locations

<table>
<thead>
<tr>
<th>State</th>
<th>Region</th>
<th>Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>QLD</td>
<td>2 regional cities</td>
<td>PhARIA Region 1</td>
</tr>
<tr>
<td>SA</td>
<td>Adelaide and 1 regional city</td>
<td>PhARIA Region 1</td>
</tr>
<tr>
<td>VIC</td>
<td>4 coastal suburbs</td>
<td>PhARIA Region 1</td>
</tr>
<tr>
<td>TAS</td>
<td>Hobart and 1 rural/coastal area</td>
<td>PhARIA Regions 1 and 5</td>
</tr>
<tr>
<td>NSW</td>
<td>3 remote rural and regional towns</td>
<td>PhARIA Regions 4 and 6</td>
</tr>
<tr>
<td>WA</td>
<td>Perth and 3 regional and rural towns</td>
<td>PhARIA Regions 1, 3, 4, 5</td>
</tr>
</tbody>
</table>

Data analysis

Pharmacists make claims for payments for accreditation and re-accreditation to Medicare Australia. Campbell Research analysed de-identified data provided by the Department on the number, location, distribution and workload of Accredited Pharmacists by PhARIA region.

The analysis included an assessment of the number of Accredited Pharmacists by different regions (at least broken down by state and territory and PhARIA region) to identify the rate of accreditation before 1 April 2006 and the rate of accreditation / reaccreditation post 1 April
2006. The MRAI Program commenced on 1 December 2006 with incentives paid for accreditation or re-accreditation from 1 April 2006. The analysis sought to determine the extent to which the incentives have been associated with uptake of accreditation; the extent to which the size of the workforce appears to be increasing or diminishing; and inform the surveys of Accredited and non-Accredited Pharmacists to identify incentives and barriers to accreditation.

**Quantitative Research with Accredited Pharmacists**

Campbell Research surveyed Accredited and non-Accredited Pharmacists. The surveys were administered on-line to Accredited and non-Accredited Pharmacists. The survey provided for two inputs to the evaluation:

- A quantification of the findings from the qualitative research to assess how issues and opinions raised by individual stakeholders held across the sector; and
- An opportunity for broad and inclusive input.

The survey contained the following key sections, the contents of which were based on the discussion areas from the qualitative research. Key sections included:

- A demographic section containing details such as the nature of the stakeholder organisation (e.g. pharmacy), location of the stakeholder organisation, size of the stakeholder organisation
- Information about the rebate claims system including consideration of administrative processes and the impact on stakeholders
- Motivators and barriers to accreditation and the extent to which the incentives provided under the MRAI Program are sufficient to overcome the barriers.

The survey was designed using a modular structure with some common questions for all respondents, and sets of specific questions for specific stakeholder groups.

Campbell Research sought the Department’s approval of the draft questionnaire before testing, and the final questionnaire before the implementation of the fieldwork. The questionnaire was also submitted to and received clearance from the Statistical Clearing House of the Australian Bureau of Statistics (ABS).

**Accredited Pharmacists and non-Accredited Pharmacists on-line survey**

An online survey was administered to Accredited and non-Accredited Pharmacists, using Campbell Research’s in-house online survey tool. Emails were sent to pharmacists via the Australian Association of Consultant Pharmacy (AACP) and the Pharmacy Guild of Australia. Each of the relevant association’s appropriate email address contacts received email links and an invitation to complete the online survey. A reminder letter was sent out by the AACP a week after the initial invitation. Response rate is indicated below. (Table 3).

The on-line self completion method was chosen for the convenience of the respondent to complete the survey at a time that suits them, and for the greatest efficiency given the large sample size. The survey was conducted between 21 October 2009 and 10 November 2009,
with a total of 338 Accredited Pharmacists and 260 non-Accredited Pharmacists completing the survey.

### Table 9: Key online survey information – surveys of Accredited and non-Accredited Pharmacists

<table>
<thead>
<tr>
<th></th>
<th>Accredited Pharmacists (AACP)</th>
<th>Non-Accredited Pharmacists AACP distribution</th>
<th>Non-Accredited Pharmacists Guild distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample frame</td>
<td>1,814</td>
<td>647</td>
<td>4,100</td>
</tr>
<tr>
<td>Date initial email sent</td>
<td>21 Oct</td>
<td>21 Oct</td>
<td>6 Nov</td>
</tr>
<tr>
<td>Date of reminder email</td>
<td>28 Oct</td>
<td>28 Oct</td>
<td>n/a</td>
</tr>
<tr>
<td>Date fieldwork completed</td>
<td>4 Nov</td>
<td>4 Nov</td>
<td>10 Nov</td>
</tr>
<tr>
<td>Number of responses</td>
<td>338</td>
<td>260</td>
<td></td>
</tr>
<tr>
<td>Response rate</td>
<td>19%</td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>

The differences in response rates could be attributed to the higher level of interest in the subject by Accredited Pharmacists.

**Case studies**

Campbell Research conducted case studies with five non-Accredited Pharmacists from around Australia. These pharmacists were from PhARIA regions 4 to 6, areas where it is difficult to recruit suitable workforce and the volumes of HMRs or RMMRs is likely to be small. The case studies were aimed at providing useful insight into the impact of incentives on accreditation in different rural and remote parts of Australia.

In order to understand the diversity of circumstances in which pharmacists decide to or decline to become accredited, or re-accredited, Campbell Research sought a diverse mix of participants in the sample of five pharmacists. Key factors that were considered when recruiting, were socio-economic backgrounds, geographical location, current working arrangements (whether conducting HMRs or RMMRs), and accreditation.

As RMMR is typically the element which provides strongest support for a business model around medication reviews, towns or regions which do not have a high level of demand for RMMRs were targeted for these case studies. These case studies did not involve a full diary system in the same way as was required for the RMMR case studies. To enable the flexibility to cover a range of locations – particularly for more remote regions – the in-depth interviews with
pharmacists for these case studies were conducted by telephone rather than in person. Recruitment was through a cold-calling random recruitment approach.

Three case studies were conducted in PhARIA Regions 5 and 6. Two were conducted in PhARIA Region 4. The five case study pharmacists were from Tasmania, Victoria, Northern Territory South Australia and Western Australia.
Appendix C: Non-Accredited Pharmacist Questionnaire

About your role in pharmacy

These questions are about you, your role in pharmacy and the businesses for which you work.

Q1. How long have you been working in the pharmacy sector?
   Write ‘1’ if you have been working as a pharmacist for less than 1 year
   □ ___________________ Years

Q2. Which of the following best describes your role as a pharmacist?
   If you have more than one role, please describe the role in which you spend most of your time
   □ Pharmacy owner
   □ Employee at a pharmacy owned by someone else
   □ Not currently employed as a pharmacist
   □ Hospital pharmacist
   □ Other, please describe ____________________________ ____________________________

Q3. Is this pharmacy located in a metropolitan, regional centre, rural or remote area?
   Please select only one option, the pharmacy where you spend the most time
   □ Metropolitan
   □ Regional centre
   □ Rural
   □ Remote

Q4. In which state/territory is the pharmacy (or other organisation)?
   If more than one pharmacy, please answer for where you spend the most time
   □ _________ DROP BOX FOR STATES
### Accreditation

Q5. Are you currently accredited to do Residential Medication Management Reviews and Home Medicine Reviews?

- [ ] Yes  GO TO Q8
- [ ] No  CONTINUE

Q6. Have you ever been accredited to do Residential Medication Management Reviews and Home Medicine Reviews

- [ ] Yes
- [ ] No

Q7. What are the main reasons why you are currently not accredited?  
Please tick all that apply

- [ ] I do not have time to do the necessary study and exams
- [ ] Accreditation is too expensive
- [ ] There is no opportunity to do reviews in my area, so no need to become accredited
- [ ] Accreditation will not lead to increased revenue for me/my business
- [ ] I see little value in medication reviews, therefore am not interested in becoming accredited
- [ ] Other, please specify

Q8. Do you intend to become accredited (or re-accredited) in the future?

- [ ] Yes, within the next 12 months
- [ ] Yes, within the next 5 years
- [ ] Yes, within the next 10 years
- [ ] No, I do not intend to become accredited
- [ ] Don’t know

Q9. Were you aware that a financial incentive is available for pharmacists who attain accreditation?

- [ ] Yes
- [ ] No
- [ ] Not sure

Display message for all: pharmacists who achieve accreditation receive a one-off payment of $1,500. The pharmacist also receives an annual payment of $750 for each year they remain accredited. The incentive is known as the Medication Review Accreditation Incentive, or MRAI.
Q10. Does the availability of these incentives make it more likely that you will apply for accreditation in the future?

☐ A lot more likely
☐ A bit more likely
☐ No effect – the incentives do not influence my decision to apply for accreditation
☐ Don’t know

IF Q6 = NO, GO TO Q23. ALL OTHER RESPONDENTS CONTINUE.

Medication Review Accreditation Incentive

These questions are about the incentive payment that is made to pharmacists when they become accredited, and the yearly payment that is made for ongoing accreditation. The incentive is known as the Medication Review Accreditation Incentive, or MRAI.

Pharmacists who achieve accreditation receive a one-off initial payment of $1,500. The pharmacist also receives an annual payment of $750 for each year they remain accredited.

Initial payment

Q11. Did you claim the initial payment when you became accredited (or when the payment came in for those who were already accredited at that time)?

☐ Yes GO TO Q16
☐ No CONTINUE
☐ Don’t know GO TO Q16

Q12. Why did you not claim the initial payment?

☐ I was not aware that the incentive was available
☐ I did not get around to claiming the incentive
☐ My claim was rejected
☐ Other, please describe __________________

ALL RESPONDENTS TO Q16

Q13. How much did the initial payment influence your decision to remain accredited?

☐ A lot
☐ A little
☐ Did not influence my decision
Q14. Was the amount paid for the initial payment enough to cover the costs of?

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>More than enough</th>
<th>Enough</th>
<th>Not enough</th>
<th>Don't know</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Studying to become accredited</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materials required to become accredited</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel costs associated with becoming accredited</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q15. Would you have become accredited without the initial payment?

☐ Yes
☐ No
☐ Don't know

Yearly payment

A yearly payment is available to pharmacists who maintain their accreditation under MRAI.

Q16. Have you ever claimed the yearly payment that is available through MRAI to Accredited Pharmacists?

☐ Yes GO TO Q18
☐ No   CONTINUE
☐ Don't know

Q17. Why have you not claimed the yearly payment?

☐ I have not been accredited for a full year
☐ My accreditation has lapsed
☐ I was not aware that an annual incentive was available
☐ I did not get around to claiming the yearly payment
☐ Other, please describe __________________

ALL RESPONDENTS GO TO Q23

Q18. How much did the yearly payment influence your decision to remain accredited?

☐ A lot
☐ A little
☐ Did not influence my decision
Q19. Is the amount given for the yearly payment enough to cover the costs of …

<table>
<thead>
<tr>
<th></th>
<th>More than enough</th>
<th>Enough</th>
<th>Not enough</th>
<th>Don’t know</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing education to maintain accreditation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Materials required to maintain accreditation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Travel costs associated with maintaining accreditation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Q20. Would you maintain your accreditation without the yearly payment?

☐ Yes
☐ No
☐ Don’t know

Q21. Do you intend to renew your accreditation in the next 12 months?

☐ Yes  GO TO Q23
☐ No  CONTINUE

Q22. What are the main reasons why you will not renew your accreditation? Please choose all that apply.

☐ Lack of demand for Home Medication Reviews
☐ Lack of opportunity to provide Residential Medication Management Reviews
☐ Lack of time
☐ Business pressures
☐ Family commitments
☐ Other ________________
For those not conducting RMMRs

Q23. Have you ever conducted Residential Medication Management Reviews (RMMRs)?
☐ Yes  GO TO END
☐ No

Q24. Why is it that you have not conducted RMMRs?
Please tick all that apply
☐ Lack of time
☐ Lack of opportunity – other pharmacists hold the contracts as RMMR Providers
☐ I am unable to get another pharmacist to attend my pharmacy while I am doing RMMRs
☐ RMMRs are not profitable for me/ my business
☐ My accreditation has lapsed
☐ I am not interested in doing RMMRs
☐ Other________

Q25. Given the opportunity, would you like to conduct RMMRs in the next 12 months?
☐ Yes  GO TO END
☐ No  GO TO END
☐ Don't know

Q26. What would have to change in order for you to start conducting RMMRs
Please tick all that apply
☐ I would need to become accredited
☐ A contract would need to become available at an aged care home in my area
☐ The payment would have to increase to cover costs
☐ I would need to source a another pharmacist to attend my pharmacy while I do RMMRs
☐ I would just need more time during the working day
☐ I would need to become re-accredited
☐ Don't know

END