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Beyond Barriers: Developing an Optimised Workflow to Increase Home Medicines Review Uptake in Support at Home Recipients

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Abstract

Introduction:

Home Medicines Reviews (HMRs) are a structured, multidisciplinary, government-funded service to optimise medication use and reduce medication-related harm. Despite meeting eligibility criteria for an HMR, many people receiving home care support (called the Support at Home [SAH] program) do not receive an HMR.

Aim

To explore enablers for the uptake of HMRs for those who receive SAH programs from a healthcare professionals' perspective; and to create an optimised workflow model, based on these enablers, providing strategies that support increased uptake of HMRs for recipients of SAH programs.

Method

Six Nominal Group Technique sessions were conducted with healthcare professionals (general practitioners (GPs), pharmacists, and nurses). Participants generated, then prioritised enablers of HMR delivery, which informed an optimised workflow comprising micro (individual), meso (organisational), and macro (system) level strategies.

Results

Twenty-six healthcare professionals participated (GPs n = 7, pharmacists n = 7, nurses n = 11). Three enablers were consistently prioritised across all groups: systems to identify participants, healthcare professional education, and strong multidisciplinary communication. Workflow analysis identified actions at multiple levels that may improve HMR uptake: clinically focused HMR reports (micro), embedded screening tools (meso) and changes to policy to facilitate broader referral and reduce GP burden (macro).

Conclusion

Increasing HMR uptake requires coordinated action across individual, organisational, and system levels. GPs play a central role in HMR delivery; however, providing education to all healthcare professionals on the role they can play in supporting the process (e.g., patient identification, referral pathways, content of the written HMR) was identified as an enabler of HMR uptake. Identifying a clear patient need was important, indicating an opportunity for nurses and pharmacists to support HMR identification and

referral. Embedding this shared responsibility across the healthcare system may increase HMR uptake for this vulnerable population.

IMPACT STATEMENTS

- Home Medicines Review uptake is critically low among Support at Home recipients
- Nurses, pharmacists and GPs identified patient identification as the top priority
- Poor awareness of Home Medicines Reviews among health professionals limits uptake
- An optimised workflow maps actions at individual, organisational and policy levels
- Expanding nurse and pharmacist roles in referral can reduce burden on GPs

INTRODUCTION

Medications are prescribed to prevent, treat and manage health conditions, with the aim of improving patient outcomes and quality of life. Medications are the most common therapeutic intervention provided in healthcare, with general practitioners (GPs) serving as the primary prescribers for most older Australians living in the community.(1) However, each year, approximately 260,000 hospital admissions among older Australians are attributable to medication-related factors, including adverse drug events, non-adherence and overdose.(2) Internationally, adverse drug reactions account for 3%-23% of hospitalisations, and adverse drug events account for 12%-18%.(3) Contributing to this problem is the high use of potentially inappropriate medications (PIMs), defined as medications where the potential for harm outweighs the potential for benefit.(4) Approximately 1 in 3 older adults are prescribed at least one PIM each year globally, the majority of whom are managed in primary care.(5)

To support Australians to live independently in the community, the Australian Government introduced a variety of programs, including the Support at Home (SAH) program and Home Medication Reviews (HMR). The SAH program is for older Australians (aged ≥ 65 years or ≥ 50 years for First Nations people), providing individualised care and services such as wound care, chronic disease management, assistance with activities of daily living, and assistance with medications.(6) SAH programs are delivered by government-approved aged care providers.(7) A HMR is a structured, multidisciplinary process for reviewing an individual's medications to identify medication-related problems and opportunities to optimise medication use. HMRs are initiated through a doctor's referral to an HMR-credentialed pharmacist.(8) The current model requires a GP to refer to a credentialed pharmacist, and credentialed pharmacists are capped at providing 30 HMRs per month.(8) To receive funding for this service, referring doctors must confirm that the patient has a chronic medical condition or a complex medication regimen, and is not having their therapeutic goals met.(8, 9) Following this assessment, the doctor refers the patient to an HMR-credentialled pharmacist, who reviews the patient. The pharmacist provides the referring doctor with a report, who then develops a written medication management plan which is provided to the patient's chosen community pharmacy.(8, 9) HMR recipients express high satisfaction with the service, greater understanding about their medicines, and increased willingness to

advocate for medication changes.(10, 11) Research shows HMRs can enhance medication appropriateness and reduce drug-related problems, and improve adherence.(12, 13)

Despite the benefits of HMRs, uptake has been low. Individuals taking five or more regular medicines (polypharmacy) are recommended to receive a medication review every 24 months;(8) 40% of Australians aged ≥ 75 years meet this criteria.(14) Uptake in individuals receiving SAH packages is particularly low, with only 4% receiving an HMR between 2013 and 2017, and only 2% in 2024.(15, 16) Given approximately 293,000 Australians received home care support in 2025, improving uptake of HMRs has the potential to benefit a substantial number of older adults.(17)

Low uptake of HMRs may partly be attributed to their structured, multistep funding model which requires coordination between several healthcare professionals.(8, 9) Limited consumer awareness may also contribute. In a 2012 survey, only 23% of eligible non-recipients were aware of the HMR service. However, once informed, 82% of reported they would be willing to receive an HMR if it were recommended by their general practitioner.(10) This highlights GP engagement as a key lever for improving HMR uptake. While previous research has explored medication reviews conducted in residential aged care facilities or focused on consumers' perspectives of HMRs,(10, 18, 19) little is known about how uptake can be improved from the perspectives of the health professionals involved in caring for people receiving SAH programs. Understanding these perspectives may help identify how to increase the uptake of this service.

AIM

This study had two aims: 1) to explore enablers for the uptake of HMRs for those who receive SAH programs from a healthcare professionals' perspective; and 2) to create an optimised workflow based on these enablers to improve uptake of HMRs for recipients of SAH programs.

METHOD

This qualitative study was conducted between November 2025 and March 2026. Nominal group technique (NGT) was employed to elicit and prioritise healthcare professionals' perceived enablers for HMRs.(20, 21) Workflow analysis was then conducted by the authors based on the identified enablers from the NGT. Study reporting was guided by the COnsolidated criteria for REporting Qualitative (COREQ) Checklist (Appendix A).(22) Ethical approval was granted by the Monash University Human Research Ethics Committee in September 2025 (Project ID: 48099).

Study participants and participant recruitment

Participants were healthcare professionals (GPs, credentialled HMR pharmacists or nurses) who had current or recent experience (within the last two years) with the SAH program, HMRs, or both. Participant recruitment involved different methods for different health professionals. GPs were invited through a

Primary Health Network, personal contacts, and via local medical clinics. Nurses were invited to participate via a national SAH provider. Pharmacists were invited to participate through professional organisations and a Consultant Pharmacists Australia Facebook group. Demographic characteristics were collected.

NGT procedure

NGT provides a structured approach for idea generation and prioritisation across 7 structured steps (Fig. 1). NGT facilitates balanced participation among participants and supports the identification of participant priorities through a transparent ranking process.(23, 24) Prior to commencement of the NGT session, participants were provided with an explanatory statement, pre-reading and a run sheet to indicate timings for each step. NGT sessions were conducted via an online/in-person hybrid format or entirely on Zoom, using virtual whiteboards to document ideas and themes. All sessions were recorded using Zoom. NGT sessions were conducted by an experienced facilitator (First Author/Senior Author; Appendix B), who asked the participants to consider "*what enables the delivery of HMRs for community-dwelling older adults who receive support at home?"* Steps 1 through 6 led participants to individually generate ideas, create themes as a group and then individually prioritise the top 5 themes they deemed most important in answering the question. Rankings were summed to produce a group priority list, which the group confirmed accurately represented the session (step 7). A multigroup analysis was conducted to create a single priority list for each healthcare professional group.(25)

Workflow analysis

A generic HMR workflow diagram from the Pharmacy Programs Administrator was used as a starting point for the workflow analysis (Fig. 2).(8) The workflow analysis was completed through a series of iterative steps using the workflow optimisation research method.(26, 27) First, priorities from the NGT sessions were mapped onto the current workflow model. Next, the model was refined to incorporate specific actions mentioned by participants in the NGT sessions. Actions were then grouped according to health system level of implementation: micro (actions that can be taken by individual healthcare professionals), meso (actions that can be taken by healthcare organisations such as GP clinics or aged care providers) or macro (actions that come from health policy and government).(28) Finally, the model received 5 rounds of iterative review from practicing GPs, nurses, pharmacists, and SAH managers to ensure the steps were relevant and applicable to front-line practice.

RESULTS

Six NGT sessions were conducted with 26 participants, ranging in duration from 90 to 120 minutes. The sessions were separated by profession: two sessions were conducted with nurses (n = 11), two with pharmacists (n = 7), and two with GPs (n = 7), (Table 1).

Enablers for improving HMR uptake

The top priorities to the question "*what enables the delivery of HMRs for community-dwelling older adults who receive support at home?"* included having a structured process for identifying suitable patients, educating healthcare professionals about the HMR process, and fostering multidisciplinary collaboration and communication (Table 2). Similar priorities arose across all groups.(25)

Patient identification

All groups identified patient identification as a priority, with pharmacists and nurses ranking it as their top priority for enabling HMRs. Participants emphasised the need for proactive processes to identify eligible patients who would benefit most. Those at higher risk of medication-related harm or with complex needs were considered a high priority. GPs described that HMR referrals that clearly highlight the clinical need enabled the process. Conversely, nurses and pharmacists stated that system-level approaches to flagging SAH recipients who met eligibility criteria would enable HMRs if a clinical need exists (Table 2).

Education for healthcare professionals

All groups considered that increased knowledge of the HMR process by healthcare professionals would enable uptake. Participants highlighted that education to address gaps in awareness and understanding of HMR purpose, processes, and benefits of HMRs would enable increased uptake of HMRs.

Communication and Collaboration

Participants actively involved in delivering HMRs noted that clear multidisciplinary communication and collaboration (between health professionals, and between health professionals and patients) is vital to clinically relevant HMRs being conducted. Consistent communication and collaboration was therefore prioritised. Participants noted that emphasising the need for an HMR to both the patient and healthcare professional team would likely increase acceptance and satisfaction. Shared decision-making and expanding roles so more health professionals were comfortable to identify and refer patients were other ideas for how this could be improved.

Workflow strategies and actions to optimise HMR uptake

Participants discussed that embedding mechanisms within their respective workflows would support HMR uptake. Analysis identified several existing service delivery stages where enablers could be leveraged to optimise workflow (Figure 3, Table 3). The findings demonstrated that while the HMR funding model requires HMRs to be GP-initiated, improved collaboration and a shared responsibility involving nurses, pharmacists, allied healthcare professionals and healthcare organisations would improve meaningful uptake. The strategies generated through the workflow analysis translated the above enablers into practical actions that could be implemented across micro, meso and macro levels.

Micro (Individual Healthcare Professionals)

At the individual level, participants identified several strategies to support HMR uptake. It was important for healthcare professionals to clearly explain the purpose of an HMR to patients and how it would align with their goals of care. Participants also recommended expanding the role of nurses and allied healthcare professionals in initiating conversations about HMRs and encouraging referrals when medication-related risks were identified. GPs stated that concise, actionable, clinically focused HMR reports prioritising quality use of medicines and patient safety, rather than generic documentation, increased their confidence in the HMR service, and thus their motivation to refer (Table 2). Actively communicating the purpose and urgency for an HMR supports all members of the care team to work towards patient-centred care. These strategies were intended to improve communication, strengthen shared decision-making, and reduce reliance on GPs as the sole drivers of the HMR process.

Meso (Healthcare Providers)

At the organisational level, participants proposed embedding patient identification processes within routine service delivery. Specific strategies included admission screening tools, clinical trigger tools activated by changes in health status, chronological reminders for review, dispensing software alerts, and the use of existing care coordination systems to identify people at increased risk of medication-related harm. Participants suggested that these processes would enable more consistent identification of eligible individuals.

Macro (Healthcare System Level)

At the system level, participants identified several policy strategies to increase HMR uptake. These included targeted education programs for healthcare professionals, public awareness campaigns to increase consumer demand, reform of funding arrangements, and empowering healthcare professionals to refer to GPs for an HMR referral. Participants viewed these strategies as necessary to support greater multidisciplinary involvement and reduce structural barriers within the existing HMR model.

DISCUSSION

Key enablers that support the uptake of HMRs by SAH package recipients were identified by GPs, pharmacists and nurses. Structured approaches to patient identification, educating healthcare professionals, and fostering multidisciplinary collaboration were identified as key enablers. A revised workflow model was created outlining strategies that can be undertaken by individuals, organisations and policy makers to support the uptake of HMRs. Since HMR uptake in SAH populations remains critically low at 2–4% of eligible patients, this study provides prioritised strategies for addressing the gap between previous research and practice change.(15) This points to a need for clear, actionable workflow models to drive practice change, rather than continued documentation of barriers and enablers in isolation.

Identifying patients who would most benefit from an HMR emerged as a central leverage point across all professional groups. This aligns with previous research demonstrating that proactive identification of eligible patients is one of the most effective strategies for increasing HMR uptake.(15, 29, 30) Notably, this study found that different professions conceptualise identification differently. GPs focused on individual clinical need, while nurses and pharmacists favoured system-wide approaches to flag patients who meet the funding eligibility criteria. This divergence highlights a potential fragmentation in current perspectives that our optimised workflow seeks to address. SAH organisations provide services administered and delivered by nurses who do not have a specified role within the current HMR workflow, despite being well-positioned to identify patients who would benefit from review and support implementation of recommendations. A previous medication optimisation project based in a home nursing organisation, the Visiting Pharmacist (ViP) study, similarly found that community nurses were not formally included in the HMR process, were not informed when a review occurred, and were not able to directly refer clients, despite regularly identifying patients with medication-related need.(31) This represents a significant and underutilised opportunity; by including nurses in the referral pathway to the GP (who can then refer to the HMR-credentialed pharmacist), SAH organisations could substantially increase the reach of the HMR program to patients with a clinical need. Our findings support this, with nurses and pharmacists prioritising system-level patient identification prompts to ensure there was a clinical need for an HMR (aligning with GP priorities); this is rarely done within the current GP-initiated HMR model. Broadening and redistributing identification responsibilities across the care team reflects the realities of SAH service delivery and aligns with evidence supporting interprofessional collaborative models as drivers of improved medication management outcomes.(32)

Coordinated action at every level of the healthcare system is required to increase HMR uptake for the SAH population. Evidence suggests that strategies targeting higher system levels (macro and meso) have the greatest propensity to produce downstream effects at the micro level, making them particularly powerful levers for change.(33) Health policies are most effective in driving appropriate medication use when they engage multiple stakeholders and are embedded within clear national strategies, rather than relying on isolated individual-level initiatives.(33) Similarly, research on psychotropic monitoring in long-term care settings found greater evidence of impact for mandatory strategies when compared to non-mandatory approaches.(34) This suggests that system-level policies may result in more substantial change than educating individual clinicians alone.(34) Applied to HMRs, this implies that macro-level policy may set the precedent for other strategies at different levels to succeed. At the macro level, current funding models place disproportionate responsibility on GPs to initiate the HMR process and find a credentialed pharmacist. Policy reform that support SAH care providers to alert GPs of patients who may benefit from an HMR, remove the current cap on how many HMRs a credentialed pharmacist can complete per month, incentivise interprofessional participation, and actively promote the HMR service is likely to produce flow-on effects at both the meso and micro level. At the meso level, service providers delivering SAH packages could embed patient identification processes within routine care delivery (including admission screening tools, clinical trigger alerts, and chronological reminders; nothing that participants in the NGT sessions recognised the need for healthcare professionals to validate a clear

clinical need for an HMR and not refer every eligible client) to ensure eligible patients are systematically identified without relying on reactive clinical recognition. Although participants suggested that education of healthcare professionals may be beneficial, evidence from health system–embedded interventions suggests that isolated educational initiatives produce only modest benefits without broader organisational support structures in place.(32) At the micro level, individual healthcare professionals could prioritise communication that clearly articulates the personal and clinical benefit of an HMR for each patient.

Research consistently demonstrates that person-centred communication, including tailored health information and clear explanation of purpose, is central to both patient willingness and clinician engagement in referral and review processes.(10, 35) Expansion of pharmacist, nurse and allied health roles within the HMR process to allow them to refer individuals for an HMR also aligns with the Australian Health Practitioner Regulation Authority's Interprofessional Collaborative Practice Statement.(36) If supported by clear role definitions and interdisciplinary collaboration, this could reduce GP burden while increasing referrals. Together, these multi-level strategies reflect a shift from a predominantly GP-led model towards a shared responsibility model that may produce sustained improvements in HMR uptake for SAH recipients.

Strengths and limitations

A key strength of this study is the chosen NGT methodology.(37, 38) NGT is well suited to identification of priorities in primary care,(39) as it enables participants to independently generate ideas, engage in structured group discussion, and collectively prioritise recommendations. This approach promotes equitable participation by ensuring all participants have equal opportunity to contribute.(40)

National organisations assisted in recruiting participants from across Australia in the hopes of making the results broadly transferable. While recruitment was promoted widely across Australia, most participants came from Victoria. This may limit generalisability of our results to other countries and clinical settings. Although many measures were taken to collect demographic information, some participants did not respond which means some results are missing. As with other qualitative studies, our results may not be truly generalisable because of self-selection bias, where only those who were interested in the study agreed to take part.

CONCLUSION

This study identified and prioritised key enablers of HMR delivery for people receiving SAH packages, and translated these into a practical, optimised workflow that maps opportunities for action across individual, organisational, and system levels. Patient identification, healthcare professional education and multidisciplinary communication emerged as the most consistently prioritised enablers across all professional groups. The optimised workflow represents a shift away from the current GP-initiated model towards a shared responsibility model that actively incorporates the roles of nurses and

pharmacists in identifying eligible patients and facilitating HMRs. Meaningful improvement in HMR uptake will require coordinated action across all levels of the healthcare system. Policy reform to promote the service, organisational embedding of systematic identification processes, and interprofessional collaboration in everyday care delivery are all necessary components of a sustainable solution.

Declarations

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Author Contribution

Author contribution statement: AMM: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Project administration, Resources, Validation, Visualization, Writing – original draft, Writing – review & editingAVL: Conceptualization, Investigation, Methodology, Resources, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editingER: Conceptualization, Investigation, Methodology, Resources, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editingRO: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing – review & editingFO: Data curation, Formal analysis, Funding acquisition, Investigation, Project administration, Resources, Supervision, Validation, Visualization, Writing – review & editingAH: Investigation, Resources, Validation, Visualization, Writing – review & editingDH: Investigation, Resources, Validation, Visualization, Writing – review & editingJPT: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing

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Data Availability

All data/code/materials relevant to the study are included in the article or are available as supplementary files.

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Tables

Table 1: Demographics of NGT session participants

Healthcare Professional Role	N	Years of experience in this role Median (range)	State/territory N (%)	Gender N (%)
General practitioner	7	11.5 (6-20)	VIC = 7 (100%)	Woman = 4 (57.1) Man = 3 (42.9)
Pharmacist	7	30 (6-51)	VIC = 2 (28.6) NSW = 2 (28.6) ACT = 1 (14.3) QLD = 1 (14.3) SA = 1 (14.3)	Woman = 6 (85.7) Man = 1 (14.3)
Nurse	11[1]	8.5 (2-30)[1]	VIC = 10 (100%)[1]	Woman = 10 (100%)[1]

1. Demographics data is missing for two participants. Vic = Victoria, NSW = New South Wales, ACT = Australian Capital Territory, QLD = Queensland, SA =South Australia

Table 2: Top Six Enablers to improve HMR uptake

Rank	Top Six Enablers	Description of Enabler
General practitioners		
1	**Quality HMR reporting focusing on quality use of medicines**	GPs identified that receiving a structured, clinically meaningful and actionable HMR report that clearly highlights medication-related problems and optimisation opportunities increases their confidence in the value of the service and their motivation to refer future patients.
2	**Supportive funding models**	Current Australian Medicare funding structures limit HMR access. GPs identified that reforming funding arrangements (e.g., removing annual caps, expanding who can initiate referrals) would reduce structural barriers and allow more eligible patients to be referred.
3	**Education to HCPs to increase awareness**	GPs acknowledged that limited awareness of the full scope and value of HMRs among healthcare professionals inhibits referral. Targeted education would improve understanding of the purpose, process, and patient benefit of an HMR.
4	**Patient identification: therapeutic need**	GPs identified that proactively seeking out patients who would clinically benefit (using indicators such as polypharmacy, recent hospital discharge, or cognitive decline) rather than waiting for patient request, is a key enabler of increased HMR uptake.
5	**Trust between doctor, pharmacist and patient**	Strong, established working relationships between GPs, pharmacists, and patients were seen as foundational to the HMR process. Trust facilitates referral initiation, engagement with the review, and follow-through on recommendations.
6	**Multidisciplinary communication and collaboration**	Coordinated communication across the healthcare team supports GPs to initiate HMRs and act on their findings. Shared information and clear communication pathways between GPs, pharmacists, and other healthcare professionals improve the utility and uptake of the service.
Pharmacists		
1	**Patient identification: structured processes**	Clear, standardised processes for identifying eligible patients (such as checklists, referral prompts, or care coordination triggers) enable HMRs to be offered consistently and equitably, rather than relying on ad hoc recognition.
2	**Multidisciplinary communication and collaboration**	Active communication of HMR findings and recommendations to the broader care team (including GPs, nurses, allied health and service providers) throughout the HMR process ensures the review is understood, acted upon, and followed up effectively.
3	**Education to HCPs to increase awareness**	Improving awareness among healthcare professionals of the HMR process, eligibility criteria, and the clinical value of medication review increases the likelihood of referral and engagement with the service.
4	**Educating and empowering the community**	Patients and carers who understand what an HMR involves and how it may benefit them are more likely to want an HMR and engage meaningfully in the review, increasing both demand and uptake.

4	**Supportive funding models**	Funding constraints (e.g., caps on the number of HMRs an accredited pharmacist can conduct) limit service delivery. Revised funding models would enable accredited pharmacists to conduct more HMRs and expand service reach.
5	**Promotion of credentialled pharmacists to healthcare team**	Referrers may be unaware of which pharmacists hold HMR accreditation. Greater visibility of credentialled pharmacists (e.g., through promotion within healthcare networks or shared directories) would streamline referral pathways.
6	**Patient identification: technology**	Shared electronic health records and care coordination systems accessible across the healthcare team could be used to flag patients meeting HMR eligibility criteria, reducing reliance on any single professional to identify candidates.
Nurses		
1	**Patient identification: a screening tool on admission**	A standardised screening tool used by nurses at the point of SAH admission could systematically identify patients at high medication risk who would benefit from an HMR referral, ensuring eligible individuals are not missed.
2	**Patient identification: Chronological reminders**	Automated reminders in patient records (triggered by time since last HMR, recent hospital discharge, or change in health status) would prompt nurses to initiate or suggest HMR referrals at appropriate intervals.
3	**Education to HCPs to increase awareness**	Nurses who understand HMR eligibility, processes, and outcomes are better positioned to advocate for patients and facilitate referrals.
4	**Patient identification: Screening tool for change in health status**	A targeted screening approach activated by clinically significant changes (e.g., new diagnosis, new medication, hospitalisation) would help nurses identify patients whose medication regimen may need review.
5	**Educating and empowering the community**	Nurses in SAH settings are well placed to explain to patients and carers what an HMR is, what to expect, and why it is beneficial, improving acceptance and engagement.
6*	**Multidisciplinary communication and collaboration**	Nurse involvement in HMR workflows (including follow-up and monitoring) strengthens care coordination and implementation of recommendations.
6*	**Expanded access (e.g., telehealth)**	Telehealth-delivered HMRs increase access for patients in rural, remote, or mobility-limited settings.

Note: * = received equal ranking scores. GP + General Practitioner, HCP = Healthcare Professional, HMR = Home Medication Review, SAH = Support at Home

Table 3: Actions across system levels

Level	Strategies
Micro	• Shared understanding of patient needs and goals • Ensuring a therapeutic need for an HMR • Clear roles and shared responsibility for identification and referral • Strong and respectful multidisciplinary communication • Clinically meaningful and actionable report
Meso	• Embedded patient identification systems for different professions (e.g., screening tools, data prompts) • Integrated workflows across service providers, GP clinics, and pharmacies • Use of existing data and care coordination systems to trigger HMRs • Clear processes, feedback loops and local governance • Workforce education and training on HMRs • Structured processes for referral
Macro	• Public awareness to increase demand for and understanding of HMRs • Supportive Funding models that enable multidisciplinary collaboration (e.g. removal of quantity restrictions for credentialed pharmacists) • Policy and regulatory settings that support shared responsibility and streamlined referral pathways • Increased accessibility (e.g., telehealth)

GP = General practitioner

Figures

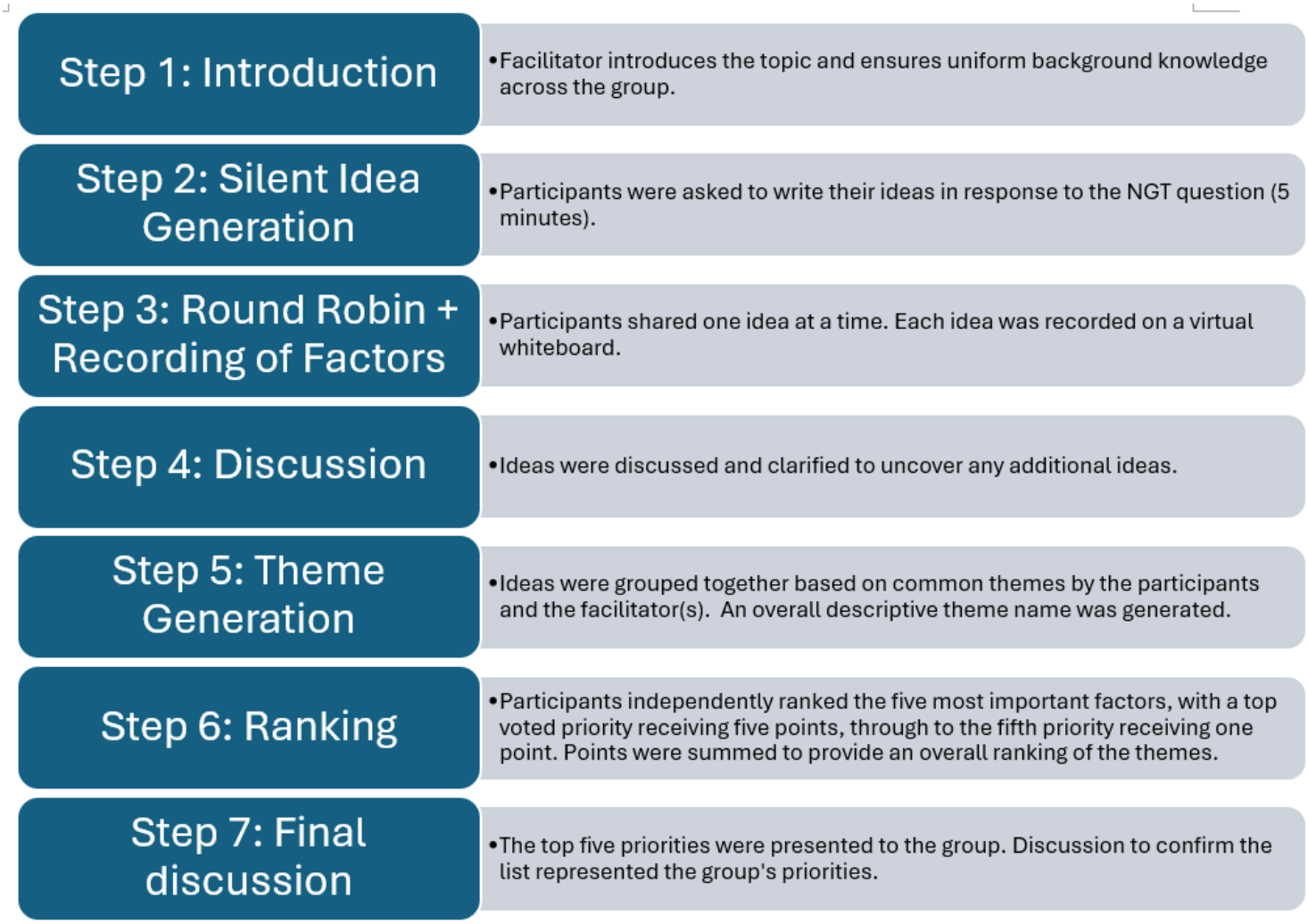


Figure 1

NGT process

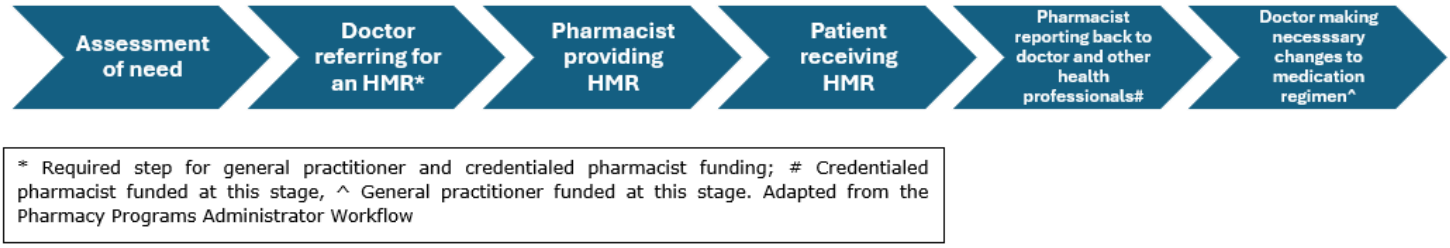


Figure 2

Existing HMR workflow, adapted from the Pharmacy Programs Administrator workflow.(8)

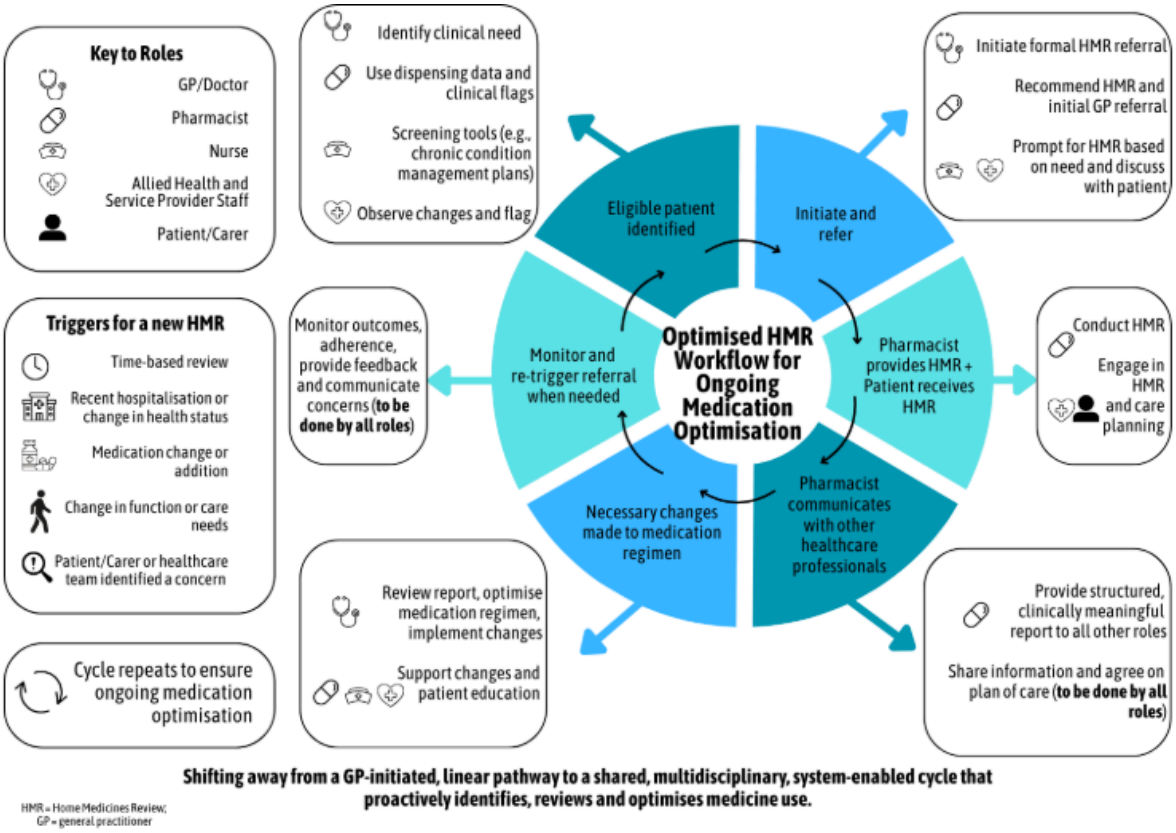


Figure 3

Optimised workflow diagram with profession-specific actions

Supplementary Files

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- Appendices250826.docx