## A rural AOD pharmacotherapy model

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**Aim:** To develop and deliver a pharmacotherapy program in regional/rural Victoria that meets the needs of clinicians and clients. Traditionally, general practitioners (GPs) and pharmacists have been reluctant to engage with AOD clients, due to a minority who demonstrate behaviours which impact on other customers negatively. There has been poor clinician take-up for the pharmacotherapy program as funding and workforce issues provide few incentives for participation. Despite recent sector reforms, lack of strategies addressing these fundamental issues means minimal progress has been made to date.

Additionally, current experts in addiction medicine are rapidly nearing retirement age. The system is currently unsustainable. Clients in rural and regional parts of the state are most immediately affected as there are entire areas with no prescriber or dispenser available and public transport options to services are limited or non-existent.

This program has been established as a pilot to address the needs of rural and regional clients who require an opiod-replacement pharmacotherapy program. Using clinicians who understand rurality factors in the delivery of health services, it has been designed to engage local clinicians in working with their patients through a state-wide mentoring and training program which provides secondary and joint consultations to develop confidence and skills. Working with the whole of the practice, it recognises the difficulties that can arise from working with the client group and aims to provide strategies and solutions to those issues through building workforce capacity.

**Methods:** This pilot operates across the rural areas of Victoria, collecting a few key measures to define the 'success' of the pharmacotherapy program. These include: % increase in clinicians engaged into the full program; % increase in clients receiving care closer to home; % increase in clients in pharmacotherapy; % increase in clinicians trained to prescribe/dispense. Also as part of the project, patient flows will be mapped to identify gaps in service availability across the state. Reports will be published each year for the 3-year pilot period. Methods include participatory action research through PDSA cycles.

**Relevance:** This pilot is replicable for other parts of Australia, demonstrating how to efficiently use limited specialist workforce and enhance workforce capacity. While this model addresses pharmacotherapy, the model remains applicable to any chronic disease requiring specialist care in rural areas.

**Conclusions:** The model potentially shows how collaboration across sectors can support better access to specialist care, using a combination of local clinics, telehealth, mentoring, and practice visits. It also demonstrates the necessity of looking at what levers there are for engagement across the continuum of care for chronic disease.