A rural AOD pharmacotherapy model

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Background

In January 2013, in response to the Victorian Pharmacotherapy Review, the Department of Health (Victoria) released a directions paper called *Enhancing the Victorian Community Based Pharmacotherapy System* undertaken by Alison Ritter, Trevor King, and Linda Berends in 2011. An outcome of this initiative was to fund 5 networks across the state (3 rural, 2 Metro) to address the shortages identified in the review of prescribers and dispensers, particularly in the rural regions.

The paper outlined the current state of the pharmacotherapy program within Victoria and made a case for significant change. The shortages were causing significant hardship for clients who often had to travel some distance in order to access services, in areas where public transport options were nonexistent or severely limited. Pharmacotherapy was increasingly incompatible with employment as access was a time-consuming affair.

The following barriers were identified as 'key' to improvement:

- **Reluctance of General Practitioners to engage in prescribing.** As small businessmen, there are few incentives for GPs to engage with what are sometimes difficult clients. Even those who might participate in the program, often face pressure from their business partners, causing few to actively or openly participate. Despite the fact that many of the clinics already have clients with alcohol and/or other drug issues that they are treating for a range of primary health problems, the perception that somehow these are 'other' clients is hard to overcome. And the truth is that like most clients with chronic disease, these clients have multiple issues that do take additional time to treat in combination. It is a specialty area that many GPs lack confidence to work in.

- **Reluctance of Pharmacists to dispense.** Again, as a small business, pharmacies are often struggling if they become 'known' to have regular customers who source their methadone or other pharmacotherapy at their store. All it takes is one incident within a small community to make the pharmacist withdraw their service. While research has highlighted the potential for pharmacists to provide an invaluable monitoring role as an ancillary to the GP, there are few incentives for the Pharmacy to provide this function.

- **Disconnect between the Primary Healthcare system and the Specialist AOD treatment system.** While core to the Pharmacotherapy program are the GP, Pharmacist and client, often there is a complete lack of awareness of available resources, and referral pathways between the primary health system and the AOD treatment system. In Victoria, massive reforms to the bulk of AOD services have caused even further disruptions, and traditional referral pathways are no longer there. For many GPs, the whole treatment issue is becoming 'too hard'.

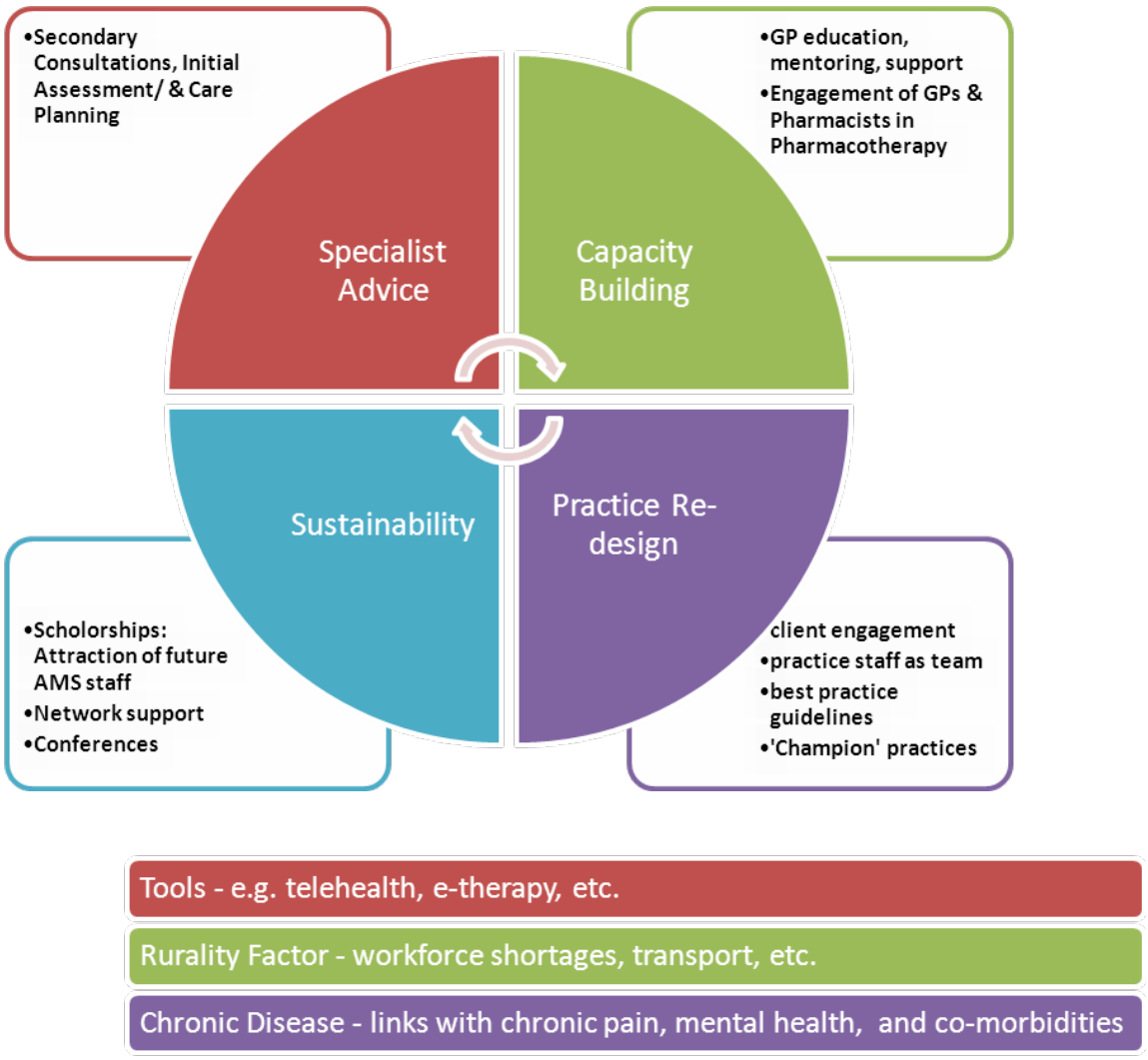
The Rural Addiction Medical Pharmacotherapy Services (RAMPS)

In 2014, the successful consortia members for the 5 networks were announced. The Networks were comprised of a Manager and specialist nurse position, and designed to support and build partnerships between the various parts of the system to enhance referral pathways and access to services. The governance structures of the networks were designed to bring the various players within the ORT system together to integrate efforts and improve client outcomes.

Additional resources were made available to engage addiction medical specialists (AMS) to provide secondary consultations and advice in order to further engage GPs into the system. As the resourcing was inadequate to engage an addiction medical specialist for each network, (and due to the scarcity of AMS generally), further collaborations were encouraged between networks to pool resources to develop a specialist referral service that would increase the quality of the ORT provided. Out of this collaboration and effort, the RAMPS services were developed and the following components are currently provided or in development.

Service Description

The following depicts the RAMPS service elements:



Core specialist pharmacotherapy advice

At the heart of the RAMPS service is the provision of advice and support to rural GPs regarding the needs of AOD patients. A growing concern for many GPs in rural areas is the number of their patients who have become dependent on pain medication due to injury or other factors. Unable to differentiate between those who are not 'traditional' AOD clients exhibiting drug-seeking behaviour and those who have been inappropriately provided ever higher doses of pain medication due to pharmacological tolerance or other complications of long term treatment with opioids for chronic pain, GPs feel inadequate to correctly manage and prescribe for these two groups of patients. Access to pain clinics is often not available to rural patients, and the GP can feel harassed to provide medication. The AMS provides guidance through secondary consultations and/or initial examination and assessment of clients. Together with the GP, a care plan is prepared that includes the patient that 'tailors' treatment based on individual circumstances – critical in rural areas with limited local services and transport options. The AMS does not accept a 'traditional' referral in that the patient may be 'seen' by the AMS via Telehealth or Skype, with a report shared with the GP and patient through a shared 'chronic management plan' type arrangement. This type of 'enhanced consultation' is intended to build GP capacity and add value for the patient through the 'sharing' of the GP/AMS consultation information.

Capacity building: GP education, mentoring and support

Following on from the basic advice and support provided through the AMS, a local team of specialist nursing and clinical staff provide educational support and practical liaison between the GP Practices, Pharmacies and other AOD services within the geographic area. As local senior clinicians, they are able to connect patients into the pathways to facilitate the care planning. These small teams work within each sub-region to provide a 'first point of contact' and work to engage more prescribers and dispensers into the program. They provide the triage function that ensures that the AMS are not unnecessarily accessed, as AMS hours are a limited and expensive resource. The team provides the administrative functions as well, acquitting the funding that comes through the state-funded AOD program and monitoring key reporting areas..

Practice re-design

In addition to providing specialist advice, the AMS also conducts local CPD accredited seminars and mentoring to a few "champion" practices with potential to develop into local leadership. They will assist practices who wish to re-engineer their processes to more adequately work with the client group, including addressing issues such as client engagement, poor behaviour, not showing up for appointments, etc. This involves the whole practice team, and works to ensure that the practice meets established guidelines. It is not the intent of the program to have single practices become AOD super clinics, rather to 'normalise' inappropriate drug use as a chronic health condition with best practice guidelines like any other chronic illness. Like many chronic conditions, it is most effectively treated in primary health, but its also true that patients often have other co-morbidities that need treatment. While most patients, once stabilized, can be effectively managed within the scope of the GP practice, there are some patients that due to their behaviour, require additional specialist services and this service provides the linkages needed to connect to those services. Strict codes of behaviour are encouraged with patients to manage their impact on other patients of the practice.

Sustainability

Underpinning the whole program is the principle of sustainability. Most GPs and Pharmacists are not interested in working with the client group. This program works to engage with practitioners and to provide a network to provide continued support between local groups. In addition, AMS work with tertiary institutions to teach AOD and will be seeking to take on Addiction Medicine registrars to encourage interest in the program from medical students and hospital interns and HMOs.

There are also few incentives to attract practitioners to go on to become addiction medical specialists. This program provides a modest scholarship to attract specialist AOD staff to engage in additional training and increase their expertise to deliver services. There are currently very few qualified AMS within Victoria. It is the intention of this program to try and encourage more GPs to proceed to that status. It also is aimed at nurse practitioners, nursing staff and pharmacists to specialise in this area as demand continues to increase.

Other key factors in the rural context

- Tools & Enablers – Key enablers within the rural region is the use of telehealth and ehealth solutions. These include software that enables shared client records (CMS software), software that supports face2face consultations (Skype +, face2face, etc.) and therapies delivered via internet.

- Rurality Factors - All clinicians recruited must have experience within the rural sector. A thorough understanding of the constraints faced by rural practitioners and rural clients are key to successfully constructing care plans that will be implemented. Lack of services, transport and employment options, reputational risks within small towns, impact on families and friends, limited social options all are features of working in rural areas and must be considered when constructing a realistic care plan. These are often compounded by workforce shortages that force practitioners to look for creative solutions to the realities of their rural practice.

- Contextualizing problematic drug use within a Chronic Disease Management framework– For too long, AOD use has been seen as a parallel specialist treatment system outside of primary health. This program seeks to move pharmacotherapy within the normal primary health system, building

competency within practices to deal with the many associated medical co-morbidities related to addiction, while providing pathways into more specialist services where and when needed. The overlap with mental health and with pain management services requires greater competency in dealing with these issues at the primary entry points into the health system.

In rural areas, it is increasingly challenging to differentiate between clients with these problems and as with other sufferers of chronic disease, co-morbidities are the rule rather than the exception. Bringing together experts in multiple diagnosis to assist in treating clients' conditions concurrently provides both efficiencies and better client outcomes as they are not 'lost' in the system.

Evaluation and research

Inherent in any new program and policy direction is the need to ensure that impacts and outcomes are measured and evaluated. Process evaluation and outcome evaluation has been built into the program through a collaborative relationship with Deakin University.

In addition to client data collected through normal monitoring processes, regular PDSA (plan, do, study, act) cycles are conducted with practitioners to identify areas for improvement and capture changes as they occur. This methodology also allows ownership by those most involved in the clinical practice, however a client group is also convened to ensure that the program remains client-centred and responsive. Clients are represented both by 'practice' staff and by patients with AOD issues (through separate groups).

Conclusion

This model has only commenced and has yet to demonstrate its effectiveness, however already preliminary results have shown greater numbers of GPs are engaging and continuing with the program. We would like to engage with other models in order to compare results and encourage anyone interested to get in contact.

Presenters

Glenda Stanislaw is CEO of Great South Coast Medicare Local. With postgraduate qualifications in public policy, primary health care, public health, and counselling psychology, she has extensive experience working in national, state and local government bodies, as well as multiple positions in several non-profit organisations. Her passion for community development and capacity building has led to work in three developing countries, while gaining an appreciation of what diverse cultures can bring to Australian life. Glenda currently chairs a Victorian Primary Care Partnership, while leading an innovative and dedicated team developing and coordinating a range of primary care services in Victoria's south west. Her consulting experience includes working with government departments, NFP Boards and senior management to strategically position themselves to embrace sector and system change; to evaluate current performance and priorities and to develop internal capacity for excellence.

Dr Rodger Brough is an addiction medicine physician who has worked as the alcohol and drug physician at South West Healthcare (formerly Warrnambool & District Base Hospital) since 1987. He is also a consultant with Turning Point's Drug and Alcohol Clinical Advisory Service. He is a fellow of the Australian College of Rural and Remote Medicine and the Australasian Chapter of Addiction Medicine and the Royal Australian College of Physicians. Over the past 30 years, following his term as an HMO at Warrnambool and District Base Hospital and 11 years in general practice (Cambourne Clinic) he has worked in a number of specialist alcohol and drug treatment services including Pleasant View Centre (Melb 1984), St Vincent's Hospital Department of Drug and Alcohol Studies (Melb), Warinilla Clinic (Adelaide), and the WRAD Centre, Warrnambool (1988–2007). Since 2007, he has been involved in the Mental Health Curriculum Working Party and since the School of Medicine opened in 2008 has played a role as Senior Clinical Lecturer (conjoint appointment) in AOD across the medical school curriculum. His principal interests are in the management of drug withdrawal, medical alcohol and other drugs education and rural AOD issues.