Pharmacotherapy maintenance services: A reform agenda

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Basis for this presentation

Victorian Pharmacotherapy Review

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Full report available at:
http://docs.health.vic.gov.au/docs/doc/Victorian-Pharmacotherapy-Review

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Background: Original goals of the Victorian ORT system

The Victorian 'community-based' Opioid Replacement Therapy (ORT) service model was established in the late 1980's - early 1990's

- 1987 – 390 clients (mostly in government services)
- 1994 – 2600 clients (expansion in community ORT services)

Goals:

- Accessible an affordable treatment provided by general practitioners and community pharmacies close to where clients live
- Emphasis on normalising and de-stigmatising opioid dependence
- Funded 'specialist services' to treat the most serious and complex and provide the necessary supports to community-based ORT providers.

Current situation

- Approximately 13,000 clients are currently in ORT in Victoria
- Medications prescribed are: methadone 63%; buprenorphine-naloxone (Suboxone) 30%; and buprenorphine 7%
- 400 active GP ORT prescribers
- 442 active dosing points across Victoria (92% in community pharmacies; 6.0% in correctional facilities; 1.0% in specialist services and 1.0% in hospitals)
- Four metropolitan-based specialist services cater for <5% of the ORT client group
- Widespread agreement (including by DOH) that the Victorian ORT service system is under stress and needs to be reformed. Review commissioned

Methodological features of the review

- Relied on literature reviews conducted recently by DPMP (e.g. Polygon, Ritter & Chalmers 2009); multiple Victorian AOD service reviews; and unpublished DOH data
- Key stakeholder feedback (clients, policymakers, service providers, peak body representatives). Contributions via an advisory group; focus groups and key stakeholder interviews
- We were keen to take a ‘Green field’ approach to the identification of solutions. So based on the literature we identified and described 43 potential strategies to reform aspects of the service system.

Methodology …(cont)

Examples of options included for stakeholder consideration:

- Removing all ORT training requirements for GPs
- Providing on-line training only
- Providing some methadone & buprenorphine supply via ATM-style vending machines
- Establishing a prescribing and/or dispensing ‘bus’ service to increase rural access
- Pursuing pharmacist prescribing
- Providing GP and pharmacist financial incentives
- Proposing that all buprenorphine-naloxone (Suboxone) be delivered unsupervised (monthly scripts)

Methodology …(cont)

Consultative Options paper development

- Based on research evidence this paper outlined 43 options to address identified issues in the Victorian ORT system. The options were considered in light of ORT goals, evidence, expected benefits and concerns

Pre Consultation checklist

- A checklist was developed based on the options paper for completion by all stakeholders. Respondents were asked to indicate the level of priority they would attach to each option (high, medium, low). There was also opportunity to rate an item as not an option (nil priority)

- We wanted to gauge the level of support for different strategies and establish the basis for subsequent debate. Also important information for a government wanting to introduce change

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Data analysis

- 43 checklists were completed and returned.
- We combined high and medium priority scores for each option and retained them if the score reached an arbitrary cut-off point of 65%
- Some that were close to the threshold level were closely examined. The research, stakeholder feedback and % nominating the option as a nil priority were considered prior to exclusion/inclusion
- Any option with 50% of more respondents indicating a nil priority rating was automatically excluded.

Findings

We categorised and ranked the ORT issues under the following headings:

- Lack of program affordability for clients
- Insufficient treatment places (prescribers and dispensers)
- Inadequate specialist system
- Poor referral and support pathways between specialist and primary care
- Workforce development and support issues
- Quality of care issues

Only the top three categories will be considered today

1.The ORT system is not affordable or equitable

- There was almost unanimous agreement that the financial burden of dispensing fees is an issue for treatment access and retention and needs to be addressed urgently. Multiple service evaluations have reached this conclusion.

‘ *‘We have this pathetic fee system that discriminates against these people and places a massive burden on them and just impedes their treatment progress, for what, a couple of bucks? It’s just ludicrous: false economy: it’s terrible, it’s not right, it shouldn’t happen’*

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High fees and consequences

- Dispensing fees are at least $1500 per year in Victoria
- The majority of ORT clients are unemployed and in receipt of some form of government benefit (up to 75%)
- Medical and travel costs also add to the overall financial burden to clients
- Approximately 45% of ORT terminations in community pharmacies are due to financial difficulties
- 38% of client calls to the Victorian Pharmacotherapy Advocacy Mediation and Support Service (PAMS) (HRV) concern fee payment and pharmacy debt issues
- There is no fee relief in the specialist system in Victoria
- There is limited fee relief for others deemed to be ‘high risk’ (clients under 19 years; Juvenile Justice clients on Community Based Orders; prisoners for 4 weeks post-release)

Strategies to address affordability and equity

- Most effective way to do this would be for costs to be covered by the PBS in the same/similar way to other medications (95% support for Victoria lobbying the Commonwealth)
  - Normal concessional co-payments and safety net provisions would relieve what is now an unacceptable financial burden
- The next level strategy supported by KIs was for the State to pay the dispensing fees of certain high risk groups (HIV+, pregnant and breastfeeding women, serious co morbid mental health issues) in addition to those already funded
- Establishment of a new fund be to support clients experiencing financial difficulties (emergency fee relief). Suggested that it could be administered by PAMS
- Travel support strategies to be explored at a regional level recommended

Addressing affordability and equity

- Strategies not supported
  - State to pay all dispensing fees (62% supported)
  - State to pay all dispensing fees or all dispensing fees for clients for 4 weeks (61% supported)

2. There are insufficient treatment places

- Client numbers in ORT continue to go up (at a rate of 10-20% per year)
- There is anecdotal evidence of unmet demand for OST in Victoria – difficult to quantify
- GP interest in ORT participation is low and declining (<10% involved and a 25% decline in numbers since 2008)
  - Consequently a small number of GPs service very large numbers of clients (13% of prescribers now service more than 100 clients each or more than 70% of all Victorian ORT clients)
  - Pharmacy involvement in ORT is low but stable (40% of Victorian pharmacies are involved - a 2.5% increase since 2008)
- Rural and outer metropolitan access issues are acute

Strategies to bolster treatment access

- Greater support needed for GPs & community pharmacists from Addiction Medicine Specialists

'The way to extend the ORT system is through specialist support…[GPs] are afraid of being unsupported'.

'Complex clients are the reason the pharmacists don't take on ORT. Specialist services providing support is important'

Strategies:

- Invest in funded AMS positions
- Commit to AMS training
- Redevelop specialist services to ensure AMS support for generalist ORT providers
- Redevelop specialist services (including rural hubs) to improve client pathways in and out of specialist treatment

Strategies to bolster treatment access …(cont)

Differentiate the permitting and training system for methadone and buprenorphine-naloxone (70% support)

> *'Most AOD doctors and the vast majority of Addiction Medicine Physicians are calling for Suboxone to be de-regulated. Even if the uptake by doctors is low it immediately allows us to build shared-care links and slowly encourage further GP uptake of prescribing'.*

Strategies:

- Maintain existing/similar prescribing arrangements for methadone (unanimous agreement)
- Relax arrangements for buprenorphine-naloxone prescribing
  - » Encourage greater unsupervised monthly scripting for stable clients

Strategies to bolster treatment access …(cont)

- Develop guidelines for unsupervised treatment (63% support)
- Develop a 2-tiered training system to match the training requirements to the safety profile of the medications (70% support)
  - Tier one. AMS-GP evidence of liaison or on-line training for buprenorphine-naloxone prescribing
  - Tier two. Supervised clinical placement in a specialist service or a combined on-line and face-to-face course for other medication prescription

- Strategies not supported:
  - Remove all GP training requirements (14% support)
  - Allow limited GP prescribing outside training requirements (46%)
  - All training to go on-line (55%)
  - Provide unsupervised monthly scripting for all buprenorphine-naloxone prescribing (48%)

Strategies to bolster treatment access …(cont)

- Nurse Practitioner prescribing (61% support)
  - Supported in principle but acknowledged that we are a long way from nurses playing an important role ('long and torturous process to get accreditation')
- Trial of a prescribing and/or dispensing 'bus' to increase rural access (64% support)
  - Mobile service provision in rural areas where there are serious access problems

Other strategies not supported:

- Pharmacist prescribing (41% support)
- Financial incentives for pharmacists (55% support)
- Financial incentives for GPs (60% support)
  - *'It should be like any other form of illness and GPs shouldn't get paid any more for treating drug dependants than asthma or whatever'.*
- Vending machine supply of ORT medications (24%)
  - *'Vendor machine supply is just downright dangerous'*

3. The specialist system is inadequate

- Four specialist services cater for a small number of Melbourne-based clients (less than 5% of all ORT clients and falling - all residing within 15 km of the CBD).
- Not all specialist services have a funded Addiction Medicine Specialist on staff
- Not all specialist services dispense on-site or provide the full range of ORT medications)
- There is no good evidence that the complexity of clients differs between specialist services and GP prescribers & community pharmacies
- There is only very limited evidence that specialist services are able/do provide support to GPs and pharmacists involved in ORT.
- Referral pathways between specialist and generalists are inadequate
- Capacity to address pain management/pharmaceutical opioid dependence treatment is limited

The specialist system is inadequate

- *'I think that Victoria has no specialist pharmacotherapy capacity. [The ORT program] has grown at least threefold and the capacity of the specialist pharmacotherapy services hasn't kept up with it at all. So they're not acceptable'*

- *'Most specialist treatment is done by GPs, sometimes well, sometimes poorly, out in the community because that's where the patients are. The specialist services are boutique services that a very small number of patients can access'*

Strategies to improve the specialist system

- Review and redevelopment of the specialist service system (90% support)
- Recruitment of AMS to be attached to all specialist services (92% support)
- Development of referral pathways between generalists and specialists (98% support)
- Ensure that specialist services have reserved treatment places for special needs/high risk groups (94% support)
- Provision of secondary consultation and case management support to community programs (95% support)
- Development of linked Regional Specialist Hub Services (96% support)
  - Co-located AOD specialist services in key rural areas with an AMS attached to provide specialist services and support for community-based services (prescribers, dispensers)

Three areas of reform that would make a difference

1. Changes to the PBS arrangements are critical and long overdue

- Introduction of co-payment and safety net provisions. Potential for a significant reduction of the cost burden for those least able to pay
- This may also impact on ORT accessibility (pharmacies would have greater obligation to supply medications – Sec 92 of the National Health Act)
- Costs will be substantial
- Leadership and one voice from the sector on this issue is required. Is it still on the agenda?

Reform opportunities

2. Buprenorphine-naloxone (Suboxone) provides the best opportunity to expand client numbers, increase program flexibility and destigmatise opioid dependence treatment

- Unsupervised treatment (monthly scripting) for stable clients
- Permitting and training requirements commensurate with the safety profile of the medication (guidance on the medication, the client group, assessing stability; on-line education resources; liaison opportunity with AMS (24 hour clinical advice)

Reform opportunities

3. Redefine the role of specialist services to reflect that they are a valuable but limited resource

- Provide leadership on clinical management issues (teaching, mentoring, secondary consults)
- Treat small numbers of complex/unstable clients in a shared care arrangement with other providers (GPs, AOD services, Mental Health etc)
- Provide pain management and opioid dependence treatment expertise (mostly secondary consults)

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