‘Just Like Any Other Patient’

Client and Health Provider perceptions following transfer of opioid agonist treatment clients to Primary Care

Benjamin Sherriff[1], Gina La Hera Fuentes[2], Catherine Foley[3], Gillian Raby[2], Michael Doyle[4], Stella Settumba Stolk[3], Anthony Shakeshaft[3,5], Alison Seccull[2,3,6]

The Difference is Research

Background

Opioid use disorder (OUD) is a significant public health issue in Australia and internationally. It is characterized by an inability to control opioid use, leading to physical, social, and psychological harms(1). Opioid Agonist Treatment (OAT) is widely accepted as the treatment of choice for OUD(2). It provides clients with a regular, legally-obtained opioid (methadone or buprenorphine) to reduce cravings and withdrawals(3).

Introduction

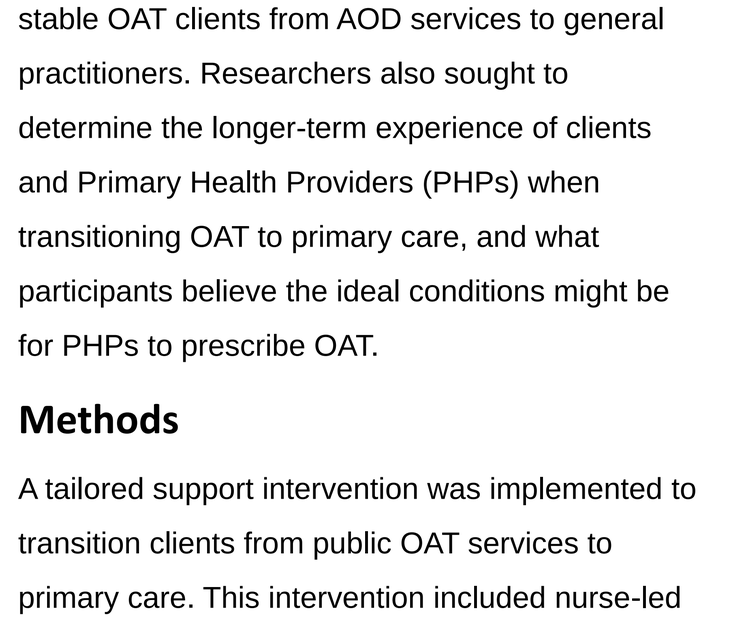
Since 2014, the number of OAT clients in NSW has increased by more than 70% from 14,255 to 24,475 in 2023(3). Of these, 26% (n=6,345) are dosed through public AOD services which often have high numbers of long-term low-risk clients, reducing their capacity to take on clients with a greater need for assertive management(4). Primary care is the ideal setting to provide OAT to clients who are stable in treatment but despite numerous initiatives access is constrained by a lack of OATP , especially in rural and regional areas(5).

Aim

This study sought to pilot select elements of the co-designed model for the transition small numbers of stable OAT clients from AOD services to general practitioners. Researchers also sought to determine the longer-term experience of clients and Primary Health Providers (PHPs) when transitioning OAT to primary care, and what participants believe the ideal conditions might be for PHPs to prescribe OAT.

Methods

A tailored support intervention was implemented to transition clients from public OAT services to primary care. This intervention included nurse-led support, access to a local helpline, in-service education, administrative advice, and patient advocacy. To assess the intervention, client and health professional interviews were conducted at intervals from transfer and up to 15-months post-transfer.



Results

- Eleven clients were transitioned from the public AOD service to primary care practices (n=8) for the provision of OAT under the care of eight general practitioners (GPs) and have remained there for over twelve months.
- Most GPs (n=7) had no prior experience with OAT.
- No clients have returned to hospital-based services, and all remain on OAT.
- All participating GPs have expressed a willingness to continue prescribing.
- Seven clients, three GPs and one practice nurse participated in follow-up interviews

Client experiences and perceptions

- Improved QOL
- Prescriber relationship and continuity of care

“I prefer it, a hundred per cent more… there’s no comparison. It’s just so much more relaxing and…I’m more confident in going to my doctor, because we’ve got a relationship… I think it’s the best thing I’ve ever done”.

-Client Interview 1

“[Primary care is] just so much better because your GP knows your…medical history…She’s my GP and she can keep an eye on me personally…she’s there to support me um through the program and um she does it with my, you know, mental health and physical health as well”.

-Client Interview 3

- Comorbidity management

“I’m finding that it’s overall care than just the fact of one thing”

-Client Interview 1

Prescriber experience and perception

- Rewarding

“The experience was good. It’s easy to do. You get good feedback from patients, get to have a chat about how things are going. you see them regularly and get to know them”.

-PHP Interview 2

- Availability issues were managed well by support systems

“[The patient went] back and forward because I wasn’t working full-time… [at the end] of the last year…and then when she get to the other GP…there is a little bit of hiccup and disputes about that. But later on, I hand over totally and I took full responsibility for the patient”.

-PHP Interview 1

“Difficulty? Only when he goes overseas or something because he's very busy and if he's not there, the [AOD liaison nurse] will find me a doctor to write my script”.

-Client interview 2

- Nurse-led support and implementation was crucial to uptake

“I think the reason [the doctor] took me on, is [the OAT Liaison Nurse] actually rang her and offered her support … because she didn't know anything about the program, she really didn't want to get involved… But once she got that support happening with [the OAT Liaison Nurse], she was more than happy to take me on because she knew [the OAT Liaison Nurse] was available by phone … and it has made a difference to her dealing with me… I think the GPs could use a little bit of support … initially when they take somebody on”.

-Client Interview 3

Implications

The service delivery model addresses a key gap in integrated service provision, providing a framework for feasible and acceptable transfer of stable OAT clients to primary care with retention of supportive and feasible shared care following transfer.

Conclusion

With appropriate selection and preparation, people who are stable in treatment can successfully be transitioned to primary care. By combining tailored interventions with a concierge approach, health services can increase the capacity of PHPs to provide OAT and reduce the potential impact of losing rural prescribers with high numbers of clients.

Acknowledgements

We wish to thank the study participants for generously giving up their time to participate in the study. Thank you to Dr Tony Gill Clinical Director for Alcohol and Other Drug Services MNCLHD, and David Hedger (District Manager for Alcohol and Other Drug Services) for permitting and supporting this project. Thank you to Gillian Raby (Rural Clinical Campus, University of New South Wales (UNSW) Sydney, Coffs Harbour, Australia) for your tireless efforts in supporting the prescribers and clients involved in the pilot trial. Thanks to Shellie Hayman (Nurse Manager for OAT/Substance use in Pregnancy and Parenting Service, and Alcohol and Other Drug Services MNCLHD) for providing support to patients.

References

(1). Buresh, M., Stern, R. & Rastegar, D. Treatment of opioid use disorder in primary care. *BMJ* **373**, n784 (2021)

(2). Longman, C., Temple-Smith, M., Gilchrist, G. & Lintzeris, N. Reluctant to train, reluctant to prescribe: Barriers to general practitioner prescribing of opioid substitution therapy. Aust. J. Prim. Health. 18, 346-351 (2012).

(3). Australian Institute of Health and Welfare. National Opioid Pharmacotherapy Statistics Annual Data collection. https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics (2024).

(4). Bui, J., Day, C., Hanrahan, J., Winstock, A. & Chaar, B. Senior nurses' perspectives on the transfer of opioid substitution treatment clients from clinics to community pharmacy. Drug. Alcohol Rev. 34, 495-498 (2015).

(5). Jones, N. R. et al. Retention of opioid agonist treatment prescribers across New South Wales, Australia, 2001-2018: Implications for treatment systems and potential impact on client outcomes. Drug. Alcohol. Depen. 219, 108464 (2021).

[1]Rural Clinical Campus, University of New South Wales (UNSW) Sydney, Port Macquarie, Australia, [2]Rural Clinical Campus, University of New South Wales (UNSW) Sydney, Coffs Harbour, Australia,[3]National Drug and Alcohol Research Centre, UNSW Sydney, Sydney, Australia, [4]Central Clinical School, University of Sydney, Sydney, Australia,[5]Poche Centre for Indigenous Health, University of Queensland, Brisbane, Australia.[6]Opioid Treatment Program, Coffs Harbour Health Campus, Pacific Highway, Coffs Harbour, Australia