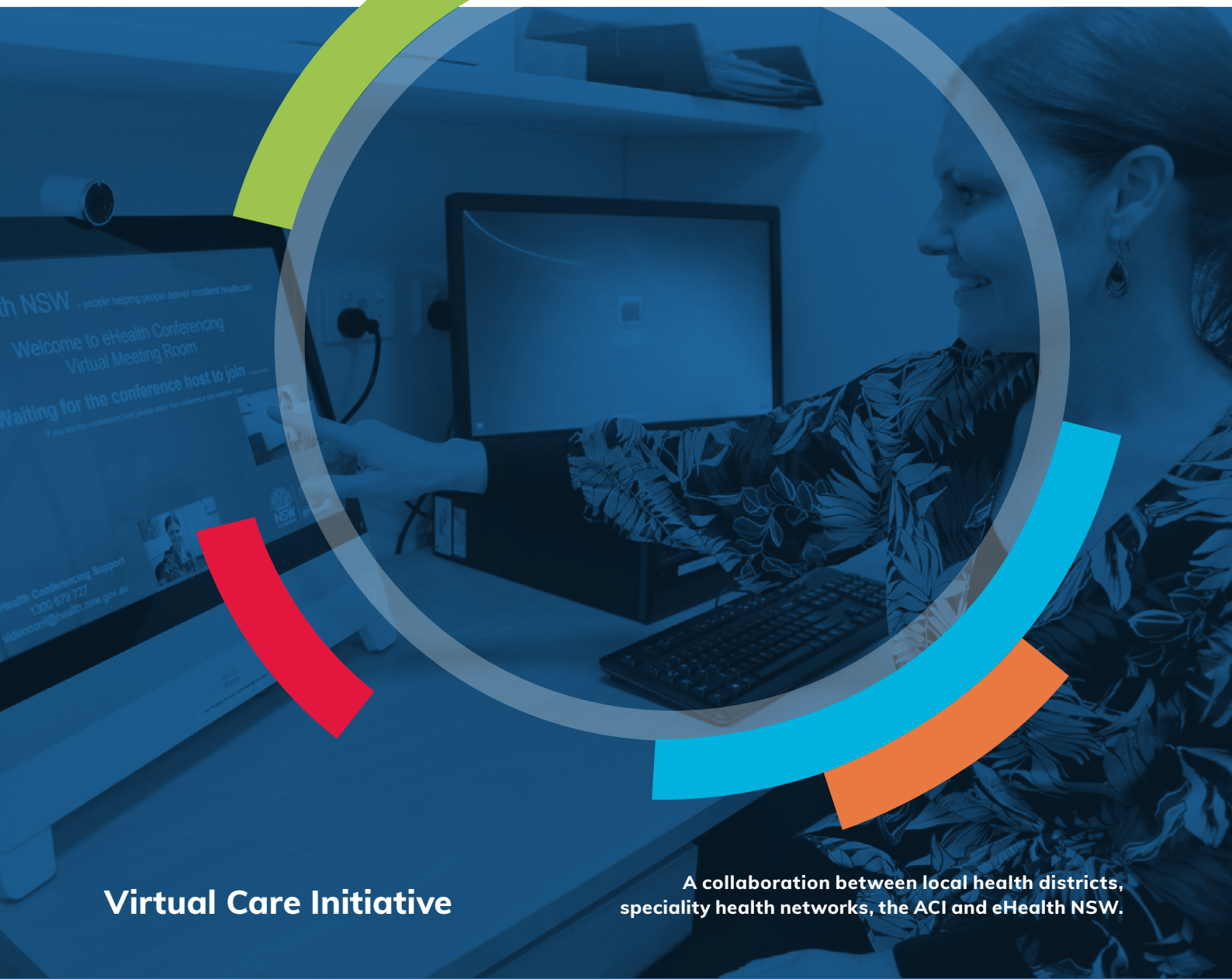
NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

Spotlight on virtual care: Alcohol and Drug Telehealth Service

Alcohol and Drug Telehealth Service
St Vincent's Hospital Network and Murrumbidgee Local Health District

JUNE 2021



Virtual Care Initiative

A collaboration between local health districts, speciality health networks, the ACI and eHealth NSW.

The 'Spotlight on Virtual Care' reports showcase innovation and leadership in virtual health care delivery across NSW. The series aims to support sharing of learnings across the health system and outlines the key considerations for implementation as identified by local teams.

Each initiative within the series was selected and reviewed through a peer-based process. While many of the initiatives have not undergone a full health and economic evaluation process, they provide models that others may wish to consider and learn from.

These reports have been documented by the Virtual Care Accelerator (VCA). The VCA is a multi-agency, clinically focused unit established as a key partnership between eHealth NSW and the ACI to accelerate and optimise the use of virtual care across NSW Health as a result of COVID-19. The Virtual Care Accelerator works closely with Local Health Districts (LHDs) and Specialty Health Networks (SHNs), other Pillars and the Ministry of Health.

Agency for Clinical Innovation

1 Reserve Road St Leonards NSW 2065
Locked Bag 2030, St Leonards NSW 1590

T +61 2 9464 4666 E aci-info@health.nsw.gov.au
www.aci.health.nsw.gov.au

Further copies of this publication can be obtained from the Agency for Clinical Innovation website at **www.aci.health.nsw.gov.au**

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Introduction

The Alcohol and Drug Telehealth Service (ADTS) at St Vincent's Hospital Sydney (SVHS) uses videoconferencing technology to connect Addiction Medicine Specialist Services to clients located in Murrumbidgee Local Health District (MLHD).

Access to specialist substance use disorder treatment in rural and remote areas is limited. General practitioners (GPs) often have limited local referral networks to offer specialist support for people with complex needs. There can also be a shortage of appointments with doctors who are authorised to prescribe methadone and buprenorphine as part of opioid substitution therapy (OST), leading to low coverage and treatment delays.

Fly-in-fly-out models of specialist support are often used by local health districts (LHDs) to support increased access. This model is costly and may not provide adequate coverage or continuity of care. Prior to the introduction of the SVHS ADTS, MLHD relied on a fly-in-fly-out model of specialist support and a one day-a-week specialist clinic located in Wagga Wagga. This resulted in a waiting period of up to three months for people requiring input from an Addiction Medicine Specialist in many areas of the LHD.

The ADTS was launched as a pilot initiative in August 2019 to improve access to addiction medicine specialist services and build the capacity of drug and alcohol (D&A) clinicians in MLHD.

Since February 2021, SVHS has secured ongoing funding to act as an 'Alcohol and Drug Virtual Care Hub' to service rural and remote areas of NSW. This has enabled SVHS to continue service provision in MLHD, provide further support to WNSWLHD and also expand the service further to Southern NSW LHD (SNSWLHD) and Far West LHD (FWLHD). This report will focus on the partnership and service provision between SVHS and MLHD.

St Vincent's Hospital Australia's (SVHA) mission is to care for people who are poor and vulnerable. This service aligns to the mission, as a large proportion of clients with substance use disorders are identified as vulnerable.

Reported benefits of the model

Client benefits

- Increased access to addiction medicine specialists who are authorised to prescribe OST
- Treatment received closer to home, removing the burden of travelling long distances
- Reduced waiting times to see a specialist
- Clients build trust and rapport with the local D&A clinician as they are co-located with them during each consultation
- Improved continuity of care, as the client remains with the same D&A clinician throughout their treatment plan
- Virtual access is supported, removing the need for the client to navigate the use of technology on their own.This also removes the cost associated with accessing virtual consultations
- Improvement in overall physical health through improved access to GPs, as clients access their GP more frequently and some clients may not have previously engaged with a GP.

Clinician benefits

- A rewarding service that fills a recognised gap in specialist support to people who are vulnerable and require addiction treatment
- Greater variation for specialists who see a broader range of clients in different geographical areas with varying concerns
- Increased specialist involvement increases the quality of care and D&A clinician satisfaction with their work
- D&A clinicians based in rural and remote communities gain education, training and skill development in addiction treatment
- The collaborative service model supports bi-directional learning between rural clinicians and specialists working in metropolitan areas
- The service supports rural GPs, who are not registered to prescribe methadone or buprenorphine, to upskill and become registered.

Service benefits

- Virtual care provides greater flexibility for clinics and supports booking of urgent appointments if required
- Reduced reliance on fly-in-fly-out models, with specialist wait times reducing from three months to less than one week
- The cross-organisational partnership between metropolitan and rural health services has resulted in a faster and more responsive service
- Increased access to opioid addiction treatment in rural areas
- An effective service model that can be replicated and expanded
- The service has demonstrated its value and benefits, which has enabled it to secure ongoing funding from the Ministry of Health (MoH)
- Virtual care alleviates the barriers of recruiting addiction medicine specialists in rural LHDs whilst still offering, timely and high-quality care.

Overview of the model

Key elements of the model

Element	Detail
Patient population/Service users	• All clients 18+ with substance use disorders under the care of MLHD Drug and Alcohol Service (including individuals recently released from custody) • Clients 16+ with substance use disorders under the care of MLHD Drug and Alcohol Service, with the approval of the Clinical Director at the SVHS and MLHD Drug and Alcohol Service
Referral pathway	Step 1 - Client referral pathway to MLHD D&A Service: • Referrals primarily come through Accessline (a 24-hour mental health/drug and alcohol telephone acute service that triages referrals) to the MLHD D&A service • Self-referral • Referral from carer/family member and/or GP • Justice Health may use Accessline or contact the MLHD D&A service directly Step 2 - Client referral pathway to ADTS: • Referral letter or form from either a GP, specialist or Aboriginal Medical Service (AMS) doctor to SVHS via MLHD D&A clinicians • MLHD D&A clinicians obtain client consent using the ADTS consent form and send this to SVHS
Healthcare team	SVHS: • Additional medicine specialists • Project manager • Administration officer Murrumbidgee: • D&A clinicians • GPs • Staff at AMSs • Opioid Treatment Program (OTP) clinical lead
Technology	• Cisco DX80 videoconferencing devices (SVHN) • Cisco DX80 or laptop with a webcam is used at the client's location (MLHD D&A service) • Pexip videoconferencing platform • SVHS Community Health Information Management Enterprise (CHIME) system and MLHD eMR (PowerChart).

'The service (ADTS) has given me everything that I need, and I get to see the same doctor continuously which is great. Getting on the program is the best thing I ever did... I was a pretty heavy drug user and now I no longer crave drugs.'

CLIENT QUOTE FROM TUMUT COMMUNITY MENTAL HEALTH/DRUG AND ALCOHOL SERVICE

Services

The ADTS uses videoconferencing technology to enable access to addiction medicine specialists with the aim of:

- improving access to a range of specialist addiction management services, including opioid addiction treatment and
- delivering education for health professionals based in rural and remote areas, building their capacity to support individuals affected by substance use disorder, particularly opioid dependence.

The service provides treatment through a 'shared care' approach where addiction medicine specialists work in conjunction with D&A clinicians as part of a multi-disciplinary team. This consists of:

- clients living in rural areas receiving specialist assessment, care and support via videoconferencing and;
- in-person day-to-day care by the local D&A clinicians in between virtual care appointments.

The ADTS provides virtual care consultations to eligible clients that are referred from the MLHD region. Clients must first be engaged with their local D&A Service and, where they require specialist care, they can be referred to the ADTS by GPs, specialists or doctors working at AMSs*. D&A clients without a GP will be connected with one by the D&A clinician and a GP referral to the service will be obtained.

The D&A clinicians at MLHD triage referrals and complete an in-person assessment with the client before arranging an appointment with the ADTS specialist. Initial in-person assessment with the MLHD D&A clinician includes:

- Australian Treatment Outcomes profile (ATOP) assessment tool
- comprehensive drug and alcohol assessment including a review of client's past medical history.

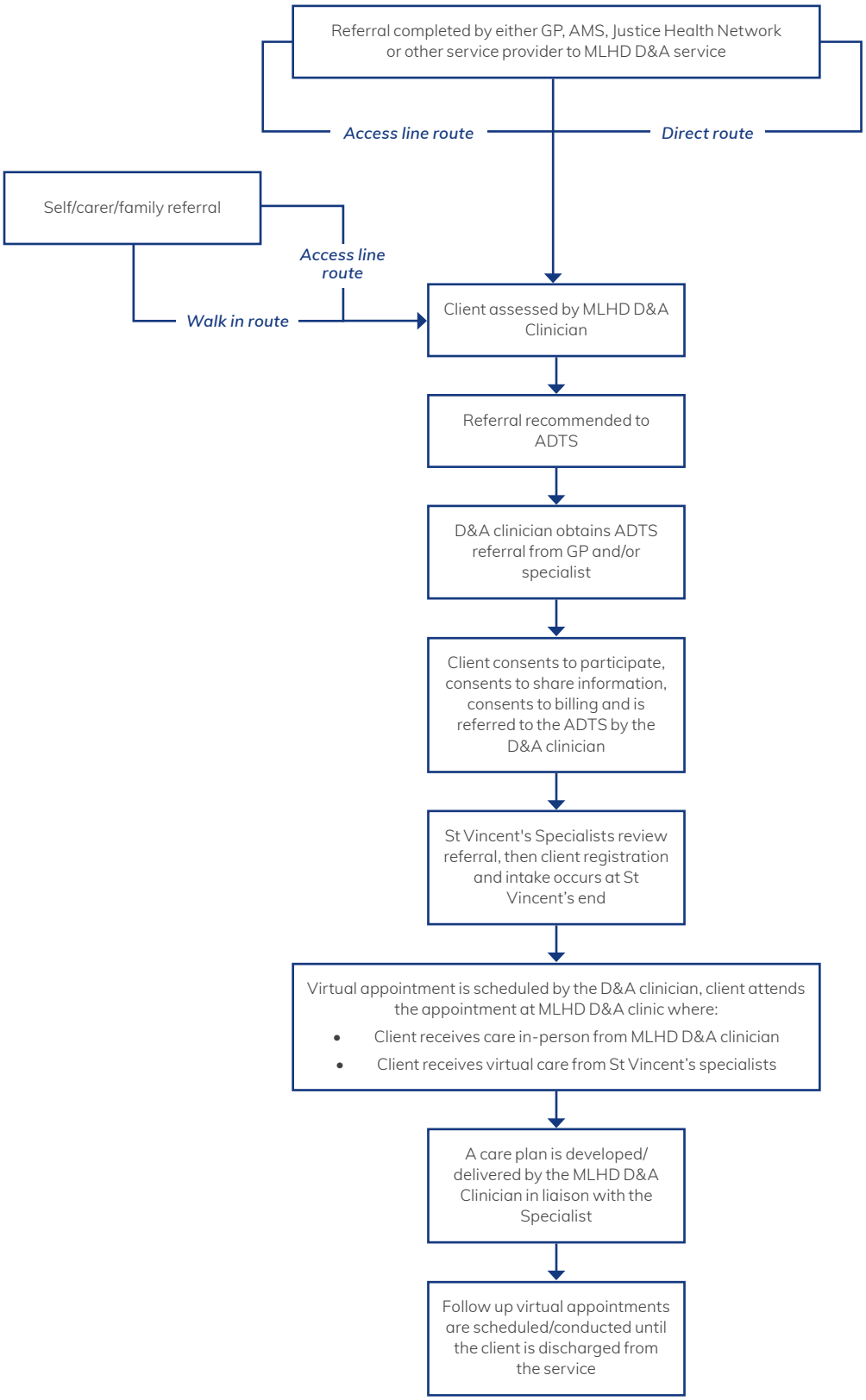
Following this, appointments with ADTS specialists are conducted as below, supported by referral and follow up steps as demonstrated in the workflow diagram (Figure 1):

- Clients are registered by the D&A clinicians, a service request is opened and the referral and consent are uploaded into eMR. Appointments are booked onto the eMR scheduling system and clients are notified of their appointment date and time by the D&A clinician.
- Once the appointment has been booked in MLHD's eMR scheduling system, it is duplicated by the SVHS administrator onto their respective system (see Workforce and resourcing section for further details).
- Scheduling appointments and contacting clients remains the responsibility of the local D&A clinician. If a virtual clinic is underbooked, D&A clinicians from other locations within the district can be given access to the clinic to book their client. The SVHS administration officer monitors clinic utilisation prior to each clinic and will contact the D&A clinicians to support this process.
- If clinics are overbooked or a client from another location requires an urgent assessment with the specialist, the local LHD OTP clinical lead at MLHD will support the decision-making process to determine which clients should be given priority access to the specialist.
- Clinical notes taken during the consultation are entered into MLHD's eMR system by both the clinician and the specialist. The specialist copies these notes over to the SVHS CHIME system. Specialist clinical letters are dictated, transcribed and uploaded into the MLHD eMR, then sent via mail to the GPs or specialist referrers. Scripts are scanned and uploaded to the MLHD eMR and sent via post to the MLHD D&A clinician, who is responsible for delivering these scripts to the dispensing point.

*See ADTS Referral Form in Supporting documents list.

Workflow diagram

Figure 1 – Referral, care provision and consent workflow



Client case study

Helen* was seen in St Vincent's Alcohol and Drug Telehealth Service clinic. She had developed a problem with opioid medication dependence and began sourcing these illicitly after initially being prescribed opioid analgesia following a dental procedure.

While prescribing opioids for dental pain is not uncommon, Helen had previously experienced challenges with methamphetamine use and using opioids became a way of helping her to deal with her stressful social situation. After being dependent on prescription opioids for almost two years Helen was referred to the Alcohol and Drug Telehealth Service.

With the support of the local D&A team, Helen was assessed virtually by an addiction medicine specialist at St Vincent's. She agreed to commence taking Suboxone as part of the NSW Opioid Treatment Program. The D&A team at MLHD provided ongoing support to Helen.

Helen had a virtual follow-up appointment with the St Vincent's Addiction Medicine Specialist a month after commencing her treatment. She cried during the consultation as she was so grateful for the service, which she described as 'giving her her life back'. Helen reported no longer being preoccupied with opioids and was no longer worrying about how she was going to acquire them. She also reported that she was now able to be more present for her four children and had been able to maintain the employment that she had just commenced prior to starting Suboxone.

Without the virtual service, Helen may have had to wait up to three months to commence treatment. By then, there could have been more significant issues with her employment, her family and even the more serious consequence of opioid overdose.

** Name changed to protect client privacy and confidentiality*

Making it happen

This section outlines the key enablers and challenges identified by those involved in implementing this model. Addressing these factors effectively has been critical to successful implementation and these learnings can be used by other health services in the development of local models. The resources listed in the Supporting documents section at the end of this report also supplement these learnings and have been identified throughout the following sections.

Local planning, service design and governance

Service planning

- An existing relationship had already been established between MLHD and SVHS, which enabled preliminary discussions to determine need and interest in a virtual alcohol and drug service. SVHS then proceeded to develop a model of care for the ADTS, with review and input by MLHD.
- The MLHD service commenced as a pilot program in August 2019 for an initial period of nine months. The program was funded by SVHA's Inclusive Health Program, which allocates funding each year to programs that support and deliver the SVHA mission. The pilot aimed to provide addiction specialist services to MLHD.
- The pilot was subsequently extended due to high service uptake, positive client outcomes, and high satisfaction levels reported by clients and D&A clinicians. During the pilot period, the service was delivered to MLHD under a memorandum of understanding (MOU).
- During the design phase of the service, consultation was undertaken by SVHS with a peer worker to discuss the objectives of the model of care and to obtain feedback regarding service assets such as client information sheets, consent forms and referral forms.
- Consultation was also undertaken with Aboriginal health workers to assess the cultural appropriateness of the service.
- Using positive outcome data from the pilot, SVHS successfully obtained ongoing funding from the MoH to extend the MLHD ADTS model and act as a 'hub' to provide virtual alcohol and drug services to other rural and remote communities in NSW. This arrangement is managed through a permanent service level agreement between SVHS and the MoH.

Billing processes

- A valid referral from a doctor (GP or specialist) is required for clients to be seen by a specialist in the ADTS where they are bulk billed via Medicare (where eligible and with the client's consent). The referring doctor's provider number must be included on the referral as this enables SVHS to bill Medicare.
- The client provides written consent to bill Medicare at the time of their initial assessment appointment with the D&A clinician.*
- Where a client is not eligible for Medicare or does not consent to bulk billing, the service is provided at no cost to the client. The activity is recorded in the SVHS patient administration system with a non-charge financial class which is then reported as activity-based funding (ABF) to the MoH. At the time of the specialist consultation, the appropriate Medicare item number is claimed reflective of the care provided to the client.
- This information is uploaded onto SVHS patient administration system, which triggers an electronic claim to be submitted to Medicare.
- At the MLHD end, the D&A clinician's notes are recorded and their time is typically captured in the PowerChart eMR as 'audio-visual client end with clinician' for patient care and ABF purposes.

Clinical protocols

- Day to day clinical care for clients remains the responsibility of the local D&A clinicians and GPs in MLHD. This includes ongoing in-person support between specialist consults, communicating with hospitals or pharmacies dispensing medication and responding to client enquiries. Where a SVHS specialist is a client's nominated OST prescriber, that specialist is responsible for all prescription renewals/changes and other clinical enquiries.
- For OST, the in-person component of the care provided by the local D&A clinician and the clinical staff at the OST dispensing point is a key enabler for specialist input to work effectively using virtual care.
- When specialist input is required in between appointments for OST registered clients (for example for missed doses, script changes, renewals, etc.) the local D&A clinician can notify the specialist of an urgent request for OST script changes via an email to the service administration officer using the 'OAT Changes Form'[‡].
- Clear documentation of the model of care ensures all parties involved understand how the service operates and outlines their role and responsibilities. The roles of the teams at both sites are critical to the success of the service model and are equally dependent on each other.

Service model

- Specialist care is provided to clients via videoconferencing in the presence of their local D&A clinician at a local health facility. In some cases, clients may connect directly with the specialist from their home or workplace using their own technology. In these instances, the local D&A clinician is still always in attendance at the virtual consultation, usually connecting from the D&A clinic. This is generally only applicable to follow up patients who are well engaged with treatment, stable and in close contact with their MLHD D&A clinician and/or their GP as part of their addiction treatment. In these circumstances, the local D&A clinician will always be aware of the client's location in the event of an emergency.
- The beginning of each virtual clinic is reserved for a clinical review meeting (CRM) between the D&A clinician and the specialist. This enables discussion of treatment plans for clients of the service, as well as facilitating clinical collaboration, capacity building and information sharing.
- The service aims to build the capacity of local D&A clinicians (and GPs where applicable) to support individuals affected by substance use disorder, particularly opioid dependence. Where local GPs are not registered to prescribe, the service offers upskilling and support to prescribe OST or become registered.
- Client safety is managed by the local D&A clinicians who are present in the room with the client during the virtual consultation and supported by the specialist at SVHS via videoconferencing.

Clinical governance

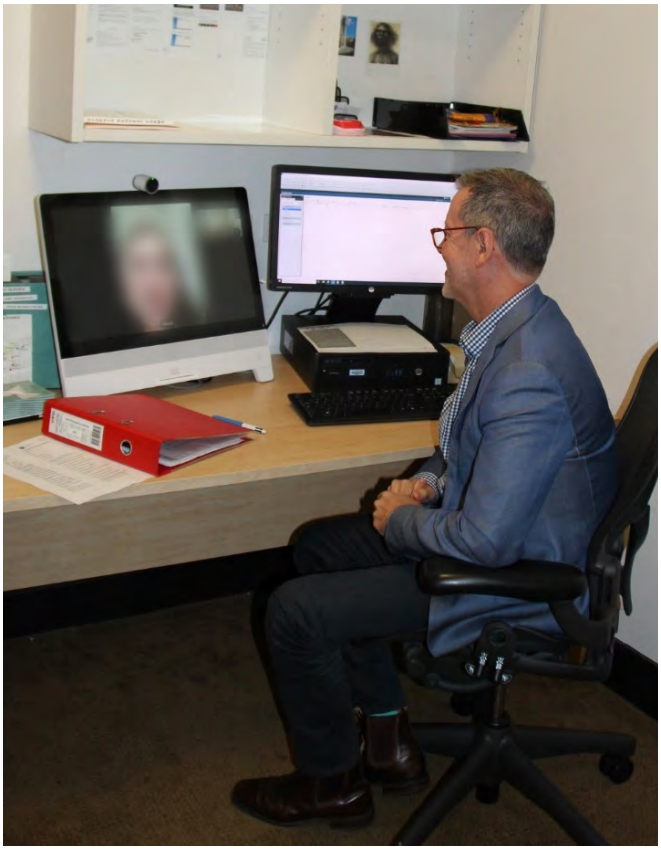
- Clinical governance at MLHD and SVHS operates in accordance with local protocols and procedures. The clinical governance of the ADTS is overseen by the ADS clinical governance committee at SVHS.
- The D&A clinicians and specialists are in regular contact and work closely as an integrated care team. Both teams meet regularly in accordance with the review schedule as outlined in the ADTS' collaborative services agreement.
- The SVHS specialists are credentialled and appointed as visiting medical officers (VMOs) at MLHD and are professionally accountable to the Clinical Directors of Drug and Alcohol at both MLHD and SVHS. There are regular service monitoring meetings where the service managers and directors from both SVHS and MLHD can discuss any service issues.
- There is an interagency incident management protocol which outlines the response required when a clinical incident occurs within the ADTS. This involves the teams at both sites notifying one another to ensure immediate action is taken and that any follow-up actions are implemented. All clinical incidents are recorded in both clinical systems: MLHD's Incident Management System (ims+) and SVHS's risk management system (Riskman).

[‡]See OAT Changes Form in Supporting documents list.

Building engagement

Key partners and stakeholders

- The successful delivery of the ADTS model is based on the relationships established between the teams at SVHS and MLHD. Relationships have been strengthened through the support network established at SVHS by both the specialists and non-clinical staff. For example, the SVHS administration officer will contact the MLHD D&A clinicians and/or the LHD OTP clinical lead via telephone if support is required with clinic bookings. Equally, the responsiveness of the MLHD support team is also crucial to the success of the ADTS, as it ensures that the service operates at its optimal level and responds to service needs
- A key element in building trust, rapport and the credibility of the service is the openness to learning and willingness to genuinely collaborate demonstrated by metropolitan providers
- Hospital and local pharmacy engagement is important, as they are responsible for dispensing medication (including but not limited to OST medications) in accordance with prescriptions that are issued by the specialists and locally coordinated by the D&A clinician. The local D&A clinician contact details have been shared with hospitals and pharmacies to assist with prescription queries. Additionally, the support of the Pharmaceutical Regulatory Unit (PRU) at the MoH is essential for provision of OST via a virtual care service model. PRU were consulted and gave their formal approval of the MoC prior to the commencement of the ADTS.
- Prior to the service's launch, information briefings were conducted by SVHS with the D&A clinicians. This included how to engage with the ADTS, and was supported by the MLHD D&A management team.



An addiction medicine specialist at St Vincent's Hospital using a Cisco DX80 to connect and provide a virtual assessment to a client.

- SVHS staff visited MLHD at the start of the service and, in partnership with MLHD, provided information to local GPs about the service model and its benefits. Engagement with GPs continues to be a priority and is supported by the local D&A clinicians who visit GP practices regularly to encourage referrals into the service.
- Murrumbidgee Primary Health Network (PHN) supports engagement with local GPs. The MLHD team and SVHS share information about ADTS and training courses on the PHN's monthly bulletin to encourage interest from GPs.

Staff engagement and ownership

- The clinical lead of the ADTS took on the role of clinical champion at SVHS to promote the service to other specialists.
- SVHS completed a series of internal project steering committee meetings during the service development period, which focused on engaging specialists and development of the model of care. This enhanced medical staff engagement with the service.
- Engagement with specialists was also achieved by aligning the objectives of the service to the organisation's mission: to care for the poor and vulnerable (noting that individuals experiencing substance use disorder are identified as vulnerable and a priority for support by SVHS). SVHS also has a strategic objective of being an innovator within the alcohol and other drugs (AOD) sector.
- The MLHD Director of Mental Health and Drug and Alcohol, Manager Strategic Development Drug and Alcohol and Early Intervention Programs and LHD OTP clinical lead took on responsibility for orienting SVHS to MLHD systems and processes, promoting the project across the LHD and engaging staff and stakeholders in the service.
- Providing local clinicians and GPs with education, training and skill development in opioid addiction treatment has led to increased satisfaction rates amongst local staff. This supports better engagement with the ADTS and higher rates of referral.
- The D&A clinicians at MLHD act as champions and promote the service by sharing their experiences with other facilities and with local GPs.

Engaging with clients

- Local D&A clinicians play an important role in helping clients to navigate through the experience of receiving care virtually (e.g. advising what to expect during the assessment through the provision of advice and client information sheets)[§]. They also manage a client's day-to-day care and are the local contact for the ADTS if a client or GP has a query.
- The service offers continuity of care by providing clients with a single point of contact (the local D&A clinician) as well as access to an addiction medicine specialist throughout their treatment. This has led to increased engagement from clients to the service.
- The LHD OTP clinical lead and D&A clinicians have worked closely with the community and local GPs to provide education on service inclusions.

'Our partnership with St Vincent's Alcohol and Drug Telehealth Service assists to address equity and quality of access issues for rural and remote drug and alcohol clients and clinicians. In particular, the service has demonstrated the capacity to alleviate the rigours of remote area travel, assist with transport/access issues, assist with GP and medical specialist access and provide flexibility enabling timely interventions.'

- GAYLE LINDEMAN, DRUG AND ALCOHOL ACTING CLINICAL LEADER, MLHD

[§]See ADTS Client Information Sheet in Supporting documents list.

Workforce and resourcing

Appropriate technology

- The model uses the Pexip videoconferencing platform to connect clients and D&A clinicians to the specialist.
- Cisco DX80s are used at the specialist end and either a DX80 or laptop with a webcam is used at the client's location.
- Assisted videoconferencing is used by the service, where the client attends a technology enabled consultation in a local health facility with the support of a local D&A clinician who is involved in their care.
- The SVHS specialists have remote access to the MLHD electronic medical record (eMR). Clinical notes are recorded in MLHD's eMR and then transcribed/copied to SVHS's CHIME system.
- For clients commencing OST, the prescription is scanned and uploaded onto the two eMR systems by SVHS. The original prescription is sent via mail from SVHS to the relevant D&A clinician at MLHD who forwards onto the pharmacy where the medication has been dispensed.
- Due to the interagency nature of the ADTS model, all clinical notes/scripts must be entered onto both clinical systems at MLHD and SVHS for record keeping purposes.

Staff training

- To support specialists to transition to virtual care, resources from professional colleges were used to provide guidance on delivering care using videoconferencing. For example, guidance on virtual care etiquette during consultations and patient safety processes were shared.
- Virtual eMR training was delivered by the Mental Health D&A Information Manager Clinical Data at MLHD to the SVHS ADTS team. An ADTS telehealth procedure guide was developed to outline the system processes involved for the client pathway.
- Instructional guides for the ADTS specialists and clinicians were developed to assist training on how to use the pexip videoconferencing platform.
- All specialists working in the ADTS complete training related to:
  - the staff profile of MLHD D&A
  - D&A services that are available within the region
  - OTP prescribers in MLHD and other considerations for working in rural/remote areas
  - cultural competency.

Staffing model

SVHS:

- 0.2 FTE addiction medicine specialists - based at SVHS. Lead the service and provide clinical care to clients who live in MLHD region.
- 0.7 FTE project manager - coordinates the development, implementation and ongoing management of the service, provides technical support, monitor service outcomes and ensures cost effectiveness of the model.
- 0.7 FTE administration officer - provides administrative support for tasks such as Medicare billing, clinic bookings and prescription coordination. This role is critical to ensure clinic capacity is maximised and that the specialists are supported with administrative tasks associated with providing clinics and issuing prescriptions. Having a dedicated administration resource is essential for the service to operate effectively. This is not only required for the interagency system management but also the administrative work related to the regulatory requirements involved with OST prescriptions.
- 0.05 FTE clinical lead (addiction medicine specialist) - oversees the clinical management of the service and acts as a clinical champion.

'Interagency management and logistics are the key challenges associated with operating this type of service. Without dedicated administration support the service would not operate effectively.'

MARIE HAMILTON-SMITH, PROJECT MANAGER, ALCOHOL AND DRUG TELEHEALTH SERVICE, ST VINCENT'S HOSPITAL

MLHD:

- The MLHD Director of Mental Health and Drug and Alcohol, Manager Strategic Development Drug and Alcohol and Early Intervention Programs and LHD OTP clinical lead provide in kind contributions as part of their substantive roles in developing the pilot, implementing the ADTS model, monitoring service delivery/outcomes and overseeing the program from the MLHD side.
- Existing D&A clinicians (generally a nurse or allied health worker) based in the MLHD region are involved in day-to-day care of clients in liaison with the specialist. The D&A clinicians provide significant in-kind support to the service by ensuring all relevant administrative and clinical processes are in place before the client has their appointment with the specialist. Their role is a key enabler of the service as they act as the central point of contact for GPs, clients and the specialists.

Considerations for funding and sustainability

- Introducing new ways of working or new services requires a review into the current workload of clinicians and support positions to assess their role and how they can deliver the service objectives.
- The ADTS bulk bill all eligible clients through Medicare. While this generated a revenue stream for the ADTS, this alone was insufficient to cover the ongoing operating costs of the service which led to financial sustainability concerns. Securing ongoing block funding from the MoH in February 2021 addressed this shortfall and enabled the service to continue and expand beyond the pilot period.
- The number of clients seen in each virtual clinic directly influences the revenue generated by the service. 'Did not attend' (DNA) rates are generally higher in drug and alcohol services than other clinical services due to the nature of the client's substance use issues. When clients do not attend their appointment, the specialist wages are still paid by the service even though the service cannot bill Medicare for the specialist's time when clients do not attend. To mitigate this, where notice of cancellation is provided, appointments are offered to other MLHD D&A clinicians. Specialists often use time from missed appointments to undertake clinical reviews with the D&A clinicians or to complete script writing. The D&A clinicians also contact clients before appointments and send a reminder to attempt to reduce DNA occurrences.
- Operating an interagency specialist addiction service is labour intensive due to coordinating client appointments and clinical information across multiple systems. There is also a high burden associated with OST care delivery due to regulatory compliance tasks and handling secure document exchange for OST scripts. The administrative resource on both the SVHS and the LHD side is essential to support these tasks.
- A considerable amount of work must be completed outside of clinic session times to support the effective delivery of a client's treatment. Examples include providing advice to MLHD D&A clinicians in relation to clients seen, providing prescriptions, and preparing new prescriptions when there are changes to OST medication arrangements. Each of these activities result in 'non-billable' work by the specialist.

'I have been on the Opioid Treatment Program with four different services in Queensland and NSW. When we were moving from Newcastle to country NSW, I was quite worried about transferring to a rural Opioid Treatment Program.

Then I came into the care of Dr Gill from St Vincent's ADTS Telehealth Service, and Gayle, the local Opioid Treatment Clinician. I have found the service is incredible and better than any other I have ever dealt with – public or private. It is such a good idea. From a rural town, I have access to the best doctors in the country. The service is above and beyond what I thought was possible. And, Pexip/Telehealth saves on greenhouse emissions – there are so many positives.'

CLIENT TESTIMONIAL, DENILIQUIN COMMUNITY MENTAL HEALTH/DRUG AND ALCOHOL SERVICE, MLHD

Benefits of the model

Results

There were 553 non-admitted patient occasions of service conducted between August 2019 and May 2021.

In the first year of service delivery, 98 multi-disciplinary clinical review meeting sessions were conducted by SVHS specialists supporting MLHD D&A clinicians.

196 individual clients received treatment with the service between August 2019 and May 2021.

90 clients have been supported through the service by SVHS addiction medicine specialists to access the NSW Opioid Treatment Program (OTP), with 58 clients actively receiving OTP as of May 2021.

Average wait time is less than one week from receipt of referral to first virtual care appointment with an Addiction Medicine Specialist, compared to two to three months before the service commenced.

Pilot results

100% of clients would be happy to have a future consult using virtual care.

100% of clients agree a virtual consultation was a convenient way to receive their care.

67% of clients neither agreed or disagreed that in-person care was preferential and 17% disagreed altogether.

100% of clients agreed that virtual care saved them time.

Benefits

1. Wait times to receive specialist addiction management care have significantly reduced.
2. MLHD D&A clinicians have been provided with increased opportunities to receive specialist supervision, guidance and capacity building.
3. SVHS specialists work closely with local GPs to provide mentoring support to build confidence and experience with OST prescribing.
4. Ensures continuity of care, as clients remain with the same D&A clinician and specialist throughout their treatment program.
5. Establishment of an effective and sustainable partnership across rural LHDs and metropolitan health services.

Monitoring and evaluation

- SVHS continues to collect occasions of service data and patient experience measures on a monthly basis. These are reported at local governance committees.
- A high-level evaluation report was completed at the closure of the pilot to present client survey feedback and a summary of activity delivered during the pilot period. The results have shown a high satisfaction rate amongst clients (see results section).
- SVHS was awarded with a Translational Research Grants Scheme (TRGS) from the MoH to further evaluate the outputs and outcomes of the ADTS pilot program (August 2019 – December 2020). The TRGS funded initiative, known as 'The Hub Project', is a multi-research study designed to evaluate the effectiveness of the model of care and its financial sustainability. The research study will also evaluate the costs of fly-in-fly-out addiction management services compared with the cost of virtual care. Initial findings from the pilot program indicate that virtual care offers a cost-effective model, however, formal results of the study will not be available until late 2022.

A D&A clinician from Deniliquin community drug and alcohol service connecting with a SVHS specialist for a clinical review meeting.

Opportunities

- The ADTS demonstrated high levels of client and clinician satisfaction, which has enabled it to expand the model to other rural LHDs such as WNSWLHD, SNSWLHD and FWLHD with MoH funding. Service inclusions may differ for each rural LHD, for example at WNSWLHD clients may receive in-person consultations by a specialist, as well as virtual care.
- Unassisted videoconferencing would operate well at both rural and metropolitan sites for other addiction treatment services that do not involve prescribing, where the client has the technology/capacity to join the virtual consultation and it has been deemed clinically appropriate for the client to join from a suitable location, i.e. their home or workplace. A MLHD D&A clinician would still need to be present in the consultation (i.e. joining from the clinic), due to the shared care approach in the model of care.
- Specialised psychology, broader mental health and pain management are services that would integrate well with the ADTS virtual care model and would provide a more holistic approach to the client's care.
- The model of care developed by SVHS and MLHD is highly scalable and could be implemented by other LHDs interested in acting as a hub. At present, SVHS is sharing the ADTS model of care, processes and lessons learnt with Hunter New England LHD, which has recently been funded by the MoH as the other key hub for providing virtual alcohol and drug services to rural and remote communities in NSW.
- As myVirtualCare (myVC) continues to be rolled out across the state, there may be an opportunity to transition from using Pexip to myVC as the primary platform for ADTS care delivery.

Supporting documents

OAT Changes Form – A form used by the D&A clinicians to request prescription changes with the SVHS specialists.

ADTS Consent Form – A form used by the MLHD D&A clinician to obtain patient consent prior to referring to the ADTS.

ADTS Referral Form – The referral form used to refer clients to the ADTS.

ADTS Client Information Sheet – Information sheet provided to clients before their virtual consultation.

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Glossary and definitions

Alcohol and Drug Telehealth Service	ADTS	St Vincent's Hospital Sydney, Alcohol and Drug Service
Australian Treatment Outcome Profile	ATOP	Validated brief instrument used in alcohol and drug services, that is clinician administrated, self-reported and assesses clients' range of substance use, health and well-being measures over the past 28 days.
Fly-in-fly-out model	FIFO	FIFO involves addiction medicine specialists from other areas visiting the LHD or remote health facility at agreed intervals to deliver health services to clients who live in that area.
In-person care		A method of providing care where patients attend in person with the clinician for assessment and treatment
Opioid substitution therapy	OST	Long-term treatment approaches that involve the regular provision of long-acting opioid medicine in addition to regular monitoring and psychosocial supportive care
Opioid treatment program	OTP	The NSW Opioid Treatment Program (OTP) provides opioid replacement therapy for people who are dependent on opioids such as heroin, morphine and oxycodone.
Peer worker		An individual employed based on their personal lived experience of substance use disorders and recovery, or their experience of supporting family or friends with this.
Virtual care		A modality used to connect and provide care – it connects clinicians or any other person(s) responsible for providing care to patient(s) and carer(s). It can be used for the purposes of assessment, intervention, consultation, education and/or supervision.

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