PHARMACOTHERAPY

CHAIR: BRYAN AMBROSIUS, CATCHMENT MANAGER, ODYSSEY HOUSE

1. Pharmacotherapy - A Consumer Perspective
2. Will Victoria's troubled heroin treatment program survive?
3. An implementation-efficacy trial of a collaborative prescriber-pharmacist model for MATOD

vaada CONFERENCE FEBRUARY 9-10 2023
Shifting Landscapes
Building the Holistic Treatment Mosaic

An implementation-efficacy trial of a collaborative prescriber-pharmacist model for MATOD

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EPIC-MATOD Implementation Study

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Background

- Demand for Medication Assisted Treatment for Opioid Dependence (MATOD) exceeds capacity
- In Victoria, it was estimated that there were 1054 prescribers for 14,804 people in 2021
    - In the last 5 years have lost 386 prescribers
- Efforts to attract and retain new prescribers have largely been unsuccessful

Extending the role of Community Pharmacists to improve access to MATOD

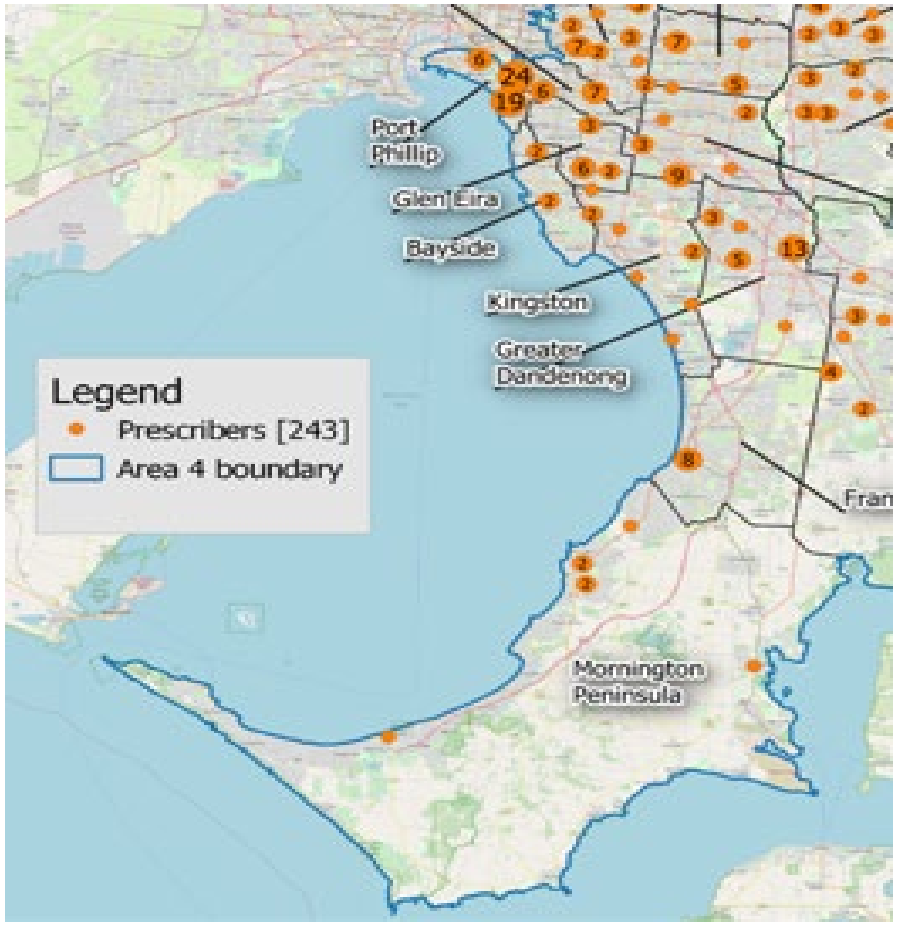
- 92% of MATOD supervised dosing in Victoria occurs in community pharmacies
- Broader geographical spread of MATOD pharmacies compared to prescribers
- Opportunity to extend roles within pharmacist scope of practice

Collaborative care models of MATOD internationally

- Pharmacist-prescriber shared-care improves treatment access & retention & reduces prescriber workload (DiPaula and Menachery 2015)
- Collaborative model was safe, considered highly feasible by both pharmacists and patients, and adaptable to changing patient needs during COVID-19 (Green et al., 2020)
- Physician-delegated induction with buprenorphine associated with higher retention than usual care (Green et al., 2023)

Enhancing Pharmacist Involvement in Care (EPIC)-MATOD project

- High levels of socioeconomic disadvantage and opioid-related harm relative to other areas in Victoria
- Poor public transport (2 hrs to get to a prescriber)
- 15 MATOD prescribers in the whole region with most patients managed by 2-3 prescribers in Frankston (est. 1400 patients each)
- Efforts to ↑ GP prescribers have failed



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MATOD = Medication Assisted Treatment for Opioid Dependence

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Developing partnerships to guide development of a Collaborative Care Model

- FMP-PCP & Peninsula Health, MARC, peak professional bodies (AMA, RACGP, Pharmacy Guild, PSA, HRVic)
- Area Pharmacotherapy Network
- Collaboration & involvement of peak bodies key to ensuring co-design
- Peer involvement at every stage

Settings assessment & co-design with Clinical reference group

Interviews with consumers, pharmacists, prescribers and other stakeholders (n = 30)

Identify barriers and enablers to address through implementation

- Understand training needs
- Confidence/competence
- Attitudes to collaborative care arrangements
- Resource needs
- Physical space requirements in pharmacies
- Information sharing and clinical record keeping systems

Workshopped model of care with Clinical Reference Group

Implementation strategies/model features identified through settings assessment

- Training and **competency assessment** (OSCE) to support prescriber confidence to delegate tasks
- **Individualised treatment agreements** to inform care
- **Flexibility to delegate** (or not delegate) specific tasks (dose adjustment, adjusting takeaway doses, and reinducing patients after missed doses), depending on patient needs and pharmacist relationship
- **Standardised review process, validated tools**, clear points for contacting the prescriber, structured reinduction protocol
- Extensively reviewed **Clinical Practice Guidelines** to support practice
- Requirement for separate room or **confidential space**
- **Remuneration** to allow scheduling of additional pharmacist
- Dosing fees paid for in the pilot study to remove this as a confounding factor
- Clearly specified **communication requirements** (e.g., Communication log and standardised forms for clinical records)
- Changes in the treatment plan **communicated by pharmacist** within 24hrs

Training requirements

- EPIC-MATOD training and OSCE
- Victorian Opioid Pharmacotherapy Program (PSA)
- Long-acting Injectable Buprenorphine (PSA)
- Mental Health First Aid/Suicide Prevention

Collaborative Treatment Agreement

Appendix 4: Collaborative treatment agreement (CTA)

Enhancing Pharmacist Involvement in Care in Medically Assisted Treatment for Opioid Dependence (EPIC-MATOD)

Collaborative Treatment Agreement

[SAMPLE AGREEMENT]: This document establishes formal agreement for the participating pharmacist(s) to continue, discontinue, taper, and modify opioid agonist treatment within a shared care treatment plan. This agreement is to serve as a delegation of specific roles, functions and authority by and between prescriber(s) and the pharmacist(s) herein. A formal guidance document for collaborative-care with opioid agonist treatment will provide a detailed description of the type and extent of services the pharmacist(s) will provide. This will ensure that each patient referred to the pharmacist(s) for opioid agonist treatment will receive a pre-established standard of care. and the referring provider(s) will have detailed information about the services the

Qualifications of participating pharmacist

- *Pharmacist(s) must be registered with AHPRA and completed the shared-c credentialing*

Qualifications of participating prescriber

- *Medical practitioner(s) participating in this agreement must hold a curren opioid-dependent person with methadone or buprenorphine and have con 2 of the training for pharmacotherapy prescribers outlined in the Victorian opioid dependence*

Informed consent

- *Prior to providing services to patients pursuant to this agreement, the pre from each patient, which will be reflected by signing this agreement.*
- *Signing the treatment agreement shall indicate consent for: (1) the releas between the pharmacy and prescriber; (2) the treatment services the patie the pharmacist; and (3) awareness of the right to withdraw at any time fr may withdraw consent at any time by submitting a verbal or written requ*
- *Currently, collaborative care is only available as part of the 'Enhancing Ph Medication Assisted Treatment for Opioid Dependence' Study. Consent fo data for research purposes will be obtained separately.*

Communicating/acceptable methods of communication

- *All communication of health information, including via electronic means, r patient's privacy. All personal and health information must be handled in Records Act 2001 and The Information Privacy Act 2000.*
- *Communication relating to clinical care will occur within timeframes outli*

Individualised agreement

Scope of disease agreement

- *Pharmacist(s) and collaborating prescriber(s) will manage patients receiving medication assisted treatment for opioid dependence.*

Eligibility

- *Patients with a serious medical condition that, in the opinion of the study medical clinician, would make participation difficult or medically hazardous/unsafe this could include will not be eligible to participate. These conditions may include but are limited to acute psychiatric disorders, presence of suicidal or homicidal ideation and pregnancy*

Minimum pharmacy review frequency (determined by the prescriber)

- *The patient should be reviewed by the pharmacist at least every _____weeks until _____[date]*
- *Pharmacist reviews must be documented in the patient file and an electronic/faxed copy provided to the prescriber within 24 hours of review completion.*

Delegation of tasks

- *The delegated pharmacist will provide services to **assess progress in opioid agonist treatment** and make recommendations for treatment, including opioid agonist therapy changes. Opioid agonist therapy changes will be documented in the review summary which will form part of the patients file, with an electronic/faxed copy provided to the prescriber within 24 hours of completion.*
- *The pharmacist(s) may alter the opioid agonist treatment regimen within the following parameters, and according to the study clinical guidance document:*

Task to delegate.	Not delegated
1. Adjust doses of drug name _____ between the range of _____mg to _____mg per day	❑
2. Determine the number of takeaways provided a week, between the range of _____ to_____ (Not applicable for LAIB)	❑
3. Perform a review and recommence treatment if the patient has missed 4 consecutive doses, but no more than 28 consecutive buprenorphine doses (or LAIB equivalent) or 6 consecutive methadone doses, provided the prescription is still valid.	❑

Signature_____ Date _____

Patient (Name)_____(DOB)_____

Signature_____ Date _____

Pharmacist (Name)_____(Practice Address)_____

Signature_____ Date _____

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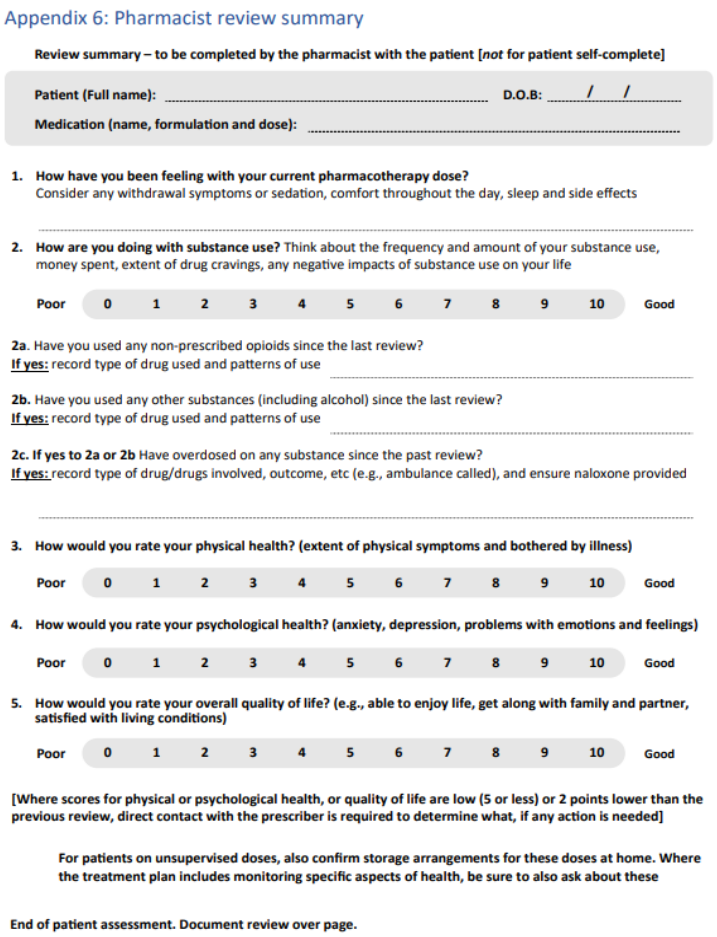
Pharmacist review summary

- Completed by the pharmacist and sent to the prescriber within 24 hours of completion
- Includes items from the ATOP and TEA
- Short (~15 min) but with key prompts around stability and risk factors
- Developed to facilitate pharmacists' clinical record-keeping and provide consistency in reviews



Appendix 6: Pharmacist review summary

Review summary – to be completed by the pharmacist with the patient [*not* for patient self-complete]

Patient (Full name): _____ **D.O.B:** ___/___/___

Medication (name, formulation and dose): _____

1. **How have you been feeling with your current pharmacotherapy dose?**
Consider any withdrawal symptoms or sedation, comfort throughout the day, sleep and side effects

2. **How are you doing with substance use?** Think about the frequency and amount of your substance use, money spent, extent of drug cravings, any negative impacts of substance use on your life

Poor 0 1 2 3 4 5 6 7 8 9 10 Good

2a. Have you used any non-prescribed opioids since the last review?
If yes: record type of drug used and patterns of use

2b. Have you used any other substances (including alcohol) since the last review?
If yes: record type of drug used and patterns of use

2c. If yes to 2a or 2b Have overdosed on any substance since the past review?
If yes: record type of drug/drugs involved, outcome, etc (e.g., ambulance called), and ensure naloxone provided

3. **How would you rate your physical health? (extent of physical symptoms and bothered by illness)**

Poor 0 1 2 3 4 5 6 7 8 9 10 Good

4. **How would you rate your psychological health? (anxiety, depression, problems with emotions and feelings)**

Poor 0 1 2 3 4 5 6 7 8 9 10 Good

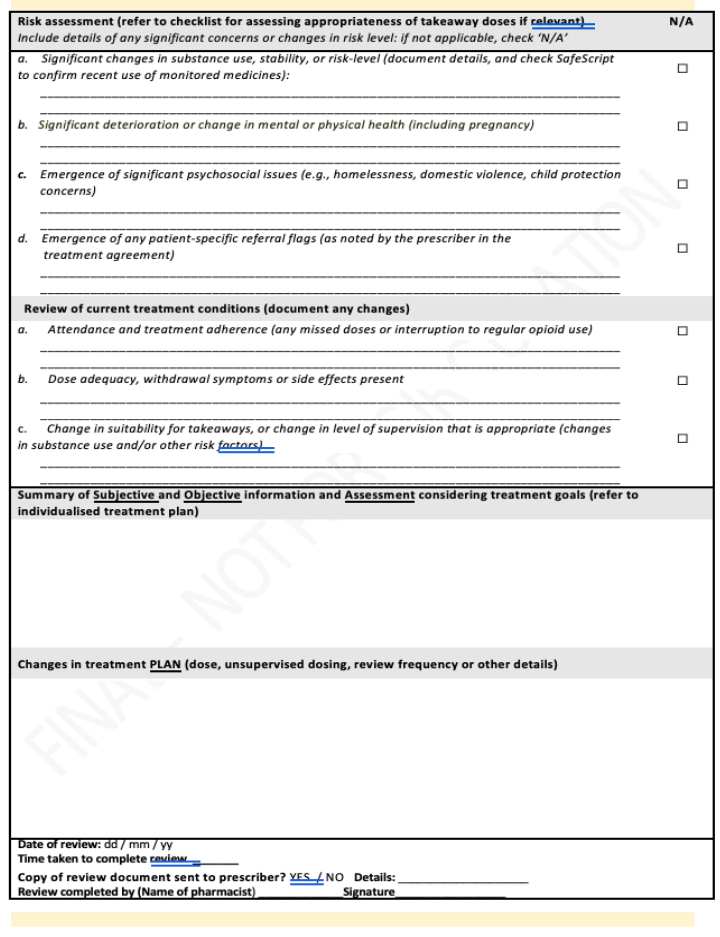
5. **How would you rate your overall quality of life? (e.g., able to enjoy life, get along with family and partner, satisfied with living conditions)**

Poor 0 1 2 3 4 5 6 7 8 9 10 Good

[Where scores for physical or psychological health, or quality of life are low (5 or less) or 2 points lower than the previous review, direct contact with the prescriber is required to determine what, if any action is needed]

For patients on unsupervised doses, also confirm storage arrangements for these doses at home. Where the treatment plan includes monitoring specific aspects of health, be sure to also ask about these

End of patient assessment. Document review over page.



Risk assessment (refer to checklist for assessing appropriateness of takeaway doses if relevant) N/A
Include details of any significant concerns or changes in risk level: if not applicable, check 'N/A'

a. *Significant changes in substance use, stability, or risk-level (document details, and check SafeScript to confirm recent use of monitored medicines):* ☐
b. *Significant deterioration or change in mental or physical health (including pregnancy)* ☐
c. *Emergence of significant psychosocial issues (e.g., homelessness, domestic violence, child protection concerns)* ☐
d. *Emergence of any patient-specific referral flags (as noted by the prescriber in the treatment agreement)* ☐

Review of current treatment conditions (document any changes)

a. *Attendance and treatment adherence (any missed doses or interruption to regular opioid use)* ☐
b. *Dose adequacy, withdrawal symptoms or side effects present* ☐
c. *Change in suitability for takeaways, or change in level of supervision that is appropriate (changes in substance use and/or other risk factors)* ☐

Summary of Subjective and Objective information and Assessment considering treatment goals (refer to individualised treatment plan)

Changes in treatment PLAN (dose, unsupervised dosing, review frequency or other details)

Date of review: dd / mm / yy
Time taken to complete review: _____
Copy of review document sent to prescriber? YES / NO **Details:** _____
Review completed by (Name of pharmacist) _____ **Signature** _____

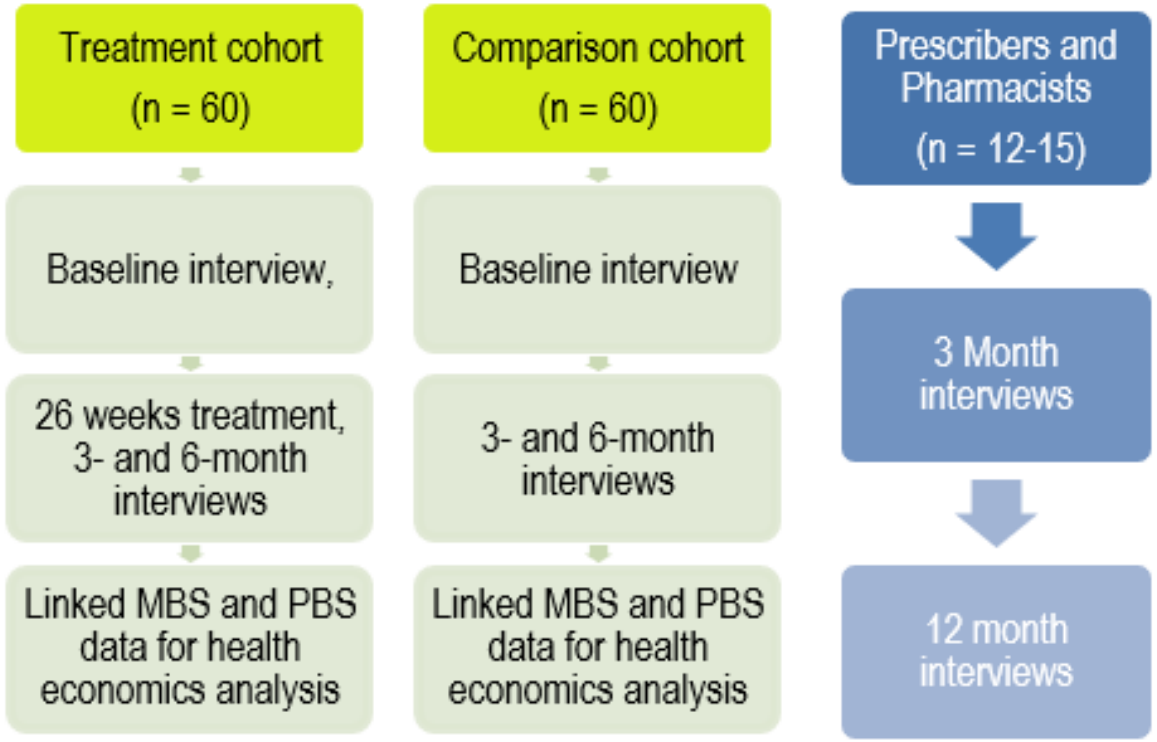
Current practice vs EPIC-MATOD model

Current practice	EPIC-MATOD model
Patients attend regular appointments with their prescriber for treatment reviews (range in guidelines)	Pharmacists conduct face-to-face assessments at the frequency determined by the prescriber (meaning patients see the prescriber as little as once every 6 months)
Pharmacists cannot adjust doses unless range is prescribed	Pharmacists can adjust doses
Pharmacists need to contact the prescriber for authorisation to change the no. of take-away doses	Pharmacists can determine the number of takeaway doses provided a week
Patients need to be seen by their prescriber to be re-started onto MATOD if they have missed 4+ doses	Pharmacists can reinduct patients after a pre-specified number of missed doses (up to 6 for methadone, and 28 for buprenorphine)

The EPIC-MATOD implementation study[17]

(ACTRN12621000871842)

Hybrid Implementation-Effectiveness Trial design



Contents lists available at ScienceDirect

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A prospective, multisite implementation-efficacy trial of a collaborative prescriber-pharmacist model of care for Medication Assisted Treatment for Opioid Dependence: Protocol for the EPIC-MATOD study

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Outcomes (mapped to the RE-AIM framework)

REACH	Number of pharmacists, prescribers, and patients recruited
EFFECTIVENESS	26-week retention; substance use, mental health, physical health, quality of life
ADOPTION	Number, proportion, and geographical representatives of the MATOD pharmacists and prescribers; extent to which pharmacists & prescribers implement the model
IMPLEMENTATION	Fidelity with treatment protocol, time and costs to deliver model of care, treatment satisfaction and healthcare provider satisfaction, barriers to delivering the model of care
MAINTENANCE	Retention of pharmacists and prescribers in model of care

Results (so far)

Pharmacists recruited: 12/?

- 12 pharmacists from 9 pharmacies: 6 (from 5 pharmacies) providing collaborative care

Prescribers recruited: 2/?

- 2 prescribers from 2 clinics (Frankston and St Kilda)

Patients recruited: 30/120

- 20 collaborative care, 10 controls

Early learnings

- Model appears to be feasible and acceptable to patients, pharmacists, and prescribers
- Prescribers have typically delegated all tasks to pharmacists
- Benefits for patients include greater convenience and fewer appointments with their GP

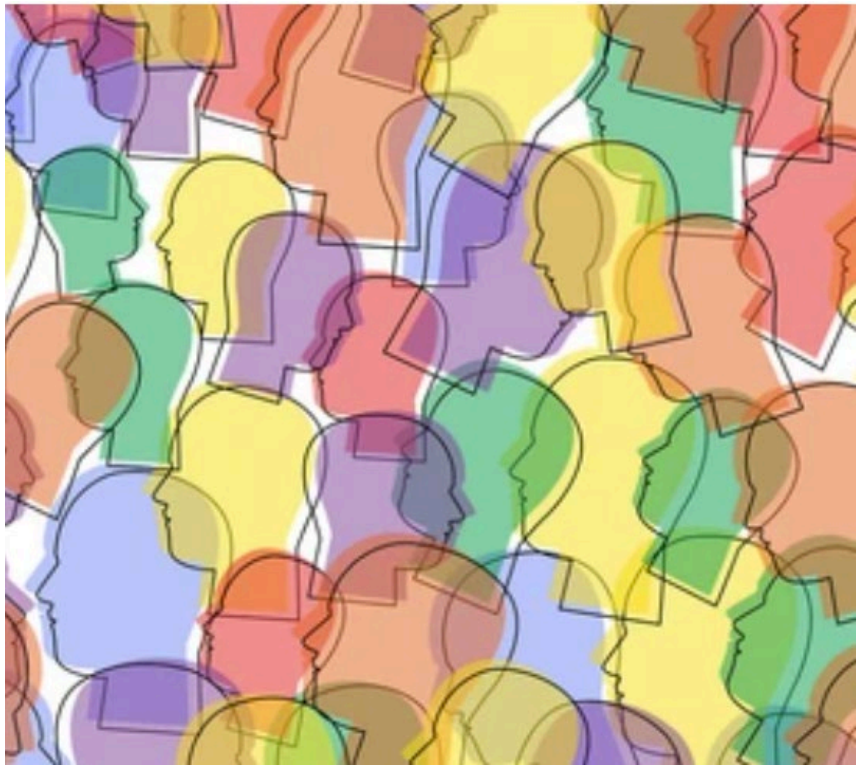
"Really satisfied with it. It's just easier…I only have to go to the one place" [Patient]

"Frankston is a long way away, it's a good 40-45 minutes away from here, so...when I don't have a car or a license it makes it pretty hard" [Patient].

I just feel like I can talk to [pharmacist] a lot easier about what I need to do for me, to get better [Patient]

Early learnings - Reach

- Prescribers and pharmacists felt currently stable patients were the focus
- Prescriber involvement may be particularly important to patients with more complex health needs
- To have greater impact, a broader range of patients would need to be involved (e.g. patients with complex needs require more prescriber time)



Early learnings - Adoption

- High level of interest but moderate uptake among pharmacists
  - Difficult for some (but not all) to balance with the demands of their regular workload
  - Ongoing staff shortages in some pharmacies
- Has utility for regions beyond the FMP

Early learnings - Implementation and Maintenance

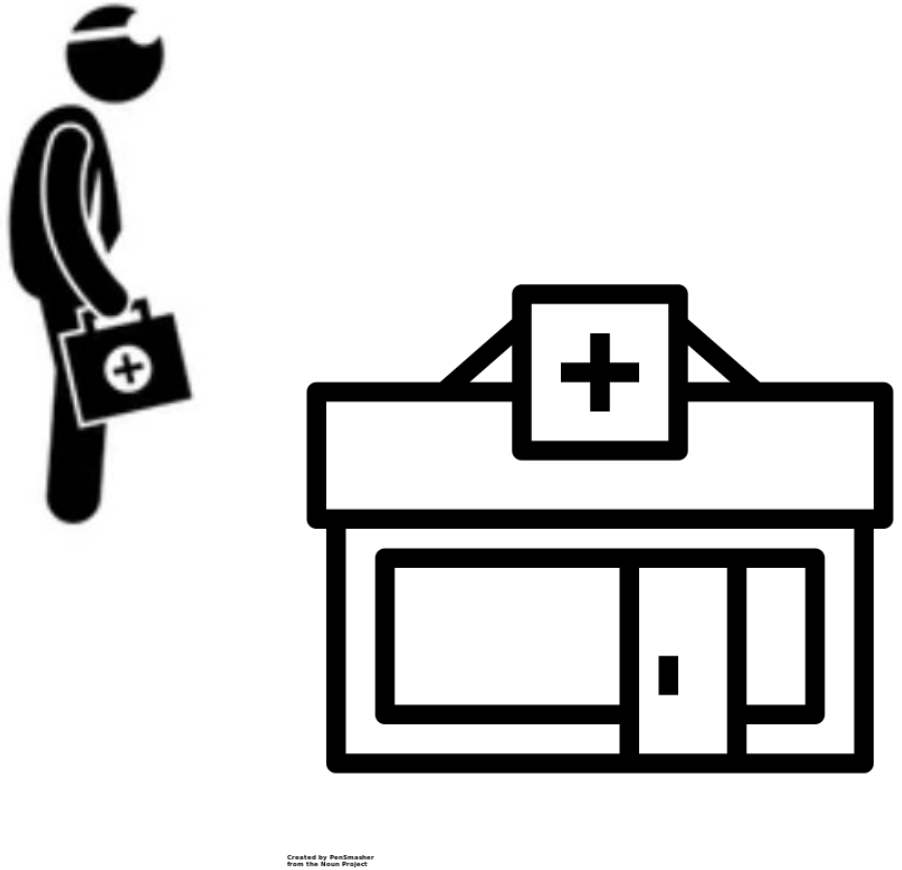
- Pharmacists need time to gain experience and build confidence. Prescriber involvement appears essential at this stage
- Multiple pharmacists per pharmacy would ensure no gaps in patient care if one leaves
- Remuneration is important if collaborative arrangement is to be ongoing

"Having to make certain decisions, like maybe restarting a patient on methadone, it just feels quite high risk. So I suppose there's a bit of lack of confidence in the decisions I made and the risks that come along with that" [Pharmacist]

"Having more pharmacists on, more support in terms of staffing and continuing the renumeration is the main thing" [in determining whether the model can be sustained] [Pharmacist]

Other learnings – Implementation and Maintenance

- Broader challenges with the pharmacotherapy system, and media on divisive topics like independent pharmacist prescribing can impact prescriber morale
- The potential for a collaborative model with the pharmacist embedded in a clinic environment has been raised (more than once!) for exploration



Next steps

- Aim to finish recruitment by mid-2023
- Collect data on clinical outcomes, implementation, and cost-effectiveness
- Explore potential for scale up to regions outside the FMP

Thank you!

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END OF DAY ONE

NEXT: 6:00PM CONFERENCE DINNER

CLIVEDEN ROOM, PULLMAN HOTEL

VAADA acknowledges the traditional owners of the land on which the conference is gathered, the Wurundjeri People of the Kulin Nation and pay their respects to Aboriginal culture and Elders past and present.