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**Clinician guide for shared care discussions with clients:**

When discussing shared care with a client it is important to inform them about the natural progression of moving to shared care as they progress through their recovery. For example, you could congratulate your client for participating in treatment and progressing to a stage where they no longer need intensive case management, then explain shared care and how you will be supporting them to transition to the model of care. Using statements such as “you have the option of shared care” or “if you agree we can do shared care” invites ambivalence and promotes reliance on our service rather than a recovery focused treatment.

Your aim is to support the client to move to shared care by addressing concerns and identifying barriers. This does not mean everyone needs to be moved into shared care quickly or immediately, (and our more complex clients may never be transitioned) but the discussion should start occurring on admission for new clients and on review for existing clients.

The following are FAQs and response guide that should be discussed with clients when talking about shared care.

**What is meant by shared care?**

You have done the hard work and have progressed well in your treatment. This means you no longer need intensive case management. Your GP (or other suitable prescriber) is now the perfect person to monitor and maintain your opioid treatment along with your general health – just like any other chronic health condition. They will attend to your routine monitoring and script provision and we will step back but be there to help when needed.

**Why are you moving to shared care arrangements?**

The focus of a specialised health service is to provide assessment and treatment planning, with ongoing case management and specialty care reserved for people with complex health needs whose care cannot be managed by community doctors. Routine monitoring and management are then transferred to your doctor. By having a shared care arrangement, we help you receive the right treatment at the right place and right time, and we continue to provide timely access to our specialist services.

**What does this mean for me?**

* Your health care will be monitored by one person in one place.
* Your dosing will not change! Your doctor will provide your script to your pharmacy just as we have done.
* You will remain registered with our clinic and will still have a case manager. They will support you and your doctor during the change to shared care and be a backup if either of you have any concerns.
* Your case manager will check-in with your doctor to ensure your treatment remains appropriate and any issues are addressed quickly.
* Your regular reviews will now be with your doctor, and you will be reviewed at the clinic once a year.

**Do I have to move to a shared care arrangement?**

Shared care is now the standard model of care for the Alcohol and Drug Service. This does not mean that you will be made to enter shared care before you are ready, but if your treating team have assessed you as suitable we will start working with you to address any concerns you may have and to resolve any barriers to shared care.

**What will I have to do?**

That’s the good part – you don’t have to do anything!! If you would like to talk to your doctor about your treatment and their involvement - go for it, but if not, we will talk to them and make sure they have everything they need to support your ongoing treatment. We will let you know when you need to attend your first appointment with your doctor and can answer any other questions you might have.

**What if I don’t have a regular doctor?**

To maintain good health, it is important to have a regular doctor – someone who makes sure you receive the right health assessments and monitoring. If you don’t currently have a regular doctor, we can help you find one in your area.

**Will I have to pay for my treatment now?**

If your doctor currently bulk bills your appointments this should not change.

While we have no control over how much a doctor charges, we will advocate for bulk billing of your opioid treatment visits when discussing your shared care with them. The cost of your medication at the pharmacy should remain unchanged.

**Clinician guide for shared care discussions with doctors (community):**

When speaking to a potential approved prescriber (AP), it should be emphasised that this is a supported monitoring role – just like the care of other chronic health conditions requiring specialist input. Some of the FAQs we receive and response guides when speaking to doctors are below:

**What will I have to do?**

* Conduct a patient review at least every three months.
* Provide monthly QOTP prescriptions to a nominated pharmacy (you can provide 6 months of prescriptions in advance – however we recommend providing 3 months to keep in line with review schedule).
* Provide regular reports to your patient’s case manager (every three months).

**How will the patient be assessed as suitable for me to manage?**

Patient suitability for QOTP shared care:

* The patient can be prescribed buprenorphine (Subutex®, Sublocade®, Buvidal®), buprenorphine-naloxone (Suboxone®) or methadone (Aspen methadone syrup, Biodone Forte™).
* The patient is medically stable on opioid pharmacotherapy.
* The patient is compliant with program requirements and review appointments.
* There will be no significant illicit substance use and/or no reports of use affecting psycho-social functioning or behaviour.
* The patient's mental health is stable and if mental illness is present; a management plan is in place, agreed to by the patient and positive outcomes identified.
* The patient will have stable personal functioning to the extent they can live independently in the community (this includes those who require a carer).
* The patient has managed take away doses (TAD) appropriately when provided.

**What can I do for my patient?**

* You can alter the dosing regimen if your patient is prescribed Suboxone®, from single (daily) dosing to double or triple dosing (i.e. the patient receives a dose every 2 or 3 days respectively), providing the dose received does not exceed 32mg. These dosing regimens are outlined in the Queensland Medication-Assisted Treatment of Opioid Dependence Clinical Guidelines 2018 (MATOD Guidelines).
* You can manage TAD as per the MATOD Guidelines.
* You can change the nominated dispensing pharmacy; however, any new pharmacy must be recognised by Queensland Health’s Healthcare Approvals and Regulation Unit (HARU) as a QOTP dosing pharmacy.
* You can refer your patient to the Alcohol and Drug Service at any time for further assessment or management. Referral is initiated through the case manager.

**What can’t I do?**

* You can’t change the patient’s dose independently. If the patient requests a dose change you would contact the case manager for guidance.
* You can’t provide QOTP for patients not specified in the HARU approval.
* You can’t transfer your prescribing approval to another prescriber.

**What support will I receive?**

The shared care model is designed to support the community prescriber. The alcohol and drug service understand there are concerns around the complexity of treating patients with substance use issues and the regulatory demands of the Queensland Opioid Treatment Program. So, we have put in place a range of supports such as:

* Access to information and advice from case managers, addiction specialists and advisory services.
* General Practice staff support through education and training.
* A suite of documents to ensure scripting, ongoing assessment and support is time efficient and streamlined.
* Prompt referral process to transfer care back to the Alcohol and Drug Service if you are unable or unwilling to continue the shared care of your patient for any reason.
* Ongoing education if you wish to learn more about treating those with substance use issues.

When we contact you, you can be assured the patient has been medically stabilised, provided with support and counselling (if required) and reviewed by a multidisciplinary team to ensure they are suited to a shared care arrangement.

**I am concerned there may be pressure to take on high numbers of QOTP patients if I agree.**

An important aim of shared care is to ensure patients are provided holistic health care in a relevant setting.  We are asking you work to with us to monitor the ongoing health and stability of people who you are quite often already treating. We will always contact our patient’s nominated GP first but there may be times we approach you to take on a patient who does not have a regular GP. However, there will never be an expectation that you do so. You will **not** be listed as a QOTP prescriber and patients will **not** be directed to approach you independently for access to the QOTP.

Our aim is for shared care to provide recovery focussed treatment and have patients treated where they receive their primary health care. You can decide how many shared care patients you treat, and your decision will be respected by the service.

**Can/will patients receive other support if needed?**

While the Alcohol and Drug Service will only transfer patients who are stable in their treatment, sometimes they need a little more support. Even though you are now managing your patients’ opioid treatment with specialist input, your patient can be referred to their clinic case manager if they need additional support or would like to access psychosocial counselling. In addition, patients are always able to contact adis, the 24/7 alcohol and drug support phone line.

**I have concerns for the safety of self, staff and other patients if I take on QOTP patients.**

We understand that you may have concerns about the safety of your patients, staff and self. The alcohol and drug service will only transfer patients who are stable in their treatment. This means that the clinical team have assessed the patient as being suitable to receive treatment with their GP, and no longer requiring the intense case management provided by specialist clinics.

There is no evidence to suggest stable OTP patients are of any greater risk than other patients, however some research and evidence indicates that; prescribing GPs are less likely to be targeted for doctor shopping, and patients in a waiting room are unable to correctly identify patients on a substance use treatment program. In addition, disruptive waiting room behaviours are more often attributed to poor parental supervision than intoxicated patients, and reasons for leaving a practice are routinely attributed to long wait times and fee increases rather than patient “type”.

**I am concerned I will be targeted by Government regulators for my opioid prescribing if I take on a shared care patient.**

Some doctors are concerned that becoming a shared care prescriber for patients on an opioid treatment program will restrict their ability to prescribe opioids to their other patients, or they will be identified as high-level opioid prescribers by regulators. This is not the case.

Queensland Health’s HARU will approve you as a shared care provider for a specific patient treated with a specified opioid treatment medication. If these conditions are maintained, being a shared care provider will not affect your normal prescribing practices.

**I am concerned shared care will require a significant amount of time and that I will be financially disadvantaged in taking on a patient.**

The routine review of a patient can be done in either a standard or long consultation with the inclusion of a nursing assessment where appropriate. We do advocate for bulk billing of our patients when managing QOTP related activities and can provide a list of Medicare Benefit Scheme Rebates that could be applied for your services. We have also developed quick and easy documentation for your use to minimise time on administrative duties and to guide assessments.

**What happens if I can’t manage this patient, or if they become unstable?**

You have the option to refer your patient to the Alcohol and Drug Service clinic at any time (noting that some clinics are closed on weekends). Discuss any issues you have with your patient’s case manager - we may be able to provide extra support or assistance that allows you to continue managing the patient.