Provision of a remote telehealth opioid substitution therapy clinic in a regional Victorian community

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Background
Patient demand for alcohol and other drug services currently far outstrips the capacity of the sector, a challenge that becomes more pronounced in regional and rural areas where specialist services are minimal.

Objective
This paper describes a model of a telehealth-based opioid substitution therapy (OST) clinic, established in partnership between three Victorian health services. A retrospective file audit was conducted of the electronic medical records of patients enrolled through the clinic.

Discussion
With local coordination, the clinic has reviewed and commenced 23 patients on OST, all via telehealth consultations with addiction medicine specialists based remotely. The clinic's preliminary successes supporting patients on OST locally demonstrates an innovative solution to a longstanding problem. The small sample size requires that further study is necessary; however, the feasibility of this model shows how patients in regional and rural areas can have similar access to OST as their metropolitan counterparts.

The availability of good medical care tends to vary inversely with the need for it in the population served.

– Julian Tudor Hart[1]

Our community is quite isolated, especially when it comes to accessing healthcare. Many clients don't have GPs and haven't seen a doctor in many years.

– SCHS Program Manager

There are increasing disparities in health access, health equity and the social determinants of health the further one moves from major metropolitan areas in Australia.[2] Patient demand for alcohol and other drug services far outstrips the service capacity of public hospitals, with few addiction medicine outpatient clinics within the sector. This situation is particularly pertinent in Victoria, where there are no large-scale public prescribing facilities.[3] Furthermore, there are a limited number of private prescribers, who each care for large numbers of patients on opioid substitution therapy (OST).[4] A review by the Australian Institute of Health and Welfare (AIHW) counted 79 Victorian prescribers who held more than 100 OST permits.[3]

Aim

This paper reports on a partnership between a community health service in a Victorian regional city with addiction medicine specialists (AMSs) based in a metropolitan community health service. The partnership saw the development of a telehealth model allowing for the assessment and treatment of patients requesting assistance for issues related to opioid use. The use of telemedicine or telehealth to deliver OST is a well-established intervention and is known to increase access and, in some cases, improve attendance to clinics.[5–8] This clinic's preliminary successes demonstrate how such a model might improve access to treatment and see patients living in regional and rural areas having similar access to OST as their metropolitan counterparts.

Issues providing OST in a regional Victorian community

The regional city of Mildura, 550 km north-west of Melbourne has a population of ~55,000. As is the case in many rural and regional areas in Australia, there is a long-term shortage of general practitioners (GPs).[9] As a result, some patients with opioid use disorder (OUD) living in the region and seeking OST were travelling 6–12 hours to larger centres including Melbourne, Bendigo or Swan Hill to receive treatment, where others were unable to access OST at all. The Sunraysia Community Health Service (SCHS) in Mildura collaborates with Orticare, the Grampians–Loddon–Mallee pharmacotherapy area-based network to improve access to opioid pharmacotherapy services for those living in the region. Following meetings between Orticare and

Table 1. Patient characteristics assessed in the telehealth clinic

Characteristic	n (%)
Gender	
Male	16 (69.6)
Female	7 (30.4)
Age (years)	
18–30	1 (4.3)
30–40	7 (30.4)
40–50	11 (47.8)
>50	4 (17.4)
Aboriginal or Torres Strait Islander status	
Aboriginal or Torres Strait Islander	8 (34.8)
Not Aboriginal or Torres Strait Islander	15 (65.2)
Opioid substitution therapy	
Methadone	5 (21.7)
Sublingual buprenorphine	13 (56.5)
Long-acting injectable buprenorphine	5 (21.7)
New vs continuing treatment	
New	19 (82.6)
Continuing	4 (17.4)
Referral pathway	
SCHS	16 (69.6)
ACCHO	3 (13.0)
Local GP	4 (17.4)
Retention in treatment (as of December 2024)	
0–6 months	6 (26.1)
6–12 months	14 (60.9)
Lost to follow-up	3 (13.0)

ACCHO, Aboriginal Community Controlled Health Organisation; GP, general practitioner; SCHS, Sunraysia Community Health Service.

cohealth, a Melbourne-based not-for-profit community health organisation, which employs AMSs to work in primary care roles, a model was proposed to assess and treat patients in the Mildura region with OUD. This clinic complements an existing GP-led, face-to-face clinic conducted approximately two hours per week at SCHS.

The clinic is coordinated by SCHS, with an intake coordinator responsible for managing initial enquiries, arranging GP referrals, coordinating appointments, liaising with the cohealth team and facilitating access to the telehealth platform (with patient's personal or SCHS devices). They also support referrals to SCHS nurses to administer long-acting injectable buprenorphine (LAIB) for patients where prescribed. The clinic operates for four hours per week. Initial appointments are one hour and utilise video telehealth where possible. The initial appointment involves taking a thorough history and brief physical examination via video, after which the formulation of the management plan is discussed with the patient. Where it is agreed that the commencement of OST is warranted, a local pharmacy is contacted to confirm that they are willing to dispense OST, and prescribing is initiated accordingly. Follow-up appointments are generally 15 minutes in length.

Methods

A retrospective file audit of the cohealth electronic medical record (EMR) was conducted for all patients who attended the telehealth clinic. From the initiation of this trial, all patient notes were transcribed into cohealth's EMR and patients were booked into a set weekly session allocated for the clinic. Manual review of the appointment book for the telehealth clinic was conducted to identify the patients for this study (summarised in Table 1).

Discussion

OST has long been recognised as a mainstay of treatment for OUD; however, the dearth of prescribers in some regional areas in Victoria limits many patients' capacity to access this program that is both clinically effective and cost-effective.[10] Telehealth models for providing OST have been demonstrated to be effective and maximise attendance and accessibility to alcohol and other drug services.[6] Furthermore, it is a technology that is applicable and appropriate for high-risk groups including Aboriginal and Torres Strait Islanders, with Aboriginal Community Controlled Health Organisation (ACCHO)-based telehealth clinics seeing increased numbers of patients accessing primary healthcare via telehealth.[11] The diverse patient demographic reveals accessing support through this telehealth clinic model was a viable proposition.

In the first 11 months of operation, the clinic has seen 23 patients, during which time the clinic has demonstrated high

retention rates. As of December 2024, 20/23 patients (87%) continue to be reviewed every 1–2 months, with duration in treatment ranging from 2 to 10 months since the clinic first commenced in March 2024. Only three patients have ceased to attend regular appointments as of December 2024, where their average period in treatment was three months. For each, their reasons for their cessation of treatment are unknown.

Key to this model's function is the local community pharmacy sector. There is increasing recognition that community pharmacists are well-positioned to take on expanded roles in the management of OST patients, given their long history and experience in providing OST. Work is continuing to develop collaborative models of care that involve community pharmacists in pharmacotherapy delivery.[12] There are currently six pharmacies dispensing pharmacotherapy in the greater Mildura region, two of which are around one hour's drive from Mildura. Pharmacies in the region are similarly struggling with an acute workforce shortage, with an associated increase in pharmacist workload and resultant limitation in capacity to dispense OST.[13]

The clinic received $50,000 of infrastructure funding from Orticare to establish the service, and the clinic is otherwise Medicare funded. For patients with Medicare access, visits are bulk billed, and for non-Medicare-eligible patients, the consultation costs are absorbed by cohealth. The initial telehealth specialist assessment (Medicare Benefits Schedule [MBS] Item 91822) reimburses $81.30, compared to $250.65 for in-person assessments. Follow-up telehealth visits (MBS Item 91833) yield a maximum benefit of $40.85, regardless of consult complexity.[14]

To bill Medicare, a GP referral is required. However, access to general practice services in Mildura is severely limited, restricting patients' ability to obtain referrals. In response, cohealth arranged brief telehealth consultations with its GPs to facilitate referrals. These initial consultations are ineligible for MBS telehealth billing because patients must have had a face-to-face assessment within the prior 12 months. Under this same eligibility criteria, a similar clinic run by GPs would not be able to claim any MBS consultation items.

MBS remuneration is inadequate to cover the running costs of the clinic without the infrastructure support to cover ancillary costs, making it financially unviable to run a specialist service based solely on telehealth fees. Additionally, the clinic coordinator role is unfunded, and there is no additional funding for the cohealth pharmacotherapy coordinator's work.

This study highlights the need to decouple the OST telehealth model from the current Medicare billing structure. The requirement for a pre-existing face-to-face relationship with a patient before telehealth items can be billed is a key limitation. Exemption from this requirement, as applies for blood-borne viruses, sexual and reproductive health telehealth items, would greatly enhance capacity to deliver this model of care in rural areas.[15] Rebates also need to be further increased beyond the current provisions for telehealth given the highly complex nature of this patient group and the corresponding resources necessary to support them, for which current bulk-billing incentives are insufficient.

Currently, the clinic is not financially sustainable with Medicare funding alone. Financial support from Orticare is also dependent on ongoing (and uncertain) state government funding, so the viability of the clinic remains in question. The local coordinator role is unfunded for this work and there remains a significant shortfall in funding to SCHS. Further risks involve IT and telehealth, with many patients having limited access to IT/video conferencing devices. Finally, limited pharmacy capacity might restrict access to OST as the program expands.

Finally, this study reflects a small number of patients and thus a small sample size. Further higher-powered studies might be useful to address the viability of this care model in the Australian context, although data from overseas do suggest OST telehealth clinics can provide ongoing support for people in regional and remote regions.[16]

Conclusion

People in parts of regional Victoria have limited access to treatments for OUD. This places them at considerable risk of complications from their substance use and affects their families and the communities in which they live. Here is described an innovative community health-based telehealth model, facilitated by addiction medicine specialists and a supportive local health service. It has demonstrated an effective response to this problem and could serve as a model of care for other regional areas. This service is currently not financially viable based on the Medicare billing model and for such a service to continue, either MBS telehealth rebates need to increase or such a service requires external funding and to operate outside the Medicare billing system.

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