EXPANDING ACCESS TO ADDICTION MEDICINE SPECIALIST CARE IN REGIONAL NSW THROUGH TELEHEALTH

ST VINCENT'S HOSPITAL SYDNEY

BACKGROUND

Australians living in regional and remote areas face barriers to accessing Alcohol and Other Drug (AOD) services.
Pre-COVID fly-in-fly-out (FIFO) models of care involve metropolitan-based specialists flying to regional areas to deliver care for short periods of time.
This model relies on availability of scarce addiction medicine resources and incurs travel costs.
Providing telehealth AOD healthcare services may improve access to health services for people living in regional communities in a cost effective manner.

METHOD

A **"shared care"** approach was employed; A central coordinating service (St Vincent's Hospital Sydney) provided additional (Murrumbidgee LHD - MLHD) or FIFO-replacement (Western NSW LHD - WNSWLHD) telehealth consultations

- **Change in appointment numbers** pre-and-post telehealth implementation (late-2019/early-2021) - *interrupted time series analysis*
- Mean **cost comparison** - *independent t-test*

Assessing acceptability were conducted with staff and clients - *semi-structured interviews*

KEY FINDINGS

Addiction medicine specialist consultation rates remained relatively constant at WNSWLHD (Fig 1), with a decrease cost of $173 per consultation (p<.001) , while addiction medicine consultation rates increased in and smoothed out at MLHD (Fig 2) with a decrease in cost per consultation of $350 (p<.001).

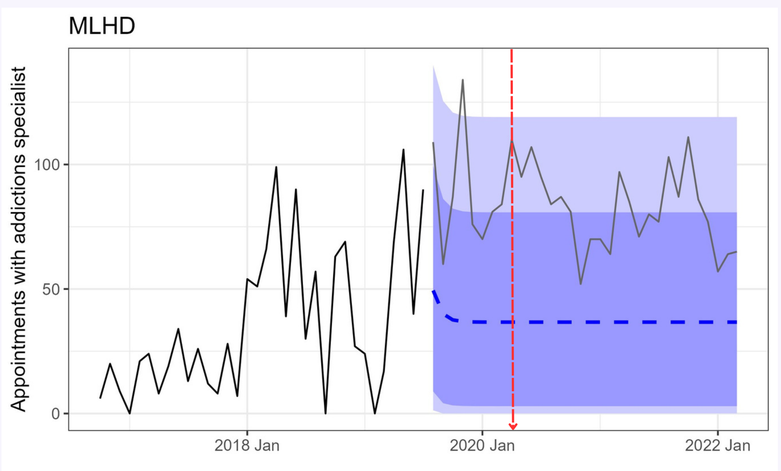

Figure 1 *Time series of observed consultations at MLHD (solid line) and counter-factual post-telehealth series forecast from consultations made pre-telehealth (dashed line) with shaded 80% and 95% confidence interval regions. Red arrow to indicate March 2020, approximate beginning of COVID-19 public health response*

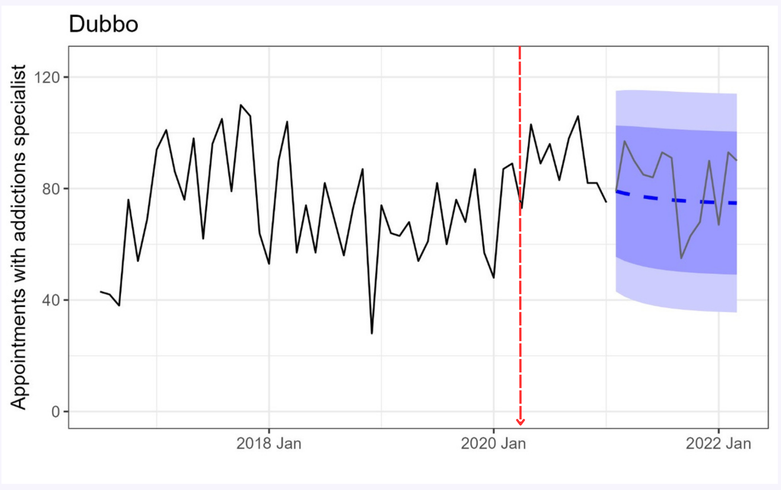

Figure 2 *Time series of observed consultations at Dubbo (solid line) and counter-factual post-telehealth series forecast from consultations made pre-telehealth (dashed line) with shaded 80% and 95% confidence interval regions. Red arrow to indicate March 2020, approximate beginning of COVID-19 public health response*

Semi-structured interviews

Clients: (MLHD = 9; WNSWLHD = 3)

- **Social anxiety reduction**
- More accessible for rural communities
- Limited issues with service

Clinicians: (MLHD = 5; SVHS = 7; WNSWLHD = 4)

- **Increases access to rural areas**
- Overall acceptable - referring to engagement

CLIENT OF TELEHEALTH

"It's a massive improvement and it's really helpful. So much better than having to fly in and out, particularly for someone with what I've got yeah. It's really, such a big improvement."

STAFF OF TELEHEALTH

"So, the advantages are access, breaking down the geographical barriers, which is a huge benefit. ... it means we can do more or regular reviews, that wouldn't otherwise happen."

CONCLUSIONS

Post-COVID, telehealth has become a common feature of service delivery.
This study shows that:
Clients and staff involved in the telehealth service expressed favourable experiences.

- Clients reported decreased levels of anxiety associated with attending telehealth appointments
- Clinicians found telehealth broke down geographical barriers, increasing access to services

Telehealth made specialist care more accessible

- Increased number of consultations in MLHD
- Reduced burden of long travel for appointments

Delivering care via telehealth was economically feasible

- Lowered costs per appointment in both LHDs while maintaining quality care and enabling predictability
- Enables delivery of specialist care, with reduced travel costs and time spent travelling for specialists

Clare S Smylie[1,2], Carl I Moller [1,2], Robyn Manzie[3], Scott C Clark[4], Jonathan Brett[5,6] Evelyn Lee[7], Zhixin Liu, Krista J Siefried[1,2,9], Anthony Shakeshaft[8,9] Adrian Dunlop,[10,11] Frances Kay-Lambkin[12], Darren Roberts[5], Brendan Clifford[1,2,9], Lucy McWilliams[1,2,9], Liam Acheson[1,2,9], Mark Chambers[9], Bronte Speirs[12],Clare Corliss[12], Jane Rich[12], Nadine Ezard[1,2,9,10]

1Alcohol and Drug Service, St Vincent's Hospital Sydney, Sydney, Australia,
2National Centre for Clinical Research on Emerging Drugs, UNSW, Sydney, Australia,
3Mental Health and Drug and Alcohol, Murrumbidgee Local Health District, Murrumbidgee, Australia,
4Mental Health and Drug and Alcohol, Western New South Wales Local Health District, Dubbo, Australia,
5Department of Clinical Pharmacology and Toxicology, St Vincent's Hospital Sydney, Sydney, Australia
6Medicines Intelligence Centre for Research Excellence, UNSW, Sydney, Australia
7Macquarie Business School, Macquarie University, Sydney, Australia,
8Poche Centre for Indigenous Health, University of Queensland, Toowong, Australia
9National Drug and Alcohol Research Centre, UNSW, Sydney, Australia,
10Drug and Alcohol Clinical Research and Improvement Network, NSW Health, Sydney, Australia
11Drug and Alcohol Clinical Services, Hunter and New England Health District, Newcastle, Australia,
12School of Medicine and Public Health, University of Newcastle, Newcastle, Australia

This study was funded by a NSW Ministry of Health Translational Research Grant Scheme (H19/53776). No investigators have any conflicts of interest to declare