KIT1
Transfer of stable public clinic opioid dependent patients to GP prescribers.

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State-Wide Advisory Team (SWAT)
Drug Health Shared Care
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- The Pharmacy Guild of Australia (NSW Branch) for hosting and providing administrative support for the workshop.

In addition, the authors would like to thank Dr Vince Roche for his contribution to the information on bulk billing, and Ms Kanan Gandecha for her advice on requirements for unaccredited prescribers.

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Introduction

What is the Kit for?

The Patient Journey Kit 1 will support general practitioners (GPs) working with other professionals and users to develop combined care and business plans for the management of opioid dependent patients.

Use of this Kit will maximise the appropriate utilisation of existing care and referral pathways and will optimise both the quality of care delivered to patients and the financial remuneration obtained by those delivering care in the community, specifically GPs, but also pharmacists and allied health professionals.

Kit 1 is also suitable for use by all public health care workers involved in providing treatment to patients on the Opioid Treatment Program (OTP) in NSW, and to people receiving treatment for opioid dependence on this program.

In addition, this Kit identifies that it is the responsibility of all involved to ensure that the patient has a pivotal role in the treatment provided. Patient consent is necessary for the delivery of high quality care but also for the informed sharing of information between professionals. The Kit provides patients with a genuine opportunity to be an active partner in treatment.

Background

The core objective of the State-Wide Advisory Team (SWAT) project was to increase the capacity of public and community services to provide care to those with opioid dependence. Integrating the care of patients into community based services, such as GPs and community pharmacies, is part of the NSW Health Drug and Alcohol Plan 2006-2010.

Although there has been an increase over the last five to seven years in the number of patients dosed at community pharmacies, the engagement of GPs in opioid treatment has remained persistently low. The Patient Journey Kit 1 has been developed to increase the participation of GPs in the NSW Opioid Treatment Program (OTP).

Support Services

For patients (NSW)
Alcohol and Drug Information Service (ADIS) Sydney 02 9361 8000
or for callers outside Sydney 1800 422 599

For health professionals
NSW Drug and Alcohol Specialist Advisory Service (DASAS) Sydney 02 9361 8006
or for callers outside Sydney 1800 023 687

For GPs
GP Psych Support provides GPs with patient management advice from psychiatrists within 24 hours http://www.psychsupport.com.au

The terms ‘client’ and ‘patient’ have been used interchangeably according to the context in this document.
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Important Notices

What if I do not routinely bulk bill?

Approximately one third of all patients on methadone or buprenorphine receive their treatment through publicly funded clinics, at no cost. For patients attending a private prescriber and a pharmacy, the combined cost ($30-35 per week for pharmacy dosing, plus a gap payment for a consultation) may be prohibitive, especially in the early stages of treatment or transfer, when two to three visits a week may be optimal.

At a time in patients’ lives when things are going well, such financial hurdles may jeopardise their ability to start or continue in treatment, as it impacts on their basic living requirements—especially if they are on benefits. All this at a time when we are urging them to avoid high risk activities previously adopted by some to finance their illicit drug use. Is there another way?

We would respectfully ask GPs or practices that would not usually consider bulk billing to view patients on methadone or buprenorphine as possible (and very infrequent) exceptions to their usual practice. Infrequent? At present, less than 5% of all GPs in NSW prescribe methadone or buprenorphine; in most cases we would expect no GP to have more than one or two patients on methadone or buprenorphine. A few exceptions are unlikely to breach the levee bank—and potentially could make the difference for those with the health care problem of opioid dependence.

The SWAT team suggest that where possible optimal use of the care plans within a bulk billing framework could have a truly significant public health impact and are worth adopting:

- GP Mental Health Care Plan Item 2710 100% Medicare Australia Rebate $150.00
- GP Management Plan Item 721 100% Medicare Australia Rebate $124.95
- Team Care Arrangement Item 723 100% Medicare Australia Rebate $98.95 (Team Care Arrangement with dispensing pharmacist and local drug & alcohol worker would meet these requirements)
- Home Medicines Review Item 900 100% Medicare Australia Rebate $134.10

The additional remuneration obtained by utilising these care plans, Home Medicines Review and other related item numbers will offset to some degree any loss incurred through bulk billing — as well as improving care and health outcomes in this population and their families.

Prepared with the assistance of Dr Vince Roche, GP prescriber.

NEW DVD

A new DVD information resource Access All Areas has been developed to answer questions from in and out of treatment drug users. It will be available towards the end of 2007 Contact adam.winstock@sswahs.nsw.gov.au for your copy.
**Commonly used abbreviations in this Kit**

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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>ADIS</td>
<td>Alcohol and Drug Information Service</td>
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<td>AGPN</td>
<td>Australian General Practice Network (formerly ADGP)</td>
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<tr>
<td>AHS</td>
<td>Area Health Service</td>
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<td>BBV</td>
<td>Blood-borne Viruses</td>
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<td>BDI</td>
<td>Beck Depression Inventory</td>
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<td>CDM</td>
<td>Chronic Disease Management</td>
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<tr>
<td>DASAS</td>
<td>NSW Drug and Alcohol Specialist Advisory Service</td>
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<td>DoHA</td>
<td>Department of Health and Ageing</td>
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<td>DMMR</td>
<td>Domiciliary Medication Management Review</td>
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<td>EPC</td>
<td>Enhanced Primary Care</td>
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<td>FPS</td>
<td>Focused Psychological Strategies</td>
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<td>GPMHCP</td>
<td>GP Mental Health Care Plan</td>
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<td>GPMP</td>
<td>GP Management Plan</td>
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<td>HMR</td>
<td>Home Medicines Review</td>
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<td>K10</td>
<td>Kessler Psychological Distress Scale</td>
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<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<td>MMP</td>
<td>Medication Management Plan</td>
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<td>MSE</td>
<td>Mental State Examination</td>
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<td>NUM</td>
<td>Nursing Unit Manager</td>
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<td>OTP</td>
<td>Opioid Treatment Program</td>
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<td>PAC</td>
<td>Pharmacotherapies Accreditation Course</td>
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<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PG</td>
<td>The Pharmacy Guild of Australia</td>
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<td>PPC</td>
<td>Patient’s Priorities for Care</td>
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<td>PSB</td>
<td>Pharmaceutical Services Branch of NSW Health</td>
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<td>PSIS</td>
<td>Prescription Shopping Information Service</td>
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<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
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<td>SF12</td>
<td>Medical Outcomes Study Short Form 12</td>
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<td>TCA</td>
<td>Team Care Arrangement</td>
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<td>SWAT</td>
<td>State-Wide Advisory Team</td>
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<td>UDS</td>
<td>Urine Drug Screen</td>
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Who can use Kit 1 and why?

**General Practitioners** | Go to Steps 2-12

The Kit provides details on how all GPs can apply existing plans for managing mental health and chronic medical conditions to the care of a patient on an OTP. This Kit addresses the appropriate and coordinated use of the Medicare Better Access to Mental Health Care initiative item numbers, the Chronic Disease Management item numbers and the pharmacy Home Medicines Review (HMR) in caring for this patient group.

Providing the GP has access to specialist drug and alcohol support services, the GP may manage a small number (up to 5) of opioid dependent patients without completion of the Pharmacotherapies Accreditation Course (PAC). In doing this, the GP will take on the role of the prescriber of opioid treatment as well as the provider of the patient's primary health care. GPs who have practice nurses may also wish to engage them in the development and implementation of management plans for opioid dependent patients. In addition, some GP practices may wish to employ a mental health nurse using the Mental Health Nurses Incentive Program.

Kit 1 will also guide GPs as to what they may expect from specialist drug and alcohol public clinic staff in terms of information processes and documentation for patient transfers, and in terms of ongoing support in caring for opioid dependent patients (see Returning your patient to clinic care when unstable).

**Public Clinic Staff** | Go to Step 1

Kit 1 will support public OTP clinic staff in identifying patients suitable for transfer to a GP and will provide guidance on working with patients to support and engage them in this process. It will also guide staff as to the information exchange processes needed, including the content and form of documentation, to facilitate the transfer. The aim of the transfer is that the GP will take over prescribing from the public clinic prescriber, and also the planning of care.

**Pharmacists** | Go to Step 3

Kit 1 will encourage community pharmacists to increase their level of involvement in the care delivered to patients receiving methadone, buprenorphine (Subutex®) or buprenorphine-naloxone (Suboxone®) at their pharmacy. This will occur through the development of information exchange processes between the GP, the pharmacist, and the patient. Specifically Kit 1 provides details on how the Home Medicines Review can be utilised and appropriately integrated into GP care plans for this patient group. Through the HMR pharmacists can provide additional monitoring and support to both patient and GP.

A secondary outcome of Kit 1 may be the engagement of pharmacists not already involved in the delivery of OTP.

**Consumers** | Go to Steps 1-12

Kit 1 informs patients of the nature of information to be exchanged between professionals involved in their care and it highlights how patients can actively contribute to their own care plan.

**Allied health** | Go to Step 5

Kit 1 provides information and guidance to a range of other health care workers, such as psychologists, social workers and occupational therapists who may be involved in the care of an OTP patient. Processes supporting optimal referral from GPs to allied health workers are identified in the Kit.

**Other mental health professionals (nurses, Aboriginal Health Workers)**

The Better Access initiative also makes provision for mental health nurses and Aboriginal Health Workers to participate as providers. At the time of writing this Kit, details of provider numbers were under development. In addition, from July 2007, the Mental Health Nurses Incentive Program will be available to eligible GP practices who wish to employ a mental health nurse.

The process by which an unaccredited prescriber such as a GP takes on the prescribing of methadone or buprenorphine to a patient who has been stabilised is as follows:

1. GP completes a yellow (methadone) or purple (buprenorphine and buprenorphine-naloxone) form and returns it to Pharmaceutical Services Branch (PSB) of NSW Health (phone 02 9879 5246 or fax 02 9859 5170).
2. On the form the GP nominates their accredited pharmacotherapy prescriber supervisor (usually a local specialist or experienced GP).
3. A prescriber supervisor may be accessed through local drug and alcohol services.
4. PSB will then call the doctor and confirm they are familiar with the processes required to take over the prescribing for the patient.
5. PSB will then give approval to the GP, permitting the GP to commence prescribing at that time.
6. PSB then forwards the application and the GP’s details for ratification at the next meeting of the Prescriber Credentialing Subcommittee (PCS).

Under this arrangement, the GP may take up to five patients, seeking individual approval to prescribe for each patient.

If the GP wishes to take on more than five patients, the GP must successfully complete the Prescribers Pharmacotherapies Accreditation Course (PAC). This course is free of charge to GPs, and is conducted regularly throughout NSW. For more information on this course, go to [http://www.pac.med.usyd.edu.au/newpac/about.html](http://www.pac.med.usyd.edu.au/newpac/about.html)

Prepared with the assistance of Ms Kanan Gandecha, Deputy Chief Pharmacist, Pharmaceutical Services Branch, NSW Health

Written by Dr. Adam Winstock and Dr. Jill Molan
Roles and Responsibilities

**General Practitioners**

- Be honest and transparent with the patient over any clinical decisions you make
- Provide access to good quality primary care
- Prescribe methadone/buprenorphine — safe sensible prescribing
- Review patient regularly and ensure safe provision of takeaways
- Liaise with community pharmacy regularly (before each script)
- Support the patient in explicitly contributing to their care plan and achieving their goals
- Provide feedback as required to pharmacies and to patients as part of HMR
- Utilise GPMHCP and GPMP/TCA to provide better access to additional medical and allied health services
- Give a copy of any care plans to the patient
- Organise cover for prescribing and reviews if necessary when you go on leave or retire

**Public Clinic Staff**

- Be honest with the patient about how and why the transfer is being offered
- Provide excellent care to the patient
- Identify stable patients suitable for transfer
- Engage the patient in a discussion about transferring to a GP
- Provide evidence to the GP supportive of patient stability
- Provide clinical summaries in a format to suit GPs
- Provide the GP with the name of a specialist medical doctor, other experienced prescriber or experienced nurse or case manager whom the GP can contact for advice
- Arrange the transfer of prescribing to the GP
- Facilitate, where required, use of the community pharmacy as a means of important feedback and support (HMR)
- Support the GP in the development of care plans (GPMHCP, GPMP or TCA)
- Provide ongoing support to the GP as required
- Agree to work with the GP if the patient becomes unstable, and take the patient back to the clinic, either temporarily or permanently, if indicated

**Consumers**

- Be honest with health care providers about substance use and risky behaviours or other concerns
- Attend for dosing and other health appointments
- Provide feedback to the health care providers about what you would like addressed in your treatment
- Be involved in your care plan
- Ask for help or advice if you need it

**Allied Health**

- Be honest and transparent with the patient over any decisions regarding treatment or feedback you make
- Support the patient in engaging with your service
- Provide feedback as required to other health providers especially the GP
- Support patient care planning in collaboration with the GP
- Provide tailored treatments to support the patient in attaining their goal

**Pharmacists**

- Be honest with the patient should you have any concerns
- Provide safe dispensing of opioid medications
- Advise on safe storage of take away medication
- Ensure script is adhered to by the patient i.e. enhance compliance
- Notify the GP if a patient misses 3 or more doses, diverts a dose or demonstrates other signs suggestive of instability
- Provide routine feedback to the GP about the progress of the patient
- Provide advice and other healthcare to the patient
- Provide support and advice to the patient if appropriate
- Be flexible in delivery of treatment to patient
How to use this Kit

Part 1 provides a summary, whilst Part 2 provides details of each step.

**PART 1 contains:**
Summary of the steps involved in the successful transfer of a patient to a GP prescriber.
If you are familiar with Medicare care plans and drug use problems you may only need to review the first section of the Kit.

**PART 2 contains:**
Details of each step summarised in Part 1.
If you are less familiar with GP care plans and the specific issues related to drug use problems the first and second parts of the Kits may be useful.

Part 1

**Summary steps in planning care for a patient with opioid dependence**

Kit 1 describes the referral pathways and required information exchange processes necessary to support the transfer of a patient from a public clinic prescriber to a GP prescriber (bold arrow B). The initial transfer of the patient from public dosing to pharmacy dosing (arrow A) is assumed to have already taken place (see Flowchart 1). Refer to the section on Transfers to a pharmacy.

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**Figure 1 Streamed Shared Care: Patient transfer from public to private services**
Flowchart 1: Patient Transfer from Clinic to GP

A.

1. Patient commences treatment at public clinic

2. Does not have a GP for primary care
   - Clinic helps patient find GP for primary care

3. Already has GP for primary care
   - Already has GP for primary care

4. Clinic determines whether patient has existing GP

5. Does not have a GP for primary care
   - Clinic helps patient find GP for primary care

6. Already has GP for primary care
   - Already has GP for primary care

7. Clinic dosing until patient stable

8. Transfer to a community pharmacy for dosing

9. Minimum 3 months remains stable at pharmacy

B.

10. Clinic staff initiate discussion with patient re transfer to GP

11. Already has GP for primary care who is happy to take on prescribing

12. Clinic staff offer to contact GP OR assist client with a letter to GP

13. GP agrees to see patient. Clinic or patient makes first appointment with GP. Clinic faxes relevant documents (history, identification, current script) to GP.

14. Patient keeps first appointment. GP completes assessment and agrees to accept patient. GP initiates GPMHCP with patient agreement. GP notifies clinic of intention to accept transfer. GP lodges application with PSB. Makes appointment for one week’s time. May initiate HMR.

15. Clinic exits patient the day before the GP’s authority commences

16. HMR referral and feedback from pharmacist

17. Patient keeps second appointment with GP one week after the first. GP confirms authority, writes first prescription (for two weeks), and faxes it to the pharmacy. GP and patient complete MMP. GP gives a copy of MMP to patient and to pharmacy.

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Flowchart 2: GP plans and schedule of appointments and reviews

Steps 1-3

Initial appointment
Refer to Flowchart 1

Appointment made for about 1 week from first appointment

Possible HMR referral and feedback from pharmacist

Steps 4-7

GPMHCP Item 2710
Some patients will need both plans

POSSIBLE REFERRALS TO:

Steps 8-12

GPMP Item 721

With POSSIBLE Preparation of TCA Item 723

POSSIBLE REFERRALS TO:
Specialists e.g. dietician, physiotherapist, dental (specific conditions). Chronic Disease Management item numbers for Allied Health

Routine appointments at:
2 weeks - 2 weeks - 1 month - 1 month
GPMH Consultation Item 2713 OR Level B or Level C consultation

Review Plan at 6 months or sooner if indicated
GPMHCP Item 2712 or GPMP Item 725
+/- TCA review Item 727

Further routine appointments at:
1 month - 3 month - 3 months - 3 months
GPMH Consultation Item 2713 OR Level B or Level C consultation

Prepare New Plan at 2 years or 1 year if indicated
GPMHCP Item 2710 or GPMP Item 721 or TCA Item 723
# Using a GP Mental Health Care Plan (GPMHCP)

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<th>Process</th>
<th>Documentation and information exchange</th>
<th>Forms:</th>
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<td>• Paper based or&lt;br&gt;• Electronic</td>
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### For public clinic staff

**Step 1.1** Public clinic talks to patient about having a GP for primary care with a view to future transfer to a GP for prescribing.

- If the patient has a GP, clinic staff discuss with patient the possibility of that GP becoming the prescriber.
- If the patient does not have a GP or does not want their primary care GP to become their prescriber, then clinic staff need to negotiate a place with another GP.
- Public clinic or patient approaches GP to take over primary care / prescribing and gains agreement from GP.

- **Letter from clinic to client**
- **Letter from Clinic to Client**
- **Initial letter from clinic to GP**
- **Letter from Clinic to GP**
- Public clinic checks the GP's registration at [www.nswmb.org.au](http://www.nswmb.org.au) to ensure that the GP does not have any restrictions on S8 prescribing.
- **Summary assessment form or referral letter from clinic to GP outlining clinical history and medication.**
- **Clinic summary – standard assessment transfer form (local format)**
- **Confirmation of stability provided to GP by clinic.**

**Step 1.2** Public clinic prompts patient re issues they need to consider before first meeting with GP.

- **Public clinic provides patient with checklist (PPC).**
- **The Patient's Priorities for Care (PPC)**

### For GPs

**Step 2.1** Patient attends GP for first assessment and GP decides whether to accept patient or not (and vice versa).

- **PPC may be provided or used in discussion with GP.**
- **PPC (optional)**
- **GP does clinical assessment.**
- **Appropriate PSB form (methadone, buprenorphine)**
- **GP lodges PSB authority to take over prescribing.**
- **Review appointment in 1 week.**

**Step 2.2** GP initiates care plan in consultation with the patient

- **Most appropriate care plan is GP Mental Health Care Plan, however GP may decide to also initiate GP Management Plan (see Steps 8-12)**
- **GP Mental Health Care Plan (GPMHCP) item 2710**
- **Sample standard GPMHCP form (scroll down website)**
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<th>Documentation and information exchange</th>
<th>Forms:</th>
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<td><strong>Step 3</strong></td>
<td>GP requests Home Medicines Review (HMR) (item 900) from dosing community pharmacy, with patient consent. The use of the HMR is valid in these cases because it involves medication with a narrow therapeutic index.</td>
<td>GP explains HMR to patient and obtains consent for HMR from patient. GP should consider any risks for the pharmacist attending the patient’s home and communicate this to the pharmacy (although the pharmacist will conduct their own assessment of risk).</td>
<td>Patient Information Sheet, HMR referral form, Software templates for HMR forms, Medicare requirements to claim item 900 HMR, HMR referral from GP sent to pharmacy.</td>
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<tr>
<td><strong>Step 3 cont.</strong></td>
<td>Pharmacy conducts HMR in a location convenient to the patient (not necessarily the home).</td>
<td>Risk assessment prior to HMR by pharmacy. Any child protection issues that arise during the visit must be appropriately addressed.</td>
<td>Pharmacy provides written feedback to GP. Pharmacy HMR Report (local format)</td>
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<tr>
<td><strong>For GPs</strong></td>
<td>GP reviews patient in about one week. GP discusses HMR report with patient and develops Medication Management Plan (MMP). GP provides feedback to both patient and pharmacy.</td>
<td>GPMHCP and Medication Management Plan (based on HMR) are completed. Copy of GPMHCP and Medication Management Plan are offered to the patient. Medication Management Plan is copied to pharmacy.</td>
<td>GPMHCP, HMR Medication Management Plan</td>
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<tr>
<td><strong>For pharmacies</strong></td>
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<td>Step</td>
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<tr>
<td><strong>For allied health professionals</strong></td>
<td><strong>Documentation and information exchange</strong></td>
<td><strong>Forms:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Step 5** | GP refers to allied health professionals or registered GP as required for focussed psychological strategies (FPS) or to clinical psychologist for psychological therapy services. GP locates allied health professional who is 1. registered with Medicare; 2. has a practice orientation that caters to adults with drug and alcohol problems; 3. has the current capacity to see the patient in a timely way. | The following links are not exhaustive.  
- Find a Mental Health Psychologist  
- Find a Mental Health Social Worker  
- Find a Mental Health Occupational Therapist | Standard GP referral processes, no specific forms  
Feedback from allied health personnel (local format)  
Client will sign Medicare form if allied health professional is bulk billing |
| GP refers patient to psychiatrist for assessment and management plan for GP to follow collaboratively with patient (item 291) Review of management plan (item 293) Initial consultation for psychiatrist to manage patient (item 296) | | Standard referral processes |
| **For GPs** | **Step 6** | Regular appointment review schedule, some of which may be as GP Mental Health Consultation, some as regular Level B or C consultations. Suggest minimum of monthly reviews for the first 3 months. Enhanced Primary Care (EPC) Case Conference if required. | GP Review Proforma for Opioid Dependent Patients  
Pharmacy Guild Review Form  
Monitoring stability in community dosed OTP clients by pharmacists Item 2713 GPMH Care Consultation OR Level B or C Consultation Case conference (under EPC item numbers) |
| **Step 7** | Review of GPMHCP | Six monthly (or three monthly if indicated). Contact dosing pharmacist prior to review to monitor stability. | GP Review Proforma for Opioid Dependent Patients  
GPMHCP Review item 2712  
Pharmacy Guild Review Form |
Using a GP Management Plan (GPMP)

<table>
<thead>
<tr>
<th>Step</th>
<th>Process</th>
<th>Documentation and information exchange</th>
<th>Forms:</th>
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<tr>
<td></td>
<td><strong>For GPs</strong></td>
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<tr>
<td><strong>Step 8</strong></td>
<td>Patient attends GP for review and assessment of chronic diseases identified as requiring additional plan (e.g. hepatitis C).</td>
<td>PPC may be provided/used by patient in discussion with GP.</td>
<td>The Patient’s Priorities for Care (PPC)</td>
</tr>
<tr>
<td></td>
<td>GP decides whether a Team Care Arrangement is appropriate.</td>
<td>GP develops additional care plan for the chronic disease (GP Management Plan).</td>
<td>GP Management Plan (GPMP) item 721: Sample GPMP form (scroll down website)</td>
</tr>
<tr>
<td></td>
<td>GP undertakes health check for patients aged 45 to 49 yrs.</td>
<td>GP starts Team Care Arrangement for patients requiring multidisciplinary care.</td>
<td>45-49 yr old Health Check item 717</td>
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<td>GP undertakes health check for Aboriginal patients.</td>
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<td>Aboriginal Health Checks items 704-710</td>
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<tr>
<td><strong>Step 9</strong></td>
<td>GP reviews patient.</td>
<td>GPMP is provided to patient. Team Care Arrangement (TCA) completed.</td>
<td>TCA item 723: Sample TCA form (scroll down website)</td>
</tr>
<tr>
<td><strong>Step 10</strong></td>
<td>GP refers to allied health professionals as required e.g. chiropractor, podiatrist, physiotherapist.</td>
<td>Standard GP referral processes. Various item numbers</td>
<td>Allied Health referral form under EPC</td>
</tr>
<tr>
<td></td>
<td>GP refers for dental care – specific conditions.</td>
<td>Information about dental referrals Dental referrals Fact sheet.</td>
<td>Dental referral form under EPC</td>
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<td>NOTE: New Dental Care items will become available through Medicare on November 1st 2007.</td>
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<tr>
<td>Step</td>
<td>Process</td>
<td>Documentation and information exchange</td>
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<tr>
<td>Step 11 (as for Step 6)</td>
<td>Regular appointment review schedule</td>
<td>Suggest minimum of monthly reviews for the first 3 months.</td>
<td>GP Review Proforma for Opioid Dependent Patients, Pharmacy Guild Review Form, Monitoring stability in community dosed OTP clients by pharmacists, Level B or level C consultations, Case Conference items 740, 742, 744, 759, 762, 765</td>
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<td>Enhanced Primary Care (EPC) Case Conference if required.</td>
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<tr>
<td>Step 12 (as for Step 7)</td>
<td>GPMP Review and TCA Review</td>
<td>Six monthly (or more often if indicated).</td>
<td>GP Review Proforma for Opioid Dependent Patients, GPMP Review item 725, TCA Review item 727</td>
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<tr>
<td>Next Step</td>
<td>Patient becomes unstable and GP seeks support from the specialist service.</td>
<td>In addition to local specialist service: NSW Drug and Alcohol Specialist Advisory Service (DASAS) Tel: Sydney 9361-8006 Or for callers outside Sydney 1800 023 687 GP Psych Support 1800 200 588 or <a href="http://www.psychsupport.com.au">www.psychsupport.com.au</a> GPs should also give patients the Alcohol and Drug Information Service (ADIS) telephone number for out-of-hours support (02 9361 8000 or 1800 422 599 for callers outside Sydney).</td>
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PART 2
Detailed steps in planning care for a patient with opioid dependence

Step 1  Initial discussions about transfer

Step 1.1  Public clinic or patient approaches GP to take over primary care and/or prescribing

Process

Step 1.1.1  Initial discussions with client and identifying a GP

All clients should be advised when commencing treatment at a public OTP clinic that the ultimate aim once they are stable is to gradually transfer their care to the community—initially with dosing at a community pharmacy, followed by a transfer of their treatment (prescribing and primary care) to a GP.

Clients should therefore be encouraged to develop a relationship with a GP as early in treatment as possible, first of all to ensure their access to primary care, but also to ensure the future smooth transfer of opioid prescribing to a community based GP who is already familiar with them and their health care needs. It may be helpful to provide the client with a letter that explains the benefits of them eventually transferring their care to their GP (see Sample Letter from Clinic to Client).

In many cases, clients will have a GP who provides their primary care. In such cases, this GP should be the one approached in the first instance either by the client, or by the clinic with the client’s agreement, to take over opioid prescribing at a time when the client is stable.

When the client does not have a GP, the clinic needs to help them find one. Setting up ongoing supportive relationships with local GPs is likely to be helpful to the clinic in this process. Information about local Divisions of General Practice may be located at the Divisions Directory.

Step 1.1.2  Approaching the GP

The initial approach to the GP may be through a phone call or a written request. The clinic may do this, or may provide the client with a letter to take to the GP (see Sample Letter from Clinic to GP). Initial information provided about the client should confirm the suitability of the client for transfer and the client’s willingness for the GP to become the prescriber.

In order to engage GPs in areas that for many will sit a little outside their comfort zone, GPs need to be reassured that if a transferred client becomes unstable while in their care the client can be transferred back to the specialist service for restabilisation (see Returning your patient to clinic care when unstable). Other options include the client’s temporary transfer back to the care of the clinic or a return to clinic dosing. It is vital that the clinic has processes in place to ensure access for unstable clients to return as required.

Documentation and Forms to GP

Documentation to the GP should provide a basic clinical history, clinical treatment, most recent script and a Stability Assessment Flowchart. This may be provided as an electronic or hard copy (faxed) as preferred by the GP. Many such clinical summary forms are available already and as long as they highlight the key information required by the GP, their precise format is not important.

The assessment information that a GP will need about the prospective new client will include, apart from the client’s identification details:

- current treatment including dosing location;
- current drug use and drug use history;
- current mental health and history;
- medical history including BBVs if known;
- current medications;
- social circumstances (family, children (with ages), employment, housing);
- other care providers and current supports;
- any ongoing clinical management issues.

Note: Regardless of how well an assessment is conducted, people and their problems are dynamic and there may always be crises or issues that arise in the client’s life which may precipitate them into instability.

Note: The GP can use information provided by the clinic as part of the GP Mental Health Care Plan (GPMHCP), GP Management Plan (GPMP) and the Team Care Arrangement (TCA).
Step 1.2 Public clinic prompts patient re issues to consider about transferring care

Process
The transfer of care can be a time of uncertainty and anxiety for all patients with chronic conditions. The patient’s contribution to the transfer arrangements will be crucial to the successful establishment of a new relationship with the GP. The loss of existing therapeutic relationships with their public clinic care providers needs to be acknowledged.

To ensure a successful transfer, the patient may need some additional support until a sound therapeutic relationship is established with the new care provider. In particular, if finances are of concern to the client in relation to paying GP consultation costs, budgeting advice may be helpful to the patient and can be provided by clinic staff or the prescriber depending on their skills and experience in this area. When required, the client may be referred to one of the local community groups or non-government agencies which assist with budgeting advice.

In addition, the transition period may also be a challenge for the GP, particularly for those with limited experience in the management of opioid dependence.

Documentation and Forms
Feedback from consumer organisations has suggested that it is not uncommon for patients to feel uneasy when meeting a new prescriber. To assist patients to identify key areas that may be usefully discussed with a new prescriber, a checklist—The Patient’s Priorities for Care (PPC)—has been developed in collaboration with user groups. It acts as a prompt for patients before and during their initial assessment with their new prescriber.

Specifically the PPC prompts patients to consider concerns or uncertainty around moving treatment, such as what can be done to ease the transition; any issues around current pharmacy dosing arrangements; current dose adequacy; current drug use; prescribed medications including any side effects or interactions; general health related concerns, including teeth; involvement with any other health care providers; the option of having a support person involved in the plan; any commitments that may affect the keeping of appointments, for example, work or study; goals and a timeframe for achieving them.

Patients are encouraged to consider these issues before presenting to a new GP. Some patients may wish to write down questions or relevant history details and take these with them to the GP appointment to highlight their own treatment priorities.

Information exchange should be encouraged in all cases and is most likely to flourish within the context of a healthy therapeutic relationship between the patient and their care providers.

A patient’s consent should always be sought when sharing information between service providers.

Step 2  GP assesses for transfer and initiates GP Mental Health Care Plan (GPMHCP)

Step 2.1 Patient attends GP for first assessment and GP decides whether to accept patient (and vice versa)

Process
The focus in this step is on the assessment and planning required, however if the GP has already been involved in the delivery of primary care to the patient, much of this will have already been discussed. Ideally patients will have established a relationship with a GP well in advance of the proposal to transfer their opioid prescribing to that GP.

If this is the first appointment with this GP, an extended consultation (i.e. 45 minutes) should be requested at the time of making the first appointment so that all issues can be adequately addressed. At the time of the appointment, the GP will already have received the clinic referral with a clinical summary. The GP reviews the documentation provided, and assesses and examines the patient.

The patient may find it helpful to use The Patient’s Priorities for Care as a prompt during the discussion.

With the patient’s agreement, the GP will provisionally accept the patient (for primary care and/or prescribing).

At the end of the consultation the GP phones the clinic to confirm that he or she will take over prescribing and sets a date for commencement of prescribing—usually the following week. The clinic is then able to arrange the timely exit of the patient from their current public prescriber (through notification to the PSB) on the day prior to the GP commencing prescribing.

The GP must complete a PSB authority form identifying the date of commencement of prescribing for that patient so that he or she is able to take over care of that patient the day after the patient is exited from the public clinic (PSB phone 02 9879 5246 or fax 02 9859 5170).

All GPs newly commencing prescribing should understand their responsibilities in taking on the care of patients on an Opioid Treatment Program, especially in regard to organising cover when the GP is away, or is considering leaving or retiring from practice.
Step 2.2 GP initiates care plan/s in consultation with the patient

Deciding on which care plan to use

There are two potentially suitable care plans under Medicare which may be used by GPs for planning the management of opioid dependent patients: the GP Mental Health Care Plan (Medicare item 2710) and the GP Management Plan (Medicare item 271). Both also have related items.

The best initial plan is the GP Mental Health Care Plan (GPMHCP) which includes ‘Drug use disorders’ as a primary indication for its use and which is therefore suitable for all opioid dependent patients. The GP Management Plan (GPMP) is suited for a narrower group of patients whose drug use disorder is associated with chronic physical conditions (such as hepatitis C) requiring treatment, or who have an additional independent chronic physical condition (such as diabetes).

- Steps 2 to 7 will detail the ways in which the GPMHCP and related items can be used in the care of opioid dependent patients

- Steps 8 to 12 will detail the additional ways in which the GPMP and related items can also be used in the management of some opioid dependent patients

Assessment (as part of a GPMHCP)

The GP will develop an initial care plan, a GPMHCP (see Sample GPMHCP). Since ‘Drug use disorder’ is a primary indication to use this item, the use of a GPMHCP initially will enable access to the Medicare Better Access initiative mental health item numbers for a mental health consultation, plan and review (see Flowchart for the three components of the Better Access initiative) with the possibility of onward referral to allied health care specialists such as psychologists for counselling. For comprehensive information, go to Better Access to Mental Health Care initiative then go to the Better Access Orientation Manual.

The steps detailed below are required in the assessment process in order to claim the Medicare GPMHCP item.

Patient’s agreement

The patient’s agreement is required for the service, recorded in the patient’s file, as for all treatment and information exchange.

Relevant history

The clinical summary provided by the clinic will supplement the GP’s own assessment.

Mental State Examination (MSE)

An MSE is conducted as for any patient. A stable dose of methadone/buprenorphine should in no way impact upon a MSE and this should be approached as for any other patient. (see the Can Do initiative: Managing Mental Health and Substance Use in General Practice on the AGPN website).

Assess risk and comorbidity

There are four specific areas for assessment in opioid dependent patients, in addition to the usual examination and assessment. Follow each link for more details on these.

1. Medication stability
2. Drug use
3. Other health issues (may indicate need for GPMP)
4. Psychosocial

Diagnosis

All patients must have a diagnosis of opioid dependence to be on an opioid treatment program. In addition, it is common for this patient group to have hepatitis C (over seventy percent) and about one third will have a current psychiatric diagnosis (most commonly depression, anxiety, post-traumatic stress disorder (PTSD), personality disorder or another substance use problem). Other common diagnoses include chronic pain, hepatitis B and dental caries.

Outcome Measures

There are no commonly used outcome tools that are in routine use within a primary care setting to monitor the progress of drug problems. Nevertheless, there are several good clinical indicators that do provide information to help guide a clinician about how their patient is going. Some of these are objective measures such as attendance for dosing, inspection of injection sites, and urine drug screens. Others are serial assessments and data collection from the patient and third parties that help inform the clinician as to how treatment is progressing. These are compiled in the GP Review Proforma for Opioid Dependent Patients. In addition, for general information on outcome measures, see http://www.gpcare.org

Objective measures

- Urine drug screens (see Medicare Urine Drug Screen items)
- Attending for all doses and appointments
- Compliance with dosing procedure i.e. no diversion
- No evidence of recent injecting on examination
- Alcohol Breath Analysis where clinically indicated
- Psychiatric screening instruments as appropriate
- BDI / K10 /SF12

Self report

- Reduced high risk activities including drug use, injecting, risky sexual practices, crime, violence
- Engagement in employment or education activities
- Improved family relationship including parenting

Feedback from third parties

- Pharmacy information on patient presentation, missed doses, refused doses
- Feedback from other agencies e.g. child protection, probation and parole, employers, education providers
Developing a Plan as part of GPMHCP

Feedback on assessment findings to the patient
The GP discusses the assessment with the patient, including the mental health and substance use formulation and diagnoses.

Discuss referral and treatment options
The GP discusses with the patient the options for treatment, including referrals to allied health professionals (such as for counselling). See Step 5.

Agreeing goals with the patient
Below are some suggestions regarding goals that may be suitable for opioid dependent patients, for the prescriber and for the patient. The GP can draw on these to reach agreement with the patient on the goals to be included in the GPMHCP.

<table>
<thead>
<tr>
<th>GP prescriber goals specific to opioid dependent patients</th>
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<tbody>
<tr>
<td>1. Medication stability</td>
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<tr>
<td>2. Drug use stability</td>
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<tr>
<td>3. Health improvement</td>
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<tr>
<td>4. Psychosocial support</td>
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Some patient specific goals of treatment
- Cessation / reduction in heroin use
- Improved level of stability in day to day life
- Improved access to other health care
- Reduced levels of supervision and increased access to takeaways
- Quickest way to safely come off treatment
- Parenting support

Actions to achieve set goals
- Identify optimal dose and type of medication for the patient
- Safely storing methadone takeaways
- Address side effects and concerns over medication
- Advise your patient how to get the most out of treatment
- Focus on engaging and addressing other goals of the patient
- Be transparent about the need for and the range of monitoring processes, including the frequency of reviews and the requirement for drug screening
- Use the Stability Assessment Flowchart and completion of other proformas to track progress
- Regular reviews
- Provision of urine for drug screen
- Referral to specialist providers for treatment including community nursing or allied health professionals

Provision of psychoeducation
The GP must provide some psychoeducation relating to the patient’s diagnoses. For patients with opioid dependence on an OTP, this education includes avoiding overdose and engaging in relapse prevention strategies. For further information, see http://www.gpcare.org (select ‘Psychological Interventions’ then click on ‘Psychoeducation’).

Crisis intervention and/or relapse prevention plan

Crisis
All patients should be provided with information on what to do in the event of a crisis. Should the patient be in need of urgent advice, they should be directed to either phone the GP surgery or the public clinic from which they were transferred.

In addition, all patients must be given the Alcohol and Drug Information Service (ADIS) telephone number for out-of-hours support (02 9361 8000 or 1800 422 599 for callers outside Sydney).

Should patients be concerned about their physical or mental health out-of-hours they are advised to go to Emergency Department and request any discharge information be copied to the GP.

Patients should also be aware that doctors and nurses across NSW can access 24 hour drug and alcohol specialist support through contacting the NSW Drug and Alcohol Specialist Advisory Service (DASAS) line (02 9361 8006). Patients may advise clinicians unaware of this service of its existence.

Relapse prevention
Patients who have successfully completed a planned gradual reduction off maintenance treatment should be offered relapse prevention and access to ongoing counselling. They must also be advised of the risk of fatal overdose on return to opioid use because of low tolerance. Relapse prevention should focus on the identification of triggers and high risk situations and explore coping strategies to manage ‘craving-rich situations’ (people, places and things) and techniques to ‘surf the craving’ (cravings come and go like a wave, use distraction until it passes, have a list of distractions ready). Referral to specialist drug and alcohol services or psychologists may be helpful in such cases. These patients should be encouraged to represent as soon as possible to the prescriber or local clinic in order to return to treatment. For more information go to http://www.gpcare.org (select ‘Psychological Interventions’, then click on ‘Relapse Prevention’).

Referrals
Under the GPMHCP, the GP may refer patients for a range of services from other professionals. These referral routes are set out at Patient Pathways. For more detail, go to Step 5.

Documentation
There is a sample GP Mental Health Care Plan (GPMHCP) which can be modified for use for patients with opioid dependence/drug and alcohol problems. Appropriate documentation may be developed by the GP for their own use, or may involve the use of existing materials such as RACGP templates or the use of software programs such as Medical Director or Best Practice. Specific clinical issues related to the management of those on prescribed opioids for the treatment of opioid dependence can be added to the plan.

Written by Dr. Adam Winstock and Dr. Jill Molan
These forms can be augmented in the case of managing those with opioid dependence with Stability Assessment Flowcharts and clinical assessment pro formas which are consistent with current best practice in determining stability in injecting drug users and their suitability to receive takeaways doses of medication. All should be based on current Medicare requirements.

Finally, give a copy of the care plan to the patient.

**Step 3** GP requests Home Medicines Review (HMR) of patient and receives feedback

HMR is also known as Domiciliary Medication Management Review (DMMR)

**Process**

Although most GPs will be familiar with the use of Home Medicines Review (HMR) for a range of medication related issues, they may not be aware that patients on methadone, buprenorphine or buprenorphine-naloxone are also eligible for an HMR under the DoHA criteria for HMR (see Medicare item 900, point A.26.4.). These medications fall under the category of ‘medication with a narrow therapeutic index or medications requiring therapeutic monitoring’. HMR can be undertaken once per patient per year or more often if medications or other factors change significantly. Full guidelines for the use of the HMR service can be found on the DoHA website at [HMR Guidelines](https://www.doha.gov.au).

The information exchange that occurs through the HMR is a potentially powerful source of support for GPs in working with their patient to develop a treatment plan, whether a GP Mental Health Care Plan, a GP Management Plan or a Team Care Arrangement.

**Step 3.1 Starting the HMR**

- Patient can be identified by the GP or practice staff or any care provider
- GP obtains informed consent from the patient for the HMR service

The HMR is an optional component of care, and patient consent is required, and must be recorded. In these discussions with the patient, the GP may use the Patient Information Sheet and Consumer brochures (and Translations) available on the DoHA website.

The benefit of an HMR to the patient is that it provides an opportunity to have a period of uninterrupted time with a pharmacist to address a range of health care and medication related needs and concerns. An HMR can also provide information on the optimal management of side effects (for both prescription and over-the-counter medication) and other issues such as compliance and storage. Other potential benefits include the detection of health care conditions for which the patient is not currently being treated and the experience of having a health care provider focus on issues other than drug use or depression.

**Step 3.2 GP initiates HMR referral to a community pharmacy**

The pharmacy should be of the patient’s choice, ideally their dosing pharmacy where they are known. With the patient’s agreement, the HMR referral should include the following information: presenting problems; diagnosis; medications; current pathology; medical and surgical history; and clinical monitoring. The better the information on referral, the better the pharmacist’s report.

**Step 3.3 Pharmacist conducts an interview with the patient**

The GP or pharmacist should determine the most appropriate location to conduct the HMR in discussion with the patient. It is not mandatory that the HMR interview be done in the patient’s home, as long as it is in a location in which the patient and the pharmacist are both comfortable, and the patient’s privacy is protected. In part, an acceptable location will be determined by factors such as convenience and patient preference.

In cases where the pharmacist is considering conducting such a review in the patient’s home, a risk assessment should be undertaken by the pharmacist regarding such factors as the presence in the home of persons with a history of violence and pets, particularly dogs, in the home. Also, any child protection issues that arise must be appropriately addressed.

**Step 3.4 Pharmacist writes a report to the GP**

The report contains ‘findings’ or what the pharmacist found at the interview; and ‘recommendations’ as a result of those findings. The pharmacy HMR report provided back to the GP will address a range of issues relevant to patient management such as: dose adequacy; other medications taken (including over-the-counter (OTC) and herbal); compliance; side effects; safe storage; interactions; contraindications; potential for misuse and prescription shopping.

**Step 3.5 Patient agreement to Medication Management Plan**

At the next appointment (see Step 4), and in collaboration with the patient, the GP will incorporate the pharmacy HMR report into a Medication Management Plan. The Medication Management Plan contributes to the development of the patient’s overall treatment plan, and this discussion ensures that the patient is consulted about how this feedback is used.

Copies of the plan are provided to the patient and to the pharmacy.

**Step 3.6 GP submits item 900 claim**

**Documentation and Forms**

Information exchange between the patient, the referring GP and the pharmacy can be conducted using existing documents. The DoHA website includes links to a GP Fact Sheet and Process Chart, an HMR Referral Form, and a Medication Management Plan Form. In addition, The Pharmacy Guild of Australia provides a page of detailed information on Home Medicines Review, including links to software templates for GPs.

The GP must provide a copy of the Medication Management Plan to the pharmacy as part of the requirements of Medicare item 900. This facilitates the support that the pharmacy can offer the patient.

GPs should also provide a copy of the Medication Management Plan to the patient to ensure the patient has ongoing access to the plan.
The patient needs to attend the GP for their first prescription some days before the new authority to prescribe comes into effect. Although the GPMHCP, (or the GPMP and the TCA) could have been completed at the initial appointment (i.e. Step 2), it is preferable for the GP to make an appointment for the patient to return the following week. During this time, any concerns and treatment delivery issues can be resolved, including the transfer of ‘authority to prescribe’ through PSB and finalisation of the HMR report by the pharmacy.

If the GP has received the HMR report from the pharmacy, then the Medication Management Plan can be completed at this appointment in discussion with the patient (see Step 3.5). The GP will provide the plan to the patient and to the pharmacy. This plan will then contribute to the overall management plan/s. The GP should then complete all plan/s (GPMHCP, GPMP, TCA) commenced at the initial appointment.

The GP should confirm transfer of authority to prescribe with PSB as requested the previous week, to commence from the next day (both fax and phone numbers on the application form). The first prescription will then be written at this appointment and faxed direct to the pharmacy. The original script will then be mailed to the pharmacy.

The first prescription should generally not be for more than 2 weeks (4 weeks maximum). Prescriptions are never to be provided directly to the patient and must always be faxed (and then posted) to the pharmacy. Prescribers are advised to routinely contact the pharmacy prior to providing any prescription to ensure that the patient has not missed any doses, been refused any doses or been intoxicated at presentation (see Step 6).

**Documentation**

The DoHA website includes templates which can be adapted for use for patients with opioid dependence. See Sample GPMHCP and Sample GPMP and TCA.

**Step 4  GP reviews patient in one week and completes transfer**

**Process**

Under the GPMHCP, the GP may refer patients for a range of services provided by other professionals. Referral routes and services are set out at Patient Pathways and include referral to a clinical psychologist for psychological therapy services or referral to a registered GP, a psychologist, social worker or occupational therapist for focussed psychological strategies (FPS). These services will in future also be provided by mental health nurses and Aboriginal Health Workers with appropriate qualifications and experience.

These health care workers must be registered with Medicare to be eligible to claim for the available rebates. For contact details of registered professionals, refer to Finding a Mental Health Allied Health Professional. In addition to these services, the GP may refer the patient directly to a psychiatrist for initial consultation (item 296); assessment and development of a management plan (item 291); review of a management plan (item 293). For further information on fees and rebates, refer to Better Access Medicare items.

Patients may receive up to 12 individual and/or group mental health allied health services per calendar year. After the first six sessions, the allied health professional is required to report back to the referring GP. If indicated by a review of the patient's needs, the GP may refer for a further six sessions. In exceptional circumstances an additional third set of six services is available per patient per calendar year.

To make a referral to a mental health allied health professional under the Better Access initiative, the GP follows these steps.

1. Locate an allied health professional registered with Medicare: Find a Mental Health Psychologist, Find a Mental Health Social Worker, Find a Mental Health Occupational Therapist

2. Ensure that the practitioner has a practice orientation that caters to adults with drug and alcohol problems. Some practitioners may specialise in child and family services, for example, and not adults with drug and alcohol problems.

3. Check that the professional has the current capacity to see the patient in an appropriate time (depending on the patient’s needs).

In addition, GPs will find information for consumers about psychologists at Consumer information.

Patients should be made aware prior to attending the first appointment with an allied health professional that some will bulk bill, while others will not and the payment will need to be made at the time of the consultation and claimed by the patient.
There may be a gap which the patient must pay themselves. It is essential when the professional indicates what the cost will be when the patient makes the first appointment. Professionals who do not bulk bill may be reluctant to take on some patients, believing that attendance at appointments may be erratic or that payment is not guaranteed.

**Documentation**

While referrals to allied health do not require a special form, in order for the professional to be paid by Medicare, the referral must include (in addition to relevant patient details), the name of the referring doctor, the provider number, the date, and a request for psychological treatment.

**Step 6 Regular review appointments (GPMHCP or GPMP or TCA)**

**Process and Documentation**

After the first week, the GP and patient need to agree on an appointment schedule for routine reviews. Initially more frequent appointments may work well for both patient and prescriber, particularly in order to establish their therapeutic relationship (though cost may mean that some patients are less keen on this than their doctor, even if the doctor is bulk billing).

A suggested appointment schedule following the initial GP plan is at:

- 2 weeks
- 4 weeks
- 8 weeks
- 12 weeks and then
- a minimum of three monthly.

Patients should be advised by the clinic that these are the maximum intervals and the GP may insist on more frequent visits.

- Patients should be advised by clinic staff and the GP that non-attendance at the GP for scheduled appointments may jeopardise their script provision and may result in a loss of takeaways if the GP is no longer able to obtain sufficient information to support their ongoing provision.

Scripts should not usually be provided for more than one month during the first 3 months of treatment. After the first 3 months, scripts can be provided for a maximum of 3 months. This schedule ensures that the prescriber reviews the patient at least 6 times during the first 12 months of transfer. These are routine reviews (such as Level B or C consultations) and not a full review of the care plan (see Step 7), however they can on occasions qualify for a routine mental health care consultation (item 2713).

Should a patient who has already been receiving takeaway doses from a community pharmacy be transferred to a new prescriber (i.e. the GP), the patient should be aware that their new prescriber has a responsibility to ensure that it is still appropriate for the patient to continue to receive takeaways on the existing schedule. The assessment supporting the provision of ongoing takeaways needs to be documented (such as by using the Stability Assessment Flowchart). Where there is evidence to support the patient’s continued stability, in most cases it will be appropriate to continue with the inherited prescription, keeping the takeaway provision as it was.

For further guidance on prescribing unsupervised doses see the current New South Wales Opioid Treatment Program Clinical Guidelines; suitability for unsupervised medication doses in the treatment of opioid dependence.

Each time the GP provides a prescription they must ensure that it reflects the needs and stability of their patient, specifically the dose, any flexibility with regard to increases or decreases in dose and that the provision of takeaways has been considered. Thus before giving a patient a prescription, the GP should address the following areas:

- medication stability;
- drug use stability;
- psychosocial stability; and
- any unmet health care needs.

To assist in this process, GPs may choose to use the Stability Assessment Flowchart or the GP Review Proforma for Opioid Dependent Patients. The completion of the latter could usefully form part of the 6 monthly review.

In addition, information must be obtained from the dosing site prior to the provision of any prescription. This may be supported by the use of pharmacy monitoring feedback forms. Key areas to be enquired about are:

- Any missed doses?
- Any refused doses?
- Any intoxicated presentations?
- Is the patient paid up-to-date?
- Any other concerns?

Local arrangements may need to be developed to ensure that the pharmacist knows when the review date is—though usually this will be a week or so before the script expires.

If the GP is using a GPMP, the GP may decide to organise a Team Care Arrangement (TCA) at any point where collaboration with other health professionals would support the patient. In addition, under the Enhanced Primary Care item numbers, a Community Case Conference may be organised if indicated. The GP may either participate in (items 740, 742, 744) or be the organiser of a Community Case Conference (items 759, 762, 765).

At six months, unless indicated earlier, the GP may conduct a Review of the GPMHCP or GPMP (see Step 7).
**Consideration for rural and remote areas.**
Rural isolation may place limitations on some patients’ ability to travel. The impact of these hurdles needs to be recognised, especially early in treatment where they may act as a disincentive to remaining in treatment. In terms of frequency of appointments, both clinics and GPs need to ensure a balance between what is reasonable to expect from a patient in terms of travel (cost, time, presence of public transport), other responsibilities and their clinical needs.

In some circumstances, scripts may need to be provided for periods in excess of the recommended 3 month maximum period. Where this occurs, every effort should be made to ensure that the script is flexible to meet the patient’s needs while not compromising safety or promoting destabilisation.

Where community drug and alcohol workers are available the GP may request that they review the patient to ensure that they are on a stable dose and not in receipt of inappropriate takeaway doses. In addition, appropriate reporting mechanisms should be in place between the pharmacy and the prescriber to ensure that in between reviews, should problems emerge, these can be identified early. Such contact should be at least 3 monthly.

In rural areas, isolated practitioners or pharmacies with few support staff may feel vulnerable should they encounter episodes of aggression from patients. It may be that additional work is required within rural and remote areas to engage and retain both GPs and community pharmacies who may have an negative opinion of the work involved in delivering opioid treatment.

Additionally local services will need to work collaboratively to incorporate rural doctors into routine prescribing, to achieve manageability in support of the patients. This is an area the clinic NUMs can manage by providing community support and liaison.

Contracts covering pharmacies and public sites should also extend to doctors’ consulting rooms to ensure the patient is aware that expectations of reasonable behaviour are not limited to dosing sites.

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**Step 7  Review of plan (GPMHCP or GPMP or TCA)**

**Process and Documentation**
Review conducted 4 weeks to 6 months after initial plan.

The review date should be set and documented at the time of plan preparation. The review should cover each aspect of the original plan, so that each item can be ticked off. Patient consent is required, and a further review date is to be set at the conclusion of each review. The requirements of the review include the patient’s agreement and a record of progress against goals, with modification of the plan if required. Any outcome tools used in the initial assessment must be readministered.

Formal review of the GPMHCP (or GPMP) is recommended six monthly, but it may be done more frequently if indicated by a change in the patient’s level of stability.
Additional Steps

**Step 8  Additional steps for the development of a GP Management Plan (GPMP)**

**Process**
A GP Management Plan (GPMP) (item 721) and related items may be used in addition to a GPMHCP when a patient has a chronic physical problem, such as hepatitis C, requiring treatment. The plan must be developed by the patient’s ‘usual’ GP for a condition that has, or will, last for more than six months. A GPMP may be completed in addition to a GPMHCP, and may now be done on the same day.

The patient’s consent must be obtained for the development of the GPMP, and an explanation given to the patient of the steps involved. The plan must be a comprehensive document that sets out and enables evidence-based management of the patient’s health and care needs.

A large part of the information obtained to complete the GPMHCP can appropriately be utilised in the development of a GPMP. Additional information regarding the specific chronic medical conditions will need to be explored as required.

It is recommended that the following items be included in the GPMP:

- the patient’s health care needs, health problems and relevant conditions;
- management goals with which the patient agrees;
- actions to be taken by the patient;
- treatments and services the patient is likely to need;
- arrangements for providing the treatment and services; and
- a review date for the GPMP.

The GPMP and the patient’s agreement must be documented in the patient’s file.

Upon completion, a copy of the plan should be offered to the patient.

In addition, the GP may decide it is appropriate to conduct a 45 Year Old Health Check (item 717) or an Aboriginal Health Check (items 704-710).

**Documentation**
A checklist and GPMP sample form are available at the DoHA website.

**Step 9  Team Care Arrangement (TCA)**

**Process**
Under the Enhanced Primary Care Program (EPC) Chronic Disease Management (CDM) item numbers, if a GPMP is in place, the GP may also institute a Team Care Arrangement (TCA) (item 723). A TCA is appropriate for patients who require ongoing care from a multidisciplinary team of at least three health care providers (including the GP). We recommend in the case of those with opioid dependence that a TCA also be developed as well as a GPMP. The GP can use the information provided by the OTP clinic and the HMR report from the pharmacy to complete a TCA.

The patient’s consent must be obtained for the development of a TCA, and an explanation given to the patient of the steps involved. The GP should discuss with the patient the collaborating providers who would contribute to and provide treatment and services to the patient.

A TCA requires preparation of a document that describes:

- the treatment and service goals for the patient;
- the treatment and services that collaborating providers would provide to the patient;
- actions to be taken by the patient; and
- a review date for the TCA.

The TCA and the patient’s agreement to it must be documented in the patient’s file.

Upon completion, a copy of the TCA should be offered to the patient and relevant parts of the TCA given to the collaborating providers.

**Documentation**
A checklist and sample TCA form are available at the DoHA website.

**Step 10  GPMP and TCA referral to allied health**

**Process and Documentation**
Under the GPMP, when a TCA is in place, the GP may refer to a range of eligible allied health professionals (including physiotherapists, dieticians, podiatrists and others) for a limited number of sessions per year.

In addition, dental referrals may be made for a limited range of conditions when a dental problem is impacting on other health problems. A Dental Care Factsheet is available which details these conditions. Current Referral form for Dental Care is available for use with the GPMP and TCA.

NOTE: New Dental Care items will become available through Medicare on November 1st 2007

**Steps 11-12 as for Steps 6-7**
 Patients transferred to your care under the ‘patient journey’ are supported by a guarantee, so that should a GP find they are no longer able to prescribe because of concerns about the patient’s well-being, they are able to return the patient to the care of the clinic, for either short term or long term care by clinic staff and specialist prescriber.

For urgent professional support, ring the NSW Drug and Alcohol Specialist Advisory Service (DASAS) (Sydney 02 9361 8006 or for callers outside Sydney 1800 023 687). DASAS is a 24 hour telephone service for the clinical management of patients with alcohol and other drug related problems.

In addition, GP Psych Support is a free service available in all States and Territories which provides GPs with patient management advice from psychiatrists within 24 hours and now includes advice on substance use (1800 200 588 or www.psychsupport.com.au, a secure and password protected website).

The following steps should be taken should you wish your patient to be reviewed by or returned to the clinic or to the specialist prescriber.

1. Any concerns you have about the patient’s stability should be addressed as soon as possible.
2. Your concerns should be discussed with the patient.
3. In the absence of available local specialist advice (perhaps out of hours) the GP can contact the DASAS (numbers above).
4. As soon as possible, the clinic should be contacted, specifically either the NUM or the specialist or the patient’s previous case manager.
5. The nature of your problem/concern/request should be made clear.
6. The clinic’s response should without fuss, delay or prevarication be to respond in a positive manner to your request.
7. Discuss the clinic’s response with the patient.

8. Appropriate responses by the clinic will be determined by the nature of the request and may include the following scenarios:

8.1 The clinic arranges urgent clinical review by a staff member.

8.2 The GP continues to prescribe but the patient returns to the public clinic for dosing in the short term until stability is regained. This will require cancelling of the existing script with the pharmacy and a new script by the GP for clinic dosing. The GP must notify the pharmacy of the change in dosing site and cancellation of the script.

8.3 Temporary respite prescribing taken over by the specialist prescriber until the patient has restabilised, in addition to the change in dosing site. In such cases the GP needs to notify the pharmacy of the change in dosing site, cancel the existing script and notify the PSB that another doctor will be acting as a locum prescriber on their behalf for this patient. The specialist prescriber will provide a script for clinic dosing.

8.4 Full return of the patient’s prescribing to the public prescriber, in addition to the change in dosing site. In such cases the GP needs to notify the pharmacy of the change in dosing site and cancel the existing script with the pharmacy.

The GP also needs to notify PSB that another prescriber is taking over prescribing for this patient. This involves submitting an Exit Form to PSB. The Exit Form should be dated to match with the date the specialist prescriber will commence prescribing, and will require liaising with the clinic to ensure the smooth transfer of authority to prescribe.

8.5 The GP need not be discouraged and should take on another stable patient as soon as practical.
Transferring a Patient’s Dosing from a Public Clinic to a Community Pharmacy

Typically the first step in transferring a patient’s care from specialist clinic to community care is to transfer the patient’s dosing to a community pharmacy. A period of maintained stability at a community pharmacy following transfer is a good indication that the patient has continued to do well and will be suitable for transfer to a GP for prescribing.

For many patients there will be budgetary issues associated with the cost of dosing at a community pharmacy (and paying GP consultation costs), and these can be discussed between the patient and the clinic. Budgeting advice may be helpful to the patient and can be provided by clinic staff depending on their skills and experience in this area. When required, the patient may be referred to one of the local community groups or non-government agencies which assist with budgeting advice.

Transfer of patients from a public clinic dosing site to a community pharmacy dosing site allows greater flexibility in dosing hours, and provides the patient greater control in organising their daily lives. The patient will have usually been stable for a minimum of three months at a public clinic to be eligible for this transfer (this may be less, especially for those on buprenorphine). Prescribing and care planning remain with the clinic at this stage.

The Stability Assessment Flowchart is recommended for use by either the clinic staff or the prescriber to assess patient suitability for transfer. The flowchart is designed to be completed in consultation with the patient. It can then, with the patient’s informed consent, be faxed to the pharmacist with the patient’s identification details and prescription. This will assist the pharmacist to know what assessment has been conducted at the clinic, and it will also provide a list of items for the pharmacist to consider in providing routine feedback to the clinic (such as attendance and overall presentation) at time of prescription reviews.
## Time Frames for Care Planning and Reviews*


The Medicare Benefits Schedule book contains all the requirements of a GPMP, TCA and GPMHCP and it is essential you check these details yourself before billing these items.

### 1. GPMHCP & review

<table>
<thead>
<tr>
<th>Name Better Access Item</th>
<th>Item No</th>
<th>Rebate $</th>
<th>Recommended frequency</th>
<th>Minimum Claiming Period*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of a GPMHCP</td>
<td>2710</td>
<td>150.00</td>
<td>2 yearly</td>
<td>12 months*</td>
</tr>
<tr>
<td>Mental health care consultation</td>
<td>2713</td>
<td>66.00</td>
<td>3 monthly</td>
<td>12 months*</td>
</tr>
<tr>
<td>Review of a GPMHCP</td>
<td>2712</td>
<td>100.00</td>
<td>6 monthly</td>
<td>3 months*</td>
</tr>
</tbody>
</table>

### 2. GPMP, Review, TCA, Review

<table>
<thead>
<tr>
<th>Name Chronic Disease Management item</th>
<th>Item No</th>
<th>Rebate $</th>
<th>Recommended frequency</th>
<th>Minimum Claiming Period*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of a GP Management Plan</td>
<td>721</td>
<td>124.95</td>
<td>2 yearly</td>
<td>12 months*</td>
</tr>
<tr>
<td>Preparation of Team Care Arrangements</td>
<td>723</td>
<td>98.95</td>
<td>2 yearly</td>
<td>12 months*</td>
</tr>
<tr>
<td>Review of a GP Management Plan</td>
<td>725</td>
<td>62.50</td>
<td>6 monthly</td>
<td>3 months*</td>
</tr>
<tr>
<td>Coordination of Review of Team Care Arrangements</td>
<td>727</td>
<td>62.50</td>
<td>6 monthly</td>
<td>3 months*</td>
</tr>
<tr>
<td>Contribution to a multidisciplinary care plan or Team Care Arrangements</td>
<td>729</td>
<td>43.40</td>
<td>6 monthly</td>
<td>3 months*</td>
</tr>
</tbody>
</table>

*These services can also be provided more frequently in ‘exceptional circumstances’—where there has been a significant change in the patient’s clinical condition or care circumstances (such as development of comorbidities or complications, deteriorating condition, illness/death of carer etc) that require a new GPMHCP or review, a new GPMP, TCA or review service.

### 3. Other

<table>
<thead>
<tr>
<th>Item Name</th>
<th>Item No</th>
<th>Rebate $</th>
<th>Recommended frequency</th>
<th>Minimum Claiming Period*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Check</td>
<td>704-710</td>
<td>167.45–236.85</td>
<td>Annually for under 15 and over 55; once every 18 months for others</td>
<td></td>
</tr>
<tr>
<td>45 Year Old Health Check</td>
<td>717</td>
<td>100.00</td>
<td>Once between ages 45-49</td>
<td>Once only</td>
</tr>
</tbody>
</table>
An Example of Medicare Items and Rebates first 12 months*


The Medicare Benefits Schedule book contains all the requirements of a GPMP, TCA and GPMHCP and it is essential you check these details yourself before billing these items.

**Patient flow – first six weeks…**

| 1st Cons Admission; Needs assessment | GP Mental Health Care Consultation | Item 2713 +/- 23, 10990 | $66.00 +/- $37.40 |
| 2nd Cons GPMHCP | GP Mental Health Care Plan | Item 2710 +/- 23, 10990 | $150.00 +/- $37.40 |
| 3rd Cons GPMP | GP Management Plan | Item 721 +/- 23, 10990 | $124.95 +/- $37.40 |
| 4th Cons TCA | Team Care Arrangement | Item 723 +/- 23, 10990 | $98.95 +/- $37.40 |
| 5th Cons Continuing care | Level B | Item 23 | $32.10 +/- $5.30 |
| 6th Consultation Possible HMR | HMR | Item 900 +/- 23, 10990 | $134.10 +/- $37.40 |
| **Totals** | | | **$509.40—$657.25** |

**Patient flow – the next three months…**

| 7th Cons Wk 8 Ongoing Care | Level B | Item 23 | $32.10 +/- $5.30 |
| 8th Cons Wk 10 Ongoing Care | Level B | Item 23 | $32.10 +/- $5.30 |
| 9th Cons Wk 12 Case Conference | Case Conference 15-30 minutes | Item 740 +/- 23, 10990 | $83.75 +/- $37.40 |
| 10th Cons Wk 14 GP Plan Review | GP Mental Health Care Plan Review | Item 2712 +/- 23, 10990 | $100.00 +/- $37.40 |
| 12th Cons Wk 18 TCA Review Ongoing Care | TCA Review | Item 727 +/- 23, 10990 | $62.50 +/- $37.40 |
| **Totals** | | | **$372.95—$554.35** |

**Patient flow – Ongoing yearly cashflow**

| Week 0—6 | | | **$509.40—$657.25** |
| Week 7—18 | | | **$372.95—$554.35** |
| Week 19—30 | | | **$372.95—$554.35** |
| Week 30—52 | | | **$372.95—$554.35** |
| **Total** | | | **$1628.25—$2320.30** |
Dear client

You have been receiving treatment at this clinic for ….. months / years. We have been very happy with your progress and at this point we would like you to consider transferring your care (including prescribing your opioid treatment) to a GP of your choice.

The advantages of having a GP become your prescriber are:

1. integration of all your health care with one doctor;
2. access to a host of Medicare services that can be very useful to you, such as psychology, dental, and occupational therapy;
3. increased flexibility of your treatment;
4. not having to come to this clinic!

Should you ever require a specialist review of your problem your GP always has access to us (and of course you can always pick up the phone and call us if you need to).

We want to move stable patients on so that our specialist doctors can look after other patients such as those with multiple problems who may need treatment urgently, especially those who have not received treatment before, and who will benefit from the skills of the specialist doctors.

Finally we understand that for some of you a move to a GP will mean additional costs. We hope that most GPs will be bulk billing and we have processes in place to help them in maximising the income they can generate by providing your opioid treatment care.

Finally, when you move to a new prescriber there is often the requirement to see them more frequently initially than you would have been seeing your public prescriber. This is because they will want to get to know you (and you them) and get comfortable with prescribing, especially when takeaways are involved. It also means that they can plan other treatments or referrals you may need. If accessing your GP more frequently is a problem, please discuss this with us or your GP.

In order to help you access a GP about this issue we have developed a letter for you to take to them which you can have on request. If you have any questions, ask us.

<INSERT NAME AND POSITION – NUM, CASE MANAGER ETC>
Sample Letter from Clinic to GP

Dear GP

Your patient… Your patient’s name …has been in treatment as a client of our service for the last …… years. We can confirm that the client is doing very well, that is, is stable (a stable dose of medication, a significant reduction or cessation of injecting heroin or other drugs, good attendance, no dose refusal or diversion, no risk of overdose, no acute physical or mental health problems). In our assessment this client could appropriately be managed in primary care. At the clinic we are keen to encourage stable clients to consider having their own GP become their prescriber, in addition to being their primary care provider.

While the advantages of holistic and integrated care for the client are obvious, the benefits also extend to the wider local population. This clinic will be able to offer treatment to new clients and those with specialist needs as stable clients transfer to primary care. Patients of primary care providers are able to access a wider range of community based health care services through the use of Medicare care plans and rebates.

Don’t worry if you have never prescribed before! Even if you are not an accredited prescriber, you are still able to prescribe for up to five (5) patients under the supervision of an accredited prescriber (usually a specialist or an experienced GP).

The clinic staff would be able to support you by providing the following:

1. A clinical summary of the client’s history and assessment of stability.
2. Guidance on prescribing safely.
3. Advice on using the community pharmacy to conduct a Home Medicines Review (HMR).
4. A guide to maximising both the care you provide and the remuneration you can obtain through the use of existing GP care plan rebates such as the GPMHCP, GPMP, TCA and related items.
5. An assurance of ongoing support to you, and patient review should this be required.

We have discussed this with your patient, and we were hoping that you might be interested in taking over the prescribing of …… Your patient’s medication……. The patient is currently prescribed ……mg /day ……. alternate day buprenorphine……, receives……takeaways each week, and is dosed at …… Your patient’s pharmacy……. At present the patient is seen by our prescriber every …… weeks.

Should you have any issues or concerns regarding the stability of your patient or the most appropriate management, we are very happy to support and advise you as required. If requested, the service / specialist will review the patient and if necessary, bring the patient back to the clinic for a period to time to allow restabilisation.

The specialist doctor who would be your support is Dr…………………………………………………………………………………………………………………..

The Caseworker is ……………………………………………………………………………………………………………………………………………………..

The Nurse Unit Manager is…………………………………………………………………………………………………………………………………………………..

If you think you would be interested in taking over the management of this client’s opioid treatment, please let your patient know and we will contact you so we can commence the transfer process.

If you would like to discuss this further please call me on…………………………………………………………………………………………………………………..

………………………………………………<NUM>
………………………………………………<CLINIC CONTACT DETAILS>
Contraindications to transfer to community pharmacy: (behaviour last 4-8 weeks)
Any of these should be seen as a contraindication to community transfer.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication stability</td>
<td></td>
</tr>
<tr>
<td>Recent diversion</td>
<td></td>
</tr>
<tr>
<td>Erratic / threatening behaviour</td>
<td></td>
</tr>
<tr>
<td>Irregular attendance for pick up</td>
<td></td>
</tr>
<tr>
<td>Episodes of refused dosing / presenting intoxicated</td>
<td></td>
</tr>
<tr>
<td>Regular problematic injecting drug use</td>
<td></td>
</tr>
<tr>
<td>Urine drug screen results</td>
<td></td>
</tr>
<tr>
<td>Unstable / risky substance use</td>
<td></td>
</tr>
<tr>
<td>Recent attempts at self harm / overdose</td>
<td></td>
</tr>
<tr>
<td>Acute significant mental health problems</td>
<td></td>
</tr>
<tr>
<td>Acute significant physical health issues</td>
<td></td>
</tr>
<tr>
<td>Unstable accommodation</td>
<td></td>
</tr>
<tr>
<td>Budgeting concerns</td>
<td></td>
</tr>
<tr>
<td>Child risk or protection issues</td>
<td></td>
</tr>
</tbody>
</table>

The client should remain at the clinic and in discussion with their case manger/prescriber causes for current instability should be identified and addressed in a revised care. Transfer should be revisited in 8 weeks.

Indications to support transfer. If no contraindications, then consider for transfer.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attends regularly / good presentation</td>
<td></td>
</tr>
<tr>
<td>Budgeting capacity</td>
<td></td>
</tr>
<tr>
<td>No recent diversion</td>
<td></td>
</tr>
<tr>
<td>Urines and examination show significantly reduced / nil use</td>
<td></td>
</tr>
<tr>
<td>No dependence upon benzodiazepines / alcohol</td>
<td></td>
</tr>
<tr>
<td>Employment / carer requirements</td>
<td></td>
</tr>
<tr>
<td>Stable accommodation / social situation</td>
<td></td>
</tr>
<tr>
<td>Education commitments</td>
<td></td>
</tr>
<tr>
<td>No refused doses</td>
<td></td>
</tr>
<tr>
<td>No recent / regular / IV use / overdose</td>
<td></td>
</tr>
<tr>
<td>No current mental health issues</td>
<td></td>
</tr>
<tr>
<td>Patient does not want to be dosed at public clinic</td>
<td></td>
</tr>
</tbody>
</table>

Find pharmacy
Arrange prescriber review
Arrange transfer
Remind re safe storage of medications

Maximum of 4 week scripts for first 3 months.
No or very limited takeaway
Regular feedback /contact with dosing pharmacy.
# The Patient’s Priorities for Care

<table>
<thead>
<tr>
<th>Patient name &amp; date</th>
</tr>
</thead>
</table>
| How do I feel about having to move my treatment?  
What can be done to ease this transition? |
| Do I have any problems at the pharmacy? |
| Am I on enough methadone or buprenorphine? Am I hanging out before dosing?  
Do I feel like using? Do I go on the nod? |
| Is my use of drugs or alcohol causing me worry, problems or putting me or others at risk? |
| Am I taking any over the counter or prescribed medications that I need to tell my doctor about? |
| Any side effects of medication I want to talk about?  
e.g. headache, constipation, sweating, sexual problems, nausea, sedation |
| Am I seeing any other doctors, health care workers, or support people from child protection, probation and parole, Centrelink? |
| Do I have any health concerns I’d like to address over the next few months? For example hepatitis C, my teeth? |
| Would I like somebody close to me to be involved in my care as a support person? |
| Are there commitments that may affect me keeping appointments, for example, work, study, that I need to tell my GP about? |
| Is there anything I ever wanted to know about treatment but was afraid to ask? |
| Do I want a copy of my care plan? |
| Where do I want to be in six months time?  
Twelve months time?  
Five years time? |
GP: Assessing Risk and Comorbidity

There are four specific areas for assessment in opioid dependent patients, in addition to the usual examination and assessment.

1. Medication stability

The following questions are useful for assessing the patient’s medication stability:

- Is your patient free from withdrawal symptoms for the full inter-dosing period?
- Do they crave for heroin?
- Do they use heroin on top of their medication?
- If they do inject, do they obtain a significant positive effect?
- If they experience withdrawal before dosing are they continuing to crave or are they using heroin? (Where the patient is ‘hanging out’ before dosing or when ‘on-top’ heroin use is positively reinforcing, the patient should be encouraged to increase their dose).
- Do they experience any side effects such as sexual dysfunction, sweating or constipation that you may be able to help with?
- Do they experience peak dose sedation and sleep during the day, making sleep at night difficult?
- Do they mix their methadone or buprenorphine with other sedative drugs or alcohol?
- Do they drink excessive amounts of caffeine-containing drinks?
- Do they need sleep hygiene interventions?
- Do they ever miss doses?
- Does the dosing site have any concerns about their presentation or the possibility of diversion?
- If takeaway doses are provided, are they stored safely and out of reach of children?

2. Drug use

- Do they use other drugs especially CNS depressants that may put them at risk of overdose?
- Do they prescription-shop for benzodiazepines? (see Prescription Shopping Program)
- Do you need to get them to sign a Medicare ‘prescription shopping’ (formerly known as ‘doctor shopping’) form?
- If they use any other substances, what is the route of administration? If they are still injecting (even if rarely), do they share equipment? Have they been advised of the risks of sharing, and where to get clean needles? Do they dispose of used needles safely?

3. Other health issues (may indicate need for GPMP)

- Has the patient been screened for hepatitis?
- Do they need or want a referral for treatment or vaccination?
- Do they have any other chronic medical conditions you can help with?
- Is there a current mental illness that needs treating?
- Are they on psychiatric medication? Do they take it?
- Can the pharmacist dispense psychiatric medication or medications with a misuse potential in smaller quantities with an increased frequency of pick up? (This may increase compliance and reduce the risk of diversion.) If so, at what cost?
- Is the patient at risk of overdose or self harm?

4. Psychosocial

- Are there issues relating to parenting, work, education, accommodation, driving, or criminal justice that you need to address with the patient?
**GP: Prescriber Goals Specific to Opioid Dependent Patients**

**Medication stability**
- Cessation or a significant reduction in injecting opioid use
- Cessation or a significant reduction in other injecting drug use
- Free from withdrawal for the full interdosing period
- Free from severe side effects or toxicity

**Drug use stability**
- Cessation or a significant reduction in use of alcohol / benzodiazepines
- Cessation of binge polydrug use and alcohol
- Reduction in risk of overdose
- Reduction in risk of BBV transmission

**Health improvement**
- Mental health
- Tobacco cessation
- Diet and exercise
- Sleep hygiene
- Reduction / management of medication related side effects
- Dental support
- Improved management of hepatitis C virus
- Vaccination for hepatitis B
- Improved sexual health and family planning

**Psychosocial support**
- Parenting support and child risk reduction
- Employment and education
Patients should be supported to reduce their dose if they request it. However this should only be done when such a reduction is unlikely to precipitate destabilisation. The process of gradual withdrawal is often interrupted by setbacks and thus requires careful monitoring. It is for this reason that reducing scripts should specify a dose to which the patient may reduce before requiring another prescriber review. For example if a patient is on 80mg (16mls) methadone daily, the patient may reduce by 2.5mg-5mg, (½ - 1ml) every 1-2 weeks at patient request to a minimum of 60mg (12mls) daily before next review. That is, if the patient wants to reduce below 60mg they need to see you the prescriber.

Equivalent dose reductions for those on buprenorphine maintenance are typically 2mg every 1-2 weeks as tolerated by the patient. In monitoring those on a reducing script, consideration should be given to risks for a return to illicit opioid use. These may include social factors such as the return of an opioid using partner or the loss of a loved one, or an increase in craving for opioids if the patient were to experience withdrawal as the dose was reduced. When the prescriber orders a reducing script, it is important that the pharmacy acts at the patient’s request, within the script. Any concerns of the pharmacist in providing reducing doses should be discussed directly with the prescriber.

Should a patient return to injecting drug use during a period of a gradual withdrawal from treatment, they should be advised to stop their reduction and request urgent review with the prescriber. In most cases an increase in dose would be required to restabilise the patient. You may choose to discuss such cases with another prescriber or your support specialist at the public clinic.
**GP: Review Proforma for Opioid Dependent Patients**

<table>
<thead>
<tr>
<th>Medication stability – adequacy of prescribed dose</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient experience any withdrawal between doses?</td>
<td></td>
<td></td>
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<tr>
<td>Does the patient go ‘on the nod’ after dosing (peak dose sedation)?</td>
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<tr>
<td>Is the patient still experiencing craving for heroin?</td>
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<tr>
<td>If the patient is using heroin do they get a significant effect (induction of tolerance)?</td>
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<tr>
<td>Does the patient experience any problematic adverse effects?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Is the patient on other prescribed medications?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are any changes to current script required?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Drug Use</strong></td>
<td>Present</td>
<td>Absent</td>
<td>Comments/Change treatment</td>
</tr>
<tr>
<td>Is there evidence of recent injection on examination?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you having problems obtaining urines from the patient?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there evidence of drug use from the urine screen?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Is there any evidence from the pharmacy that suggests instability such as missed doses/ intoxicated presentations/refused doses etc?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient reporting ongoing drug use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychosocial Stability</strong></td>
<td>Present</td>
<td>Absent</td>
<td>Comments</td>
</tr>
<tr>
<td>DNA at prescriber reviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNA at case manager reviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour concerns-violence/aggression</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Employment/education concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child risk issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant mental health/self harm risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant active physical health issues</td>
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</tbody>
</table>
**Patient Review Form (Pharmacy Guild)**

**CONFIDENTIAL**

**PATIENT REVIEW FORM - COMMUNITY PHARMACY BUPRENORPHINE / METHADONE TREATMENT**

Date:____________________

<table>
<thead>
<tr>
<th>PATIENT’S NAME:</th>
<th>PRESCRIBER’S NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>DOB:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>ADDRESS:</td>
<td></td>
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</tbody>
</table>

**Treatment with:**
- Methadone ☐  Buprenorphine (sublingual technique checked) ☐

Current dose: ___________ T/A per week ___________

Client is aware of the correct storage of T/A doses Yes ☐ No ☐

Current medications which may interact with or affect the metabolism of methadone or buprenorphine:
________________________________________________________________________________________________________________________________________

Number of occasions the patient presented intoxicated in last month: ___________

Does the pharmacist or staff have concerns about patient behaviour: ___________

Number of missed doses in last month: ___________

Are takeaway doses safely stored: Yes ☐ No ☐

**Has the patient presented with any of the following Clinical symptoms?**

(Indicate by circling symptom)
- sleep disturbance,
- aches, pains,
- teeth/dental problems,
- reduced libido,
- lethargy,
- excessive sweating

Any known problems with illicit drug use? Yes ☐ No ☐

Any recent symptoms or issues relating to the patient which may be relevant to their treatment e.g. health, social, financial, family or emotional problems Yes ☐ No ☐

Would you like the prescriber to contact you? Yes ☐ No ☐

Pharmacist’s telephone number: ____________________________

**PHARMACIST’S SIGNATURE:**______________________________

Date:____________________

This facsimile/Review Form contains confidential information, which is intended only for use by the addressee. If you have received this facsimile/Review Form in error you are advised that any copying, distribution, disclosure or the taking of any action based on the contents of this information is strictly prohibited. If you are not the intended recipient could you please notify us immediately.
# Monitoring Stability in Community Dosed OTP Patients by Pharmacists

<table>
<thead>
<tr>
<th>Name: ___________________________</th>
<th>Dosing period: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy name: ___________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor</th>
<th>Outcome</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any missed doses (insert number)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erratic/threatening behaviour (Y or N)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment (up to date or $ debt)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episodes of refused dosing/presenting intoxicated*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent diversion attempts*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerns over patient stability*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last dose and reported medication stability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose changes (up, down, the same)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathology requests for urine screen provided to patient by pharmacy (number, no, or N/A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child risk or protection issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* any of these may lead you to request an early clinic or prescriber review

**Please answer the following questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you happy to continue to provide dosing for this patient?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Do you think they are doing well?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Do you think the number of takeaways provided is appropriate?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Do you have any concerns at all about this patient?</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Would you like someone from the clinic to contact you?</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>

**Any other comments?**

<table>
<thead>
<tr>
<th>Pharmacist</th>
<th>Date</th>
<th>Patient</th>
<th>Date</th>
</tr>
</thead>
</table>

Written by Dr. Adam Winstock and Dr. Jill Molan
Prescription Shopping Program

Medicare Australia provides a service which assists doctors to identify patients who are getting Pharmaceutical Benefits Scheme (PBS) medicines in excess of medical need. For more information, go to the Medicare Prescription Shopping Program website.

Usually, patient consent is obtained before a GP accesses this service, however Medicare Australia has the authority to disclose without consent, specific and limited PBS information to a doctor about their patients who may be getting PBS medicine in excess of medical need. The specific details of the circumstances under which this may occur are detailed by the federal Office of the Privacy Commissioner in Information Sheet 19-2007, The Prescription Shopping Information Service (PSIS) and The Privacy Act.

First, the doctor needs to register, that is, complete and sign the Registration Form and fax it to (02) 6124 7820. Medicare Australia will provide confirmation of registration by fax within 2 business days or by mail if a fax number is not provided. Once registered, a doctor can call the Information Service 24 hours a day, seven days a week on 1800 631 181.

Medicare Australia can also contact a prescriber if their patient is identified under the Prescription Shopping Program.

Medicare Urine Drug Screen Item Numbers*

*Details current at June 2007

Under the Medicare Benefits Schedule (MBS), Category 6 Pathology Services, there are a number of Medicare item numbers available for urine drug screening in various circumstances. The most appropriate for GPs to use with those patients on an OTP is item 66626, which has a limit of 36 services per year.

For other patients not on an OTP, item 66623 may be more appropriate. Pathology laboratories are able to advise on this matter. For further information, see Search the MBS. If a particular test is required GPs should confirm which drugs will be tested for in addition to opioids.

Driving

‘The Road Transport (Safety and Traffic Management) Act 1999 provides police with the power to stop a person suspected of driving under the influence of any drug. There is no evidence that methadone has any effect on driving skills where the individual is on a stable dose. A person's driving may, however, be impaired if they have just commenced methadone treatment, have had a change in dose or have used alcohol or other drugs in addition to their methadone treatment. As a result, methadone takeaway doses are labelled with a warning to this effect. As with all drugs, including alcohol, it is the individual's responsibility to gauge their ability to drive. Health professionals are advised to inform an individual of the potential effect of a drug on driving-related skills. The use or attempted use of a vehicle under the influence of alcohol or any other drug including methadone is an offence prosecuted under the Road Transport (Safety and Traffic Management) Act 1999.’ Extract taken from the current issue of the NSW ‘Guidelines for Police: Methadone and other Pharmacotherapies’, page 6.

The issue of driving is one of concern to both individuals and to communities. Loss of a licence to drive has the potential to dramatically affect an individual's living standards. The significance of this should be fully understood by all parties. Where there is concern about fitness to drive, the clinician should advise the patient of their concerns and request that they notify their local driving authority. In cases where the clinician is concerned by the risks that the patient poses to themselves and to others, should they continue to hold a driving licence, consideration should be given to the patient’s doctor directly notifying the driving authority in their State. For further information please go to www.austroads.com.au.
KIT1: Transfer of stable public clinic opioid dependent patients to GP prescribers.

Written by Dr. Adam Winstock and Dr. Jill Molan

Links to Resources

New South Wales Medical Board
http://www.nswmb.org.au

Search the Medicare Benefits Schedule

Support services
For patients (NSW)
Alcohol and Drug Information Service (ADIS) Sydney 02 9361 8000 or for callers outside Sydney 1800 422 599

For health professionals
NSW Drug and Alcohol Specialist Advisory Service (DASAS) Sydney 02 9361 8006 or for callers outside Sydney 1800 023 687

For GPs
GP Psych Support provides GPs with patient management advice from psychiatrists within 24 hours

GP Care
For diagnostic and treatment related information go to http://www.gpcare.org/

Clinical Guidelines
NSW Health New South Wales Opioid Treatment Program Clinical Guidelines for Methadone and Buprenorphine Treatment of Opioid Dependence (2006)
http://www.racp.edu.au/index.cfm?objectId=1A4852EF-FF7C-429D-B7D38051518D41CF

Australian General Practice Network (AGPN)
Divisions Directory


Three components of the Better Access Initiative

Fees and Rebates for Better Access items

Finding a Mental Health Allied Health Professional

Can Do initiative: Managing Mental Health and Substance Use in General Practice

Chronic Disease Management (CDM)

Mental Health Nurses Incentive Program

Department of Health and Ageing
GP Mental Health Care Plan (GPMHP) information

GPMHP Referrals to Allied Health Mental Health

GP Management Plan (GMPM) and Team Care Arrangement (TCA) Information

GPMHP/TCA Referrals to Allied Health and Dental Health (not Mental Health)

45 Year Old Health Check

Aboriginal Health Check

Prescription Shopping Program

Privacy information related to Prescription Shopping Program

Pharmaceutical Benefits Scheme

FORMS
Sample GPMHP (scroll down page)

Sample GPMP and TCA (scroll down page)

Referral Form GPMP Allied Health (not Mental Health)

Referral Form GPMP Dental Health

HMR Referral Form

Medication Management Plan Form

Home Medicines Review (HMR) Information
Department of Health and Ageing

The Pharmacy Guild
http://www.guild.org.au/nsw/content.asp?id=1082 (NSW Branch)