Take a long-term approach

Transcript

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Part I

Working with patients who are dealing with alcohol and other drugs issues is really a long-term chronic disease style problem. A lot of these patients will have comorbid chronic diseases and some of the substance use disorders are chronic diseases and mental health disorders in their own right.
Regardless, we play the long game. Sometimes it's tempting to feel like I just need to get this over with.

But if we are really going to attend to someone's health issue, (which is what this is), that has developed probably over years if not months (certainly there's a chronicity over the development of this), we have to think about and reframe our approach. Think about the long-term and slow burn of helping patients through this rather than just seeking quick wins. The quick wins may be there sometimes but most the time it's the slower stuff that takes time that actually reaps the rewards.

So, we need to invest in time, and there are a few things we can do that makes it easier on ourselves, both from a patient point of view but also at an administrative and business point of view that makes it a bit easier to ensure that we do have the time, so we don't get so burnt out and frustrated and we appropriately pace things.

My suggestion is when you first meeting a patient, there are a few things we need to prioritise. A risk assessment for suicidality for example would be high priority very early on to ensure we not going to miss something that is potentially very life threatening. We know that comorbid mental health conditions and suicidality, in its own right, are commonly associated with alcohol and other drugs.

So please look at that risk assessment very early and then reassess it over time. Things do change.
Outside of that clinical critical stuff there are a few other things I would recommend you do prioritise early.

Try to focus less on problem solving and problem definitions. Part of that is allowing the patient to feel comfortable with you and allowing them to talk. One of the things you can do is prioritise rapport. Look at your language, what language are you using, what message are you conveying to the patient about their problems. Are they feeling heard, are they feeling like there is stigma in the room or the waiting room? You can demystify and make them more comfortable. In the first few visits, if you can destigmatise and make people comfortable with just the conversation – it's about your health, it's not about legal issues or moral issues, I'm here to help you with your health.

When you are planning treatment, with any chronic diseases, there is a lot of value in spending a bit of time, or even a whole consultation, outlining all the things you have assessed so far, with your patient, and then negotiating where the priorities are. I find often these things are much more social and psychological and there will often be physical things too. Sometimes the physical things override the social and psychological. But looking at frequency, social issues are the ones that are most common and also are the ones take the longest to repair or attend to, and the ones we are trained less in.

A lot of this is allowing the patient to find their solutions (refer to motivational interviewing training).

Look at planning things and then with your patient negotiate the prioritization of those. And you may be surprised that the treatment of their physical comorbidity may not be highest on their agenda but repairing their occupational or their intimate relationship may be highest. So, you work with that. Unless there is an overriding medical reason. Sometimes we got to trump the patient's agenda if there is an urgent need. Suicidality is the classical one. Something that is quite urgent or really severe, for example someone in decomplicated liver disease or

hematemesis, that needs addressing more so than how we going to deal with the relationship with the angry neighbour. We need to work with the patients and bring them along with us.

Most times, we don't have these crises and the patient can drive the agenda, and they own it and then we can guide them through some of the solutions or the options, or some of the challenges. Just acknowledging that its hard can be just enough therapeutic benefit than sometimes providing the answer.

Focus on planning with the patient and that allows you to pace various aspects. Ideally after you have planned an agenda, you can then allocate certain consultations to certain topics. So, you are less likely to get derailed and can dive deeper rather than covering things superficially all the time.

Part II

In terms of practical things, use the MBS. Use consultation item numbers that are appropriate for this. If you are doing telehealth as we speak, there are options around that to use this remotely, as well in a face-to-face or phone environment. There is also the chronic disease care plan numbers and the EPC team care arrangement numbers. A lot of patients with comorbid issues will have other providers of healthcare that you can incorporate as a team care arrangement. Utilise those processes, not only from a funding point of view, but also to help you structure your planning and coordination of care.

It's very hard to do it all by yourself so get a team involved and foster that team. Get your local team, meet them, get them involved so they are happy to talk to you and you happy to talk to them, so it's a team environment rather than just a paperwork team environment.

The other thing about funding is that mental health treatment plan item numbers are very applicable for a lot of these patients. Substance use disorders by themselves are mental health diagnoses that are eligible.

Patients that haven't got an SUD, assess for comorbid mental health conditions. Anxiety and depression are the two must common and are very commonly associated. It doesn't take too much assessment for most of our patients to realise that there is another area there that we can address, but also Medicare funding to help support the extra time that this all takes.

The other aspect with funding is take the opportunity to get some case conferences happening where appropriate to organise that team. They are funded as a case conference and you actually get a lot more reward getting everyone together. This makes it much more efficient, and everyone works as a team, and it fosters that rapport amongst the team members and certainly helps our patients.

My last tip for time management is don't try and reinvent the wheel over and over again. If you need to do things more than twice, automate as much as possible. Have a short cut folder on your desktop with your go to resources. Have some standard templates that you can then fill in (eg drug and alcohol assessment, comorbid assessment, care plan stuff), not all the details as you need to individualise it but make it easy so you don't need to reinvent the wheel. If you are doing an alcohol detox and you've got a particular regime, have it available as a printout or an email ready to go. Don't reinvent the wheel. Get your practice manager or your IT support to help you with the IT side of things. Try to make sure that you are investing your time with your patient and not with the software. That's my tip for time management.

This does take time but it's a slow burn. It's usually a chronic problem that has taken many years to manifest and get to this point. It's not going to be a quick fix and what I find professionally most rewarding about this is that over time the rewards for the patient and me witnessing those rewards, absolutely outweigh some of the difficulties and challenges along the way. So good luck and be time efficient.