PRIMARY CARE MAT: A STANDARDIZATION ATTEMPT

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· I have no conflicts to disclose.
OVERVIEW

- Patient presentation
- Current practice culture and context
- Potential MAT population
- A proposed methodology for risk stratification for MAT in primary care
THE PATIENT

- 19 years old
- Drug of choice- opiate pills
- Addiction history: abusing alcohol intermittently along w/ cocaine
- Family support: limited
- Psych history: unknown, no prior assessments
- Addictions history: never engaged prior

The Request:
- The patient wants to quit opiates and wants to start Suboxone! Can you start him on Suboxone ASAP?
CHANGING THE CULTURE - CLACKAMAS EXPERIENCE

- As of 2013: many patients on chronic opiates, lack of standardization or following guidelines
  - Methadone common (OHP legacy), co-prescribing as well
  - Indications questionable, drug screens inconsistent, provider practice variable

- Solutions
  - Patience
  - Creation of policy
  - Provider adoption and/or substitution
  - Support staff at all levels
  - Change the culture: one patient at a time over several years
  - **Build towards the future: MAT, leverage team-based, adding integrated care**
  - Find a hobby, this is hard work
POPULATION AND POTENTIAL CLINICAL IMPACT
MED V MAT

MED = Milliequivalents of Morphine

DSM-5 criteria for Diagnosis of Opioid Use Disorder (OUD)
THE IDENTIFIED NEED

- There are plenty of MAT guides to help guide systems manage patients in primary care.
- These tend to be extensive and rather long (but again- are very helpful).
- One of the most crucial decisions for MAT in primary care is the initial presentation/encounter.
  - New providers find this challenging- are all MAT patients to be treated similarly in primary care? What characteristics help and/or challenge a patient?
  - Most providers learn with experience and further training is informal.
  - This creates variation in practice (more on that in a minute).
LEARNING WHILE DOING

- Building MAT capacity in primary care includes:
  - Changing culture amongst staff
  - Building policies
  - Ensuring enactment of said policies
  - Constant communication and collaboration in the beginning
  - Pushing the envelope for different delivery systems that ensure patient centered, harm reduction model
  - Engaging staff at all levels, the front line needs a consistent message along with MAs, RNs, and BHCs.
THE BEHAVIORIST

• HELP!!!

• Setting: Patients presenting wanting primary care based MAT at our Oregon City clinic
  • It has 4 x-waivered prescribers
  • Each has their own variations on practice/policy, all within the DEA guidelines
  • And of course, every patient who desires/qualifies for outpatient MAT is different

• This puts the behaviorist in a difficult situation- caught between helping meet a patient’s request and an individual prescriber’s tolerance/practice pattern.
WHAT IS MISSING?

• A common language / systematized approach to primary care-based MAT

• Pathways that reflect the mosaicism of patients presenting in the primary care setting pursuing MAT

• A standardized approach that ensures, with reasonable variation, patients and providers are clear in the approach, expectation, and progress for outpatient MAT
AN IDENTIFIED VOID

- There is no JNC-8 or DSM-5 for patient centered, evidence-based(ish), standardized care for the primary-care based MAT patient
- This tends to be an art, which is great if you are the teacher
- Systems unfamiliar with MAT in primary care may struggle with:
  - Provider practice variation
  - Patient expectation/adherence/satisfaction
  - Creating plans of care that are patient-driven, yet reasonably standardized
ONE SOLUTION: THE HUB AND SPOKE

- Primary care (PC) identifies and refers patient to addictions ‘hub’
- Addictions hub screens, induces, provides counseling, and ‘stabilizes’ patient
- Once patient ‘graduates,’ they are referred back to PC
- This assumes:
  - Either more advanced OUD or patient is open to intensive approach
  - Patient has minimal time, financial, and transportation barriers
  - Patient agrees their disease severity is congruent with what is on offer

- Our Experience:
  - Insurance a major barrier along with lack of patient buy-in
  - 10% success rate from referral placed to MAT initiation
- This demanded more pathways but no great way to risk stratify
### WHAT IS RISK AND WHAT IS PROTECTIVE?

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Points</th>
<th>Opportunities</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-occurring EtOH disorder</td>
<td></td>
<td>15 Prior MAT experience</td>
<td>5</td>
</tr>
<tr>
<td>No prior engagement in addictions</td>
<td></td>
<td>5 Stable and engaged support system</td>
<td>2</td>
</tr>
<tr>
<td>Centralized Pain d/o</td>
<td>Fibromyalgia</td>
<td>2 Active behavioral health home</td>
<td>5</td>
</tr>
<tr>
<td>Sig psych hx (SPMI/Axis I)</td>
<td></td>
<td>5 Pt consistently attends appointments/group</td>
<td>2</td>
</tr>
<tr>
<td>Housing instability</td>
<td></td>
<td>5 Consistent UDS, PDMP, Pt Hx</td>
<td>2</td>
</tr>
<tr>
<td>Other substance abuse</td>
<td></td>
<td>10 ACES score &lt; 4</td>
<td>5</td>
</tr>
<tr>
<td>Chronic pain, poorly controlled</td>
<td></td>
<td>5 (Adverse Childhood Event Score)</td>
<td></td>
</tr>
<tr>
<td>Frequent loss to follow-up/poor prior attendance</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 25</td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>Total Challenges- Total Opportunities =</strong></td>
<td></td>
</tr>
</tbody>
</table>

If no challenges, opportunity total will be < 0

**Note:** If patient unable to maintain sobriety for 24 hours, consider categorizing as high risk, regardless of scenario.
<table>
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<th><strong>RISK CORRIDORS</strong></th>
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**Inclusionary Criteria:** Drug of Choice must be opiates | >18 years old  
Exclusionary: active addiction with little capacity to change | Pregnant | <18  
Clinical correlation strongly suggested for all risk categorization

<table>
<thead>
<tr>
<th><strong>Risk Color</strong></th>
<th><strong>Points</strong></th>
<th><strong>Induction Setting (If Applicable)</strong></th>
<th><strong>Behavioral Health</strong></th>
<th><strong>Refill Duration</strong></th>
<th><strong>Drug Screen(UDS) Frequency</strong></th>
<th><strong>Visit Frequency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>&gt;25</td>
<td>Strongly Consider Speciality Addictions (SA). If primary care (PC), see Purple</td>
<td>Specialty setting, minimum 12 mos</td>
<td>Weekly, add by qWeek as appropriate. Max duration 1 month total (no RF)</td>
<td>every appointment in first month, extend to q3 months</td>
<td>weekly x 2, bi-weekly x 2, consider monthly</td>
</tr>
<tr>
<td>Orange</td>
<td>&lt;20</td>
<td>SA preferred. PC is acceptable. Wrap around required (must be specialty), &lt;1 month to establish after induction</td>
<td>Specialty setting strongly preferred (essential in PC). PC based if intensive. 6-12 mos minimum</td>
<td>See Red. 60 day duration after 6 mos of 1 month</td>
<td>See Red, expand beyond q3 mos only after 6 mos of affirming UDS</td>
<td>after initiation, bi-weekly x 2, monthly x 2, then extend to 2 mos after RF duration of 60 days achieved</td>
</tr>
<tr>
<td>Yellow</td>
<td>&lt;10</td>
<td>SA if pt requests/interested. PC- wrap around PC based, acceptable</td>
<td>PC based: intake, assessment, plan (6 mos). Ongoing pt focused</td>
<td>Start with 1 week, then 2 weeks, extend to 1 month as earned. Max RF is 2 mos</td>
<td>Minimum: At initiation, 1 month follow-up, ok to q6 mos after 3 affirming UDS</td>
<td>after initiation, 2 weeks, monthly, then driven by RF frequency</td>
</tr>
<tr>
<td>Green</td>
<td>&lt;0</td>
<td>PC is optimal. Wrap-around : baseline assessment or ongoing treatment</td>
<td>PC based: assessment. Ongoing is pt. driven</td>
<td>See Yellow. Ok to progress to total Rx duration of 3 mos (2 RF)</td>
<td>Minimum: At initiation, 1 month follow-up, ok to yearly after 6 mos of affirming UDS</td>
<td>after initiation, 2 weeks, monthly, then driven by RF frequency</td>
</tr>
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**Indications for risk increase (towards Red):**  
Failed UDS  
Early refill request

**Indications for ’graduation’ to lower risk (away from Red):**  
3-6 months of pathway plan adherence  
Reduction in risk factors (improved social support/housing)
REVISITING THE PATIENT

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The Request:
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HOW DOES OUR PATIENT SCORE?

- Risk factors: age, new to addictions, other substance abuse
  - Note, EtOH use is occasional, so did not include in risk score
- Protective factors: none, though lack of trauma not known
- Result: RED pathway
ANOTHER PATIENT

- 28 year-old
- IVDU started at 22, ended up at methadone clinic eventually
- Failed several rehab attempts
- History of sexual and physical childhood trauma
- Recent forced detox during short incarceration (non-addiction related)
- Presents in withdrawal, with desire to start MAT
- Stable housing, supportive family, active and engaged in parenting
- Active behavioral health home
- RESULT? Green pathway
QUESTIONS AND THANK YOU!