Organization of Primary Care and Early MOUD Discontinuation

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Introduction

- Primary care providers (PCPs) increasingly offer MOUD treatment.[1,2]
- 50-70% of patients drop out within 6 months, posing risks for return to use, overdose, legal system involvement, morbidity, and mortality.[3-8]
- About half of patients who discontinue treatment in the first 6 months do so within 30 days of MOUD initiation.[9,10]
- This qualitative study explored patients', PCPs', and administrators' perspectives on the relations between the work structures of primary care clinics and early MOUD dropout.
- Re-examining the organizational structure and operations of primary care can inform strategies for improving MOUD retention

Methodology

- Semi-structured interviews were conducted with primary care patients, PCPs, and clinic administrators from major mid-Atlantic academic health systems.
- Data were analyzed using a multi-phase modified grounded theory approach.

Results

We interviewed 30 participants: 12 patients, 12 PCPs, and 6 administrators

*Please scan QR code for **Tables 1 & 2** on participants characteristics, and **Figure 1** for the drivers of early MOUD discontinuation in primary care and the strategies to improve retention.*

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Theme 1: Patient access vs. operational efficiency:

"There were only certain doctors [who prescribed MOUD] and they were only there once, maybe twice a week." Patient

"We're dealing with different patient populations. What one group appreciates, another may find inconvenient or frustrating. A more flexible system greatly benefits some people, but it also leads to longer wait times for those who show up on time." Administrator

Theme 2: Organizing care delivery:

"I have to explain [my problem to the first doctor]…then the next time I go, instead of being able to follow up with that, I have to re-explain the whole story to the next person because…we're not on the same page that I was with this other person." Patient

"In my practice, I see about 20-25 patients daily and about three of them require Suboxone; it's a healthy mix. It reduces stigma and normalizes the treatment. When I'm away from the office, other providers prescribe refills the way we do for all care." Clinician

"I think the concentrated approach is better. Patients are more likely to get a consistent level of knowledge and expertise. There's a dedicated support staff who knows the patients and the drill. I think it's easier to follow-up with patients and make sure they get in. Regular primary care clinic can be difficult to get in." Administrator

Theme 3: Managing comorbid chronic pain and polydrug use

"Suboxone has been helping me because I haven't been getting sick, but when I'm going through pain, I still need opioid pills to ease it. However, I'm very scared because I don't want my friends to give me something that could cause me to overdose like I did previously." Patient

"I don't blame them because they don't want to support me abusing drugs or narcotics. But…I have to go undertreated because the medications that they are giving to me don't work very well." Patient

"A few of us started offering MOUD without formal training in addiction medicine. We knew it was needed and got the X-waiver to prescribe buprenorphine. As some cases are getting more complex, more expertise and support would be helpful." Clinician

Theme 4: The importance of interdisciplinary teamwork within the clinic's logistical capabilities and resource constraints.

"None of the pain management specialists engage in chronic opioid prescribing. They don't assist with tapers, they don't step in. Their focus is interventional. They've abandoned the space." Administrator

"It's hard to implement the recommendations of a collaborating psychiatrist. There is too much distance between the psychiatrist and the patient…I feel like I'm getting information that I could get from a textbook, it's not personalized or very helpful." Clinician

Conclusions

Recommendations:

- Revise clinic procedures for improved access and support for walk-ins and late arriving patients.
- Adopt flexible PCP scheduling that uses both concentrated and dispersed approaches
  - A dual system, with the flexibility to transition patients between concentrated care and dispersed appointments based on clinical need, may be optimal.
- Treat chronic pain and polydrug use from the start of MOUD treatment.
- Strengthen teams with mental health therapists, case managers, and peer support for enhanced coordination and support.

These steps will require organizational adjustments, increased resources, and expansion of treatment modalities.

References

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Conflict of Interest Disclosures

None