Massachusetts Model: Primary Care Approach to Addiction Treatment

Founder(s)

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Reference:

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Massachusetts Model: Description of Primary Care Approach

1. OVERVIEW, DESCRIPTION, AND RATIONALE

1.1 General Description of Approach

Punyamurtula S. Kishore, M.D., M.P.H. served as the Acting Medical Director at the Washingtonian Center for Addictions situated in Jamaica Plain Massachusetts before it closed in 1980. This experience with one of the few remaing vestiges of the Washingtonian Movement changed his entire medical career plan. Dr. Benjamin Rush's concept of a therapeutic approach to addiction had influenced the Movement's founders and attracted Dr. Kishore to the field of Addiction Medicine.

Over the next decade, he worked in most of the major addiction programs in Massachusetts. He had experience in every phase of treatment whether inpatient, outpatient, or residential and a variety of philosophies from sobriety based to maintenance or twelve step to therapeutic community based.

In 1990 while the Associate Medical Director for the Department of Corrections at Bridgewater State Hospital he founded "Home Free" a pilot home detoxification program in cooperation with the local Visiting Nurses Association. This innovative model was recognized in 1994 by an award from AMERSA (Association of Medical Education and Research on Substance Abuse).

In 1996, he opened the first office of Preventive Medicine Associates (PMA) a private medical practice focused on Addiction Medicine. It was a quaint one-room office in Brighton Massachusetts with a small library in another room to host community meetings. The practice was built around a model of primary care rather than an addiction treatment program using the construct of community oriented primary care (COPC) as the model for the office. He chose this model based on his fellowship at Carney Hospital in the early 1990s. He found early on that using this model made it possible to survive as a private practice but require continual modifications of the practice to meet the frequently changing demands of the current health care system.

The practice was successful and required additional office space after a few years. As the practice grew it became apparent that additional sites were necessary to provide easier access for patients traveling long distances to reach the office. Request came from community members, physicians, or the political structure of various communities requesting additional sites be developed in their community.

The current network of sites developed by Preventive Medicine Associates is based on the principles of Preventive Medicine and Community Responsive Care (CRC) and focuses on the health of individuals, communities, and defined populations. Its goal is to protect, promote, and maintain health and wellbeing and to prevent disease, disability, and death. The emphasis is on how communities can work collaboratively with the healthcare sector, such as physicians, public health officials, insurers, and providers to develop cooperative strategies

that promote health. It provides the link between defining the community, health care needs, and program development.

The practice has become a statewide network of sites offering a full spectrum of services, available to all patients at all sites. In addition, by providing access to sober housing in all areas of the Commonwealth, the network enhanced the continuity of care. Each practice location consists of a multi-disciplinary team, which typically includes a mix of physicians, psychiatrists, nurse practitioners, physician assistants, counselors, office managers and medical assistants. From this experience he developed a model of care which he called the Massachusetts Model of Addiction Recovery.

The Massachusetts Model approach is characterized by a thorough and ongoing medical assessment of patients and of multimodal therapeutic approaches. It may include full and comprehensive physical examinations, laboratory testing, toxicology, cardiac, neurological and pulmonary evaluations, education and support, and other methods.

A multidisciplinary team of professionals (e.g., nurse practitioners, physicians, physician assistants, psychologists, nurses, peer group counselors) plan and assist in the treatment process. The physician or nurse practitioner meets individually with the patient to conduct an interview, review the client's test results, and plan medical goals and objectives. The assumption is that abstinence is ideal.

Treatment provides tools and a context for the client to learn new ways of living without alcohol and other drugs. This type of treatment can be employed on an outpatient basis.

1.2 Goals and Objectives of Approach

The philosophy of the Massachusetts Model is based on current evidence based treatment for chronic disease. The primary goal is lifetime abstinence from alcohol and other mood altering chemicals and improved quality of life. This goal is achieved by applying the principles of brief interventions and changes in daily behaviors. The ultimate goal is sobriety maintenance so that resources could be utilized to stabilize or change basic thinking, feeling, and acting in the world.

1.3 Theoretical Rationale/Mechanism of Action

Addiction Medicine is not a codified science at this time. Similar to where we were with Diabetes in the1920's where glycemic control was the main focus, sobriety maintenance currently is the focus for the chronic disease of addiction.

1.4 Agent of Change

The main agent of change is the medical process with the nurse practitioner serving as change agent.

1.5 Conception of Drug Abuse/Addiction, Causative Factors

Addiction is seen as a primary, chronic, and progressive disease It is chronic because a patient cannot return to "normal" use once the addiction is established. It is progressive because symptoms and consequences continue to occur with increasing severity as use continues.

2. CONTRAST TO OTHER APPROACHES

2.1 Most Similar Approaches

The most similar approaches are the treatment of chronic physical health disorders (e.g., diabetes, heart disease, emphysema), and learning to live with any chronic illness. The model has similarities with most other accepted treatment models. It incorporates the sobriety maintenance philosophy of the Minnesota Model with the surveillance aspects of the Maintenance Models (Methadone, Suboxone).

2.2 Most Dissimilar Approaches

Psychoanalysis is a dissimilar approach.

3. FORMAT

3.1 Modalities of Treatment

The primary care model of health care is a basic modality of treatment. The utilizing of evidence based medicine includes the extensive use of medication assisted recovery in addition to other modalities. Antagonist therapy such as naltrexone both orally and in its depot formulation Vivitrol is widely used. Referral for agonist therapy such as Methadone or Suboxone is made where appropriate. In certain cases, Antabuse has been used.

Approximately 60 percent of the treatment occurs in individual sessions; the remaining 40 percent are in educational group sessions. Most individual sessions are with medical providers and consist of reviewing progress using standard evidence based medical practices and modified brief interventions. Individual sessions with psychiatrists or psychologists address issues that cannot be addressed by the medical providers or in groups.

Most group treatment is conducted by licensed mental health professionals or peer group leaders. Some specific educational group may be conducted by nurses. Occasionally special issue groups; focusing on topics specific to clients who have special characteristics are formed. In addition, all patients are encouraged to attend identified self help groups in the community such as Alcoholics Anonymous, Narcotics Anonymous, Smart Recovery or Rational Recovery which have been established and submit a Forum Attendance Log to the practice.

3.2 Ideal Treatment Setting

The ideal treatment setting is a patient and family friendly primary care setting located in a readily accessible site in the community.

3.3 Duration of Treatment

The Model follows the principles of Community Oriented Primary Care derived from epidemiology, primary care, preventive medicine, and wellness promotion. It advocates the provision of community responsive health services that are accessible locally, culturally appropriate, and effective. A prime conviction is that no single treatment is appropriate for all patients. The model supports the belief that attending to the multiple needs of the individual and continuously modifying a plan with long term engagement provides the most effective treatment. Because primary care is based on the principle of continuous, coordinated, comprehensive care the duration of treatment is potentially life long.

3.4 Compatibility With Other Treatments

This approach is compatible with most accepted modes of therapy. In order to ensure comprehensive care where appropriate, referrals are made for specific treatments that are not available within the model.

3.5 Role of Self-Help Programs

Involvement in self-help groups is considered a valuable adjunct to treatment. Patients are encouraged to join groups that are geographically accessible. They also are educated about the existence of groups that might meet specific needs of their particular situation.

4. PROVIDER CHARACTERISTICS AND TRAINING

4.1 Minimum Educational Requirements

Each practice location consists of a multi-disciplinary team, which typically includes a mix of a physicians, psychiatrists, nurse practitioners, physician assistants, counselors, office managers and medical assistants. Physicians-MD or DO Nurse Practitioners Master's Degree Physician's Assistant-Master's Degree Counselor-Master's Degree.

4.2 Training, Credentials, and Experience Required

State licensure is required for all providers. In addition, physicians have completed postgraduate training and most are members of the American Society of Addiction Medicine. In addition, most have specialty certifications by the member boards of the American Board of Medical Specialties (ABMS). Other providers are Master prepared as a minimum credential. The level of prior experience varies widely on entry to the practice. An active peer training program exists which utilizes the entire range of resource within the network of sites.

4.3 Counselor's Recovery Status

Counselors may be in an active program of recovery or never have had the chronic condition of addiction.

5. CLIENT- PRACTITIONER RELATIONSHIP

5.1 Therapeutic Alliance

The model follows the age old principle of medicine that health care is a therapeutic alliance between patients and practitioners.

6. TARGET POPULATIONS

6.1 Clients Best Suited for This Approach

All patients are offered evaluation on demand and are most are seen within 24 to 48 hours after initial contact. At the initial visit, all patients are required to be accompanied by a sober responsible adult who is designated as a support/safety person (SSP). An initial assessment is made and treatment is started if the patient, support/safety person (SSP) and practitioner all agree that the program is suitable for the patient. The patient, support/safety person (SSP), and practitioner then sign a preliminary treatment plan and a safety contract and treatment begins. Initially patients are seen daily for the first 3 to 5 days.

There is a physician available by telephone when the office is closed.

6.2 Clients Poorly Suited for This Approach

If there is agreement that the patient is poorly suited for this approach, (major mental illness, social instability, etc.) an attempt is made to case manage the patient to a suitable program.

7. ASSESSMENT

The complete initial assessment generally takes place over the first 3 to 5 days. It includes a physical examination, various questionnaires regarding substance use history and mental health status and family/social history. If de-addiction therapy is indicated, it occurs during this period. Prescriptions for medications are written for one day only and the support/safety person (SSP) is instructed concerning their proper administration.

Qualitative and quantitative urine toxicology testing is performed daily.

8. SESSION FORMAT AND CONTENT

8.1 Format for a Typical Session

Interactive patient/ provider clinical session.

8.2 Several Typical Session Topics or Themes

Session structure depends upon the patient's current status. With initial stabilization, visits are then spread out to 3 times a week, then weekly and then in slowly increasing intervals depending on the patients clinical situation. If a patient desires antagonist therapy, it is during time of the third week that education regarding its use is begun.

Modified brief interventions regarding a variety issues such as diet, exercise, nutrition, family interactions, relapse prevention, and relapse usually occur during the periods of time when visits are schedule weekly, biweekly, monthly or quarterly.

8.3 Session Structure

Session structure is driven by needs of the patient and depends upon the patient's current status.

9. ROLE OF SIGNIFICANT OTHERS IN TREATMENT

Family members and significant others are an integral part of the treatment plan. They are encouraged to be involved in the course of treatment whenever it is possible for them to do so. Most of the patient's care is delivered in settings that involve the family.