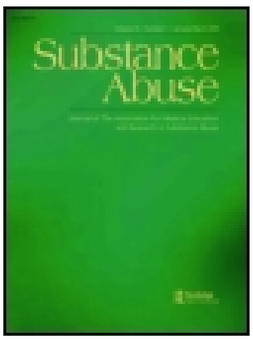

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ORIGINAL RESEARCH



# "It's a place that gives me hope": A qualitative evaluation of a buprenorphine-naloxone group visit program in an urban federally qualified health center

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**ABSTRACT**

*Background:* Medication for opioid use disorder (MOUD) with buprenorphine is effective in treating opioid use disorder yet remains underutilized. Scant research has examined the experience of patients, clinic staff, and providers in a "low-threshold" group-based MOUD program. This study evaluates a "low-threshold" MOUD program at a federally qualified health center (FQHC) in Philadelphia, Pennsylvania through the perspectives of its key stakeholders. *Methods:* This qualitative study involved focus groups of patients, providers, and clinic staff. Focus groups were conducted between October 2017 and June 2018. Grounded theory was used for analysis. *Results:* There were a total of 10 focus groups, including 20 patient participants and 26 staff members. Program participants noted that a strength of the program is its person-centered harm reduction approach, which is reflected in the program's policies and design. Program participants discussed the programmatic design choices that facilitated their participation and engagement in the program: ease of access, integration into primary care, and group-based visit model. Challenges in program implementation included varying acceptance and understanding of harm reduction among staff, the unpredictability of clinic volume and workflow, and the need to balance access to primary care and MOUD. *Conclusion:* This group-based MOUD program's philosophy of person-centered harm reduction, low-barrier approach, the structure of group-based visits, and integrated care contributes to increased patient access and retention. Understanding the strengths and challenges of the program may be useful for other safety-net clinics considering a MOUD program.

**KEYWORDS**

Buprenorphine; medication for opioid use disorder; opioid-related disorders; group-based visits; harm reduction; low-threshold

## Introduction

Medication for opioid use disorder (MOUD, formerly known as medication-assisted treatment [MAT]) with buprenorphine is effective in treating opioid use disorder (OUD),[1] yet remains underutilized and under accessed.[2] Closing this treatment gap is critical, given that over 100 people in the United States die each day from an opioid-related overdose.[3] A "low-threshold" approach is one way to increase access and engagement in treatment. Program policies and designs that decrease treatment barriers include same-day treatment entry, a harm reduction orientation, and flexible care in nontraditional settings.[4] Treatment engagement and retention are just as critical as access. Unfortunately, many who start MOUD leave treatment prematurely,[5,6] which is associated with poor prognosis.[7] Reasons for patients leaving MOUD programs prematurely include the conflict between patients and program staff, noncompliance with program rules, and interference with life obligations.[8] MOUD programs can improve treatment engagement and retention by making deliberate programmatic choices to create an accessible, high-quality program.

We developed our MOUD program using a "low-threshold," person-centered, harm reduction orientation to offer immediate and ongoing access to OUD treatment. The program is embedded within primary care in a federally qualified health center (FQHC) and designed for a low-income, housing-insecure, and predominantly Black population. There has been little published regarding the practical aspects of how to create and maintain a "low-threshold" group-based MOUD program for this population. There is even less qualitative research exploring the experience of patients, clinic staff, and providers in a program using this approach. Understanding how staff and participants experience program implementation is critical for program improvement.

As part of a larger quality improvement project, we conducted focus groups of patient participants, staff members, clinicians, and clinic leadership. We asked focus group participants about the strengths and limitations of our program. This qualitative study explores the benefits of this approach to MOUD treatment as well as unintended consequences from the lens of multiple key stakeholders.

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## Methods

### Setting

This group-based MOUD program started in March 2017 and is embedded within an FQHC in a large urban area. This program has been previously described.[9] Briefly, the group-based MOUD program consists of weekly psychoeducational group sessions and a brief individual medical provider check-in. Team members include: a MOUD care coordinator, a licensed behavioral health provider, a peer specialist, a buprenorphine-waivered medical provider, and a medical assistant. The MOUD care coordinator is responsible for scheduling appointments, verifying insurance, checking patients in, and supporting general case management needs. The licensed behavioral health provider, with help from the peer specialist, leads the group visits, providing psychoeducational and psychosocial support. The medical provider manages additional health concerns and buprenorphine prescribing. The medical assistant collects urine drug screens, provides vaccines, and performs laboratory draws as needed. At the time the study took place, groups were offered 5 times per week, with morning and afternoon options. Group visit times were discussed with participants at intake and provided in written format. Groups do not require prior scheduling by participants and participants can attend as many groups per week as they feel they would benefit from. Otherwise, individual behavioral health support is available on an as-needed basis through certified recovery specialists, behavioral health consultants, and/or a psychiatric nurse practitioner. Group visits are 1 hour in duration and topics are generally determined by participant requests (education or support). Groups typically range in size from 8 to 20 people. Individual medical provider check-ins occurred if there was a clinical concern or dose adjustment required. At a minimum, medical provider check-ins occurred once per month for each participant. If a participant missed the group visit and did not have a medical appointment, but needed a prescription, the participant would receive a "bridge prescription" until the next group visit (generally the next day).

### Study design

We held focus groups to evaluate the strengths and limitations of the group MOUD program. The study was categorized as exempt by the Institutional Review Board at Thomas Jefferson University.

### Data collection

The team wanted to capture the perspectives of people who have direct contact with MOUD patient participants, either through clinical or administrative responsibilities. The team used purposeful sampling to create focus groups based on programmatic roles, including staff members, clinic leadership, behavioral and medical providers, and patient participants. Participants were separated based on functional roles to allow participants to speak freely, without being influenced by other staff who operate in different roles. Participants were approached using in-clinic announcements for the clinic staff and patient participants. There were 10 focus groups, including 20 patient participants and 26 staff members. Focus groups lasted an hour and were held between October 2017 and June 2018. The interview guide for every focus group included questions about key components of the MOUD program. For example, every focus group asked: What are your thoughts and impressions of the program? What are 3 key strengths of the program? What are 3 key limitations of the program? What might you change about the program to make it better? In what ways is this program similar to other drug and alcohol programs and in what ways is this program different? Field notes were taken during focus groups. Participants provided oral informed consent prior to any data collection. Patient participants were compensated $10 for their time and participation. The focus groups were audio-recorded and transcribed using a professional transcription service.

### Data analysis

Members of the all-female research team included a physician PI (L.W.) and a licensed clinical social worker who facilitate the group visits (R.D.), a physician trained in qualitative methods (S.L.), a physician who does healthcare quality and safety research (E.L.), a research coordinator with experience in qualitative methods (A.S.), an on-site research coordinator (S.A.), and a researcher (E.K.) with substantial experience in populations experiencing mental illness and substance use disorders. The on-site research coordinator (S.A.) scheduled and coordinated the focus groups. A second research coordinator (A.S.), not involved in the MOUD program, conducted the focus groups. A peer counselor was present at the patient focus groups solely for patient support. Data were analyzed using an inductive grounded theory approach. The analysis started with 3 coders (L.W., R.D., and A.S.) who used open coding to identify categories and concepts, which was followed by axial coding, the creation of a mind map, and the development of a codebook. Each of the 3 coders coded transcripts individually and then met to review the coding as a group. All coding discrepancies were resolved through consensus, as coding proceeded. Members of the team (L.W., R.D., S.L., E.L., and A.S.) went through an iterative process examining the relationships between the codes to arrive at the central themes. Data saturation was achieved when no new information or themes emerged from the data after multiple rounds of coding. The researchers enhanced the validity of the findings by cross-checking their preliminary results with staff and patient participants over 3 meetings (1 with patient participants and 1 with staff members) after the initial data analysis period. These preliminary results were presented during in-person meetings, to a convenience sample of the same groups. Staff and patient participant feedback was used to confirm that the themes developed during data analysis were accurate.

**Table 1.** Staff demographics.

| Characteristic | Participants ($n = 26$) |
|---|---|
| Professional role, No. (%) | |
| Clinic leadership | 4 (15) |
| Behavioral health providers | 4 (15) |
| Nurses | 2 (8) |
| Medical Assistants | 5 (19) |
| MAT physician providers | 2 (8) |
| MAT Case Manager | 1 (4) |
| Administrative staff | 5 (19) |
| Volunteer | 1 (4) |
| Community health workers | 2 (8) |
| Age, No. (%) | |
| 22–32 | 10 (38) |
| 33–42 | 10 (38) |
| 43–52 | 3 (11) |
| 53–62 | 2 (8) |
| Missing | 1 (4) |
| Gender, No. (%) | |
| Men | 21 (81) |
| Women | 5 (19) |
| Race, No. (%) | |
| White | 16 (61) |
| Black | 8 (31) |
| Asian/Pacific Islander | 2 (8) |
| Ethnicity, No. (%) | |
| Non-Hispanic | 24 (92) |
| Hispanic | 2 (8) |
| Years worked at clinic, No. (%) | |
| <1 year | 8 (31) |
| 1–3 years | 9 (35) |
| 4–6 years | 4 (15) |
| >7 years | 3 (11) |
| Missing | 2 (8) |
| Years working with people with substance use disorders, No. (%) | |
| <1 year | 4 (15) |
| 1–3 years | 7 (27) |
| 4–6 years | 8 (31) |
| >7 years | 5 (19) |
| Missing | 2 (8) |

**Table 2.** Patient demographics.

| Characteristic | Participants ($n = 20$) |
|---|---|
| Age, No. (%) | |
| 31–41 | 6 (30) |
| 42–52 | 10 (50) |
| 53–62 | 3 (15) |
| Missing | 1 (5) |
| Gender | |
| Men | 10 (50) |
| Women | 10 (50) |
| Race, No. (%) | |
| White | 8 (40) |
| Black | 9 (45) |
| American Indian/Alaskan Native | 1 (5) |
| Missing | 2 (10) |
| Ethnicity, No. (%) | |
| Non-Hispanic | 11 (55) |
| Hispanic | 4 (20) |
| Missing | 5 (25) |
| Time spent as patient in clinic, No. (%) | |
| 1–3 months | 2 (10) |
| 4–6 months | 7 (35) |
| 6 months to <1 year | 3 (15) |
| 1–3 years | 4 (20) |
| Missing | 4 (20) |
| Time spent as participant in MAT group, No. (%) | |
| 1–3 months | 4 (20) |
| 4–6 months | 8 (40) |
| 6 months to <1 year | 3 (15) |
| 1–3 years | 2 (10) |
| Missing | 3 (15) |
| Duration of opioid use | |
| <1 year | 2 (10) |
| 1–10 years | 6 (30) |
| 11–20 years | 8 (40) |
| >20 years | 3 (15) |
| Missing | 1 (5) |
| No. of times in inpatient drug or alcohol treatment programs, No. (%) | |
| 1 | 3 (15) |
| 2 | 4 (20) |
| 3 | 3 (15) |
| 4 | 1 (5) |
| >5 | 9 (45) |
| No. of times in other drug or alcohol treatment programs, No. (%) | |
| 1 | 5 (25) |
| 2 | 4 (20) |
| 3 | 4 (20) |
| 4 | 1 (5) |
| >5 | 5 (25) |
| Missing | 1 (5) |
| Housing status in past 30 days, No. (%) | |
| Own or rent | 11 (55) |
| Someone else's house | 6 (30) |
| Transitional housing | 2 (10) |
| Group home | 1 (5) |
| Source of income in past 30 days, No. (%) | |
| Work | 5 (25) |
| Public assistance | 11 (55) |
| Work and public assistance | 1 (5) |
| No source of income | 2 (10) |
| Missing | 1 (5) |

## Results

### *Sample characteristics*

The characteristics of the staff and patient participants are summarized in Tables 1 and 2.

### *Key components of the program*

Patient participants, frontline staff, leadership staff, and clinicians highlighted the benefits and challenges of four key components of the MOUD program's design: harm reduction, integration within primary care, accessibility, and use of a group-based model.

### *Implementation of harm reduction philosophy*

A person-centered, harm reduction orientation is at the core of the program founders' philosophy. Staff identified two key components of how the program operationalizes harm reduction, by allowing participants to define their own recovery goals and not imposing an abstinence-only standard.

> Staff: We're allowing the patient to define themselves, what their life is, what their addiction is, rather than sort of paternalistically telling them what their addiction is.

> Staff: I don't think abstinence-only is an effective way to treat those in recovery. Having a harm reduction approach with abstinence being a possible goal is a more holistic and realistic way to pursue care. I think it sets people up for success instead of failure.

Additional ways that the program operationalizes harm reduction are through its rules and expectations. The program leadership acknowledges that the typical course of opioid use disorder includes episodes of recurrence and remission and does not dismiss OUD patients who have these experiences. As a result, participants experience safety

and acceptance, which in turn increases their treatment engagement and retention.

> Participant: I think it's a good thing, because me, personally, I struggle. So, if it was one of those things where you had to definitely give up a clean urine to stay here, I don't think I would be here.

> Participant: That they love me. It's a place to me that gives me hope that I can be more than my past and the defects that are in me. I can see that I can overcome the things that I face in my own self. It gives me hope.

However, the focus groups identified several challenges with a harm reduction approach. From a patient's perspective, some individuals expressed wanting more stringent rules imposed for their own recovery:

> Participant: Some things need to be forced on us for us to see the other side. If you know you ain't gonna get in trouble, you're gonna keep doing what you're doing no matter what.

Some participants also did not like that others may come to the group intoxicated, as this may jeopardize their recovery by triggering cravings for opioids.

> Participant: I see you with a high, I want that high. So I know I can't be around that.

While many staff members promoted harm reduction, front-line staff were more likely to promote an abstinence-only approach and viewed MOUD as enabling addiction and expressed concerns about the effectiveness of this treatment modality:

> Medical assistant: I definitely think they should be sober.

> Medical assistant: What is Suboxone? Because I think it's just another drug to put them on for them to get addicted to. I don't get the purpose. I don't even get the program. I know we are supposed to be non-judgmental and we're here to help, but how is we really helping?

Finally, clinicians acknowledged that a harm reduction approach accepts the risk of medication diversion (the transfer of medication from the individual for whom it was prescribed to another person). For staff, this diversion may make it more difficult to gauge a patient's treatment engagement, as it is unclear how adherent a patient may be to the medication regimen, but also raises concerns about unintended harm within the community.

> Staff: What's happening to that Suboxone when it goes out into the community, who's benefiting from it, who is it harming, who's having to pay for it, what does it mean if we continue to prescribe to someone who takes some of their Suboxone some of the time, as opposed to more of it more of the time.

Conversely, some staff and patients recognized that diverted buprenorphine-naloxone may have unintentional benefits, like providing an impetus for people with opioid use disorder to want to be on buprenorphine-naloxone for recovery or to seek out safer sources of medication to reduce withdrawal and cravings.

> Participant: I started buying the Suboxone off the street. So one day I was here for an appointment and I overheard somebody talking about getting their subs. And I'm like, hold on, wait a minute. It's like this is a sign because I needed to stop buying them off the street and I needed to have a program, be able to come and do groups and stuff like that.

### *Embedded within primary care*

The integration of the program into a primary care medical home increases patients' linkage to MOUD as well as to medical, mental health, and social services.

> Participant: It's like a one stop shop, you don't have to go there and here, and run all over the place. I don't know about anyone else, but for me that stuff is so stressful. It's just that so much is offered here. It's great. I love it.

From an organizational perspective, embedding the program in primary care facilitates interdisciplinary communication and team-based care. This contributes to improved work satisfaction and decreased burnout.

> Staff: It's already challenging enough to provide medical and behavioral health treatment, but to do it in a way that it's done sort of simultaneously or in an integrated way seems like a really creative approach to ensuring access.

> Staff: It just seems like all the interdisciplinary players are there and talking to each other in the moment.

> Staff: I've seen so much burnout and so much high turnover [in other programs] which impedes patient care. But that doesn't happen here.

Nonetheless, challenges remain with this model. While participants benefit from having the program embedded within a primary care medical home, billing regulations deter clinics from providing both a primary care appointment and MOUD group visit on the same day, or a psychiatric mental health nurse practitioner visit and MOUD group visit on the same day. If a patient has two visits with the same type of provider on the same day, although an FQHC can bill for both visits, only one visit will be reimbursed. As such, staff were concerned that this may be a barrier for patients seeking primary care.

> Staff: They're already here, they're a captive audience, they're waiting for their script. It's a perfect time to address their diabetes or their high blood pressure. I think we're going to get more bang for your buck to say for the patient if we can serve them while they're here and not push them off to another day because they're not going come back again if they're already coming back once a week.

### *Accessibility*

The program has multiple offerings for group visits throughout the week and participants can attend any group session they choose, without prior scheduling. This approach enables people to get into treatment as soon as they are ready. Participants noted the importance of getting a timely appointment as external circumstances could quickly change their desire to seek treatment.

> Participant: You could change your mind in a day. As soon as you get some money.

However, allowing participants to choose when they want to join group also means introducing an element of

unpredictability, which can impact volume and workflow throughout the clinic.

> Staff: There are some times when people won't come for a month, and then they're all here on the same day. And when you have people who are coming weekly, that means you have this constellation of forces and suddenly there's like 16 people.

Despite the flexibility of the current schedule, some participants expressed that they would like more availability on weekends and evenings, especially for people who work.

> Participant: They should help out the people that work. Because I work 7 to 3, and it's like, I've got to keep taking off or leaving work to come here, and it's jeopardizing my job right now.

While the organization would like to expand group offerings, staff members noted two major limitations: lack of physical space and shortage of primary care providers and behavioral health providers.

### *Group-based model*

Participants noted significant benefits from a group-based model, including peer support and community.

> Participant: If I come in and I have some things that I have been struggling with during the week, I can release them here. And I get a lot of good feedback from it that I can take home with me.

> Participant: It connects you with your peers. Like I call a couple of the girls when we don't have group. I call them up just to check on them, see how they're doing.

Both staff and participants voiced that a larger group size may make it more challenging to address all the needs of the participants.

> Staff: It was just overwhelming, the amount of people in that group. And they needed to be there, so they were getting some access and some support, but it was not enough time or space to safely process what needs to be processed.

> Participant: Some people don't always get to release what they want to say, so sometimes I wish the group was a little bit longer.

Both staff and participants have noted the loss of individual attention in exchange for the communal aspect of group visits, which can also be a valuable source of support.

> Staff: We've kind of lost that [one-on-one] piece, and gained this social support piece, which I think is excellent. But we're missing out on that one-on-one piece that I feel like is really beneficial.

> Participant: This is the only day I have time to be here. And it's kind of hard to see the psych if you need to. I know they have programs on other days too, but I just wish I could have a few minutes with him on the day that I could be here, you know?

## Discussion

This study explored the complexity and risk-to-benefit considerations when implementing a MOUD program that uses a philosophy of harm reduction and "low-threshold" design in an FQHC. This study filled a gap in knowledge by exploring how programmatic choices impact treatment access, patient retention, and organizational processes. Importantly, this study included the perspective of patients, staff members, and clinicians.

The dominant narrative of the healthcare experiences of people who use drugs is often markedly negative.[10–13] When treatment programs employ an abstinence-only or zero-tolerance approach to substance use treatment, patients are stigmatized and often do not complete the program either from administrative or self-discharge.[11,14–16] However, recent research on treatment engagement and retention describes the benefits of a person-centered harm reduction approach.[4,10,11,13] Experiencing trust and respect is critical for people to access treatment. Many program participants in this study used the language of "hope," "love," and "care" when describing their experience at the clinic. Patients in this study appreciated the program's acknowledgment of the relapsing-remitting course of addiction. Patients reported remaining in the program because they found encouragement to achieve their personal recovery goals. Our findings support the therapeutic alliance that can result when programs adopt a harm reduction approach to MOUD treatment.

To increase uptake of MOUD, some organizations have advocated for "low-threshold" models to substance use care.[4,12,14,16] While there is no universal standard, proposed features typically address accessibility and treatment design barriers.[14] In our study, program participants mentioned 3 specific areas that facilitated their participation and engagement in the program: ease of access, integration in primary care, and group-based visit model. Rapid-entry scheduling enables people to access treatment quickly, which increases the proportion of people who initiate treatment.[4] Group-based models increase access to MOUD and provide unique supportive mechanisms, such as emotional support, accountability, shared identity, and community.[17] Integration in primary care can increase access to primary care, behavioral health, and psychosocial services, destigmatize treatment for substance use disorder, and facilitate care coordination and team-based care.[18] Our findings provide qualitative support for the benefits of a "low-threshold" model.

Based on our experience and findings, we offer the following recommendations in response to the challenges we encountered with our MOUD program. While many participants benefited from the program's philosophical orientation, some participants felt that more stringent requirements were needed to regulate the behaviors of other participants and to support their own recovery, suggesting that a single approach does not match all participants' needs. It is important to support patients on the entire spectrum of harm reduction, including a desire for abstinence. Compared to clinicians and clinic leadership, medical assistants were most likely to favor abstinence and view buprenorphine as a medication that enabled addiction. When using a harm reduction approach, it is critical to incorporate the perspectives and voices of all staff, including frontline staff, during program development and implementation, provide training to all staff on harm reduction, trauma-

informed care, and self-care, and implement initiatives to support staff to prevent burnout.

From an organizational standpoint, a large group size can make it more difficult to meet participants' primary care and mental health needs fully. Capping group size to 8-12 participants may be helpful to avoid this, but same-day or next-day access may be affected and the administrative requirements for scheduling may increase. Therefore, access and availability of group visits must be balanced with the ability to address participants' recovery needs. Lastly, when delivering a group-based MOUD program at an FQHC, billing regulations are important to consider for financial sustainability. For example, at our FQHC, behavioral health visits are billed to Philadelphia's behavioral health managed care organization, Community Behavioral Health (CBH). CBH is a nonprofit 501c(3) corporation contracted by the City of Philadelphia to manage the delivery of behavioral health services for Medicaid recipients of Philadelphia County. There is no difference in reimbursement for behavioral health visits that are in a group or one-on-one. Most patients at this FQHC are insured through Medicaid, some through Medicare, and some who are dual-eligible for Medicaid/Medicare. The medical provider visit, whether group or one-on-one, is billed through the patient's medical insurance provider. Uninsured patients are also able to receive services. However, if a participant has two visits with the same type of provider (medical or behavioral health) on the same day, Medicaid/Medicare will only reimburse one of those visits. Despite this, our program has decided to continue to see patients for primary care on the same day as their MOUD group visit. To maximize the benefits of integrated care, insurance policies should allow for multiple primary care appointments on the same day to take advantage of the co-location of these services.[19]

In addition, our results must be reconsidered within the novel set of circumstances now posed by the COVID-19 pandemic. Some of the programmatic choices reflected in the present study may in part be less feasible (i.e., in-person group-based visits) while others, such as accessibility, harm reduction philosophy, and integration in primary care may become more vital to promoting treatment engagement and retention.

Limitations of this research include the cross-sectional design, which did not allow us to capture change as people and the program evolved. This was also a single site study in one urban FQHC with specific resources that may not be available to other sites. Finally, this was a convenience sampling. Though all staff and MOUD participants were invited, we only interviewed the people who wanted to participate and were present on the days of the focus groups.

In conclusion, this program increases access and retention through its philosophy of person-centered harm reduction and "low-threshold" design utilizing easily accessible group-based visits and integrated care. Plans to improve the program include developing a patient advisory council (PAC), increasing the number of waivered providers, ongoing training and education of all staff and patients regarding harm reduction, trauma-informed care, and self-care, and expanding a refined model to satellite sites. We must also rapidly adapt our program to continue to provide easily accessible MOUD for our patients, in the face of ongoing challenges presented by the COVID-19 pandemic. Future research will focus on a more comprehensive implementation evaluation, in partnership with the PAC, tracking of patient-identified important outcomes, and adapting services to broader circumstances, such as global pandemics. While the opioid crisis may not be resolved with any one individual solution, improving the way we deliver MOUD by listening to patients and providers is important to close the treatment gap.

## Authors' contributions

Sunny Lai was involved in data analysis and report writing. Erica Li was involved in data analysis and report writing. Alexis Silverio was involved in conducting focus groups, data analysis, and report writing. Robin DeBates was involved in data analysis and reporting writing. Erin Kelly was involved in report writing. Lara Weinstein was the physician principal investigator and was involved in study design, data analysis, and report writing. All authors have approved the final article.

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