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Examining the Primary Care Experience of Patients with Opioid Use Disorder: a Qualitative Study

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Abstract

Objectives: Despite substantial investment in expanding access to treatment for opioid use disorder (OUD), overdose deaths continue to increase. Primary care holds enormous potential to expand access to OUD treatment, but few patients receive medications for OUD (MOUD) in primary care. Understanding both patient and clinician experiences is critical to expanding access to patient-centered MOUD care, yet relatively little research has examined patient perspectives on primary-care based MOUD. We sought to examine the care experiences of patients with OUD receiving medication-based treatment in a primary care setting.

Methods: We conducted semi-structured interviews with patients receiving MOUD at a single primary care site at the University of Utah. Interviews were performed and transcribed by qualitative researchers, who employed rapid qualitative analysis using a grounded theory-based approach to identify key themes pertaining to patient experiences receiving medication-based OUD treatment in primary care.

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AUTHOR CONTRIBUTIONS:

MI and AJG conceived the project. MI obtained funding for the project. MI wrote the initial draft. All authors provided critical feedback and contributed to the writing of the manuscript.

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Results: 21 patients were screened, and 14 completed the interview. In general, participants had numerous medical and psychiatric co-morbidities. Five key themes pertaining to primary care-based OUD treatment were identified: 1) overall health improvement, 2) team-based care, 3) comparing primary care to specialty addiction treatment, 4) access to medications for OUD, and 5) discrimination and stigma.

Conclusions: Patients reported many advantages to receiving primary care-based MOUD treatment. In particular, the flexibility and added support of team-based care along with the convenience of receiving addiction treatment alongside regular medical care were highly valued. These findings can be used to develop patient-centered initiatives aimed at expanding OUD treatment within primary care.

Keywords

Opioid-Related Disorders; Primary Care; Humans; Qualitative

Introduction:

Harms from opioids and opioid use disorder (OUD) continue to impact the lives of tens of thousands of Americans each year. Despite more than a decade of investment in expanding OUD treatment services, 2020–21 saw more opioid overdose deaths than any year in recent history. While the reasons for this are multifactorial, a persistent deficit in treatment access remains a crucial factor. At present less than half of people with OUD receive any treatment, and fewer receive medication-based treatment for opioid use disorder (MOUD) which includes formulations of buprenorphine, methadone, and extended-release naltrexone.[1,2] In the US, buprenorphine and extended-release naltrexone can be prescribed outside of specialized opioid treatment programs, including within primary care settings.[2]

Primary care settings hold enormous potential to expand OUD treatment access.[3–5] Buprenorphine-based MOUD delivered in primary care settings may be comparable in quality to care provided by addiction specialists, and national stakeholders have increasingly sought more primary care provider (PCP) involvement in OUD and MOUD care.[3,6–8] Several characteristics of primary care, including expertise in chronic disease management and a holistic approach to patient health, are key components of effective OUD care.[5,9,10] Moreover, primary care's broad geographic reach and telehealth infrastructure may be particularly important in expanding OUD treatment in under-resourced areas that have been disproportionately affected by the opioid crisis.[11–17]

However, few PCPs prescribe medications to treat opioid use disorder, and many who do provide MOUD do so to only a small volume of patients.[18–20] Understanding both patient and PCP experiences with MOUD is critical to expanding access to evidence-based OUD care in the primary care setting.

Prior research has examined PCP perspectives on OUD treatment;[21,22] however, little is known about patient experiences receiving primary care-based MOUD. Small qualitative studies have found that patients may prefer receiving MOUD in the non-specialty settings,[23,24] but much of this research has taken place in the context of specific OUD

treatment initiatives such as hub-and-spoke models.[24] Elements of modern primary care delivery designed to improve chronic disease management, such as team-based care, integrated behavioral health, and on-site case management, may be optimized through structured patient feedback to improve treatment experience and efficacy for people with OUD, but data examining patients' experiences receiving MOUD within an integrated primary care model is lacking. Our study adds to existing literature by examining the perspectives of patients receiving MOUD treatment in a general primary care environment with on-site ancillary services and a team-based care model to elucidate specific barriers and facilitators of MOUD inherent to the primary care setting.

Methods:

Study Design:

A qualitative methodology was chosen to examine participants' perspectives on primary care-based OUD treatment. We conducted and evaluated semi-structured interviews with patients receiving MOUD at a single primary care clinic. Verbal informed consent was obtained by the research team prior to each interview. The study was approved for human subjects through the institutional review board at the University of Utah.

Setting:

The setting of this study is a single academic primary care clinic in an urban setting. All participants were existing patients receiving full-spectrum primary care from a PCP who was simultaneously providing comprehensive OUD care. All participants had access to on-site integrated behavioral health specialists, clinical pharmacists, nurses, and case managers as a part of routine primary care according to a patient-centered medical home model.[25] No staff were hired or trained explicitly to facilitate MOUD, nor did staff have protected time or additional funding dedicated to MOUD.

Participants:

We identified potential participants from July 1 to August 31, 2021. We used the electronic health record to identify eligible patients, who were then invited to participate in the study by a PCP during routine clinic visits. Inclusion criteria included proficiency in the English language and receiving MOUD from a PCP within the clinic. Exclusion criteria included those potential subjects who did not have access to a telephone. Participants were renumerated with a $50 gift card upon completion of the interview.

Interview Guide:

Semi-structured interviews were conducted using open-ended questions to explore the perspectives of patients receiving treatment for OUD in the primary care setting. Interviews were conducted via telephone within 2 weeks of enrollment and were limited to 30 minutes. Interview questions were drafted by the study team (MI, EK, PG) based on existing qualitative research examining primary care-based MOUD.[24] Questions were designed to prompt discussion of key facets of primary care treatment such as perceptions on overall health and interactions with a health care team. Sample probe questions included: "*How has receiving addiction treatment as a part of primary care made it easier to manage your other*

health conditions?" and "*Tell me about your experience with the 'team approach' utilized for your care in this clinic. How does the team approach here compare to other addiction treatment programs?"*.

Data Collection

Data was collected by trained interviewers from the University of Utah. The interviewers had no clinical relationship to the participants. Interviews were audio recorded, transcribed verbatim, and de-identified. Basic demographic information and treatment history were collected from the electronic health record.

Data Analysis.

Rapid qualitative analysis was used to code all interviews.[26–28] Summaries were created for each interview and textual quotations were divided by interview questions. Thematic analysis employing a grounded theory-based approach was used to allow investigators to identify naturally occurring themes. Two trained qualitative coders reviewed the summaries and captured quotations. The coders created 7 emergent themes based on the interview content. The content expert (MI) reviewed the captured quotations and themes and chose 5 themes most critical to the topic of opioid use disorder for presentation of the data. Any disagreements were discussed and adjudicated. We followed COREQ guidelines for reporting qualitative results.[29]

Results:

We approached 21 patients for the study. One patient was ineligible due to lack of telephone access. Six patients did not respond to any of the three outreach calls from the research team. In total, 14 patients completed the interview. Mean age was 34.8, and 43% of participants were female. 79% of participants carried more than 5 medical diagnoses, including 36% with chronic hepatitis C and 21% with comorbid behavioral health diagnoses. All participants had active prescriptions for formulations of buprenorphine prescribed by their PCP. The mean length of treatment for participants in the primary care clinic was 22 months. No patients experienced an overdose since establishing with the primary care clinic. Table 1 summarizes characteristics of the study participants.

Participants described the following 5 main themes pertaining to their respective experiences receiving MOUD treatment within primary care: 1) overall health improvement, 2) team-based care, 3) comparing primary care to specialty addiction treatment, 4) access to medications for OUD, and 5) discrimination and stigma.

Overall Health Improvement

Participants commented that going to primary care for OUD treatment made it easier to treat other health conditions. Several participants reported that before starting primary care-based OUD treatment they did not have regular access to a PCP, despite approximately 80% having more than 5 medical diagnoses. Chronic medical problems such as hypertension and hepatitis C, which in many cases had gone on for years without adequate treatment, were addressed incrementally over the course of regularly scheduled visits.

- "I've had problems with dieting, sleep, and stuff like that. And we've kind of just been setting goals for certain things I need to work on. And then just three months attacking that, and then moving on to the next. You know what I mean?"

Some participants reported that they completed hepatitis C treatment during PCP-based OUD treatment. Other participants reported better control of hypertension and diabetes after starting primary care-based MOUD.

- "Well, when I first came in, I'm a diabetic so my sugars and stuff were kind of out of control. And we've been working on that really hard for a couple years. And now I'm almost to the point where I don't need insulin no more. So I would say they do a pretty kickass job."

Participants commented that they appreciated going to one trusted clinician for all health-related concerns, as opposed to going to a dedicated, specialty OUD treatment program.

- "I have a couple of health issues that are kind of chronic, in addition to my addiction issue, so it's an important part of my life to have a good doctor. And they handle everything."

Team-Based Care

Several participants commented on their experience with members of the care team other than their PCP. Overall participants felt respected by the entire staff at the clinic and noted that a team-based approach to care made accessing healthcare more convenient.

- "I just feel like whatever issues are going on they're all working together to help me do better with my diabetes and the addiction itself. So, it's nice to have them even when I'm not there they're talking to each other how to solve issues or get stuff done"

When patients faced unanticipated events such as transportation problems or medication side effects they were able to easily reach the care team who served as a liaison to the participants' respective PCPs and offered tools such as telehealth appointments to preserve treatment access.

- "Prior to coming into treatment, I was homeless. I didn't have a car. And my mom would drive me to my appointments sometimes, but if my mom and I had a falling out, I didn't have a way to get to the appointment. And he [PCP] would do – and I had called once to cancel the appointment, and it was like, "No, you don't need to. We'll just do telehealth. We can work around this problem."

Some participants developed positive rapport with certain care team members that helped them to feel more welcome in the clinic during medical visits.

- "I feel like they all generally care about what's going on, even outside the medical part. Just in general. All his [PCP] nurses have been super cool to me. That's why I've never been with a provider this long. I feel like I can go to him with anything and he's not going to judge me or anything like that."

Despite the presence of integrated behavioral health at the clinical site, only 36% of participants reported engaging with behavioral health supports.

Comparing Primary Care to Specialty Addiction Treatment

All participants reported engaging in specialty addiction programs in the past. Participants frequently commented that having a consistent team of providers helped them to feel valued as individuals, rather than being "just a number".

- "I went to the methadone clinic, they pretty much just wanted to get me in and out of the office. They didn't care about my well-being, it didn't seem like. And they didn't care whether I succeeded or not. They just pretty much just wanted their money, is what it seemed like. As to the [clinic], I mean, you guys show that you actually care about us as human beings and care about our well-being and help us succeed, rather than just push us in and out of the door"

Participants appreciated that they did not have to repeat their medical histories to a new provider at every visit, which helped preserve a sense of privacy around sensitive aspects of their respective medical histories and built trust with their medical teams.

- "I don't have to go to different places or see different people. It's all with one person. So I can get comfortable with that person and take care of all the needs that I need to be taking care of because it's hard to get comfortable with the doctor. And so once you're comfortable with one doctor, and you got to go be comfortable with another doctor to go for your other issues that you have going on."

Participants commented that compared to specialty addiction programs the primary care team was quickly responsive to web-based messages, refill requests, and phone calls. They also commented that their PCPs "really cared" and explored a variety of treatment modalities during their visits, as compared to past experiences with specialty addiction practice in which providers "just threw meds" at them.

- "I would say the difference is I feel like he [PCP] actually cares and he doesn't just give me medication and hope everything is fixed, like other places [addiction treatment programs]. He's always asking questions, working with me through stuff. So I feel like when I am there, he's invested in what's going on with me instead of just trying to feed me medication like that's the fix."

Approximately 40% had evidence of illicit substance use in the past 3 months, but no participants reported feeling like they were judged or in danger of being dismissed from the clinic.

- "I'm always honest with him [PCP]. Whenever I have slip ups, whatever, he knows what I've been going through. He knows the bad. He knows the good. He knows me, and I just feel like he helps. He helps. He gives me ideas. He doesn't tell me, "Go check into [residential treatment]," but he'll say, "Hey, it's an option. I've got connections. I got the numbers… If I need numbers for… other resources sometimes he can give me that are numbers or he can refer me to."

Reflections on Current Treatment Modalities

All participants reported taking buprenorphine-based MOUD. Participants reported that the primary care clinic was flexible and prioritized access to medications, even if there were barriers to attending appointments at times. Participants generally commented that accessing buprenorphine was easy and viewed as a normal part of healthcare. Some participants reported that local pharmacies were intermittently out of stock of buprenorphine, interrupting treatment access. One participant commented that they were previously getting buprenorphine from a cash-only practice, which was often cost-prohibitive. Participants generally commented that buprenorphine helped them to engage with healthy activities such as family life and employment. 100% of participants were prescribed intranasal naloxone.

- "I guess, when it comes down to it… now that I know this route of treatment, I wouldn't choose a different one because this one has been - it's been able to allow me to, like I said, keep my job. I've been able to still be in my daughters' lives. And I've been able to just live my life while being treated rather than being pulled away from society for two, three months to go into an inpatient treatment center."

Discrimination and Stigma

All participants reported feeling stigmatized in healthcare environments in the past. Several participants shared specific stories about negative encounters with the healthcare system where they were denied routine medical treatment, were "interrogated" about substance use even during unrelated medical visits, felt "dismissed", and felt that their medical concerns were ignored.

- "I'd always end up getting frustrated and feeling dismissed and leaving and it's just really embarrassing… I just think you end up feeling just really dismissed, and I don't know. I don't know. It's pretty terrible or really frustrating to not get to get medical help when you actually needed it. You know?"

One participant reported that he was told to "shoo" from a medical office in the past.

- "Yeah. (Other healthcare environments were) Kind of just treating me like a child or a dog. I don't know. I've literally been told to shoo before"

No participants reported feeling stigmatized by their primary care team. In general, participants reported feeling "respected" and treated "like a regular person".

- "I don't know what it is about being in a (addiction treatment) facility setting… it just reminds me of me getting arrested and then having to go through all these things, even if it's not… Just seeing a normal doctor…made it seem less like I was doing the same crap I was when my life was a mess, and I was going to jail, and a criminal, and feeling that way."
- "I have relapsed a lot and usually I just wouldn't go back to - I don't know if it's out of shame or - I mean maybe that's part of it. But it's helpful because I can go back there… and tell him [PCP], "Look, I've been having problems with this," and be honest about it with him about what's going on and still have medical

support. Rather than what I normally would've done in the past, I just wouldn't go back to see the doctor and then I wouldn't be seeing a doctor, period."

Discussion:

Increasing the provision of high-quality MOUD treatment within primary care is a critical avenue through which to increase treatment access and reduce opioid-related harms nationally. Dedicated efforts to integrate MOUD treatment into primary care must focus on supporting both PCPs and patients. While prior research has examined barriers that PCPs face to adopting OUD treatment,[21,22] few studies have evaluated patient perspectives and priorities. Through qualitative analysis, our study identified ways in which the primary care environment may be optimized to improve the overall health of patients with OUD and elucidated patient priorities for primary care-based OUD treatment.

The convenience of seeing one medical team for both OUD treatment and general primary care was highlighted as a particular advantage of primary care-based OUD treatment. 80% of participants interviewed had greater than 5 medical diagnoses, and many participants reported no or suboptimal care for conditions such as hypertension and type 1 diabetes prior to establishing at the study site. Receiving care for these conditions concomitantly with MOUD led to the perception of improved overall health. Patients reported that treating OUD alongside other medical conditions also removed some of the stigma that may be associated with going to a dedicated addiction treatment program. This was evidenced by multiple patient responses highlighting positive relationships with care team members and the sense that their healthcare team knew them as individuals.

Participants also reported that flexibility and team-based care were major advantages of receiving OUD treatment in primary care. Primary care has decades of experience developing and implementing models to improve chronic disease management. These include the use of telehealth, electronic health record-based tools, integration of behavioral health and case management services, and engagement of nurses and clinical pharmacists to augment the care provided by PCPs. These tools may be optimized to overcome barriers that commonly affect patients with OUD. For example, several participants shared stories in which unexpected life events such as unreliable transportation would have prevented them from attending appointments. In these instances, the participants were generally able to contact the primary care team and leverage tools such as telehealth and case management to preserve access to treatment. Multiple participants commented that without these supports they had fallen out of care with previous providers leading to a return to illicit substance use.

All participants reported taking buprenorphine for treatment of opioid use disorder. In all cases, this was prescribed by their primary care provider. Few patients reported problems accessing medications to treat OUD. Despite all patients actively engaging with medication-based OUD treatment, approximately 40% of participants reported using illicit drugs within the previous 3 months. This is consistent with other studies of primary care-based OUD treatment.[30] Only 36% of the study participants engaged in behavioral health supports. This may be due to a combination of insurance coverage deficits, limited access to appointments,

and transportation barriers. Having greater on-site presence from peer-support services and behavioral health specialists may improve access to behavioral health supports.

Consolidating primary care and OUD treatment has other possible benefits for health systems not assessed in this study. These include the potential to reduce health care expenditures and use of emergency medical services.[31,32] Further study is needed to compare retention in treatment, overdose rates, illicit substance use, and functional outcomes such as employment, mood-related symptoms, and housing in primary care-based treatment vs. specialty addiction treatment settings.

As demonstrated in this study, primary care-based OUD treatment provided a sense of trust and flexibility for patients that was paramount in providing effective, patient-centered care. More than specialty expertise in addiction medicine, a team-based approach that allowed for multiple points of contact (case manager, clinician, nurse, medical assistant, etc) to facilitate rapid assessment in the event of a missed visit or other destabilizing life event, was identified as critical to preserving access to MOUD with minimal interruption. Several participants commented that they had left or been dismissed from previous practices because of these events, risking recovery and safety. The need for consistent, flexible, and at times rapid access to medical care parallels other health conditions such as congestive heart failure and asthma that are commonly managed in primary care. Structures such as team-based care and telehealth that have been developed to prevent costly and dangerous decompensation for these health conditions can be leveraged to support patients and PCPs in providing high quality care for patients with OUD. All interventions at the study site utilized existing primary care infrastructure without hiring additional staff. Patient feedback on care experience is critical in helping to optimize the primary care environment to the specific needs and priorities of this vulnerable patient group.

Limitations:

This study was conducted with a convenience sample from a single primary care site that included a PCP who was dual-trained in addiction medicine, which may limit the generalizability of the results. The average time receiving care at the study site was 22 months, which may select for patients who had a positive relationship with the staff and providers at the clinic. The rapid nature of the qualitative analysis (i.e., no formal coding was performed on interview transcripts) may be prone to investigator bias in identifying key themes and representative quotations. Finally, one investigator (MI) involved in analyzing emergent themes played a clinical role in the care of several participants, perhaps introducing bias to the study. However, we feel that these limitations do not significantly weaken the main conclusions or relevance of this study.

Conclusions:

Patients reported many advantages to receiving OUD treatment within the context of primary care. In particular, the flexibility and added support of team-based care along with the convenience of receiving addiction treatment alongside regular medical care were highly valued. These findings can be used to develop patient-centered initiatives aimed at expanding OUD treatment within primary care.

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DECLARATION OF INTERESTS:

AJG receives an honorarium for an online chapter on alcohol management in the perioperative period from the UpToDate online reference and is on the board of directors of the American Society of Addiction Medicine (ASAM), the Association for Multidisciplinary Education and Research in Substance use and Addiction (AMERSA), and the International Society of Addiction Journal Editor (ISAJE), all non-for profit organizations of which he receives no remuneration. AJG receives current grant support from the Veterans Health Administration (VHA) and NIH.

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TABLE 1:

Participant Demographics

Participant Demographics	
Number of Participants	14
Average Age in Years	34.8
% Female	43%
% White	79%
Average Time in Clinic	22.2 months
% participating in behavioral therapy	36%
% with any substance use in past 3 months	43%
% living with HIV	0%
% with chronic hepatitis C	36%
% with tobacco use	57%
% with 5 or more medical diagnoses	79%
% with comorbid psychiatric diagnoses	21%