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Implementing group visits for opioid use disorder: A case series

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Abstract

Background: Group-based models of Office-Based Opioid Treatment with buprenorphine-naloxone (B/N) are increasingly being implemented in clinical practice to increase access to care and provide additional therapeutic benefits. While previous studies reported these Group-Based Opioid Treatment (GBOT) models are feasible for providers and acceptable to patients, there has been no literature to help providers with the more practical aspects of *how* to create and maintain GBOT in different outpatient settings.

Case series: We present 4 cases of GBOT implementation across a large academic health care system, highlighting various potential approaches for providers who seek to implement GBOT and demonstrate "success" based on feasibility and sustainability of these models. For each case, we describe the pros and cons and detail the personnel and resources involved, patient mix and group format, workflow logistics, monitoring and management, and sustainability components.

Discussion: The implementation details illustrate that there is no one-size-fits-all approach, although feasibility is commonly supported by a team-based, patient-centered medical home. This approach includes the capacity for referral to higher levels of mental health and addiction support

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services and is bolstered by ongoing provider communication and shared resources across the health system. Future research identifying the core and malleable components to implementation, their evidence base, and how they might be influenced by site-specific resources, culture, and other contextual factors can help providers better understand how to implement a GBOT model in their unique clinical environment.

Keywords

Buprenorphine-naloxone; GBOT; group visit; shared medical appointment; group psychotherapy; implementation science; case series

Introduction

Opioid use disorder (OUD) has become a public health crisis in the United States. Since 2000, the rate of opioid overdose deaths (from prescription opioid pills, heroin, and fentanyl) has more than tripled. There are now more than 115 overdose deaths per day, bypassing motor vehicle accidents and firearms as the leading cause of injury death.[1,2]

Since 2000, with implementation of DATA (Drug Addiction Treatment Act), the U.S. Food and Drug Administration has made treatment of OUD available in the outpatient setting with a form of medication treatment, buprenorphine-naloxone (B/N), that can be prescribed by physicians, physician assistants, and nurse practitioners who obtain a waiver. Treatment of OUD with B/N has been shown to be medically effective (increasing retention in treatment and decreasing use of illicit opioids) and cost-effective.[3–8] It yields high patient satisfaction and quality of life[9] and is associated with diagnosis and treatment of other medical problems.[10]

Within the past decade, Group-Based Opioid Treatment (GBOT) models have begun to emerge in clinical practice and research, in which B/N prescribing is coupled with office-based group counseling. This approach increases access to care and provides additional benefits that individual prescribing of B/N cannot.[11] Group-based approaches have a long, established history in addiction treatment and recovery and have been shown to enhance recovery for all types of addictions.[12–15] Specifically, delivery of B/N via outpatient groups enhances patient recovery by creating a sense of accountability, a shared identity, and a supportive community unlikely to be achieved through one-to-one provider-to-patient visits.[16] Coupling counseling with medication prescribing has been encouraged as a best practice, enabling providers to treat the physiologic component of addiction through medication while the behavioral component of addiction is addressed through group process and support.[12]

GBOT can be delivered in two main formats: (1) shared medical appointments (SMAs), in which B/N prescribing and group-based counseling all occur concurrently within the presence of the prescribing clinician, and (2) group psychotherapy, in which B/N prescribing occurs during individual patient appointments while group psychotherapy sessions can occur at a different day or time during the week.[12]

A systematic review demonstrated that GBOT is feasible for providers and acceptable to patients, although the efficacy remains unclear.[11] Yet, there has been little published with the

purpose of helping providers manage the more practical aspects of *how* to create and maintain group visits for GBOT in the outpatient setting. Lack of knowledge about the logistical and operational details of implementation can reduce likelihood of dissemination.[17] Therefore, in order to support providers who are interested in delivering B/N via a group visit format, we provide a case series of GBOT implementation across a large academic health system, highlighting potential approaches for providers to consider based on their specific health care context.

Case series presentation: GBOT across a large academic health system

Within our health care system, we have designed a coordinated approach to treating substance use disorders. Our system includes 13 primary care sites, 2 community-based hospitals, and partnerships with local tertiary care centers. We offer primary care-based addiction treatment as well as intensive outpatient program (IOP) treatment provided through a specialized outpatient addiction services site. All primary care sites offer B/N to patients with OUD, through individual or group-based appointments, 11 sites offer IM naltrexone, and all sites have integrated behavioral health, complex care management, and social work services to further support patients. We have 3 regional office-based opioid treatment (OBOT) nurse care managers (RNCMs) and over 100 B/N-waivered prescribers. In this model, care begins with the centralized OBOT RNCMs.[18] Patients are referred to these RNCMs from primary care providers within our system, from higher levels of care inside and outside of our system, such as inpatient Transitional Support Services and Clinical Stabilization Services (TSS/CSS; American Society of Addiction Medicine level of care 3.1 and 3.5, respectively), IOP, methadone maintenance treatment programs, or halfway houses and from patients new to our system looking to access addiction services. The RNCMs serve as the first point of contact. They screen the patients based on a templated triaging script and continue to follow and support those who are triaged into our GBOT programs.

Below, we present 4 general models of GBOT implementation that have emerged within this health care system, each of which is substantially distinct from one another. For each model, we provide a general overview, highlight the unique features and pros and cons, and distill implementation details. See Tables 1–4.

Discussion

This case series demonstrates 4 models of GBOT implementation across a health care system. This includes both shared medical appointments and group psychotherapy approaches, with varying implementation components: facilitators running groups, types of psychoeducation provided, duration of group, composition of group members, opportunities for individual appointments vs group-only appointments, timing of B/N prescribing, and team members involved in providing care.

It should be noted that these 4 models represent implementation of GBOT across 6 different outpatient sites. Where sites employ similar implementation approaches, their features were consolidated and represented within one of these 4 models. These models are not firmly distinct from one another but rather overlap in shared characteristics and are evolving as

sites learn from each other and site-specific variables change. Rather, the framing of GBOT into these 4 models allows providers looking to implement GBOT a way to understand potential approaches based on their resources, training, and operational and logistical opportunities and constraints. This 4-model framing also demonstrates feasibility and sustainability to clinical administrators looking to expand access to care for patients with OUD.

While several iterations of the GBOT model have been employed, feasibility and sustainability across the system is bolstered by three underlying principles that should not be overlooked:

1. Team-based approach: All our primary care sites are National Committee for Quality Assurance (NCQA) Level III patient-centered medical homes. Our patients receive care from an interdisciplinary team of providers with clearly defined roles and responsibilities working collaboratively and to the top of their license to provide comprehensive care addressing patients' complex medical and psychosocial needs.[27–30]

2. Continuity and access to a "higher level" of addiction care: Systems must provide a continuity of care services, including higher level of care options for patients who do not do well in primary care-based group visit approaches. Within our system, patients can be referred to a specialized outpatient addictions services facility in the outpatient psychiatry department to provide enhanced group-based treatment or individualized mental health and addiction support needs. Additionally, while our GBOT model includes psychoeducation components with varying degrees of rigor, psychotherapeutic counseling is not necessary for successful outcomes in B/N treatment.[21] Some sites may lack the resources to provide these services, and some patients may not be able to attend such a structured format. Thus, systems should also consider offering lower threshold models that focus solely on B/N delivery and hence expand access to medication.

3. Provider support: Providing care for patients with OUD can lead to emotional exhaustion and burnout without the right support.[31–33] All GBOT providers (including primary care physicians, physician assistants, psychiatrists, OBOT RNCMs, and administration staff) have developed an infrastructure that provides ongoing support to each other. We meet monthly and participate in an addiction-related e-mail list, allowing us to share best practices, develop resources and guidelines, pose questions, and stimulate discussion to continuously enhance the safety and quality of patient care. B/N-prescribing providers also serve as "backup" prescribers when the main provider is unavailable, such as away on vacation. Additionally, we on-board new GBOT providers gradually, and they receive support from those who have more experience with GBOT implementation. For example, medical assistants and nurses at one experienced site will coach similar providers who are launching GBOT at a new site.

In our setting, GBOT has been implemented within a comprehensive, well-resourced health care infrastructure. This foundation likely supports successful implementation. However,

providers looking to offer GBOT should not feel that such an infrastructure is obligatory for feasibility and sustainability to occur. Rather, efforts should be made to employ these three underlying principles as a foundation to support the more granular implementation components.

While we illustrate several potential GBOT models, there are likely others that could be successfully employed. Future research should explore other health systems that have developed similar and different GBOT models to further broaden generalizability. Additionally, future research should identify the core and malleable components to implementation, their evidence base, and how they might be influenced by site-specific resources, culture, and other contextual factors to help providers better understand how to implement a GBOT model optimally in their unique clinical environment.

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Table 1.

Model #1: "Leveled" shared medical appointments with individual appointments offered periodically.

General Overview and Unique Features:
This model takes a shared medical appointment group visit approach in a primary care setting, in which patients receive psychotherapeutic support coupled with B/N prescribing from a team with enhanced addiction experience. Individual appointments are offered to a few patients at the end of group to address other acute issues or psychosocial comorbidities. Chronic problems are managed by their on-site primary care physician.

Pros:
• Individual appointments are scheduled around the time the patient attends group, fostering more comprehensive and increased access to primary care services. Patients can still be referred to their on-site primary care provider for more complex and chronic medical problems.
• Patients in early recovery receive care from a team of providers with more experience working with patients who struggle with addictions than most other on-site providers.
• Leveled groups keep patients in a similar cohort of recovery together, thus helping build relationships between group members over time.
• The clinic provides increased access to care in which 5–10 patients can be treated for OUD (with both pharmacological and behavioral support) in a 1-hour period of time with minimal clinical staff.

Cons:
• Leveled groups may prevent opportunities for mentorship among patients in different stages of recovery.
• The B/N provider running group may spend time after group addressing medical problems among patients who have other primary care providers.

Personnel and resources
Provider type: 1 Internal Medicine physician; 1 back up PA
Behavioral health provider type: +/− psychologist
Other staff: 1 OBOT RNCM, 1 medical assistant,1 designated front desk staff
Total resources: This site dedicates one 4-hour clinic session to GBOT per week. The primary care provider and psychologist use 1/8 full-time equivalent (FTE) and the medical assistant uses 1/10 FTE to meet this need. A full-time OBOT RNCM covers 3 practices (with a total case load of about 125 patients), dedicating 1/3 of her time to each (and this) site.

Patient mix and group format
Type of group: Leveled[19] (patients in similar stages of recovery); weekly, biweekly, monthly groups offered
Number of weekly groups offered: 2–3
Length of group: 45–60 minutes (longer when psychologist present)
Average number of patients in group: 5–10
Psychotherapy techniques utilized: Mix of psychoeducational, support, skills development, and cognitive behavioral therapy (CBT)

Workflow logistics:
Requirements before starting group:
• Patients attend individual appointments with both the OBOT RNCM who determines appropriateness of patient for group and the B/N-prescribing primary care provider.
• Patients begin B/N prior to starting group and are given a bridging prescription until the start of their first group where subsequent prescribing occurs.
• After starting B/N, patients receive follow-up telephone call 3–5 days later.[12,20,21]
When prescriptions are provided: At the end of group
Individual visits offered: Yes, 3–4 patients are seen individually for 15-minute appointments after the group (identified ahead of time by the B/Nprovider and as needed)

Monitoring and management:
Toxicology testing: Urine toxicology samples are obtained prior to the start of each group.
Patient incentives for doing well: Patients can be spaced out to less frequent visits based on urine toxicology testing results (must be free of all nonprescribed substances, including marijuana), 75% attendance rate, respectful patient behavior, and social and functional outcomes (jobs, family and child care, housing). Generally, patients must be in weekly group for 1 year before receiving privileges. These criteria have been developed by the treatment team as part of general patient expectations. The team can exercise discretion in applying them at the individual patient level.
How patients who are struggling are handled: Patients are called by the physician or nurse or pulled aside before or after group to discuss enhanced support, such as referral for an individual psychotherapist, 12-step meeting attendance, or advancement to a higher level of addiction care.
Team coordination: Team members meet weekly to monthly (as needed) to discuss individual patients needing more support and develop plans for each.

Sustainability
Billing for group: Internal Medicine physician bills 99213 for all patients seen in group/99214 if patients are also seen individually after group, consistent with current Medicare rules around CBT billing and coding.[18]
Duration this model has existed: 3 sites included in this model: 2, 8, 9 years
Number of patients treated in group: The RNCM carries 100–200 patient case load on average at any given point in time.

Table 2.

Model #2: “Mixed” shared medical appointments without individual appointments.

General overview and unique features:
In this model, group visits take the form of shared medical appointments, in which the group visit focuses solely on addiction care and no individual appointments are offered in conjunction with group. Patients’ medical care is maintained by their on-site primary care physician.
This model has been set up within a family medicine residency training clinic. Patients in early recovery are cared for by a team of providers with addiction experience. Concurrently, family medicine residents learn about addressing addiction care from an interdisciplinary, team-based group visit approach. Patients doing well in recovery after 6 months of attending the shared medical appointment can return to their on-site primary care providers (including residents), who prescribe their B/N during the patient’s primary care visits; at that point, the patient no longer is required to attend the group.

Pros:
• The addiction-only focus of group allows patients to maintain connections with their primary care provider.
• Patients in early recovery receive care from a team of providers with more experience working with patients with OUD than most other on-site providers.
• Residents get training in managing patients in early recovery and later get experience building addiction care into regular primary care appointments.
• “Mixed groups” allow those patients with more experience in recovery to serve as mentors to those in earlier recovery, benefiting both types of patients.
• Robust team coordination can help support patients with psychosocially complex problems.
• The clinic provides increased access to care in which 8–16 patients can be receive treatment for OUD (with both pharmacological and behavioral support) in a 1-hour period of time.

Cons:
• Patients with acute or chronic medical complaints must make separate appointments and cannot expect these medical issues to be addressed during or around the time that the group visit is offered.
• With “mixed” groups, patients at more advanced stages of their recovery who attend less frequently might feel less connected to group members in earlier stages who attend more regularly; they might develop less group investment.
• Since the shared medical appointment model is the only way to access OUD treatment at this site, this model offers little flexibility to patients unable to participate in group for various reasons (such as scheduling and language barriers and cognitive/emotional concerns).

Personnel and resources
Provider type: 1 family medicine physician or 1 PA (each assumes primary leadership for 2 groups/week); 4 backup B/N providers
Behavioral health provider type: +/− psychologist (facilitates every other week)
Other staff: 1 OBOT RNCM, 1 designated medical assistant (with backup, 2 designated front desk staff
Total resources: This site dedicates two 4-hour clinic sessions to GBOT per week. There are two primary care providers each using 1/8 full-time equivalent (FTE), 2 psychologists each using 1/8 FTE, 1 designated medical assistant and front desk staff, each using a total of 1/5 FTEs to meet this need. The OBOT RNCM serves in a full-time role (with a caseload of about 125 patients).

Patient mix andgroup format
Type of group: Mixed (patients in different stages of recovery); patients attend either weekly, biweekly, monthly, or every other month, based on their earned privileges. Patients included those with OUD and/or alcohol use disorder (AUD), taking B/N or IM naltrexone.
Number of weekly groups offered: 4; one group is offered after work hours to accommodate patients who are working
Length of group: 60 minutes
Average number of patients in group: 8–16
Psychotherapy techniques utilized: Mix of psychoeducational, support, skills development, and cognitive behavioral therapy

Workflow Logistics:
Requirements before starting group:
• Patients attend individual appointments with both the OBOT RNCM who determines appropriateness of patient for group and the B/N-prescribing primary care provider.
• Patients begin B/N prior to starting group and are given a bridging prescription until the start of their first group where subsequent prescribing occurs.
• After starting B/N, patients receive follow-up telephone call 3–5 days later.[12,20,21]
When prescriptions are provided: At the end of group
Individual visits offered: No. Patients with acute issues are booked with any available provider in clinic; patients with chronic issues are booked with their primary care provider.

Monitoring and management:
Toxicology testing: Urine toxicology samples are obtained prior to the start of each group.
Patient incentives for doing well: Patients are reevaluated at 12-week intervals and those who are deemed to be doing well are allowed to come less frequently: every other week, then monthly, then every 2 months. Once they are spaced out to monthly appointments (and after attending the group for a minimum of 6 months), they are given the option to leave group and receive their addiction care and B/N prescriptions from their primary care provider at individual appointments but will return to the group visit if they do poorly individually.
“Success” in recovery is based on urine toxicology testing results (patients must be free of all nonprescribed substances, cannabis is not included), 100% attendance rate, respectful patient behavior, and social and functional outcomes (jobs, family and child care, housing). These criteria have been developed by the treatment team as part of general patient expectations. The team can exercise discretion in applying them at the individual patient level.
How patients who are struggling are handled: Patients are called by the physician or nurse or pulled aside before or after group to discuss enhanced support, such as referral for an individual psychotherapist, 12-step meeting attendance, or advancement to a higher level of addiction care.
Team coordination: Team members meet twice/week—1 meeting after each of the 2 back-to-back groups—to discuss patient care, particularly those needing more support, and to plan operational/logistical issues.

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Sustainability

Billing for group: The family medicine physician or PA bills 99213 for all patients seen in group.
Duration this model has existed: 4 years
Number of patients treated in group: The RNCM carries on average 100–200 patient caseload at any given point in time.

Table 3.

Model #3: Group psychotherapy coupled temporally with individual primary care visits.

General overview and unique features:
All patients with OUD are referred to one of the onsite B/N-prescribing physicians and also to the local integrated therapists when needed. Patients attend individual appointments with the physician, and groups are held separately, run by a psychotherapist and offered around the same time of the individual appointment. Every patient with addiction is welcome and encouraged to attend group, but only those requiring extra support and structure are required to attend as a condition for remaining in treatment.

Pros:

• Primary care providers with minimal addiction training can still offer addiction support at their site by referring to the B/N-prescribing providers and available groups.
• Patients who are unable to attend the group sessions (due to schedule/logistics or cognitive/emotional concerns) are still able to get their addiction care needs met, thus increasing access to B/N treatment.
• Uncoupling individual appointments from group visits allows patients to benefit from increased access to group psychotherapeutic support while receiving medical management frequency that is tailored to their status in recovery.
• Patients struggling in their recovery can be addressed at an individual level, in a more private setting than would otherwise be allowed through a shared medical appointment visit approach.
• For the prescribing physicians, knowing that patients will have additional support and monitoring from the therapist leading the group allows them to tailor discussion in their 1:1 time to issues that cannot be addressed in group. It also fosters clinically sophisticated team-based care, in which therapist and physician discuss patient care and share ideas and expertise.
• From a clinical sustainability perspective, services are billed for both an individual physician visit as well as a group therapy session. Coordinating these appointments in the same half-day improves attendance at both.
• For this type of coordinated care to work optimally, time should be allocated for the therapists and prescribing physicians to discuss challenging cases. However, even when time is not formally allocated, the ease of “on-the-fly” conversations in a primary care practice with fully integrated behavioral health services allows for informal care coordination to occur.

Cons:

• This model may discourage other providers from incorporating care for patients with OUD into their practice, since they may feel under-equipped if their clinical availability does not coincide with the therapist-led groups.
• Patients required to attend group must attend a separate individual appointment to receive their B/N prescription; thus, there is an extra time requirement.

Personnel and resources

Provider type: 2internal medicine physicians; 2 backup B/N providers
Behavioral health provider type: 1 psychologist
Other staff: 1 OBOT RNCM, 1 medical assistant partnered with prescribing B/N physician for that session, usual clinic front desk staff
Total resources: This site dedicates two 4-hour clinic session to GBOT per week; there are two primary care providers each utilizing 1/8 full-time equivalent (FTE), a psychologist using 1/4 FTE, a medical assistant and a front desk staff member,each using 1/10 FTE. The OBOT RNCM serves in a full-time role, carrying about 125 patients.

Patient mix and group format

Type of group: Mixed (patients in different stages of recovery)
Number of weekly groups offered: 2; one group is offered after work hours
Length of group: 60 minutes
Average number of patients in group: 5–10
Psychotherapy techniques utilized: Cognitive behavioral therapy with a concentration on mindfulness, support, and skills development

Workflow logistics:

Requirements before starting group:
Patients attend an individual appointment with the B/N-prescribing primary care provider (PCP). They are either referred by a PCP in the same clinic (who continues to manage patients for their non-addiction-related medical care) *or* the B/N-prescribing physician becomes these patients’ PCP (among new patients or those who have minimal connection to their previously assigned PCP).
When prescriptions are provided: At individual appointments with the B/N-prescribing physician. For patients who have seen the prescriber prior to group, they get their prescription at the end of group via the OBOT RNCM.
Individual visits offered: Yes. The B/N-prescribing physicians see patients with OUD individually during two designated half-day clinic sessions per week, coupled temporally with a group psychotherapy session run by the behavioral care provider. Most patients are required to attend group. Those deemed stable in their recovery or whose work schedules preclude group attendance are booked for individual appointments and, per the B/N-prescribing providers’ discretion, do not have to attend the group. The B/N-prescribing physicians will also see patients during other clinical hours throughout the week in order to accommodate those unable to attend the sessions exclusively designated for addiction care. Individual appointments are 20 minutes long and include urine toxicology testing, review of prior testing results, management of the patients’ addiction and other medical problems, and prescribing of B/N. If the patient has a different PCP, the B/N prescriber focuses on their addiction management and defers other medical care to the designated PCP.

Monitoring and management:

Toxicology testing: Urine toxicology samples are obtained prior to each individual appointment.
Patient incentives for doing well: As patients get more stable in recovery, their visit intervals are increased, and they may no longer be “required” to attend groups. In general, patients attend group on the day they are seeing the prescriber for an individual visit. Some patients attend group more often than just the days of their individual visits, and all patients are welcome to attend as often as they want.

How patients who are struggling are handled: Patients are addressed at individual appointments with the B/N-prescribing physician. Patients in need of more recovery support are asked to see their team more often (the shortest possible visit interval is weekly appointments); those needing more support are referred to an individual psychotherapist, 12-step meeting attendance, or an advanced level of addiction care.
Team coordination: The integrated behavioral health care provider and B/N provider coordinate patient care on an as needed basis through electronic health record messaging and also via informal "on-the-fly" conversations.
Billing for group: The psychologist bills 90853 for patients seen in group; the internal medicine physician bills 99213 or 99214, depending on level of complexity, for patients seen individually by the primary care provider before or after group.
Duration this model has existed: 3 years
Number of patients treated in group: The RNCM carries on average 100–200 patient caseload at any given point in time.

Table 4.

Model #4: Group psychotherapy coupled temporally with individual outpatient psychiatry visits at a specialized, outpatient addiction clinic.

General overview and unique features:
For patients who need a higher level of addiction care and psychiatric support than our primary care sites can provide, our system offers group visits at a separate, specialized Outpatient Addictions Services facility in the Department of Psychiatry. Group visits are provided via a continuum of weekly, biweekly, and monthly groups. This site also runs an IOP that offers 3 hours of group visit programing for 3 days a week. Most patients enroll for 4 weeks.
Patients who cannot tolerate or do not benefit from the group approach can be seen for individual therapy appointments.
This "higher level of care" option is thus able to tailor substance use treatment to individual patient needs.
Pros:
• "Higher" level of care is provided by a robust team with significant training in substance use disorder (SUD).
• Patients attending group visits for addiction also receive additional individualized appointments for both their addiction and associated psychological comorbidities, providing more comprehensive and in-depth approach to management.
• Uncoupling individual appointments from group visits allows patients to benefit from increased access to group psychotherapeutic support while receiving medical management frequency that is tailored to their status in recovery.
Cons:
• Location: Because the specialty program is in a separate location (city) than many primary care offices, patients accessing these services might find them inconvenient.
• Separate appointments (group psychotherapy, individual appointments with the psychiatrists for B/N prescribing, and individual appointments with psychiatric nurse practitioner for psychopharmacology) require more investment of patient time.
• Primary care services occur separately.
Personnel and resources
Provider type: 7 total B/N-prescribing providers including addiction psychiatrists, psychiatrists, and psychiatric residents; 1 person assumes "backup" role each weekday.
Behavioral health provider type: 2 full-time and 3 part-time licensed independent clinical social workers, 1 nurse practitioner, and a part-time psychologist all contribute to running the groups.
Other staff: 1 OBOT RNCM, 1 medical assistant, 1 clinic front desk staff, 1 OBOT RNCM
Total resources: Because Outpatient Addiction Services focuses solely on care for patients who struggle with SUDs, staff are hired to meet this need to provide approximately 20 groups per week. This includes 7 full-time equivalents (FTEs) for B/N-prescribing providers, 3 FTEs for licensed independent clinical social workers, 1 FTE for the nurse practitioner (NP), ½ FTE for the psychologist, 1 FTE for the medical assistant, 1 FTE for front desk staff, and 1 FTE for the OBOT RNCM.
Patient mix and group format
Type of group: Leveled[19] (patients in similar stages of recovery); weekly, biweekly, monthly groups offered.
Number of weekly groups offered: 26 groups; 17 groups (plus an additional 9 offered through IOP).
Length of group:60 minutes. The IOP consists of 3 consecutive groups from 9 am to noon every Monday, Wednesday, and Friday.
Average number of patients in group:10 (this is the cap per state Medicaid rules)
Psychotherapy techniques utilized: A mix of psychoeducational, support, skills development, cognitive behavioral therapy, dialectical behavioral therapy,[22] Internal Family Systems,[23,24] mindfulness,[25] and contingency management.[26]
Workflow logistics:
Requirements before starting group:
• Patients enter via referral from primary care or B/N-prescribing providers within the system ("step-up" approach) or from detoxification, psychiatric hospitalization, or addiction treatment facilities (a "step-down" approach).
• Intakes occur through several venues: at a designated "walk-in" clinic offered once a week or at direct appointments, referred from outpatient or inpatient psychiatry within our system.
When prescriptions are provided:
• Patients have B/N intake with an addictions psychiatrist, a general psychiatrist, or a psychiatry resident and receive their first prescription.
• The RNCM conducts in-office inductions or observed dosing when medically appropriate.
• B/N prescriptions are picked up at groups early in treatment, and then continued B/N prescriptions are provided in individual appointments outside of group by on-site psychiatrists and PGY4 psychiatry residents once stable pattern of group attendance is established.
Individual visits offered: Yes. Individual appointments are provided: B/N-prescribing psychiatrists generally focus solely on managing OUD and other co-morbid substance use disorders, the nurse practitioner focuses on non-B/N psychopharmacologic medications, and psychologists and social workers provide individual therapy and manage individual case coordination.
Monitoring and management:
Toxicology testing: Urine toxicology; frequency is determined by patient risk (based on developed algorithm with weekly for high-risk, biweekly for moderate-risk, and monthly for low-risk patients).
Patient incentives for doing well: Group attendance and urine toxicology screen results are used to determine frequency of B/N prescriptions. Groups attendance, urine toxicology screen results, stabilization of mental and physical health, and achievement of individualized goals are used to identify when patients are ready to move to the next level of group treatment.
How patients who are struggling are handled: Patients who are struggling with ongoing opioid use or other high-risk substance use may have frequency of group treatment increased, frequency of individual visits increased, frequency of urine toxicology screens increased, and length of B/N prescriptions shortened. B/N dose may be increased if indicated. Other levels of care will also be considered including referrals to a detoxification program for co-occurring SUD, residential treatment, or methadone maintenance.
Team coordination: Care coordination occurs during a weekly clinical multidisciplinary team meeting among all team members with timed drop-in visits from B/N prescribers.

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Billing for group: Individual psychiatry visits are billed using CPT codes 99213 or 99214. Group visits run by social workers, psychologists, or clinical nurse specialists are billed as 90853. The IOP is billed as a bundled group visit with the code of H0015.
Duration this model has existed: 12 years
Number of patients treated in group: The RNCM carries on average 100–200 patient caseload at any given point in time.