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ORIGINAL RESEARCH

Patient Perspectives on a Rapid Access, Walk-in, Medication for Addiction Treatment Clinic

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Purpose: Rapid access addiction medicine (RAAM) walk-in clinics offer low-barrier, prompt treatment for substance use disorders (SUDs). These models differ from bridge clinics, which primarily address the barriers of transitioning between inpatient and outpatient SUD treatment settings. Previous RAAM models have been shown to be effective in urban areas. Through patient interviews, this qualitative study sought to describe the unique challenges and successes of a RAAM clinic that serves a primarily rural area.

Patients and Methods: Adult patients with a SUD who utilized a medication for addiction treatment (MAT) walk-in clinic participated in semi-structured, recorded interviews. Participants were asked about facilitators and barriers to attaining treatment, as well as their perspectives/experiences and unmet wants/needs. Interviewee responses were transcribed, qualitatively coded, and analyzed for prominent trends.

Results: Twelve patients participated. Stigma, lack of rural treatment options, and accessibility concerns were identified as general barriers to receiving SUD care. MAT walk-in clinic specific barriers included distance to clinic, clinic hours, and transportation. Patients identified the clinic's walk-in structure as a primary facilitator of receiving quality SUD care and felt the clinic offered a non-judgmental and accessible environment, differing positively from past treatments. Unmet wants and needs that patients identified included more extensive social services and communication after leaving the clinic.

Conclusion: This MAT walk-in clinic is the only RAAM-style clinic offering same-day dual-diagnosis medication management in the state of Iowa. The walk-in structure was a key facilitator for patients accessing initial care. Expanding RAAM models in rural areas and incorporating telehealth may help address proximity barriers reported by patients.

Keywords: substance use disorders, qualitative evaluation, rural health

Introduction

Meeting individuals where they are is a tenet of patient-centered treatment. Considering only 23.6% of individuals in the United States with a substance use disorder (SUD) received any treatment in 2023,[1] it is of high public health importance to maximize motivation for recovery when it presents. Offering addiction care that is low-barrier, convenient, and easy to navigate is one potential solution. Shifting from appointment-based care to walk-in care is a novel approach that allows for patients previously unknown to the healthcare system to present, receive the current standard of care, and connect with long-term treatment.

Emergency departments (EDs) have historically offered walk-in services, initiating patients on medications for addiction treatment (MAT) and referring to subsequent outpatient treatment.[2] However, this places an onus on emergency providers to facilitate addiction treatment for a high volume of patients. Substance use-related ED visits rose 45% from 2013 to 2018.[3] The COVID-19 pandemic also coincided with a significant increase in substance use-related ED visits.[4] Decreasing ED burden is beneficial to all of healthcare,[5] but can only be achieved when patients have alternative treatment options.

People who use drugs (PWUD) have also reported feeling stigmatized in EDs, contributing to some patients leaving without treatment or delaying care entirely.[6,7] Negative attitudes by healthcare professionals towards PWUD are not

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unique to the ED, and have been seen throughout many care settings.[8] This also intersects with pre-existing healthcare disparities experienced by those with addiction.[9]

To address these concerns, a model of rapid access addiction medicine (RAAM) clinics was created. Originating from Canada, RAAM clinics are staffed with a multidisciplinary team, connected to primary care for longitudinal addiction follow-up, and offer walk-in hours.[10] A retrospective cohort analysis of 876 patients showed that RAAM utilization had significantly reduced odds of any ED-visit, hospitalization, or death.[10] Another specialized RAAM clinic aimed at diverting patients from the ED for alcohol-related causes led to a 10% reduction in ED return visits. This clinic required an ED referral, however, and notably, 40% of patients never presented.[11] The RAAM model differs from typical bridge clinics, which primarily serves to fill gaps in care continuity and minimize delays by providing a transitional setting between inpatient and outpatient care.

Notably, RAAM clinics primarily exist in major cities with public transportation, which supports individuals without other means for travel. We sought to create a low barrier, walk-in MAT clinic—staffed by addiction-trained physicians, case managers, and peer recovery specialists—to serve a primarily rural, midwestern United States population. A subset of patients who visited our clinic were assessed on their experiences through semi-structured interviews. We hypothesized that there was an unmet service need for PWUD and/or alcohol, and that a clinic with walk-in hours would help narrow this treatment gap.

Methods

Setting

The MAT walk-in clinic was established in December 2021 as an extension of the already existing university-based clinic to reduce barriers in accessing addiction treatment. The existing MAT clinic scheduled new appointments through provider, community, and self-referrals. The clinic also facilitated MAT initiation in the ED and offered care coordination and mutual support services. Although our clinic is located in urban Iowa City and part of University of Iowa Health Care, this system serves as a primary regional referral center for many patients who live in the surrounding rural areas.

As the existing MAT clinic became more established, new delays in care were identified. Many patients seeking MAT were waiting weeks for initial appointments, and buprenorphine initiation in the ED was often limited by historic buprenorphine-waiver requirements and providers' lack of comfort with unobserved initiations. The new walk-in clinic was established at a community outreach site affiliated with the academic hospital. This location was selected due to there being available clinical space, the department wanting that space to be primarily in-person, and onsite laboratory services. Authors AW, BM and NLB were initial physician members of the clinic, providing both short-term (ambulatory withdrawal management) and long-term (MAT, mental health medication) treatments for co-occurring disorder. The MAT walk-in clinic also employed case managers who provided care coordination, connection to social services, financial assistance, scheduling, and transportation services. Peer recovery specialists, who were in recovery from substance use disorder(s), were also available to clients. PRSs offered mutual support, mentorship, and access to community recovery resources and counseling.

Participants

Participants were 18 years or older, had an active SUD as defined by the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5),[12] and had attended at least one appointment with the walk-in MAT clinic between December 2021 and December 2022.

Patients provided verbal informed consent to be recorded and for their anonymous responses, including quotes, to be used in research publications. The University of Iowa Institutional Review Board deemed the study Not Human Subjects Research and waived the requirement for written consent due to the voluntary nature of participation, absence of identifiers, and the study's quality improvement focus. This study complies with the Declaration of Helsinki.

Data Collection

All 132 patients who had presented to the MAT walk-in clinic between December 2021 and December 2022 were initially recruited for this study via email. Twenty-one patients responded to the initial recruitment message, but nine of

these patients were unable to be reached via email or phone to schedule an interview. One-on-one virtual interviews (via phone and video call) were conducted by author LP with the remaining twelve patients. Population size of this study was limited by time constraints as well as participant responses. Many of the patients contacted had presented initially for walk-in appointments but were either no longer following with our clinic, non-responsive to follow-up recruitment communication, or unable to participate due to the time required to conduct a detailed interview.

All participants received $30 as a check or gift card in compensation for their feedback. Interviews were conducted in a semi-structured manner following the interview protocol (interview template available as Supplemental Table 1), as well as variable follow-up questions based on patient responses. Interviews were recorded and uploaded to Otter.ai[13] for transcription. Transcripts were then reviewed manually and edited for any transcription error.

Data Analysis

Initial codes were developed using an integrative inductive-deductive approach through initial review of recorded interviews as previously done by Bradley et al.[14] This approach to creating a codebook involved establishing broad themes for analysis prior to data collection, then subsequently reading through interview transcripts and selecting sub-themes (within our established categories) that emerged from data review. Thus, prior to coding, both coders (LP, NLB) read through all interview transcripts once. Each coder then reviewed the transcripts a second time to create individual code books structured around four a priori categories: barriers, facilitators, perspectives/experiences, and unmet wants/needs. Coders met to discuss and combine individual codes into one shared codebook. This codebook was used by both coders to individually code each interview using Dedoose.[15] Coders then met to discuss and reconcile both sets of coded excerpts. The final data set was reviewed, and redundant excerpts and unused codes were removed.

Results

Twelve individuals participated (8 female, 4 male) with a mean age of 41 (SD: 9.8) years. Eleven participants were residents of the state of Iowa, with one being a resident of Illinois. All patients were diagnosed with opioid use disorder and received buprenorphine prescriptions at their first appointment. Two patients received concurrent psychiatric care at their initial visit. Seven participants attended a one-week follow-up appointment, while five patients did not.

Four parent codes (barriers, facilitators, perspectives/experiences, and unmet wants/needs) were used to organize the data. Following data analysis, codes within "barriers" were further divided into two main themes: barriers to receiving general SUD treatment, and barriers to receiving care at the walk-in MAT clinic.

Barriers

General SUD Treatment barriers

Half of participants endorsed experiencing stigma in past SUD treatment encounters (see Figure 1). These included worries that healthcare professionals would "find out" about their substance use or their method of use (eg, injection). Individuals worried that their care quality would be subsequently negatively impacted after being labelled a "drug addict". Interviewees reported concerns that healthcare providers would assume they were "looking for drugs", including experiences with a pharmacy telling a patient they were trying to get medication "too early". Patients were concerned with how a chart diagnosis of SUD would be perceived by future providers. One interviewee felt they previously received inadequate emergency department care due to their documented history. Stigma was also reported as coming from peers and outside therapy providers regarding being on MAT, including the perception that patients on buprenorphine were "still getting high".

Eight (67%) participants reported difficulty in receiving SUD care within their hometown or the state of Iowa broadly (see Figure 1). Several patients noted that if the MAT walk-in clinic had not been an option, they "probably would not have" received any addiction care. Patients felt that clinics closer in proximity required them to "jump through all these hoops" to obtain a prescription. Patients also voiced difficulty receiving MAT from their primary care physicians, which was compounded by a lack of healthcare options in general. One interviewee reflected that in their town, "we don't even have a hospital."

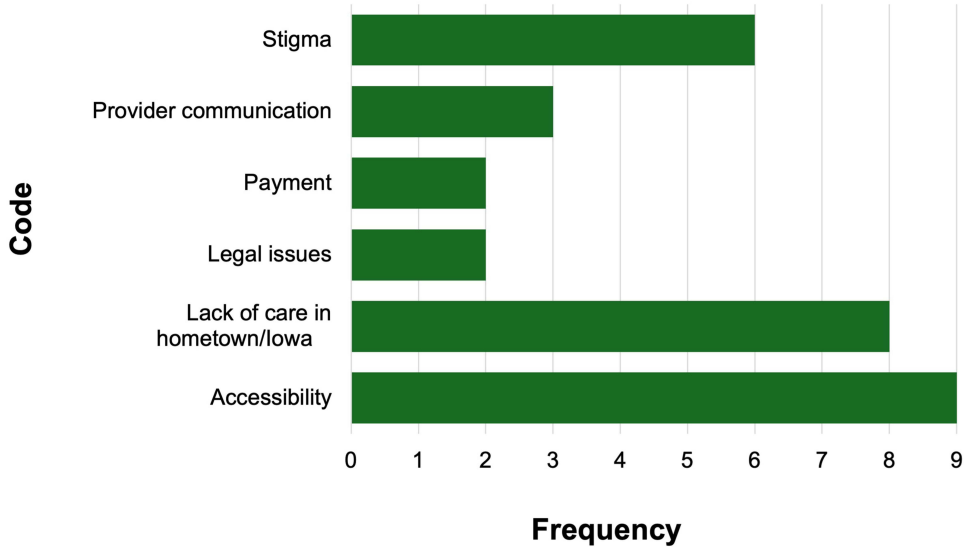

Figure 1 Patient-identified barriers to accessing addiction care in the past.
Notes: Twelve patients who attended a walk-in medication for addiction treatment clinic between December 2021 and December 2022 were interviewed regarding barriers to previously accessing addiction care. Patient responses were coded into prevalent themes.

Accessibility concerns were often cited as barriers to prior SUD treatment. These included extended wait times, inconsistent transportation, high prescription costs, and regulations around medications. One interviewee struggled with consistently attending daily methadone dosing appointments, which led to mandated dose reductions. Another participant reported strict rules regarding buprenorphine:

> I would have to go to group four nights a week after work… bring all three of my [medications] and take them [at] one time in front of the counselor.

MAT Walk-in Clinic-Specific Barriers

Patients cited distance, clinic hours, and transportation as key barriers to accessing the MAT walk-in clinic. Seven participants (58%) reported that the distance they had to travel to the clinic made it difficult to receive prompt care (see Figure 2).

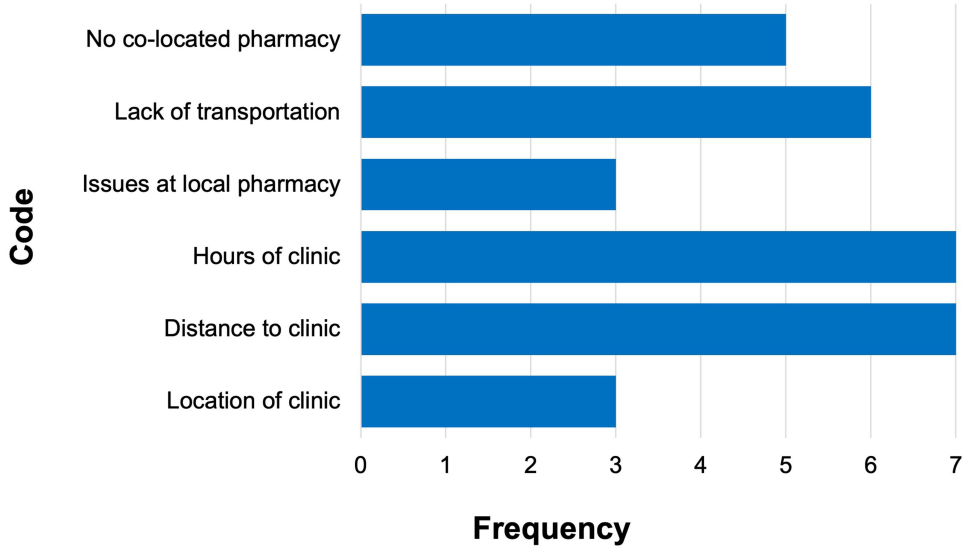

Figure 2 Patient-identified barriers to receiving care at the MAT walk-in clinic.
Notes: Twelve patients who attended a walk-in medication for addiction treatment clinic between December 2021 and December 2022 were interviewed regarding barriers to accessing addiction care at the MAT walk-in clinic. Patient responses were coded into prevalent themes.

Participants travelled for an average of 87 (SD=66) miles to reach the clinic. This was especially challenging for the six participants who did not have access to reliable transportation (see Figure 2).

MAT walk-in clinic hours (Wednesday afternoons) also posed a challenge to patients who had prior commitments. Patients reported conflicts with employment: "usually I work Wednesdays" or "only having one day kind of sucks". Patients also reported needing to travel on short notice:

> We didn't find out about the place until Wednesday morning. So we had to, you know, kind of rush and hurry and get up there.

Five participants (42%) cited difficulties with not having a co-located pharmacy at the clinic where they could pick up medication (see Figure 2). This particularly impacted individuals who were hoping to start buprenorphine that day and were experiencing opioid withdrawal. Patients obtained their prescriptions either at local pharmacies or the university's main hospital pharmacy. Respondents voiced concern that their local pharmacies would not stock MAT. Additionally, multiple people reported that travelling to the university's main hospital, navigating parking, and the overall size of the hospital compounded difficulties with obtaining their initial prescription.

Facilitators

All patients were asked about how they first heard about the walk-in clinic. These sources included family, other medical providers, harm reduction organizations, and the clinic's website. However, the clinic's walk-in structure was the most frequently reported facilitator for receiving care (see Table 1). Patients valued there being no referral or appointment requirement. Many patients presented on the earliest walk-in date available after having heard about the clinic. Several patients felt relief and gratitude about having expedited access to care to quickly treat withdrawal symptoms:

> that was my breaking point…nobody knew what to do…it just so happened that the clinic was open that day, and that I was able to get in there.

Another participant reported the walk-in clinic structure allowed them to seek care as soon as they had made the decision to do so:

> if I had to set an appointment that was, you know, two or three days out, that gives me time in between to change my mind or come up with an excuse.

Perspectives/Experiences

Patient perspectives/experiences with the MAT walk-in clinic were overwhelmingly positive and focused heavily around feeling comfortable and accepted. Patients also reported satisfaction regarding staff interactions, acquiring an initial prescription, and establishing follow-up care (Table 2). Ten participants (83%) specifically reported feeling heard or being grateful for a lack of judgment. Patients even expressed surprise with the clinic environment as they had explicitly expected bias or admonishment for their substance use history. Ten patients (83%) reported that their experience at the MAT walk-in clinic differed from past treatment in a positive manner.

Table 1 Selected Patient Quotes on the Walk-in Structure of the MAT Clinic

"I kind of have a problem like sticking to appointments, so, having that be open is really nice."
"It was helpful that way I could get in…sooner than later."
"I think my doctor told me they're open, you can just go on over."
"It just so happened that the clinic was open that day. And that I was able to get in there."
"It was just easier for me to…fit it into my schedule, because I could go anytime."

Notes: Twelve patients who attended a walk-in medication for addiction treatment clinic between December 2021 and December 2022 were interviewed about their experience with the clinic's walk-in structure. Interview excerpts were obtained from 5 individual interviewees.

Table 2 Selected Patient Quotes Regarding Perspectives and Experiences at the MAT Walk-in Clinic

Differs from past treatment	There's nothing out there like Iowa City available to people.
Ease of continued care	"A lot of the times, like I continued care only because they reached out to me, like in the very, very beginning a couple of times." "I think I had two or three in person visits and then the rest were through telehealth because they know we're two and a half, three hours away." "They made sure I never ran out of meds even if it was like, just giving me a week at a time until I had my appointment."
Ease of obtaining MAT prescription	"I could, you know, go up and get my meds and then not have to worry about it for a month." "[Physician] was really quick to get my medication sent to the pharmacy and get it filled, so I could start to feel better." "I just thought it was kind of nice that they were like… here's the option, you can do it today. That way you can start today, you're not waiting for a couple of days for your pharmacy to order whatever."
Feeling comfortable	"From the minute I walked in, I felt like okay, this is, this is it. After, I like, I instantly, like I didn't physically like, get better, obviously. But I instantly felt relieved." "They…made me feel comfortable, like I could be open and honest, about, you know, my past."
Feeling heard/lack of judgment	"For the first time, somebody was listening to me." "I don't have to worry about [physician] judging me or taking away my care." "I felt like, embarrassed, and I felt ashamed. So having somebody that told me that I didn't have to feel like that made 100% difference." "They didn't treat you like a drug addict like a lot of places do…They actually listened and had conversations with you."
Peer recovery specialists	"I cannot remember the gentleman's name, but he introduced himself and he shook my hand. And he said that he'd been on maintenance treatment for the past 20 years of his life. And he said, it's, it completely saved his life. So that right there, I was, like, I am gonna give it a shot." "He would call me, you know, periodically throughout the week and be like, hey, you know, like, how's it going? Like, what's going on? You know, any questions?" "When I was talking to [peer recovery counselor] the one time he's like, Dude, I do not care if it's three o'clock in the morning, and you are, you know, you are about to do something stupid. He's like, call me. Like, I mean, it was that—I mean, that level of dedication."
Questions and understanding	"[Case managers] were always just a text away. And they always, you know, cleared anything up for me if I had any questions." "[Physician] made sure I understood what she was talking about."
Recommend/visit again	"If the time comes…I'd recommend it to anybody." "[MAT clinic] would be the first piece I would go. And if I knew anybody that was struggling that needed help, I would refer them immediately." "I've actually, have recommended it to a few people? A few family members."

Notes: Twelve patients who attended a walk-in medication for addiction treatment clinic between December 2021 and December 2022 were interviewed regarding their perspectives and experiences during treatment. Quotes are organized by code as determined during qualitative analysis. Interview excerpts feature 8 individual interviewees.

Interviewees noted medical staff made it a priority to provide prescriptions quickly and put them at ease with starting new treatments. Providers were described as accommodating and understanding when answering questions about initiating MAT (see Table 2, "Questions and Understanding"). Several patients noted that providers and case managers were easily accessible, responding quickly to unexpected concerns or lapses in continued follow-up appointments (see Table 2). PRSs were cited as an important resource and perceived as friendly and approachable. One participant conveyed that the experience relayed by the PRS served as encouragement to start their own recovery (see Table 2, "Peer Recovery Specialists"). Several patients reported that virtual follow-up appointments made continued care easier after initial walk-in visits. All participants endorsed that they would recommend the clinic to others in need of treatment, or, if they were currently maintained on treatment, that they would visit again if they experienced a lapse in their current care.

Table 3 Selected Patient Quotes Regarding Unmet Wants and Needs at the MAT Walk-in Clinic

Financial assistance	"I do have trouble with like gas and sometimes food." "My Medicaid, it's not going to last like forever because I started working…that could be a problem in the future, especially with paying for medication and everything like that."
Increased contact/ communication	"Maybe more frequent, like check ins? Like, not so much as far as like, hey, come into the office…just calling and just saying like, hey, like, you know, okay, you have been at it, for, you know, a day now or two days now or three days, you know. Like, how do you—how are you feeling."
Methadone	"Or at least the option to, you know, have some type of decision making? To at least be able to have the knowledge to be like, Okay, well, you know what, methadone seems like, it'll work better for me than suboxone would."

Notes: Twelve patients who attended a walk-in medication for addiction treatment clinic between December 2021 and December 2022 were interviewed regarding their unmet wants and needs during and after treatment. Quotes are organized by code as determined during qualitative analysis. Interview excerpts feature 3 individual interviewees.

Unmet Wants/Needs

When asked about unmet wants and needs, patients expressed a desire for more social services, especially financial assistance (see Table 3). Several patients endorsed difficulty affording medication as well as food insecurity. Gas was an additional financial barrier even when a patient had a reliable form of transportation. After being started on medication, four patients (33%) desired more consistent communication about possible adverse reactions, withdrawal symptoms, and delays in acquiring future prescriptions.

Discussion

The University of Iowa MAT walk-in clinic is the only RAAM-style clinic offering same-day dual-diagnosis medication management in the state of Iowa. This project reviewed clinic strengths as well as continued gaps in SUD care patients may have experienced. This study provides preliminary findings which suggest that a walk-in structure was a key facilitator for patients accessing initial care. In contrast, reported barriers to receiving care included affording transportation, distance to the clinic, limited walk-in hours, and the lack of a co-located pharmacy.

Previous literature on low-threshold models in American urban areas have centered around bridge clinics providing transitional care between inpatient and outpatient settings. Qualitative investigations have found that patients may experience difficulties transitioning out of these settings.[16] Other RAAM models have demonstrated continued care after an initial walk-in visit, but still have lost more than half of patients to follow-up.[17] The walk-in model described in this study lowers the threshold to both initial and continued care by 1) being open to all patients who are available during clinic hours regardless of most recent treatment or recovery status, and 2) allowing patients to continue to follow with the clinic for MAT and mental health care after their initial visit. Patients found this model imminently accessible, especially when they were struggling with how to start or maintain their recovery. Of the twelve participants in this study, nine were continuing to follow with clinic providers at the time of interview. The others were either referred to a methadone treatment clinic or later returned to care with primary care providers. This model differs from most traditional bridge clinics as patients were able to continue seeing providers and staff whom they had already established rapport and trust with.

All participants reported feeling comfortable receiving care at the MAT walk-in clinic and valued the interdisciplinary approach. The clinic team included staff physicians, resident physicians, a clinical pharmacist, case managers, and PRSs. This multidisciplinary team provided patients with a point of contact for future questions or concerns. PRSs were viewed as particularly integral, connecting patients with a team member who had shared, lived experience. This is consistent with a recent review, which reported that the use of PRSs improved relationships with treatment providers and increased treatment retention and satisfaction.[18]

Previous qualitative studies indicate that patients value harm-reduction approaches and compassionate care integrated into low-threshold treatment settings.[16] Our patient responses also reflect this. Many participants expressed positive differences in their care at the MAT clinic when compared to previous experiences trying to obtain MAT. Patients appreciated the emphasis on immediate access to medication without requiring in-person observation (ie, home induction) or inpatient treatment

completion, features that had previously served as barriers to maintaining recovery. Our sample was small and also heavily weighted towards opioid use disorders. Recent findings highlight that the prompt utilization of MAT is a key mechanism to improve outcomes.[19]

The described clinic uses telehealth commonly for follow-up visits. Walk-in clinic patients with long commutes or transportation barriers found virtual visits essential for maintaining follow-up and recovery. Patients valued providers' flexibility in offering telehealth for MAT prescriptions, viewing it as a harm-reduction practice. Similarly, studies regarding the shift to virtual care during the COVID-19 pandemic found that patients frequently preferred telehealth and valued the mutual trust it fostered.[20] Virtual visits may also serve as one solution to the walk-in clinic barriers identified by study participants, as the clinic's location essentially necessitated travel by private vehicles. This is a common barrier for patients living in areas with limited public transportation. Notably, as the average distance traveled to the clinic was nearly 90 miles, most patients in our sample would not have benefitted from a more robust local transportation infrastructure. In a study examining over 20,000 patients prescribed methadone, those residing in the Midwest had greater distance traveled to access opioid treatment.[21] While patients identified the success of our model by describing the MAT walk-in clinic as a unique provider of both accessible and quality care, this also suggests the need for a greater number of similar models in the Midwest.

Other areas identified for improvement of the MAT walk-in clinic included establishing a co-located pharmacy and providing more medication options, including methadone. While our study population reported filling prescriptions at local pharmacies or the university main hospital pharmacy, many walk-in clinic patients utilize the pharmacy at a third location, a university clinic building that is smaller than the main hospital and easier to navigate. Our study did not include patient perspectives on this third location. The MAT walk-in clinic was also unable to offer methadone as the university was not designated as a federally certified opioid treatment program at the time of this investigation. Thus, our clients who desired to pursue treatment with methadone necessitated referral to other local treatment centers. A few patients also desired to have more regular communication with the clinic, which further highlights the challenges of serving widely distributed patients. These patients often rely on phone calls or messaging to communicate with staff and may go for extended periods between in-person visits. Of note, our clinic does use an interdisciplinary team involving staff such as case managers who field and triage patient inquiries and concerns. Expansion of these services may help address these barriers.

This study does have limitations. The sample size was not large enough to draw definitive conclusions about the clinic's overall efficacy during its first year of operation. However, findings suggest that the clinic addressed a critical gap in immediately accessible substance use treatment in Iowa. The lack of similar clinics in Iowa prevents direct comparison to alternative options. Our data also offers valuable preliminary insight into the clinic's successes and suggests areas for quality improvement. Our limited sample was related to difficulty with recruiting patients for extended qualitative interviews. Study participants were identified by emailing all those who accessed the clinic during a set timeframe and then following up with those who responded. Therefore, it was also not a random selection. These factors may have biased results. A future extension of this investigation could include recruitment of recent patients for a larger sample, incorporating quantitative data of the walk-in model for further analysis, and recruiting participants more consistently following their initial presentations. Rural barriers to SUD treatment, and subsequent treatment retention with the application of low threshold models, also warrants further investigation.

Conclusion

The MAT walk-in clinic established at the University of Iowa is a unique model of care for both its harm reduction approach as well as its immediate accessibility. Expanding low barrier, rapid access clinics may be particularly beneficial to those living in areas where treatment options and public transportation are limited. Barriers for our model included limited clinic hours, wide geographic distribution of patients necessitating extensive travel times, and less consistent communication with patients. Although limited by sample size, our data suggests that patients found this model to be a supportive, accessible environment that facilitated immediate SUD treatment, with patients expressing high satisfaction with the ease of obtaining a MAT prescription. Patients recommended future improvements such as expanding the range of offered medications for addiction treatment and enhancing communication and social support services.

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Disclosure

The authors report no conflicts of interest in this work.

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