CME/MOC

Clinician Perspectives on Delivering Medication Treatment for Opioid Use Disorder during the COVID-19 Pandemic: A Qualitative Evaluation

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Objective: The coronavirus disease 2019 (COVID-19) pandemic necessitated changes in opioid use disorder care. Little is known about COVID-19's impact on general healthcare clinicians' experiences providing medication treatment for opioid use disorder (MOUD). This qualitative evaluation assessed clinicians' beliefs about and experiences delivering MOUD in general healthcare clinics during COVID-19.

Methods: Individual semistructured interviews were conducted May through December 2020 with clinicians participating in a Department of Veterans Affairs initiative to implement MOUD in general healthcare clinics. Participants included 30 clinicians from 21 clinics (9 primary care, 10 pain, and 2 mental health). Interviews were analyzed using thematic analysis.

Results: The following 4 themes were identified: overall impact of the pandemic on MOUD care and patient well-being, features of MOUD care impacted, MOUD care delivery, and continuance of telehealth for MOUD care. Clinicians reported a rapid shift to telehealth care, resulting in few changes to patient assessments, MOUD initiations, and access to and quality of care. Although technological challenges were noted, clinicians highlighted positive experiences, including treatment destigmatization, more timely visits, and insight into patients' environments. Such changes resulted in more relaxed clinical interactions and improved clinic efficiency. Clinicians reported a preference for in-person and telehealth hybrid care models.

Conclusions: After the quick shift to telehealth-based MOUD delivery, general healthcare clinicians reported few impacts on quality of care and highlighted several benefits that may address common barriers to MOUD care. Evaluations of in-person and telehealth hybrid care models, clinical outcomes, equity, and patient perspectives are needed to inform MOUD services moving forward.

Key Words: opioid use disorder, MOUD, telehealth, qualitative, COVID-19

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The emergence of the coronavirus disease 2019 (COVID-19) pandemic amid an ongoing opioid overdose epidemic raised concerns (eg, the effect of social distancing, reliance on in-person treatment, social isolation, housing instability) about access to medication treatment for opioid use disorder (MOUD).[1,2] Moreover, emerging literature on COVID-19 indicates higher drug overdose–related deaths post–COVID-19 onset compared with corresponding months in 2019.[3] Medication treatment for opioid use disorder reduces the risk of opioid use, overdose, and mortality and is a key feature of national efforts to combat a rising trend in opioid overdose deaths in the United States.[4–9] Medication treatment for opioid use disorder consists of formulations of methadone, buprenorphine, and naltrexone.[10]

To reduce the risk of COVID-19 transmission, several temporary changes were made to federal regulations to minimize disruptions in MOUD care.[11,12] One example is the temporary exemption of a Ryan Haight Act of 2008 requirement, mandating an in-person evaluation before prescribing a controlled substance. This temporary exemption permitted clinicians to prescribe buprenorphine using telehealth (telephone or video) for the initial evaluation of new patients.

While information on the effects of COVID-19 on MOUD care in general healthcare settings is emerging, largely from commentaries and surveys, little is known about clinicians' experiences delivering MOUD care during the pandemic.[13–18] Changes in practice noted from a few studies include transitioning at least some MOUD care to telehealth,[13–17] reductions in toxicology testing,[14,16,17] and an interest in continued use of telehealth to deliver MOUD after the pandemic.[14,16] Qualitative methods are an optimal way to identify and conceptualize clinicians' experiences and beliefs or preferences regarding healthcare practices.[19] To date, few qualitative inquiries have focused solely on the experiences of providing MOUD from clinicians in general healthcare clinics during the pandemic.[20–22]

We qualitatively assessed clinicians' perspectives on MOUD care during the pandemic to understand their experiences delivering MOUD, their beliefs about the impact on quality of care, and to identify barriers and facilitators to providing care. Interviews were completed with clinicians at Department of Veterans Affairs (VA) facilities participating in the VA Stepped Care for Opioid Use Disorder Train-the-Trainer (SCOUTT) initiative to increase access to MOUD treatment in general healthcare clinics.

METHODS

SCOUTT Initiative

Information regarding the SCOUTT initiative has been reported.[23,24] Briefly, SCOUTT is a multisite, ongoing, national VA initiative to improve patient access to MOUD (specifically buprenorphine and injectable naltrexone) in general healthcare clinics, defined as primary care, pain, and mental health clinics. The initiative began with a request for all 18 regional VA network Directors to identify one facility and an interdisciplinary team of clinicians and clinical leaders to implement MOUD in at least one general healthcare clinic. The interdisciplinary team of clinicians (or implementation team) was to include a MOUD advocate, also known as a clinical champion, at least one prescriber (ie, physician, nurse practitioner, or physician assistant), a registered nurse, a therapist (ie, psychologist, social worker, or addiction therapist), and a clinical pharmacist. Implementation teams received training in MOUD, stepped care, and models of MOUD care delivery at an in-person conference in August 2018 and subsequently received monthly education, external facilitation calls, and resources from dedicated Web sites. Implementation teams were tasked with implementing MOUD in at least one general healthcare clinic, although several teams implemented MOUD in more than one. While the SCOUTT initiative is ongoing and expanding to additional VA facilities, this evaluation focused on the original facilities that began implementation in 2018.

Setting

The current project is part of a mixed-methods quality improvement evaluation of the initiative in partnership between the VA Office of Mental Health and Suicide Prevention and investigators. Teams aimed to implement SCOUTT in 26 general healthcare clinics (13 primary care, 10 pain, and 3 mental health). Qualitative evaluation efforts were in progress when COVID-19 began, providing an opportunity to revise the interview guide to understand how the pandemic impacted MOUD care. The VA Puget Sound Health Care System Institutional Review Board confirmed that this quality improvement evaluation did not require approval as human subjects' research. The COnsolidated criteria for REporting Qualitative research Checklist (COREQ) was used as a guide to report findings (see PDF, Supplemental Digital Content 1, COREQ checklist, http://links.lww.com/JAM/A416).[25]

Participants and Procedures

We aimed to interview the clinical champion and one other member of each implementation team, using a snowball sampling approach, between May and December 2020. Invitations were sent to clinical champions and to additional implementation team members often identified by clinical champions.[26] Implementation team members were sent up to 3 individualized emails inviting them to participate.

Framework and Interview Guide

The data presented are from questions added to a semi-structured interview guide (see PDF, Supplemental Digital Content 2, interview guide, http://links.lww.com/JAM/A417). The primary question was, "Has COVID-19 impacted delivery of MOUD in your clinic?" If responses did not elicit sufficient detail, structured probes solicited information about future concerns related to COVID-19 and MOUD care, potential impacts to initiations, and telehealth experiences. Although the interview did not distinguish between buprenorphine and injectable naltrexone, buprenorphine was the more frequently prescribed medication.[24]

Data Collection and Analysis

Telephone interviews were conducted individually by research health science specialists, AML and AND, 2 experienced qualitative interviewers. Participants were informed that the interviewers were part of the SCOUTT evaluation team, with a goal to evaluate the implementation of the initiative. There were no direct relationships between the interviewers and participants.

With consent, interviews were audio recorded and transcribed verbatim. Two clinicians declined to be audio recorded, and notes taken during interviews were used as transcripts. Participants completed a demographic questionnaire.

Transcripts were inductively coded and analyzed by AML and EJH in Atlas.ti using template analysis, which involved using a subset of transcripts to develop a coding template, which was then applied to the remaining transcripts.[27] The template was refined throughout analysis and previously coded interviews were reviewed. Discrepancies were resolved through discussion and data review. Thematic saturation was reached.[28,29] The coded data were analyzed to identify and group principal concepts, resulting in several themes and subthemes.[27,30] Together, AML and EJH produced written descriptions of each theme and subtheme.

RESULTS

Table 1 shows the demographic characteristics of clinicians interviewed. Of 39 clinicians invited, 30 were interviewed (76.9%), 1 declined, and 8 did not respond. The average age was 47.7 years (SD, 10.2 years), and the majority were women (56.7%), White (60.0%), and physicians (60.0%). On average, clinicians had been practicing 16.4 years (SD, 9.1 years) overall and 8.9 years (SD, 6.1 years) at the VA. They represented 17 of the 18 VA regional networks (94.4%) and 21 of the 26 general healthcare clinics (80.8%) aiming to implement SCOUTT, including 9 primary care, 10 pain, and 2 mental health clinics.

Average time to complete the interviews was 32 minutes. The analysis identified the following 4 themes and several subthemes: overall impact of the pandemic on MOUD care and patient well-being, with subthemes quality of MOUD care and concerns about patients; features of MOUD care impacted, including subthemes new medication initiations/transfers and monitoring; MOUD care delivery, with subthemes telehealth care, in-person care, and potential improvements in MOUD care; and continuance of telehealth for MOUD care (Table 2). With respect to endorsement of perspectives detailed hereinafter, most is defined as more than 50% of participants (n = 30), many as 20% to 50%, and a few as less than 20%.

TABLE 1. Demographic Characteristics of Clinicians Interviewed

	(N = 30)	
Characteristic	**n**	**%**
Age, M (SD), yr	47.7	10.2
Years in practice, M (SD)	16.4	9.1
Years at VA, M (SD)	8.9	6.1
Years in clinic (n = 29), M (SD)	5.2	4.9
Interviewees per clinic type		
Pain	17	
Primary care	*12	
Mental health	2	
Sex		
Women	17	56.7
Men	13	43.3
Race/ethnicity		
Asian	5	16.7
Black or African American	3	10.0
Hispanic/Latino	3	10.0
White	18	60.0
Prefer not to answer	1	3.3
Degrees		
Medical doctor/doctor of osteopathic medicine	18	60.0
Advanced registered nurse practitioner/doctor of nursing practice	4	13.3
Doctor of pharmacy	4	13.3
Registered nurse	3	10.0
Doctor of philosophy in psychology	1	3.3

*One interviewee represented pain and primary care.
VA indicates Department of Veterans Affairs.

Overall Impact of the Pandemic on MOUD Care and Patient Well-being

This theme captured clinicians' general impressions/experiences with how the pandemic impacted patient care and well-being, resulting in the subthemes: quality of MOUD care and concerns about patients.

Quality of MOUD Care

Most reported minimal impact of the pandemic on the overall quality of MOUD care, particularly regarding existing patients.

P1... [I]n general we've been able to continue providing the service. Before [COVID-19], basically all of the [MOUD] appointments were face-to-face. Most of them now are done by video care.... [U]sing video hasn't affected the delivery of the care in general.

P2 So I would say minimally, we're able to still prescribe and follow the guidelines that were provided. I think we've been able to adapt, and we're doing well.

Concerns About Patients

Few had concerns about patients being isolated from support due to COVID-19, increasing risk of overdose and/or psychological distress.

P3... there's a mental health crisis, and there's been an increase in lethal overdoses of opioids during this [COVID-19] situation.... [P]eople are feeling pretty depressed and isolated, and it's pretty tough sledding [i.e., a difficult period of time] for people with substance use disorders. A lot of them are feeling cut off from their support....

Features of MOUD Care Impacted

This theme captures clinicians' discussion of specific parts/components of MOUD care that were impacted, resulting in the subthemes: new medications initiations/transfers and monitoring.

New Medication Initiations/Transfers

Most clinicians reported no patient-related impacts of the pandemic on MOUD initiations or accepting transfers of patients' care from substance use disorder specialty care. Of this group, a minority reported medication initiations were done remotely before COVID-19 onset, while the majority reported they transitioned to remote medication initiations without delaying care. Some did note that there were logistical challenges and an initial discomfort transitioning to remote initiations.

P4 [W]e started to do the home [initiations], because prior to [COVID-19] it was just in clinic. And we had just talked about the home [initiations] a little bit, but really weren't comfortable with that. And then [post–COVID-19], that certainly

TABLE 2. Overview of Themes, Definitions and Subthemes

Themes	Definitions	Subthemes
Overall impact of the pandemic on MOUD Care and patient well-being	Captures clinicians' discussions that were broad in nature, covering general impressions and/or experiences with how the pandemic impacted patient care and patient well-being.	Quality of MOUD care Concerns about patients
Features of MOUD care impacted	Includes clinicians' discussions of specific parts/components of MOUD care impacted by the pandemic.	New medications initiations/transfers Monitoring
MOUD care delivery	Includes clinicians' experiences with how care is delivered (ie, via telehealth or in-person) and how MOUD care may be improved postpandemic.	Telehealth care In-person care Potential improvements in MOUD care
Continuance of telehealth for MOUD care	Captures clinicians' discussions about the continued use of telehealth postpandemic.	

No subthemes noted for continuance of telehealth for MOUD care.
MOUD indicates medication treatment for opioid use disorder.

changed,... even after the pandemic, we'll probably primarily do home [initiations]. It's worked out very well.

Few reported an impact on patient access to MOUD care, noting that other clinics stopped transferring patients to their clinics or initiations for new patients were temporarily delayed as face-to-face initiations were on hold.

P5... it just slowed down transferring patients probably. Back in March, I think [Addiction Treatment Service] ended up keeping some folks that otherwise might've transferred just because they already knew them.

Monitoring

Many reported a reduction in urine drug screens (UDS), noting that the risks of COVID-19 exposure were greater than perceived benefits of UDS. A few reported continuing UDS monitoring.

P6 The other impact would be that we have been looking at the role of UDS screening and how often and when.... And making sure we're not just ordering a UDS because it's a follow up visit.... And that's a change, [COVID-19] has made us do that because, it used to just be, 'you're coming in, go get your UDS.'

MOUD Care Delivery

This theme describes clinicians' experiences with care delivery and how MOUD care may be improved postpandemic, resulting in the following subthemes: telehealth care, in-person care, and potential improvements in MOUD care.

Telehealth Care

Most reported positive telehealth experiences, noting that it removed logistical challenges patients face to attend care in-person, resulting in less stress and fewer distractions for patients. As a result, appointments were more likely to start on time and no shows decreased. They noted that telehealth visits destigmatized MOUD treatment, improved patients' autonomy and participation in their care, and provided a view into patients' environments. Clinicians indicated their clinics ran more efficiently, and they felt more relaxed and empowered during clinical interactions.

P6 [We] were talking about how telehealth [and] OUD treatment has been really, even another level of liberation, like people are happy to talk to us, 'I couldn't wait for my appointment today, I'm so glad you called.' And we're working with them, if they're an essential worker, they're just able to step out on a break. It's really seemed to destigmatize it quite a bit for them. It's not like a doctor's appointment, it's like part of their normal everyday life, and they can deal with their everyday life with this addiction and make different choices. I think we all feel really empowered by the telehealth technology and really see maintaining a lot of telehealth in this clinic moving forward.

P7 I think it's impacted delivery in a positive way. I think that prior to [COVID-19], a lot of clinics only provided face to face service.... [COVID-19] helped demonstrate that treatment is equally successful if it's done through the different technologies... and it better meets the needs of Veterans....

P8 We are a fairly rural state, with a lot of our patients coming from potentially hours away, so it really helped take away that barrier.... It allowed us to go right into their home and develop that relationship.

Many, however, highlighted technological challenges, such as patients lacking devices (eg, computer/phone), poor connectivity, and inadequate computer literacy.

In-person Care

Many noted a need for in-person MOUD care, highlighting concerns about patients' growing isolation and noting missed opportunities to recognize a return to opioid use, and promote physical movement and interpersonal interactions that patients naturally benefit from when attending care in-person.

P9 I think the hardest part with COVID-19 is just that our patients are really prone to isolation.... For a lot of patients, our appointment was one of the few interpersonal interactions that they had in their lives, where they were kind of talking about themselves. So I think those are important for a lot of folks, and I think the telephone doesn't always offer that. And similarly, it was allowing patients to get out of their home, which, for a lot of our patients for whom pain is sort of an additional issue, getting up and moving can be an important therapy.

P10 There's a small proportion of patients, like 20% or 10%, they would still like to see you face to face, in person. But the rest of the patients are ok. I'm ok. I'm a lot more relaxed.... It's less stressful.

Many also reported a preference for in-person MOUD care, citing the importance of in-person interactions to establish

a clinician-patient alliance and the ability to easily collect information (eg, vitals, UDS, and observational cues).

P11 As a provider, I think being able to see a patient face-to-face is preferable but being able to see them through video offers different insights that you wouldn't get if they were coming to the clinic.... So, kind of pros and cons to each.

Potential Improvements in MOUD Care

Potential improvements to MOUD care included patient-centered care and relaxed regulations. Many reported accommodating patient preferences by offering multiple treatment options, such as in-person, phone, or video visits.

P11 Since [COVID-19], we have primarily moved all of our visits to virtual visits.... As restrictions have been eased, we have been seeing some patients in clinic on an as needed basis.

Many noted the positive impact relaxed regulations have had on care (eg, benefits for patients, improved treatment efficiency, and improved access).

P9 We've been able to start patients over the phone now, and I think the loosening of some of those regulations has been really important. I think those are things that probably shouldn't have been there in the first place, and hopefully they stay gone once this crisis is over.

Continuance of Telehealth for MOUD Care

This theme captured clinicians' discussions about the continued use of telehealth. Many indicated that they see and/or would like to see telehealth MOUD continue to some degree postpandemic, citing improved patient access, accommodation of patients' preferences, and overcoming limited clinic space.

P12 [Video appointments] I think [are] the future. You know, the patients can be at their house, I can be here, or I can be at my house. You just connect to the patient, and they love it.

DISCUSSION

Factors associated with the delivery of MOUD in general healthcare clinics after COVID-19 onset were organized into 4 themes including overall impact of the pandemic on MOUD care and patient well-being, features of MOUD care impacted, MOUD care delivery, and the continuance of telehealth for MOUD care. Consistent with prior studies, most of which have queried samples of clinicians from diverse clinic settings (eg, group practices, substance use disorder specialty care, etc), we found that most clinicians reported little impact on the overall quality of care, noting the major differences being the shift from in-person treatment to telehealth and reductions in frequency of monitoring.[13,14,16,17,20,21,31] Also consistent with prior studies, clinicians highlighted technological challenges with telehealth care, such as limited access to devices, familiarity with technology, and poor connectivity.[13,14,16,20–22,32]

Clinicians highlighted positive aspects to telehealth. Our finding regarding clinicians' belief that telehealth care reduced stigma is a novel and important finding, given concern about stigma's impact on help-seeking behaviors.[33] Consistent with prior studies, clinicians in this evaluation noted that telehealth reduced patients' issues with transportation, resulting in timely visits[20,21,31] and fewer no shows/cancellations.[20,21] Clinicians also reported telehealth provided a view into patients' environments, a finding previously reported.[20–22,31] A finding that was less well documented in prior studies was clinicians' reports that patients felt more relaxed during clinical interactions.[14] It is not clear why these findings were more prominent in our evaluation, although our focus on general healthcare settings may account for differences in themes compared with evaluations in other settings. Finally, most clinicians in our evaluation reported a quick transition to remote assessment and medication initiation, a finding that has been mixed in prior studies.[14,15,20] As a prior study found that clinicians at federal healthcare facilities, such as the VA, Department of Defense, and Indian Health Service, were more likely to prescribe remotely to new patients during COVID-19,[13] this finding may be due to characteristics of federal healthcare systems, such as the usage or availability of telehealth before the pandemic and/or the ability to mail medications to patients.[34]

There are several clinical and research implications to our findings. Telehealth allows for flexibility in care delivery, may improve access, destigmatize treatment, and supports patient-centered care for certain groups of patients. Moreover, patients and clinicians may feel more relaxed during telehealth than in-person care, which could have implications for engagement and retention. For instance, patients also have reported feeling more comfortable with and less stigmatized by telehealth treatment for OUD,[35] findings that warrant further study to understand the underlying mechanisms. It will also be important to address how best to identify patients who would benefit from MOUD in virtual settings compared with those who may prefer or benefit from in-person interactions. Technological issues will also need to be addressed to diminish the risk of exacerbating healthcare disparities.[20,22,34,36] In addition, programs should consider ways to decrease patient isolation that may be a long-term consequence of virtual care. Given the rising drug overdose epidemic, strategies that increase access or retention in care, such as extending the flexibility to initiate MOUD without an in-person assessment and re-evaluating the frequency of monitoring (eg, UDS), warrant consideration.[37] The association between monitoring and clinical outcomes also warrants further consideration. As telehealth may increase access to care and was endorsed by clinicians as patient centered, permanent exemption of the in-person assessment requirement may address well-known disparities and warrants further evaluation to assess potential influences on equity.[38] It is important to note that regulations around MOUD treatment have changed and may continue to change given the national strategies put forth by the Biden-Harris Administration to address substance use and the overdose epidemic.[39] While clinicians seem to favor a hybrid model of in-person and telehealth care, research is needed to identify the combination that maximizes access and quality of care. Furthermore, new models of care should be informed by patient preference.

Our evaluation had several limitations. The sample recruited was composed of clinicians from the VA healthcare system, which is less impacted by reimbursement and state regulatory policies related to MOUD care than non-VA healthcare systems. Thus, these findings may not generalize to settings outside of the VA. These findings also may not generalize to other VA healthcare settings, as the sample recruited was part of an initiative involving

facilitation efforts that may have aided in overcoming pandemic-related barriers. The evaluation does not include patients' perspectives, an important source of information for assessing the pandemic's impact. Because few participants were mental health clinicians, findings primarily reflect the perspectives of primary care and pain clinicians. Finally, we did not assess how findings vary by characteristics of clinics, clinicians (eg, years of experience providing MOUD care) or patients (eg, reside in rural areas), which have been shown to be associated with remote prescribing of buprenorphine and a preference to continue telehealth care.[13,14]

CONCLUSIONS

While the COVID-19 pandemic required changes in MOUD care, clinicians who provide MOUD care in VA general healthcare settings reported positive experiences related to use of telehealth and interest in telehealth use beyond the pandemic. Those interviewed also reported a belief that access and quality of care were largely sustained in their VA general healthcare clinics. Evaluations of hybrid in-person and telehealth MOUD models and long-term impact of the shift to telehealth on clinical outcomes are needed, as is obtaining patient perspectives and monitoring of patient engagement and quality of care as services adapt to a postpandemic environment.

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