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Response to coronavirus 2019 in Veterans Health Administration facilities participating in an implementation initiative to enhance access to medication for opioid use disorder

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Abstract

The actions needed to mitigate the spread of the coronavirus 2019 (COVID-19) have forged rapid paradigm shifts across healthcare delivery. In a time of crisis, continued access to and delivery of medication for opioid use disorder (M-OUD) is essential to save lives. However, prior to COVID-19, large variability in M-OUD adoption existed across the Veteran Health Administration (VHA) and it is unknown whether the COVID-19 pandemic exacerbated this divide. For the past two years, our team worked with eight VHA facilities to enhance adoption of M-OUD through a multi-component implementation intervention. This commentary explores these providers' responses to COVID-19 and the subsequent impact on their progress toward increasing adoption of M-OUD. Briefly, the loosening of regulatory restrictions fostered accelerated adoption of M-OUD, rapid support for telehealth offered a mechanism to increase M-OUD access, and reevaluation of current practices surrounding M-OUD strengthened adoption. Overall, during the COVID-19 crisis, facilities and providers responded positively to the call for increased access to

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M-OUD and appropriate care of patients with OUD. The VHA providers' responses and continued progress in enhancing M-OUD amidst a crisis may, in part, be attributable to their participation in an implementation effort prior to COVID-19 that established resources, expert support, and a community of practice. We anticipate the themes presented are generalizable to other healthcare systems grappling to deliver care to patients with OUD during a crisis. We propose areas of future research and quality improvement to continue to provide access and high quality, life-saving care to patients with OUD.

Keywords

COVID-19; coronavirus; medication for opioid use disorder; opioid use disorder; implementation

Commentary

The novel coronavirus 2019 (COVID-19) has rapidly changed how healthcare is delivered, particularly in substance use disorder (SUD) care. Nevertheless, during a time of crisis, the continued high prevalence of persons with opioid use disorder (OUD) highlights the critical need to maintain essential access to quality, evidence-based treatment. Medications for OUD (M-OUD) are recommended as a first-line treatment and include buprenorphine (including buprenorphine, buprenorphine/naloxone, and other forms approved for OUD), methadone, and naltrexone (injectable and oral forms).[1] Access to life-saving M-OUD is paramount during a crisis when the critical need for viral mitigation means clinics are not seeing patients face-to-face, patients may feel increased fear and social isolation leading to higher relapse,[2–9] and pharmacy access may be limited.

The Veteran Health Administration (VHA) is one of the largest integrated healthcare systems in the nation and provides care to over 9 million Veterans across 1,255 healthcare facilities, including 170 VHA medical centers.[10] The VHA has long been a proponent of initiatives aimed to increase access to and use of M-OUD. Prior to COVID-19, large variability in M-OUD adoption existed across the VHA and it is unknown whether the pandemic exacerbated this divide between high and low adopting VHA facilities. For the past two years, our team worked with eight VHA facilities to enhance adoption of M-OUD through a multi-component implementation intervention through a VHA grant titled ADvancing Pharmacological Treatments for Opioid Use Disorder [ADaPT-OUD]; VA IIR 16-145).[11] The eight facilities were randomly selected among the bottom quartile of M-OUD adoption in the VHA, defined by a facility-level ratio of patients receiving M-OUD over the total number of patients with OUD.[11] Each facility was staggered for the start date and the study completed the formal implementation intervention in July 2020. Briefly, the ADaPT-OUD implementation intervention consisted of a qualitative assessment of stakeholder perceptions of barriers and facilitators to M-OUD adoption, an in-person visit to the facility at the start the intervention, and 12-months of continued implementation facilitation.[11] The year-long, ongoing facilitation—which encompassed the COVID-19 era—consists of monthly calls with the local facility's identified implementation team, access to expert consultation as needed, and quarterly reports with key metrics to track progress and quarterly cross-facility collaboration calls with key stakeholders.[11] Participation in the local

facility implementation team varied by site and consisted of facility leadership and providers (e.g., physicians, advance-practice nurses, pharmacists) interested in enhancing access to M-OUD at their facility. Teams generally included clinic leadership and providers, while some also included representation from other interested clinics including general mental health, pain clinic, and primary care. Table 1 presents the VHA facility characteristics, measures of M-OUD prescribing, and most recent progress report for facilities.

In May 2020, we completed our final cross-site collaboration call for all sites, and, by email, invited everyone involved in the local implementation teams to share any COVID-19 related changes to their facility's delivery of M-OUD, discuss barriers to accessible care, and collaboratively identify solutions. Seven of the eight facilities participated in this last call with 1–3 representatives per site including pharmacists, psychiatrists, physicians, social workers, and nurse practitioners. We sent a follow-up email to the facility who had no representation on the call and received a written response regarding the discussion points.

This commentary explores how COVID-19 and the VHA providers' responses to COVID-19 impacted their progress in increasing adoption of M-OUD. In this commentary, we use information gleaned from the cross-site collaboration call in the context of ongoing collaboration with the facilities and understanding of their barriers and facilitators to M-OUD prescribing prior to COVID-19 from quantitative and qualitative data. Importantly, this commentary prompts actionable discussion around the impact of COVID-19 on M-OUD access and care delivery at facilities already engaged to enhance M-OUD access. We anticipate the themes noted are generalizable to other healthcare systems grappling to deliver of care to patients with OUD and implementing M-OUD, as the opioid crisis continues despite the presence of COVID-19. We propose areas of future research and quality improvement to continue to provide access and high quality, life-saving care to Veterans and non-Veteran patients with OUD.

First, rapid changes in federal regulatory restrictions allowed low-adopting VHA facilities to accelerate M-OUD implementation efforts. Prior to the COVID-19 era, the stringent federal regulations communicated to facilities that an abundance of caution is warranted when expanding prescribing of M-OUD. As federal regulations relaxed with the onset of COVID-19, this served as an indication that local, facility-level restrictions may safely be relaxed as well. For example, prior to the COVID-19 era, some VHA facilities had strict regulations in place regarding who could prescribe M-OUD (e.g., psychiatrists only), where M-OUD could be initiated (e.g., main hospital facility only and not in surrounding outpatient clinics), and how frequently patients had to be seen and monitored. Overcoming barriers at the external healthcare system level (i.e., federal regulations) may be a prerequisite to M-OUD adoption at the local facility level. The declaration of a national medical emergency in the United States allowed revisions and relaxing of regulations regarding M-OUD.[12,13] Specifically, providers with a new Drug Enforcement Administration (DEA) license for buprenorphine prescribing can apply to immediately work with 100 patients, rather than starting with 30 patients during the first year of holding a DEA license.[13]

Under the national medical emergency, the Ryan Haight Act has been temporarily adjusted to allow providers to initiate and maintain M-OUD treatment via phone or video, instead of requiring a face to face consultation.[13] The relaxation in federal regulations communicated to providers the perceived dangers associated with M-OUD may not be as salient as previously believed. Once regulatory restrictions were lifted, low-adopting facilities leveraged existing resources to be creative with M-OUD implementation. For example, providers reported allowing mailed prescriptions and telehealth visits, when these practices routinely used face-to-face medication pick-up at the VHA facility. Collaborative work by multiple stakeholders is urgently needed to proactively plan for how to re-adapt and sustain these modified, but anecdotally successful, care models or processes once regulations potentially revert to more restrictive forms following the cessation of the "medical emergency" that allowed for revised regulations. Stakeholders and policy investigators can also use this time when regulatory restrictions have eased to examine the impact on access, patient outcomes, and unintended consequences to inform policymakers and clinical operations.[3]

Second, rapid advances in national VHA support for telehealth offered low-adopting VHA facilities a mechanism to increase M-OUD access. Facility representatives described various forms of telehealth (e.g., video, phone) and coordination models (e.g., signing orders remotely, registered nurses calling for follow-up) employed to manage patients with M-OUD during the COVID-19 era. One representative believed telehealth was more patient-centered and particularly successful in engaging and treating patients with SUDs. It is possible telehealth was more convenient for patients and helped reduce stigma that has been associated with receiving care within SUD or mental health specialty clinics.[14] Several facilities had been offering some visits through a video conference calls for M-OUD maintenance before COVID-19 and found it easy to continue care for patients with OUD using this technology. During COVID-19, several facilities expanded to offer telehealth for M-OUD initiation (also called induction) on buprenorphine. Telehealth for patients receiving M-OUD shows acceptance of this mode of care delivery by clinicians and patients, both within and outside VHA settings.[15,16] Several, but not all facilities have used video visits to initiate patients on M-OUD. One facility did not have the technological support and is subsequently following their patients using phone visits. While COVID-19 expedited the expansion of telehealth for M-OUD to mitigate the viral spread, it also exposed and potentially exacerbated disparities for those who have difficulty accessing the internet or do not have compatible devices.[12,17] Additionally, some patients may have existing conditions such as hearing, visual, or cognitive impairments that may be challenged with the use of virtual visits.

COVID-19 has resulted in reduced face-to-face contact and—subsequently—providers, patients, and healthcare leaders are making complex decisions about OUD treatment delivery and engagement. Developing and employing standardized clinical algorithms to risk-stratify patients receiving M-OUD can assist with the shared decision-making process to inform the most appropriate level of service delivery needed. Shared-decision making is recommended in clinical guidelines as an effective method of making treatment decisions.[18] For example, clinicians and leadership may choose to manage select patients completely using telehealth for those identified as low risk for imminent relapse or other adverse

events. Future work can evaluate innovative models of care in a time of crisis (e.g., COVID-19, natural disasters) that balance individual patient needs and preferences with effective delivery of care that translates to improved patient outcomes.

With the increased use of telehealth, VHA facility representatives discussed concern over possible gaps in new modes of care delivery when the oversight role of the prescribing provider is less clear in the process. For example, one facility–which lacked access to a prescriber at the same physical location–initiated a pharmacy-led M-OUD patient management model and, thus, relied on prescribers via telehealth. When using the pharmacy-led model, it did not appear that processes or policies were in place—at the local facility or healthcare system level—to provide guidance on the frequency and mode of oversight by the prescribing provider through telehealth, leading to concerns as to whether current practice was meeting care standards for prescribing provider oversite. Ultimately, the prescribing provider is responsible for the overall management of a patient, which requires a system of communication and updates. One facility is currently not initiating any patients on M-OUD until they can develop such policies and procedures, further limiting access to M-OUD.

Future work needs to evaluate innovative models of care to ensure changes in care delivery are not a replacement for practicing at top of provider's licenses and ensuring adherence to good clinical practice guidelines. Facilities often create their own policies that may not be adaptable during a crisis when urgency is essential, and the healthcare context is rapidly evolving. Thus, to best assist providers during this time of crisis, organizations must prioritize establishing clear policies for care management and oversight of M-OUD, while also providing clinical teams with the appropriate training and support to comply with new guidelines. However, clear guidance must also be balanced with allowing clinicians the flexibility to innovate within safe parameters.

Finally, low adopting VHA facilities are reevaluating current practices surrounding M-OUD that may have hindered adoption prior to COVID 19. For example, many facilities were previously hesitant to provide buprenorphine in clinics that did not have laboratory services on-site, which prevented the expansion of M-OUD to smaller, community-based outpatient clinics. During a pandemic, such in-person urinary drug screens may be limited due to reduced clinic hours and reductions in face-to-face visits. Facilities engaged in discussion whether current process guidelines for urinary drug screens were a one size fits all approach and could be revised in the future to reduce patient/provider burden and healthcare costs post pandemic. Currently, no mandate exists for urinary drug screen frequency for M-OUD in office-based care (in contrast to dispensation of methadone or buprenorphine in federally licensed opioid treatment programs).[19] Consequently, providers are making individual decisions on the frequency of screening necessary based on their clinical judgment on how closely a patient needs to be monitored. Prior to COVID-19, some providers mandated frequent screening for illicit substances that were not possible during the COVID-19 era. Future work is needed to explore, implement, and evaluate innovative algorithms and clinical pathways to identify for whom, when, and how frequently monitoring should occur to be cost-effective, safe and patient-centered.

The COVID-19 era is rapidly evolving the healthcare landscape and, consequently, how care is delivered to patients with OUD both within and outside of the VHA. As a result, COVID-19 has generated a resounding call to adapt treatment of OUD (e.g., provide telehealth), relax treatment requirements (e.g., reduce frequency of urine drug screens or target high-risk patients for these screens, allow for mail-out M-OUD medications), and engage patients with OUD in novel models of care (e.g., pharmacy-led management).[2–4,20–39]

In sum, the purpose of this commentary was to briefly outline three themes we noted from interaction with VHA facilities engaged in an M-OUD implementation effort during the COVID-19 era: loosening of regulatory restrictions fostered accelerated adoption of M-OUD, rapid support for telehealth offered a mechanism to increase M-OUD access, and reevaluation of current practices surrounding M-OUD strengthened adoption. Overall, these VHA facilities appeared to respond positively to the call for increased access to M-OUD and appropriate care of patients with OUD in the setting of COVID-19. This may, in part, be attributable to their participation in an implementation effort prior to COVID-19; thus, the facilities had resources, expert support, and a community of practice already established.

Other VHA and non-VHA facilities with low M-OUD prescribing rates may require similar support to ensure care sustains or improves, rather than becoming less accessible, during this challenging time. Future work is needed to evaluate innovative care models and promote sustainability of access to M-OUD once regulations potentially revert to previous restrictions following the pandemic's end. The COVID-19 pandemic, while devastating, provides a unique opportunity to recreate care delivery to expand access, reduce disparities, minimize downstream healthcare costs, and ultimately save lives of patients with OUD.

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Table 1.

VHA facility characteristics, measures of M-OUD prescribing, and most recent progress report for facilities. The Substance Use Disorder-16 (SUD-16) is a VHA metric calculating the facility level proportion of patients receiving M-OUD over the total patients with OUD.

Facility #	Region	Urban or Rural	Clinics Involved in Prescribing (2018)	Clinics Involved in Prescribing (May 2020)	SUD-16 (2018)	Most Updated SUD-16 (March 2020)	Progress Reports (May 2020)
1	Rocky Mountain	Rural	● None	● Mental Health Clinic ● Residential Rehabilitation Program	4.0%	20.3%	● Initiations are done in the hospital ● Established patients are managed and provided group sessions via telehealth ● Outpatient Mental Health Clinic is open once per week for urine drug screens
2	Rocky Mountain	Urban	● Substance Use Disorder Clinic	● Substance Use Disorder Clinic ● Primary Care Clinic ● Community Based-Outpatient Clinics via telehealth	15.6%	36.4%	● Evaluations are completed via telehealth before patients come for initiation at the hospital
3	Southeast	Rural	● Substance Use Disorder Clinic	● Substance Use Disorder Clinic with expansion in the number of providers able to prescribe	10.4%	33.6%	● Initiations are on hold until a procedure can be created ● Established patients receive follow-up by telephone
4	Northwest	Urban	● None	● Substance Use Disorder Clinic ● Primary Care Clinic	4.1%	29.2%	● All evaluations and visits are done by telephone
5	North Central	Urban	● Substance Use Disorder Clinic	● Substance Use Disorder Clinic ● Primary Care Clinic ● Residential Rehabilitation Treatment Program	19.2%	30.6%	● Home initiations occurring via a video connect platform ● Established patients are followed-up via phone or the video connect platform ● Patients are completing urinary drug screens in-clinic every 3 months
6	Southwest	Urban	● Substance Use Disorder Clinic	● Substance Use Disorder Clinic ● Primary Care Clinic ● Pain Clinic	34.9%	31.7%	● Home initiations and management are occurring via video connect platform
7	Southeast	Urban	● Substance Use Disorder Clinic	● Substance Use Disorder Clinic with expansion in the number of providers able to prescribe	18.8%	26.1%	● Outpatient Substance Abuse Clinic is open 2 weekdays per week for evaluations of new patients ● Established patients have less frequent follow-up appointments and urine drug screens at least yearly ● Long acting injection of Naltrexone is administered in a mobile unit outside the hospital to reduce foot traffic
8	Northcentral	Urban	● Substance Use Disorder Clinic	● Substance Use Disorder Clinic with expansion in the number of providers able to prescribe ● Residential Rehabilitation Treatment Program ● Second, nearby VHA campus	28.5%	42.4%	● Home initiations via video connect platform were being done before COVID-19 so the process has continued ● Mailing out prescriptions ● Began using injectable buprenorphine (long-acting buprenorphine)[40]