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The provision of counseling to patients receiving medications for opioid use disorder: Telehealth innovations and challenges in the age of COVID-19



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ABSTRACT

Historically, federal and state policies have narrowly defined treatment models that have resulted in limited access to and engagement in counseling for individuals receiving medications for opioid use disorder (MOUD; e.g., methadone and buprenorphine). In response to the coronavirus pandemic, outpatient MOUD treatment providers rapidly transitioned from traditional, in-person care delivery models to revised COVID-19 protocols that prioritized telehealth counseling to protect the health of patients and staff and ensure continuity in MOUD care. These telehealth innovations appear to mitigate many of the longstanding barriers to counseling in the traditional system and have the potential to forever alter MOUD care delivery. Drawing on data from a Rhode Island-based clinic, we argue that MOUD counseling is achievable via telehealth and outline the need for, and anticipated benefits of, hybrid telehealth/in-person MOUD treatment models moving forward.

When taken as prescribed, medications for opioid use disorder (MOUD), including methadone and buprenorphine, can reduce opioid withdrawal, cravings, and use—ultimately saving lives (Kampman & Jarvis, 2015; NIDA, 2018). Historically, MOUD care delivery has been guided by strict federal and state policies and rigid treatment models that have created barriers to accessing counseling for many patients who could benefit from such care. For example, policies previously required methadone patients to receive a minimum of 1 h per month of in-person counseling in order for providers to bill for their monthly methadone dispensing time (Huskamp et al., 2018). Additionally, traditional MOUD outpatient treatment models have often required patients to receive in-person counseling during daytime hours (typically between 6 am and 3 pm) either weekly or monthly, depending on the patients' stage of recovery. Although many patients benefit from the structure and support of this treatment framework, the inflexibility of these traditional counseling models has also prevented many people with opioid use disorder (OUD) from initiating or remaining engaged in

MOUD care.

The delivery of counseling via telehealth (i.e., phone or internet-based video on a smartphone/tablet/personal computer) has been shown to be effective for treating substance use disorders (Eibl et al., 2017; Gros et al., 2013; King et al., 2009; Zheng et al., 2017), but has been underutilized in the context of MOUD care (Huskamp et al., 2018). Privacy concerns, assumptions that individuals living with OUD would be unable or unmotivated to participate in telehealth counseling, and a general reluctance on the part of providers and clinic administrators to change long-standing practices have all served as barriers to the use of telehealth for MOUD counseling (Brooks et al., 2013; McNall et al., 2009; Uscher-Pines et al., 2020). Further, low Medicaid reimbursement rates for telehealth and a reluctance on the part of professional associations, licensing boards, and public oversight entities have historically restricted providers' ability to implement new technologies (Douglas et al., 2017; Page et al., 2017; Uscher-Pines et al., 2020). However, the swift and unprecedented arrival of the coronavirus

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pandemic and corresponding social distancing mandates have challenged many assumptions regarding the feasibility and acceptability of delivering MOUD counseling via telehealth.

In response to the coronavirus pandemic (COVID-19), outpatient substance use and mental health treatment programs, such as VICTA in Providence, Rhode Island, rapidly implemented emergency protocols to prevent gaps in MOUD-related counseling for individuals with OUD. These changes include lifting in-person counseling requirements and allowing counseling to be delivered via telehealth. Under the new care model, aimed at minimizing the risk of COVID-19 for patients and staff, clinicians at VICTA received laptops to facilitate the delivery of telehealth counseling to patients receiving MOUD. The switch to telehealth enabled clinicians to work more flexible hours which, in turn, allowed patients to receive therapy during evening or weekend hours. Such changes were made possible, in part, due to a number of federal and state policy changes. Indeed, on January 27, 2020, the Secretary of the U.S. Department of Health and Human Services (HHS), Alex M. Azar II, declared a nationwide health emergency to aid the nation's healthcare community in responding to the coronavirus pandemic. Soon after, HHS lessened HIPAA requirements (Center for Disease Control and Prevention, 2020) to allow for the use of telehealth via free platforms, such as Google Hangouts and FaceTime (U.S. Department of Health and Human Services, 2020). Locally, Rhode Island Governor Gina Raimondo issued an executive order mandating that Medicaid and managed care organizations must cover all forms of telehealth, including counseling (State of Rhode Island, 2020a, 2020b). These rapid changes demonstrate that, with governmental support and provider and administrator commitment to ensure access to care for all patients, it is possible to deliver counseling for patients on MOUD via telehealth.

The change to emergency COVID-19 procedures at VICTA, which include the delivery of remote MOUD counseling, appears to have—perhaps paradoxically—resulted in improved access to care for many patients living with OUD. In the months following the onset of the COVID-19 outbreak, VICTA provided telehealth counseling to 101 new MOUD patients, some of whom reported that they were previously unable to access such services due to structural and societal barriers. Patients described prior barriers including limited time to travel to the clinic, lack of transportation or childcare, and the stigma-related fear of being seen at a MOUD clinic. Both new and existing VICTA patients have also described the benefit of not having to account for travel time when scheduling telehealth counseling appointments, as well as the improved flexibility provided by the new evening and weekend hours. Patient reports of increased care accessibility appear to have translated into higher retention in care rates clinic-wide. A chart review comparing all types of scheduled and completed visits (e.g., individual and group counseling alone and together with medication management, intensive outpatient group program visits) found that 88% of VICTA patients kept their appointments since the implementation of telehealth compared to 77% of patients in the months prior when VICTA offered only in-person visits. Given that the telehealth counseling that VICTA provides is the same length and intensity as the in-person counseling, these findings highlight the potential for telehealth counseling to optimize treatment engagement.

Although these rapid and innovative changes to enable MOUD counseling via telehealth have increased access to care for many patients, the use of remote counseling has also highlighted, and in some cases, exacerbated, existing inequities among people with OUD. For example, many individuals who seek out or receive MOUD do not have consistent access to internet-capable devices or even a telephone. Clinics like VICTA have worked to mitigate these barriers to care by offering clinic space, as well as computer and telephones access, for patients to use in connecting with their counselors who are working offsite. Although clinic-based access to technology is a tremendous benefit for patients who need it, having to travel to the clinic presents risks for coronavirus exposure and could lead to the widening of COVID-related disparities among low-income individuals relative to

higher-income individuals living with OUD.

Moreover, even for current and potential MOUD patients who have access to an internet-capable device or a telephone outside of the clinic, additional barriers remain, including not having a quiet or private space to meaningfully engage in counseling. Individuals with serious and persistent mental illness are also at a unique disadvantage, as many of these individuals struggle to connect cognitively and emotionally with their counselor via telehealth platforms (Naslund et al., 2015). Further, some types of counseling cannot be optimally delivered via telehealth. For example, traditional intensive outpatient programs typically involve three or more hours per day of group therapy, several days a week, which can be overwhelming to some patients when delivered via telehealth. The provision of counseling for individuals with complex mental health histories is also potentially problematic via telehealth as some of these individuals may be at risk for suicidal or homicidal ideation (Briere & Spinazzola, 2009), and crisis intervention can be difficult, though not impossible, to manage via telehealth (Gros et al., 2013). These barriers to telehealth for some patients receiving MOUD counseling underscore the need for hybrid telehealth/in-person care delivery models that balance both patient and clinic needs and that consider the current, ever-changing local and national contexts of the coronavirus pandemic.

As a field, we should consider the possibility of continued use of remote or hybrid MOUD counseling delivery models, even after the coronavirus pandemic subsides. There are several ways in which the ongoing use of telehealth for MOUD counseling can shape the field of addiction treatment moving forward. In addition to attenuating some of the barriers to access and improving patient retention rates, the routine use of telehealth can improve the cost, efficiency, and outcomes of MOUD counseling provision (Perle & Nierenberg, 2013). For example, patient “no shows” are a chronic problem for in-person counseling that can lead to financial losses for an organization. The use of telehealth counseling can improve efficiency following a missed appointment by allowing a provider to immediately fill a timeslot with a patient who is on the waitlist or in need of an urgent care visit. Additionally, since online platforms can track the length of the visit, telehealth can hold clinicians accountable, reduce the potential for fraudulent billing, and ensure that patients receive their needed or required dose of counseling. Telehealth counseling for patients on MOUD could also help to overcome the common challenge of staff turnover, as flexible work hours, including the ability to telecommute, can lead to improved job satisfaction and increased employee retention (Fonner & Roloff, 2010; McNall et al., 2009). In addition to reducing staff-related costs for clinics, improved clinician retention could lead to better treatment outcomes for patients who are able to maintain their long-term therapeutic relationships with counselors.

COVID-19 has brought enormous challenges and hardships for governments, businesses, and individuals alike. However, rapid policy changes and swift changes to MOUD treatment delivery via telehealth have enabled patients to receive ongoing counseling at clinics like VICTA. Agencies now providing telehealth MOUD services should consider maintaining these services in the wake of the coronavirus pandemic to ensure ongoing access to life-saving MOUD care and optimal treatment outcomes for individuals living with OUD.

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