Barriers and Facilitators to Buprenorphine Prescribing for Opioid Use Disorder in the Veterans Health Administration During COVID-19

To the Editor:

The SARS-CoV-2 novel coronavirus (COVID-19) pandemic has precipitated unprecedented changes in the delivery of care for opioid use disorder (OUD), as recently discussed by Davis and Samuels.[1] Ensuring patient access to medication treatment for OUD (M-OUD), including formulations of buprenorphine, naltrexone, and methadone, remains paramount; however, baseline challenges, such as shortages of buprenorphine prescribers and clinical infrastructure to support the intensity of care required by many patients with OUD, complicate these changes in care delivery. While these barriers have been studied, little is known about provider perceptions to M-OUD in the current clinical environment.[2–5] We, therefore, assessed perceptions of barriers and facilitators to M-OUD among buprenorphine prescribers.

In June 2020, we emailed a 6-item short-answer survey to all buprenorphine prescribers in a 5-state region of the Veterans Health Administration (VA). Providers were asked about their perceptions regarding COVID-19 changes in care delivery, current use of and recommendations for provider incentives for OUD treatment, top barriers and facilitators to M-OUD, and whether free buprenorphine waiver (X-waiver) training or continuing medical education (CME) offerings would be likely to improve access to M-OUD. The survey was emailed to 88 providers; 15 had incorrect emails and/or were unable to be contacted. Of the remaining 73 providers successfully contacted, 23 responded (response rate = 31.5%). Results were independently coded by 2 coders and discrepancies were reviewed through iterative discussions until consensus was reached. The activity was deemed a quality improvement project by our IRB.

A summary of barriers and facilitators is presented in Table 1. Time/scheduling constraints and inadequate staffing/support were the most commonly reported barriers to M-OUD, whereas professional satisfaction/gratification and leadership support were the most commonly reported facilitators. Virtual care delivery was not a top barrier for any respondent, only 9% of respondents felt that lack of incentives led to limited access to treatment, and only 4% stated that incentives increased access to M-OUD. A majority of respondents (52%) stated that free M-OUD training as a means to increase buprenorphine prescribers would not be effective. Consistent with VA policies, a majority of providers reported most or all of their care had been delivered virtually, through telephone and/or VA video connect services, since the COVID-19 pandemic began.

Our findings suggest that top barriers to M-OUD since COVID-19 began are largely unchanged from baseline, and that virtual care delivery is not perceived as a top barrier. However, among this limited sample of VA buprenorphine prescribers, we found little evidence that incentives for X-waiver training or CME would be likely to increase buprenorphine prescribing.[6,7] Many resources and programs are designed to reduce or remove barriers to obtaining sufficient training and expertise in buprenorphine prescribing.

TABLE 1. Barriers and Facilitators to M-OUD Reported Among VA Buprenorphine Prescribers in VISN 19

Barriers	n	%
Time constraints/inflexible schedule	12	52%
Inadequate staffing and support	12	52%
Lack of patient treatment, testing & education resources	5	21%
Lack of incentives	2	9%
Difficult patients	2	9%
Inappropriate referrals	2	9%
Lack of training	1	4%
Facilitators		
Professional satisfaction/gratification	17	77%
Support from leadership and co-workers	12	52%
Confidence in treatment effectiveness	7	30%
Incentives	1	4%
Interest in developing new skills	1	4%
Panel size controls	1	4%

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In the current environment, addressing clinical barriers, such as administrative/leadership support and facilitation of patient care through improved scheduling and protected provider time for M-OUD, may be more effective in increasing buprenorphine prescribing.[8] As the COVID-19 pandemic causes us to reflect on changes in policy and practice for M-OUD care in a "new-normal," greater study regarding clinical support and resource allocation for M-OUD should be considered. Additional incentives for M-OUD training may not be enough.

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