ADVANCING PHARMACOLOGICAL TREATMENT FOR OPIOID USE DISORDER (ADAPT-OUD)

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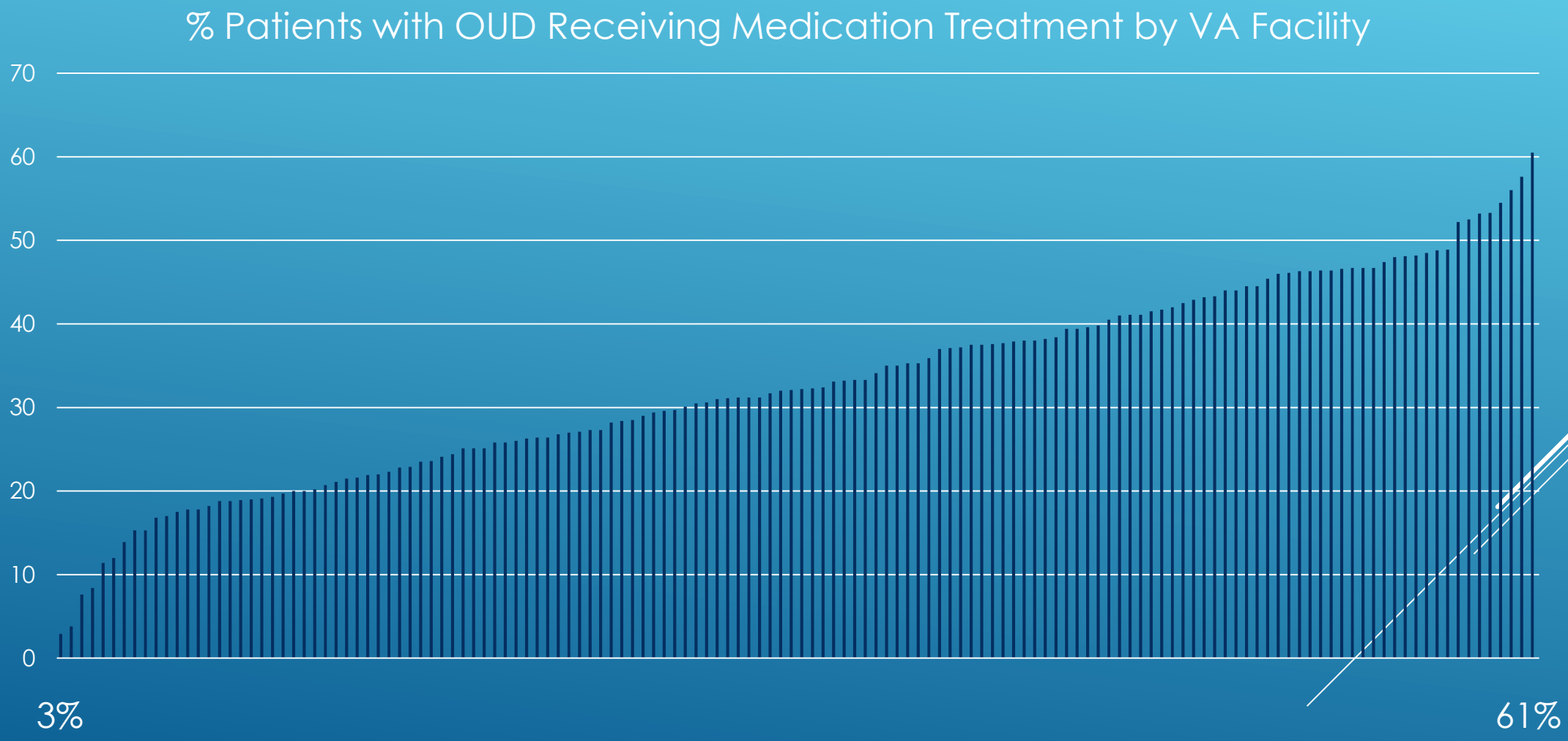
ADaPT
Advancing Pharmacologic Therapy for Opioid Use Disorder

RATIONALE:


% Patients with OUD Receiving Medication Treatment by VA Facility
70
60
50
40
30
20
10
0
3%
61%

OBJECTIVE: INCREASE ACCESS TO MEDICATION TREATMENT FOR OUD IN LOW PERFORMING FACILITIES

- Identified VA facilities in the lowest quartile of percent of patients with OUD receiving medication treatment
- Stratified by prescribing rate (ultra low vs. low) and number of actionable patients (low vs. high)
- Randomly selected 2 sites from each strata for recruitment
- Initiated contact with SUD specialty care clinic
- Started intervention with 2 sites per quarter for one year

IMPLEMENTATION INTERVENTION

- Developmental Evaluation
- Site Visit
- Monthly facilitation calls with local implementation team
- Quarterly feedback
- On-demand, as-needed consultation

IMPLEMENTATION STRATEGY: EXTERNAL FACILITATION

- Complemented by other strategies as determined by site needs:
  - alter incentives
  - conduct local consensus discussions
  - create a learning collaborative
  - develop educational materials
  - identify and prepare local champions
  - obtain formal commitments
  - promote adaptability
  - purposely reexamine the implementation
  - stage implementation scale up
  - tailor strategies

Powell et al., Implementation Science, 2015

BARRIERS AND FACILITATORS DURING EARLY IMPLEMENTATION

METHODS

- Pre-implementation semi-structured interviews with 10 stakeholders per site:
- Start with SUD leadership and expand using snowball technique
  - SUD Specialty Care providers: Prescribers, nurses, pharmacists, therapists
  - Facility leadership: Chief of Staff, Mental Health, Primary Care, Pharmacy, Nursing Managers
  - Providers outside SUD who may have interest or may be pulled into effort

METHODS

- Interview transcripts rapidly analyzed using matrices organizing barriers by broad Integrated Promoting Action on Research Implementation in Healthcare Systems (i-PARIHS) constructs
  - Innovation
  - Recipients
  - Context

VERY EARLY LESSON LEARNED!!

- Facilities would not be able to dramatically increase access to medication treatment for OUD without involving clinics other than SUD specialty care (Primary Care, General Mental Health, Pain Clinics)
    1. Some patients, particularly patients on prescribed opioids, are not comfortable attending appointments in SUD specialty care
    2. SUD specialty clinics may become overwhelmed if they can't send stable patients back to another clinic.

BARRIERS: INNOVATION

- Requires X-waiver training: Increased time burden and increased fear
- Viewed office-based medication treatment for OUD as too complex to integrate into clinics outside of SUD specialty care.
- Occasionally, medication treatment for OUD did not fit with providers' philosophy regarding treatment of substance use disorders.

BARRIERS: RECIPIENTS (PROVIDERS)

- No training in substance use disorders or their treatment
- Misconceptions about patients with OUD: ALL patients will be complex, highly unstable, etc.
- Beliefs that “recovery” is rare in OUD
- Belief that medications HAVE to be combined with intensive psycho-social treatments

BARRIERS: CONTEXT

- Not on non-SUD providers' radar, don't know what to tell patients
- Siloed care: Didn't know colleagues in SUD clinic, no mechanism for warm hand-offs
- Lack of fully functional interdisciplinary teams
- Administrative hurdles: Only certain types of providers can prescribe; re-credentialing and privileging
- Other highly pressing facility-level issues taking precedence (access, transition to new electronic medical record system)

- “It just took so long and I had asked previously to get in to the suboxone program but it took more than one try. I attempted to get in through my primary care, but there were so many hurdles to jump. It’s not easy to get into this program .”

- “Getting it provided for me was some of the obstacles. You know you can’t just go in to your primary care and say “I want to get on suboxone”. You got to go through mental health to get this initiated. I think at the front line this is a bad thing, this is a bad disease. You ought to just be able to walk in and say hey I need the help and get it, instead of waiting.”

PATIENT PERSPECTIVE

FACILITATORS

- INNOVATION: Generally, well recognized that medication treatment is THE evidence-based treatment for OUD
- RECIPIENTS: At least one experienced provider on-site
- LOCAL CONTEXT: Facility-level leadership: Help secure resources and maintain focus
- OUTER CONTEXT: National and VHA-level intensive focus on addressing the opioid crisis

IMPLEMENTATION/FACILITATION LESSONS

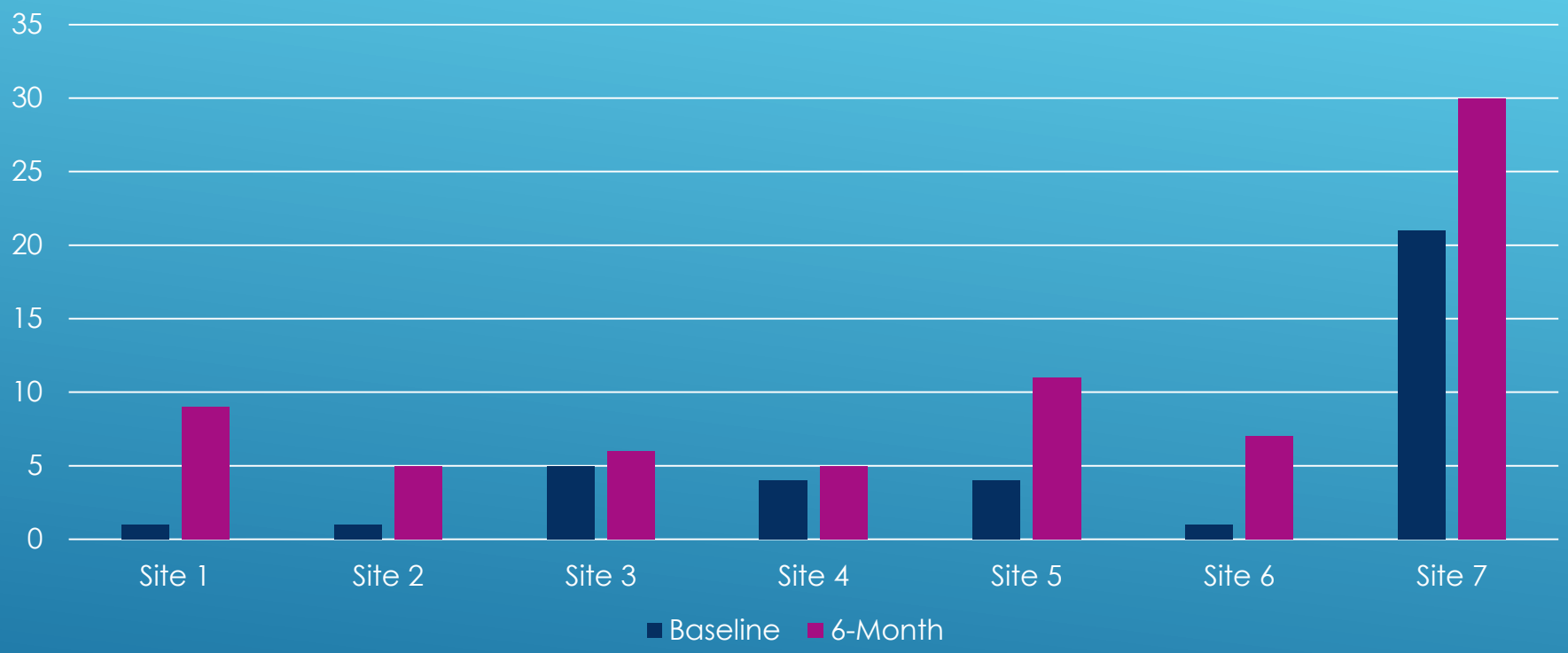
- Face-to-face time is essential, probably the more the better
- Educate about possible models but allow sites to adapt to fit their resources and structure
- Must identify internal champion(s) who:
  1. Has the available time/interest to do the work required to implement
  2. Is in a position with enough power to direct resources and maintain focus

INTERIM PROGRESS ON QUANTITATIVE OUTCOMES

METHODS

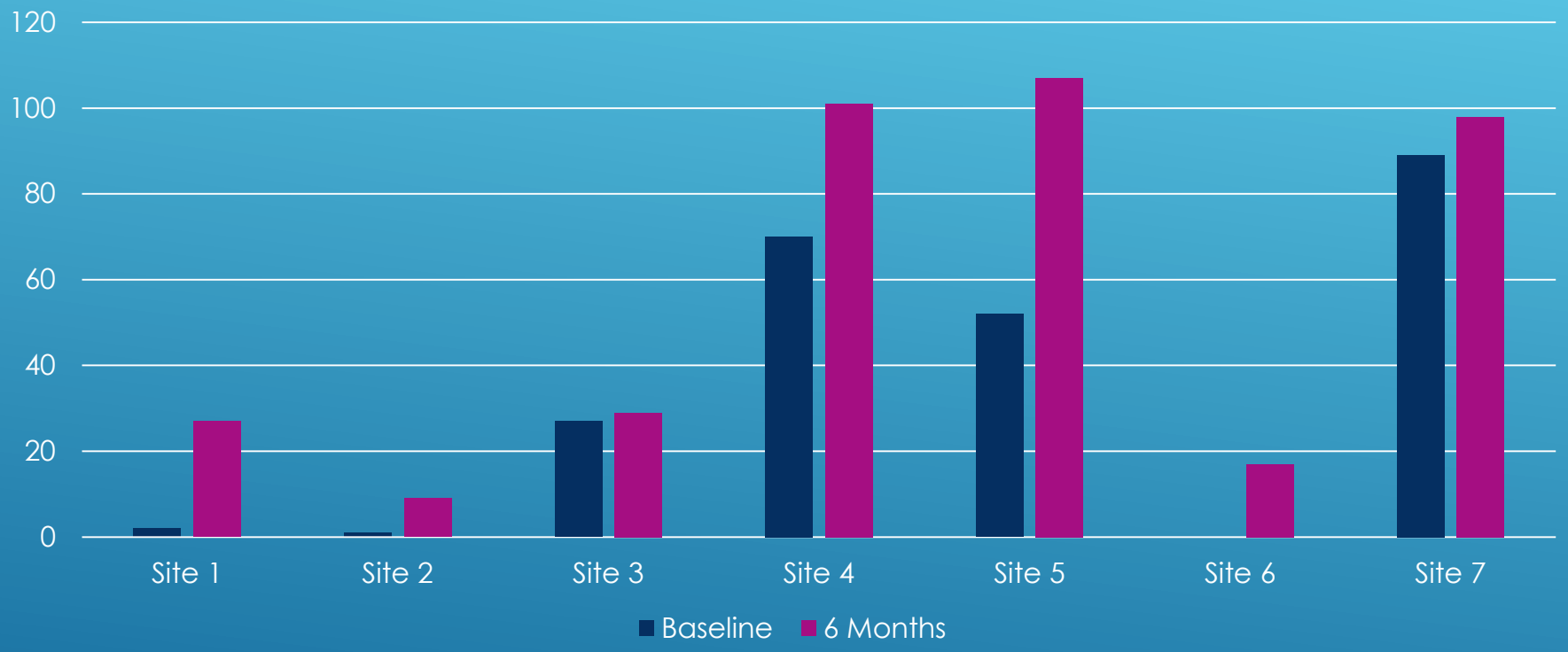
- Each intervention site matched to 2-4 other low prescribing sites stratified by prescribing rate (≤14.65% vs. >14.65-20.50) and actionable patients (≤230 vs. >230)
- Quantitative outcome measures:
  - Number of buprenorphine waivered prescribers
  - Number of patients with OUD diagnoses prescribed buprenorphine
  - Percent of patients with OUD receiving medication treatment for OUD
- Outcomes assessed each Fiscal Year Quarter (FYQ)
- Compared at FYQ prior to intervention start and at FYQ ending at least 6 months after intervention start

WAIVERED PROVIDERS



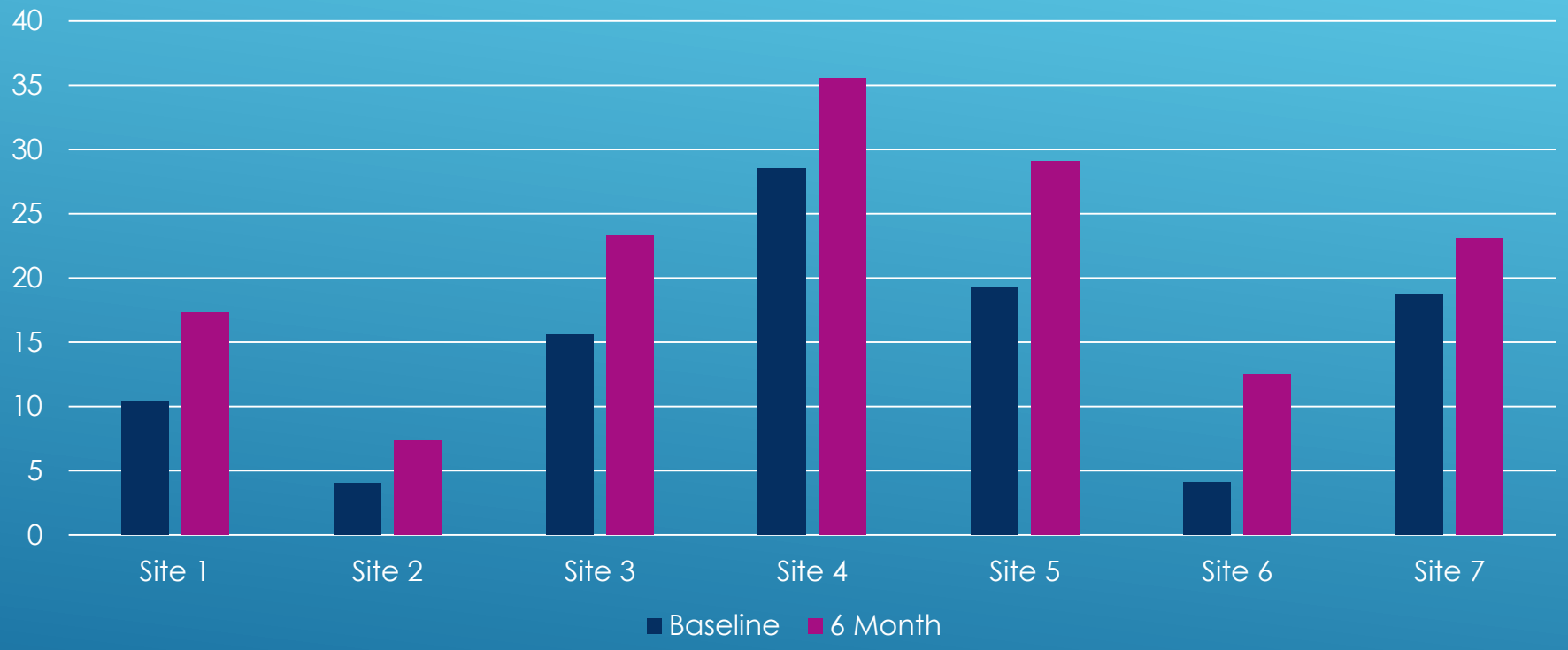
- Mean change of 5.1 ± 3.2, 95% CI=(2.7, 7.5)

NUMBER OF PATIENTS RECEIVING BUPRENORPHINE



- Mean change of 21.0 ± 18.1, 95% CI= (7.6, 34.4)

PERCENT PATIENTS WITH OUD RECEIVING MEDICATION TREATMENT



- Mean change 6.8% ± 2.3, 95% CI= (5.1, 8.5)

COMPARISON TO CONTROLS

- Matched control sites also showed significant increases in all three variables, on average.
- Difference in difference analysis:
  - Intervention sites had a significantly greater increase in waivered providers compared to matched control sites (3.3, 95% CI = 0.2, 6.4).
  - No significant difference between intervention and matched controls for patient-level variables.

COMPARISON TO MATCHED CONTROLS

Number of Control Sites Outperformed By Intervention Site			
Site	Waivered Providers	Buprenorphine Patients	% Patients with OUD on Medication
1	4/4	3/4	1/4
2	4/4	3/4	1/4
3	1/3	2/3	2/3
4	1/3	3/3	2/3
5	2/2	1/2	2/2
6	2/3	2/3	2/3
7	3/4	2/4	1/4

WHY ARE INTERVENTION SITES LESS LIKELY TO OUTPERFORM ON % OF PATIENTS PRESCRIBED OUD MEDICATION VARIABLE?

- Numerator includes patients prescribed buprenorphine, methadone or naltrexone.
- Impact of prescribing to a few new patients depends on denominator
- Some sites have reduced denominator by reassessing OUD diagnoses
  - e.g., in 5 control sites, number of patients prescribed buprenorphine dropped while % of patients prescribed medications increased

CONCLUSIONS

- Strong signal for early impact suggesting possible additional impact on patient-level variables as intervention continues
- Outperformed many, but not all control sites
  - Many other VHA and state-level efforts targeting the same outcomes

SUMMARY

- Provider education is essential but not sufficient to increase prescribing - New waivers are step one!
- Having a mentor/experienced provider on-site is a major facilitator
- Implementation is much more complex than getting a provider to write a prescription
- Implementation takes time: Teams have to figure out how to integrate treatment into their context and overcome multiple barriers to make it happen
- In the face of other pressing issues, maintaining focus is essential

IT TAKES A VILLAGE….THANK YOU TO:

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QUESTIONS??

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