Implementation and Evaluation of Medications for Treatment of Opioid Use Disorder

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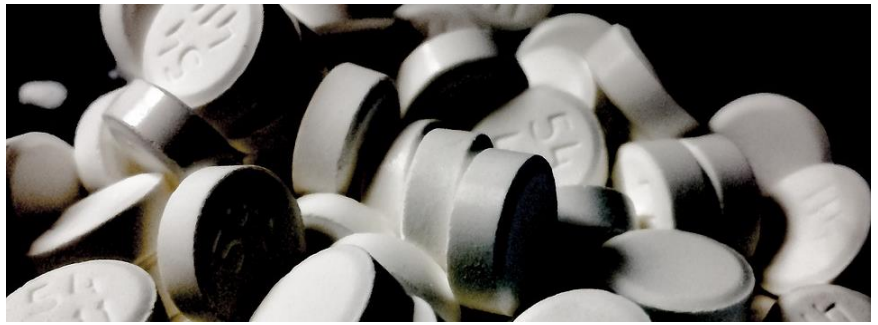
For Cyberseminar 2/6/20

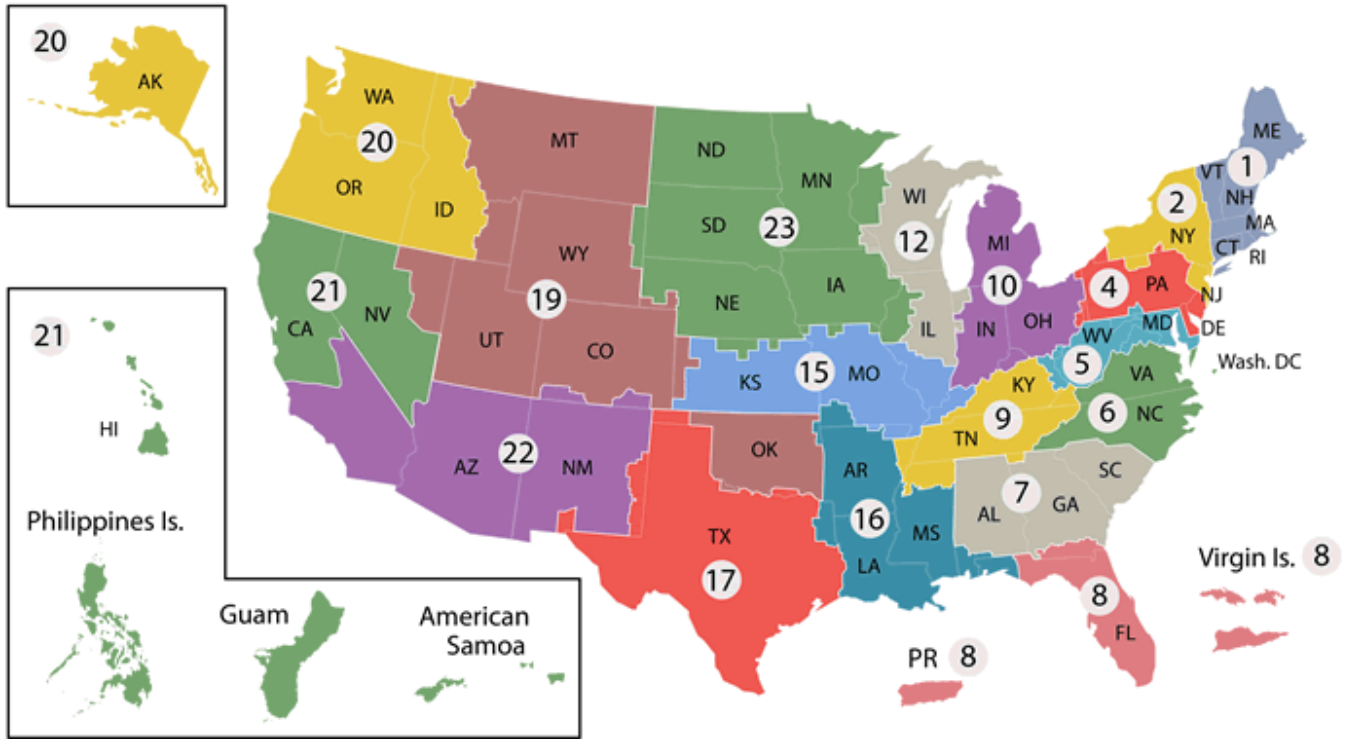
OUTLINE

- Background
  - Opioid Use Disorder (OUD)
  - Medication for Addiction Treatment (MAT)
  - National variation in the Veterans Health Administration (VHA)
- National Implementation Efforts
  - Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) Initiative (PECs 19-001, 18-203)
  - Consortium to Disseminate and Understand Implementation of Opioid Use Disorder Treatment (CONDUIT; PII 19-321)



VETERANS HEALTH ADMINISTRATION

- Largest integrated healthcare system in the US
  - >150 VA hospitals, including >1000 clinics
  - Divided up into 18 Veterans Integrated Service Networks (VISNs)
- In FY2018, ~6 million Veterans visited a VA clinic
  - <1% (n = 49,398) had a diagnosis of OUD



Characteristics of Medications for Opioid-Addiction Treatment.

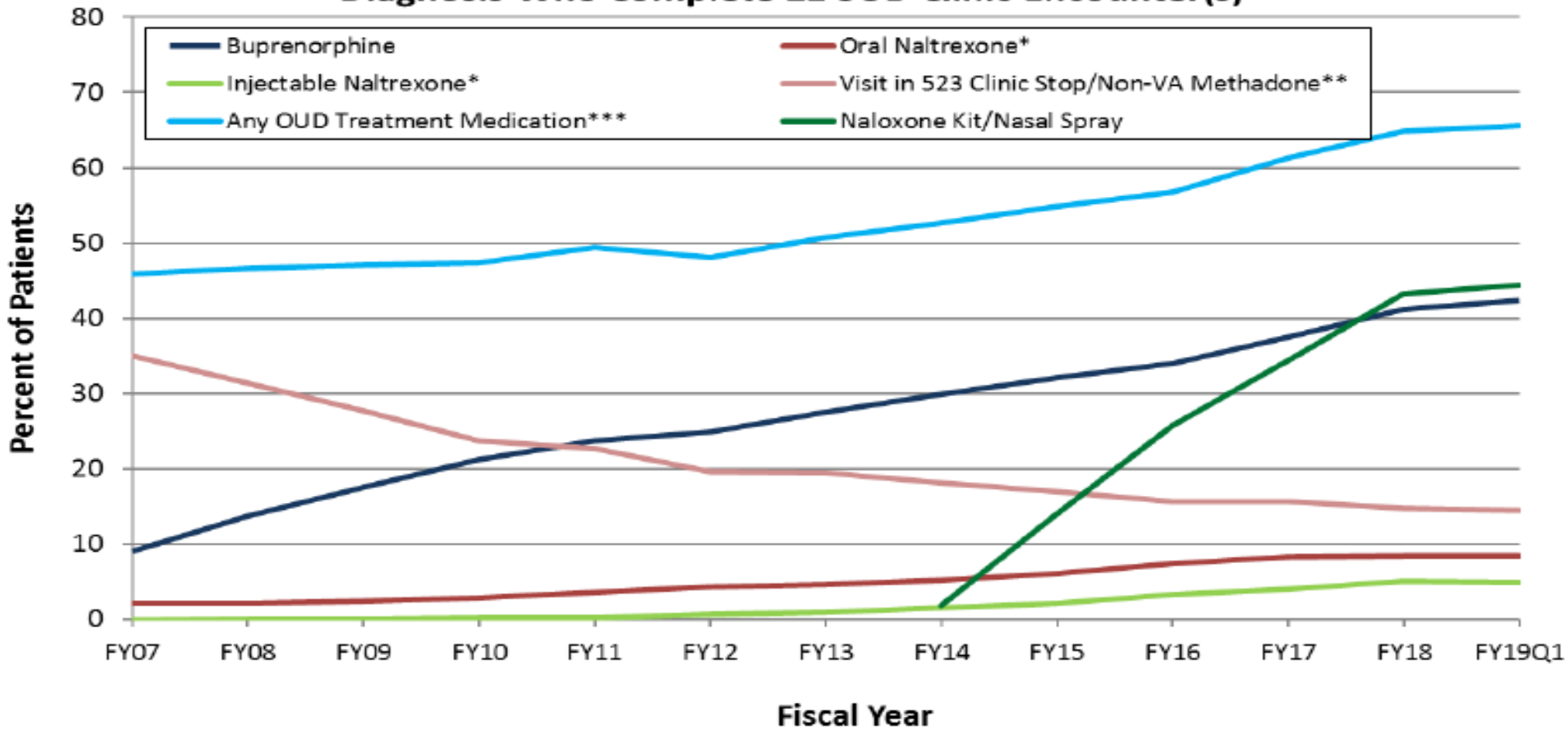
Characteristic	Methadone	Buprenorphine	Naltrexone
Brand names	Dolophine, Methadose	Subutex, Suboxone, Zubsolv	Depade, ReVia, Vivitrol
Class	Agonist (fully activates opioid receptors)	Partial agonist (activates opioid receptors but produces a diminished response even with full occupancy)	Antagonist (blocks the opioid receptors and interferes with the rewarding and analgesic effects of opioids)
Use and effects	Taken once per day orally to reduce opioid cravings and withdrawal symptoms	Taken orally or sublingually (usually once a day) to relieve opioid cravings and withdrawal symptoms	Taken orally or by injection to diminish the reinforcing effects of opioids (potentially extinguishing the association between conditioned stimuli and opioid use)
Advantages	High strength and efficacy as long as oral dosing (which slows brain uptake and reduces euphoria) is adhered to; excellent option for patients who have no response to other medications	Eligible to be prescribed by certified physicians, which eliminates the need to visit specialized treatment clinics and thus widens availability	Not addictive or sedating and does not result in physical dependence; a recently approved depot injection formulation, Vivitrol, eliminates need for daily dosing
Disadvantages	Mostly available through approved outpatient treatment programs, which patients must visit daily	Subutex has measurable abuse liability; Suboxone diminishes this risk by including naloxone, an antagonist that induces withdrawal if the drug is injected	Poor patient compliance (but Vivitrol should improve compliance); initiation requires attaining prolonged (e.g., 7-day) abstinence, during which withdrawal, relapse, and early dropout may occur

MEDICATIONS FOR ADDICTION TREATMENT (MAT*)

- Methadone
  - 32 Methadone clinics in the VA
    - Delivered in licensed Opioid Treatment Programs
- Naltrexone*
  - Use of oral and injectable
- Buprenorphine
  - Prescribed in a variety of settings
    - Substance Use Disorder Specialty care
    - Primary care

*MAT is often referred to as MOUD as well

Receipt of Medications by Patients with an Opioid Use Disorder Diagnosis Who Complete ≥1 SUD Clinic Encounter(s)



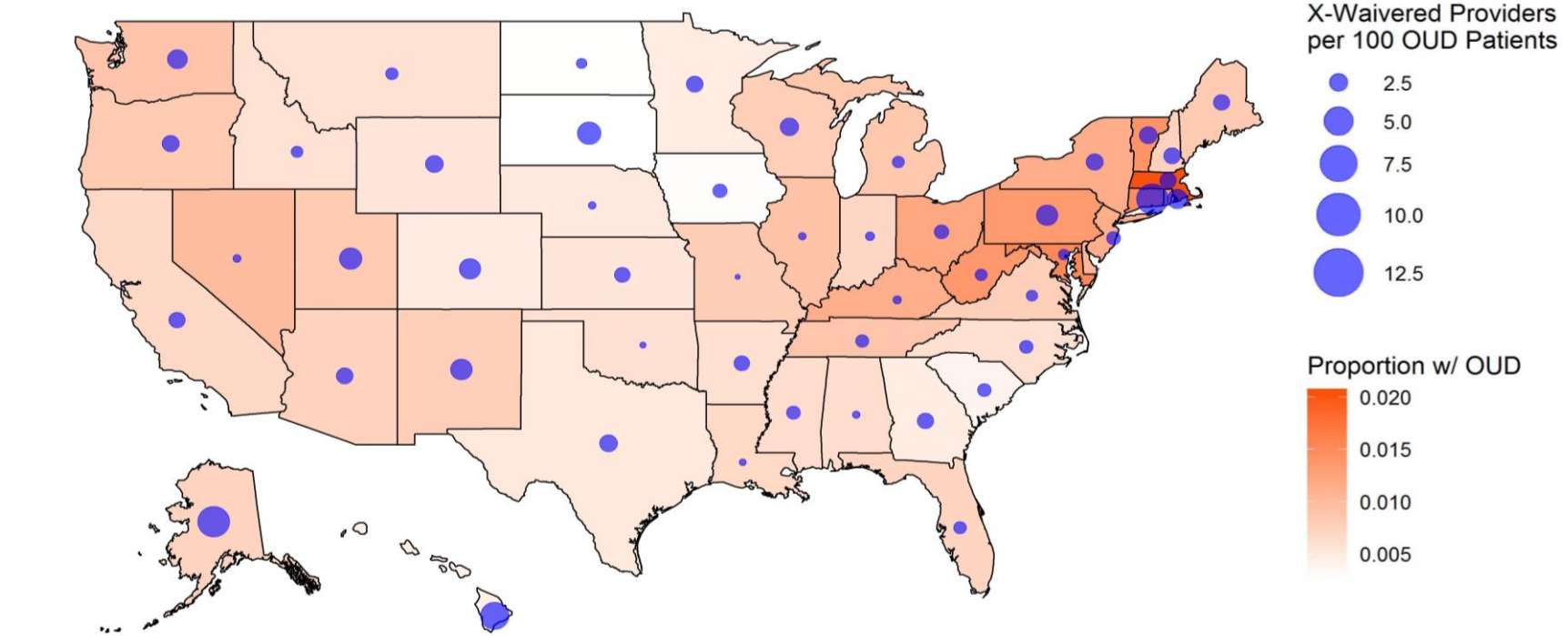
*Approximately 35 to 40% per FY also received an alcohol use disorder
**Excludes patients with visits in Clinic Stop 523 who received buprenorphine
***Includes visits in Clinic Stop 523.

X-WAIVERED PROVIDERS PER 100 PATIENTS WITH OUD, BY STATE

FY18

2,063 providers with a DEA X-waiver

4.2 X-waivered providers per 100 OUD patients.



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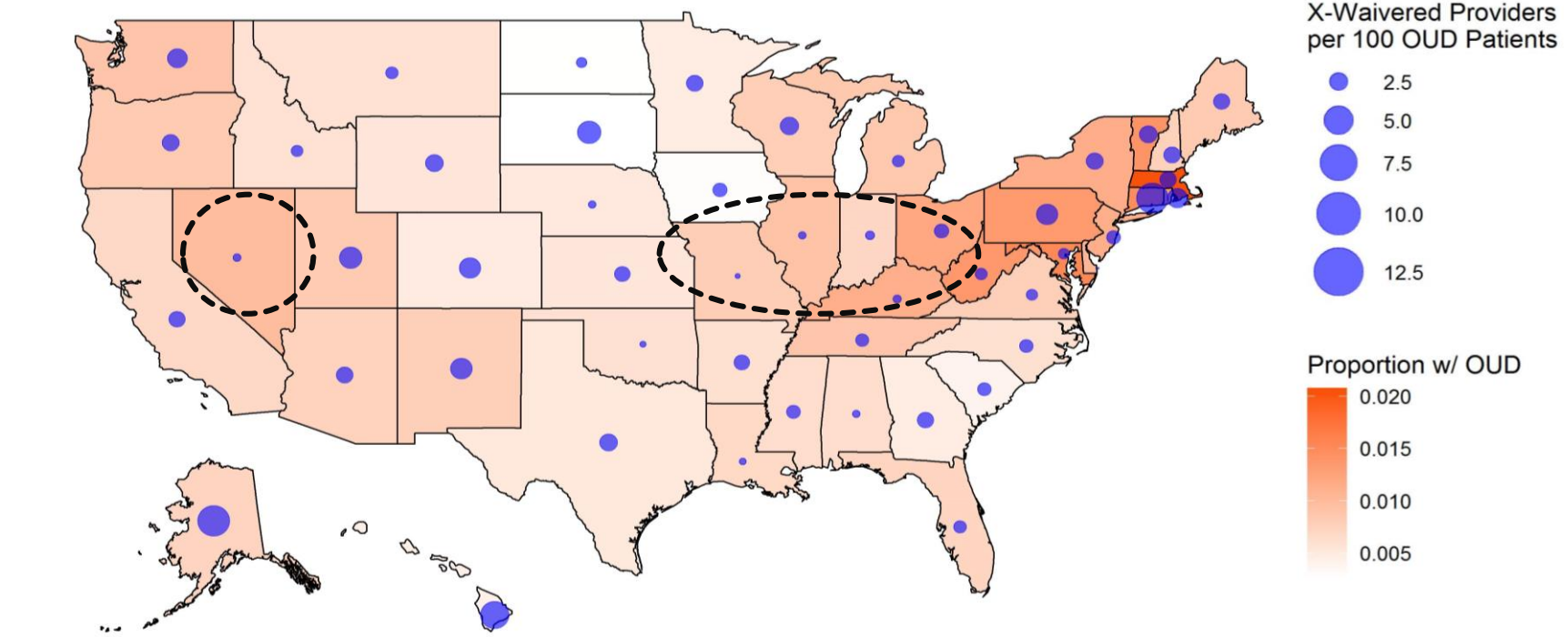


IMPLEMENTATION

TWO LARGE-SCALE, PARTNER-BASED IMPLEMENTATION INITIATIVES

Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT)

I. National Kick-Off Conference (Aug 2018)

II. 2 years of follow-up Implementation Facilitation

Phase 1 – Implementation at one VA facility in year 1

Phase 2 – Implementation at another VA facility in year 2

Goal: Implementation of stepped care models for MAT for OUD. For example:

- Standard Medical Management Model
- Collaborative Care Model

VISN-Partnered Implementation Initiatives (PII) - CONDUITå

I. **Phase 1** - 1-year pilot implementation

II. **Phase 2** - 3-year rolling implementation at >50 sites using Implementation Facilitation (Phase 2)

Goal: Implementation of MAT for OUD in a variety of clinical settings (e.g., primary care, specialty care, emergency department) using different models (e.g., telehealth)

SCOUTT vs. CONDUIT

SCOUTT

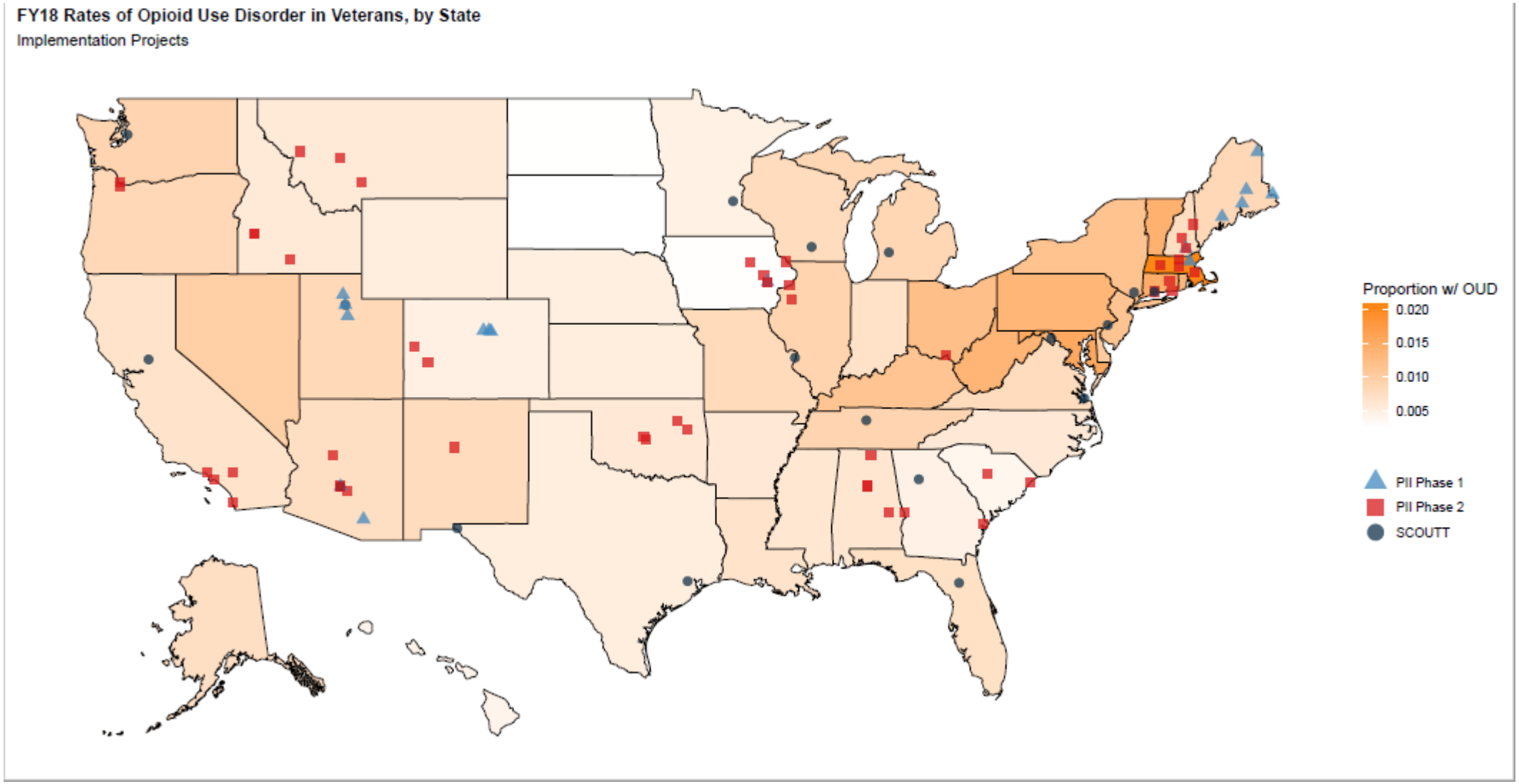
August 2018
National Train-the-Trainer Conference + 2-year implementation
18 VISNs
>130 VA hospitals

CONDUIT

April 2018	October 2019
Phase 1 1-year pilot	**Phase 2** 3-year implementation
5 VISNs	6 VISNs
8 VA hospitals	20 VA hospitals

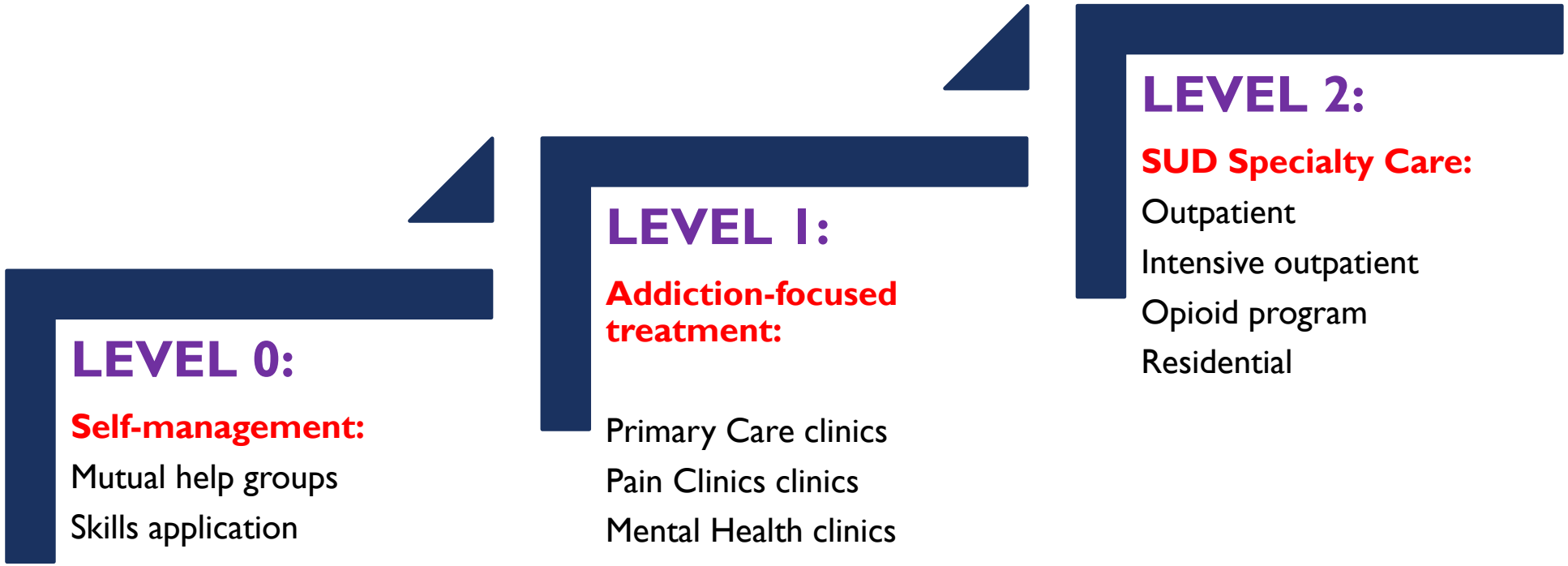
FY18 Rates of Opioid Use Disorder in Veterans, by State

Implementation Projects



SCOUTT

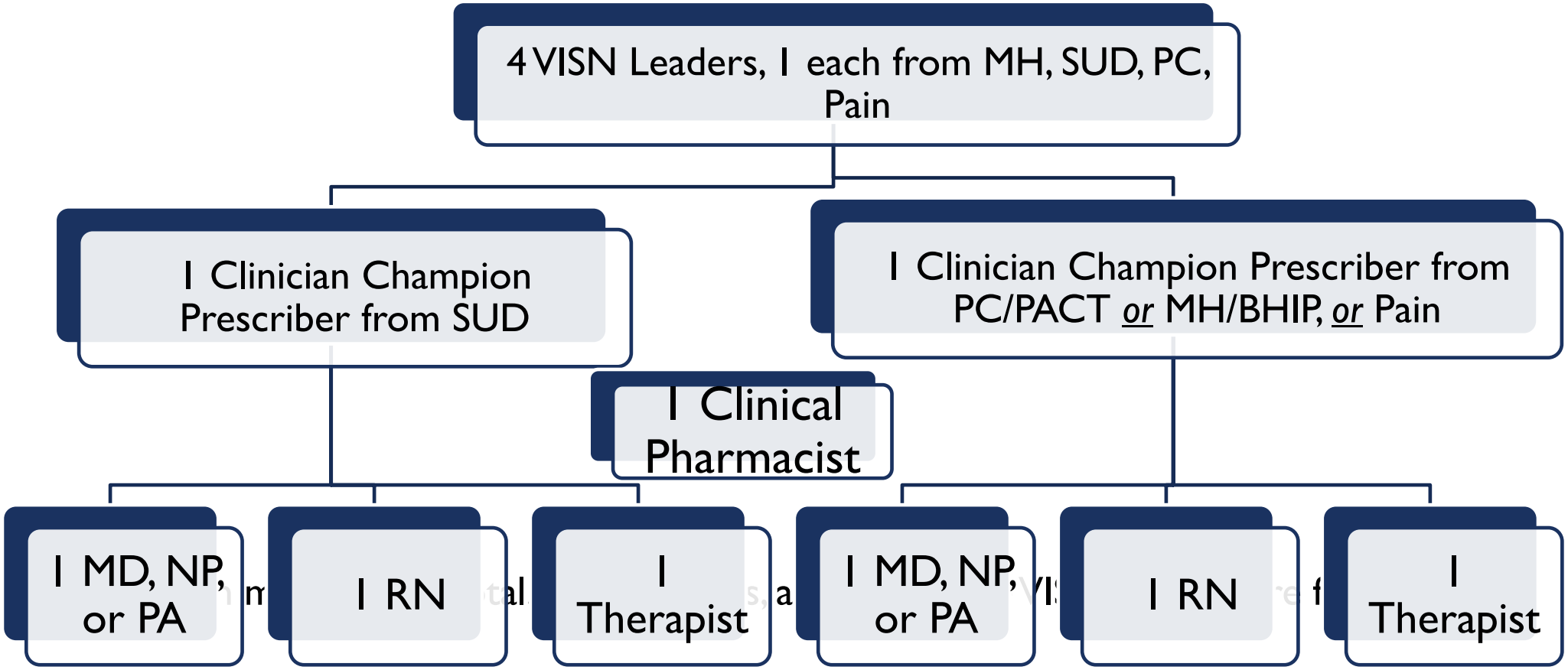
STEPPED CARE FOR OUD



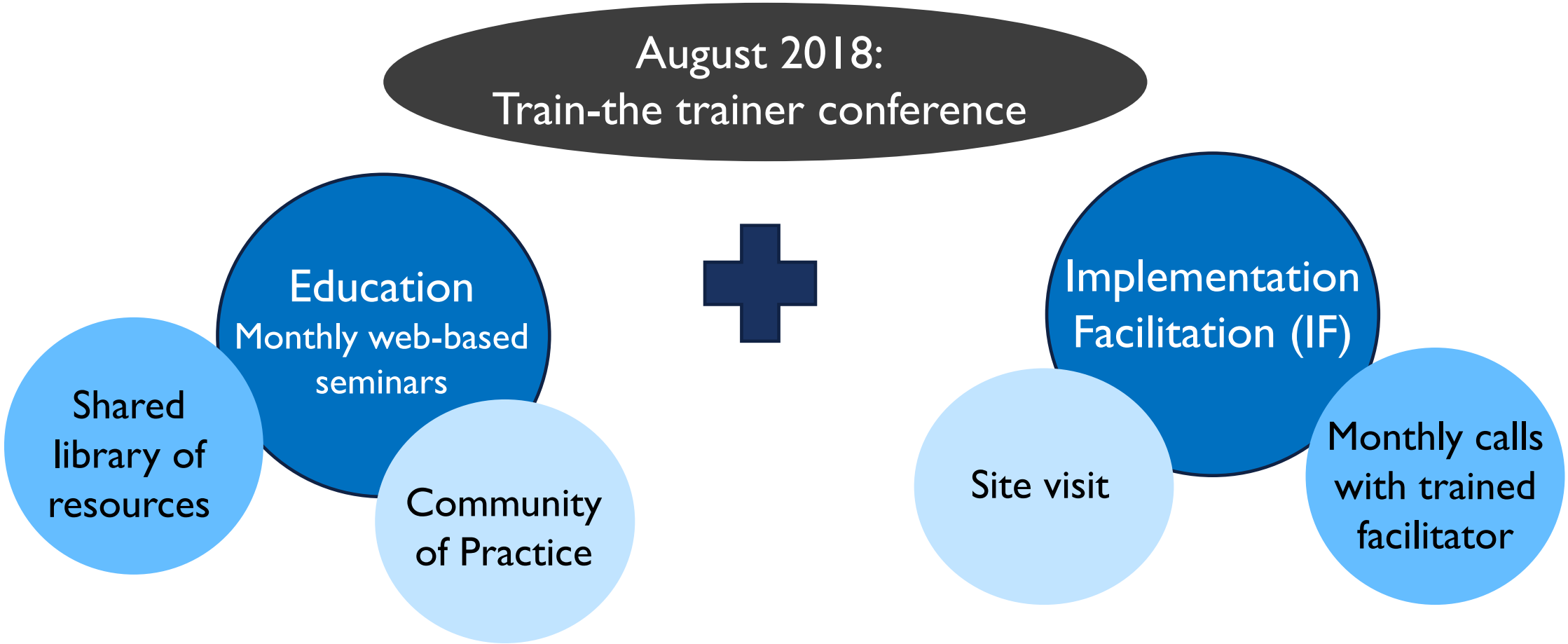
SCOUTT (NATIONAL)

- Coordinated by the Office of Mental Health and Suicide Prevention's Substance Use Disorder (SUD) group
- Cross-disciplinary teams (13 members each) from each of the 18 VISNs attended a two-day train-the-trainer conference in August, 2018
- Follow-up implementation strategies
  - Education delivered at least monthly via web-based seminars
  - Community of practice calls (2x a month)
  - Implementation Facilitation (IF)
    - One site visit
    - Monthly calls between trained facilitator and VISN team, tailoring IF activities to the needs of the site/team
    - Email or other phone contact as needed
    - Concierge mentoring

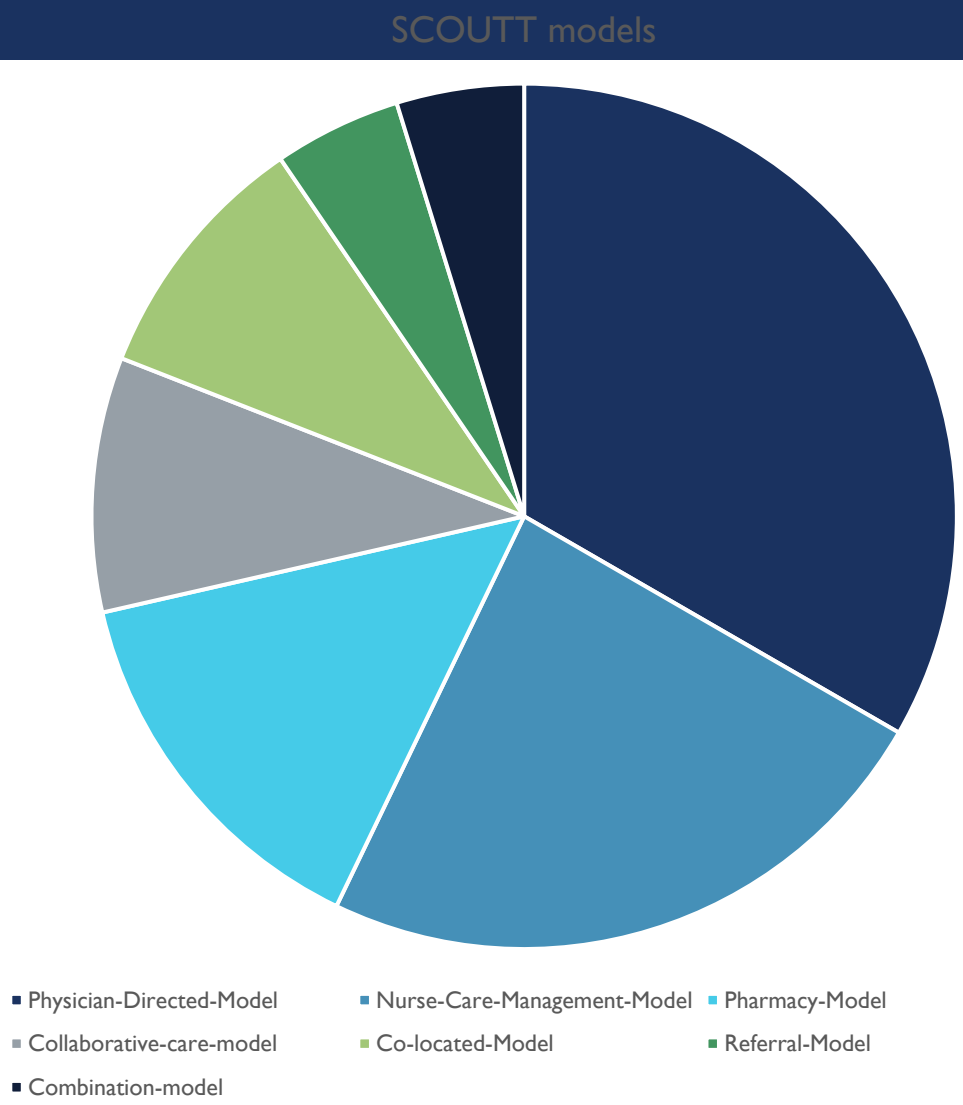
SCOUTT TEAM COMPOSITION



SCOUTT (NATIONAL)

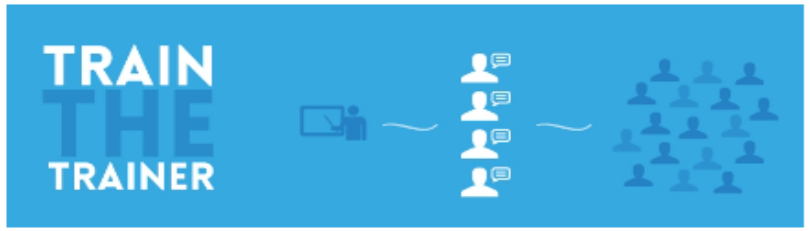


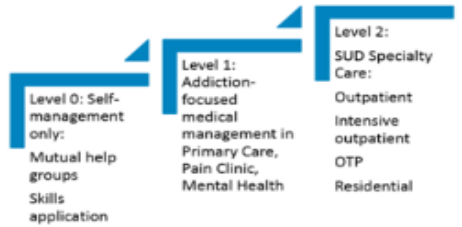
MODELS ACROSS SITES



Stepped Care for Opioid Use Disorder

Welcome to the Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) home page. Please see below and the quick links in the sidebar for SCOUTT resources, contacts and other information.





The goals and objectives of this program is to focus on implementing a comprehensive plan to train interdisciplinary teams in Primary Care, General Mental Health, Pain Clinics and SUD Specialty Care clinics to deliver a stepped care model of medication treatment for OUD in order to provide treatment services around the Veteran at his/her preferred point of care. The intent is to improve Veteran access to medication treatment outside the confines of specialty addiction care and to capitalize on the Stepped Care for Opioid se Train the Trainer (SCOUTT) training that occurred in August of 2018, where VISN teams are learning two models to integrate stepped care into VA facilities, and will be accomplished through a series national and VISN-level face-to-face meetings and regular and ad-hoc community of practice webinars.

Table of Contents	SCOUTT Calendar	Webinars	Pilot Teams Documents	Available Training
SCOUTT VISN Pilot Team Rosters	Planning Committee Members	Resources	Discussion	Questions

SCOUTT SHAREPOINT SITE:

www.tinyurl.com/SCOUTT-VA

CONDUIT

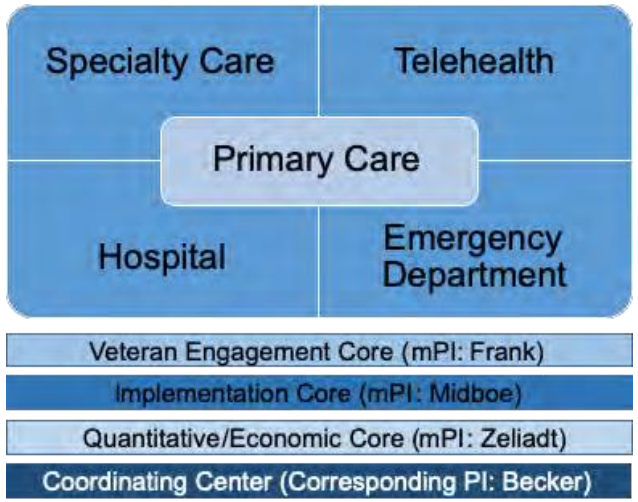
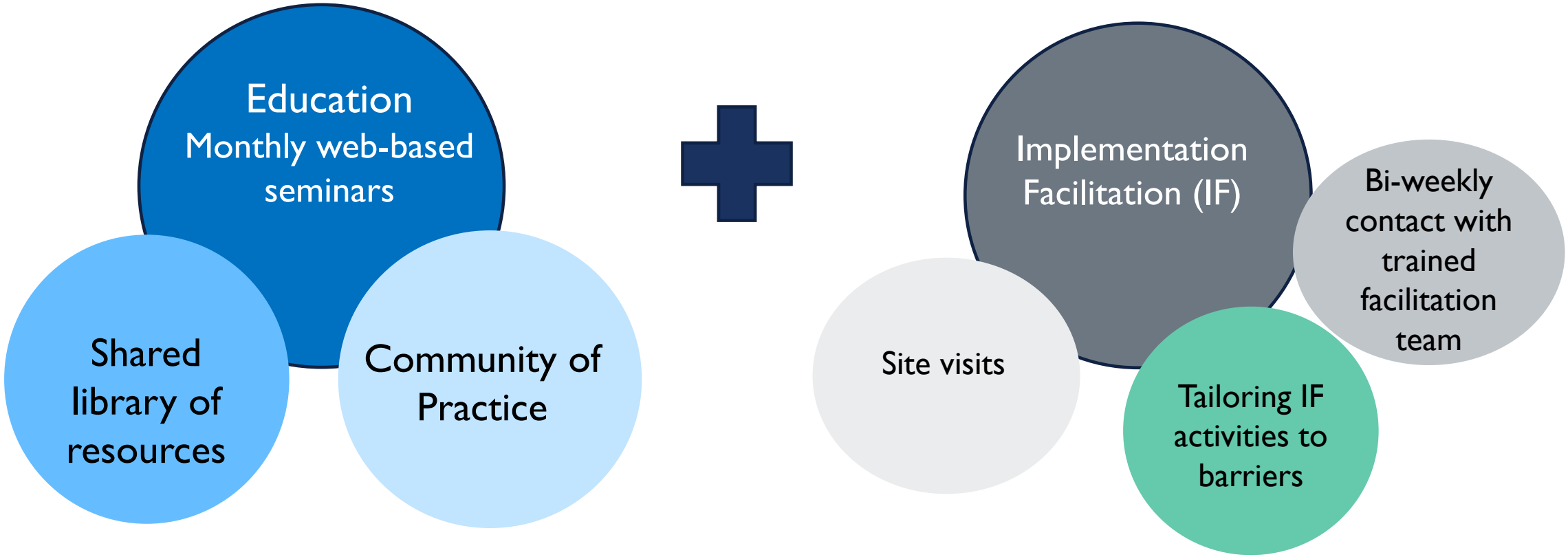


Figure 1. Continuum of OUD care and CONDUIT Core organization

CONDUIT

- Coordinated by a small team of researchers and implementation experts working with operational partners
- Targets low-performing sites to increase uptake of MAT for OUD
  - Includes a variety of clinical settings – e.g., inpatient, rural
- Implementation Strategies
  - Education, community of practice, shared resources from SCOUTT are available
  - Implementation Facilitation, with implementation activities tailored to barriers at the sites
    - Example 1: When MAT is delivered via video telehealth it may require enhanced technical assistance for technology.
    - Example 2: When there is a strong resistance to change, incentivizing of providers may be needed.

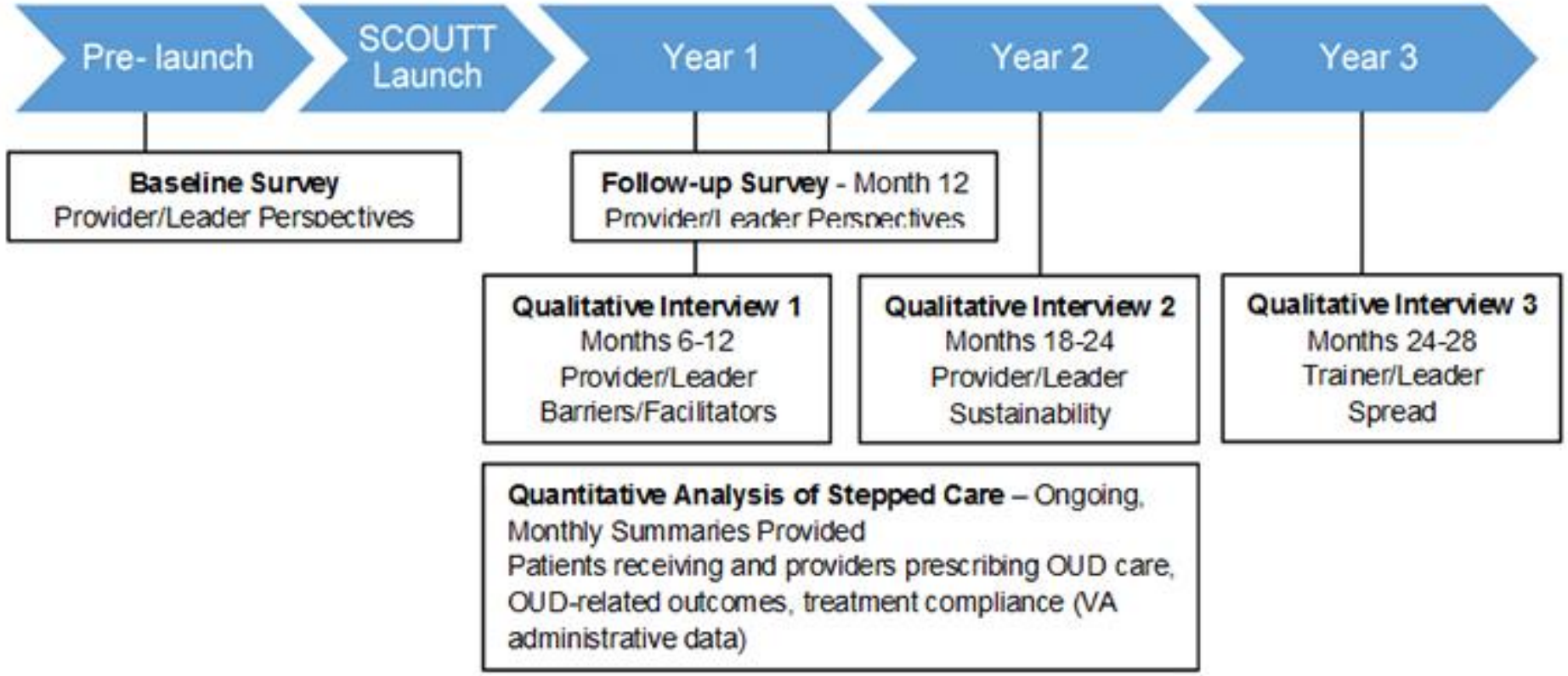
CONDUIT


Education
Monthly web-based seminars
Shared library of resources
Community of Practice
Implementation Facilitation (IF)
Bi-weekly contact with trained facilitation team
Site visits
Tailoring IF activities to barriers

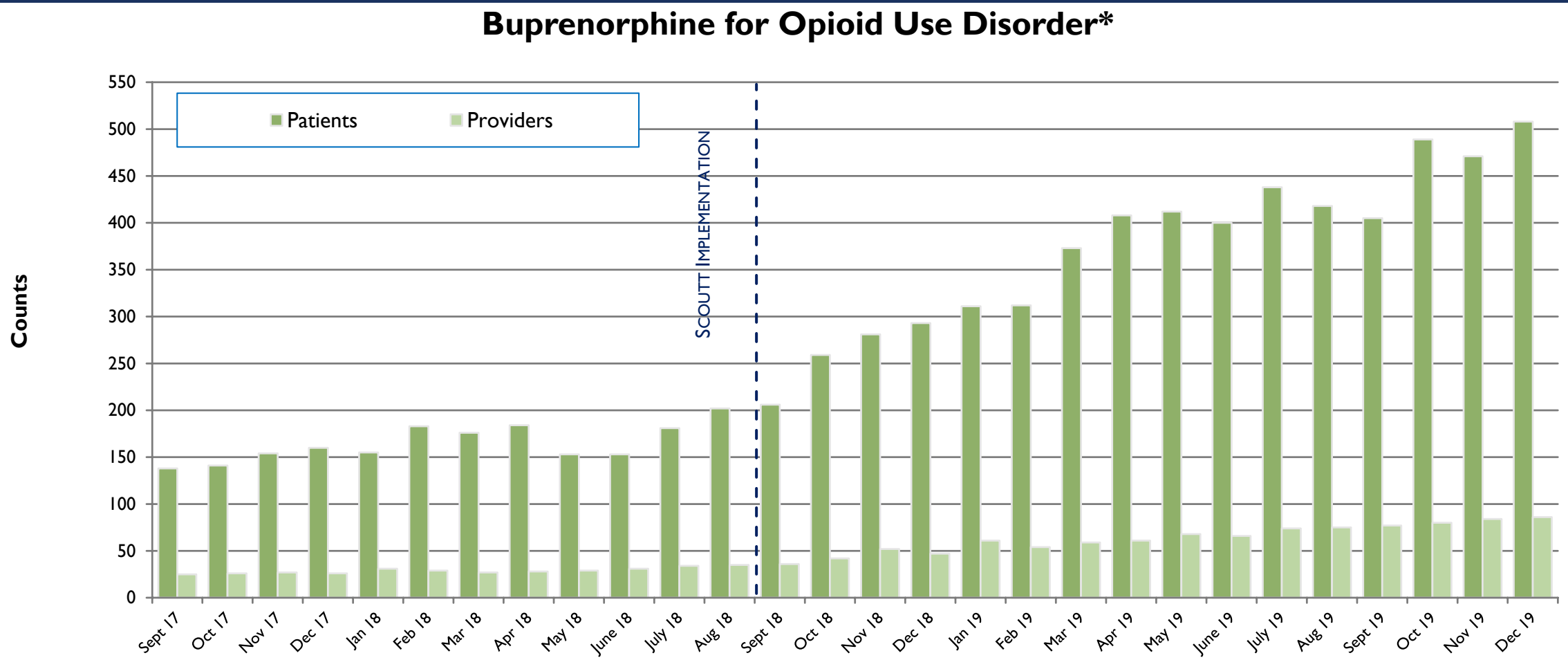
EVALUATION

SCOUTT EVALUATION

Figure 1. Evaluation Procedures

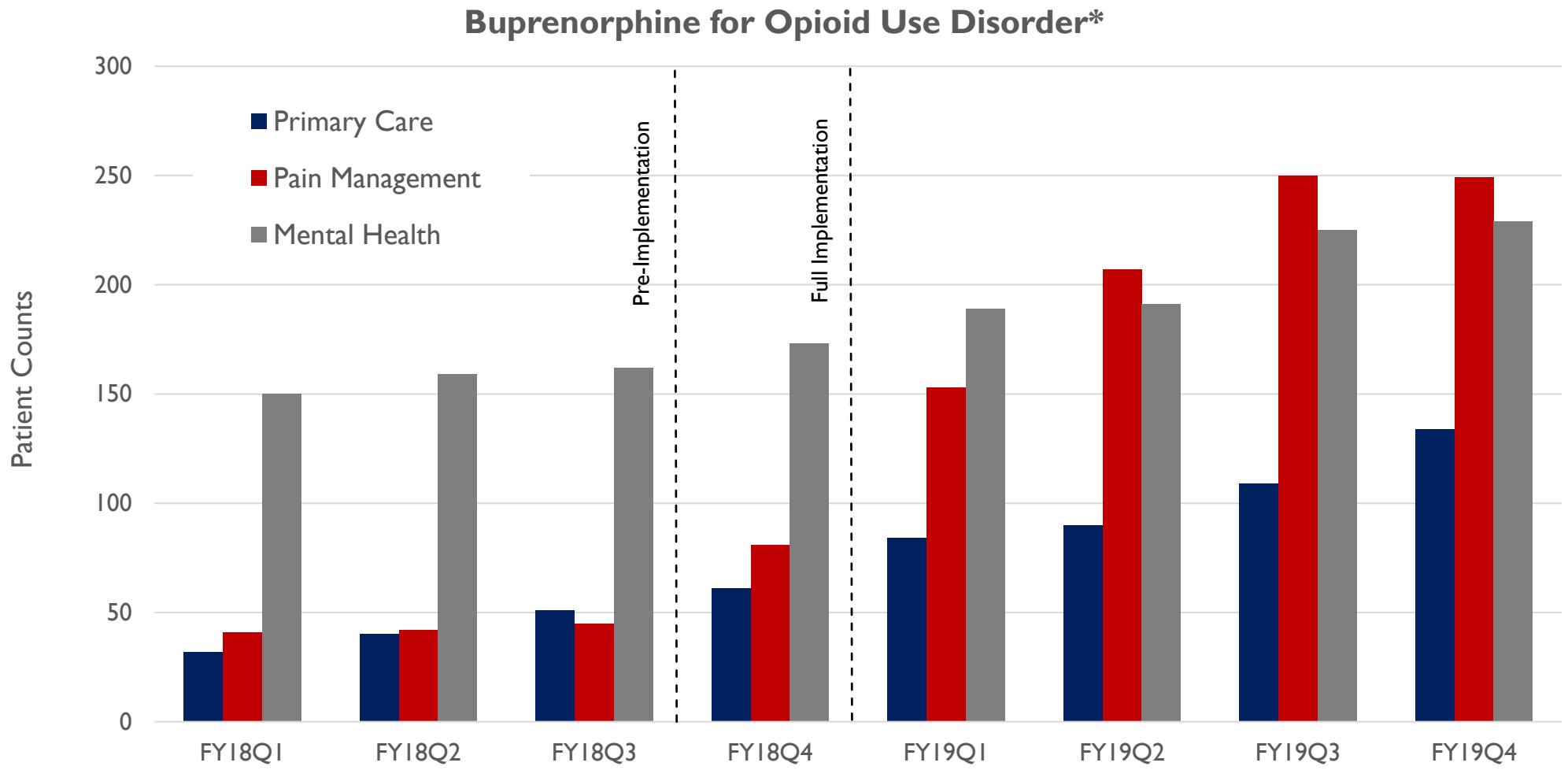


NATIONAL BUPRENORPHINE PRESCRIBING FOR OUD AMONG SCOUTT IMPLEMENTATION CLINICS 12-MONTHS BEFORE AND AFTER SCOUTT LAUNCH



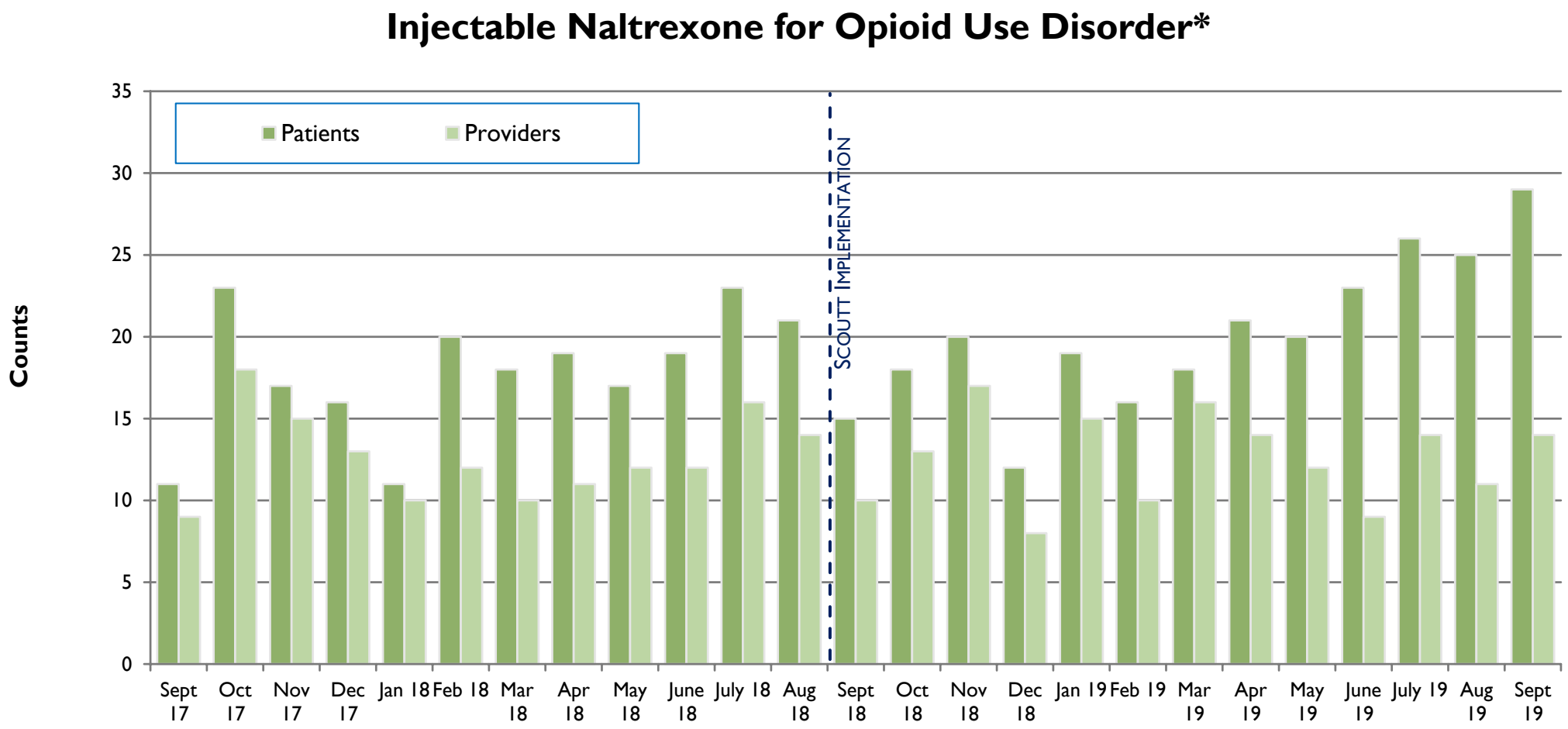
*Includes patients with a diagnosis of OUD seen in the implemenation clinic.

NATIONAL BUPRENORPHINE PRESCRIBING FOR OUD AMONG IMPLEMENTATION CLINICS 12-MONTHS BEFORE AND AFTER SCOUTT LAUNCH BY CLINIC TYPE



*Includes patients with a diagnosis of OUD seen in the implementation clinics.

NATIONAL INJECTABLE NALTREXONE PRESCRIBING FOR OUD AMONG IMPLEMENTATION CLINICS 12-MONTHS BEFORE AND AFTER SCOUTT LAUNCH BY CLINIC TYPE



*Includes patients with a diagnosis of OUD seen in the implementation clinic.

CONDUIT EVALUATION

	FY20				FY21				FY22			
	PII Phase 2											
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Implementation												
Launch Phase 2 (n of sites)		10	13		13							
Implementation Facilitation												
Evaluation												
Implementation data collection												
ERIC survey												
IF log												
Formative evaluation												
Quantitative data collection												
Refine cohort/risk criteria												
Extract/finalize CDW outcomes												
Implementation analysis												
ERIC survey analysis												
IF log analysis												
Formative evaluation analysis												
Quantitative/Econ analyses												
Report Phase 1 outcomes												
Preliminary Phase 2 outcomes												
Final outcomes												
Report implementation cost												
Downstream costs impact												
Implementation Reporting												

Formative Evaluation Data Collection

- Developmental FE
  - Facilitators & barriers data via rapid analysis techniques
  - Will be conducted on a site-specific call
  - Core will develop semi-structured interview guide
- Progress-Focused FE
  - Data will be collected via monthly IF logs
  - Focus will be tracking progress & new barriers
  - Core will provide monthly reports on IF logs to facilitation teams
- Interpretive FE
  - Post-maintenance interviews at 3-5 sites per EF team
  - Interviews with key stakeholders including Veterans (75-125 total participants)
  - Implementation core & Drs. Drummond & Mattocks will conduct

Implementation Facilitation Log & Training

- Sample of facilitation log: Opening questions

CONDUIT monthly facilitation log

Please complete the survey below. Thank you!

Site location _____

Responder's initials _____

Role of person taking survey

☐ Internal Facilitation Team
☐ External Facilitation Team

Month captured by log

☐ January
☐ February
☐ March
☐ April
☐ May
☐ June
☐ July
☐ August
☐ September
☐ October
☐ November
☐ December

Implementation Facilitation Log & Training

- Sample of facilitation log: Tracking activities

Approximately how many minutes total did you spend engaging with the external facilitator to support CONDUIT during the past month? _____

In the past month, did you engage the internal facilitator to support CONDUIT implementation?

☐ Yes
☐ No

How many times during the past month did you engage the internal facilitator to support CONDUIT implementation?

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6 or more

ERIC Survey

- Expert Recommendations for Implementing Change
- Baseline reporting
- Repeat at end of each FY
- Site leads

CONDUIT ERIC Survey

The following questions list descriptions of individual quality improvement strategies. The strategies may be used alone or with other strategies. Please select ALL strategies that describe ANY efforts to increase **medications for opioid use disorder (MOUD)** for **opioid use disorder (OUD)** at your facility from [start of site engagement] to [present]. If a strategy was not used, select "No".	
1. Did your center employ any of these strategies to engage patients or consumers as a way of promoting MOUD for OUD?	
Develop strategies to obtain and use patient and family feedback	☐ Yes ☐ No
Involve patients/consumers and family members directly in implementation efforts	☐ Yes ☐ No
Engage in efforts to prepare patients to be active participants (e.g., conduct education sessions to teach patients about what questions to ask about MOUD OUD treatment)	☐ Yes ☐ No
Engage patients/consumers to promote uptake and adherence of MOUD	☐ Yes ☐ No
Use mass media (e.g., local public service announcements; magazines like VANGUARD, newsletters, online/social media outlets to reach large numbers of people)	☐ Yes ☐ No
Promote demand for MOUD among patients through any other means	☐ Yes ☐ No

RE-AIM Measures

Table 5. Outcomes Mapped to RE-AIM Constructs

RE-AIM Construct	Primary Outcome(s)	Secondary Outcomes
Reach	Number of patients with OUD initiating MOUD during the implementation period in implementation sites[1]	
Effectiveness	Number of patients with OUD retained on MOUD at 90 days and 180 days during the implementation period (i.e. treatment retention)[1]	▪ Hospitalizations and ED visits related to OUD post-implementation[1] ▪ Opioid-related or other drug overdoses in patients with OUD post-implementation ▪ Opioid dose for patients on LTOT post-implementation[1] ▪ Concomitant opioid-sedative prescriptions post-implementation[1]
Adoption	Number of providers (and/or clinics) providing MOUD post-implementation, stratified by type of provider, clinical setting[1]	Number of VISTA x-waivered providers post-implementation [1]
Implementation	▪ Facilitators and barriers to implementation[2] ▪ Fidelity, as measured by frequency and duration of Implementation Facilitation strategies[3] and other implementation strategies[4] ▪ Cost of implementation[1,3]	Variation in facility-level use of implementation strategies over time
Maintenance	▪ Summary of facilitators and barriers at implementation clinics 6 months post-implementation[2] ▪ Elements of program maintained, including adaptations[2] ▪ Number of VISTA x-waivered and prescribing providers 6-month period post-implementation	Number of OUD patients receiving MOUD 12-24 months after implementation

Data source: [1]CDW; [2]Semi-structured interviews; [3]REDCap facilitation tracking logs; [4]REDCap survey of ERIC strategies.

COST OF IMPLEMENTATION AND RETURN ON INVESTMENT

- Primary economic outcome - cost per additional Veteran initiating MOUD.
  - Implementation costs and costs of delivering the clinical program/intervention.

- Return on investment will include total costs, including concurrent/downstream treatment and medical care costs.

ACKNOWLEDGMENTS

- HSR&D QUERI PEC (PECs 19-001-Gordon, 18-203-Hawkins) and PII funding (PII 19-321)
- Office of Mental Health and Suicide Prevention
  - Karen Drexler, MD
- PII PIs – Will Becker, Adam Gordon, Joe Frank, Marc Rosen, David Moore, Evelyn Chang, Hilary Mosher, Steve Zeliadt
- VISN Leadership
- Pharmacy Benefits Management's Academic Detailing Service
- Lara Troszak, MA
- Taryn Erhardt, MS

CONFLICT OF INTEREST AND DISCLOSURE

- Drs. Midboe and Gordon have no fiduciary conflicts of interest
- The views expressed in this presentation are Drs. Midboe's and Gordon's and do not necessarily reflect the position or policy any institution, agency, or government