Unidentified: Welcome to the VA HSR&D Investigator Insights podcast series. In this episode, QUERI dissemination coordinator Diane Hanks speaks with investigator Hildi Hagedorn about her work evaluating and implementing the use of medication assisted treatment for veterans with opioid use disorders.

Diane Hanks: Before we talk about the study, please tell us about the importance of medication assisted treatment for OPI. Brain use disorder.

Dr. Hagedorn: Among veterans that receive care within the VA, approximately one percent have an opioid use disorder diagnosis, and that is about 60,000 veterans. And medication treatment is the gold standard treatment for opioid use disorder. It’s often referred to as medication assisted treatment, but we’re actually trying to change that language to be medication treatment for opioid use disorder because people assume that medication is one piece of the gold standard treatment when actually the medication is the gold standard treatment. So that’s not to say that these individuals would not benefit from all sorts of wrap-around services, counseling and groups and mental health assistance and all that. But what we’re trying to avoid is the situation where if someone’s willing to take a medication but they’re not willing to do all that other stuff, they should still have access to the medication. Because it’s very clear that the medication by itself reduces mortality, which is ultimately what the goal is.

Diane Hanks: I would imagine for veterans living in rural settings that makes a huge difference because they don’t have to travel to see a therapist or medication is something they can pick up at their pharmacy. Or is this something that they have to pick up at a VA hospital?

Dr. Hagedorn: So buprenorphine can be mailed out to pharmacies. They are VA’s that are willing to mail it out to people’s homes. The problem with that is because it’s a controlled substance, you have to sign for it. So if you’re working full-time or something like that, people will get a post office box because they can leave it locked in the post office box without a signature. So yeah, exactly for access issues, if you live too far away from your facility or if you’re working full-time and you can’t get there during regular business hours, it just makes it much more convenient for people to access the treatment.

Diane Hanks: And which medications are we talking about? I think there are two or three that are used.

Dr. Hagedorn: Yes. So there’s methadone, buprenorphine, and naltrexone. Methadone can only be prescribed in DEA licensed substance use disorder treatment facilities and it has to be—the person has to take the medication on site. Buprenorphine can be prescribed from anyone’s office. So obviously, physician, or provider, nurse, practitioner, physicians, assistant but can be prescribed from an office. So in VA, most of that prescribing has been done in substance use disorder specialty clinics. And So what we’re really working on now is expanding access where providers in mental health and primary care and pain clinics will also be willing to write those prescriptions.   
  
And it’s interesting because outside of VA, it’s almost flipped. Buprenorphine is much more frequently provided through primary care settings and not as much through substance use disorder specialty care because outside of VA, a lot of SUD specialty care doesn’t have prescribers. So outside VA, the problem’s almost the reverse. And then naltrexone is the third one and that’s considered second line. So methadone and buprenorphine are opioid agonists. Well, methadone is agonist and buprenorphine is partial agonist. It is an opioid. Naltrexone reduces craving for opioid use disorder. It is not an opioid.   
  
Some people really want to be completely off all opioids. And so they are more interested in naltrexone. But it is not as effective mainly because of adherence issues. You decide you want to use opioids to stop taking your naltrexone. So really the injectable naltrexone that lasts 30 days is really—it’s really the only option that we recommend. And with that, the danger is that if the injection starts to wear off and they don’t come back for the next one and they start using again, their tolerance is gone. So that can be a very dangerous time. So that’s why methadone and buprenorphine are considered first line.

Diane Hanks: So tell us about your study and implementation phase because implementation is important to studies and doing it right and for further spread.

Dr. Hagedorn: The goal of this study is to increase access to medication therapy for opioid use disorder in the lowest performing VA facilities in the country. On average across facilities about 30 percent to 40 percent of patients with opioid use disorder are receiving medications. Arguably, that’s still too low. But if you look across facilities, the mean may be 30 percent, but you have clinics or facilities that are up to 60 percent and you still have facilities that are virtually at 0. So we took the lowest quartile facilities, which meant that they’re prescribing weight was less than 20 percent at baseline and we randomly selected eight of those facilities and reached out to their substance use disorder specialty care leadership and ask them if they would like to be included in this study. Which basically provides extensive external facilitation to help them figure out a strategy to increase access to some medications.   
  
In those lowest performing sites, some of the sites had a couple, a few dozen actionable patients and some had several hundred. When you think about the VA metrics, so sub-16, which is the percentage of patients with opioid use disorder who are on approved treatment medication treatment, then that gives you the number of actionable patients and actionable patient is someone who has opioid use disorder who is not yet on an approved medication treatment. So we figured that the implementation challenges at those sites would be very different from each other because you’re talking about very rural facilities versus very urban facilities that are just not able to keep up with this huge demand. And so we have a mix of those.   
  
We purposefully selected a mix of those types of facilities and we basically, we start interviewing everyone that will give us the time. That’s step number one. We interviewed at least ten people from each of the eight facilities. We put together a site report for them which basically described, this as your current situation. These are the barriers you identified for why you’re not expanding. Facilitators, potential strategies, and we took that site report on a site visit. Dr. Adam Gordon, who’s my co-PI, and I spent a day and a half at every site, and he provided ex-waiver training in order to prescribe buprenorphine in an office-based setting. Providers have to do an eight-hour training and get a DEA X waiver.   
  
So first thing we did, do the X waiver training so at least they have the option. And then he also does other didactic education about how to do this in your office setting, cause that’s what he does in primary care. And then we reserve about four hours of that site visit are really about action, planning and strategizing. And so we come away from the visit with, these are the top three goals we have for our year. And these are the barriers related to each and the steps that need to be taken and the people that are going to be responsible. And then over the next year, we have conference calls with them once a month. We have four sites are done with their year and then our last four site, we’ve got four more that we’ll be wrapping up…

Diane Hanks: So are you seeing any findings yet?

Dr. Hagedorn: Yeah. So I think it’s really encouraging. We have a statistically significant increase in the number of providers that have their waiver, which is step one. The number of patients that have a prescription at this point, each one of our sites is paired with three to four control sites and at this point, the difference between the intervention and the control sites is only significant for the number of waivered providers. The control sites have also increased on all those metrics, but the intervention sites have increased more on the number of waiver providers in the first six months. Because we only have complete data for all sites up to six months right now.   
  
So what we’re hoping is that since they outperformed unwaivered providers in the first six months that maybe in the second six months then you’ll see them outperforming on patient prescriptions. But there are so many initiatives going on right now in VA and in the States and nationally that are targeting the exact same issue. So being able to tease out that this [overlapping conversation] was the thing that—I mean, it’s going to be hard, but for me, the reason that I do this kind of work is because I want to help these facilities and their providers and their patients and of course I like getting fabulous statistically significant results and amazing publications, but it doesn’t happen all the time so.

Diane Hanks: But just knowing that you’re changing the lives of some veterans and you’re bound to. That’s a huge contribution to their lives, to their families lives. And who knows who they tell. If one person changes, he or she could change five other people’s opinions about taking methadone or buprenorphine for opioid use disorders.

Dr. Hagedorn: And we see that with providers as well. If you can get one primary care provider to just start doing this, and generally speaking once people overcome—they get their training, they overcome the fear, I mean, there’s a lot of fear about starting someone on this medical. Once they start one or two people, they become the hugest champions ever because you see a dramatic, almost instantaneous difference for the patients because they have to come in and withdrawal. And you give them the medication and they’re feeling better right away. They leave feeling better.

Diane Hanks: They can go back to their lives.

Dr. Hagedorn: They go back to their lives. And we hear people say things like, I have my life back.

Diane Hanks: Yeah, it’s great work.

Dr. Hagedorn: Thank you.

Diane Hanks: Yeah, as usual. Good work.

Dr. Hagedorn: Thank you.

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