Operator: Welcome to the VA HSR&D Investigator Insights podcast series. In this episode, Rob Offrey of the Center for Information Dissemination and Education Resources talks with Dr. Hildi Hagedorn, a core investigator and Director of the Implementation Core for the Center of Care Delivery and Outcomes Research in Minneapolis.

Dr. Hagedorn has a long-established career with HSR&D and has focused on system-changing implementations of best practices for treating substance use disorders.

Interviewer: Hello, Dr. Hagedorn. Welcome and thank you for agreeing to this interview. If I understand correctly, you are here at the 2022 Academic Health Annual Research meeting presenting research that is similar to, or an extension of, work that you have recently won the HSR&D Systems Impact Award for.

Hildi Hagedorn: Yes, yes.

Interviewer: Congratulations.

Hildi Hagedorn: Thank you.

Interviewer: Can you go into a little bit of detail about that?

Hildi Hagedorn: Yes. So, I think, I mean, the systems impact world I’ve been working in – implementation science within the area of substance use disorders for my entire VA career. So, I like to think that it was in recognition of the whole trajectory of my work.

But what was highlighted in the award is the IIR project that I'm going to be projecting tomorrow, which is we use the acronym ADAPT OUD so, it’s Advancing Pharmacological Therapy for Opioid Use Disorder.

I think what was really unique about that was, you know, if you look at the percentage of patients that receive medication treatments for opioid use disorder at the national level, that number looks great compared to outside of VA.

But if you look at every facility in the VA, just like with everything else, you’re going from essentially zero access to phenomenal, like 60%-plus of patients receiving that evidence-based treatment.

So, we really honed in on that left side of the curve; the lowest quarter of facilities. We randomly chose eight of those facilities to intervene with, which was a very intensive external facilitation intervention, which just means that someone from the outside is coming in to help them develop an action plan and strategies and goals and monitor their progress and help them keep their eye on the ball, so to speak, when they’re being obviously distracted by ten million other high-priority clinical issues.

So, we worked with those eight sites for a year. The results I'm going to present tomorrow are, as with almost any implementation project, the impact was varied. But in general, seven out of the eight facilities improved quite a bit. And we had our match control group and that was close to a significant impact.

Well, we have one – one site was very odd in many ways that I’ll go into detail tomorrow. But if you take that site out, we had a significant impact on the access to the medications.

So, it was really just kind of this one strange site that the intervention did not have any effect there.

Interviewer: Thank you. I'm going to ask you to back up just a little bit.

Hildi Hagedorn: Yes.

Interviewer: Did you find that that inequity had to do with rurality or socioeconomic status?

Hildi Hagedorn: Well, it was interesting because of that lowest quartile group, we decided to select sites – there were a couple variables that we stratified sites on. So, one was how much prescribing were they doing already. Because even in that low quartile, you’re talking sites that had zero and sites that had like 20% of their patients receiving medication treatments.

So, we felt like the difference of starting from nothing and the difference of expanding from something could present different challenges.

And the other variable that we stratified on was just the raw number of patients with opioid use disorder that were not receiving medication treatments. So, some sites had a few hundred or maybe even a few dozen, and some sites had hundreds.

So, we ended up with a sample that ranged from extremely, extremely rural to large metro and it did turn out that the impact was influenced by those variables.

So, almost in an opposite way of what you might guess in that the bigger – like the more metro, the more patients, the ones that already had some prescribing going on; there was less of an impact of the intervention. And my hypothesis about that is that number one; they had enough going on that leadership wasn’t breathing down their neck as much about their metric in that area. Because this is one of the sale metrics – MOUD prescribing.

And then, the other is just the sheer volume of patients makes it more challenging to address the problem. Because you can’t just have a team; you have to have many different avenues to address the problem.

So, I think it was just more complex and less high-salient for those facilities. So, we had our best impact with the tiny little ones.

Interviewer: What conclusions were you left with?

Hildi Hagedorn: To me, I think VA has spent – well, I mean, ever since I’ve been with VA, this has been an issue of getting evidence-based treatments for opioid use disorder to patients. So, it’s been a really important issue for operations for over a decade, for sure. And there have been a lot of top-down interventions, you know, like, “We’re going to put a mandate in place,” “We’re going to put a sale metric in place,” “We’re going to host conferences,” “We’re going to put out a bunch of educational resources, do a bunch of webinars.”

So, all that stuff was that. And when you think of that curve, it was very effective in pulling the national number of over those years but it left the tail end behind.

I think that the facilities that have the time, interest, energy, and resources to utilize of all of those top-down educational resources and trainings and conferences; then, they were doing okay. And the ones that weren’t able to, for whatever reason, access and use those resources, I think, really needed that more intensive, “We’re going to come and hold your hand now for a year and we’re going to drag you along and keep your eye on the ball for a year. And we’re going to connect you with all those resources directly so that you don’t have to go out searching for them.”

So, I think the main conclusion is if you’re trying to implement evidence-based practice in a large system, you can try starting with the relatively low-cost, low-touch interventions. See how it works and then, target the more intensive – because it is very resource-intensive to do this kind of intervention. You can’t do it with 150 facilities. So, you can target the facilities that are unable to make changes from the other resources you provide.

Interviewer: I see from your abstract that facilities that had the intervention almost doubled the number of patients with opioid use disorder receiving MOUD from 18% to baseline 30%.

Hildi Hagedorn: Yes.

Interviewer: That’s impressive.

Hildi Hagedorn: Yes. And I think part of the reason is that they had so – most of them had so little going on that they had huge room to grow. I don’t think you could see – like if you’re starting at 50%/60%, you’re not going to see a jump like that. But if you’re starting at zero – and particularly, these little rural sites – you’re not talking about a lot of patients either.

So, if you treat 25 patients, you went from 10% to 30% or something. So, yes.

Interviewer: So, did you see personally how that affected veterans?

Hildi Hagedorn: We had done some interviewing of veterans at the start of the intervention to try to get stories to share with the sites. And so, most of our stories come from veterans that were struggling to access this treatment.

So, I think what really struck me was just veterans saying things like, you know, “The VA prescribed all the opioids to begin with and now they turn around and tell me” – and I had to even use the word because I don’t use this word but – “Now they’re calling me an addict and they want me to go to a substance use disorder clinic or go to a mental health clinic and I don’t feel like I fit there. And I should be able to have my primary care provider prescribe this medication.”

Even some of the folks that were willing to try to access specialty care, you know, it was just like, “Well, you start with primary care and then, they tell you to go to specialty care. And then, you go to specialty care and then, well, some of them didn’t have prescribers in specialty care. So, then, you’ve got to go get community care.” And this is like weeks-, weeks-long process and yet, those vested are immersed in research and substance use disorders.

When someone comes and asks for help, if you can’t do something right now, you know, the motivation is going to quickly change. So, if you’re making them jump through a bunch of hoops for weeks at a time, they may very well lose that motivation. And we had people saying, “Well, it took me – I was trying to access this treatment. I ended up buying this medication on the street and spending my own money to treat myself,” basically.

Interviewer: That sounds difficult.

Hildi Hagedorn: So, hopefully, for some veterans at those sites that we worked with, hopefully, that has changed.

Interviewer: So, you say you’ve been doing this type of work for most, if not all, of your career.

Hildi Hagedorn: Yes.

Interviewer: What brought you to the VA originally and what keeps you here?

Hildi Hagedorn: I grew up in the Air Force. My dad was a veteran and so, I think I just always had a fondness for military culture and for veterans.

The VA has the most astounding internship – psychology internship – program. And so, when I had the opportunity when I was getting my PhD and looking for internships, I interviewed and toured at all these different locations. I wanted to be back in Minneapolis. And I was just really impressed with the VA, the support for research, and I just have always wanted to help veterans. I mean, it’s kind of cliché but that’s what I wanted to do.

Interviewer: So, what do you find rewarding now? What keeps you here?

Hildi Hagedorn: What I love about being an implementation scientist is that my work is all about changing and improving care. So, of course, I love to get papers published and I love to have people read my papers and tell me they like the paper and I like doing presentations at academic conferences.

But at the end of the day, what I like about my work is that I know at those eight sites, there are people prescribing this medication that weren’t before and there are veterans that are able to access it that couldn’t before, or access it more easily than they could before.

And when we were just starting up this project, then, there was also a national initiative funded by Operations to address the same issue, basically. So, it’s the SCOUTT – Step Care for Opioid Use Disorder Train the Trainer initiative. And so, we were just kicking off our site visits when they had their first national SCOUTT conference. And what happened was that I was identified as someone doing this type of work with these eight facilities and kind of at the last minute before this conference, they were like, “Well, we all know we can do this big giant conference. Everyone will come, they’ll learn new things and be all excited, and then, they will go home and not do anything.”

And so, my co-PI, Adam Gordon, and I were brought on to that conference to plan for the facilitation of the attendees to help facilitate change at their facilities going forward after the conference.

So, now, we’ve been working with – it started with 18 facilities and then, 36, and I think we’re up to like 40 or something by now. So, just expanding the number of facilities that we can help.

Interviewer: It sounds like you’re a boots-on-the-ground kind of gal.

Hildi Hagedorn: Absolutely.

Interviewer: Well, thank you very much. Is there anything that you’d like to add?

Hildi Hagedorn: No, I really appreciate the opportunity to talk about my work and I really am very passionate about both serving veterans in this way and, also, improving care for substance use disorders because it’s just such a profound issue and it does not get the attention that it deserves. You know, even now with the opioid crisis, all the focus is on the opioids and we still – you know, more people die from alcohol use disorder than from opioid use disorder every single year.

And so, it’s great, but so many other issues to address.

Operator: The views and opinions expressed in the preceding podcast are concerned with the scope of recently-concluded or ongoing VA HSR&D-funded research and do not necessarily reflect currently or to-be-implemented VA policy. To learn more about this research, visit the VA HSR&D website at www.HSRD.Research.VA.gov.