

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

Hildi J. Hagedorn, PhD



CCDOR

Center for Care Delivery
and Outcomes Research



VA

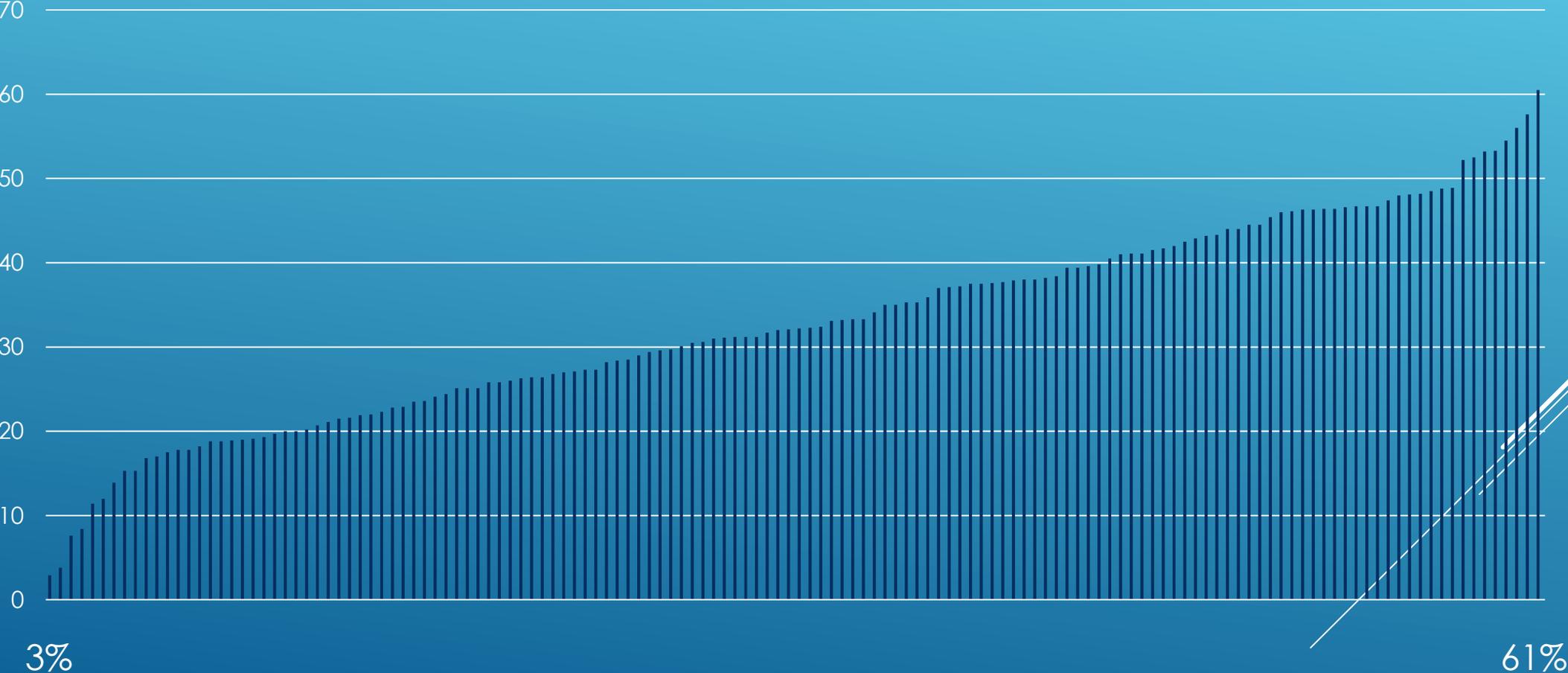
U.S. Department
of Veterans Affairs



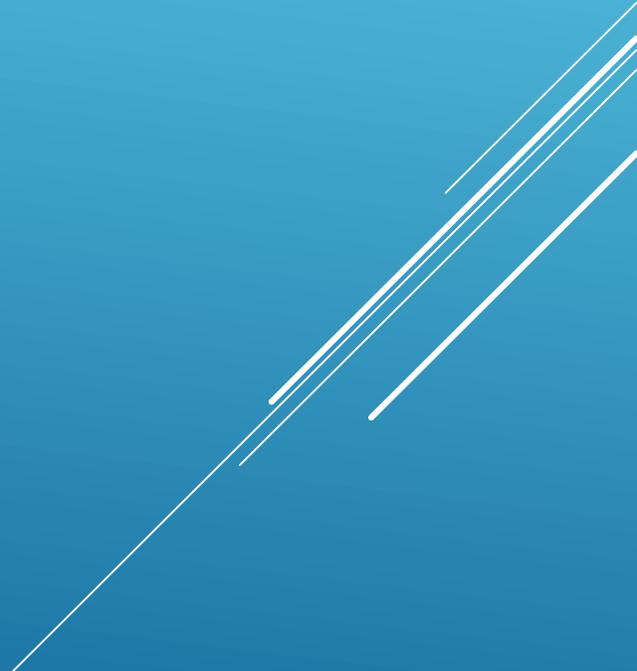
Advancing Pharmacologic Therapy
for Opioid Use Disorder

RATIONALE:

% Patients with OUD Receiving Medication Treatment by VA Facility



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

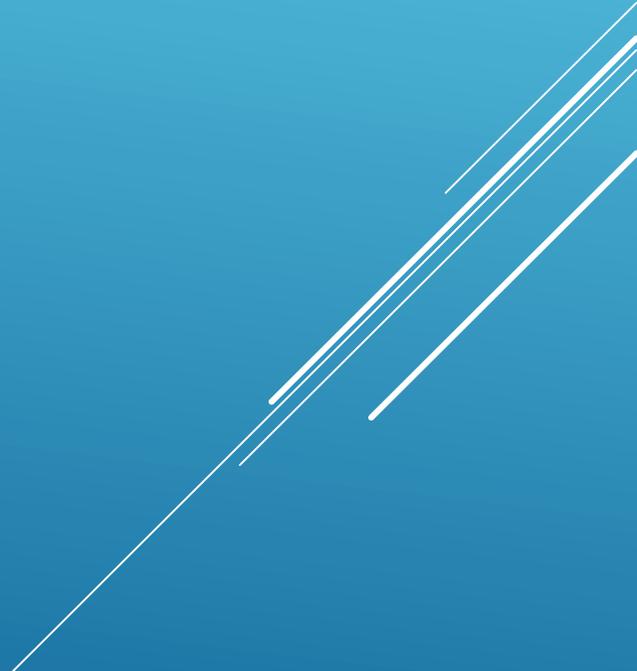
- ▶ Developmental Evaluation
 - ▶ Site Visit
 - ▶ Monthly facilitation calls with local implementation team
 - ▶ Quarterly feedback
 - ▶ On-demand, as-needed consultation
- 

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 broad i-PARIHS (Integrated Promoting Action on Research Implementation in Healthcare Systems) 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.

- ▶ 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: INNOVATION



- ▶ 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: RECIPIENTS (PROVIDERS)

- ▶ 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)

BARRIERS: CONTEXT

- ▶ **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

FACILITATORS

- ▶ 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

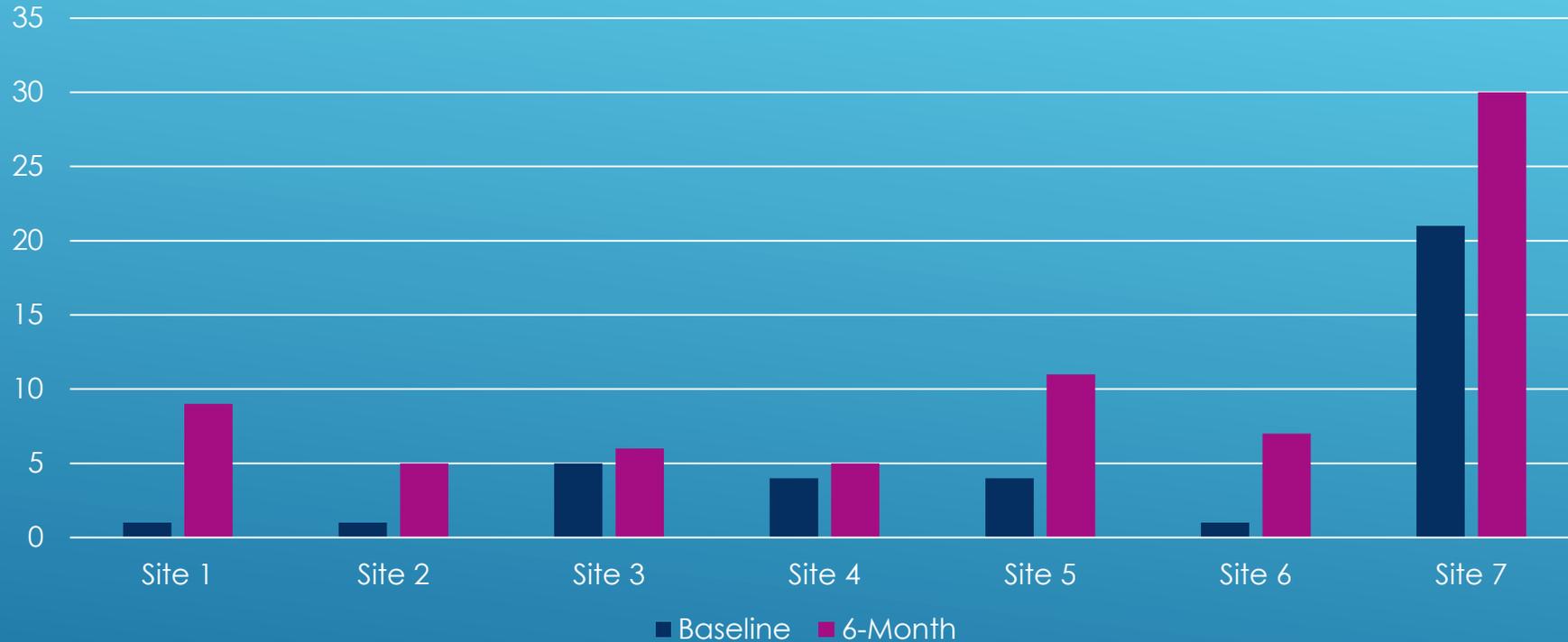
LESSONS LEARNED

INTERIM
PROGRESS
ON
QUANTITATIVE
OUTCOMES

- ▶ Each intervention site matched to 2-4 other low prescribing sites stratified by prescribing rate ($\leq 14.65\%$ vs. $> 14.65-20.50$) and actionable patients (≤ 230 vs. > 230)
- ▶ Quantitative outcome measures:
 - ▶ Number of buprenorphine waived 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

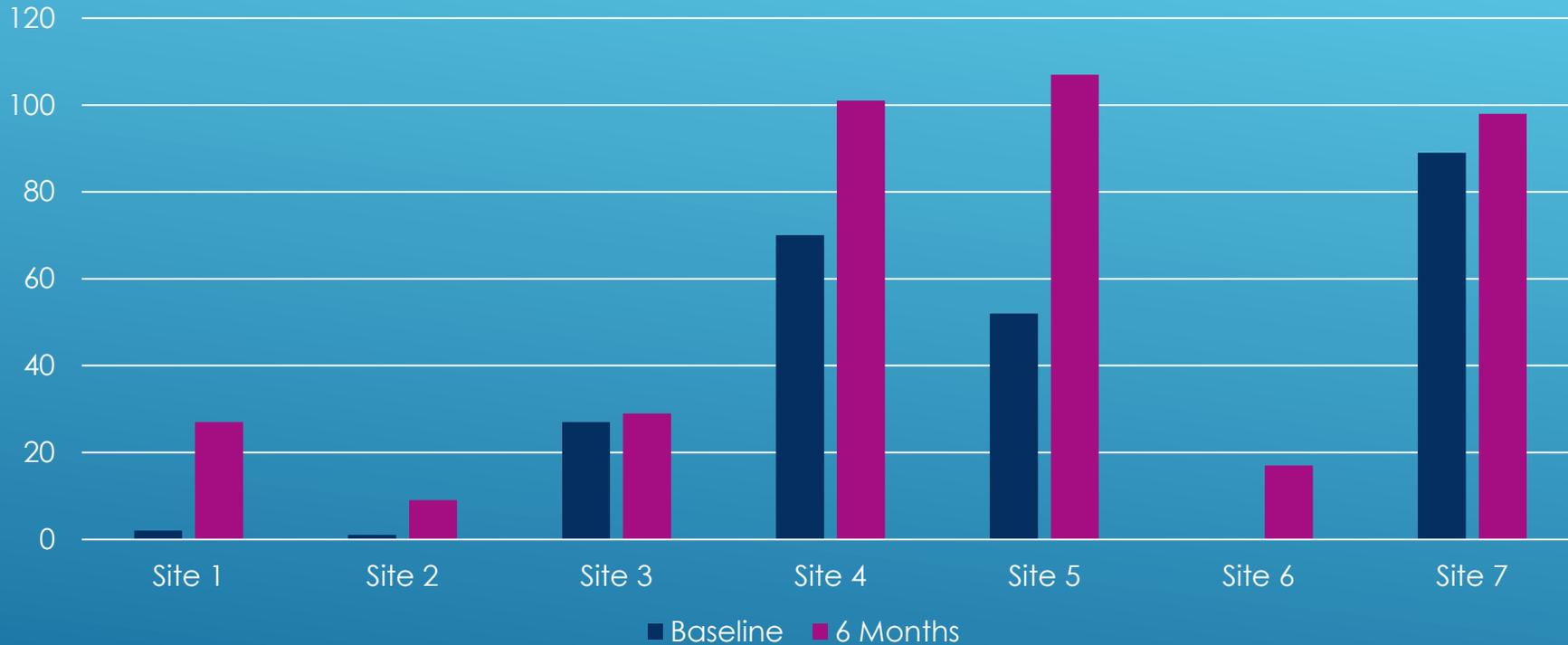
METHODS

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% \pm 2.3, 95% CI= (5.1, 8.5)

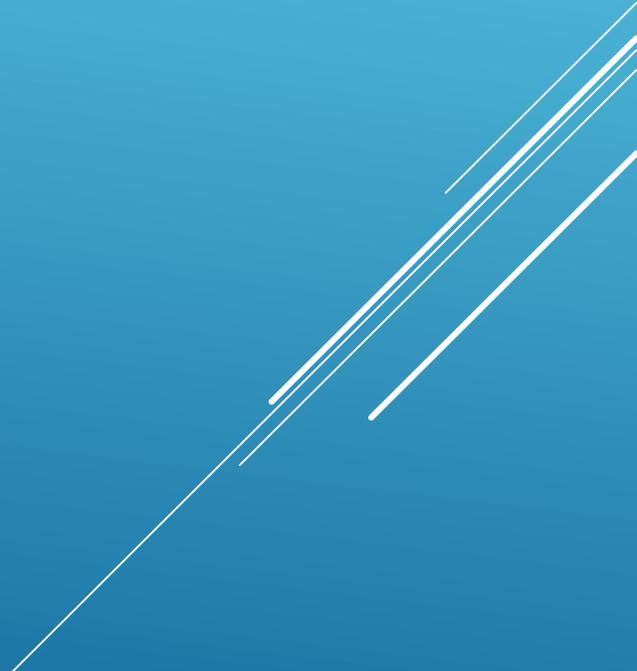
- ▶ Matched control sites also showed significant increases in all three variables, on average.
- ▶ Difference in difference analysis:
 - ▶ Intervention sites had a significantly greater increase in waived providers compared to matched control sites (3.3, 95% CI = 0.2, 6.4).
 - ▶ No significant difference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

COMPARISON TO CONTROLS

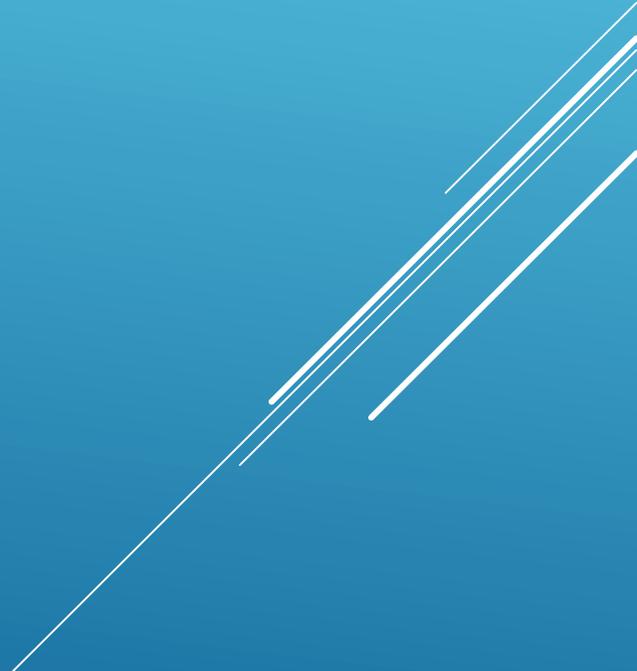
COMPARISON TO MATCHED CONTROLS

	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

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
- 

IT TAKES A VILLAGE...THANK YOU TO:

- ▶ Co-PI: Adam Gordon, MD
 - ▶ Co-Investigators: Princess Ackland PhD, Siamak Noorbaloochi, PhD, Alex HS Harris, PhD, Mark Bounthavong, PhD
 - ▶ Study Staff: Marie Kenny, Hope Salameh, Ann Bangerter, Barb Clothier, Matthew Dungan, Carla Garcia
 - ▶ Plus, the implementation teams at our 8 sites!!
- 

QUESTIONS???

hildi.hagedorn@va.gov

