Veteran and Primary Care Provider Perspectives on Improving Alcohol-Related Care

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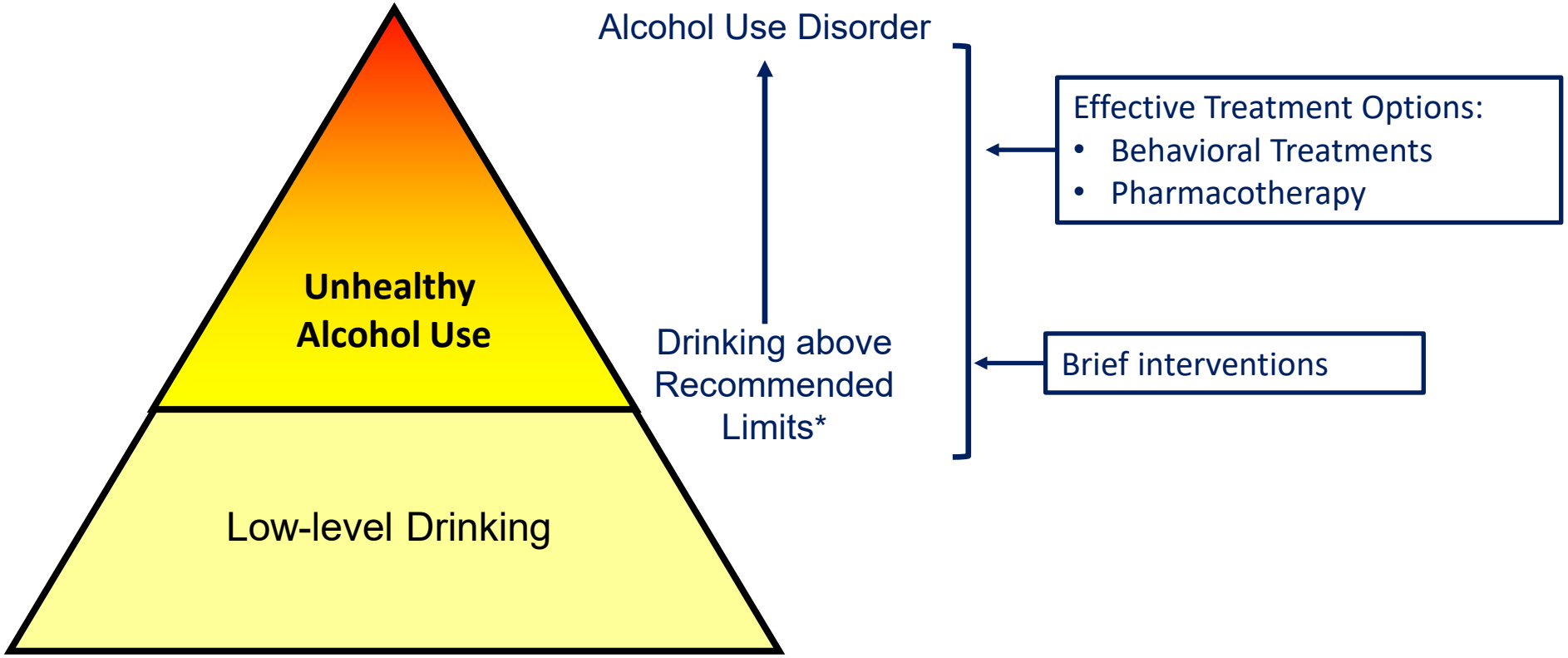
Evidence-Based Care: Unhealthy Alcohol Use



*≤ 14 drinks/week or 4/occasion for men; ≤ 7 drinks/week or 3/occasion women

NIAAA Clinician's Guide; Saitz, New Eng J Med, 2005; Cohen 2007; Glass JGIM 2016

U.S. Preventive Services Task Force

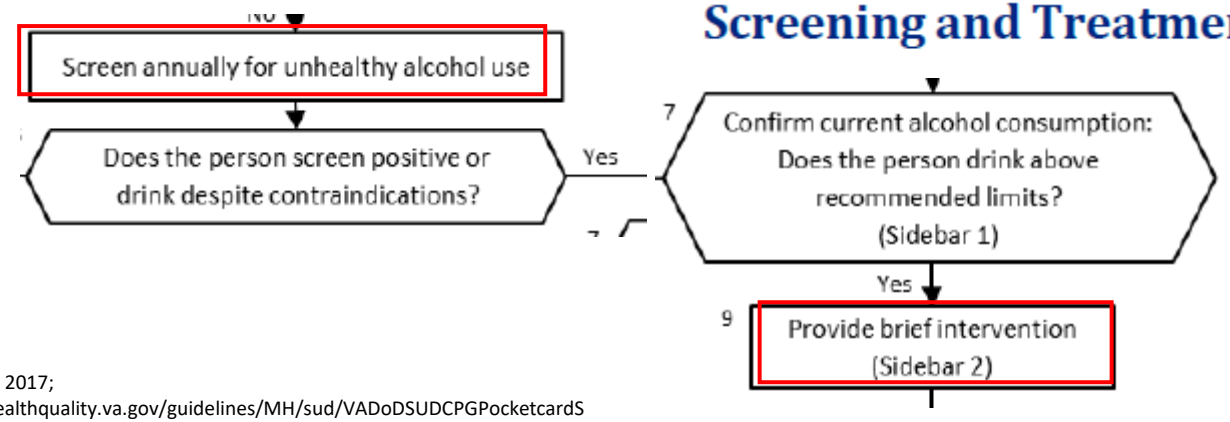
Table 2. Priorities for Improving Utilization of Clinical Preventive Services

Services (Short Name)	Description	CPB	CE	Total
Childhood immunization series	ACIP childhood immunization series[a]	5	5	10
Tobacco use, brief prevention counseling, youth	Provide interventions to prevent initiation, including education or brief counseling	5	5	10
Tobacco use screening and brief counseling, adults	Screen adults for tobacco use and provide brief cessation counseling and pharmacotherapy	5	5	10
Alcohol misuse screening and brief intervention	Screen adults' misuse and provide brief counseling to reduce alcohol use	3	5	8[b]
Aspirin chemoprevention for those at higher risk of CVD	Low-dose aspirin use for primary prevention of CVD in adults ages 50-59 y with ≤10%, 10-y CVD risk and other factors	3	5	8
Cervical cancer screening	Screen for cervical cancer in women aged 21 to 65 y with cytology (Papanicolaou smear) every 3 y	4	4	8
Colorectal cancer screening	Screen adults aged 50-75 y routinely	4	4	8[b]
Chlamydia and gonorrhea	Screen for chlamydia and gonorrhea in sexually active women aged ≤24 y, and	3	4	7[b]

VA

VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders

Screening and Treatment Pocket Card



Sidebar 2: Brief Intervention Overview

1. Express concern
2. Advise (abstain or decrease drinking)
3. Provide feedback linking alcohol use and health
4. Offer referral to addiction treatment if appropriate

Sidebar 3: Pharmacotherapy

Alcohol Use Disorder

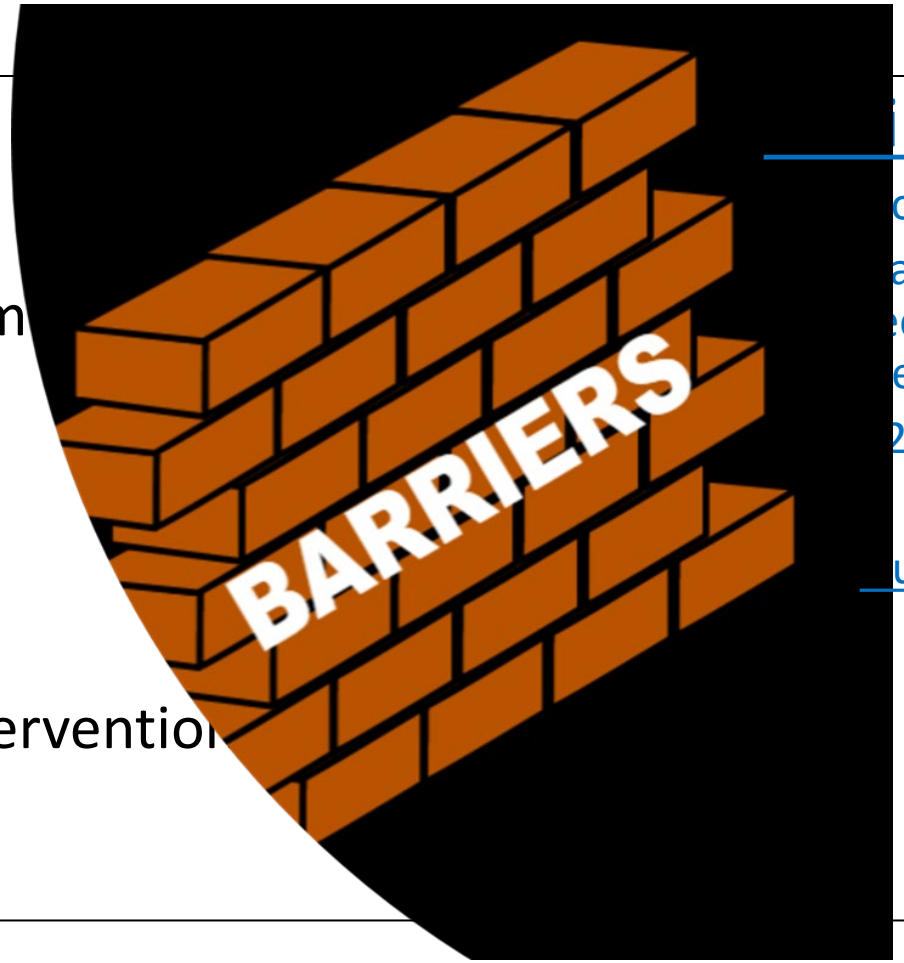
Recommended: acamprosate, disulfiram, naltrexone, topiramate

Suggested: gabapentin

Maciosek et al., 2017;
https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGPocketcardScreeningandTreatmentRevised081017.pdf

Alcohol-Related Care in VA Primary Care

- VA pioneered implem
  alcohol-related care:
  - 2004 → AUDIT-C
  - 2008 → Brief intervention



implementation work?

ot related to decreased drinking

as not increased access to
ecommended services, like specialty
eatment or medication

25% do not receive BI

ualitative work revealed:

- Inadequately addressed PC needs (e.g., training)
- Potentially undermined alcohol care delivery

Bachrach et al., 2018; Bradley et al., 2006; Frost et al., 2019; Williams et al., 2010, 2014, 2016

What are the gaps in care?

No warning that the EHR would be updated to include this care

No structured training in screening/BI delivered on the ground before roll-out

Gaps in knowledge related to effective care

Non-standard delivery of the AUDIT-C

Culture of ‘checking boxes’

Lack of understanding regarding the goal of screening and BI

Feeling of under-preparedness to address alcohol-related issues

Stigma

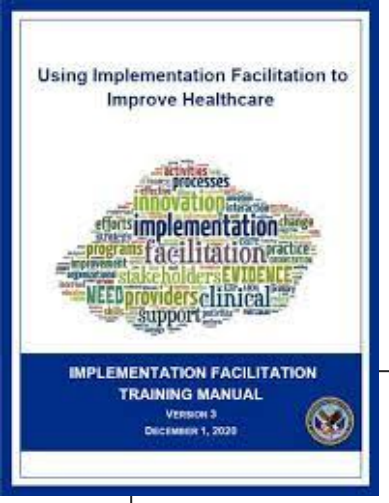
How do you follow-up with patients after a BI?

Assuming patient needs (“Patients do not want this help”)

BI has not improved care for those with AUD

Williams et al., 2016; Williams et al., 2015

How can we improve alcohol-related care in VA?



A promising implementation strategy:

Facilitation

Evidence-based implementation strategy

Provides tools, knowledge, and other supports to increase adoption of evidence-based treatments

Tailored to a clinic's needs

Baskerville et al., 2012; Ritchie et al., 2020

VA Career Development Award

- Pilot test whether **facilitation** can improve access to evidence-based alcohol-related care in a VA primary care clinic
- Evidence-based care:
  - Population-based alcohol screening (AUDIT-C)
  - Brief alcohol intervention (for those endorsing unhealthy drinking)
  - Prescribing medication for alcohol use disorder
  - Referral to primary care-mental health integration team
  - Referral to specialty substance use care

CDA Specific Aims

Aim 1: Use qualitative methods to further understand barriers and facilitators to high-quality alcohol care in one PC clinic and use results to develop and hone a facilitation intervention.

Individual interviews with Veterans [N=20-25] and VA PC staff/providers [N=10-15]

Aim 2: Assess the feasibility and acceptability of the facilitation intervention in a small group of VA PC staff and providers (N=5-7) to further refine the intervention accordingly.

Aim 3: Pilot test the refined facilitation intervention in one VA PC clinic to understand whether facilitation improves PC-based alcohol-related care.

Implementation outcomes: Reach, Adoption, Maintenance

Effectiveness outcome: Decrease unhealthy alc use

Aim 1 Methods: Recruitment

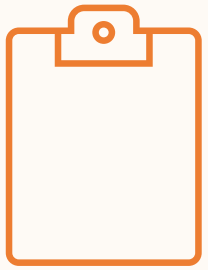
Providers

- Recruited from 1 VA primary care clinic via secure email and Teams
- Purposive snowball sampling
- Target sample size: 10-15
- Ended recruitment once reached saturation

Veterans

- Screened via EHR: ≥18 yrs, seeking care at the VA PC clinic, diagnosis of AUD and/or an AUDIT-C ≥5; Mailed outreach letters, follow-up phone calls to screen and schedule
- Purposive sampling: varying age, sex, race/ethnicity, and treatment experiences
- Target sample size: 20-25
- Ended recruitment once reached saturation

Methods: Procedures



Interview guide:

Semi-structured

Conducted via phone

Audio-recorded, transcribed, and verified

Veterans compensated $35 for their time

Interview questions:

Interviews guided by The Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009)

Questions avoided jargon; tried to be accessible

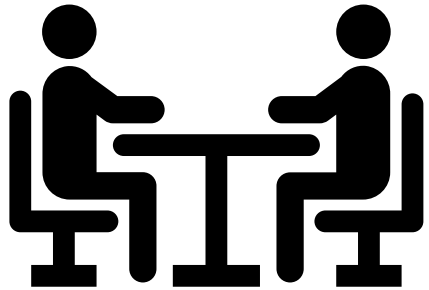
CFIR

- Questions informed by CFIR:
  - Developed to help guide evaluations and increase implementation knowledge (i.e., what works and does not work) across clinical contexts.

- Barriers and facilitators across 5 domains:
  1. **Intervention characteristics** (e.g., complexity, cost, adaptability)
  2. **Inner setting** (e.g., clinic culture, readiness for implementation, communication)
  3. **Outer setting** (e.g., patient needs, peer pressure, external policies)
  4. **Characteristics of individuals** involved in providing care (e.g., knowledge, self-efficacy, readiness)
  5. **The implementation process** (e.g., engaging leaders, champions)

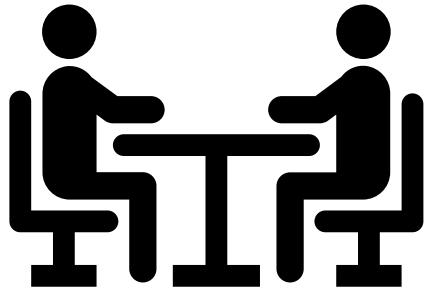
Provider Interview Questions

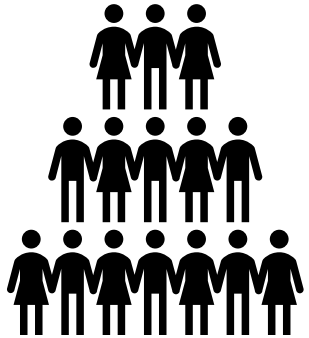
- How do you work with patients with unhealthy alcohol use or alcohol use disorder in your practice?
- After you identify patients are drinking too much, then what do you typically do?
- What resources and/or treatments do you offer?
- How do you decide what resources and/or treatments to offer (e.g., patient's level of alcohol use, medical comorbidities, pregnancy status)?
- Who else do you think needs to be involved (e.g., other clinicians, family members, etc.)?
- If your clinic were to do more to address unhealthy alcohol use, what would be needed?
- For the next few minutes, I'd like to get your feedback on some ideas we have about how we could help support providing care for unhealthy alcohol use in PC…



Veteran Interview Questions

- When you are receiving healthcare, what do you feel you need to make important treatment choices?
- Tell me about your experiences with drinking alcohol. What, if any, impact has it had on your life? On your health?
- Have you ever sought or gotten help for your drinking or other substance use?
- If you haven't sought out or gotten help for alcohol use but have considered it or might consider it, what information might you need or want to make a decision about seeking help?
- Have you and your primary care doctor ever talked about your drinking? What can you remember about those conversations?
- What role could the VA or any health system have in making it easier for you and others to get help with your drinking if you have concerns about your drinking? By VA or health system we mean your primary care doctor, nurse or any health professional or medical staff.
- If your primary care doctor suggested it, would you be open to talking with a primary care psychologist, social worker, or clinical pharmacist about your alcohol use? Why or why not?



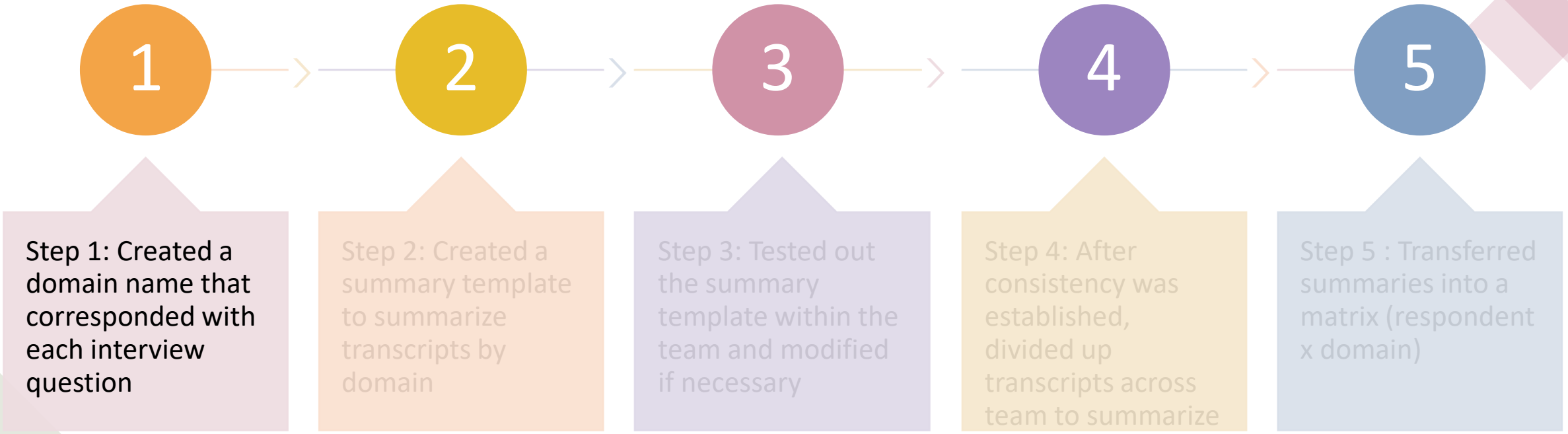


Data Analysis:
Rapid Qualitative Analysis/Rapid Assessment Process

- "Quickly develop a preliminary understanding of a situation from the insider's perspective" (Beebe, 2001)
- Typically for projects lasting 1 year or less
- Helpful for implementation & health services research
  - Stakeholder demands for products/changes
  - A pragmatic need for qualitative data exists
  - Efficient and cost-effective
  - Can incorporate theory – what do you think is driving behavior?
- "Rapid" is specific to the project
  - Do you need transcripts or can you code while interviewing?
  - Do you have one year vs. three months
- Aim 1 Timeline: 1 year

Hamilton, 2020

Rapid Analysis Steps:



Hamilton, 2020

Summary Template Codes: Domain Paired with your Questions

Codebook: PC Provider/Staff Aim 1 Interviews

Role in clinic; experiences & thoughts on treating patients with unhealthy alcohol use	
Codes	**Questions**
1. General role	-Please describe your general role in the clinic.
2. Thoughts on VA stance	-What do you think about VA's stance or policies related to treating patients with unhealthy alcohol use in the primary care setting?
3. General approach to patients with unhealthy alcohol use	-How do you work with patients with unhealthy alcohol use or alcohol use disorder in your practice? What is your approach? -What level of alcohol use do you consider concerning for your patients? -How can you tell they are exceeding this level? -FOR PC LPNs ONLY: How do you administer the alcohol screening questions? How comfortable are you in administering it? What would make you feel more effective in administering it? -After you identify patients are drinking too much, then what do you typically do?

Example Summary Template

TEMPLATED TRANSCRIPT SUMMARY: PC PROVIDERS/STAFF STAKEHOLDERS

Participant Study ID:	**Prepared by:**
Date of Interview:	**Date of summary template:**
Interviewer (Rachel or Cécile):	

VA clinic location: VA Pittsburgh	**Participant's clinical training:**
Participant's specialty:	**Participant's years in PC clinic:**
Participant's hours/week of patient care:	

Role in clinic; experiences & thoughts on treating patients with unhealthy alcohol use	
1. General role	•
2. Thoughts on VA stance	•
3. General approach to patients with unhealthy alcohol use	• •
3o. How COVID pandemic affects alc-related care	•

Matrix

Training	Specialty	General role	Thoughts on VA stance re: treating unhealthy alc use in PC	Approach to patients with unhealthy alc use	How COVID pandemic affects alc-related care	How to tailor alc-related care to historically marginalized groups
PharmD	Primary Care/Ambulatory Care					
Fellow/MD	Internal Medicine/Women's Health					
MD	Internal Medicine					
PharmD	Primary care chronic disease mgmt					
Clinical Pharmacist	Ambulatory Care					
LCSW	Primary Care/PTSD Tx					

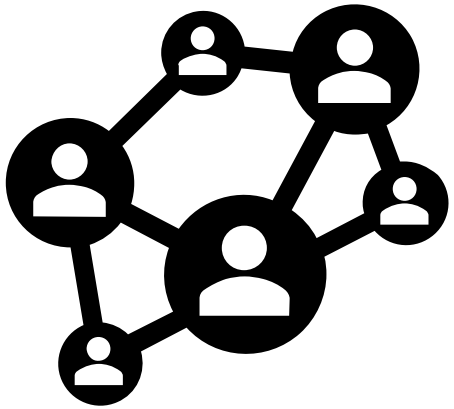
Sample: Providers

- 10 PC providers
- Interviews conducted: March-June 2021

Characteristic	Participants (N=10) No (%) / Mean (Range)
Discipline	
Physician	3 (30%)
Clinical Pharmacist	3 (30%)
Social Worker	2 (20%)
Nurse	1 (10%)
Psychologist	1 (10%)
Years at VA	5.79 (0.75-18.0)
Years in Primary Care	2.56 (0.25-6.0)
Hours/Week – Patient care	26.65 (4.5-38.0)

Results: Barriers

- **Knowledge** about the definition and treatment for unhealthy alcohol use
  - CFIR: Individuals/Inner
- **Varying confidence** in providing evidence-based alcohol care
  - CFIR: Individual Charachteristics
- **Interdisciplinary communication** surrounding evidence-based care
  - CFIR: Inner Setting
- **Logistical** issues (e.g., competing clinical priorities)
  - CFIR: Inner Setting



Barrier: Knowledge

"I honestly, I don't even know like what the NIH or the CDC would define it [binge drinking] as. I would probably say any excessive drinking that occurs – I don't even really know if there's a number in my head. I guess if it just doesn't sound right."

"I think education, right? So I think you bring everybody, all the players together, and say, 'Here's how to identify Alcohol Use Disorder. Here's how to use it in [electronic health record]. And here's how to refer.' And I think the other thing is, too, is making it as simple as possible."

Barrier: Confidence

“I remember like, ‘I don’t know what to do with this person. They want help but I don’t know how to help them.’”

“So I think that if I had, at this point, if I had a Veteran that told me, ‘Oh, I know I drink too much, and I’m really interested in stopping,’ I would definitely need to get another clinician involved.”

Barrier: Communication

"I guess when I'm talking to patients…I'll talk about [integrated behavioral health] as like shorter term, whereas sometimes I find that patients can have more long-term care with [specialty substance use clinic]. But again, I'm a little unclear on what the actual, even though I do this, I'm unclear a little bit on the actual rules that regulate that."

"I'm concerned about how some medical providers still view people with SUDs and the stigma around it…I'm concerned that that drives people away…because they're afraid to sort of get that lecture or to be judged because of it. I do think that there are some physicians in the Primary Care Clinic that still follow that sort of approach."

Barrier: Logistics

"…the biggest barriers are that there are often a lot of other issues that we have to cover in the clinic visit, and so we sort of may not get around to figuring out that the patient has unhealthy alcohol use."

"I think that there is a lot of, 'Oh, you're drinking more than you should? Do you want to go to [specialty substance use clinic]? No? Okay, well let us know if you ever do.' … But I think sometimes when that happens it's not laziness, it's time, comfort and competing priorities."

Results: Facilitators

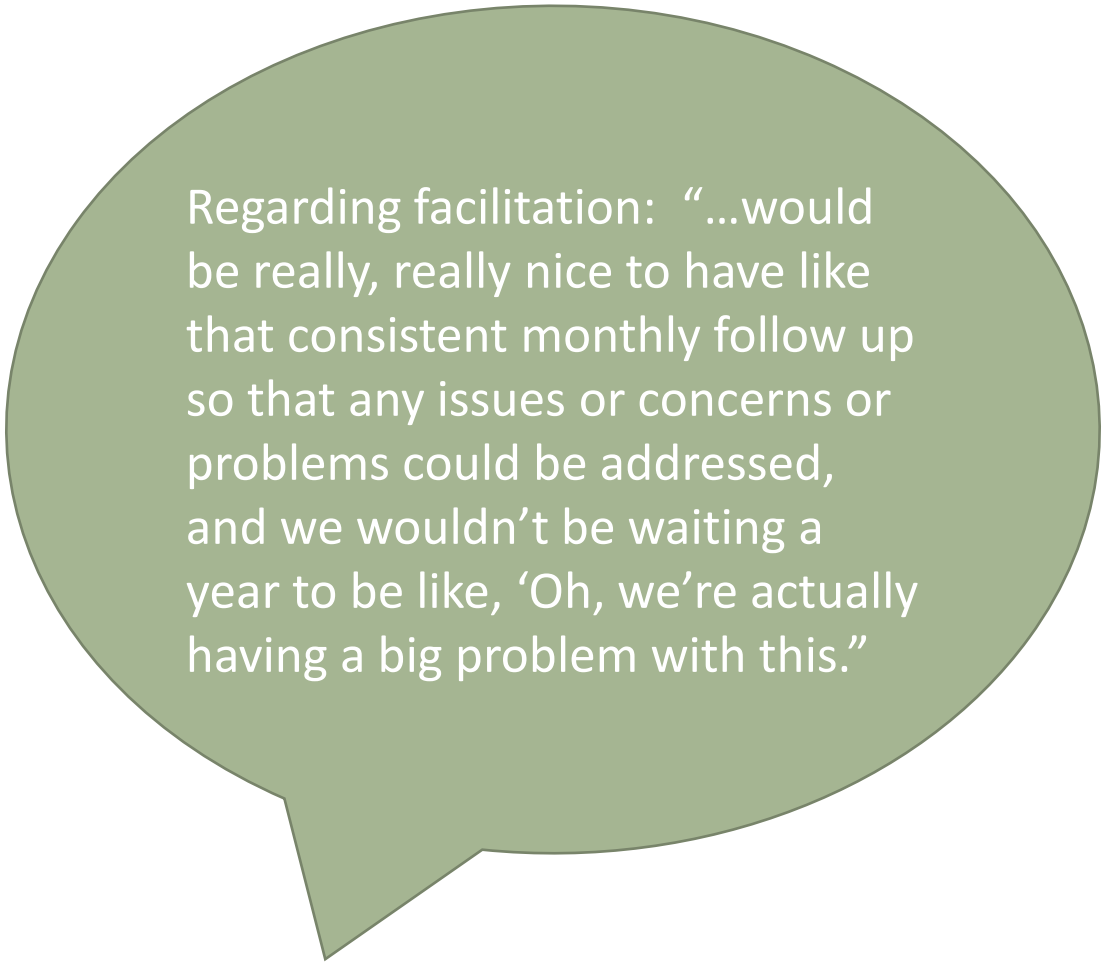
- Belief in alcohol-related prevention and intervention in PC
- Discipline-level leadership support
- Expert multidisciplinary staff (MD, psychologist, pharmacist) qualified to be clinical champions
- Support for most facilitation ideas presented (e.g., facilitation meetings, audit & feedback)

Facilitators: Belief in Alcohol Care

"I think it [providing alcohol-related care] can be a way that we can make a huge difference in people's lives. You can stop so much harm. You can stop people from ever developing the complications that we see when we do inpatient medicine."

"I think it lowers the barrier to getting care… especially because there's so many patients who don't want to go to different places for specific treatment for Alcohol Use Disorder. They can sort of do it along with all their other Primary Care, and I think that normalizes it. And it doesn't require them to either come back or have another phone appointment even."

Facilitators: Support for Facilitation



Feedback on our planned implementation strategy (facilitation)

- Keep facilitation meetings to <= 1 hour
- Create educational materials for both providers and Veterans
  - Describe levels of care, treatment at each level, medications for alcohol use disorder
- Interested in receiving ongoing support from a clinical champion(s)
- Provide real-time data for feedback in person, not via email
  - Ensure audit & feedback comes across as helpful and not punitive

Sample: Veterans

- 22 Veterans
- Interviews conducted: June-Sept 2021

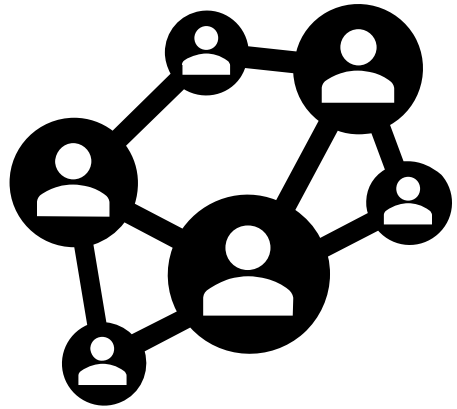
Characteristic	Participants (N=22) No (%) / Mean (Range)
Sex	
Female	10 (45%)
Male	12 (55%)
Race	2 (20%)
Black	9 (41%)
White	9 (41%)
Asian	1 (5%)
Native Hawaiian/Pacific Islander	1 (5%)
Multiracial	2 (9%)
Hispanic	1 (5%)
Age	60.2 (29-79)
AUDIT-C	4.2 (0-11)

Results: Themes

- Positive experiences in primary care

- Varying interest and experience with alcohol-related care

- Desire for shared-decision making



- Open to receiving interdisciplinary care

Theme: Positive Experiences in PC

“She actually shows that she cares and takes a deep interest in my well-being”

“Actually very, very good…an overall pretty positive experience”

“[My PCP] treated me very positive. I have a real good relationship with Primary Care.”

“[PCP was] confident about their diagnoses and treatments, and for the most part I always felt comfortable and pleased with the care I received.”

Theme: Alcohol-related care interest/experience

Attended Alcoholics Anonymous because "when I got into recovery, I was too ashamed to ask the VA for help"

"[I] Don't need [treatment]. I do those things on my own…I just quit. That's the way I deal with things."

"I honestly think that [alcohol] therapy definitely changed my life for the better."

"I reached out to them [the VA] because I wanted to take the drug, Naltrexone…and they got back to me right away."

Theme: Shared-decision making

"…when I was seriously drinking, the only [treatment] I knew existed was AA…I think that making [options] known is important… That they know about all of the different options so that they don't feel like, 'Oh, I have to go to AA to get help.'…there are a lot of other ways out there to get help."

PCPs should "be projecting openness, understanding, compassion to help. And empathy."

"[My PCP] talks to me. She listens to me. When something ain't right she takes care of it right then. She don't say, 'I'll get to it.' Or, 'I'll do this later'…I can communicate with her."

"She [PCP] listened to what my needs were, not what she wanted me to do. She gave me a choice of making my own decision, instead of throwing in my face, 'Oh, cause you know it's going to kill you.'"

Theme: Interdisciplinary Care

"I think if I were to look for help … I think it would have to be a peer situation…if I had met people who were like me and we talked about [alcohol], it would be something I'd be interested in than just feeling like I was being judged"

"[I] wouldn't mind [talking with other providers to] "figure out what's going on and try to do a better job at treating it."

"You never know how that question may hit you that day, say, 'You know what, I'm tired of it. I would like some more information or a referral.'"

Results: Barriers

- **Shame** and judgement
  - CFIR: Individuals

- **Turnover** in providers (e.g., trainees)
  - CFIR: Outer/Inner setting

- Lack of **knowledge**
  - Alcohol and health
  - VA treatment options
  - CFIR: Individuals/Inner

Implications/Conclusions from Veterans

Barriers fell within the CFIR Inner Setting, Outer Setting, and Characteristics of Individuals constructs

Providers should continue building compassionate relationships with Veterans

Offer repeated non-judgmental evidence-based advice and treatment options for unhealthy alcohol use and use shared-decision making

→ Implications: De-stigmatize care, reduce shame, increase motivation to change

Some patients open to PC leveraging resources beyond the PCP (e.g., warm hand-offs to interdisciplinary providers such as peers, pharmacists) to optimize care

→ Implications: Increase access, de-stigmatize care

Implications/Conclusions from Providers

Key barriers fell within the CFIR Inner Setting and Characteristics of Individuals constructs

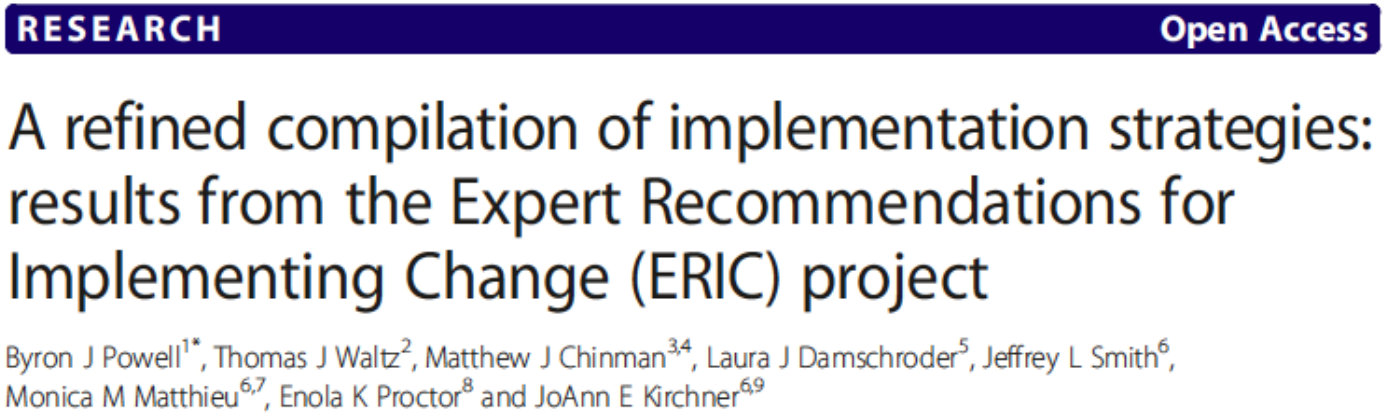
Multidisciplinary providers' perspectives on alcohol-related care supported development of a tailored facilitation intervention that capitalizes on facilitators and minimizes barriers.

Used the CFIR-ERIC (Expert Recommendations for Implementing Change) match tool to help guide and inform implementation/facilitation strategy planning

CFIR-ERIC Match Tool:

https://cfirguide.org/choosing-strategies/

- Barriers → implementation strategies
- Experts in implementation science developed a tool that helps researchers "match" strategies to barriers (Waltz et al., 2019)
- Implementation strategies were drawn from the Expert Recommendations for Implementing Change (ERIC) list of strategies (Powell et al., 2015)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A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project

Byron J Powell[1*], Thomas J Waltz[2], Matthew J Chinman[3,4], Laura J Damschroder[5], Jeffrey L Smith[6], Monica M Matthieu[6,7], Enola K Proctor[8] and JoAnn E Kirchner[6,9]

CFIR-ERIC Match Tool Output

ERIC Strategies	Cumulative Percent	Patient Needs & Resources	Networks & Communications	Available Resources	Access to knowledge & information	Knowledge & Beliefs about the Intervention	Self-efficacy
Conduct educational meetings	173%	10%	13%	0%	79%	56%	15%
Conduct educational outreach visits	87%	5%	4%	0%	28%	28%	22%
Make training dynamic	51%	0%	0%	0%	10%	0%	41%
Conduct ongoing training	104%	0%	4%	9%	38%	12%	41%
Develop educational materials	127%	10%	0%	4%	59%	36%	19%
Distribute educational materials	84%	5%	4%	0%	55%	16%	4%

CFIR-ERIC Match Tool Output

ERIC Strategies	Cumulative Percent	Patient Needs & Resources	Networks & Communications	Available Resources	Access to knowledge & information	Knowledge & Beliefs about the Intervention	Self-efficacy
Build a coalition	90%	14%	39%	17%	3%	16%	0%
Create a learning collaborative	134%	0%	35%	9%	45%	16%	30%
Organize clinician implementation team meetings	90%	0%	52%	9%	14%	4%	11%
Capture and share local knowledge	131%	10%	26%	22%	31%	24%	19%
Facilitation	83%	0%	26%	4%	10%	20%	22%

Top actionable implementation strategies

- Educational meetings/materials/learning collaborative
- Identify clinical champions, ongoing training
- Organize implementation team meetings/facilitation

Preparing for Aims 2 and 3

Meetings with mentors to discuss Aim 1 findings in prep for creating an implementation guide

Assess acceptability and feasibility of our implementation strategies/ideas

Review Aim 1 findings and introduce facilitation to PC clinic; currently pilot testing

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Recommended Readings

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Thank You!

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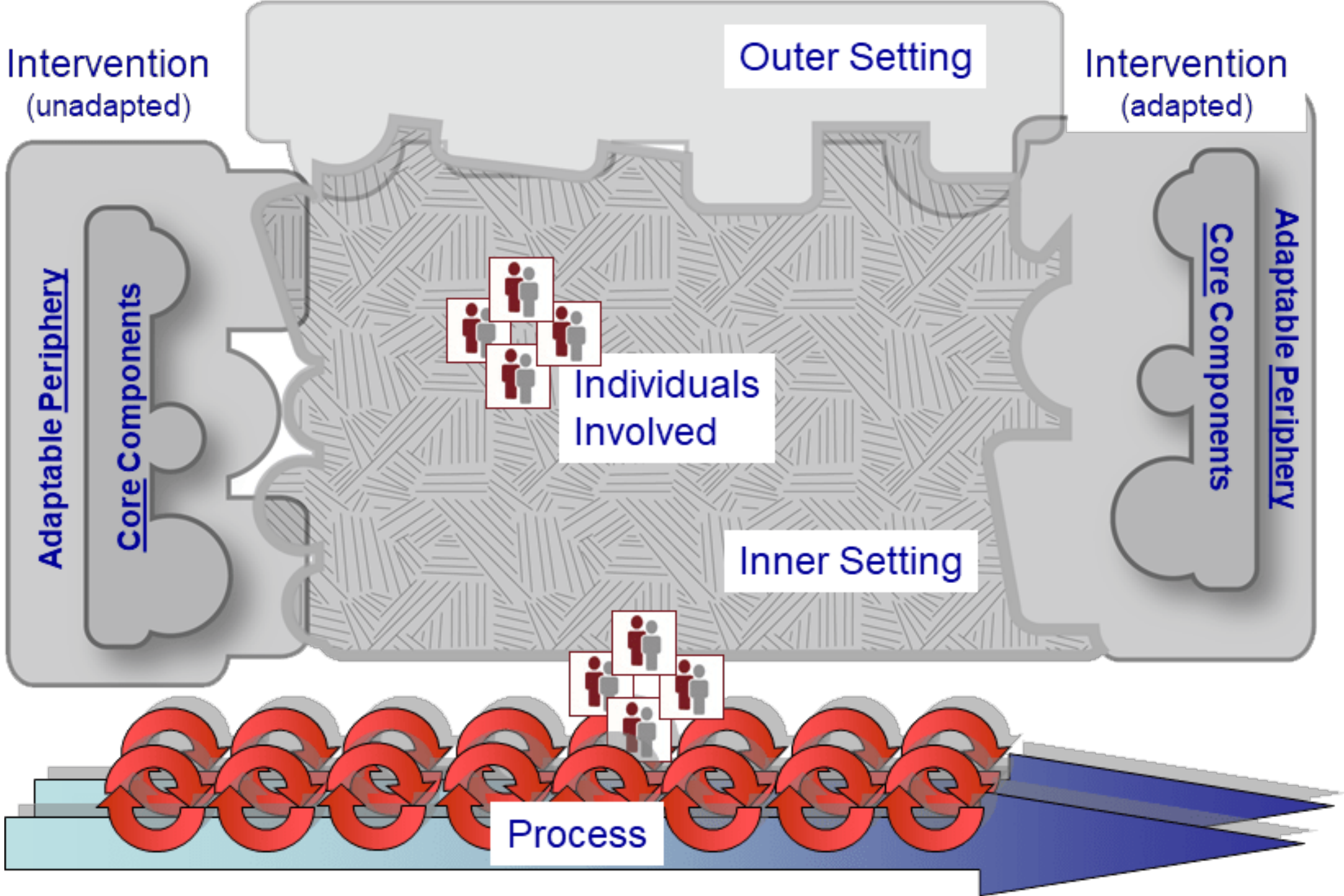
Intervention
(unadapted)
Outer Setting
Intervention
(adapted)
Adaptable Periphery
Core Components
Individuals
Involved
Core Components
Adaptable Periphery
Inner Setting
Process