Cyberseminar Transcript

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Session: Increasing Access to Medication-Assisted Treatment in VISN 22: Using Data to Guide Implementation

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Amanda: Hello everyone and welcome to Using Data and Information Systems in Partnered Research a Cyberseminar Series hosted by VIReC, the VA Information Resource Center. Thank you to CIDER for providing promotional and technical support. This series focuses on VA data use in both quality improvement and operations research partnerships. This includes QUERI projects and partnered evaluation initiatives.

This series is held on the third Tuesday of every month at 12:00 PM Eastern. You can find more information about the series and other VIReC Cyberseminars on VIReC’s website. You can also catch our previous sessions on HSR&D’s VIReC Cyberseminars’ archive.

A quick reminder for those of you just joining us. The slides are available for download. This is a screenshot of the email you should have received today before the session. In it you will find the link to downloads of the slides.

Today’s presentation is titled Increasing Access to Therapies for Opioid Use Disorder in VISN 22: Using Data to Guide Implementation and will be presented by Rebecca Oberman, Evelyn Chang, Shawn Toy, and Adam Resnic. Evelyn Chang is a primary care physician and investigator at the VA Greater Los Angeles. Her research interests are in primary care, mental health integration, and complex high risk patient populations, and addiction disorders. She leads the QUERI partnered implementation project to increase access to medication assisted treatment for opioid use disorder in VISN 22 and the National Evaluation of the PACT Intensive Management Initiative funded by VA Primary Care. As a primary care provider, she manages a specialty medical home for high risk patients with serious mental illnesses and co-morbid substance use disorders. Rebecca Oberman is a clinical social worker and project director who has been with Greater VA Los Angeles for over 15 years. Her work has focused on improving implementation and utilization of evidence based practices for Veterans with serious mental illnesses including primary care, mental health integration, weight management interventions, and health informatics. She is the project director on the QUERI partner and implementation project to increase access to medical, excuse me, medication assisted treatment for opioid use disorder in VISN 22. Shawn Toy is the, excuse me, Pharmacy Informatics Program Manager for VISN 22. Shawn has been with the VA for over 20 years with roles in Clinical Pharmacy Informatics, Education, and Leadership. Shawn’s current responsibilities include national education initiatives, CERNER electronic health record integration workshops, clinical and operation data modeling and reporting, database administration, and leadership activities across VISN 22. Adam Resnic is an analyst for the VA Greater Los Angeles. Adam analyzes data and creates reports for the Medication Assisted Treatment for Opioid Use Disorder Project for VISN 22. He also conducts research into alternative medicine as a part of the Complementary and Integrative Health Evaluation Center team. In addition to his work at the VA, Adam is a health policy and management PhD student at UCLA. His primary research interests include organizational reform, mental health and prevention. Thank you so much for joining us today.

Rebecca Oberman: All right. Great. Can you see my screen?

Amanda: Yep.

Evelyn Chang: Yes we can.

Amanda: Yep.

Rebecca Oberman: All right. Well I want to say thank you to VIReC for inviting us to speak today and thank you, Amanda, for the nice introduction. My name is Rebecca Oberman and I’m a clinical social worker and the director of the project that we’re going to be talking about today. And, as Amanda mentioned, my co-presenters are Dr. Evelyn Chang, a primary care physician who is the PI of this project, Shawn Toy, the Pharmacy Informatics Program Manager for VISN 22, and Adam Resnic, an analyst for the VA Greater Los Angeles. And we also want to acknowledge Dr. Araceli Revote, our VISN CMO and the co-PI of this VISN partnered project.

So you may have already seen these learning objectives for our talk today. So we’re going to describe this partnered implementation initiative to implement access to medications for opioid use disorder, the use of VA data to support implementation in this project and some of the implementation challenges to increasing access to MOUD and Complementary and Integrative Health Therapies and lessons learned.

So this is just a brief outline of what we’ll go over today. So we’re going to give you some background. We’ll review some of our baseline data and our implementation and tool development, and we’ll talk about our outcomes and next steps.

So first we’re going to do a couple poll questions.

Amanda: All right. So that poll is now launched. What is your role in research and/or quality improvement? And your choices are investigator, PI, Co-PI; data manager, analyst or programmer; project coordinator; or other. Please describe the other via the Q&A function. And so answers are coming in. We’ll just let that run for a few more seconds to level off. All right seems as though things have slowed down so I’m going to go ahead and close the poll and share the results.

Eighteen percent of those answers said investigator, PI, Co-I, 33% said data manager, analyst, or programmer, 21% said project coordinator, 27% said other and those are implementation facilitator and clinical pharmacist and pain management. I’ll turn things back over to you.

Rebecca Oberman: Okay. Then we have our next poll question here.

Amanda: All right. And that poll is now launched. How many years of experience do you have working with VA data? One year or less; more than one, less than three years; at least three, less than seven years; at least seven, less than 10 years; or 10 years or more. All right. And it seems like that has slowed down so I’m going to go ahead and close that and share the results.

Thirty-four percent of those answers said one year or less, 29% said more than one, less than 3, 29% said at least three, less than seven. Three percent said at least seven. And 6% said 10 years or more. Thank you everyone. And I’ll turn things back over to you, Rebecca.

Rebecca Oberman: Okay. All right. So first we want to give you a little bit of background on this project. So as most of you are probably aware, reducing opioid related mortality is a high priority nationally both in and outside of the VA. And we know that opioid related mortality can be reduced by treating opioid use disorder, or OUD, and chronic pain using medications for opioid use disorder, which we call MOUD, and those, some examples are; methadone, buprenorphine, and naltrexone. And also helping to treat chronic pain with non-pharmacologic alternatives such as Complementary and Integrative Health Therapies. So some examples of those are; acupuncture, massage, chiropractic manipulation, yoga, things like this. Unfortunately, the uptake of MOUD and CIH have been slow, particularly in primary care settings. So our goal of this project is really to increase awareness and access to OUD treatments in primary care where many of these patients are already being seen for chronic disease management.

So in response to the national push to address opioid related mortality, QUERI has funded a large scale partnered based initiative which is known as the VISN PII and these are rolled out in two phases. In this talk we’re going to focus primarily on phase one and specifically on our phase one project in VISN 22. And then we’ll briefly touch on phase two in some of our last slides about next steps. So our goal with our phase one project was really the implementation of MOUD in a variety of clinical settings, primary care specifically.

So we partnered with VISN 22 on this initiative to increase access to MOUD and CIH therapies among patients with opioid use disorder. Our implementation strategy was something called Evidence Based Quality Improvement, or EBQI. Our pilot sites in VISN 22 were Phoenix VA and Tucson VA, otherwise known as Southern Arizona VA, and we had startup funding from QUERI for about 18 months.

So this is just giving you a geographic visual of our sites. And Phoenix and Tucson were initially selected by VISN as pilot sites because they had already been engaging in improving their OUD treatment for some time.

So our vision in VISN 22 was really the idea of no wrong door. We wanted to increase access to MOUD in all settings of the VA Healthcare System; so primary care, psychiatry, ER, inpatient, and addictions. So patients could access treatment anywhere since many patients really are very reluctant to access services in addiction. And we also wanted to offer various CIH therapies as some non-pharmacological pain management options.

So as I mentioned, our implementation strategy was Evidence Based Quality Improvement. And some of the components of EBQI are illustrated here. So these include QI training and practice facilitation and also regular discussions of formative data feedback using administrative data and qualitative data to help us understand the problems and to guide decisions and to develop the interventions.

So this is a timeline of how our implementation unfolded and we’ll go over most of these in more detail throughout the talk. So I’m going to hand over to Adam now to talk about some of this baseline data that we presented to our advisory committee.

Adam Resnic: Thank you, Rebecca. Yeah. I just want to review the baseline data that has really been instrumental in forming our work for this project and I want to thank Shawn Toy for developing the infrastructure to gather this data. It was a lot of work and he did a great job. We primarily used CDW and, specifically, the S-patient, outpatient, inpatient, and pharmacy tables to identify OUD patients as well as the OUD patients utilizing medication assisted treatment, how much they’re using, and other healthcare utilization that they’re using. We also used PIT data to identify those things as well. And so the first thing I want to talk about is the number of OUD patients at each of these sites. You can see Tucson had about 740 patients compared to about double that for Phoenix. At both sites the average age is about, you know, 53, 54-years-old. It’s overwhelmingly male. The two sits differed a little bit in terms of opioids being prescribed to OUD patients in the past six months. At both of these sites there was relatively low numbers of heroin overdoses presenting to the emergency room among these patients. Next slide.

Another thing that we were interested in is where are the opportunity for treatment for these patients. And so one of the things that we looked at is MOUD patients who have, who are not taking any medication assisted treatment in the past three years. So these are potential patients who are good candidates for outreach. There’s a lot of patients that meet such criteria at both Tucson and Phoenix and they’re interacting with the health system quite frequently. In Tucson and Phoenix about two-thirds of them have had a primary care visit in the past six months, about half of them have a mental health visit in the past six months, about a third are visiting the emergency room. So there’s a lot of contact with the health system and yet they’re being put on medication assisted treatment.

The last thing I’ll review comes from the Academic Detailing Report and we’re curious to know within the sites what is the capacity that the sites actually have to provide MOUD to patients? And so the Academic Detailing Report allows us to look at the number of providers that have X-waivers, meaning that they can prescribe MAT therapy to OUD patients. There’s about 21 in Tucson and 32 in Phoenix. In Tucson they also contract with a methadone clinic as well. And then of those X-waiver clinicians, at the two sites, overwhelming they’re in psychiatry, although we do see some in pain in Tucson, Arizona and a couple primary care clinicians in Phoenix. And for the most part, most of the X-waiver clinicians are prescribing to at least one patient, about two-thirds of the providers are prescribing between 1 and 30 patients with a few prescribing more than that.

Rebecca Chapman: Thanks Adam, yeah. So this data really showed us where the capacity to increase prescribing was adding to these sites and we can see that most of these providers that already have the X-waiver that permits them to prescribe suboxone most of them are not prescribing to very many patients at all with a few of them prescribing to none.

So this is just an example of an Academic Detailing Report that shows providers with X-waivers recognized by VA as having buprenorphine prescribing privileges. So this is what we used to pull this data.

So in addition to the quantitative data that we collected at the beginning of this project we also drew upon qualitative data to understand perspectives among our stakeholders because we knew that stories and anecdotes can really serve as powerful data in kind of changing people’s point of view and perspectives.

And we knew that it was important to start with the patient, with the Veteran, and involve all the relevant stakeholders that impact their OUD treatment.

So we conducted several interviews with patients at both of these sites. And generally these patients expressed a lot of satisfaction with the buprenorphine programs in the addiction treatment setting but they were reporting that they did not receive a lot of information about buprenorphine as an option from primary care. So here we have a quote from one of our Veteran’s. And he said, “I was actually going to go to a private clinic with a suboxone program. And the clinic, the first thing they said was, ‘Why aren’t you going to the VA? The VA has this program.’ And I had no idea at all that the VA even offered the program. Back in the day, primary care physicians were not saying anything about it. They weren’t saying, ‘Hey, we have a suboxone program if you would like to get off pain meds.’ I was never told that.”

So we also did quite a bit of interviewing with clinicians at these sites and we heard a lot about barriers to prescribing MOUD. We heard a lot of stigma. So providers felt that these are “difficult patients, time consuming patients.” We heard about a lack of knowledge and training. The providers did not feel equipped to manage the needs of this population within primary care and they felt MOUD was best left to specialty treatment. And then we heard about some process barriers, so very lengthy process for credentialing and privileging that most of these providers did not have the bandwidth to deal with. And some of those barriers with credentialing and privileging have changed since this time which we’re very happy about.

Generally we heard a strong reluctance to prescribing MOUD in primary care due to insufficient support, primary care turnover, burnout, and some nursing burnout. So this is a very powerful quote we heard from a primary care lead at one of our sites. And she said, “No primary care providers want to do it. At our facility, PCPs don’t have enough support. Lots of non-clinical work falls on them. The nursing leadership does not want to help with the workload. Because of this, there’s lots of turnover. PCPs burn out because they are constantly being asked to take on more. Honestly, my reaction to this idea is ‘no frickin’ way, you’re not going to put more on my docs or I will lose them.’ This always happens. A good idea comes down that gets dumped on Primary Care because no one else wants to do it.”

So we also spoke with our clinicians about their use of Complementary and Integrative Health Therapies. And we heard basically that there was good awareness and utilization of these by clinicians in primary care. There was some talk about the frequency of classes was limited. And some of the modalities like acupuncture were limited to patients that were not on opioids. We also heard that the availability at some of the CBOC’s was not great. But generally the clinicians were successfully using these CIH therapies to taper patient’s down. One quote that we heard from a primary care provider. “It’s pretty integrated. We’re using it as a way to reduce opiates.” So given that our clinicians already had good awareness of these resources at both of our sites our efforts during the implementation period primarily focused increasing access to MOUD.

So this is really where, the point of our implementation, where it really began and tool development took place. So after we had already collected baseline data and presented it to our all stakeholders.

So based on the baseline data that we had collected we knew that primary care was a potential setting for treating OUD but that very few primary care providers had X-waivers and even those that had them, were not prescribing. So we started off with training primary care clinicians on how to recognize OUD and, also, offering several X-waiver trainings to allow them the opportunity to get their X-waiver and be credentialed to prescribe. So we believe these grand rounds helped to increase awareness of OUD and how to assess for it and helped to shift attitudes around MOUD and primary care.

So of the few primary care providers at our Phoenix site who were already X-waivered, none of them had prescribed buprenorphine yet. So we knew it was important for them to increase their familiarity with buprenorphine. So the Phoenix site they provided a half day or full day clinical preceptorship to newly X-waiver prescribers in primary care which allowed them to shadow experts in addiction and pain and this preceptorship resulted in a checklist of training elements that became a tool that they developed and that they have since shared with other sites as well. So some key elements of this training were, of course, the shadowing where primary care providers were able to observe an evaluation, an induction appointment, a follow up appointment. Some key talking points about reducing stigma for patients which was really a major issue contributing to patients reluctance to accept this treatment. So discussion about how to work with patients who don’t neatly fit a traditional OUD diagnosis. So we call these gray zone patients, patients who would never really self-identify as candidates for addiction treatment. And so this was very useful at the Phoenix site.

Our Tucson site used pharmacy data to identify patients who were both on opioids and benzodiazepines. And they sent this letter that we developed to 313 patients to try to do some direct to consumer marketing. So this letter included information about opioids and non-pharmacological treatments. And also had a Veteran narrative on treatment for OUD which we developed from one of our qualitative interviews with Veterans. And we developed both a letter version of this and a flier version that could be distributed in clinic. You can see on the left is the letter version and on the right is the flier version.

Our Tucson site did a lot of extensive work using existing VHA quality dashboards as an audit and feedback tool to identify patients with OUD who could benefit from treatment and also patients who have been inappropriately diagnosed and patients who might benefit from some risk mitigation strategies so urine drug screens or naloxone kit. So in each case when they would identify these patients, primary care providers would be notified about what the actionable steps were so they would suggest referring to addiction treatment or revising and counter coding and this was usually done either through a phone call or an email or a one-on-one meeting. So this led to the development of a Dashboard Manual to help spread these best practices to other providers and other sites.

And we also developed a handout on the buprenorphine monitoring dashboard that we developed for PACT nurses to use to become familiar with this tool.

So these are some examples of the VHA quality dashboards that are available through Academic Detailing and that were used by our project sites, especially the Tucson site. So this is the Psychotropic Drug Safety Initiative Dashboard or PDSI. And this can be used to identify patients that may benefit from treatments and also to identify patients that were coded inappropriately and you can find the link at the bottom of each of these slides.

Then we have the STORM Dashboard or Stratification Tool for Opioid Risk Mitigation and this can be used to identify patients who need treatment and coding issues and also to identify patients that may benefit from some risk mitigation strategies.

This is the OEND Dashboard that can also be used for several of these means, so identifying patients that need treatment, identifying places were coding was done inappropriately, and distributing the Naloxone kits.

This is a PBM report called the OUD Patient Report. Also can be used to identify patients and those in need of some risk mitigation.

And this is the Buprenorphine Dashboard which is really useful for providers who are working with a panel of patients on buprenorphine. It can help them to manage it and find patients who may have expired buprenorphine coverage and may benefit from reengagement.

So we presented data to our advisory committee about midway through the project but I’m going to show you some outcome data here that is reflecting the full implementation period through the end of Fiscal Year ’19.

So our main outcome in this project was the SAIL SUD-16 measure. And so you can see on the left here is the percent of eligible patients receiving OUD. So ideally, all sites would be at 100%. And the bottom of this graph is, from left to right, the time periods from Fiscal Year ’15 to Fiscal Year ’19 and we extended the data for two quarters of 2020 as well. The yellow box here is our implementation period. And the graph lines represent the percentile rankings across all VA. With the redline showing the 10% and the yellow line showing the 50% and the green line showing the 90%. So the blue line here represents our Phoenix site and the orange line represents our Tucson site. So you can see that when we started implementation both of our sites had already improved to about the 80%. And as we progressed, they both met or exceeded the 90% of all medical centers that’s represented here by the green line and maintained that well into Fiscal Year 2020.

So this is just another way of looking at the same SAILI SUD-16 data. At the end of Fiscal Year ’19 our pilot sites were at number one and number 15 across VHA. And all the VISN 22 sites improved from quarter three to quarter four in Fiscal Year 2019 in the SUD-16 measure. So since this area is a high priority nationally and there’s a lot of scrutiny on this measure, all these temporal trends are in a positive direction. And we are going to begin work with some of these other sites within this year which we’ll talk about later.

So at the end of our implementation we conducted some exit interviews with our stakeholders.

So we spoke again with the clinicians that we spoke to at the beginning of the project and also some others that had become involved through the course of implementation. And we heard that there had been some shift in attitudes and processes around MOUD at their sites. So particularly acceptability within primary care. So this is a quote from a pain provider at one of our sites. And she said, “I have definitely noticed an organizational shift. This is something that went from being something very super-specialty care, like, it really just needs a buprenorphine consult to something that people see as possibly being able to be managed. If it’s mild-to-moderate opiate use disorder, people can view it as something that can be managed within a primary care setting or primary psychiatry setting as well, and then triaging more complicated cases to specialty care.”

And when we spoke with them about their experiences with Complementary and Integrative Health Therapies over the course of this project, the primary care providers reported that they were integrating these therapies into treatment for patients to address chronic pain issues and as a replacement for medication therapies. So we have a couple of quotes from a primary care provider at one of our sites and he said, “Sometimes you hear, ‘Well, it’s working in the case of the cravings, but my shoulder, which is why I got addicted in the first place, is still bothering me,’ I can offer them then some of those CIH therapies in addition to just prescribing them suboxone.” “One of the first issues I’ll address, just to explain how dangerous these medicines are and so forth, and we really need to get on a wean-down, wean-off program. But at the same time, we're going to replace those opioids with much safer treatments and medicines and modalities like physical therapy and chiropractic and yoga and Thai Chi and relaxation techniques. We're definitely integrating with our patients.”

So here we just have a summary of some of what we feel are the key elements to this project that allowed this to work. So we focused very strongly on providing data to frontline staff, facility leadership, VISN leadership, and our advisory committee. And this really helped us with understanding the problem and the potential solutions. So leadership and frontline staff they don’t usually have the time or the resources to pull data. So our data showed that we needed an intervention to increase provider comfort with prescribing buprenorphine and led us to focus on education and clinical preceptorship. It showed us that primary care and mental health are potential OUD treatment locations and that there was very little capacity in primary care to prescribe at that point. We feel that our research clinical partnership really enabled the frontline staff to get creative with their problem solving, to be able to troubleshoot. We allowed our providers from our different sites to network together and talk and be able to come up with some creative solutions to get through some of the obstacles and barriers that they faced. And it also allowed for the sharing of the various tools that we developed so our education tools, our mass media, and our audit and feedback. And we really believe that the provider review of the Academic Detailing Dashboards with the feedback that was provided was a really powerful tool especially at the Tucson site we think that it really contributed to their success. So that was something that we really focused on.

So next steps. We’ve now received funding to disseminate these tools that were developed by the pilot sites to the rest of the medical centers within VISN 22. So during Fiscal Year ’20 through ’22 we’re partnering with medical centers across VISN 22 to increase access to MOUD and CIH in primary care. And this VISN 22 effort is part of a phase two VISN Partnered Implementation Initiative. And it’s a nationally integrated initiative that spans six VISN’s and 57 sites called Consortium to Disseminate and Understand Implementation of Opioid Use Disorder Treatment, or CONDUIT.

And so this is just a visual of some of our upcoming sites in Fiscal Year ’20. We’re beginning work with Loma Linda VA and Greater Los Angeles and San Diego VA. And in Fiscal Year ’21 we will begin engaging with Long Beach VA, Northern Arizona, and New Mexico. And so we’re very excited about our upcoming work in the next couple years.

So before we open it up to questions, I just want to acknowledge our project team members on both the VISN sites and the evaluation team for the pilot phase of this project.

And also our advisory committee.

And most importantly, our quality improvement team members from the Tucson and Phoenix sites. So they are the ones who really did the on-the-ground work.

So now we can open it up to any questions.

Amanda: Great. Thank you so much. So our first questions are regarding the baseline data. For overdose data, how did you get non-VA based overdose information?

Shawn Toy: So this is Shawn. I’ll take that question. With non-VA overdose information, we found that with the non-VA data, the fee basis data which has now become the PIT data, that that was available. And for patients that would go to the nearest emergency room and that came back as emergency room data. Now one limitation of the data is it’s predicated on when the bill comes through and when that’s processed. So for more recent non-VA overdoses, that dataset has still to be developed. But over time, looking through records, we found that as far as overdose information that was easy to obtain from those fee-basis records.

Amanda: And were emergency department visits identified from stop codes as well?

Shawn Toy: Yes. We used stop codes in VA data. Stop codes are a VA data metric. So we did use those to look at emergency room visits. As far as overdose visits and, not presented here, were there changes in visits over time as we went through the OUD process. And thinking of the historical data, I can’t remember any statistically significant changes in ED admissions for opioid use disorder patients as we went through this. But that is one of the metrics that we used stop codes for to track and see if there was a difference.

Amanda: Great. Now we have some questions about training providers. Is the VA considering training and credentialing non-MD’s, non-MP for X-waiver credentialing to take the load off of PCP’s?

Evelyn Chang: This is Evelyn Chang. So I think that there are definitely roles for other staff to help to support providers. So when Phoenix did their X-waiver trainings, they actually made their trainings inter-professional. So they actually included nursing staff, pharmacy, and other specialists. However, because nursing staff and pharmacists can also be very valuable in helping to support buprenorphine prescribing, it was actually critical for them to also be involved in the same training so they could also have the same understanding. So I’m not sure if those are the particular staff that the audience member was thinking about. But in collaborative care management of opioid use disorder, most often nurse care managers and pharmacists can play a valuable role in assessing patients for opioid use disorder and also following those who are on buprenorphine to make sure that they’re stable on their doses.

Amanda: And even before training PCPs, did you consider restructuring teams so that the PCPs were more willing to engage in the process?

Evelyn Chang: So there are a lot of options in terms of prescribing buprenorphine in any clinical setting. And so what we usually do is when we go into a site we offer a lot of different options. And there’s also evidence based models of opioid use disorder prescribing in primary care. For instance, office based management, that’s where the provider takes on most of the responsibility and then also collaborative care management, that I already mentioned, where they usually have a nurse or a pharmacist who helps to support. So whenever we offer these suggestions, it’s up to the teams in deciding what they would like to do. It often is very dependent on the resources and the interest that’s already at the site. So for instance, in one of the site, if nursing was not as interested then that was going to be more likely an office based management where it was mostly on the providers. However, with time and with familiarity it may change so that nursing can provide more support, for instance, in that setting.

Amanda: Great. Excellent research and great presentation. I know the VA has been a leader in telehealth, especially in mental health. I saw you briefly mentioned telehealth earlier. How did you engage and retain OUD patients via telehealth or other virtual outreach methods in addition to in-person provider visits?

Evelyn Chang: Rebecca, do you want to take that on or would you like me to?

Rebecca Oberman: Sure. Yeah. So telehealth has actually become very salient, of course, during Covid-19. Many of our prescribing providers have switched over to VVC visits with their patients, or phone visits. And we feel that this is going to be developing this capacity is going to be very helpful for future capacity building as well since many Veterans are in rural areas where they can’t always make it to a facility for all of their visits. It has required some adjusting of guidelines. For example, there has been some adjustment to the buprenorphine prescribing guidelines to allow for prescribing without an in-person visit as the first visit, so doing home inductions. Also adjusting the frequency of the required urine drug screens has been necessary. But so far we have found that it’s been working out quite well and has actually allowed the providers to engage with a much broader array of Veterans then they could before when they had to have weekly or monthly in-person visits.

Amanda: Great. What is the average duration of Veterans on MAT?

Evelyn Chang: That’s a really good question. I think it’s hard to say. We try to maintain patients for at least three to six months based on research that shows that maintenance improves mortality and morbidity for patients with opioid use disorder over time. That’s one of the things that we’ll be looking at in the next phase of CONDUIT where all of our study, or all of our sites will actually be looking at maintenance and this is actually one of the PDSI metrics. And PDSI is one of the quality dashboards on psychotropic drugs, so buprenorphine trying to see how long we are retaining people on that.

Amanda: What, if any, input was provided by the Pharma industry?

Evelyn Chang: That’s an interesting question. We actually have relied a lot on our pharmacists during this initiative. Our pharmacists have actually been invaluable, especially our academic detailers and we’ve usually depended on the site specific academic detailers as well as our VISN wide. I would say I don’t think we had as much Pharma non-VA. The only way I can think that they may have been involved is for some of VA sites they are starting to use other non-oral formulations of buprenorphine. So for instance, there’s Sublocade and Butrans. And there is for Sublocade which was an injection there can be some pain associated with the injection for that depo. So I know that they were doing some research around how to mitigate or minimize that kind of pain. But we didn’t have very much outside pharmaceutical influence.

Amanda: And are you willing to host your code on VA GitHub?

Evelyn Chang: Sure. If there’s any code that you’re interested in, particularly for our baseline or our outcome slides, we’d be happy to share whatever we have.

Amanda: Wonderful. Well I think those are all the questions that we have for now. Thank you so much to our presenters for taking the time to present today’s session. To the audience, if you have any other questions for presenters, you can contact them directly. And please join us for VIReC’s next Using Data and Information Systems in Partnered Research on September 15 at 12:00 PM Eastern.

This session is titled Opioid Prescribing Patterns and Informatics Tools presented by Dr. Adam Gordon. We hope to see you there, and thank you again so much to our presenters and our audience. Have a wonderful day.

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