Moderator: …presenter, Dr. Bachrach. Can I turn things over to you, Rachel?

Dr. Rachel Bachrach: Yes. Can you hear me okay?

Moderator: Yes, you’re all set.

Dr. Rachel Bachrach: Great, thanks. So I’m going to stop my video while I present. But today I’m going to be talking about the Aim 1 of my Career Development Award, and that is “Veteran and Primary Care Provider Perspectives on Improving Alcohol-Related Care”. Okay, so I have no disclosures to announce or no conflicts of interest.

This research was funded by HSR&D. I received the award in April 2020 and started the project in October 2020. So as many here probably know, unhealthy drinking prevalence ranges widely, but approximately 15% of veterans seen in primary care report unhealthy alcohol use, which is a spectrum ranging from drinking above recommended daily limits to meeting criteria for alcohol use disorder, or AUD. So therefore, laid out by SAMHSA and others, those that screen positive for unhealthy drinking should receive a brief alcohol-related intervention by their primary care provider. And moreover, those that are screening positive for a potential alcohol use disorder should also then be referred to specialized substance use treatment and/or offered pharmacotherapy.

And the U.S. Preventative Services Task Force also rates alcohol screening and brief intervention is one of the top priorities for improving health. And VA substance use disorder clinical guidelines recommend that all patients screening positive for unhealthy alcohol use receive a brief intervention and that those with alcohol use disorder are, of course, offered additional interventions, including medication and specialty addiction treatment, which isn’t seen on the slide.

So therefore, the VA was an early adopter of these clinical recommendations from the task force. The VA implemented alcohol screening with the AUDIT-C in 2004 and then in 2008 incentivize brief intervention with a performance measure linked to financial incentives. And although pilot research showed initial reductions in drinking after a brief intervention delivery, subsequent analyses of national VA did not corroborate these findings. So for those with alcohol use disorder, brief intervention implementation has not really appeared to increase access to recommended services, such as specialty addiction treatment and pharmacotherapy. And approximately 25% of veterans with unhealthy alcohol use still aren’t receiving a brief intervention when they’re screening positive.

So to try and understand why alcohol-related care wasn’t effective, qualitative researchers went back and asked staff and providers their experiences with the rollout of this care. And this research revealed that local implementation processes may have inadequately address their needs, and so barriers to effective care in the VA remain. And so what are some of these barriers. Some of this mixed methods research led by one of actually my CDA mentors, Emily Williams, revealed numerous gaps in care. And this has included there was no prior warning of electronic clinical reminders in the electronic health record signifying the need to perform alcohol-related care. No structured training in screening or brief intervention delivered on the ground before rollout of these procedures.

This led to several negative implementation consequences, including gaps in knowledge related to delivery of effective care. Nonstandard delivery of the AUDIT-C. A culture of just checking boxes, which may not really accurately reflect the clinical encounter. A lack of understanding regarding the goal of screening and brief intervention. So for example viewing this as a method of identifying alcohol use disorder as opposed to what it actually is, which is a part of population-based preventative care. Also a feeling of under preparedness to address alcohol-related issues. Stigma about providing this care in primary care. Not knowing how to follow-up with patients after delivering a brief intervention. Not believing that patients really want or need this help. And in addition, brief intervention of limitations, again, hasn’t appeared to improve care for veterans with AUD as medication for treating AUD, for example, is still pretty severely under prescribed at about 10-13%.

So this work part really suggests that effective implementation strategies that build skills and address these barriers are sorely needed. And to improve care, efforts will probably need to facilitate learning and improving of skills to combat beliefs that are not in line with evidence-based care and address the anxiety providers are conveying about the lack of time and the logistics of including this care into their workflow. So work at multiple levels is needed on the ground to really improve high-quality alcohol care with and the primary care setting.

Which brings us to what is called facilitation, which we believed was a, and is, a promising implementation strategy that could close the quality gaps in VA’s alcohol-related care. And in practice facilitation, a facilitator offers providers tools, knowledge, and other supports to increase adoption of evidence-based treatments. It’s a multilevel implementation strategy, meaning that several individual strategies fall under the umbrella of facilitation. And the last component that I think is super important is that facilitation is really tailored to a clinic’s needs; and therefore, we think really could be instrumental in supporting primary care to improve alcohol-related care within their specific clinic.

Which brings us to my Career Develop Award, which aims to test whether facilitation can improve alcohol-related care in one VA primary care clinic. And when I mentioned improving evidence-based care, I’m talking really about the spectrum of alcohol-related care, which includes delivering population-based alcohol screening with the AUDIT-C, delivering brief alcohol-related interventions for those endorsing unhealthy drinking, prescribing medications for those with alcohol use disorder, referring appropriate cases to the primary care mental health integration team, as well as referring more severe cases to specialty substance use treatment.

So therefore, my CDA aims to first use qualitative methods to further understand the barriers and facilitators to high-quality alcohol care of one primary care clinic, and then use these results to develop and hone a facilitation intervention. And this is what I’ll be primarily talking about in today’s presentation. Aim 2 is to then assess the feasibility and acceptability of the facilitation intervention in a small group of VA primary care providers to further refine the intervention. And last, Aim 3 is to then pilot test this refined facilitation intervention in one primary care clinic to better understand whether facilitation holds promise to improve primary care-based alcohol-related care. And for the Aim 3 outcomes, we’re interested in both implementation-related outcomes, so things like reach, adoption of this care, and maintenance of the care, as well as effectiveness outcomes, including whether or not alcohol use decreases after the intervention.

So getting back to Aim 1, that’s going to include both interviewing veterans and primary care providers within the clinic. So first, I’m going to talk briefly about the methods of recruitment for providers. Providers were recruited from one large VA primary care clinic via email and secure teams messaging. We used purposive snowball sampling methods to recruit providers by asking participants for suggestions of other key clinicians who may offer a different or worthwhile perspective regarding alcohol care. And the aim was to interview between 10 and 15 providers, or until we reached a saturation of themes or until no new themes emerged.

Switching to the veterans, the veterans were screened for eligibility via the electronic health record. Veterans had to be at least 18 years old seeking care at the specific primary care clinic where we were conducting the intervention and had either a documentation of an AUDIT-C score indicating unhealthy alcohol use. And within the VA, that’s a score of five or more. And/or had a past year diagnosis of an alcohol use disorder. And then based on review of this EHR screening data, we mailed outreach letters to potentially eligible participants, and then veterans were given a phone number to opt out of the study. And then those who chose not to opt out within two weeks of the mailed letter were then called by our team to assess their interest in participating. And then similar to the primary care clinicians, purposive sampling was used to try and ensure that results reflected the perspectives of veterans of varying ages, sex, race, ethnicity, and treatment experiences. And again, we aim to interview between 20 and 25 veterans, or until we reach saturation.

The interview guides were semi-structured for both providers and veterans. All interviews were conducted via phone. All were audio recorded and transcribed and then verified by a second transcriber. Veterans were then compensated $35 for their time. And the interview guides were informed by The Consolidated Framework for Implementation Research, or the CFIR, which I will discuss in detail little bit more in a minute. But within the interviews, we really aimed for questions to be inviting, for them to be accessible, easily analyzable, for reasons such as we decided to use rapid qualitative methods to analyze the data, which I will also discuss shortly in a moment.

So as I just mentioned, the qualitative interviews were guided by CFIR, which was developed to help systematically guide evaluations and increase implementation knowledge as in what works and what’s not going to work across multiple clinical contexts. And the CFIR helps to identify specific barriers and facilitators to care that fall within five main domains, and these domains include, 1) the intervention characteristics. So how much does your evidence-based treatment cost? How complex is it? 2) The inner setting, and this is referring to what the clinic culture is like, whether providers are ready for change or ready for implementation. 3) The outer setting. This includes things like patient needs, peer pressure from external sources, external policies. 4) Characteristics of individuals and providing care, so the provider’s knowledge about the evidence-based treatment, their self-efficacy in implementing it, and their readiness. And 5) The implementation process, and this gets at things like engaging leaders in implementing this change, finding clinical champions that can promote the evidence-based practice to other providers, et cetera.

So here’s an example of the kinds of questions we asked the providers. So we asked things like, how you work with patients with unhealthy alcohol use or alcohol use disorder? After you identify these patients, then what do you typically do with them? What resources and treatments do you offer? How do you decide what resources and treatments to offer? Who else you think needs to be involved in their care? And if your clinic were to do more to address unhealthy alcohol use, what do you think would be needed? And then we asked specific questions about facilitation to get a better sense for whether or not they viewed facilitation as a useful implementation strategy for their specific clinic.

And here are some examples of the kinds of questions we asked veteran participants. So when you’re receiving healthcare, what do you feel you need to make important treatment choices? Tell me about your experiences with dragging alcohol. What if any impact has it had on your life and on your health? Have you ever sought or gotten help for your drinking or other substance use? If you haven’t gotten help but might consider it, what information might you need or want to make a decision about getting help? Have you and your primary care doctor ever talked about your drinking? What can you remember about these conversations? What role could the VA or any health system have in making it easier for you to get help? And if your primary care doctor suggested it, would you be open to talking with a primary care psychologist, social worker, clinical pharmacist, et cetera, about your alcohol use? And why or why?

In terms of data analysis, like I mentioned earlier, because facilitation really includes a menu of several different implementation strategies such as providing education and training, providing audit feedback to clinicians, we believe that the qualitative interviews could really help inform the strategies we chose. And so we decided that rapid qualitative analysis was a great way to analyze our data quickly but still rigorously. And so here’s some basic information about rapid analysis. It, I think, first emerged in the literature in the early 2000’s as way to develop a preliminary understanding of a situation from the insider’s perspective. It’s typically for projects lasting one year of less, so on more of a rapid timeframe. It can be very helpful for implantation and health services research where stakeholders are asking for specific demands and asking for specific products where there’s really a pragmatic need for the qualitative data. It can be pretty efficient and, therefore, cost-effective.

And you can still incorporate theory such as why do you think the behavior is—or what do you think is driving the behavior? And rapid really is just specific to the project. Some projects maybe are three months, as opposed to one year. And if a project is less than one year, maybe you don’t need to transcribe. Maybe you can code while you’re doing the interview. So these are decisions that you can make along the way that is specific to your project and goals. For my CDA, we had about one year to conduct the qualitative interviews.

And here are some just basic steps of our data analysis process, which was guided by experts such as Alison Hamilton, who is at the Los Angeles VA, and this really ensured we were conducting our analyses in a systematic and rigorous way. So first we created domain names that corresponded with each interview question. We then created a summary template to summarize each transcript by domain. We then tested out that summary template within our team to make sure we were summarizing consistently, and then modify the template if necessary. And after consistency was established, then we divided up the transcripts across the team to summarize. And last, we transferred our summaries into what’s called a data matrix, which I’ll show everybody in a minute, which is just a way to display the data so that you’re seeing all of the respondent’s information within each domain.

So here’s an example of our template where we defined our domain names, which are listed here on the left, paired with our interview questions on the right. And the domains are pretty face valid making it really easy to quickly know which domain names are paired with each question. And here’s an example of our blank summary template where you input participant information and demographics here at the top and our summary of the interview within each domain entered below. And the idea is to try and be as brief as possible. We sometimes would, though, include quotes within those cells, but it’s really suggested to only include shorter quotes here. If there are longer quotes, which of course there were, that we felt really were emblematic of specific barriers and facilitators, we created a separate cell, and we call those strong representative quotes. And we put all of those quotes within that cell.

And so here’s an example of what are matrix looked like without the data in it obviously. Each row represents one participant and each column represents each domain name from the template. And so the data is then transferred from each summary template to each corresponding cell so that all 10 or 20 of your templates are now within one Excel document, making it easy to see all the data by domain. We had one matrix for providers, and then one matrix for veterans. We then used the matrix to help us summarize and extract our key barriers, facilitators, and ideas and suggestions for our facilitation intervention.

So first, I’m going to go over the provider results. We ended up recruiting ten providers of varying disciplines, and we interviewed those clinicians between March and June 2021. We recruited three physicians, three clinical pharmacists within primary care, two primary care social workers, one nurse, and one psychologist, all with a primary care. The clinicians worked at the VA an average of almost six years. They had spent an average of two and a half years in primary care, and they saw patients for about 26.5 hours a week.

So we found four main barriers that kept appearing in many of our provider interviews, and the barriers were then mapped onto the various CFIR domains, which are noted below here on the slide. The first barrier was really varying knowledge about the definition and treatment for unhealthy alcohol use. Some providers were pretty confident on their knowledge, while others were quite unsure about how to define unhealthy alcohol use and how to treat it. And in terms of the CFIR, so that barrier fell within the individual characteristics and inner setting domain. Number two, there really was varying confidence in providing evidence-based care. So some providers were very confident; others were not. And this fell within the CFIR domain of individual characteristics. Third, there seemed to be difficulties in terms of communication between the disciplines within primary care surrounding evidence-based care. So some folks were unsure as to what others were doing when they were talking with patients about unhealthy alcohol use. And this barrier fell within the inner setting. And last, logistical issues were a huge barrier. So several providers talked about not having enough time to discuss unhealthy alcohol use, having competing clinical priorities take precedence. Things of that nature. And this fell within the CFIR domain of the inner setting.

So I’ve listed here some quotes that I think are emblematic of each barrier. First, in terms of knowledge, “I honestly don’t even know what the NIH or the CDC would define 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.” And, “I think education, right? So I think you bring everybody together, all the players together, and say here’s how to identify alcohol use disorder. Here’s how to use it in the electronic health record. And here’s how to refer. And I think the other thing is making it as simple as possible.”

In terms of confidence, one provider said, “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.” And another provider stated, “ 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.”

In terms of communication, one clinician said, “I guess when I’m talking to patients, I’ll talk about the integrated behavioral health team as like shorter-term, whereas sometimes I find that patients can have more long-term care with the specialty substances clinic. But again, I’m a little unclear on what the actual, even though I do this, I’m unclear a little bit on actual rules that regulate that.” And another provider stated, “I’m concerned about how some medical provider still view people with substance use disorders 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.” So I think this is indicating that this provider thinks they know what other clinicians do, but they’re not quite sure. So again, just signifying that there’s a real lack of communication between providers related to this care.

And last, logistics. One clinician stated, “The biggest barriers are that there are often a lot of other issues that we have to cover in the clinic, and so we sort of may not get around to figuring out that the patient has unhealthy alcohol use.” And another provider stated, “I think that there’s a lot of, ‘Oh, you’re drinking more than you should? Do you want to go to the 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.”

We also extracted several facilitators of alcohol-related care, including the belief in the importance of providing this kind of care in primary care, which we were pleased to see. Also we received discipline-level leadership support, so folks talked about how leaders would most likely support improving this kind of care. And third, we also were able to identify, through the interviews, several staff who could be qualified to be clinical champions for this kind of care. And this included a physician, a psychologist, and a pharmacist. And then last, when we gave a little bit of information about facilitation and what that entails to the participants, we received a lot of support for the ideas presented.

So I just have a couple more quotes here for the facilitators in terms of belief and alcohol care. One provider said, “I think it 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.” Another provider said, “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 their other primary care, and I think that normalizes that. And it doesn’t require them to either come back or have another phone appointment even.” And then regarding support for facilitation, “It would be really, really nice to have like that consistent monthly follow up so that any issues or concerns or problems could be addressed, and we wouldn’t be waiting a year to be like, ‘Oh, we’re actually having a big problem with this.’”

We also gathered, like a said, useful feedback and information about our planned facilitation strategies. So a lot of the provider’s mentioned that it would probably be much more feasible to keep any meetings associated with the facilitation intervention to one hour or less, due to everybody’s busy schedules. There was a lot of interest in having more readily available education materials, both for providers and also things to give the veterans. Specifically, providers were interested in materials that described the levels of care for substance use disorder treatment, and then really detailing the treatment within each level of care, as well as much more information about medications for alcohol use disorder.

And there was a lot of interest in receiving ongoing support from a clinical champion or champions. And people were somewhat enthusiastic of the idea of providing sort of real-time data for feedback, which is often in terms of audit and feedback in the literature. But folks stressed that if we were to do something like this, it would probably be more helpful to do it within a meeting that was in person or via teams, as opposed to sending feedback via email since many providers felt that clinicians were probably a bit too busy to open emails and look at a feedback information sheet. And a few providers also wanted to make sure that the audit and feedback, if we decided to do that, came across as helpful as opposed to punitive, so not feeling like people were getting in trouble because they weren’t providing evidence-based alcohol care.

So now I’m going to switch gears briefly and talk about the veteran findings. We ended up interviewing 22 veterans. Interviews were conducted between June and September 2021. We were able to recruit a sample that was almost half female, half male. So 55% identified as male, and 45% is female. About 41% identified as Black, and 41% identified as white. Another 5% identified as Asian, 5% as Native Hawaiian/Pacific Islander, and the remaining 9% is multiracial. And then of those, about 5% identified also as Hispanic. The average age was older, not surprisingly, given that this is a VA sample, so the average age was 60. We had quite a range of ages, though, so participants range in age from 29 to 79. So we were happy about that. The average AUDIT-C—so we asked the AUDIT-C again, so we could get current alcohol use information. The average AUDIT‑C was a 4. AUDIT-C ranges from 0 to 12, and within our sample it ranged from 0 to 11. So we really did have the spectrum of alcohol use, including those who had stopped drinking.

So there were about four main themes that emerge from the veteran interviews, then I’ll go over these first. First, most described positive primary care experiences and found that their clinicians were really caring and relatable. So we were happy to hear that. Second, there was varying interest and experience with alcohol-related care. For example, many reported never seeking treatment for their alcohol use, while some had sought VA-related inpatient and outpatient care. And in addition, several had really never discussed alcohol with their primary care provider, while others described having in-depth discussions with their primary care provider about alcohol use and how it has affected their health. And then not surprisingly, interest in medications related to alcohol use disorder vary. Some were interested and had taken them. Others were not and were not interested in ever taking them. Third, there was a real desire for shared decision-making. So for example, many stressed that ongoing nonjudgmental conversations about alcohol use could be acceptable and that veterans really just wanted to make treatment decisions in partnership with their doctor, as opposed to always being told what to do or that they were wrong. And last, some were open to involving other primary care clinicians in treatment decisions, such as clinical pharmacists or peer specialists.

So here are just some quotes that I wanted to highlight. In terms of positive experiences in primary care, some veteran said, “She actually shows that she cares and takes a deep interest in my wellbeing.” Someone else said, “Actually very, very good. An overall pretty positive experience.” And then, “My PCP treated me very positive. I have a real good relationship with primary care?” And last, “My PCP was confident about their diagnoses and treatments, and for the most part, I always felt comfortable and pleased with the care I received.” Regarding alcohol-related care interest and past experience, one veteran said, in relation to attending Alcoholics Anonymous, or AA, they said, “Because when I got into recovery, I was too ashamed to ask the VA for help.” So that’s one person’s experience.

Another participant stated, “I don’t need treatment. I do those things on my own. I just quit. That’s the way I deal with things.” A third patient said, “I honestly think that alcohol therapy definitely change my life for the better.” And last, veteran stated, “I reached out to them,” meaning the VA, “because I wanted to take the drug naltrexone, and they got back to me right away.” So I think this is really emblematic of the kinds of varying responses we received related to treatment experience. So you really see the gamut from quitting on one’s own to group therapy to possibly individual therapy to medication.

Terms of shared decision-making, one veteran stated, “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.” Another veteran stated, “PCPs should be projecting openness, understanding, compassion to help, and empathy.” A third veteran stated, “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.” And then last, a veteran stated, “She listen 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 it in my face, ‘Oh, ‘cause you know it’s going to kill you.’”

And last, quotes related to interdisciplinary care. One veteran stated, “I think if I were to look for help, I think it would have to be a peer situation. If I 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.” Another veteran stated, “I wouldn’t mind talking with other providers to figure out what’s going on and to try to do a better job in treating it.” And last, a veteran said, “You never know how that question may hit you on that day, say, ‘You know what, I’m tired of it. I would like some more information or a referral.’”

So then moving onto some barriers. We found that three main barriers emerged from the interviews. First, many reported experiences of shame and judgment in treatment settings that prevented them from seeking help in various points. And I think that that was a little bit evident in some of the quotes that I just read. And again, this barrier fell within the CFIR domain of individual characteristics. A second barrier, some expressed frustration that there seemed to be frequent provider turnover, and this was most likely attributable to the training nature of this specific primary care clinic. So they have many residents that train within this clinic. And this barrier fell within the both outer setting and inner setting. And finally, many did not know about alcohol’s substantial negative influence on health and were unsure about treatment options offered by this specific VA, so there’s just a real lack of knowledge there. And this barrier fell within the CFIR domains of individual characteristics and inner setting.

So terms of conclusions and implications, it seemed evident that providers should really continue building compassionate relationships with veterans; that they should offer repeated nonjudgmental, evidence-based advice and treatment options related to unhealthy alcohol use and use shared decision-making. And I think the implications of this are really to—are or could be—destigmatize care to reduce shame and to potentially increase motivation to change. And it was clear that some patients were very open to primary care leveraging the resources beyond the physician or PCP to optimize this kind of care. And this could include things like warm handoffs to other interdisciplinary providers within the clinic, such as peer specialists, psychologists, pharmacists, et cetera. And I think the implications of this are, of course, 1) increasing access to care, but also, 2) really destigmatize this care, making it normal to talk about alcohol use with providers.

Thinking back to the provider conclusions again, key barriers fell within the CFIR inner setting and characteristics of individual constructs or domains. And it was clear that gathering provider perspectives on alcohol-related care seem to at least initially support development of a tailored facilitation intervention that could really capitalize on facilitators and minimize barriers. And so what we ended up doing next was using something called the CFIR-ERIC Match Tool to help further guide and inform the facilitation strategies that we were going to plan to use. And this is what I will discuss next, since it’s a bit of a mouth full.

So if you’re using CFIR to help identify potential barriers to implementation, this knowledge can then be used to help choose which implementation strategies will reduce those barriers potentially. And experts in implementation science developed a tool that could help researchers do this, and this is basically by matching specific implementation strategies to specific barriers. And this is what’s called the CFIR-ERIC Match Tool. And up here on the left is the website where you can go and find the tool and read a little bit about it and actually use it. The ERIC part stands for the Expert Recommendations for Implementing Change, and this was a publication in 2015 that listed about 73 implementation-related strategies. And this is then what was used for the CFIR-ERIC Match Tool.

And the tool was developed based on survey responses from implementations science experts in the field. About 169 experts participated, and they were asked to choose up to seven implementation strategies that they believed really would best address each CFIR barrier. And this tool, which I will show next, provides basically a prioritized list of strategies to consider based on your specific barriers. However, there is a caveat. And I think something helpful to keep in mind if you’re going to use this tool is that it’s helpful to know that the experts really had a lot of differences in opinions, and so it just suggests that it’s a tool. It’s one thing to use when you’re deciding implementation strategies, but you also want to consult the relevant literature and colleagues in order to really choose the best strategy for your project. And also really thinking about what’s feasible for you.

So this is an example of our output table that lists our main CFIR barriers across the top here and the ERIC implementation strategies that were suggested on the left-hand column here. The strategies are sorted by cumulative level of endorsement, which is this column here, which indicates basically the strength of endorsement for that strategy across all of the CFIR barriers listed. So here, for example, conduct educational meetings had the highest cumulative percentage of endorsement at 173%, meaning that the majority of experts thought that this strategy would help overcome many of the barriers listed here to the right. The green color coding lets you know that a majority of experts endorse that particular strategy for that barrier. I believe the cutoff was 50% or more. And the yellow color coding indicates that at least 20% of experts endorse that specific strategy to address that specific barrier.

Within this table, we actually ended up rearranging it a bit so that similar strategies were clumped together, since many implementation strategies tend to overlap a bit. So this is why our cumulative percentage column isn’t sorted from highest to lowest. So for example we lumped all of the strategies that talked about conducting some sort of education or ongoing training. And here’s a list of some of the other strategies that emerge is possibly important to consider. So you can see here facilitation and is the fifth one down here listed, and that had a cumulative percentage of 83%, indicating that most experts thought this was a good strategy for reducing many of the particular barriers listed to the right. I will point out that for patient needs and resources, one of the top suggested strategies was conducting a local needs assessment, which is essentially what we did with our veteran qualitative interviews. That’s just not shown on this particular table.

So taking all this information into account and based on the tables and based on what we really thought was feasible within the timeframe and resources within this specific CDA project, we came up with several top actionable implementation strategies. And these were conducting educational meetings, developing materials, and possibly creating a learning collaborative, identifying clinical champions who could really promote evidence-based alcohol-related care within the clinic, and maybe providing some ongoing training related to this care. And also organizing an implementation team that could have ongoing meetings and all under the umbrella of facilitation, so hiring a facilitator who could come into the clinic and help direct and start up and guide some of these changes.

Really briefly, I’ll just mention after summarizing and analyzing this data, I, of course, had meetings with my mentors to discuss the findings. And through those meetings, we prepared an initial implementation guide, and this is what we then used as the basis for my Aim 2 focus group meetings with several primary care providers where we then assessed the acceptability and feasibility of our implementation strategies and ideas. And through those focus groups, we modified the implementation guide slightly because things had changed a little bit by the time we conducted those focus groups within the clinic. And then my facilitator and I met with primary care leadership and staff to review these findings and then introduce the final facilitation plan, which we are now currently pilot testing.

So that’s it for this presentation. I want to mention that this work really would not have been possible without the tremendous support and guidance from a mentorship team, specifically Emily Williams and Matt Chinman, who are my co-primary mentors on this project. And also, I would love to shout out Angie Phares, who is my project facilitator, so she’s on the ground in the clinic. And of course HSR&D for funding this work. And that’s it. Happy to take questions.

Moderator: Thank you, Dr. Bachrach. We had a couple questions come in early regarding access to the slides. I don’t have any right—actually, that’s not true. Okay, this one’s for both, so bear with me, okay? “With so many educational needs for providers identified, are there any plans to partner with existing national VA resources or program offices to leverage existing expertise? (Academic detailing, peer, support, et cetera., an enhanced sustainability of the intervention.)

Dr. Rachel Bachrach: Yeah, thank you for that question. I’m glad actually you mention that. So through the qualitative interviews, it became apparent that clinical pharmacy had a real interest nationally related to providing evidence-based alcohol-related care. And so one of the clinical pharmacists pointed me towards the academic detailing website. And through that, I developed a relationship with a different clinical pharmacist in primary care who is actually an academic detailer. So a certain percentage of her position is academic detailing, and she had just finished training within alcohol-related care. She had had training before, but I think national office had updated the materials related to alcohol related treatment. And so they had held trainings regarding those materials and those updated products, and so she is now one of my clinical champions, luckily. And so she’s actually providing trainings to the clinic.

And because of her position, like you mentioned in your comment, she’s very flexible. So we were nervous that we would have to find times were everybody in the clinic could come and do the same training at the same time. But because of her position, she’s again very flexible, so she can provide education and training one-on-one. She can provide in small groups, in large groups, so she’s really doing a mix of that. And she’s also focusing on providing training to one specific clinical pharmacist within the clinic who’s going to become basically like a point person for unhealthy alcohol use related care.

Moderator: Thank you. “What are the limitations of your study, and what further research is recommend? “

Dr. Rachel Bachrach: Yeah, I think the limitations probably are that the findings from the qualitative aims aren’t going to be necessarily generalizable to every clinic across VA. So this work is really time intensive, and so I think if you wanted to pick this up and do this in a different clinic, you could probably glean some useful knowledge from these findings. But that doesn’t mean you wouldn’t have to then go and do some of your own digging in your own clinic to figure out what your specific barriers or facilitators are. So maybe that’s just a general limitation of probably qualitative work in general, but obviously, there’s other advantages to it as well.

I just think in terms of further directions, I don’t know if we know how best to—or I don’t know if we have the resources to provide ongoing fidelity checks to make sure that, for example, brief interventions are being delivered with fidelity. I think that we probably need to do a little bit more work in that area to ensure that what people are calling a brief intervention is what’s really happening in a clinical encounter, as opposed to checking a box or doing something in a way that’s not really based in the evidence. Thanks.

Moderator: Thank you. “AUDIT-C is a screen indicating further evaluation, doesn’t not provide a diagnosis. Do you see providers are not comfortable with diagnosing AUD? Any indications from your interviews as to who/where the further eval should/could be done?”

Dr. Rachel Bachrach: Yeah, that’s a great question. So you’re right. So the AUDIT-C isn’t a diagnostic tool necessarily, although even in some of—for example, like the academic detailing resource says what they’ve done to help providers with that is they’ve broken down the score based on research in terms of what it suggests. And there’s certain scores that suggest that an alcohol use disorder is likely, but further assessment really is needed to validate that diagnosis. And there are certain tools that can be utilized within CPRS, although this is by hospital. But at least in our VA, I believe there are decision tools in CPRS that can help providers assess for an alcohol use disorder. So luckily, our VA has that information already embedded into the electronic health record. So it takes some time to do it within the clinical encounter, obviously, but it’s at least there for you. And it really just helps you do it, at least in a quick and efficient way, as opposed to figuring out how to assess for this within timeframe that’s unrealistic.

So I think if folks are interested in that sort of thing, talking to leadership about making some sort of decision tools in CPRS to help facilitate this care or the screening. And the other piece, though, is if that’s not feasible for some folks, capitalizing on your primary care mental health integration team. So those are usually psychologists and social workers embedded within the primary care clinic that would be happy to do a functional assessment for the physician to better understand whether or not this person might meet criteria for an alcohol use disorder. And they can make those suggestions, and then the team can go from there in terms of treatment recommendations.

Moderator: “Given that your veteran subjects were balanced between male and female veterans, where there any gender-specific barriers?”

Dr. Rachel Bachrach: Yeah, thank you for that. So in terms of gender, the women veterans, I would say many of them talked about wanting women-specific resources, really groups that were composed or comprised of just women. We heard that a few times. That a lot of times the women veterans were hesitant to seek treatment at the VA related to substance use because they felt like they were always the only woman in the room or in the group, and they just didn’t feel super comfortable seeking treatment for that reason. So that was one sex-specific theme that emerged, but I think that was it.

Moderator: “What automated tool did you use? Example, ATLAS.ti.”

Dr. Rachel Bachrach: We didn’t. So we ended up—so with rapid analysis, I suppose you could, but often times with rapid analysis you don’t use a tool like ATLAS. You simply audio record, as you normally would, through Teams or through a recorder device, have a transcriber transcribe if that’s what your goals are and you have time to do that. And as they’re transcribing interviews, you’re also summarizing templates at the same time. So things are happening in concert with each other, as opposed to transcribing everything—taking time to transcribe all the interviews. And then once that’s finished, then summarize. So we didn’t do that. We did everything simultaneously through Word.

Moderator: Thank you. This one was a clarifying question from a person. I think you were actually answer the question at the time that they wrote this in. And they say, “And the average age is approximately 60?”

Dr. Rachel Bachrach: Of the veterans, yes.

Moderator: Well, that’s all the questions that we have queued up now, and we’re just about out of time. So if you’d like to make closing comments, please go ahead.

Dr. Rachel Bachrach: I just thank you all for attending and for asking such thoughtful questions. And if you have other questions that you think of, feel free to email me, reach out. My email is here on the slide. So thank you.

Moderator: Thank you again, Dr. Bachrach. Attendees, when I close the webinar momentarily, a short survey will pop up. Please do take a few moments and provide answers to those questions. We count on them to continue to bring you high-quality cyberseminars such as this one. Once again, Dr. Bachrach, thanks again. And with that, I’ll just close and wish everyone a good day.

Dr. Rachel Bachrach: Thanks.