Primary care provider and U.S. Veteran perspectives on barriers and facilitators to alcohol-related care and ideas for improvement in the Veterans Health Administration

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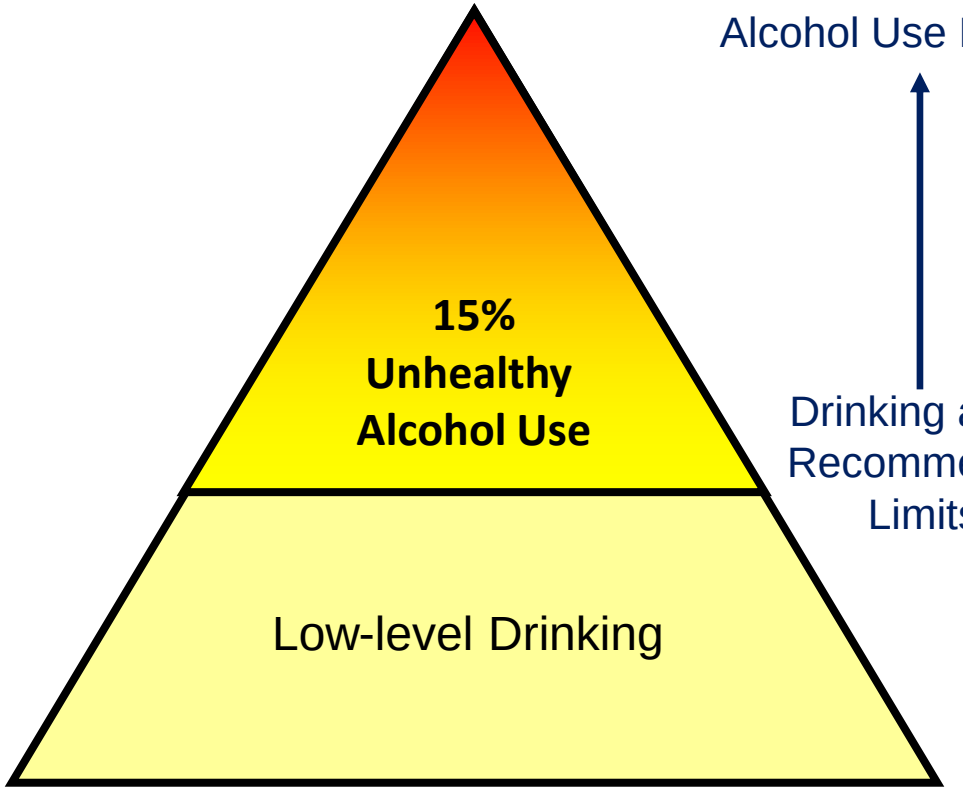
Disclosures and Acknowledgments

- No conflicts of interest to disclose

- Research Funding:
  - Findings presented here were supported by a Health Services Research & Development Career Development Award (CDA 20-057, PI: Bachrach)

- The contents of this presentation do not necessarily reflect those of the funders, institutions, the U.S. Department of Veterans Affairs, or the United States Government

Evidence-Based Care: Unhealthy Alcohol Use



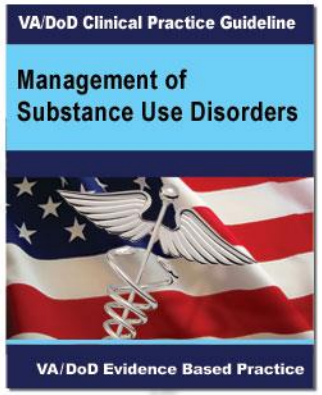
Alcohol Use Disorder

Drinking above Recommended Limits*

Effective Treatment Options:
- Behavioral Treatments
- Pharmacotherapy

Brief interventions

U.S. Preventive Services TASK FORCE

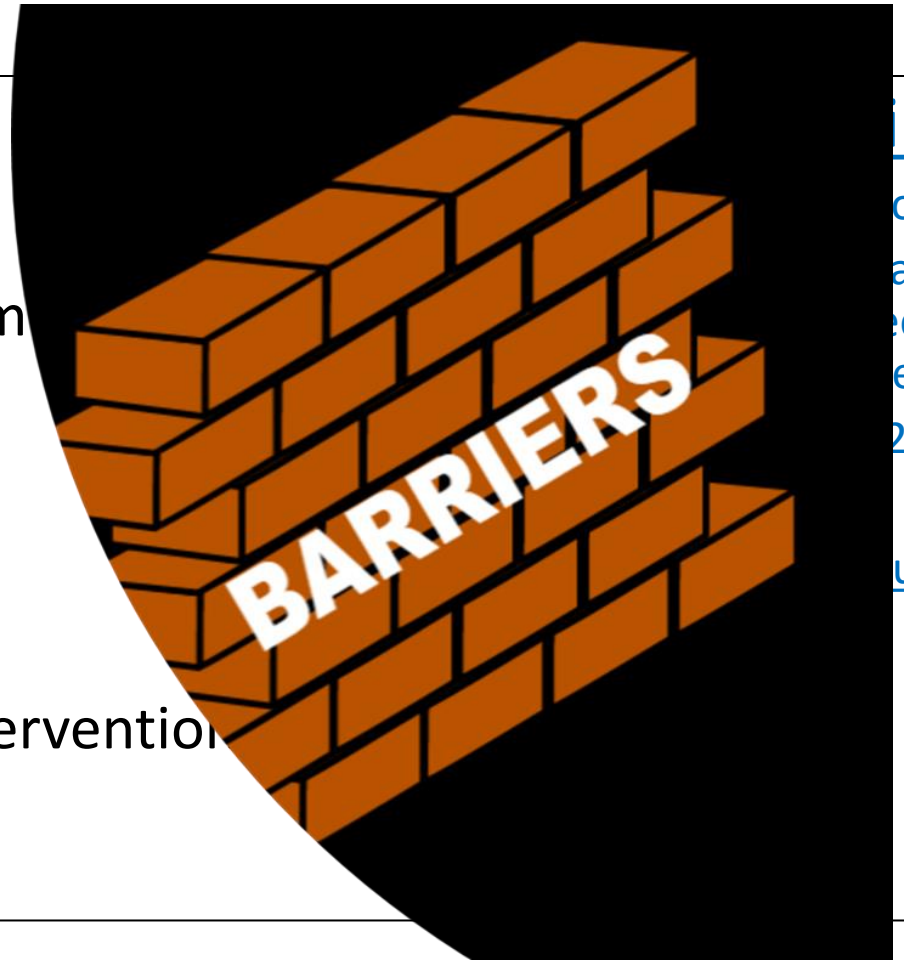


*≤ 14 drinks/week or 4/occasion for men; ≤ 7 drinks/week or 3/occasion women

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

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

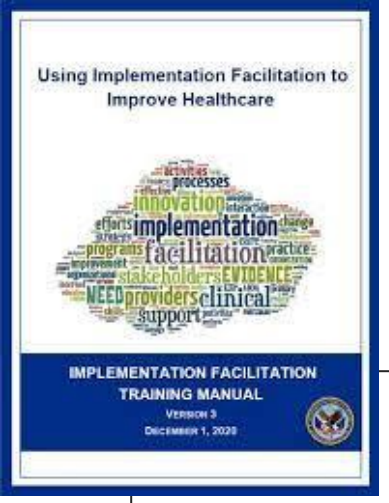
25% do not receive BI

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

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

<u>Aim 1</u>: 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]

<u>Aim 2</u>: 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.

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

<u>Implementation outcomes</u>:
Reach, Adoption, Maintenance

<u>Effectiveness outcome</u>:
Decrease unhealthy alc use

Aim 1 Methods: Recruitment

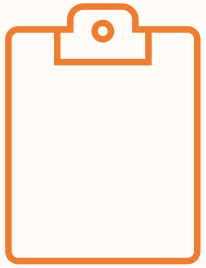
Providers

- 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 and Analysis



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

Rapid Qualitative Analysis

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)

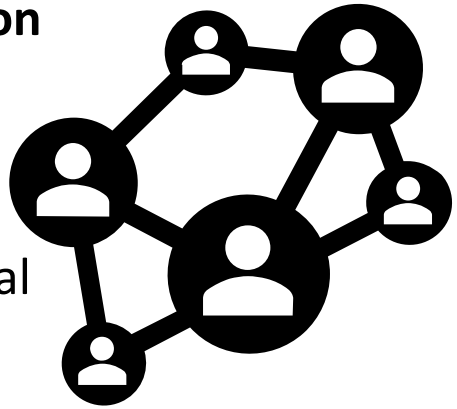
Sample: Providers

- 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

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



Barriers: Knowledge and Confidence

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

Barriers: Communication and Logistics

"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 rules [are] that regulate that."

"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)

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

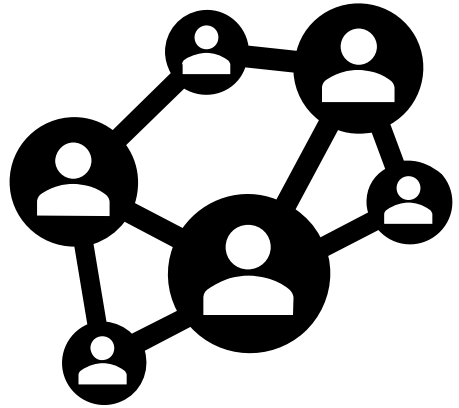
Sample: Veterans

- 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
  - *"She actually shows that she cares and takes a deep interest in my well-being"*
- Varying interest and experience with alcohol-related care
  - *"[I] Don't need [treatment]. I do those things on my own…I just quit. That's the way I deal with things."*
- Desire for shared-decision making
  - *"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…"*
- Open to receiving interdisciplinary care
  - *"[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."*



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

Next Steps: Choose/Refine Implementation Strategies

- Used the CFIR-ERIC (Expert Recommendations for Implementing Change) match tool to help guide and inform implementation/facilitation strategy planning
  - https://cfirguide.org/choosing-strategies/
- If using CFIR to identify barriers to implementation, this knowledge can then help choose which implementation strategies will reduce those barriers
- Developed based on survey responses from “implementation experts” (n=169) who were asked to chose up to 7 implementation strategies they believed would best address each CFIR barrier (Waltz et al., 2019)

Top actionable implementation strategies

- Facilitation/Organize implementation team meetings
- Develop educational meetings/ materials/learning collaborative
- Identify clinical champions, ongoing training

Limitations

- Qualitative Interviews
  - Not generalizable
- CFIR-ERIC Match Tool
  - Many implementation strategies overlap with one another
  - Experts did not agree on the best strategy for each barrier

Preparing for Aims 2 and 3

Created initial implementation/facilitation guide

Assess acceptability and feasibility of our implementation strategies/ideas

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

Acknowledgements

CDA Mentors and Staff:

- Emily Williams, PhD, MPH
- Matt Chinman, PhD
- Keri Rodriguez, PhD
- Kevin Kraemer, MD, MSc
- Maria Mor, PhD
- Angie Phares, MS, PA-C
- Cecile Garfunkel, MS
- Karley Atchison, MA
- Gloria Klima, MA
- Nicole Beyer, MA

VA Fellowship Mentors:

- Karin Daniels, PhD
- Adam Gordon, MD, MPH, FACP, DFASAM

VA Pittsburgh Research Center Directors:

- CHERP: Michael Fine, MD, MSc
- MIRECC: Gretchen Haas, PhD

Data sources/funding:

- VA CDA K2HX003087, HSRD CDA 20-057, PI: Bachrach, Mentors: E. Williams & M. Chinman

Thank You!

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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

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."

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