

# Implementation Research to Improve Access, Equity, and Delivery of Evidence-Based Care for Unhealthy Alcohol and Other Substance Use in Medical Settings



**W** HEALTH SYSTEMS AND POPULATION HEALTH  
SCHOOL OF PUBLIC HEALTH

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# Acknowledgments

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# Acknowledgments

## Research Funding

- VA Health Services Research & Development (HSR&D)
  - Career Development Award (12-276)
  - Investigator Initiated Research (IIR-17-120)
- Implementation Research Institute Fellowship supported through an award from the National Institute of Mental Health (R25 MH080916-01A2) and VA HSR&D and QUERI
- VA Substance Use Disorders Quality Enhancement Research Initiative (QUERI RRP 09-178, 11-268, 12-528; LIPs 59-031 and 59-047)
- National Institute on Alcohol Abuse and Alcoholism (R21 AA022866 and R21AA025973).
- Patient Safety Center of Inquiry Program, Department of Veterans Affairs

# Outline

- Positionality/Disclosure
- Implementation Science
  - Definitions, resources, and select tools we use in our work
- Application of Tools: Selected Research
  - Implementing alcohol-related care in VA Primary Care + Lessons learned
  - Current Application to VA Liver Care: Tailoring an implementation intervention for testing
- Questions

# Positionality/Disclosure

# Positionality/Disclosure Statement



**Implementation Scientist  
and Addictions Health  
Services Researcher:**



**Educator, Mentor,  
and Administrator:**

**Addictions Health Services Researcher**

**Patient:** Living with  
chronic condition  
with regular need  
to navigate a health

## **CONFLICT OF INTEREST STATEMENT:**

I have no financial or other business conflicts of interest, but I come with biases as a result of socialization and life experiences.

# Implementation Science

# Implementation Science: Definitions

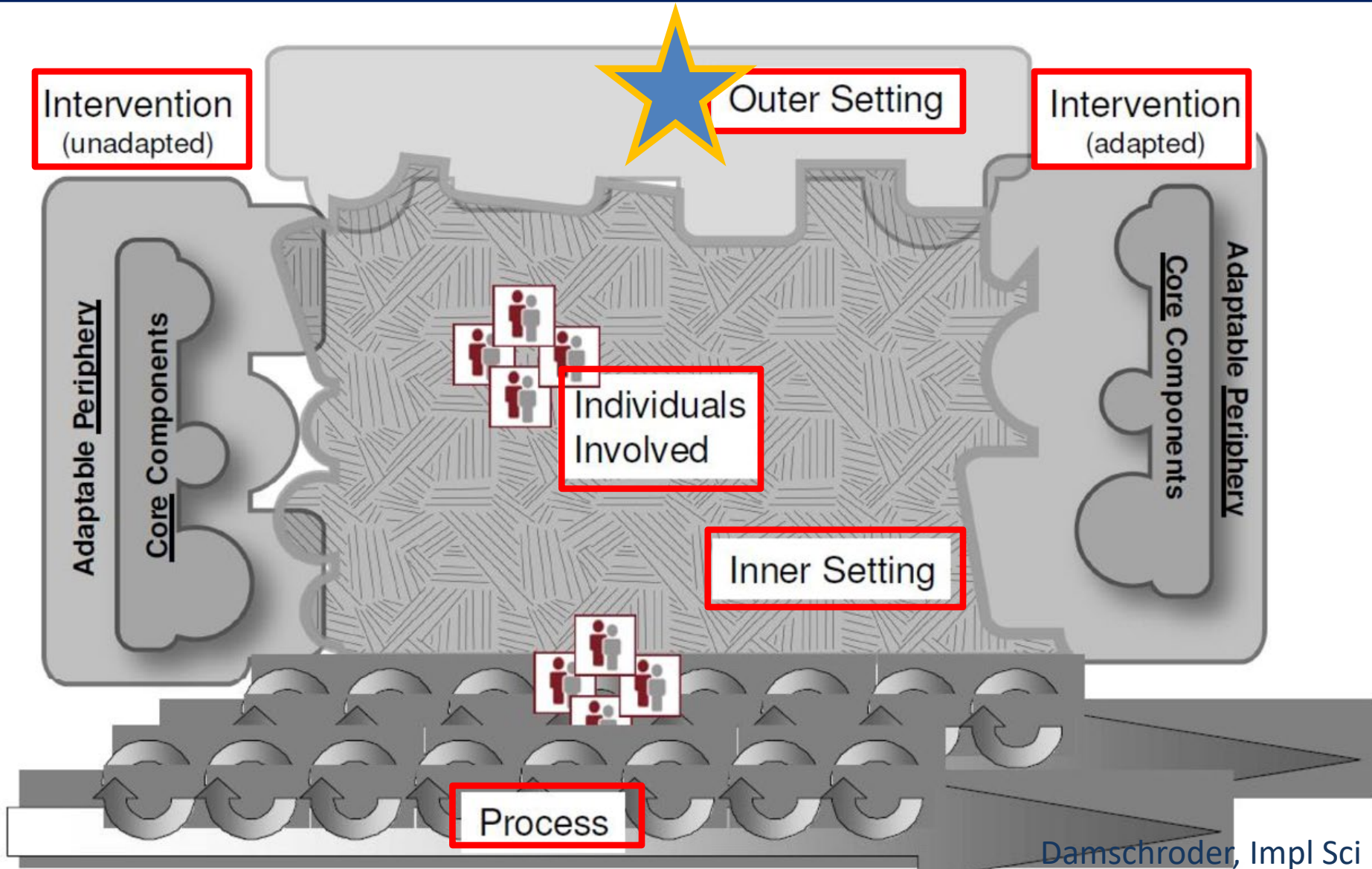
## Implementation Science is:

- “The scientific study of methods and strategies that facilitate the uptake of evidence-based practice and research into regular use by practitioners and policymakers.” –*UW Imple Sci*
- “The scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices (EBPs) into routine practice, and, hence, to improve the quality and effectiveness of health services.” –*Eccles and Mittman, Impl Sci, 2006*

“Implementation scientists aim to understand barriers (what makes it harder to implement) and facilitators (what makes it easier to implement), and design and test different strategies to scale evidence-based practices, to ensure that the promise of scientific discovery is realized” —*Rinad Beidas, Penn Medicine*



# Consolidated Framework for Implementation Research



# Formative Evaluation as a Tool of Implementation Science

## The Role of Formative Evaluation in Implementation Research and the QUERI Experience

Cheryl B. Stetler, PhD, RN, FAAN,<sup>1</sup> Marcia W. Legro, PhD,<sup>2,3</sup> Carolyn M. Wallace, PhD,<sup>2</sup>  
Candice Bowman, PhD, RN,<sup>4</sup> Marylou Guihan, PhD,<sup>5</sup> Hildi Hagedorn, PhD,<sup>6</sup>  
Barbara Kimmel, MS, MSc,<sup>7,8</sup> Nancy D. Sharp, PhD,<sup>2</sup> Jeffrey L. Smith (PhD candidate)<sup>9</sup>

<sup>1</sup>Independent Consultant, Amherst, MA, USA; <sup>2</sup>VA Puget Sound Health Care System, Seattle, WA, USA; <sup>3</sup>University of Washington, Seattle, WA, USA; <sup>4</sup>VA San Diego Healthcare System, San Diego, CA, USA; <sup>5</sup>Edward Hines, Jr. VA Healthcare System, Hines, IL, USA; <sup>6</sup>Minneapolis VA Medical Center, Minneapolis, MN, USA; <sup>7</sup>Baylor College of Medicine, Houston, TX, USA; <sup>8</sup>Houston Veterans Affairs Medical Center, Houston, TX, USA; <sup>9</sup>Central Arkansas Veterans Healthcare System, Little Rock, AR, USA.

This article describes  
of formative e  
ing of how to imp  
in order to improv

*“In an action-oriented improvement program, summative data are essential but insufficient to meet the needs of implementation/QI researchers... .*

*Implementation researchers need to answer critical questions about the feasibility of implementation strategies, degree of real-time implementation, status and potential influence of contextual factors, response of participants, and any adaptations necessary to achieve optimal change”*

# Uses of Formative Evaluation in Implementation Science

Table 2. Potential Uses of Formative Evaluation<sup>10,13,16,20-27</sup>

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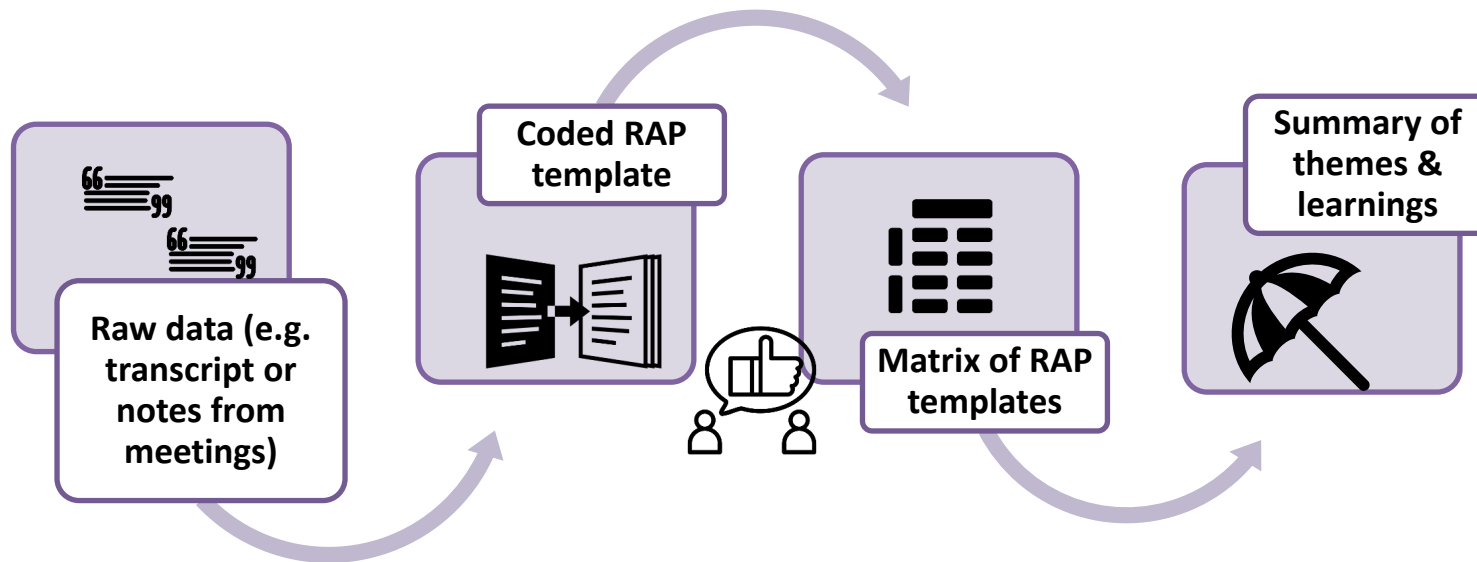
Understand the nature of the local implementation setting
Assess whether a program or intervention addresses a significant need
Modify a proposed program or intervention, as needed
Determine the extent, fidelity, and qualities of the implementation of an intervention program . . . (e.g., to) describe the activities actually implemented. ... (and) ... explain program operations <sup>21</sup>
Systematically detect and monitor unanticipated events (and adjust if appropriate)
Optimize/control implementation to improve the potential for success
Obtain ongoing input for short-term adjustments
Document continual progress
Inform future similar implementation efforts, e.g., within other health care sites or a larger system
Avoid type III errors: "Failing to detect differences between the original intervention plan and the ultimate manner of implementation" <sup>13</sup> ; or failure to understand how complex the phenomena of interest really are
Understand the extent/dose, consistency, usefulness, cost-effectiveness
Understand the nature and implications of local adaptations
Assist interpretation of program outcomes or worth in terms of local conditions
Foster an understanding of the causal events leading to implementation
Standardize on-going implementation
Understand the experience of those directly affected by implementation

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- ✓ Understanding the nature of the local implementation setting
- ✓ Understanding the experience of those directly affected by implementation efforts
- ✓ Modifying intervention as needed
- ✓ Informing future similar implementation efforts

# Rapid Assessment/Analysis Process (RAP)

“Rapid assessment is defined as **intensive team-based** qualitative inquiry using **triangulation, iterative data analysis**, and additional data collection to quickly develop a **preliminary understanding** of a situation from the insider’s perspective.”



# RAP Example

## TEMPLATED TRANSCRIPT SUMMARY – ROUND 2 SSP COVID-19 INTERVIEWS

RAP template created by:	
Interview ID#:	
Interview conducted by:	
Interview date:	

### Background SSP information:

SSP name:	
Program organizational affiliation:	
Program location (city, state):	
Interviewee role (please describe):	

\*When adding quotations, please use quotations marks and indicate the interview PID in brackets (example: "quote" [ID123])

\*Please use [brackets and italics] for any additional context/comments, including items not directly discussed in the transcript.

Current approach to syringe / exchange distribution services	
Distribution approach (in general and COVID-specific)	•
Facilitators to distribution (e.g. mail order distribution, secondary distribution, home delivery)	•
Barriers to distribution	•
Changes to service model they intend to maintain after COVID	•
Financial impacts of COVID	
Changes to program financing due to COVID (in general, and for specific aspects of service delivery)	• <i>Descriptive summaries of data &amp; strong representative quotes</i>
Other financial changes (not COVID specific)	• <i>quotes</i>
Program response to financial impacts (e.g. planned or actual changes)	•
Current approach to HIV & HCV testing	
Current HIV / HCV testing approach (if restarted, when/why did it restart?)	•
Changes to HIV and/or HCV	•

## Example RAP Matrix

Site ID	Distribution approach	Facilitators to distribution	Barriers to distribution
Site 1	<ul style="list-style-type: none"> <li>Mostly mobile delivery, less use of fixed sites</li> <li><i>"We hardly do any onsite distribution now; most of our approach involves our staff getting out there to meet people where they are at." [S2]</i></li> </ul>	<ul style="list-style-type: none"> <li>Partnerships with other agencies</li> <li><i>"We couldn't have maintained our outreach without the help of the clinic we partner with" [S1]</i></li> </ul>	<ul style="list-style-type: none"> <li>Many staff are volunteers and unable to work as much</li> <li>Difficulty getting enough syringe supply</li> <li><i>"It's been so hard to find syringe suppliers that aren't back-ordered." [S1]</i></li> </ul>
Site 2	<ul style="list-style-type: none"> <li>More mobile</li> <li>Increase in secondary exchanges</li> </ul>	<ul style="list-style-type: none"> <li>Client "appreciation" of new approaches like mail order or text-based delivery scheduling</li> <li><i>"There was so much appreciation for these new methods, clients kept telling us how much they wished we had provided this earlier" [S2]</i></li> </ul>	<ul style="list-style-type: none"> <li>Supply shortages (e.g. syringes)</li> <li>Need to maintain COVID social distancing precautions</li> <li><i>"We can't give out as many syringes as we'd like, it would wipe out our supply" [S2]</i></li> </ul>

## Example RAP Template



# RAP Gets The Job Done!

Open access

Research

## BMJ Open Can rapid approaches to qualitative analysis deliver timely, valid findings to clinical leaders? A mixed methods study comparing rapid and thematic analysis

Beck Taylor, Catherine Henshall, Sara Kenyon, Ian Litchfield, Sheila Greenfield

**To cite:** Taylor B, Henshall C, Kenyon S, *et al*. Can rapid approaches to qualitative analysis deliver timely, valid findings to clinical leaders? A mixed methods study comparing rapid and thematic analysis. *BMJ Open* 2018;**8**:e019993. doi:10.1136/bmjopen-2017-019993

► Prepublication history and additional material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2017-019993>).

Received 6 October 2017  
Revised 16 May 2018  
Accepted 14 August 2018

### ABSTRACT

**Objectives** This study compares rapid and traditional analyses of a UK health service evaluation dataset to explore differences in researcher time and consistency of outputs.

**Design** Mixed methods study, quantitatively and qualitatively comparing qualitative methods.

**Setting** Data from a home birth service evaluation study in a hospital in the English National Health Service, which took place between October and December 2014. Two research teams independently analysed focus group and interview transcript data: one team used a thematic analysis approach using the framework method, and the second used rapid analysis.

**Participants** Home birth midwives (6), midwifery support workers (4), commissioners (4), managers (6), and community midwives (12) and a patient representative (1) participated in the original study.

**Primary outcome measures** Time taken to complete analysis in person hours; analysis findings and recommendations matched, partially matched or not matched across the two teams.

**Results** Rapid analysis data management took less time than thematic analysis (43 hours vs 116.5 hours). Rapid analysis took 100 hours, and thematic analysis took 126.5 hours in total, with interpretation and write up taking much longer in the rapid analysis (52 hours vs 8 hours). Rapid analysis findings overlapped with 79% of thematic analysis findings, and thematic analysis overlapped with 63% of the rapid analysis findings. Rapid analysis recommendations overlapped with 55% of those from the thematic analysis, and thematic analysis overlapped with 59% of the rapid analysis recommendations.

### Strengths and limitations of this study

- Our study lag in research policy into practice
- This is a method both researchers and planners
- The work and analysis planning
- Due to the study design participants
- The study comparing teams of this area

**Results** Rapid analysis data management took less time than thematic analysis (43 hours vs 116.5 hours). Rapid analysis took 100 hours, and thematic analysis took 126.5 hours in total, with interpretation and write up taking much longer in the rapid analysis (52 hours vs 8 hours). Rapid analysis findings overlapped with 79% of thematic analysis findings, and thematic analysis overlapped with 63% of the rapid analysis findings. Rapid analysis

approach methods include: early work to identify areas for focus; throughout a study to explore processes and user experience; and following a trial or intervention implementation to explain outcomes and/or identify stakeholder experiences, to explore in more depth questions or issues identified through quantitative work and to problematise or 'unpack' issues or topics taken for granted.<sup>2</sup>

# Common IS Study Designs

## Effectiveness-implementation Hybrid Designs

### *Combining Elements of Clinical Effectiveness and Implementation Research to Enhance Public Health Impact*

*Geoffrey M. Curran, F  
Jeffrey M. P.*

**Objectives:** This study proposes methods for blending components of clinical effectiveness and implementation research. Such blending can provide benefits over pursuing research independently; for example, more rapid transference of more effective implementation strategies, and more information for decision makers. This study proposes an “effectiveness-implementation” typology, describes their use, outlines the design decisions that must be made, and provides several real-world examples.

**Results:** An effectiveness-implementation hybrid design takes a dual focus a priori in assessing clinical effectiveness and implementation. We propose 3 hybrid types: (1) testing a clinical intervention on relevant outcomes while observing and gathering information on implementation; (2) dual testing of effectiveness and implementation interventions/strategies; and (3) testing an implementation strategy while observing and gathering information on the clinical intervention’s impact on relevant outcomes.

**Conclusions:** The hybrid typology proposed herein is considered a construct still in evolution. Although traditional effectiveness and implementation trials are likely to remain the most common approach to moving a clinical intervention from efficacy research to public health impact, judicious

**TABLE 3.** Hybrid Design Characteristics and Key Challenges

Study Characteristic	Hybrid Trial Type 1	Hybrid Trial Type 2	Hybrid Trial Type 3
Research aims	Primary aim: determine effectiveness of a clinical intervention Secondary aim: better understand context for implementation	Coprietary aim*: determine effectiveness of a clinical intervention Coprietary aim: determine feasibility and potential utility of an implementation intervention/strategy	Primary aim: determine utility of an implementation intervention/strategy Secondary aim: assess clinical outcomes associated with implementation trial
Research questions (examples)	Primary question: will a clinical treatment work in this setting/these patients? Secondary question: what are potential barriers/ facilitators to a treatment’s widespread implementation?	Coprietary question*: will a clinical treatment work in this setting/these patients? Coprietary question: does the implementation method show promise (either alone or in comparison with another method) in facilitating implementation of a clinical treatment?	Primary question: which method works better in facilitating implementation of a clinical treatment? Secondary question: are clinical outcomes acceptable?
Units of randomization	Patient, clinical unit	Clinical effectiveness: see type I Implementation: see type III, although may be nonrandomized, for example, case study	Provider, clinical unit, facility, system
Comparison conditions	Placebo, treatment as usual, competing treatment	Clinical effectiveness: see type I Implementation: see type III, although may be nonrandomized, for example, case study	Provider, clinical unit, facility, system: implementation as usual, competing implementation strategy
Sampling frames	Patient: limited restrictions, but some inclusion/ exclusion criteria Provider, clinical unit, facility, system: choose subsample from relevant participants	Patient: limited restrictions, but some inclusion/ exclusion criteria Providers/clinics/facility/systems; consider “optimal” cases	Provider/clinic/facility/system: either “optimal” cases or a more heterogeneous group Secondary: all or selected patients included in study locations
Evaluation methods	Primary aim: quantitative, summative Secondary aim: mixed methods, qualitative, process-oriented, could also inform interpretation of primary aim findings	Clinical effectiveness aim: quantitative, summative Implementation aim: mixed method; quantitative, qualitative; formative and summative	Primary aim: mixed-method, quantitative, qualitative, formative, and summative Secondary aim: quantitative, summative
Measures	Primary aim: patient symptoms and functioning, possibly cost Secondary aim: feasibility and acceptability of implementing clinical treatment, sustainability potential, barriers and facilitators to implementation	Clinical effectiveness aim: patient symptoms and functioning, possibly cost effectiveness Implementation aim: adoption of clinical treatment and fidelity to it, as well as related factors	Primary aim: adoption of clinical treatment and fidelity to it, as well as related factors Secondary aim: patient symptoms, functioning, services use
Potential design challenges	Generating “buy in” among clinical researchers for implementation aims Insuring appropriate expertise on study team to conduct rigorous Secondary aim These studies will likely require more research expertise and personnel, and larger budgets, than nonhybrids	Generating “buy in” among implementation researchers for clinical intervention aims These studies will require more research expertise and personnel, as well as larger budgets, than nonhybrids Insuring appropriate expertise on study team to rigorously conduct both aims “Creep” of clinical treatment away from	Primary data collection with patients in large, multisite implementation trials can be unfeasible, and studies might need to rely on subsamples of patients, medical record review, and/or administrative data. Patient outcomes data will not be as extensive as in traditional effective-

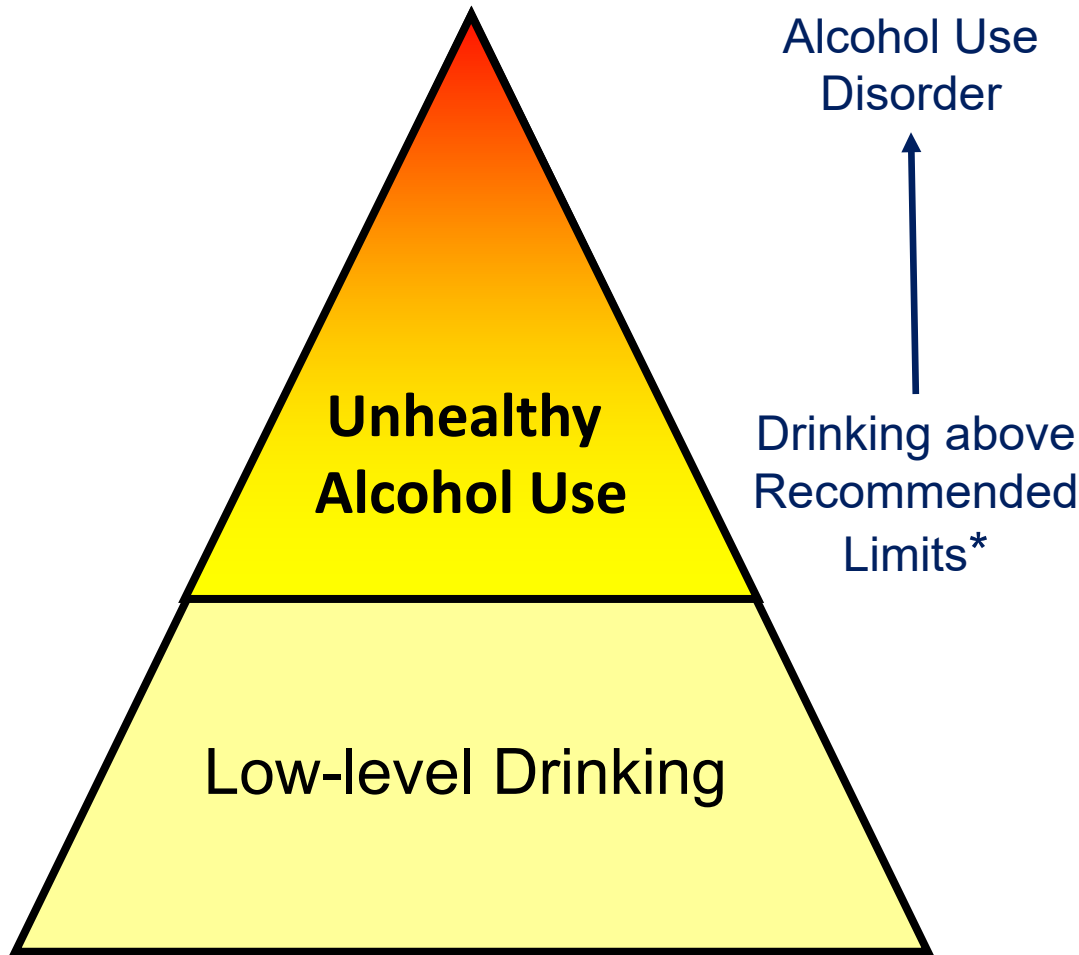


Questions?



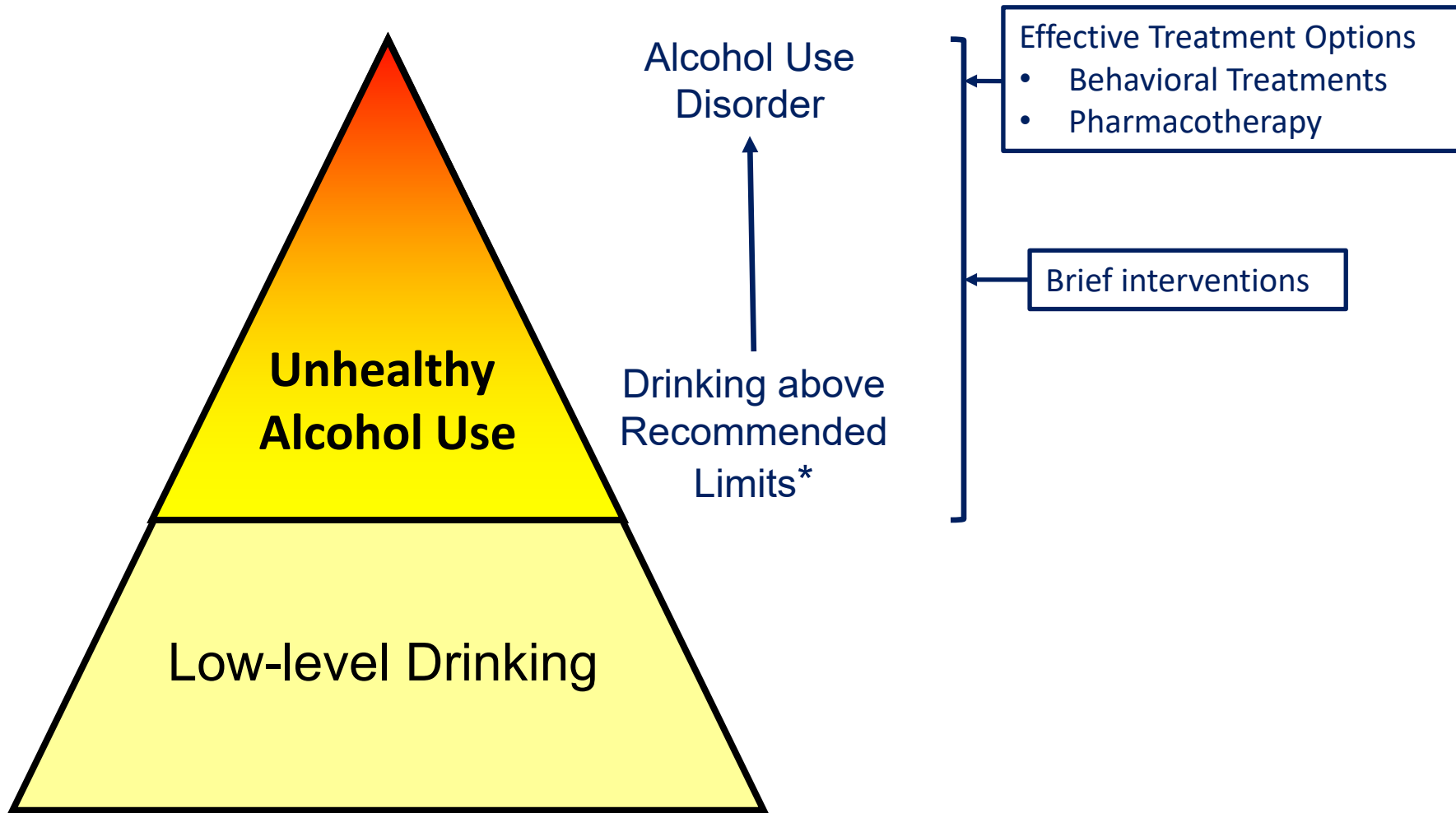
# Applications: Select Research

# Spectrum of Unhealthy Alcohol Use



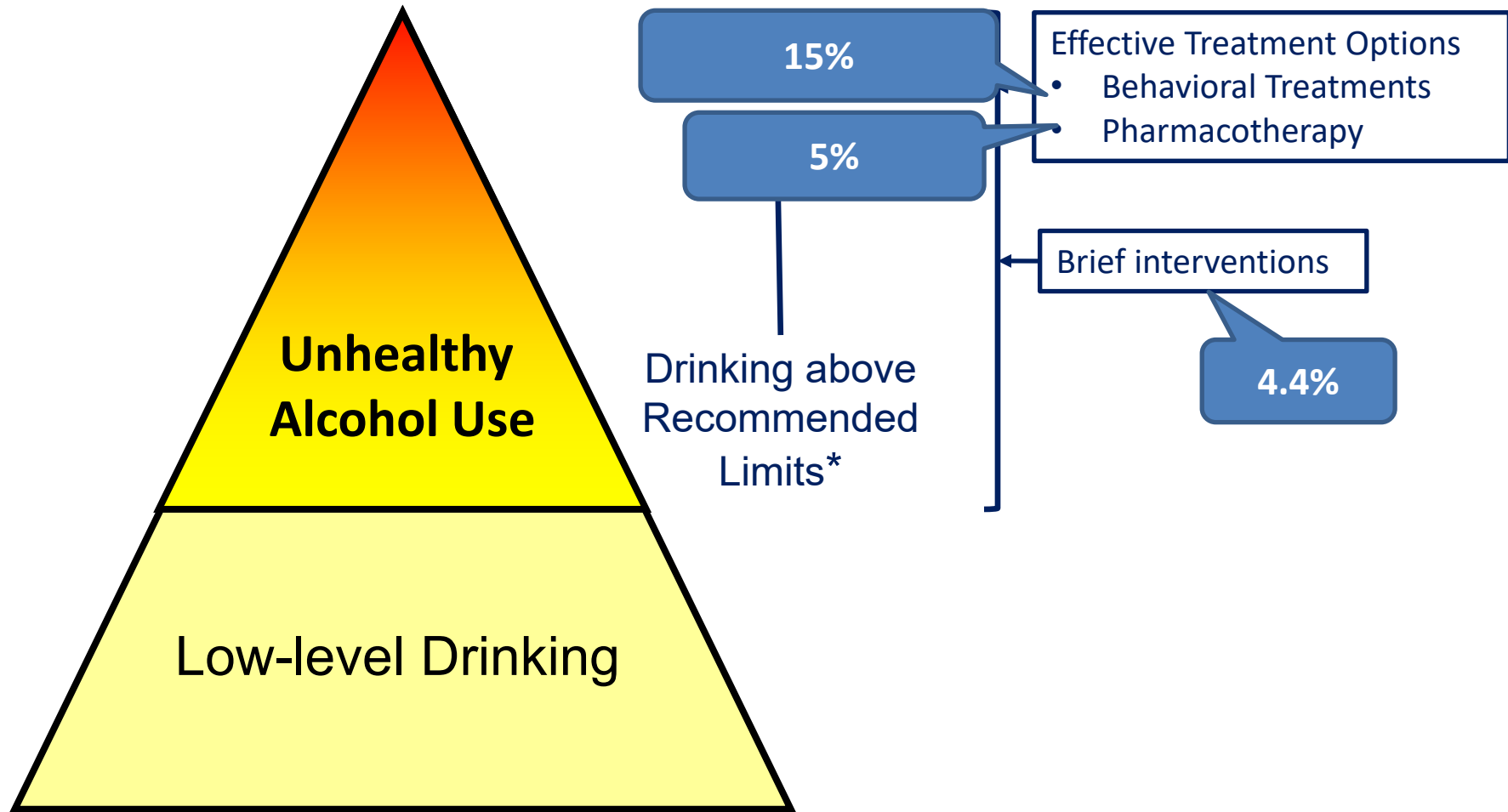
\* $\leq$  14 drinks/week or 3/occasion for men;  $<$  7 drinks/week or 3/occasion women

# Evidence-Based Care: Unhealthy Alcohol Use



\*  $\leq$  14 drinks/week or 3/occasion for men;  $<$  7 drinks/week or 3/occasion women

# These Interventions are Historically Rarely Received by Patients Who Need Them



\* $\leq$  14 drinks/week or 3/occasion for men;  $<$  7 drinks/week or 3/occasion women

# Historically Challenging to Implement

Scandinavian Journal of Primary Health Care, 2006; 24: 5–15



## REVIEW ARTICLE

### Effectiveness of strategies to implement brief alcohol intervention in primary healthcare

A systematic review

PER NILSEN<sup>1</sup>, MAURI AALTO<sup>2</sup>, PREBEN E

<sup>1</sup>Department of Health and Society, Division of Social Medicine, University of Tampere, Finland, and <sup>2</sup>Department of Mental Health and Alcohol Research, National Institute for Health and Welfare, Finland

#### Abstract

**Objective.** To review systematically the available literature on the effectiveness of strategies to implement brief alcohol intervention in primary healthcare in order to determine the effectiveness of the interventions. **Question.** To what extent have the efforts to implement brief alcohol intervention been successful? **Method.** Literature search from 1980 to 2005 in Medline, PsycInfo, and CINAHL. **Results.** A total of 11 studies encompassing 11 countries from Europe, the USA, and Australia. **Main results.** Intervention effectiveness (measured as the proportion of screen-positive patients offered brief intervention) generally increased with the intensity of the intervention. Nevertheless, the overall effectiveness was rather modest. **Conclusions.** Brief alcohol intervention is a scientifically rigorous enough, and applied too brief follow

Journal of Public Health | Vol. 33, No. 3, pp. 412–421 | doi:10.1093/pubmed/ckq095 | Advance Access Publication 17 December 2010

### Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence

M. Johnson, R. Jackson, L. Guillaume, P. Meier, E. Goyder

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Address correspondence to: M. Johnson, E-mail: m.johnson@sheffield.ac.uk

#### ABSTRACT

**Background.** This review aimed to synthesize qualitative evidence for barriers and facilitators to implementing screening and brief intervention for alcohol misuse in adults and children over 10 years.

**Methods.** A search of medical and social science databases was carried out and augmented by hand searching of key journals. Qualitative evidence was synthesized thematically.

**Results.** A total of 47 papers varying in design and quality were included in the review. Most studies were conducted in primary care settings. Implementation was reported to be limited by lack of resources, training and support, and inappropriate context in which discussions take place was reported as an acceptability barrier. Professionals require sufficient knowledge about alcohol guidelines and risk in order to implement screening and brief intervention.

**Conclusions.** Whilst brief screening and brief intervention have been shown to be effective in primary care, implementation is challenging. Adequate resources, training and support are the main facilitators in primary care. More research is needed to assess implementation barriers and facilitators.

**Keywords:** alcohol consumption, health services, public health

Psychology of Addictive Behaviors

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0893-164X/11/\$12.00 DOI: 10.1037/a0022102

### Strategies to Implement Alcohol Screening and Brief Intervention in Primary Care Settings: A Structured Literature Review

Emily C. Williams, M. Laura Johnson, and  
Gwen T. Lapham  
VA Puget Sound Health Care System, Seattle, Washington, and  
University of Washington

Ryan M. Caldeiro  
Group Health Cooperative, Seattle, Washington, and University  
of Washington

Lisa Chew and Grant S. Fletcher  
Harborview Medical Center, Seattle, Washington, and  
University of Washington

Kinsey A. McCormick  
Brigham and Women's Hospital, Boston, Massachusetts

William G. Weppner  
Boise VA Medical Center, Boise, Idaho, and University of  
Washington

Katharine A. Bradley  
VA Puget Sound Health Care System, Seattle, Washington,  
University of Washington, and Group Health Research Institute

Although alcohol screening and brief intervention (SBI) reduces drinking in primary care patients with unhealthy alcohol use, incorporating SBI into clinical settings has been challenging. We systematically reviewed the literature on implementation studies of alcohol SBI using a broad conceptual model of implementation, the Consolidated Framework for Implementation Research (CFIR), to identify domains addressed by programs that achieved high rates of screening and/or brief intervention (BI). Seventeen articles from 8 implementation programs were included; studies were conducted in 9 countries and represented 533,903 patients (127,304 patients screened), 2,001 providers, and 1,805 clinics. Rates of

CFIR during implementation is associated with successful implementation of alcohol screening, as well as which elements may be associated with successful, sustained implementation of BI.

Large study, well-funded by the WHO, described rates of 10% of screen-positive patients being offered brief intervention as “high” rates in 2004.

Nilsen et al, Scandinavian J Primary Health Care. 2006.

Johnson et al, J Pub Health, 2010.

Williams et al, Psych Addict Behav, 2011

Anderson, et al, Alcohol Alcohol, 2004

# VA Offered Prime Opportunity for Implementation ~2003/2004

- National electronic health record
- Performance Measures to incentivize quality care
  - Performance feedback given to networks quarterly
- Clinical Decision Support (“clinical reminders”)
- Condition-specific research/clinical partnerships (former SUD QUERI program) enabled expert input
- Large Health Study—most Veterans with unhealthy alcohol use reported not getting needed help

# VA's Iterative Implementation: Started with Screening

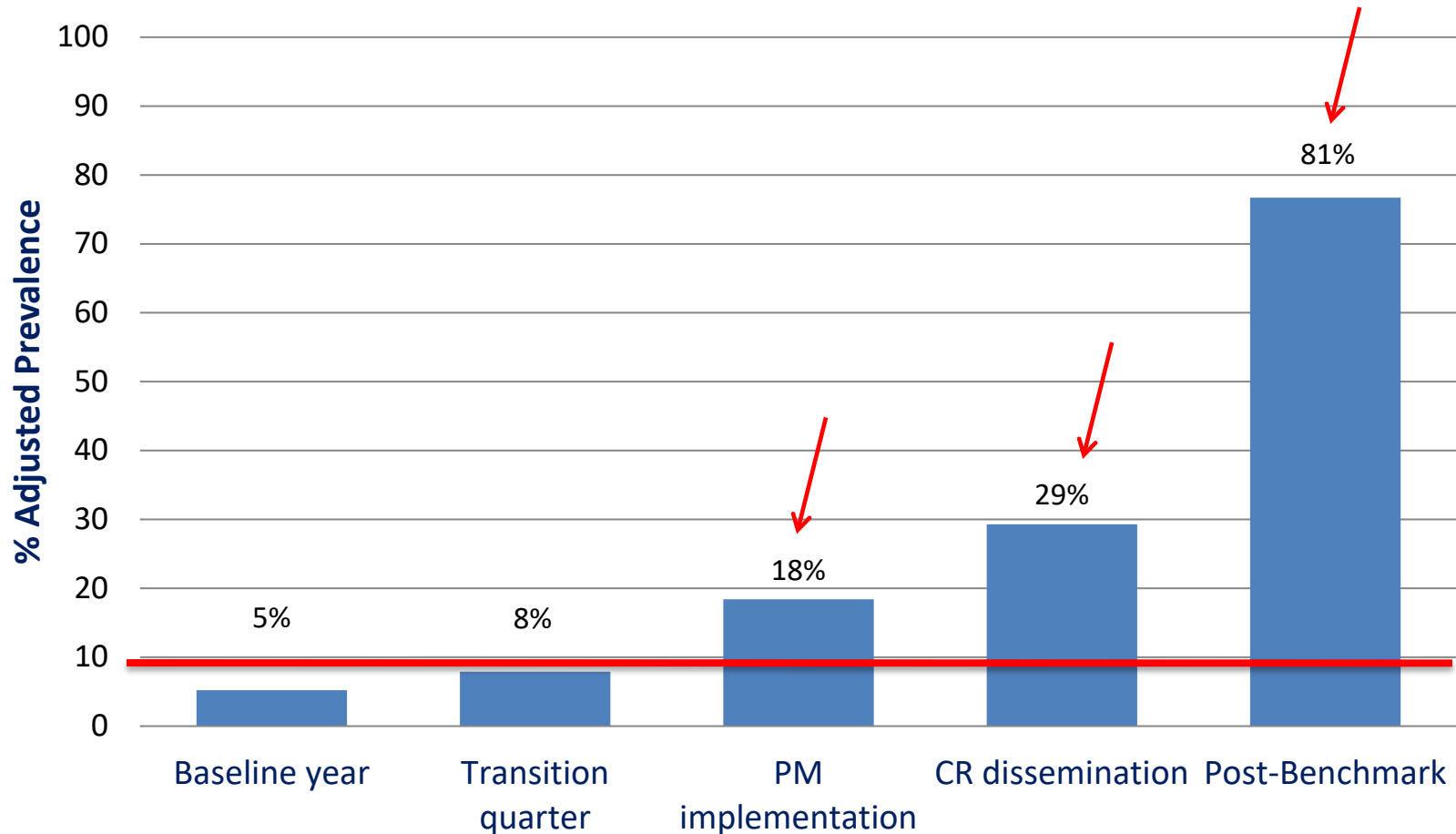
- VA implemented annual screening for unhealthy alcohol use starting in 2004:
  - National performance measure incentivized screening
  - Self-scoring electronic clinical reminder disseminated nationally to prompt and document results of screening with the validated Alcohol Use Disorders Identification Test Consumption (AUDIT-C) Questionnaire
- The AUDIT-C clinical reminder was used 1.5 million times in its first year
- >90% of all established outpatients have had documented screening since 2004
  - >30 million screens documented in last 5 years

# National Implementation of Brief Intervention in VA

- Brief intervention implementation took more time and was preceded by development and local pilot tests of the electronic clinical reminder.
- National Implementation had four phases:
  - Medical record review began monitoring follow-up on positive screening (2006)
  - Performance measure for brief intervention announced (2007)
  - National dissemination of revised clinical reminder for brief intervention (2008)
  - Benchmark goal set (2010)

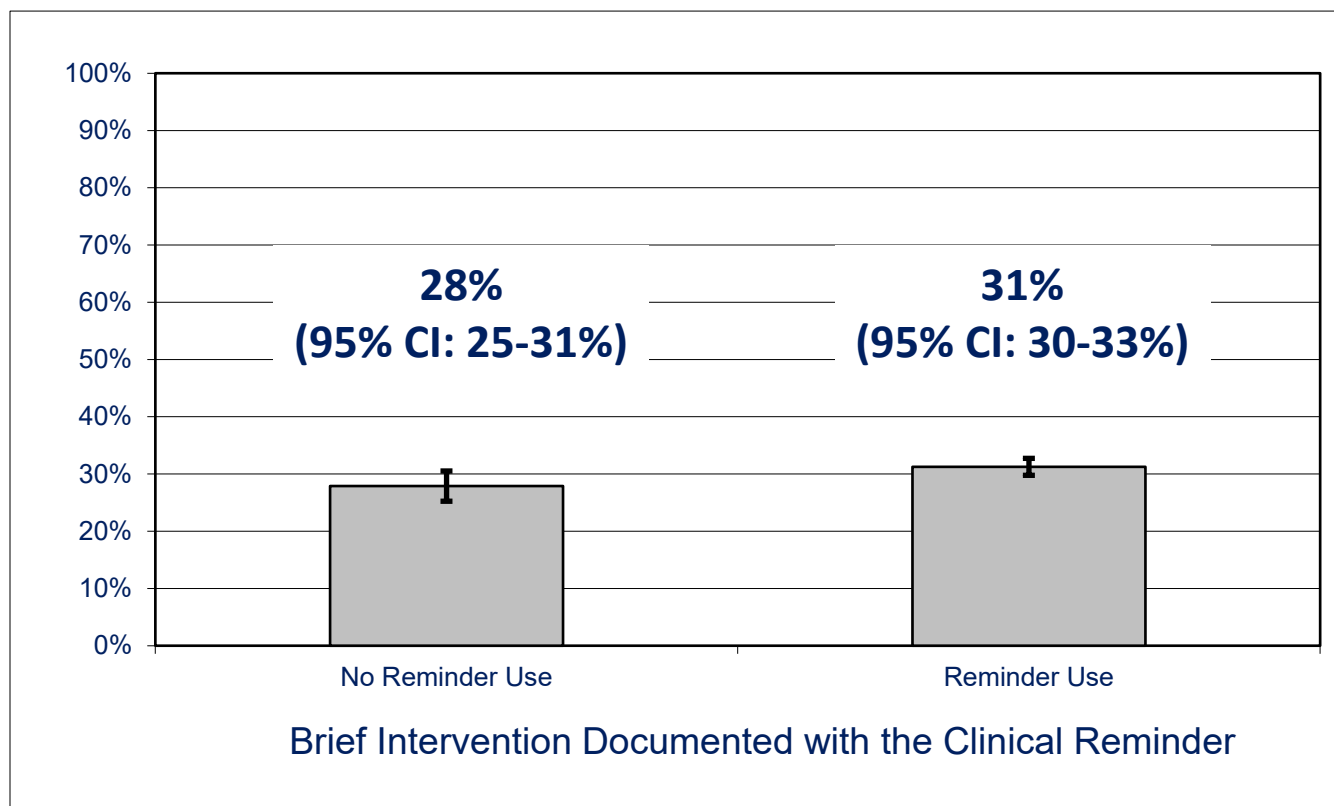


# National Implementation of Brief Intervention in VA



# Documented Brief Intervention Associated with Reduced Drinking at Follow-up

Adjusted odds of screening negative at follow-up:  
1.18, 95% Confidence Interval 1.03 – 1.34 (p=0.013); NNT = 25



# Summary of VA's Implementation Successes

- Both screening and brief intervention reached high rates after announcement of performance measures and dissemination of clinical reminders
- Results of an early pilot evaluation of the clinical reminder were hopeful regarding the effectiveness of brief intervention when offered in practice.

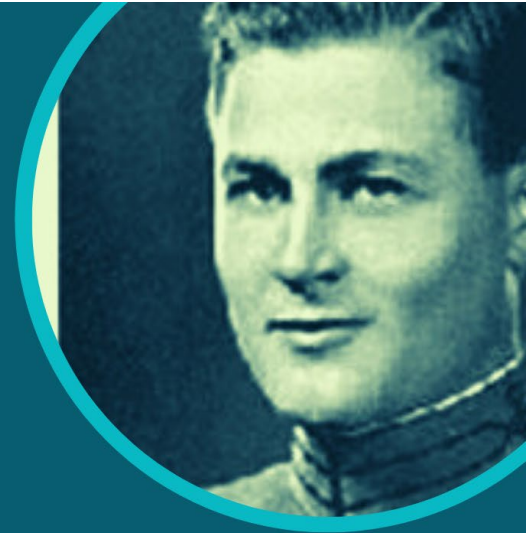
# Too Good to Be True?

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“

*“If everything seems to be going well, you obviously don't know what's going on.”*

— Edward Murphy



# Identification of Quality Issues

## Examining Quality Issues in Alcohol Misuse Screening

Eric J. Hawkins, PhD  
Daniel R. Kivlahan, PhD  
Emily C. Williams, MPH  
Steven M. Wright, PhD  
Thomas Craig, MD, MPH  
Katharine A. Bradley, MD, MPH

**SUMMARY.** The Veterans Health Administration (VHA) has success-  
based alcohol misuse screening with the AUDIT-C. The purpose of  
ate clinical alcohol screening during the first year after implementation  
review and mailed patient surveys collected during 2004 by VHA Office  
formance, this study analyzed concordance of screening results among pati  
both data sources. Among 1,637 patients with AUDIT-C from both sou  
medical record screening prevalence rate of alcohol misuse, 24.6% (95%  
was significantly lower than the survey rate, 33.4% (31.1% to 35.7%). Of  
as nondrinkers in medical records, 24% reported past year alcohol use an  
for alcohol misuse on surveys. Lower rates of alcohol use and misuse doc

## Quality Concerns with Routine Alcohol Screening in VA Clinical Settings

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Carol E. Achtmeyer, MN, ARNP<sup>1</sup>, Emily C. Williams, PhD, MPH<sup>1,5</sup>, Rachel M. Thomas, MPH<sup>1</sup>,  
and Daniel R. Kivlahan, PhD<sup>1,2,6</sup>

<sup>1</sup>Health Services Research & Development (HSR&D), Veterans Affairs (VA) Puget Sound Health Care System, Seattle, WA, USA; <sup>2</sup>Center of Excellence in Substance Abuse Treatment and Education (CESATE), Seattle, WA, USA; <sup>3</sup>General Medicine Service, Veterans Affairs (VA) Puget Sound Health Care System, Seattle, WA, USA; <sup>4</sup>Department of Medicine, University of Washington, Seattle, WA, USA; <sup>5</sup>Department of Health Services, University of Washington, Seattle, WA, USA; <sup>6</sup>Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, WA, USA.

**BACKGROUND:** Alcohol screening questionnaires have typically been validated when self- or researcher-administered. Little is known about the performance of alcohol screening questionnaires administered in clin-

**CONCLUSION:** Use of a validated alcohol screening questionnaire does not—by itself—ensure the quality of alcohol screening. This study suggests that the quality of clinical alcohol screening should be monitored, even

## KEY FINDINGS

- Approximately one-quarter of patients identified as “non-drinkers” in clinical screening reported past-year drinking on survey screen.
- 61% of patients who screened positive on surveys screened negative during clinical screening.

but not both. Multivariable logistic regression was used to estimate the prevalence of discordance in different patient subgroups based on demographic and clinical characteristics, VA network and temporal factors (e.g. the order of screens).

**KEY RESULTS:** Whereas 11.1% (95% CI 10.4–11.9%) of

identify patients who might benefit from brief alcohol counseling.  
The Veterans Affairs (VA) Health Care System implemented routine screening for alcohol misuse in 2004,<sup>8</sup> and since 2006 has required that the Alcohol Use Disorders Identification Test—Consumption Questions (AUDIT-C) be used for screening. Each VA is expected to meet performance targets, but the approach used to implement alcohol screening is left up to individual

# Identification of Quality Issues

Addiction

RESEARCH REPORT

doi:10.1111/add.12600



## An early evaluation of implementation of brief intervention for unhealthy alcohol use in the US Veterans Health Administration

Emily C. Williams<sup>1,2</sup>, Anna D. Rubinsky<sup>1</sup>, Laura J. Chavez<sup>1,2</sup>, Gwen T. Lapham<sup>1,3</sup>, Stacey E. Rittmueller<sup>1</sup>, Carol E. Achtmeyer<sup>1,4</sup> & Katharine A. Bradley<sup>1,2,3,5</sup>

Health Services Research and Development (HSR&D), Veterans Affairs (VA) Puget Sound Health Care System, Seattle, WA, USA,<sup>1</sup> Department of Health Services, University of Washington, Seattle, WA, USA,<sup>2</sup> Group Health Research Institute, Seattle, WA, USA,<sup>3</sup> Primary and Specialty Medical Care Service, Veterans Affairs (VA) Puget Sound Health Care System, Seattle, WA, USA<sup>4</sup> and Department of Medicine, University of Washington, Seattle, WA, USA<sup>5</sup>

### ABSTRACT

**Aims** The US Veterans Health Administration [Veterans Affairs (VA)] used performance measures and electronic clinical reminders to implement brief intervention for unhealthy alcohol use. We evaluated whether documented

unhealthy alcohol use than those without ( $P$ -values < 0.05). Adjusted prevalences of resolution were 47% [95% confidence interval (CI) = 42–52%] and 48% (95% CI = 42–54%) for patients with and without documented brief intervention, respectively ( $P = 0.50$ ). **Conclusions** During early implementation of brief intervention in the US Veterans Health Administration, documented brief intervention was not associated with subsequent changes in drinking among outpatients with unhealthy alcohol use and repeat alcohol screening.

**Keywords** Alcohol, brief intervention, implementation, unhealthy alcohol use, veterans.

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## KEY FINDING

- Documented brief intervention was NOT associated with resolution of unhealthy alcohol use at follow-up screening in the 6 months following brief intervention implementation

# Other Gaps in Care: AUD Pharmacotherapy

## Pharmacotherapy of Alcohol Use Disorders in the Veterans Health Administration

Alex H. S. Harris, Ph.D.  
Daniel R. Kivlahan, Ph.D.  
Thomas Bowe, Ph.D.  
Keith N. Humphreys, Ph.D.

**Objective:** Acamprosate, oral and long-acting injectable naltrexone, and disulfiram are approved for treatment of alcohol dependence. Their availability and consideration of their use in treatment are now standards of high-quality care. This study determined rates of medication initiation among Veterans Health Administration (VHA) patients. **Methods:** VHA pharmacy and administrative data were used to identify patients with alcohol use disorder diagnoses in fiscal years (FY) 2006 and 2007 and the proportion (nationally and by facility) who received each medication. Patient characteristics associated with receipt were also examined. **Results:** Among more than a quarter-million patients with alcohol use disorder diagnoses, the percentage receiving any of the medications increased from 2.8% in FY 2006 to 3.0% in FY 2007. Receipt of these medications was more likely among patients who received specialty addiction care, those with alcohol dependence (compared with abuse), those younger than 55 years, and females. In the patient subgroups examined, the largest proportion to receive any of the medications was 11.6%. Across 128 VHA facilities, rates of use among patients in the sample who had received past-year specialty addiction treatment ranged from 0% to 20.5%; rates ranged from 0% to 4.3% among those with no specialty treatment. Patient preferences and medical contraindications could not be determined from the data. **Conclusions:** Findings suggest the need to better understand systemwide variation in use of these medications and their use as a rough proxy for availability and consideration of pharmacotherapy—a standard of care with strong

only 139,000 an  
macotherapy wi  
tions—.07% ov  
those seeking  
(2,3). Other esti  
rates among per  
disorders vary f  
13%, depending  
tions, setting o  
medication, wit  
found for naltre  
dependent patie  
tion treatment s  
large surveys of  
programs have  
versal adoption  
for alcohol use  
put this in pers  
prevalence of al  
roughly half tha  
(3.8% and 7.2%  
however, 336 t  
scriptions were  
antidepressants

## Pharmacotherapy of Alcohol Use Disorders by the Veterans Health Administration: Patterns of Receipt and Persistence

Alex H. S. Harris, Ph.D., M.S.  
Elizabeth Oliva, Ph.D.  
Thomas Bowe, Ph.D.  
Keith N. Humphreys, Ph.D.  
Daniel R. Kivlahan, Ph.D.  
Jodie A. Trafton, Ph.D.

**Objective:** This study assessed changes since 2007 at Veterans Health Administration (VHA) facilities (N=129) in use of the medications approved by the U.S. Food and Drug Administration for treatment of alcohol use disorders. **Methods:** VHA data from fiscal years (FYs) 2008 and 2009 were used to identify patients with a diagnosis of an alcohol use disorder who received oral or extended-release naltrexone, disulfiram, or acamprosate as well as the proportion of days covered (PDC) in the 180 days after initiation and the time to first ten-day gap in possession (persistence) for each medication. Multilevel, mixed-effects logistic regression models examined the association between patient and facility characteristics and use of medications. **Results:** Nationally, 3.4% of VHA patients with an alcohol use disorder received medications in FY 2009 (11,165 of 331,635 patients), up from 3.0% in FY 2007. Use of medications by patients at the facilities ranged from 0% to 12%. In fully adjusted analyses, facilities offering

rum (1) and adopted as a performance measure by the American Psychiatric Association Physician Consortium for Performance Improvement and the National Committee for Quality Assurance (2). All Veterans Health Administration (VHA) facilities are mandated to make available and consider the use of medications for alcohol dependence (3). Nevertheless, receipt of the medications by patients is rare overall and varies highly among and within health care systems (4,5).

In 2009 in the VA, only 4.7% of patients with diagnosed alcohol use disorder filled prescriptions for AUD medications

across the VHA system. Interventions are needed to optimize initiation of and persistence in use of these medications. (*Psychiatric Services* 63: 679–685, 2012; doi: 10.1176/appi.ps.201000553)

cially addiction care, patients with alcohol dependence (versus abuse), patients younger than 55 years old,



# Unequal Treatment



Mulia et al 2014; Glass et al DAD 2010; Dobscha et al JSAD 2010; Williams et al ACER 2012, Williams et al ACER 2016; Williams et al DAD 2017; Glass et al Soc Psych Psych Epi, 2017; Lehavot et al DAD 2017; Owens et al DAD, 2018; Williams et al JSAT 2017; Zemore et al JSAD 2017



# Receipt of Alcohol-Related Care among PLWH

Drug and Alcohol Dependence 174 (2017) 113–120

Contents lists available at ScienceDirect

 **ELSEVIER**

Drug and Alcohol Dependence

journal homepage: [www.elsevier.com/locate/drugaldep](http://www.elsevier.com/locate/drugaldep)



Full length article

Among patients with unhealthy alcohol use, those with HIV are less likely than those without to receive evidence-based alcohol-related care: A national VA study 

Emily C. Williams<sup>a,c,f,\*</sup>, Gwen T. Lapham<sup>a,f</sup>, Susan M. Shortreed<sup>f,g</sup>, Anna D. Rubinsky<sup>a,h</sup>, Jennifer F. Bobb<sup>f</sup>, Kara M. Bensley<sup>a,c</sup>, Sheryl L. Catz<sup>e</sup>, Julie E. Richards<sup>c,f</sup>, Katharine A. Bradley<sup>a,b,c,d,f</sup>

<sup>a</sup> Health Services Research and Development (HSR and D) Veterans Affairs (VA) Puget Sound Health Care System, Center of Innovation for Veteran-Centered Value-Driven Care (COIN) Veterans Affairs (VA) Puget Sound Health Care System, Seattle, WA, United States  
<sup>b</sup> Center of Excellence in Substance Abuse Treatment and Education (CESATE) Veterans Affairs (VA) Puget Sound Health Care System – Seattle Division.

Received in revised form 10 January 2017  
Accepted 11 January 2017  
Available online 6 March 2017

**Keywords:**  
Alcohol  
HIV  
Brief intervention

received by PLWH and HIV- patients.  
**Methods:** Outpatients from the Veterans Health Administration who had one or more positive screen(s) for unhealthy alcohol use (AUDIT-C  $\geq 5$ ) documented in their medical records 10/2009-5/2013 were eligible. Primary and secondary outcomes were brief intervention documented  $\leq 14$  days after a positive alcohol screen, and a composite measure of any alcohol-related care (brief intervention, specialty addictions treatment or pharmacotherapy documented  $\leq 365$  days), respectively. Unadjusted and adjusted regression analyses compared alcohol-related care outcomes in PLWH and HIV- patients.  
**Results:** The sample included 830 825 outpatients (2514 PLWH), reflecting 1 173 606 positive screens

## KEY FINDING

- Among VA patients screening positive for unhealthy alcohol use, PLWH were less likely than HIV-uninfected persons to receive brief intervention, specialty addictions treatment, and pharmacotherapy for alcohol use disorders

# Similar Lower Access to Care for Other Groups

ALCOHOLISM: CLINICAL AND EXPERIMENTAL RESEARCH

Vol. 36, No. 5  
September 2012

## Variation in Documented Care for Unhealthy Alcohol Consumption Across Race/Ethnicity in the Department of Veterans Affairs Healthcare System

Emily C. Williams, Gwen T. Lapham, Eric J. Hawkins, Anna D. Rubinsky, Leo S. Morales, Bessie A. Young, and Katharine A. Bradley



ELSEVIER

Racial/ethnic differences in the treatment of alcohol use disorders in the

Kara M. Bensley, M.S.  
Rhonda Jones-Webb



ELSEVIER

journal homepage: [www.elsevier.com/locate/drugalcdp](http://www.elsevier.com/locate/drugalcdp)



- Racial/Ethnic Minorities
- Persons with Hepatitis C
- Persons Living in Rural Areas
- Women

## THE JOURNAL OF RURAL HEALTH



ORIGINAL ARTICLE

### Differences in Perceptions of and Practices Regarding Treatment of Alcohol Use Disorders Among VA Primary Care Providers in Urban and Rural Clinics

Jessica P. Young, MPH, MSW;<sup>1</sup> Carol E. Achtmeyer, ARNP;<sup>1,2</sup> Kara M. Bensley, PhD, MsC;<sup>1,3</sup> Eric J. Hawkins, PHD;<sup>1,4,5</sup> & Emily C. Williams, PhD, MPH<sup>1,3</sup>

Qualitative Data:  
Barriers to High-Quality Alcohol-Related Care

# Three Qualitative Studies Identified Barriers

## Factors Underlying Quality Problems with Alcohol Screening Prompted by a Clinical Reminder in Primary Care: A Multi-site Qualitative Study

Emily C. Williams, PhD, MPH<sup>1,5</sup>, Carol E. Achtmeyer, MN, ARNP<sup>1,2,3</sup>, Rachel M. Thomas, MPH<sup>1</sup>, Joel R. Grossbard, PhD<sup>3</sup>, Gwen T. Lapham, PhD, MSW, MPH<sup>1,7</sup>, Laura J. Chavez, MPH<sup>1,5</sup>, Evette J. Ludman, PhD<sup>6,7</sup>, Douglas Berger, MD, M Litt<sup>2,4</sup>, and Katharine A. Bradley, MD, MPH<sup>1,3,4,5,7</sup>



Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment



## Local Implementation of Alcohol Screening and Brief Intervention at Five Veterans Health Administration Primary Care Clinics: Perspectives of Clinical and Administrative Staff<sup>☆</sup>



Emily C. Williams, Ph.D., M.P.H. <sup>a,e,g,\*</sup>, Carol E. Achtmeyer, M.N., A.R.N.P. <sup>a,b,c</sup>, Jessica P. Young, M.S.W., M.P.H. <sup>a</sup>, Stacey E. Rittmueller, M.P.H. <sup>h</sup>, Evette J. Ludman, Ph.D. <sup>f,g</sup>, Gwen T. Lapham, Ph.D., M.S.W., M.P.H. <sup>a,c,g</sup>, Amy K. Lee, M.P.H. <sup>a,g</sup>, Laura J. Chavez, M.P.H. <sup>a,e</sup>, Douglas Berger, M.D., M.Litt. <sup>b,d</sup>, Katharine A. Bradley, M.D., M.P.H. <sup>a,c,d,e,g</sup>



## Barriers to and Facilitators of Alcohol Use Disorder Pharmacotherapy in Primary Care: A Qualitative Study in Five VA Clinics

Emily C. Williams, PhD, MPH<sup>1,2</sup>, Carol E. Achtmeyer, MN, ARNP<sup>1,3,4</sup>, Jessica P. Young, MSW, MPH<sup>1</sup>, Douglas Berger, MD, M Litt<sup>3,5</sup>, Geoffrey Curran, PhD<sup>6</sup>, Katharine A. Bradley, MD, MPH<sup>1,2,4,5</sup>, Julie Richards, MPH<sup>1,2</sup>, Michael B. Siegel, MD, MPH<sup>7</sup>, Evette J. Ludman, PhD<sup>8</sup>, Gwen T. Lapham, PhD, MSW, MPH<sup>1,4</sup>, Mark Forehand, PhD<sup>9</sup>, and Alex H. S. Harris, PhD<sup>10</sup>

# Three Qualitative Studies: Overview

## Study #1:

**Understanding factors underlying quality issues in screening**

- Observational ethnographic study at 9 primary care clinics.

➤ Observed staff



## Study #2:

**Understanding perspective of the frontline post-implementation**

- Qualitative interview study with staff,



## Study #3:

**Understanding barriers to provision of AUD**

**All analyzed with both inductive and deductive methods as guided by the broad domains of the Consolidated Framework for Implementation Research (CFIR)**

➤ Interviewed 24 providers

# Barriers Across CFIR Domains

OUTER  
SETTING

INNER  
SETTING

PROCESS OF  
IMPLEMENTATION

INDIVIDUAL  
CHARACTERISTICS



# Barriers Across CFIR Domains

## OUTER & INNER SETTING

- Pervasive culture of addiction-related stigma
- Historical separation of addiction treatment from medicine
- Treatment availability (e.g., limited staff)
  - Worry that alcoholism is a chronic condition that requires ongoing care
  - Demand for scare tactics to increase demand for scare

*"We don't need anybody to drum up business for that program, I mean they can hardly keep up."*

*"I feel like I'm turning folks away and I can't really help them."*

# Barriers Across CFIR Domains

## PROCESS OF IMPLEMENTATION

- Clinical reminders “Just Showed Up”
- No standardized training offered on the ground for screening or brief interventions
- Providers did not know what to look out for when prescribing pharmaceuticals

*“It [the reminders] just showed up as a notification on the computer screen.”*

*“We don’t get trained to do this in our practice, either in our medical school or in our residency.”*

*“If I’ve never prescribed it, it’s not in my scope of practice, then I don’t know what to tell them to look out for.”*



# Barriers Across CFIR Domains

## INDIVIDUAL CHARACTERISTICS

- Discomfort

- Staff expressed discomfort conducting alcohol screening
- Staff and providers worked to ameliorate discomfort and

*"We don't do verbatim screening because it feels too direct. We each have our own kind of..."*

*"the dance is to try and have a person feel comfortable enough where they can disclose."*

# Barriers Across CFIR Domains

## INDIVIDUAL CHARACTERISTICS

- Beliefs

- Misunderstanding

- Perceived

- Focused

AUD

- Believed

was needed

*"If we really think they've got a problem, and we think they need help overcoming it, as*

*most pe*

*would*

*make*

*subst*

*sensitive*

*"Do I think you can start somebody on naltrexone and then pat them on the back and then send them on their way? No I don't. ... my impression is, if this is where it stops we're not going to be successful."*

- Belief that medications have to be offered in conjunction with specialty addictions treatment

# Barriers Across CFIR Domains

## INDIVIDUAL CHARACTERISTICS

- Attitudes / Expressions of societally-driven biases

- Lack

- Mult



*"I guess the most disappointing thing is...you don't feel*

*"Many alcoholics are not particularly interested in it anyway,*

*"Telling someone that you may have a genetic predisposition to this issue is, what's the word, kind of. . .it doesn't excuse them from their choices and their behavior."*

# Also Several Facilitators Identified

## FACILITATORS

### Outer/Inner Setting

- Support from VA and local clinical leadership

### Process of Implementation

- Training and information
- Reframing goals and purposes
  - e.g., reframing medications as a potential “foot in the door”
- Sharing success Stories

### Individual Characteristics

- Beliefs in importance of addressing alcohol use
- Belief that providing AUD treatment in PC might catalyze change while reducing stigma and other barriers to care

# Summary: Implementation of Alcohol-Related Care in VA

- **Despite successes in provision of alcohol-related care in VA:**
  - Quality issues and continued gaps in care exist
- **Factors Underlying Gaps Appeared to Reflect:**
  - Lack of Training
  - Discomfort
  - Misunderstanding the preventive agenda
  - Lack of optimism
  - Beliefs
  - Alcohol-related Stigma (cultural and individual-level)
    - May be heightened for people with multiple marginalized identities
- **Identification of key facilitators offered opportunity to build and improve**



Individuals

# So, We Are Now Building on These Learnings



# PRACTICE FACILITATION: An Evidence-Based Implementation Strategy

Practice Facilitation: a process of interactive problem solving and support that occurs in a context of a recognized need for improvement and a supportive interpersonal relationship.

Internal and External facilitators: Apply multiple discrete implementation strategies with both flexibility and strong interpersonal skills

# PRACTICE FACILITATION: An Evidence-Based Implementation Strategy

**Practice Facilitation:** a process of interactive problem solving and support that occurs in a context of a recognized need for improvement and a supportive interpersonal relationship.

**Internal and External facilitators:** Apply multiple discrete implementation strategies with both flexibility and strong interpersonal skills

Employing humble inquiry to link and align ourselves with and train interested clinical staff to create an environment of collaboration toward shared goals.



# TESTING INTERNAL AND EXTERNAL FACILITATION IMPLEMENTATION STRATEGIES

Facilitation: a process of interactive problem solving and support that occurs in a context of a recognized need for improvement and a supportive interpersonal relationship.

Internal and External facilitators: Apply multiple discrete implementation strategies with both flexibility and strong interpersonal skills

## SPARC (Bradley):

- Alcohol
- 25 PC clinics
- KP WA

## VA Liver Clinics (Williams):

- Alcohol
- 4 VA Liver Clinics
- Western U.S.

## SUPPORT (Williams, Hawkins):

- Opioids
- VA PC

## Bachrach CDA (Bachrach):

- Alcohol
- 1 VA PC clinic

# TESTING INTERNAL AND EXTERNAL FACILITATION IMPLEMENTATION STRATEGIES

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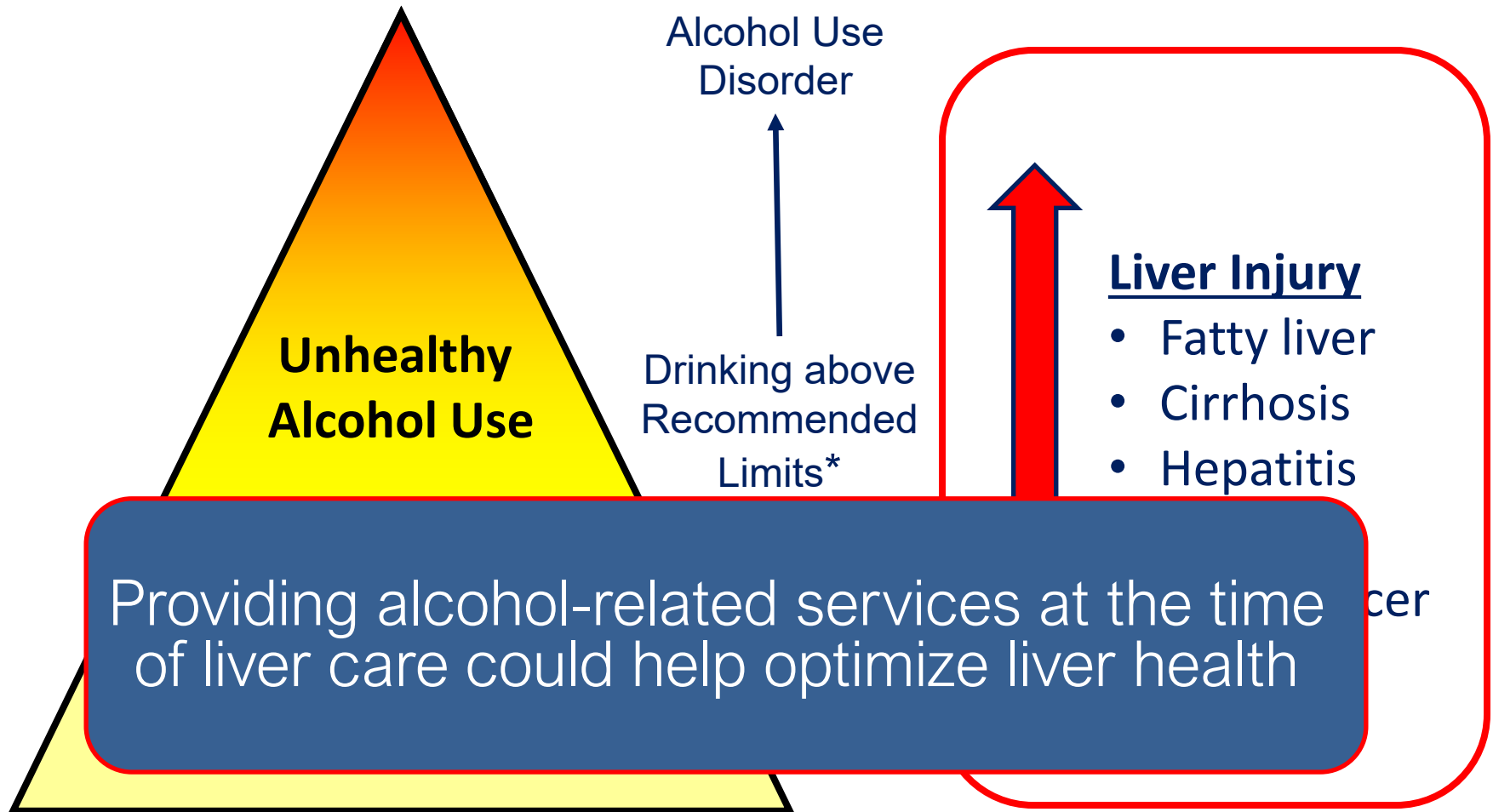
## SUPPORT (Williams, Hawkins):

- Opioids
- VA PC

## Bachrach CDA (Bachrach):

- Alcohol
- 1 VA PC clinic

# ALCOHOL USE AND LIVER HEALTH



\* $\leq$  14 drinks/week or 3/occasion for men;  $<$  7 drinks/week or 3/occasion women

# HCV ELIMINATION AS A CATALYST



U.S. Department  
of Veterans Affairs

## I'm free of hepatitis C You can be, too

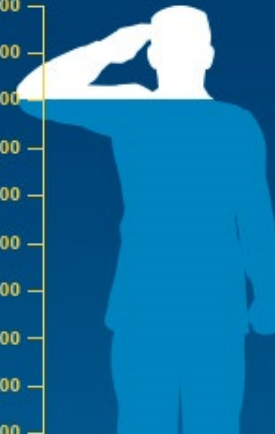
Tens of thousands of Veterans enrolled in  
VA care have been cured of hepatitis C.

---

Ask about hepatitis C testing and treatment.  
Learn more at [www.hepatitis.va.gov](http://www.hepatitis.va.gov)



100,000  
90,000  
80,000  
70,000  
60,000  
50,000  
40,000  
30,000  
20,000  
10,000



The March to Cure  
**100,000**  
Veterans

# HCV ELIMINATION AS A CATALYST

August 27, 2018


Chronic Hepatitis C Virus (HCV) Infection: Treatment Considerations

*from the Department of Veterans Affairs National Hepatitis C Resource Center and the HIV, Hepatitis, and Related Conditions Program in the Office of Specialty Care Services*

Updated: August 27, 2018

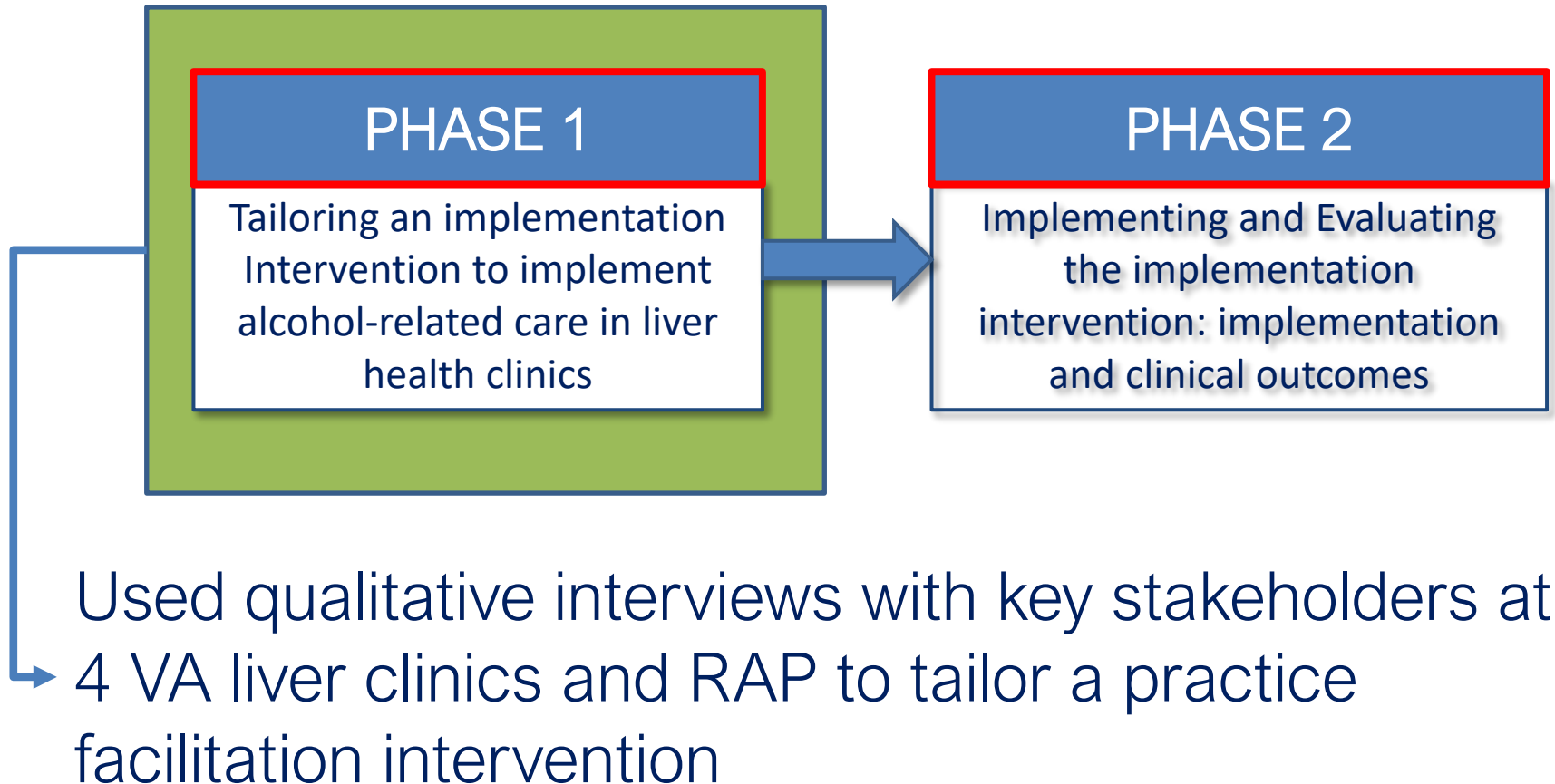
*“Ongoing substance use. . .should not be an automatic exclusion criterion for HCV treatment. There are no published data supporting. . .that these patients are less likely to achieve SVR with HCV treatment.”*

# OPPORTUNITY FOR IMPROVEMENT



Implementation work to increase access to evidence-based alcohol-related care

# 2-PHASE HYBRID TYPE III STUDY



# PLANNED PRACTICE FACILITATION





# PLANNED PRACTICE FACILITATION

Liver Clinic  
Teams



Practice  
Coach



## Practice Coach

- Content training and support in developing systems for communication and workflow
- Local implementation team/champion
- 3 Hour Design Events
- Ongoing support via monthly teleconferences
- Patient Educational Materials

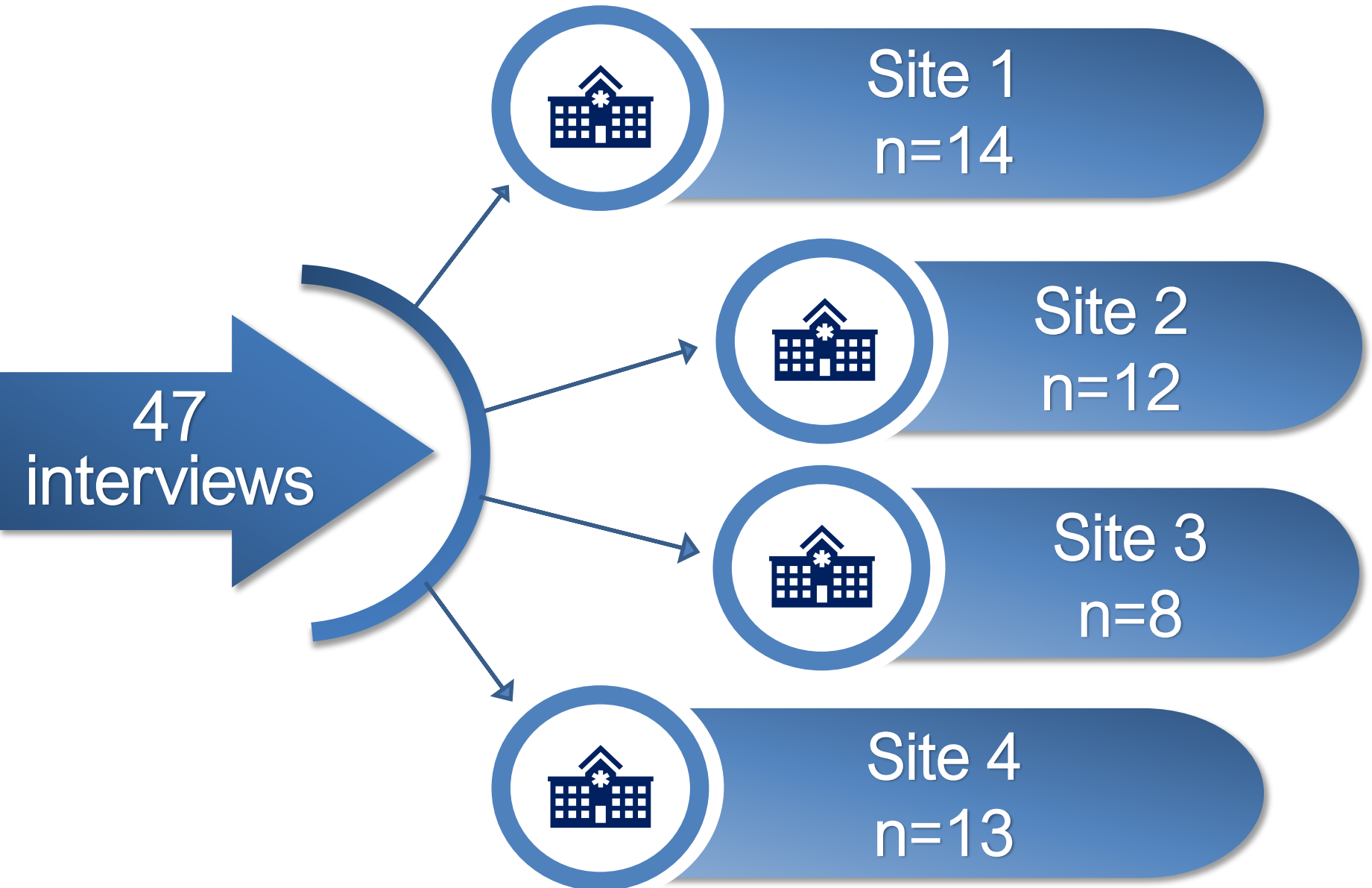
## Informatics Tools

- Order set for Rx
- Consultation Menu

## Performance Feedback

- Monitoring and data feedback of screening, brief intervention, and AUD Rx

# STAKEHOLDER INTERVIEWS



# FACILITATORS AND BARRIERS

OUTER  
SETTING

INNER  
SETTING

INDIVIDUAL  
CHARACTERISTICS



# FACILITATORS AND BARRIERS

## OUTER SETTING

- VA's HCV elimination effort and related treatment guidelines were generally viewed positively and served as facilitators, but also created some challenges (e.g., some providers not aware of new guidelines and some still concerned about treatment adherence with alcohol use).



# FACILITATORS AND BARRIERS

## INNER SETTING

### Facilitators

- Leadership support
- Foundational knowledge and experience
  - Both alcohol use & quality improvement efforts

### Barriers

- No standard approach to alcohol screening
- Logistical challenges (time, space)
- Staffing challenges and wants (e.g., belief/want for care offered by behavioral health)



# FACILITATORS AND BARRIERS

## INDIVIDUAL CHARACTERISTICS

- Variability in belief in importance of addressing alcohol use within liver clinics (Some strong advocates, some resisters)
- Variability in interest in, knowledge of, and comfort with addressing unhealthy alcohol use (Need/wants for training!)



# PLANNED PRACTICE FACILITATION

Liver Clinic  
Teams



Practice  
Coach



## Practice Coach

- Content training and support in developing systems for communication and workflow
- Local implementation team/champion
- 3 hour design events
- Ongoing support via monthly teleconferences
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## Informatics Tools

- Order set for Rx
- Consultation Menu

## Performance Feedback

- Monitoring and data feedback of screening brief intervention, and AUD Rx

# KEY SITE-LEVEL VARIATION

## SITES DIFFER IN:

- Structure and size
- Staffing models
- Availability of onsite mental health resources
- QI History
- Communication mechanisms
- Influential people
- Etc. . .



# TAILORED PRACTICE FACILITATION

Liver Clinic  
Teams



Practice  
Coach



## Facilitation

- Content training
- Patient education materials
- Monthly meetings
- Information re: treatment resources
- Engagement of key advocates
- Support in developing systems for communication and workflow

## EHR Tools

- Standard screening tool
- Order set for Rx

## Performance Feedback

- Screening, brief intervention, AUD Rx
- Prevalence of unhealthy alcohol use
- Liver Outcomes

# TAILORED PRACTICE FACILITATION

Hepatology  
Teams



Practice  
Coach



## Facilitation

- Content training
- Patient education materials
- Monthly meetings
- Information re: treatment resources
- Engagement of key advocates
- Support in developing systems for communication and workflow

## EHR Tools

- Standard screening tool
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## Performance Feedback

- Screening, brief intervention, AUD Rx
- Prevalence of unhealthy alcohol use
- Liver Outcomes

# TAILORED PRACTICE FACILITATION

Hepatology  
Teams



Practice  
Coach



## Facilitation

- Content training
- Patient education materials
- Monthly meetings
- Information re: treatment resources
- Engagement of key advocates
- Support in developing systems for communication and workflow

## EHR Tools

- Standard screening tool
- Order set for Rx

## Performance Feedback

- Screening, brief intervention, AUD Rx
- Prevalence of unhealthy alcohol use
- Liver Outcomes

# TAILORED ACCORDING TO SITES

## Example 2.

Sites 3 and 4 have strong fellowship training programs; fellows provide all the patient care with supervision → need to train fellows and attendings

# WHERE WE ARE NOW

- Feedback from semi-structured interviews with clinical stakeholders at 4 VA liver clinics was useful for refining a practice facilitation implementation intervention when analyzed rapidly using RAP!!
- Currently testing the revised intervention which:
  - Capitalizes on key facilitators: strong context for change, leadership support, foundations in both alcohol use and QI, and key advocates for the importance.
  - Addresses key barriers: particularly re: knowledge, skills, attitudes, and role changes.

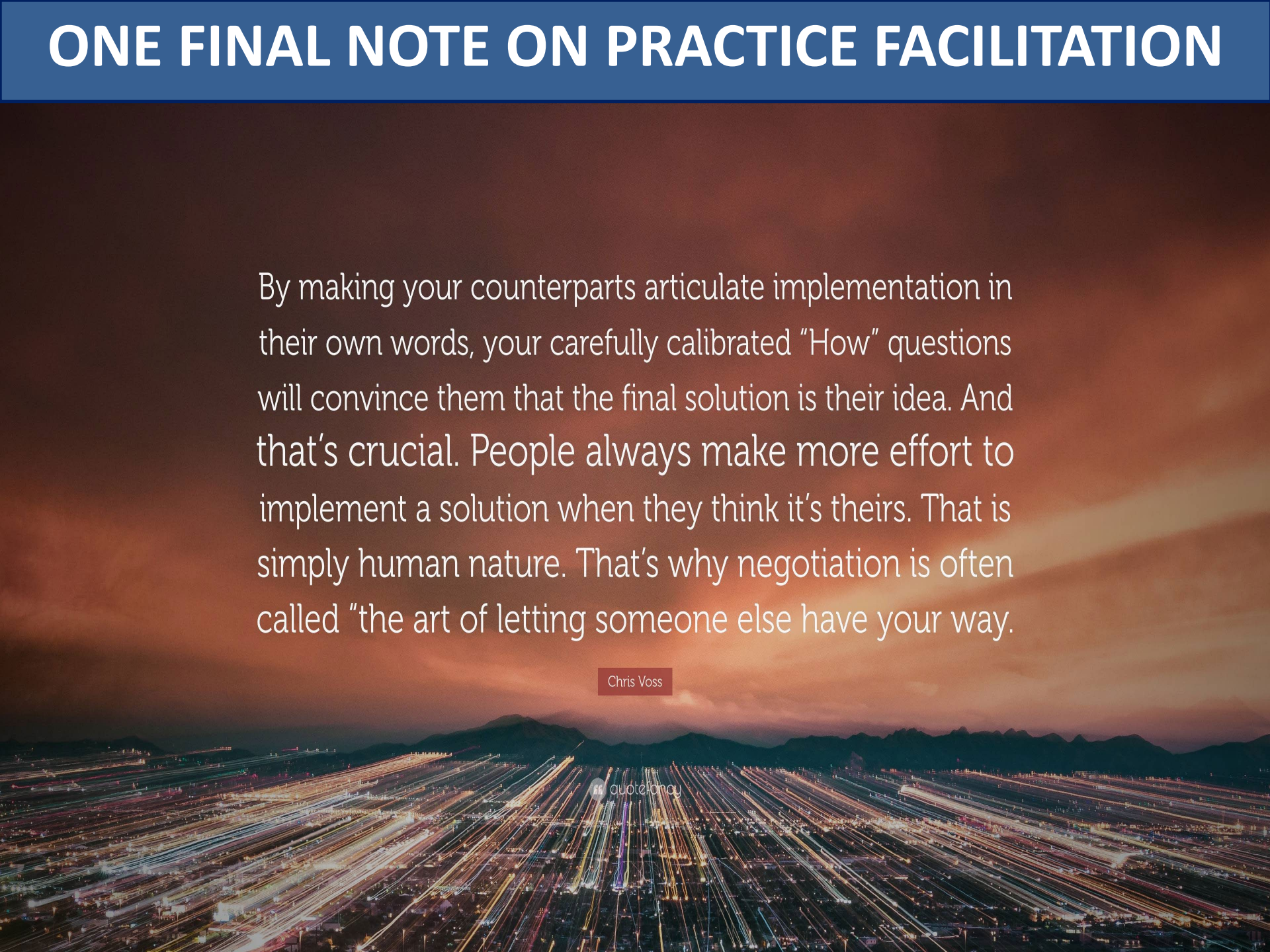


# ONE FINAL NOTE ON PRACTICE FACILITATION

By making your counterparts articulate implementation in their own words, your carefully calibrated “How” questions will convince them that the final solution is their idea. And that’s crucial. People always make more effort to implement a solution when they think it’s theirs. That is simply human nature. That’s why negotiation is often called “the art of letting someone else have your way.”

Chris Voss

quoteancy



# BIRD'S EYE VIEW SUMMARY

- We work with clinics to integrate evidence-based care for unhealthy alcohol use (and other substance use—particularly opioids) using implementation science principles and strategies
  - We've seen big successes + learned to address challenges!
- Our research is generally mixed methods, which is key to iterative adaptation of implementation efforts
  - You saw some of this in our refining of the liver clinic intervention, but I have more examples if you want to know
- Our efforts have helped get alcohol SBI (and pharmacotherapy) on the VA's primary care and liver agendas:
  - CFIR, formative evaluation, and RAP = key





# OTHER RELATED WORK



## Implementing Medications for OUD

- Patient Safety Center
  - VA Primary Care
  - Internal Facilitation
  - Evaluation Submitted for Publication
- CHAMP—NIMH HEAL Study
  - 12 Primary Care Clinics Nationally
  - External Practice Facilitation
  - Recent pub on OUD screening (*Austin et al JGIM*)

## Addressing Inequity

- New NIDA R01 (Chen/Williams)
  - Mixed methods
  - Guided by Critical Race Theory
- **Operationally-partnered VA research**
  - Led by Jess Chen/Rachel Bachrach
  - Qualitative inquiry to understand high and low performing sites on AUD pharm and MOUD







Questions?

# UNSOLICITED WORDS OF WISDOM

Ideas are easy.  
Implementation  
is hard.

Guy Kawasaki

"I AM READY TO FACE ANY  
CHALLENGES THAT MIGHT  
BE FOOLISH ENOUGH TO  
FACE ME"

-DWIGHT





**THANK YOU**