

Improved Patient Outcomes and Reduced Wait Times: Transforming a VA Outpatient Substance Use Disorder Program

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Systematic evaluation and redesign of a substance use disorder treatment program resulted in elimination of wait times, same-day treatment, and increased pharmacotherapy for patients with alcohol and opioid use disorders.

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Substance use disorders (SUDs) are an increasing public health concern in the US. The 2015 National Survey on Drug Use and Health indicated that 27 million people (8% of the US population) reported current use of recreational drugs or misuse of alcohol or prescription medications.¹ The 2013 National Survey on Drug Use and Health indicated that 1.5 million veterans (roughly 6.6%) met the criteria for a SUD.² More than 50% of patients awaiting entry into a SUD treatment program will never achieve admission due, in part, to long wait times.³⁻⁵

National attention has been focused on increasing veteran access to quality treatment based on evidence-based practices (EBPs). Several national legislative measures and treatment protocols have been implemented: the Uniform Mental Health Services in US Department of Veterans Affairs (VA) medical centers and clinics; Veterans Access, Choice, and Accountability Act (2014); Cognitive Behavioral Therapy for Substance Use Disorders (CBT-SUD) Training Program; and the Psychotropic Drug Safety Initiative (PDSI).⁶⁻⁸ Consistent with these directives and in line with American Society of Addiction Medicine (ASAM) and Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines for medication-assisted therapies (MAT), the James A. Haley Veterans' Hospital (JAHVH) Mental Health and Behavioral Sciences Service (MH&BSS) Substance Use Disorders Service (SUDS) in Tampa, Florida, implemented an evidence-based, treatment-on-demand model of care.⁹⁻¹¹

Meeting SUD Treatment Needs

What does the new supervisor of a clinical program do when a 24-employee outpatient VA Alcohol and Drug Addiction Treatment Program (ADATP) has an average 33-day wait time for treatment with 54% of patients lost to care between initial evaluation and admission?¹² Patients lacked consistent access to SUD pharmacotherapy. The national VA clinical performance indicators were substandard and there are no additional resources available to apply to the program.

At JAHVH the program supervisor enlisted hospital leadership to support program redesign. The redesign sought to improve operational efficiency and eliminate patient wait time; adopt national standards for assessment and treatment developed by ASAM; implement strictly evidence-based psychotherapeutic treatments; educate program psychiatrists about evidence-based psychopharmacologic treatments and hold them accountable for patient adherence; streamline documentation templates; free clinical providers from nonclinical tasks; create an inpatient addiction consult team to diagnose and treat chronic hospitalized patients with SUDs; ensure continuity of care; and, standardize consistent, objective measures of patient response to treatment to track the program's effectiveness.

In this article, the authors provide an explanation of the clinical, theoretical foundation and the practical steps taken to design and implement this transformation. They then describe the lessons learned, hoping

that their process will serve as a model for those in similar situations.

PROGRAM REDESIGN

July 1, 2015, a new program supervisor was hired and began a 2-month evaluation and analysis of the program with input from leadership, staff, and hospital/community stakeholders. September 1, the monthlong process of developing the redesign began. On September 30 the plan was presented to, and approved by, MH&BSS leadership. October was spent preparing for change with an implementation date of November 2 selected. On November 2, 2015, the complete redesign was implemented.

Needs Assessment

A needs assessment yielded improvement opportunities in program structure (levels of care); clinical content; staff and resource allocation, including clinical workflow and management systems. Staff identified philosophical and practical variance in the program, often leading to confusion for patients and clinicians and potentially resulting in disparate quality care and patient outcomes. Recommendations for addressing these needs included incorporating ASAM guidelines for assignment to clinically appropriate levels of care, implementation of consistent EBPs for SUD and comorbid conditions,⁹ and emphasis on staff training and development to champion evidence-based program philosophy and service delivery.

The assessment determined that the average waitlist time was 33 days, and patients were required to abstain from substance or alcohol use prior to admission to the Intensive Outpatient Program. If a waitlisted patient relapsed, she or he was removed from the waitlist and denied admission. A study conducted at JAHVH reported that 54% of waitlisted patients in this clinic (prior to November 2, 2015) never were admitted to the program.¹² Access to care was considered a significant issue.

Program Implementation

September was spent developing a comprehensive redesign of the SUD clinic. The vision included incorporating all ASAM levels of care; creating an evidence-based, treatment-on-demand model of care; and,

securing the support of MH&BSS leadership team, staff, and patients for the redesign. The supervisory clinician interviewed staff both individually and as a group. Clinicians were provided extensive training on EBP for SUDs, including psychotherapies, psychosocial treatments, and psychopharmacologic interventions. A journal club was started with staff-generated topics that offered articles sharing current research, EBPs, and psychotherapeutic techniques, continuing education on substances, and management of coexisting diagnoses. Clinicians increased the frequency of SUD in-service trainings. Psychiatrists provided several Grand Rounds to the MH&BSS service. All counselors were assigned to 1 of the program's 3 clinical psychologists for individual weekly clinical supervision.

By providing all staff with current, evidence-based, clinically relevant treatment information and emphasizing its relationship to successful patient outcomes, program leadership energized staff support. Staff were encouraged to perform at the top of their scope of practice and engage in training and consultation. Each staff member was delegated a role in the process to inspire buy-in.

Preparation for the Shift

October was spent preparing for a seamless, one-day implementation of proposed changes, including implementation of updated clinical policies, procedures, and document templates (rewritten to include only clinically appropriate information required by VA policy or the Joint Commission); streamlined staff schedules; and utilization of staff-developed and research/policy-driven EBP handbook. Finally, the Brief Addiction Monitor (BAM) was selected as objective criteria to consistently assess patient progress in treatment, and staff were instructed to use this measure at regular intervals and for all levels of care.

Emphasis was placed on ongoing fortification of staff and patient support for the reorganization. For example, the Addiction Severity Index, though not required by policy, was historically used, adding 90 minutes to the evaluation and admission session. Staff agreed to remove this measure to improve clinician availability. Staff were also empowered to rename the redesigned

program, and chose Substance Use Disorders Service (SUDS).

Process Changes

To achieve same-day access to clinical care, program leadership created a daily morning orientation group. Patients are scheduled or may attend as a walk-in. The orientation's purpose is to explain what services are available and to offer each patient an opportunity for immediate evaluation and treatment. Staff schedules were modified to provide patient evaluation appointment slots immediately following orientation. The number of immediate evaluation slots was initially assessed by analyzing the demand for treatment over the previous 6 months, determining the daily mean, and setting the number of slots to accommodate 3 standard deviations above the daily mean. If a patient in a daily orientation group expresses a willingness to engage in treatment, he or she is immediately evaluated by a counselor during a 90-minute session and seen by a psychiatrist to determine whether pharmacologic treatment would be appropriate. If needed, the medication is prescribed that day. The primary purpose of the patient's initial clinical evaluation is to determine the most appropriate level of care based on ASAM criteria. Also available were 90-minute afternoon evaluation appointments with psychiatrists for patients who walk into the clinic after the morning orientation group had ended.

Prior to the redesign, clinic psychiatrists were minimally prescribing evidence-based pharmacotherapy for sobriety support. At the time of redesign, only 8% of patients diagnosed with opioid use disorders (OUDs) were prescribed buprenorphine/naloxone or naltrexone. Just 1.9% of patients diagnosed with alcohol use disorder (AUD) were prescribed naltrexone or acamprosate. With the redesign, access to these medications has significantly expanded.

All templates were redesigned to ensure consistent documentation. This change decreased the overall provider task burden, and explicitly supported the use of ASAM multi-dimensional criteria and the Brief Addiction Monitor (BAM) to identify a pretreatment baseline score and track each patient's clinical progress.¹³ Evidence-based written curricula were standardized for individual and group

psychotherapies to reduce provider and programmatic variation.

The redesign creates distinct levels of care based on ASAM criteria, including harm reduction, ambulatory detoxification, outpatient group and individual psychotherapy, an evidence-based Intensive Outpatient Program (IOP), and aftercare. Application of the ASAM standards has allowed clinicians to make accurate placement decisions that best meet individual patient needs and to serve as effective stewards even with limited treatment and financial resources. Although JAHVH does not have a residential SUD program, procedures were developed to refer veterans to community-based residential treatment programs when appropriate.

Group Therapies

With the redesign, SUDS was no longer exclusively a 12-step program; however, it still supported and recognized the value of this approach for some patients. A psychologist periodically audits group sessions to prevent drift from that group's curriculum. Counselors are assigned to weekly hour-long clinical supervision sessions with a psychologist to review patient care and reinforce the application of evidence-based individualized treatment.

After reviewing empirical literature and VA directives, CBT-SUD was adopted. It encompasses individual and group interventions, such as motivational interviewing (MI), contingency management (CM), and medication-assisted therapies as primary therapeutic modalities, all of which have demonstrated efficacy as measured by length of sobriety postintervention.^{9,14,15}

Clinical Staff Improvements

Staff were reorganized into 3 interdisciplinary treatment teams. A weekly team meeting is scheduled to coordinate care and discuss the treatment of complex patients. Clinical staff focus has shifted from case-management to diagnosis and treatment; now patients are referred to their primary care team's social worker for case management services. Allowing clinical staff to focus solely on the diagnosis and clinical treatment of SUDs has significantly enhanced productivity and morale.

Staff receive training in the newly adopted interventions during brief monthly refresher courses provided by inhouse psychologists. Additional training includes participation in local and national SUD teleconferences and onsite meetings with experts in harm reduction and motivational interventions. During the transition, clinicians were encouraged to attend staff resiliency training. Continuing education was available to the SUDS psychiatrists and all inpatient and outpatient psychiatrists at JAHVH. Recently, this educational initiative was expanded to include all primary care and inpatient internal medicine physicians.

Implementation

On November 2, 2015, all planned programmatic changes were simultaneously implemented. On that day, clinician and patient schedules changed, the new EBP curriculum was administered, the use of streamlined documentation procedures began, and daily orientation groups followed by same-day evaluations were initiated.

The pretreatment sobriety requirement was eliminated as a barrier to care, and the program began to use a harm-reduction treatment track as recommended by ASAM guidelines. Patients with urgent or emergent medical or psychiatric problems were immediately assessed by SUDS health care providers and treated in the clinic or transported to the emergency department. Previously unavailable, patient access to ambulatory detoxification was initiated. The prescription of buprenorphine/naloxone for the treatment of OUD treatments increased from 1 prescriber to all 3.

Three months after program reorganization, the leadership reviewed overall workflow, conducted patient satisfaction surveys, and evaluated facility use and productivity. To address patient needs and facilitate optimal use of space, the number of same-day evaluation slots was reduced while the number of individual therapy slots was increased.

Staff meet in workgroups to discuss EBPs and further refine content with feedback from the supervisory clinician and team psychologists who routinely audit group therapy sessions. Staff report ongoing benefit from weekly supervision with a clinical psychologist. An inpatient addiction consultation

team that uses existing manpower and resources has been developed.

PROGRAM GOALS AND OUTCOMES

The SUDS program serves more patients at multiple levels of standardized care with 2 fewer full-time positions. One counselor and one advanced practice registered nurse were reallocated to different programs within the JAHVH VA mental health clinic. Following a review of all program clinic profiles in the VA's Computerized Patient Record System (CPRS) for utilization, accuracy, and necessity, and allowing for accurate program data capture, the transition resulted in a reduction of distinct clinics from 114 to 67 (-58.7%). In fiscal year 2018, review of CPRS yielded 19,786 total visits (3,645 unique visits).

Eliminate Patient Wait Time

Patient wait time, as measured in CPRS from date of initial evaluation to date of treatment was reduced from an average of 33 days to 0 within 2 weeks of program implementation. A review of CPRS data also indicated that preadmission attrition dropped from 54% to < 1%; all patients desiring treatment are assigned a counselor and treatment is initiated the same day.

Adopt ASAM Criteria

After the redesign, patients have received more appropriate care based on individualized treatment plans. Due to the implementation of a fluid and supportive model, patients can move through levels of care as clinical need dictates rather than failing treatment and having to reengage. Staff receive ongoing education on the use of ASAM. Evaluation and treatment plan templates now reflect assignment to level of care rationale using ASAM guidelines.

Use of Evidence-Based Psychotherapeutic Treatments

More consistent, coordinated, and effective psychotherapies have improved patient care. The program's previous issues with patients receiving conflicting treatment guidance from different providers has been resolved. Duplicate and ineffective treatments, including multiple readmissions to the IOP level of care, overemphasis of abstinence-based modalities for patients in

active use, and referrals to inpatient SUD care under the assumption that “higher level of care is better” have ceased through staff education, leadership support, and appropriate staffing and communication. Review of patient advocate complaints tracked by and resolved by the service demonstrated an 80% decrease in patient advocate complaints regarding SUD clinic services.

Implement Evidence-Based Psychopharmacologic Treatments

The pharmacotherapy education initiative yielded tangible benefits and is likely a significant contributor to the program’s improved clinical outcomes. Prescription of pharmacotherapy for patients with OUD has risen from 8% to 25.1% in eligible patients. Appropriate medication prescription for the treatment of AUD has risen from 1.9% to 9.8% in eligible patients. These data are reflected in the VA Pharmaceutical Drug Safety Initiative (PDSI) dashboard.

Streamline Documentation

Significantly reducing the charting burden was likely a significant contributor to increased provider productivity and improved patient outcomes. Regular meetings between SUDS leadership and clinical informatics ensure that standardized note templates meet hospital policy and gather all necessary accreditation information.

Improve Employee Morale

Increased staff morale is indicated by a noticeable reduction in employee sick days; a decrease of > 20% (over the same time period the previous year), per the VA electronic timekeeping system, during the first 6 months following the November 2 program implementation.

SUDS Inpatient Addiction Consult Team

In January of 2017, SUDS began an inpatient medicine consultation service to offer evaluation, pharmacotherapy, and supportive counseling to patients diagnosed with SUDs who had been admitted to inpatient medical and surgical services. This team includes existing SUDS staff members reallocated to the inpatient service, is led by a SUDS psychiatrist, and includes 3 multidisciplinary clinicians with extensive training in assessment, diag-

nosis, and treatment planning of SUDs and comorbid conditions. Prior to implementation, the SUDS inpatient addiction consult team met with hospital leadership and attending physicians for inpatient medicine and psychiatry physicians.

To access the SUDS inpatient addiction consult team, physicians request a consult. Patients are offered an evaluation and are assigned to a level of care with orders for outpatient appointments with a counselor and psychiatrist within 7 days of hospital discharge. Medication-assisted treatment for chronic SUDs is implemented while patients remain admitted to the inpatient medical service. In fiscal year 2018, the SUDS inpatient addiction consult team performed 1,428 inpatient evaluations.

Consistent Treatment Outcome Measures

The BAM is a clinical tool designed to measure patient outcomes in substance use disorders.¹³ Its 17-item scale measures substance use risk factors that may lead to relapse, and protective factors that are recovery-oriented behaviors that help prevent relapse. It demonstrates sensitivity to change and has excellent test-retest reliability. The BAM has been in use in the addictions treatment program since 2011 but was previously administered only after admission to the IOP and again after a 30- to 90-day follow-up period. Since the program redesign, all SUDS patients are administered the BAM at their initial evaluation and at each individual appointment thereafter. The initial BAM assessment encompasses the previous 30 days; this 30-day version is also used for monthly follow-ups. For BAM assessments that occur within 30 days from the time of the last evaluation, a 7-day version is used. Prior to the redesign, about 24% of patients received a follow-up 30-day BAM assessment.¹² Per CPRS review of veterans participating in continued treatment, the rate rose to 100% 3 months after the redesign.

When program staff compared preredesign and postredesign BAM data, they detected significant clinical differences. Data demonstrate a 22.2% improvement in protective factors, including patient confidence in their ability to remain abstinent; engaging in self-help activities, such as attending

Alcoholics Anonymous meetings; engaging in organized spiritual activities; going to school, working, or volunteering; securing a regular income; and time spent with friends or family who are supportive of recovery.

The data also show a marked reduction in substance use at follow-up points in treatment and a corresponding decrease in risk factors. One item of the BAM assesses patient level of satisfaction with their treatment. Since the redesign, patients report that they are “considerably” satisfied with their SUD treatment.

Currently, program staff are conducting a review of BAM scores by level of care to further parse the impact of various treatments and best target patient need using measurement-based care and EBP, such as contingency management, which provides small monetary incentives when patients maintain clean urine drug screens.¹⁶ In addition, the program plans to achieve more uniformity in BAM assessment intervals at all levels of care, and possibly also integrate BAM data into SUD group therapies. Correlation of the BAM scores to other metrics, such as readmission to inpatient medicine, relapse, urine drug screen, or critical laboratory values, will provide additional insight into impact of programmatic changes.

DISCUSSION

Feedback from other clinics and services within the hospital has been very positive. Some providers have reported that they appreciate the ease and availability of access to SUDS. Additionally, patients engaged in treatment prior to the redesign have been contacted for an updated evaluation and assignment to a counselor and appropriate level of care. From the staff’s perspective, the shift to immediate access to care has allowed a more streamlined process with fewer hurdles for patient admission. Staff report that they now feel empowered to meet the needs of veterans in a comprehensive, same-day fashion.

The success of our redesign was contingent on internal and external stakeholder buy-in and input, clear communication of vision and rationale from leadership, with an emphasis on implementing an evidence-based, treatment-on-demand model of care

that showed fidelity to VA and Joint Commission policy. Regular review and revision of local policies and procedures, both to support additional changes and improve access to high-quality care, were also critical to success. Revision of documentation to streamline staff workload encouraged an emphasis on patient care as an organizing principle of our changes. Support from leadership for ongoing, monthly trainings in evidence-based psychotherapies and pharmacologic treatments helped ensure continued professional development of skill and knowledge and improve the mental health outcomes of our patients. Staff were encouraged to attend roundtable discussions regarding program redesign. Program leadership considered staff as important stakeholders in the redesigned.

The successful implementation of these changes has revealed several important elements regarding patient care. The first lesson was that improving access and integrating best practices is possible without additional resources, outside monies, or disruption to patient services. With the support of MH&BSS leadership, the program streamlined existing processes and used both staff and clinic resources more efficiently.

The second lesson involved the importance of continually reviewing and revising standard operating procedures to match the needs of the current patient population. Policies and procedures that once were viewed as potential barriers to change have been replaced with a more flexible approach and willingness to evolve.

As a result, far fewer patients have been lost to treatment. The time and resources that staff historically dedicated to nonclinical patient care are now redirected to immediate service provision. This increase in operational efficiency and treatment efficacy has resulted in a boost to staff morale, even during a time of immense change and increased productivity. Program staff are now able to personally witness the significant changes in their patients’ lives and feel a sense of pride at being a member of a hard-working team that provides the highest quality of substance use treatment. This is critical to job satisfaction and meets the VA mission to provide timely, effective, and evidence-based treatments to patients.

CONCLUSION

JAHVH strives to continue to provide the highest quality of SUD treatment available. Future directions aim to streamline clinic operations by constantly monitoring and reviewing workloads, while also considering patient feedback. A continuous review of EBP is part of our clinic's culture. Program leadership endeavors to promote an open environment where providers can share their triumphs and frustrations and foster a team approach to problem solving. Further plans include expanding the range of treatment levels offered by developing a residential SUD treatment facility.

Author disclosures

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Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the US Government, or any of its agencies.

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