Understanding tobacco treatment implementation in Veterans Health Administration substance use disorder residential programs

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QUERI Quality Enhancement Research Initiative

VA Office of Patient Care Services — Excellence in the 21st Century

Presenter Disclosures

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(1) The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

"No relationships to disclose"

Contributors & Collaborators

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QUERI Quality Enhancement Research Initiative

PUBLIC HEALTH

TCCRC Tobacco Cessation Clinical Resource Center — VA Cincinnati

Gaps in Care

- Smoking among VHA Veteran enrollees declined from 33% in 1999[1] to 20% in 2011[2]
- Individuals with SUD are:
  - 3 to 4 times more likely to have concurrent nicotine dependence[3-6]
  - More likely to suffer death and illness from tobacco use than other addictions[7]
- Integrated tobacco treatment did not interfere with recovery process; may improve long-term abstinence [8-12]

Objectives

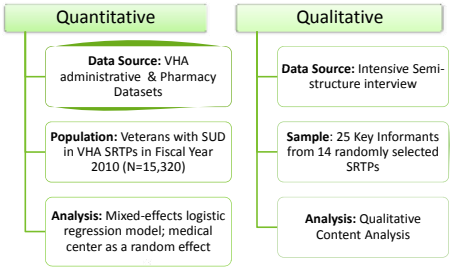
1. Characterize current status of integrated tobacco treatment implementation in VHA SUD Residential Treatment Programs (SRTP)
   - Tobacco dependence, nicotine treatment utilization
   - Patient-level predictors of NRT utilization
2. Identify barriers and facilitators to implementing integrated Tobacco Dependence (TD) treatment

Why SUD Residential Treatment Programs?

- TD Treatment in VHA SUD Residential Treatment Programs (SRTPs)
  - 63 VHA SRTPs nationally
  - Long-term, supportive environment
  - Readily available staff and peer support

Methods

Study design: Mixed methods guided by the Promoting Action on Research Implementation in Health Services (PARiHS) framework



6

Quantitative Results

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Estimated tobacco users among SRTP Patients

- Based on being diagnosed or treated for TD in FY09 and/or FY10
  - 79% of SRTP patients (12,097 of 15,320) are estimated tobacco users

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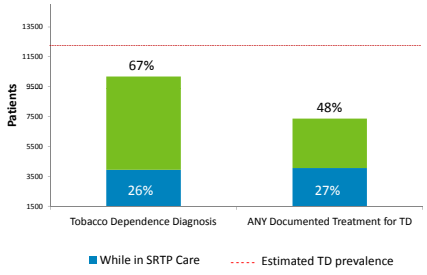
Characteristics of SRTP TD Patients in FY10 (N=12,097)

Variable	TD Patients
Female	4.3%
White*	58.8%
OEF/OIF/OND	9.8%
Married*	16.0%
Homeless	49.1%
Age	
less than 30	7.5%
30-55*	63.8%
greater than 55*	28.7%
Co-occuring DX	
Any*	87.9%
Bipolar*	18.8%
Depression*	44.0%
PTSD	38.6%

*Statistically significant difference between TD and non-TD patients

9

TD Diagnoses and Treatment for SRTP Patients in FY10 (N=15,320)



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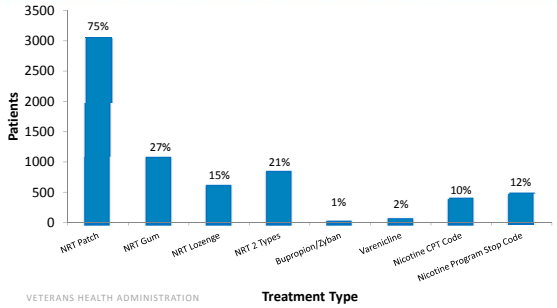
10

Treatment Type for SRTP Patients While in Care in FY10 (N=4,052)



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11

Multivariate Model Predicting Receipt of Any NRT in SRTP Among TD Patients in FY10

Variable	Estimate	SE	z	Odds Ratio	95% CI - lower	95% CI - upper
TD diagnosis in SRTP during FY10 (ref: none)	0.23	0.05	4.82	1.25	1.14	1.38
TD Treatment in FY09 (ref: none)	0.16	0.04	3.63	1.17	1.07	1.27
Age (ref: >55)						
30-55	0.26	0.11	2.38	1.29	1.04	1.61
<30	0.13	0.05	2.79	1.14	1.04	1.25
White (ref non-white)	0.16	0.05	3.56	1.18	1.07	1.29
Co-Morbid psych - any (ref: none)	0.25	0.07	3.60	1.27	1.11	1.46
Intercept	-1.406	0.10	-14.43			

Note: Mixed-effects logistic regression model with a random effect for facility.
Nagelkere R-Square = 0.12.

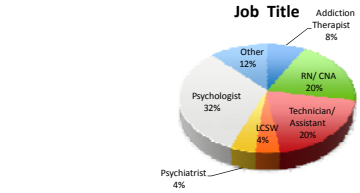
12

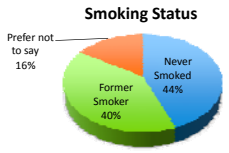
Limitations

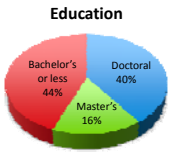
- VHA datasets do not accurately address tobacco counseling in residential treatment
- Identification of patients prescribed bupropion for smoking
- Definition of SRTP tobacco users
  - Possible underestimation of prevalence

Qualitative Results

Sample Characteristics (N=25)







15

Provider Knowledge, Attitudes & Beliefs

Knowledge

- Most aware of pharmacotherapy or counseling as general categories of TD treatment
  - Limited knowledge of specific EBPs for tobacco cessation
  - Limited training specifically related to TD treatment

Attitudes/Beliefs

- General support for the idea of tobacco cessation; some reservations.
  - Not a high priority activity for SRTPs
  - Tobacco use perceived as a patient's right
  - Patients "too overwhelmed" to stop using tobacco
  - Quitting tobacco could jeopardize patient sobriety

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Tobacco Use Service-Delivery

- Few programs have integrated, consistent, and fully integrated tobacco treatment
- All programs report screening for tobacco use and offer nicotine replacement therapy
- Most programs offer individual tobacco cessation counseling although most indicated it was rarely used by veterans.

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Top 10 Barriers Reported by Staff

1. Not enough time (88%)
2. Lack of training (85%)
3. Other MH problems require more attention (85%)
4. Challenges with enforcement (83%)
5. Patients not interested (76%)
6. Union resistance (75%)
7. Patients not compliant (73%)
8. Concern that patients would leave program (69%)
9. Smoking with patients occasionally a good way to bond (56%)
10. Too much to ask patients to give up (53%)

18

Facilitators to Implementing Integrated Tobacco Treatment

- Tobacco-free facility, no tobacco tolerance policy
- Training provided for staff and important partners
  - Address common myths
  - Help patients & staff understand connection between smoking & SUD
  - Teach evidence-based treatments
- Track program and patient progress toward tobacco cessation
  - Status reports in staff and community meetings
  - Praise patients and staff on progress
- Help programs partner with other SRTPs for mentoring, support, and problem solving

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Conclusion

- Tobacco Treatment is underutilized in SRTPs
  - ~ 1/3 of Veterans with tobacco dependence are diagnosed or treated
- Patient, provider and systems-level barriers exist
  - Need targeted efforts to address staff beliefs and attitudes
  - Need training and tools to support implementation
- Significant opportunities
  - Identified need
  - Systematic implementation efforts will likely be needed to overcome cultural barriers and rectify gaps in care

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Next Steps – Integrated Tobacco Treatment Toolkit

- Develop , implement and evaluate a toolkit with a social marketing messaging framework for integrated TUD treatment in SUD specialty care
  - **Title:** Marketing integrated tobacco treatment to Veterans Health Administration substance use disorder treatment providers
  - **Poster Session:** Tuesday, October 30, 2:30 to 3:30 pm
  - **Presenter:** Joy Austin-Lane

Thank you!

"Our lack of progress in tobacco control is more the result of failure to implement proven strategies than the lack of knowledge about what to do."

- David Satcher, M.D, Ph.D., Surgeon General

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