Utilizing Implementation Science to Identify Barriers and Facilitators to Implementing Harm Reduction Services in the Veterans Health Administration

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BACKGROUND

- **Although harm reduction services (HRS) are highly evidence-based and effective, implementation in most healthcare settings is limited**
- **Recent policy changes create a unique opportunity to integrate harm reduction into VA healthcare[1]**
- **This exploratory study sought to:**
  - **Identify barriers and facilitators to the integration of HRS**
  - **Identify appropriate implementation strategies to support the integration of a comprehensive bundle of HRS in the VHA**

METHODS

- 15 semi-structured, qualitative interviews were conducted across 5 VA Medical Centers. Participants included clinical pharmacists, primary care clinicians, hospitalists and emergency room clinicians, social workers, and directors of addiction and mental health services
- Interviews explored how harm reduction is currently understood and elicited input on perceived facilitators and barriers to implementation
- Data were analyzed using a directed content analysis approach utilizing the Practical, Robust Implementation and Sustainability Model (PRISM) Framework[2]
- Barriers, facilitators, and implementation strategies suggested by participants during interviews were identified and categorized
- Barriers and facilitators were then mapped to potentially effective implementations strategies using the Consolidated Framework for Implementation Research - Expert Recommendations for Implementing Change (CFIR – ERIC) tool[3]

CONCLUSIONS & IMPLICATIONS

- **Many of the barriers identified in this exploratory study may be addressed using evidence-based implementation strategies**
- **Additional research is needed to identify implementation strategies that are effective for addressing stigma, which remains a major challenge to the provision of integrated healthcare services for this patient population**
- **These results highlight the internal and external perspectives and characteristics that may improve adoption of HRS within a large, national integrated healthcare system**

RESULTS

Figure 1: Practical, Robust Implementation and Sustainability Model Framework (PRISM)[2]

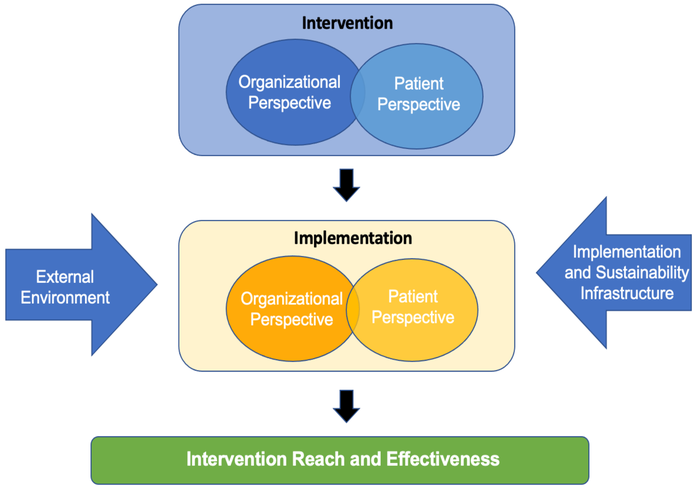

Table 1: PRISM Domains and Examples of Facilitators and Barriers Identified by Participants

	DOMAIN	External environment	Implementation and sustainability infrastructure	Organizational characteristics	Organizational perspective of the intervention	Patient characteristics	Patient perspective of the intervention
Examples of Facilitators and Barriers Identified by Participants	BARRIERS	Limited partnerships between VHA, community harm reduction agencies, especially in rural areas	Lack of dedicated funding to support HRS and inability to identify Veterans who would benefit	Provider unfamiliarity with harm reduction and limited experience in the care of patients using substances	Cultures of care that promote abstinence over harm reduction Provider liability concerns	Residential and financial instability, competing medical needs, trauma history	Concern that disclosure of drug use will impact quality of care
	FACILITATORS	Recent policy changes allowing federal funds to be used for sterile injection equipment	VHA patient safety and error prevention initiatives	VHA social support programming (housing, job training, etc)	Strong evidence base for HRS	Existing connections to VHA services and healthcare providers	Patients' lived experience

LIMITATIONS

- Limited sample size
- Potential for selection bias of participants
- Patient perspectives and characteristics were based on providers' perceptions

REFERENCES

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Table 2: Barriers, Facilitators, and Implementation Strategies to Facilitate Uptake of Harm Reduction Services within the VHA

		ERIC Implementation Strategy	Potential Solution Identified by Participants	Frequency of Recommendation from Participants
BARRIERS	Policies and regulations	• Build a coalition • Use advisory boards and workgroups • Change accreditation or licensure standards	• Communication around change in federal policies • Easing restrictions limiting access to MOUD	+ ++
	Limited provider knowledge and experience	• Develop educational materials • Create a learning collaborative and conduct ongoing trainings • Train the trainer strategies	• In-person, interactive trainings for frontline staff • Incorporating program rollout into departmental provider meetings	+++ ++
	Lack of designated funding and staff time	• Revise professional roles and incentive structures • Fund and contract for clinical innovation • Develop formal implementation blueprint	• Develop workload credit • Standardized workflows and clear role delineation	++ ++
	Accessibility to all Veterans	• Conduct local needs assessment • Tailor strategies to location and community	• Targeted outreach to patients in rural areas or experiencing homelessness • Low-barrier services	+++ +
	Care fragmentation and distrust of healthcare system	• Involve patients and families in intervention design and continuously elicit feedback • Direct outreach to patients to enhance uptake	• Peer support specialists • Patient navigators • Provider training on patient-centered substance use care • "One-stop shop" substance use care	+++ + ++ +
	Stigma around substance use	• Identify and prepare champions • Engage leadership • Mass media campaigns	• Institutional buy-in and support from leadership • Anti-stigma campaign • Encourage harm reduction and non-abstinence-based care	+++ + +
FACILITATORS	Local Champions	• Identify champions and early adopters • Recruit, designate, and train for leadership	• Utilizing clinical pharmacists • Build on comprehensive care model addressing social determinants of health	+ +
	Existing Infrastructure	• Provide both centralized and local technical assistance • Develop and implement tools for quality monitoring • Relay metrics and clinical data to providers	• Leverage existing IT infrastructure to mine EHR to build data dashboards • Order sets for infection screening, automated naloxone refills, referrals	+ +

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