# Medications for Opioid Use Disorder in VHA Acute Care Settings: A Quality Improvement Study

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**Submitter** Brian Fuehrlein

**Affiliation** VA Connecticut

## SUBMISSION DETAILS

**If your paper is not accepted, please elect if you would like your submission to be reviewed as a poster.** Yes, I would like to be reviewed as a poster.

**Summary** The Veterans Health Administration (VHA) has identified access to medications for opioid use disorder (MOUD), including buprenorphine and methadone, as a top clinical priority. While MOUD initiation commonly occurs in outpatient settings, patients are frequently cared for in acute care settings-including inpatient medicine and emergency departments (ED)-during periods of high vulnerability. These encounters represent an opportunity to initiate MOUD, which can significantly reduce the risk of post-discharge overdose and mortality. It is unclear if MOUD is uniformly initiated in these settings and what common barriers and facilitators are.
To address this knowledge gap, we conducted a national needs assessment to evaluate the current landscape of acute care setting initiation of MOUD across VHA. After an email solicitation to service chiefs, 270 clinical leaders and frontline providers responded. Respondents represented 152 unique acute care settings including inpatient (n=71), ED (n=53), urgent care (n=4) and other (e.g., mental health) (n=24). The following reported the ability to initiate buprenorphine/methadone: inpatient=70%/44%, ED=72%/23%, other=63%/8%, urgent care=0%/0%. Despite this, only 15% reported use of standard operating procedures (SOP).
The most common barriers to MOUD initiation included lack of clinical guidance (46%) (e.g., protocols, SOPs), inadequate training in OUD diagnosis and management (32%), and limited access to follow-up care (32%). Facilitators included an established referral system for rapid follow-up (36%), ease of availability of medications (34%), and the presence of a local champion (30%).
This assessment directly informs the development of a national VHA toolkit designed to bridge these gaps. The toolkit includes SOP templates, clinical training modules, and an implementation checklist to facilitate implementation. By shifting the culture of acute care from stabilization-only to active treatment initiation, VHA can expand a seamless continuum of care for Veterans with OUD.

The questions following the above will ask you to breakdown your summary.

**Background** Despite the availability of evidence-based medications for the treatment of OUD, it remains a chronic, relapsing and remitting illness. Medications like buprenorphine and methadone

remain generally underutilized for a variety of reasons. Patients with OUD frequent acute care settings (e.g., EDs, inpatient medicine) related to their OUD or for unrelated acute medical concerns. Patients with untreated OUD remain at elevated risk for overdose death and the 12-month period following an acute care discharge is particularly associated with a markedly increased risk of fatal overdose.
Initiating MOUD during these acute encounters is a high-impact intervention that can increase the likelihood of long-term treatment engagement. However, anecdotally, VHA facilities have evidenced significant variability in their ability and capacity to provide this care. Many facilities have lacked the protocols and training necessary to move beyond simple withdrawal management and toward definitive treatment initiation. Additionally, the challenge of securing timely follow-up post discharge has historically varied considerably across VHA. This quality improvement study was designed to map these national variations and identify the specific resources needed to enhance facility engagement in MOUD care and to empower acute care clinicians to provide comprehensive MOUD services.

Educational Learning Objectives

**Learning Objective 1** Identify the primary institutional and clinical barriers to initiating MOUD, e.g., buprenorphine and methadone, within VHA acute care settings.

**Learning Objective 2** Evaluate the discrepancy between clinical practice (initiation rates) and institutional infrastructure (presence of SOPs and protocols).

**Learning Objective 3** Discuss the essential components of a national MOUD toolkit designed to standardize care and improve follow-up coordination for Veterans.

**Methods** From November, 2024 to January, 2025, leaders and clinicians in VHA acute care settings, including inpatient medicine, ED and urgent care were emailed invitations to participate in a needs assessment survey of MOUD initiations in their setting. The 19-item survey evaluated MOUD initiation practices, the availability of SOPs, automated dispensing cabinet stocking, and referral pathways. Descriptive statistics were used to analyze the frequency of MOUD initiation, the prevalence of institutional barriers, and the availability of clinical facilitators.

**Results** Surveys were received from providers (n=270) in 152 unique VHA acute care settings including inpatient (n=71, 47%), ED (n=53, 35%), urgent care (n=4, 3%) and other (e.g., mental health) (n=24, 16%). Most reported the ability to initiate buprenorphine (inpatient=70%, ED=72%, other=63%, urgent care=0%). As expected, ability to initiate methadone was less common (inpatient=44%, ED=23%, other=8%, urgent care=0%). The most common barriers to MOUD initiation included lack of clinical guidance (46%) (e.g., protocols, SOPs), inadequate training in OUD diagnosis and management (32%), and limited access to follow-up care (32%). Facilitators included an existing system for referral and rapid follow-up (36%), ease of availability of medications (34%), and the presence of a local champion (30%). Notably, 40% of respondents remained unsure if their facility possessed an SOP.

**Conclusion** Acute care settings represent an opportunity to improve access to MOUD. Most VHA providers reported initiating buprenorphine, which marks significant recent national strides.

Expectedly, initiating methadone was less common. Unclear access to educational resources, the lack of available SOPs and protocols, and difficulty obtaining timely follow-up were cited as barriers in the initiation of MOUD in acute care settings. The development and national dissemination of a standardized toolkit—incorporating clinical SOPs, training resources, and referral checklists—may be a means to institutionalize MOUD as a standard of care in every VHA facility, including acute care settings.

**Scientific Significance** This study provides a large-scale evaluation of the institutional readiness of VHA to deliver MOUD in acute care settings. By identifying the primary hurdle as a lack of standardized protocols, rather than simply provider resistance, this work emphasizes the need to target structural interventions. These findings may serve as a blueprint for large-scale health systems to implement quality improvement initiatives that leverage acute care encounters as critical entry points for evidence-based addiction treatment and ultimately reduce post-discharge morbidity and mortality.