

## Research paper

# Using nominal group technique among clinical providers to identify barriers and prioritize solutions to scaling up opioid agonist therapies in Ukraine



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## ABSTRACT

**Background:** Opioid agonist therapies (OAT) like methadone and buprenorphine maintenance treatment remain markedly under-scaled in Ukraine despite adequate funding. Clinicians and administrators were assembled as part of an implementation science strategy to scale-up OAT using the Network for Improvement of Addiction Treatment (NIATx) approach.

**Methods:** Nominal Group Technique (NGT), a key ingredient of the NIATx toolkit, was directed by three trained coaches within a learning collaborative of 18 OAT clinicians and administrators to identify barriers to increase OAT capacity at the regional “oblast” level, develop solutions, and prioritize local change projects. NGT findings were supplemented from detailed notes collected during the NGT discussion.

**Results:** The top three identified barriers included: (1) Strict regulations and inflexible policies dictating distribution and dispensing of OAT; (2) No systematic approach to assessing OAT needs on regional or local level; and (3) Limited funding and financing mechanisms combined with a lack of local/regional control over funding for OAT treatment services.

**Conclusions:** NGT provides a rapid strategy for individuals at multiple levels to work collaboratively to identify and address structural barriers to OAT scale-up. This technique creates a transparent process to address and prioritize complex issues. Targeting these priorities allowed leaders at the regional and national level to advocate collectively for approaches to minimize obstacles and create policies to improve OAT services.

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## Background

Ukraine has the highest HIV prevalence in Europe, primarily concentrated in people who inject drugs (PWID) (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2016). Expanding opioid agonist therapies (OAT) with methadone or buprenorphine

is the most cost-effective, evidence-based strategy for reducing HIV transmission in Ukraine (Alistar, Owens, & Brandeau, 2011). Buprenorphine was introduced in Ukraine in 2004 (Bruce, Dvoryak, Sylla, & Altice, 2007), followed by methadone in 2008 (Lawrinson et al., 2008). Both OAT medications are currently available free of charge through international and domestic funding sources.

Funding was allocated to scale-up OAT for 30,000 PWID by 2015, yet for the past 7 years, OAT coverage has not exceeded 2.7% of the estimated 310,000 PWID in Ukraine who need it. As part of a larger implementation science project to come up with regional

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and national strategies to expand OAT in Ukraine, Rapid Change Cycles were introduced within the Network for the Improvement of Addiction Treatment (NIATx) Model (Campbell et al., 2009; Capoccia et al., 2007; Fitzgerald & McCarty, 2009; Hoffman, Ford, Choi, Gustafson, & McCarty, 2008; McCarty & Chandler, 2009; McCarty, Gustafson, Capoccia, & Cotter, 2009; McCarty et al., 2007) to improve addiction treatment services. NIATx was chosen because it is an evidence-based strategy for implementing process changes that facilitate access to and retention in addiction treatment. NIATx is based on the assumption that organizational change occurs when process barriers are systematically identified and altered to attain a desired (e.g., OAT scale-up through increased access and entry, reduced retention and increased treatment capacity) outcome (Brown & Melchior, 2008; Capoccia et al., 2007; Fitzgerald, 2006; Hoffman et al., 2008; Johnson, Isham, Shah, & Gustafson, 2011; McCarty et al., 2009; Quanbeck, 2009; Roosa, Scripa, Zastowny, & Ford, 2011). Using this model, organizations select a series of change projects using a Plan, Do, Study, Act (PDSA) model (Fig. 1) to advance toward the target (e.g., increased capacity) that they collectively prioritize (Deming, 1982; Quanbeck, 2009). NIATx is grounded in a collaborative learning process developed by the Institute for Healthcare Improvement (IHI) to help healthcare organizations achieve “breakthrough” improvements in quality (Institute for Healthcare Improvement, 2003). The driving vision behind the IHI Breakthrough Series is that gaps between what we know and what we do can be reduced rapidly by interested and motivated organizations participating in short-term, focused learning collaboratives.

One of the most immediate HIV prevention goals for Ukraine is to increase entry into and retention in OAT. In October 2014, representatives from 25 regions in Ukraine were invited to form a learning collaborative and began working with NIATx trained coaches to learn strategies to improve processes and make regional organizational changes to promote improved OAT service delivery. Such outcomes coincide with and support the overall project goal of expanding OAT access within Ukraine. Prior to this meeting, three Ukrainian OAT experts were trained as NIATx coaches by two experienced US coaches who remain involved with the learning collaborative. The three Ukrainian coaches who worked with regional sites were national OAT leaders. One coach was the national OAT Coordinator for the Ukrainian CDC, while the other two were from the Alliance for Public Health with roles as OAT coordinator and as director of OAT treatment and procurement.

Previously, we used qualitative and survey methods among 199 PWID to identify patient-, structural- and program-level barriers to entering and remaining on OAT (Bojko et al., 2015, 2016; Mazhnaya et al., 2016), but clinicians and administrators had not been surveyed. In these qualitative interviews, patients identified numerous barriers, but these barriers were not prioritized and did not include clinicians and advocates. Because such stakeholders are crucial for scaling-up OAT services, nominal group technique

(NGT) methods (Delbecq, Van de Ven, & Gustafson, 1975) were deployed as a key ingredient of the NIATx Toolkit to identify barriers to OAT scale-up and to suggest and prioritize solutions to overcome OAT scale-up barriers.

## Methods

The current implementation science strategy used in this study is central to the Promoting Action on Research Implementation (PARIHS) framework (Stetler, Damschroder, Helfrich, & Hagedorn, 2011), which focuses on an understanding of the available *evidence* (i.e., opioid agonist therapies are the most effective treatment for opioid use disorders and very effective HIV prevention strategies), *context* (i.e., the key ingredient addressed during this NGT activity) and *facilitation* (i.e., the process through which coaching is provided, specifically the NIATx treatment improvement process). The Rapid Change Cycle of the NIATx Model was introduced to national, regional and local OAT leaders, stakeholders and clinic staff in Ukraine in October 2014. Clinicians and administrators (N=38) who were motivated to scale up OAT from 21 regions of Ukraine agreed to establish regional change teams and traveled to Kyiv to participate in NIATx activities. Participants in the first collaborative meeting (October 2014) included 10 Chief Narcologists (a specialist in addiction treatment), 17 Narcologists, 2 Nurses, 1 Psychologist, 4 Directors of NGOs and 4 Social Workers from OAT programs. These members were selected by the Chief Narcologist in each region based on the individual's ability to improve treatment regionally. In April 2015, the NIATx learning collaborative met again to report results of their initial rapid cycle change projects and to continue their collaborative discussions and learning.

As part of the second NIATx meeting in April 2015, 18 participants representing clinical providers and administrators from different regions providing OAT throughout Ukraine were asked to use NGT to explore the following question: “What gets in the way of increasing the number of slots for OAT services at the regional “oblast” level?” The question was selected by the implementation project's administrative team in response to the urgent need to scale-up OAT in Ukraine as part of strategy to better understand the perceived barriers to scale up and to prompt a guided group discussion regarding scale up. The 18 participants in the NGT discussed in this paper all attended the first meeting in October 2014 as well as the second meeting in April 2015 and included a chief narcologist, 2 chief regional doctors, 7 local narcologists, 2 OAT nurses, 3 NGO representatives, 2 social workers and a psychologist. They were divided into three Teams (A,B,C) based on their national NIATx coach assignment. The overall NGT process was facilitated by the US coaches and participants in the three teams were led by the Ukraine coaches (co-authors S.F., I.I. and V. K). A note-taker was assigned to each group to collect additional commentary during the NGT process. These notes were reviewed after the NGT process and included in the discussion, where relevant.

NGT was selected because it is a method that can be implemented within a relatively short time period and is easily understood by participants. Responses are weighted by participants, and the process is transparent, inclusive and can be easily replicated (Delbecq et al., 1975). NGT was developed in the United States in the late 1960s as a method for structuring group priority setting processes to elicit ideas regarding a particular issue, then facilitating group consensus of priorities by pooling individual ratings of those ideas. The NGT used in the current study employed the following four steps: (1) silent generation of ideas in writing; (2) round-robin feedback from group members to record each idea in a terse phase on a flip chart; (3) discussion of each recorded idea for clarification and evaluation; and (4) individual voting on

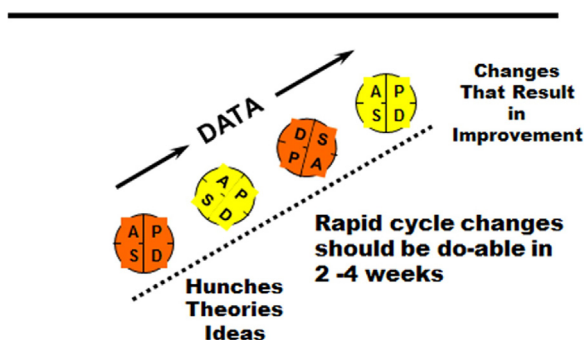


Fig. 1. Plan, Do, Study, Act (PDSA) rapid cycle model.

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