Medication Management Model

Team Experimental Design

Experiment	Our Question	Our Hypothesis	Our Findings	Our Decisions
Base Case	How do we improve the quality of MM in our teams, so that more of our patients are getting an evidence-based course of EBPharm? And, what is the impact in our team on MM care, if we make no new decisions care over the two years?	If we made no new decisions in our team, then over the next two years things would stay the same and we would not be offering EBPharm for AUD or OUD in our team, we would be starting less patients in EBPharm for OUD than we would like.	We found that a lot was going on in our team that we didn't expect, things don't stay the same. In fact, if do nothing new then we will serve about 20 less Veterans OUD EBPharm than we today over the next two years. Two more Veterans waiting to start at the end of two years.	We need to do something or we will continue to over worse quality care than we'd like over time. Next time we will adjust our RVI to meet the VA quality measures.

Experiment 1	How do we improve the quality of MM in our teams, so that more of our patients are getting an evidence-based course of EBPharm? And, what is the impact in our team on MM care, if adjust our RVI to meet the VA quality measures.	If we adjust our RVI for AUD from 11 to 4 weeks, and RVI for OUD from 11 to 4 weeks, and Depression RVI from 12 to 15 weeks, and leave the other needs the same, then we expect that we will see more pressure in form patients to start, lower start rate for OUD & AUD, but for Depression we are extending the RVI out by momre weeks.	We were right for OUD the number of patients waiting to start increased from 0 to 40 and it increased for AUD, but not by as much. But, for depression patients we went to zero patients waiting to start. We would also see more depression patients.	Next we will test whether we can increase the proportion of patients would can get MM for AUD and OUD by adjusting how we divide up our local appointment supply.

Experiment 2	How does adjusting our appointment supply influence the proportion of patients would can get MM for AUD and OUD?	If we adjust our appointment supply not by adding supply, but by reallocating our Dep appointment supply w/X waiver to OUD slots, and reallocate our Dep appointment supply w/out X waiver to AUD slots, and we increase our referral rates for AUD or OUD to 6 ppw, then we hope we will serve AUD and OUD (more patients in MM, less patients waiting MM), turn off team data for starting rate.	The number of depression patients waiting to start MM would increase for 1 year and then go back to BC by 2 years. The number of Dep in MM would drop from 200 to 100 by end of one year. By the end of 2 years we would serve 5 x's more Veterans MM for OUD. More OUD patients starting less patients waiting to start.	We will look to see what happened to AUD patients. Think through combining experiment 1 and 2 to see if we can balance these tradeoffs.
Experiment 3	How does combining experiment 1 and 2 balance tradeoffs so there aren't such severe downsides for any patient cohort?	If we adjust our appointment supply not by adding supply, but by reallocating our Dep appointment supply w/X waiver to OUD slots, and reallocate	We would see a 20x's increase in MM for OUD in our team over two years, we would have no OUD patients	Review these finds in detail and think through clinical decisions we might be willing to make in our team. So we went back to our BC

	our Dep appointment supply w/out X waiver to AUD slots, and we increase our referral rates for AUD or OUD to 6 ppw AND we adjust the RVI to meet quality measures (4 wks OUD and AUD, and 15 weeks between visit depression), then we hope we will serve AUD and OUD (more patients in MM, less patients waiting MM), without compromising care for depression patients as several, turn off team data for starting rate.	waiting to start. Starting around 1 year after these changes we would see 4 ppw DEP starting, and 2 ppw AUD starting. CHECK OUT MORE FINDINGS	referral rate, rather than 6 ppw for AUD and OUD, so a realistic RR 4 Dep ppw, 2 AUD ppw 1 OUD patient every 2 weeks.

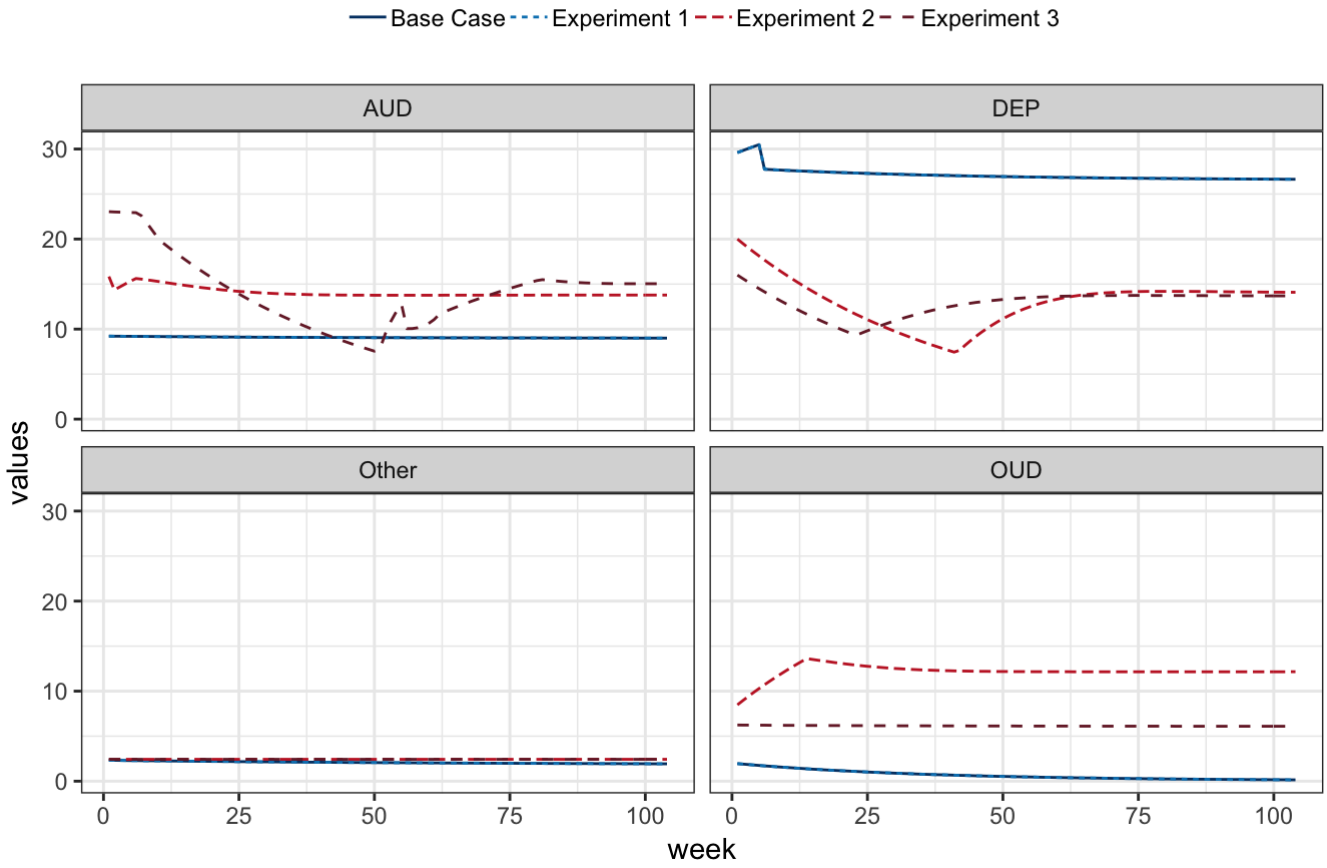
Changes to Model Parameters Relative to Base Case

Experiment	Variable	values
Experiment 1	AUD - Referral Rate	1.97
Experiment 1	DEP - Referral Rate	6.06
Experiment 1	OUD - Referral Rate	0.61
Experiment 1	Other - Referral Rate	0.37

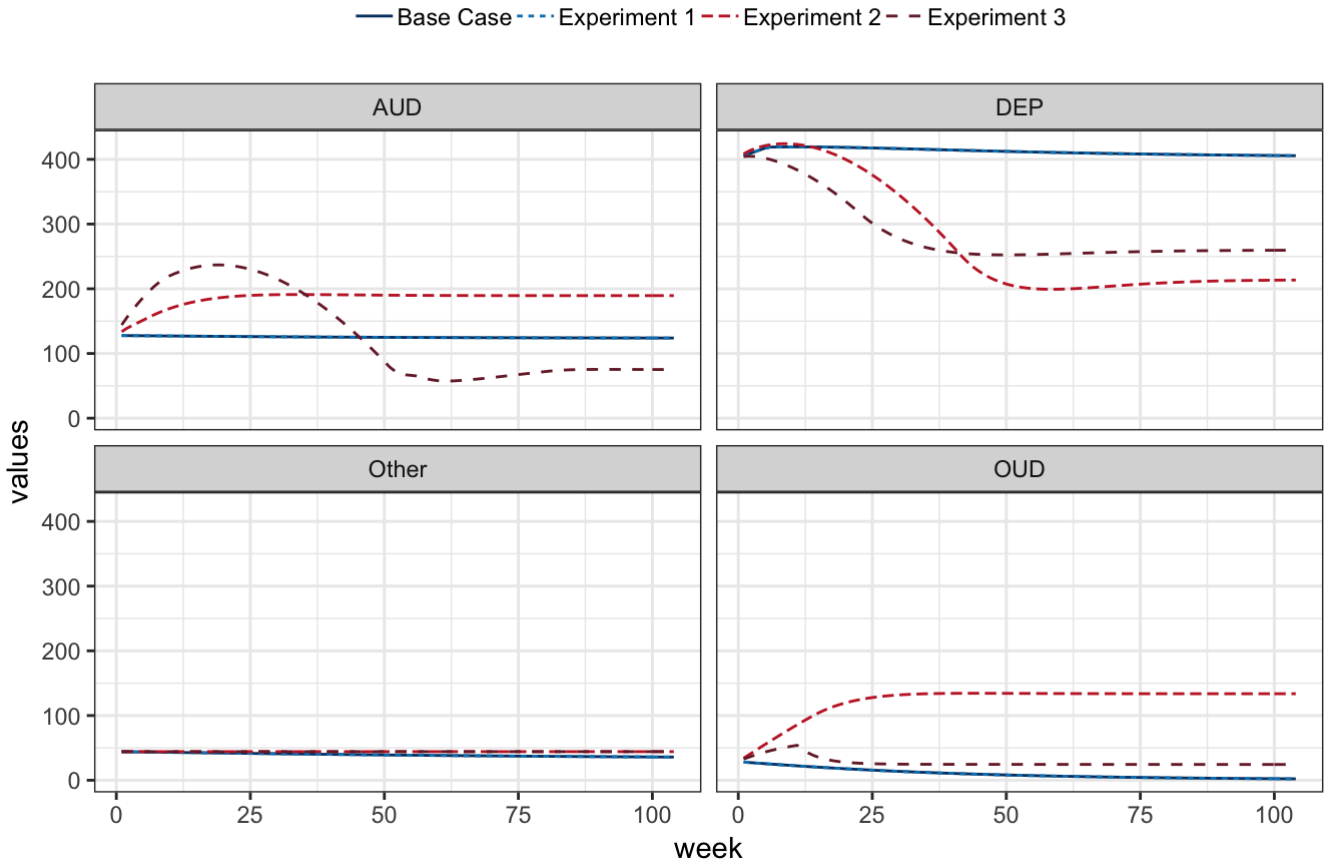
Experiment 1	AUD - Target Wait Time	4.00
Experiment 1	DEP - Target Wait Time	4.00
Experiment 1	OUD - Target Wait Time	15.00
Experiment 2	AUD - Referral Rate	6.00
Experiment 2	DEP - Referral Rate	2.28
Experiment 2	OUD - Referral Rate	6.00
Experiment 2	Other - Referral Rate	0.40
Experiment 2	Other - Starting Rate	0.40
Experiment 2	Other - Waiting to Start	0.60
Experiment 2	AUD - Referral Rate	6.00
Experiment 2	AUD - Slots Allocation (No X Waiver)	0.50
Experiment 2	DEP - Slots Allocation (No X Waiver)	0.39
Experiment 2	DEP - Slots Allocation (with X Waiver)	0.31
Experiment 2	OUD - Referral Rate	6.00
Experiment 2	OUD - Slots Allocation (with X Waiver)	0.50
Experiment 2	Use Team Data for Starting Rate	0.00
Experiment 3	AUD - Referral Rate	1.97
Experiment 3	DEP - Referral Rate	2.28
Experiment 3	OUD - Referral Rate	0.61
Experiment 3	Other - Referral Rate	0.40
Experiment 3	Other - Starting Rate	0.40
Experiment 3	Other - Waiting to Start	0.60
Experiment 3	AUD - Return Visit Interval	4.00
Experiment 3	AUD - Slots Allocation (No X Waiver)	0.50
Experiment 3	DEP - Return Visit Interval	15.00
Experiment 3	DEP - Slots Allocation (No X Waiver)	0.39
Experiment 3	DEP - Slots Allocation (with X Waiver)	0.31
Experiment 3	OUD - Return Visit Interval	4.00
Experiment 3	OUD - Slots Allocation (with X Waiver)	0.50
Experiment 3	Use Team Data for Starting Rate	0.00

Team Graphs

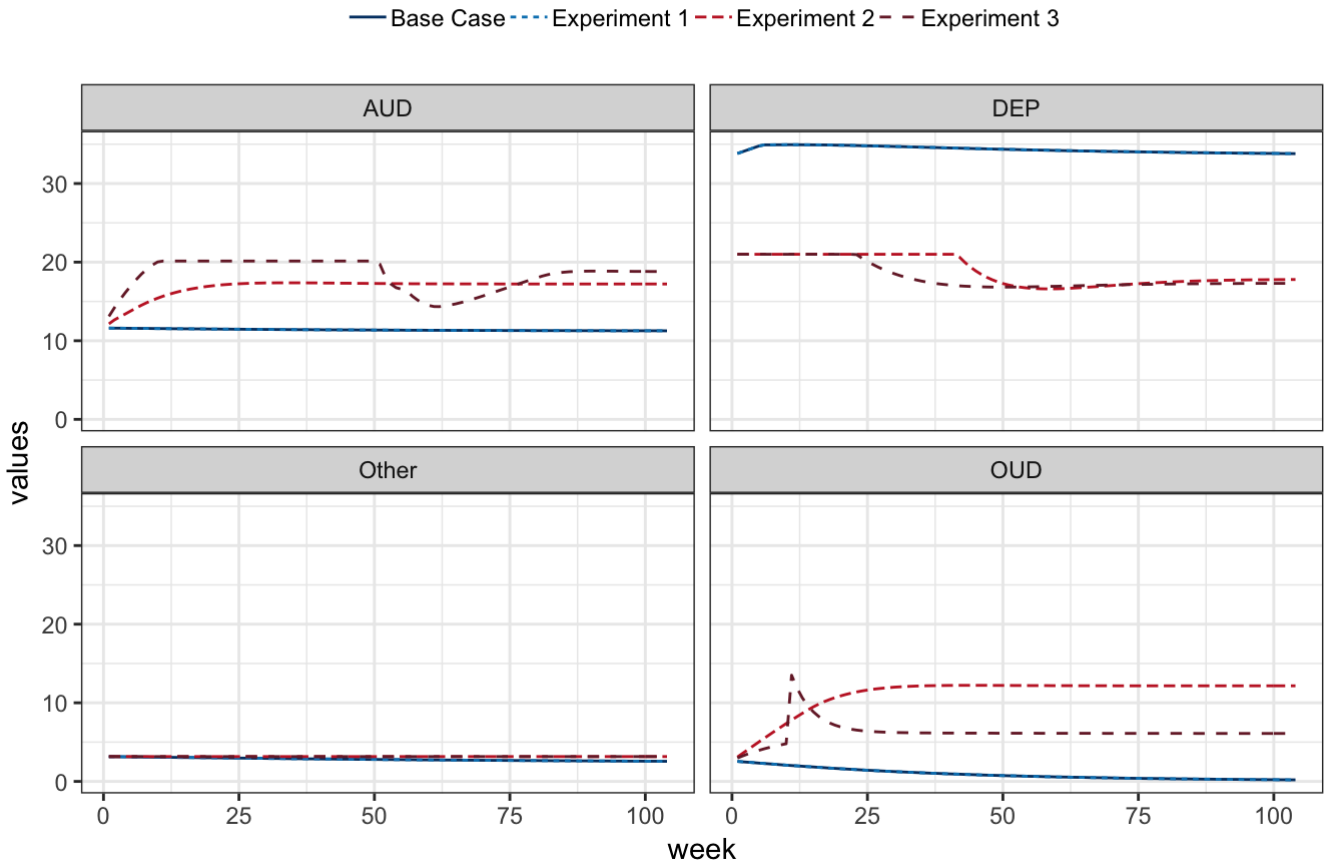
Compare Patient Cohort: Booking Rate



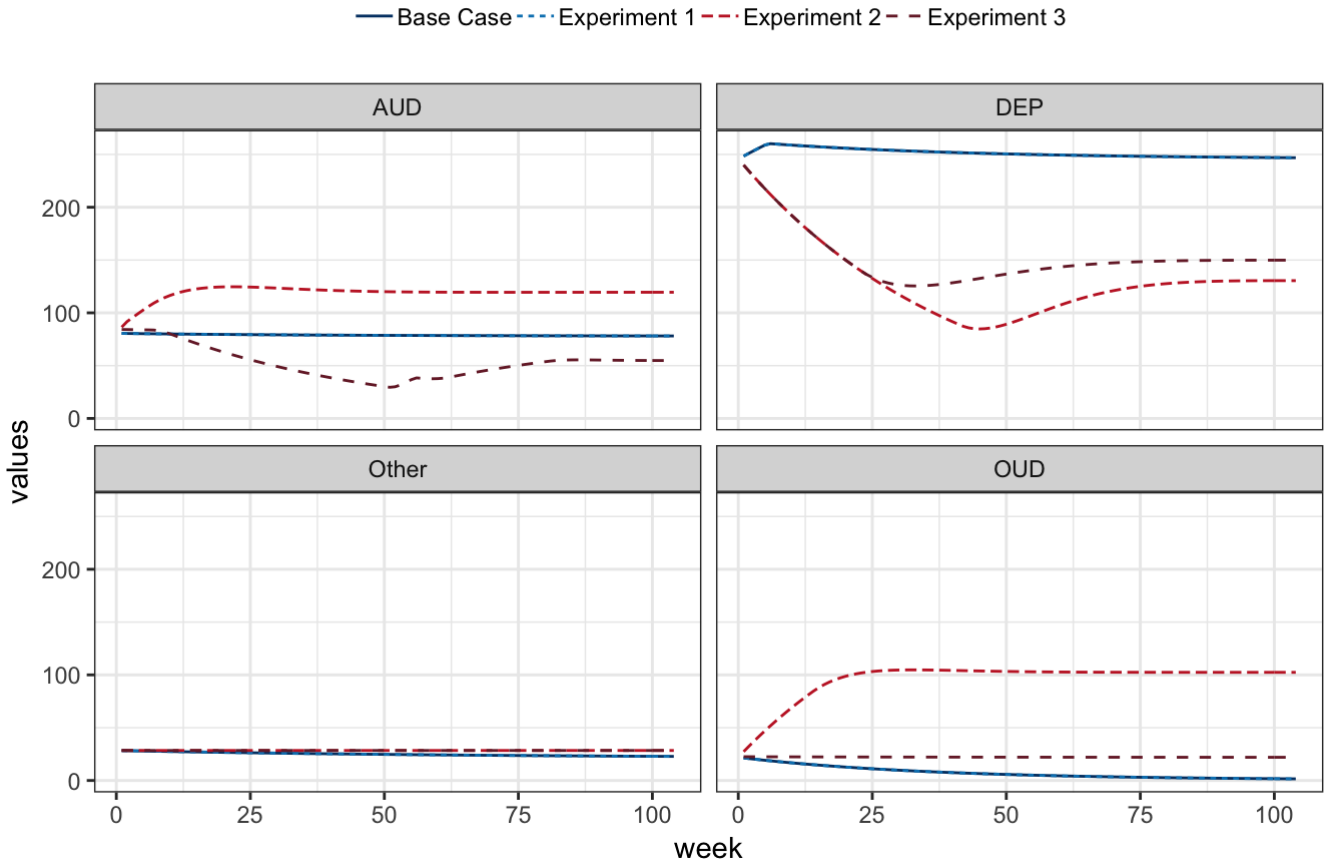
Compare Patient Cohort: Appointments in MM



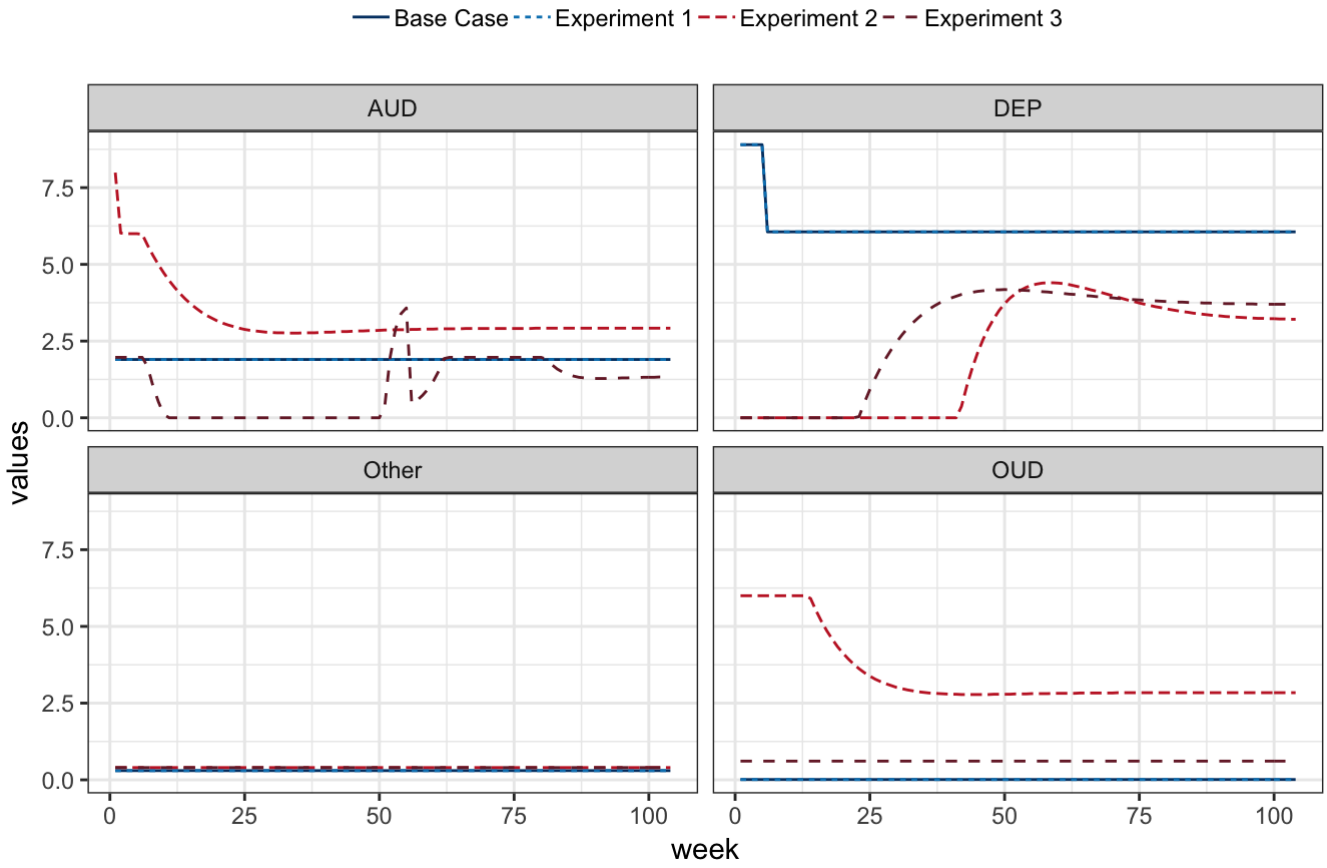
Compare Patient Cohort: Completing Rate



Compare Patient Cohort: Patients in MM



Compare Patient Cohort: Starting Rate



Compare Patient Cohort: Waiting to Start