Opioid Epidemic Within a Pandemic: The Veterans Health Administration’s Multifaceted Response and the Critical Role of Psychologists

Elizabeth Oliva, PhD
VA National Opioid Overdose Education and Naloxone Distribution (OEND) Coordinator, VA Office of Mental Health and Suicide Prevention (OMSHP) Investigator, VA Center for Innovation to Implementation

APA Division 18 Webinar
9.27.21
Disclaimer

- Most links to resources are internal VA links
- When possible, external links will be used
Addressing the Opioid Epidemic in the United States
Lessons From the Department of Veterans Affairs

- Education
  - Opioid Overdose Education and Naloxone Distribution (OEND)
- Pain Management
  - Stepped pain treatment
  - Interdisciplinary teamwork
  - Joint VA/DoD Pain Education Program
  - Complementary and Integrative Health
- Risk Mitigation
  - Opioid Safety Initiative (OSI)
  - Opioid Therapy Risk Report (OTRR)/Stratification Tool for Opioid Risk Mitigation (STORM)
  - Medication Take-Back
- Addiction Treatment
  - Buprenorphine in the VA Initiative
  - Psychotropic Drug Safety Initiative (PDSI)
  - Outpatient, Inpatient, and Residential Treatment for Substance Use Disorders

JAMA Intern Med. 2017 May 1;177(5):611-612
Bottom Line Up Front (BLUF)

• Alarming increases in drug overdoses—Overdose Prevention needed NOW more than ever!
• What can psychologists do?
  • **Education:** Opioid Overdose Education and Naloxone Distribution (OEND) (internal/external)
  • **Pain Management:**
    • Stepped Care Model for Pain Management
    • Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)
    • Stratification Tool for Opioid Risk Mitigation (STORM) Data-Based Risk Reviews
    • Tapering and discontinuation (opioids, benzos)—high risk periods! Keep patients on your radar!
  • **Risk Mitigation:**
    • Improve post-overdose care
      • VHA→report overdoses using Suicide Behavior and Overdose Report (SBOR), be part of Overdose Review Team
      • Support Syringe Service Programs (external) and Fentanyl Test Strips as appropriate
  • **Addiction Treatment:**
    • Identify Opioid Use Disorder (OUD) and support initiation of Medication for OUD (SCOUTT; external)
    • Identify and connect patients with Substance Use Disorder (SUD) Treatment (esp alcohol and stimulants)
An Epidemic in the Midst of a Pandemic: Opioid Use Disorder and COVID-19

G. Caleb Alexander, MD, MS; Kenneth B. Stoller, MD; Rebecca L. Haffajee, JD, PhD, MPH; and Brendan Saloner, PhD

The COVID-19 pandemic strikes at a moment when our national response to the opioid crisis was beginning to coalesce, with more persons gaining access to treatment and more patients receiving effective medications (10). COVID-19 threatens to dramatically overshadow and reverse this progress. Some disruptions in the care of patients with opioid use disorder are inevitable during the weeks and months to come. However, extraordinary planning and support can limit excessive disruption and its dire consequences. These efforts will require new partnerships, unprecedented use of technology, and the dismantling of antiquated regulations. The greatest strength of the treatment system has always been compassion and care for the most vulnerable—qualities needed now more than ever.
National Center for Health Statistics: Provisional Drug Overdose Death Counts

Drug Overdose Deaths

February 2020: 74,234
February 2021: 96,801

22,567 MORE DEATHS

30.4% increase

12 Month-ending Provisional Number of Drug Overdose Deaths

30.4% increase
Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic: Distributed via the CDC Health Alert Network

December 17, 2020, HAN Archive - 00438 | Health Alert Network (HAN) (cdc.gov)
More than 93,000 people died of a drug overdose in the U.S. last year — a record number that reflects a rise of nearly 30% from 2019, according to new data released by the Centers for Disease Control and Prevention. Officials said the increase was driven by the lethal prevalence of fentanyl as well as pandemic-related stressors and problems in accessing care.
The combined number of deaths among Americans from suicide and unintentional overdose increased from 41,364 in 2000 to 110,749 in 2017 and has exceeded the number of deaths from diabetes since 2010.

1) “Deaths of Despair” – opioid use as a way of coping with lack of opportunity, the demand side hypothesis

2) Supply side hypothesis – greater availability and rapid decline in illicit drug pricing

→ Both pathways are relevant and must be addressed
<table>
<thead>
<tr>
<th>Goal and Intervention</th>
<th>Population, Defined According to Level of Opioid Exposure and Misuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low-Risk Regimen of Prescription Opioids</td>
</tr>
<tr>
<td><strong>Identifying who is at risk for suicide and overdose</strong></td>
<td></td>
</tr>
<tr>
<td>Determination of risk score on basis of medical record</td>
<td>+</td>
</tr>
<tr>
<td>Assumption that high level of opioid exposure and misuse puts the patient at risk</td>
<td>+</td>
</tr>
<tr>
<td><strong>Preventing suicide or overdose among those identified as being at risk</strong></td>
<td></td>
</tr>
<tr>
<td>Treatment for mental health conditions, when present</td>
<td>+</td>
</tr>
<tr>
<td>Cognitive behavioral therapy for suicide risk and motivational interviewing for overdose risk*</td>
<td>+</td>
</tr>
<tr>
<td>Patient-centered taper of opioid dosage†</td>
<td></td>
</tr>
<tr>
<td>Overdose education and naloxone distribution*</td>
<td>+</td>
</tr>
<tr>
<td>Medication-assisted treatment‡</td>
<td></td>
</tr>
</tbody>
</table>

* Although these interventions would ideally be available to all persons identified as having any risk of suicide or unintentional overdose, resource constraints are likely to preclude this approach. Given that these approaches can address risks specifically related to opioid use, they should be prioritized for those with riskier levels of use.

† Patient-centered tapering is based on an evaluation of the risks and benefits for a specific patient, at a reasonably slow pace of dosage reduction and with the patient’s engagement in the treatment decision making.

‡ Treatments include methadone, buprenorphine–naloxone, and naltrexone.
- 1 in 2—Any touchpoint
- 1 in 5—Opioid Rx/Opioid detoxification
- 1 in 6—Nonfatal Overdose
- 1 in 10—Release from incarceration
- 1 in 16—Injection-related infection
Bottom Line Up Front (BLUF)

- Alarming increases in drug overdoses—Overdose Prevention needed NOW more than ever!
- What can psychologists do?
  - **Education:** Opioid Overdose Education and Naloxone Distribution (OEND) (internal/external)
  - **Pain Management:**
    - Stepped Care Model for Pain Management
    - Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)
    - Stratification Tool for Opioid Risk Mitigation (STORM) Data-Based Risk Reviews
    - Tapering and discontinuation (opioids, benzos)—high risk periods! Keep patients on your radar!
  - **Risk Mitigation:**
    - Improve post-overdose care
      - VHA→report overdoses using Suicide Behavior and Overdose Report (SBOR), be part of Overdose Review Team
    - Support Syringe Service Programs (external) and Fentanyl Test Strips as appropriate
  - **Addiction Treatment:**
    - Identify Opioid Use Disorder (OUD) and support initiation of Medication for OUD (SCOUTT; external)
    - Identify and connect patients with Substance Use Disorder (SUD) Treatment (esp alcohol and stimulants)
What is OEND?

- Risk mitigation initiative that aims to prevent opioid-related overdose deaths
  - One of many risk mitigation strategies employed by VA to minimize risk of opioid-related adverse events
- Target patient populations
  - Patients with opioid use disorder
  - Patients prescribed opioids
  - NOTE: Data also suggest targeting patients who recently discontinued opioids and patients with substance use disorder (esp stimulant use disorder given rise in fentanyl adulteration)

- Opioid Overdose Education (OE)
  - Provide patient education on how to prevent, recognize, and respond to an opioid overdose

- Naloxone Distribution (ND)
  - Provide patient with naloxone
    - Train patient and potential bystanders on how to use naloxone
• Naloxone is a highly effective treatment for reversing opioid overdose, if administered at time of overdose
• It can take minutes to hours to die from an opioid overdose
• Naloxone acts quickly, usually within minutes
• Naloxone’s effects start to wear off after ~30 minutes and are gone by ~90 minutes
• Excellent safety profile; inert unless opioids are present
VA OEND

- National program launched in 2014
- OEND provides opportunity to discuss risk of opioids
  - A few minutes of training could save a life!
- No cost to at-risk patients (eliminated copays for naloxone and training)
  - Please help us get OEND to at-risk Veterans!!!

VHA Rapid Naloxone Initiative (3 elements):
1. OEND to VHA patients at-risk for opioid overdose
   - Over 314,100 Veterans dispensed naloxone (over 2,200 opioid overdose reversals)
2. VA Police Naloxone
   - 3,552 VA police officers with naloxone (136 opioid overdose reversals)
3. Select Automated External Defibrillator (AED) Cabinet Naloxone
   - 1,095 AED Cabinets with naloxone (10 opioid overdose reversals)

2020 John M. Eisenberg National Level Innovation in Patient Safety and Quality Award
<table>
<thead>
<tr>
<th>Barrier Level</th>
<th>Barrier</th>
<th>Mechanism of Change</th>
<th>Implementation Strategy/Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran</td>
<td>Risk awareness</td>
<td>Perceived vulnerability</td>
<td>Risk communication, use mass media</td>
</tr>
<tr>
<td></td>
<td>Ability to use naloxone in overdose</td>
<td>Caregiver knowledge, self-efficacy, skills</td>
<td>Develop and distribute educational materials, obtain family feedback, activate Veterans and family</td>
</tr>
<tr>
<td></td>
<td>Cost</td>
<td></td>
<td>Alter office fees, make billing easier (naloxone provided free of charge)</td>
</tr>
<tr>
<td>Clinician/clinical team</td>
<td>Ability to identify high-risk Veterans</td>
<td>Knowledge, clinical decision-making</td>
<td>Develop clinical analytics to identify at-risk Veterans</td>
</tr>
<tr>
<td></td>
<td>Lack of expertise in naloxone prescribing</td>
<td>Knowledge, skills, goals, self-efficacy, subjective norms</td>
<td>Offer educational trainings, train-the-trainer</td>
</tr>
<tr>
<td></td>
<td>Prescribing naloxone</td>
<td>Behavioral cueing, environment resources</td>
<td>Change electronic medical record templates</td>
</tr>
<tr>
<td></td>
<td>Awareness of progress</td>
<td>Feedback processes, subjective norms</td>
<td>Audit and feedback, relay data to clinicians</td>
</tr>
<tr>
<td>Hospital/practice</td>
<td>Competing priorities</td>
<td>Professional role change, reinforcement</td>
<td>Mandate change, policy directive(s) for all facilities, identify and prepare champions</td>
</tr>
<tr>
<td></td>
<td>implementation variability</td>
<td>Knowledge, subjective norms</td>
<td>Values, standardize tools, guidance, resources implementation plans</td>
</tr>
<tr>
<td></td>
<td>Cost to facilities</td>
<td>Reinforcement</td>
<td>Policy change, change cost to hospital (no cost)</td>
</tr>
<tr>
<td>Health system</td>
<td>Low availability of naloxone</td>
<td>Environmental context, social roles</td>
<td>Use advisory boards and national workgroups</td>
</tr>
<tr>
<td></td>
<td>Unstandardized naloxone kit</td>
<td>Environment resource</td>
<td>Place naloxone kits on national formulary</td>
</tr>
<tr>
<td></td>
<td>Lack of best practice</td>
<td>Knowledge, skills, decision processes, social learning</td>
<td>Create learning collaborative, centralized technical assistance and facilitation</td>
</tr>
<tr>
<td></td>
<td>Coordination across service disciplines</td>
<td>Professional role, norms, motivation</td>
<td>Change availability of services and mix of clinicians offering treatment</td>
</tr>
<tr>
<td></td>
<td>Union support</td>
<td>Professional role, social influences, norms</td>
<td>Obtain formal commitments</td>
</tr>
</tbody>
</table>

The Department of Veterans Affairs Rapid Naloxone Initiative: National Diffusion of a Promising Practice
The initiative included these elements:

1. Opioid overdose education and naloxone distribution (OEND) to VHA patients at-risk for opioid overdose. The team used education to highlight the true risks of opioids to both prescribers and patients so both understood the risks to taking opioids (even if they were prescribed) and for providers to consider prescribing an antidote, naloxone, just in case a patient accidentally overdosed. Overdose prevention education for patients also explained how mixing opioids with alcohol or benzodiazepines could possibly lead to an accidental overdose.
2. Equipping Veterans Administration police with naloxone and stocking automated external defibrillator (AED) cabinets with naloxone. By doing so, the VA showed its commitment to ensuring that no one would die of an opioid overdose on their watch. Naloxone has FDA-approved layperson routes of administration and VHA made it rapidly available while also training responders how to use it.
“Perhaps the greatest learning is how much impact our system can have when everyone works together toward a common goal of preventing overdose among veterans. I have been humbled by the tremendous support from program offices across the Veterans Health Administration and the many community partners who have helped us along the way. We are standing on the shoulders of giants and are grateful for the remarkable work they continue to do every day to increase access to naloxone in the community. We are all in this together and need everyone working together to ensure rapid availability of naloxone to prevent opioid overdose deaths. Moreover, we have been underscoring the need to couple lifesaving naloxone (intervention) with lifesaving and life-transforming medications for opioid use disorder (treatment).”

Elizabeth M. Oliva, PhD, Veterans Health Administration 2020 Eisenberg Award winner for Innovation in Patient Safety at the National Level
Critical Junctures for OEND

• Provider Education
  - Ensure all staff are trained in OEND and that naloxone is available to staff as appropriate
  - The OE part of OEND is in the scope of many providers (i.e., patient education on how to *prevent, recognize and respond* to an opioid overdose)
    - **A few minutes of training that could save a life!**

• Patient Identification
  - Patients with opioid use disorder
  - Patients with substance use disorder given increase in opioids/fentanyl found in other drugs
  - Patients prescribed opioids (including patients recently discontinued)
  - Within VA, can also use dashboards (e.g., OEND Risk Report, VA Stratification Tool for Opioid Risk Mitigation)

• Patient Education (at the very least the OE part of OEND)
  - Provide at INTAKE/SCREENING
  - Provide at treatment start (opportunity to review/re-educate)
  - In residential treatment, provide BROAD TRAINING to residential milieu—NOT just at-risk patients—and in friends and family classes (if available)
    - Will ensure other residents, friends, and family members know how to RECOGNIZE and RESPOND to an overdose (call 911 right away; rescue breathing/chest compressions)
VA OEND Technical Assistance (POC: Elizabeth.Oliva@va.gov)

- **VA Academic Detailing Service OEND Campaign**
  - Patient education brochures, “Kit” brochures, DVDs for providers and patients—order through [depot](#)
- **VA National OEND SharePoint**
  - Program Models; OEND Monthly COP Call (transitioned to [Opioid Safety and Risk Mitigation COP Call](#))
- **VA OEND Videos** (external link to all videos)
  - [Intro for People with Opioid Use Disorders](https://youtu.be/-qYXZDzo3cA)
  - [Intro for People Taking Prescribed Opioids](https://youtu.be/NFzhz-PCzPc)
  - [How to Use the VA Naloxone Nasal Spray](https://youtu.be/0w-us7fQE3s)
  - [How to Use the VA Intramuscular Naloxone Kit](https://youtu.be/lg1LEw-PeTE)
- **Accredited Monthly Community of Practice Call**
  - [Opioid Safety and Risk Mitigation](#)
- **Panel Management Tools**
  - [OEND Patient Risk Dashboard; Stratification Tool for Opioid Risk Mitigation; Opioid Therapy Risk Reduction Report](#)
- **Accredited VA TMS training:** TMS trainings 27440 and 27441
- **VA TMS training 37795:** [How to Use Naloxone Nasal Spray (Narcan®)](https://www.train.org)
- **Psychotropic Drug Safety Initiative (PDSI) & VHA Pain Management**
### VA OEND Risk Report

**As of 10/24/2020, new data for patients that comes from any of the Center sites (e.g., Spokane) will no longer be captured in any of the ADS data tools. This will continue to expand as new Center sites go live until our resources are revised. ADS will be posting announcements in the future as our tools go live with Center data.**

<table>
<thead>
<tr>
<th>Location/Prescriber</th>
<th># Naloxone Fills (All Time)</th>
<th>% Nasal Fills (90d)</th>
<th>% Auto-Inj. Fills (90d)</th>
<th>% IM Fills (90d)</th>
<th># Naloxone Patients</th>
<th># Naloxone Prescriptions</th>
<th># Naloxone Uses</th>
<th># Successful Reversals</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>612,905</td>
<td>91.82</td>
<td>0.60</td>
<td>0.60</td>
<td>314,106</td>
<td>35,181</td>
<td>74.17</td>
<td>2099</td>
</tr>
</tbody>
</table>

### Naloxone Rx Released to Patient (1 Year) / Total Patient Cohort

<table>
<thead>
<tr>
<th>Location / Prescriber</th>
<th>Potential Risk Factor</th>
<th>Patient Cohort</th>
<th>Score</th>
<th>National Score</th>
<th># Patients w/ No Fill</th>
</tr>
</thead>
</table>

### Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)

- **RIOSORD Risk Class (View Publication)**
  - All Patients: 63.2% 63.2% 103,142
  - Risk Class ≤ 3: 72.6% 72.6% 1,278
  - Risk Class ≥ 4: 41.1% 41.1% 177,093

### Opioid Pharmacotherapy

- **Opioid + Benzodiazepine**
  - All Patients: 49.3% 49.3% 4,629

- **MEDD ≥ 50 (Last 30 days)**
  - All Patients: 52.6% 52.6% 15,045

- **MEDD ≥ 60 in Past Year w/No Fill in the Past 90 Days**
  - All Patients: 31.9% 31.9% 2,962

### Methadone (Outpatient Rx or Active Non-VA Medication)

- All Patients: 42.7% 42.7% 7,471

### OUD & MOUD Pharmacotherapy

- **OUD Diagnosis (Updated)**
  - All Patients: 54.3% 54.3% 27,031

- **Possible Overdose (3 Years)**
  - All Patients: 37.9% 37.9% 7,260

- **Buprenorphine SL (Outpatient Rx or Active Non-VA Medication)**
  - All Patients: 64.9% 64.9% 0,650

- **Naltrexone (Outpatient Rx/Active Non-VA, or Recent Clinic Order)**
  - OUD Patients: 62.6% 62.6% 359

- **OUD-Related Fee Basis**
  - All Patients: 44.4% 44.4% 5

### Other Potential Risks

- **Potentially Homeless Veterans**
  - All Patients: 47.2% 47.2% 15681

- **HOMES Veterans**
  - All Patients: 45.3% 45.3% 6808
VA OEND Monthly COP Call (FY21: Opioid Safety and Risk Mitigation)

- OEND in Special Populations: SUD Treatment, Veterans Justice Outreach, HUD-VASH (July 2020)
  - Shannon Douglas: Substance Use Dependency Evaluation Program (SUDEP) OEND; Ron Michaelson: Veterans Justice Outreach Approaches to OEND (Slide 22); Kenny Breummer: OEND in HUD-VASH (Slide 29)
- Overdose Awareness; Naloxone distribution (October 2019)
  - Jane Manning: Naloxone Distribution in VISN 20 (Slide 25); William Kuykendall: OEND at VA Southern Nevada (Slide 35); Christina Taylor: Naloxone Distribution to High-Risk Vets (Slide 45)

OPIOID OVERDOSE EDUCATION AND SIMULATION

- Target audience:
  - VA staff—Any staff member can opt into the training (PCPs, PCP-trained nurses, social workers, front desk clerks (AMSAs))
  - Plan to expand to patients was halted by COVID-19
- Set-up and equipment:
  - Typically in a conference room
  - Computer with a 3D computer generated mannequin is used in the simulation
  - Naloxone demo
- Training is ~1 hour, typically 10-18 people split into 2-3 groups
  - Pre-test (total scores average 57-64/80)
  - PowerPoint slide deck (see Addendum slides)
  - Simulation involves 15 minutes per group, each group goes through 2-3 scenarios
    - Track how long it takes them to respond (e.g., call for help; get PPE on; yellow isolation garb; medical gloves; and give first dose of naloxone)
      - Detailed (want more, what was challenging) trainee provides feedback after debrief
  - Post-test (usually scores average 77-95/80)
  - Post-training evaluation conducted via emailed link to attendees
    - Substance Use Dependency Evaluation Program (SUDEP) OEND
Updated Academic Detailing
OEND Resources*

Provider

Prescribe Naloxone and Save a Life!
Clinician’s Guide

IBD: 10-1522 | P97042

Not available for order at this time - coming soon.

*Should soon be available at: https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp
Clinician Guide*
Prescribe Naloxone and Save a Life!

Contents
Overview of OEND ........................................... 1
Understanding opioid overdose ........................................... 2
Lethal means safety ........................................... 3
GROW framework ........................................... 4
Who is at risk for an overdose? ........................................... 5
Using dashboards to find at-risk Veterans ........................................... 5
Providing overdose education and naloxone to Veterans, their friends, and family members can save a life ........................................... 6
Naloxone products ........................................... 7
Considerations for specific opioids when providing naloxone and education ........................................... 8
After an overdose, it is essential to provide follow up and support to prevent a future overdose ........................................... 9
References ........................................... 11

*Should soon be available at: https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp

Understanding opioid overdose
Overdoses can be accidental or intentional. Among Veterans, 86% of overdoses were accidental in 2017.\textsuperscript{13}

Figure 1. Veterans are at higher risk for opioid overdose.\textsuperscript{10}

<table>
<thead>
<tr>
<th>Risk for opioid overdose*</th>
<th>27.5</th>
</tr>
</thead>
<tbody>
<tr>
<td>US Veterans enrolled in VHA</td>
<td>20.8</td>
</tr>
<tr>
<td>Non-Veterans</td>
<td>19.9</td>
</tr>
</tbody>
</table>

*Age Adjusted Rate per 100,000 includes intentional and accidental opioid overdoses.

Figure 2. Non-fatal overdose is associated with an increased risk of future overdose.\textsuperscript{15}

Among patients who died of an overdose, 1 in 6 had a non-fatal overdose in the year prior.

Naloxone can be an added safety measure to prevent death when opioids are involved in an overdose.

Figure 3. Opioid overdose survivors not only have a higher risk of overdose but also suicide.\textsuperscript{10}

100x more likely to die by drug overdose in the next year

18x more likely to die by suicide compared to general population

- Diagnosis of opioid use disorder (OUD) is 7 times higher in VHA patients than non-VHA patients.\textsuperscript{17}
- Opioid-related suicide deaths are 13 times higher in people with OUD.\textsuperscript{16,19}
- Opioids are the most common class of substances found in suicide by overdose.\textsuperscript{14}

Providing overdose education and naloxone to Veterans, their friends, and family members can save a life

Start the conversation
Keep the conversation open and create a safe space for the Veteran to talk.

Ask
- “Accidental overdoses are a leading cause preventable death. Do you know what puts you at risk for an overdose?”
- “Do you have naloxone?”
  - if yes, ask where it is, if they have any questions about it, how to use it, and if they have used it before. Encourage the Veteran to keep naloxone on hand and let people know where they keep it.
  - if no, let them know how naloxone can save not just their lives, but also the lives of others.
  - Review how and when to use naloxone.

Reinforce
- Discuss how easy it can be to overdose—loss of tolerance when in treatment, mixing substances, and the importance of having naloxone “just in case.”
- Review the signs and symptoms of an overdose with the Veteran, family members, and acquaintances.
- Review how to use naloxone. If Veterans or their family members are concerned that having naloxone could increase opioid misuse, try using this analogy: “Think of naloxone like a fire extinguisher you would have just in case of an emergency. If you have a fire extinguisher at your home, it can stop a fire, but it does not make you start a fire.”
- Ask, “Do you have any questions about overdose prevention or using naloxone?”
- Provide handouts: e.g., Naloxone Nasal Spray, Opioid Overdose Prevention and Reversing an Overdose with Naloxone
- Links to Videos: Naloxone Nasal Spray, Naloxone Intramuscular Injection

Encourage the Veteran to contact their healthcare team after naloxone is used or after an overdose

- Getting a refill is vital.
- Connecting the Veteran with services after an overdose is critical to prevent a possibly fatal future overdose.
Figure 5. Tips for discussing opioids as lethal means using the GROW framework

G
GET READY
What is the Veteran’s suicide risk?
What is the Veteran’s risk for overdose?
Does the Veteran live with other people?

R
REASON FOR THE DISCUSSION
Help the Veteran understand the rationale for the conversation.

O
OFFER BRIEF ADVICE
Safety planning, e.g., discuss safe storage and disposal of any opioid medications.
Encourage treatment for pain and substance use disorders.

W
WE ARE HERE TO HELP
Prescribe naloxone for Veterans with access to opioids.
Provide resources such as the Veterans Crisis Line to all Veterans.

Reducing access to lethal means, including opioids, works!

Figure 6. Lethal means safety—opioids, naloxone, and safe disposal

- Locking up opioids and other medications can prevent suicide attempts.
- Having naloxone on hand and easily available can help reverse intentional and unintentional opioid overdoses.
- Offer medication disposal envelopes* and encourage disposal of medications if they are discontinued or no longer needed.

Once Veterans are identified as being at risk for overdose and/or suicide, discussing lethal means safety is important.

(See Figure 7 for who is at risk.)

“Sometimes when a crisis hits, people can experience thoughts of killing themselves. There are things you can do to stay safe if that were to happen. Is it okay if I talk with you more about how to stay safe?”

Should soon be available at:
https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp
Patient Guide*: Opioid Overdose Prevention and Reversing an Overdose with Naloxone

Opioid overdose:
- Opioid overdose occurs when a person takes more opioids than the body can handle. The person may pass out and have difficulty breathing or slow breathing. In some cases, the person may die.
- Do not use opioids alone. Tell your family, friends, and others how to recognize an overdose.
- Do not share your opioids with another person. The amount you take may be too much for a person who is not regularly taking opioids.

Things that put you at higher risk for an accidental overdose:
- **Loss of tolerance:** If you stop taking opioids even for a few days (like during a hospital stay), you may lose your tolerance. This means that the dose you took before could be too much and lead to an overdose.
- **Medical conditions:**
  - Sleep apnea
  - Smoking, cigarettes, and marijuana
  - Reduced liver or kidney function
  - Chronic obstructive pulmonary disease (COPD)
  - Advanced AIDS
  - Other lung problems
- **Older age:** As a person gets older, they do not process medicines as well, and many need lower doses.

Mixing opioids with other substances puts you at higher risk for an accidental overdose. Avoid mixing opioids with:
- Alcohol
- Benzodiazepines, like alprazolam (Xanax®), clonazepam (Klonopin®), or lorazepam (Ativan)
- Only take if directed by your healthcare provider.
- Sleep medicines such as zolpidem (Ambien®), muscle relaxants like cyclobenzaprine (Reax®), or other antihistamines
  - Some antihistamines and sleep medicines like gabapentin and pregabalin (Lyrica®)
- Ask your healthcare provider or pharmacist if you have questions.

Ask a VA clinician if naloxone is right for you
Naloxone is a medicine that can temporarily reverse an opioid overdose.
- Opioid overdose can happen quickly. Make sure your family and friends know how and when to use naloxone and where you store it.
- Naloxone is not a substitute for safe use of opioids.
- Naloxone is available as an easy-to-use nasal spray. There is an intramuscular injection available if you are unable to use the nasal spray.
- Check the expiration date of your naloxone every year. Ask for a renewal before it expires.

Dispose of opioids to keep others safe
- **Prescribed medicine disposal:**
  - If you have prescribed opioids left over, ask your pharmacy for safe disposal instructions.
  - Contact the VA Pharmacy to request medical disposal envelopes or to find the nearest location where you can bring your medicines for disposal.

Opioids are a type of medicine used to treat pain, cough, and addiction. Opioids can also be non-prescribed substances like heroin.

**Common opioid medicines:**
- Codeine (Tylenol #3)
- Fentanyl (Actiq®)
- Hydrocodone (Vicodin®)
- Methadone (Methadose®)
- Morphine (MS Contin®)
- Oxycontin (Oxycodone (Percocet®)
- Hydromorphone (Dilaudid®)

**SAFER USE OF OPIODS**

- **ANY OPIOID:**
  - There is no safe dose of opioids.
  - Naturally found opioids have the same risks as those made in a lab.
  - Go slow. If you have not used opioids in a few days, your usual dose may cause an overdose.
  - Wash if you use an opioid, wait long enough to feel the effects before taking more.
  - Many who overdose do so when using opioids alone. Tell someone so they can check on you.
  - Mixing opioids with alcohol and other substances can cause an overdose.
  - Naloxone is a medicine that can reverse the effects of an opioid overdose.

- **PRESCRIBED OPIOIDS:**
  - Know the name of the opioid, strength, and amount taken each day.
  - Take prescribed medicines exactly as instructed by your healthcare provider.
  - Do not stop opioids abruptly since this can cause withdrawal.
  - Review the booklet Safe and Responsible Use of Opioids with your healthcare provider.
  - Download a quick reference guide at the right.

- **NON-PREScribed OPIOIDS:**
  - If you choose to use, go slow.
  - Even a few days off opioids could make you more sensitive to them.
  - Reduce your dose to half or less after any period of not using (even a couple of days).

*Should soon be available at: [https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp](https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp)
Patient Guide (continued)

Opioid Overdose Prevention and Reversing an Overdose with Naloxone

Responding to an overdose

Safety check: Look for signs of an overdose

1. Check
   - Sleepy
   - Heavy nodding
   - Deep sleep
   - Hard to wake
   - Vomiting

2. Listen
   - Slow or shallow breathing (1 breath every 5 seconds)
   - Snoring
   - Rassy, gurgling, or choking sounds

3. Look
   - Blush or grayish
   - Tips
   - Fingernails
   - Skin

4. Touch
   - Clammy, sweaty skin

If the person responds to the initial safety check, continue to monitor them. Some opioids can take longer to take effect. Stay with the person until help arrives. If they do not respond then follow the steps below:

STOP

1. Check for a response
   - Give the person a light shake. Yell their name. Firmly rub their sternum (bone in center of chest where ribs connect) with knuckles and your hand in a fist.
   - If no response, continue to Step 2.

2. Shout for help, call 911, and get naloxone
   - Shout for nearby help.
   - Call 911 or if someone else is around, have them call 911.
   - Give your address and location. Say the person is not responding.
   - Get naloxone.
   - If available, get an automatic external defibrillator (AED).

3. Check for breathing
   - Look at the chest to see if it rises and falls. Check mouth to make sure airway is clear. The person is not breathing normally if:
     - The chest does not rise or fall.
     - You see slow or shallow breathing. This means about 1 breath every 5 seconds or longer.
     - You hear snoring, gurgling, or choking sounds.

   X If the person is NOT breathing normally, start life-saving treatment:

   a. Give naloxone and use an AED if available:
      - If you have naloxone nasal spray. DO NOT PERM OR TEST the spray device. Gently insert tip of needle into nose and press the plunger firmly to give the dose.
      - If you have intramuscular naloxone, inject syringe through rubber plug with vial upside down and pull back on plunger to 1 ml, inject 1 ml at a 90-degree angle into a large muscle (upper arm, upper leg or buttock).

   b. Start chest compressions:
      - Place heel of one hand over center of the person's chest (between nipples).
      - Place one hand on top of your other hand, keep elbows straight, shoulders directly above hands.
      - Use body weight to push down, at least 2 inches, at a rate of 100 to 120 per minute.
      - Continue until EMS arrives.

   c. Start rescue breathing (if trained in CPR):
      - After 30 chest compressions, open airway using the head-tilt, chin-lift maneuver.
      - Put your palm on the person's forehead and gently tilt the head back. Then gently lift the chin forward with the other hand. Give 2 rescue breaths.
      - Continue chest compressions and rescue breaths at a rate of 2 breaths for every 30 compressions.

   X If the person is breathing normally, prevent worsening:

   a. Tap and shout.
   - Reposition into the recovery position.
   - If person stops responding, give naloxone.
   - Continue to observe until EMS arrives.

4. Consider a second dose of naloxone if:
   1. The person does not start breathing in 2 to 3 minutes after the first dose of naloxone.
   2. Naloxone may wear off in 20 to 90 minutes. A second dose may be needed if the person stops breathing again. Stay with the person until EMS takes over or for at least 90 minutes to make sure the person does not stop breathing again.

5. Place in recovery position
   - If the person is breathing but unresponsive, put them on their side to prevent choking if they vomit.

References:
VA Opioid Use Disorder Program: www.va.gov/policy/dea/18b
Substance Use Treatment Services Information: https://www.va.gov/substanceuse

Help is available anywhere:
- Local Emergency Services: 911 - National Peer Hotline: 1-800-222-1222
- Veterans Crisis Line: 1-800-273-TALK (8255), or text “svcs” to 838255

U.S. Department of Veterans Affairs
**Opioid Overdose Rescue with Naloxone Nasal Spray**

*Should soon be available at: [https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp](https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp)*

### What is an opioid?
Opioids are a type of medicine used to treat pain, cough, and addiction. Examples of prescribed opioid medicines are hydrocodone, morphine, and oxycodone. Opioids can also be non-prescribed substances like heroin. Fentanyl is an opioid that can be prescribed, but also is made illegally. Non-prescribed fentanyl can be sold separately or mixed in heroin and other drugs like cocaine and methamphetamine.

### Opioid overdose
Opioids can slow or stop a person’s breathing. Opioid overdose occurs when a person takes more opioids than the body can handle. The person may pass out and have difficulty breathing and sometimes may lead to death.

### Overdose prevention

#### Safer use of opioids

**ANY OPIOID**
- There is no safe dose of opioids.
- Naturally found opioids have the same risks as those made in a lab.
- Go slow! If you have not used opioids in a few days, your usual dose may cause an overdose.
- Wait! If you use an opioid, wait long enough to feel the effects before taking more.
- Many who overdose do so when using opioids alone. Tell someone so they can check on you.
- Avoid mixing opioids with alcohol, benzodiazepines (like clonazepam or alprazolam), or medicines that can make you sleepy. In some cases, this can cause an overdose.
- **Naloxone is a medicine that can reverse the effects of an opioid overdose.**

#### Safety check: Look for signs of an overdose

- **Check**
  - sleepy
  - heavy nodding
  - deep sleep
  - hard to wake
  - vomiting

- **Listen**
  - slow or shallow breathing (1 breath every 5 seconds)
  - snoring
  - raspy, gurgling, or choking sounds

- **Look**
  - bluish or grayish:
    - lips
    - fingernails
    - skin

- **Touch**
  - clammy sweaty skin

---

**Prescribed Opioids**
- Know the name of the opioid, strength, and amount taken each day.
- Take prescribed medicines exactly as instructed by your healthcare provider.
- Review the booklet *Safe and Responsible Use of Opioids* with your healthcare provider. Download using the QR code at the right.

**Non-Prescribed Opioids**
- If you choose to use, go slow!
- Even a few days without opioids could make you more sensitive to them.
- Reduce your dose to half or less after any period of not using (even a couple of days).
Opioid Overdose Rescue with Naloxone Nasal Spray (continued)

Responding to an opioid overdose

1. Check for a response
2. Shout for help, call 911, and get naloxone
3. Check for breathing—if not breathing normally, give naloxone and start cardiopulmonary resuscitation (CPR)
4. Consider a second dose of naloxone
5. Place in recovery position

1. Check for a response

Give the person a light shake. Yell their name. Firmly rub their sternum (bone in center of chest where ribs connect) with knuckles and your hand in a fist.

If the person does not respond by waking up and staying awake, go to step 2.

2. Shout for help, call 911, and get naloxone

- Shout for nearby help.
- Call 911 or if someone else is around, have them call 911.
- Give your address and location. Say the person is not responding and may have overdosed.
- Get naloxone.
- If available, get an automatic external defibrillator (AED).

3. Check for breathing

Look at the chest to see if it rises and falls. Check mouth to make sure airway is clear.

The person is not breathing normally if:
- the chest does not rise or fall.
- you see slow or shallow breathing. This means about 1 breath every 5 seconds or longer.
- you hear snoring, raspy, gurgling, or choking sounds.
**Opioid Overdose Rescue with Naloxone Nasal Spray (continued)**

**Is the person breathing normally?**

- **X** If the person is **NOT** breathing normally:
  - Start life saving treatment (see next page)
- **✓** If the person is **breathing normally**:
  - Prevent worsening (see page 11 for more)
  - Tap and shout.
  - Reposition into the recovery position.
  - If person stops responding, give naloxone.
  - Continue to observe until EMS arrives.

**If the person is not breathing normally**

- Give naloxone and use an AED if available. See page 15 for detailed instructions for giving naloxone.
- Start CPR. See next page for instructions.

**How to give naloxone:**

1. Peel back the tab and remove the nasal spray device.
2. Hold the device with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.
3. DO NOT PRIME OR TEST THE SPRAY DEVICE. Gently insert the tip of the nozzle into one nostril. Your fingers will be on either side of the nozzle and against the bottom of the person’s nose.
4. Press the plunger firmly to give the entire dose of naloxone nasal spray. Remove the naloxone nasal spray from the nostril after giving the dose.

**Start CPR until emergency medical services (EMS) arrives**

**Start chest compressions:**

- Place heel of one hand over center of the person’s chest (between nipples).
- Place one hand on top of your other hand, keep elbows straight, shoulders directly above hands.
- Use body weight to push straight down, at least 2 inches. Push at a rate of 100 to 120 per minute.
- Continue until EMS arrives.

**Start rescue breathing (if trained in CPR):**

- After 30 chest compressions, open airway using the head-tilt, chin lift maneuver.
- Put your palm on the person’s forehead and gently tilt the head back. Then gently lift the chin forward with the other hand.
- Give 2 rescue breaths.
- Continue chest compressions and rescue breaths at a rate of 2 breaths for every 30 compressions.

**If the person is breathing normally**

**Prevent worsening:**

- Tap and shout to keep the person awake.
- Reposition into the recovery position. This will make it easier to breathe and prevent choking if the person vomits (see page 13 for more details).
- If the person stops responding, give naloxone.
- Continue to observe until EMS arrives.
4. Consider a second dose of naloxone
   Two situations in which to consider a second dose of naloxone:

1. If the person does not start breathing in 2 to 3 minutes after the first dose of naloxone.

2. Naloxone may wear off in 30 to 90 minutes. A second dose may be needed if the person stops breathing again.
   Stay with the person until EMS takes over or for at least 90 minutes to make sure the person does not stop breathing again.

5. Place in recovery position
   If the person is breathing but unresponsive, put the person on their side to prevent choking if they vomit.

---

**Medicine instructions**

- Always keep two naloxone nasal sprays with you.
- Contact your provider as soon as possible if:
  - you use your naloxone nasal sprays
  - your naloxone nasal sprays are close to expiring
- Each nasal spray contains one dose and cannot be reused.
- Store naloxone nasal sprays:
  - at room temperature (59° to 77° F)
  - away from light
  - avoid extremes of heat or cold
- Throw away (dispose of) any used naloxone nasal spray device in a place that is away from children.

Download the video How to use the VA Naloxone Nasal Spray by scanning this QR code with your phone.
Opioid Overdose Rescue with Naloxone Nasal Spray (continued)

Detailed instructions for naloxone nasal spray

1. Remove naloxone nasal spray from the box.
2. Peel back the tab and remove the nasal spray device.
3. Hold the device with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

* This guide is not meant to replace the naloxone nasal spray instructions. Please review the instructions included with your naloxone nasal spray.

Detailed instructions for naloxone nasal spray (continued)

4. Do not prime or test the spray device. Gently insert the tip of the nozzle into one nostril. Your fingers will be on either side of the nozzle and against the bottom of the person’s nose.
5. Press the plunger firmly to give the entire dose of naloxone nasal spray. Remove the naloxone nasal spray from the nostril after giving the dose.
6. If there is no reaction in 2 to 3 minutes or if the person stops breathing again, give a second dose of naloxone. Use a new naloxone nasal spray device in the other nostril.

Resources for help are available:

VA Substance Use Disorder Treatment Program Locator: www.va.gov/directory/guide/SUD.asp

Resources for Pain Management: www.va.gov/PainManagement/Veteran_Public/index.asp

Buddies take care of Buddies. Share this card with a friend or family member.

www.mentalhealth.va.gov/substance-use

(Undated from the Harm Reduction Coalition, Oakland, CA)

Help is available anytime.

- Consider seeking long-term help at your local VA Substance Use Disorder Treatment Program: www.va.gov/directory/guide/SUD.asp
- Local Emergency Services: 911
- National Poison Hotline: 1-800-222-1222
- Veterans Crisis Line: 1-800-273-TALK (8255), or text – 838255
- Never Use Alone Hotline: 1-800-484-3731 www.neverusealone.com
My Pain Medicine: Am I at risk for an accidental overdose?

Do you know what is TRUE and FALSE about opioids (examples: prescription pain medicines or nonprescribed substances like heroin)?

Please read this important information if you are taking any of the following:
- codeine (Tylenol #3)
- fentanyl (Duragesic)
- heroin
- hydrocodone (Vicodin®)
- hydromorphone (Dilaudid®)
- oxycodone (Percocet®)
- oxymorphone (Opana®)
- methadone
- morphine (MS Contin®)
- tramadol (Ultram®)

Let us test what you know!
Please circle either true or false to test what you know (see back for answers):
1. I am not at risk of an accidental overdose if I take my opioid medicine as prescribed. TRUE or FALSE
2. Only people addicted to heroin or fentanyl are at risk of having an opioid overdose. TRUE or FALSE
3. Certain medicines or substances can increase my risk of accidental overdose if they are combined with an opioid. TRUE or FALSE

What are opioids?
- Prescription medicines usually used to treat pain (example: oxycodone, hydrocodone)
- Illegal illicit or street drugs (example heroin)

What is an overdose or drug poisoning?
- An overdose or drug poisoning is when your body has too much of a drug.
- An opioid overdose or opioid poisoning can cause you to stop breathing and die.

In the U.S. in 2020, every day 191 people died of an opioid overdose.

Synthetic opioids:
Fentanyl is a synthetic opioid that is 50 times stronger than heroin and 100 times stronger than morphine. It is prescribed to treat cancer pain and other types of severe pain. Fentanyl can also be illegally made and mixed into other drugs. It is often pressed into counterfeit pills or mixed with heroin, cocaine, or methamphetamine without the users knowledge.

Check your answers:
1. FALSE. Opioids can cause accidental overdose even when you take them as prescribed. Many things can increase your risk: sleep apnea, lung diseases, alcohol use. Ask your provider about your risks and if an opioid is the safest way to manage your pain.
2. FALSE. Any patient taking an opioid has a risk of accidental overdose. Remember, it is the opioid that can be dangerous, not the person taking it.
3. TRUE. Other medicines such as benzodiazepines (Xanax®, Klonopin, Valium®) and alcohol are very dangerous when used with opioids.

Did you know?
An opioid overdose can occur with any dose, large or small. You may think you are safe because you have been taking opioids for a long time. No matter how long you have been taking opioids, you can be at risk for harm. Risks increase if you are older in age or have certain medical conditions like sleep apnea, lung conditions, reduced kidney or liver function, or smoke cigarettes or cannabis. If you stop taking opioids, even for a few days, you might lose your tolerance. This means that the dose you took before could be too much and lead to an overdose.

What is naloxone?
Naloxone is a part of opioid safety and can lower your risk of accidental opioid overdose death. Naloxone is a medicine used in an emergency during an overdose. It can help a person start breathing again by reversing the side effects of opioids.

Please click here or scan the QR code to see the video:
How to Use the VA Naloxone Nasal Spray

What can you do?
1. Talk to your provider about the risks and benefits of opioids. Find out if there are ways to reduce your risk of an accidental opioid overdose.
2. Ask your provider if naloxone is right for you.

*Should soon be available at: https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp

The Veterans Crisis Line also offers free, confidential support and crisis intervention 24 hours a day, 7 days a week, 365 days a year. To reach the crisis line, call 1-800-273-8255 and press 1.
Memorandum Prescribing Naloxone for Veterans with OUD

- **Goal:** Increasing naloxone dispensing rates by 25% for STORM-identified patients with OUD by December 31, 2021
- **Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD)** – deep dive into implementation resources, including FAQs
- Academic Detailing Service [OEND](#) site - helpful patient and provider education resources
- National [OEND](#) site - implementation resources, e.g.,
  - Secure messaging approach
  - Telephone-based pharmacy consult clinic
  - Letter-based approaches
- National POC: Elizabeth.Oliva@va.gov
Rationale for National Clinical Reminders

3. Providers must document if a Veteran with an OUD diagnosis who has not received naloxone declines naloxone or has obtained it outside of VA (there are national health factors available to assist with tracking these cases). Opioid overdose education and naloxone prescribing can be facilitated in a variety of ways including by phone, letter or during face to face or telehealth visits. Resources to support patient education are available through VA Academic Detailing Service and specific approaches to improve naloxone dispensing are available on the VA Opioid Overdose Education and Naloxone Distribution (OEND) Implementation SharePoint.

More info in FAQ slides

• The National Clinical Reminder Workgroup has approved a Clinical Reminder and Clinical Reminder Order Checks to support these efforts (below is from original SBOR):
National Clinical Reminder

- Identifies patients with opioid use disorder with no naloxone in past 335 days
- Shows due 30 days in advance of a year to give buffer for patients currently dispensed naloxone to assist proactive outreach
National Clinical Reminder (expanded)
Veterans Integrated Service Network (VISN) 15 has been developing these TWO CROCs. Plan is to incorporate Human Factors Engineering recommendations for display and to highlight the National Clinical Reminder and National Note Template being developed to ensure use of standardized, health factored approaches to opioid overdose education and naloxone prescribing.

- NOTE: Health factors are incorporated into clinical decision support to facilitate and streamline outreach efforts.

**CROC 1:** Identifies patients for which a Medication for Opioid Use Disorder (MOUD)* is being ordered who have an encounter for F11.1x (opioid abuse) or F11.2x (opioid dependence) in the previous year and no naloxone filled in the past 335 days.

- *MOUD: buprenorphine SA inj, buprenorphine implant, buprenorphine SL tab, buprenorphine/naloxone formulation, naltrexone SA inj, OATP methadone

Medication for OUD

**********************************************************************************

**ACTION:** Strongly consider prescribing naloxone

Use the NALOXONE PRESCRIBING progress note -OR- the OFFER NALOXONE PRESCRIPTION reminder (Check Due/Applicable Sections) to document overdose education and to order naloxone

**RATIONALE:** Patient being prescribed a med for OUD -AND- no naloxone ordered in the previous 335 days.
Clinical Reminder Order Checks

• **CROC 2**: Identifies patients for which a CN101 medication is being ordered and patient has an encounter for F11.1x (opioid abuse) or F11.2x (opioid dependence) in the previous year and no naloxone filled in past 335 days.

Opioid ordered with OUD history

******************

**ACTION**: Strongly consider prescribing naloxone

Use the NALOXONE PRESCRIBING progress note -OR- the OFFER NALOXONE PRESCRIPTION reminder (Check Due/Applicable Sections) to document overdose education and to order naloxone.

**RATIONALE**: Patient being prescribed an opioid, has a history of OUD -AND- no naloxone ordered in the previous 335 days.
Bottom Line Up Front (BLUF)

- Alarming increases in drug overdoses—Overdose Prevention needed NOW more than ever!
- What can psychologists do?
  - **Education**: Opioid Overdose Education and Naloxone Distribution (OEND) ([internal](#)/[external](#))
  - **Pain Management**:
    - Stepped Care Model for Pain Management
    - Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)
    - Stratification Tool for Opioid Risk Mitigation (STORM) Data-Based Risk Reviews
    - Tapering and discontinuation (**opioids**, **benzos**)—high risk periods! Keep patients on your radar!
  - **Risk Mitigation**:
    - Improve post-overdose care
      - VHA→report overdoses using **Suicide Behavior and Overdose Report (SBOR)**, be part of Overdose Review Team
      - Support **Syringe Service Programs** ([external](#)) and Fentanyl Test Strips as appropriate
  - **Addiction Treatment**:
    - Identify Opioid Use Disorder (OUD) and support initiation of Medication for OUD ([SCOUTT](#); [external](#))
    - Identify and connect patients with **Substance Use Disorder (SUD) Treatment** (esp alcohol and stimulants)
VHA Pain Management

For Providers

This provider education section of the VA Pain Management website provides up to date information and resources for healthcare providers who care for Veterans and others with pain.

Chronic pain is among the most common, disabling, and costly chronic illnesses in the US and Veterans are more likely to experience severe pain than the general US population.

Confusion by both patients and healthcare providers about the most appropriate way to understand and manage chronic pain can be a barrier to effective management. This confusion, often stems from using a simplistic biomedical model (derived from conventional approaches to acute pain) to approach the multidimensional biopsychosocial condition of chronic pain and can lead to over-reliance on passive therapies such as opioids and procedures.

Stepped Care Model for Pain Management (SCM-PM)

VHA is improving pain care through implementation of the Stepped Care Model for Pain Management (SCM-PM).

VHA Pain Management

For Veterans/Public

VHA Pain Management - Home

Opioid Safety

Providers

Veterans/Public

Veterans/Public - Home

Chronic Pain 101

Self Management

Complementary Treatments

Home Practice Exercises

Yoga/Tai Chi

Physical Therapy

Acupuncture

Whole Health

Medical Treatments

Millions of people suffer from pain and are looking for answers. Unfortunately, it can be difficult to separate myths and misunderstanding from facts when it comes to treating pain. Our goal is to help you work with your medical team so you can make the best decisions about your healthcare.
CBT-CP Training Program

Cognitive Behavioral Therapy for Chronic Pain

Therapist Manual

VA CBT-CP Training Program

• Part of VA Evidence Based Psychotherapy (EBP) initiative

• Have trained over 1000 clinicians since started in 2012

• Network of behavioral pain experts:
  • 20 VISN/regional Trainers serving their regions
  • 60 Consultants reviewing sessions, providing feedback

• Delivered virtually since 2015 so easy to continue during COVID
You may feel alone, but you’re not.
Some Veterans may turn to alcohol or drugs to cope with their symptoms.

https://www.treatmentworksforvets.org/
What is the VA Stratification Tool for Opioid Risk Mitigation (STORM)?

- Identifies patients at-risk for overdose-/suicide-related adverse events
- Provides patient-centered opioid risk mitigation strategies

Oliva et al., Development and applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to improve opioid safety and prevent overdose and suicide. Psychol Serv. 2017 Feb;14(1):34-49
Risk increased slightly with increasing MEDD
• e.g., 120 MEDD would increase modeled risk by about as much as a PTSD or AUD diagnosis
# STORM Patient Detail Report

**Stratification Tool for Opioid Risk Mitigation**

Data displayed has a 3-2 day lag from CPRS entry. This report is to be used along with the electronic medical record and clinical discussion with the patient to help facilitate decision making. STORM predicts risk of overdose or suicide-related health care events or death. STORM should not be used for research, only for operations and quality improvement purposes. Warning: Discontinuing opioids does not necessarily reduce your patient’s risk and may actually increase their risk. Always discontinue opioids with caution and clinical judgment.

<table>
<thead>
<tr>
<th>Total Patients: 5</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Risk:</strong></th>
<th><strong>STORM Risk Score:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide or Overdose (1 yr)**</td>
<td>Very High - Active Opioid Rx 6%</td>
</tr>
<tr>
<td>RF - High Risk for Suicide: No</td>
<td></td>
</tr>
<tr>
<td>JGQ0R Score: 43 Risk Class: 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Active Station(s):</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(600) Long Beach, CA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Patient Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong> ZETTESTPATIENT, BATMAN MACK</td>
</tr>
<tr>
<td><strong>Last Four:</strong> 2179</td>
</tr>
<tr>
<td><strong>Age:</strong> 29</td>
</tr>
<tr>
<td><strong>Gender:</strong> M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Risk:</strong></th>
<th><strong>STORM Risk Score:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide or Overdose (1 yr)**</td>
<td>Very High - Active Opioid Rx 6%</td>
</tr>
<tr>
<td>RF - High Risk for Suicide: No</td>
<td></td>
</tr>
<tr>
<td>JGQ0R Score: 43 Risk Class: 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Active Station(s):</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(600) Long Beach, CA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Contributing Risk Factors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health: Major Depressive Disorder Other MH Disorder</td>
</tr>
<tr>
<td>Medical: Chronic Pulmonary Dis Diabetes, Uncomplicated Hypertension Lymphoma Neurological Disorders - Other Psychiatric Peripheral Vascular Disease Sleep Arousal</td>
</tr>
<tr>
<td>Adverse Event: Related to Falls</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Relevant Diagnoses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-VA</td>
</tr>
<tr>
<td>Opioid MORPHINE Months in Treatment: 1</td>
</tr>
<tr>
<td>ACETAMINOPHEN/HYDROCODONE Months in Treatment: 6</td>
</tr>
<tr>
<td>Pain Medications (Sedating)</td>
</tr>
<tr>
<td>PREGABALIN</td>
</tr>
<tr>
<td>TOPIRAMATE</td>
</tr>
<tr>
<td>Opioid Prescription History</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Relevant Medications</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Risk Mitigation Strategies</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Regimen</td>
</tr>
<tr>
<td>Data-Based Opioid Risk Review</td>
</tr>
<tr>
<td>MADD &lt;= 90**</td>
</tr>
<tr>
<td>Naloxone Kit</td>
</tr>
<tr>
<td>PDMP</td>
</tr>
<tr>
<td>State PDMP List</td>
</tr>
<tr>
<td>Psychosocial Assessment</td>
</tr>
<tr>
<td>Psychosocial Tx</td>
</tr>
<tr>
<td>Suicide Safety Plan</td>
</tr>
<tr>
<td>Timely Follow-up (30 Days)</td>
</tr>
<tr>
<td>Timely UDS (1 Year)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Non-pharmacological Pain Tx</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Therapies</td>
</tr>
<tr>
<td>CBT Therapies</td>
</tr>
<tr>
<td>Chiropractic Care</td>
</tr>
<tr>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Pain Clinic</td>
</tr>
<tr>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Specialty Therapy</td>
</tr>
<tr>
<td>Other Therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Care Providers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Therapies</td>
</tr>
<tr>
<td>CBT Therapies</td>
</tr>
<tr>
<td>Chiropractic Care</td>
</tr>
<tr>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Pain Clinic</td>
</tr>
<tr>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Specialty Therapy</td>
</tr>
<tr>
<td>Other Therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Recent Events</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Appointment</td>
</tr>
<tr>
<td>4/16/2017 Primary Care/Medicine</td>
</tr>
<tr>
<td>Other Event</td>
</tr>
<tr>
<td>1/27/2017 Telephone Case Management</td>
</tr>
<tr>
<td>Specialty Pain</td>
</tr>
<tr>
<td>9/4/2017 Pain Clinic</td>
</tr>
<tr>
<td>MH Appointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Upcoming Events</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Appointment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Care team &amp; Follow-up</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>User Guide</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Link to user guides for all STORM reports</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Helpdesk</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Link to helpdesk</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SSN Lookup</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Quick View Report</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Save/Share Current View</strong></th>
</tr>
</thead>
</table>

---

**U.S. Department of Veterans Affairs**
CONDUCT OF DATA-BASED CASE REVIEWS OF OPIOID-EXPOSED PATIENTS WITH RISK FACTORS

1. VHA is committed to enhancing the safe and efficacious care of patients who are exposed to opioid drugs. Deploying risk mitigation strategies or modifying treatment plans for opioid-exposed patients at elevated risk of experiencing an adverse event can reduce the likelihood of these events and improve patient outcomes.

2. This VHA notice maintains policy on implementation of Opioid Safety Initiative (OSI) case reviews, and Title IX, Subtitle A, Section 911(a)(2) of the Comprehensive Addiction and Recovery Act of 2016 (CARA) (Public Law 114-166). These case reviews must be documented in the medical record using a note title or titles, or a health factor, that include the terms "Opioid Risk Review" and "Data-based." Completion and documentation of case reviews is required for the following two groups of patients:

   a. Patients identified as being in the "Very High - Opioid Prescription" risk category for an overdose or suicide-related event by the Structuring Tool for Opioid Risk Mitigation (STORM) must receive a case review by an interdisciplinary opioid review team, the VA medical facility "opioid review team." 

   b. Patients being considered for new opioid prescriptions, before initiating opioid therapy, must receive a case review by the VA health care provider who would initiate the prescription at the point of care.

3. Detailed background, implementation instructions, and monitoring plans regarding this notice are available at: https://spotes.cdw.va.gov/sites/OMHO_PsychPharm/vtb/bin/ReportServer?https://spotes.cdw.va.gov/sites/OMHO_PsychPharm/AnalyticsReports/STORM/MemoRdlbrs.Command-Renderers?form=PDF. NOTE: This is an internal VA Web site that is not available to the public.

4. A recorded presentation providing an overview of the STORM reports and requirements of this notice is available at: https://www.portal2.va.gov/sites/PERC/STORM/SitesPages/STORM%20Monthly%20Call.aspx. NOTE: This is an internal VA Web site that is not available to the public. In addition, an ongoing monthly call accredited for continuing education credits various aspects of implementation. Calls are recorded and available at the site listed in this paragraph. For access to the STORM implementation team at V21PALSTORMteam@va.gov for technical assistance with the STORM reports, add people to the listserver, or to assist with developing strategies and processes for case review.

5. VA medical facility Directors and other appropriate VA medical facility leadership should facilitate implementation of case reviews by:

   a. Ensuring that the STORM implementation team at V21PALSTORMteam@va.gov has up-to-date names and contact information for the designated contact person or team of people at each VA medical facility for this initiative (STORM POCs). The STORM POCs will receive information about updates and trainings on STORM and opioid risk mitigation and may be contacted for qualitative information about their implementation at the VA medical facility. The current list of STORM POCs is maintained at: https://www.portal2.va.gov/sites/PERC/STORM/Resource%20library/STORM%20POCs.doc. NOTE: This is an internal VA Web site that is not available to the public.

   b. Ensuring that the VA medical facility opioid risk review team has interdisciplinary representation and adequate time dedicated to complete the case reviews and follow-up required in paragraph 2.a. Year 1 of the "very high" risk reviews focused on setting up processes at the VA medical level for case reviews on a limited population of the highest risk patients. Goals for this year focus on expansion of the established review process to the broader population of high-risk patients. The expectation is that this goal will take longer to achieve compared to year 1 goals and will require additional resourcing of interdisciplinary opioid risk review teams.

   c. Ensuring local training of VA health care providers and point of contact staff on the requirements to conduct reviews of risk factors before initiating opioid therapy, per paragraph 2.b., as well as adequate time to conduct the reviews. Staff training may be developed locally, use national training materials, or a combination. National materials are located here: https://www.portal2.va.gov/sites/PERC/STORM/SitesPages/Supporting%20Materials.aspx. NOTE: This is an internal VA Web site that is not available to the public.

   d. Requiring that a Clinical Application Coordinator (CAC) at the VA medical facility maintain note templates or health factors that include "Opioid Risk Review" and "Data-based" in the title.

6. Questions regarding this VHA notice should be directed to Dr. Friedhelm Sandbrink, National Program Director for Pain Management, VHA, at Friedhelm.Sandbrink@va.gov or the STORM implementation team at V21PALSTORMteam@va.gov.

7. VHA Notice 2018-08, Conduct of Data-Based Case Reviews of Patients with Opioid-Related Risk Factors, dated March 8, 2018, is rescinded.

8. This VHA notice will be archived as of August 31, 2020.

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Lucilla B. Beck, PhD
Deputy Under Secretary for Health for Policy and Services

DISTRIBUTION: Emailed to the VHA Publications Distribution List on August 9, 2019.

STORM Randomized Program Evaluation: Chinman et al., 2019; Minegishi et al., 2018, 2019; Rogal et al., 2020
Outcomes associated with getting an interdisciplinary case review among patients in top 1-5%

Identifying high risk patients and mandating they receive an interdisciplinary review was associated with a decrease in all-cause mortality within 127 days

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Odds Ratio</th>
<th>CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>0.78**</td>
<td>0.65 - 0.93</td>
</tr>
<tr>
<td>Any SAE</td>
<td>0.99</td>
<td>0.87 - 1.13</td>
</tr>
<tr>
<td>Case Review</td>
<td>5.13***</td>
<td>3.64 – 7.23</td>
</tr>
</tbody>
</table>

- For patients in the top 1-5% of estimated risk, being included in the mandated list of patients for review was associated with a 23% reduction in all-cause mortality in the subsequent 4 months.
- These patients were 5.1 times more likely to receive a case review than controls.
  - During the early expansion period studied in the trial, only 31% of those in the top 1-5% received a full case review. This may have underestimated the benefits of the fully implemented program.
Tapering and Discontinuation as Critical Periods
Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation

Elizabeth M Oliva,1,2 Thomas Bowe,1,2 Ajay Manhapa,3,6,5 Stefan Kortesz,7,8 Jennifer M Hah,9 Patricia Henderson,1 Amy Robinson,10 Meenah Pak,1 Friedhelm Sandbrink11,12,13 Adam J Gordon,14,15,16 Jodie A Trafton12,17

ABSTRACT

OBJECTIVE
To examine the associations between stopping treatment with opioids, length of treatment, and death from overdose or suicide in the Veterans Health Administration.

DESIGN
Observational evaluation.

SETTING
Veterans Health Administration.

PARTICIPANTS
1,394,102 patients in the Veterans Health Administration with an outpatient prescription for an opioid analgesic from fiscal year 2013 to the end of fiscal year 2014 (1 October 2012 to 30 September 2014).

MAIN OUTCOME MEASURES
A multivariable Cox non-proportional hazards regression model examined death from overdose or suicide, with the interaction of time varying opioid cessation by length of treatment (≤30, 31-90, 91-400, and >400 days) as the main covariates. Stopping treatment with opioids was measured as the time when a patient was estimated to have no prescription for opioids, up to the end of the next fiscal year (2014) or the patient’s death.

RESULTS
2887 deaths from overdose or suicide were found. The incidence of stopping opioid treatment was 57.4% (n=799668) overall, and based on length of opioid treatment was 32.0% (<30 days), 8.7% (31-90 days), 22.7% (91-400 days), and 36.6% (>400 days). The interaction between stopping treatment with opioids and length of treatment was significant (P=0.001); stopping treatment was associated with an increased risk of death from overdose or suicide regardless of the length of treatment, with the risk increasing the longer patients were treated. Hazard ratios for patients who stopped opioid treatment (with reference values for all other covariates) were 1.67 (<30 days), 2.80 (31-90 days), 3.05 (91-400 days), and 6.77 (>400 days). Descriptive life table data suggested that death rates for overdose or suicide increased immediately after stopping or stopping treatment with opioids, with the incidence decreasing over about three to 12 months.

CONCLUSIONS
Patients were at greater risk of death from overdose or suicide after stopping opioid treatment, with an increase in the risk the longer patients had been treated before stopping. Descriptive data suggested that starting treatment with opioids was also a risk period. Strategies to mitigate the risk in these periods are not currently a focus of guidelines for long-term use of opioids. The associations observed cannot be assumed to be causal; the context in which opioid prescriptions were started and stopped might contribute to risk and was not investigated. Safer prescribing of opioids should take a broader view on patient safety and mitigate the risk from the patient’s perspective. Factors to address are those that place patients at risk for overdose or suicide after beginning and stopping opioid treatment, especially in the first three months.

Oliva et al., 2020, BMJ
Hazard ratios for patients who stopped opioid treatment (reference values for other covariates)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Parameter estimate</th>
<th>Standard error</th>
<th>Hazard ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stopped treatment with opioids</td>
<td>1.91</td>
<td>0.06</td>
<td>—*</td>
</tr>
<tr>
<td>Stopped treatment with opioids × duration of last prescription for opioids (reference &gt;400 days):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤30 days</td>
<td>-1.40</td>
<td>0.08</td>
<td>—*</td>
</tr>
<tr>
<td>31-90 days</td>
<td>-0.88</td>
<td>0.11</td>
<td>—*</td>
</tr>
<tr>
<td>91-400 days</td>
<td>-0.54</td>
<td>0.08</td>
<td>—*</td>
</tr>
<tr>
<td>Age (centered)</td>
<td>-0.02</td>
<td>0.002</td>
<td>0.98 (0.98 to 0.98)</td>
</tr>
<tr>
<td>Female sex</td>
<td>-0.57</td>
<td>0.08</td>
<td>0.56 (0.48 to 0.66)</td>
</tr>
<tr>
<td>Currently married</td>
<td>-0.63</td>
<td>0.04</td>
<td>0.53 (0.49 to 0.58)</td>
</tr>
<tr>
<td>Rural residence</td>
<td>-0.07</td>
<td>0.04</td>
<td>0.93 (0.86 to 1.01)</td>
</tr>
<tr>
<td>No of medical diagnoses</td>
<td>0.02</td>
<td>0.01</td>
<td>1.02 (1.01 to 1.04)</td>
</tr>
<tr>
<td>Substance use disorder (excluding nicotine)</td>
<td>0.91</td>
<td>0.05</td>
<td>2.48 (2.25 to 2.72)</td>
</tr>
<tr>
<td>Nicotine use disorder</td>
<td>0.03</td>
<td>0.04</td>
<td>1.03 (0.95 to 1.12)</td>
</tr>
<tr>
<td>Mental health disorder</td>
<td>0.43</td>
<td>0.04</td>
<td>1.54 (1.41 to 1.68)</td>
</tr>
</tbody>
</table>

Table 2: Multivariable Cox non-proportional hazard regression model estimates for death from overdose or suicide in patients with an outpatient prescription for an opioid in fiscal year 2013 at the Veterans Health Administration.

*Hazard ratios and associated 95% confidence intervals were not estimated for these variables as this was an interaction model. To better understand the interaction, the estimated hazard ratios for patients who stopped opioid treatment (with reference values for all other covariates) were 1.67 (≤30 days), 2.80 (31-90 days), 3.95 (91-400 days), and 6.77 (>400 days).
<table>
<thead>
<tr>
<th>Length of opioid treatment</th>
<th>Observed overdose/suicide mortality rate (first 25 days per 100,000 patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤30 days</td>
<td>20</td>
</tr>
<tr>
<td>31-90 days</td>
<td>40</td>
</tr>
<tr>
<td>91-400 days</td>
<td>58</td>
</tr>
<tr>
<td>&gt;400 days</td>
<td>104</td>
</tr>
</tbody>
</table>

Fig 1 | Conditional probability of death from overdose or suicide over 375 days (in 25 day intervals). Top panel = probability in patients treated with opioids (for patients who started treatment with opioids (n=952,918) in fiscal year 2013) and after stopping opioid treatment (n=799,668). Bottom panel = probability by length of treatment with opioids in those who stopped opioid treatment.
Discussion

• Findings consistent with:
  • Veterans Affairs/Department of Defense Clinical Practice Guideline against starting long-term opioid treatment
  • US Department of Health and Human Services (HHS) guide for clinicians on the appropriate dosage reduction or discontinuation of long-term opioid analgesics
  • Dowell, Haegerich, & Chou, 2019, NEJM. No shortcuts to safer opioid prescribing.

• Implications for clinical care
  • Provide patient-centered care that looks at broad array of risk factors
  • Closely monitor patients for at least 3 months after patients stop opioid treatment, especially those on long-term opioid therapy or those with other risk factors (e.g., MH/SUD comorbidities)
  • Continually manage and treat pain and comorbid conditions
  • Preserve relationships with healthcare providers, especially post-opioid cessation
  • Enact flexible policies that allow providers to take into account patient’s unique circumstances when making clinical decisions about prescribing opioids
  • Provide detailed guidance and standard risk mitigation for opioid initiation & cessation
BMJ Opinion: What an opioid safety initiative can teach us about using information to improve patient outcomes

Key take-home message

- Addressing the opioid crisis requires us to move beyond solely focusing on opioids.
- Factors associated with increased risk when patients are prescribed opioids are also associated with risk when opioids are no longer part of the patient’s treatment plan (e.g., mental health disorders, medical complexity, other medications).

VHA is a learning healthcare system

- Committed to identifying factors associated with outcomes for patients prescribed opioids; built on decade of opioid safety efforts (Gellad et al., 2017).

VHA’s integrated system allows it to move quickly on new evidence

- Opioid Safety Initiative launched in 2013
  - Focused on both opioid prescribing factors (high-dose, co-prescribing with benzodiazepines) and risk mitigation (urine drug screening).
  - Opioid Overdose Education and Naloxone Distribution (OEND)
    - Over 200,000 Veterans have received naloxone with more than 700 documented opioid overdose reversals.

VA Stratification Tool for Opioid Risk Mitigation (STORM) can help with risk mitigation (Oliva et al., 2017)

- Uses predictive analytics to identify patients at-risk for overdose or suicide and provides individualized risk mitigation recommendations.
- Consistent with other predictive models, STORM found that opioid dose was a weak predictor of overdose/suicide when other clinical risk factors were taken into consideration.

We encourage providers to take a patient-centered approach, stay engaged and communicate with their patients, and address risk factors that might place patients at risk for overdose or suicide whether they continue or stop treatment with opioid analgesics.
Association of Dose Tapering With Overdose or Mental Health Crisis Among Patients Prescribed Long-term Opioids

Alicia Agnoli, MD, MPH, MHS; Gulbo Xing, PhD; Daniel J. Tancredi, PhD; Elizabeth Magnan, MD, PhD; Anthony Jerant, MD; Joshua J. Fenton, MD, MPH

**RESULTS** The final cohort included 113,618 patients after 203,920 stable baseline periods. Among the patients who underwent dose tapering, 54.3% were women (vs 53.2% among those who did not undergo dose tapering), the mean age was 57.7 years (vs 58.3 years), and 38.8% were commercially insured (vs 41.9%). Posttapering patient periods were associated with an adjusted incidence rate of 9.3 overdose events per 100 person-years compared with 5.5 events per 100 person-years in nontapered periods (adjusted incidence rate difference, 3.8 per 100 person-years [95% CI, 3.0–4.6]; aIRR, 1.68 [95% CI, 1.53–1.85]). Tapering was associated with an adjusted incidence rate of 7.6 mental health crisis events per 100 person-years compared with 3.3 events per 100 person-years among nontapered periods (adjusted incidence rate difference, 4.3 per 100 person-years [95% CI, 3.2–5.3]; aIRR, 2.28 [95% CI, 1.96–2.65]). Increasing maximum monthly dose reduction velocity by 10% was associated with an aIRR of 1.09 for overdose (95% CI, 1.07–1.11) and 0.18 for mental health crisis (95% CI, 1.14–1.21).

**CONCLUSIONS AND RELEVANCE** Among patients prescribed stable, long-term, higher-dose opioid therapy, tapering events were significantly associated with increased risk of overdose and mental health crisis. Although these findings raise questions about potential harms of tapering, interpretation is limited by the observational study design.

https://jamanetwork.com/journals/jama/fullarticle/2782643
Table 2. Primary and Secondary Outcomes in a Study of the Association of Dose Tapering With Overdose or Mental Health Crisis Among Patients Prescribed Long-term Opioids

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Tapered</th>
<th>Not tapered</th>
<th>Adjusted incidence rate difference per 100 person-years by tapering status (95% CI)</th>
<th>Adjusted incidence rate ratio (95% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of events/total person-years</td>
<td>Adjusted incidence rate per 100 person-years (95% CI)</td>
<td>No. of events/total person-years</td>
<td>Adjusted incidence rate per 100 person-years (95% CI)</td>
<td></td>
</tr>
<tr>
<td>Overdose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entire cohort</td>
<td>3241/22097</td>
<td>9.3 (8.5-10.1)</td>
<td>11433/152194</td>
<td>5.5 (5.3-5.8)</td>
<td>3.8 (3.0-4.6)</td>
</tr>
</tbody>
</table>
| Baseline opioid dose, MME/d
| 50-89 | 530/5321 | 6.6 (5.3-7.8) | 3277/53260 | 4.6 (4.2-5.0) | 2.0 (0.3-3.3) | 1.43 (1.15-1.77) | .008 |
| 90-149 | 676/5524 | 7.7 (6.4-9.1) | 2607/38994 | 5.1 (4.6-5.5) | 2.6 (1.2-4.1) | 1.67 (1.34-2.00) |
| 150-299 | 1047/6864 | 10.9 (9.2-12.7) | 3462/38782 | 6.5 (6.0-7.0) | 4.4 (2.6-6.2) | 2.36 (1.93-2.79) |
| ≥300 | 986/4388 | 16.2 (13.9-18.4) | 2087/21159 | 7.4 (6.6-8.2) | 8.8 (6.4-11.1) | 3.51 (2.94-4.09) |
| Mental health crisis |         |             |                                                                                     |                                       |         |
| Entire cohort | 3117/22097 | 7.6 (6.5-8.6) | 8258/152194 | 3.3 (3.0-3.6) | 4.3 (3.2-5.3) | 2.28 (1.96-2.65) | <.001 |
| Baseline opioid dose, MME/d
| 50-89 | 525/5321 | 5.2 (3.8-6.5) | 2801/53260 | 3.4 (3.0-3.9) | 1.8 (0.4-3.2) | 1.51 (1.14-2.01) | .003 |
| 90-149 | 615/5524 | 5.8 (4.3-7.4) | 2045/38994 | 3.2 (2.7-3.7) | 2.6 (1.0-4.2) | 1.70 (1.21-2.19) |
| 150-299 | 1080/6864 | 8.7 (6.6-10.9) | 2051/38782 | 3.0 (26-3.5) | 5.7 (3.5-7.8) | 2.54 (1.84-3.24) |
| ≥300 | 897/4388 | 11.9 (8.8-15.0) | 1361/21159 | 3.8 (3.0-4.7) | 8.1 (4.9-11.3) | 3.47 (2.45-4.49) |
| Secondary mental health end points |         |             |                                                                                     |                                       |         |
| Depression | 2485/22097 | 5.5 (4.6-6.4) | 6174/152194 | 2.2 (2.0-5) | 3.3 (2.4-4.2) | 2.46 (2.05-2.96) | <.001 |
| Anxiety | 505/22097 | 1.4 (1.2-1.7) | 1737/152194 | 0.8 (0.7-0.9) | 0.6 (0.4-0.9) | 1.79 (1.48-2.15) | <.001 |
| Suicide attempt | 127/22097 | 0.4 (0.2-0.5) | 347/152194 | 0.1 (0.08-0.13) | 0.3 (0.1-0.4) | 3.30 (2.19-4.98) | <.001 |
Opioid Tapering Practices—Time for Reconsideration?

Marc Larochelle, MD; Pooja A. Lagisetty, MD; Amy S. B. Bohnert, PhD

Patients at highest baseline risk for physical and psychological comorbidities during and after an opioid taper likely warrant an even slower taper and closer monitoring for potential adverse outcomes than those without this baseline risk. However, this is the very patient population for which a prescriber may instinctively accelerate tapering.9 Multiple factors likely contribute to this counter response, including concern related to worsened risks with continued therapy. For patients with signs of an opioid use disorder (OUD), prescribers may be concerned about legal repercussions of continued prescribing.

What is an alternative approach? For a patient at heightened risk for adverse outcomes or with active OUD, clinicians could consider a multipronged plan: (1) confirm therapeutic alliance with the patient, (2) consider a slow taper over several months rather than several weeks, (3) institute harm reduction measures to reduce risk during tapering, and (4) engage the patient in shared decision-making around an OUD diagnosis and management when indicated.

Patients prescribed opioids for chronic pain and those with OUD each report substantial stigma from clinicians.12 A clinician’s clear, sincere expression of alignment with the patient and a commitment to continued care is crucial to maintaining trust when navigating a transition in opioid analgesic regimen. Tapering of 10% per week over 10 to 12 weeks or longer should be slow enough to avoid withdrawal and provide time to build therapeutic alliance. Harm reduction strategies include frequent follow-up, with weekly check-ins if possible and by phone if necessary. Electronic prescribing of controlled substances allows for shorter prescriptions—ideally no more than 1 week—to minimize risk based on available dosages and likelihood of running out of medication early. Clinicians also should prescribe naloxone and ensure that the patient and other individuals living with the patient know how to use this overdose reversal medication. With these measures in place, motivational interviewing could be used to engage the patient in understanding of OUD diagnosis and treatment options and may improve eventual acceptance of a transition to OUD management.

https://jamanetwork.com/journals/jama/fullarticle/2782662
It is increasingly clear that opioid tapering needs to be approached with caution. **In almost all cases, rapid or abrupt discontinuation should be avoided.** Achieving the goals of minimizing risk yet also improving pain and function will require individualizing care and evidence-based approaches with more nuanced strategies that embrace the clinical complexity of the population of patients with chronic pain.

https://jamanetwork.com/journals/jama/fullarticle/2782662
VA Academic Detailing Opioid Taper Tool

- Helps providers determine which patients may be good candidates for opioid taper
- Reviews how to approach the taper, how to discuss tapering with patients, provides example tapers, and recommended follow up schedules
- Withdrawal symptoms reviewed and medications to help reduce withdrawal

Example Tapers for Opioids

<table>
<thead>
<tr>
<th>Slowest Taper (over years)</th>
<th>Slower Taper (over months or years)</th>
<th>Faster Taper (over weeks)</th>
<th>Rapid Taper (over days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed</td>
<td>Reduce by 5 to 20% every 4 weeks with pauses in taper as needed</td>
<td>Reduce by 10 to 20% every week</td>
<td>Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day</td>
</tr>
</tbody>
</table>

Consider for patients taking high doses of long-acting opioids for many years

*PHI's Whole Health Approach: http://www.mhra.gov/PATIENT/ENTER/CARE/explore/about/whole-health.jsp

Updates forthcoming; for most recent version: https://www.pbm.va.gov/PBM/academicdetailingservicehome.asp
Slowly Stopping Opioid Medications

**Helpful Tips to Getting Off Your Opioid Successfully**

**Is Your Opioid Medication Helping You or Hurting You?**

The goal of chronic pain treatment is to help you regain the ability to move and participate in activities that are important to you. Opioid medications may be helpful after an acute injury or surgery, but can lose their effect on reducing pain over time. This could keep you from reconnecting with what is important to you. It is time to discover a different way to treat your pain. Talk to your provider about alternatives to opioids and how to safely reduce your opioid medications.

**Possible Risks of Opioids**
- Feeling tired or drowsy
- Constipation
- Memory problems
- Worsened pain

What concerns do you have about taking opioid medications?

**How Will You Feel While Slowly Reducing Your Opioid Medication?**

If you have been taking opioids for longer than a few months, your body is used to taking them. Stopping it quickly can cause withdrawal symptoms like:
- Muscle aches
- Difficulty sleeping
- Restlessness
- Anxiety
- Worsening pain

To keep you from having these withdrawal symptoms, your provider will very slowly reduce the opioid dose. This will minimize the discomfort you experience. If you experience any of these symptoms, notify your care team and they can help with withdrawal symptoms usually only last for a short period.

Once you start reducing the opioid dose, do not take extra doses or try going back to your original dose without talking to your provider. Your body may no longer be used to the higher dose. Taking more opioids can put you at risk for an overdose.

**Time of Withdrawal**

- Withdrawal Symptoms:
  - Not all patients experience withdrawal
  - Symptoms can occur in the first 24 hours after decreasing a dose, but may take longer with medicines like methadone

- These symptoms will go away with time (5–10 days for methadone) but can last longer in some patients

**Self-Care You Can Do While Reducing the Opioid Dose**

- Participate in wellness activities: meditation, relaxation, prayer.
- Focus on deep breathing: sit in a quiet place with eyes closed and deeply breathe in and out.
- Work closely with your provider and report symptoms of withdrawal and craving for the opioid.
- Enlist support from friends and family consider a support/recovery group.
- Know that withdrawal is temporary and while it may be uncomfortable, it is not life-threatening.
- Stopping opioid medications may improve your pain and allow you to be more active.
- If your pain remains a problem, ask your primary care provider for help.

**Please call (303) 461-2089 with any questions or concerns.**

Veterans Crisis Line
1-800-273-TALK (8255) or Text: 838255

**Tap an Opioid Schedule:**

- Start taper:

**Spanish Translation**

**Slowly Stopping Opioid Medications**

**Guía para el paciente**

**¿Están ayudando a su medicación de opioides?**

El objetivo del tratamiento de dolor crónico es ayudarle a recuperar la capacidad de moverse y participar en actividades importantes para usted. Las medicaciones opioides pueden ser útiles después de un daño agudo o una cirugía, pero pueden perder su efecto en la reducción del dolor con el tiempo. Esto podría impedirle volver a lo que es importante para usted. Es tiempo de descubrir un método diferente para tratar su dolor. Comuníquese con su proveedor sobre alternativas a los opioides y cómo reducir de manera segura sus medicaciones opioides.

**Posibles riesgos de los opioides**
- Sensación de cansancio o somnolencia
- Constipación
- Problemas de memoria
- Agravamiento del dolor

¿Cuáles son las preocupaciones que tiene sobre el consumo de medicamentos opioides?

**¿Cómo se sentirá mientras reduce lentamente su medicación de opioides?**

Si ha estado tomando opioides durante más de algunos meses, su cuerpo está acostumbrado a tomarlos. Pararlos rápidamente puede causar síntomas de abstinencia como:
- Aches musculares
- Dificultad para dormir
- Inquietud
- Ansiedad
- Agravamiento del dolor

Para evitar que usted experimente estos síntomas de abstinencia, su proveedor reducirá de manera lenta la dosis de opioides. Esto minimizará el malestar que experimente. Si experimenta alguno de estos síntomas, comuníquese con su equipo de atención y ellos pueden ayudarlo con los síntomas de abstinencia, que normalmente persisten por un período corto.

Cuando comienza a reducir la dosis de opioides, no tome dosis extras ni trate de regresar a su dosis original sin hablar con su proveedor. Su cuerpo ya no estará acostumbrado a la dosis más alta. Tomar más opioides puede ponerle en riesgo para un sobredosis.

**Tiempo de abstinencia**

- Síntomas de abstinencia:
  - No todos los pacientes experimentan abstinencia
  - Los síntomas pueden comenzar en las primeras 24 horas después de reducir la dosis, pero pueden tardar más con medicamentos como la metadona

- Estos síntomas desaparecerán con el tiempo (5–10 días para la metadona) pero pueden durar más en algunos pacientes

**Autocuidado que puede hacer mientras reduce la dosis de opioides**

- Participar en actividades de bienestar: meditación, relajación, oración.
- Centro de respiración profunda: sentado en un lugar tranquilo con los ojos cerrados y profundamente respirando.
- Trabajar estrechamente con su proveedor y informar sobre los síntomas de abstinencia y el deseo por el medicamento.
- Obtener apoyo de amigos y familia y considerar un grupo de apoyo/recovering.
- Saber que la abstinencia es temporal y aunque puede ser incómoda, no es vida-threatening.
- Detenerse de tomar opioides puede mejorar su dolor y permitirle ser más activo.
- Si su dolor sigue siendo un problema, hable con su proveedor de atención primaria.

**Por favor llame (303) 461-2089 con cualquier pregunta o preocupación.**

Línea de crisis de veteranos
1-800-273-TALK (8255) o Mensaje: 838255

**Cuadrícula de reducción de opioides:**

- Inicio de reducción:

**Spanish Translation**

**Slowly Stopping Opioid Medications**

**Guía para el paciente**

¿Están ayudando a su medicación de opioides? El objetivo del tratamiento de dolor crónico es ayudarle a recuperar la capacidad de moverse y participar en actividades importantes para usted. Las medicaciones opioides pueden ser útiles después de un daño agudo o una cirugía, pero pueden perder su efecto en la reducción del dolor con el tiempo. Esto podría impedirle volver a lo que es importante para usted. Es tiempo de descubrir un método diferente para tratar su dolor. Comuníquese con su proveedor sobre alternativas a los opioides y cómo reducir de manera segura sus medicaciones opioides.

¿Cuáles son los riesgos posibles de los opioides?
- Sentirse cansado o adormecido
- Constipación
- Problemas de memoria
- Agravamiento del dolor

¿Cuáles son las preocupaciones que tiene sobre el consumo de medicamentos opioides?

¿Cómo se sentirá mientras reduce lentamente su medicación de opioides? Si ha estado tomando opioides durante más de algunos meses, su cuerpo está acostumbrado a tomarlos. Pararlos rápidamente puede causar síntomas de abstinencia como:
- Dolores musculares
- Dificultad para dormir
- Inquietud
- Ansiedad
- Agravamiento del dolor

Para evitar que usted experimente estos síntomas de abstinencia, su proveedor reducirá de manera lenta la dosis de opioides. Esto minimizará el malestar que experimente. Si experimenta alguno de estos síntomas, comuníquese con su equipo de atención y ellos pueden ayudarlo con los síntomas de abstinencia, que normalmente persisten por un período corto.

Cuando comienza a reducir la dosis de opioides, no tome dosis extras ni trate de regresar a su dosis original sin hablar con su proveedor. Su cuerpo ya no estará acostumbrado a la dosis más alta. Tomar más opioides puede ponerle en riesgo para un sobredosis.

Tiempo de abstinencia
- Síntomas de abstinencia:
  - No todos los pacientes experimentan abstinencia
  - Los síntomas pueden comenzar en las primeras 24 horas después de reducir la dosis, pero pueden tardar más en algunos pacientes

- Estos síntomas desaparecerán con el tiempo (5–10 días para la metadona) pero pueden durar más en algunos pacientes

Autocuidado que puede hacer mientras reduce la dosis de opioides
- Participar en actividades de bienestar: meditación, relajación, oración.
- Centro de respiración profunda: sentado en un lugar tranquilo con los ojos cerrados y profundamente respirando.
- Trabajar estrechamente con su proveedor y informar sobre los síntomas de abstinencia y el deseo por el medicamento.
- Obtener apoyo de amigos y familia y considerar un grupo de apoyo/recovering.
- Saber que la abstinencia es temporal y aunque puede ser incómoda, no es vida-threatening.
- Detenerse de tomar opioides puede mejorar su dolor y permitirle ser más activo.
- Si su dolor sigue siendo un problema, hable con su proveedor de atención primaria.

Por favor llame (303) 461-2089 con cualquier pregunta o preocupación.

Línea de crisis de veteranos
1-800-273-TALK (8255) o Mensaje: 838255

Cuadrícula de reducción de opioides
- Inicio de reducción:
Slowly Stopping Benzodiazepines

Your benzodiazepine may not be helping as much as you think!
Many people who take benzodiazepines (e.g., Alprazolam [Xanax®], Duazepam [Valium®], Lorazepam [Ativan®]) get used to the medicine. As a result, when a dose is skipped or lowered, anxiety and sleep problems can get worse. Tapering is a way to slowly reduce your dose to help prevent withdrawal symptoms.

Possible risks of benzodiazepines:
- Feel tired or drowsy
- Problems with memory and thinking
- Depression, mood changes, irritability, anger
- Worsening of PTSD symptoms
- Become dependent on the medicine
- Withdrawal symptoms
- Car crash
- Arrest for driving while impaired
- Unsteady walking
- Falls, broken bones, or concussion
- Overdose—especially when combined with alcohol, strong pain medicine (opioids), non-prescribed medicines
- Birth defects
- Withdrawal symptoms in newborn

The key to success
The best way to reduce or stop benzodiazepines is to work with your provider to very slowly decrease your dose. This may take months, but it is the safest approach.

Withdrawal symptoms are temporary. In time, you will have more energy, a clearer mind, and sleep better.

Possible signs of benzodiazepine withdrawal:

Common symptoms:
- Trouble sleeping/nightmares
- Anxious / irritable
- Muscle stiffness
- Flu-like symptoms
- Numbness or tingling
- Stomach upset

Less common symptoms:
- Feeling that you are not really in your body
- Memory problems

Rare symptoms:
- See or hear things that are not really there
- Sulfures

Tips for successfully stopping your benzodiazepines:
- Work with your provider and report symptoms of withdrawal.
- Ask for support from friends and family.
- Use relaxation techniques such as meditation, deep breathing, or yoga.
- Develop a routine around bedtime to make falling and staying asleep easier.
- Limit caffeine and alcohol.

Do not stop taking any medicine without first speaking to your provider.

Tapering schedule:

Please call _________________ with any questions or concerns.

Veterans Crisis Line: 1-800-273-TALK (8255) or Text 838255
Bottom Line Up Front (BLUF)

• Alarming increases in drug overdoses—Overdose Prevention needed NOW more than ever!
• What can psychologists do?
  • **Education:** Opioid Overdose Education and Naloxone Distribution (OEND) ([internal]/[external])
  • **Pain Management:**
    • Stepped Care Model for Pain Management
    • Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)
    • Stratification Tool for Opioid Risk Mitigation (STORM) Data-Based Risk Reviews
    • Tapering and discontinuation ([opioids], [benzos])—high risk periods! Keep patients on your radar!
  • **Risk Mitigation:**
    • Improve post-overdose care
      • VHA → report overdoses using *Suicide Behavior and Overdose Report (SBOR)*, be part of Overdose Review Team
    • Support *Syringe Service Programs* ([external]) and Fentanyl Test Strips as appropriate
  • **Addiction Treatment:**
    • Identify Opioid Use Disorder (OUD) and support initiation of Medication for OUD ([SCOUTT]; [external])
    • Identify and connect patients with *Substance Use Disorder (SUD) Treatment* (esp alcohol and stimulants)
Post-Overdose Response

- VA Computerized Patient Record System (CPRS) National Note Templates
  - Suicide Behavior and Overdose Report (SBOR)
    - Use to capture any overdose event among VA patients (goal is to improve care post-overdose)
  - Naloxone Use Note
    - Use to capture any time a VA patient’s naloxone is used on someone other than the patient (need to identify if patient may need support/changes in treatment plan as patient may be around people who are overdosing)

KEY POINT: Non-fatal overdose events are clinically significant events that represent critical opportunities to intervene to improve care for patients and prevent future overdose
### Table 1

Fatal opioid overdose standardized mortality ratios (SMR) and population attributable fractions (PAF) associated with exposure to opioid prescription and critical encounter touchpoints in past 12 months, Massachusetts, 2014.

<table>
<thead>
<tr>
<th>Touchpoint</th>
<th>Person years (%)</th>
<th>Opioid deaths (%)</th>
<th>Opioid death incidence rate per 100,000 person years</th>
<th>SMR (95% CI)</th>
<th>PAF (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All residents</td>
<td>6,717,390 (100%)</td>
<td>1315 (100%)</td>
<td>19.6</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Any touchpoint</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High dosage</td>
<td>36,330 (0.5%)</td>
<td>100 (7.6%)</td>
<td>275</td>
<td>15.1 (12.1, 18.0)</td>
<td>0.07 (0.06, 0.09)</td>
</tr>
<tr>
<td>Opioid prescription touchpoint</td>
<td>348,535 (2.2%)</td>
<td>269 (20.5%)</td>
<td>181</td>
<td>12.6 (11.1, 14.1)</td>
<td>0.19 (0.17, 0.21)</td>
</tr>
<tr>
<td>Opioid detoxification</td>
<td>16,541 (0.2%)</td>
<td>259 (19.7%)</td>
<td>1,844</td>
<td>66.1 (58.0, 74.1)</td>
<td>0.19 (0.17, 0.22)</td>
</tr>
<tr>
<td>Nonfatal opioid overdose</td>
<td>9,208 (0.1%)</td>
<td>223 (17.0%)</td>
<td>2,422</td>
<td>111 (96.7, 126)</td>
<td>0.17 (0.15, 0.19)</td>
</tr>
<tr>
<td>Injection-related infection</td>
<td>5,752 (0.1%)</td>
<td>81 (6.4%)</td>
<td>1,408</td>
<td>54.1 (42.4, 65.8)</td>
<td>0.06 (0.05, 0.07)</td>
</tr>
<tr>
<td>Release from incarceration</td>
<td>14,686 (0.2%)</td>
<td>126 (9.6%)</td>
<td>958</td>
<td>30.0 (24.8, 35.3)</td>
<td>0.09 (0.08, 0.11)</td>
</tr>
</tbody>
</table>

- **1 in 2**—Any touchpoint
- **1 in 5**—Opioid Rx/Opioid detoxification
- **1 in 6**—Nonfatal Overdose
- **1 in 10**—Release from incarceration
- **1 in 16**—Injection-related infection
Suicide Behavior and Overdose Reporting

Memorandum

Department of Veterans Affairs

Date: July 20, 2021

From: Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11)

Subj: Suicide Behavior and Overdose Reporting (VIEWS 5503335)

To: Veterans Integrated Services Network (VISN) Director (10N1-23)
Medical Center Directors (00)
VISN Chief Mental Health Officers (10N1-23)
VISN CMO (10N1-23)

1. The purpose of this memorandum is to enhance tracking of overdose events to reduce the risk of Veteran overdose deaths, in addition to updating the requirements for reporting suicide behaviors. Reporting of all self-directed violence behaviors of suicidal and undetermined intent, and all overdose events, regardless of suicidal intent, are now required through the national standardized note templates (i.e. Suicide Behavior and Overdose Report or Comprehensive Suicide Risk Evaluation) as described in the attachment.
Requirements:

1. Clinical staff are now required to report all self-directed violence (SDV) behaviors of suicidal and undetermined intent, and all overdose events, regardless of suicidal intent, through national standardized note templates.

2. Clinical staff, as defined in the [Department of Veterans Affairs (VA) Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Staff Specific Guidance](https://www.va.gov/), will notify the Suicide Prevention Team of suicidal and undetermined SDV behaviors upon completion of the SBOR or Comprehensive Suicide Risk Evaluation (CSRE).

3. For accidental and undetermined overdose events, facilities must have a process in place to ensure that these events are reviewed (e.g., Overdose Review Team) with a focus on engaging patients in treatment.

   **NOTE:** Overdose Review Teams will likely require addiction, mental health, and/or pain management expertise.

SBOR Resources

- **TMS Training**
  - Suicide Behavior and Overdose Report (SBOR)
    - **Course Number:** VA 45626
    - **Target audience:** Suicide Prevention Coordinators and suicide prevention teams, VA medical center staff members, and Veterans Integrated Service Networks (VISN) leaders.
    - **Credit Hours:** 1

- **Training materials, FAQ, screenshots, and additional resources available at:**

- **Questions**
  - Questions about suicide behavior reporting: VHASPPFieldOperations@va.gov
  - Questions about overdose event reporting: Elizabeth.Oliva@va.gov
Suicide Behavior and Overdose Report

- Nationally standardized medical record note template designed to standardize and streamline the process of suicide behavior and overdose reporting across VA
- Enhance the visibility of suicide events and accidental overdoses within the Veteran’s medical record
- Improve clinical care after the suicide/overdose event
- Facilitate real-time tracking of suicide and overdose event data, for use in clinical decision support tools and local/national aggregate reporting needs

Training materials, FAQ, screenshots, and additional resources available at:
https://dvagov.sharepoint.com:/f:/r/sites/VACOMentalHealth/Safety%20Planning%20SBR/Suicide%20Behavior%20and%20Ovedose%20Reporting
(available within VA network only)
More than Just Documentation...

• The SBOR Template provides clinical decision support to guide patient care post-overdose

Risk Factors Listed in the SBOR:
• Previous overdose
• Periods of abstinence from opioids
• Opioid tapering
• Substance use disorder/substance misuse
• Mental health
• Use of sedatives
• Unmet pain management needs
• Use of non-prescribed opioids
• Use of prescribed opioids
• Medical
• History of falls
• Emergency department visits
• History of HIV
• Homelessness
• Family Stressors
• Financial concerns and unemployment
MAIN CHANGES:
- Added Safety Planning recommendation
- Updated tapering % based on current recommendations
- Added more substance use disorder resources
Main Changes:
- Added link to VA/DoD CPG for Mental Health
- Added benzodiazepine resources
- Added Pain Informational Guide to relevant sections
MAIN CHANGES:

- Added additional resources
MAIN CHANGES:
• Added additional resources and recommendations
Syringe Service Programs (SSP) Directive Development

- **Memo** as interim guidance
  - Released May 24, 2021
  - FAQ on SharePoint is updated

- **Directive development**
  - Steering committee convened with approval from ADUSH for Clinical Services
  - Represents a collaborative effort between Specialty Care and Mental Health
  - Stakeholders include:
    - Specialty Care: HHRC, NIDS, PMOP
    - Mental Health: Substance Use Disorders, OEND
    - Homeless Program
    - Risk Management: Ethics
    - Patient Care Services: PBM, Social Work
    - Regulations, Appeals, and Policy
  - VHA medical centers operate syringe services programs (SSPs) to provide supplies and education to Veterans enrolled in VHA care where such programs are not prohibited under state, county, or local law
  - National note template
  - National education resources
  - Standardization of kit components
  - Timeline: 4-6 months (pending note template development)
  - Post directive, going from 2 facilities with SSPs to potentially 106+ facilities across 38 states (excluding 12 states that prohibit SSPs)

- We would like to address concerns from the field; your feedback and questions are appreciated!
• Hoping to develop a **basic** SSP kit model (using success of naloxone kits as a model):
  – Sterile syringes (100 OR 25):
    • 30g 5/16 1cc
    • 29g 1/2” 1cc
    • 27g 5/8” 1 cc
  – Alcohol pads
  – Sharps container
  – Cottons
  – Education handout
• Additional components might include:
  – Sterile water
  – Band-Aids
  – Ascorbic acid powder
  – Condoms
  – Fentanyl test strips
• Other key services:
  – Screening, care, and treatment for viral hepatitis, HIV, and sexually transmitted infections
  – Vaccinations, including hepatitis A and B
  – Abscess and wound care
  – Referral to social work, mental health, and other medical services
Initial Danville VA process (2018)

- Pick up:
  - Outpatient pharmacy
  - Urgent Care (Omnicell)
- Mailed locally from Outpatient Pharmacy
- #20 syringes given out at a time, initially (now #100)
  - 2 Patient Handouts included
  - No prescription
  - No information taken from patient
- **2800 syringes given out since 2018**
Updated Process—VISN 12 ADS Pilot: Harm Reduction Kits

- 200 kits, to be shared among V12 facilities
- Kit contents to be purchased with awarded National ADS funds
- Plan to use in clinic order for local tracking
  - Re-evaluate after Cerner
- Beyond this pilot, and for facilities nation-wide:
  - National workgroup working to support implementation (e.g., note template, kits/order set)
Join our SSP Affinity Group!

- Meets every other month, 4th Thursday at noon ET
- Share promising practices, ask questions, discuss local and national issues
- We have a Teams channel for discussion in between calls

SSP SharePoint: https://dvagov.sharepoint.com/sites/vhahiv-aids/syringe-exchange-resources/SitePages/SSP-Home.aspx

- Elizabeth.Maguire@va.gov
- VHASSPActionGroup@va.gov
## Fentanyl Test Kits Program
San Francisco VA HCS

### Problem
- Unregulated drugs often mixed with fentanyl (e.g., cocaine, meth, heroin)
- Increased fentanyl-related overdose deaths in the US
- Rates in California are highest in counties served by the SFVAHCS

### Intervention
- Offered harm reduction education and fentanyl test kits
- Veterans can test drugs before using to see if fentanyl/analogs are present
- Offered naloxone

### Outcome
- Information on fentanyl was new to many
- Used strategies to reduce risk when results were positive (e.g., test dose, smaller dose, threw away)
- Provided education to others
- Unexpected positive results was a motivator not to use
- Did not increase drug use
# Fentanyl Test Kits Program

## San Francisco VA HCS

**What can I do?**

- Submit a logistics request to purchase fentanyl test kits ($25 each + shipping, 5 strips per kit) and/or strips (100/bottle, $1 each + shipping)
- Consider creating a consult for education and provision of fentanyl test kits/strips
- Consider offering in existing programs/settings (e.g., SUD, ED, mental health, HUD/VASH)

**Who should I offer to?**

- Current or past use of non-prescribed drugs
- Recent drug overdose
- Around others using drugs
- Homeless, unstably housed, residing in HUD/VASH housing
- Anyone who might benefit!

**Where can I go for resources?**

- Fentanyl test kit product page: [https://www.btnx.com/HarmReduction](https://www.btnx.com/HarmReduction)
- How to use fentanyl test kit: [https://youtu.be/YrZ6KGsjIJM](https://youtu.be/YrZ6KGsjIJM)
- How to use fentanyl test strips: [https://youtu.be/-ngMXiNc6k4](https://youtu.be/-ngMXiNc6k4)
- Additional resources available here: [HIV SharePoint Home - SF-FTS-Resources - All Documents](https://www.btnx.com/HarmReduction)

---

**Tessa Rife, PharmD, BCGP**

Academic Detailing Program Manager → PMOP Coordinator

[Tessa.Rife@va.gov](mailto:Tessa.Rife@va.gov), feel free to message me on Teams

---

Tessa Rife, PharmD, BCPG; August 2021 VA National Opioid Safety and Risk Mitigation Call Presentation
Bottom Line Up Front (BLUF)

• Alarming increases in drug overdoses—Overdose Prevention needed NOW more than ever!
• What can psychologists do?
  • **Education:** Opioid Overdose Education and Naloxone Distribution (OEND) (internal/external)
  • **Pain Management:**
    • Stepped Care Model for Pain Management
    • Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)
    • Stratification Tool for Opioid Risk Mitigation (STORM) Data-Based Risk Reviews
    • Tapering and discontinuation (opioids, benzos)—high risk periods! Keep patients on your radar!
  • **Risk Mitigation:**
    • Improve post-overdose care
      • VHA→report overdoses using Suicide Behavior and Overdose Report (SBOR), be part of Overdose Review Team
    • Support Syringe Service Programs (external) and Fentanyl Test Strips as appropriate
  • **Addiction Treatment:**
    • Identify Opioid Use Disorder (OUD) and support initiation of Medication for OUD (SCOUTT; external)
    • Identify and connect patients with Substance Use Disorder (SUD) Treatment (esp alcohol and stimulants)
Stepped Care for Substance Use Disorders

Self-management:
- Mutual help groups
- Skills application
- Mobile apps

Management in non-SUD specialty care:
- Primary Care
- Pain Clinic
- Mental Health

SUD Specialty Care:
- Outpatient
- IOP
- OTP
- Residential

Patient Complexity

Care Complexity
### VA-DoD Clinical Practice Guideline for SUD

- Screening and Brief Alcohol Intervention
- Treatment (Pharmacotherapy and Psychosocial Interventions)
  - Alcohol use disorder
  - Opioid use disorder
  - Cannabis use disorder
  - Stimulant use disorder
- Promoting Group Mutual Help Involvement (e.g., AA, NA, Smart Recovery)
- Address Co-occurring Mental Health Conditions and Psychosocial Problems
- Continuing care guided by ongoing assessment
- Stabilization and Withdrawal
- Principles of care: Shared Decision Making and Motivational Principles

---

#### SUD Medications Psychosocial Intervention

<table>
<thead>
<tr>
<th>SUD</th>
<th>Medications</th>
<th>Psychosocial Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Acamprosate</td>
<td>Behavioral Couples Therapy</td>
</tr>
<tr>
<td></td>
<td>Disulfiram</td>
<td>Cognitive Behavioral Therapy (CBT-SUD)</td>
</tr>
<tr>
<td></td>
<td>Naltrexone</td>
<td>Community Reinforcement Approach (CRA)</td>
</tr>
<tr>
<td></td>
<td>Topiramate</td>
<td>Motivation Enhancement Therapy (MET)</td>
</tr>
<tr>
<td></td>
<td>Gabapentin*</td>
<td>Twelve-step Facilitation (TSF)</td>
</tr>
<tr>
<td>Opioid</td>
<td>Buprenorphine</td>
<td>Medical Management**</td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td>Contingency Management (CM)/Individual Drug Counseling (IDC)**</td>
</tr>
<tr>
<td></td>
<td>ER-Injectable Naltrexone*</td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td>CBT/MET</td>
<td></td>
</tr>
<tr>
<td>Stimulant</td>
<td>CBT/CRA/IDC +/- CM</td>
<td></td>
</tr>
</tbody>
</table>

*Suggested **Recommended only with Medication

Medications for OUD Reduces Mortality for Those with OUD

- Retention in methadone and buprenorphine treatment is associated with reduced overdose and all-cause mortality

- The first 4 weeks of methadone induction and the first month after discontinuing either medication is associated with higher mortality
• More focus on stepped care

• Clarifying DSM-5 vs. ICD-10

• HIV PrEP information included

• More details on medications for OUD
Patient Information: Trifold

Check your answers
Here are answers to the quiz on the inside left of this brochure.

1. FALSE. Your body gets used to the opioids the longer you take them. It does not matter if you are taking them for pain or for other reasons. You can get used to them even if your provider prescribes them.

2. FALSE. Any opioid can cause someone to develop opioid use disorder.

3. FALSE. Opioid use disorder is not a choice. It is a brain disease that needs treatment, just like other diseases such as diabetes or high blood pressure.

4. FALSE. Effective treatment is available. For most patients, medication treatment is best. Medication helps patients engage in other forms of treatment such as peer-support groups and counseling.

5. FALSE. People with opioid use disorder can recover and live full and productive lives.

What can you do if you are concerned about opioid use?
Talk to your provider.
✓ Ask if there are safer ways to manage pain.
✓ Discuss any concerns about opioid dependence or opioid use disorder.
✓ Find out about the benefits of treatment.
✓ Ask about the risks of accidental overdose and your options for receiving opioid overdose education and naloxone.

Do you Know the Truth About Opioid Use Disorder?
Get informed. Learn the facts. If you or someone you know uses opioids.
Common opioids include:
- Hydrocodone
- Oxycodone
- Morphine
- Fentanyl
- Codeine
- Tramadol
- Oxymorphone
- Hydromorphone
- Heroin

Let’s test what you know
Please circle either TRUE or FALSE to test what you know.
1. If opioids are taken for pain it is not possible to become dependent on them.
   ✔ TRUE or ✗ FALSE

2. heroin is the only opioid that can cause opioid use disorder.
   ✔ TRUE or ✗ FALSE

3. Developing opioid use disorder is a choice.
   ✔ TRUE or ✗ FALSE

4. The only effective treatment for opioid use disorder is stopping all opioid use.
   ✔ TRUE or ✗ FALSE

5. People with opioid use disorder will never recover.
   ✔ TRUE or ✗ FALSE

What is opioid use disorder?
Opioid use disorder develops over time and is not a choice or weakness.

- It is a brain disorder that needs treatment, just like other diseases such as diabetes and high blood pressure.
- Signs of possible opioid use disorder:
  - Craving or a strong urge to use opioids
  - Difficulty with work, relationships, activities
  - Hard to control opioid use even when it causes harm, such as after an overdose

Treatment works
Ask your provider about using medication as part of your treatment plan.
Three different medications can treat opioid use disorder.
- Sustained-release naltrexone (Suboxone®)
- Methadone
- Naltrexone injection (Vivitrol®)

Behavioral support
Taking medications is one part of your treatment. Attending mutual help groups or peer support groups such as Narcotics Anonymous or SMART Recovery can help you engage in treatment and support your recovery.

Work with your provider to find the right treatment options for you.

Recovery is possible.
A return to opioid use can be helped if treatment has failed. Reach out to your VA provider to discuss possible changes to your treatment plan.

https://www.pbm.va.gov/PBM/academicdetailingservice home.asp
# Patient Information: Factsheet

## Medications for Opioid Use Disorder

Opioid use disorder develops over time and is not a choice or a weakness. It is a brain disorder that needs treatment, just like other diseases such as diabetes and high blood pressure.

Medication treatment can help you stop or lower your opioid use if you have opioid use disorder. It can also lessen the craving for opioids and help you engage with treatment. Medication treatment may be needed for days, months, or years—ever as long as needed to support recovery. Talk to your provider about your treatment plan.

### Medications to consider as part of your treatment plan

<table>
<thead>
<tr>
<th>Naltrexone Injection</th>
<th>Buprenorphine*</th>
<th>Methadone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How does it work?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blocks the effect of opioid drugs</td>
<td>Prevents and relieves withdrawal</td>
<td>Prevents and relieves withdrawal</td>
</tr>
<tr>
<td></td>
<td>Reduces craving and the high from taking other opioids</td>
<td>Reduces craving and the high from taking other opioids</td>
</tr>
</tbody>
</table>

| **How do I take it?** |                |           |
| Injected into the buttocks muscle, every month | Dissolve under the tongue once daily | By mouth once daily |

| **Where do I get it?** |                |           |
| Prescribed by doctors or other qualified prescribers OR Licensed Opioid Treatment Programs (OTPs) | Prescribed by doctors or other qualified prescribers OR Licensed Opioid Treatment Programs (OTPs) | Methadone can only be used to treat opioid use disorder by prescribed opioid treatment programs (OTPs) |

*Includes buprenorphine/naloxone, such as Suboxone®. Buprenorphine long-acting injectable and implant are also approved for OUD.

### What are some of the side effects?

- **Naltrexone injection**
  - Change in appetite
  - Back, muscle, or joint pain
  - Constipation or diarrhea

- **Buprenorphine**
  - Constipation
  - Upper stomach or vomiting
  - Feeling dizzy or sleepy

- **Methadone**
  - Constipation
  - Upper stomach or vomiting
  - Feeling dizzy or sleepy

### What side effects should I report to my provider?

- **Naltrexone injection**
  - Allergic reaction or swelling
  - Chest tightness or Trouble breathing
  - Anxiety, trouble sleeping, depression, or unusual thoughts
  - Dark or tea-colored urine
  - Yellowing of eyes or skin

- **Buprenorphine**
  - Extreme stomach pain, vomiting, or diarrhea
  - Dark or tea-colored urine
  - Light-colored bowel movements
  - Yellowing of eyes or skin

- **Methadone**
  - Allergic reaction or swelling
  - Chest tightness, heart palpitations, or trouble breathing
  - Extreme dizziness, weakness, or sweating
  - Samares
  - Cold, clammy skin
  - Slow or uneven heartbeat

### Have naloxone available.

Patients with opioid use disorder are at higher risk of overdose. Help stay safe by having naloxone available. Naloxone is an opioid reversal medication.

Know the signs of overdose:
- Trouble breathing, slow or shallow breathing;
- Snoring, grunting, or choking sounds;
- Extreme tiredness, heavy nodding, or loss of consciousness;
- Clammy, sweaty skin or bluish or grayish lips, fingernails, or skin.

Return to use (or relapse) is not treatment failure. You may need multiple attempts to reduce or stop opioid use. This only means your treatment plan may need to be changed. Talk to your VA provider about your treatment options.
Identify Veterans with OUD, make the diagnosis, and provide OEND.

If you are a qualifying practitioner and interested in increasing access to OUD care, get your X-waiver.

Offer medication as first-line treatment to Veterans with OUD.
SUD SharePoint: SCOUTT resources

Important Links
- SCOUTT Calendar
- Table of Contents
- Frequently Asked Questions
- SCOUTT Conferences
- Webinars
- Pilot Teams Documents
- Available Training
- Planning Committee
- Resources
- X-Waiver
- SCOUTT Publications

Trainings and Audioconferences

VA Accredited Webinar Training Series (enduring content available for CEUs)
- Step2 Care for Opioid Use Disorder Train-the-Trainer
- Providing Veterans with the Best SUD Care Anywhere
- Tobacco Use Treatment Audioconference Series
- VA Academic Detailing – Continuing Education

Upcoming Opportunities
- Webinar: Best Practices in Treatment Planning
  Tue, Sep 28, 2:00 PM
- Webinar: Revised VA/DoD Clinical Practice Guidelines for Management of SUD
  Tue, Nov 23, 2:00 PM

Other Enduring TMS Trainings
- Shared Decision Making: Journey Together
- Advanced Training in the Safety Planning Intervention

VA Podcast Series
(available on Spreaker, Apple Podcasts, Spotify, and more)

Battling Two Frontiers: Substance Use Epidemic during a Pandemic

The Art of Medicine - Opioid Dependence
Learning that promises the best care for our veterans

U.S. Department of Veterans Affairs
# SUD SharePoint: SUD Resource Directory

## Substance Use Disorder Resource Directory: 2021

### Key SharePoint Sites:
- VA National SUD Program
- Measurement-based Care
- Opioid Formulations
- Office of Mental Health & Suicide Prevention

### SUD National Points of Contact:

<table>
<thead>
<tr>
<th>Name</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joseph Liberto, M.D.</td>
<td><a href="mailto:Joseph.Liberto@va.gov">Joseph.Liberto@va.gov</a></td>
</tr>
<tr>
<td>James McKay, Ph.D.</td>
<td><a href="mailto:James.McKay@va.gov">James.McKay@va.gov</a></td>
</tr>
<tr>
<td>Dominick DePhillips, Ph.D.</td>
<td><a href="mailto:Dominick.DePhillips@va.gov">Dominick.DePhillips@va.gov</a></td>
</tr>
<tr>
<td>Andrew Saxton</td>
<td><a href="mailto:Andrew.Saxton@va.gov">Andrew.Saxton@va.gov</a></td>
</tr>
<tr>
<td>Eric Hawkins, Ph.D.</td>
<td><a href="mailto:Eric.Hawkins@va.gov">Eric.Hawkins@va.gov</a></td>
</tr>
<tr>
<td>Jodie Trohin, Ph.D.</td>
<td><a href="mailto:Jodie.Trohin@va.gov">Jodie.Trohin@va.gov</a></td>
</tr>
</tbody>
</table>

### National SUD Consultation – Please email AskTheExpert-SudConsultative@va.gov if you have questions related to SUD treatment or program operations. Colleagues with expertise in treating SUDs across the healthcare system are available to respond to questions.

### Mail Groups:

<table>
<thead>
<tr>
<th>VHIA VHMSBP National SUD Community of Practice</th>
<th>List Owner (Please contact to be added to a group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHIA VHMSBP SUD PTSD Specialties</td>
<td>All List, email: <a href="mailto:All.List@va.gov">All.List@va.gov</a></td>
</tr>
<tr>
<td>VHIA VHMSBP Buprenorphine Providers</td>
<td>Lindsay Daniels, email: <a href="mailto:Lindsay.Daniels@va.gov">Lindsay.Daniels@va.gov</a></td>
</tr>
<tr>
<td>VHIA VHMSBP Opioid Treatment Programs</td>
<td>All List, email: <a href="mailto:All.List@va.gov">All.List@va.gov</a></td>
</tr>
<tr>
<td>VHIA VHMSBP SUD IOP Teams</td>
<td>All List, email: <a href="mailto:All.List@va.gov">All.List@va.gov</a></td>
</tr>
<tr>
<td>VHIA VHMSBP SUD Couples &amp; Family</td>
<td>All List, email: <a href="mailto:All.List@va.gov">All.List@va.gov</a></td>
</tr>
<tr>
<td>VHIA VHMSBP Gambling Disorders</td>
<td>All List, email: <a href="mailto:All.List@va.gov">All.List@va.gov</a></td>
</tr>
<tr>
<td>VHIA VHMSBP Addiction Therapists</td>
<td>Elizabeth Okva, email: <a href="mailto:Elizabeth.Okva@va.gov">Elizabeth.Okva@va.gov</a></td>
</tr>
</tbody>
</table>

### SUD VISN Points of Contact:

<table>
<thead>
<tr>
<th>VISN</th>
<th>Name</th>
<th>State</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Marc E. Brown, M.D.</td>
<td>VA Connecticut</td>
<td><a href="mailto:Marc.R.Winter@va.gov">Marc.R.Winter@va.gov</a></td>
</tr>
<tr>
<td>02</td>
<td>Brian Hanes, M.D.</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Brian.Hanes@va.gov">Brian.Hanes@va.gov</a></td>
</tr>
<tr>
<td>03</td>
<td>Christopher C. Chase, M.D.</td>
<td>VA New Jersey HCS – East Orange</td>
<td><a href="mailto:Christopher.C.Chase@va.gov">Christopher.C.Chase@va.gov</a></td>
</tr>
<tr>
<td>05</td>
<td>Stephanie O’Connell</td>
<td>VA New York Harbor HCS</td>
<td>Stephanie.O’<a href="mailto:Connell@va.gov">Connell@va.gov</a></td>
</tr>
<tr>
<td>06</td>
<td>Ashley Engels, Ph.D.</td>
<td>VA New Jersey HCS – West Orange</td>
<td><a href="mailto:Ashley.Engels@va.gov">Ashley.Engels@va.gov</a></td>
</tr>
<tr>
<td>07</td>
<td>Hugh Morris, M.D.</td>
<td>VA New Jersey HCS – East Orange</td>
<td><a href="mailto:Hugh.Morris@va.gov">Hugh.Morris@va.gov</a></td>
</tr>
<tr>
<td>08</td>
<td>Pamela Brown, Ph.D.</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Pamela.Brown@va.gov">Pamela.Brown@va.gov</a></td>
</tr>
<tr>
<td>09</td>
<td>Cali-Med, Inc.</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Cali-Med.Inc@va.gov">Cali-Med.Inc@va.gov</a></td>
</tr>
<tr>
<td>10</td>
<td>Elizabeth Dool</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Elizabeth.Dool@va.gov">Elizabeth.Dool@va.gov</a></td>
</tr>
<tr>
<td>11</td>
<td>Jason Green, M.D.</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Jason.Green@va.gov">Jason.Green@va.gov</a></td>
</tr>
<tr>
<td>12</td>
<td>Gary East</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Gary.East@va.gov">Gary.East@va.gov</a></td>
</tr>
<tr>
<td>13</td>
<td>Rodney Ether, M.D.</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Rodney.Ether@va.gov">Rodney.Ether@va.gov</a></td>
</tr>
<tr>
<td>14</td>
<td>Jenny M. Roche, M.D.</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Jenny.Roche@va.gov">Jenny.Roche@va.gov</a></td>
</tr>
<tr>
<td>15</td>
<td>Catherine Hackett</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Catherine.Hackett@va.gov">Catherine.Hackett@va.gov</a></td>
</tr>
<tr>
<td>16</td>
<td>Bernadette Finner</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Bernadette.Finner@va.gov">Bernadette.Finner@va.gov</a></td>
</tr>
<tr>
<td>17</td>
<td>Laura Tamayo</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Laura.Tamayo@va.gov">Laura.Tamayo@va.gov</a></td>
</tr>
<tr>
<td>18</td>
<td>Carolyn Wilhite, M.D.</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Carolyn.Wilhite@va.gov">Carolyn.Wilhite@va.gov</a></td>
</tr>
<tr>
<td>19</td>
<td>Christopher Goldby</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Christopher.Goldby@va.gov">Christopher.Goldby@va.gov</a></td>
</tr>
<tr>
<td>20</td>
<td>Katherine Bailey</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Katherine.Bailey@va.gov">Katherine.Bailey@va.gov</a></td>
</tr>
<tr>
<td>21</td>
<td>Benjamin Weiss, M.D.</td>
<td>VA New York Harbor HCS</td>
<td><a href="mailto:Benjamin.Weiss@va.gov">Benjamin.Weiss@va.gov</a></td>
</tr>
</tbody>
</table>

### Key SUD Clinical Resources and Support:

- VA Substance Use Disorder (SUD) Program Locator: [www.va.gov/directory-gui/SUD.Asp](http://www.va.gov/directory-gui/SUD.Asp)

### VA National SUD Provider Toolkit:


### SUD-Related SharePoint and Internet Sites:

- SUD UTI Initiative: [www.sudmc.org](http://www.sudmc.org)
- SUD-related SharePoint and Internet Sites: [www.sudmc.org](http://www.sudmc.org)

### SUD Conference Calls:

<table>
<thead>
<tr>
<th>Title</th>
<th>Day and Time (Pacific Time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA National SUD Community of Practice</td>
<td>2nd Tuesday every other month @ 2:00 PM</td>
</tr>
<tr>
<td>Best SUD Care Anywhere (SES-sponsored)</td>
<td>2nd Tuesday every other month @ 2:00 PM</td>
</tr>
<tr>
<td>National Opioid Medications Conference</td>
<td>3rd Wednesday every other month @ 1:00 PM</td>
</tr>
<tr>
<td>Tobacco Use Treatment Academic Conference</td>
<td>4th Tuesday of every other month @ 12:00 PM</td>
</tr>
<tr>
<td>Caregiver Care for SUD (SES-sponsored)</td>
<td>1st Tuesday every other month @ 12:00 PM</td>
</tr>
<tr>
<td>VA Opioid Safety and Risk Mitigation Conference</td>
<td>4th Tuesday of every other month @ 12:00 PM</td>
</tr>
<tr>
<td>National SUD Roundtable</td>
<td>1st Tuesday of every other month @ 12:00 PM</td>
</tr>
<tr>
<td>SUD Mental Health First Friday Call</td>
<td>1st Friday of every other month @ 12:00 PM</td>
</tr>
</tbody>
</table>

### Scheduled SUD Conference Calls:

- **Title:** VA National SUD Community of Practice
- **Day and Time:** 2nd Tuesday every other month @ 2:00 PM

### VA SUD Policies and Procedures:

- VA SUD Policies: [www.va.gov/sud/policy](http://www.va.gov/sud/policy)

---

Additional SUD resources and links can be found on the "Applicable Links" page on the SUD SharePoint site.
<table>
<thead>
<tr>
<th>Title</th>
<th>Day and time (Eastern time)</th>
<th>Meeting Details</th>
<th>POC</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHA National SUD Community of Practice Call</td>
<td>4th Tuesday every other month @ 2:00 PM Feb., Apr., Jun., Aug., Oct., Dec.</td>
<td>Join WebEx Meeting; Meeting number: 199 682 1768; Meeting password: rpPAMXQ*625</td>
<td><a href="mailto:Joseph.Liberto@va.gov">Joseph.Liberto@va.gov</a></td>
</tr>
<tr>
<td>Best SUD Care Anywhere (EES-sponsored webinar)</td>
<td>4th Tuesday every other month @ 2:00 PM Jan., Mar., May, Jul., Sep., Nov.</td>
<td>Adobe with VANTS for audio, register in TMS for CEUs</td>
<td><a href="mailto:Dominick.Dephilippis@va.gov">Dominick.Dephilippis@va.gov</a></td>
</tr>
<tr>
<td>National OTP Leaders Call</td>
<td>1st Monday @ 1:00 PM</td>
<td>Join Microsoft Teams Meeting</td>
<td><a href="mailto:Joseph.Liberto@va.gov">Joseph.Liberto@va.gov</a></td>
</tr>
<tr>
<td>SUD-PTSD Specialist Call</td>
<td>1st Tuesday every other month @ 1:00 PM Feb., Apr., Jun., Aug., Oct., Dec.</td>
<td>Join WebEx Meeting; Meeting number: 199 085 8527; Meeting password: hpJ9g3pBy@9</td>
<td><a href="mailto:Joseph.Liberto@va.gov">Joseph.Liberto@va.gov</a></td>
</tr>
<tr>
<td>Tobacco Cessation Community of Practice Call</td>
<td>4th Thursday @ 12:00 PM</td>
<td>VANTS, 17538#</td>
<td><a href="mailto:Dana.Christofferson@va.gov">Dana.Christofferson@va.gov</a></td>
</tr>
<tr>
<td>Tobacco Use Treatment (EES-sponsored webinar)</td>
<td>4th Monday every other month @ 3:00 PM Feb., Apr., Jun., Aug., Oct., Dec.</td>
<td>Adobe with VANTS for audio, register in TMS for CEUs</td>
<td><a href="mailto:Kim.Hamlett@va.gov">Kim.Hamlett@va.gov</a></td>
</tr>
<tr>
<td>Stepped Care for OUD (EES-sponsored webinar)</td>
<td>2nd Wednesday @ 1:00 PM</td>
<td>Adobe with VANTS for audio, register in TMS for CEUs</td>
<td><a href="mailto:Jacob.Baylis@va.gov">Jacob.Baylis@va.gov</a></td>
</tr>
<tr>
<td>VHA Opioid Safety and Risk Mitigation Call</td>
<td>2nd Wednesday @ 3:00 PM</td>
<td>Adobe Connect, register in TMS for CEUs</td>
<td><a href="mailto:Elizabeth.Oliva@va.gov">Elizabeth.Oliva@va.gov</a></td>
</tr>
<tr>
<td>VISN 1 Buprenorphine Echo Calls</td>
<td>2nd Monday @ 12:00 PM</td>
<td></td>
<td><a href="mailto:Heather.Fries@va.gov">Heather.Fries@va.gov</a></td>
</tr>
<tr>
<td>SUD-MBC National Community of Practice Call</td>
<td>1st Friday @ 2:00 PM</td>
<td>Join Microsoft Teams Meeting</td>
<td><a href="mailto:Dominick.Dephilippis@va.gov">Dominick.Dephilippis@va.gov</a></td>
</tr>
<tr>
<td>Adv. MI/MET Consultation</td>
<td>2nd Tuesday @ 3:00 PM and 3rd Friday @ 2:00 PM</td>
<td></td>
<td><a href="mailto:Jacob.Baylis@va.gov">Jacob.Baylis@va.gov</a></td>
</tr>
<tr>
<td>SCOUTT Facilitation Call</td>
<td>1st Wednesday @ 12:00 PM</td>
<td>Join meeting; Number: 199 273 1663; Password: JMbMXJC?536</td>
<td><a href="mailto:Jacob.Baylis@va.gov">Jacob.Baylis@va.gov</a></td>
</tr>
<tr>
<td>VIP Webinar</td>
<td>4th Wednesday @ 2:00 PM</td>
<td>Join meeting; Number: 199 273 1663; Password: JMbMXJC?536</td>
<td><a href="mailto:Nodira.Codell@va.gov">Nodira.Codell@va.gov</a></td>
</tr>
<tr>
<td>MAT – VA/SUD Journal Club Webinar</td>
<td>3rd and 4th Wednesdays @ 12:00 PM</td>
<td>(3rd Weds) <a href="https://1990726679@veteransaffairs.webex.com">1990726679@veteransaffairs.webex.com</a> Number: 199 072 6679; Password: sGWsJx9J@83 (4th Weds) <a href="https://1997327688@veteransaffairs.webex.com">1997327688@veteransaffairs.webex.com</a> Number: 199 732 7688; Password: YMmYmVu@843</td>
<td><a href="mailto:Matthew.Dungan1@va.gov">Matthew.Dungan1@va.gov</a></td>
</tr>
</tbody>
</table>
OMHSP Health Care Provider Resources: SUD

Substance Use Treatment

Evidence-Based Psychotherapy

Evidence-based psychotherapy or “talk therapy” is effective for treating substance use disorders. Each VA medical center offers one or more talk therapies as well as effective medications for the treatment of SUDs. Many VA medical centers and clinics provide other clinical services for SUD in addition to the evidence-based treatments listed below.

Cognitive Behavioral Therapy for Substance Use Disorders (CBT-SUD)

CBT-SUD, which is one of the evidence-based talk therapies provided in VA, teaches Veterans how to reduce their substance use to improve their quality of life, usually in weekly meetings with a therapist for about 12 weeks. The treatment helps Veterans develop more balanced and helpful thoughts about themselves, others, and the future. It also helps Veterans manage the urge to drink or use drugs, effectively refuse alcohol and drug use opportunities, learn a problem-solving approach to deal with substance use, and achieve their personal goals.

Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET)

MI, another evidence-based intervention, is a conversation between the Veteran and provider to draw out and strengthen motivation for change. The MI approach explores the reasons why you might want to make a change and the potential benefits of the change.

Motivational Interviewing (MI) is a version of MI that involves a brief assessment with feedback and focuses specifically on changing alcohol and/or substance use. MI is particularly helpful when Veterans are first considering making changes or are unsure about the extent of their problems with alcohol and drug misuse. If you are concerned about your alcohol or drug use — or the substance use of someone you care about — and you want to learn about treatment options (if any) to pursue, MET can help.

Contingency Management (CM)

CM is an evidence-based treatment for Veterans who misuse drugs, specifically cocaine, methamphetamine, or marijuana. In CM, the Veteran receives rewards for abstinence that is verified by urine drug screens. The rewards increase when abstinence is consistent, i.e., repeated negative test results. Extensive research on CM has shown that it is a very effective treatment for helping Veterans maintain abstinence and stay in treatment.

Medical Options

VA also offers proven medication options, like:

- Medications to reduce cravings, prevent relapse, and reduce the risk of death from substance use disorder. Including:
  - Buprenorphine, Injectable Naltrexone, or Methadone for Opioid Use Disorder
  - Acamprosate, Disulfiram, Naltrexone and Topiramate for Alcohol Use Disorder
  - Nicotine replacement therapy, Bupropion, and Varenicline for Tobacco Use Disorder

- When indicated, medically-managed detoxification to stop substance use safely, and to get stable
- Read more about Effective Medications for Opioid Use Disorder

Resources


The National Institute on Alcohol Abuse and Alcoholism (NIAAA) [2] provides information on the latest research-based treatments and what to consider when choosing among them.

Reframing Drinking [2]

Offers valuable research-based information on drinking habits and how they may affect your health, along with support for making a change.

Medications [2]

Helps answer health questions by bringing together information from the National Library of Medicine, the National Institutes of Health, and other government agencies and health-related organizations.

Substance Abuse and Mental Health Services Administration (SAMHSA) [2]

Provides fact sheets, videos, brochures, and more in the publications section.

National Institute on Drug Abuse (NIDA) [2]

Features information on drug abuse, drug-related legislation, and more.

National Alcohol & Drug Addiction Recovery Month [2]

Provides resources throughout the year to promote the societal benefits of treatment for alcohol and drug use disorders.


Examine treatment availability and alcohol and drug addiction treatment options available for Veterans and their families.

Mutual Help Organizations

Alcoholics Anonymous [2]

This international fellowship supports men and women with alcohol use disorders.

Cocaine Anonymous Officers [2]

This 12-step program is modeled closely after alcoholic anonymous.

Crystal Meth Anonymous [2]

This fellowship offers an opportunity for people who have used crystal meth to share their experiences — and their strength and support.

Marijuana Anonymous [2]

This organization supports those wishing to stop using marijuana.

Narcotics Anonymous [2]

This international, community-based association of recovering drug users sponsors more than 20,000 weekly meetings in 133 countries.

Smart Recovery [2]

This international program aims to help people recover from all types of substance use and addictive behaviors including alcohol and drug problems and gambling.

SMART Recovery sponsors face-to-face meetings around the world and daily online meetings.

Opioid Overdose Education and Naloxone Distribution (OEEND)

In an effort to prevent fatal opioid overdoses, VA developed a national OEEND program to train Veterans on how to prevent, recognize, and respond to an opioid overdose. The following brief video shows clinicians discussing OEEND with Veterans and having them to see VA surgical naloxone kits.

Opioid Overdose Education and Naloxone Distribution (OEEND)

introduction to Naloxone for People with Opioid Use Disorders [2]

introduction to Naloxone for People Training Prescribed Option [2]

How to Use the VA Naloxone Intramuscular Kit [2]

How to Use the VA Intranasal Naloxone Kit [2]

Opioid Overdose Education and Naloxone Distribution (OEEND) [2]

introduction to Naloxone for People with Opioid Use Disorders [2]

introduction to Naloxone for People Training Prescribed Option [2]

How to Use the VA Naloxone Intramuscular Kit [2]

How to Use the VA Intranasal Naloxone Kit [2]

VA Opioid Overdose Education and Naloxone Distribution (OEEND)

introduction to Naloxone for People with Opioid Use Disorders [2]

introduction to Naloxone for People Training Prescribed Option [2]

How to Use the VA Naloxone Intramuscular Kit [2]

How to Use the VA Intranasal Naloxone Kit [2]
Motivational Interviewing (MI)

“Motivational interviewing is a person-centered counseling style for addressing the common problem of ambivalence about change” (Miller & Rollnick, 2012)

• Rationale
  • MI is an evidence-based treatment that is effective in many settings and for a variety of behaviors
  • MI is useful when a Veteran is ambivalent about a change that is clearly in their best interest to make (e.g., substance use; smoking cessation; chronic disease management)

• Additional resources:
  • https://www.treatmentworksforvets.org/provider/
  • www.motivationalinterviewing.org
  • https://www.padesky.com/clinical-corner/

Motivational Interviewing and Motivational Enhancement Therapy

Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) are brief evidence-based (meaning well researched), treatments used to draw out and strengthen one’s motivation for change. These treatments offer Veterans acceptance and compassion as they consider making changes in their lives. MI and MET therapists are accepting and compassionate and work with Veterans to explore values and goals. They focus on the Veteran’s reasons for changing problem behaviors and openly discuss the mixed feelings that are a normal part of making changes. MI and MET help Veterans use their personal strengths to improve their lives.

What are MI and MET?

MI and MET are psychotherapies, or “talk therapies,” that usually take 1 to 4 sessions, each session about an hour long. MI and MET help Veterans to make treatment choices and to get the most out of the therapy they choose. MI can help Veterans develop healthier habits with regard to substance use, diet, exercise, management of chronic health problems (HIV, heart disease, diabetes), and reduction of risky behaviors (unprotected sex, gambling, and unsafe needle use). In VA, MET is used primarily with Veterans who are thinking about changing their use of alcohol or drugs. MI and MET work on their own or in combination with other treatments. MI and MET can make other treatments more effective by helping patients engage in treatment and improving their response to treatment.
SUD Consultation and Support

National SUD Program in collaboration with the National Telemental Health Center has augmented the existing SUD Telemental Health “Ask the Expert” program with additional subject matter experts (SMEs) to answer questions from the field. Capacity for:

• **General clinical questions about substance use disorders**

• **Questions related to program operations, national policy, and requirements**

• **Questions related to provision of care across clinical settings (i.e., primary care, pain management, general mental health, ED, SUD specialty care)**

• **Direct consultation regarding specific clinical cases including options to submit a formal e-consult as well as for an experienced SUD provider to meet with the Veteran to offer recommendations.**

Questions can be submitted to: [AskTheExpert-SubstanceUseDisorder@va.gov](mailto:AskTheExpert-SubstanceUseDisorder@va.gov)

• **Please do not include patient specific Protected Health Information (PHI)**

• **Please let us know if the question is time-sensitive**
Bonus Slide for VA Psychologists!
August 2021 National Opioid Safety and Risk Mitigation Call

• **Agenda (in EST)**
  - 3-3:05—International Overdose Awareness Day
  - 3:05-3:10—Suicide Behavior and Overdose Report and Overdose Review Team example
  - 3:10-3:15—Community Care Emergency Department Data and Analytics
  - 3:15-3:20—Pain Management, Opioid Safety, and Prescription Drug Monitoring Program (PMOP) Office
  - 3:20-3:25—Whole Health
  - 3:25-3:30—Primary Care
  - 3:30-3:35—Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT)
  - 3:35-3:40—Clinical Pharmacy Practice Office (CPPO)
  - 3:40-3:45—Contingency Management
  - 3:45-3:50—Syringe Service Program (SSP): Danville VA and VISN 12
  - 3:50-3:55—Fentanyl Test Kits: San Francisco VA
  - 3:55-4:00—Academic Detailing Resources

• Every presentation has a “Call To Action to Address Alarming Increases in Drug Overdoses”
• In honor of International Overdose Awareness Day (August 31), hoping that you will commit to at LEAST ONE NEW ACTION on a “Call To Action” slide
Bottom Line Up Front (BLUF)

• Alarming increases in drug overdoses—Overdose Prevention needed NOW more than ever!
• What can psychologists do?
  • **Education:** Opioid Overdose Education and Naloxone Distribution (OEND) ([internal](#) / [external](#))
  • **Pain Management:**
    • Stepped Care Model for Pain Management
    • Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)
    • Stratification Tool for Opioid Risk Mitigation (STORM) Data-Based Risk Reviews
    • Tapering and discontinuation ([opioids](#), [benzos](#))—high risk periods! Keep patients on your radar!
  • **Risk Mitigation:**
    • Improve post-overdose care
      • VHA → report overdoses using *Suicide Behavior and Overdose Report (SBOR)*, be part of Overdose Review Team
      • Support *Syringe Service Programs* ([external](#)) and Fentanyl Test Strips as appropriate
  • **Addiction Treatment:**
    • Identify Opioid Use Disorder (OUD) and support initiation of Medication for OUD ([SCOUTT; external](#))
    • Identify and connect patients with *Substance Use Disorder (SUD) Treatment* (esp alcohol and stimulants)
YOU Are CRITICAL to Addressing
This Epidemic Within a Pandemic!!
Thank You For Your Service!!

Questions??
Elizabeth.Oliva@va.gov
When Should an SBOR be Completed?

An SBOR should be completed when a clinical staff member learns of a VA patient’s:

- Behaviors with suicidal or undetermined intent within the **last 12 months**, including:
  - Death by suicide
  - Non-fatal suicide attempts
  - Preparatory behaviors for suicide

- Overdose events within the **last 12 months**, including:
  - Suicidal *and* accidental overdoses
  - Fatal *and* non-fatal overdoses
  - Severe adverse drug events after an overdose (e.g., respiratory depression, loss of consciousness, seizures) should be reported to VA ADERS
Review of Overdose Events

• Facilities must have a process in place to ensure review of all reported overdoses.
• Each facility is empowered to assign a team to review reported overdoses, with a focus on engaging patients in treatment.
• Overdose review teams will likely require addiction, mental health, pharmacology, and/or pain management expertise.
• Review your local facility's process for overdose review.
Syringe Services Programs (SSPs): Resources and Strategies to Support Opioid Safety and Risk Mitigation

Elizabeth Maguire, MSW
Communications Lead, SSP Affinity Group Lead
HIV, Hepatitis, and Related Conditions Program
SSPs are internationally recognized harm reduction practice standard, providing preventive and treatment services, including provision of sterile syringes and needles to people who inject drugs (PWID)

Harm reduction:

- a set of interventions to reduce the negative health consequences of drug use
- evidence-based approach to working with persons who inject drugs to prevent HIV, hepatitis C, soft tissue infections and drug overdoses
- neither condones nor condemns drug use, focuses on meeting individuals “where they are” and working with them to ensure they have the knowledge and resources to protect their health
- incorporating harm reduction strategies, we can help affect positive changes in the lives of our most vulnerable patients
Since their introduction in the 1980s to combat HIV transmission among PWID, SSPs have proven to be a safe and highly effective approach to delivering preventive and treatment services. According to the CDC, SSPs have been shown to:

- increase the likelihood of entry into SUD treatment by 5-fold
- increase the likelihood of PWIDs reducing or discontinuing injection drug use by almost 3-fold
- reduce the incidence of new HIV and HCV infections by 50%
- prevent overdose deaths
- increase safe disposal of used syringes

SSPs have not been found to:

- increase illegal drug use
- increase the crime rate in the geographic area where they are located

Federal Support

• Endorsed by:
  – Executive Office of the President
  – United States (US) Centers for Disease Control and Prevention (CDC)
  – US Surgeon General
  – National Institutes of Health (NIH)
  – World Health Organization (WHO)
  – American Medical Association (AMA)
  – American Bar Association (ABA).

• Key component of the Ending the HIV Epidemic Initiative

• Released in April, the Biden-Harris Administration’s Statement of Drug Policy Priorities for Year One includes mandates for federal agencies to: remove barriers to federal funding for SSPs; integrate and build linkages between funding streams to support SSPs; and identify state laws that limit access to SSPs, naloxone, and other services.

Legal Status

• Under Federal law and regulations, VHA has clear legal authority to operate SSPs.
  – SSPs meet the criteria for inclusion in the VA Medical Benefits Package described at 38 CFR §17.38, because they are considered accepted standards of medical practice and promote, preserve, or restore health as described in both: (i) Outpatient medical, surgical, and mental health care, including care for substance abuse, and under (2) Preventive care, as defined in 38 U.S.C. 1701(9), which includes: (iv) Mental health and substance abuse preventive services.

• Prohibitions against using certain Federal funds to purchase syringes do not apply to VA.

• VA-SSPs can operate out of any VA location (including facilities, community-based outpatient clinics (CBOCs) and mobile clinics) with appropriate procedures in place and where not prohibited under state, county, or local law.

• Current guidance recommends facilities work with regional counsel to determine where/how SSPs can operate in their catchment area.
• Hoping to develop a **basic** SSP kit model (using success of naloxone kits as a model):
  – Sterile syringes (100 OR 25):
    • 30g 5/16 1cc
    • 29g 1/2” 1cc
    • 27g 5/8” 1 cc
  – Alcohol pads
  – Sharps container
  – Cottons
  – Education handout
• Additional components might include:
  – Sterile water
  – Band-Aids
  – Ascorbic acid powder
  – Condoms
  – Fentanyl test strips
• Other key services:
  – Screening, care, and treatment for viral hepatitis, HIV, and sexually transmitted infections
  – Vaccinations, including hepatitis A and B
  – Abscess and wound care
  – Referral to social work, mental health, and other medical services
• Stigmatization of PWID is increasingly recognized as a major barrier to care for this population.
• It is VHA policy that staff provide clinically appropriate, comprehensive, Veteran-centered care in accordance with VHA’s I CARE values of respect and dignity to all enrolled or otherwise eligible Veterans who use injection drugs. Veterans must not be denied VHA services solely because they are participating in a program such as SSPs.
• In addition to VA-SSPs, Veterans may want to access community resources. Partnerships with local SSPs are key!
Syringe Service Programs:
Danville VA and VISN 12

Beth Dinges, PharmD
VISN 12 Academic Detailing Service
elizabeth.dinges2@va.gov

August 2021 VA National Opioid Safety and Risk Mitigation Call Presentation
Patient Handouts

We are committed to providing you with the care you need.

If you are currently using IV drugs, please read these tips for keeping yourself as safe as possible.

If you need substance abuse treatment, please call:
217-554-4177 to schedule an appointment.

Needle Exchange Locations

Springfield
Phoenix Center
100 E. Lawrence Ave.
Springfield, IL
217-526-9259

Champaign
DIAM
201 Kenyon Road
Champaign, IL
217-441-1459

Veteran Resources:

VA Illinois HCS & Community Based Outpatient Centers (CBOPCs):
- 1600 E. Main St, Danville, IL
- 711 E. Orange Prairie Rd, Peoria, IL
- 901 S. 6th St, Peoria, IL
- 901 W. Springfield Ave, Springfield, IL
- 501 Lakeland Blvd, Suth G, Mattoon, IL
- 3020 W. Miners Rd, Champaign, IL

For more information call:

Safe Injection Practices

We can help.

FREE & CONFIDENTIAL SYRINGE ACCESS

Help stop the spread of disease.

ONE NEEDLE.
ONE SYRINGE.
ONETIME.

Questions?
Call Beth Dugan, PharmD
at 217-274-6961

Other items available through prescription (ask your provider include syringe in case of rapid overdose and conditions.)

VA Illiana Health Care System
1200 East Main Street
Danville, IL 61832
(217) 554-3300

U.S. Department of Veterans Affairs

VA
U.S. Department of Veterans Affairs
Danville VA HR Order Menu

**Plan to add:**
- Quick order for 31G syringe 5/16” 1 ml, #100 with refills
- Clinic order for kits

**V12 Leadership approval for sites to upload menu, and identify site lead**
VISN 12 ADS Pilot: HR Kit Contents

- Syringes: 31G, 5/16”, 1 ml (size preference varies)
- Fentanyl Test Strips (not kit, instruction sheet included)
- Alcohol swabs
- Cotton (filter)
- Condoms: male/female
- Steri-cup (cooker)
- Tourniquets (non-latex)
- Bags: Ziploc type (small & large) & paper bag to contain kit
- Sterile water ampule 2-5 ml
- Sharp disposal container
- Purchase info all available: Elizabeth.Dinges2@va.gov
Saving Lives: The Veterans Health Administration (VHA) Rapid Naloxone Initiative


Gery P. Guy Jr., PhD; Tamara M. Haegerich, PhD; Mary E. Evans, MD; Jan L. Losby, PhD; Randall Young, MA; Christopher M. Jones, PharmD, DrPH

1 naloxone Rx for every 69 high-dose opioid Rx

1 in 6

- Remarkably, the COVID-19 pandemic had minimal impact on naloxone dispensing to VHA patients.

*data courtesy of Michael Harvey and PBM*
VA Steps Up Efforts To Help Veterans Fighting Opioid Addiction

A VA police officer, Lieutenant Richard Lucuk, said the veteran who was revived after overdosing close to the emergency room might have died if he had been elsewhere on VA property. But, now, he said, with the 34 VA police officers able to administer the nasal spray in parking lots and VA buildings where there is “no medical staff on hand,” lives can be saved.

Army veteran Lonnie Groom, 61, of New Haven, survived two overdoses because of naloxone. Now, after 45 years of “off and on” drug use, he’s been sober for more than a year and has received a naloxone kit from the VA.

“I still know people” with drug addictions, Groom said. “If I can help them, I’d be more than happy to do so. I see myself in them because I used to be like them,” he said.

Lieutenant Richard Lucuk is one of 34 VA police officers now trained to administer naloxone.

BACKGROUND

- VHA's Stratification Tool for Opioid Risk Mitigation (STORM) uses predictive analytics to identify patients at-risk for overdose/suicide among those prescribed opioids, lists factors that place patients at risk, and recommends evidence-based risk mitigation strategies and non-pharmacologic treatment options.1
- VHA recently completed a 3-year Randomized Program Evaluation (RPE) of VHA's Stratification Tool for Opioid Risk Mitigation (STORM) implementation which included both quantitative and qualitative components.2,3

This presentation will examine the impact of mandating interdisciplinary team case reviews of very high-risk STORM patients and stepped-wedge expansion of the proportion of patients identified as “very high-risk” from 1% to 5% on all-cause mortality and serious adverse events (SAEs).

METHODS

Effectiveness Evaluation

- 23-month randomized stepped-wedge RCT (2018-2020) across all 140 VHA health care systems randomized to expand the mandate for a case review at 9 months (n=70) or 15 months (n=70).
- 64,783 patients actively prescribed opioid analgesics
- Evaluation questions:
  - Evaluate randomization to policy memo vs policy memo with oversight
  - Implementation Evaluation

Implementation Evaluation

- Evaluate randomization to policy memo vs policy memo with oversight
- Evaluation questions:
  - Which implementation strategies were used to implement case reviews for very high-risk Veterans?
  - Did the implementation strategies differ by randomization arm (oversight vs. no oversight)?

RESULTS (Effectiveness)

Identifying high risk patients and mandating they receive an interdisciplinary review was associated with a decrease in all-cause mortality within 127 days

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Odds Ratio</th>
<th>CI</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>0.78**</td>
<td>0.65 - 0.93</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Any SAE</td>
<td>0.99</td>
<td>0.87 - 1.13</td>
<td>0.22</td>
</tr>
<tr>
<td>Case Review</td>
<td>5.13***</td>
<td>3.64 - 7.23</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

RESULTS (Implementation)

<table>
<thead>
<tr>
<th>Covariate</th>
<th>AIRR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≤ 35 years (vs. older)</td>
<td>1.35 (1.09-1.67)</td>
</tr>
<tr>
<td>Years in primary role &lt; 5 years</td>
<td>1.23 (1.01-1.51)</td>
</tr>
<tr>
<td>Academic detailing through pain campaign</td>
<td>1.40 (1.12-1.75)</td>
</tr>
<tr>
<td>Implementation Strategy</td>
<td>AIRR (95% CI)</td>
</tr>
<tr>
<td>Regular monitoring and adjusting practices</td>
<td>1.40 (1.11-1.77)</td>
</tr>
<tr>
<td>Promoting adaptability</td>
<td>1.28 (1.03-1.60)</td>
</tr>
<tr>
<td>Initial training session</td>
<td>1.23 (1.02-1.50)</td>
</tr>
<tr>
<td>Create/participate in a group that regularly shares lessons learned</td>
<td>1.32 (1.09-1.59)</td>
</tr>
</tbody>
</table>

DISCUSSION

- Mandated review was associated with a significant decrease in all-cause 127-day mortality.
- Mandated review patients were six times more likely to receive a case review than non-mandated patients with similar risk.
- Interdisciplinary reviews appear to be a key component of high-quality care; various implementation strategies support uptake.
- Results suggest that providers can leverage predictive analytic-targeted population health approaches and interdisciplinary collaboration to improve patient outcomes.

REFERENCES


Questions? Contact kiersten@bu.edu

Work funded by VA Health Services Research & Development (SDR 16-193, SDR 16-196; QUERI PEC 16-001). The views expressed here are the authors’ and do not necessarily represent those of the Department of Veterans Affairs.
VHA Rapid Naloxone Timeline: Inception to National Diffusion

**November 2012**
Veterans Health Administration (VHA) leadership formally endorses naloxone distribution as part of Mental Health Residential Rehabilitation Treatment (MH RRTP) Culture of Safety Initiative.

**July 2014**
Implementing Overdose Education and Naloxone Distribution: A Formative Evaluation VA Health Services Research & Development (HSR&D) Quality Enhancement Research Initiative (QUERI) grant begins.

**May 2014**
VHA launches national Opioid Overdose Education and Naloxone Distribution (OEND) program.

**March 2015**
VA Boston develops program to equip all VA Police Officers with naloxone.

**June 2016**
VA Boston presents innovations on VHA National Monthly OEND Call.

**November 2016**
VA Boston’s practice selected as 1 of 13 Gold Status Practices in the 2nd VHA Shark Tank Competition.

**December 2016**
The Joint Commission (TJC) concurs with VA Boston’s approach to increase naloxone availability through placement in facility selected Automated External Defibrillator (AED) cabinets.

**February 2016**
The Joint Commission (TJC) concurs with VA Boston’s approach to increase naloxone availability through placement in facility selected Automated External Defibrillator (AED) cabinets.

**December 2016**
Initial replication of VA Police naloxone across Veterans Integrated Service Network (VISN) begins as a part of the Diffusion of Excellence.

**May 2017**
Initial replication across VISN 8 is completed for VA Police Officers.

**April 2017**
Finalized VHA AED Cabinet Naloxone Program Toolkit.

**January 2018**
Diffusion of Excellence Governance Board recommends VHA Rapid Naloxone Initiative for National Diffusion.

**May 2019**
VHA Rapid Naloxone Initiative Workgroup convenes in Washington DC to develop a formal National Diffusion strategy for Phase I.

**December 2018**
Effectiveness of a Rescue Medication in Preventing Opioid Overdose in Veterans VA HSR&D grant begins.

**February 2020**
VA Police Naloxone plenary presentation at VA Chief of Police Training Symposium.

**November 2018**
Met with TJC to discuss requirements and standards for AED Cabinet Naloxone.

**May 2019**
VHA Rapid Naloxone Initiative Workgroup convenes in Washington, DC to evaluate Phase I and develop Phase II strategy.

**December 2020**
VHA Rapid Naloxone Initiative featured in QUERI Roadmap for Implementation and Quality Improvement.

**July 2021**
VHA Rapid Naloxone Initiative receives John M. Eisenberg award for Innovation in Patient Safety and Quality at the National Level.

**March 2021**
VHA memorandum requesting update on VHA Rapid Naloxone implementation status.

**October 2021**
VHA Rapid Naloxone Initiative featured at VHA Innovation Experience (IEX).

**May 2017**
VHA Rapid Naloxone Initiative featured in QUERI Roadmap for Implementation and Quality Improvement.

**November 2018**
Met with TJC to discuss requirements and standards for AED Cabinet Naloxone.

**February 2019**
Shortened VA Talent Management System (TMS) training released to field.

**October 2018**
VisN-specific implementation support calls begin for Phase I of National Diffusion.

**November 2018**
VisN-specific implementation support calls begin for Phase I of National Diffusion.

**June 2016**
VA Boston presents innovations on VHA National Monthly OEND Call.

**March 2021**
VHA memorandum requesting update on VHA Rapid Naloxone implementation status.

**January 2018**
Diffusion of Excellence Governance Board recommends VHA Rapid Naloxone Initiative for National Diffusion.

**July 2018**
VHA Rapid Naloxone Initiative team convenes in Washington DC to develop a formal National Diffusion strategy for Phase I.

**April 2019**
VHA Rapid Naloxone Initiative featured in QUERI Roadmap for Implementation and Quality Improvement.

**November 2018**
Met with TJC to discuss requirements and standards for AED Cabinet Naloxone.

**Rapid naloxone questions added to National Center for Patient Safety (NCPs) Patient Safety Cornerstone annual assessment.

**December 2018**
Effectiveness of a Rescue Medication in Preventing Opioid Overdose in Veterans VA HSR&D grant begins.

**May 2019**
VHA Rapid Naloxone Initiative Workgroup convenes in Washington DC to evaluate Phase I and develop Phase II strategy.

**October 2019**
VHA Rapid Naloxone Initiative featured in QUERI Roadmap for Implementation and Quality Improvement.

**July 2021**
VHA Rapid Naloxone Initiative receives John M. Eisenberg award for Innovation in Patient Safety and Quality at the National Level.

**October 2019**
VHA Rapid Naloxone Initiative featured in QUERI Roadmap for Implementation and Quality Improvement.

**February 2019**
Shortened VA Talent Management System (TMS) training released to field.

**November 2018**
VisN-specific implementation support calls begin for Phase I of National Diffusion.

**February 2019**
Shortened VA Talent Management System (TMS) training released to field.

**October 2019**
VHA Rapid Naloxone Initiative featured in QUERI Roadmap for Implementation and Quality Improvement.

**March 2021**
VHA memorandum requesting update on VHA Rapid Naloxone implementation status.

**February 2019**
Shortened VA Talent Management System (TMS) training released to field.

**November 2018**
VisN-specific implementation support calls begin for Phase I of National Diffusion.

**February 2019**
Shortened VA Talent Management System (TMS) training released to field.

**October 2019**
VHA Rapid Naloxone Initiative featured in QUERI Roadmap for Implementation and Quality Improvement.

**March 2021**
VHA memorandum requesting update on VHA Rapid Naloxone implementation status.

**October 2019**
VHA Rapid Naloxone Initiative featured in QUERI Roadmap for Implementation and Quality Improvement.

**March 2021**
VHA memorandum requesting update on VHA Rapid Naloxone implementation status.

**Additionally, this initiative has been presented on the following VA National Monthly OEND Calls:**

- June 2017
- July 2017
- August 2017
- September 2018
- October 2018
- November 2018
- February 2019
- April 2019
<table>
<thead>
<tr>
<th>Barrier Level</th>
<th>Barrier</th>
<th>Mechanism of Change</th>
<th>Implementation Strategy/Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran</td>
<td>Risk awareness</td>
<td>Perceived vulnerability</td>
<td>Risk communication, use mass media</td>
</tr>
<tr>
<td></td>
<td>Ability to use naloxone in overdose</td>
<td>Caregiver knowledge, self-efficacy, skills</td>
<td>Develop and distribute educational materials, obtain family feedback, activate Veterans and family</td>
</tr>
<tr>
<td></td>
<td>Cost</td>
<td></td>
<td>Alter office fees, make billing easier (naloxone provided free of charge)</td>
</tr>
<tr>
<td>Clinician/clinical team</td>
<td>Ability to identify high-risk Veterans</td>
<td>Knowledge, clinical decision-making</td>
<td>Develop clinical analytics to identify at-risk Veterans</td>
</tr>
<tr>
<td></td>
<td>Lack of expertise in naloxone prescribing</td>
<td>Knowledge, skills, goals, self-efficacy, subjective norms</td>
<td>Offer educational trainings, train-the-trainer</td>
</tr>
<tr>
<td></td>
<td>Prescribing naloxone</td>
<td>Behavioral cueing, environment resources</td>
<td>Change electronic medical record templates</td>
</tr>
<tr>
<td></td>
<td>Awareness of progress</td>
<td>Feedback processes, subjective norms</td>
<td>Audit and feedback, relay data to clinicians</td>
</tr>
<tr>
<td>Hospital/practice</td>
<td>Competing priorities</td>
<td>Professional role change, reinforcement</td>
<td>Mandate change, policy directives(s) for all facilities, identify and prepare champions</td>
</tr>
<tr>
<td></td>
<td>Implementation variability</td>
<td>Knowledge, subjective norms</td>
<td>Values, standardize tools, guidance, resources implementation plans</td>
</tr>
<tr>
<td></td>
<td>Cost to facilities</td>
<td>Reinforcement</td>
<td>Policy change, change cost to hospital (no cost)</td>
</tr>
<tr>
<td>Health system</td>
<td>Low availability of naloxone</td>
<td>Environmental context, social roles</td>
<td>Use advisory boards and national workgroups</td>
</tr>
<tr>
<td></td>
<td>Unstandardized naloxone kit</td>
<td>Environment resource</td>
<td>Place naloxone kits on national formulary</td>
</tr>
<tr>
<td></td>
<td>Lack of best practice</td>
<td>Knowledge, skills, decision processes, social learning</td>
<td>Create learning collaborative, centralized technical assistance and facilitation</td>
</tr>
<tr>
<td></td>
<td>Coordination across service disciplines</td>
<td>Professional role, norms, motivation</td>
<td>Change availability of services and mix of clinicians offering treatment</td>
</tr>
<tr>
<td></td>
<td>Union support</td>
<td>Professional role, social influences, norms</td>
<td>Obtain formal commitments</td>
</tr>
</tbody>
</table>
QUERI Roadmap for Implementation and Quality Improvement

The Department of Veterans Affairs Rapid Naloxone Initiative: National Diffusion of a Promising Practice

Implementation

Implement an Intervention

In April of 2018, the VA Under Secretary for Health selected the Rapid Naloxone Initiative for national diffusion. In July of 2018, an interdisciplinary workgroup with stakeholders from the following programs and agencies met face to face to develop a formal national diffusion strategy:

- Veterans Health Administration Diffusion of Excellence
- Pharmacy Benefits Management (including the pharmacy Academic Detailing Service)
- Department of Veterans Affairs:
  - Police
  - National Center for Patient Safety
  - National Center on Homelessness Among Veterans
  - Office of Nursing Services
  - Office of Mental Health and Suicide Prevention

To implement the plan, the Rapid Naloxone Initiative team partnered with the Diffusion of Excellence initiative and the Opioid OEND national coordinator to manage the spread throughout the VA. The team developed two implementation toolkits. One was created for the automated external defibrillator cabinet naloxone program, and another was created for equipping VA Police with intranasal naloxone. The team selected a number of implementation strategies to address barriers identified through pilot and regional spread efforts (Table 23).

<table>
<thead>
<tr>
<th>Implementation barrier</th>
<th>Implementation strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid OEND clinician training and education</td>
<td>Standardized educational resources, academic detailing</td>
</tr>
<tr>
<td>Naloxone training for at-risk Veterans, caregivers</td>
<td>Consumer brochures, materials, education delivered by interdisciplinary VA clinicians</td>
</tr>
<tr>
<td>Identification of high-risk consumers eligible for naloxone</td>
<td>Clinician decision support tools</td>
</tr>
<tr>
<td>Implementation guidance</td>
<td>Standardized Opioid OEND implementation plan, clinical guidance, resources via centralized web-based portal, technical assistance by Diffusion of Excellence and Opioid OEND national program staff</td>
</tr>
<tr>
<td>Cost of naloxone</td>
<td>Waiver of copay fee via policy change to consumers and costs to local facilities</td>
</tr>
<tr>
<td>Leadership support</td>
<td>National workgroup of operational office, policy mandates, policy changes in formulary</td>
</tr>
<tr>
<td>Local union support</td>
<td>Memorandum of understanding signed with union groups to allow VA Police to carry naloxone</td>
</tr>
<tr>
<td>Automated external defibrillator cabinet regulatory approval</td>
<td>Guidance from the Joint Commission on standards for labeling, securing, monitoring, and maintaining naloxone in automated external defibrillator cabinets</td>
</tr>
<tr>
<td>Marketing to Department of Veterans Affairs and non-Division of Veterans Affairs stakeholders</td>
<td>Multi-channel marketing campaign using print media, social media (e.g., Facebook, Ted Talks), presentation on national VA clinical and leadership calls, academic detailing, community of practice, centralized websites</td>
</tr>
<tr>
<td>Local site barriers</td>
<td>External facilitation by Opioid OEND national coordinator and initiative implementation team; sharing problems and successes on a monthly community of practice call</td>
</tr>
<tr>
<td>Data collection and outcome monitoring</td>
<td>Creation of standardized clinician templates for electronic medical record, national dashboard on program metrics</td>
</tr>
</tbody>
</table>
Key Resources

- VA Substance Use Disorder (SUD) Resources
  - SUD SharePoint: https://vaww.portal.va.gov/sites/OMHS/SUD/default.aspx
  - SUD Internet site: https://www.mentalhealth.va.gov/substance-abuse/index.asp
  - SUD Program Locator: https://www.va.gov/directory/guide/SUD.asp
  - SCOUTT SharePoint: https://vaww.portal.va.gov/sites/OMHS/SUD/SCOUTT/default.aspx
  - VA Academic Detailing Resources: https://vaww.portal2.va.gov/sites/ad/SitePages/Campaigns.aspx
    - Alcohol Use Disorder (AUD): https://vaww.portal2.va.gov/sites/ad/SitePages/AUD.aspx
    - Opioid Use Disorder (OUD): https://vaww.portal2.va.gov/sites/ad/SitePages/OUD.aspx
    - Opioid Overdose Education and Naloxone Distribution (OEND): https://vaww.portal2.va.gov/sites/ad/SitePages/OEND.aspx
  - Evidence-Based Psychotherapy: http://vaww.mentalhealth.va.gov/ebp/programs_protocols.asp
    - Behavioral Couples Therapy for SUD: https://dvagov.sharepoint.com/sites/VACOMentalHealth/bct-sud/SitePages/Home.aspx
    - Motivational Interviewing and Motivational Enhancement Therapy: https://dvagov.sharepoint.com/sites/VACOMentalHealth/MI/SitePages/Home.aspx
  - Tobacco & Health SharePoint: https://dvagov.sharepoint.com/sites/VHAtobacco/default.aspx
  - Measurement-Based Care (MBC) SharePoint: https://vaww.portal.va.gov/sites/OMHS/omhostrongpractices/MBC/default.aspx

- External SUD resources

- VA Dashboards