Harm Reduction Throughout the VA Hospital System: How to Implement Change Within Large Organizations

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overdoseleadershipsummit.org

Presented by

BLUF: Harm Reduction

- Integration into healthcare relatively new; requires leadership support
- Build upon experiences and lessons learned with naloxone
  - VA Quality Enhancement Research Initiative (QUERI) Roadmap for Implementation and Quality Improvement
  - Opioid Overdose Education and Naloxone Distribution: Development of the VHA's National Program (Oliva et al., 2017)
  - Saving Lives: The VHA Rapid Naloxone Initiative (Oliva et al., 2021)
  - Implementing Syringe Services Programs Within the Veterans Health Administration: Facility Experiences and Next Steps (Rife-Pennington et al., in press)

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- Harm Reduction Background for Leaders
- VA Naloxone: Exemplar for Healthcare-Based Harm Reduction
- Expansion of VA's Harm Reduction Efforts

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Harm Reduction Background for Leaders

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National Drug Control Strategy (2022)

"Harm reduction is an approach that emphasizes working directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer flexible options for accessing substance use disorder treatment and other health care services. In other words, harm reduction is people-centered. It means helping people who use drugs access services they need to stay alive. It means building trust with them so that when they wish to seek help, they know where to turn."

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National Drug Control Strategy (2022)

"***Specifically, the Biden-Harris Administration's focus on harm reduction includes naloxone, drug test strips, and syringe services programs.*** *Syringe services programs are community-based programs that can provide a range of services, including links to substance use disorder treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and links to care and treatment for infectious diseases….Access to these proven, lifesaving interventions[8] should not depend on where someone lives and instead should be available to all who need them.*"

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National Drug Control Strategy (2022): Guiding Principles on Harm Reduction

Care
Support
Connection
Respect

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ONDCP's Guiding Principles on Harm Reduction

Research and experience have shown how and why harm reduction approaches are effective. The following principles are integrated into harm reduction programs.

1. Care. Staff and peer outreach workers must support individuals in accessing the care they need and to overcome obstacles. This can include: naloxone and overdose prevention strategies and tools; sterile syringes and other injection equipment; medications for opioid use disorders and other SUD treatment; and physical health and mental health services. Entry into different types of low-threshold group support and mentoring relationships, including through peer workers, also must be supported.

2. Support. Ongoing support is often required after harm reduction or SUD treatment services are initiated. People who are in SUD treatment or have completed an episode of substance use disorder treatment may resume or continue to use substances. This can be addressed through ongoing support provided by harm reduction programs, or other evidence-based interventions. Substance use should not be a reason for punishment or to limit access to health or social services. PWUD accessing services through harm reduction organizations also need access to housing, nutritious food, education or training, and employment.

3. Connection. PWUD, especially those who inject drugs, those who are experiencing homelessness, or those who experience social marginalization, must have regular access to harm reduction services and the opportunity to connect with staff or volunteers—without preconditions. All PWUD in the United States deserve the opportunity to forge a personal connection with a caring non-judgmental individual as part of receiving health and social services. PWUD deserve support not just in reducing drug or alcohol use, but also in improving any aspect of their lives they want to work on.

4. Respect. PWUD are often in psychological or physical pain. They are generally aware of the negative consequences of their substance use on themselves and others, including family members. This knowledge can cause shame, despair, and embarrassment and create additional obstacles to treatment entry to someone who wishes to do so. Research finds that individuals who have a voice in when and how they will receive help, who establish their own harm reduction, treatment, or recovery goals, and who are treated with respect, dignity, and a recognition of their autonomy, are more receptive to receiving help and achieve better outcomes.

National Drug Control Strategy (2022): Harm Reduction Principles

1. Integrating Harm Reduction into the U.S. Substance Use Disorder System of Care Is Necessary to Save Lives and Increase Access to Treatment
2. Collaboration on Harm Reduction with Public Safety Agencies
3. Foster Changes in State Laws and Policies to Support Harm Reduction
4. Support Partnerships on Harm Reduction

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VA Naloxone: Exemplar for Healthcare-Based Harm Reduction

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VA National Opioid Overdose Education and Naloxone Distribution (OEND) Program

- Established in 2014
  - Informed by pilot programs
  - National, cross-program office workgroup
    - Pharmacy, mental health, pain management, nursing, primary care, emergency medicine, employee education
- Major innovations
  - Policy and clinical guidance
  - Educational resources
  - Implementation and evaluation resources
  - Pharmacy-driven

Journal of the American Pharmacists Association 57 (2017) S168–S179

Contents lists available at ScienceDirect

Journal of the American Pharmacists Association

journal homepage: www.japha.org

APhA

EXPERIENCE

Opioid overdose education and naloxone distribution: Development of the Veterans Health Administration's national program

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We hope that VHA's experience will inform OEND implementation efforts among other health care systems. VHA is committed to continuing to identify ways to ensure that at-risk veterans get life-saving OEND and will continue to innovate and support VHA staff in these efforts. To optimize the life-saving potential of OEND, VHA emphasizes 3 key components of OEND: opioid overdose prevention, recognition, and response with naloxone. Although naloxone distribution is a key component in combatting the United States opioid overdose epidemic, failure to train patients and potential bystanders on how to recognize an overdose could result in missed opportunities to intervene and save lives. Moreover, overdose prevention is the ideal outcome, and we need to improve patients' understanding of overdose risk factors and ways to mitigate risk. Opioid overdose is preventable and pharmacists are central to health care system–based OEND implementation that is necessary to help combat the current opioid overdose epidemic.

Acknowledgments

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~300 individuals/groups acknowledged

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References

1. Rudd RA, Seth P, David F, Scholl L. Increases in drug and opioid-involved overdose deaths—United States, 2010-2015. *MMWR Morb Mortal Wkly Rep*. 2016;65:1–8.
2. Bohnert AS, Ilgen MA, Galea S, McCarthy JF, Blow FC. Accidental poisoning mortality among patients in the Department of Veterans Affairs Health System. *Med Care*. 2011;49:393–396.
3. VA/DoD Opioid Therapy for Chronic Pain Work Group. *Clinical practice guideline for opioid therapy for chronic pain*; 2017. Available at: http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp. Accessed March 1, 2017.
4. VA/DoD Management of Substance Use Disorders Work Group. *VA/DoD clinical practice guideline for the management of substance use disorders*; 2015. Available at: http://www.healthquality.va.gov/guidelines/MH/sud/. Accessed December 24, 2016.
5. Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Ann Intern Med*. 2013;158(1):1–9.
6. Walley AY, Xuan Z, Hackman HH, Quinn E, Doe-Simkins M, Sorensen-Alawad A, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. *BMJ*. 2013;346:f174.
7. VA Pharmacy Benefits Management Services. *Recommendations for issuing naloxone rescue for the VA Opioid Overdose Education and Naloxone Distribution (OEND) program*; 2016. Available at: http://www.pbm.va.gov/PBM/clinicalguidance/clinicalrecommendations.asp. Accessed September 14, 2016.
8. Zedler B, Xie L, Wang L, Joyce A, Vick C, Brigham J, et al. Development of a risk index for serious prescription opioid-induced respiratory depression or overdose in Veterans' Health Administration patients. *Pain Med*. 2015;16(8):1566–1579.
9. Oliva EM, Bowe T, Tavakoli S, 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;14(1):34–49.
10. Public Law No: 114-198. Comprehensive Addiction and Recovery Act of 2016. Available at: https://www.congress.gov/bill/114th-congress/senate-bill/524. Accessed February 24, 2017.
11. Tiffany E, Wilder CM, Miller SC, Winhusen T. Knowledge of and interest in opioid overdose education and naloxone distribution among US Veterans on chronic opioids for addiction or pain. *Drugs Educ Prev Pol*. 2016;23(4):322–327.
12. Wilder CM, Miller SC, Tiffany E, Winhusen T, Winstanley EL, Stein MD. Risk factors for opioid overdose and awareness of overdose risk among veterans prescribed chronic opioids for addiction or pain. *J Addict Dis*. 2016;35(1):42–51.
13. Veterans Health Administration, Department of Veterans Affairs. Under Secretary for Health's Information Letter. Implementation of opioid overdose education and naloxone distribution (OEND) to reduce risk of opioid-related death. IL 10-2014-12.
14. VA Pharmacy Benefits Management Services. *Interim recommendations for issuing naloxone kits for the VA Overdose Education and Naloxone Distribution (OEND) program*. 2014.
15. Bounthavong M, Harvey M, Wells D, et al. Trends in naloxone prescriptions prescribed after implementation of a National Academic Detailing Service in the Veterans Health Administration: a preliminary analysis. *J Am Pharm*. 2017;57(2)S:S68–S72.

OEND

- Risk mitigation initiative to prevent opioid-related overdose deaths
  - Opportunity to discuss risk of opioids→**A few minutes of training could save a life!**
  - **No cost to at-risk VHA patients (eliminated copays)**
- Opioid Overdose Education (OE)
  - How to *prevent, recognize, and respond* to an opioid overdose
- Naloxone Distribution (ND)
  - Provide patients with *naloxone*
- Target patient populations
  - Patients with opioid use disorder and patients prescribed opioids
  - **Patients with stimulant use disorder, recent opioid discontinuation, opioid-/stimulant-related overdose**

Video link

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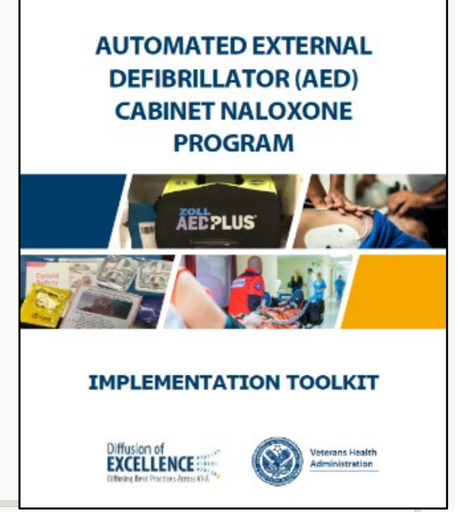
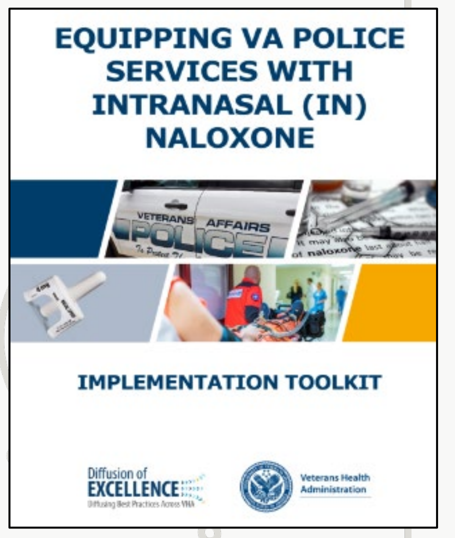
VA Academic Detailing Service OEND site (patient and provider education resources; internal/external); National OEND internal site (implementation models/ approaches); Oliva et al. (2017; 2021); Bounthavong et al. (2017, 2020); QUERI Roadmap; NPR feature; Eisenberg—The Joint Commission (TJC) Journal on Quality and Patient Safety Paper, Podcast, Blog; VA Press Release

VHA Rapid Naloxone Initiative

- 3 elements:
  - OEND, VA Police Naloxone, Select Automated External Defibrillator (AED) Cabinet Naloxone
- 2020 John M. Eisenberg National Level Innovation in Patient Safety and Quality Award
  - OEND (November 2022): More than 405,100 Veterans dispensed naloxone prescribed by over 46,000 prescribers with over 3,400 reported overdose reversals
  - VA Press Release: 3,552 VA police officers with naloxone (136 opioid overdose reversals); 1,095 AED Cabinets with naloxone (10 opioid overdose reversals) [April 2021]





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VA Academic Detailing Service OEND site (patient and provider education resources; internal/external); National OEND internal site (implementation models/ approaches); Oliva et al. (2017; 2021); Bounthavong et al. (2017, 2020); QUERI Roadmap; NPR feature; Eisenberg—The Joint Commission (TJC) Journal on Quality and Patient Safety Paper, Podcast, Blog; VA Press Release

VHA Rapid Naloxone Timeline

NATIONAL OVERDOSE PREVENTION LEADERSHIP SUMMIT

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

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

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

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

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

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
Initial replication of VA Police naloxone across Veterans Integrated Service Network (VISN) 8 begins as a part of the Diffusion of Excellence

April 2017
Finalized *VHA AED Cabinet Naloxone Program* Toolkit

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

November 2017
National Association of Government Employees (NAGE), American Federation of Government Employees (AFL-CIO) and National Veterans Affairs Council (NVAC) sign memorandum allowing VA Police Officers to carry and administer naloxone

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

April 2018
Under Secretary for Health (USH) selects VHA Rapid Naloxone Initiative for National Diffusion

June 2018
Finalized *Equipping VA Police Services With Intranasal (IN) Naloxone* Toolkit

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

2012 | 2014 | 2015 | 2016 | 2017 | 2018

September 2018
VHA memorandum endorsing and promoting the VHA Rapid Naloxone Initiative. Includes formal request for baseline implementation status.

October 2018
VISN-specific implementation support calls begin for Phase I of National Diffusion

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

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

March 2019
VHA memorandum requesting update on VHA Rapid Naloxone implementation status

May 2019
- VHA Rapid Naloxone Initiative Workgroup convenes in Washington DC to evaluate Phase I and develop Phase II strategy
- VA Police Naloxone plenary presentation at VA Chief of Police Training Symposium

October 2019
VHA Rapid Naloxone Initiative featured at VHA Innovation Experience (iEX)

December 2020
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

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

2018 | 2019 | 2020 | 2021

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

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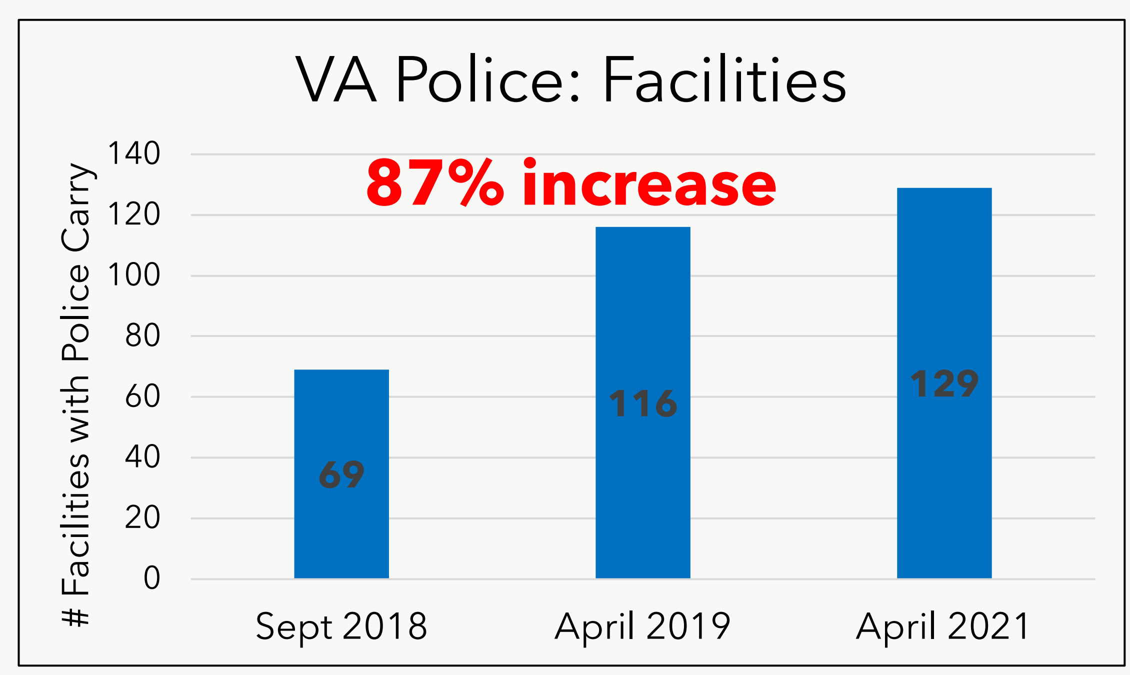

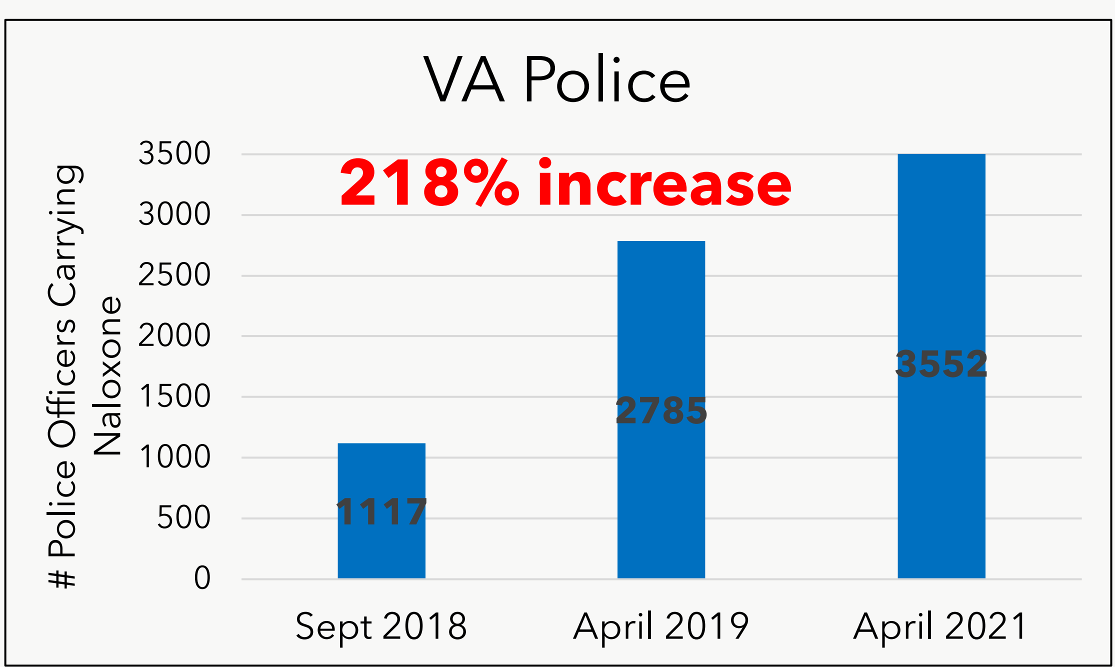

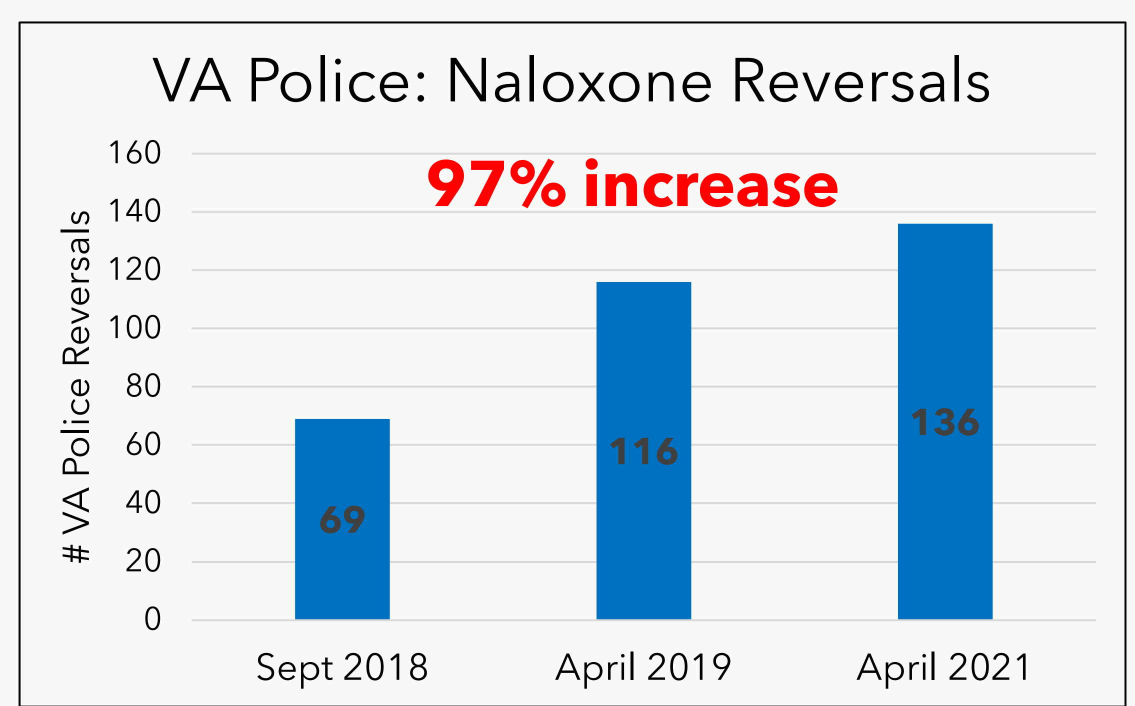

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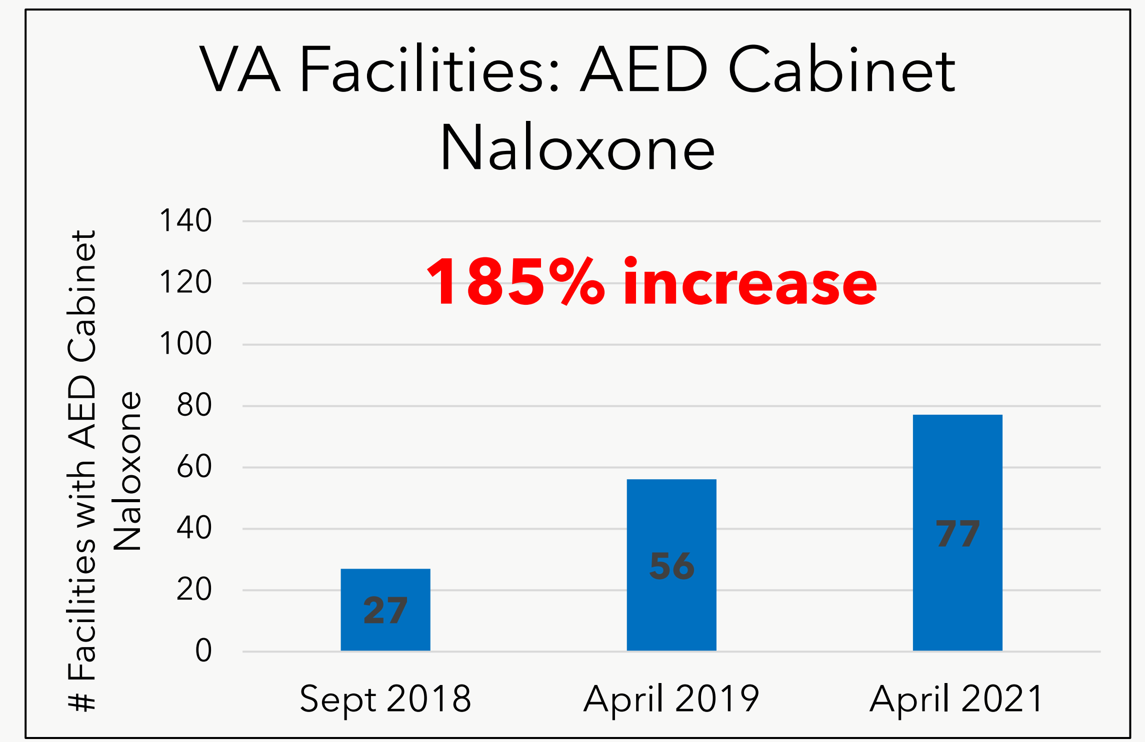
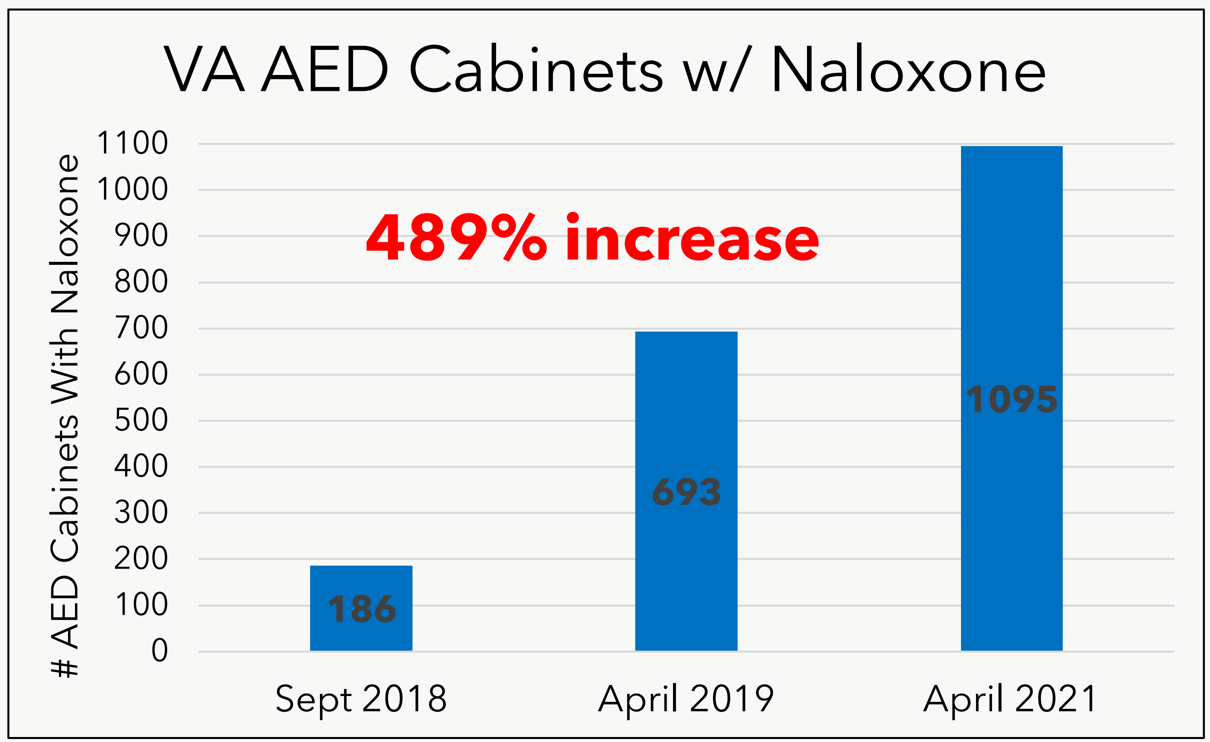
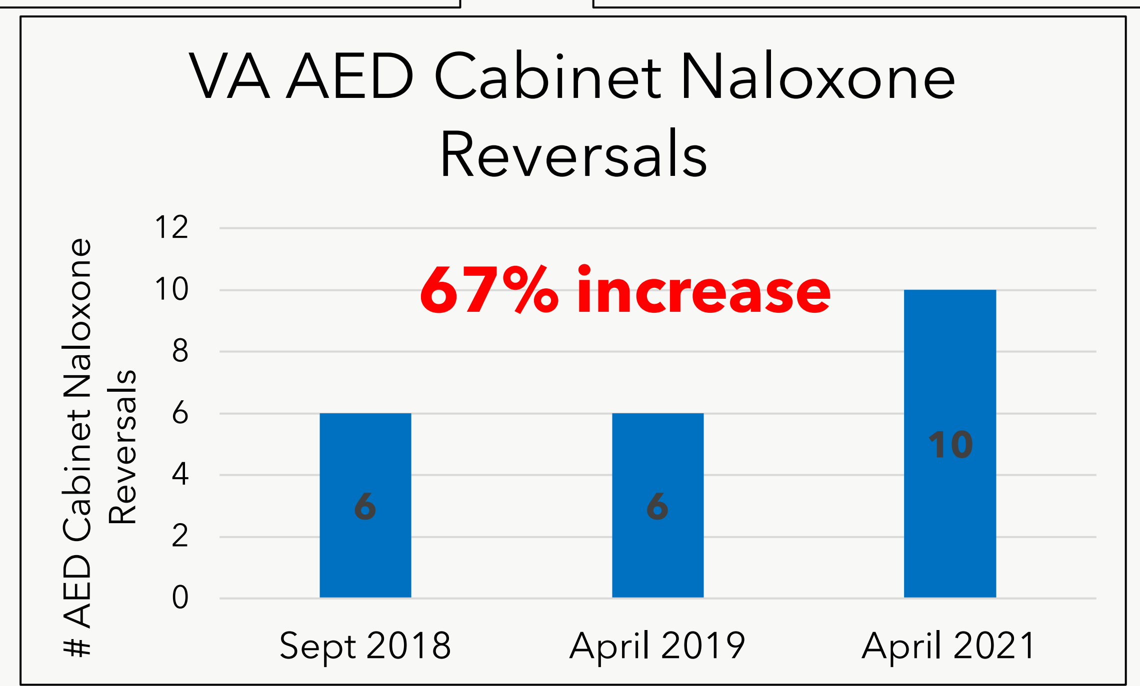
Oliva et al., 2021







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Oliva et al., 2021

- **Slight dip at start of pandemic, rebounded by next quarter**
- **30,818 VHA patients received naloxone from 6,855 prescribers in FY2020Q3**
  - 3.7% and 7.9% decrease, respectively, from previous quarter
- **30,902 VHA patients received naloxone from 7,720 prescribers in FY2020Q4**
  - 0.3% and 12.6% increase, respectively, from previous quarter
- **No dip in prescribing to high-risk patient populations**

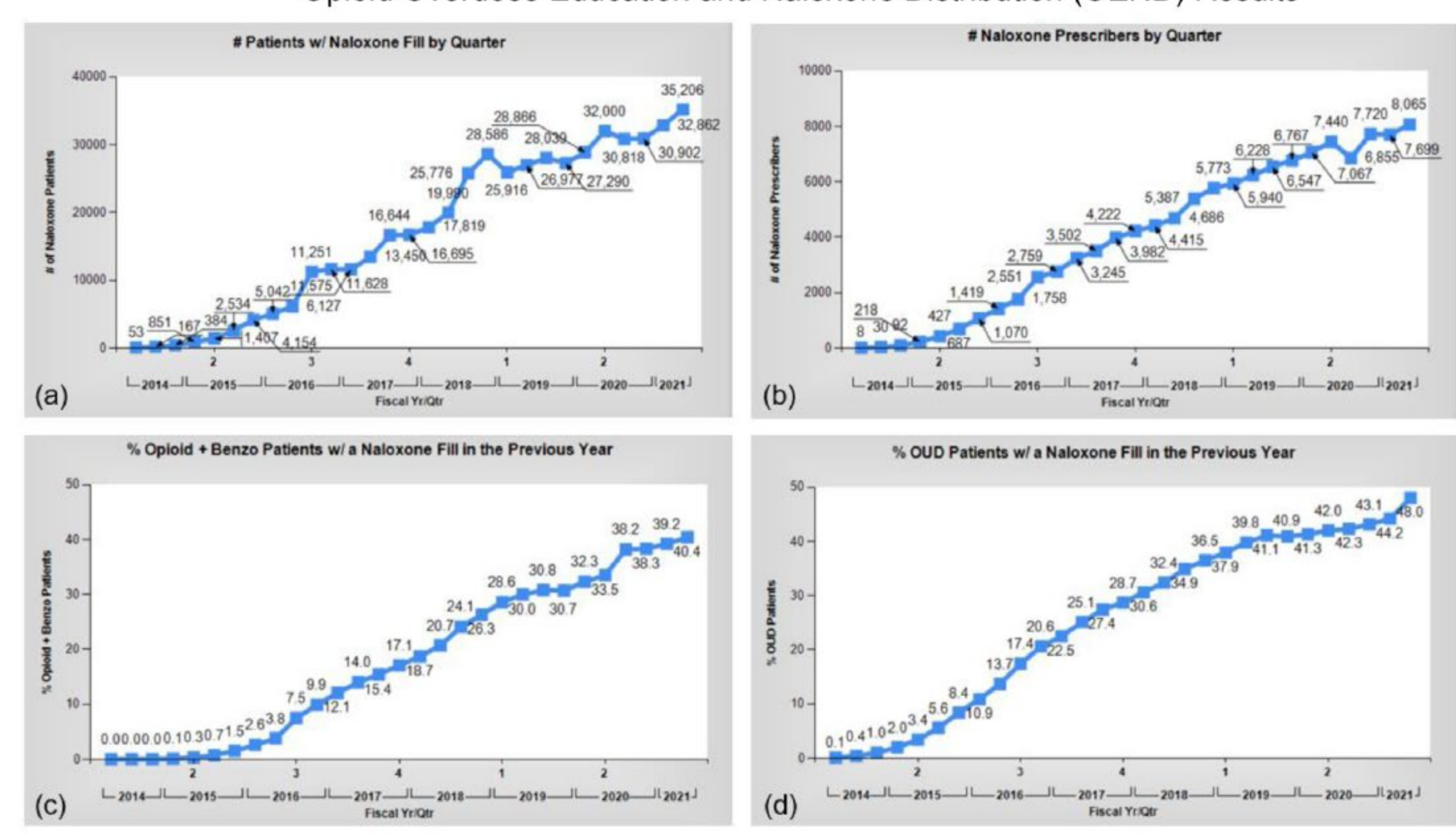

Figure 3: These graphs show (a) the number of unique Veterans Health Administration (VHA) patients dispensed naloxone, (b) the number of unique naloxone prescribers, (c) the percentage of VHA patients prescribed opioids and benzodiazepines who were dispensed naloxone in the past year, and (d) the percentage of VHA patients with an opioid use disorder who were dispensed naloxone in the past year by fiscal quarter from fiscal year (FY)2014 quarter 2 to FY2021 quarter 2. OUD, opioid use disorder.

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Oliva et al., 2021

Morbidity and Mortality Weekly Report

Vital Signs: Pharmacy-Based Naloxone Dispensing — United States, 2012–2018

Gery P. Guy, Jr., PhD[1]; Tamara M. Haegerich, PhD[1]; Mary E. Evans, MD[1]; Jan L. Losby, PhD[1]; Randall Young, MA[2]; Christopher M. Jones, PharmD, DrPH[3]

1 naloxone Rx for every 69 high-dose opioid Rx

1 in 6

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Oliva et al., 2021

VA Quality Enhancement Research Initiative (QUERI) Roadmap for Implementation and Quality Improvement

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Table 2. A Theory-based Approach to Mapping Barriers to Implementation Strategies: The Department of Veterans Affairs OEND Initiative

Barrier Level	Barrier	Mechanism of Change[25,124]	Implementation Strategy/Technique[121,126]
Veteran	Risk awareness	Perceived vulnerability	Risk communication, use mass media
	Ability to use naloxone in overdose	Caregiver knowledge, self-efficacy, skills	Develop and distribute educational materials, obtain family feedback, activate Veterans and family
	Cost		Alter office fees, make billing easier (naloxone provided free of charge)
Clinician/clinical team	Ability to identify high-risk Veterans	Knowledge, clinical decision-making	Develop clinical analytics to identify at-risk Veterans
	Lack of expertise in naloxone prescribing	Knowledge, skills, goals, self-efficacy, subjective norms	Offer educational trainings, train-the-trainer
	Prescribing naloxone	Behavioral cueing, environment resources	Change electronic medical record templates
	Awareness of progress	Feedback processes, subjective norms	Audit and feedback, relay data to clinicians
Hospital/practice	Competing priorities	Professional role change, reinforcement	Mandate change, policy directives(s) for all facilities, identify and prepare champions
	Implementation variability	Knowledge, subjective norms	Values, standardize tools, guidance, resources implementation plans
	Cost to facilities	Reinforcement	Policy change, change cost to hospital (no cost)
Health system	Low availability of naloxone	Environmental context, social roles	Use advisory boards and national workgroups
	Unstandardized naloxone kit	Environment resource	Place naloxone kits on national formulary
	Lack of best practice	Knowledge, skills, decision processes, social learning	Create learning collaborative, centralized technical assistance and facilitation
	Coordination across service disciplines	Professional role, norms, motivation	Change availability of services and mix of clinicians offering treatment
	Union support	Professional role, social influences, norms	Obtain formal commitments

VHA Rapid Naloxone Technical Assistance (POC: Elizabeth.Oliva@va.gov)

- **Federal Register: Elimination of Copayment for Opioid Antagonists and Education on Use of Opioid Antagonists**
- VA Academic Detailing Service OEND Campaign (internal site)
  - Patient education brochures, "Kit" brochures, DVDs for providers and patients—order through depot
- VA National OEND SharePoint (internal site)
  - Program Models; OEND Monthly COP Call (transitioned to Opioid Safety and Risk Mitigation COP Call)
- VA PBM Clinical Recommendations (February 2022 Naloxone Rescue: Recommendations For Use; internal sites)
- VA OEND Videos **(links 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://www.youtube.com/watch?v=lg1LEw-PeTE
- **Accredited Monthly Community of Practice Call**
  - Opioid Safety and Risk Mitigation (internal site)
- **Panel Management Tools**
  - OEND Patient Risk Dashboard; Stratification Tool for Opioid Risk Mitigation (internal sites)
- **Accredited TMS training:** TMS trainings 27440 and 27441
  - Available outside VA on www.train.org: https://www.train.org/main/course/1087390/
- **VA TMS training 37795:** How to Use Naloxone Nasal Spray (Narcan®) (internal site)
  - Available outside VA on www.train.org: https://www.train.org/main/course/1092122/
- **Psychotropic Drug Safety Initiative (PDSI)**, **VHA SUD**, **&** **VHA Pain Management** (internal sites)

Rule

Elimination of Copayment for Opioid Antagonists and Education on Use of Opioid Antagonists

A Rule by the Veterans Affairs Department on 09/20/2021

SUMMARY:

The Department of Veterans Affairs (VA) is amending its medical regulations that govern copayments to conform with recent statutory requirements. VA is eliminating the copayment requirement for opioid antagonists furnished to veterans who are at high risk of overdose of a specific medication or substance in order to reverse the effect of such an overdose. VA is also clarifying that no copayment is required for the provision of education on the use of opioid antagonists. This final rule is an essential part of VA's attempts to help veterans at high risk of overdose.

DATES:

This rule is effective October 20, 2021.

(i) For purposes of this paragraph (c)(12), a veteran who is at high risk for overdose of a specific medication or substance in order to reverse the effect of such an overdose is a veteran:

(A) Who is prescribed or using opioids, or has an opioid use history, and who is at increased risk for opioid overdose as determined by VA; or

(B) Whose provider deems, based on their clinical judgment, that the veteran may benefit from ready availability of an opioid antagonist.

(ii) Examples of a veteran who is at high risk for overdose of a specific medication or substance in order to reverse the effect of such an overdose include, but are not limited to, the following:

(A) A veteran with an opioid or substance use disorder diagnosis;

(B) A veteran receiving treatment for an opioid or substance use disorder diagnosis, such as receiving opioid agonist therapy or inpatient, residential, or outpatient treatment for such diagnosis, or attending a support group for such diagnosis;

(C) A veteran with a history of prescription opioid misuse or injection opioid use;

(D) A veteran with a history of previous opioid overdose;

(E) A veteran who is taking an extended-release or long-acting prescription opioid;

(F) A veteran with household or community access to opioids who is at increased risk for overdose (*e.g.*, psychiatric disorder or high risk for suicide) as determined by VA; or

(G) A veteran predicted to be at high risk for overdose based on standardized assessments or predictive models (*e.g.*, Risk Index for Overdose or Serious Opioid-induced Respiratory Depression [RIOSORD]; Stratification Tool for Opioid Risk Mitigation [STORM]).

© 2022, Public Health Institute. https://www.federalregister.gov/documents/2021/09/20/2021-20196/elimination-of-copayment-for-opioid-antagonists-and-education-on-use-of-opioid-antagonists

Naloxone Rescue: Recommendations for Use

Naloxone Rescue [Naloxone HCl Nasal Spray (Narcan®, Kloxxado®) and Injection (Zimhi®)] for the VA Opioid Overdose Education and Naloxone Distribution (OEND) Program

February 2022

VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives

RECOMMENDATIONS AND INFORMATION FOR OFFERING NALOXONE RESCUE

The nasal spray formulations of naloxone are our preferred products; however, the naloxone 5 mg/0.5ml Injection is available for those patients who have a contraindication to or are unable to use the preferred nasal product (e.g., allergy, anatomic nasal obstruction).

Assess the risk of opioid-related adverse events. ***Discuss*** the provision of naloxone rescue as an opioid risk mitigation option with patients and/or family/caregivers. ***Offer*** naloxone rescue to Veterans prescribed or using opioids who are at increased risk for opioid overdose or whose provider deems, based on their clinical judgment, that the Veteran has an indication for ready naloxone availability. ***Educate*** patients and caregivers on opioid overdose prevention, recognition, and response, including the proper use and storage of naloxone rescue medications. ***Document*** OEND-related discussions and overdoses in patients' medical records, including reversal events with VA naloxone rescue medications, using nationally recommended and standardized documentation tools (see *Computerized Patient Record System Products* section).

The Risk Index for Overdose or Serious Opioid-induced Respiratory Depression (RIOSORD) is a practical and relatively simple and brief risk assessment instrument that has been automated by VA to assess a patient's baseline risk. Another automated tool is the VA Stratification Tool for Opioid Risk Mitigation (STORM) which helps identify patients – including patients prescribed opioids – who are at risk for adverse events such as drug overdose or suicide. The Opioid Therapy Risk Report (OTRR) and the Current Opioid Misuse Measure (COMM)™ are also useful tools (see Overdose Risk Assessment and Opioid Risk Mitigation, pages 6-11).

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February 2022 Naloxone Rescue: Recommendations For Use

OVERDOSE PREVENTION LEADERSHIP SUMMIT

Examples of Candidates for Naloxone Rescue include *but are not limited to*:

Veterans with:

- History of previous opioid overdose †
- An opioid use disorder or substance use disorder diagnosis (including individuals receiving treatment, such as medications for opioid use disorder or inpatient, residential, or outpatient treatment, or attending support groups) †
- History of prescription opioid misuse or injection opioid use †
- Use of non-prescribed drugs (e.g., heroin, cocaine, methamphetamine or other stimulants) which could be contaminated with potent opioids like illicitly manufactured fentanyl †
- Prescribed or using opioids, or have an opioid use history, and who are at increased risk for opioid overdose as determined by provider
- Whose provider deems, based on their clinical judgment, that the Veteran may benefit from ready availability of an opioid antagonist
- Chronic hepatitis, cirrhosis, alcohol use disorder, sleep apnea or pulmonary disease and taking opioids
- Household or community access to opioids who are at increased risk for overdose (e.g., psychiatric disorder or high risk for suicide)
- Predicted high risk for overdose based on standardized assessments or predictive models (e.g., Risk Index for Overdose or Serious Opioid-induced Respiratory Depression [RIOSORD], Stratification Tool for Opioid Risk Mitigation [STORM])
- An extended-release or long-acting opioid prescription
- An opioid prescription of ≥ 50 mg morphine equivalents per day
- Concurrent use of central nervous system depressant, such as benzodiazepine, non-benzodiazepine sedative hypnotic (e.g., zolpidem), skeletal muscle relaxant, or alcohol
- Homeless or unstably housed
- Veterans who receive VA or non-VA care in these situations:
    - HIV education / prevention program (which may provide care to people who inject drugs)
    - Syringe service program
    - Emergency departments (e.g., for opioid poisoning / overdose or intoxication)
    - Primary health care (e.g., for follow-up of recent opioid poisoning / overdose or intoxication)
    - Inpatient residential care or community-based treatment for homeless Veterans taking an opioid

NOTE: Veterans in the above examples may be at-risk even after a period of abstinence from opioids (e.g., due to treatment, detoxification, incarceration) because loss of tolerance can increase the risk for an overdose. High risk patients that have gone through a period of abstinence may be candidates for the 8mg nasal spray where physical dependence and the chances for precipitated withdrawal are low.

† These patients may be candidates for the 8mg naloxone nasal spray. Providers should exercise clinical judgment when prescribing the 8mg naloxone nasal spray, currently there are no clinical trials to help guide its place in therapy and identify the most appropriate candidates for its use. The higher C_{max} and $AUC_{0\text{-}inf}$ achieved with the 8mg nasal spray may provide a better opioid overdose reversal response in select patients, e.g. those who OD on the stronger fentanyl synthetic analogues or patients who required multiple 4mg doses in prior revival attempts, but these higher levels may also potentially increase the risk for precipitated withdrawal when compared to the 4mg nasal spray (See *Precipitated Opioid Withdrawal* section below). The use of the 8mg nasal spray should be based on a shared patient-provider decision process, e.g., if biggest concern is that the naloxone dose won't be enough, the patient-provider may agree on the 8mg dose; if biggest concern is for withdrawal symptoms, the 4mg dose may be used.

Table 2: NALOXONE (NARCAN®) NASAL SPRAY AND IM (GENERIC) KIT [22-23]

All products are FDA-approved forms of naloxone that the FDA states can be considered as options for community distribution. The Nasal Spray was specifically designed for layperson use, e.g., product labeling includes instructions for layperson use, and is ready-to- use with no assembly required.	Nasal Spray (4 mg) (Preferred Naloxone Formulation)	Nasal Spray (8 mg)	Injectable IM (0.4mg) generic	Injection (5 mg/0.5ml)
Trade name	Narcan	Kloxxado	Not applicable	Zimhi
Strength	4 mg/0.1ml	8 mg/0.1ml	IM: 0.4 mg/ml	5 mg/0.5ml
Total volume of kit/package	8 mg/0.2 ml	16 mg/0.2 ml	IM: 0.8 mg/2ml	10 mg/1ml

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VHA Memoranda Supporting Naloxone Distribution

Department of Veterans Affairs **Memorandum**

Date: February 24, 2021

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

Subj: Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD)

To: Veterans Integrated Service Network (VISN) Directors (10N1-23)
Medical Center Directors (00)

Thru: Assistant Under Secretary for Health for Operations (15)

2. VA medical facility Directors are responsible for ensuring that all Veterans with an OUD diagnosis who have not received naloxone, as determined by a review of VA's Stratification Tool for Opioid Risk Mitigation (STORM) dashboard "Actionable" patients, be offered patient education and a prescription for naloxone no later than December 31, 2021. The intended goal is to increase facility-level naloxone dispensing rates by 25% for STORM-identified patients with OUD. This is also an opportunity to review the care provided to Veterans with OUD and assist with linkages to Substance Use Disorder care for those Veterans not already engaged with treatment, as clinically appropriate.

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.

Department of Veterans Affairs **Memorandum**

Date: October 15, 2021

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

Subj: Implementation of the Psychotropic Drug Safety Initiative (PDSI) Phase 5: Stimulant Safety Initiative (VIEWS 6089962)

To: Veterans Integrated Services Network (VISN) Director (10N1-23)
VISN CMOs (10N1-23)
VISN Chief Mental Health Officers (CMHO) (10N1-23)

Step 1 (January 2022 to December 2022) will increase capacity to provide guideline concordant treatment to Veterans with stimulant use disorder and continue previous PDSI and Overdose Education and Naloxone Distribution (OEND) activities in the areas of substance use disorder (SUD) pharmacotherapy. All facilities will focus on each of the following objectives.

- **Objective 1**. Increase capacity to deliver guideline concordant evidence-based practices for patients with stimulant use disorder, including Cognitive-Behavioral Therapy for Substance Use Disorder (*Metric: CBT-SUD_Provider*) and Contingency Management (*Metric: CM_Program*). Each facility will choose to focus on at least one of these metrics.
- **Objective 2**. Expand OEND to patients with stimulant use disorder (*Metric: Naloxone_StimUD*).
- **Objective 3**. Continue efforts related to PDSI Phase 3 SUD pharmacotherapy (*Metrics: SUD_16PDSI and ALC_top*). Facilities may choose to continue work on previous priority metrics or switch priority metrics.

VA OEND Dashboard

OEND Dashboard

Definitions	
Export	Feedback

Update Status:	Not Started
Last Updates:	12/4/2022

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

Location/Prescriber	# Naloxone Fills (All Time)	% Nasal Fills (90d)	% Auto-Inj. Fills (90d)	% IM Fills (90d)	# Naloxone Patients	#Naloxone Prescribers	# Naloxone Uses	# Successful Reversals
National	872,141	99.94	0.00	0.06	406,639	46,201	3795	3273

		Naloxone Rx Released to Patient (1 year) / Total Patient Cohort			
Location / Prescriber	Potential Risk Factor	Patient Cohort	Score	National Score	Patients w/ No Fill
Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD)		RIOSORD Cohort Inclusive of All Opioid, OUD, and OAT Risk Group Patients			
National	RIOSORD Risk Class (View Publication)	All Patients	68.3%	68.3%	188,475
		Risk Class ≥ 8	76.2%	76.2%	680
		Risk Class 5-7	69.2%	69.2%	3,297
		Risk Class ≤ 4	45.4%	45.4%	184,498
Opioid Pharmacotherapy					
National	Opioid + Benzodiazepine	All Patients	55.5%	55.5%	3,362
	MEDD ≥ 50 (Last 30 days)	All Patients	60.9%	60.9%	10,761
	MEDD ≥ 90 in Past Year w/ No Fill in the Past 90 Days	All Patients	32.0%	32.0%	4,133
	Methadone (Outpatient Rx or Active Non-VA Medication)	All Patients	56.0%	56.0%	4,295
OUD & MOUD Pharmacotherapy					
National	OUD Diagnosis	All Patients	61.9%	61.9%	21,887
	Possible Overdose (3 Years)	All Patients	49.6%	49.6%	4,823
	Buprenorphine SL (Outpatient Rx or Active Non-VA Medication)	All Patients	72.6%	72.6%	5,231
	Naltrexone (Outpatient Rx, Active Non-VA, or Recent Clinic Order)	OUD Patients	63.8%	63.8%	280
	OUD-Related Fee Basis	All Patients			0
	Stimulant Use Disorder (New)	All Patients	32.0%	32.0%	59,153
Other Potential Risks					
National	Potentially Homeless Veterans	All Patients	42.6%	42.6%	26123
	HOMES Veterans	All Patients			0

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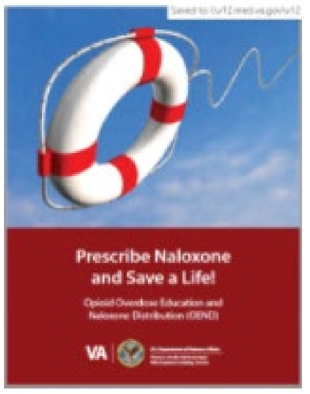
Academic Detailing OEND Resources

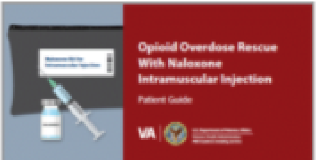


Prescribe Naloxone and Save a Life!

Clinician's Guide

IB#: 10-1522 | P97042 | Order

Naloxone Instructions



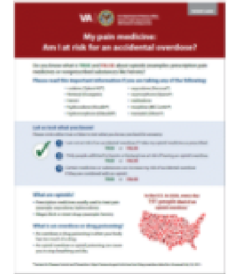
Opioid Overdose Rescue with Naloxone Intramuscular Kit

IB#: 10-1537 | P97057 | Order

Opioid Overdose Rescue with Naloxone Nasal Spray

IB#: 10-1538 | P97058 | Order

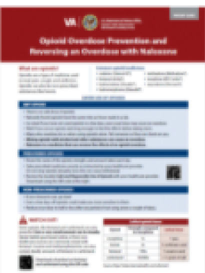
Brochures & Handouts



My Pain Medicine: Am I at risk for an accidental overdose?

Direct to Consumer

IB#: 10-1541 | P97061 | Order



Opioid Overdose Prevention and Reversing an Overdose with Naloxone

Replaces 10-784, 10-786 & 10-787

IB#: 10-1539 | P97059 | Order

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Clinician Guide: Prescribe Naloxone and Save a Life!

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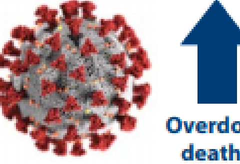
Prevent death from an overdose with opioid overdose education and naloxone distribution (OEND)

Overview of OEND

Drug overdoses—both intentional and accidental—are a leading cause of death.[1,2] Opioid overdoses alone contributed to nearly 450,000 deaths in the United States between 1999-2018.[3,4] In the United States in 2020, 255 people died every day from a drug overdose.[5]



Overdose deaths

Drug overdose deaths declined by 4.1% between 2017 to 2018,[6] **however in 2020, there was a 29.4% increase in deaths.** This increase is thought to be related to the prevalence of fentanyl in non-prescribed substances along with stress related to the pandemic and a reduction in access to health care.[7]

OEND is a risk mitigation initiative to prevent opioid-related overdose deaths.

Naloxone, along with opioid overdose education, can prevent a fatal overdose—a few minutes of training that could save a life.[8,9]

- **Opioid Overdose Education (OE)**
  - Provide education to the Veteran, family members, friends, acquaintances, and potential bystanders on how to prevent, recognize, and respond to an opioid overdose.
- **Naloxone Distribution (ND)**
  - Provide the Veteran with naloxone.
  - Train the Veteran and potential bystanders on how to use naloxone.

It is time to take action and reverse the course of opioid overdose deaths. Putting naloxone in the hands of at-risk Veterans and training their family and friends is critical. Opioid overdose education helps Veterans reduce risky opioid use behaviors and can reduce the need to use naloxone.

Naloxone temporarily reverses the effects of opioids and can save lives.

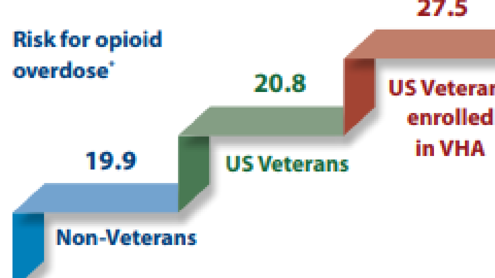
Naloxone is like a fire extinguisher—everyone at risk for an opioid overdose should have one.

- At-risk Veteran Health Administration (VHA) patients can get naloxone for **FREE**—no co-pay.
- VA handouts and videos are available on the **Academic Detailing OEND SharePoint** to help with patient education.

Understanding opioid overdose

Overdoses can be accidental or intentional. Among Veterans, 86% of overdoses were accidental in 2017.[10]

Figure 1. Veterans are at higher risk for opioid overdose.[10]



Fatal overdoses mostly involve opioids.[11] Despite reductions in opioid prescribing in the VHA, opioid overdoses continue to increase.[12,13,14] Synthetic opioids like fentanyl comprise most Veteran overdose-related fatalities with an estimated 56.9% in 2017.[10,12]

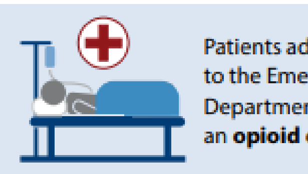
*Age Adjusted Rate per 100,000. Includes intentional and accidental opioid overdoses.

Figure 2. Non-fatal overdose is associated with an increased risk of future overdose.[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.[16]



Patients admitted to the Emergency Department (ED) for an **opioid overdose**

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.[17]
- Opioid-related suicide deaths are 13 times higher in people with OUD.[18,19]
- Opioids are the most common class of substances found in suicide by overdose.[20]

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

Start the conversation

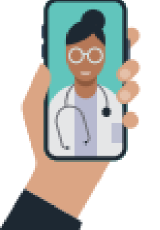
Keep the conversation open and create a safe space for the Veteran to talk.

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.

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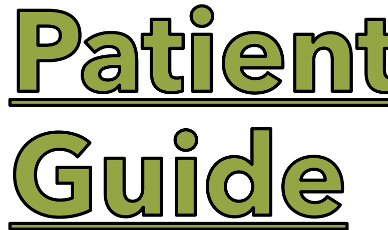

PATIENT GUIDE

Opioid Overdose Prevention and Reversing an Overdose with Naloxone

What are opioids?

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®)
- hydromorphone (Dilaudid®)
- methadone (Methadose®)
- morphine (MS Contin®)
- oxycodone (Percocet®)

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.
- **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 using the QR code 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).

WATCH OUT!

Some opioids, like fentanyl and carfentanil, are very powerful. **Even a very small amount can be deadly.** Opioid tablets purchased online or from non-healthcare sources are commonly mixed with fentanyl. Cocaine and methamphetamine can also contain deadly amounts of fentanyl or carfentanil.

Download a handout on fentanyl and carfentanil using this QR code.

Lethal opioid doses

Opioid	Strength compared to morphine	Lethal dose
morphine	1x	1 pea
heroin	2x	1 sunflower seed
fentanyl	100x	1 sesame seed
carfentanil	10,000x	< ½ grain of salt

Source: https://www.clearvuehealth.com/sufentanil

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
  - Reduced liver or kidney function
  - Advanced AIDS
  - Smoking cigarettes and cannabis
  - Chronic obstructive pulmonary disease (COPD) or 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 (Flexeril®), some antidepressants, and nerve pain 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.

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Patient Guide

Non-prescribed medicine/illicit substance disposal:

- Sharps containers may be available from the VA Pharmacy to safely dispose of syringes.
- Substances, cookers, spoons, and pipes can be placed in a coffee can, laundry detergent jug, or other heavy plastic container.
  - Crush and dissolve solid substances in a liquid. Add to the container.
  - Place sharp objects like broken glass or syringes in the container.
  - Add kitty litter, sawdust, dirt, or coffee grounds to the container. Seal container.
  - Destroy any information that may contain your name. Dispose in trash.

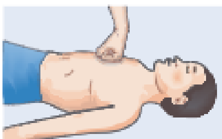
Responding to an overdose

Safety check: Look for signs of an overdose

Check	Listen	Look	Touch
• sleepy • heavy nodding • deep sleep • hard to wake • vomiting	• slow or shallow breathing (1 breath every 5 seconds) • snoring • raspy, gurgling, or choking sounds	bluish or grayish: • lips • fingernails • skin	• clammy sweaty skin

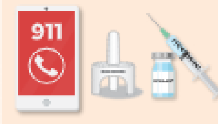
If the person responds to the initial safety check, continue to monitor them. Some opioids can take longer to take effect. Stay with the person until help arrives. If they do not respond then follow the steps below:

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, raspy, gurgling, or choking sounds.

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

Give naloxone and use an AED if available:

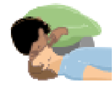
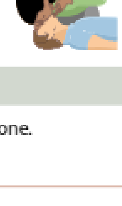
- If you have **naloxone nasal spray**, DO NOT PRIME OR TEST the spray device. Gently insert tip of nozzle into one nostril and press the plunger firmly to give the dose.
- If you have **intramuscular naloxone**, insert syringe through rubber plug with vial upside down and pull back on plunger to 1ml. Inject 1 ml at a 90-degree angle into a large muscle (upper arm, upper leg, or buttocks).

Naloxone nasal spray

Intramuscular naloxone

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.

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:

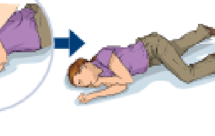
- Tap and shout.
- Reposition into the recovery position.
- If person stops responding, give naloxone.
- Continue to observe until EMS arrives.

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 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.



Resources:

VA Substance Use Disorder Program Locator: www.va.gov/directory/guide/SUD.asp
Substance Use Disorder Treatment Locator for Non-Veterans: https://findtreatment.samhsa.gov
Prescribe to Prevent: www.prescribetoprevent.org
Syringe Service Programs: www.hiv.va.gov/patient/ssp.asp

Help is available anytime

Local Emergency Services: 911 • National Poison Hotline: 1-800-222-1222
Veterans Crisis Line: 1-800-273-TALK (8255), or text–838255

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Fentanyl & Carfentanil

One time could be the LAST time

What are fentanyl and carfentanil?

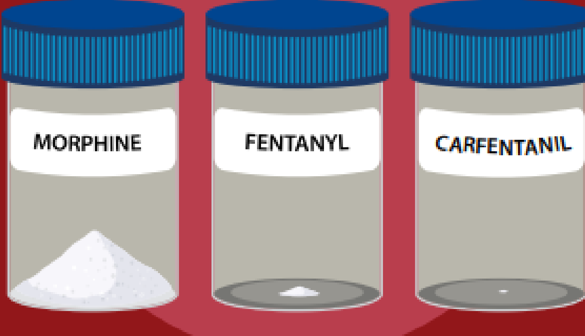
Fentanyl is a synthetic (man-made) opioid that works like morphine. It may be used to treat severe pain after surgeries and for pain at the end of life in patients with cancer. Carfentanil is another synthetic opioid. It is used as a tranquilizer for very large animals like elephants.

Opioid overdoses are on the rise. Fentanyl and carfentanil can be deadly when injected, smoked, snorted, swallowed, or used in the rectum. Touching or inhaling fentanyl powder in the air or on surfaces does not cause an overdose.

Why are we concerned?

Fentanyl and carfentanil are prescription drugs that are used for medical purposes. They are also made illegally and added to street drugs like heroin, cocaine, and methamphetamine.

Illegally made fentanyl and carfentanil are added to counterfeit pills. They look just like prescription pills and can cause death within seconds.

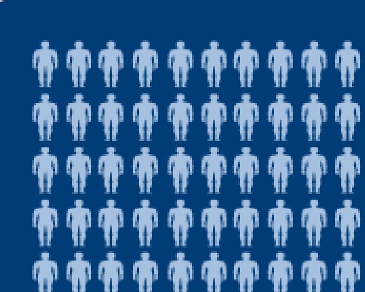


How strong is fentanyl?

Fentanyl is 100 times more potent than morphine and 50 times more potent than heroin.

How strong is carfentanil?

Carfentanil is 10,000 times more potent than morphine and 100 times more potent than fentanyl.



2 mg dose will knock out an average size elephant...

...and is enough to kill about **50 people**

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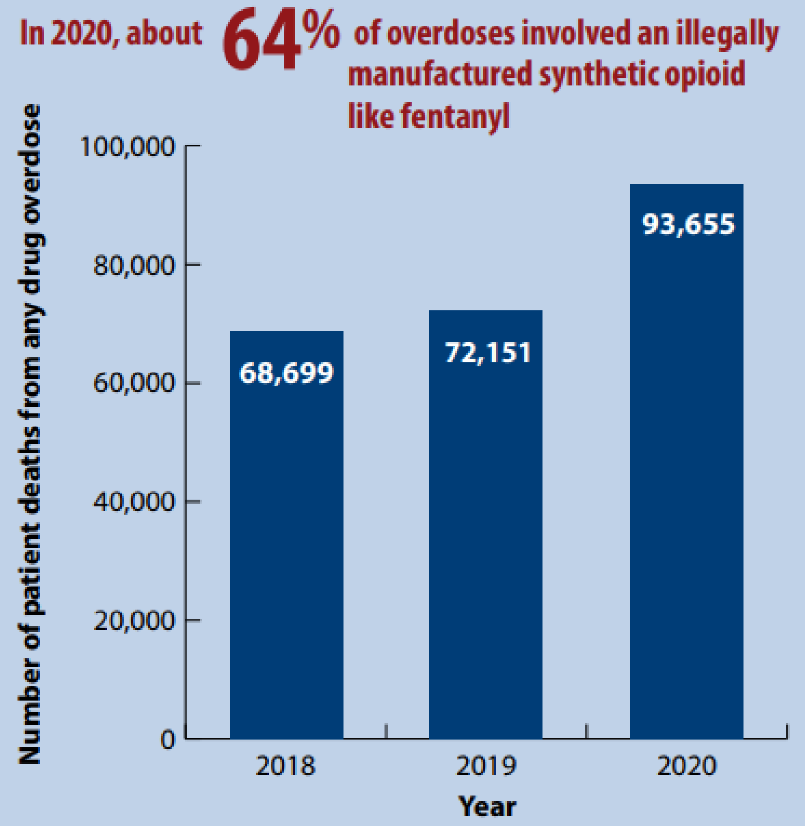
Drug overdoses continue to increase with nearly 100,000 deaths in 2020



NEVER USE ALONE.

If you are going to use by yourself, call 1-800-484-3731.
https://neverusealone.com

What can you do?

There are treatments that work to help you stop using opioids. Talk to your VA provider to get started if:

- You are using street drugs.
- You are unable to control how much street drugs you use.
- You have accidentally overdosed in the past on street drugs.
- You are around others who are using or have overdosed on street drugs.

Your provider can offer treatments, such as:

1. Naloxone, a life-saving medicine that temporarily reverses opioid overdose. It can be sprayed in the nose or injected.
   - Always keep naloxone with you and know how to use it.
   - Make sure friends and family know where you keep naloxone and how to use it.
2. Medications to help people who want to stop using opioids:
   - buprenorphine/naloxone (Suboxone®)
   - methadone
   - naltrexone injection
3. Referral to substance treatment programs
4. Test strips/kits to test drugs for fentanyl/carfentanil may be available from the VA and community harm reduction programs. People who sell drugs may not know the drugs contain fentanyl/carfentanil.
5. Other supplies that can reduce harms from drug use, such as sterile syringes and sharps containers

NALOXONE SAVES LIVES

Please call ______________ with any questions or concerns.

February 2022 IB 10-1550 P97070 www.va.gov

Veterans Crisis Line
DIAL 988 then PRESS 1
or Text-838255

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National Note—
Overdose Education and Naloxone

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- Supports standardized OEND
- Streamlined note with key health factors

Overdose Education and Naloxone Version 2.1

This national note is meant to support standardized Opioid Overdose Education and Naloxone Distribution (OEND). OEND should include critical education on opioid overdose prevention, recognition, and response. OEND also offers an opportunity to identify if the patient used a previous naloxone prescription and/or had an overdose event. If so, it should be documented in a national note template to improve post-overdose care (e.g., Suicide Behavior and Overdose Report).

Most Recent Naloxone Prescription

Information:
No prior Naloxone prescription was found.

Patient has an indication for OEND due to following:

- ☐ Opioid prescription
- ☐ Recent opioid discontinuation
- ☐ Opioid use disorder/opioid dependence (current or past)
- ☐ Stimulant use disorder (current or past; e.g., cocaine, methamphetamine)
- ☐ Other substance use disorder
- ☐ Other:

EDUCATION*

- ○ Education could not be provided (e.g., outside scope of practice, patient/caregiver not present)
- ○ Education provided

NALOXONE

- ○ Order naloxone
- ○ Provider notified of request for naloxone
- ○ Has current naloxone (i.e., not used and not expired)
- ○ Patient declined naloxone
- ○ Other:

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Reminder Dialog Template: Overdose Education and Naloxone

Overdose Education and Naloxone Version 2.1

This national note is meant to support standardized Opioid Overdose Education and Naloxone Distribution (OEND). OEND should include critical education on opioid overdose prevention, recognition, and response. OEND also offers an opportunity to identify if the patient used a previous naloxone prescription and/or had an overdose event. If so, it should be documented in a national note template to improve post-overdose care (e.g., Suicide Behavior and Overdose Report).

Most Recent Naloxone Prescription

Information:

No prior Naloxone prescription was found.

Patient has an indication for OEND due to following:

- [x] Opioid prescription
- [x] Recent opioid discontinuation Comment:
- [x] Opioid use disorder/opioid dependence (current or past) Comment:
- [x] Stimulant use disorder (current or past; e.g., cocaine, methamphetamine) Comment:
- [x] Other substance use disorder Comment: *
- [x] Other: *

EDUCATION*

- ( ) Education could not be provided (e.g., outside scope of practice, patient/caregiver not present)
- (•) Education provided

Education should cover:

- opioid overdose prevention, recognition, and response
- naloxone use and disposal
- importance of training/educating potential bystanders on opioid overdose

Education provided to:

- [ ] Patient
- [ ] Patient's caregiver or other designee

The following resources were shared:

VA resources (Academic Detailing OEND SharePoint -includes Naloxone Recommendations For Use)

- [ ] Naloxone Patient Guide
- [ ] YouTube video: Introduction to Naloxone for People with Opioid Use Disorders
- [ ] YouTube video: Introduction to Naloxone for People Taking Prescribed Opioids
- [ ] YouTube video: How to use the VA Naloxone Nasal Spray
- [ ] YouTube video: How to Use the VA Intramuscular Naloxone Kit - YouTube
- [ ] Other (specify)
- [ ] Used teach back to ensure information provided was clearly understood.

NALOXONE

- ( ) Order naloxone
- ( ) Provider notified of request for naloxone
- (•) Has current naloxone (i.e., not used and not expired) Comment: *

++Please be sure to record any naloxone medication received outside of VA in the "Non-VA Medications" section of the "Meds" Tab in CPRS. Add the date the patient received the naloxone as the start date.++

- ( ) Patient declined naloxone
- ( ) Other:

Visit Info | Finish | Cancel

NATIONAL OVERDOSE PREVENTION LEADERSHIP SUMMIT

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National Clinical Reminder for Patients with OUD and Stimulant Use Disorder—*Offer Overdose Education and Naloxone*

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- Patients with OUD or Stimulant Use Disorder with no naloxone in past 335 days
- 30-day buffer to assist proactive outreach

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Reminder Resolution: Offer Overdose Education and Naloxone

Overdose Education and Naloxone Version 2.2

This reminder will come due for any patient that has had:
one or more outpatient Opioid Use Disorder (OUD) OR Stimulant Use Disorder encounter diagnoses in the past two years
-OR-
one or more inpatient OUD OR Stimulant Use Disorder diagnoses in the past year
-AND-
No naloxone ordered in the past 335 days

This reminder supports standardized Opioid Overdose Education and Naloxone Distribution (OEND). Because OUD and Stimulant Use Disorder are strong risk factors for overdose, OEND is recommended. Specifically, the majority of overdose deaths are opioid-related, including stimulant overdose deaths given high rates of polysubstance use and rise in illicit stimulants containing deadly amounts of fentanyl or carfentanil.
OEND should include critical education on opioid overdose prevention, recognition, and response.

EDUCATION*

- ( ) Education could not be provided (e.g., outside scope of practice, patient/caregiver not present)
- ( ) Education provided

NALOXONE

- (•) Order naloxone
- ( ) Provider notified of request for naloxone
- ( ) Has current naloxone (i.e., not used and not expired)
- ( ) Patient declined naloxone
- ( ) Other:

National Naloxone Clinical Reminder Order Checks (CROCs) for Patients with OUD and Stimulant Use Disorder

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- Identifies patients with OUD being prescribed a MOUD with no naloxone in past 335 days

Order Checking

(1 of 1) MEDICATION FOR OPIOID USE DISORDER
****

ACTION: Strongly consider prescribing naloxone

Use the OVERDOSE EDUCATION AND NALOXONE progress note -OR- the OFFER OVERDOSE EDUCATION AND NALOXONE 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.

Perform Allergy Assessment | Drug Interaction Monograph | Accept Order | Cancel Order

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- Identify patients with OUD or Stimulant Use Disorder being prescribed an opioid with no naloxone in past 335 days

Order Checking

(1 of 1) NALOXONE RECOMMENDED FOR OPIOID OR STIMULANT USE DISORDER
****
ACTION: Strongly consider prescribing naloxone

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

RATIONALE: Patient being prescribed an opioid, has a history of OUD or Stimulant Use Disorder -AND- no naloxone ordered in the previous 335 days.

Perform Allergy Assessment | Drug Interaction Monograph | Accept Order | Cancel Order

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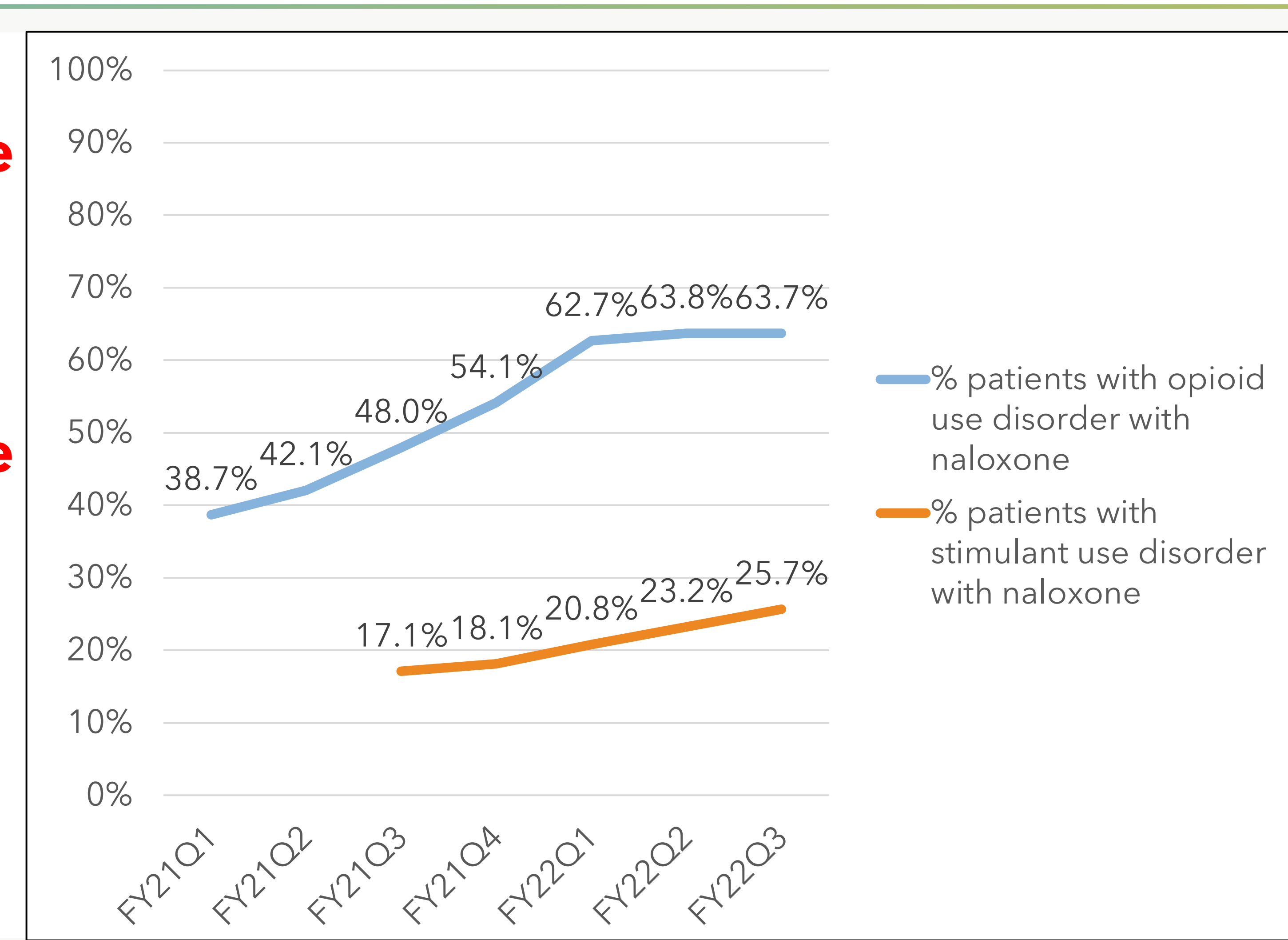
Naloxone Distribution Among Patients with Opioid Use Disorder (OUD) and Stimulant Use Disorder

- Between FY2021Q1 (38.7%) and FY2022Q1 (62.7%)–**62.0% increase in percentage of patients with OUD with naloxone**
- Between FY2021Q3 (17.1%) and FY2022Q3 (25.7%)–**50.3% increase in percentage of patients with stimulant use disorder with naloxone**
- ~4% of patients with stimulant use disorder and 5% of patients with OUD decline naloxone



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Expansion of VA's Harm Reduction Efforts

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Syringe Services Programs (SSP)

Policy development

- Specialty Care: HIV/Hepatitis, Infectious Disease, Pain Management, Opioid Safety, and Prescription Drug Monitoring
- Mental Health: Substance Use Disorders, OEND
- Homeless Program
- Risk Management: Ethics
- Patient Care Services: Pharmacy, Social Work
- Regulations, Appeals, and Policy

Tools to assist in national implementation and standards

- National note template
  - Includes critical services like HIV, HCV, STI testing, PrEP and Naloxone prescribing
- National education resources
  - Both patients and providers
- Standardization of kit components
  - 6 kits w/ syringes, sharps container, alcohol swabs, cottons, education

Innovation

- Ability for local facilities to support local champions and population needs
- Making sure facilities that can't prescribe syringes are able to provide other harm reduction services and education

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Slide courtesy of Elizabeth Maguire, MSW

Interim SSP Memorandum

Department of Veterans Affairs **Memorandum**

Date: May 24, 2021

From: Assistant Under Secretary for Clinical Services (11)

Subj: Interim Guidance on Syringe Services Programs (SSPs) in the Veterans Health Administration (VHA) (VIEWS# 05009598)

To: Veterans Integrated Service Network (VISN) Directors (10N1-23)
VHA Network CMOs (10N1-23)
VISN Pharmacist Executives (10N1-23)

1. Syringe Services Programs (SSPs) have historically been community-based harm reduction programs providing preventive and treatment services, including provision of sterile syringes and needles to people who inject drugs (PWID). Since their introduction in the 1980's to reduce human immunodeficiency virus (HIV) transmission among PWID, SSPs have become an internationally recognized harm reduction practice standard. Their use is endorsed by the Department of Health and Human Services, the US Surgeon General, the National Institutes of Health, the World Health Organization, the American Medical Association, and the American Bar Association. The US Centers for Disease Control and Prevention (CDC) has stated that SSPs should be considered by state, local, territorial, and tribal jurisdictions as essential public health infrastructure that should continue to operate during the COVID-19 pandemic.

2. The Biden-Harris Administration's Statement of Drug Policy Priorities for Year One, published in April 2020, 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. More information on this plan is available at the following link: https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf

3. PWID can substantially reduce their risk of acquiring and transmitting infections like HIV, viral hepatitis, and endocarditis by using a sterile syringe for every injection. In many jurisdictions in the US, PWID can access sterile syringes without a prescription from SSPs, health care organizations, and pharmacies, or with a prescription written by a health care provider.

4. Under Federal law and regulations, the Veterans Health Administration (VHA) has clear legal authority to operate SSPs. SSPs meet the criteria for inclusion in the Medical Benefits Package described at 38 CFR §17.38. Prohibitions against using certain Federal funds to purchase syringes do not apply to VA. VHA provider must write a patient-specific outpatient prescription in order for VHA pharmacy to provide prescription fulfillment services for syringes.

5. It is VHA's recommendation that VHA Medical Centers develop SSPs or otherwise ensure Veterans enrolled in VHA care have access to SSPs where such programs are not prohibited under state, county, or local law. Questions regarding local legality should be directed to Regional Counsel. Resources to establish VAMC-SSPs are available here: https://dvagov.sharepoint.com/sites/vhahiv-aids/syringe-exchange-resources/SitePages/SSP-Home.aspx

6. It is VHA policy that staff provide all enrolled or otherwise eligible Veterans clinically appropriate, comprehensive, Veteran-centered care in accordance with VHA's I-CARE values. Stigmatization is a common barrier to care for PWID, both in terms of access to SSPs and accessing needed medical or mental health treatment due to participation in an SSP. This is an opportunity to review the care provided to Veterans who inject drugs and assist with linkages to addiction services, mental health treatment and medical care.

7. Questions should be directed to VHA SSP Actions at: VHASSPActionGroup@va.gov.

Kameron Leigh Matthews, M.D., J.D., FAAFP

Attachment

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VA Innovators

- Danville*
- Orlando
- Cincinnati
- San Francisco
- Hines
- Puget Sound (Seattle and Tacoma)
- West Haven
- Salt Lake City
- Tampa

*Beth Dinges is a shark tank winner for work implementing the first SSP at VA!

- Programs in various stages of development in more than 20 additional sites
- Generally small and manageable to start but impact can be big for Veterans served
- VA SSP resources are on the SSP SharePoint (internal link)
- Learn more about current programs and technical assistance to start a program with our Affinity Group (internal link)

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Slide courtesy of Elizabeth Maguire, MSW

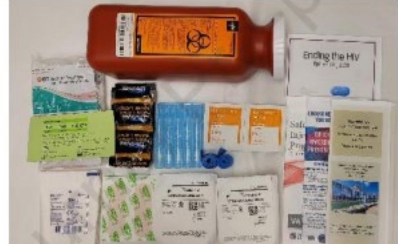
Implementing Syringe Services Programs Within the Veterans Health Administration: Facility Experiences and Next Steps

- Veterans Affairs facilities in Danville, IL; Orlando, FL; and San Francisco, CA worked to clarify legal considerations, address barriers, and implement SSPs
- Since 2017, engaged ~400 Veterans and distributed nearly 10,000 syringes, 2,500 fentanyl test strips, 50 wound care kits, and 45 safer sex kits
- Programs, both led by and in collaboration with clinical pharmacist practitioners, paved way for nationwide implementation within VHA
- Describes successes, challenges, and proposed next steps to increase Veteran access to syringe services programs

Figure 1. Pictures of Harm Reduction Supplies and Education Handouts Provided to Veterans

Danville, Illinois

San Francisco, California


Orlando, Florida

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Rife-Pennington T, Dinges E, Ho MQ. (in press). *Journal of the American Pharmacists Association.* doi: https://doi.org/10.1016/j.japh.2022.10.019.

Reaching the tipping point

- Coming soon! Contracted SSP kits:
  - Sterile syringes (100 OR 20):
    - 30g 5/16 1cc
    - 29g 1/2" 1cc
    - 27g 1/2" 1 cc
  - Alcohol pads
  - Sharps container
  - Cottons
  - Education handout
- Additional components might include:
  - Sterile water
  - Ascorbic acid powder
  - Condoms
  - Fentanyl test strips
- National note template
- Dashboard
  - Submitted request to CDC for new ICD code to capture injection drug use (IDU)

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Standardized Note Template

- Track services provided:
  - Education
  - SSP kits
  - Additional supplies
- Link to related orders and referrals:
  - SUD treatment
  - Naloxone
  - Social work
  - HIV PrEP
  - Infectious disease testing

Harm Reduction: Syringe Service Programs (SSP)

This national note is meant to support standardized Syringe Service Programs (SSPs) and harm reduction. Research has demonstrated benefits of SSPs (e.g., 50% reduction in HIV/HCV incidence; 5-fold increase in entering drug treatment; 3-fold decrease in injection frequency). SSPs also play a key role in linking patients with substance use disorder (SUD) treatment and providing additional harm reduction such as infectious disease testing and vaccinations as well as provision of Pre-exposure Prophylaxis (PrEP) and overdose education and naloxone.

DISPLAY Data object for last SSP kit DISPENSED [use NDFs]

- **Type of kit dispensed and date dispensed**

Patient has an indication for SSP due to the following*:

[ ] Injection drug use **[HF: VA-SSP IDU]**

Estimated injections per week (use to guide number of syringes/kits given):

[ ] Open free text for number **[HF: VA-SSP # INJECTIONS/WK]**

[ ] Comment [free text] **[HF: VA-SSP INDICATION]**

Patient has used the following substances—prescribed or non-prescribed—in the past year:

[ ] Opioids (e.g., heroin, fentanyl) **[HF: VA-SSP PAST YR OPIOID]**
[ ] Sedatives (e.g., benzodiazepines) **[HF: VA-SSP PAST YR SEDATIVES]**
[ ] Stimulants (e.g., amphetamine, cocaine) **[HF: VA-SSP PAST YR STIMULANTS]**
[ ] Cannabis/Marijuana **[HF: VA-SSP PAST YR CANNABIS]**
[ ] Alcohol **[HF: VA-SSP PAST YR ALCOHOL]**
[ ] Other [free text] **[HF: VA-SSP PAST YR OTHER SUBSTANCE]**

[ ] Order SSP kit

[ ] VA SSP Kit **[VA-SSP KIT]**

[ ] Pharmacy-dispensed kit [VA-SSP KIT RX]

Notes: Ask Veteran their preference. If they aren't sure, the larger gauge (27g) is better for drugs with impurities like tar heroin. Thinner needles (30g or 29g) are better for injecting in smaller veins like those in the hands. In addition to syringes, kits contain alcohol pads, cotton pellets, a sharps container, and an educational brochure.

[ ] 30g 8mm 1ml **[VA-SSP KIT RX 30G]**
[ ] 20 syringes **[VA-SSP KIT RX 30G 20 SYRINGES]**
[ ] 100 syringes **[VA-SSP KIT RX 30G 100 SYRINGES]**
[ ] 29g 12.7mm 1 ml **[VA-SSP KIT RX 29G]**
[ ] 20 syringes **[VA-SSP KIT RX 29G 20 SYRINGES]**
[ ] 100 syringes **[VA-SSP KIT RX 29G 100 SYRINGES]**
[ ] 27g 12.7mm 1 ml **[VA-SSP KIT RX 27G]**
[ ] 20 syringes **[VA-SSP KIT RX 27G 20 SYRINGES]**
[ ] 100 syringes **[VA-SSP KIT RX 27G 100 SYRINGES]**
[ ] Additional harm reduction supplies (please specify any additional harm reduction supplies included with the SSP kit): **[VA-SSP KIT ADD HR SUPPLIES]**
[ ] Condoms **[VA-SSP KIT ADD CONDOMS]**
[ ] Fentanyl test strips **[VA-SSP KIT ADD FTS]**
[ ] Naloxone **[VA-SSP KIT ADD NALOXONE]**
[ ] Sharps containers (additional) **[VA-SSP KIT ADD SHARPS]**
[ ] Other [SPECIFY] **[VA-SSP KIT ADD OTHER]**

[ ] Logistics-supplied kit [VA-SSP KIT LOGISTICS]

Notes: Ask Veteran their preference. If they aren't sure, the larger gauge (27g) is better for drugs with impurities like tar heroin. Thinner needles (30g or 29g) are better for injecting in smaller veins like those in the hands. In addition to syringes, kits contain alcohol pads, cotton pellets, a sharps container, and an educational brochure.

[ ] 30g 8mm 1 ml **[VA-SSP KIT LOGISTICS 30G]**
[ ] 20 syringes **[VA-SSP KIT LOGISTICS 30G 20 SYRINGES]**
[ ] 100 syringes **[VA-SSP KIT LOGISTICS 30G 100 SYRINGES]**
[ ] 29g 12.7mm 1 ml **[VA-SSP KIT LOGISTICS 29G]**
[ ] 20 syringes **[VA-SSP KIT LOGISTICS 29G 20 SYRINGES]**
[ ] 100 syringes **[VA-SSP KIT LOGISTICS 29G 100 SYRINGES]**
[ ] 27g 12.7mm 1 ml **[VA-SSP KIT LOGISTICS 27G]**
[ ] 20 syringes **[VA-SSP KIT LOGISTICS 27G 20 SYRINGES]**
[ ] 100 syringes **[VA-SSP KIT LOGISTICS 27G 100 SYRINGES]**
[ ] Additional harm reduction supplies (please specify any additional harm reduction supplies included with the SSP kit): **[VA-SSP KIT LOGISTICS ADD HR SUPPLIES]**
[ ] Condoms **[VA-SSP KIT ADD CONDOMS]**
[ ] Fentanyl test strips **[VA-SSP KIT ADD FTS]**
[ ] Naloxone **[VA-SSP KIT ADD NALOXONE]**
[ ] Sharps containers (additional) **[VA-SSP KIT ADD SHARPS]**
[ ] Other [SPECIFY] **[VA-SSP KIT ADD OTHER]**

DISPLAY DATA OBJECTS FOR [past year]:

- Last possible overdose based on SBOR/ICD-10 codes/CC data—date
- Last naloxone Rx—date dispensed
- Last HIV test (screening, viral load)—date and result
- Last Hepatitis A serostatus (HAV Ab) —date and result
- Last Hepatitis B test(HBsAg, HBeAg, HBsAb)—date and result
- Last Hepatitis C test (screening HCV Ab, HCV RNA)—date and result
- Last Syphilis STI test (screening)—date and result
- Last Chlamydia/Gonorrhea STI test (screening urine/oral/rectal) —date and result
- Last PrEP Rx—date dispensed

EDUCATION:

[ ] Education provided **[HF: VA-SSP ED PROVIDED]**

Education should cover:

- Clean injection technique, risk of sharing needles
- Infectious disease prevention and treatment
- Opioid overdose education and naloxone distribution (OEND)
- SUD treatment
- That other VHA services will not be denied due to SSP participation.

Education provided to:

[ ] Patient **[HF: VA-SSP ED PROVIDED TO PT]**

[ ] Patient's caregiver or other designee **[HF: VA-SSP ED PROVIDED TO OTHER]**

The following resources were shared

VA SSP resources

[ ] VA SSP handout **[HF: VA-SSP ED NTL HANDOUT]**

[ ] SSP Community Resources (National SSP locator) **[HF: VA-SSP ED COMMUNITY RESOURCES]**

VA Infectious Disease resources

[ ] STI prevention and treatment **[HF: VA-SSP ED STI HANDOUT]**

[ ] Hepatitis A, B and C resources **[HF: VA-SSP ED HEP ABC RESOURCES]**

[ ] PrEP resources **[HF: VA-SSP ED PREP RESOURCES]**

VA OEND Resources (Academic Detailing OEND SharePoint, includes Naloxone Recommendations For Use)

[ ] OEND Patient Guide **[HF: VA-SSP ED NALOXONE HANDOUT]**

[ ] YouTube video: Introduction to Naloxone for People with Opioid Use Disorders **[HF: VA-SSP ED NALOX OUD VIDEO]**

[ ] YouTube video: How to Use the VA Naloxone Nasal Spray **[HF: VA-SSP ED NALOX NASAL VIDEO]**

[ ] YouTube video: How to Use the VA Intramuscular Naloxone Kit **[HF: VA-SSP ED NALOX IM VIDEO]**

VA SUD Resources

[ ] VA Medications for Opioid Use Disorder Handout **[HF: VA-SSP ED MOUD HANDOUT]**

[ ] Other (specify)* [text box] **[HF: VA-SSP ED OTHER]**

[ ] Patient verbalized understanding of information given and was provided the opportunity to ask questions.

[ ] Education could not be provided (e.g., outside scope of practice) [reason required] **[HF: VA-SSP ED NOT PROVIDED]**
Reason*: [text box]

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[ ] ADDITIONAL ORDERS, LABS, REFERRALS (e.g., naloxone)

Orders

[ ] Condoms **[HF: VA-SSP CONDOMS]**
[ ] Naloxone **[HF: VA-SSP ORDER NALOXONE]**
- [ ] Order naloxone prescription
- [ ] Provider notified of request for naloxone prescription
- [ ] Has current naloxone medication (i.e., medication not used and not expired)
- [ ] Patient declined naloxone prescription
- [ ] Other

[ ] Pre-exposure Prophylaxis (PrEP) to prevent HIV infection **[HF: VA-SSP PREP]**
[ ] MOUD **[HF: VA-SSP MOUD]**

Lab Tests

[ ] Hepatitis A serostatus HAV Ab **[HF: VA-SSP HAV TEST]**
[ ] Hepatitis B screening test (if serologies not available) **[HF: VA-SSP HBV TEST]**
[ ] Hepatitis C screening (HCV Ab test) **[HF: VA-SSP HCV TEST]**
[ ] Syphilis screening **[HF: VA-SSP SYPHILIS TEST]**
[ ] Chlamydia/Gonorrhea (screening oral/rectal/urine)**[HF: VA-SSP CHLAMYDIA/GONORRHEA TEST]**
[ ] HIV screening (Ag/Ab and RNA) **[HF: VA-SSP HIV TEST]**
[ ] TB screens (quantiferon gold) **[HF:VA-SSP TB SCREEN]**
[ ] TB screen (CBOC D,E,F) **[HF:VA-SSP TB SCREEN]**

- ☐ **Referrals**
  *Does the patient need immediate care?
  - ☐ Yes
    - ☐ Employ facility response for immediate care needs (e.g., escort to emergency department/urgent care)
    - ☐ Other: ____
  - ☐ No
    - ☐ Refer to substance use disorder (SUD) treatment
    - ☐ Refer to social work
    - ☐ Refer to infectious disease (e.g., PrEP)
    - ☐ Refer to liver clinic (e.g., hepatitis treatment)
    - ☐ Refer to PCMHI or mental health treatment
      - Suicide prevention consult
    - ☐ Refer to primary care provider or PACT team
    - ☐ Refer to wound care (nursing, urgent care, etc.)
    - ☐ Other: ____
    - ☐ None
    - ☐ Patient declined referral(s)
  - ☐ Additional comments: ____

To facilitate care coordination and ensure treatment providers are aware, please include Primary Care and any other relevant treatment providers (e.g., Mental Health, Infectious Disease, etc.) as additional signers of this note.

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- ✓ Think about how past histories of trauma, violence, disadvantage and stigma may affect a patient's ability to engage.
- ✓ Ask *all* your patients about drug use and sex to learn about their practices and preferences. The more you do it, the easier it will be.
- ✓ Affirm any positive changes your patient is willing to make. Even one step can help reduce risk!

https://www.hiv.va.gov/products/safer-injection-practices.asp

IB 10-1654	P9709 6	Safer Injection Brochure

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Provider handout: Resources (internal link)

Addressing Common Concerns

SSPs do NOT lead to increased drug use.	New participants in SSPs are 5x more likely to start substance use treatment and 3x more likely to stop injecting drugs.
SSPs do NOT lead to increased used supplies on the streets.	Communities with SSP programs have 86% fewer used syringes on the streets, reduced needlestick injuries among first responders and the public, and increased safe disposal.

Understanding the Benefits of Harm Reduction

Sterile Syringes
50% reduction in HIV and HCV
90% reduced risk for infectious endocarditis

Medications for Opioid Use Disorder (MOUD)
53% reduction in mortality
66% reduction in HIV and HCV when provided with sterile syringes

HIV Pre-Exposure Prophylaxis (PrEP)
74% reduction in HIV transmission via injection drugs

General Talking Tips

- Recognize how past histories of trauma, violence, and stigma may impact a patient's ability to engage.
- Ask all your patients about drug use and sexual history. This is critical to identify needed screenings and prevention education. The more you do it, the easier it will be.
- Affirm any positive changes your patient is willing to make.

Take a Drug Use History

Normalize the conversation.
"Some of my patients use drugs, such as heroin, cocaine, methamphetamine. Have you ever used any drugs?"

Ask about recent use.
"In the last six months, which of these substances have you used?"
"Do you typically use these with other people or alone?"

Ask about routes of use, including supplies.
"How do you typically use [insert drug name], for example, snorting, smoking, injecting?"

Ask about harm reduction.
"How might you make your substance use safer?"
"Tell me about your needle practices."
"Do you ever share needles?"
"How do you protect yourself when using [insert drug name]?"

Take a Sexual History - The Five 'P's

Partners
"How many people have you had sex with in the past year? Who are your sexual partners?"

Practice
"What kinds of sex do you have? Vaginal, oral, anal?"

Past history of STIs
"Have you ever been diagnosed with or treated for an STI?"

Protection from STIs
"What is your approach to avoiding STIs?"

Pregnancy Intention
"Are you concerned about getting pregnant or getting your partner pregnant? Do you need any information on birth control?"

Promote Harm Reduction

Education	
Talk about safer injection practices and safer drug use.	Provide education and discuss the key strategies to reducing harm. Resources available: https://www.hiv.va.gov/patient/ssp.asp
Screenings and vaccinations	
Vaccinations	Vaccinate for hepatitis A and B, human papillomavirus (HPV), tetanus-diphtheria-pertussis, influenza, streptococcus pneumoniae, and COVID-19, as needed. More information: http://vaww.prevention.va.gov/CPS/index.asp (internal VA link)
HIV & viral hepatitis screening	Every adult age 18-65 should be screened at least once for HIV, HCV (through age 79), and hepatitis B (and immunized if non-immune). Individuals with sexual or substance use risk factors for HIV and HCV should be screened at least annually. Those with elevated risk may be screened every 3-6 months. Resources available: www.hiv.va.gov, www.hepatitis.va.gov
Sexual health	In sexually active people with risk factors: screen every 3-6 months for syphilis, chlamydia/gonorrhea (urine, vagina, rectal, pharyngeal depending on individuals and sites used for sex). Consider annual trichomonas screening in people at elevated risk. Prescribe HIV Pre-Exposure Prophylaxis (PrEP), condoms (internal/external), contraception, lubricant, etc. as needed. Resources available: https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/CPHP/HIV/SitePages/STIs.aspx (internal VA link)
Supplies and prescriptions	
Provide syringes, syringe kits	You CAN provide syringes for VA patients if SSPs are not prohibited in your area. Ask patients what syringe sizes they prefer, then use local processes to provide supplies (prescription or supply items) and use national standardized documentation.
Overdose Edu & Naloxone Distribution (OEND)	Prescribe naloxone (reverses opioid overdose). Resources to support OEND are available: https://dvagov.sharepoint.com/sites/vhaacademicdetailing/SitePages/OEND.aspx (internal VA link)
Medication for Opioid Use	Prescribe/refer for MOUD, for example buprenorphine. Resources available: https://dvagov.sharepoint.com/sites/vhaacademicdetailing/

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Fentanyl Test Strips

- This year VA will be convening a national workgroup to develop national guidance and resources to support implementation of fentanyl test strips

- The guidance will likely be similar to Syringe Services Programs (SSPs) guidance

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Fentanyl Test Strips – Logistics

How to order

- Submit a logistics request:
  - BTNX fentanyl test kits: $25/kit + shipping
  - BTNX fentanyl test strips: $1/strip + shipping

Where to store

- Outpatient pharmacy
- Inpatient pharmacy
- Locked area in clinical settings

How to distribute

- Mail to veterans
- Outpatient pharmacy pickup
- Add to discharge medications

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Fentanyl Test Strip Process Map

Veteran
(no restrictions or criteria)

Referred by VA staff (no service restrictions)
- "Opioid Harm Reduction Education" consult
- Microsoft Teams
- Encrypted email
- Phone call
- Additional signer on a CPRS note

Inpatient?

Yes

Education needed?

Yes

Contact veteran's bedside phone and/or cell to provide education

Education note documented

No

Contact inpatient pharmacy x27381 to prepare fentanyl test kit(s) for discharge

Discharge pharmacist adds veteran to tracking sheet

When veteran is ready for discharge, inpatient pharmacy technician adds fentanyl test kit(s) and education handouts to discharge medications

No

Education needed?

Yes

Call veteran to provide education (x3 attempts)

No

Enrolled in the Intensive Outpatient Program (IOP)

Participates in virtual harm reduction education group class

Education note documented

Veteran accepts fentanyl test kit?

No

No fentanyl test kit provided

Yes

Patient letter note documented

Email pharmacy secretary to mail letter and education handouts

Microsoft Teams message outpatient pharmacy technician group to prepare fentanyl test kit(s) for mail to veteran, staff, or for window pick-up

Identified via clinical dashboard (e.g. STORM)

Risk note documented

Recent use of drugs that were/ could be mixed with fentanyl?

No

Yes

Recommend care team enter "Opioid Harm Reduction Education" Consult

SFVA FTS Process Map

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San Francisco VAMC

STANDARD OPERATING PROCEDURES FOR VA-SYRINGE SERVICES PROGRAM (SSP) OR SSP COMMUNITY REFERRAL PATHWAY AT SAN FRANCISCO VETERANS AFFAIRS HEALTH CARE SYSTEM

SOP [NUMBER]

San Francisco VA Health Care System
San Francisco, California 94121

Service Line(s):
Primary Care, Mental Health, Pharmacy, Infectious Disease, Nursing, Social Work, Logistics

Signatory Authority:
Medical Facility Director

Responsible Owner:
Chief of Pharmacy

Effective Date:
Month Day, Year

Recertification Date:
Month Day, Year

1. PURPOSE AND AUTHORITY

a. Per the Centers for Disease Control and Prevention (CDC) and the US Department of Health and Human Services (HHS), syringe service programs (SSPs) are an effective component of a comprehensive, integrated approach to prevention of human immunodeficiency virus (HIV) and hepatitis C virus (HCV) among people who people who use drugs (PWUD). The purpose of this standard operating procedure (SOP) is to ensure PWUD have access to harm reduction education, supplies, resources, and services through the San Francisco Veterans Affairs Health Care System (SFVAHCS) SSP.

b. This SOP sets forth mandatory procedures and processes to ensure compliance with the Department of Veterans Affairs Memorandum issued by the Assistant Under Secretary for Clinical Services (11), Interim Guidance on Syringe Services Programs (SSPs) in the Veterans Health Administration (VHA) (VIEWS# 05009598).

c. **Obtaining Sterile Syringes and Supplies.** Eligible individuals who seek sterile syringes and/or supplies from the SSP:

(1) Will be directed to the VA facility's SSP Lead and/or health care team member(s) to offer sterile syringes, other harm reduction supplies, education, and related services and referrals:

(a) Sterile syringes to minimize transmission of bloodborne pathogens among PWUD, their sexual partners, and those they use drugs with. PWUD can substantially reduce risk of obtaining and transmitting HIV, HCV, and other infections by using a sterile needle and syringe for every injection.

(b) Syringe disposal (i.e., sharps) containers for safe disposal of used syringes to minimize loose syringes in the street or public garbage, which can result in needlestick injuries and disease transmission.

(c) Opioid overdose education and naloxone (Narcan) kits to reverse a life-threatening opioid overdose.

(d) Fentanyl test strips/kits to test drugs for fentanyl so PWUD can be more informed about drugs they/others are using and reduce risk for accidental fentanyl overdose.

(e) Safer supplies to dissolve drugs prior to injection (e.g., sterile water vials, sterile saline vials, ascorbic acid powder) and reduce use of non-sterile, dirty, or harmful liquids (e.g., puddle water, toilet water, soda, lemon juice, vinegar).

(f) Skin cleaning supplies (e.g., alcohol pads, sanitizer, soap) to use prior to injection to remove bacteria and germs that can be pushed into the skin during the injection process.

(g) Wound care supplies (e.g., gauze, Band-Aids, triple antibiotic ointment, gloves) to stop blood flow after injection, reduce excess bruising and bleeding, reduce infections, and promote healing.

(h) Safer sex supplies (e.g., condoms, lubricant, spermicidal gel) to reduce the risk for sexually transmitted infections (STIs) and unintended pregnancy.

SFVA SOP

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VA Puget Sound Health Care System

THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

PUGET SOUND HEALTH CARE SYSTEM

ADDICTION TREATMENT CENTER (ATC) **MARCH 2022**

SUBJECT: FENTANYL TEST STRIP DISTRIBUTION

1. **Purpose –** To outline procedures for provision of fentanyl test strips to Veterans in ATC.
2. **Scope –** Veterans identified as using non-prescribed stimulants or opioids, and those with a history of overdose with these substances.
3. **Definitions –** Fentanyl test strips (FTS): strips that can identify the presence of fentanyl in unregulated drugs; Harm reduction: A set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use and built on a belief in, and respect for, the rights of people who use drugs; Syringe Services Programs (SSPs): Prevention programs that offer patients vaccinations and test for diseases, referrals to treatment for substance use disorders and other diseases (such as viral hepatitis and HIV), and sterile injection equipment to prevent the spread of infectious diseases.
4. **Responsibilities –** All ATC staff; ATC Clinical Pharmacy Specialist

VA Puget Sound SOP

5. **Procedures**
   a. Both campuses will identify at least one "Subject Matter Expert" (SME) who will be tasked with the following:
      i. Managing storage of FTS and coordinating ordering of FTS with logistics and the clinical pharmacy specialist.
      ii. Provide consultation to clinical staff on harm reduction interventions.
   b. All ATC staff will complete an annual competency on FTS that will include education on the following:
      i. How to use FTS.
      ii. How to document provision of FTS in CPRS.
      iii. Basic harm reduction interventions with Veterans including:
         1. Safe drug use practices
         2. Access to Naloxone
         3. Overdose awareness
         4. WA State Good Samaritan Law
         5. How to access SSPs
   c. Clinicians requesting FTS will contact their site SME who will provide the clinician access to FTS.
   d. Veterans receiving FTS will be provided handouts on how to use FTS, safe drug use practices, and overdose awareness.
   e. Clinicians providing FTS directly to Veterans will:
      i. facilitate Naloxone education and kit ordering/distribution prn.
      ii. Clinicians will document in CPRS number of strips distributed and education provided to Veteran on harm reduction interventions and overdose awareness.
   f. Low barrier access to FTS will be made available for Veterans without direct clinician involvement and will include educational materials on safe drug use practices, how to obtain access to Naloxone, overdose awareness, Good Samaritan Law, and accessing SSPs.
6. **References-** US Depart of Health and Human Services (Centers for Disease Control and Prevention); National Harm Reduction Coalition; VHA Opioid Overdose and Education and Naloxone Distribution (OEND) program

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VA Puget Sound Health Care System CPRS Template

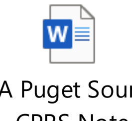
Veteran provided with (#) fentanyl test strips and provided education/handout on how to use the strips. Also, addressed the following:

[ ] Safe use practices
[ ] Overdose awareness education
[ ] Access to Naloxone:
  [ ] Veteran has an active kit
  [ ] Veteran has an expired kit – will request replacement kit
  [ ] Veteran in need of a kit – education provided on how to use naloxone and kit ordered by a medical practitioner
[ ] Education on the WA State Good Samaritan law
[ ] Accessing Syringe Services Programs
[ ] Other:

****

15 min counseling, unspecified (in person)

DSM 5 Diagnosis:
  Cocaine use disorder, moderate



VA Puget Sound CPRS Note

Narrative:
Met with Veteran for unscheduled drop-in visit. Purpose of visit was to provide Veteran with fentanyl test strips and education on how to use the strips (test residue; add 10 drops water to residue; hold strip in water by blue end in mixture no deeper than first blue line for 15 secs; remove strip and lay on clean surface for 60 seconds; 1 line = positive, 2 lines = use caution). Provided Veteran with (10) FTS. Discussed how he can obtain access to strips in the future. Also, addressed the following:

[x] Safe use practices
[x] Overdose awareness education
  [x] Current trends in King County and public health alert that all white powders likely contain fentanyl and fentanyl recently being sold as "rock" cocaine
  [x] signs/symptoms of an overdose
[x] Access to Naloxone:
  [x] Veteran has an active kit: picked up today, 6/3/2022
  [ ] Veteran has an expired kit: will request replacement kit
  [ ] Veteran in need of a kit: education provided on how to use naloxone and kit ordered by a medical practitioner
[x] Education on the WA State Good Samaritan law
[ ] Accessing Syringe Services Programs
[ ] Other:

Assessment:
APPEARANCE AND BEHAVIOR: well groomed; cooperative, friendly
ORIENTATION AND CONSCIOUSNESS: alert and attentive
COGNITIVE FUNCTIONING: Memory, concentration and attention are unimpaired
SPEECH:Coherent; normal rate and rhythm; organized and relevant to topic

AFFECT: euthymic
MOOD: "good"
PERCEPTUAL DISTURBANCE: No hallucinations
THOUGHT PROCESS AND ASSOCIATION: Linear and goal directed
THOUGHT CONTENT: No delusions
INSIGHT AND JUDGMENT: poor
RISK ASSESSMENT: No evidence of suicidality (ideation, plan, or intent); No evidence of dangerousness to others (ideation, plan, or intent)

Plan:

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VA Puget Sound Health Care System Competency

ATC FENTANYL TEST STRIP ADMINISTRATION COMPETENCY

Position Title: SW/Psychologist/MD/trainee/Other ____________________

Name: ____________________ Unit/Department: MHC/ATC Campus: ____________

Instructor/Designee: ____________________

Knowledge:

☐A. Test-Passing ☐B. Simulation or Scenario ☐C. Verbalization of Understanding

Skills & Behaviors:

☐D. Direct Observation ☐ E. Medical Record Audit ☐F. Return Demonstration

Key Concepts

1. Staff will demonstrate knowledge and/or verbalize understanding of the following Critical Elements of Competency for staff working in the Addiction Treatment Center

Critical Elements of Competency	Check List		
	S= Satisfactory	U= Unsatisfactory	NA = Not Applicable
Understanding of basic harm reduction interventions: Safe Injection Practices Safer Smoking	☐S	☐U	☐NA
Knowledge of how to use and demonstrate use of test strips: How to use FTS	☐S	☐U	☐NA
Knowledge of test strip documentation in EMR: CPRS Template.docx	☐S	☐U	☐NA
Awareness of site Subject Matter Expert(s) for additional consultation	☐S	☐U	☐NA
Knowledge of Overdose Reversal Medication (Naloxone) and how to assess for access/use and coordinate distribution	☐S	☐U	☐NA
Knowledge of handouts on how to use FTS, safe drug use practices, and overdose awareness: Safe Injection Practices Opioid Overdose Prevention How to use FTS Quick guide	☐S	☐U	☐NA
Knowledge of Syringe Service Programs and how to refer Veterans for SSP services SSP Memo	☐S	☐U	☐NA

References

Assistant Under Secretary for Clinical Services Memo “Interim Guidance on Syringe Services Programs in the Veterans Health Administration (VHA); www.hiv.va.gov; VHA Academic Detailing

I affirm that I have been trained to the competency and the verification of this competency is valid and accurate.

Employee Signature/Date: ____________________

Instructor Signature/Date: ____________________

Action Plans for Unmet Elements:

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Comprehensive Harm Reduction: San Francisco VAMC Exemplar

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San Francisco VA Harm Reduction & Syringe Services Program (SSP)

Referral-Based

- Opioid harm reduction education consult in CPRS (any staff can refer)
- Teams message
- Email
- Monthly Intensive Outpatient Program (IOP) Group Class

Services Provided

- Prescription naloxone and other harm reduction supplies
- Free harm reduction kits for HUD-VASH
- Free fentanyl test strips
- Education
- Linkage to lab testing, immunizations, treatment, community resources

Supplies Delivery

- Pick up at outpatient pharmacy
- Added to discharge medications
- Mail to veteran
- Mail to VA staff to take to veteran
- HUD-VASH housing site visits

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Prescription Harm Reduction Supplies

Infection Prevention

- Alcohol pads
- Band-Aids
- 10g and 30g triple antibiotic ointment
- 1" and 2" surgical tape
- 2"x2" and 4"x4" gauze pad
- 4"x75" stretch gauze
- Small to x-large latex and vinyl gloves
- 10 mL saline and sterile water single use vials
- Skin closure strips

Safer Injection

- 1- and 2-gallon sharps container
- 31G 8mm 1mL, 0.5mL
- 30G 12mm 1mL
- 29G 12mm 1mL
- 28G 12mm 1mL, 0.5mL
- 27G 5/8in 1mL
- 2.5-3mL luer lock tip syringe
- 19G 1.5in needle
- 20G 1.5in needle
- 22G 1.5in needle
- 25G 1.5in needle

Safer Sex

- Latex lubricated condoms
- Latex plain condoms (NF)
- Non-latex lubricated condoms
- Non-latex plain condoms (NF)
- Internal/female condoms
- Vaginal contraceptive gel
- Vaginal moisturizer gel
- Finger cots, nitrile, medium (NF)
- K-Y lubricant jelly

Additional Supplies

- Medication disposal packet
- Naloxone
- 120mL and 240mL sunscreen lotion
- Sunscreen face cream

NF, non-formulary

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Harm Reduction Order Menu in Development

HARM REDUCTION SUPPLIES ORDER MENU

DISPOSAL & STORAGE
- Medication disposal packet
- 1 gallon sharps disposal container
- 2 gallon sharps disposal container (mail only)

INFECTION PREVENTION SUPPLIES
- Alcohol pads
- Band-Aid bandage
- Skin closure strips
- 10g triple antibiotic ointment
- 30g triple antibiotic ointment
- Saline single use vials
- Sterile water single use vials
- 1in water repellant tape
- 2in water repellant tape
- 2in x 2in gauze pad
- 4in x 4in gauze pad
- 4in x 75in stretch gauze

LATEX GLOVES
- X-Large latex gloves
- Large latex gloves
- Medium latex gloves
- Small latex gloves

VINYL GLOVES
- X-Large vinyl gloves
- Large vinyl gloves
- Medium vinyl gloves
- Small vinyl gloves

SAFER SEX SUPPLIES
- Latex lubricated condom
- Non-latex lubricated condom
- Internal/female condom
- Nonoxynol-9 4% vaginal contraceptive gel
- Vaginal moisturizer gel (Replens)
- K-Y lubricant jelly
- Finger cot nitrile medium

OVERDOSE EDUCATION AND NALOXONE
- Order naloxone nasal spray
- Naloxone/OEND Patient Telephone Training (education and prescription completed by pharmacy)
- Opioid Harm Reduction Education (education on fentanyl and fentanyl analogs; risk for overdose; provide fentanyl test kit)

SYRINGES FOR INTRAVENOUS INJECTION
- 31G 8mm 1mL
- 30G 12mm 1mL
- 29G 12mm 1mL
- 28G 12mm 1mL
- 27G 16mm 1mL

SYRINGES FOR INTRAMUSCULAR INJECTION
- 2.5-3mL luer lock tip syringe

- 19G 1.5in needle
- 20G 1.5in needle
- 22G 1.5in needle
- 25G 1.5in needle

OTHER SUPPLIES
- Sunscreen lotion 120mL
- Sunscreen lotion 240mL
- Sunscreen face cream

EDUCATION RESOURCES (Click below to view)
- Provider education resources
- Patient education resources
- Patient education videos

COMMUNITY RESOURCES (Click below to view)
- Syringe services programs
- Prescription medication disposal resources
- Naloxone resources
- Harm reduction services/supplies

ORDER MENUS
- WH Contraceptive Medication Menu
- Sexually Transmitted Infection (STI) Order Menu
- Clinic Immunization/Skin Test/Injection Orders
- Buprenorphine Order Menu
- Alcohol Use Treatment Medication Menu
- Smoking Cessation Medications/Referrals

CONSULTS
- Addiction Consult/Prescription Opioid Safety Team
- Opioid Treatment Program
- Oakland Substance Abuse txt program
- Infectious Diseases Consult Outpatient
- Infectious Diseases Consult Inpatient
- Liver Clinic
- Social Work Oakland
- Social Work Amb Care Specialty Clinic
- Social Work MP/WC/ID PACT Consult
- Social Work Service Clearlake
- Social Work Service Eureka
- Social Work Service San Bruno
- Social Work Service Santa Rosa
- Social Work Service Ukiah

PATIENT GROUPS AND REFERRALS
- SFVAMC
- Downtown
- Santa Rosa
- Eureka

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Opioid Harm Reduction Education Consult

Veterans are offered education, free fentanyl test strips and additional supplies:

Please offer veteran additional harm reduction supplies available as a prescription:

- [ ] Naloxone (Narcan) kit
- [ ] Safer injection supplies (e.g., syringes, sharps container, alcohol swabs)
- [ ] Wound care supplies (e.g., antibiotic ointment, bandages/gauze, sterilewater, sterile saline, latex/vinyl gloves)
- [ ] Safer sex supplies (e.g., lubricant, condoms, vaginal contraceptive gel, vaginal moisturizer)
- [ ] Medication disposal bag
- [ ] Sunscreen
- [ ] Information on community harm reduction programs

Additional relevant details:

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HUD-VASH Harm Reduction Kits

Hygiene and wound care

- 3 rolls sterile gauze
- 3 hygiene kits each containing: 1 toothbrush, 0.3 oz toothpaste, 0.5 oz bar soap, comb, 2 washcloth tablets
- 2 wound care kits each containing: 1 pair gloves, 3 vials 15 mL sterile saline, 2 packets triple antibiotic ointment, 2 alcohol-free moist towelettes, 2 4"x4" sterile gauze pads, 1 2"x4" bandage, 6 sterile skin closure strips
- 1 roll tape
- 1 bottle hand sanitizer

Safer sex

- 25 finger cots
- 20 packets of water-based lubricant 3 mL
- 14 lubricated condoms variety pack
- 2 flavored and scented latex dental dams
- 2 vaginal contraceptive films

Safer injection

- 2 small 1 qt sharps container
- 2 personal sharps containers
- 40 insulin syringes 1 mL 30 G 12 mm
- 40 insulin syringes 1 mL 31 G 8 mm

Safer smoking

- 5 packs of sugar-free gum
- 2 tubes of organic, scent-free lip balm

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Education handouts developed and added to kits:

- Safer injecting
- Safer smoking
- Safer snorting
- Safer swallowing
- Safer booty bumping
- Safer sex
- Safer storage and disposal of drugs and supplies

SF VA Safer Injection

SF VA Safer Smoking

SFVA Safer Snorting

SFVA Safer Swallowing

SF VA Safer Sex

SFVA Safer Storage

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Challenges Integrating Into Healthcare

- Lack of clinician awareness, comfort, or buy-in
- Access–Balancing privacy and documentation
- Re-evaluating structure of abstinence-based programs
- Scopes of practice for non-prescribers
- Lack of dedicated staffing
- Prescription vs supply item
- Pathways for purchasing via federal agency
- Federal vs local laws
- Veterans ineligible for VA care or not enrolled
- Engaging veterans with lived experience
- Creating a role for peer specialists

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Conclusion—BLUF: Harm Reduction

- Integration into healthcare relatively new; requires leadership support
- Build upon experiences and lessons learned with naloxone
  - VA Quality Enhancement Research Initiative (QUERI) Roadmap for Implementation and Quality Improvement
  - Opioid Overdose Education and Naloxone Distribution: Development of the VHA's National Program (Oliva et al., 2017)
  - Saving Lives: The VHA Rapid Naloxone Initiative (Oliva et al., 2021)
  - Implementing Syringe Services Programs Within the Veterans Health Administration: Facility Experiences and Next Steps (Rife-Pennington et al., in press)

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THANK YOU!!! QUESTIONS???

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