Harm Reduction Policy in Practice

December 11, 2019

Co-sponsored by:

The Network for Public Health Law

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1. Open the Q&A panel
2. Select “All Panelists”
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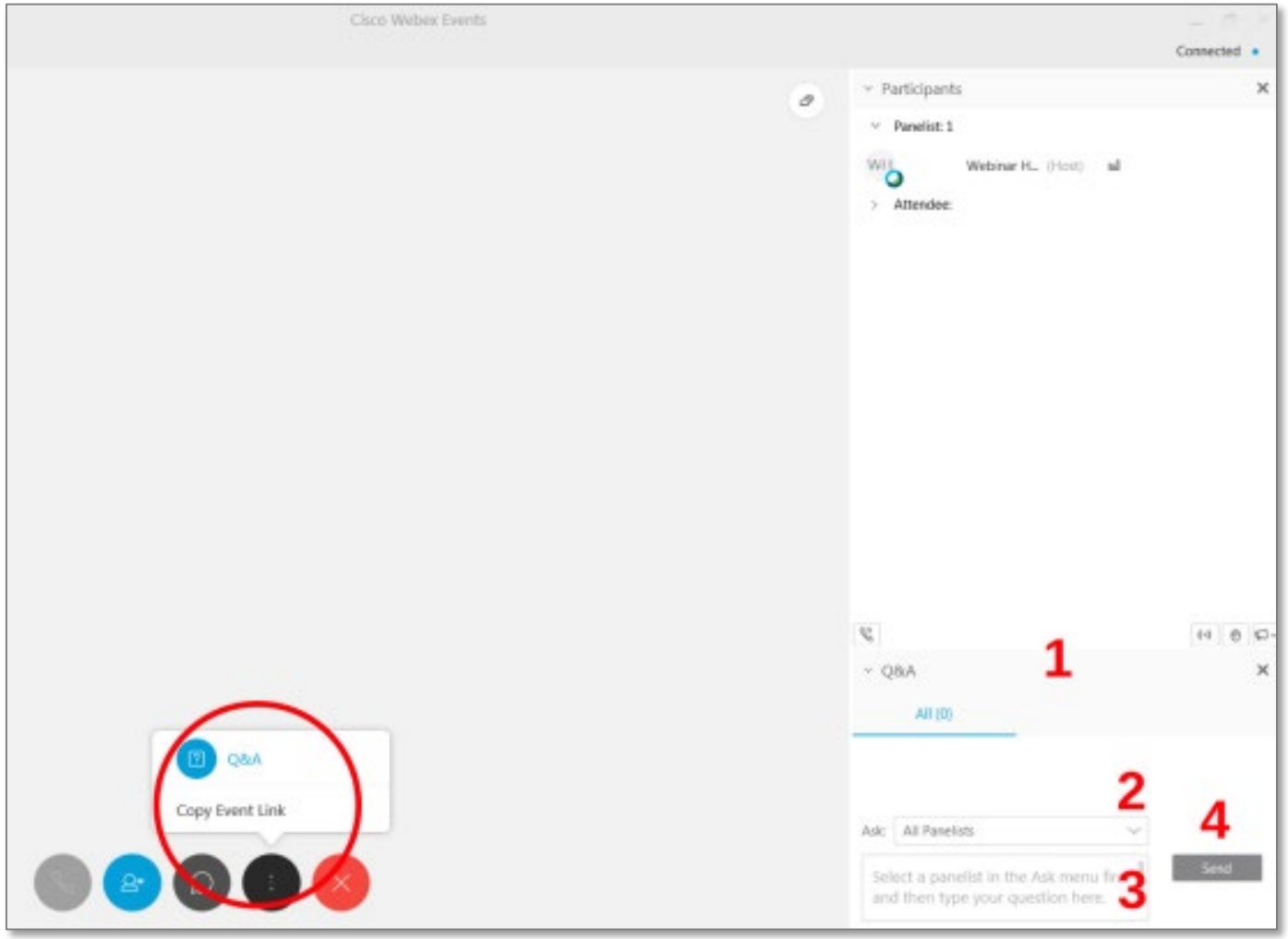
4. Click “Send”



Moderator

Corey Davis, Deputy Director, Network for Public Health Law – Southeastern Region, Director, Harm Reduction Legal Project

- J.D., Temple University
- M.S.P.H., University of North Carolina Chapel Hill
- Research interests/areas of expertise:
  - Overdose prevention
  - Health equity
  - Harm reduction law and policy
  - Affordable Care Act and Medicaid

Presenter

Elizabeth Oliva, National Opioid Overdose Education and Naloxone Distribution Coordinator, Veterans Health Administration

- Ph.D., University of Minnesota
- Research interests/areas of expertise:
  - Opioid Crisis
  - Clinical and Development Psychology
  - Substance Abuse

Presenter

Brad Ray, Associate Professor and Director of the Center for Behavioral Health and Justice, Wayne State University

- PhD, Sociology and Anthropology, North Carolina State University
- MA, Sociology, DePaul University, 2004
- Research interests/areas of expertise:
  - Behavioral Health and Criminal Justice Systems
  - Research Design
  - Mixed-Methods Analysis
  - Program Evaluation

Presenter

Mairead O'Reilly, Attorney, Vermont Legal Aid

- J.D., University of Connecticut School of Law
- Research interests/areas of expertise:
  - Opioid Use Disorders
  - Medical-Legal Partnerships
  - Health Equity

The Network for Public Health Law

Harm Reduction Legal Project

The Network's **Harm Reduction Legal Project** works to address the legal and policy barriers that impede the establishment and expansion of evidence-based harm reduction measures such as naloxone distribution, syringe access programs, and access to evidence-based substance use disorder treatment.

The Project provides guidance and consultation in navigating the often extremely confusing maze of existing laws and regulations that hamper harm reduction initiatives. The Project also provides non-partisan, evidence-based publications and training regarding the state of laws impacting individuals who use drugs, individuals in recovery, and their communities, as well as research regarding the impact of those laws.

For assistance, email harmreduction@networkforphl.org. Follow the Project on Twitter at @harmreduxlegal.

Harm Reduction Principles

- Health & dignity
- Person-centered
- Participant involved
- Recognize & address inequalities & injustices
- Respect autonomy
- Pragmatism/realism

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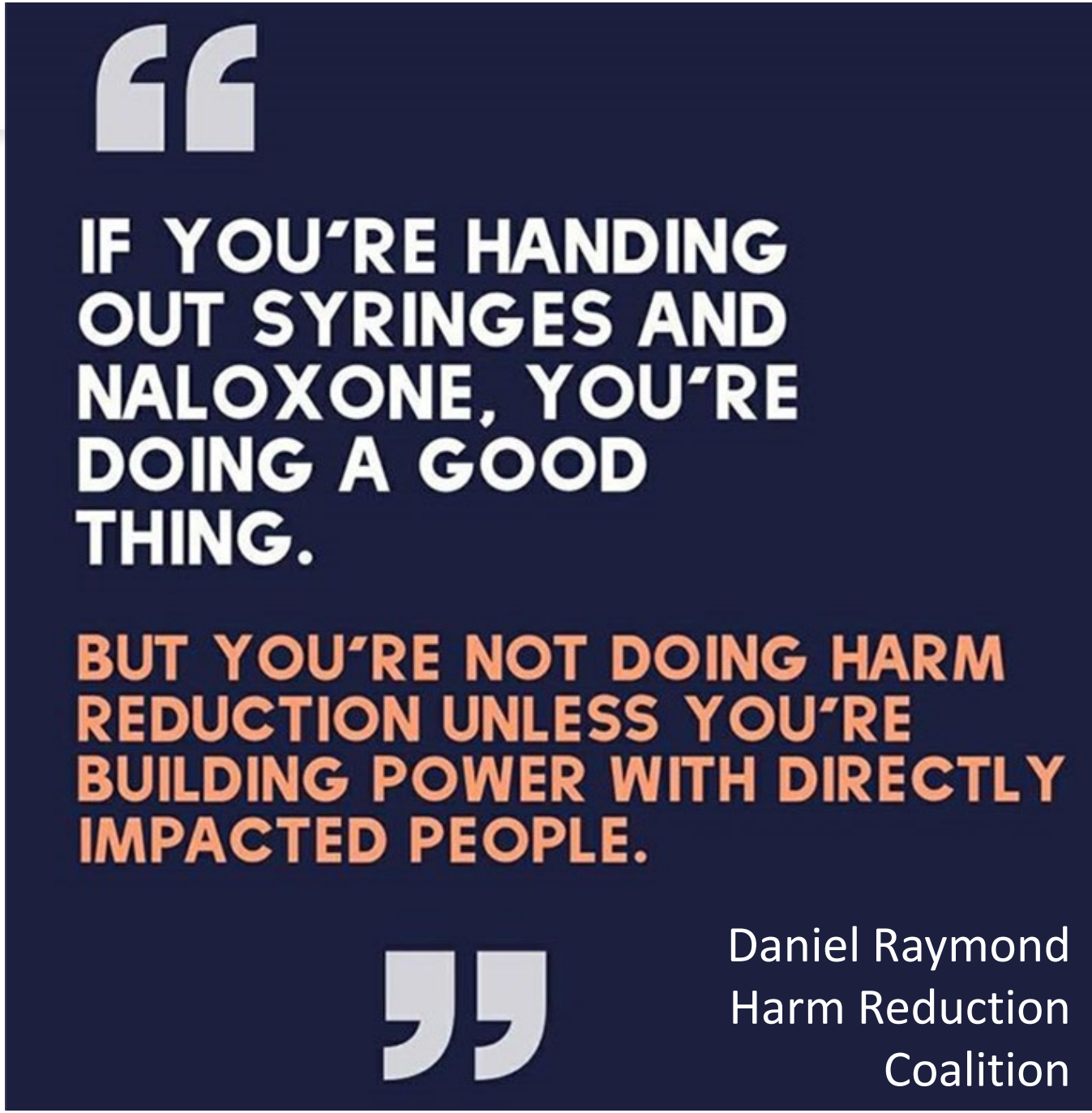
Harm reduction is a way of seeing, treating, and interacting with people. It is not a set of services or strategies.



U.S. Department of Veterans Affairs

Opioid Overdose Education and Naloxone Distribution (OEND) Within the Veterans Health Administration

Elizabeth Oliva, PhD

VA National OEND Coordinator

VA Program Evaluation and Resource Center

VA Office of Mental Health and Suicide Prevention

Investigator

VA Center for Innovation to Implementation

VA Palo Alto Health Care System

Network for Public Health Law Monthly Webinar

December 11, 2019

ACKNOWLEDGMENTS

- Veterans Health Administration
  - Staff across the country getting lifesaving OEND to Veterans!
  - VA OEND National Support & Development Workgroup; VA OEND Spanish Translation Workgroup
  - Pharmacy Benefits Management Services (PBM); PBM Academic Detailing Services
  - Office of Mental Health and Suicide Prevention
  - Homeless Programs
  - Office of Nursing Services
  - Specialty Care Services (Pain Management; Emergency Medicine; Enterprise Opioid Strategy team)
  - Patient Care Services (Primary Care, Social Work)
  - Employee Education System
  - Diffusion of Excellence, National Center for Patient Safety, Office of Security & Law Enforcement
  - Health Services Research & Development (IIR 16-078); Quality Enhancement Research Initiative (RRP 13-446)
- Community
  - Eliza Wheeler and Sharon Stancliff
  - Alexander Walley
  - Phillip Coffin
  - Maya Doe-Simkins
  - Corey Davis
  - Traci Green
  - Jeffrey Bratberg
  - Robert Childs
  - Andrew McAuley

WHAT IS OEND?

- Risk mitigation initiative that aims to prevent opioid-related overdose deaths
  - **One of many risk mitigation strategies** employed by VA to minimize risk of opioid-related adverse events
  - **Target patient populations***
    - Patients with opioid use disorder
    - Patients prescribed opioids
- **Opioid Overdose Education (OE)**
  - Provide patient education on how to ***prevent, recognize, and respond*** to an opioid overdose
- **Naloxone Distribution (ND)**
  - Provide patient with ***naloxone***
    - Train patient and potential bystanders on how to use naloxone

*VA Clinical Guidance: "***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"

VIEWPOINT

Addressing the Opioid Epidemic in the United States
Lessons From the Department of Veterans Affairs

Walid F. Gellad, MD, MPH
Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing, University of Pittsburgh, Pittsburgh, Pennsylvania.

Chester B. Good, MD, MPH
Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing, University of Pittsburgh, Pittsburgh, Pennsylvania.

David J. Shulkin, MD
Office of the Under Secretary for Health, US Department of Veterans Affairs, Washington, DC.

Over the past 15 years, more than 165 000 people in the United States have died from overdoses related to prescription opioids,[1] and millions more have suffered adverse consequences.[2,3] The misuse and abuse of prescription opioids have contributed to a precipitous increase in heroin and fentanyl overdoses.[1]

Patients treated in the health care system of the Department of Veterans Affairs (VA) are part of this epidemic. Chronic pain impacts half of veterans using the VA, co... of psychiatric comorbidities s... traumatic stre... offi... tic... op... n... ment's data capabil... tives reduced the use of opioid ... proved the safety of opioid prescribing, while expanding alternative pain therapies (**Figure**). By mid-2016 compared with mid-2012, the number of veterans dispensed an opioid each quarter had decreased by 172 000, or about 25%. Moreover, there were 57 000 (47%) fewer patients receiving concomitant opioids and benzodiazepines and 22 000 (36%) fewer patients receiving daily opioid dosages of more than 100 morphine-milligram equivalents, both measures of potentially unsafe opioid use. Between 2010 and 2015, the rate of

pharmacists engage directly with opioid prescribers, similar to detailing by pharmaceutical representatives. The VA detailers use sophisticated dashboards with real-time prescriber-level data to engage clinicians in adopting best practices around opioid prescribing. This focus is not simply on reducing opioid medications, but rather on improving the safe use of opioids. Beyond detailing, the VA developed an overdose education and naloxone distribution system that has distributed tens of thousands of naloxone doses and developed standardized patient and provider education to complement broader educational efforts outside of the VA that ...scribing.

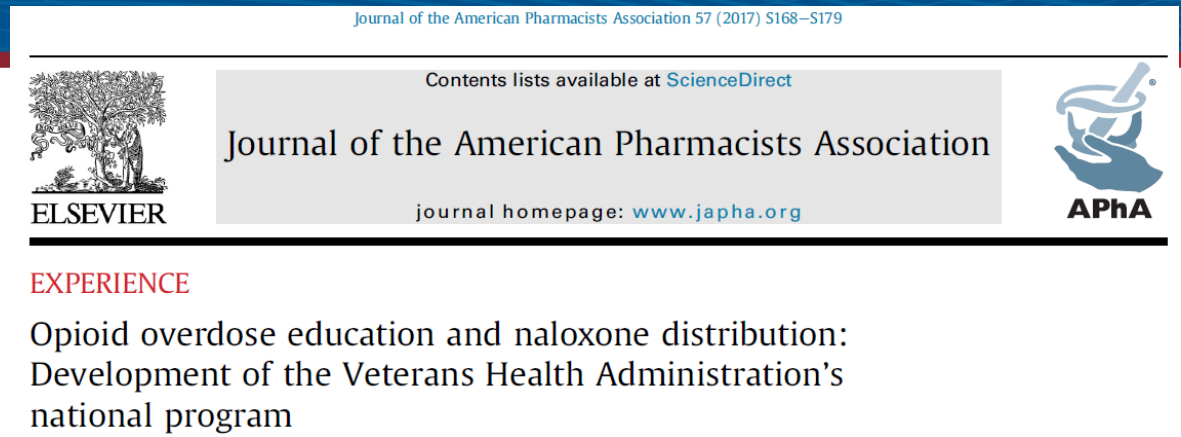
Strategies to Address the Opioid Epidemic
The VA has employed 4 broad strategies to address the opioid epidemic: education, pain management, risk mitigation, and addiction treatment (eTable in the Supplement).

...macologic ... expanded mini-residency ... consult capabilities for primary care clinic... improve their management of pain.

Risk Mitigation

The VA implemented several strategies to support and track risk mitigation activities for opioid therapy (eTable in the Supplement). A key component of the Opioid

NATIONAL VA OEND PROGRAM



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

EXPERIENCE

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

- In 2014, VA established a national OEND program
  - Informed by pilot VA OEND programs
  - Developed by national, cross-program office workgroup
    - Composed of representatives from pharmacy, mental health, pain management, nursing, primary care, emergency medicine, and employee education
    - National workgroup members facilitated presentations to program offices to garner leadership and staff buy-in
- Major innovations
  - Policy and clinical guidance
  - Educational resources
  - Implementation and evaluation resources
  - Pharmacy-driven

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington, DC 20420

IL 10-2014-12
Reply to: 10P4

May 13, 2014

UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

IMPLEMENTATION OF OPIOID OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION (OEND) TO REDUCE RISK OF OPIOID-RELATED DEATH

4. VA providers should consider providing OEND to Veterans who are at significant risk of opioid overdose. Clinical judgment about risk/benefit and patient-centered care involving Veterans and their significant others in shared decision-making should guide decisions on provision of OEND.

- Naloxone layperson formulations added to National Drug File
- "Free-to-Facilities" Naloxone Initiative
  - Funding for naloxone to be dispensed to VA patients without the medical center incurring the cost of naloxone has been provided by VA Pharmacy Benefits Management Services (PBM) and CARA funds
  - To allow the initiative to last as long as possible, funds go to purchasing the nasal spray (the current preferred option when clinically appropriate)
- CARA *Section 915. ELIMINATION OF COPAYMENT REQUIREMENT FOR VETERANS RECEIVING OPIOID ANTAGONISTS OR EDUCATION ON USE OF OPIOID ANTAGONISTS*
  - Exempts copays for naloxone as well as training on naloxone (when visit is solely for naloxone)
- Recommendations for Issuing Naloxone (September 2019; RFU)

Naloxone Rescue: Recommendations for Issuing

Naloxone Rescue [Naloxone HCl nasal spray (Narcan®) or Naloxone HCl autoinjector (Evzio®)] for the VA Opioid Overdose Education and Naloxone Distribution (OEND) Program

September 2019

VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives
in collaboration with the VA OEND National Support and Development Work Group

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/carers. ***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 carers on the proper use and storage of naloxone rescue medications. ***Document*** OEND-related discussions and opioid overdoses in patients' medical records and through appropriate diagnostic coding, including documenting any reversal events with VA naloxone rescue medications using a nationally recommended and standardized note template (see VA National OEND SharePoint for more information).

- ***Assess*** risk
- ***Discuss*** naloxone as an option
- ***Offer*** naloxone
- ***Educate*** patients and caregivers
- ***Document*** OEND-related discussions and opioid poisonings and overdoses (including reversal events)

EVOLUTION OF NALOXONE WITHIN VHA

VA Intranasal Naloxone Kit

- 2 mucosal atomizer devices
- 2 Luer-lock prefilled syringe naloxone 1 mg/mL (2mL)
- 1 Laerdal face shield
- 1 pair nitrile gloves
- 1 opioid safety brochure
- 1 intranasal naloxone kit brochure
- 1 blue zippered pouch

VA Intramuscular Naloxone Kit

- Two 3 ml, 25g, 1-inch syringes
- 2 vials naloxone 0.4 mg/mL (1 mL) injection
- 1 Laerdal face shield
- 1 pair nitrile gloves
- 2 alcohol pads
- 1 opioid safety brochure
- 1 intramuscular naloxone kit brochure
- 1 black zippered pouch

Naloxone Nasal Spray (4 mg)

Carton/box contains:

- Two 4 mg naloxone nasal sprays (each spray includes a Quick Start Guide)
- 1 prescribing information and patient instructions for use

Naloxone Auto-Injector (2 mg)

Carton/box contains:

- 1 auto-injector trainer
- 2 naloxone 2 mg auto-injectors
- 1 prescribing info
- 2 instructions for use

VA TECHNICAL ASSISTANCE

- **VA National OEND SharePoint (internal VA site)** Step-by-step instructions for implementation; Quick Guide; **TWO** VA Patient Education Brochures (English and Spanish): (1) patients with opioid use disorder and (2) patients prescribed opioids; Posters; "Program Models"
- **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 Auto-Injector Naloxone Kit https://youtu.be/-DQBCnrAPBY
- **VA Academic Detailing**
  - Patient education brochures, "Kit" brochures, DVDs for providers and patients (VA staff can order through depot)
- **Panel Management Tools**
  - OEND Patient Risk Dashboard; Stratification Tool for Opioid Risk Mitigation; Opioid Therapy Risk Reduction Report
- **VA Monthly OEND Call**
- **Accredited TMS training:** VA TMS trainings 27440 and 27441
  - Available outside VA on www.train.org: https://www.train.org/main/course/1064943
- **VA TMS training 37795:** How to Use Naloxone Nasal Spray (Narcan®)
- **Opioid Safety Initiative (OSI) & Psychotropic Drug Safety Initiative (PDSI)**

VA Academic Detailing OEND SharePoint (internal site)

Provider Materials

Quick Reference Guide

IB#: 10-788 | Order

Preventing Rx Overdoses

Centers for Disease Control

Opioid Overdose Toolkit

SAMHSA

Patient Materials

Naloxone Instructions

Naloxone Nasal Spray

IB#: 10-926 | Order

Naloxone Auto-injector

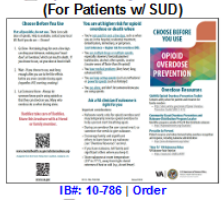
IB#: 10-780 | Order

Brochures & Handouts

Opioid Safety Brochure
(For Patients on Opioids)

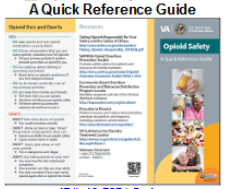
IB#: 10-784 | Order
Spanish: View | IB#: 10-783 | Order

Opioid Safety Brochure
(For Patients w/ SUD)



IB#: 10-786 | Order
Spanish: View | IB#: 10-785 | Order

Opioid Safety Brochure
A Quick Reference Guide



IB#: 10-787 | Order

Am I At Risk? Brochure

IB#: 10-921 | Order
508 Version: View

Order DVDs

Patient (IB#: 10-769) | Provider (IB#: 10-770)

Academic Detailing Service Data Resources

Available Tools and When to Use Them

Do I Have Access? | Do Others Have Access?

Risk Dashboard

Data: VISN/Facility/Provider Scores
Target Audience: Admin/Leadership

Priority Panel Report

Data: Provider Panel Opportunities
Target Audience: Academic Detailers

Trend Reports

National | VISN | Facility | Prescriber
Target Audience: Admin/Leadership

Patient Risk Report

Data: Patient Information
Target Audience: Clinicians

Detailed Patient Report

Data: Patient Information
Target Audience: Clinicians

Daily Appointment Report

Data: Clinic & Patient Information
Target Audience: Clinicians

Implementation Status Report

Data: National/VISN/Facility Summaries
Target Audience: Admin/Leadership

Naloxone Rx Release Report

Data: Patient Information
Target Audience: Supervisors/Clinicians

Additional Data Resources

Distribution Report

Data: VISN/Facility Summary
Target Audience: Admin/Leadership

STORM

Data: Summary & Patient Data
Target Audience: All Users

OTRR

Data: Patient Information
Target Audience: PACT & BHIP Teams
Special Access Required

VA Patient Education Brochure: Patients with Opioid Use Disorder (English/Spanish)

Choose Before You Use

If at all possible, do not use. There is no safe dose of opioids. Help is available, contact your local VA. But if you do use—Choose!

1. Go Slow - Not taking drugs for even a few days can drop your tolerance, making your "usual dose" an "overdose," which can result in death. If you choose to use, cut your dose at least in half.

2. Wait - If you choose to use, wait long enough after you use to feel the effects before you even consider dosing again *(regardless if IV, snorting, smoking)*.

3. Let Someone Know - Always let someone know you're using opioids so that they can check on you. Many who overdose do so when dosing alone.

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

www.mentalhealth.va.gov/substanceabuse.asp

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

www.va.gov

You are at higher risk for opioid overdose or death when

- You've not used for even a few days, such as when you are in the hospital, residential treatment, detoxification, domiciliary, or jail/prison.

  Lost tolerance = higher risk for overdose (OD).
- You use multiple drugs or multiple opioids, especially: downers/ benzodiazepines/ barbiturates, alcohol, other opioids, cocaine *(cocaine wears off faster than the opioid)*.
- You have medical problems *(liver, heart, lung, advanced AIDS)*.
- You use long-acting opioids *(such as methadone)* or powerful opioids *(such as fentanyl)*.
- You use alone, and don't let someone know you are using opioids.

Ask a VA clinician if naloxone is right for you

Important considerations:

- Naloxone works only for opioid overdose and may temporarily reverse opioid overdose to help a person start breathing again.
- During an overdose the user cannot react, so someone else needs to give naloxone.
- Encourage family and significant others to learn how to use naloxone *(see "Overdose Resources" section)*.
- If you have naloxone, tell family and significant others where you keep it.
- Store naloxone at room temperature (59^0 to 77^0 F), away from light. Avoid extremes of heat or cold *(e.g., do not freeze)*.

IB 10-786, P96788 Revised: 09/16

Overdose Resources

SAMHSA Opioid Overdose Prevention Toolkit
Contains safety advice for patients and resources for family members
- *http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742*

Community-Based Overdose Prevention and Naloxone Distribution Program Locator
Identifies programs outside of the VA that distribute naloxone
- *http://hopeandrecovery.org/locations/*

Prescribe to Prevent
Patient resources and videos demonstrating overdose recognition and response, including naloxone administration
- *http://prescribetoprevent.org/video/*

"How To" VA Naloxone Video
VA Naloxone Nasal Spray:
- *https://youtu.be/0w-us7fQE3s*

VA Naloxone Auto-Injector Kit:
- *https://youtu.be/-DQBCnrAPBY*

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Employee Education System

Signs of Overdose

Signs of an Overdose*

Check: Appears sleepy, heavy nodding, deep sleep, hard to arouse, or vomiting

Listen: Slow or shallow breathing *(1 breath every 5 seconds)*; snoring; raspy, gurgling, or choking sounds

Look: Bluish or grayish lips, fingernails, or skin

Touch: Clammy, sweaty skin

- If the person shows signs of an overdose, see next section "Responding to an Overdose"

* *Even if the person responds to an initial safety check, bystanders should continue to monitor any person with these signs constantly to make sure the person does not stop breathing and die.*

Resources

Consider seeking long-term help at your local VA substance use disorder treatment program

Help on the Web

» VA Substance Use Disorder Program Locator: www2.va.gov/directory/guide/SUD.asp

» Substance Use Disorder Treatment Locator for non-Veterans: https://findtreatment.samhsa.gov/

» VA PTSD Programs: www.va.gov/directory/guide/PTSD.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**

Responding to an Overdose

1. Check For A Response

- Lightly shake person, yell person's name, firmly rub person's sternum *(bone in center of chest where ribs connect)* with knuckles, hand in a fist
- If person does not respond—**Give Naloxone, Call 911**

Rub Sternum

2. Give Naloxone, Call 911

- If you have naloxone nasal spray, DO NOT PRIME OR TEST the spray device. Gently insert the tip of the nozzle into one nostril and press the plunger firmly to give the entire dose of naloxone nasal spray.
- If you have the naloxone auto-injector, pull device from case and follow voice instructions.
- When calling 911, give address and say the person is not breathing.

Nasal Spray (4 mg)

OR

Auto-injector

3. Airway Open

Rescue Breathing *(if overdose is witnessed)*

- Place face shield *(optional)*
- Tilt head back, lift chin, pinch nose
- Give 1 breath every 5 seconds
- Chest should rise

Chest Compressions *(if collapse is unwitnessed)*

- Place heel of one hand over center of person's chest *(between nipples)*
- Place other hand on top of first hand, keep elbows straight, shoulders directly above hands
- Use body weight to push straight down, at least 2 inches, at rate of 100 compressions per minute
- Place face shield *(optional)*
- Give 2 breaths for every 30 compressions

Rescue Breathing *(if overdose is witnessed)*

OR

Chest Compressions *(if collapse is unwitnessed)*

4. Consider Naloxone Again

- If person doesn't start breathing in 2-3 minutes, or responds to the first dose of naloxone and then stops breathing again, give second dose of naloxone
- Because naloxone wears off in 30 to 90 minutes be sure to stay with the person until emergency medical staff take over or for at least 90 minutes in case the person stops breathing again

5. Recovery Position

- If the person is breathing but unresponsive, put the person on his/her side to prevent choking if person vomits

VA Patient Education Brochure: Patients Prescribed Opioids (English/Spanish)

What are Opioids?

Opioids are a type of drug found in some pain or other prescription medications, and in some illegal drugs of abuse *(e.g., heroin)*. In certain situations, opioids can slow or stop a person's normal breathing function.

Opioid harms

- Taking too much opioids can make a person pass out, stop breathing and die.
- Opioids can be addicting and abused.
- Tolerance to opioids can develop with daily use. This means that one will need larger doses to get the same effect.
- If a person stops taking opioids, he/she will lose tolerance. This means that a dose one takes when tolerant could cause overdose if it is taken again after being off of opioids.
- An opioid dose a person takes could cause overdose if shared with another person. Another person may not be tolerant.

Share this brochure with a friend or family member.

www.va.gov

Safe Use of Opioids

Safe use of opioids prevents opioid harms from happening to not only you, but also to family, friends and the public.

To use opioids safely

- Know what you're taking *(e.g., color/shape/size/name of medication)*
- Take your opioid medication exactly as directed
- Review the booklet *Taking Opioids Responsibly for Your Safety and the Safety of Others* with your provider
- DON'T mix your opioids with:
  - » Alcohol
  - » Benzodiazepines *(Alprazolam/Xanax, Lorazepam/Ativan, Clonazepam/ Klonopin, Diazepam/Valium)* unless directed by your provider
  - » Medicines that make you sleepy

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Important considerations:

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IB 10-784, P96786 Revised: 09/16

Resources

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Taking Opioids Responsibly for Your Safety and the Safety of Others
- *http://www.ethics.va.gov/docs/policy/Taking_Opioids_Responsibly_2013528.pdf*

VA Substance Use Disorder Treatment Locator
- *www2.va.gov/directory/guide/SUD.asp*

VA Posttraumatic Stress Disorder (PTSD) Treatment Locator
- *www.va.gov/directory/guide/PTSD.asp*

"How To" VA Naloxone Video
- *VA Naloxone Nasal Spray: https://youtu.be/0w-us7fQE3s*
- *VA Auto-Injector Naloxone Kit: https://youtu.be/-DQBCnrAPBY*

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Opioid Overdose

Opioid overdose occurs when a person takes more opioids than the body can handle, passes out and has no or very slow breathing *(i.e., respiratory depression)*.

» Overdose can occur seconds to hours after taking opioids and can cause death

Signs of an Overdose*

Check: Appears sleepy, heavy nodding, deep sleep, hard to arouse, or vomiting

Listen: Slow or shallow breathing (1 breath every 5 seconds); snoring; raspy, gurgling, or choking sounds

Look: Bluish or grayish lips, fingernails, or skin

Touch: Clammy, sweaty skin

- If the person shows signs of an overdose, see next section "Responding to an Overdose"

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Patient resources and videos demonstrating overdose recognition and response, including naloxone administration

- *http://prescribetoprevent.org/video/*

Responding to an Overdose

1. Check For A Response

- Lightly shake person, yell person's name, firmly rub person's sternum *(bone in center of chest where ribs connect)* with knuckles, hand in a fist
- If person does not respond—**Give Naloxone, Call 911**

Rub Sternum

2. Give Naloxone, Call 911

- If you have naloxone nasal spray, DO NOT PRIME OR TEST the spray device. Gently insert the tip of the nozzle into one nostril and press the plunger firmly to give the entire dose of naloxone nasal spray.
- If you have the naloxone auto-injector, pull device from case and follow voice instructions.
- When calling 911, give address and say the person is not breathing.

Nasal Spray (4 mg)

OR

Auto-injector

3. Airway Open

Rescue Breathing *(if overdose is witnessed)*

- Place face shield *(optional)*
- Tilt head back, lift chin, pinch nose
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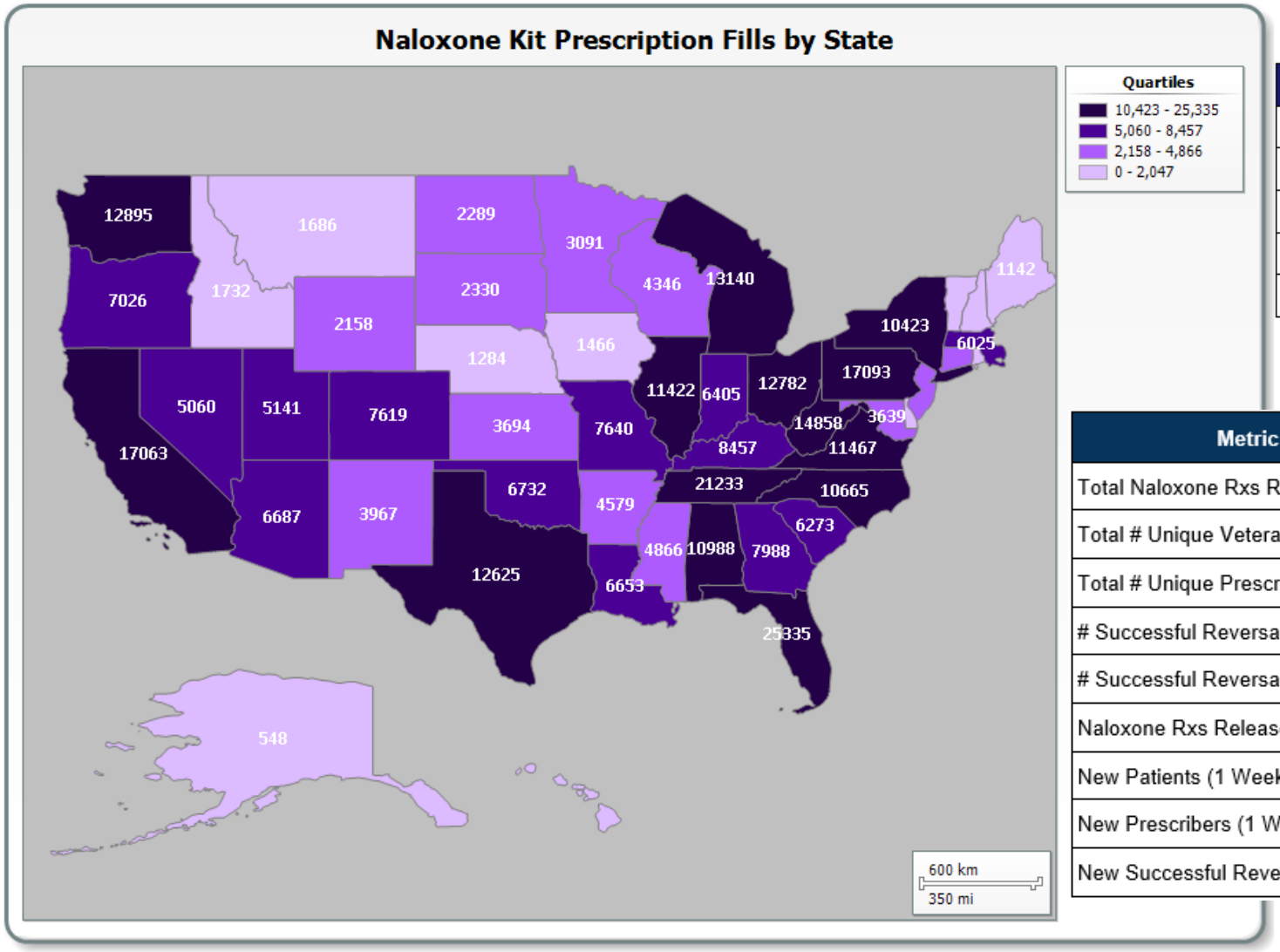
4. Consider Naloxone Again

- If person doesn't start breathing in 2-3 minutes, or responds to the first dose of naloxone and then stops breathing again, give second dose of naloxone
- Because naloxone wears off in 30 to 90 minutes be sure to stay with the person until emergency medical staff take over or for at least 90 minutes in case the person stops breathing again

5. Recovery Position

- If the person is breathing but unresponsive, put the person on his/her side to prevent choking if person vomits

VHA Naloxone Distribution (12/9/2019)



State	Kit Rx Fill Count
DE	1,880
NJ	2,379
Manila	88
Puerto Rico	1,294
RI	2,047

Metric Name	Metric Value
Total Naloxone Rxs Released	342,683
Total # Unique Veterans	214,122
Total # Unique Prescribers	23,094
# Successful Reversals (Pilot)	172
# Successful Reversals (Note)	764
Naloxone Rxs Released (1 Week)	2,374
New Patients (1 Week)	1,032
New Prescribers (1 Week)	129
New Successful Reversals (1 Week)	13

OEND National Trends

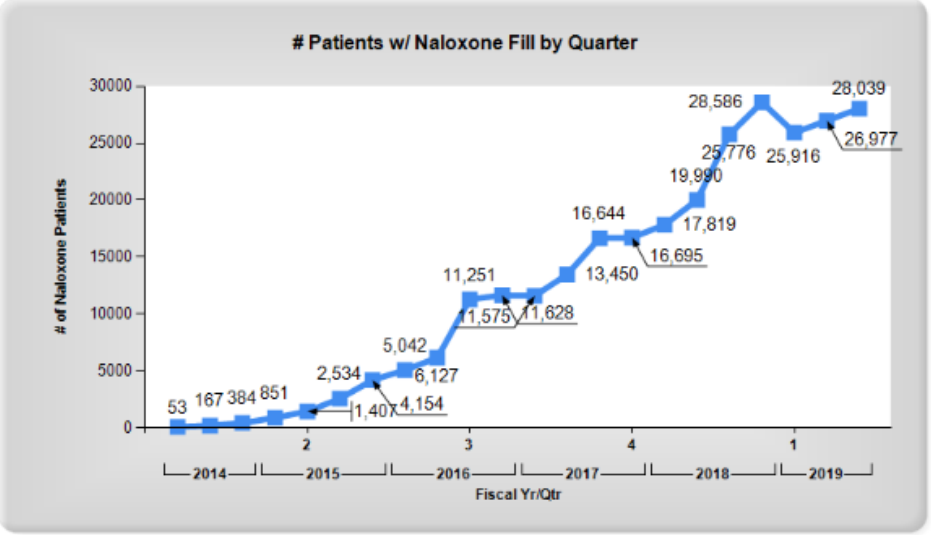
Feedback

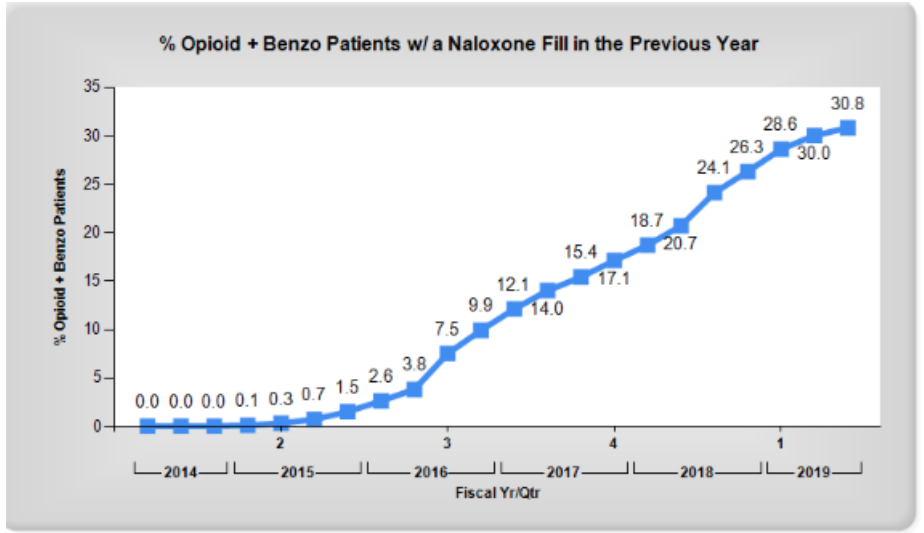
Definitions

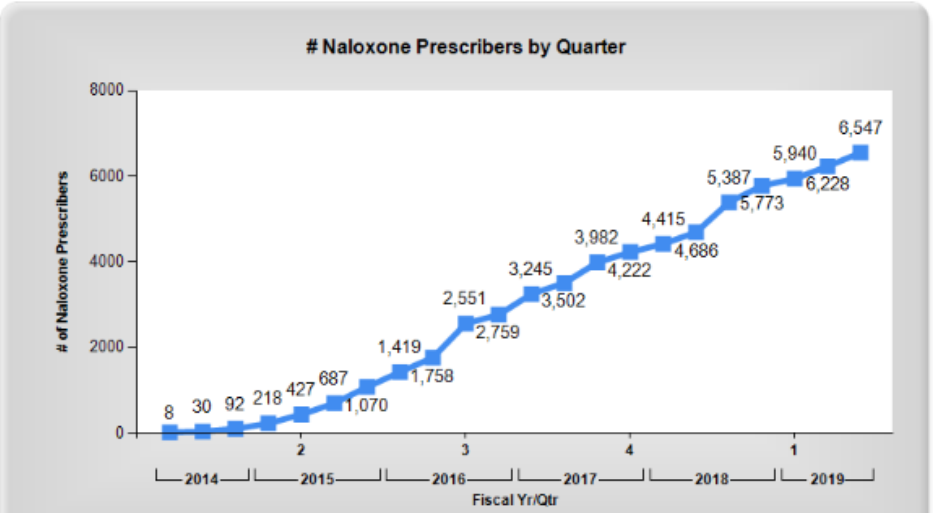
AD Visits (Salesforce) Last Update:	9/30/2019

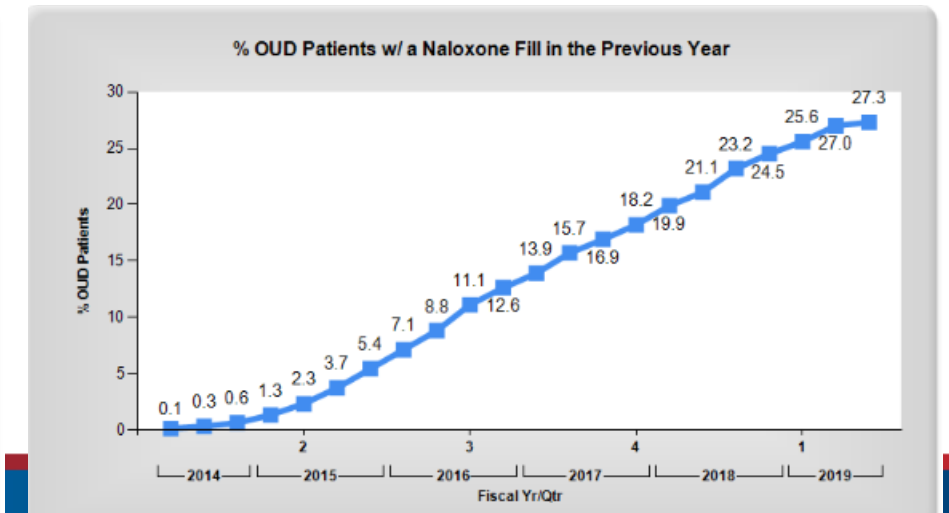
Go to:

General Trends • RIOSORD Trends • Risk Group Trends









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

VA | U.S. Department of Veterans Affairs

1 in 5

*data courtesy of Michael Harvey and PBM

KEY IMPLEMENTATION CONSIDERATIONS

- Provider Education
- Patient Identification
- Patient Education
- Post-Overdose Care

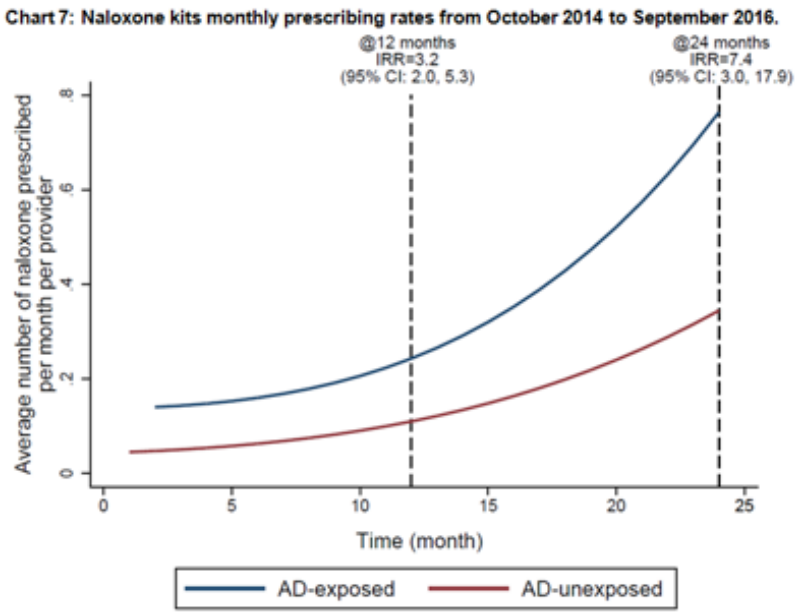
PROVIDER EDUCATION

- In-person training
  - Academic Detailing
- Web-based training
  - Available outside VA on www.train.org: https://www.train.org/main/course/1064943
- Monthly national call
- Address stigma and misperceptions (e.g., risk compensation)

Academic Detailing Services resulted in 7 times greater prescribing rate of Naloxone to Veterans at risk of overdose at 24 months

From October 2014 to Sept 2016, detailed providers had prescribing rate of naloxone >3 times higher than non detailed providers 1 year after first OEND-related AD visit, and >7 times greater at 2 years.

Moreover, the average rate of increase in naloxone prescribing was 7.1% greater in the AD-exposed versus the AD-unexposed providers (95% CI: 2.0%, 12.5%)



Bounthavong et al., 2017

KEY IMPLEMENTATION CONSIDERATIONS

- Provider Education
- **Patient Identification**
- Patient Education
- Post-Overdose Care

VA Academic Detailing OEND Risk Dashboard (internal site)

OEND Dashboard

Definitions | Export | Feedback

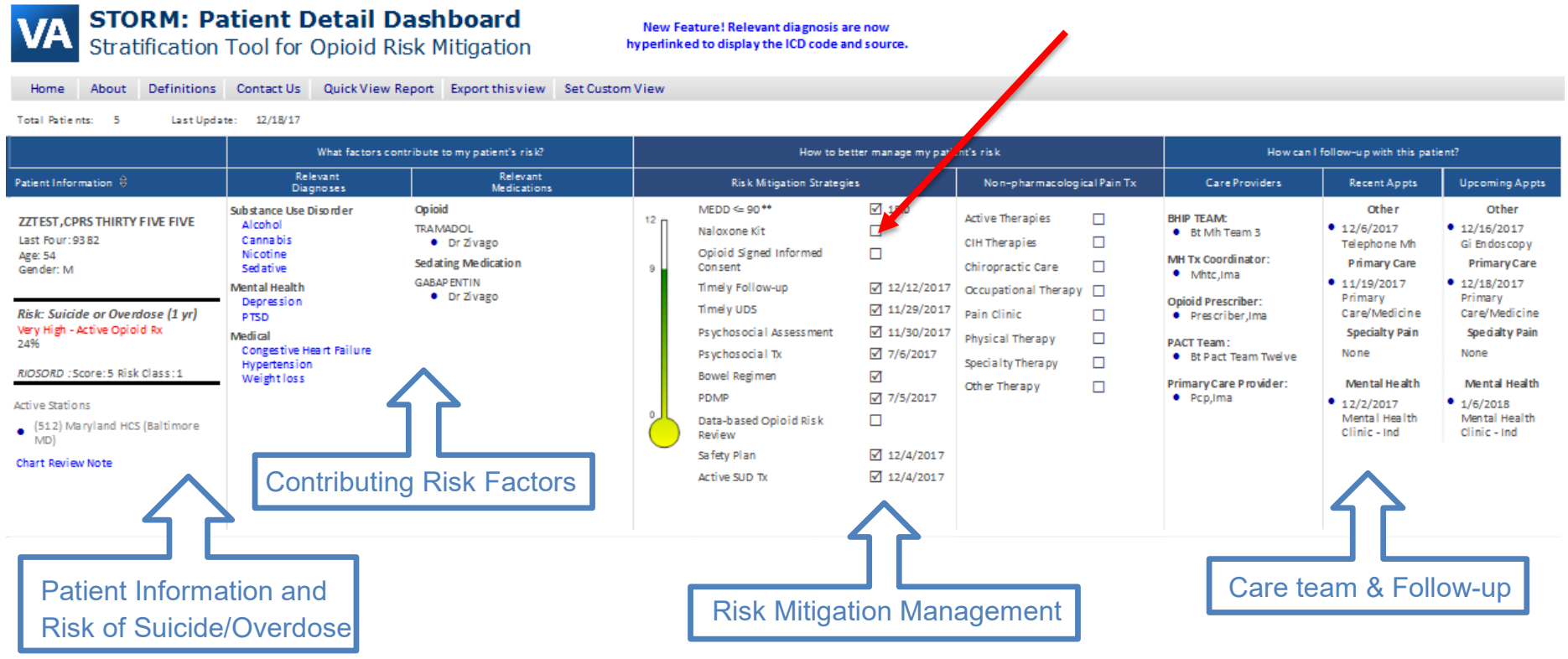
Update Status: Not Started
Last Updates: 12/9/2019

Location/Prescriber	# Naloxone Fills	% Nasal Fills (90d)	# Naloxone Patients	#Naloxone Prescribers	# Naloxone Uses
National	342,690	100.0%	214,124	23,095	1014

		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	46.1%	46.1%	250,426
		⊞ Risk Class ≥ 8	58.5%	58.5%	2,223
		⊞ Risk Class 5-7	47.2%	47.2%	7,911
		⊞ Risk Class ≤ 4	26.6%	26.6%	240,292
Opioid Pharmacotherapy					
National	Opioid + Benzodiazepine	All Patients	35.9%	35.9%	8,597
	MEDD ≥ 50 (Last 30 days)	All Patients	40.7%	40.7%	24,720
	MEDD ≥ 90 in Past Year w/ No Fill in the Past 90 Days	All Patients	20.8%	20.8%	4,776
	Methadone (Outpatient Rx or Active Non-VA Medication)	All Patients	33.1%	33.1%	10,296
OUD & OAT Pharmacotherapy					
National	OUD Diagnosis	All Patients	23.3%	23.3%	81,482
	Possible Overdose (3 Years)	All Patients	37.1%	37.1%	6,460
	Buprenorphine SL (Outpatient Rx or Active Non-VA Medication)	All Patients	45.3%	45.3%	9,522
	Naltrexone (Outpatient Rx, Active Non-VA, or Recent Clinic Order)	OUD Patients	45.6%	45.6%	805
	OUD-Related Fee Basis	All Patients	32.0%	32.0%	2,200
Other Potential Risks					
National	Potentially Homeless Veterans	All Patients	36.8%	36.8%	20998

VA Stratification Tool for Opioid Risk Mitigation (internal site)

➢ Main Page



Opioid Therapy Risk Report - Panel

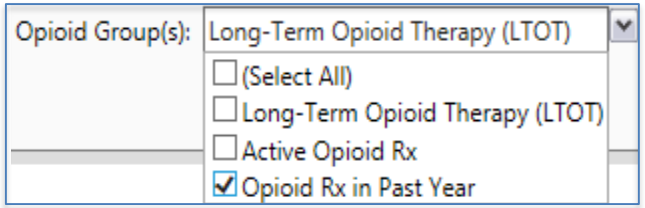
→ Create Panels by **Provider**, **Prescriber**, & **Teams**

→ Choose Opioid Group(s)

Any Opioid in Past Year

Long-Term Opioid Therapy

Active Rx



VSSC

Current As Of: 11/16/2018

ALL OPIOIDS
PATIENT LIST

For: [redacted]

Double Asterisk identifies values evaluated for past two years

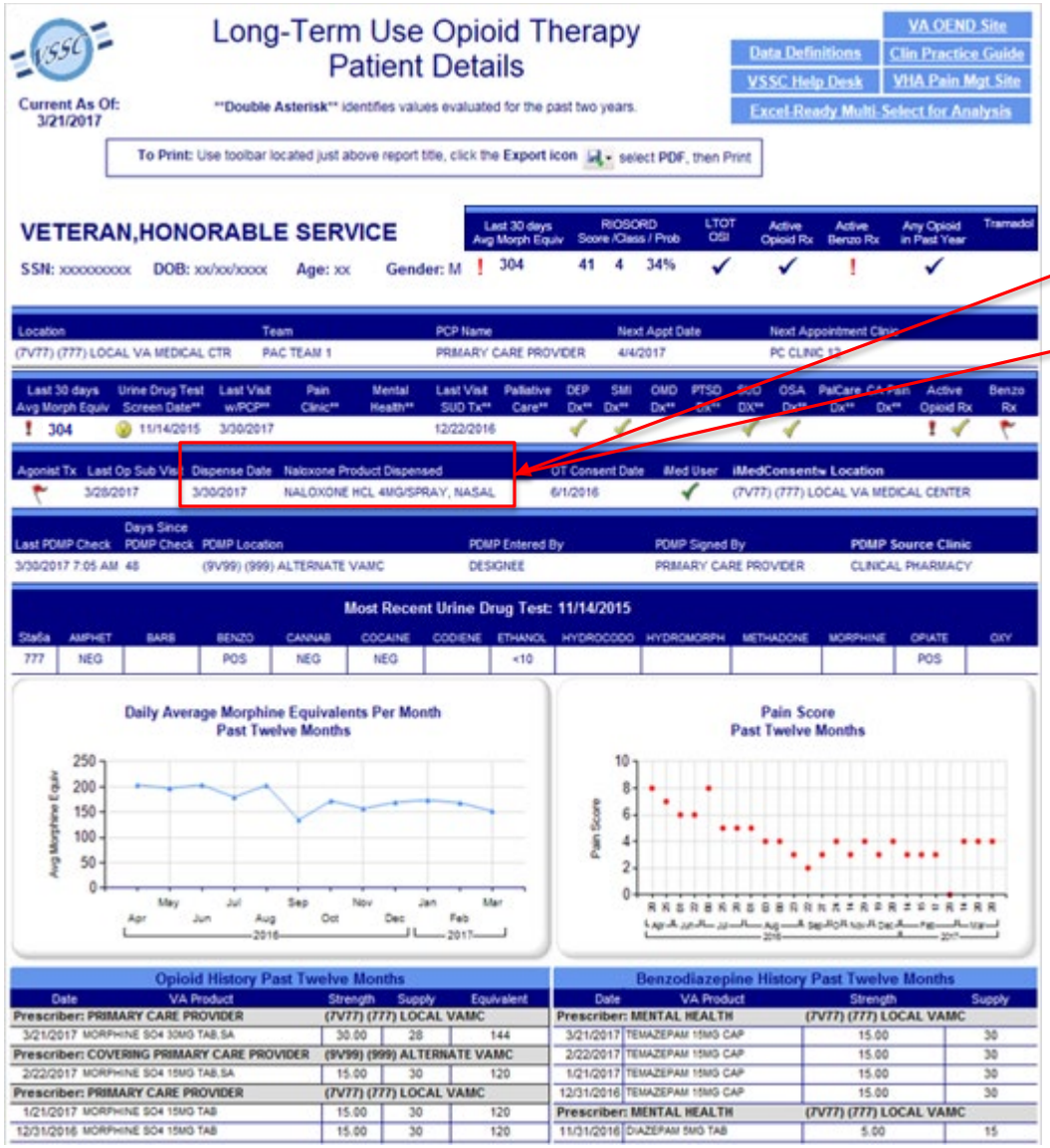
Data Definitions Updated 04/27/2017
VSSC Help Desk | VHA Pain Mgt Site
Opioid OEND | PDMP Resources
OTRR - Analyst MultiSelect
Use to Export Entire Pt List to Excel

Naloxone Dispense Date

Patient Name	PatientSSN	Date of Birth	Age	Gender	Last 30 Days Avg Morph Equiv	RIOSORD Score /Class / Prob			Last PDMP Check	Days Since PDMP	Last Urine Drug Test**	Entry Date National OT Consent	Signed by IMED USER	Long-Term Opioid Therapy	Active Opioid Rx	Active Benzo Rx	Last Naloxone Dispensed	Last Visit w/PCP**
[redacted]				M	182	35	3	24%	10/30/2018	18	9/7/2018	2/22/2018	✓	✓	✓		9/7/2018	
[redacted]				M	113	25	2	14%	10/31/2018	17	8/31/2018	3/14/2018	✓	✓	✓		3/27/2018	

★ Veteran-Focused ★ Actionable

Opioid Therapy Risk Report (OTRR)

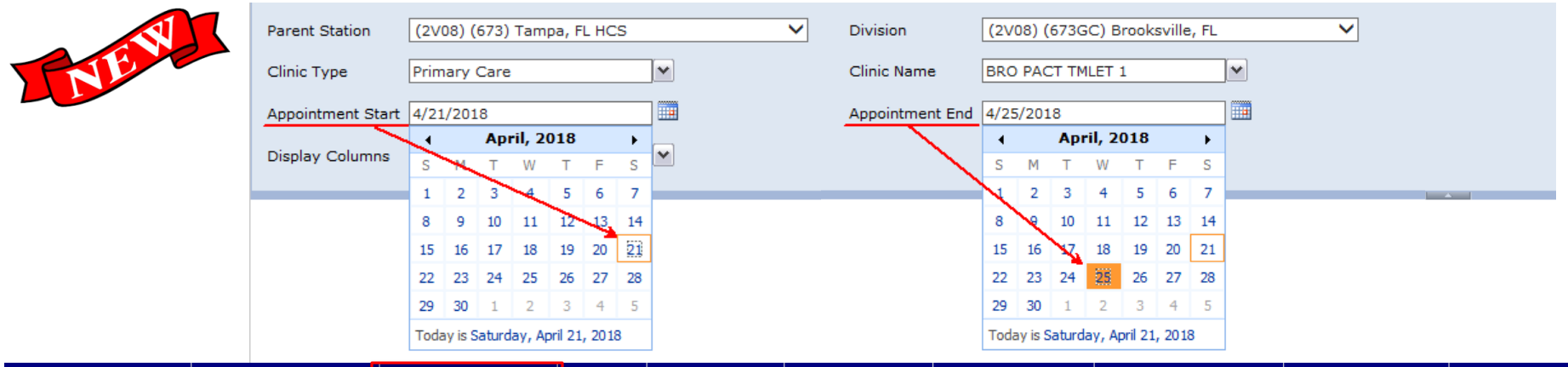


Veteran Details

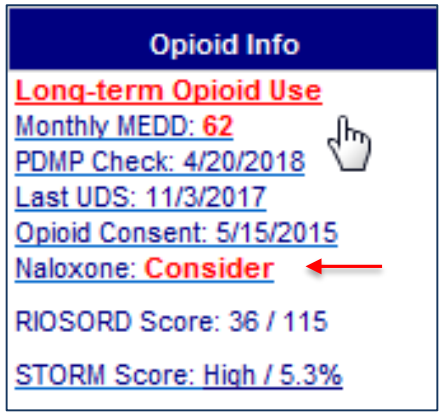
- All data **refreshed daily**
- Naloxone **Dispense Date**
- Naloxone **Product Dispensed**
- Quickly determine which patients require **proactive clinical action**
- Check recent **interactions w/other VA health providers**
- Latest information from across the VA **regardless of location**
- One Year history of Prescribed **Opioids**, **Benzos**, & **Pain Scores**

★Veteran-Focused ★Actionable

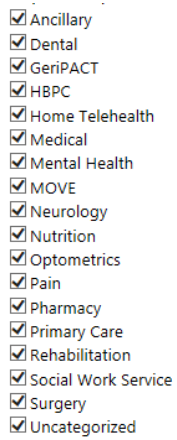
Clinic Huddle Patient Appointments Planning Tool



Appointment Info	Patient	Opioid Info	Diagnoses	Med Info	Labs	Screening	Prevention	Behavioral Health Scores	Care Coordination
04/25/2018 @ 10:00 AM (30 min) Est Patient CID/PID: 04/25/2018 (Wait: 0 days) Scheduled on: 03/17/2018 By: SCHEDULER 1 Comments: MOVED TO NEW CLINIC NoShow Count: 7 Miles to Clinic: NA	Patient, Number 4 SSN: 000000004 DOB: 5/22/1946 (72) Gender: M Disruptive Behavior: N Phone: 555-555-55555	Long-term Opioid Use Monthly MEDD: 62 PDMP Check: 4/20/2018 Last UDS: 11/3/2017 Opioid Consent: 5/15/2015 Naloxone: Consider RIOSORD Score: 36 / 115 STORM Score: High / 5.3%	CAN 90 day: 90 ACSC rank: 95 COPD DEPRESSION DIABETES HTN OBESITY HxTOBACCO	Active Meds: 18 Non-Supply: 15 Supply: 3 Controlled-Sub: 1 Last PDMP Check: 4/20/2018	BP: 152/86 (4/17/2018) A1c: 10.2 (3/6/2018) LDL: 73 (3/6/2018) eGFR: 75 (4/20/2018) SCr: 1.0 (4/20/2018)	CRC Screening: Reminder: GAP: Action Now Action Type: Recommendation or Clinical Endpoint Needed Action Due: 4/26/2018	Flu: 10/31/2017 PPSV23: 11/20/2014 PCV13: 12/15/2017 Other: 1/1/2006 PNEUMOCOCCAL, UNSPECIFIED FORMULATION Td: 1/15/2011 Tdap: 1/19/2012 Shingles:	AUDC: 1 (9/15/2017) PHQ-2: 0 (6/8/2017) PHQ-9: None in past year PC PTSD: 0 (10/27/2015)	Last PC Visit: 01-25-2018 Last Clinic: PACT CLINIC ALPHA # VA ED/UC Visits Past 12 Mo: 0 # VA Discharges Past 12 Mo: 1 Pending Labs: 16 Open Consults: 1



- **Actionable, Time-Sensitive, Cross-functional**
  - Address issues essential to veteran health & well-being
  - Efficient, Consistent
  - Pulls data from across the VA into one place
  - Select specific clinics by Name & Date Range
  - Links directly to full details



KEY IMPLEMENTATION CONSIDERATIONS

- Provider Education
- Patient Identification
- **Patient Education**
- Post-Overdose Care

PATIENT EDUCATION: A FEW EXAMPLES

Targeted Outreach

- Patients prescribed opioids
  - Various efforts using MEDD (<50 or 100); Co-Rx benzodiazepines; Intrathecal pump patients
  - Primary care, Pain clinics, Pharmacy
- Patients with opioid use disorder
  - Substance Use Disorder Treatment programs (including Medication Assisted Treatment; Residential treatment); detoxification; inpatient; emergency department

Increasing Awareness

- "Am I At Risk?" brochure
- E-board
- Buttons

Educational Efforts

- Individual and group visits in primary care and pain clinics
  - Schedules "scrubbed" daily for same-day education opportunities
  - Phone-outreach by care team with educational materials mailed and discussed via phone and/or in a group visit
- Residential treatment
  - Initial assessment/evaluation; Upon admission and at discharge; classes for all residents; ensure naloxone can be kept on person and taken on passes
- Medication Assisted Treatment Programs
  - Offered upon enrollment; during medication management visits
- Pharmacy
  - Window dispensing; Consult Service; Residency projects
- Electronic Medical Record
  - Standardized notes for OEND
  - Health factor added to opioid refill note
  - Included in order sets
- Letter-based

Images from Mendes, 2/22/17 presentation

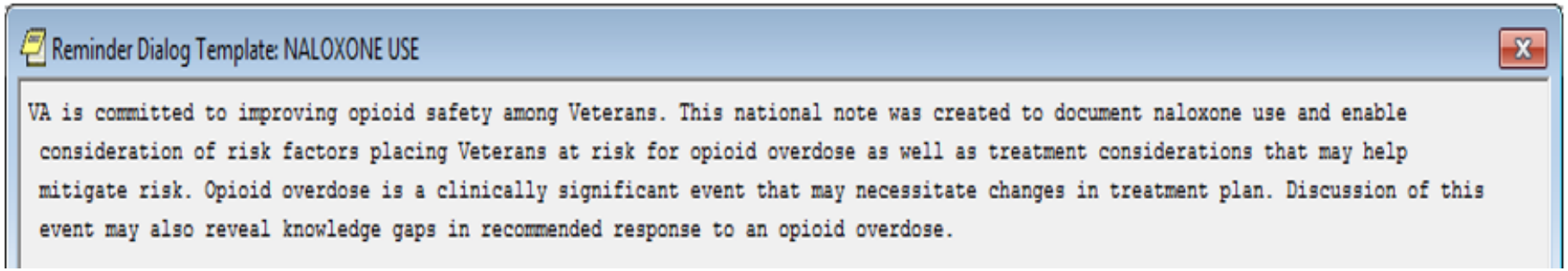
KEY IMPLEMENTATION CONSIDERATIONS

- Provider Education
- Patient Identification
- Patient Education
- **Post-Overdose Care**

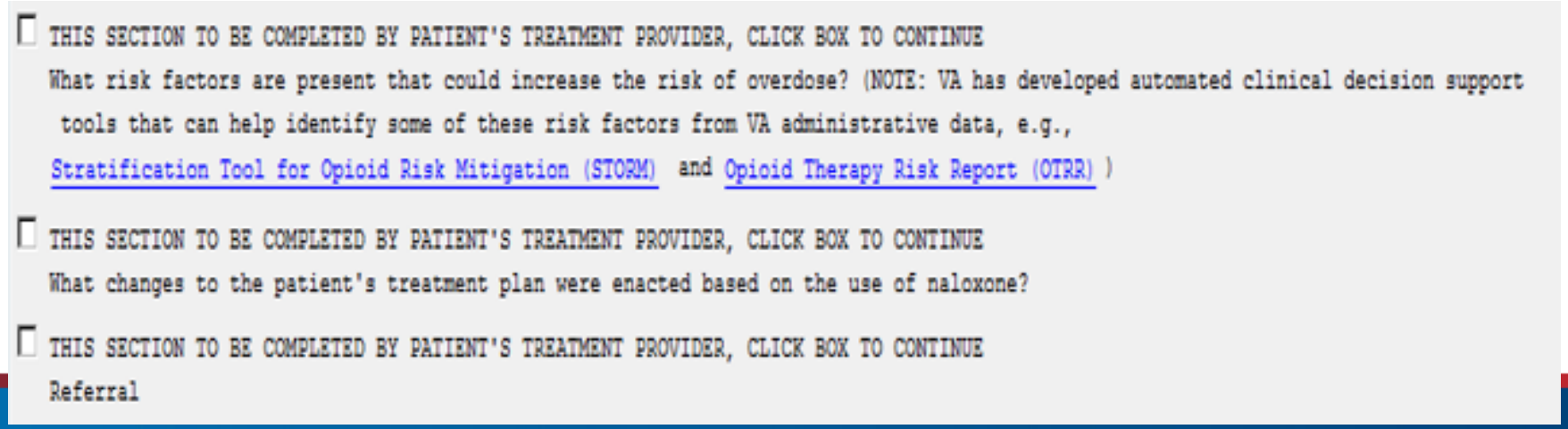
POST-OVERDOSE RESPONSE

- It is important to clarify post-overdose response and reporting responsibilities given the diverse reporting systems at the facility level
- Examples of reporting systems include:
  - **VA Police System (VAPS)/Report-Exec System which is replacing VAPS**
    - Use as the primary legal documentation/record for VA Police emergency responses to overdoses, including when naloxone is used, among both VA patients and visitors
  - **Joint Patient Safety Reporting (JPSR) System**
    - VA and Department of Defense reporting system; Use to capture when VA staff respond to any on-campus overdose, including when naloxone is used, among both VA patients and visitors
  - **VA Adverse Drug Event Reporting System (VA ADERS)**
    - Any adverse drug event among VA patients, including prescription-related overdoses, should be reported in this system
  - **VA Computerized Patient Record System (CPRS) National Note Templates**
    - **Suicide Behavior and Overdose Report (SBOR)**
      - **Use to capture any overdose event among VA patients (goal is to improve care post-overdose)**
    - Naloxone Use Note
      - Use to capture any time a VA patient's naloxone is used on someone other than the patient (need to identify if patient may need support/changes in treatment plan as patient may be around people who are overdosing)
- **KEY POINT: Non-fatal overdose events are clinically significant events that represent critical opportunities to intervene to improve care for patients and prevent future overdose**

VA National Naloxone Use Note



- Improve care post-overdose
- Cover sheet reminder component if patient's treatment provider does not complete sections of the note specified for patient's treatment provider



HEALTHCARE SYSTEM CONSIDERATIONS

- One tool in clinical armamentarium—not a panacea, not just about naloxone!
- Numerous levers—policy, funding, technical assistance
  - Coordination across program offices
  - Academic Detailing can help support implementation
- Patient Identification
  - Patients prescribed opioids
  - Patients with opioid use disorder
- Provider and Patient Education
  - Provide patient education on how to ***prevent, recognize, and respond*** to an opioid overdose
    - **A few minutes of training that could save a life!**

CLINICAL CONSIDERATIONS

- Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)
  - OEND lifesaving; MAT lifesaving and life-transforming
- Post-overdose care
  - Non-fatal overdose—critical juncture
    - OEND and MAT
    - Standardize response (e.g., national note templates)
- Consider comorbidities and ANY history of opioid use
  - Even if opioids are no longer being taken (prescribed or illicit) high risk patients are still at-risk; naloxone is still needed + risk mitigation targeting comorbidities
    - Patients with OUD, even if in treatment
    - Patients with past chronic opioid therapy; even if opioids are no longer prescribed; also need to address pain and other risk factors!!

VHA Rapid Naloxone Initiative

The program increases the availability of naloxone in the following ways:

VA Police Naloxone
Equips VA police with naloxone and trains them in its use

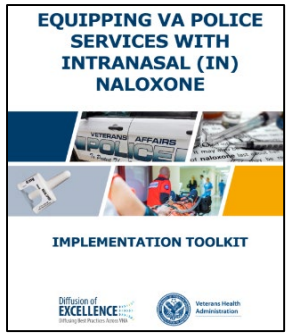
Naloxone-stocked in AED cabinets
Stocked in areas such as cafeterias, substance use disorder treatment programs, and primary care clinics

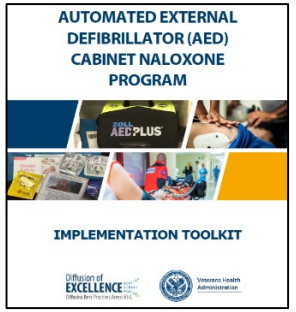
Opioid Overdose Education and Naloxone Distribution (OEND)
Educates at-risk patients and their families in how to *prevent, recognize, and respond to an overdose*, including how to respond with naloxone

The Impact

Making naloxone more readily available will increase the likelihood of successful overdose reversal, potentially saving hundreds of Veteran lives.

VA Boston Healthcare System implementation of all three elements resulted in 132 opioid overdose reversals.





- Implementation (April 2019)
  - OEND in all VA facilities
  - VA Police Naloxone (116 facilities, 2,785 police officers, 120 reversals)
  - AED Cabinet Naloxone (56 facilities, 693 AED Cabinets, 6 reversals)
- Media
  - Diffusion of Excellence Gold Status Practice (medium.com; VAntage Point)
  - Ted-style Talk on VA gold status practice that inspired this initiative
  - NPR feature
- Questions about the initiative can be sent to VHARapidNaloxoneNaloxone@va.gov

U.S. Department of Veterans Affairs

THANK YOU!!!

Elizabeth.Oliva@va.gov

Community-Engaged Research and the Overdose Epidemic

Dr. Brad Ray

Director, Center for Behavioral Health and Justice

Associate Professor, Wayne State University School of Social Work

We work with local communities, organizations, and behavioral health and law enforcement agencies across Michigan to provide

EXPERTISE, EVALUATION, TRAINING, and TECHNICAL ASSISTANCE

to optimize diversion of individuals with mental health or substance use disorders from jail or prison.

We Help Stakeholders

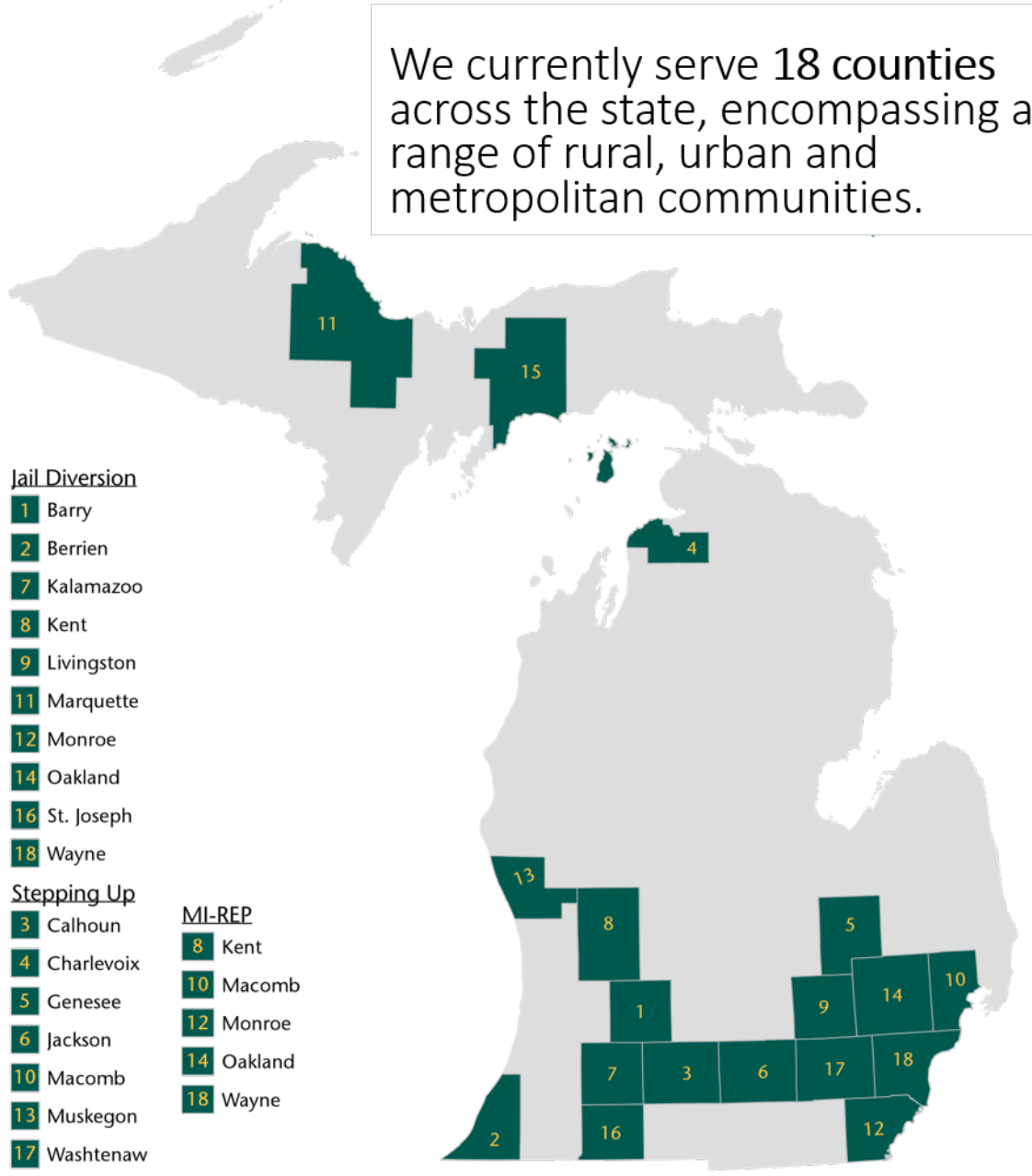
Implement best and innovative practices at every intercept of the criminal/legal continuum.

Collect and use data to drive decisions.

Create linkages to solve problems.

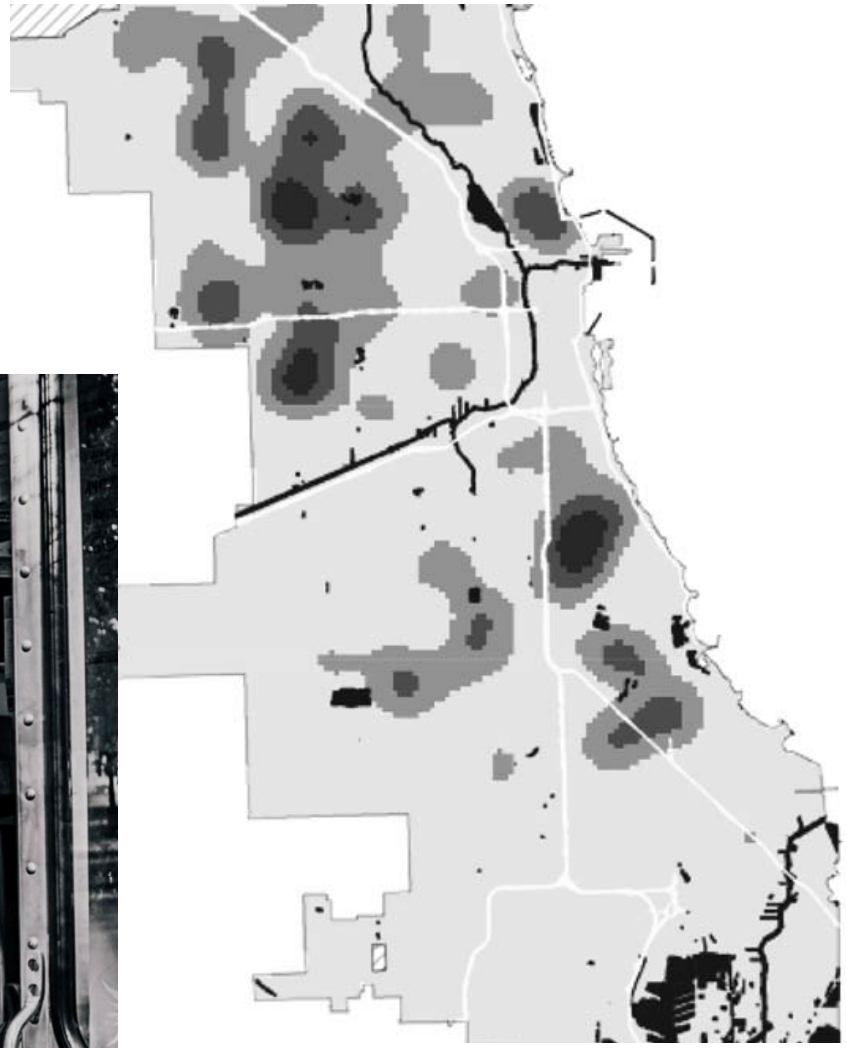
Develop action plans to achieve goals and sustain initiatives.

We currently serve 18 counties across the state, encompassing a range of rural, urban and metropolitan communities.



Prior Research with Harm Reduction and Overdose

- Chicago Department of Public Health / DePaul University
- Using toxicology reports as epidemiological data to examine geographic trends in fatal overdose



Data: Cook County, IL

INDIANA

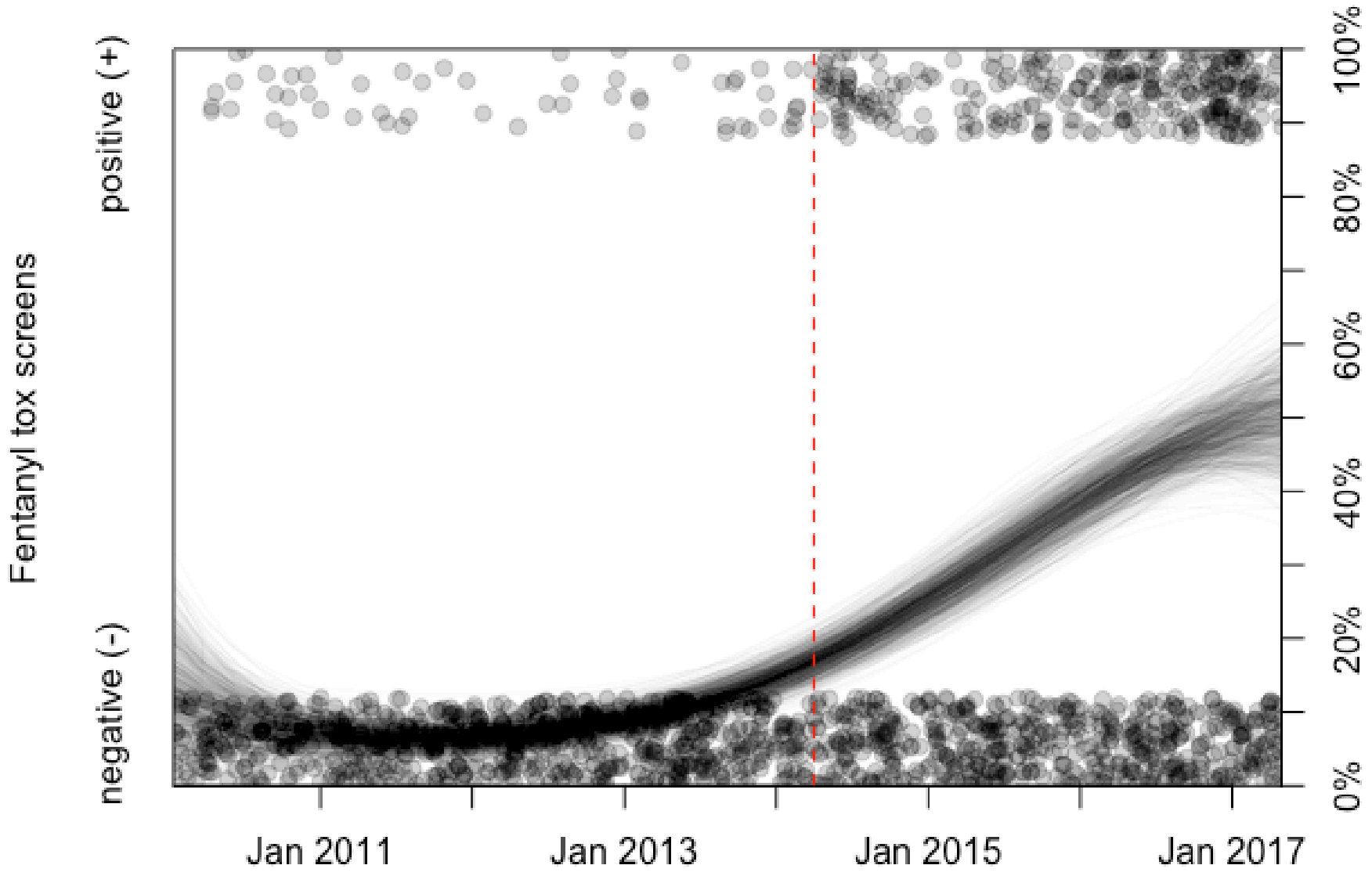
25.7 deaths
per 100,000 people
1,715 lives lost

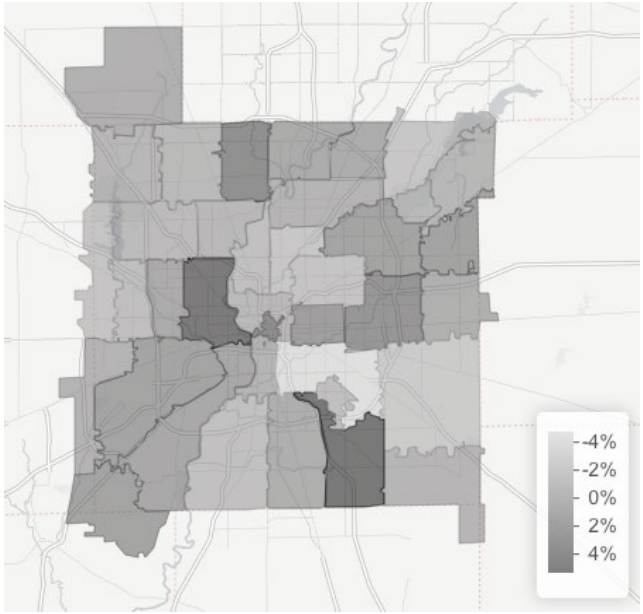
U.S.

22.4 deaths
per 100,000 people
72,827 lives lost

Indiana University Richard M. Fairbanks School of Public Health. The Changing Landscape of the Opioid Epidemic in Marion County and Evidence for Action. October 2018.

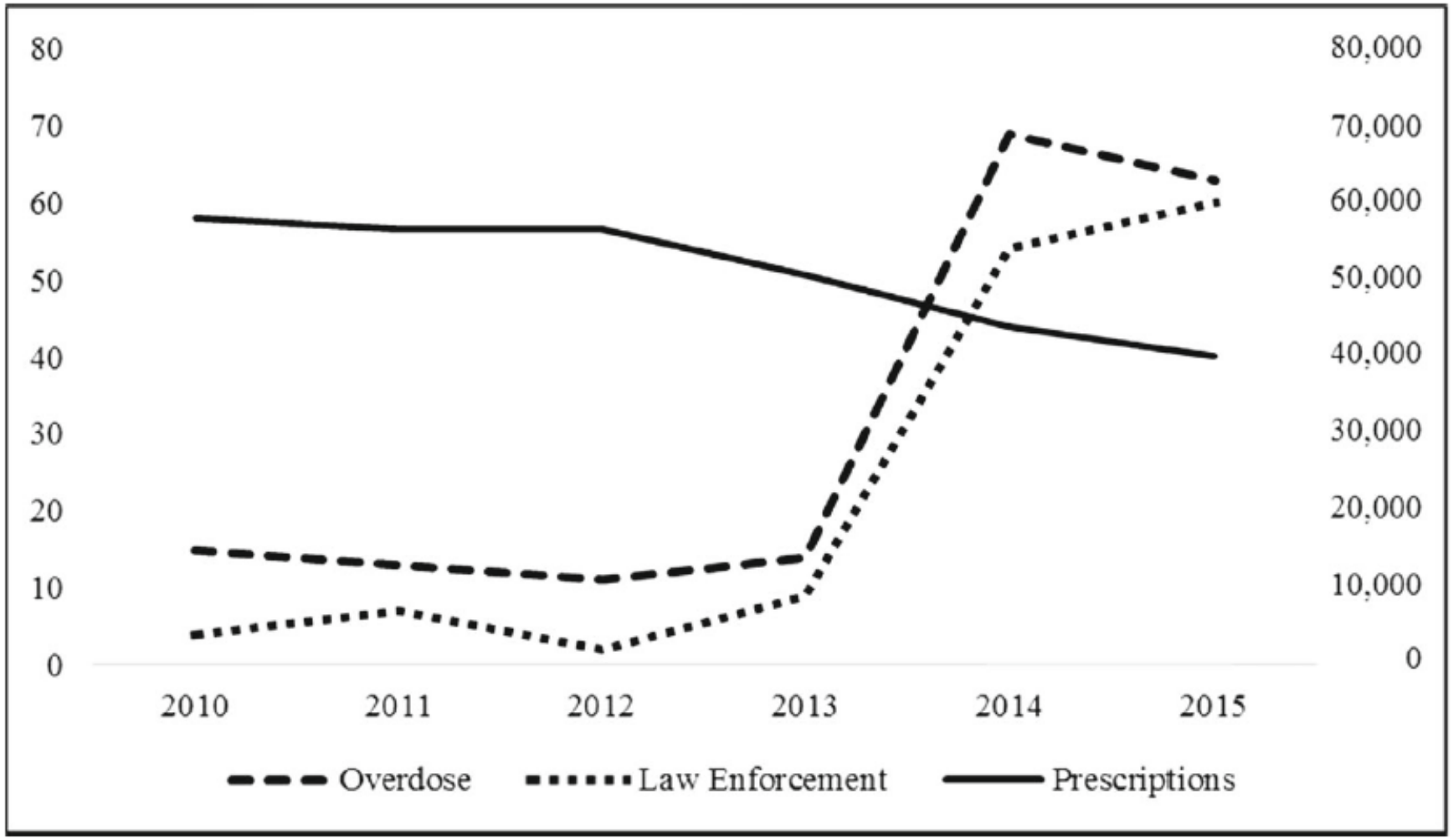
Fentanyl-Related Overdose Trends





Data: Marion County, IN

Fentanyl: Prescription, Toxicology, and Drug Seizures



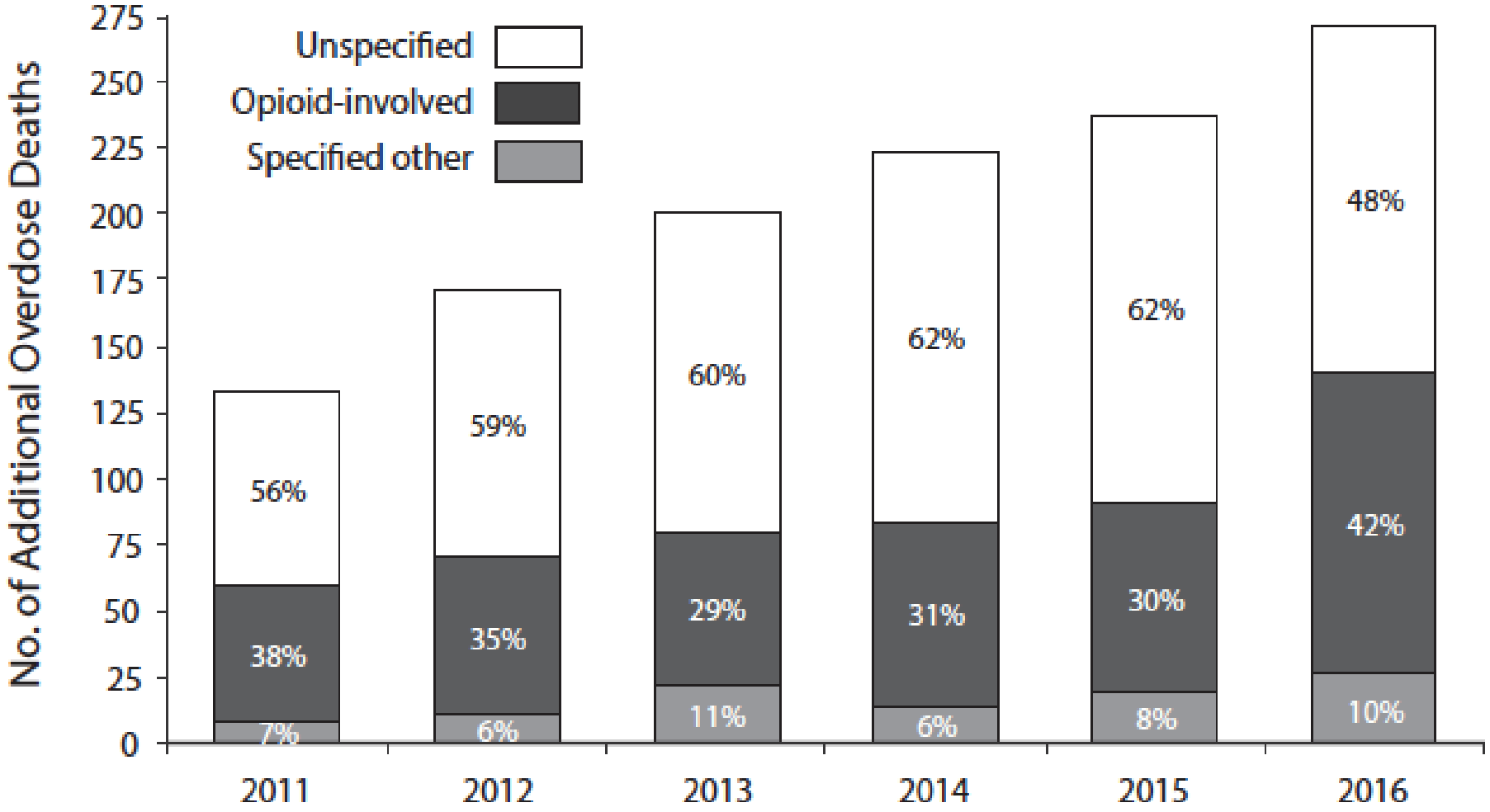
Note: Left Y-axis represents overdose and law enforcement counts and right Y-axis represents prescription counts.

Data: Marion County, IN

Undercounting the Overdose Epidemic

		CASES IN WHICH NO DRUG WAS SPECIFIED	
STATE	ALL DEATHS	TOTAL	SHARE
Louisiana	**996**	**473**	**47.5%**
Pennsylvania	4,627	2,075	44.8
Alabama	756	308	40.7
Montana	119	46	38.7
Indiana	1,526	547	35.8
Delaware	282	99	35.1
Nebraska	120	37	30.8
Alaska	128	2	1.6
Maine	353	5	1.4
Massachusetts	2,227	29	1.3
New Hampshire	481	5	1.0
Washington, D.C.	269	2	0.7
Connecticut	971	7	0.7
Rhode Island	326	1	0.3

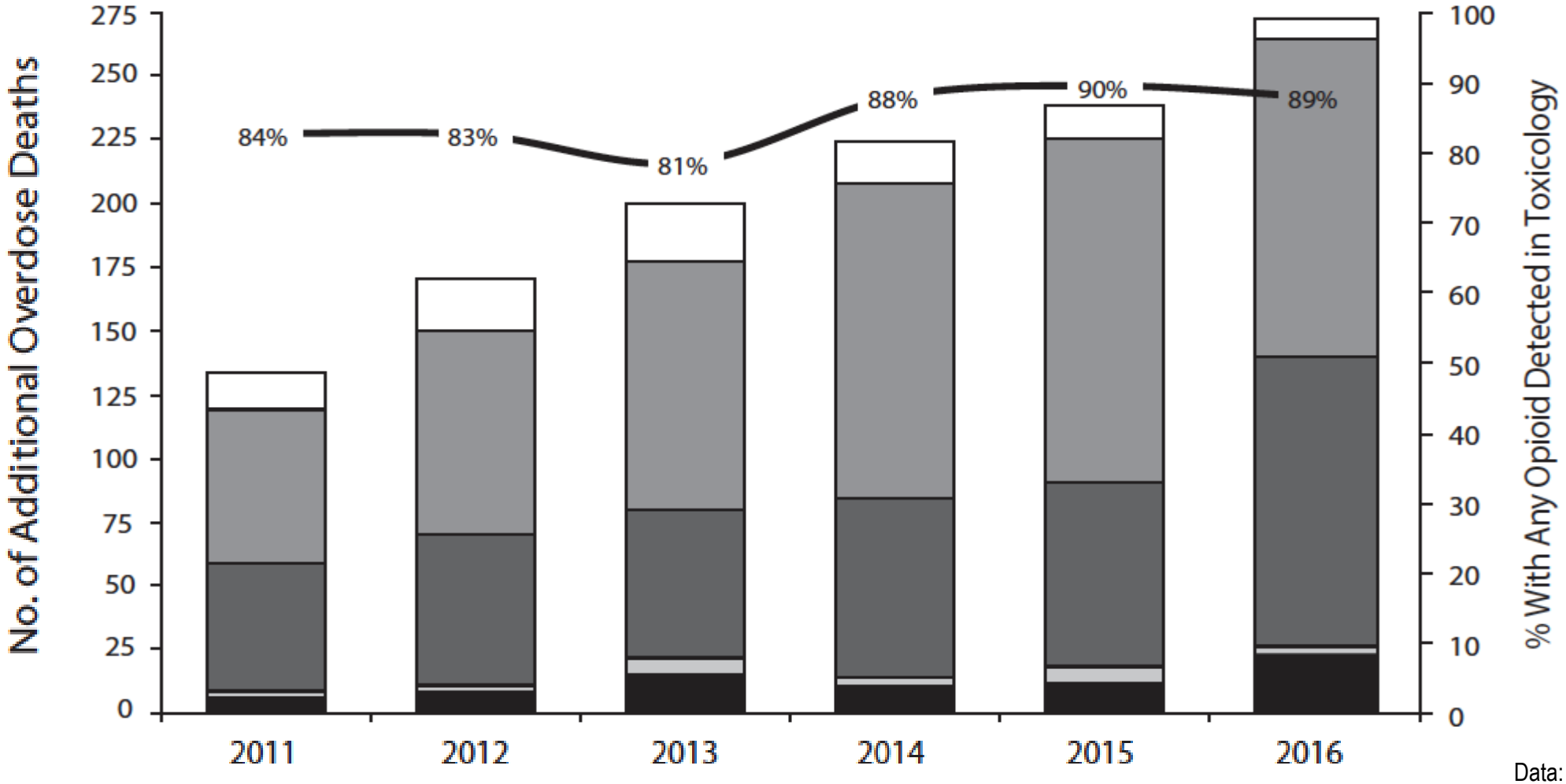
Undercounting the Overdose Epidemic



Data: Marion County, IN

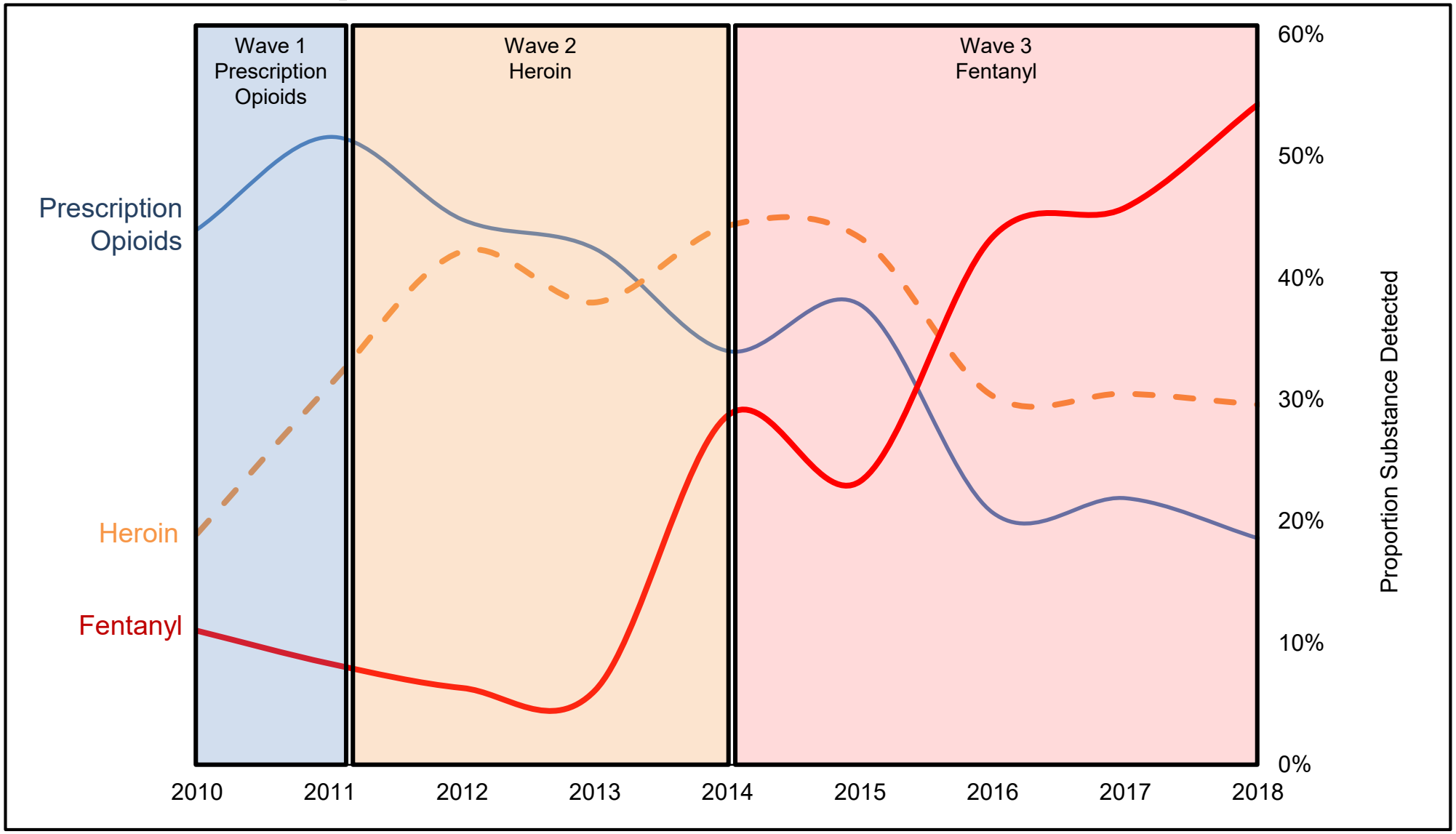
Undercounting the Overdose Epidemic

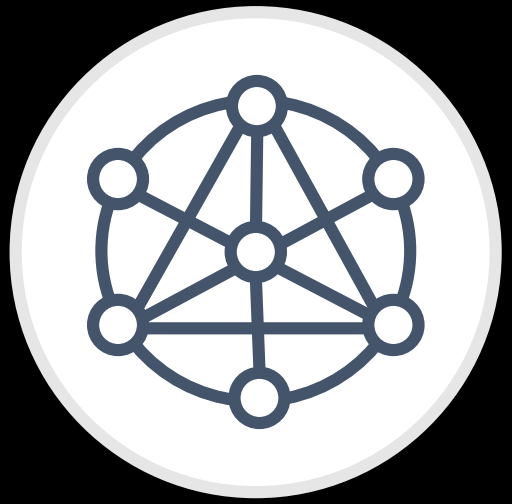
86% of unspecified cases screened positive for an opioid in the toxicology results



Data: Marion County, IN

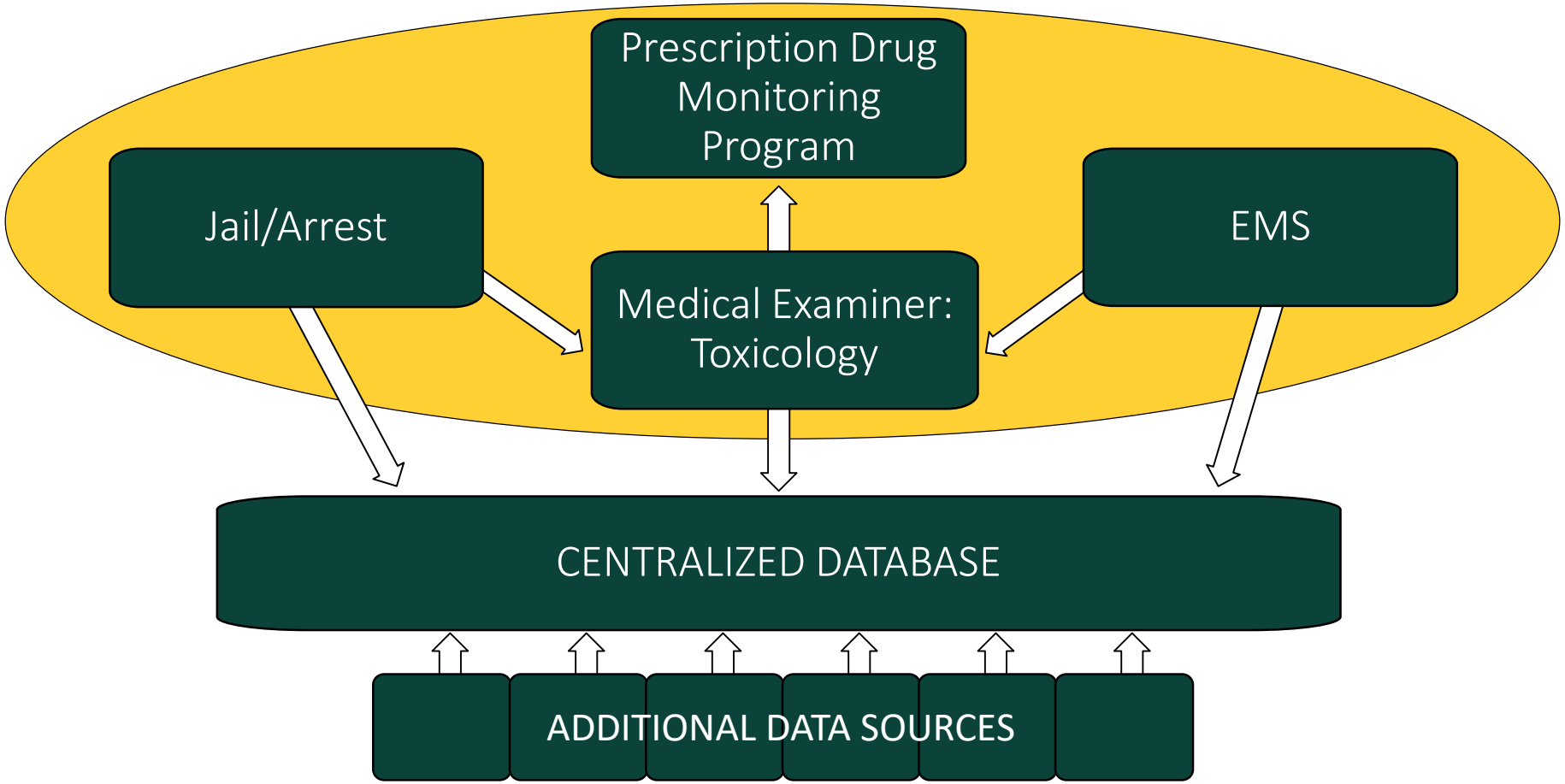
Epidemic Trend Analysis





Data Linkage

Data Integration



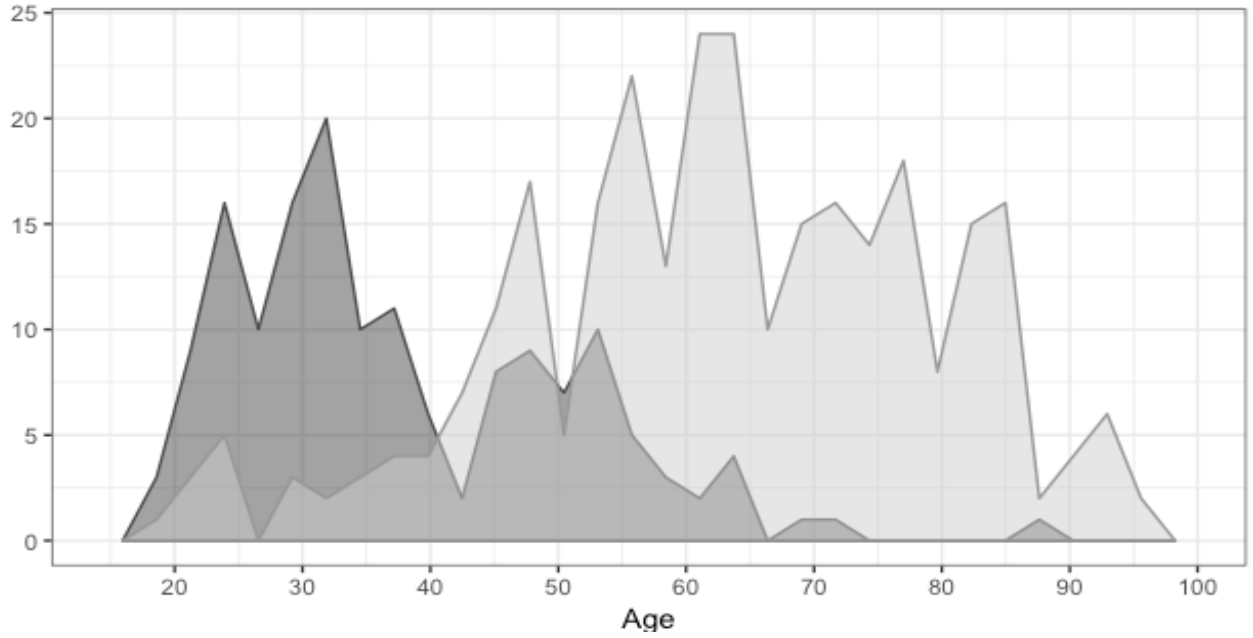
Mortality Following Naloxone

- Linked EMS naloxone administrations (2011-2016) to death records

- *Most had only one naloxone encounter (87%)*

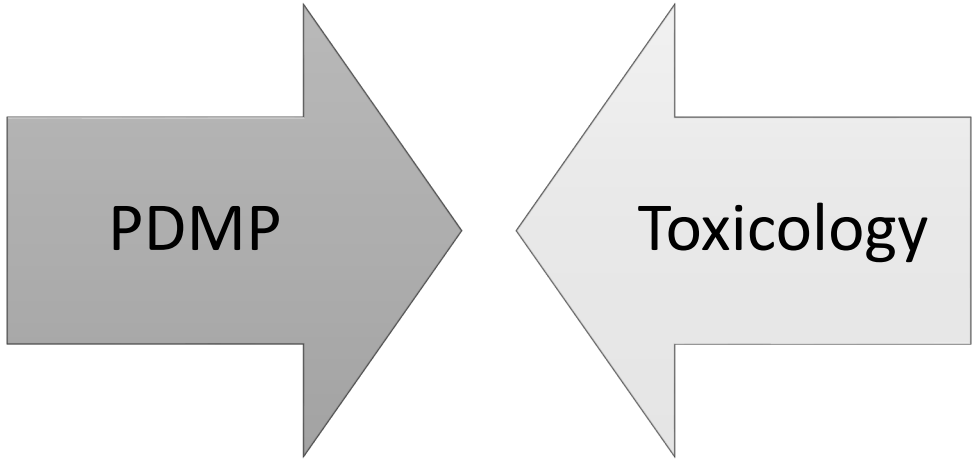
- *10% had died at follow-up*

- *79% of naloxone patients did not have any addition administrations or mortality following an initial resuscitation*



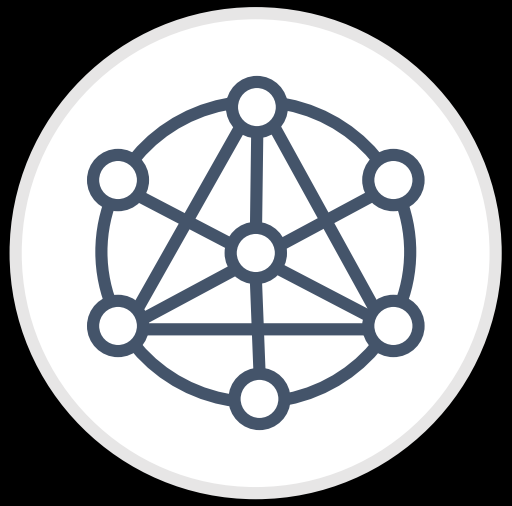
Data: Marion County, IN

Identifying Intervention Points



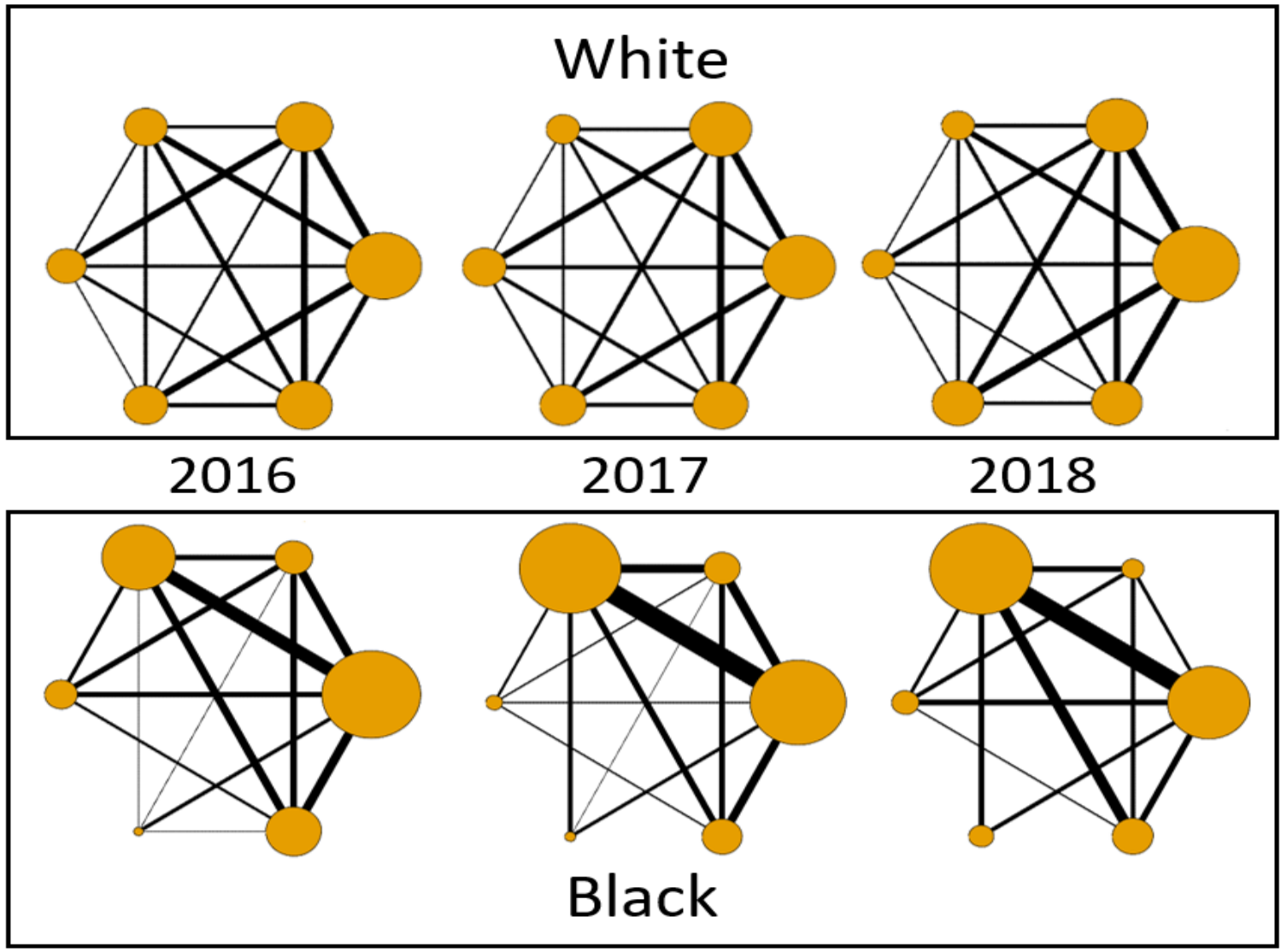
- Linked toxicology results to dispensations for 625 cases in 2016-2017.
- 47% had a PDMP record within year prior
- 38% had an opioid analgesic prescribed
  - 42% *also* has a prescription for a benzodiazepine
- Those with a prescription were significantly older and more likely to be female.

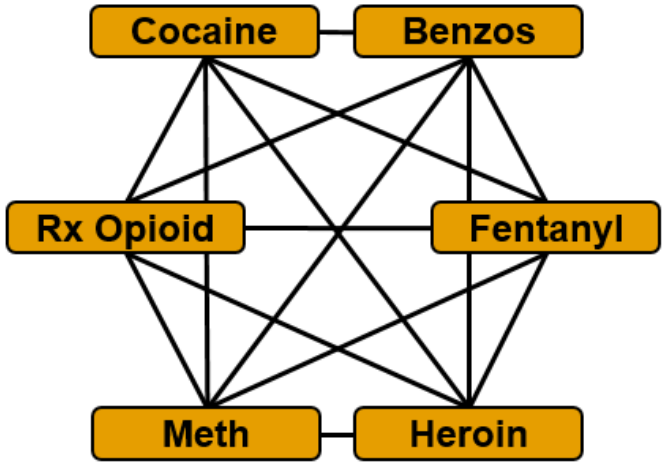
Data: Marion County, IN



Drug Testing Technologies

Polydrug Overdose





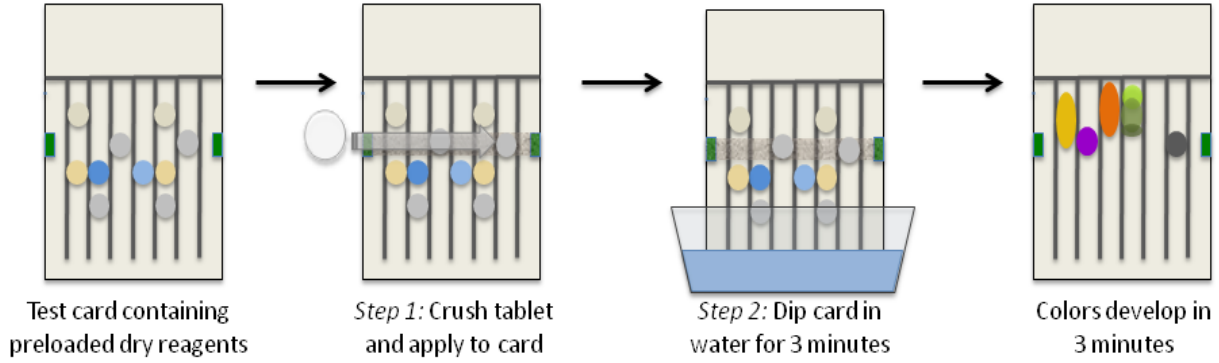
Data: Marion County, IN

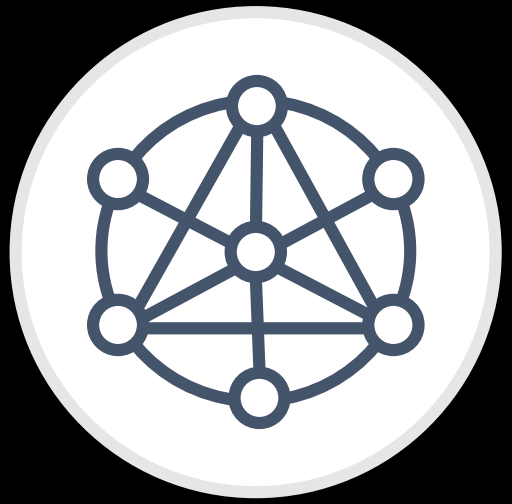
Drug Testing Technologies

- Single color tests are not able to perform general identification or classification, and the user must break glass vials of corrosive reagents.

- The idPAD is capable of identifying multiple drug types and cutting agents, and potentially can signal the presence of unexpected chemicals involved in overdose

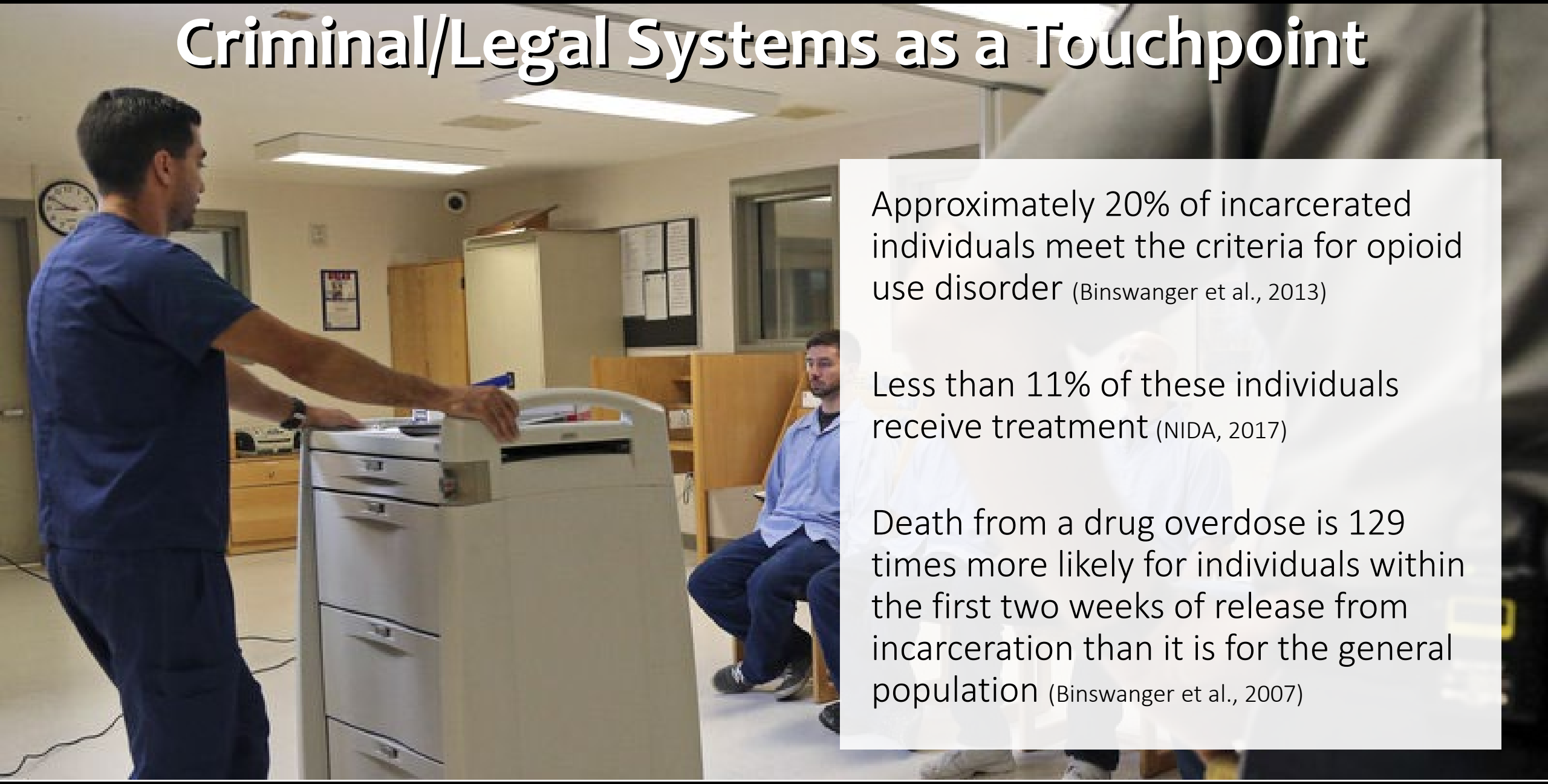
- Validating using illicit substances from death investigations





MOUD in Correctional Settings

Criminal/Legal Systems as a Touchpoint



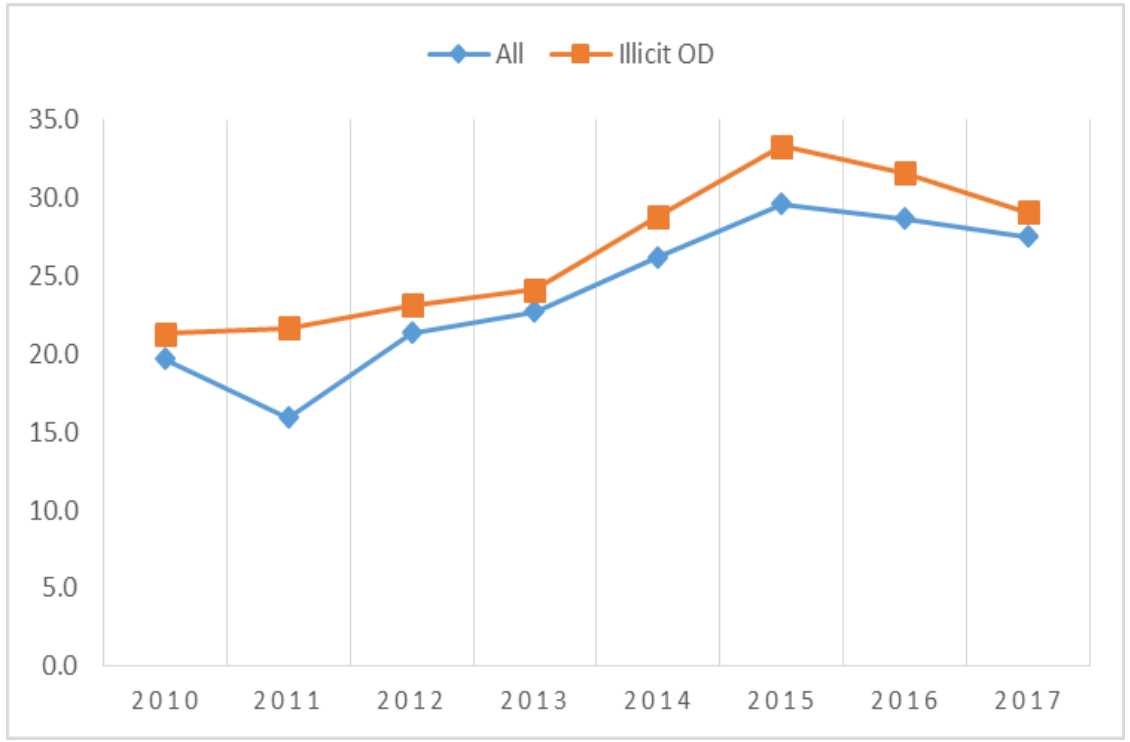
Approximately 20% of incarcerated individuals meet the criteria for opioid use disorder (Binswanger et al., 2013)

Less than 11% of these individuals receive treatment (NIDA, 2017)

Death from a drug overdose is 129 times more likely for individuals within the first two weeks of release from incarceration than it is for the general population (Binswanger et al., 2007)

Identifying Intervention Points

Rate of Prior Incarceration



- 25% of the overdose deaths were in jail in the *year* prior to their death (2010-2017)
- Average of 8 prior jail bookings (lifetime)
- Nearly one-third (31%) were booked on property crime at last event
- Those who died with illicit drugs in their system were consistently more likely to have been incarcerated prior to their death

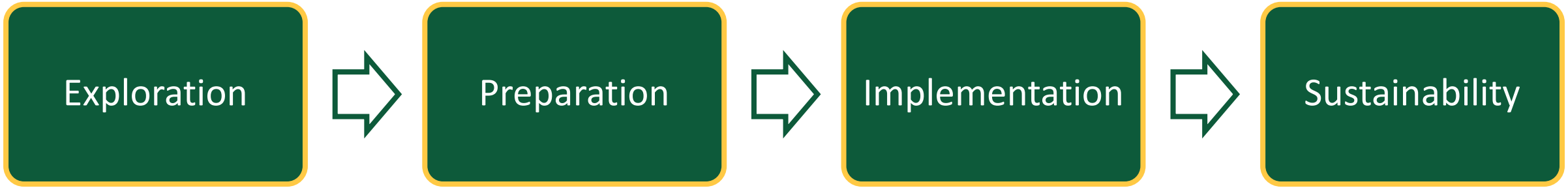
Data: Marion County, IN

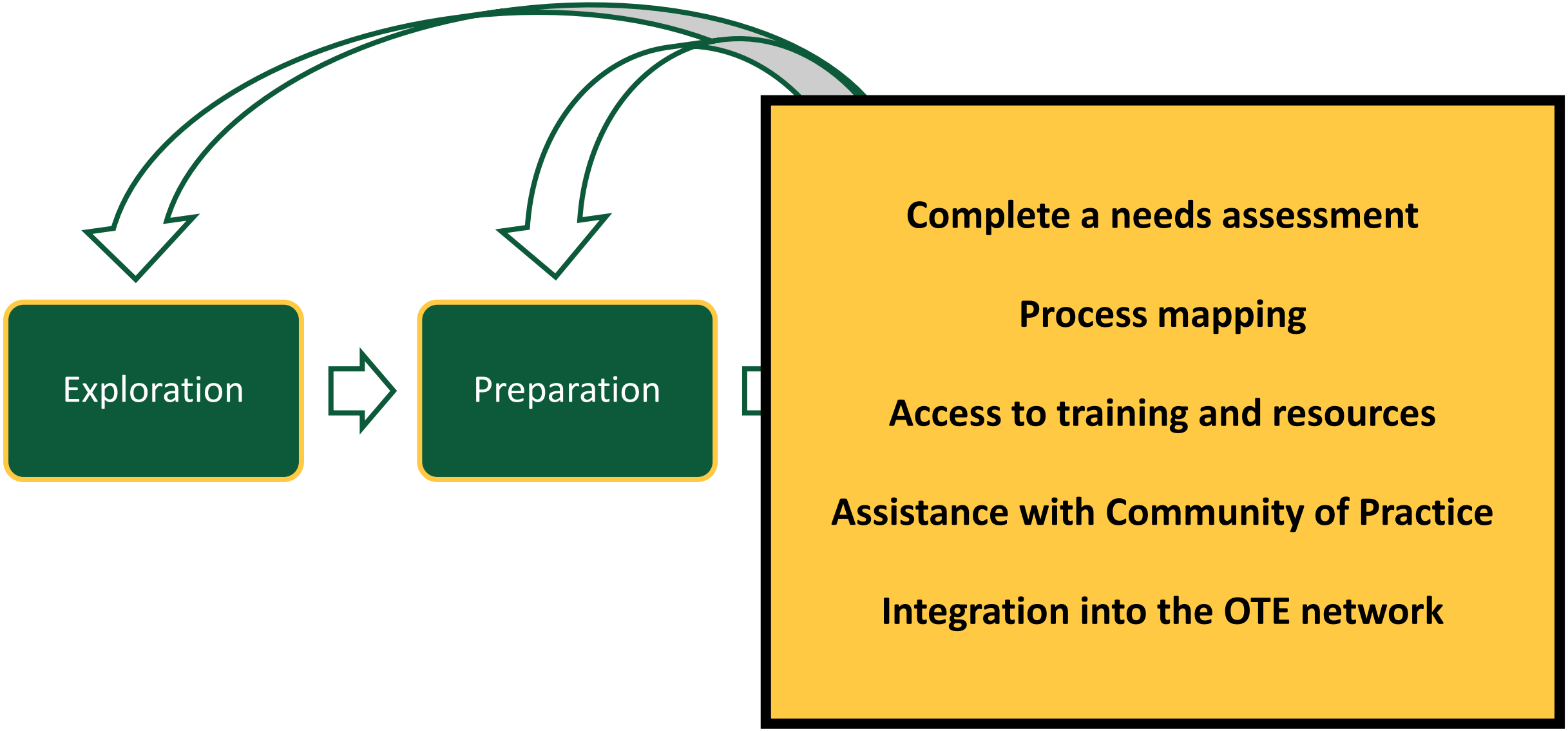
Center for Behavioral Health and Justice Team

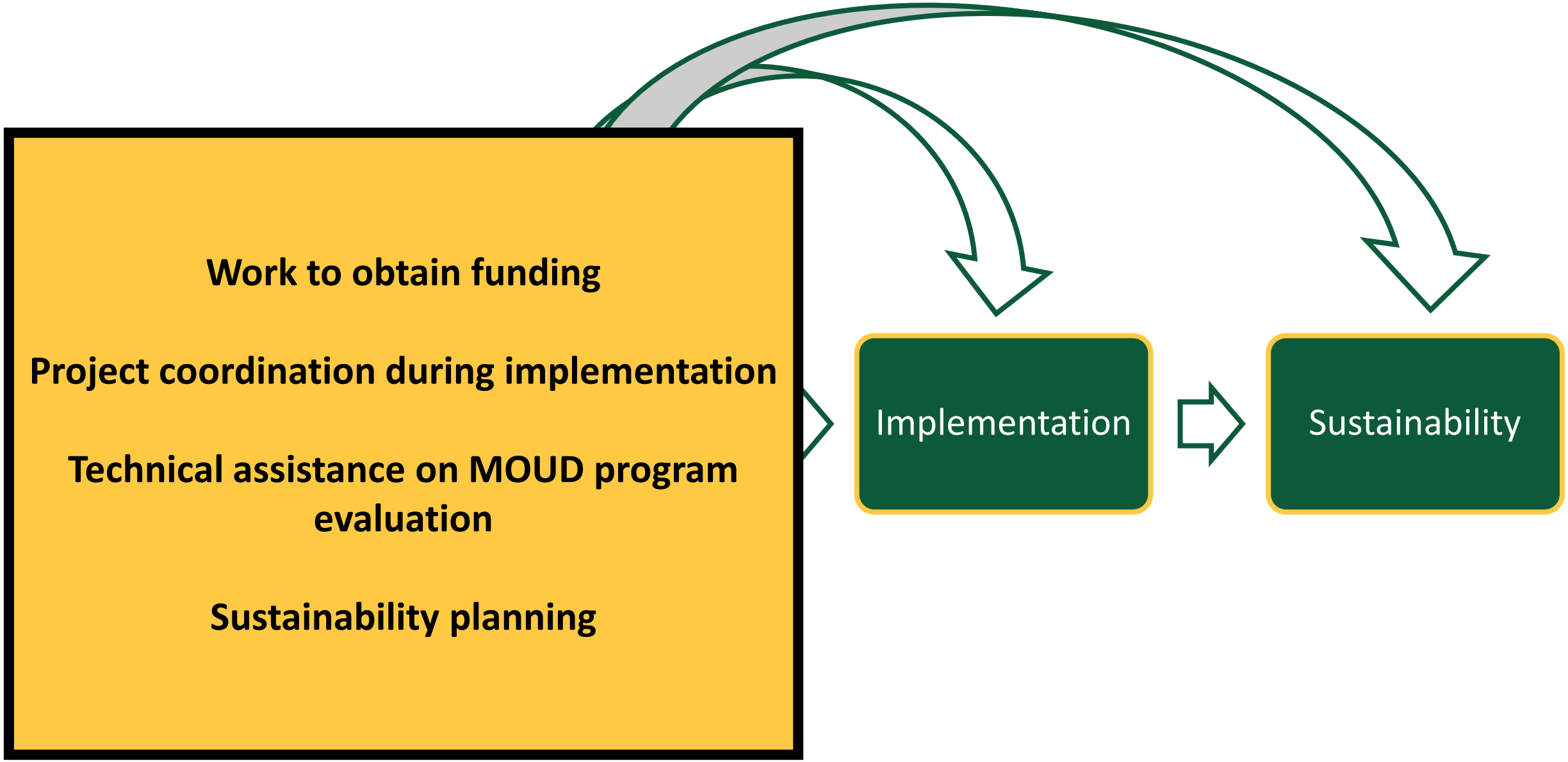
County	Funding/Opioid Treatment Ecosystem Scope	WSU Center for Behavioral Health and Justice OTE Coordinator	First responder intervention	MOUD in jail intervention	Community reentry intervention	Community of Practice Sessions (Monthly/Bi-Monthly)	Community of Practice Summit (2/yr)
Kent	MHEF: Full OTE	Becca Newman	Y	Y	Y	Y	Y
Monroe	MHEF: Full OTE	Nicole Hamameh	Y	Y	Y	Y	Y
Jackson	CFSEM/MOP: MOUD in Jail	Rahni Cason	no	Y	no	Y	Y
Muskegon	CFSEM/MOP: MOUD in Jail	Bob Butkiewicz	no	Y	no	Y	Y
Wayne	CFSEM/MOP: MOUD in Jail (tentative)	Tyler Logan	no	Y	no	Y	Y
Marquette	MOP (tentative)	*pending*	*pending*	*pending*	*pending*	*pending*	*pending*
Genesee	(tentative)	*pending*	*pending*	*pending*	*pending*	*pending*	*pending*

- Matt Costello, Project Manager
- Worked in program services unit of metro Detroit jail for 29 years
- Corrections-based knowledge and social work background have created a unique perspective on implementing jail-based services

Technical Assistance Framework




Exploration
Preparation
Complete a needs assessment
Process mapping
Access to training and resources
Assistance with Community of Practice
Integration into the OTE network


Work to obtain funding
Project coordination during implementation
Technical assistance on MOUD program evaluation
Sustainability planning
Implementation
Sustainability

Thank you

Brad Ray, PhD

Director, Center for Behavioral Health and Justice

Associate Professor, Wayne State University School of Social Work

bradray@wayne.edu

Vermont's Legal Advocacy in Recovery Services (LAIRS) Project

MAIREAD O'REILLY, ESQ.

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Vermont's LAIRS Clinic

- **What & Where:** Medical-Legal Partnership (MLP) Clinic at three sites in two Vermont counties
  - Needle exchange + low barrier buprenorphine clinic
    - Low barrier program started in 2018
    - "The unburnable bridge to treatment"
  - Two methadone clinics (Hubs)

- **LAIRS Mission:** to address health-harming legal needs (social determinants of health) facing low income Vermonters with substance use disorder, by providing necessary civil legal interventions.

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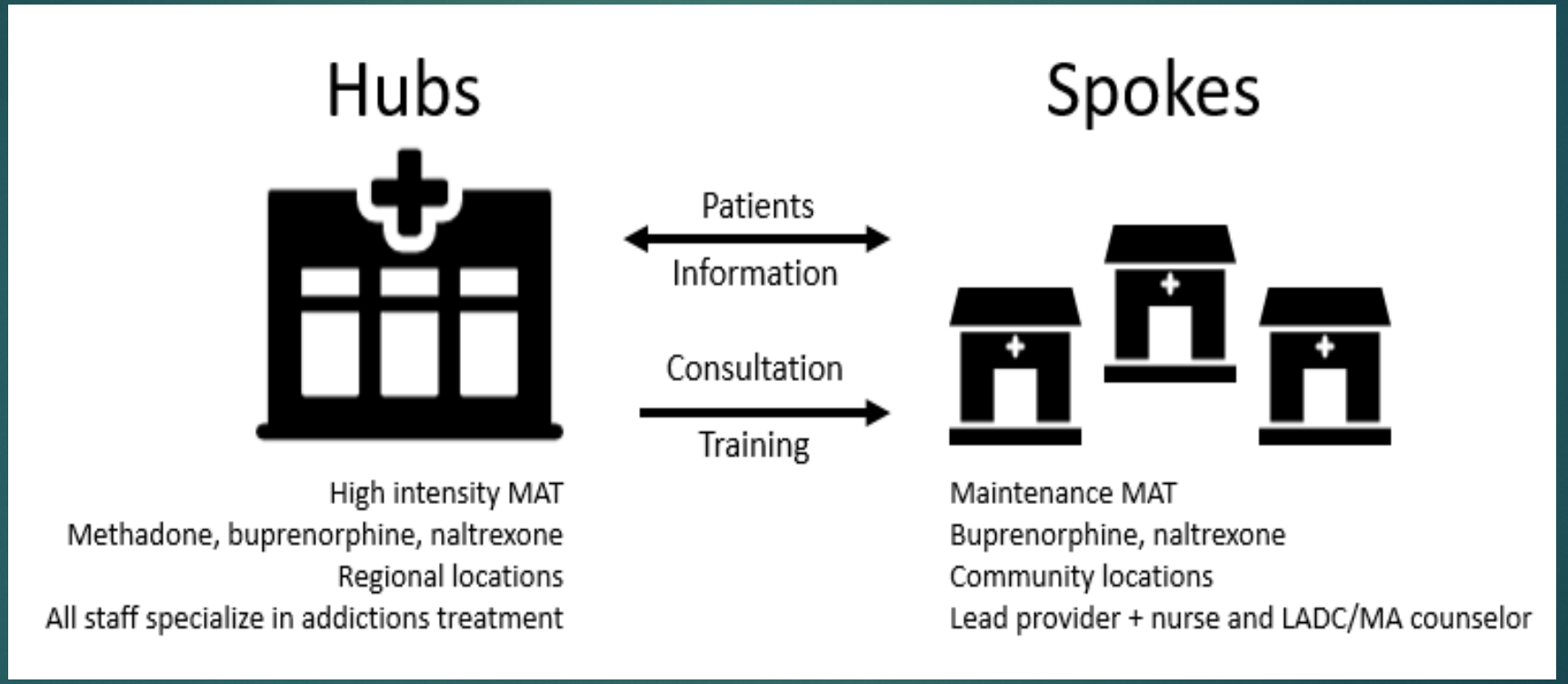
Context: Vermont's OUD Treatment System



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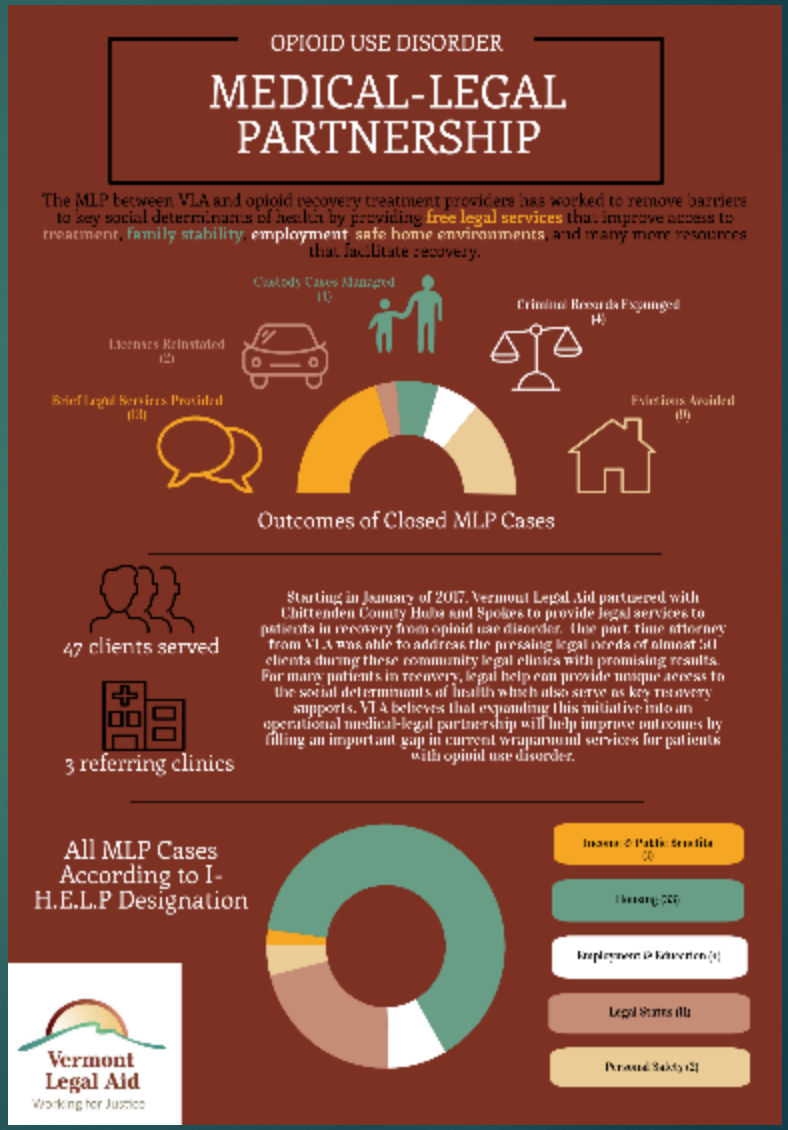
Context: Vermont Legal Aid

- Non-LSC funded legal aid organization
- Poverty Law Fellowship *(2016-2018)*
  - Piloted "MLP-esque" clinic
  - Hired AmeriCorps VISTA volunteer *(2018-19)*
- Dept. of Health Presentation *(May 2019)*
- Signed 1-year MOU *(July 2019)*
- Commenced Clinic Work *(September 2019)*



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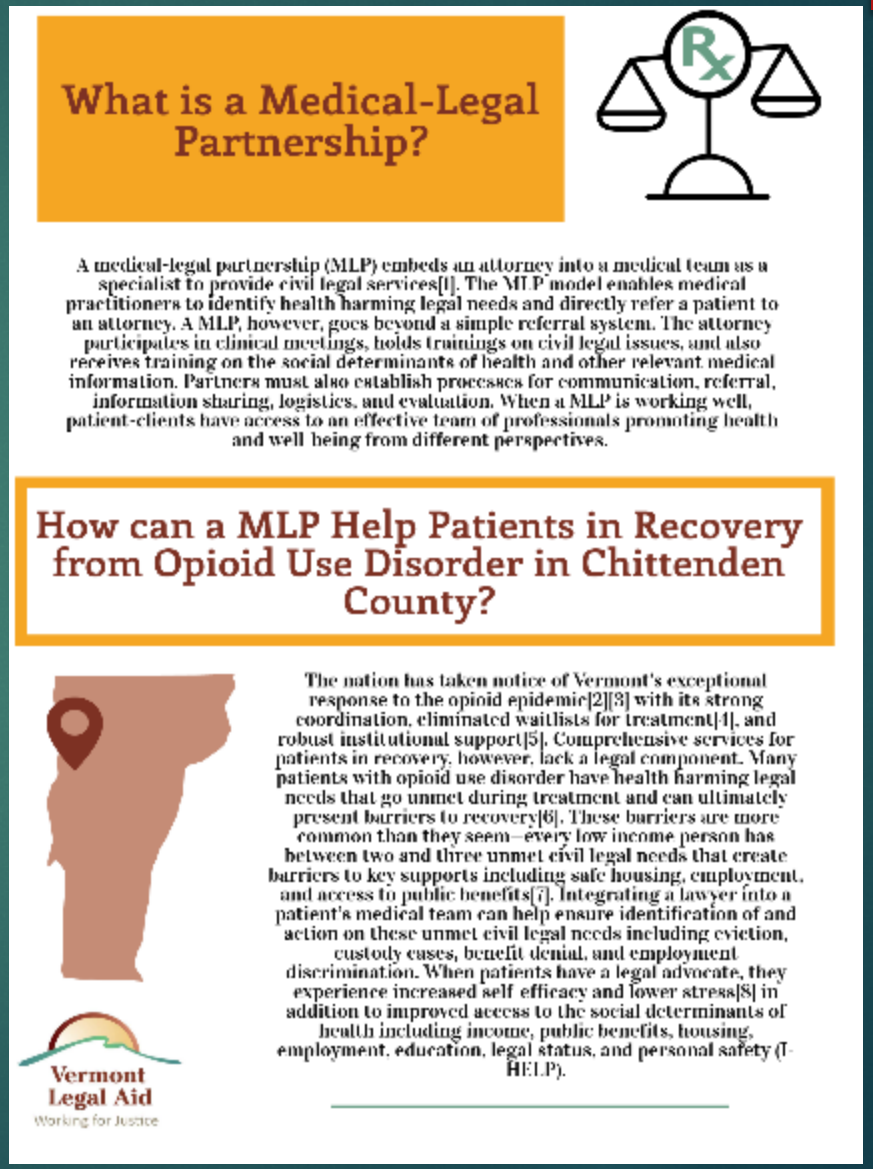
FUNDING

- Division of Alcohol & Drug Abuse Programs (ADAP) at the Vermont Department of Health oversees our grant
  - SAMHSA State Opioid Response (SOR) funding is the funding source.
  - This the first MLP in the nation to use SOR funding for a SUD-specific MLP
  - Spring-time negotiations are anticipated



What is a Medical-Legal Partnership?

A medical-legal partnership (MLP) embeds an attorney into a medical team as a specialist to provide civil legal services[1]. The MLP model enables medical practitioners to identify health harming legal needs and directly refer a patient to an attorney. A MLP, however, goes beyond a simple referral system. The attorney participates in clinical meetings, holds trainings on civil legal issues, and also receives training on the social determinants of health and other relevant medical information. Partners must also establish processes for communication, referral, information sharing, logistics, and evaluation. When a MLP is working well, patient-clients have access to an effective team of professionals promoting health and well being from different perspectives.

How can a MLP Help Patients in Recovery from Opioid Use Disorder in Chittenden County?

The nation has taken notice of Vermont's exceptional response to the opioid epidemic[2][3] with its strong coordination, eliminated waitlists for treatment[4], and robust institutional support[5]. Comprehensive services for patients in recovery, however, lack a legal component. Many patients with opioid use disorder have health harming legal needs that go unmet during treatment and can ultimately present barriers to recovery[6]. These barriers are more common than they seem—every low income person has between two and three unmet civil legal needs that create barriers to key supports including safe housing, employment, and access to public benefits[7]. Integrating a lawyer into a patient's medical team can help ensure identification of and action on these unmet civil legal needs including eviction, custody cases, benefit denial, and employment discrimination. When patients have a legal advocate, they experience increased self efficacy and lower stress[8] in addition to improved access to the social determinants of health including income, public benefits, housing, employment, education, legal status, and personal safety (I-HELP).

Vermont Legal Aid
Working for Justice

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Clinic Work: Collaboration with Healthcare Professionals

- Train healthcare partners to screen for legal needs
- Develop referral process
- Provide substantive legal training for healthcare partners
- Host "clinic hours"
- Case work, team approach
- Collect front-end data
- Design follow-up instruments to understand impact

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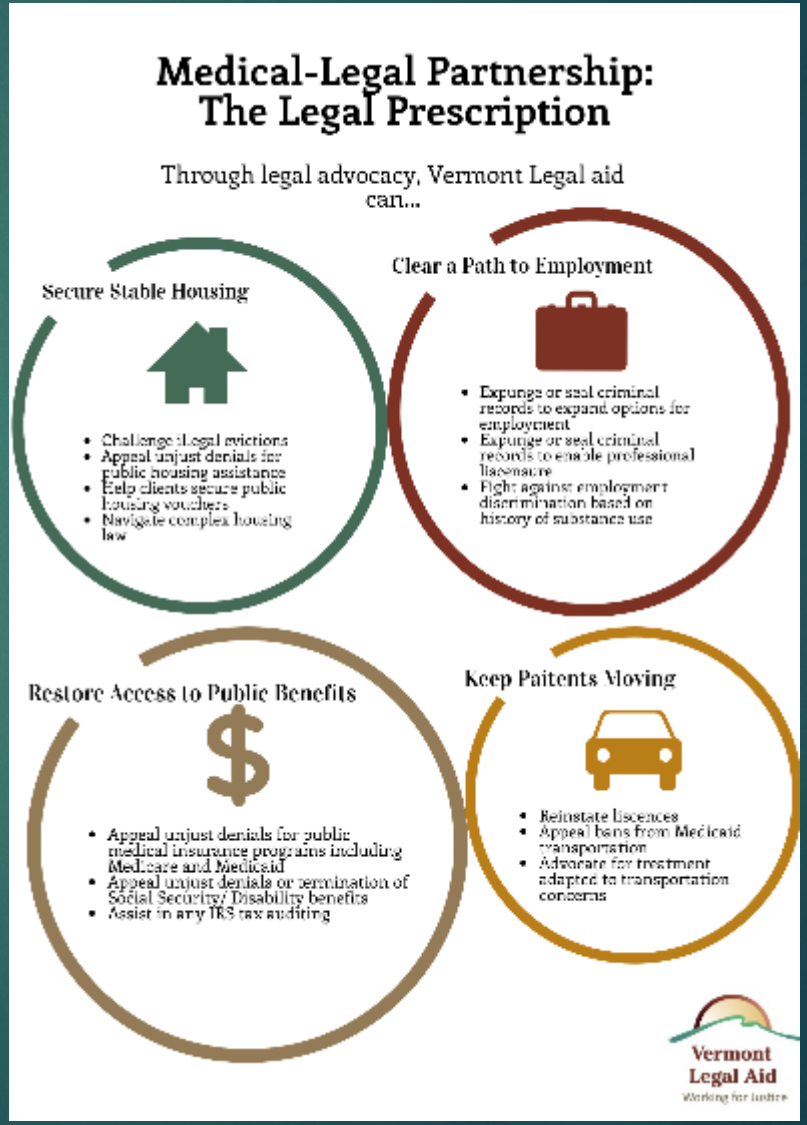
Clinic Work: advice and representation in individual cases in "I-HELP" priority areas

- I-HELP
  - Income
  - Housing
  - Education/Employment
  - Legal Status
  - Personal & Family Stability



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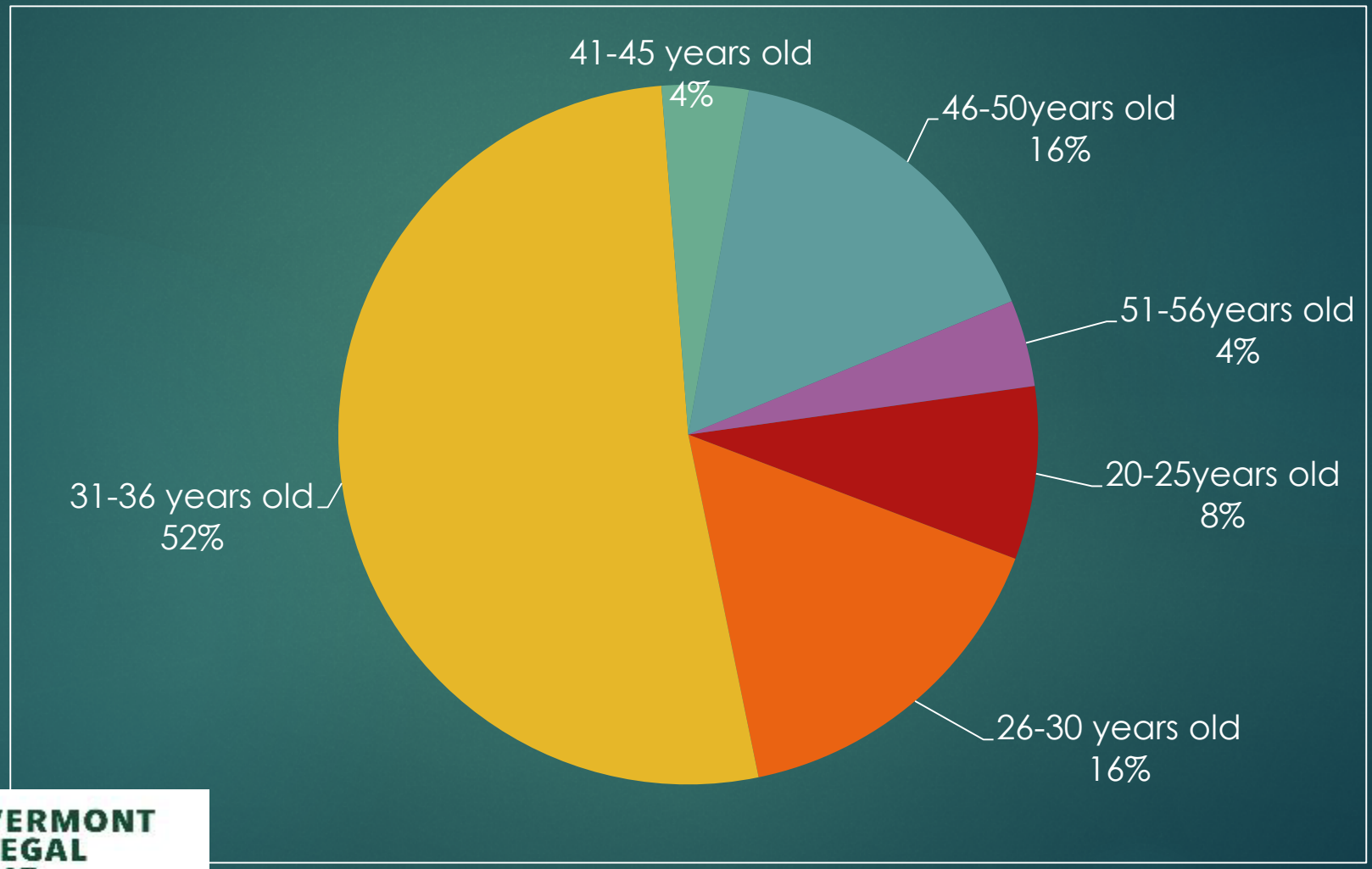
Client Demographics: Age



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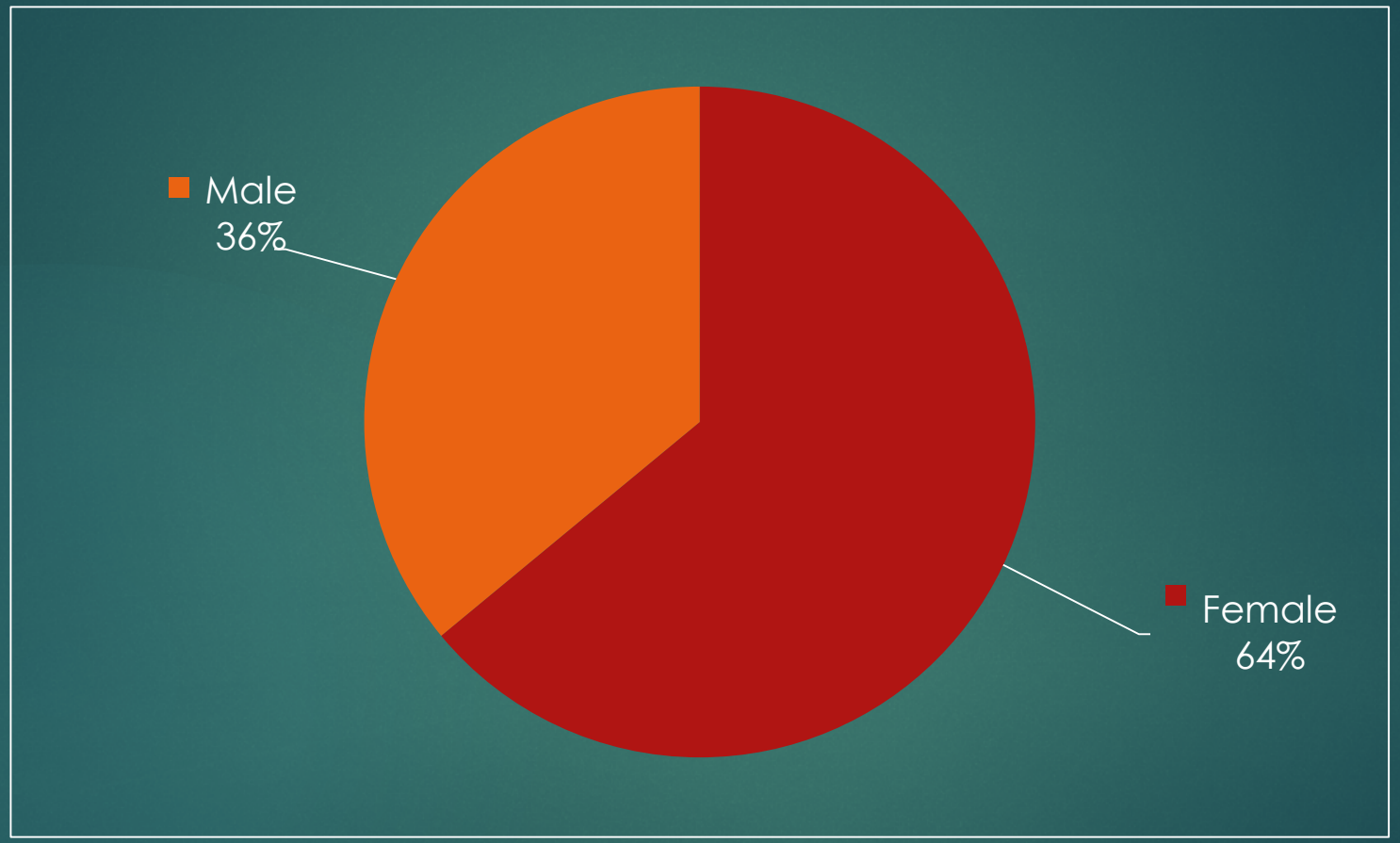
Client Demographics: Gender



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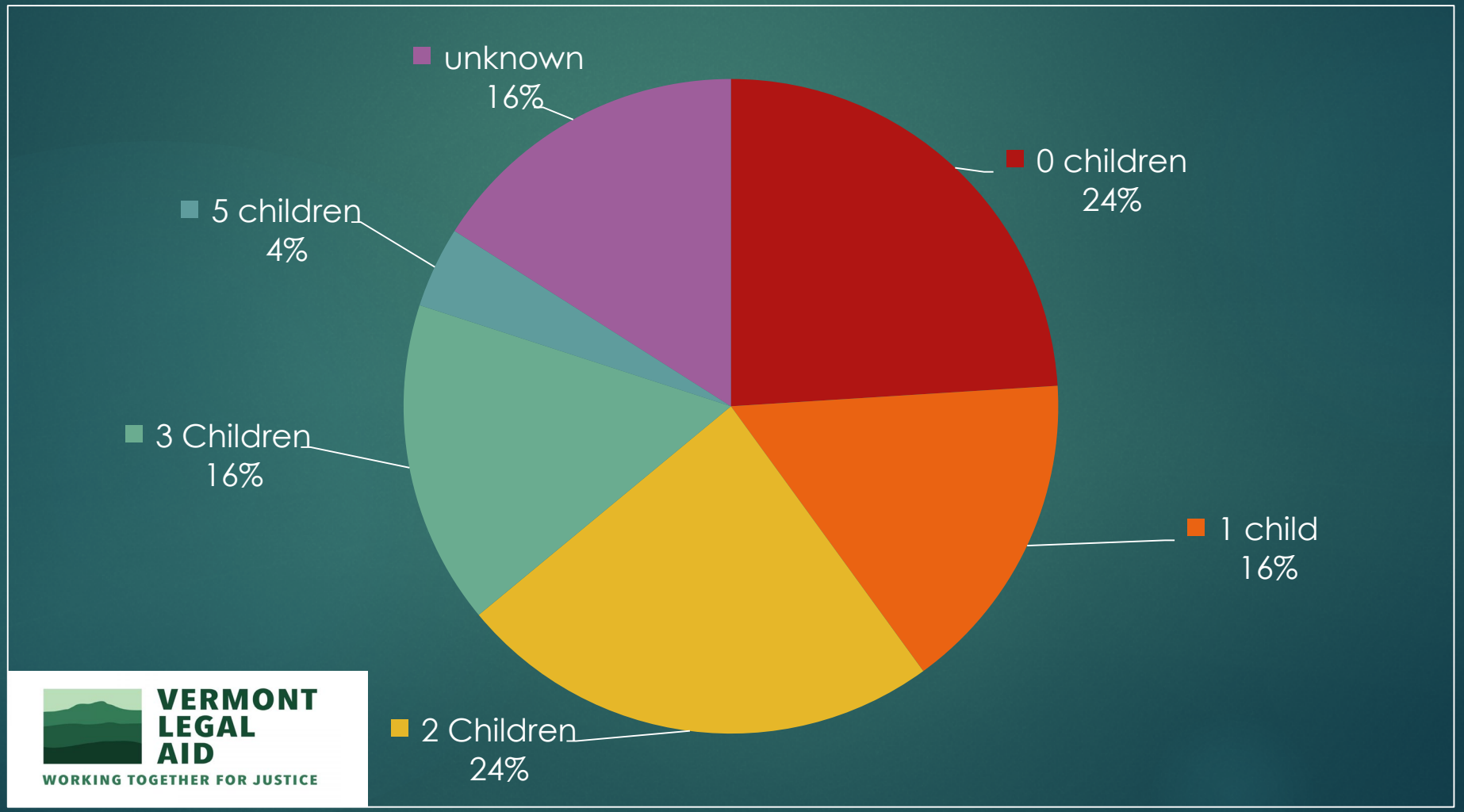
Demographics: Clients with Children



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Case Narratives: the impact of legal interventions on recovery

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Systemic Work

- *Legislative Advocacy*
  - Criminal Record Expungement & Surcharge legislation
  - Recovery Residence legislation
  - Decriminalization of Possession of Buprenorphine Without a Prescription legislation
  - Drivers License Suspensions*
- *Multi-faceted Systems Advocacy*
  - "Delivery with Death Resulting" prosecutions + other partnerships with public defenders

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Thank you for your attention

- Contact me with thoughts or questions at:
  - Email: mcoreilly@vtlegalaid.org
  - Phone: 802-383-2225
  - Twitter: @MaireadCOReilly

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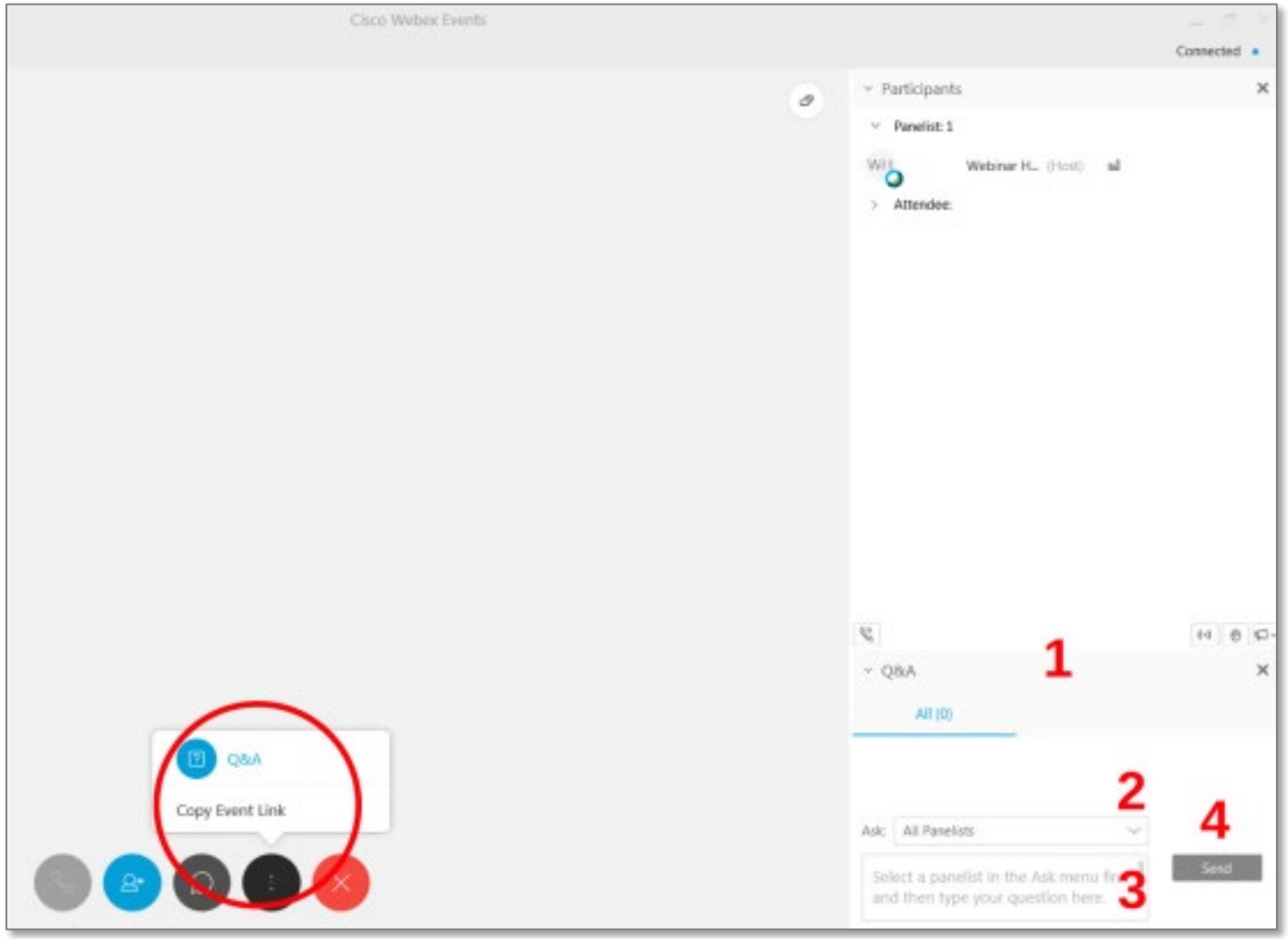
How to Use WebEx Q & A

1. Open the Q&A panel
2. Select “All Panelists”
3. Type your question
4. Click “Send”



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January 14, 2020, 2:00 – 3:30 p.m. EST

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