How to Use WebEx Q & A

1. Open the Q&A panel
2. Select “All Panelists”
3. Type your question
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
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
Harm reduction is a way of seeing, treating, and interacting with people. It is not a set of services or strategies.

"If you’re handing out syringes and naloxone, you’re doing a good thing. But you’re not doing harm reduction unless you’re building power with directly impacted people."

Daniel Raymond
Harm Reduction Coalition
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"
Addressing the Opioid Epidemic in the United States
Lessons From the Department of Veterans Affairs

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

Patients treated in the healthcare system of the Department of Veterans Affairs (VA) are part of this epidemic and chronic pain impacts half of veterans using the VA. Over the past decade, the number of psychiatric comorbidities among veterans has increased dramatically, and traumatic brain injury and chronic pain are now leading causes of disability among veterans.

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).

Vlad 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.
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
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)
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 screw-lock prefilled syringe naloxone
- 1 mg/mL (2 mL)
- 1 Luer-Lok face shield
- 1 pair nitrite 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 Luer-Lok face shield
- 1 pair nitrite 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](https://youtu.be/-qYXZDzo3cA)
  - Intro for People Taking Prescribed Opioids [https://youtu.be/NFzhz-PCzPc](https://youtu.be/NFzhz-PCzPc)
  - How to Use the VA Naloxone Nasal Spray [https://youtu.be/0w-us7fQE3s](https://youtu.be/0w-us7fQE3s)
  - How to Use the VA Auto-Injector Naloxone Kit [https://youtu.be/-DQBCnrAPBY](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

- **VA TMS training 37795:** How to Use Naloxone Nasal Spray (Narcan®)

- **Opioid Safety Initiative (OSI) & Psychotropic Drug Safety Initiative (PDSI)**
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 Status
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 & BHP Teams
Special Access Required
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)

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° to 77°F), away from light. Avoid extremes of heat or cold (e.g., do not freeze).

CHOOSE BEFORE YOU USE

OPIOID OVERDOSE PREVENTION

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://youtube.be/0w-px7QE3s
VA Naloxone Auto-Injector Kit:
• https://youtube.be/-0Q8mAP6Y
Signs of 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: Blush 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.

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 fist
   - If person does not respond—Give Naloxone, Call 911

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.

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 witnessed)
     - 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

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

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
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.

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, Oxazepam/Klonopin, Diazepam/Vallium) unless directed by your provider
  - Medicines that make you sleepy

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°F to 77°F), away from light. Avoid extremes of heat or cold (e.g., do not freeze).

Resources

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

Taking Opioids Responsibly for Your Safety and the Safety of Others

VA Substance Use Disorder Treatment Locator
- [www2.va.gov/directory/guide/SUD.nsf](http://www2.va.gov/directory/guide/SUD.nsf)

VA Posttraumatic Stress Disorder (PTSD) Treatment Locator
- [www.va.gov/directory/guide/PTSD.nsf](http://www.va.gov/directory/guide/PTSD.nsf)

“How To” VA Naloxone Video
- VA Naloxone Nasal Spray: [https://youtu.be/dW-as7qQ3E5](https://youtu.be/dW-as7qQ3E5)
- VA Auto-Injector Naloxone Kit: [https://youtu.be/_DB8cnAPBY](https://youtu.be/_DB8cnAPBY)
Opioid Overdose

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

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.

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

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.
Go to:
- General Trends
- RIOSORD Trends
- Risk Group Trends
1 in 5

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

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

1 naloxone Rx for every 69 high-dose opioid Rx

*data courtesy of Michael Harvey and PBM
KEY IMPLEMENTATION CONSIDERATIONS

• Provider Education
• Patient Identification
• Patient Education
• Post-Overdose Care
• **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 2.3 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

### OEND Dashboard

<table>
<thead>
<tr>
<th>Location/Prescriber</th>
<th># Nasoxone Fills</th>
<th>% Nasal Fills ($3d)</th>
<th># Nasoxone Patients</th>
<th># Nasoxone Prescribers</th>
<th># Nasoxone Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>342,090</td>
<td>100.0%</td>
<td>214,124</td>
<td>23,095</td>
<td>1014</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Location / Prescriber</th>
<th>Potential Risk Factor</th>
<th>Patient Cohort</th>
<th>Score</th>
<th>National Score</th>
<th>Patients w/ No Fill</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RiOSRD)</strong></td>
<td>RiOSRD Risk Class (View Publication)</td>
<td>All Patients</td>
<td>46.1%</td>
<td>46.1%</td>
<td>250,426</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk Class ≥ 8</td>
<td>58.5%</td>
<td>58.5%</td>
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<tr>
<td></td>
<td></td>
<td>Risk Class 5-7</td>
<td>47.2%</td>
<td>47.2%</td>
<td>7,911</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk Class ≤ 4</td>
<td>26.6%</td>
<td>26.6%</td>
<td>240,292</td>
</tr>
</tbody>
</table>

### Opioid Pharmacotherapy

<table>
<thead>
<tr>
<th>Location</th>
<th>Potential Risk Factor</th>
<th>Patient Cohort</th>
<th>Score</th>
<th>National Score</th>
<th>Patients w/ No Fill</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>Opioid + Benzodiazepine</td>
<td>All Patients</td>
<td>35.9%</td>
<td>35.9%</td>
<td>8,597</td>
</tr>
<tr>
<td></td>
<td>MEDD ≥ 50 (Last 30 days)</td>
<td>All Patients</td>
<td>40.7%</td>
<td>40.7%</td>
<td>24,720</td>
</tr>
<tr>
<td></td>
<td>MEDD ≥ 90 in Past Year w/ No Fill in the Past 90 Days</td>
<td>All Patients</td>
<td>20.8%</td>
<td>20.8%</td>
<td>4,776</td>
</tr>
<tr>
<td></td>
<td>Methadone (Outpatient Rx or Active Non-VA Medication)</td>
<td>All Patients</td>
<td>33.1%</td>
<td>33.1%</td>
<td>10,296</td>
</tr>
</tbody>
</table>

### OUD & OAT Pharmacotherapy

<table>
<thead>
<tr>
<th>Location</th>
<th>Potential Risk Factor</th>
<th>Patient Cohort</th>
<th>Score</th>
<th>National Score</th>
<th>Patients w/ No Fill</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>OUD Diagnosis</td>
<td>All Patients</td>
<td>23.3%</td>
<td>23.3%</td>
<td>81,482</td>
</tr>
<tr>
<td></td>
<td>Possible Overdose (3 Years)</td>
<td>All Patients</td>
<td>37.1%</td>
<td>37.1%</td>
<td>6,460</td>
</tr>
<tr>
<td></td>
<td>Buprenorphine SL (Outpatient Rx or Active Non-VA Medication)</td>
<td>All Patients</td>
<td>45.3%</td>
<td>45.3%</td>
<td>9,522</td>
</tr>
<tr>
<td></td>
<td>Naltrexone (Outpatient Rx, Active Non-VA, or Recent Clinic Order)</td>
<td>OUD Patients</td>
<td>45.6%</td>
<td>45.6%</td>
<td>805</td>
</tr>
<tr>
<td></td>
<td>OUD-Related Fee Basis</td>
<td>All Patients</td>
<td>32.0%</td>
<td>32.0%</td>
<td>2,200</td>
</tr>
</tbody>
</table>

### Other Potential Risks

<table>
<thead>
<tr>
<th>Location</th>
<th>Potential Risk Factor</th>
<th>Patient Cohort</th>
<th>Score</th>
<th>National Score</th>
<th>Patients w/ No Fill</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>Potentially Homeless Veterans</td>
<td>All Patients</td>
<td>36.8%</td>
<td>36.8%</td>
<td>20,998</td>
</tr>
</tbody>
</table>
Main Page

VA Stratification Tool for Opioid Risk Mitigation

Patient Information and Risk of Suicide/Overdose

Continuous Risk Factors

Risk Mitigation Management

Care team & Follow-up
→ Create Panels by **Provider, Prescriber, & Teams**

→ Choose Opioid Group(s)

**Any Opioid in Past Year**

**Long-Term Opioid Therapy**

**Active Rx**

---

**Opioid Group(s):**
- Long-Term Opioid Therapy (LTOT)
- Opioid Rx in Past Year

---

**Naloxone Dispense Date**

---

### Patient List

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient ID</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Gender</th>
<th>Last 10 Days Avg Monthly Dose</th>
<th>RISORST Score/Class / Risk</th>
<th>Last PUMP Start</th>
<th>Days Since PUMP</th>
<th>Last Urgent Drug</th>
<th>Last Urgent Dose</th>
<th>Last Date Naloxone Granted</th>
<th>Long Term Opioid Therapy</th>
<th>Active Opioid Rx</th>
<th>Active Rx Rx</th>
<th>Last Naloxone Dispensed</th>
<th>Last Visit WP/CP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

- **Veteran-Focused**
- **Actionable**
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

- 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
• 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
• 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 revaluations.

- **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](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**
THANK YOU!!!
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
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

<table>
<thead>
<tr>
<th>State</th>
<th>All Deaths</th>
<th>Cases in Which No Drug Was Specified</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Louisiana</strong></td>
<td>996</td>
<td>473</td>
</tr>
<tr>
<td><strong>Pennsylvania</strong></td>
<td>4,627</td>
<td>2,075</td>
</tr>
<tr>
<td><strong>Alabama</strong></td>
<td>756</td>
<td>308</td>
</tr>
<tr>
<td><strong>Montana</strong></td>
<td>119</td>
<td>46</td>
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<tr>
<td><strong>Indiana</strong></td>
<td>1,526</td>
<td>547</td>
</tr>
<tr>
<td><strong>Delaware</strong></td>
<td>282</td>
<td>99</td>
</tr>
<tr>
<td><strong>Nebraska</strong></td>
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<td><strong>Alaska</strong></td>
<td>128</td>
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<tr>
<td><strong>Maine</strong></td>
<td>353</td>
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<tr>
<td><strong>Massachusetts</strong></td>
<td>2,227</td>
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<tr>
<td><strong>New Hampshire</strong></td>
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</tr>
<tr>
<td><strong>Washington, D.C.</strong></td>
<td>269</td>
<td>2</td>
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<tr>
<td><strong>Connecticut</strong></td>
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<td>7</td>
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<tr>
<td><strong>Rhode Island</strong></td>
<td>326</td>
<td>1</td>
</tr>
</tbody>
</table>
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

![Bar chart showing the number of additional overdose deaths and the percentage with any opioid detected in toxicology from 2011 to 2016.](chart.png)
Data Linkage
Data Integration

- Jail/Arrest
- Prescription Drug Monitoring Program
- Medical Examiner: Toxicology
- EMS

CENTRALIZED DATABASE

ADDITIONAL DATA SOURCES
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)
Preliminary Results: Jail Incarceration Prior to Death

- 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

- 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

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

- Exploration
- Preparation
- Implementation
- Sustainability
Complete a needs assessment

Process mapping

Access to training and resources

Assistance with Community of Practice

Integration into the OTE network
Exploration

Preparation

Implementation

Sustainability

Work to obtain funding

Project coordination during implementation

Technical assistance on MOUD program evaluation

Sustainability planning
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.
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.
Context: Vermont’s OUD Treatment System

**Hubs**
- High intensity MAT
  - Methadone, buprenorphine, naltrexone
  - Regional locations
  - All staff specialize in addictions treatment

**Spokes**
- Maintenance MAT
  - Buprenorphine, naltrexone
  - Community locations
  - Lead provider + nurse and LADC/MA counselor

Patients
- Information
- Consultation
- Training
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)
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.
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
Clinic Work: advice and representation in individual cases in “I-HELP” priority areas

- I-HELP
  - Income
  - Housing
  - Education/Employment
  - Legal Status
  - Personal & Family Stability
Client Demographics: Age

- 26-30 years old: 16%
- 31-36 years old: 52%
- 41-45 years old: 4%
- 46-50 years old: 16%
- 51-56 years old: 4%
- 20-25 years old: 8%
- 26-30 years old: 16%
Client Demographics: Gender

- Female: 64%
- Male: 36%
Demographics: Clients with Children

- 0 children: 24%
- 1 child: 16%
- 2 children: 24%
- 3 children: 16%
- 5 children: 4%
- Unknown: 16%
Case Narratives: the impact of legal interventions on recovery

Our Impact: According to Clients

We asked our clients to tell their stories and found five key themes that illustrate the success of our opioid use disorder legal clinic.

- **Outstanding legal issues prevent patients from accessing the social determinants of health.**
  - When I applied at one of the places around here for assistance in housing they denied me because of my past recovery.

- **Clients feel disempowered when navigating our inaccessible legal system alone.**
  - I can’t think of anything more stressful than being on the street, stepping on the curb. Every day you think about “where am I going to sleep?”

- **Legal interventions improve mental health and well-being, greatly including diminished feelings of stress.**
  - My VA attorney was someone to lean on, you know, because I couldn’t do it myself. I don’t have the ability to write [a subsidy appeal] and get it onto paper and stuff.

- **For the boys it helped tremendously. Now they understand that this is our house, this is our team.**
  - The positive impacts of legal interventions are felt not only by the patients, but by others in the patient’s life.

- **Clients are satisfied with both the legal services provided and the outcomes of their cases.**
  - It’s all very comfortable and informed and relaxed and mild, and effective too, right? I mean [Legal Aid] gets things done.

VERMONT LEGAL AID
WORKING TOGETHER FOR JUSTICE
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
Thank you for your attention

Contact me with thoughts or questions at:

- Email: mcoreilly@vtlegalaid.org
- Phone: 802-383-2225
- Twitter: @MaireadCOReilly
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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Data Governance: Ensuring Trust and Managing Risks
January 14, 2020, 2:00 – 3:30 p.m. EST

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