VETERANS HEALTH ADMINISTRATION

Review of Clinical Care Transition from the Department of Defense to the Veterans Health Administration for Service Members with Opioid Use Disorder

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Executive Summary

The VA Office of Inspector General (OIG) conducted a national review to evaluate the transition of clinical care of service members with opioid use disorder (OUD) from the Department of Defense (DoD) to the Veterans Health Administration (VHA).[1] OUD is an established risk factor for opioid overdose death and suicide.[2] In 2020, opioids were responsible for approximately 75 percent of overdose related deaths.[3] According to the 2021 Joint Commission Journal on Quality and Patient Safety, veterans were "twice as likely to die from accidental overdose compared to non-veterans."[4] Failure to identify and document a patient's known OUD history may decrease the likelihood of future providers using this medically relevant information in clinical decision-making and place patients at risk for adverse outcomes, such as overdose.

There are challenges within the first 12 months after discharge from DoD associated with leaving active duty and transitioning to civilian life, such as homelessness, reintegrating with family, employment, substance mismanagement, and the risk of suicide.[5] In response to the needs of transitioning service members, the Department of Homeland Security (DHS), DoD, and VA created a joint action plan to address "seamless access to mental health treatment and suicide prevention resources for transitioning uniformed service members in the year following discharge, separation, or retirement."[6] The joint action plan emphasizes the importance of

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[1] VA/DoD, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders*, Version 4.0, 2021. Care transition refers to the transition of healthcare from DoD to VHA for a service member upon separation from the military; Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, Text Revision (DSM-5-TR), "Substance Related and Addictive Disorders," accessed December 15, 2022, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x16_Substance_Related_Disorders. OUD is defined as a "problematic pattern of opioid use leading to clinically significant impairment or distress" as manifested by at least two symptoms from a list of psychological, physical, occupational, interpersonal, or recreational consequences, within a 12-month period. Opioids and OUD are further discussed in subsequent report sections.

[2] VHA Assistant Under Secretary for Health For Clinical Services/Chief Medical Officer, "Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD)."memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) Medical Center Directors (00), February 24, 2021.

[3] "Death Rate Maps & Graphs: Drug Overdose Deaths Remain High," Centers for Disease Control and Prevention, accessed December 15, 2022, https://www.cdc.gov/drugoverdose/deaths/index.html#:~:text=Opioids%20were%20involved%20in%2068%2C630, and%20without%20synthetic%20opioid%20involvement.

[4] Elizabeth M. Oliva et al., "Saving Lives: The Veterans Health Administration (VHA) Rapid Naloxone Initiative," *The Joint Commission Journal on Quality and Patient Safety* 47-8, (August 2021): 469-480, https://doi.org/10.1016/j.jcjq.2021.06.004.

[5] "Executive Order 13822 Fact Sheet," (web page) VA, accessed April 5, 2022, https://www.mentalhealth.va.gov/transitioning-service/docs/FINAL_EO_Fact_Sheet_508.pdf.

[6] Exec. Order No. 13822 (2018); VA, DoD, DHS, Joint Action Plan for Supporting Veterans During Their Transition from Uniformed Service to Civilian Life, March 9, 2018 (revised April 18, 2018).

identifying patients with risk factors including substance abuse issues, such as OUD, who require additional support and care when transitioning from DoD to VHA.[7]

The OIG started this national review on March 1, 2022. Two VHA patient groups were identified from a study population of 1,783 discharged service members from DoD between October 1, 2016, and September 30, 2019, with an OUD diagnosis documented in a DoD treatment record (see figure 1).

- Patient Group 1 consisted of 1,362 records without an OUD diagnosis identified in VHA administrative data. From that group, 200 were randomly selected and reviewed to determine the sample population of 96 patients with a confirmed OUD in DoD treatment records and a VHA primary care or mental health comprehensive intake evaluation between the date of discharge from the DoD and July 4, 2021.[8]

- Patient Group 2 consisted of 45 patients from the study population with identified deaths. Twenty had an opioid-related death through July 4, 2021.

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[7] VA, DoD, DHS, *Joint Action Plan*; VA/DoD, *VA/DoD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide*. version 2.0, 2019. Risk factors for suicide "including but not limited to: current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, and agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms."

[8] Of the 1,783 patients, 421 were excluded from Patient Group 1 because the records had an OUD diagnosis identified in VHA administrative data.
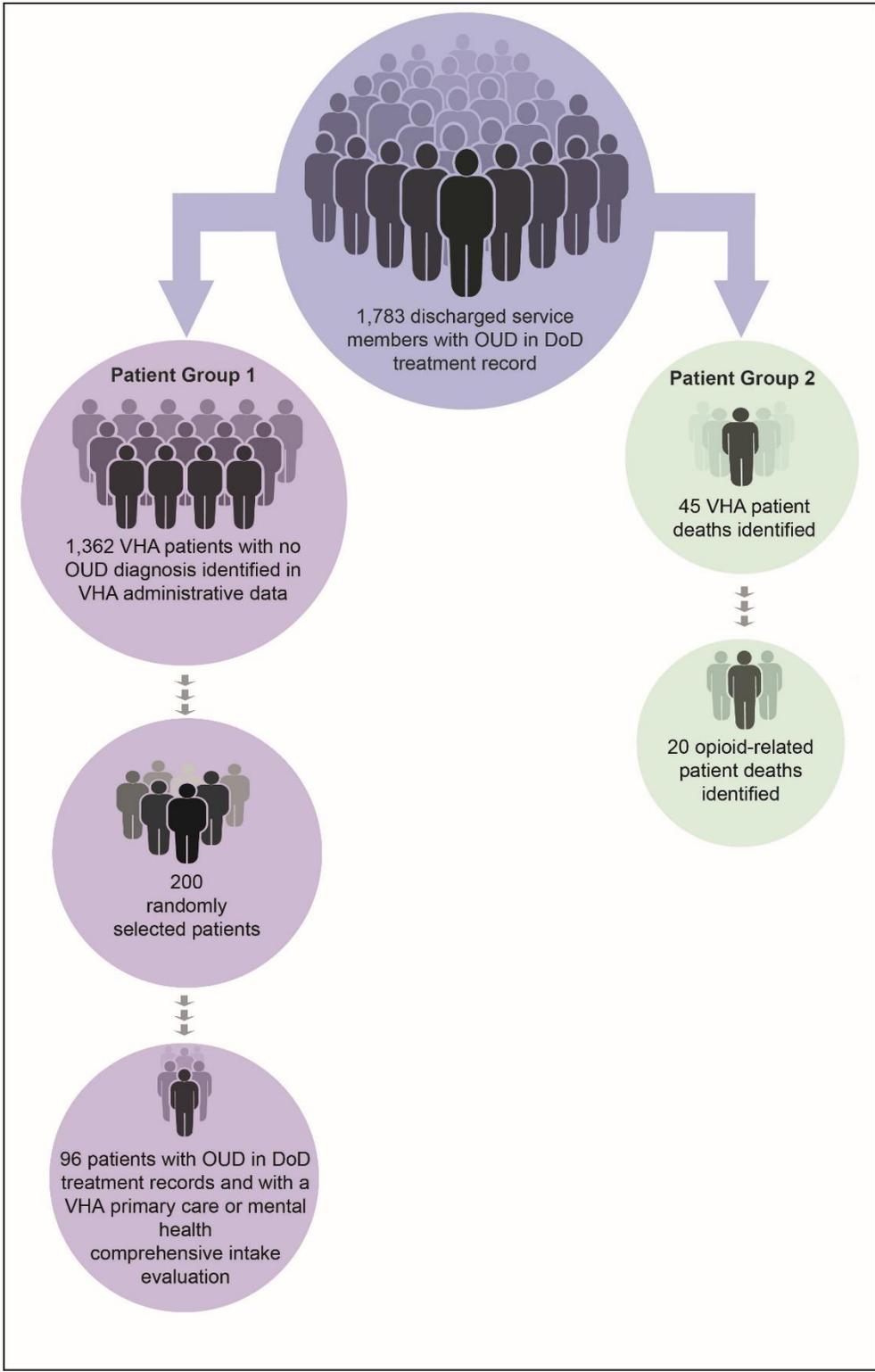
Figure 1. Study population, Patient Group 1, and Patient Group 2 for this review.
Source: The OIG developed this figure based on scope and methodology for this review.
Note: Due to both Patient Groups 1 and 2 being from the original study population of 1,783, a patient could be in both Patient Group 1 and Patient Group 2.

The OIG reviewed VHA electronic health records of the sample population for documented evidence that primary care and mental health providers were aware of a patient's previous diagnosis and treatment of OUD. The OIG reviewed patient electronic health records for documentation of OUD in progress notes and problem lists. Additionally, the OIG evaluated provider perceptions of potential barriers to the documentation of OUD diagnosis during the transition of clinical care and assessed the use of risk mitigation strategies such as dispensing opioid reversal agents.

VHA policy expects providers to evaluate and document substance use history when completing a comprehensive intake evaluation for service members transitioning their care to VHA.[9] When information regarding OUD is identified, providers should document this information in an encounter note, a progress note, and the problem list.[10] The OIG determined 19 percent of records in Patient Group 1 included documentation of an OUD diagnosis or acknowledgment of a history of opioid misuse in an initial primary care or mental health comprehensive intake evaluation, and 90 percent of records in Patient Group 2 included documentation of OUD or acknowledgment of a history of opioid misuse in progress notes. None of Patient Group 1 and 55 percent of Patient Group 2 had OUD documented in the VHA problem list, which is used in electronic health records to identify active and inactive problems relevant to a patient's health.

The VHA Office of Primary Care and Office of Mental Health and Suicide Prevention leaders indicated an expectation for providers to review a patient's past medical history through Joint Longitudinal Viewer (JLV); however, the VHA Office of Health Informatics leaders relayed there is no national training requirement for JLV. The OIG found that more than half of the 47 VHA providers who responded to the OIG questionnaire reported no expectation of reviewing DoD treatment records when completing an intake for transitioning service members. More than half of the providers who responded that they reviewed DoD treatment records identified barriers to accessing DoD treatment records through JLV.[11] Some of the barriers included, but are not limited to, issues related to navigation, timeliness of information availability, inadequate search function, and provider time constraints. Additionally, only 45 percent of the responding providers indicated receiving training on the use of JLV. The VHA Office of Health Informatics

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leaders reported that nationally there are no JLV training requirements. Lack of training requirements for JLV may result in inconsistent use by VHA providers and affect continuity of care for newly transitioned service members.

The *VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain* recommends assessment of current and past medical and mental health conditions for veterans with chronic pain.[12] The OIG found a small percentage of patients were prescribed opioids at their first comprehensive intake evaluation at VHA (3 percent in Patient Group 1) despite having a diagnosis of OUD in DoD treatment records. None of the 3 percent of patients had OUD documented in the VHA comprehensive intake evaluation or problem list. Failure to identify a diagnosis of OUD could pose a risk to patients, including the danger of reintroducing opioids to a high-risk population.

VHA policy requires VHA facilities make treatment services available to patients with substance use disorders.[13] The *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders* recommends medications for the treatment of OUD.[14] The OIG found VHA providers offered substance use disorder treatment or medication assisted treatment to 80 percent of patients with an identified DoD OUD diagnosis in Patient Group 2 who died from an opioid-related overdose.[15] OUD diagnoses not identified in the progress notes or problem lists could result in future providers not offering OUD treatment to patients.

In February 2021, the VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer issued a memorandum requiring naloxone be offered to patients with OUD who had an increased risk of death by overdose or suicide.[16] While offering naloxone to all patients with OUD is a requirement, the OIG learned the Stratification Tool for Opioid Risk Mitigation (STORM) used to support naloxone distribution only includes patients with an OUD diagnosis documented in an encounter or stay in the past year. The OIG found only 35 percent of patients who died from an opioid-related overdose in Patient Group 2 were offered or provided naloxone. A lack of provider knowledge of an established OUD diagnosis may have contributed to naloxone not being provided to some patients.

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[12] VA/DoD, *VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain*, Version 4.0, May 2022.

[13] VHA Handbook 1160.01(1).

[14] VA/DoD, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders*.

[15] The OIG did not identify any overdose events in Patient Group 1.

[16] Naloxone is a US Food and Drug Administration approved medication used to temporarily reverse the effects of opioids until emergency medical treatment can be obtained. "Naloxone DrugFacts," (web page) National Institute on Drug Abuse (NIDA), accessed on June 2, 2022, https://nida.nih.gov/download/23417/naloxonedrugfacts.pdf?v=8b748408194dff241c227cf6c7c9d04e. VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD)," memorandum.

The OIG identified opportunities to improve prescribing practices, treating OUD, and dispensing opioid reversal agents.

The OIG made five recommendations to the Under Secretary for Health related to the identification of barriers for providers when documenting OUD in electronic health records including on problem lists; training on the use, navigation and retrieval of DoD treatment record information; evaluation of the barriers to access and use of DoD treatment records; and evaluating and updating processes for the identification of patients with OUD.

VA Comments

The Under Secretary for Health concurred with the recommendations and provided an acceptable action plan (see appendix B). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
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Contents

Abbreviations

DoD	Department of Defense
JLV	Joint Longitudinal Viewer
OIG	Office of Inspector General
OUD	Opioid Use Disorder
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a national review to evaluate the transition of clinical care of service members with opioid use disorder (OUD) from the Department of Defense (DoD) to the Veterans Health Administration (VHA).[1] In 2020, opioids were responsible for approximately 75 percent of overdose related deaths.[2] According to the 2021 Joint Commission Journal on Quality and Patient Safety, veterans were "twice as likely to die from accidental overdose compared to non-veterans."[3] The OIG reviewed VHA electronic health records for primary care and mental health providers' recognition and treatment of OUD in service members who had a clinical history of OUD documented in DoD treatment records. Specifically, the OIG analyzed the documentation of encounters, progress notes, and problem lists. Additionally, the OIG evaluated potential barriers to documentation of OUD diagnosis by VHA providers during the transition of clinical care and the use of risk mitigation strategies.

Background

Every year approximately 200,000 service members transition from US military service to civilian life.[4] "VA research shows the year following discharge from active duty military service can pose many transition-related challenges—such as homelessness, family reintegration, employment, posttraumatic stress disorder, and substance misuse—that can increase the risk for suicide."[5] In response to the needs of transitioning service members, the Department of Homeland Security (DHS), DoD, and VA created a joint action plan to address "seamless access to mental health treatment and suicide prevention resources for transitioning uniformed service

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[1] VA/DoD, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders*, version 4.0, 2021. Care transition refers to the transition of healthcare from DoD to VHA for a service member upon separation from the military; *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition*, Text Revision (DSM-5-TR), "Substance Related and Addictive Disorders," accessed December 15, 2022, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x16_Substance_Related_Disorders. OUD is defined as a "problematic pattern of opioid use leading to clinically significant impairment or distress" as manifested by at least two symptoms from a list of psychological, physical, occupational, interpersonal, or recreational consequences, within a 12-month period. Opioids and OUD are further discussed in subsequent report sections.

[2] "Death Rate Maps & Graphs: Drug Overdose Deaths Remain High," Centers for Disease Control and Prevention (CDC), accessed December 15, 2022, https://www.cdc.gov/drugoverdose/deaths/index.html#:~:text=Opioids%20were%20involved%20in%2068%2C630, and%20without%20synthetic%20opioid%20involvement.

[3] Elizabeth M. Oliva et al., "Saving Lives: The Veterans Health Administration (VHA) Rapid Naloxone Initiative," *The Joint Commission Journal on Quality and Patient Safety* 47-8, (August 2021): 469-480, https://doi.org/10.1016/j.jcjq.2021.06.004.

[4] VA, "The Military to Civilian Transition, A Review of Historical, Current, and Future Trends," 2018.

[5] "Executive Order 13822 Fact Sheet," (web page) VA, accessed April 5, 2022, https://www.mentalhealth.va.gov/transitioning-service/docs/FINAL_EO_Fact_Sheet_508.pdf.

members in the year following discharge, separation, or retirement."[6] The ultimate goal of the joint action plan is to achieve zero suicides, and calls for DoD and VHA to "improve actions to ensure the needs of at risk Veterans are identified and met."[7] The joint action plan emphasizes the importance of identifying patients with risk factors, including substance abuse issues, such as OUD, that require additional support and care when transitioning from DoD to VHA.[8]

Opioids and Opioid Use Disorder

According to the National Institute on Drug Abuse, "Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others."[9] Opioids reduce pain "by binding to receptors in the brain or body to reduce the intensity of pain signals reaching the brain."[10] Prescription opioids such as oxycodone, morphine, and hydrocodone are used to treat sudden or chronic pain.[11] Opioids can also make a user feel relaxed or "high," which makes the drugs highly addictive.[12] The likelihood of chronic opioid use increases after a few days of initial prescription opioid use.[13]

OUD is a substance use disorder "characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal."[14] Individuals withdrawing from opioids can experience symptoms such as sleep difficulties, vomiting, diarrhea, cold flashes,

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[6] Exec. Order No. 13822 (2018); VA, DoD, DHS, Joint Action Plan for Supporting Veterans During Their Transition from Uniformed Service to Civilian Life, March 9, 2018 (revised April 18, 2018).

[7] VA, DoD, DHS, *Joint Action Plan*.

[8] VA, DoD, DHS, *Joint Action Plan*; VA/DoD, *VA/DoD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide*, version 2.0, 2019. Risk factors for suicide "including but not limited to: current suicidal ideation, prior suicide attempt(s), current psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, and agitation), prior psychiatric hospitalization, recent bio-psychosocial stressors, and the availability of firearms."

[9] "Opioids," NIDA, accessed July 19, 2022, https://nida.nih.gov/research-topics/opioids.

[10] LeShaundra Cordier Scott and Sarah Lewis, "Opioids for Chronic Pain," *Journal of the American Medical Association*, vol. 315, 15 (April 19, 2016): 1672. doi:10.1001/jama.2016.3224.

[11] Scott and Lewis, "Opioids for Chronic Pain."

[12] "Prescription Opioids DrugFacts: What are Prescription Opioids?"(web page), National Institute on Drug Abuse (NIDA), accessed July 19, 2022, https://nida.nih.gov/publications/drugfacts/prescription-opioids. Based on the addictive (abuse) potential, the opioids are classified as a schedule II controlled substance. Controlled Substances Act. 21 USC § 812. February 8, 2023, 21 USC 812: Schedules of controlled substances (house.gov).

[13] "How Opioid Addiction Occurs," Mayo Clinic, accessed May 24, 2022, https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/how-opioid-addiction-occurs/art-20360372; Stephen E. Nadeau, Jeffery K. Wu and Richard A Lawhern, "Opioids and Chronic Pain: An Analytic Review of the Clinical Evidence," *Frontiers in Pain Research*, accessed June 6, 2022, https://www.frontiersin.org/articles/10.3389/fpain.2021.721357/full. Chronic Opioid use is defined as 10 renewed opioid prescriptions or 120 days of consecutive opioid use within a one-year period.

[14] "Medications for Opioid Use Disorder For Healthcare and Addiction Professionals, Policymakers, Patients, and Families, Treatment Improvement Protocol TIP 63," Substance Abuse and Mental Health Services Administration, accessed July 20, 2022, https://www.ncbi.nlm.nih.gov/books/NBK574910/pdf/Bookshelf_NBK574910.pdf.

uncontrollable movements, and intense cravings. Withdrawal symptoms from opioids can be very uncomfortable, making independent discontinuation difficult.[15] OUD, a lifelong chronic disorder, could potentially result in relapse and death.[16]

Patients with a history of OUD in remission are at high risk for relapse when prescribed opioids for pain treatment.[17] Opioids are prescribed with caution due to potentially dangerous side effects, such as drowsiness and slowed breathing.[18] Opioids are one of the most common drugs involved in deaths due to overdose.[19] Signs of an opioid overdose include sleepiness, slowed breathing, confusion, clammy skin, and shaking.[20] If untreated, overdose can lead to death approximately one to three hours after use of an opioid.[21] Individuals with OUD are 13 times more likely to die by suicide, and evidence suggests that this risk is even higher for veterans. [22]

Opioid Use Disorder Epidemic

In the late 1990s, the United States medical community was informed that opioid pain relievers were not addictive, resulting in high opioid prescription rates used to treat pain.[23] The increase in prescriptions led to widespread misuse of prescription and non-prescription opioids before the medical community recognized these medications could be highly addictive.[24]

The opioid epidemic has a staggering death toll, with an increase of more than eight times the overdose deaths in 2020 compared to 1999.[25] According to the Centers for Disease Control and

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[15] "Prescription Opioids DrugFacts: What are Prescription Opioids?" (web page) NIDA.

[16] *Merriam-Webster*, "relapse," accessed July 20, 2022, https://www.merriam-webster.com/dictionary/relapse. Relapse is defined as slipping back into a prior worse state; "Opioid Use Disorder," American Psychiatric Association, accessed July 20, 2022, https://www.psychiatry.org/Patients-Families/Opioid-Use-Disorder.

[17] VA Pharmacy Benefits Management Academic Detailing Service, *Acute Pain Management, Meeting the Challenges: A VA Clinician's Guide*, July 2017, accessed June 6, 2022.

[18] "Prescription Opioids DrugFacts: What are Prescription Opioids?" (web page) NIDA.

[19] "Death Rate Maps & Graphs: Drug Overdose Deaths Remain High,"(web page) CDC.

[20] Department of Justice/Drug Enforcement Administration, *Narcotics Drug Fact Sheet*, April 2020, accessed July 19, 2022, https://www.dea.gov/sites/default/files/2020-06/Narcotics-2020.pdf.

[21] "Opioid Overdose Risk," (web page) American Psychological Association, accessed May 31, 2022, https://www.apa.org/topics/substance-use-abuse-addiction/overdose-risk.pdf.

[22] VA Pharmacy Benefits Management Academic Detailing Service, *Identifying and Managing Opioid Use Disorder (OUD): A VA Clinician's Guide*, September 2020.

[23] "What is the U.S. Opioid Epidemic?," US Department of Health and Human Services, accessed May 26, 2022, https://www.hhs.gov/opioids/statistics/index.html (web page removed).

[24] "What is the U.S. Opioid Epidemic?," US Department of Health and Human Services website.

[25] "Glossary" (web page) CDC, accessed May 25, 2022, https://www.cdc.gov/csels/dsepd/ss1978/Glossary.html#epidemic. Epidemic is defined as "the occurrence of more cases of disease, injury, or other health condition than expected in a given area or among a specific group of persons during a particular period. Usually, the cases are presumed to have a common cause or to be related to one another in some way;" "The Drug Overdose Epidemic: Behind the Numbers," CDC, accessed July 26, 2022, https://www.cdc.gov/opioids/data/index.html#:~:text=The%20Drug%20Overdose%20Epidemic%3A%20Behind%20the%20Numbers%20More,the%20brain%20to%20reduce%20the%20intensity%20of%20pain.

Prevention, nearly 500,000 people have died from 1999–2019 from an opioid overdose.[26] According to the US Department of Health and Human Services, in 2019, an estimated 10.1 million people aged 12 or older misused opioids in the last year.[27] The VA Pharmacy Benefits Management Academic Detailing Service reported a 65 percent increase in veteran opioid-related deaths from 2010 to 2016.[28] According to the CDC, 136 people die every day from prescription and illegal opioids.[29] Of those daily deaths, 38 people die daily from prescription opioids alone.[30]

On October 16, 2017, the opioid epidemic was declared a public health emergency by the United States government.[31] The COVID-19 pandemic increased the risk for individuals with OUD who relied on face-to-face health care to access medications to treat addictions.[32] In 2020, during the pandemic, the rate of deaths from opioid overdose was the highest rate on record in the United States.[33]

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[26] "Understanding the Opioid Overdose Epidemic,"(web page) CDC, accessed May 25, 2022, https://www.cdc.gov/opioids/basics/epidemic.html.

[27] "Opioid Crisis Statistics," (web page) US Department of Health and Human Services, accessed May 25, 2022, https://www.hhs.gov/opioids/statistics/index.html.

[28] VA Pharmacy Benefits Management Academic Detailing Service, Identifying and Managing Opioid Use Disorder (OUD): A VA Clinician's Guide.

[29] "Understanding the Opioid Overdose Epidemic," (web page) CDC.

[30] "Opioid Data Analysis and Resources," (web page) CDC, accessed May 25, 2022, https://www.cdc.gov/opioids/data/analysis-resources.html.

[31] Mark R. Jones et al., "A Brief History of the Opioid Epidemic and Strategies for Pain Medicine," *Pain and Therapy* 7, (2018): 13-21.

[32] G. Caleb Alexander et al., "An Epidemic in the Midst of a Pandemic: Opioid Use Disorder and COVID-19," *Annals Internal Medicine* 173(1), (April 2, 2020): 57-58.

[33] Gian-Gabriel P. Garcia et al., "Opioid overdose decedent characteristics during COVID-19," *Annals of Medicine* 54-1, (April 25, 2022):1081-1088.

VA Response to the Opioid Epidemic

In 2009, VA established a national office to improve and coordinate pain management practices.[34] In 2011, VA developed standardized metrics for prescription opioid use. In 2013, VA introduced the Opioid Safety Initiative with the aim of ensuring the use of prescription opioids in a safe, effective, and judicious manner.[35]

As part of the initiative, VA deployed strategies to address the opioid epidemic, including pain management, education, addiction treatment, and risk mitigation.[36] According to the *Journal of the American Medical Association*, by 2017, fewer veterans were receiving high doses of prescribed opioids; alternatively, they received nonopioid therapies, access to opioid reversal medications, and substance use disorder treatment.[37]

In 2021, the *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders* was updated to incorporate opioid overdose education and distribution of naloxone for patients at elevated risk of overdose, including OUD.[38]

Scope and Methodology

The OIG started this national review of the transition of clinical care for service members with an OUD diagnosis with VHA on March 1, 2022.

The review study population included 1,783 service members who had an active OUD diagnosis within one year prior to discharge; were discharged from DoD between October 1, 2016, and September 30, 2019; and had a VHA primary care or mental health encounter between the date of discharge from the DoD and July 4, 2021.[39] The OIG reviewed two groups of patients from the study population. The two groups included a random selection of patients from the study population with no OUD diagnosis identified in VHA administrative data (Patient Group 1), and patients in the study population who died through July 4, 2021, (Patient Group 2) (see figure 1).

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[34] Walid F. Gellad, Chester B. Good, David J. Shulkin, "Addressing the Opioid Epidemic in the United States: Lessons from the Department of Veterans Affairs." *Journal of the American Medical Association Internal Medicine.* 177(5), (May 2017): 611-612.

[35] Gellad, "Addressing the Opioid Epidemic in the United States: Lessons from the Department of Veterans Affairs."

[36] Gellad, "Addressing the Opioid Epidemic in the United States: Lessons from the Department of Veterans Affairs;" *Merriam-Webster*, "mitigate," accessed June 21, 2022. https://www.merriam-webster.com/dictionary/mitigate. The definition for mitigate is to alleviate, make less painful or severe.

[37] Gellad, "Addressing the Opioid Epidemic in the United States: Lessons from the Department of Veterans Affairs."

[38] VA/DoD, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders*.

[39] The study population did not include service members who were in remission from an opioid use disorder unless they also had an active OUD diagnosis during the year prior to discharge from the DoD. The DoD records included direct care at a DoD medical treatment facility, as well as purchased care through Tricare.

To construct Patient Group 1, the OIG analyzed VHA administrative data from the study population and identified 1,362 records that did not have an OUD diagnosis in either primary care or mental health notes during the comprehensive intake evaluation.[40] The OIG randomly selected 200 of the 1,362 records. Of the 200 randomly selected records, 104 were excluded.[41] The OIG further evaluated the remaining 96 of 200 patient records in Patient Group 1 to determine if VHA primary care and mental health providers

- identified an opioid-related diagnosis or prescribed opioids at the initial comprehensive intake evaluation, and

- included OUD on the problem list.

None of the 96 patient records in Patient Group 1 had evidence of an opioid overdose; therefore, further review of overdose related activities was not conducted.[42]

Patient Group 2 consisted of 45 recorded deaths from the study population.[43] For these 45 patients, the OIG evaluated the VHA electronic health record, death certificates, autopsies, and toxicology reports to determine if the deaths were opioid related. Of the 45 deaths, 20 deaths were identified by the OIG as opioid related and were further evaluated to determine if VHA providers documented an opioid-related diagnosis, offered substance use disorder treatment, prescribed opioids, and offered or prescribed naloxone prior to the death of the patient (see figure 1).

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[40] Of the 1,783 patients, 421 were excluded from Patient Group 1 because the records had an OUD diagnosis identified in VHA administrative data. For the purposes of this report, a comprehensive intake evaluation refers to (1) the primary care comprehensive health assessment, which is the initial evaluation completed on each patient that includes a social and military history, health history, family history, and health risk factors; or (2) the mental health comprehensive diagnostic and treatment planning evaluation that must be completed within 30 days of initial request or referral for mental health services; VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015; VA Primary Care, *Patient Aligned Care Team Implementation Roadmap*, 2012.

[41] One hundred and four records fell outside of the criteria for further review by the OIG and were excluded. Although 98 records had administrative data that identified OUD in DoD treatment records prior to discharge, the OUD diagnosis was not confirmed through Joint Longitudinal Viewer review. Six additional records were excluded: 5 records did not include a VHA comprehensive intake evaluation, and 1 record had the comprehensive intake evaluation completed prior to discharge from the DoD.

[42] All 96 records reviewed lacked sufficient evidence of an opioid overdose event. If an overdose event had occurred, the record would have been further evaluated to determine if naloxone was prescribed or offered and if medication assisted treatment had been offered.

[43] OIG reviewed Patient Group 2 deaths from DoD discharge date through July 4, 2021.
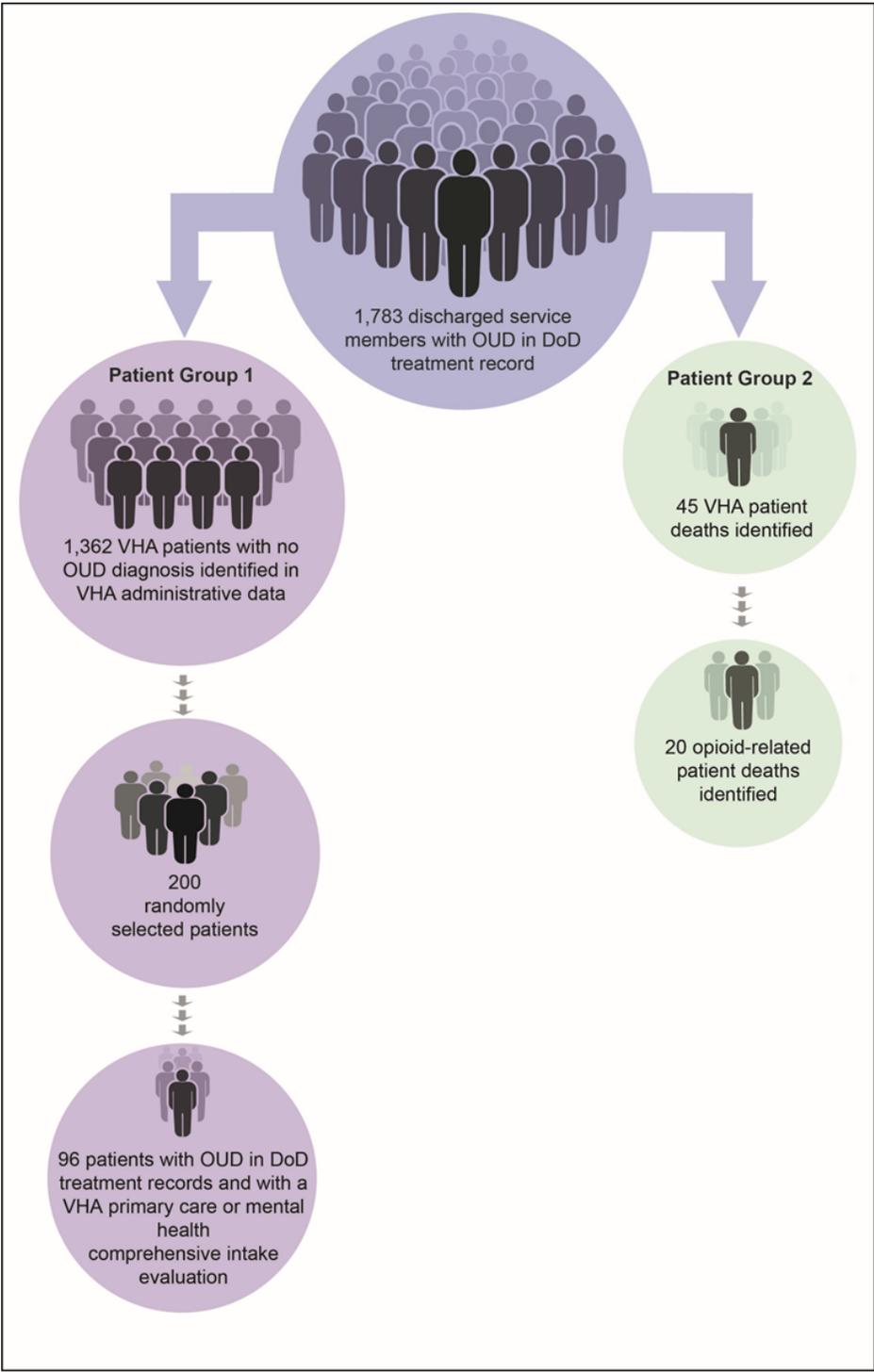
Figure 1. Study population, Patient Group 1, and Patient Group 2 for this review.
Source: The OIG developed this figure based on scope and methodology for this review.
Note: Due to both Patient Groups 1 and 2 being from the original study population of 1,783, a patient could be in both
Patient Group 1 and Patient Group 2.

The records in Patient Group 1 were utilized to identify mental health and primary care providers for a confidential questionnaire developed by the OIG to learn perspectives regarding DoD treatment records and Joint Longitudinal Viewer (JLV).[44]

The OIG distributed the questionnaire to 70 VHA primary care and mental health providers.[45] Of the 70 questionnaires, 8 were excluded due to undeliverable email addresses or the provider being off-line from VHA for an extended period of time. Of the remaining 62 questionnaires sent, 47 (76 percent) responses were received. The questionnaire consisted of seven questions (see Appendix A).[46]

The OIG requested VHA documents and policies in effect from October 1, 2016, through March 24, 2022, related to

- requirements for provider review of DoD clinical history during a comprehensive intake evaluation in primary care or mental health;

- provider training requirements related to accessing DoD records;

- provider training requirements related to screening, treating, and assessing OUD;

- naloxone distribution;

- opioid prescribing; and

- outpatient care transition from DoD to VHA.

The OIG conducted interviews with subject matter experts from the VHA Office of Primary Care, Office of Mental Health and Suicide Prevention, and Post 9/11 Transition and Case Management regarding opioid guidance, expectations, electronic health record training, and barriers accessing DoD treatment records.

The OIG reviewed relevant VHA directives and guidance, and other national literature related to opioid use and OUD, including VA/DoD clinical practice guidelines. The OIG also reviewed clinical guidance from the American Case Management Association, American Psychiatric

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[44] JLV is a web-based platform used to view available DoD treatment records for a transitioned service member and is accessible to VHA providers through the patient's electronic health record. DoD and VHA use separate electronic health record systems to document care; however, both DoD and VHA personnel can access a read-only version of the electronic healthcare record through a single application called JLV to assist with transition of care. "Joint Longitudinal Viewer (JLV)" (website), VA, http://vaww.vhadataportal.med.va.gov/ToolsApplications/JLV.aspx. (This website is not publicly accessible.); VA Office of Information and Technology, "Joint Longitudinal Viewer (JLV) 3.0 User Guide," https://www.va.gov/vdl/documents/Clinical/Joint_Longitudinal_Viewer_(JLV)/jlv_3_0_user_guide.pdf. March 2022.

[45] In the 96 patient records in Patient Group 1, one provider appeared on more than one record and the OIG could not verify 24 providers in the VA global address list.

[46] The underlined term is a hyperlink to an appendix. To return to the point of origin, press "alt" and "left arrow" keys.

Association, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, and The Joint Commission.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–24. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Results Review

The OIG found deficiencies in VHA primary care and mental health provider documentation of OUD diagnosis in VHA electronic health records. Additionally, there were barriers to VHA provider use, access, and navigation of JLV that may have affected their ability to obtain DoD treatment record information. The OIG also found opportunities for improvement in mitigation of opioid risk for patients in the two selected study groups reviewed.

1.Deficiencies in VHA Provider Documentation of an OUD Diagnosis

The OIG determined Patient Group 1 and Patient Group 2 records reviewed had deficiencies in documentation of OUD diagnosis in initial VHA encounters, progress notes, or problem lists, despite an OUD diagnosis being present in DoD records. As a result, this critical information may have not been easily accessible for medical decision-making.

In the clinical practice guidelines for managing substance use disorders, a service member's treatment for substance use disorder does not end at service separation. A plan ensuring continuity of care and collaborative coordination should be included throughout the time of transition.[47]

VHA providers are expected to evaluate and document substance use history when completing a comprehensive intake evaluation for service members transitioning their care to VHA.[48] According to VHA policy, primary care and mental health providers are required to identify

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[47] VA/DoD, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders*.

[48] VHA Handbook 1160.01(1); VA Primary Care, *Patient Aligned Care Team Implementation Roadmap*.

patients who misuse prescription medications or use illegal drugs.[49] When information regarding OUD is identified, a provider should document this information in an encounter note, a progress note, and the problem list.[50] Documenting OUD informs future providers of this relevant diagnosis that may affect clinical care.[51]

Encounters

VHA requires clinical staff document patient information in the electronic health record after a patient encounter.[52] An encounter is a professional contact between provider and patient. During an encounter, the provider is responsible for the evaluation, diagnosis, and treatment of a patient's condition.[53] Documentation must include the reason for the patient encounter, services provided, diagnoses, and active problems.[54]

After completing an initial outpatient appointment, the provider is responsible for entering the associated diagnosis codes for the encounter.[55] Data collected from patient encounters that include OUD are used in a risk mitigation tool to inform providers of opioid overdose risk.[56]

All of Patient Group 1 were missing documentation of OUD diagnosis in the VHA administrative data, which is why they were selected for review. In Patient Group 2, the OIG found 8 of 20 (40 percent) patients did not have VHA administrative data, which includes encounters, for OUD.

Progress Notes

An initial VHA outpatient appointment may occur in various settings, including primary care or mental health, depending on the unique needs of each patient.[57] Regardless of the point of entry into VHA care, a comprehensive intake evaluation is required to be completed for each new

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[49] VHA Handbook 1160.01(1).

[50] VHA Directive 1082, *Patient Care Data Capture*, March 24, 2015; VA Primary Care, *Patient Aligned Care Team Implementation Roadmap*.

[51] Eva S. Klappe, Nicolette F. de Keizer, Ronald Cornet, "Factors Influencing Problem List Use in Electronic Health Records-Application of the Unified Theory of Acceptance and Use of Technology." *Applied Clinical Informatics*, 11(3), (2020), 415-426.

[52] VHA Directive 1082.

[53] VHA Directive 1082.

[54] VHA Directive 1082.

[55] VHA Directive 1082.

[56] "Stratification Tool for Opioid Risk Mitigation (STORM) Frequently Asked Questions," (website) VHA Program Evaluation & Resource Center, https://dvagov.sharepoint.com/sites/VHAPERC/Reports/FAQs/STORM_FAQ.aspx. (This website is not publicly accessible.)

[57] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017; VHA Handbook 1160.01(1).

patient in primary care and mental health and must be documented in a progress note.[58] Primary care providers are required to complete a comprehensive intake evaluation that includes assessment of a patient's "health history, family history, risk factors, social history, and military history."[59] Additionally, primary care and mental health providers are tasked to identify substance use, including illegal drug use and misuse of prescription medications.[60] Office of Mental Health and Suicide Prevention leaders reported VHA providers are expected to document substance use history when completing a comprehensive intake evaluation.[61] The VHA national template for medical staff bylaws and rules requires the medical assessment of the patient to include "relevant past, social and family history."[62]

In Patient Group 1, the OIG found 18 of 96 (19 percent) of progress notes from comprehensive intake evaluations included documentation of OUD or acknowledgment of a history of opioid misuse.[63] The other 78 of 96 (81 percent) comprehensive intake evaluations did not contain documentation of an OUD history.

In Patient Group 2, 18 of 20 (90 percent) patients with an opioid-related death had a VHA provider progress note citing the diagnosis of OUD or acknowledging a history of opioid misuse.

Problem Lists

Problem lists are used in electronic health records to list active and inactive problems relevant to patients' health, such as a diagnosis or tobacco use, and may affect clinical treatment.[64] The VHA electronic health record system includes a problem list viewable by the user.

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[58] VHA Handbook 1160.01(1); VA Primary Care, *Patient Aligned Care Team Implementation Roadmap*; VHA, *HIM, [Health Information Management] Health Record Documentation Program Guide*, version 1.0, August 26, 2022.

[59] VA Primary Care, *Patient Aligned Care Team Implementation Roadmap*.

[60] VHA Handbook 1160.01(1).

[61] VHA Handbook 1160.01(1).

[62] VHA Office of Quality, Safety and Value, Office of Safety and Risk Awareness (OQSV/OSRA), "Bylaws and Rules and Regulations of the Medical Template," March 2017.

[63] The confidence interval for the VHA progress notes with OUD identified is (0, 36). The confidence interval (95 percent) for the review was calculated using sampling weights based on the proportions of each population sampled; "A group of continuous or discrete adjacent values that is used to estimate a statistical parameter (such as a mean or variance) and that tends to include the true value of the parameter a predetermined proportion of the time if the process of finding the group of values is repeated a number of times."*Merriam-Webster.com Dictionary*, "confidence interval," accessed on June 14, 2022, https://www.merriam-webster.com/dictionary/confidence%20interval.

[64] Eva S. Klappe, Nicolette F. de Keizer, Ronald Cornet, "Factors Influencing Problem List Use in Electronic Health Records – Application of the Unified Theory of Acceptance and Use of Technology." *Applied Clinical Informatics*, 11(3), (2020), 415-426.

VHA policy requires providers to use and manage problem lists.[65] Additionally, VHA has a national template for medical center bylaws for providers responsible for updating problem lists.[66]

The OIG found that none of the 96 patients in Patient Group 1 with a primary care or mental health comprehensive intake evaluation had OUD identified on the VHA problem list. Some patients, despite a documented OUD diagnosis in the VHA progress note, had VHA problem lists without any diagnoses. Through review of records of Patient Group 2, the OIG found 11 of 20 (55 percent) with an opioid-related death had OUD on the VHA problem list.

The OIG analysis revealed deficiencies of OUD documentation in VHA records, despite the presence of an OUD diagnosis in the DoD treatment record. Specifically, none of the VHA electronic health records from Patient Group 1 had OUD documented in any encounter or problem list and a majority had no documentation of OUD in VHA primary care and mental health progress notes from comprehensive intake evaluations. Further, records in Patient Group 2 demonstrated that of 60 percent of documented encounters, 45 percent had no documentation of OUD in problem lists and 10 percent had no documentation of OUD in any progress notes. Failure to identify and document a patient's known OUD history in encounters, progress notes, and problem lists may decrease the likelihood of future providers using this medically relevant information in clinical decision-making and place patients at risk for adverse outcomes, such as overdose.

2. Barriers to Accessing DoD Records

The OIG determined that providers did not consistently review DoD treatment records, which contributed to failures in documenting prior OUD. Through primary care and mental health providers' responses to the OIG questionnaire, the OIG identified provider perceptions and potential barriers to accessing clinical information from the DoD (see Appendix A).

VHA Office of Primary Care and Office of Mental Health and Suicide Prevention leaders stated that when assuming care of a patient, a provider is expected to "obtain relevant past medical records to insure safe and responsible continuity of care."

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[65] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. VHA rescinded this handbook and replaced with VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. The directive identified moving the Health Information Management program procedures from the handbook to the *VHA HIM [Health Information Management] Health Record Documentation Program Guide*. The handbook and *VHA HIM Health Record Documentation Program Guide* contain similar language regarding the requirements for problem list documentation.

[66] VHA Office of Quality, Safety and Value, Office of Safety and Risk Awareness (OQSV/OSRA), "Bylaws and Rules and Regulations of the Medical Template."

Provider Perceptions

The OIG found that 28 of 47 (60 percent) respondents reported there was no expectation to review DoD treatment records when completing an intake for transitioning service members. Although the majority of respondents reported no expectation to review DoD treatment records, 23 of 47 (49 percent) responded "always" reviewing while 20 of 47 (43 percent) responded "sometimes" reviewing DoD treatment records. Respondents who indicated reviewing DoD treatment records "always" or "sometimes" identified the following specific areas of the DoD record were reviewed:

- Allergies, 1 of 43 (2 percent)

- Encounter information, 11 of 43 (26 percent)

- Images and scanned documents, 24 of 43 (56 percent)

- Immunizations, 2 of 43 (5 percent)

- Laboratory results, 30 of 43 (70 percent)

- Medications, 35 of 43 (81 percent)

- Problem lists, 32 of 43 (74 percent)

- Progress notes, 34 of 43 (79 percent)[67]

VHA Provider Access and Navigation of JLV

VHA Office of Primary Care and Office of Mental Health and Suicide Prevention leaders indicated an expectation for providers to review patient's past medical history through JLV; however, the VHA Office of Health Informatics leaders relayed there is no national training requirement for JLV.

Through narrative responses on the questionnaire, the OIG found 24 of 47 (51 percent) respondents identified barriers accessing DoD treatment records through JLV and 28 of 47 (60 percent) of respondents reported barriers navigating JLV. Respondents who had barriers navigating JLV reported issues related to navigation, timeliness of information availability, inadequate search function, provider time constraints, delays in loading information and time-outs, missing information, confusion, lack of training, and connectivity.[68]

Respondents' written comments regarding accessing DoD records in JLV included "I dont [*sic*] use JLV because I have found it long and cumbersome to attempt to get the records I want" and "seems the progress notes are not always posted, especially for those veterans that recently

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[67] Respondents were able to select more than one area reviewed, if applicable.

[68] Narrative responses were evaluated for themes and could contain more than one theme.

separated from military service." Figure 2 demonstrates provider perceptions of finding patient information and navigating DoD records in JLV. During the review, OIG staff experienced similar barriers navigating JLV, including time-consuming searches for information.
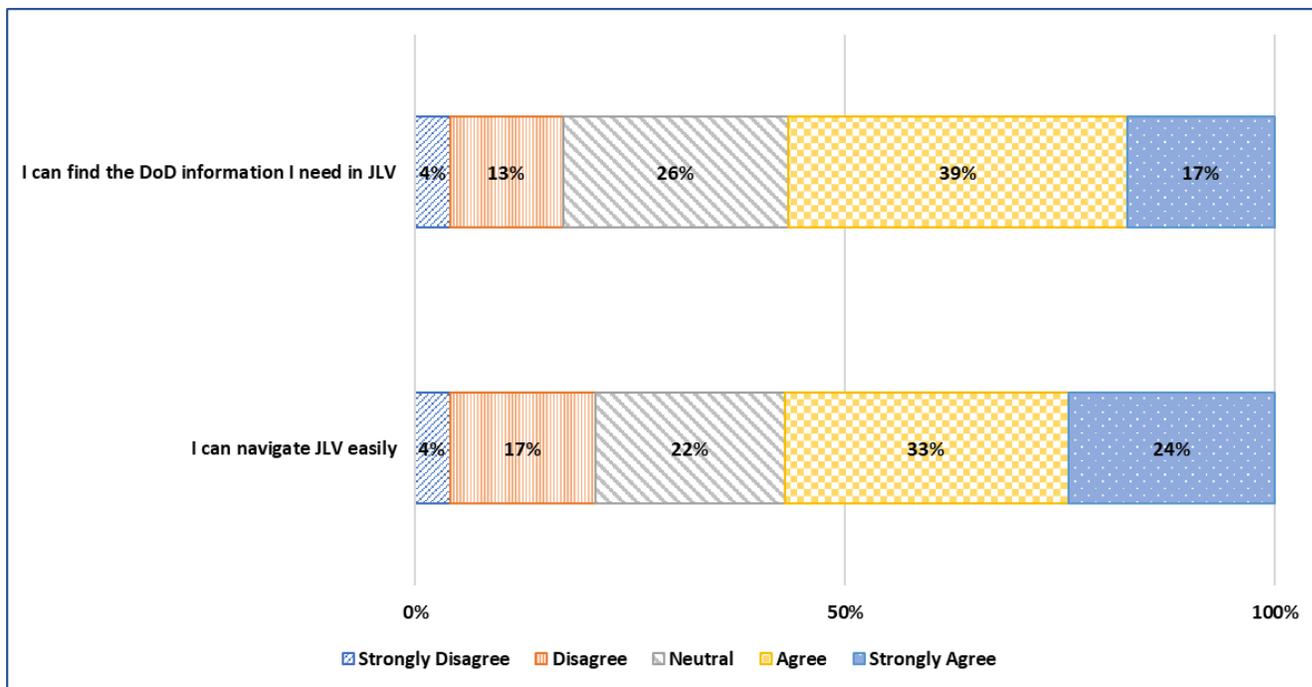
Figure 2. Respondent perceptions of JLV usage.
Source: VA OIG analysis of questionnaire responses.

During interviews, Office of Primary Care leaders reported similar barriers to accessing DoD records as those reported by questionnaire respondents, including provider time constraints, timing out of the system, and connectivity. A Post 9/11 Transition and Case Management leader reported DoD mental health records were restricted in the past. An Office of Mental Health and Suicide Prevention leader reported being unaware of any barriers to accessing DoD records.

JLV Training

The OIG found that 26 of 47 (55 percent) of questionnaire respondents reported receiving no JLV training. The other 21 of 47 (45 percent) indicated they received training and when asked what type of training was provided, responses included formal classroom, in-service, on-the-job, and Talent Management System trainings (see figure 3).[69]

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[69] The Talent Management System (TMS) is a web-based application that provides a record of training and education of VA employees. VA Directive 0004, *Education and Learning Delivery System,* April 20, 2012.

The OIG reviewed a JLV User Guide, which assists providers in learning how to access and navigate DoD records. The guide also provided troubleshooting links and contact information for when providers have difficulty accessing needed information.[70]

VHA Office of Primary Care and Office of Mental Health and Suicide Prevention leaders explained that electronic health record training is coordinated through the facility and were unsure if the training included JLV. The VHA Office of Health Informatics leaders reported that nationally there are no JLV training requirements, however, on-demand trainings are available.
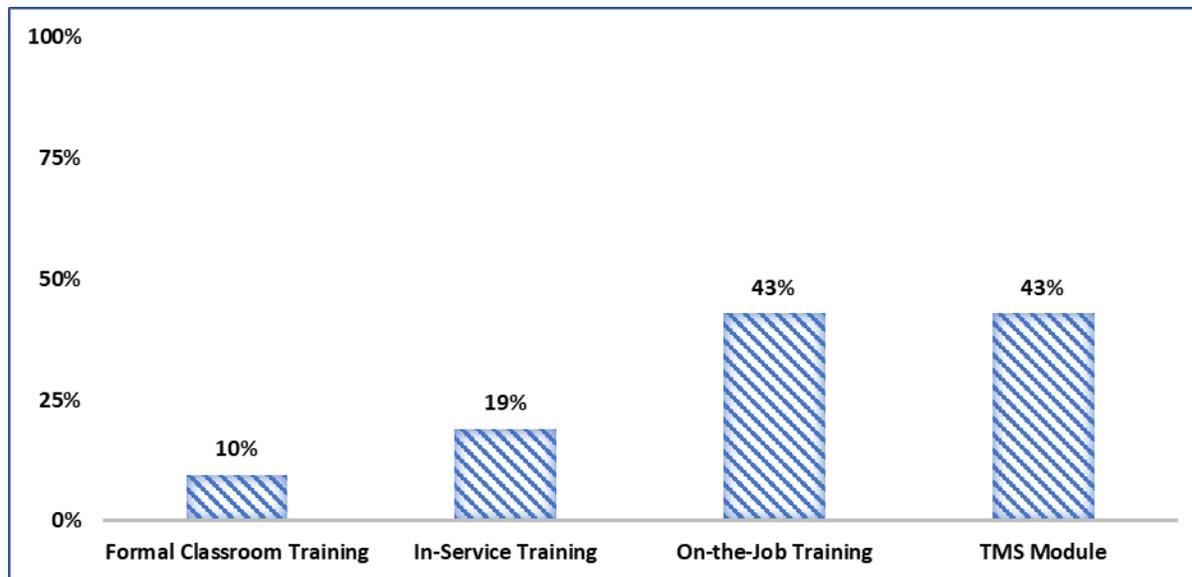
Figure 3. Respondents reported methods of JLV training.
Source: VA OIG analysis of questionnaire responses.
Note: Respondents could select more than one area (see Appendix A question Q3a).

Lack of training requirements for JLV may result in inconsistent use by VHA providers and affect continuity of care for newly transitioned service members.

3. Risk Mitigation for Opioid Overdose

The OIG determined that, while evidence of the use of risk mitigation was found, more can be done to reduce the risk of opioid overdose. Specifically, the OIG identified opportunities to improve prescribing practices, treat OUD, and dispense opioid reversal agents. OUD is an established risk factor for opioid overdose death and suicide.[71] Efforts to decrease overdose

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[70] VA Office of Information and Technology, "Joint Longitudinal Viewer (JLV) 3.0 User Guide ver. 3.0,"

[71] VHA Assistant Under Secretary for Health For Clinical Services/Chief Medical Officer, "Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD),"memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) Medical Center Directors (00), February 24, 2021.

events include improving opioid prescribing, treatment of OUD, and provision of medications to reverse overdose.[72]

Prescribing Opioids

The *VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain* recommends provider completion of a pain and biopsychosocial assessment of current and past medical and mental health conditions for veterans with chronic pain.[73]

The OIG found 3 of 96 (3 percent) patients in Patient Group 1 were prescribed opioids at the first comprehensive intake evaluation at VHA. None of the three patients had OUD documented in the comprehensive intake evaluation or problem list.

In Patient Group 2, in 5 of 20 (25 percent) records of patients whose death was opioid-related, VHA providers prescribed opioid medications. Of the five deceased patients, all had OUD history cited in the VHA progress notes; however, three did not have an OUD diagnosis in VHA encounters or problem lists. One of these patients was prescribed opioids that were later discontinued after VHA providers noted misuse issues. This patient subsequently obtained opioids and benzodiazepines from a non-VA provider and died by overdose from these combined medications.

The OIG acknowledges that, in some cases, providers may determine opioid medication is an appropriate treatment; however, identifying a previous history of opioid misuse in VHA electronic health records could assist providers with clinical decision-making.

Treating Opioid Use Disorder

VHA policy requires facilities make treatment services available to patients with substance use disorders.[74] *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders* recommends medications for the treatment of OUD.[75]

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[72] "Opioid Use Disorder," American Psychiatric Association, accessed July 20, 2022, https://www.psychiatry.org/Patients-Families/Opioid-Use-Disorder; "Preventing Opioid Overdose," (web page) CDC, accessed June 13, 2022, https://www.cdc.gov/opioids/overdoseprevention/index.html; "Suicide Behavior and Overdose Report (SBOR): Frequently Asked Questions," VHA Office of Mental Health and Suicide Prevention, August 13, 2021. VHA describes overdose events as suicidal or accidental overdose, or a fatal or non-fatal overdose.

[73] VA/DoD, *VA/DoD Clinical Practice Guidelines for the Use of Opioids in the Management of Chronic Pain*, Version 4.0, May 2022.

[74] VHA Handbook 1160.01(1).

[75] VA/DoD, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders*.

Medication assisted treatment is an evidence-based treatment for OUD and includes three Food and Drug Administration approved medications: buprenorphine, methadone, and naltrexone.[76] These medications, in combination with behavioral and counseling therapies, aid individuals in opioid addiction treatment to manage withdrawal and craving symptoms as well as prevent and reduce opioid overdose.[77]

VHA's Stratification Tool for Opioid Risk Mitigation (STORM) is a tool providers are required to use that tracks patients exposed to opioids and generates recommendations. Information found in STORM may prompt providers to offer patients risk mitigation strategies, such as substance use disorder treatment or opioid reversal medication.[78] Providers who have access to the Computerized Patient Record System are automatically permitted access to the STORM dashboard.

In Patient Group 2, the OIG found in progress notes that in 16 of 20 (80 percent) records reviewed, providers offered substance use disorder treatment or medication assisted treatment to patients identified with a DoD OUD diagnosis, while 6 of 20 (30 percent) were offered or received medication assisted treatment.[79] OUD diagnoses not identified in the progress notes or problem lists could result in future providers not offering OUD treatment to patients.

Reversing Opioid Overdose

Naloxone is a US Food and Drug Administration approved medication used to temporarily reverse the effects of opioids until emergency medical treatment can be obtained.[80] The medication is prescribed to individuals at risk for opioid overdose, including those with OUD, and, when given timely, can prevent overdose leading to death.[81] Naloxone comes in an injection

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[76] "Information about Medication-Assisted Treatment (MAT)," US Food and Drug Administration, accessed June 2, 2022, https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat#:~:text=There%20are%20three%20drugs%20approved,with%20counseling%20and%20psychosoc.ial%20support.

[77] "Medication-Assisted Treatment (MAT)," Substance Abuse and Mental Health Services Administration, accessed July 28, 2022, https://www.samhsa.gov/medication-assisted-treatment.

[78] "Stratification Tool for Opioid Risk Mitigation (STORM) Frequently Asked Questions,"(web page), VHA Program Evaluation & Resource Center, accessed June 1, 2022, https://dvagov.sharepoint.com/sites/VHAPERC/Reports/FAQs/STORM_FAQ.aspx (This web page is not publicly accessible.); VHA Assistant Under Secretary for Health For Clinical Services/Chief Medical Officer, "Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD), memorandum.

[79] The OIG identified members of the study population in Patient Group 2 who experienced an overdose event and reviewed the electronic health records to determine if medication assisted treatment was offered. No overdose events were found in Patient Group 1.

[80] "Naloxone DrugFacts,"(web page) NIDA accessed on June 2, 2022, https://nida.nih.gov/download/23417/naloxonedrugfacts.pdf?v=8b748408194dff241c227cf6c7c9d04e.

[81] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD),"memorandum.

and a nasal spray formulation and can be administered by family, friends, or others, such as VHA staff, when an opioid overdose is suspected.[82]

Naloxone distribution to patients at risk for overdose has been an adopted practice at VHA since September 2018.[83] In February 2021, the VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer issued a memorandum requiring naloxone be offered to patients with OUD who had an increased risk of death by overdose or suicide.[84] The memorandum also indicated VHA facility directors "are responsible for ensuring that all Veterans with an OUD diagnosis who have not received naloxone" as found on the STORM dashboard be provided with education and a prescription for naloxone.[85]

While offering naloxone to all patients with OUD is a requirement, the OIG learned the STORM tool used to support naloxone distribution only includes patients with an OUD diagnosis documented in an encounter or stay in the past year.[86] Therefore, given the OIG's review of missing documentation of OUD diagnosis, the STORM tool would not appear to identify all patients with OUD.

The OIG found VHA provided naloxone to 7 of 20 (35 percent) deceased patients. A lack of provider knowledge of an established OUD diagnosis may have contributed to naloxone not being provided to some patients.

Risk for Suicide

The unadjusted suicide rate the year following separation from active military service was "47.8 per 100,000 for Veterans who separated in 2019."[87] Challenges related to transition after DoD discharge include situations such as homelessness, reintegrating with family, employment, and

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[82] "Naloxone DrugFacts," (web page) NIDA; VHA Deputy Under Secretary for Health for Operations and Management Memorandum, "Rapid Naloxone Availability to Prevent Opioid-Related Death," September 5, 2018.

[83] VHA Deputy Under Secretary for Health for Operations and Management Memorandum, "Rapid Naloxone Availability to Prevent Opioid-Related Death;" VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD)," memorandum.

[84] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD)," memorandum.

[85] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD)," memorandum.

[86] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer Memorandum, "Naloxone Distribution to Veterans Diagnosed with Opioid Use Disorder (OUD)," memorandum; VHA Program Evaluation and Resource Center, *Stratification Tool for Opioid Risk Mitigation (STORM) Frequently Asked Questions*, accessed June 1, 2022, https://dvagov.sharepoint.com/sites/VHAPERC/Reports/FAQs/STORM_FAQ.aspx. (This website is not publicly accessible.)

[87] VHA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

substance mismanagement.[88] The OIG found 9 of 45 (20 percent) records in Patient Group 2 were suicides. While these patients' diagnosis of OUD may have increased their risk for suicide, there was no evidence provided in electronic health records or death certificates that documented a direct cause of death linked to either OUD or opioids.

Conclusion

The OIG found a deficiency in VHA primary care and mental health providers' documentation identifying OUD in encounters, progress notes, and problem lists for both study groups reviewed.

In Patient Group 1, the OIG found 18 of 96 (19 percent) records had OUD in the first comprehensive VHA primary care or mental health intake evaluation and none of the records had OUD documented in problem lists. In Patient Group 2, a majority of electronic health records reviewed had progress notes citing an OUD diagnosis or acknowledging a history of opioid misuse, and a majority had OUD identified on the VHA problem list. However, the OIG found 8 of 20 records from Patient Group 2 (40 percent) did not have OUD documented in VHA administrative data, which included encounters.

The failure to identify and document a patient's OUD history or diagnosis in encounters, progress notes, and problem lists could decrease the likelihood of providers using this medically relevant information in future clinical decision-making, placing patients at risk for adverse outcomes, such as overdose. While VHA leaders voiced an expectation for providers to review relevant DoD treatment records for transitioning service members, a majority of VHA providers who responded to the OIG questionnaire indicated no knowledge of this expectation. Providers reviewing DoD treatment records through JLV identified barriers including timeliness of information availability, inadequate search function, provider time constraints, delays in loading information, timing out of the system, missing information, and connectivity.

Three of the 96 (3 percent) patients in Patient Group 1 were prescribed opioids within a VHA healthcare system at the first VHA comprehensive intake evaluation. None of these three patients had OUD documented in the comprehensive intake evaluation or problem list. In addition, 5 of 20 (25 percent) of the patients in Patient Group 2 were prescribed opioids by a VHA provider prior to their deaths. In Patient Group 2, the OIG found VHA providers offered substance use disorder treatment or medication assisted treatment to a majority of patients who were identified with an OUD diagnosis in the DoD treatment record, and provided naloxone to 35 percent of the patients.

The challenges associated with leaving active duty and the risk of suicide for veterans within the first year after discharge from DoD highlight the importance of identifying and documenting

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[88] "Executive Order 13822 Fact Sheet," (web page) VA.

OUD in VHA electronic health records to ensure safe transition of care and linkage to appropriate treatment options within VHA.

Recommendations 1–5

1. The Under Secretary for Health directs the Office of Primary Care and Office of Mental Health and Suicide Prevention to identify barriers to provider documentation of opioid use disorder in progress notes and implement solutions addressing these barriers.

2. The Under Secretary for Health ensures the Office of Primary Care and Office of Mental Health and Suicide Prevention determine impediments to maintaining accurate identification of opioid use disorder in electronic health record problem lists and implement policy and training to support accurate use of problem lists.

3. The Under Secretary for Health confirms the Office of Primary Care and Office of Mental Health and Suicide Prevention evaluate barriers affecting provider access and use of Department of Defense treatment records in Joint Longitudinal Viewer and implement solutions.

4. The Under Secretary for Health ensures the Office of Primary Care and Office of Mental Health and Suicide Prevention improve continuity of care by confirming providers are educated on the navigation and retrieval of Department of Defense treatment records in Joint Longitudinal Viewer.

5. The Under Secretary for Health requires the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer to evaluate and update processes for identification of veterans with a history of opioid use disorder for the provision of opioid overdose risk mitigation strategies.

Appendix A: VHA National Healthcare Review Questionnaire

Question	Responses
Q1: Do you review DoD treatment records for clinical information to complete the intake/new patient assessment for transitioning service members establishing VHA care?	☐ Always ☐ Sometimes ☐ Never
Q1a: [If always or sometimes answered in Q1] What parts of the DoD record do you review? (Select all that apply)	[multi-select] ☐ Progress Notes ☐ Problem List ☐ Encounter Information ☐ Medications ☐ Images/Scanned Documents ☐ Labs ☐ Other: [Free Text]
Q1Explain: [If Q1 Never] Please explain	Free Text-Required if choose No to Q1
Q2: Is there an expectation at your facility for clinicians to review DoD treatment records to complete new patient intake assessments for transitioning service members establishing VHA care?	[Select One] ☐ Yes ☐ No
Q2a: [If Q2 Yes] Is this expectation formal or informal?	[Select One] ☐ Formal (SOP/Policy/Written Guidance) ☐ Informal
Q3: Have you received training specific to the use of Joint Longitudinal Viewer, previously known as Joint Legacy Viewer (JLV)?	[Select One] ☐ Yes ☐ No
Q3a: [If Q3 yes] What type of training did you receive?	[Multi-Select] ☐ Formal classroom training ☐ TMS module ☐ In-service training ☐ On the job training
Q3b: [If Q3a is selected] Please provide the title(s) of the individual who conducted the training.	Free Text-Required
Q4: Do you use JLV?	[Select One] ☐ Yes ☐ No
Q4Explain: [If Q4 no] Please explain	Free Text-Required
Q4a: [If Q4 yes] Please select the best answer: I can navigate JLV easily	[select one] ☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree

	☐ Strongly disagree
Q4b: [If Q4 yes] Please select the best answer: I can find the DoD information I need in JLV	[select one] ☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree
Q5: Are there barriers to accessing DoD records in JLV?	[Select One] ☐ Yes ☐ No
Q5Explain: [If Q5 yes] Please explain	Free Text-Required
Q6: Are there barriers to navigating JLV?	[Select One] ☐ Yes ☐ No
Q6Explain: [If Q6 yes] Please explain	Free Text-Required
Q7: Provide additional feedback, input, and comment to further explain any answers provided.	Free Text-Optional

Figure A.1. Questions asked on the OIG's VHA National Healthcare Review Questionnaire.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: May 3, 2023

From: Office of the Under Secretary for Health (10)

Subj: OIG Draft Report: Review of Clinical Care Transition from the Department of Defense to the Veterans Health Administration for Service Members with Opioid Use Disorder (#2021-02110-HI-1171)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, *Review of Clinical Care Transition from the Department of Defense to the Veterans Health Administration for Service Members with Opioid Use Disorder*. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.

2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal, M.D., MBA

Office of the Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: Review of Service Members' with Opioid Use Disorder Clinical Care Transition from the Department of Defense to the Veterans Health Administration

<u>Recommendation 1</u>. **The Under Secretary for Health directs the Office of Primary Care and Office of Mental Health and Suicide Prevention to identify barriers to provider documentation of Opioid Use Disorder in progress notes and implement solutions addressing these barriers.**

<u>**VHA Comments**</u>**:** Concur

We concur that patients are likely to benefit from a more consistent process of care-handoff of patients with Opioid Use Disorder (OUD) between the Department of Veterans Affairs (VA) and the Department of Defense (DoD). Focusing on the problem of VA providers not being aware of DoD documented opioid use disorder diagnoses upon transitioning service engagement in VA care, Office of Mental Health and Suicide Prevention (OMHSP) and Office of Primary Care (OPC) will conduct focus groups with primary care and mental health providers regarding their experience in evaluating Service members initiating VA health care and reasons why they might not recognize a previously diagnosed OUD, or not document a previously diagnosed OUD in the VA medical record.

Based on an understanding of barriers and process for identifying and documenting OUD in Service members with DoD-documented OUD who are transitioning into VA care, OPC and OMHSP will develop new workflows and processes to address gaps in identification and documentation and work to implement these consistently.

Target Completion Date: April 2024

<u>Recommendation 2</u>. **The Under Secretary for Health ensures the Office of Primary Care and Office of Mental Health and Suicide Prevention determine impediments to maintaining accurate identification of Opioid Use Disorder in electronic health record problem lists and implement policy and training to support accurate use of problem lists.**

<u>**VHA Comments**</u>**:** Concur

We concur that patients are likely to benefit from a more consistent process of care-handoff of patients with OUD between VA and DoD. OPC and OMHSP will focus on ways in which primary care and mental health providers can ensure that when a transitioning Service members with DoD-documented OUD diagnoses initiates care in

VA that diagnoses are evaluated and consistently documented in medical record problem lists when the patient still meets clinical criteria for an OUD diagnosis. Some patients may have initial visits in VA clinics other than primary care or mental health. Therefore, a process for post-initial visit review of relevant patient cases will be needed to allow primary care and mental health providers to conduct outreach and document evaluations conducted in follow-up visits when initial care is not OUD-related. OMHSP and OPC will conduct an initial review of data systems to determine technical ability to identify all transitioning Service members who had a documented OUD diagnosis within DoD medical records and identify (1) when the Service member has an initial VA health care encounter, and (2) when that initial encounter does not lead to documentation of OUD in the VA problem list.

This technical evaluation will also include assessment of ability to track whether risk mitigation strategies are offered and/or received by the patient (this assessment applies to recommendation 5). Based on technical feasibility, OMHSP and OPC will work with primary care and mental health VISN and facility teams to design a process and workflows for review and outreach to patients for whom OUD was not recognized and documented in the initial visit.

Target Completion Date: April 2024

Recommendation 3. The Under Secretary for Health confirms the Office of Primary Care and Office of Mental Health and Suicide Prevention evaluate barriers affecting provider access and use of Department of Defense treatment records in Joint Longitudinal Viewer and implement solutions.

VHA Comments: Concur

We agree that optimization of Joint Longitudinal Viewer (JLV) usability and provider education on the navigation and retrieval of DoD records via the JLV is important. We note that development and training on appropriate use of medical record viewers is a general challenge, and not limited to documentation of OUD diagnoses in mental health or primary care clinics.

OMHSP and OPC interpret this recommendation to focus on assessment of gaps in primary care and mental health provider ability to access and use JLV as needed to implement workflows specifically related to recognition and evaluation of possible opioid use disorders in transitioning Service members with DoD-diagnosed OUD initiating VA care. OMHSP and OPC will review workflows developed in recommendations 1 and 2 with primary care and mental health providers to identify barriers to implementation of these workflows related to JLV use. OMHSP and OPC will work with primary care and mental health providers to develop and review user guides that provide step-by-step instructions for use of JLV within workflows designed to ensure recognition of DoD-

diagnosed OUD, evaluation of current OUD, and documentation of evaluation findings, including addition of the OUD diagnosis in VA problem lists when appropriate.

Target Completion Date: April 2024

Recommendation 4. The Under Secretary for Health ensures the Office of Primary Care and Office of Mental Health and Suicide Prevention improve continuity of care by confirming providers are educated on the navigation and retrieval of Department of Defense treatment records in Joint Longitudinal Viewer.

VHA Comments: Concur

We agree that education on the navigation and retrieval of DoD records via the JLV is important. We note that training on appropriate use of medical records is a general challenge, and not limited to documentation of care in mental health or primary care.

OMHSP and OPC interpret this recommendation to focus on assessment of gaps in primary care and mental health provider ability to access navigate and retrieve OUD diagnoses in JLV as needed to implement workflows specifically related to recognition and evaluation of possible opioid use disorders in transitioning Service members with DoD-diagnosed OUD initiating VA care. OMHSP and OPC will review workflows developed in recommendations 1 and 2 with primary care and mental health providers to identify barriers to implementation of these workflows related to JLV navigation and/or interpretation of JLV records related to OUD diagnoses. OMHSP and OPC will work with primary care and mental health providers to develop and review user guides that provide step-by-step instructions for use of JLV within workflows designed to ensure recognition and review of JLV records related of DoD-diagnosed OUD, evaluation of current OUD, and documentation of evaluation findings, including addition of the OUD diagnosis in VA problem lists when appropriate.

Target Completion Date: April 2024

Recommendation 5: The Under Secretary for Health requires the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer to evaluate and update processes for identification of veterans with a history of Opioid Use Disorder for the provision of opioid overdose risk mitigation strategies.

VHA Comments: Concur

OMHSP and OPC interpret this recommendation to focus on the need to ensure that transitioning Service members with DoD-diagnosed OUD initiating VA care are offered opioid overdose risk mitigation interventions as soon as possible after care engagement. OMHSP and OPC will ensure that workflows developed in recommendations 1 and 2 include procedures to offer these new VA patients opioid overdose risk mitigation interventions subsequent to evaluation of opioid use disorders.

Target Completion Date: April 2024

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