US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Independent Review of VA's Fiscal Year 2024 Detailed Accounting and Budget Formulation Compliance Reports to the Office of National Drug Control Policy

Attestation Review | 24-03776-72 | March 7, 2025

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Contents

Abbreviations

FY	fiscal year
OIG	Office of Inspector General
ONDCP	Office of National Drug Control Policy
VHA	Veterans Health Administration

March 7, 2025

MEMORANDUM

TO: Chief Financial Officer
Veterans Health Administration (104)

FROM: Assistant Inspector General
Office of Audits and Evaluations (52)

SUBJECT: Independent Review of VA's Fiscal Year 2024 Detailed Accounting and Budget Formulation Compliance Reports to the Office of National Drug Control Policy

1. The OIG has reviewed the assertions made by management of the Department of Veterans Affairs, Veterans Health Administration (VHA), that are required by the Office of National Drug Control Policy (ONDCP) Circular: *National Drug Control Program Agency Compliance Reviews*, dated September 9, 2021 (the Circular). These assertions are found in the attached Detailed Accounting Report and Budget Formulation Compliance Report for the year that ended September 30, 2024, under the heading "B. Assertions" on pages 29–30 and 35 (attachments 1 and 2).
2. VHA management is responsible for the preparation of the Detailed Accounting Report and the Budget Formulation Compliance Report and the assertions contained therein, in conformity with the requirements of the Circular. VHA officials who signed these two reports are identified on pages 31 and 35 (attachments 1 and 2). The OIG's responsibility is to review VHA management's assertions and express a conclusion on them.
3. The OIG's review was conducted in accordance with generally accepted government auditing standards, which incorporate the attestation standards established by the American Institute of Certified Public Accountants. Those standards require that the OIG plan and perform the review to obtain limited assurance about whether any material modifications should be made to management's assertions for them to be fairly stated. A review is substantially less in scope than an examination, the objective of which is to obtain reasonable assurance about whether management's assertions are fairly stated, in all material respects, to express an opinion. Accordingly, here, the OIG conducted a review to obtain limited assurance and expresses a conclusion—not an

opinion—on VHA management's assertions. The OIG believes this review provides a reasonable basis for its conclusion.

4. In the Detailed Accounting Report, VHA management reported three material weaknesses, three significant deficiencies, and certain conditions regarding noncompliance with laws and regulations, as identified in the OIG report *Audit of VA's Financial Statements for Fiscal Years 2024 and 2023* (Report No. 24-00842-08, November 15, 2024). These conditions are listed in the Detailed Accounting Report in the section "Material Weaknesses or Other Findings," found on page 29 (attachment 1). A material weakness is a deficiency, or combination of deficiencies, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A significant deficiency is a control deficiency, or a combination of control deficiencies, that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.
5. Based on the OIG's review, the OIG is not aware of any material modifications that should be made to VHA management's assertions for them to be fairly stated.
6. The OIG provided VHA with the draft report for review and comment. The VHA acting under secretary for health acknowledged that the OIG determined that there were no material modifications to the assertions made in the annual Detailed Accounting and Budget Formulation Compliance Reports.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Attachments

VA Management Response

Department of Veterans Affairs Memorandum

Date: February 28, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Independent Review of VA's Fiscal Year 2024 Detailed Accounting and Budget Formulation Compliance Reports to the Office of National Drug Control Policy (VIEWS 12831817)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review the OIG's draft report regarding assertions in the Veterans Health Administration (VHA) annual Detailed Accounting and the Budget Formulation Compliance Report. VHA acknowledges that OIG determined no material modifications were needed to the assertations in the annual Detailed Accounting and the Budget Formulation Compliance Report. We appreciate the OIG's thorough review.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, M.D., MBA, FACHE

Attachment 1: Detailed Accounting Report

Statement of Disclosures and Assertions for FY 2024 Drug Control Obligations Submitted to Office of National Drug Control Policy (ONDCP) for Fiscal Year Ending September 30, 2024

In accordance with ONDCP's Circular, National Drug Control Program Agency Compliance Reviews, dated September 09, 2021, the Veterans Health Administration asserts that the VHA system of accounting, use of obligations, and systems of internal controls provide reasonable assurance that:

Obligations are based upon the actual expenditures as reported by the Decision Support System (DSS), which is the designated Managerial Cost Accounting (MCA) System of the Department of Veterans Affairs.

The methodology used to calculate obligations of budgetary resources is reasonable and accurate in all material respects and as described herein was the actual methodology used to generate the costs.

Accounting changes are as shown in the disclosures that follow.

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
Annual Reporting of FY 2024 Drug Control Funds

A. Detailed Accounting Submission

1. Table of FY 2024 Drug Control Obligations

(In Millions)

Description	FY 2024 Actual
Drug Resources by Budget Decision Unit:	
Medical Care	**$1,326.956**
Medical & Prosthetic Research	$31.680
Total	$1,358.636
Drug Resources by Drug Control Function:	
Treatment	**$1,326.956**
Research & Development	$31.680
Total	$1,358.636

2. Drug Control Methodology

Medical Care: The obligation tables for the FY 2024 Drug Control Obligations (above) and the Resource Summary (page 29) showing obligations and FTE (Full-Time Equivalent) for substance use disorder (SUD) treatment in Veterans Health Administration (VHA) are based on specific patient encounters. The specific patient encounters include all inpatient and outpatient episodes of care either provided by VHA staff or purchased in the community. The source data for VHA inpatient care is the Patient Treatment File (PTF). For outpatient care, it is the National Patient Care Database Encounter file (SEFILE). For contract care, it is either the PTF or the hospital payment file. For contract care, it is the PTF, the ViSTA payment file from Austin, and CCRS & eCAMS payment files from Corporate Data Warehouse (CDW).

All patient encounters have an associated diagnosis. The primary diagnosis is considered the reason the patient is being treated and is used to determine whether the treatment provided is a substance use disorder treatment and which type of substance use disorder. A list of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and International Statistical Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Diagnosis groups used for substance use disorders are shown in the following table:

Diagnosis Code	Description (DSM-5 and ICD-10-CM)
F11xx	Opioid Related Disorders
F12xx	Cannabis Related Disorders
F13xx	Sedative Hypnotic/Anxiolytic Related Disorders
F14xx	Cocaine Related Disorders
F15xx	Other Stimulant Related Disorders
F16xx	Hallucinogen Related Disorders
F19xx	Other Psychoactive Substance Related Disorders

It should be noted that Prescriptions and Lab tests do not have linkages to a specific diagnosis and are not included in the report.

The cost of VHA provided services is calculated by the Managerial Cost Accounting (MCA) System of the Department of Veterans Affairs (VA). MCA cost data is used at all levels of the VA for important functions, such as cost recovery (billing) and budgeting. VA MCA data is also used to calculate and measure the productivity of physicians and other care providers.

The basic unit of MCA cost is the product. For VHA a product can range from a prescription fill made through a mail-out pharmacy, to an outpatient dental exam, to a bed-day of care in an Intensive Care Unit. Every product that is delivered is fully costed. This means that all direct labor, direct supply, and associated indirect costs (to include local and national overhead costs) are applied. Once they are fully costed, products are then assigned to the applicable patient encounter.

The VHA Finance Allocation Resource Center's (ARC) Patient Workload and Costing datasets are the basis for the obligations displayed in the ONDCP report. The ARC develops outpatient encounter and inpatient discharge/census level cost by assigning direct care and indirect costs from MCA cost datasets to the in-house provided clinical workload. Certain non-patient specific costs, such as Operating costs for Headquarters, Veterans Integrated Service Network (VISN) Support, National Programs, and Capital and State Home costs are removed in the ARC Costing process. The ARC's Patient Workload and Costing datasets also include workload generated in the community and payments made for that care.

For budget purposes, ARC costs are transformed into obligations to account for the entire VHA Budget. It is a multi-step methodology that is implemented to compute obligations.

- The ARC costs are divided into their appropriations using cost centers identified in their Monthly Program Cost Report (MPCR), which is a clinical workload and MCA Account Level Budget (ALB) based report that accounts for expenditures recorded in the VHA financial system.
- A facility specific ratio of obligations to ARC cost for non-capital costs is created and multiplied by the expenditures to create medical center specific obligations.
- Assign the medical center capital obligations to VHA services proportional to cost.
- Aggregate the national overhead obligations by cost center into their appropriations and assign them to patient services proportional to cost.
- Balance the final obligations nationally to the SF133 Report on Budget Execution total proportionately.

Medical and Prosthetic Research: The obligation tables for the FY 2024 Drug Control Obligations (above) and the Resource Summary (page 29) showing Medical Research and Prosthetics obligations reflects the budget for addiction research recorded in VA's Research Allocation Forecasting System (RAFT) used for planning and budgeting. Medical and Prosthetic Research budget supports all addiction research, both prevention and treatment, including alcohol and tobacco.

MEDICAL CARE

Year in Review

In FY 2024, 271,480 Veterans who received services within VHA were diagnosed with a drug use disorder. Of these Veterans, VHA provided services by mental health clinicians in multiple settings and modalities, including outpatient, clinical video telehealth, or telephone care to nearly 85% (229,928) of Veterans with any diagnosis of a drug use disorder. Among Veterans receiving services for drug use disorders within VHA in FY 2023 Q4, approximately 16% (44,775) used amphetamines, around 23% (63,714) used cocaine, around 24% (64,574) used opioids, and around 58% (157,981) used cannabis. (These categories are not mutually exclusive.)

The number of patients treated for a SUD diagnosis across VHA health care settings was greater in FY 2024 (over 612,000) than in FY 2019 (546,300). VHA moved rapidly to ensure sustainment of treatment services, rapidly transitioning SUD specialty services to telehealth platforms. VA also worked closely with the Substance Abuse and Mental Health Services Administration (SAMHSA) to ensure continued access to medications for the treatment of opioid use disorder. VA is focusing efforts on returning utilization of intensive SUD treatment services to pre-pandemic norms (for example reopening residential treatment beds and in-person group therapy). Though fewer patients received intensive SUD treatment services in FY 2023 than prior to the COVID pandemic, the number of patients who received intensive SUD treatment increased 36% from FYs 2021 through 2024. Consistent with expansion in use of telehealth since the start of the pandemic, VA continued to utilize telehealth (telephone only and audio/visual, dependent on Veteran preference and access to technology) to support provision of SUD specialty treatment.

As requested, VA is exploring available data that would allow for more precise information related to Veteran requests for SUD treatment and subsequent engagement in care. At the current time, this information is not available. Development of SUD-specific content for the new electronic health record is continuing with the expectation that this information will be available in the future. Further, during FY 2023, VA implemented processes that allowed for capture of information regarding referrals for residential SUD treatment. During FY 2024, more than 50,000 Veterans were screened for residential treatment with admissions to the Domiciliary SUD and General Domiciliary programs as well as the Compensated Work Therapy – Transitional Residence program accounting for 78% of all admissions[1]. It is important to note that across all VHA mental health residential rehabilitation treatment programs (MH RRTPs) 97% of Veterans served have a SUD diagnosis. During FY 2024, 71.7% of Veterans screened were accepted for residential admission with 7% of Veterans referred for care in an alternate setting. Among those not accepted for residential admission, 43% were assessed as appropriate to receive care at a lower level and 34% were assessed to require a higher level of care. VA has made significant progress in identifying patients with clinical signs or mentions of substance use in the electronic medical record to support clinical case-finding and engagement in evidence-based services. VA has developed and is clinically piloting a case-finding tool to identify patients with signs of possible injection drug use to support proactive efforts to engage appropriate patients in SUD treatment, harm reduction efforts, and infectious disease prevention and treatment interventions.

[1] Residential treatment specific to SUD is most commonly provided within the Domiciliary SUD programs and the General Domiciliary programs in VHA. The Compensated Work Therapy – Transitional Residence programs provide ongoing support through transitional housing with vocational rehabilitation services to address the ongoing treatment needs of Veterans experiencing a SUD.

Expanding Access to Evidence-Based Treatment

VHA SUD Service Care Delivery

National policy and expectations for managing SUD within VHA is guided by VHA Handbook 1160.04 and the VA / Department of Defense (DoD) Clinical Practice Guidelines for the Management of SUD (https://www.healthquality.va.gov). VHA is a leader in the prevention and treatment of SUD and uses a stepped care approach to SUD treatment (in which collaborative (patient and provider) selection of treatment intensity is matched to patient characteristics and informed by data from ongoing monitoring of the patient's condition. Patients with at-risk alcohol use or the least severe SUDs may be treated with evidence-based brief interventions and/or medical management in primary care or general mental health. For those with more severe disorders, specialty SUD treatment programs provide intensive services including withdrawal management, evidence-based psychosocial treatments, SUD medication, case management and relapse prevention, all provided across various settings including outpatient, intensive outpatient, residential, and inpatient/hospital. Although the US Preventive Services Taskforce recommends population-based screening of unhealthy drug use, the 2021 VA/DoD SUD CPGs found there is insufficient evidence to recommend for or against screening for drug use disorders in primary care to facilitate enrollment in treatment. VHA is nevertheless exploring the provision of universal drug screening through primary care, as it already does for alcohol use disorder, in a manner that balances the need to better identify and engage Veterans in SUD treatment while mitigating the potential burden that such screening would bring to primary care. As an integrated healthcare system, VHA is uniquely situated to address the needs of Veterans diagnosed with a SUD, including providing support to address co-occurring medical, mental health, and psychosocial needs (e.g., housing, employment). Treatment for SUD occurs across settings and with policy-defining expectations for access to SUD treatment, including expectations for access through Community Based Outpatient Clinics (CBOC) and Health Care Centers (HCC).

VA also continues to improve service delivery and efficiency by integrating services for mental health disorders, including SUD, into primary care settings. Veterans from Operation Enduring Freedom/ Operation Iraqi Freedom/Operation New Dawn/Operation Inherent Resolve (OEF/OIF/OND/OIR) and Veterans from other eras are served in primary care teams (Patient Aligned Care Teams: PACTs) that have co-located mental health staff to identify and address potential mental health and substance use treatment needs. Secondary prevention services include diagnosis and assessment of possible substance use disorders in patients presenting medical problems that suggest elevated risk of substance use disorders (e.g., those being treated for Hepatitis C or prescribed opioid medications). Recognizing the importance of PACT-based care, VA is implementing the Behavioral Health Interdisciplinary Program – Collaborative Chronic Care Model (BHIP-CCM) at every VHA facility. BHIP – CCM is an "evidence-based approach to structuring clinical care to ensure coordinated, patient-centered, and anticipatory care" (available at https://www.ncbi.nlm.nih.gov). Implementation of BHIP – CCM teams within general mental health further supports VA's commitment to providing access to chronic disease management and treatment for substance use disorders beyond specialty SUD treatment settings.

VA has funded SUD providers in Primary Care Mental Health Integration (PCMHI) programs. PCMHI provides mental and behavioral health expertise for Veterans whose conditions can be managed collaboratively in primary care with the Veteran's PACT. The goal of PCMHI is to provide high-quality, collaborative mental and behavioral health care including SUD to improve the health of both individual Veterans and the Veteran population as a whole. PCMHI implementation includes two required components: Co-located Collaborative Care and Collaborative Care Management. Co-located Collaborative Care (CCC) providers provide consultative advice, brief assessment, and problem-focused treatment. Mental Health Collaborative Care Managers (CoCM) use the evidence-based Mental Health Collaborative Care Management Model to provide longitudinal follow-up and decision support for specific mental health conditions. PCMHI can also connect Veterans with care in general and specialty mental

health and SUD services to ensure they receive the right level of care in the most appropriate setting based on symptom severity, functional impairment, and Veteran preference.

Most Veterans with substance use disorders are treated in outpatient programs. Outpatient withdrawal management is available for patients who are medically stable and who have sufficient social support systems to monitor their status. Standard outpatient programs typically treat patients one or two hours per session and patients are generally seen once or twice a week. Intensive SUD outpatient programs generally provide at least three hours of clinical programming per day and patients attend three or more days per week. At the same time, providers in these outpatient and intensive outpatient SUD treatment settings are expected to collaborate with colleagues in inpatient and residential SUD care settings to coordinate Veterans' transitions across these levels of SUD care. Such efforts are necessary for helping ensure continuity of SUD care that is consistent with a chronic disease model of care and responsive to changes in Veterans' clinical status.

VA has also embarked on development of an app that will serve as a platform for making the wide array of VA SUD care available to Veterans in a mobile platform. The app is envisioned to provide educational information and resources on SUDs and related treatments and include features that promote awareness, monitoring and reduction of substance use, harm reduction approaches, and prevention and management of SUDs. Currently, semi-structured interviews are being conducted to obtain the perspectives of key VA stakeholders, including Veterans, subject matter experts, clinicians, and peer specialists. Rapid analyses of key stakeholder responses are underway and will be used to inform app content and functionality.

Considering the frequent co-occurrence of SUDs with posttraumatic stress disorder (PTSD), VHA also has assigned a SUD specialist to each of its hospital-level PTSD services or teams. The staff person is an integral member of the PTSD clinical services team and works to integrate substance use disorder care with all other aspects of PTSD-related care. Among the specialists' responsibilities are the identification and treatment of Veterans with co-occurring SUD and PTSD. Specialists also promote preventive services for Veterans with PTSD who are at risk for developing a SUD.

VHA provides two types of 24-hour care to patients with severe or complex substance use disorders. These include inpatient withdrawal management and stabilization in numerous medical and general mental health units, equivalent to Level 4, Medically Managed Intensive Inpatient Treatment as specified by the American Society of Addiction Medicine Patient Placement Criteria (https://www.asam.org/asam-criteria/about-the-asam-criteria), and provision of care in Mental Health Residential Rehabilitation Treatment Programs (otherwise referred to as Domiciliary beds). VHA offers care in Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) to Veterans with complex, co-occurring mental health, substance use, medical, and psychosocial needs. Specialty Domiciliary SUD programs provide treatment equivalent to Level 3.7, Medically Monitored Intensive Inpatient Services as specified by the American Society of Addiction Medicine Patient Placement Criteria. At the end of FY 2024, 77 Domiciliary SUD programs were in operation with roughly 1,800 beds focused specifically on intensive, medically monitored residential SUD treatment. In addition to those MH RRTPs formally designated as Domiciliary SUD programs, additional SUD specialized services are offered through tracks in other MH RRTPs with services equivalent to those provided by the Domiciliary SUD programs (14 programs during FY 2024). Across the more than 200 MH RRTPs serving Veterans across the country, the majority of Veterans served (more than 95%) by MH RRTPs are diagnosed with a SUD. Several new Domiciliary SUD programs are under development with the number of programs expected to grow over the next few years.

VHA recruited homeless program SUD coordinator positions enterprise-wide to engage homeless Veterans with SUD into VA SUD outpatient and residential services. In addition, because people experiencing unstable housing or homelessness are at high risk of overdose, a complementary aim aligned with the National Drug Control Strategy is the already announced objective that VA and its community partners

would place at least 41,000 Veterans experiencing homelessness into permanent housing by the end of calendar year 2024. As of September 30, 2024, 47,925 Veterans have been permanently housed, representing 116.9% of the goal. VA has exceeded the goal and will continue to connect homeless Veterans to the permanent housing and supportive services they need.

SSVF awards grants to private non-profit organizations and consumer cooperatives that assist very low-income Veteran families residing in or transitioning to permanent housing grantees provide a wide range of supportive services to eligible Veteran families that are designed to promote housing stability through rapid re-housing and homelessness prevention. SSVF Grantees cannot provide direct health care services. Additionally, clinical SUD services and other clinical type care is not an eligible SSVF activity. The addition of the SUD SSVF position has helped ensure eligible Veterans in need of SUD services are connected to VA SUD services through coordination and collaboration. Grantees are typically a first contact with the Veteran so seamless coordination can assist with improving outcomes associated with receiving SUD care and improvement of housing outcomes.

The foundation of HCHV programs is the provision of outreach services to Veterans who are homeless and assisting them in obtaining permanent housing as expeditiously as possible. The central goal of HCHV programs is to reduce homelessness among Veterans by conducting outreach to those who are the most vulnerable and who are not currently receiving VA services. Once Veterans are engaged through outreach, the goal is to connect them to treatment and rehabilitation services as well as to other VA programs and non-VA community programs that provide prevention, supportive services, and permanent housing. HCHV programs are also vital for providing a gateway to VA and community-based supportive services for eligible Veterans who are homeless. The HCHV National Program Office expects that each VA medical facility (including those who do not have an assigned HCHV Outreach Services staff) will provide HCHV Outreach Services within that VA medical facility's catchment area, either directly or in collaboration with community partners. This includes ensuring that chronically homeless Veterans and those with serious mental health diagnoses can be placed in VA and community-based programs that provide quality housing and services that meet the needs of these special populations. In addition to outreach services, HCHV programs provide care, treatment, and rehabilitative services, including case management and therapeutic transitional housing assistance by contracting with community providers.

The Grant and Per Diem (GPD) program allows VA to award grants to community-based organizations to provide transitional housing with wraparound supportive services to assist vulnerable Veterans as they move into permanent housing.

GPD programs serve a wide variety of Veteran populations with diverse needs. Therefore, GPD offers several models of transitional housing, each filling a focused purpose within the continuum of homeless services and addressing various needs of Veterans. One example is the Clinical Treatment housing model which is designed for Veterans experiencing homelessness who have a specific diagnosis related to a substance-use disorder or mental-health diagnosis. These Veterans actively choose to engage in clinical services. In this model, GPD grantees provide clinically focused treatment and services to help Veterans secure permanent housing and increase income through benefits and/or employment. Another example is the Low Demand housing model which uses high engagement and harm reduction to better accommodate Veterans experiencing chronic homelessness and Veterans who were unsuccessful in traditional treatment settings. Programming under this model does not require sobriety or compliance with mental health treatment as a condition of admission or continued stay. Overall, demands are kept to a minimum; however, services are made widely available and are actively promoted by program staff with the goal of establishing permanent housing while providing for the safety of staff and residents.

HUD-VASH is a collaborative program that provides housing and supportive services to homeless Veterans. HUD provides eligible homeless Veterans with a Housing Choice rental voucher, and VA

provides case management and supportive services so that Veterans can gain housing stability and recover from physical and mental health problems, substance use disorders, and other issues contributing to or resulting from homelessness. HUD-VASH subscribes to the principles of the Housing First model of care. Housing First is an evidence-based practice model that rapidly moves homeless individuals into housing and wraps supportive services around them as needed to help them exit homelessness and achieve housing stability as well as improve their ability and motivation to engage in treatment (available https://endhomelessness.org/resource/housing-first/). The program's goals are to help Veterans and their families gain stable housing while promoting full recovery and independence in their community.

All HUD-VASH programs are encouraged to have SUD Specialists as a part of their multidisciplinary teams. Peer specialists within HUD-VASH also provide essential services to Veterans experiencing SUD and co-occurring mental health conditions which include providing emotional support to encourage positive change during the Veteran's recovery process, including checking in with the Veteran on how he/she is feeling and managing and regularly asking about the Veteran's current needs. Peer specialists also accompany the Veteran to clinical appointments, self-help group meetings, and other meetings that directly support the Veteran's preferences for care.

Incarceration as an adult male is among the leading predictors of homelessness in Veterans (Epidemiologic Reviews, https://academic.oup.com/epirev/article/37/1/177/412707). VA therefore also conducts outreach to justice-involved Veterans through two dedicated national programs, both prevention-oriented components of VA's Homeless Programs: Health Care for Reentry Veterans (HCRV) and Veterans Justice Outreach (VJO). Known collectively as the Veterans Justice Programs (VJP), HCRV and VJO facilitate access to needed VA health care and other services for Veterans at all stages of the criminal justice process, from initial contact with law enforcement through community reentry following extended incarceration. HCRV and VJO specialists are licensed independent clinicians who provide direct outreach, assessment, and case management services, which may include assessment and referral to outpatient, residential, and other SUD specialty care. They also provide training and education to criminal justice partners, which may include information on substance use disorders, overdose risk and risk mitigation, and VA SUD specialty services.

In addition, an Enhanced Use Lease (EUL) program provides a mechanism for a non-VA entity to develop and operate supportive housing for homeless and at-risk Veterans and their families on VA property. VA enters into a long-term ground lease with a private, not-for-profit, or local government entity, which develops, constructs/rehabilitates, finances, operates and maintains the housing. This innovative tool provides Veterans with housing and an expanded range of services that would not otherwise be available on medical center campuses. VA's EUL program and implementation process are aligned with the Housing First philosophy. Since 1991, VA has executed 105 EULs, including 49 operational housing EULs nationwide comprised of more than 3,300 housing units. In addition, VA housing EULs have raised over $1.5 billion of non-VA funding. These EUL projects provide safe, affordable living arrangements near health care providers, which contribute to positive health care outcomes for Veterans. The EUL program is managed by the Office of Asset Enterprise Management. A list of awarded EUL projects, including EUL housing projects, can be found at: http://www.va.gov/assetmanagement/.

Methamphetamine

VA recognizes the threat that methamphetamine poses to our Nation's Veterans. Specific data on the rates of methamphetamine use disorder are not available. However, the overall rates of amphetamine use disorder have been increasing over the past several years. The number of Veterans who received care for amphetamine use disorder increased over the past year with 44,775 Veterans who received care in VHA during FY 2024 having an amphetamine use disorder diagnosis. VA's commitment to provision of evidence-based treatment has positioned VA well to respond to this emerging threat. Contingency Management (CM) is an evidence-based treatment with demonstrated efficacy in treating stimulant use

disorder. VHA has been able to support CM including its associated costs of toxicology surveillance and incentives to strengthen Veterans' recovery behavior. VA implemented CM in 2011, and through the end of FY 2024, VA has provided CM to over 7,200 Veterans, with 92% of the more than 95,000 urine samples testing negative for the target drug(s) (for example stimulants or cannabis). VA has launched a stimulant safety initiative that focus on expanding access to evidence-based interventions such as CM and Cognitive Behavioral Therapy for Veterans with stimulant use disorder. In addition, VA is exploring models for implementing digital therapeutics into the treatment of stimulant use disorder (as well as other SUD care). Given that almost half of stimulant overdose deaths involve opioids, VA has also mandated that Opioid Overdose Education and Naloxone Distribution (OEND) be offered to VA patients diagnosed with stimulant use disorder.

Opioid Use Disorder

Slightly less than 64,600 Veterans with an opioid use disorder (OUD) diagnosis were seen in VHA in FY 2024. Medication for OUD (M-OUD) has historically been provided in SUD specialty-care clinics, but a significant number of Veterans with clinically diagnosed OUD do not access SUD specialty care. By disseminating evidence-based models for delivery of M-OUD in primary care, mental health, and pain management clinics, Veterans are expected to have timely access to the right treatment at their preferred point of care. In August 2018, VHA launched the Stepped Care for Opioid Use Disorder Train the Trainer (SCOUTT) initiative with the intent of supporting the expansion of M-OUD in level 1 clinics (primary care, general mental health, and pain management clinics). Phase One sites in each VISN implemented this expansion during FY 2019. From August 2018 through September 2024, there was a 220% increase in the number of patients receiving buprenorphine in the Phase One level clinics and 297% increase in the number of providers prescribing buprenorphine in these clinics. Further, Veterans are being retained in care with 72% of Veterans retained on buprenorphine for more than 90 days. Phase Two of the SCOUTT initiative was launched in the Fall of 2020, and three regional conferences occurred in April 2021, attracting over 500 participants. Since the launch of Phase Two in October 2020, there has been a 1% increase in the number of patients receiving buprenorphine and a 77% increase in the number of providers prescribing buprenorphine. Among Phase Two sites, 72% of patients are retained on buprenorphine for more than 90 days. Across both Phases, over 5,430 patients have initiated buprenorphine. The infrastructure developed to support Phase 1 and 2 of the SCOUTT initiative also supports level one clinics at facilities that are not formally involved in the SCOUTT initiative, including national clinical templates in the medical record that support assessment, buprenorphine initiation, and buprenorphine medication management. Phase 3 facilities are now voluntarily being enrolled such that the SCOUTT initiative is within 93 clinics in over 60 facilities. In FY 2023, a pilot collaboration four Comprehensive Health Women's Clinics and four SCOUTT initiative facilities was initiated to improve the access and quality of care of women Veterans who have SUDs. In the Fall of 2024, a clinical dashboard was released to facilitate monitoring of each clinic's progress on the SCOUTT initiative. The dashboard displays the count of patients receiving and providers prescribing M-OUD for each SCOUTT clinic, and for all participating sites.

SCOUTT also supports 1) ongoing provider education to all (SCOUTT and non-SCOUTT) health care providers with monthly webinars reaching thousands of webinar participants annually; 2) ad-hoc consultation and resource provision to clinicians; 3) resource guides, standing operating procedures, and a library of hundreds of prior presentations/webinars to guide implementation of SCOUTT/stepped care models of care; and 4) evaluation of patient, provider, and system impacts. SCOUTT has demonstrated (and published/disseminated) unique models of care delivery for M-OUD in its network. These care models include nurse care management, pharmacy care management, and hub-and-spoke models. Almost all SCOUTT initiative clinics are involved in telehealth provision of care, proceeding and after the start of the COVID pandemic. Through a collaborative care model, clinical pharmacy practitioners within SCOUTT are now prescribing M-OUD in States that allow this provision of care. The initiative is extremely popular, valued by clinicians, and consistently growing.

In 2021, evidence-based M-OUD, including office-based treatment with buprenorphine and extended-release injectable naltrexone, was accessible to patients seen at 100% of VA medical centers. VA operates federally regulated opioid treatment programs that can provide methadone maintenance on-site at 33 larger urban locations and at a growing number of VHA facilities that maintain contractual arrangements or arrange non-VA care for providing care through community-based licensed opioid treatment programs. In FY 2024, VHA convened the first in-person conference exclusively for clinical and administrative leadership from its 33 opioid treatment Programs. Among the presenters at this conference were representatives from the SAMSHA, the Drug Enforcement Agency (DEA), and The Joint Commission. VA monitors the percent of patients with OUD who receive M-OUD (50.2% in FY 2024) as part of the Psychotropic Drug Safety Initiative (PDSI). PDSI is a nationwide psychopharmacology quality improvement (QI) program that supports facility-level QI through quarterly quality metrics, clinical decision support tools, technical assistance for QI strategic implementation, and a virtual learning collaborative. Since FY 2019 Q4, VA has seen a 2.3% increase in the number of Veterans that received M-OUD (total of 27,993 for FY 2024).

VA recognizes the importance of capturing more detailed information on providers most likely to prescribe buprenorphine for OUD and has developed tools that will allow for improved understanding of availability of buprenorphine prescribers by practice settings through initiatives such as SCOUTT, MAT-VA, and SUD VHA "Ask the Expert Program" initiatives. VHA's Office of Mental Health and Suicide Prevention's SUD Office and Office of Research Development, have supported numerous research and evaluations of these national initiatives (e.g., SCOUTT) and the system-, provider-, and patient-outcomes of M-OUD provision of care. These dedicated research and evaluations continue to inform interventions and initiatives to improve M-OUD access and quality of care. As examples, the VA is supporting an evaluation of the provision of methadone treatment using mobile services, examining the impact of telehealth in the provision of SUD services, examining retention outcomes within the SCOUTT, and developing and training a cadre of new investigators in the M-OUD scholarly field.

To expand connect Veterans to the soonest and best SUD care, VA continues to retain, invest in, and support a complement of team members to increase access to evidence-based treatment for SUD. Specifically, Clinical Pharmacist Practitioners (CPP) are scaling best practice and driving innovation both within and outside specialty SUD care. The CPP serves as the medication expert delivering comprehensive medication management (CMM) to our Veterans using a patient-centered, collaborative approach in conjunction with the health care team. In partnership with the VA Office of Rural Health (ORH), the VA Pharmacy Benefits Management (PBM) Clinical Pharmacy Practice Office (CPPO) launched a nationwide initiative in 2020 to expand the CPPs workforce focused on improving access to evidence-based treatment in OUD and alcohol use disorder (AUD) for rural Veterans. Since initiation, 51 VA facilities were awarded funding (FY 2020-23) to hire 64 CPPs across Mental Health, Pain Management, Primary Care, and SUD Specialty Care settings. As part of this project, three regional train-the-trainer clinical pharmacy boot camps were held virtually in June and July 2020 to scale best practices and drive innovation for the 234 VA CPPs in attendance. The primary goal was to advance CPPs practice in SUD care and harm reduction principles across level one clinics, in alignment with the SCOUTT initiative. All boot camp participants completed 24-hour DEA X-waiver training prior to the boot camp in anticipation that future legislation may include pharmacist practitioners as potential providers of buprenorphine-based therapy, furthering access to M-OUD. In FY 2024, 205 CPPs delivered OUD care to 25,062 Veterans totaling 44,864 patient care encounters. This represents double the number of CPPs practicing OUD care delivery since the implementation of the SCOUTT initiative. From January 2023 to September 2024, 163 CPPs with controlled substance prescriptive authority prescribed buprenorphine indicated for OUD to 2,183 Veterans across 72 VA facilities further expanding access to M-OUD since the removal of the X-waiver program as authorized by P.L. 117-328 enacted December 29, 2022.

When looking at SUD care broadly during the same time, 718 CPPs routinely delivered SUD care to over 130,000 Veterans and over 228,000 patient care encounters. SPBM CPPO has sustained its partnership with ORH and launched a continuation project for fiscal years FY 2024-26 to hire 28 mental health CPPs in PCMHI or BHIP teams to support comprehensive mental health care including SUD care. In FY 2024, the project funded CPP provided care to more than 12,000 patients (61.7%) over 27,000 encounters with the majority of care being delivered via telehealth modalities. In addition to focusing on rural Veterans, this project hosted a training for project funded CPP and 1 MH CPP Change Agent per VISN with the goal of driving health equity. The virtual training occurred in May and June 2024 focused on closing gaps in health disparities aligning with VA's goal to drive equity for women, minority, and LGBTQ+ Veterans. The case-based curriculum was crafted to raise awareness regarding disparities and highlight strategies to effectively deliver equitable MH and SUD care to rural, women, older, LGBTQ+ Veterans and those with special/social circumstances (e.g., homeless, justice involvement, food insecurity) through a trauma informed care lens. The 18 MH CPP Change Agents employed a train-the-trainer approach and diffused the training to an additional 1,000 providers. Many were MH CPPs but also CPPs in other practice areas such as primary care and geriatrics. The training was also shared with primary care providers and other members of MH teams at the facility and VISN level.

In an additional partnership with the Pain Management Opioid Safety and Prescription drug Monitoring Program (PMOP), CPPO and PMOP launched the Medication Management in Pain Management Teams (MMPMT) initiative in FY 2022 to include screening and treating OUD, when co-existing with chronic pain, as part of comprehensive chronic pain care. This initiative awarded funding for 75 VA facilities to hire a CPP and/or Nurse Practitioner/Physician Assistant who provide medication management and opioid risk mitigation as part of the collaborative Pain Management Team (PMT) services.

In FY 2024, one in-person, three-day multi-disciplinary training workshops that included case-based SUD treatment didactics, was held for 58 participants, including MMPMT and other PMT practitioners. These workshops support successful MMPMT implementation by scaling best practices and driving innovation that will connect Veterans with the soonest and best pain care with a focus on preventing Veteran overdoses and suicide and driving health equity. In addition, the MMPMT Community of Practice call series provided a multidisciplinary session focused on harm reduction and motivational interviewing in SUD care with 115 attendees. In FY 2024, 59 MMPMT funded CPPs provided OUD care for 1,231 Veterans and AUD care for 648 Veterans. Given the collaboration across CPPO, OMHSP, ORH and PMOP, VA expects significant CPP practice growth in OUD (as well as general SUD), to continue in 2025 and beyond.

Related to, but not specific to OUD treatment, in 2022 VHA mandated that OEND be offered to all patients with OUD who did not have naloxone (see OEND section below). Between FY 2021 Q1 and FY 2024 Q4 there was a 30% increase in naloxone distribution among patients with OUD (from 39% to 69%). VA is also expanding the number of Syringe Service Programs (SSPs) enterprise wide (see section on SSPs under harm reduction efforts below). Through SSPs, VA plans to support SUD treatment engagement among Veterans who use drug by injection, and among those Veterans, increase its capacity for low threshold buprenorphine treatment for Veterans with OUD. As VA expands its implementation of SSP, it is applying lessons learned from its award-winning OEND program and plans to evaluate SSP expansion to identify best practices and challenges experienced by early adopters. It is using the same evaluation team that was key in VA's groundbreaking hepatitis C virus elimination efforts.

Advancing equity in access to SUD treatment

Ensuring that all Veterans have maximal access to evidence-based SUD treatment, VA has undertaken several efforts to examine and mitigate access challenges that Veterans may be experiencing. One effort, in part driven by Section 504 of the STRONG Act, involves an examination of disparate access to SUD care attributable to geographic differences, i.e., access differences among Veterans in urban versus rural locales. VA will be submitting a report of its examination in the form of a Congressionally Mandated Report (CMR)

late in FY 2025. In addition to that examination of geographically attributable disparities in access to SUD care, VA also is seeking to identify and mitigate differences in access to evidence-based SUD treatment among various demographic sub-groups of patients. To that end, VA brought together a workgroup in June of 2021 whose goals were to investigate such differences. The workgroup is comprised of SUD SMEs, researchers, and clinical leaders from VA SUD treatment programs. The workgroup currently is focusing its attention on racial and gender disparities in access to M-OUD. In 2022, the workgroup established a pilot for targeting interventions that mitigate the largest differences. Based on the results of this pilot, VA is in the process of disseminating best practices to the field. Building on the work of the pilot project, the workgroup is continuing a quality improvement project to identify factors that differentiate sites with higher and lower disparities in access to M-OUD. The quality improvement project aims to identify challenges to equitable access to M-OUD as well as best practices to resolve such disparities and promote equity in SUD care in general across the enterprise. Furthermore, VA continues to educate its workforce about the intersection of disparities in access to SUD care and stigma surrounding SUD. In May 2024, VA convened a webinar on this matter entitled, "Addressing Disparities in Access to SUD Care."

VA continues to socialize use of the Population Analysis of Needs and Differential Access (PANDA) dashboard developed by its Northeast Program Evaluation Center to assist facilities with identifying disparities in access to evidence-based SUD care among Veterans from different demographic groups.

In addition, mental health residential treatment services, including SUD residential services for women Veterans are available in every VISN. Across the residential programs that serve women Veterans, 65% offer gender specific mental health services and 60% offer a separate, secure wing or unit for women Veterans. For those women Veterans requesting a residential program for women Veterans only, there are currently 13 programs that serve as national resources available to meet that need. Five of the women-only programs provide intensive specialty treatment for substance use. Finally, VA is developing at least two additional women only residential SUD treatment programs that will serve as national referral resources for women Veterans.

Addressing stigma in SUD treatment

VA has included language in its SUD policy (published in December 2022) aimed at stressing the importance of adopting a consistent, Veteran-centric, science-based language regarding substance use. In addition, this concept is being stressed at multiple community of practice meetings which reach SUD leadership and front-line providers across the VA enterprise. Stigma is also a topic that continues to be addressed in the VA webinar series, "Best SUD Care Anywhere!" open to federal partners including the Department of Defense. Furthermore, VA continues to educate its workforce about the intersection of disparities in access to SUD care and stigma surrounding SUD. In May 2024, VA convened a webinar on this matter entitled, "Addressing Disparities in Access to SUD Care." VA also is participating in ONDCP's interagency workgroup (IWG) on Language and Stigma Reduction that commenced in January 2024.

Strategic Communication Outreach Efforts for SUD

More than 107,000 people died of a drug overdose in the U.S. in 2023, according to data released by the Centers for Disease Control and Prevention. The number of drug overdose deaths involving synthetic opioids (including fentanyl) and stimulants (such as methamphetamine) continued to increase compared to the previous year. Each year in the U.S. excessive alcohol use is responsible for 140,000 deaths, shortening lives by an average of 26 years. On top of this, the stigma that some associate with SUDs and treatment already prevents many from seeking the care they need.

The primary goals of VA's communication and outreach efforts include (1) to raise awareness of substance use disorder (SUD) among Veterans and their family members and (2) to encourage them to seek treatment at VA and access the many resources available to them. More specifically, the goals for this communications effort are to:

- Educate Veterans and their loved ones about alcohol, drug, opioid, and stimulant use disorders, informing them of warning signs and symptoms and letting them know that SUDs are treatable.
- Increase awareness of VA's many resources and evidence-based treatment options for SUDs generally and alcohol, opioid, and stimulant use disorder specifically.
- Highlight the risk of overdose due to opioid use and the rise in overdose deaths due to opioid-laced stimulants.
- Build awareness of VA's harm reduction strategies and associated programs and resources.

Other Communication Efforts

VA continues to utilize various communication channels to provide education and awareness as it relates to de-stigmatize SUD care and providing resources. Among those efforts include the following:

- The Make the Connection campaign, available at https://www.maketheconnection.net/, is an online resource featuring over 700 Veterans who have shared their stories of strength and resilience in the hopes of encouraging others to reach out for support. The campaign connects Veterans, their family members and friends, and other supporters with information, resources, and solutions to mental health challenges affecting their lives. Make the Connection is VA's premier mental health literacy and anti-stigma website allowing users to explore mental health conditions and their signs and symptoms in plain language and find resources in their community. A variety of web pages and videos are dedicated to SUD and include information on signs and symptoms of SUD. Additionally, individuals can use built in search and filtering functionality on the site to highlight hundreds of SUD specific videos and find one that is relevant to them. Resources available at Make the Connection include education on mental health and SUD treatment, self-assessments (including Alcohol Use and Substance Abuse screenings), self-help guidance, and how to access formal care. Resources are specific to Veterans, their loved ones, clinicians, active-duty service members, and reservists, but the messages and videos themselves for how mental health support can improve a person's life are universal.
- VA's Mental Health Website – A website that provides several resources, information on treatment options, and more related to mental health. The site includes specific SUD information and further expands on topics about opioid overdose and Stimulant Use Disorder, and finally provides help and resource information for Veterans ready to take the next step.
- Utilization of VA communication channels such as posting on VA's Facebook, Instagram and Twitter platform as well as authoring blogs for VA News related to:
  - Alcohol: VA posts VantagePoint blogs intended to educate the public about safer and risky drinking levels as well as treatment available through VA.
  - Overdose prevention: VA also posts VantagePoint blogs related to overdose protection.

Enhancing evidence-based harm reduction efforts

Opioid Safety Initiative (OSI)

VA continues to pursue a comprehensive strategy to promote safe prescribing of opioids when indicated for effective pain management. The purpose of the Opioid Safety Initiative (OSI) is to ensure pain management is addressed thoughtfully, compassionately, and safely. The OSI makes the totality of opioid use visible at all levels in the organization. Based on comparisons of national data from FY 2012 Q4 through FY 2024 Q4, many aspects of OSI continue to show positive results. The number of Veterans receiving fewer long-term opioid therapy is 413,082. A reduction of 63,013 patients receiving morphine equivalent daily doses greater than or equal to 90 milligrams indicates prescribing and consumption behaviors are changing. The desired results of OSI have been achieved while VA has seen a 11.3% increase in Veterans that have utilized VHA outpatient pharmacy services.

According to the Centers for Disease Control and Prevention (CDC), over 50 million adults in the United States have chronic daily pain, with over 19 million adults experiencing high-impact chronic pain that interferes with daily life or work activities. Chronic pain is a national public health problem as outlined in the 2011 study by the Institute of Medicine (IOM). The IOM study describes in detail many concerns of pain management, including system-wide deficits in the training of our Nation's health care professionals in pain management and substance use disorders prevention and management, and the problems caused by a fragmented health care system. The overuse and misuse of opioids for pain management in the United States is a consequence of a health care system that, until recently, was less than fully prepared to respond to these challenges.

VA has identified and broadly responded to the many challenges of pain management through policies supporting clinical monitoring, education, and training of health professionals and teams with the expansion of clinical resources and programs. VHA's Pain Management Directive defines and describes policy expectations and responsibilities for the overall National Pain Management Strategy and Stepped Care pain model, which is evidence-based and has been adopted by the DoD as well. Our approach to managing opioid overuse fits into this plan, and the VA has employed broad strategies to address the opioid epidemic: education, pain management, risk mitigation, and addiction treatment. First, VHA addressed the problem of clinically inappropriate high-dose prescribing of opioids through the VA's national program, OSI. Second, VHA developed an effective system of interdisciplinary, patient-aligned pain management with the competency to provide safe and effective pain control and quality of life for Veterans for the remainder of their lives.

VA has reduced the reliance on opioid medication for pain management by more than 60% since 2012, largely by starting fewer patients newly on long-term opioid therapy and by offering pain care options that are safer and more effective in the long run. Most of the decline in VHA opioid prescriptions is not due to Veterans "getting by" with fewer opioids, but by following a Stepped Care Model for Pain treatment addressing the causes of pain with fewer Veterans requiring the initiation of long-term opioid therapy. VA has been recognized by many as a leader in the pain management field for the responsible use of opioids. Notably, VA has organized many types of interdisciplinary pain care teams to help with medication safety, patient education, pain schools, cognitive behavioral therapy and helping patients transition from a biomedical to a biopsychosocial model of pain care. As VA continues its efforts to address opioid overuse, non-opioid treatments, and complementary and integrative medicine treatments (such as massage therapy, yoga, meditation, occupational therapy, physical therapy, recreational therapy, acupuncture, tai chi, etc.) are an important component to VHA's Pain Management Strategy.

Additionally, VHA has formalized a system-wide Academic Detailing program that is in the process of being implemented throughout the organization. Academic Detailing provides specialty teams to visit facilities and provide on-site support and education to providers to further enhance pain management efforts. The Academic Detailing program is another important step to improve mental health, substance use disorder, and pain management medication therapy across all VA medical centers. As of September 30, 2024, academic detailers (specially trained VA Pharmacists) have held 101,876 outreach visits related to Opioid Safety, Overdose Education and Naloxone Distribution, opioid use disorder, and suicide prevention.

As VA continues its efforts to address opioid over-use, non-pharmacological treatments are an important component to VHA's Pain Management Strategy. VA currently offers many complementary and integrative medicine treatments, many of which may be useful in chronic pain. These treatments include acupressure, acupuncture, biofeedback, clinical hypnosis/ hypnotherapy, massage therapy, meditation, tai chi, yoga, and other services. Additionally, VA offers other non-pharmacological treatments for chronic pain including but not limited to occupational therapy, physical therapy, exercise, heated pool therapy, chiropractic services, recreational therapy, and transcutaneous electrical nerve stimulation.

VHA has several other programs that are complementary to the Opioid Safety Initiative and include:

- Prescription Drug Monitoring Programs (PDMPs): VA controlled substance prescription data are shared with 50 states, the District of Columbia, and Puerto Rico. This sharing of controlled substance prescription data can help prevent dangerous medication interaction effects and utilization of multiple sources of controlled substance medications as well as inform coordinated care efforts. VA has made querying the PDMP easy for providers by integrating functionality into the electronic health record with 52 of 54 individual state, territory, and military PDMPs currently participating in VA's solution. Since launch of the solution across VA on November 9, 2020, through the end of FY 2024, over 11.8 million PDMP queries have been executed to help guide treatment decisions. This does not include queries done manually, for example, from those states that are not yet integrated into VHA's integrated PDMP platform.
- Medication Take-Back Program: To reduce the supply of medications that could contribute to overdose, VA offers free medication take back services to Veterans through mail-back envelopes and on-site receptacles compliant with Drug Enforcement Administration (DEA) regulations. As of FY 2024 Q4, Veterans have returned 500 tons of unwanted or unneeded medication using these services. In October 2022, VA also commenced its implementation of the Dispose Unused Medications and Prescription (DUMP) Opioids Act (P.L. 117-29) with its inaugural controlled substance prescription medication take-back days on October 28 and 29. VA's bi-annual take-back days will coincide with DEA's medication take-back days in April and October of each year, thus expanding opportunities for Veterans and members of the general public to safely and securely dispose of unused medications in VA locations.

Opioid Overdose Education and Naloxone Distribution

The VA OEND program aims to decrease opioid-related overdose deaths among VHA patients by providing education on opioid overdose prevention, recognition of opioid overdose, and training on the rescue response, including provision of naloxone. One key component of VA's approach includes ensuring that all forms of naloxone and opioid antagonists that the Food and Drug Administration (FDA) has approved for community distribution are considered for addition to the VA National Formulary. VHA assembled injectable naloxone kits as part of its initial OEND program. These were replaced by the auto-injector—specifically designed for layperson use—when that formulation became available. However, the auto-injector was abruptly discontinued by the pharmaceutical manufacturer on September 30, 2020. In response, VHA began re-assembling the injectable (intramuscular) naloxone kits and has the higher dose Zimhi® injection formulation available.

VA recommends offering OEND to all patients that are at risk of an opioid overdose. To ensure Veterans at high-risk for opioid overdose receive OEND, in December 2022, VHA released a memorandum "Naloxone Distribution to High-Risk Veterans" requiring that OEND be offered to all VHA patients who did not have naloxone and who were diagnosed with opioid use disorder or stimulant use disorder, who had a previous nonfatal opioid or stimulant overdose, and/or who were identified by VHA's Stratification Tool for Opioid Risk Mitigation (STORM) as "very high" risk patients prescribed opioids.

In July 2016, Congress took the important step of eliminating copayment requirements for opioid antagonists (for example naloxone) furnished to Veterans at high risk for overdose and for education on their use (per P. L. 114-98, title IX, the Jason Simcakoski Memorial and Promise Act). This change has been implemented throughout VHA and a final rule was published in the Federal Register that amended two of VA's copayment regulations, 38 CFR 17.108 and 17.110, to accurately implement these changes into the Code of Federal Regulations. This rule defines who VA considers to be at high risk for overdose. This definition has assisted in the implementation of the public law and facilitated identification of high-risk Veterans. Early identification of these Veterans can facilitate provision of lifesaving opioid antagonist medication. In addition, to eliminating copayments, for the past decade, VA has also supported centralized

funding of naloxone making it "Free-to-Facilities" to further reduce barriers to accessing this lifesaving medication. Academic Detailing has also been critical to OEND implementation efforts through promoting OEND through individualized, evidence-based educational outreach visits and consultation for clinicians by clinicians. Through FY 2024, academic detailers had completed 38,646 such visits with 26,157 health care professionals nationwide.

Since implementation of the OEND program in 2014, 1,476,355 (nearly 1.5 million) naloxone prescriptions were prescribed by 69,098 VHA prescribers to 610,842 Veterans with 5,753 opioid overdose reversals reported through the end of FY 2024. Notably, a VHA analysis found that in 2018 VHA dispensed a naloxone prescription for 1 in 6 patients on high-dose opioids compared with 1 in 69 patients in the private sector (Guy and others, 2019). To further expand access to lifesaving naloxone, in 2018, VHA launched a Rapid Naloxone Initiative in which OEND was one key component in addition to VA Police Naloxone and select automated external defibrillator [AED] cabinet naloxone. VHA's Rapid Naloxone Initiative received the 2020 John M. Eisenberg National Level Innovation in Patient Safety and Quality Award from The Joint Commission and National Quality Forum. This prestigious award from The Joint Commission (TJC) and National Quality Forum recognizes those who have made significant and long-lasting contributions to improving patient safety and health care quality. As of September 2024, equipped 4,378 VA police officers with naloxone with 309 reported opioid overdose reversals and also equipped 1,274 AED cabinets with naloxone with 75 reported opioid overdose reversals.

Finally, as part of the broader OEND effort, VA has established a community of practice for sharing innovative and promising practices related to opioid safety and risk mitigation, which has also included discussion of non-fatal post-overdose engagement in treatment. Materials developed in support of the OEND initiative also are available to Veterans, their family members, and the broader public; these materials include a VA News report on how naloxone can save the lives of at-risk Veterans, general OEND materials and VA OEND videos. OEND efforts have also been highlighted as an exemplar in VA's Quality Enhancement Research Initiative Roadmap for Implementation and Quality Improvement as a theory-based approach to mapping barriers to implementation strategies as well as in the 2022 National Drug Control Strategy in the section on how to "Reduce fatal overdoses through data-driven efforts to get naloxone to where it is most urgently needed".

Syringe Service Programs

Syringe Services Programs (SSPs) provide a "one-stop shop" for access to harm reduction interventions. Over forty years of experience with and research on SSPs has shown they are one of the most effective public health interventions ever devised. When fully implemented, SSPs can reduce the number of new HIV and HCV infections by over 50% in their service area and increase the chances that an individual who injects drugs will enter SUD treatment. Historically, SSPs have been operated by community organizations and state and local public health departments, rather than hospitals or other health care organizations. SSP operation with a health care system such as VA has tremendous potential to increase the benefits provided by SSPs even more by facilitating referrals from harm reduction clinicians to SUD treatment, Human immunodeficiency virus (HIV) testing and treatment, and other preventive and therapeutic services In May 2021 (and re-issued in June 2023) the Assistant Under Secretary for Clinical Services issued interim guidance on SSPs, recommending that VAMCs develop SSPs or otherwise ensure Veterans enrolled in VHA care have access to SSPs where such programs are not prohibited under state, county, or local law. In addition to providing access to sterile needles, syringes, and other supplies, SSPs provide the opportunity to link to other important services such as low barrier buprenorphine initiation and programs like OEND, testing and treatment for viral hepatitis and HIV, screening for sexually transmitted infections, and referral to social work, mental health, and other medical services. An SSP directive requiring the expanded implementation of SSPs has been drafted and is close to being published. VA's budget supported the hiring of Harm Reduction Coordinators and low-threshold buprenorphine prescribers. VA also centrally funded and standardized six types of SSP kits via a contract and is utilizing funding to sustain this contract as well

as for storage and shipping of these SSP kits to VHA facilities. These six standardized VHA SSP kits help facilities stand up SSPs and facilitate consistent practices in assembling and dispensing a specified set of essential sterile items to Veterans who inject drugs. These SSP kits have also been added to VHA's national formulary which supports provision of SSP kits via pharmacy prescriptions. The budget includes funding to establish an SSP evaluation team to support implementation as well as to provide regional conferences to leadership and frontline providers on SSPs and other harm reduction activities.

In July 2023, VHA deployed an electronic medical record note for SSPs to standardize and facilitate implementation. This note supports standardized education and linkages to care, including screening for infectious diseases associated with injection drug use, vaccination services, referrals based on individualized healthcare needs (including for substance use disorder treatment), and dispensing of SSP kits along with other harm reduction products such as naloxone, fentanyl test strips, and infection prevention and safer sex supplies (for example, condoms). VA is also using natural language processing and constellations of ICD-10-CM codes to try to identify potential candidates for SSPs. These efforts have informed a national SSP dashboard designed to support patient-centered risk mitigation and safety (e.g., display relevant diagnoses, urine drug screens, infectious disease and substance use interventions/treatments) as well as quality improvement and evaluation efforts.

Further, VA has developed a patient education brochure — Safer Injection Practices for People Who Inject Drugs — and a Harm Reduction and Syringe Services Programs provider guide as standardized training to enhance provider knowledge about harm reduction and SSPs. VHA also developed a Talent Management System (TMS) training course to enhance provider knowledge about harm reduction and SSPs and give them the information they need to educate Veterans on safer injection practices and safer drug use. This TMS training course, "Harm Reduction in SUD Care," is now available as continuing education for providers. VHA supports two community of practice calls, the Harm Reduction Office Hour and the SSP Affinity Group Call, to provide educational presentation, spread innovative ideas from high performing SSP sites, and networking opportunities. At the start of 2022, there were only four VHA facilities operating SSPs. As of the end of September 2024, there were 38 VHA facilities operating SSPs with some additional facilities preparing for implementation.

Fentanyl Adulterated or Associated Xylazine

In April 2023, the Biden-Harris Administration Designated Fentanyl Adulterated or Associated with Xylazine (FAAX) as an Emerging Threat to the United States. VA is committed to addressing three major pillars of the Federal Response to this emerging threat—specifically, (1) testing, (2) evidence-based prevention, harm reduction, and treatment implementation and capacity building, and (3) basic and applied research. VA's efforts will be informed by its award-winning OEND program which utilized a theory-based approach to mapping barriers to implementation strategies (available at: https://www.queri.research.va.gov/tools/QUERI-Implementation-Roadmap-Guide.pdf).

VA's approach to addressing fentanyl combined with xylazine as an emerging threat includes:

- mandating that fentanyl be included as part of VA's basic panel for urine drug tests, which is critical given that up to 99% of xylazine-related overdose deaths involve fentanyl.
- developing and updating standardized patient and provider educational materials (e.g., patient and provider brochures).
- working with Office of Nursing Services to develop xylazine-related wound care guidance and kits.
- disseminating the most up-to-date best practices related to clinical care of patients exposed to xylazine—including the most promising overdose response, clinical stabilization, withdrawal management, and treatment guidance. Best practices have been disseminated to relevant national communities of practices, including through webinars/trainings, and through email lists.

- enlisting VA's Academic Detailing Services to deliver knowledge translation services to support dissemination of fentanyl and xylazine educational materials across the enterprise.
- leveraging standardized VA clinical notes to support systemic tracking of xylazine exposure.
- using natural language processing to help identify patients with potential xylazine exposure and to track localities and populations with emerging cases. This information will be integrated into clinical dashboards to improve treatment for Veterans.

Stratification Tool for Opioid Risk Mitigation (STORM)

To further strengthen OSI and OEND, in 2015, VHA launched STORM, a clinical decision support tool available to VHA staff members, which epitomizes how VHA supports efforts to provide comprehensive, patient-centered care to improve patient safety among patients prescribed opioids as well as those who are diagnosed with an opioid use disorder or who have had a nonfatal overdose event. The key features of STORM include (1) identifying patients who are at risk for adverse events such as drug overdose or suicide; (2) highlighting risk factors that place patients at risk (e.g., previous adverse events, mental health and medical diagnoses); (3) displaying risk mitigation strategies, including nonpharmacological treatment options, that have been employed or could be considered; and (4) displaying patients' upcoming appointments and current treatment providers to facilitate care coordination.

In FY 2024, over 22,000 interdisciplinary reviews were completed on (1) patients that STORM identified as having very high risk for an overdose or suicide-related event and who were prescribed opioids and/or recently were discontinued from opioids and (2) patients who received a new opioid prescription. A well-controlled evaluation of outcomes associated with a mandate that very high-risk STORM patients receive an interdisciplinary risk review found that being mandated for review was associated with a 22% reduction in all-cause mortality risk over the next four months. The STORM tool was featured as an Agency for Healthcare Research and Quality, Patient Safety Network innovation that shows promise for targeting prevention interventions to reduce mortality in patients who are prescribed opioids. Because of these positive results, in 2022 VHA expanded the mandated population required to receive risk reviews to include very high-risk STORM patients with recent opioid discontinuation as well as all patients with a nonfatal overdose in the prior year. Data suggests that completion of interdisciplinary team reviews for very high-risk STORM patients increased from 29.8% at the time of the well-controlled evaluation to 50% in FY 2019 Q4 and to 82.6% in FY 2024 Q4. These improvements were achieved despite expansion of the cohort of very high-risk patients to include patients who had discontinued opioid analgesics in the past six months as well as those currently taking opioid analgesics since the original evaluation. Completion of reviews for patients with past-year overdoses also increased. By FY 2024 Q4, VA interdisciplinary teams had reviewed 86.8% of this new patient population.

Post-Overdose Assessment and Care Planning

VHA has aligned the required processes for reporting overdoses with the already required reporting and post-event treatment interventions for Veterans who attempt suicide. In July 2021, VHA mandated use of a national medical record note template to report all overdoses (e.g., Suicide Behavior and Overdose Report), with a focus on improving post-overdose care. Use of a note template was designed to standardize and streamline the process of overdose reporting across VHA, enhance the visibility of overdoses within the Veteran's medical record, improve clinical care after the overdose event, and facilitate real-time tracking of overdose event data for use in clinical decision support tools and in local and national aggregate reports. Implementation of this note template requirement provides a foundation for VHA to implement strategies designed specifically to address the myriad of overdose risk factors from a patient-centered perspective and to support Veteran engagement in timely treatment following a nonfatal overdose.

As past nonfatal overdoses increase the risk of future overdose events, VHA Directive 1160.04 — VHA Programs for Veterans With Substance Use Disorders — mandates that the person filling out the required overdose note template contact the patient's primary care and mental health or SUD providers (e.g., by

phone, instant message, email) in addition to including them as additional note signers, as applicable, if the patient has immediate care needs. In addition, for Veterans hospitalized for an overdose or with emergency department or urgent care center discharges for an overdose, there must be at least four mental health or SUD outreach efforts or clinical contacts within 30 days of discharge. To support post-overdose care, patients with a nonfatal overdose must also receive an interdisciplinary team review with a focus on making care recommendations and engaging patients in treatment. To ensure that all Veterans, including those receiving Community Care (CC), benefit from these requirements, in June 2024 VHA mandated training for key CC staff to support their reporting of CC overdose events. As mentioned earlier, by the end of FY 2024, VA interdisciplinary teams had reviewed 86.8% of patients with a past year overdose.

As mentioned above, in December 2022, VHA also released a memorandum "Naloxone Distribution to High-Risk Veterans" requiring that patients with a previous opioid or stimulant overdose who did not have naloxone be offered OEND.

Advancing recovery-ready workplaces and expanding the addiction workforce/ Expanding access to recovery support services.

Improving Peer Support Services to Veterans with SUD

VHA peer specialists are professionally trained, through their required peer specialist certification, to effectively use their personal lived experience with recovery to inspire hope and serve as relatable role models of recovery for other Veterans with substance use disorders and/or mental health conditions. They assist Veterans with identifying their personal strengths, needed resources, and desirable skills that support their personal goals. Peer specialists use a host of recovery tools to help Veterans to enhance healthy coping strategies and improve self-management skills over their health conditions. They support Veterans to empower themselves to address self-care, advocate for themselves, access available resources in and outside VA, reconnect with others and find a sense of belonging in their communities. As part of the community connection work that peer specialists do with Veterans, peer specialists help Veterans connect with AA, NA, and other mutual support self-help organizations in their local communities that are of interest to the Veterans.

To close the treatment gap as required by the NDCS/NDCA and to provide a recovery environment as detailed in the Biden-Harris priorities, NDCS and PRS, services specific to Veteran engagement are required. The NDCS emphasizes that unmet needs for staffing harm reduction programs should primarily be addressed by recruiting and training new staff to serve as peer specialists. In addition, the PRS identifies the need to expand peer-led recovery. VA supports peer specialist-delivered recovery support services and continuing outreach, engagement, and intervention efforts by peer specialists to support Veterans' treatment engagement and progress on their recovery and personal wellness goals. Since 2005, peer support staff have been working in the VA health care system.

P.L. 110-387, The Veterans' Mental Health and Other Care Improvements Act Of 2008 established the requirement for the use of peer specialists and their qualifications in VA. Through this legislation, peer specialists in VA became defined as Veterans discharged under other than dishonorable conditions who are in recovery from a mental health or SUD and who are certified to provide peer support services. Over the years since that time, VA has hired hundreds of Veterans as peer specialists and continues to hire new peer specialists each year. The peer specialist hiring expansion is supported through Congressional legislation, SUD funding, and VA policies such as VHA Directive 1160.01 (2023), Uniform Mental Health Services in VHA Medical Points of Services which requires that access to peer support services must be made available to Veterans either via telehealth or referral to community service if it cannot be provided on-site. Additionally, very large VA community-based outpatient clinics are required to provide peer support services within their general mental health services. Staffing models for several VA health care service programs have evolved to now stipulate including peer specialists as part of the interdisciplinary teams that

provide health care services to Veterans with mental illnesses, SUDs, or chronic health conditions as well as Veterans experiencing homelessness, unemployment, and those involved with the criminal justice system.

Beginning in FY 2022, VA committed to hiring 284 Veterans as peer specialists to support Veterans engaged in SUD treatment. As of November 2024, 172 of these positions had been filled, bringing the total VHA peer specialist workforce to over 1,410. VHA continues to be the largest single employer of peer specialists in the United States.

To address the challenge posed by variability in state-issued peer specialist certifications, VHA implemented time-limited, peer support apprentice positions. VHA has the peer support apprentices complete a VHA-contracted peer specialist certification course and related certification exam, designed to VHA's specifications, and assists the peer support apprentices with obtaining the necessary peer specialist certification and specialized experience to qualify for permanent peer specialist positions after successfully completing their one-year, time-limited appointment as a peer support apprentice. To assist staff members helping Veterans make informed decisions about pursuing a career as a VHA peer specialist, VHA also developed the VHA-Approved Peer Specialist Certifications Guide that details the peer specialist certification requirements and provides available information about states' requirements for obtaining and maintaining state-issued peer specialist certifications.

Specific training in SUD is continuously planned and presented for peer specialists. At the annual VHA Peer Specialist and Peer Support Services Virtual National Conferences, which have taken place in August every year since 2022, peer specialists and their supervisors receive specific training focused on peer specialists' roles in assisting Veterans with SUD. Additional trainings for staff related to hiring, training, supervision of peer specialists, and examples of peer specialists' interventions for Veterans with SUD continue to be presented every year in virtual VHA conferences, webinars, and national community of practice calls.

The VHA Office of Mental Health's Peer Support Services Section participates in collaborations with other organizations regarding efforts to provide peer support services to Veterans to support the Veterans' recovery from substance misuse and mental health challenges. Examples include:

- Provided consultation to Wounded Warriors Project in response to their request to learn more about VA's implementation of current legislation that focuses on supporting Veterans who have experienced military sexual trauma where the legislation includes peer specialists as part of the VHA health care staff providing support to the Veterans.
- Participated as part of a federal interagency subject matter team that presented at the SAMHSA Office of Recovery's Power of Peers Summit in August 2024 where we discussed our respective agencies' efforts to support the evolution of the peer specialist profession and support the hiring and professional development of peer specialists.
- Provided consultation and written guidance about VA's peer specialist mental health care profession to Tennessee's Office of Consumer Affairs and Peer Recovery Services in the Department of Mental Health & Substance Abuse Services to support their office's efforts to develop a specialized certification for state-certified peer specialists that will focus on optimizing peer support service delivery for US military Veterans.
- Participated in interagency subject matter team to provide input when National Association of Peer Supporters developed their National Ethical Practice Guidelines for Peer Supporters. In FY 2023, we also sought feedback from the National Association of Peer Supporters on the drafted national practice guidelines that were developed for VHA peer specialists as part of VHA's Federal Supremacy effort.

- Provided consultation and written guidance about VHA's peer specialist mental health care profession to a representative of the South Dakota Army National Guard who is developing peer support service programming for the Army National Guard in that region.
- Continued to provide consultation to Vet-to-Vet, a grassroots peer support volunteer organization that operates throughout the U.S. and is run by Veterans in recovery from substance use disorders and co-occurring mental health conditions. The peer support recovery groups that the Vet-to-Vet facilitators lead are for fellow Veterans in recovery from health challenges.

Other Initiatives

Veterans Justice Programs

VA's policy on Uniform Mental Health Services in VA Medical Centers and Clinics (VHA Handbook 1160.01) affirmed that "Police encounters and pre-trial court proceedings are often missed opportunities to connect Veterans with VA mental health services as a negotiated alternative to incarceration or other criminal sanctions." To improve efforts at making SUD treatment available to justice-involved Veterans, VA medical centers provide outreach to such Veterans in the communities they serve. Access to VA SUD services for justice-involved Veterans is facilitated through two dedicated national programs, both a part of VA's Veteran Homelessness Programs: HCRV and VJO (known collectively as VJP). HCRV and VJO facilitate access to needed VA health care and other services for Veterans at all stages of the criminal justice process, from initial contact with law enforcement through community reentry following extended incarceration.

HCRV Specialists provide outreach to Veterans approaching release from state and Federal prisons. They briefly assess reentry Veterans' probable treatment needs, help Veterans plan to access responsive services upon release, and provide post-release follow-up as needed to ensure that Veterans are engaged with needed services. Most HCRV Specialists are based at VA medical centers, but they typically serve Veterans across a large area, often conducting outreach to prison facilities in at least one entire state, and sometimes an entire VISN.

VJO Specialists serve Veterans at earlier stages of the criminal justice process, with a three-pronged focus on outreach to community law enforcement, jails, and courts. VJO Specialists at each VAMC work with Veterans in the local criminal courts (including, but not limited to, the Veterans Treatment Courts, or VTCs), conduct outreach in local jails, and engage with local law enforcement by delivering VA-focused training sessions and other informational presentations. Each VA medical center has at least one VJO Specialist who serves as a liaison between VA and the local criminal justice system.

Veterans who are seen by HCRV and VJO Specialists access VA mental health and substance use treatment at high rates. Most Veterans seen in these programs in FY 2023 had a mental health (66%) or SUD (49%) diagnosis, or both (42%). Among Veterans seen in VJP in FY 2023, 94% connected to face-to-face VHA treatment that same year, including 67% of Veterans with mental health diagnoses and 36% of Veterans with SUD diagnoses.

In communities where justice programs relevant to Veterans exist (Veterans courts, drug courts, mental health courts, and police crisis intervention teams), VA has taken the initiative in building working relationships to ensure that eligible justice-involved Veterans get needed care. In communities where no such programs exist, VA has reached out to potential justice system partners (judges, prosecutors, police, and jail administrators) to connect eligible justice-involved Veterans with needed VA services, including addiction treatment. VJO specialists currently serve Veterans in 727 VTCs and other Veteran-focused courts, with more planned. Their duties in a Veterans Treatment Court include linkage to VHA treatment services. These specialists also educate and advocate for the availability of evidence-based SUD treatments, especially M-OUD, in criminal justice settings and in preparation for transition of patients from those

settings to community living. In communities without VTCs, VAMCs have established relationships with a range of justice system and community partners, including police and sheriff's departments, local jail administrators, judges, prosecutors, public defenders, probation officers, and community mental health providers.

Collaboration with Federal Partners

VHA is committed to working collaboratively with other Federal Partners in support of the NDCS and will continue to share insights of VHA efforts and input into the national drug strategy agenda to address SUD care with ONDCP and other interagency partners. Consistent with the NDCS, in 2024, VA participated in the field review of SAMHSA's Technical Assistance Protocol document for contingency management that would serve as national guidance on the implementation of contingency management. VA collaborates with a variety of Federal agencies on several Interagency Policy Committees (IPCs) and IWGs including the ONDCP Substance Use Disorder Data IWG, the ONDCP Recovery Research IWG, the ONDCP Cascade of Care IWG (including its three sub-committees: Sub-committee 1: Case Finding Metrics and Systems, Sub-committee 2: Core Curriculum for Substance Use Disorders, Sub-Committee 3: Training of a broad representation of health providers currently working in the field, and the ONDCP-IWG on Language and Stigma Reduction. In addition, VA joined the ONDCP Harm Reduction Interagency Working Group whose purpose is to help drive action in support of the Biden-Harris Administration's goal of increasing access to evidence-based harm reduction services through expanded Medicaid reimbursement, comprehensive Federal grant funding, research, and workforce training. VHA also works closely with HHS/SAMHSA on issues related to OTPs, SUD treatment and harm reduction initiatives, and participates in the Interdepartmental SUD Coordinating Committee (ISUDCC) and its treatment workgroup. Through VHA's interagency work, VA is participating in solutions to a variety of areas in the NDCS including enhancing Federal harm reduction efforts to support state and local partners, assessing current evidence base on harm reduction strategies and developing a plan for additional translational research, consulting with experts on harm reduction, and pursuing national case-finding.

Furthermore, VA has worked collaboratively with the Indian Health Service (IHS) and DoD on joint training opportunities in the SUD lane including overdose prevention, opioid safety and evidence-based SUD practice as well as assessment and treatment of gambling disorder. VA continues collaborating actively with HHS/SAMHSA on education related to Contingency Management and oversight of the VA Opioid Treatment Programs. VA is currently working collaboratively with DoD to share lessons learned across the agencies to support access to M-OUD, particularly for transitioning service members. To this end, VA has funded a position with its Transitions and Care Management team in the Office of Care Management and Social Work.

The accompanying Department of Veterans Affairs Resource Summary (page 29) was prepared in accordance with the following ONDCP circulars (a) National Drug Control Program Agency Compliance Reviews dated September 9, 2021, (b) Budget Formulation, dated September 9, 2021, and (c) Budget Execution, dated September 9, 2021. In accordance with the guidance provided in the Office of National Drug Control Policy's letter of September 7, 2004, VA's methodology only incorporates Specialized Treatment costs. Further, in accordance with guidance provided in the Office of National Drug Control Policy's FY 2012 certification letter of November 24, 2010, incorporates Specialized Treatment costs regardless of setting.

Specialized Treatment Costs (Dollars in Millions**)**[1]

Specialized Treatment	VHA Obligations	Care in the Community Obligations	Total Obligations	FTE
Inpatient	$279.684	$252.224	$531.909	898
Outpatient	$396.437	$61.938	$458.375	1,217
Residential Rehabilitation & Treatment[2]	$336.673	$0.000	$336.673	1,225
Total	**$1,012.794**	**$314.162**	**$1,326.956**	**3,340**

[1] Numbers may not add due to rounding.
[2] Community care payment files do not have a reliable identifier to categorize Residential Rehab Treatment provided in the community.

VA does not track obligations by ONDCP function. In the absence of such capability, obligations by specialized treatment costs have been furnished, as indicated.

MEDICAL & PROSTHETIC RESEARCH

VHA research supports the generation of new knowledge to improve prevention, diagnosis, and treatment of SUD (for example opioids, alcohol, tobacco, cocaine, cannabis, methamphetamine, and so forth), the harms associated with SUD and recovery from SUD. Veterans have experienced many of the problems of SUD that is further complicated with the co-existence of mental health and other conditions, including pain and traumatic brain injury. VHA's ORD continues to support research on SUD by maintaining existing efforts, and by developing new programs.

Pain and Opioid Use (POU) Actively Managed Portfolio (AMP). The POU AMP is a new ORD program created to coordinate research efforts between VHA's clinical service lines, particularly VHA Pain Management, Opioid Safety and Prescription Drug Monitoring (PMOP) to facilitate timely translation and implementation of research evidence to the Veteran while minimizing duplication of effort. Towards this goal, POU AMP is partnering with PMOP to focus research on key areas of clinical need including alternatives to opioids, development of precision medicine approaches for treatment effectiveness and efficiency of care, and clinical trials to provide evidence to support clinical practice. POU AMP participates and has membership on the PMOP Field Advisory Board to facilitate research collaborations with PMOP and other VHA clinical partners. One example is the use of spinal cord stimulation for chronic painful conditions. POU AMP crafted and posted a Notice of Special Interest based on PMOP guidance and has received seven pre-applications to be reviewed.

Harm Reduction

- Naloxone distribution. Studies examining the effectiveness of naloxone kits are ongoing. In addition, utilization of the Suicide Behavior and Overdose Report by clinicians is being studied to improve post-overdose care, including receipt of naloxone and SUD treatment (medication for Opioid Use Disorder (OUD) and contingency management). This study will identify barrier and facilitators of implementation, as well as disparities in receipt of these interventions and the contributing roles of stigma and social determinants of health. A publication has resulted from this study examining healthcare cost and use before and following opioid overdose (PMID: **37465971** DOI: 10.1111/add.16289)
- Promoting access to harm reduction services. Comparing community care (CC) opioid treatment to VA-based care in Veterans with acute and chronic pain. This study examines whether Veterans receiving any CC opioids are more likely to be on higher-risk opioid therapy compared with Veterans receiving only VA-prescribed opioids. In addition, the study will collect self-reported pain outcomes (pain-related functioning, pain intensity, health-related quality of life, and patient satisfaction with pain care) in CC opioid treatment compared with VA-based care, as well as

potential differences in self-reported rates of acute care episodes (hospitalizations and emergency department visits), including those occurring at non-VA facilities. This study is ongoing.

- Comprehensive programs on harm reduction. Identifying safe stimulant prescribing practices to protect patients. Initially prescribed for attention deficit and hyperactivity disorder, stimulants can lead to adverse events in certain patients. The goal of this project is to identify patients at risk (for example mental health and SUD) and develop risk scores to support patient safety and collaborative decision-making regarding stimulant prescribing. This study is ongoing.
  Advancing knowledge and increasing access for Veterans with Post-Traumatic Stress Disorder (PTSD) and SUD. This is a new study developing a web-based training course using the Concurrent Treatment of PTSD and SUD using prolonged exposure (COPE) approach for providers to use during sessions. The web-based format extends training to providers working in rural VA-affiliated community-based outpatient clinics. Web-based training will be compared to in-person training on provider satisfaction, fidelity, and knowledge acquisition.

Substance Use Disorder (SUD) Treatment

- Improving treatment engagement. Smartphone Apps to deliver psychosocial interventions that work in tandem with medication for alcohol use disorder. Step Away, an app for self-management of alcohol use problems, is designed to enhance an individual's motivation for changing drinking patterns and guide use of personalized strategies to moderate or abstain from drinking. The goals of the study are to determine efficacy of the program followed by implementation into primary care. The study is ongoing. A new study examines the use of Stand-Down, the Veteran version of Step-Away for unhealthy alcohol use.
- Improving treatment quality. VHA ORD funds several studies examining the role of opioid or medication for OUD reduction or discontinuation focusing on the patient and risk for adverse events. Recent studies focus on non-pharmacologic treatments and determining which treatments are most effective at both reducing risks and managing pain for patients with prescription opioid misuse. This study is ongoing.
- Emphasizing care for Veterans living with co-existing SUD and mental health conditions. Written exposure therapy (WET) combined with residential SUD programs is being examined for feasibility and acceptability by Veterans with PTSD-SUD. This pilot study will evaluate the impact of residential WET on functional, behavioral, safety, and clinical outcomes in patients with PTSD-SUD diagnoses. The study will inform a larger randomized clinical trial on the subject (NCT05536908). There is a clinical trial study design publication for this project. PMID: **38365173** DOI: 10.1016/j.cct.2024.107475
- What's new - Treatment for OUD. Studies examining why Veterans with OUD do not engage in OUD care, and why many Veterans with OUD discontinue buprenorphine treatment within six months of initiation. The studies focus on, 1. OUD provider – Veteran interactions, and clinical resources, and 2. Patient engagement as well as the preferences, needs, and values of Veterans with OUD that impact their willingness to engage in care. The studies seek to obtain perspectives on the process of OUD treatment.

Building a Recovery-Ready Nation

- Eliminating Barriers and Increasing Opportunities. VA researchers are identifying the barriers to and facilitators of sustained employment among Veterans with OUD/SUD. These studies examine the role of supported employment services on occupational and long-term employment outcomes, as well as sobriety, community integration and quality of life (NCT05388812 and NCT04969081). In addition, ORD has funded a multi-site clinical trial assessing the effects of individualized placement and support to treatment as usual for Veterans with OUD. The study will also assess barriers and facilitators to implementation of vocational rehabilitation services and to achieving

steady employment in Veterans recovering from OUD. A publication has resulted from one of the studies that has been completed - PMID: **38835254** DOI: 10.1176/appi.ps.20230408

- Identifying Veterans at high risk of MOUD discontinuation and opioid overdose. This new study seeks to develop a dashboard targeting Veterans in the Veterans Justice Outreach Program to predict Veterans who could benefit from MISSION-CJ (Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking-Criminal Justice version) that empowers Veterans to access and engage in care and community services to address addiction, mental health, and modifiable social determinants of health needs while promoting recovery.

In summary, VHA ORD continues its commitment to placing substance/opioid use disorders as an area of high priority in the hopes of stimulating the field to develop, test and implement novel strategies towards the treatment of SUD.

In addition, VHA continues to reduce excessive reliance on opioid medication, VA will maintain efforts in 2025 on pain-management research in areas responsive to the *Jason Simcakoski Memorial and Promise Act*, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act*, and the *Comprehensive Addiction and Recovery Act*. Towards this goal, VA continues to invest in:

- Non-pharmaceutical strategies for painful conditions: VA is a member of the National Institute of Health/Department of Defense/Department of Veterans Affairs Pain Management Collaboratory (PMC) and has funded the APPROACH trial examining Complementary and Integrative Health (CIH) self-care and clinician delivered CIH approaches versus clinician delivered or self-delivered CIH alone (NCT05097521 and The APPROACH Trial: Assessing Pain, Patient Reported Outcomes and Complementary and Integrative Health). As the APPROACH trial is sunsetting, VA has funded another trial in the PMC, the TEAMWORK Trial (TEAM-based care: Timely, person-Engaged, Activity-focused pain Management") that proposes to evaluate the effectiveness of adding Whole Health Coaching to existing Pain Management Teams with outcomes ranging from pain-related function and opioid safety to physical functioning and well-being.
- Development of non-opioid medications to treat pain: VA will continue to focus research on understanding the benefits and risks of non-opioid medications for pain management and alleviation. Examples include targeting: 1) Sodium and other ion channels which have been shown to cause pain associated with limb amputation, corneal neuralgia, chemotherapy, diabetes, trigeminal neuralgia, knee osteoarthritis, and burns. Therapeutic strategies include antibodies directed at specific cellular sites (PMID: **37446213** PMCID: PMC10341521 DOI: 10.3390/ijms241311035) and gene therapy; 2) Blocking melanocortin-4 receptors to treat inflammatory pain common in certain musculoskeletal and arthritic conditions; 3) Endomorphins, naturally occurring molecules found in the brain with powerful pain-relieving effects. Recent publications demonstrate that endomorphins compared to morphine has lower tolerance and activation of glial cells leading to reduced inflammation, while relieving pain in animal models. The results suggest that endomorphin analogs have fewer side-effects and are thus alternatives to opioids for pain (PMID: **38885918** DOI: 10.1016/j.jpain.2024.104607) These studies are ongoing.
- Develop and test technologies providing access to treatment for chronic pain and opioid misuse: VA is testing the use of telehealth, smart-apps, web- and phone-based technology to provide outreach and care to Veterans living in rural areas. These interventions include peer coaching, treatment for OUD and alcohol use disorder (see above Improving Treatment Engagement), provision of biobehavioral approaches, as well as establishing best practices for delivery of care using these modalities. These studies are ongoing.
- Using precision medicine approaches to identify biomarkers for individuals with OUD to help guide the clinical course of action. VA investigators are studying the use of imaging-based brain connectivity data and genetic information (Million Veteran Program) to determine the best clinical course of action to treat OUD (for example buprenorphine or a switch to a different medication for

OUD). This study is ongoing. In collaboration with PMOP, the POU AMP is emphasizing phenotype analysis to determine what characteristics are associated with responsiveness to certain treatments.

Specialized Function	Obligations (Millions)	Drug Control Related Percent	FTE
Research & Development	$31.680	N/A	N/A

3. Methodology Modifications – In accordance with the guidance provided in the Office of National Drug Control Policy's letter of September 7, 2004, VA's methodology for calculating Substance Abuse Treatment Costs only incorporates Specialized Treatment costs and does not take into consideration Other Related Treatment costs. Further, VA's methodology for calculating Substance Abuse Treatment Costs includes all costs of treating substance abuse, regardless of setting as stated in the Office of National Drug Control Policy FY 2012 certification letter of November 24, 2010. Drug control methodology detailed in A.1 was the actual methodology used to generate the Resource Summary (page 29).

4. Material Weaknesses or Other Findings – CliftonLarsonAllen LLP provided an unmodified opinion on VA's FY 2024 consolidated financial statements. They identified three material weaknesses, three significant deficiencies, and certain conditions regarding noncompliance with laws and regulations. The material weaknesses relate to: 1) Controls over Significant Accounting Estimates (Repeat); 2) Financial Systems and Reporting (Repeat); and 3) Information Technology (IT) Security Controls (Repeat). The three significant deficiencies are: 1) Obligations, Undelivered Orders (UDOs), and Accrued Expenses (Repeat); 2) Entity Level Controls including CFO Organizational Structure (Repeat); and 3) Loan Guarantee Liability.

   The conditions regarding noncompliance with laws and regulations include findings of noncompliance in: a) Federal Financial Management Improvement Act (FFMIA) (repeat comment); b) Federal Managers' Financial Integrity Act (FMFIA) (repeat comment); c) Noncompliance with 38 USC 5315 - collection of interest on debt owed by Veterans to VBA (repeat comment); d) Anti-deficiency Act (repeat comment); e) Payment Integrity Information Act (PIIA) for FY 2023, as reported by the Office of Inspector General (repeat comment).

5. Reprogrammings or Transfers – There were no reprogramming of funds or transfers that adjusted drug control-related funding because drug control expenditures are reported based on patients served in various VA clinical settings for specialized substance abuse treatment programs.

6. Other Disclosures – This budget accounts for drug control-related costs for VHA Medical Care and Research. It does not include all drug-related costs for the agency. VA incurs costs related to accounting and security of narcotics and other controlled substances and costs of law enforcement related to illegal drug activity; however, these costs are assumed to be relatively small and would not have a material effect on the reported costs.

B. Assertions

1. Obligations by Budget Decision Unit – VA asserts that the obligations reported by budget decision unit are the actual obligations from VA's accounting system and are consistent with the application of the approved methodology as required by ONDCP Circular, Budget Formulation, dated September 9, 2021.

2. Drug Methodology – VA asserts that the methodology used to calculate FY 2024 drug control obligations by function and budget decision unit is reasonable and accurate based on the criteria set forth in the ONDCP Circular, Budget Formulation, dated September 9, 2021.

3. Application of Methodology – VA asserts the methodology described in Section A.1 above was used to prepare the obligations contained in this report.

4. Material Weaknesses or Other Finding – VA asserts that all material weaknesses or finding by independent sources, or other known weaknesses have been disclosed.

5. Methodology Modifications – VA asserts no modifications were made to methodology for reporting drug control resources.

6. Reprogrammings or Transfers – VA asserts no changes were made to VA's Financial Plan that required ONDCP approval per the ONDCP Circular, Budget Execution, dated September 9, 2021.

7. Fund Control Notices – The data presented are associated with obligations against a financial plan that was based upon a methodology in accordance with all Fund Control Notices issued by the Director under 21 U.S.C. §1703 (f) and Section 9 of the ONDCP Circular, Budget Execution, dated September 9, 2021.

Subj: Statement of Disclosures and Assertions for FY 2024 Drug Control Obligations Submitted to Office of National Drug Control Policy (ONDCP) for Fiscal Year Ending September 30, 2024

/s/ digitally signed by Laura Duke on January 8, 2025

Laura Duke
Chief Financial Officer
VHA Office of Finance

Date

/s/ digitally signed by Andrea Brian on January 8, 2025

Andrea Brian
Associate CFO, Budget Formulation
VHA Office of Finance

Date

/s/ digitally signed by Charles Stepanek on January 8, 2025

Charles Stepanek
Supervisory Budget Analyst, Budget Formulation
VHA Office of Finance

Date

Department of Veterans Affairs
Resource Summary
Obligations (In Millions)

	2024 Actual[1]
Medical Care:	
Specialized Treatment	
Inpatient	$531.909
Outpatient	$458.375
Residential Rehabilitation & Treatment	$336.673
Specialized Treatment	$1,326.956
Medical & Prosthetics Research:	
Research & Development	$31.680
Drug Control Resources by Function & Decision Unit, Total	$1,358.636
Drug Control Resources Personnel Summary	
Total FTE	3,340
Total VHA Enacted Appropriations[2,3]	$141,173.009
Drug Control Percentage	1.0%

[1] Numbers may not add due to rounding.
[2] Includes VHA Medical Care Appropriations and Medical and Prosthetic Research Appropriation account, including supplemental appropriations only.
[3] Includes VHA Medical Care and Research portions of the Cost of War Toxic Exposures Fund and funds made available to VHA from section 707 of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Attachment 2: Budget Formulation Compliance Report

Statement of Disclosures and Assertions for FY 2026 Budget Formulation Compliance Report Submitted to Office of National Drug Control Policy (ONDCP) for Fiscal Year Ending September 30, 2024

In accordance with ONDCP's Circular, National Drug Control Program Agency Compliance Reviews, dated September 9, 2021, the Veterans Health Administration asserts that the VHA system of accounting, use of obligations, and systems of internal controls provide reasonable assurance that:

Obligations are based upon the actual expenditures as reported by the Decision Support System (DSS), which is the designated Managerial Cost Accounting (MCA) System of the Department of Veterans Affairs.

The methodology used to calculate obligations of budgetary resources is reasonable and accurate in all material respects and as described herein was the actual methodology used to generate the costs.

Accounting changes are as shown in the disclosures that follow.

DEPARTMENT OF VETERANS AFFAIRS

Veterans Health Administration

Annual Budget Formulation Compliance Report of ONDCP Funds

A. Summer Budget Information

1. Summer Budget Transmittal – Summer drug budget was submitted to ONDCP on July 30, 2024 in accordance with ONDCP Circular, Budget Formulation, Section 9.a (1), dated September 9, 2021.

2. Resource Summary Table

Budget Authority (in Millions)			
	FY 2024 Enacted	FY 2025 President's Budget	FY 2026 Summer Budget
Drug Resources by Budget Decision Unit			
Medical Care	$1,347.509	$1,401.409	$1,456.064
Medical & Prosthetic Research	$28.000	$29.000	$29.000
Total Funding	**$1,375.509**	**$1,430.409**	**$1,485.064**
Drug Resources by Budget Function /1			
Treatment	$1,347.509	$1,401.409	$1,456.064
Research and Development	$28.000	$29.000	$29.000
Total Funding	**$1,375.509**	**$1,430.409**	**$1,485.064**

Drug Resources Personnel Summary			
Total FTEs (Medical Care - direct only)	3,118	3,125	3,132
Total FTEs (Research - direct only)	-	-	-
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)	$141.5	$139.6	$178.1
Drug Resources Percentage	1.0%	1.0%	0.8%

1/ VA does not have a discrete ONDCP appropriation; VA forecasts obligations anticipated to support substance use disorder treatment programs, including opioid use disorder treatment programs, for Veterans.
2/ FY2024-2025 ONDCP estimates are consistent with FY2025 ONDCP Annual Budget Submissions. FY2025-2026 estimates will be updated based on FY 2024 Actuals for the FY 2024 Detailed Accounting Submission.
3/ Agency Budget for FY 2026 includes the Toxic Exposures Fund mandatory appropriations for both Medical Care and Medical & Prosthetic Research. Agency budget estimates are not final and subject to change following the budget/appropriation process.

B. Assertions

1. Timeliness of Summer Budget Submission – VA asserts that the FY 2026 summer drug budget was submitted to ONDCP on the date provided in Section A.1 (page 2) based on the criteria set forth in the ONDCP Circular, Budget Formulation, dated September 9, 2021 and was provided to ONDCP at the same time as the budget request was submitted to superiors in accordance with 21 U.S.C. § 1703(c)(1)(A). VA affirms the accuracy of the summer budget submission contained in the transmittal email to ONDCP.

2. Funding Levels – VA asserts the estimated obligations by Budget Decision Unit and Drug Resources as a Percent of Budget represent the funding levels in the budget submission made to the Department without alteration or adjustment by any official at the Department. A correction was made in this report subsequent to the Summer Budget Resource Summary Table in the FY 2026 Summer Budget Column, Drug Resources as a Percent of Budget, Total Agency Budget Level from "$177.7" to "$178.1." The correct value was reflected in the Fall Submission.

/s/ digitally signed by Laura Duke on January 8, 2025

Laura Duke
Chief Financial Officer
VHA Office of Finance

Date

/s/ digitally signed by Andrea Brian on January 8, 2025

Andrea Brian
Associate CFO, Budget Formulation
VHA Office of Finance

Date

/s/ digitally signed by Charles Stepanek on January 8, 2025

Charles Stepanek
Supervisory Budget Analyst, Budget Formulation
VHA Office of Finance

Date

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this management advisory memorandum, please contact the Office of Inspector General at (202) 461–4720.
Team	Gregory Gladhill, Director Ayhan Akbel Chau Bui Sabrina Gregory Jeffrey Lloyd
Other Contributors	Victoria Eatherton Bill Warhop

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
Office of National Drug Control Policy

OIG reports and memoranda are available at www.vaoig.gov.