



VA NCPS

Topics in Patient Safety®

Robin R. Hemphill, M.D., MPH
VHA Chief Safety and Risk Awareness Officer
Director, VA National Center
for Patient Safety

Editor

Derek D. Atkinson, VHA-CM
Public Affairs Officer

Graphic Design and Copy Editor

Deborah D. Royal, VHA-CM
Visual Information Specialist

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VA National Center for Patient Safety

P.O. Box 486 • Ann Arbor, MI 48106-0486

Phone (734) 930-5890

Fax (734) 930-5877

E-mail NCPS@va.gov

Internet www.patientsafety.va.gov

Intranet vawww.ncps.med.va.gov



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The Essential Role of Leadership in Developing a Patient Safety Culture

Lori Hagen, MHA, RN, CPHQ, chief of quality management
Mountain Home VA Healthcare System

Derek D. Atkinson, public affairs officer, VA National Center for Patient Safety

On March 1, 2017, The Joint Commission (TJC) published Sentinel Event Alert, Issue 57 – The essential role of leadership in developing a safety culture. The alert encourages leaders to create and maintain a culture of safety. It also places more accountability and focus on leadership's role in the safety of patients, employees and visitors.

In the alert, TJC suggests 11 actions or "Tenets of a Safety Culture," which include:

1. Absolutely crucial is a transparent, non-punitive approach to reporting and learning from adverse events, close calls and unsafe conditions.
2. Establish clear, just and transparent risk-based processes for recognizing and separating human error and error arising from poorly designed systems from unsafe or reckless actions that are blameworthy.
3. All leaders adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.
4. Policies support safety culture and the reporting of adverse events, close calls and unsafe conditions. These policies are enforced and communicated to all staff.
5. Recognize care team members who report adverse events and close calls, identify unsafe conditions, or have good suggestions for safety improvements.
6. Determine an organizational baseline measure on safety culture performance using a validated tool.
7. Analyze safety culture survey results from across the organization to find opportunities for quality and safety improvements.
8. Use information from safety assessment and/or surveys to develop and implement unit-based quality and safety improvement initiatives designed to improve the culture of safety.
9. Embed safety culture team training into quality improvement projects and organizational processes to strengthen safety systems.
10. Proactively assess system strengths and vulnerabilities, and prioritize them for enhancement or improvement.
11. Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement.

The VA National Center for Patient Safety (NCPS) has been aggressive in its pursuit of a strong culture of safety throughout the Veterans Health Administration (VHA).

LS.03.01.01: Leaders create and maintain a culture of safety and quality throughout the organization.

EP 1. Leaders regularly evaluate the culture of safety and quality throughout the organization.

EP 4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

EP 5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

TJC leadership standards associated with establishing a culture of safety.

NCPS has conducted six Patient Safety Culture Surveys since its founding in 1999, the first of which was conducted in 2000 with the latest installment in 2016. The survey has 14 dimensions and one safety grade question that give VA leadership an in-depth perspective on the culture of safety in VHA.

NCPS looks at leadership involvement to be foundational in creating a culture of safety. Dimension 13 of the Patient Safety Culture Survey focuses on senior management awareness and actions in promoting patient safety and is comprised of the following questions:

- Q54) Senior managers successfully communicate patient safety goals.
- Q55) Senior managers provide a positive climate that promotes patient safety.
- Q56) Senior managers communicate the need to maintain safe patient care.
- Q57) Senior managers set an example for compliance with policy and procedure that promote safe patient care.
- Q58) Senior managers consider patient safety when making program or policy changes.
- Q59) Senior managers are aware of the kind of mistakes that actually occur.

- Q60) Senior managers have a primary goal to ensure patient safety.

The Patient Safety Culture Survey allows VA facilities to easily analyze the organizational assessment of their safety culture over time. The findings provide valuable feedback to NCPS and facility leadership in an effort to gauge where a particular facility is strong when it comes to safety culture, and to also identify opportunities for improvement.

NCPS offers many proactive and innovative training programs to drive improvement and culture change:

- Patient Safety Training Academy.
- Patient Safety Boot Camp for Biomedical Engineers.
- Healthcare Failure Mode and Effect Analysis (HFMEA) training and tools.
- Root Cause Analysis (RCA) training, templates, and cognitive aids.
- The Daily Plan® training and tools which give Veterans the opportunity to be a valued team member in their care.
- The Advanced Patient Safety Fellowship.
- The Chief Resident in Quality and Patient Safety program.
- Various NCPS toolkits such as Wandering Reductions, Falls, Moderate Sedation and Ensuring Correct Site Surgery.

NCPS recently launched My Voice Matters (MVM), a comprehensive program that partners with VA facilities to create and sustain a Just Culture. MVM is one tool to assist facilities in the journey towards high reliability and requires a facility culture deeply committed to patient safety and risk mitigation at all levels of the organization. In this climate, staff are actively engaged in identifying and reporting potential close calls or hazards to leadership.

VA health care facilities have been instrumental in creating robust patient safety programs. This includes a focus to recognize staff who report adverse events or close calls which many facilities call the Good Catch program. Good Catch recipients are often recognized through various methods to include a monthly newsletter, non-monetary award, certificate or recognition through some other avenue.

NCPS Clinical Team Training (CTT) provides clinicians and other staff the opportunity to improve patient safety by focusing on improving team communication, situational awareness and decision making in the operational environment. In conjunction with other initiatives such as the Stop the Line campaign, the fundamentals of a safety culture can take hold and evolve. The message sent to staff is one that says that it's safe to raise concerns about safety anytime, anywhere.

Each VA facility should be commended on being proactive and innovative for already addressing and/or achieving TJC's 11 Tenets of a Safety Culture. To learn more about how NCPS can help you implement a strong culture of safety, please contact your NCPS program manager or analyst (<http://vaww.ncps.med.va.gov/contact.html#visn>). NCPS is always ready, willing and able to assist facility leadership on their journey to high reliability and the establishment of a strong culture of safety.

Joining Forces for Safer Care: Joint Patient Safety Reporting

VA National Center for Patient Safety
Defense Health Agency

The Joint Patient Safety Reporting (JPSR) system provides a standardized and simple way for a reporter to communicate safety-related incidents and issues to their patient safety professionals. This integrated effort increases the early detection and prevention of future patient harm.

“The Joint Patient Safety Reporting system is a big step towards high reliability. It will allow us to have an in-depth enterprise view of close calls, patient safety events and solutions throughout VHA,” said Dr. Robin R. Hemphill, director, VA National Center for Patient Safety.

The joint patient safety effort was initiated in response to a congressional mandate requiring the Department of Defense (DOD) and

Veterans Health Administration (VHA) to develop processes for sharing information regarding error tracking as it relates to patient care. JPSR can be accessed by DOD/VHA staff using their Personal Identification Card (PIV) and/or Common Access Card (CAC). The application provides front-line staff and other users with the ability to report a patient safety event or concern using an electronic event submission form. The patient safety manager also has the ability to track and trend data using an automated event management system and enhanced reporting features.

JPSR will increase the frequency and consistency of reporting; improve the quality and granularity of reports; aid in the identification of trends, issues and lessons learned at

a national and/or interagency level; provide a common taxonomy for patient safety events and learn from systems and process errors.

The combined efforts of DOD and VHA will also help to generate cost efficiencies by sharing software licenses and data centers, and reduce costs of system maintenance and help desk training workload across the organizations. This partnership aligns with the future expansion of data-sharing opportunities between DOD and VHA, which seek to identify common issues and solutions to create safer systems and safer care for service members and Veterans.

For more information on JPSR, please contact the NCPS JPSR team at VHANCPJPSRTeam@va.gov.

Dedicated, Motivated, Safe and Sterile

Sandra Glenn, DNP, MSN, RN, patient safety manager, Central Alabama Veterans Healthcare System
Derek D. Atkinson, public affairs officer, VA National Center for Patient Safety

The Sterile Processing Service (SPS) at the Central Alabama Veterans Healthcare System (CAVHCS) is a dedicated team of professionals in the trenches of the patient safety improvement effort throughout the Veterans Health Administration (VHA).

The SPS team collaborates with departments and clinics throughout the facility in supporting the usage of Reusable Medical Equipment (RME). SPS not only supports West Campus (Montgomery) and East Campus (Tuskegee); they also serve community-based outpatient clinics throughout Alabama and several specialty services such as dental, podiatry, optometry, women’s health, sleep lab, the operating room and urology.

Staff commitment and the utilization of best practices play a key role in this effort. Although certification is optional, 70 percent of CAVHCS

SPS employees maintain professional certification. SPS technicians are also intentional in keeping up with the expeditious pace of technological advances in health care, the dynamic equipment they use, as well as increased demands of their customers.

Due in part to the increasing complexity of device designs and components,¹ the Food and Drug Administration (FDA) requires cleaning validation studies of each device from the device’s manufacturer, to ensure adequate reprocessing of complex device designs and components.

The RME Coordinator provides education about the RME regulations and its process, while the SPS staff ensures the departments have adequate numbers and types of equipment and supplies necessary to perform direct patient care



Cassandra Williams, MSN, RN is currently the chief of sterile processing service. Members of the CAVHCS SPS team from left to right. Front row: Hui Osborn, lead technician and Cheryl Owens, MSN, RN, RME coordinator/educator. Second row: Eldon Prince, technician, Betty Boswell, technician, Cassandra Williams, MSN, RN, chief and Charles Curry, technician. Staff not available for picture: Christopher McDaniel and Gary Smith, sterile processing technicians.

activities. Oversight is provided by the VHA National Program Office for Sterile Processing² and Veterans Integrated Service Network 7, which includes unannounced site visits at random intervals and internal quality monitoring in all areas where RME items (instruments and equipment) are cleaned.

During the surgical instrumentation cleaning process, SPS staff conducts 100 percent occult blood tests on all colonoscopies. This test checks for blood (hemoglobin) residue inside a flexible endoscope, prior to the sterilization/disinfection process, and is one way in which the SPS team contributes to the larger patient safety effort throughout VHA.

Another safety priority SPS adheres to is upholding the goal of “0” percent use of Immediate Use Steam Sterilization (IUSS). IUSS describes steam sterilization cycles in which unwrapped medical instruments are subjected to an abbreviated steam exposure time and then used promptly after cycle completion. The ability to maintain adequate par levels of all sterile processing supplies help facilitate the decreased need for IUSS sterilization.

The SPS department also utilizes the Censitrac instrument tracking system, which is a web-based software solution focused on maximizing SPS efficiency through the management and tracking of instruments

processed through SPS. The best practices mentioned help create positive patient outcomes for Veterans receiving care at CAVHCS by ensuring that our customers receive the right instruments, at the right time, in the right condition.

References

1. George Sheffield. “Responsibilities for Effective Medical Device Reprocessing Procedures and Instructions.” *Biomedical Instrumentation & Technology* 46, no. 12 (2012): pp. 76-79.
2. Department of Veterans Affairs. “Sterile Processing Services”, (2016) VHA Directive 1116(1).

Purchasing for Patient Safety

Derek D. Atkinson, public affairs officer, VA National Center for Patient Safety

One trademark of a High-Reliability Organization (HRO) is a preoccupation with failure. An HRO is always thinking about what could go wrong. The VA National Center for Patient Safety (NCPS) was founded on this and other key principles of high-reliability science. Ensuring patient safety for our Veterans starts long before a patient is seen at the bedside.

NCPS collaborates with the Food and Drug Administration (FDA) and other stakeholders before products enter the VA supply chain. NCPS’s involvement has eliminated potential hazards before they reach the patient or providers. One such example started as a discussion between the NCPS Human Factors Engineering (HFE) team and a leading skin health and hygiene solution company. This dialogue was the genesis of a hand sanitizer dispenser built specifically for inpatient mental health units; it became the first hand sanitizer dispenser to receive support for use in high-risk areas by the New York State Office of Mental Health,¹ which provides the gold standard



for mental health environmental product testing.

Although death by suicide in VA inpatient mental health units is extremely rare (0.74 per 100,000 admissions²), the leading cause of those deaths is by hanging. Thus, over the past 10 years, VA has been aggressive in identifying and removing ligature points from inpatient units through the use of the highly-detailed Mental Health Environment of Care Checklist (MHEOCC). NCPS’s involvement in the company’s development process led to the inpatient hand sanitizer

dispenser featuring an anti-ligature design. The design reduces the risk of hand sanitizer units being used for self-harm.

A key component of the Veterans Health Administration’s (VHA) journey towards high reliability is the ability of NCPS and other VHA offices to recognize potential hazards before they enter the supply chain to ensure that the products used are safe, reliable and efficient.

References

1. New York State Office of Mental Health. (2017, January 13). Patient Safety Standards, Materials and Systems Guidelines Recommended by the New York State Office of Mental Health. Retrieved April 14, 2017, from New York State Office of Mental Health: https://www.omh.ny.gov/omhweb/patient_safety_standards/guide.pdf
2. Watts, B. V., et al: (2017, April 1). Sustained Effectiveness of the Mental Health Environment of Care Checklist to Decrease Inpatient Suicide. *Psychiatric Services*, Vol. 68(No. 4), 405-407.

Passion for Patient Safety

University of Michigan School of Nursing
VA National Center for Patient Safety

As a nurse with more than 20 years of experience, Leila Cherara knows that mistakes happen in hospitals. She's seen them happen and cared for patients who suffered from their devastating effects.

"If a nurse makes a mistake, it's usually not because they are a bad nurse," Cherara explained. "Most likely, there was something that triggered the mistake such as understaffing or poor communication. If a nurse is in an environment that is substandard, they will be more prone to making a mistake."

While Cherara understands why mistakes happen, she's more interested in solving the problem, instead of making excuses – an attitude that inspired her to dedicate her career to patient safety.

Taking Action

Cherara realized she could make a greater impact in patient safety if she was in a hospital leadership position, such as a patient safety nurse manager. That type of position requires an advanced degree, so she returned to school. Cherara earned a master's degree with a focus on patient safety and then enrolled in the University of Michigan School of Nursing's (UMSN) Doctorate of Nursing Practice (DNP) program.

Through UMSN's DNP program, Cherara found an ideal organization to partner with to support her goals of advancing patient safety. She's fulfilling her DNP residency credits at the Veterans Affairs National Center for Patient Safety (NCPS), based in Ann Arbor.

Gary Sculli, a UMSN adjunct professor and NCPS's director of clinical training programs and patient safety program manager, is Cherara's preceptor. Working with Sculli gives Cherara the opportunity



NCPS Program Manager Gary Sculli and Leila Cherara discuss her DNP scholarly project.

to learn about NCPS's efforts to reduce and prevent harm to patients. Patient safety managers from VA hospitals around the country actively participate in NCPS work, creating a data-rich environment.

Merging Education and the Real World

Cherara is focusing on fall prevention for her DNP scholarly project. She began her project by assessing the level of patient safety awareness in a local neurology unit. Now she is implementing a training initiative that includes developing a fall prevention team. Cherara also created a module with the latest evidence-based literature and simulations of fall scenarios for the unit.

After that work is done and the prevention team is implemented, Cherara will reassess the unit to see if there are increases in the staff's knowledge and behavior of fall prevention.

"It's important to create a patient safety culture where everyone in the hospital has a heightened awareness of preventing errors," she said. "It doesn't mean mistakes won't happen, but everyone needs

to be part of the culture. That means taking action if you see a spill, or if a subordinate sees a supervisor doing something wrong, they feel comfortable enough to speak up."

Setting an Example

Cherara also teaches clinical nursing courses at local colleges in BSN and associate degree programs. She says she's proud to be an example of lifelong learning for her students.

"I tell them, 'don't stop here. A BSN is the minimum degree you should have,'" said Cherara. "They have to promise me they'll continue their education."

Making it Work

Cherara is now in the final semester of the DNP program. She is very matter-of-fact about managing her responsibilities at work and home with her academic work and says setting priorities at the start of the DNP program helped her stay on track.

"Take the time to plan the best way to accomplish your degree," said Cherara. "Don't be afraid to reach out for support and also, take care of your health. If you do that, it can be done."

Patient Safety Training Academy – March 2017

Lisa Tighe, Ed.D., M.Ed., instructional systems specialist
VA National Center for Patient Safety

A diverse group of patient safety professionals met in Orlando to develop needed skills to improve patient safety at their facilities. Topics included Root Cause Analysis (RCA) training and simulation, Healthcare Failure Mode and Effect Analysis (HFMEA) and simulation, Just Culture, behavioral health safety, human factors engineering and many other patient safety topics and concepts.

Faculty included the VHA Chief Safety and Risk Awareness Officer Dr. Robin Hemphill, program managers from the VA National Center for Patient Safety, VISN patient safety officers and patient safety managers from Puerto Rico to California.



Putting a Face to a Name



Paul Desh, MBBS, MBA HC
Patient Safety Manager
West Palm Beach VA Medical Center
3 years with VA in patient safety



Kristie L. Power, MS, RN, VA-CM, LBB
Patient Safety Manager
Orlando VA Medical Center
8 years with VA, 2 years in patient safety



Marilyn (Mari) R. Ortiz, MSN, RN, FNP
Patient Safety Manager
Miami VA Healthcare System
1 year with VA, new to patient safety

Tools to Reduce Perioperative Opioid-Related Risks

Karthik Raghunathan, M.D., MPH, Durham VA Health Care System

Sesh Mudumbai, M.D., M.S., VA Palo Alto Health Care System

Atilio Barbeito, M.D., MPH, Durham VA Health Care System

Jodie Trafton, Ph.D., VA Palo Alto Health Care System

Introduction

The U.S. Surgeon General has asked for our help in solving the opioid epidemic facing our nation (see “[Turn The Tide Campaign](#)”).¹ As VA anesthesiologists, CRNAs and allied practitioners (physician assistants, registered nurses, etc.) we care for a group at greater risk for opioid abuse than the general population – Veterans.² In this article, we focus on three tools that you can now use to combat the opioid epidemic. CPRS users who care for Veterans at risk for opioid-related adverse events can use the “Opioid Therapy Risk Report” or “OTRR.” This tool was developed for primary care settings but can also be used for non-primary care providers.³ The second tool, the “Stratification Tools for Opioid Risk Mitigation” or “STORM,” was developed for mental health settings but can also be used by us. We are working on a third tool – “STORM SURGERY” (due in FY 2018), that will be tuned for perioperative use.

The Opioid Therapy Risk Report (OTRR)

What is it? The OTRR is an electronic ‘query’ that you can use to identify a Veteran receiving long-term opioid therapy. Viewed as a webpage in Internet Explorer, it can be accessed on any VA computer.⁴

What’s in this report? For any Veteran meeting the definition of long-term opioid therapy (i.e., opioid prescriptions filled for >50 percent of the most recent 180 days) you can view the patient name and an “as-of” date (which informs you about how current the data is). It contains details regarding opioid prescriptions (e.g., duration, amount and

type over the past 12 months); pain scores over the past 12 months and most recent urine drug test results. Certain factors that increase risks are identified, such as concomitant use of benzodiazepines, diagnoses of Obstructive Sleep Apnea (OSA), and mental illnesses like depression, PTSD or substance use. The OTRR also indicates whether naloxone has been dispensed. The most recent dates of interactions with providers in primary care, mental health, substance use disorder or pain clinics are also listed to gauge compliance.

How do I use this information?

Though targeted toward primary care, this report is available to non-primary care providers as we interact with Veterans in perioperative areas. Access to the OTRR requires you to have access to CPRS. You can use the OTRR to identify Veterans receiving long-term opioid therapy, and tailor perioperative plans accordingly.⁵

What are the limitations?

Veterans not classified as recipients of long-term opioid therapy will not be identified. In addition, opioids dispensed by some non-VA sources will not be identified (although the OTRR queries prescription drug monitoring programs in certain states).

Do I have access? To check, first login on a VA computer. Then click <http://ow.ly/ov3C30bjZ36>.⁴ Enter the Veteran’s entire SSN (without dashes) in the box on top of the webpage and you can view the OTRR immediately.

What If I am unable to view the report? Make sure your “Network Username” is added to your record in Vista. Check <http://ow.ly/Wn3s30bjZlf> for information.⁶ If you are still unable to view the report, please contact any

one of the authors via VA email or call extension 5555 for the help desk.

Stratification Tools for Opioid Risk Mitigation (STORM)

What is it? The STORM tool is an electronic ‘query’ that you can use to estimate the risk of adverse events whenever opioid medication is prescribed for any VHA patient. The STORM report can be viewed as a webpage in Internet Explorer on any VA computer. Based on risk models, updated nightly using information in the VA Corporate Data Warehouse, STORM provides estimates of risks of adverse events paired with information to mitigate these risks. Risk models specific for scheduled surgical patients are being developed by the “Patient Safety Center of Inquiry” at the Durham VA. The principal investigator, Karthik Raghunathan, M.D., MPH, along with VISN 21 Clinical Informatics Medical Director Sesh Mudumbai, M.D., M.S., and Jodie Trafton, Ph.D., director, VA Program Evaluation and Resource Center (both at VA Palo Alto, California) have partnered with the Office of Mental Health Operations to develop STORM-Surgery. STORM-Surgery is slated for release in FY18.

What is in STORM? You can view patient name, demographic and contact information for any Veteran with a VA encounter or opioid prescription in the last year who may be at risk of:

1. An overdose or suicide-related event or death in the next year;
2. Potential for an overdose, suicide, accident or fall-related event in the next 3 years; or
3. Likelihood of a respiratory depression event in the next year.^{7,8}

There is also detailed information on whether the patient has factors found to be associated with risk in other models (e.g., whether other medical and mental health diagnoses are present; whether certain prescriptions are being filled, etc.). Then, from a practical standpoint, there is a tailored list of risk-mitigation strategies – with tracking of whether the Veteran has received these risk reduction interventions. Information on recent and upcoming appointments, assigned primary care and mental health providers, and prescribers of opioids and contraindicated sedatives are also provided to facilitate care coordination.

How do I use this information?

With the STORM tool, you can look up patients scheduled for surgery to assess if they have been exposed to opioids within the last year and identify risk mitigation interventions that should be implemented proactively around surgery.

What are the limitations?

STORM provides information on current prescriptions and risk factors within the last year. Risks from a more distant past may not be identified. Opioids dispensed from non-VA sources will not be identified.

Do I have access? If you have access to patient level data in the Corporate Data Warehouse (CDW) or Business Intelligence Services Line (BISL) reports or Locally Secure View (LSV) access at any VA facility, you will be able to look up any patient using their SSN. Some providers and clinicians may already have approval as part of their work. Check <http://ow.ly/iAnT30bk0Nk> to see if you have access. Once you have access, you will be able to view the STORM report on this page. We recommend that you use the “patient SSN look-up dashboard” for checking risk on patients scheduled for surgery.

If I am unable to view the report? To register for the STORM dashboards, follow the detailed

instructions at <http://ow.ly/qlip30bk0Uz>. For justification, use the option “I need access to PHI/PII reports as part of my clinical responsibilities related to opioid safety at my facility.” You will be notified by email when your approval goes through.

What will the upcoming STORM surgery tool add? STORM was initially developed by Dr. Trafton and colleagues to facilitate the identification and monitoring for Veterans at-risk for opioid-related overdose and suicide events. The STORM surgery tool will focus on risk identification and mitigation strategies for use in the pre-intraoperative and post-operative surgery settings. It will be especially useful since the perioperative setting is predictably associated with pain and opioid use, and/or escalation of opioid prescribing. The STORM surgery tool aims to better coordinate medication handoffs by adding additional risk estimates tailored to the perioperative environment and patient populations, including risk of prolonged opioid use after surgery based on models from a recent paper published in *Pain Medicine* by Mudumbai and colleagues.¹⁰ We emphasize the following strategies to increase early cessation of opioids:

- Preoperative tapering.
- Limiting medications given to patients at risk upon hospital discharge (after surgery).
- Improving risk communication upon transfer of care back to primary care.

Tools to reduce perioperative opioid-related risks are available and the OTTR and STORM tools give all VA providers data needed to “turn the tide” on our national opioid epidemic.

References:

1. United States Surgeon General. Department of Health and Human Services. Page last updated: December 19, 2016. Available at: <https://www.surgeongeneral.gov/priorities/opioids/index.html>

2. Bohnert AS, Ilgen MA, Galea S, McCarthy JF, Blow FC. Accidental poisoning mortality among patients in the Department of Veterans Affairs Health System. *Med Care* 2011;49: 393–396.
3. VA Opioid Safety Initiative. Department of Veterans Affairs. Page last updated: December 19, 2016. Available at: https://www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_Toolkit.asp
4. Link to the OTTR Report Page updated: December 19, 2016. Available at: https://securereports2.vssc.med.va.gov/Report-Server/Pages/ReportViewer.aspx?/PC/Almanac/PAIN_PatientDataBySSN&rs:Command=Render
5. VA Opioid Therapy Clinical Practice Guidelines. Page last updated: December 19, 2016. Available at: <http://www.va.gov/PAINMANAGEMENT/>
6. Link to instructions for updating the ‘Network Username’ field in VISTA. Page last updated: December 19, 2016. Available at: <https://securereports2.vssc.med.va.gov/Reports/Pages/Report.aspx?ItemPath=%2fPC%2fAlmanac%2fNetworkUserNameAnnouncement>
7. Zedler B, Xie L, Wang L, Joyce A, Vick C, Brigham J, Kariburyo F, Baser O, Murrelle L. Development of a Risk Index for Serious Prescription Opioid-Induced Respiratory Depression or Overdose in Veterans’ Health Administration Patients. *Pain Med*. 2015 Aug;16(8):1566–79.
8. Oliva EM, Bowe T, Tavakoli S, Martins S, Lewis E, Paik M, Wiechers I, Henderson P, Harvey M, Avoundjian T, Medhanie A, Trafton JA. “Development and Applications of the Veterans Health Administration’s Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide.” *Psychological Services* 2017 (in press).
9. Check access to STORM. Page last updated: December 19, 2016. Available at: https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx
10. Mudumbai SC, Oliva E, Lewis E, Trafton J, Posner D, Mariano ER, Stafford RS, Wagner T, Clark JD. “Time to Cessation of Postoperative Opioids: A Population-level, Cross-sectional Analysis of the Veterans Affairs Healthcare System.” *Pain Medicine* 2016; doi: 10.1093/pm/pnw015.