

Implementation of Harm Reduction Syringe Services Programs at 2 Veterans Affairs Medical Centers

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Background: Syringe services programs (SSPs) aim to prevent the transmission of blood-borne pathogens, tissue infections, and overdose among people who use drugs (PWUD). This article describes the implementation of SSPs at 2 US Department of Veterans Affairs (VA) medical centers.

Observations: SSPs can increase access to sterile equipment, promote safe disposal, reduce health care costs, and improve patient access to care. Despite these developments, SSPs remain

limited. Established SSPs at the Alaska VA Healthcare System and VA Southern Oregon Healthcare System have allowed for quality harm reduction services to be provided to PWUD.

Conclusions: The newly established SSPs help clinicians provide high-quality care to PWUD. Implementation of SSPs at VA facilities (where permitted by local law) may improve patient care and reduce negative consequences associated with injection drug use.

A syringe services program (SSP) is a harm reduction strategy designed to improve the quality of care provided to people who use drugs (PWUD). SSPs not only provide sterile syringes but establish a connection to medical services and resources for the safe disposal of syringes. By engaging with an SSP, patients may receive naloxone, condoms, fentanyl test strips, opioid use disorder medications, vaccinations, or testing for infectious diseases such as HIV and hepatitis C virus (HCV). Patients may also be connected to housing or social work services.

SSPs do not lead to increased drug use,¹ increased improperly disposed supplies needed for drug use in the community, or increased crime.^{2,3} New users of SSPs are 5 times more likely to enter treatment for drug use than those who do not use SSPs.⁴⁻⁸ Further, SSPs have been found to reduce HIV and HCV transmission and are cost-effective in HIV prevention.⁹⁻¹¹

SYRINGE SERVICES PROGRAM

SSPs were implemented at the US Department of Veterans Affairs (VA) Alaska VA Healthcare System (AVAHCS) and VA Southern Oregon Healthcare System (VASOHCS). AVAHCS provides outpatient care across Alaska, with sites in Anchorage, Fairbanks, Homer, Juneau, Wasilla, and Soldotna. VASOHCS provides outpatient care to Southern Oregon and Northern California, with sites in White City,

Grants Pass, and Klamath Falls, Oregon. Both are part of Veterans Integrated Service Network 20

Workgroups at AVAHCS and VASOHCS developed SSPs to reduce risks associated with drug use, promote positive outcomes for PWUD, and increase availability of harm reduction resources. During the July 2023 to June 2024 pharmacy residency cycle, an ambulatory care pharmacy resident from the Veterans Integrated Services Network 20 Clinical Resource Hub—a regional resource for clinical services—joined the workgroups. The workgroups established a goal that SSP resources would be made available to enrolled patients without any exclusions, prioritizing health equity.

SSP implementation needed buy-in from AVAHCS and VASOHCS leadership and key stakeholders who could participate in the workgroups. Following AVAHCS and VASOHCS leadership approval, each facility workgroup drafted standard operating procedures (SOPs). Both facilities planned to implement the program using prepackaged kits (sterile syringes, alcohol pads, cotton swabs, a sharps container, and an educational brochure on safe injection practices) supplied by the VA National Harm Reduction Program.

Each SSP offered patients direct links to additional care options at the time of kit distribution, including information regarding medications/supplies (ie, hepatitis A/B vaccines, HIV preexposure prophylaxis,

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substance use disorder pharmacotherapy, naloxone, and condoms), laboratory tests for infectious and sexually transmitted diseases, and referrals to substance use disorder treatment, social work, suicide prevention, mental health, and primary care.

The goal was to implement both SSPs during the July 2023 to June 2024 residency year. Other goals included tracking the quantity of supplies distributed, the number of patients reached, the impact of clinician education on the distribution of supplies, and comparing the implementation of the SSPs in the electronic health record (EHR) systems.

Alaska VA Healthcare System

An SOP was approved on December 20, 2023, and national supply kits were stocked in collaboration with the logistics department at the Anchorage AVAHCS campus. Social and behavioral health teams, primary care social workers, primary care clinicians, and nursing staff received training on the resources available through the SSP. A local adaptation of a template was created in the Computerized Patient Records System (CPRS) EHR. The template facilitates SSP kit distribution and patient screening for additional resources. Patients can engage with the SSP through any trained staff member. The staff member then completes the template and helps to distribute the SSP kit, in collaboration with the logistics department. The SSP does not operate in a dedicated physical space. The behavioral health team is most actively engaged in the SSP. The goal of SSP is to have resources available anywhere a patient requests services, including primary care and specialty clinics and to empower staff to meet patients' needs. One patient has utilized the SSP as of June 2025.

Southern Oregon Healthcare System

Kits were ordered and stocked as pharmacy items in preparation for dispensing while awaiting medical center policy approval. Education began with the primary care mental health integration team. After initial education, an interdisciplinary presentation was given to VASOHCS clinicians to increase knowledge of the SSP. To enable documentation of SSP engagement, a local template was

developed in the Cerner EHR to be shared among care team members at the facility. Similar to AVAHCS, the SSP does not have a physical space. All trained facility staff may engage in the SSP and distribute SSP kits. The workgroup that implemented this program remains available to support staff. Five patients have accessed the SSP since November 2024 and 7 SSP kits have been distributed as of June 2025.

DISCUSSION

The SSP workgroups sought to expand the program through additional education. A number of factors should be considered when implementing an SSP. Across facilities, program implementation can be time-consuming and the timeline for administrative processes may be long. The workgroups met weekly or monthly depending on the status of the program and the administrative processes. Materials developed included SOP and MCP documents, a 1-page educational handout on SSP offerings, and a PowerPoint presentation for initial clinician education. Involving a pharmacy resident supported professional development and accelerated implementation timelines.

The facilities differed in implementation. AVAHCS collaborated with the logistics department to distribute kits, while VASOHCS worked with the Pharmacy service. A benefit of collaborating with logistics is that patients can receive a kit at the point of contact with the health care system, receiving it directly from the clinic the patient is visiting while eliminating the need to make an additional stop at the pharmacy. Conversely, partnering with the Pharmacy service allowed supply kits to be distributed by mail, enabling patients direct access to kits without having to present in-person. This is particularly valuable considering the large geographical area and remote care services available at VASOHCS.

Implementation varied significantly because AVAHCS operated on CPRS while VASOHCS used Cerner, a newer EHR. AVAHCS adapted a national template produced for CPRS sites, while VASOHCS had to prepare a local template (auto-text) for SSP documentation. Future plans at AVAHCS may include adding fentanyl test strips as

an orderable item in the EHR given that AVAHCS has a local instance of CPRS; however, VASOHCS cannot order fentanyl test strips through the Pharmacy service due to legal restrictions. While Oregon permits fentanyl test strip use, the Cerner instance used by VA is a national program, and therefore the addition of fentanyl test strips as an orderable item in the EHR would carry national implications, including for VA health care systems in states where fentanyl test strip legality is variable. Despite the challenges, efforts to include fentanyl test strips in both SSPs are ongoing.

No significant EHR changes were needed to make the national supply kits available in the Cerner EHR through the VASOHCS Pharmacy service. To have national supply kits available through the AVAHCS Pharmacy service, the EHR would need to be manipulated by adding a local drug file in CPRS. Differences between the EHRs often facilitated the need for adaptation from existing models of SSPs within VA, which were all based in CPRS.

CONCLUSIONS

The implementation of SSPs at AVAHCS and VASOHCS enable clinicians to provide quality harm reduction services to PWUD. Despite variations in EHR systems, AVAHCS and VASOHCS implemented SSP within 1 year. Tracking of program engagement via the number of patients interacting with the program and the number of SSP kits distributed will continue. SSP implementation in states where it is permitted may help provide optimal patient care for PWUD.

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Disclaimer

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Ethics and consent

Institutional review board approval was not needed for program implementation.

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