



Improving Safety for Veterans with ADHD on Stimulant Medication

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MAGNET
RECOGNIZED

AMERICAN NURSES
CREDENTIALING CENTER

60%
RISE IN VETERAN ADHD DX, 2018–22
VA OIG, 2024

3,000%
SURGE IN NEW STIMULANT RX —
SAME PERIOD
VA OIG, 2024

40%
REQUIRED SAFETY CORE GAP —
BASELINE AUDIT
Local audit, 2025

3.5×
STAFF CONTACTS PER REFILL —
REWORK BURDEN
Local audit, 2025

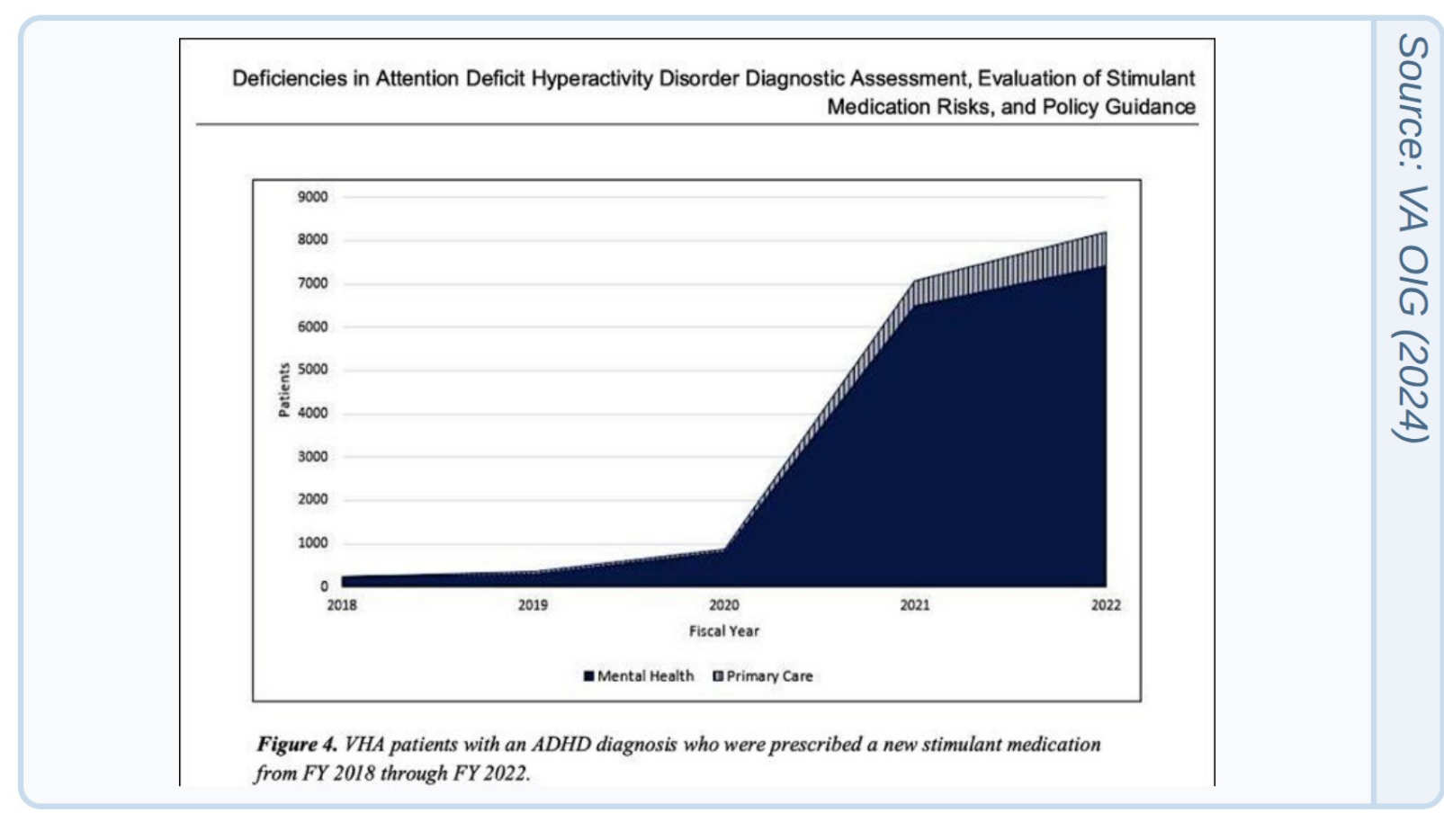
#1 MH
PATIENT ADVOCATE COMPLAINT —
REFILL PROCESS
Local data, 2025

BACKGROUND
A National Signal, Locally Confirmed

- 2024 VA OIG: VHA-wide deficiencies in CV surveillance, SUD screening & informed consent
- Locally: refills fragmented across multiple channels — no safety checkpoint, no standardized routing

BASELINE CARDIOVASCULAR RISK IN VHA VETERANS

~48% of VHA Veterans carry a hypertension diagnosis — before adding stimulant CV effects. ADHD itself is an independent CV risk factor.
Washington 2022; Li et al. 2023



PURPOSE
One Door. Two Handles. One Checklist.

- Primary:** Increase Required Safety Core compliance from ~60% to ≥70%
- Secondary:** Reduce staff contacts per refill (3.5 → ≤2.0); improve fidelity
- Design:** Pre-/post QI · 4-wk baseline (n=48) + 8-wk pilot · Johns Hopkins EBP Model

DONABEDIAN SPO FRAMEWORK — PROJECT LOGIC MODEL

Structure	Process	Outcomes
BHIP team · CPRS · Clinical Contact Center · NCM role	One Door workflow · CDS checklist · Required Safety Core	≥70% safety monitoring completion · ≤2.0 contacts/refill

INTERVENTION & METHODS
Dual Intervention: Standardized Pathway + CDS Tool

BEFORE

- Secure message (MyHealthVet)
- Telephone / voicemail
- In-person request
- Direct pharmacy contact

One Door · Two Handles
Single intake + point-of-care decision support

AFTER

- Single documented intake route
- Safety data auto-populated
- Required Safety Core reliably verified; discretionary items flagged
- Provider receives decision-ready request
- Auditable trail every refill

USE VA HEALTH CHAT
Monday – Friday | 7 AM – 7 PM
Select: **“Pharmacy Support”**
Then type: **“Stimulant refill request”**
Scan QR on back for the app!

CALL CCC
24 hours / 7 days
503-273-5183, option 2
Calls answered in order received.
Tip: Shorter waits after 6 PM or before 8 AM

SHARED GOVERNANCE
MSAs as Implementation Champions — Magnet co-design model

40% SAFETY MONITORING GAP (N=48)
3.5× STAFF CONTACTS/REFILL

Implemented State — As Deployed, March 2026

7 PDSA ITERATIONS · FINAL DESIGN MARCH 2026

TIMELINE

- 4-wk baseline audit n=48 episodes
- CDS live in CPRS Feb 17, 2026
- “One Door” launch Mar 1, 2026
- 8-week pilot & pre/post analysis

MEASURES & OUTCOMES
What We're Tracking

- Safety Monitoring Completion**
% episodes with Required Safety Core complete (BP/HR + UDS + PDMP)
Baseline ~60% → Target ≥70%
- Rework Burden**
Staff contacts per refill episode
Baseline 3.5 → Target ≤2.0
- Workflow Fidelity**
Single-channel adherence; CDS utilization
- Staff Experience**
Adapted EBPAS survey — Qualtrics, pre & post
- Balancing Measures**
Refill volume, turnaround time, Pt Advocate calls

RESULTS
8-Week Pilot · Early Findings

- Safety Compliance**
Improvement across all 3 Required Safety Core components (BP/HR, UDS, PDMP). Overall compliance trending above ≥70% target.
- Rework Contacts**
Median rework contacts per refill decreased, trending toward ≤2.0 target.
- CDS Fidelity**
Checklist fidelity improved across the pilot period.
- Staff Experience**
Pre-EBPAS: favorable attitudes. Post-survey concludes April 11.

NATIONAL FIT
BHIP 2.0 & FLOW: Why This Project Is System-Essential

BHIP 2.0 COMPLEMENTARY FUNCTIONS

- FLOW**
Step-down engine — moves stable Veterans out of specialty MH to primary care
- This Project**
Non-FLOW lane — standardizes safety & efficiency for those retained in BHIP

- Structural necessity:** Panel burden grows indefinitely. One Door + CDS is the required operational lane.
- BHIP 2.0 alignment:** Template-driven, auditable discrete-field documentation.
- National scalability:** Platform-agnostic (VistA + Federal EHR); replicable CDS template.
- OIG & FY26 alignment:** Addresses 2024 OIG findings and FY26 national guidelines.

BOTTOM LINE
Standardized intake + CDS tool improved safety monitoring above ≥70% and reduced rework.

“MAKE THE RIGHT THING TO DO, THE EASY THING TO DO”
(IHI, 2008)

DISCUSSION

- Process + cognitive failure:** Fragmented intake and absent safety prompt require dual-mechanism intervention.
- Safety, not surveillance:** Monitoring detects emerging SUD to inform individualized care, not restrict access.
- Shared governance as method:** MSA co-design yielded workflow changes not anticipated by leadership.

IMPLICATIONS FOR PRACTICE

- Any BHIP site** can replicate — no new FTEs required
- EHR-embedded CDS** reduces cognitive burden at point of prescribing
- National pathway:** iMedConsent submitted; VISION 20 scalability planned
- PMHNP-led QI** — nurse-driven safety redesign in federal systems

ACKNOWLEDGEMENTS

VAPORHCS EBP FELLOWSHIP RECIPIENT · 2024–25

Project team: Dr. Kate Oppegaard (Site Lead) · Dr. Susan Renz (Faculty Mentor) · Son Vo (Informatics) · Dr. Jon Emens (Executive Sponsor) · Courtney Covey Lewis (MHD Nurse Executive)