Development and Pilot Testing of LIMIT: a Multicomponent Tool to Support Opioid Tapering

NCT04746833

April 12, 2022

Application and Submission Instructions (IRB Form 101)

DO NOT CHANGE THE FORMATTING OF THIS DOCUMENT.
DO NOT USE THIS FORM ON A MAC; IT WILL CHANGE THE FORMATTING OF THIS DOCUMENT, WHICH WILL MAKE IRB REVIEW MORE DIFFICULT AND LENGTHIER.

☐ **- FOR CHECKBOXES - DOUBLE CLICK THE BOX - CHOOSE 'CHECKED'; HIT OK.**

- FOR TEXT BOXES - CLICK IN SHADED BOX AND TYPE.

The Principal Investigator (PI) is required to use this form to submit new research projects to the IRB. This form is to be used when there is interaction with human subjects.

Each section of the application requires a response.

Ensure all responses are consistent with the approved funded project, the informed consent, and the HIPAA Authorization, if applicable. **Ensure all sections of the application are completed or marked "Not Applicable."**

One single-sided hard copy of this application form must be submitted to the IRB Office with ALL required signatures.

The **electronic version** sent to the IRB Administrator **must** be **Word** documents, **unless** the form is already a PDF.

This application form was designed to be self-explanatory with embedded instructions and guidance to follow as the form is being completed. However, if any questions arise as the form is being completed, contact one of the IRB Administrators, Eileen.McCarthy-Dorsey@va.gov or Joan.Havey@va.gov.

THERE MAY BE OTHER DOCUMENTS YOU WILL NEED FOR YOUR PROJECT, SUCH AS THE RESEARCH STAFF FORM, INFORMED CONSENT, HIPAA AUTHORIZATION/REVOCATION FORMS, ETC., WHICH CAN BE OBTAINED FROM
Eileen.McCarthy-Dorsey@va.gov or Joan.Havey@va.gov

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SECTION 1: PI'S INFORMATION

Project Title: *SUMMIT STUDY– Phase 2*	**Initial** ☐
	Revised ☒
	CMCVAMC Version Date/Version #: 3/24/2022

1. **Name of Principal Investigator (PI)** *Manik Chhabra*

PI's VA Email:	manik.chhabra@va.gov
PI's VA Telephone Number:	215-823-4498
PI's VA Mailing Address:	3900 Woodland Ave, Philadelphia, PA 19104
PI's Other Business Email:	
PI's Other Business Telephone Number:	612-860-0053

2. **PI's Academic Degrees**: *MD*
   2.1. **PI's Board Certifications, if applicable**: *Internal Medicine*

3. **PI's Employment Status**: *(Check all that apply)*

☒ VA Employee (#8ths)	8/8
☐ Other (VA WOC, IPA)	
Specify Appointment Type:	

   3.1. **For ORD-funded studies, is the PI at least a 5/8ths VA employee?**
   Yes ☒ - (skip to question 4) **No** ☐ - (answer question 3.2) **N/A** ☐

   3.2. **If the response to 3.1 is no**, is a copy of the ORD funding service approval waiver included as part of this submission?
   Yes ☐ **No** ☐ - ***If no****, indicate when submitted for approval:*

4. **Describe the PI's qualifications to act in the capacity as PI to do the research in this project and attach a copy of his/her biosketch** (Merit Review or NIH Format)**:**
Manik Chhabra, MD, is the Principal Investigator (PI) and a staff physician at the CMCVAMC in Philadelphia. He is the Medical Director of the Indigo (PAIN) PACT, that focuses on patients with chronic pain who are prescribed high doses of opioids. He previously was a VA Advanced Research Fellow, and a Fellow in the Robert Wood Jones Clinical Scholars Program. He has experience in health services research, clinical trial design and analysis, and statistical analysis. He currently spends 50% of his effort on research and evaluation, and 50% on clinical and teaching activities.

5. **Complete the questions below regarding the PI's current research activities:**
   5.1. **What current percentage of the PI time is devoted to research activities?** *50%*

   5.2. **What percentage of the PI's time will be devoted to this project?** *10%*

   5.3. **How many active studies is the PI currently overseeing?** *1*

   5.4. **How many of the above are multisite studies in which the PI is the overall PI?** *0*

6. **Is/Are there Co-PI (s)? Yes** ☒ -(see additional questions below) **No** ☐
   6.1. **If yes,** indicate the following for each: **Name**: *William Becker, MD* **Site**: *VA CT Healthcare System (VACHS), West Haven campus*

SECTION 2: PI'S STUDY TEAM INFORMATION

1. **Study coordinator's contact Information.** ☐ **N/A**

1.1. **Name of Study Coordinator**: *Tanisha Dicks*

Study Coordinator's VA Email:	*Tanisha.Dicks@va.gov*
Study Coordinator's VA Telephone Number:	*215-823-5800 x7157*
Study Coordinator's VA Mailing Address:	*3900 Woodland Ave, Philadelphia, PA 19102*
Study Coordinator's Other Business Email:	
Study Coordinator's Other BusinessTelephone Number:	

2. **Does the above-named Study Coordinator have prior experience coordinating:**

2.1. **A VA research study? Yes** ☒ **No** ☐

2.2. **Obtaining informed consent at the CMCVAMC? Yes** ☒ **No** ☐

2.2.1. **If yes,** provide the date study coordinator took the Research Compliance Officer training course. *9/10/2020*

3. **Does this project involve a designated Coordinating Center(s)? Yes** ☒ **No** ☐

3.1. **If yes**, provide the name of the Coordinating Center(s) and contact information below.

3.1.1. **Name of Coordinating Center**: *VACHS, West Haven campus*

3.1.2. **Contact Name (Program Manager or other POC)**: *Jennifer Ibarra*

3.1.3. **Phone Number**: *203-932-5711 ext. 2431* **Email address**: *jennifer.ibarra@va.gov*

SECTION 3: PROJECT OVERVIEW

1. **What organization is funding this study?** *(Check all that apply)*

☐ **CSP** ☐ **CSR&D** ☒ **HSR&D** ☐ **RR&D** ☐ **BSLR&D** ☐ **QUERI**

☐ **VHA Central Office** ☐ **Private Nonprofit**: **Please specify**:

☐ **Department of Defense (DoD)** ☐ **Commercial Sponsor**: **Please specify**:

☐ **None;** If none is checked**, provide justification why there is no funding source**.

Funding Agency Project number: *HX002509-01A1*

2. **What are the research questions or hypotheses to be studied?**

The purpose of this research study is to evaluate the feasibility of a full-scale efficacy randomized control trial (RCT) of SUMMIT, a multi-component web program designed to enable Veterans to safely taper opioids.

The study will examine the feasibility of using the SUMMIT app in conjunction with a motivational interviewing session in opioid tapering, compared to only using an already established mobile application (Manage My Pain).

We hypothesize that the proposed feasibility trial will support a future definitive large-scale trial.

3. **Describe the relevance to Veterans of studying the above questions or hypotheses and the importance of the knowledge this project is likely to generate:**

Veterans have approximately double the rate of opioid overdose compared with non Veterans. (3) Along with the myriad potential adverse events (AEs) associated with long-term opioid therapy (LTOT), mounting evidence suggests it has modest or absent benefit. The first pragmatic long-term randomized control trial (RCT) comparing an opioid-intensive to an opioid avoidant chronic pain management strategy found no improvement in chronic pain outcomes in

Veterans and double the side effects at 12 months. Guidelines recommend tapering LTOT when harm outweighs benefit; observational data suggest improved quality of life among persons who successfully taper.

While guidelines recommending against LTOT initiation should help prevent future harms, hundreds of thousands of Veterans currently on LTOT are left vulnerable as there are insufficient resources to help them taper and/or ultimately discontinue LTOT. To afford a safe, veteran-centered tapering strategy to those currently prescribed LTOT, programs must be developed to extend the reach of face-to-face encounters with health professionals. Thus, we are developing SUMMIT as an ancillary intervention to support, reinforce, and complement provider-initiated opioid tapering initiatives across the VHA.

4. **What research methods will be used in the project?** *(Check all that apply)*

☒ Surveys/Questionnaires	☒ Interviews	☒ Audio Taping
☐ Behavioral Observations	☒ Chart Reviews	☐ Video Taping
☐ Focus Groups	☒ Randomization	☐ Double-Blind
☒ Control Group	☐ Placebo	☐ Withhold/Delay Treatment
☐ Specimen Collection	☐ Deception	☐ Other *(Specify):*

5. **Does the project involve usual care? Yes** ☐ **No** ☒ - **If no,** skip to question 6.
   - 5.1. **If yes,** answer the following additional questions:
     - 5.1.1. **Who will provide the usual care, i.e., the study team or the participant's health care provider?**
     - 5.1.2. **Clearly differentiate what is usual care and what procedures and/or interventions are being performed solely for research purposes. Indicate if usual care is limited to one arm of the study or if it is being delivered to all participants**:

Research procedures:

Usual Care:

6. **Does this project involve international research? Yes** ☐ **No** ☒

NOTE: *International research does not include studies in which VA is only one of multiple participating sites where the overall study-wide PI is not a VA investigator.*

7. **Does this project involve collaborative research? Yes** ☒ - See below **No** ☐
   - 7.1. **If yes,** delineate which research activities will be conducted as the VA portion of the overall collaborative research study:

West Haven will only be particiapint in the data analysis. *West Haven was the original site that had received funding. The implementation site for the study is the Philadelphia VA.*

NOTE*: Collaborative studies do not include studies conducted under a Cooperative Research and Development Agreement (CRADA) with pharmaceutical companies or other for-profit or non-Federal partners.*

SECTION 4: POTENTIAL RISK/BENEFIT ANALYSIS

1. **Indicate the potential risk level of the project:** *(Minimal Risk is defined as "the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.")*

☒ **Minimal** ☐ **Greater than Minimal**

NOTE: *The IRB will make the final risk level determination.*

2. **What are the potential risks or harms for participants in this project?**
(*List in bullet or number format)*

- *Psychological: The Veteran subjects may risk distress from considering opioid tapering. The study team will attempt to mitigate this risk through clear explanation of the study goals and risks prior to subject participation.*
- *Social: There may be some stress regarding potential loss of confidentiality on the part of subjects that are part of the motivational interviewing, which the study team will attempt to mitigate.*
- *Confidentiality and Privacy: There is some risk of confidentiality. Efforts by the study team will be made to minimize this risk by following protocols that will keep all research documentation secured.*

NOTE: *Risks or harms can be physical, psychological, financial, social, or legal. They may involve breaches of confidentiality and privacy. Do not include the risks of usual care unless usual care is part of the research interventions being performed.*

3. **What are the anticipated benefits, if any, to participants or to society from this project?**
(*List in bullet or number format)*

- Participants may need less opioid medication to manage pain
- Participants may experience improvement in overall functiniong.
- *Veterans may also not directly derive any benefit from participating in this research project. However, if this approach is effective, it could have tremendous benefits for society if adopted on a wide scale to help individuals effectively taper their opioid dosage.*

4. **Briefly describe the procedures for the orderly withdrawal or termination of subjects if this study involves any medical therapy. N/A** ☒

5. **Will any of the following be administered to participants or will they be exposed?**

	YES	NO
Ionizing Radiation	☐	☒
Radioactive Materials	☐	☒

6. **Check one of the boxes below based on your study design and provide the references from the protocol for the information in the table:**

☒ **Prospective Study** ☐ **Retrospective Study** ☐ **Both**

NOTE: *If retrospective is checked, some of the below categories may not apply and can be marked as "Not applicable."*

Safety Issues	Reference the protocol page and section.	If not referenced in the protocol, cite document type, page and section where it is referenced.
What Safety Information is Collected	*N/A*	

How will Safety Information be collected	*N/A*	
Frequency of Safety Data Collection	*N/A*	
Safety Conditions that Trigger Immediate Suspension of Research	*N/A*	
Procedures to notify participants or PCP of findings affecting participants' health or welfare	*Section 16, 10.1; 11.1; 13.3*	
Procedures to minimize risk	*Section 16*	
Inclusion Criteria	*Section 16, 7.1*	
Exclusion Criteria	*Section 16, 17.1*	

7. **Will an independent Data Safety Monitoring Board (DSMB) or a Data Monitoring Committee (DMC) monitor the project? Yes ☐ No ☒**
   7.1. **If yes**, provide a description of responsibilities to include frequency of meetings:
   7.2. **If no,** provide the protocol section and/or page where the data safety and monitoring plan is described, to include statistical tests to be used for analyzing the safety data to determine if harm is occurring.
   The PI will be responsible for monitoring the study. All participants will be given anticipatory guidance on when to seek medical attention. In addition, participants will be asked to report to the study team any events they feel resulted from participation in the study. They can either present in person or call on the study team. Study staff will contact the participant to collect any information on the issue and then the PI will review and determine whether it is okay to proceed, further investigation is needed, or the participant should stop the study. The PI will review all report of adverse events within 24 hours of their occurrence and on a monthly basis determine if a change in protocol is indicated due to the occurrence of adverse events.

8. **If the PI is not a clinician, is there an appropriately credentialed and privileged clinician who has been designated as a member of the study team to make required decisions to help protect the health of the subject, review data on adverse events, and report new findings? Yes ☐ No ☐ N/A ☒**

9. **How will you manage information from participating sites that might be relevant to participant protection and describe how that information will be conveyed to the IRB (i.e., reports of problems, interim results)?**
   Participating site (VACHS, West Haven campus) will not be involved in the collection of data. Any problems at VACHS such as theft, loss and unauthorized access of records, or evidence of harm will be reported immediately to the PO, ISO, and IRB. Data will be shared with the West Haven via through shared folder on the CHERP server.

SECTION 5: HUMAN PARTICIPANT INFORMATION

NOTE: *A participant is considered "enrolled" at the time the consent is signed so this number should include an allowance for screen failures prior to randomization.*

1. **How many participant records will be reviewed PRIOR to enrollment/consent occurring?**
   Approximately 1,280 participants records will be reviewed.

2. **How many participants will be screened PRIOR to enrollment/consent occurring?**
   Approximately 640 participants will be screened assuming 1 enrolled per 10 screened.

3. **How many participants will be enrolled (total number to include randomized and screen failures AFTER consent is obtained)?**
   Up to 64 participants will be enrolled.
   3.1. Will all research activity be the same at all sites? **Yes** ☐ **No** ☒ **N/A** ☐
   3.2. **If no,** please describe the activity that is different or limited (For example; 2 sites will analyze data only, or, 1 site will consent and enroll all participants etc.): *Philadelphia site will consent and enroll all participants and both Philadelphia and West Haven sites will analyze data.*

4. Are there any further screening procedures after enrollment? **Yes** ☐ **No** ☒
   4.1. **If yes,** describe:

5. **Are non-Veterans being enrolled?** ***NOTE:*** *This does **not** include non-Veterans enrolled at **non-VA** sites.* **Yes** ☐ **No** ☒
   5.1. **If yes**, provide justification.

NOTE:

- ***Every non-Veteran should sign VA form 10-0483****, Acknowledgement of the Notice of Privacy Practices (ANOP)*
- ***Once the ANOP is signed****, the research study staff must send the non-Veteran's name to the CMCVAMC Privacy Officer via encrypted e-mail. The signed ANOP must be kept in the research study binder.*
- ***If an oral informed consent is used****, the NOP should be sent to the non-Veteran via postal mail. In addition, the research study staff must write a Note-to-File that the NOP was sent to the non-Veteran.*

6. **Does this project target a specific race, gender or ethnic group as participants?**
   Yes ☐ **No** ☒
   6.1. **If yes,** indicate which group and why this group is being targeted.

7. **What is the age range of participants?** *(Check all that apply.)*

Neonates *(See note below)*	☐
Children Under 18 *(See note below)*	☐
Young Adults (18-21)	☒
Adults (22-65)	☒
Seniors (Over 65)	☒

NOTE: *If neonates or children is checked, certification by the Medical Center Director will be required. Only minimal risk research may be performed with children. Only non-invasive monitoring and/or prospective observational and retrospective record review studies that are minimal risk can be conducted in VA involving neonates.*

8. **Does the project involve the potential enrollment of any of the following populations or categories of participants? That is, are you targeting a specific group.** ***NOTE:*** *These populations must be checked "Yes" if they are not being excluded from the research.*

	Yes	No	N/A
a. Employees	☐	☒	☐
b. Students at the VA or Penn	☐	☒	☐
c Individuals with impaired decision-making capacity	☐	☒	☐
d. Pregnant women *(See below)*	☐	☒	☐
e. Economically and/or educationally disadvantaged persons	☐	☒	☐
f. Prisoners *(See Below)*	☐	☒	☐
g. Illiterate, limited, or no English language proficiency	☐	☒	☐
h. Terminally ill patients	☐	☒	☐
i. Children (See Below)	☐	☒	☐

SECTION 6: INFORMED CONSENT

1. **Will the study team obtain ☒ information or ☐ biospecimens for the purpose of screening, recruiting, or determining the eligibility of prospective subjects without the informed consent of the prospective subject or the prospective subject's legally authorized representative (LAR)? Yes ☒ -** See below **No ☐**
   - 1.1. **If no,** *skip to question 2.*
   - 1.2. **If yes,** check one or both of the below boxes if they apply to this study:
     - 1.2.1. ☐ Information will be obtained through oral or written communication with the prospective subject or the subject's LAR
     - 1.2.2. ☒ Identifiable information or biospecimens will be obtained by accessing records or stored identifiable biospecimens.

NOTE: *If either or both of the above boxes is checked an informed consent waiver request does not have to be submitted for this activity. However, a request for a HIPAA waiver will still need to be submitted and informed consent obtained for any research interventions after eligibility is established. If neither box was checked, this activity will need to be included in a request for an informed consent waiver.*

2. **Will the project involve requesting any waiver or alteration of the consent process or a waiver of documentation of consent for any part of the project? Yes ☒ -** See below **No ☐**
   - 2.1. **If no,** *skip to question 3.*
   - 2.2. **If yes,** check one or more of the following boxes and submit the applicable waiver request(s).

☐	An alteration of the informed consent process ***NOTE****: If deception is involved this box should be checked.*
☐	Waiver of informed consent for only a specific portion(s) of the study (not including recruitment). ***Specify for what portion(s) of the study the request is being submitted****:*
☐	Waiver of documentation of informed consent. ***Specify for what portion(s) of the study the request is being submitted****:*

3. **Will documented informed consent be obtained from participants? Yes ☒ No ☐**
   - 3.1. **If no,** *go to question 4.*
     - 3.1.1. **If yes,** will there be the use of surrogate consent? **Yes ☐ No ☒**
     - 3.1.2. **If yes and this is a repository study,** will a broad consent be used? **Yes ☐ No ☒**

NOTE: *Reference the CMCVAMC IRB Form 104 template, Combined ICD/HIPAA Authorization, and follow the instructions. If planning to obtain surrogate consent, check applicable state and local laws to ensure compliance.*

4. **Does the project involve photos, videos or voice recordings of a participant that are done for research purposes? Yes ☒ No ☐**

4.1. **If yes,** this must be covered in the informed consent document (ICD), information sheets, telephone screen scripts*)*

SECTION 7: HIPAA AUTHORIZATION FOR PROJECT PARTICIPANTS

***NOTE**: Written HIPAA Authorization signed by the individual to whom the information or record pertains is required when VA health care facilities need to utilize individually-identifiable health information for a purpose other than treatment, payment, or health care operations, e.g., research. (VHA Handbook 1605.1).*

1. **Check all of the following that apply if Protected Health Information (PHI) will be used. If more than one box is checked, specify the part or phase of the study to which the specific checked boxes apply:** *A project specific HIPAA Authorization combined with the informed consent document is to be used for enrollment of participants. Request for a HIPAA Waiver of Individual Authorization for recruitment purposes only is during reviewing and screening of participants records prior to enrollment.*

☒	A project specific HIPAA Authorization is combined with the informed consent document.
☐	A separate project specific participant HIPAA Authorization form (VA Form 10-0493) is attached. ***NOTE**: This is highly recommended when enrolling individuals with impaired decision making or with longitudinal studies requiring reconsent*
☐	A request for a HIPAA Waiver of Individual Authorization is attached to cover the entire study.
☒	A request for a HIPAA Waiver of Individual Authorization for recruitment purposes only is attached.
☐	A request for a HIPAA Waiver of Individual Authorization is attached to cover a portion of the study. ***Specify portion of study***:

2. **Will the project require that participants authorize release of medical records or health information from non-VA sites?** ☐ Yes ☒ No

SECTION 8: PARTICIPANT RECRUITMENT INFORMATION

1. **Describe the recruitment strategy for the just, fair, and equitable recruitment and selection of subjects, and reference recruitment procedures as cited in the protocol to include the following:** ***Step-by-step*** *how recruitment will take place, i.e., obtaining names from CPRS or other databases, use of recruitment letters, referrals, posters, phone calls etc., to include any screening procedures prior to enrollment.* ***Number steps or use bullets.***

1. *Eligible participants on LTOT will be identified through the VA Corporate Data Warehouse (CDW).*
2. *A focused electronic medical record (EMR) review will be conducted to determine inclusion/exclusion criteria.*
3. *A list of eligible participants will be compiled into an Excel file and saved on the secured CHERP server.*
4. *Eligible participants will be mailed a study letter informing them on the purpose of the study and how to opt out of being contacted if they're not interested in being contacted.*
5. *Those who do not opt out will be contacted by telephone. Five attempts will be made to make contact.*
6. *In addition, potential participants may be informed about the study by their primary care provider and be provided with a study letter.*

***NOTE:** VA policy prohibits "cold calls" to potential VA research participants. Initial contact must be made in person or by letter prior to making any telephone contact, unless there is written documentation that the subject is willing to be contacted by phone about the specific study or the specific kind of*

research. The initial telephone contact must also provide a telephone number or other means for the potential participant to use to verify the study constitutes VA research (VHA Handbook 1200.05)

2. **Will the recruitment strategies described above be allowed to vary among sites?**
Yes ☐ **No** ☐ **N/A** ☒

3. **Are any model recruitment materials going to be made available? Yes** ☒ **No** ☐
3.1. **If *yes*,** list all type of materials that will be used and indicate whether each type of material is being submitted with this application or whether it will be submitted later as an amendment. ***If there will be telephone contact during the recruitment process, a script must be provided and listed below.***

Recruitment Material Type	Included with Application
Study Letter	Yes ☒ No ☐ Will submit an amendment
Telephone Script	Yes ☒ No ☐ Will submit an amendment
	Yes ☐ No ☐ Will submit an amendment

Additional rows can be added as required.

***NOTE**: All recruitment materials **must** be reviewed and approved by the IRB **prior** to use as part of any recruitment activities. All recruitment materials **must include** a statement that the study involves VA research and a telephone number or other means for the potential participant to use to verify that the study is VA research.*

SECTION 9: PAYMENT TO PARTICIPANTS

1. **Will participants receive compensation in this study? Yes** ☒ **No** ☐
(**If *no*,** skip this section and go to Section 10.)

***NOTE:** If applicable, the method (and relative amounts) of payment should be the same at all participating sites whenever possible. Investigator will be asked to provide justification to the IRB for differences in method and/or relative amounts.*

2. **Indicate the preferred method and mode of payment as follows:**
2.1. **What form of payment will be used, i.e., check, voucher, gift card?**
Voucher
2.2. **What is the schedule of payments, i.e., one-time or after specific visits?**
$5 for bi-weekly surveys (up to 18 times over 9 months) and
$25 for quarterly surveys (up to 4 times over 9 months)
2.3. **Provide the total amount for entire participation**
Up to $190 total

3. **Provide justification that the proposed payments are reasonable and commensurate with the expected contributions of the participant to the project:**
The primary request for participants is completion of the surveys above, as study participation otherwise primarily involves making available a mobile application to use as desired, while participating in their usual care plan with their provider. As a result, we believe the propsed payments are reasonable and commensurate for the survey completion.

4. **Does the payment include transportation costs? Yes** ☐ **No** ☒
4.1. **If no,** will transportation costs be paid separately? **Yes** ☐ **No** ☒
4.2. **If yes**, explain

5. **Specify the source of payment:**
☒ CMCVAMC ☐ Other (specify):

6. **Will a social security number (SSN) be requested and/or used in making payment/compensation? Yes** ☐ **No** ☒

***NOTE:* If yes,** *be sure to include in the 'combined ICD/HIPAA' or the separate HIPAA authorization and informed consent the name of the organization making payment.*

SECTION 10: BIOLOGICAL SPECIMENS

1. **Will biological specimens be used in this protocol? Yes ☐ No ☒**
(**If *no***, skip this section and go to the next.)

2. **List the specimens that are being collected and indicate the purpose of the collection** *(one or both boxes may be checked.)*

Type of specimens	Research Use	Clinical Use
	☐	☐
	☐	☐

Additional rows may be added as required.

3. **Respond to the following questions by checking the appropriate box:**

	YES	NO
a. Does the project involve genetic testing*? If yes, see below:*	☐	☐
1) Does this include whole genome sequencing?	☐	☐
2) Will participants be informed of the results of any DNA testing?	☐	☐
b. Will specimens be kept for future use in other studies? ***If yes****, see question 7 below.*	☐	☐
c. Will samples be made anonymous to maintain confidentiality? ***NOTE:*** *Coding data is not considered making it anonymous.*	☐	☐
d. Will specimens be destroyed after the project-specific use is completed?	☐	☐
e. Will specimens be used for commercial profit? ***If yes,*** *see below:*	☐	☐
1) **If yes,** will participants share in this commercial profit?	☐	☐
f. Will participants be informed of the results of the specimen testing?	☐	☐
g. Are there any implications for family members based on specimen testing results? ***(If yes,*** *the family members may be participants.)*	☐	☐

4. **Will specimens be de-identified? Yes ☐ No ☐**
   4.1. **If *yes***, describe how the data will be de-identified, who will do it, and at what point in the process will the specimens be de-identified.

5. **What measures will be taken to minimize the potential for physical, psychological, financial, social, or legal harm from breaches of confidentiality and privacy resulting from unauthorized access to or loss of the specimens?**

6. **Describe how the destruction of samples will be substantiated:**

7. **If specimens are to be banked for future use in other studies, the following questions must be answered: ☐ N/A**
   7.1. **Indicate where the specimens will be banked**.
   7.2. **If above is a VA location**, what IRB is responsible for overseeing the operations of the tissue bank (i.e., local IRB or other multi-site IRB?).

NOTE: *If the bank is located at CMCVAMC, a Standard Operations Procedures (SOP) manual is required. Contact one of the IRB Coordinators to obtain the SOP template.*

SECTION 11: PRIVACY, CONFIDENTIALITY, AND INFORMATION SECURITY IN RESEARCH

1. **What type of data will be recorded/collected by the Principal Investigator study team?**

Check all that apply:

☐ **De-identified** – Data does not contain any identifiers that could link the data to a specific participant. *(See VHA Handbook 1605.01, Appendix B, para 2b, for a list of identifiers that must be removed before data can be considered de-identified. Data must be de-identified in accordance with HIPAA and Common Rule criteria. Scrambling of names and social security numbers is not considered de-identified information.)*

☒ **Identified** – Data contains direct identifiers sufficient to identify participants as indicated in VHA Handbook 1605.01, Appendix B, para 2b. *ALL HIPAA IDENTIFIERS INCLUDING DATES.*

☒ **Coded** – Data linked to a specific subject by a code rather than a direct identifier. While the data may contain some protected health information (PHI) only someone possessing the code can link the data to a particular participant.

1.1. **If coded data is checked,** specify how the link or code will be maintained, and list each person/role who will have access to the link or code:
Veteran's protected health and personally identifiable information will be coded and securely stored in a file cabinet behind closed doors in CHERP Room B110. Identified and coded data will be kept in two separate file locations, both located in Room B110. Any electronic data will be kept on the secured CMCVAMC server vhaphicherpnas (//vhaphifpccherp.v04.med.va.gov\shares2\Chhabra_Manik). Any audio recordings from the Motivational Interviewing sessions will be uploaded same day onto a VA computer and audio files will be saved on the secured CMCVAMC server vhaphicherpnas (//vhaphifpccherp.v04.med.va.gov\shares2\Chhabra_Manik) and subsequently erased from the audio recorder.The code linking the identified/coded data will will be maintained in a separate, password protected file, stored electronically on the CHERP server and be accessible on ly to the PI.

2. **Indicate how the PHI will be obtained by checking one or more of the boxes below:**

☒ **From existing sources such as medical records, clinical databases, or research records.**

If the above box is checked, specify each source and who maintains the database:

Database Name	Who Maintains the Database
Corporate Data Warehouse	VA
CPRS Medical Charts	VA

Additional *rows may be added as required.*

☐ **Directly from project participants during protocol procedures as described elsewhere in this application or in the protocol.**

3. **Check which of the following HIPAA identifiers will be collected and recorded during the course of the study:**

☒ Names	☒ Social Security (or scrambled SSNs)/Medical record numbers	☐ Device identifiers and serial numbers
☒ E-mail addresses	☐ IP Addresses (Internet Protocol	☐ URLs (Universal Resource Locator)
☒ All elements of dates (except year) and any age over 89 *Specify:* *DOB*	☐ Health plan beneficiary numbers	☒ All geographic subdivisions' smaller than a state *Specify:* *City/zip code information will be collected to mail letters to potential participants*
☒ Telephone numbers	☐ Account numbers	☐ Biometric Identifiers including finger and voice print
☐ Fax numbers	☐ Certificate or license numbers	☐ Full face photographic images and comparable images
☐ Vehicle ID and serial numbers including license plate numbers	☐ Other unique identifying number, characteristic, or code *Specify:*	☐ HIV (testing or infectious disease) records
☐ Sickle Cell Anemia	☐ Drug Abuse Information	☐ Alcoholism or Alcohol Use

4. **Will a non-VA entity have access to VA sensitive data?** **Yes** ☐ - See below **No** ☒

4.1. **If *yes***, specify each entity and identify their roles in the study:

Name of Non-VA Entity	Role in Study

Additional rows may be added as required.

4.2. **If yes,** will a copy of a Data Use Agreement (DUA) or a Cooperative Research and Development Agreement (CRADA) with this application? **Yes** ☐ **No** ☐ **N/A** ☒
***NOTE: If no**, a DUA or CRADA **must** be provided to the IRB for review prior to initiation of any research procedures.*

5. **List the study team members by title who will have access to the data.** *(Specify approximate number of personnel and their job categories, e.g., 2 Co-investigators, 4 Nurse Coordinators, etc.)*
1 Investigator, 1 co-investigator, 2 Collaborators (as listed in current staff form)

6. **Will specially obtained software be used?** **Yes** ☐ - See below **No** ☒

6.1. **If *yes***, describe the software, the source of the software, whether a license will be required and who will fund the license, as well was any data that will be stored in temporary files on the computer's hard drive.

7. **Will any web-based applications be used?** **Yes** ☒ - See below **No** ☐

7.1. **If yes**, identify the application and its security features. Indicate how it will be used, e.g., for recruiting subjects, completing questionnaires, or processing data.
The Manage My Pain app will be used for participants randomized to the control intervention. This app is freely available on both Android and iPhone operating systems.

SUMMIT will be used for participants randomized to the experimental intervention. Both of these web-based applications will be used on their personal mobile phones that will not collect identifiable data but solely used as educational web-tools for the participants.

The VA REDCap will be used for completion of participant questionnaires.

VA HealtheDialog texting system (ANNIE) will be used to send participants text messages in regard to completing surveys and utilizing the SUMMIT application.

8. **How will electronic data and/or paper records be secured? If data is being stored on a computer hard drive, indicate if it is encrypted per VA guidelines.**
Veteran's protected health and personally identifiable information will be coded and securely stored in a file cabinet behind closed doors in CHERP Room B110. Identified and coded data will be kept in two separate file locations, both located in Room B110. Any electronic data will be kept on the secured CMCVAMC server vhaphicherpnas (//vhaphifpccherp.v04.med.va.gov\shares2\Chhabra_Manik).
***NOTE:** Electronic research records should be stored/secured on the Research and Development server (Z drive), MIRECC server, PADRECC server or CHERP server.*

9. **Will mobile devices be used in the study, i.e., laptops, audio recorders? Yes ☒ No ☐**
9.1. **If yes**, indicate that mobile devices will be encrypted and that the encryption is FIPS 140-2 validated.
An audio recorder that meets encryption level and is FIPS 140-2 validated will be used for the Motivational Interviewing sessions in the experimental arm.

10. **How will data be transmitted and/or shipped, and how will it be protected during transmission or shipping?**
N/A

11. **How will project research data be stored?**
11.1. Indicate precisely where data will be stored to include physical site, network location/server name, type of mobile storage device, building and room number etc.
Veteran's protected health and personally identifiable information will be coded and securely stored in a file cabinet behind closed doors in CHERP Room B110. Identified and coded data will be kept in two separate file locations, both located in Room B110. Any electronic data will be kept on the secured CMCVAMC server vhaphicherpnas (//vhaphifpccherp.v04.med.va.gov\shares2\Chhabra_Manik). Any audio recordings from the Motivational Interviewing sessions will be uploaded same day onto a VA computer and audio files will be saved on the secured CMCVAMC server vhaphicherpnas (//vhaphifpccherp.v04.med.va.gov\shares2\Chhabra_Manik) and subsequently erased from the audio recorder.

***NOTE:** If data will reside on a non-VA server or non-VA equipment, specify that the server is certified and accredited as required by the Federal Information Security Management Act of 2002 (FIMSA) and that the required permissions for use of a non-VA server have been obtained. Contact the CMCVAMC Information System Security Officer (ISSO) for more information.*

11.2. **If any of the 18 HIPAA identifiers (VA sensitive information) is being stored outside the protected VA environment, the following questions must be answered**: ☒ **N/A**
11.2.1. **How are the data being protected?**
11.2.2. **Indicate what VA information will be returned to the VA, how the information will be returned, and/or the plans for its eventual destruction at the alternate non-VA site**.
11.2.3. **Is there a Memorandum of Understanding (MOU) and/or a Data Use Agreement (DUA) in place regarding the transfer and storage of the data outside the VA environment**?
Yes ☐ **No** ☐
a) **If yes,** specify and/or attach agreement.

b) **If no,** indicate why not.

12. **How long will the research data be stored and describe how the data will be destroyed once the maximum retention period as specified by the VHA Records Control schedule or the indicated retention period, if longer, is met?**

All research data will be stored and secured throughout the study process and after completion of the study. No research data may be destroyed until after 6 years after study is completed in conjunction with discussion with research liaison.

13. **What is the plan for protecting project research data from improper use or disclosure?**

NOTE: *As part of the response to this question, indicate that removal of access to research study data will be accomplished for study personnel when they are no longer part of the research team. Include that the ISO and Privacy Officer will be notified within one hour of the improper use or disclosure.*

Study staff will be the only ones who will have access to the project research data. In addition all data collected will be stored on the VA secure server. No data will leave the protected VA environment, thus no data will be returned to the VA as well. All records will be retained according to VA regulations. The removal of access to research study data will be accomplished for any study staff members that are no longer part of the research team. The ISO and Privacy Officer will be notified within one hour of the improper use or disclosure of project research data.

14. **Will a Certificate of Confidentiality (CoC) be obtained? Yes ☐ No ☒**

14.1. **If yes**, include this information in the informed consent document (ICD).

NOTE: *If this is a qualifying NIH Study, the CoC will be assumed. A CoC helps investigators protect the privacy of human research participants enrolled in biomedical, behavioral, clinical and other forms of sensitive research. Certificates protect against compulsory legal demands, such as court orders and subpoenas, for identifying information or identifying characteristics of a research participant. For more information on CoCs go to: http://grants.nih.gov/grants/policy/coc/.*

15. **Will data be disclosed (copy given) outside of VHA? Yes ☐ No ☒**

15.1. **If yes**, describe to whom the data are to be disclosed, the justification for such disclosure, and the authority for the disclosure, e.g., HIPAA authorization or VA Form 10-5045, Request for and Authorization to Release Medical Records or Health Information.

16. **Will data be banked for re-use in future studies? Yes ☐** - See Below **No ☒**

16.1. **Where will the data be banked**?

16.1.1. **Name of entity**:

16.1.2. **Location**:

16.2. **Is this an existing data repository with appropriate oversight mechanism per VHA Handbook 1200.12 or, if a non-VA entity, are the appropriate safeguards addressed in the CRADA or DUA? Yes ☐ No ☐**

16.1.1. **If no,** indicate for VA entities that approval will be sought from the local IRB where the repository will be housed, whether a separate study or amendment will be submitted to the IRB for review for creation of the data repository, OR for non-VA sites, whether the CRADA or DUA is still being negotiated.

SECTION 12: FDA-REGULATED AND OTHER PRODUCTS

1. **Does the project require use of drugs, biologics, supplements, or devices?**
   Yes ☐ **No** ☒ - **If no,** skip to Section 13

2. **Indicate the type of clinical trial if applicable?**
   ☐ **Phase I** ☐ **Phase II** ☐ **Phase III** ☐ **Phase IV**

3. **Does the project involve an Investigational New Drug Application (IND) or Investigational New Device Exemption (IDE), Abbreviated IDE, or IND Exception?** **Yes** ☐ **No** ☐
   3.1. **If *yes***, attach a copy of any applicable correspondence with the FDA and complete the following:
   3.2. **If applicable**, indicate the name of the person or organization holding the IND or IDE.
   3.3. Is there a plan for onsite data monitoring? **Yes** ☐ **No** ☐
   3.3.1. **If yes,** specify who will conduct monitoring responsibilities and how often.

4. **How will FDA-regulated products used in this study be dispensed and tracked to participating sites?**

5. **If using FDA-regulated drugs or biologics, indicate use: N/A** ☐

☐	Approved Drug(s) or Biologics For Approved Uses
☐	Approved Drug(s) or Biologics for Unapproved Uses (Use will be inconsistent with product labeling or involves a new use, labeling, advertising change, or a change in dose, dosage form, administration schedule, or recipient)

6. **List all drugs, biologics, or supplements to be used below. N/A** ☐

Generic Name	Trade Name	Manufacturer	Use Consistent with Product Labeling? Yes/No	IND Number if Applicable

Add additional rows to table if necessary

   6.1. Is an Investigator's Brochure included with the application materials? **Yes** ☐ **No** ☐
   6.1.1. **If no,** indicate why?

   6.2. For all approved drugs used for an unapproved use, describe the unapproved use: ☐**N/A**

   6.3. If an IND is **not** required, explain and/or provide sponsor or FDA documentation**:** ☐**N/A**

7. **If using FDA-regulated devices, indicate use: N/A** ☐

☐	Approved Device(s) for an Approved Use
☐	Approved Device(s) for an Unapproved Use
☐	Other *(e.g., humanitarian use device; 510k clearance) Specify:*

8. **List the FDA-regulated devices that will be used. N/A** ☐

Name	Manufacturer	Use Consistent w/ Product Labeling?	Significant Risk (SR) or Non-significant	IDE Number if Applicable

		Yes, No, or N/A	Risk (NSR), Unknown, or N/A	

8.1. Is manufacturer's device information included with the application materials? **Yes** ☐ **No** ☐

8.2. If this is a non-significant risk device study, is documentation attached with the application materials explaining the manufacturer's or a sponsor's determination why the device is not a Significant Risk (SR) device ? *(See 21 CFR 812)* **Yes** ☐ **No** ☐

8.3. If applying for an IDE, is a copy of the dated IDE application letter to the FDA attached? **Yes** ☐ **No** ☐ **N/A** ☐

SECTION 13: REQUEST FOR EXPEDITED REVIEW

☐ Check if **NOT** requesting expedited review

1. **Check the below boxes as applicable for this study. All three boxes must be checked in order for the study to qualify for expedited review:**

☒ The project presents no more than minimal risk to participants.

☒ The identification of participants or their responses will not reasonably place them at risk of criminal or civil liability or be damaging to their financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.

☒ The project is not classified.

2. **If all three boxes are checked above, indicate one or more categories below for which this study would qualify for expedited review:**

☐ Category **1:** Clinical studies of drugs and medical devices only when one of the following conditions is met.

☐ **1a:** Research on drugs for which an investigational device exemption application (21 CFR Part 812) is not required.

☐ **1b:** Research on medical devices for which:
(i) an investigational device exemption application (21 CFR Part 812) is not required; or
(ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

☐ **Category 2:** Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:

☐ **2a:** From healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8-week period and collection may not occur more frequently than 2 times per week.

☐ **2b:** From other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the

lesser of 50 ml or 3 ml per kg in an 8-week period and collection may not occur more frequently than 2 times per week.

☐ **Category 3:** Prospective collection of biological specimens for research purposes by noninvasive means.

☐ **Category 4:** Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x- rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing.

☒ **Category 5:** Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis). This category also includes research involving materials that were previously collected for either non-research or research purposes, provided that any materials collected for research were not collected for the currently proposed research.

☒ **Category 6:** Collection from voice, video, digital or image recordings made for research purposes.

☒ **Category 7:** Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

If the project does not fit into one of the above categories, it does not qualify for expedited review.

SECTION 14: ABSTRACT

1. **Objectives(s):** *The purpose of this study is to evaluate the feasibility of a full-scale efficacy randomized control trial (RCT) of SUMMIT (), a multi-component web program designed to enable Veterans to safely taper opioids.*

2. **Research Design:** *The study design is a 9-month, randomized, two-arm, parallel, open-label feasibility trial. Eligible participants will be randomized to a brief single Motivational Interview (MI) session and SUMMIT versus a pain monitoring app, Manage My Pain App. All participants will be provided a referral to speak with a clinical pharmacy specialist about their medications and options for tapering. Feasibility and outcomes planned for a full-scale RCT will be collected at one-, three-, six-, and nine-months post-intervention. Opioid dose and AEs will be collected biweekly. Given the urgency to develop effective programs to support tapering efforts, an interim analyses will be conducted at three months to evaluate trends in the recruitment rate, use of SUMMIT, and opioid dose reduction. If positive, results of these analyses will expedite the onset of the planned full-scale RCT.*

3. **Methodology:** *This study will target Veterans on long-term opioid treatment (LTOT) who will be identified using data available in the VA National Corporate Data Warehouse (CDW) and a focused electronic medical record (EMR) for Veterans who remain potentially eligible. Inclusion criteria for Veterans will be primary care patients who are dispensed ≥84 consecutive days of a stable dose of opioids (reflecting three consecutive 28-day prescriptions) or on buprenorphine through primary care and who report stable levels of pain intensity over the past month. Exclusion criteria will be Veterans on liquid methadone, have hearing or visual impairments (not corrected with hearing aids or glasses), psychiatric conditions, cognitive impairments, or participating in a concurrent pain or opioid-related research study. Up to 64 patients will be recruited to participate in Phase 2. The study visit with the participants will be conducted in a private area within the clinical care setting or in a research designated room at the CMCVAMC. After completing informed consent, participants will be trained how to electronically complete baseline assessments on their preferred device (i.e., tablet, smart phone, laptop). Afterwards, the patients will be randomly assigned to the intervention or control group.All participants will be provided a referral to speak with a clinical pharmacy specialist about their medications and options for tapering. The intervention arm will participate in a MI session lasting between 30 and 60 minutes, which will be audio recorded, and use SUMMIT. The participant will be registered into the VA HealtheDialog text messaging system to allow for surveys and the SUMMIT web application to be sent via text messages. The control arm will not participate in a MI session and will use the Manage My Pain app, which only includes a pain monitoring function. Opioid dose and AEs will be collected biweekly. Assessments will be completed electronically at one, three, six, and nine months post-randomization. A detailed report will be prepared of these findings.The team from the West Haven VA will be involved only in the data analysis of of the study data.*

4. **Clinical relationships:** *N/A*

5. **Impact/Significance:** *N/A*

SECTION 15: LIST OF ABBREVIATIONS

Provide a list of all abbreviations used in the protocol and their associated meanings.

1. LTOT – Long Term Opioid Therapy
2. CDW – Corporate Data Warehouse
3. EMR – Electronic Medial Record

SECTION 16: PROTOCOL SUMMARY

1. **Introduction**

1.1. **Provide scientific background and rationale for study.**

Marked increases in opioid prescribing in the last 25 years have led to serious patient safety issues and modest or no benefit. Opioid prescribing quadrupled from 1990-2015. Meanwhile, rates of serious harms, some that typically occur acutely and some related to cumulative long-term exposure, have increased.(1) the most catastrophic harm – overdose – has increased 5-fold since 1995 and is now the number one cause of accidental death in the u.s. by a large margin.(2) veterans have approximately double the rate of opioid overdose compared with non-veterans.(3) along with the myriad potential adverse events (aes) associated with long-term opioid therapy (LTOT), mounting evidence suggests it has modest or absent benefit. A cochrane meta-analysis of randomized and non-randomized studies lasting six months or longer in nearly 5000 participants found only a small or modest benefit among study completers (representing ~30% of participants).(4) the first pragmatic, long-term randomized controlled trial (rct) comparing an opioid-intensive to an opioid avoidant chronic pain management strategy found no improvement in chronic pain outcomes in veterans and double the side effects at 12 months.(5) moreover, survey-based studies of veterans describe high levels of ambivalence about LTOT with fears about becoming dependent and complaints about waning benefit and feeling "drugged."(6)

Guidelines recommend tapering LTOT when harm outweighs benefit; observational data suggest improved quality of life (qol) among persons who successfully taper. In view of the evidence for harm and limited benefit of LTOT, both the centers for disease control and prevention and va/dod recently released guidelines for LTOT that stood out as marked departures from previous guidelines in that they both recommended avoiding initiation of LTOT.(7, 8) regarding persons currently on LTOT, both strongly recommended tapering or discontinuing opioids when harm outweighs benefit. Concurrently, the strongest evidence to date demonstrate no added benefit of LTOT in veterans with chronic pain(5) and observational studies demonstrate that patients who successfully taper experience improved qol and stable or even improved pain.(9-12) taking all these factors together, we assert that it is patient-centered and evidence-based to inform all patients on LTOT about the known harms and typically absent benefit of this therapy and to offer all patients on LTOT the opportunity to engage in a structured supportive tapering program.

Despite the widespread calls for de-implementing LTOT, patient-centered methods of tapering or discontinuing opioid therapy are still needed. A recent systematic review found 62 studies of opioid tapering but only nine rcts.(13) benefits in pain severity, function and qol following opioid reduction or discontinuation were achieved; however, few of these interventions were conducted in primary care settings and all were of very low quality evidence. One subsequent rct of a physician assistant-led opioid tapering program compared to usual care among persons willing to taper found that the intervention group improved significantly more than the usual care group in self-reported pain interference, pain self-efficacy, and prescription opioid problems at 22 weeks.(14) yet, there was no difference in the decrease in mean opioid dose across groups. In an evaluation of an organizational level implementation intervention to improve pain care quality over four years, the proportion of primary care patients on LTOT did not change, despite improvement in several other metrics of pain care quality.(15)

1.2. **Include summary of gaps in current knowledge, relevant data, and how the study will add to existing knowledge**.

1. *Indirect data support the potential effectiveness of a patient-centered opioid tapering intervention. Qualitative and quality improvement data show that patients are willing to consider tapering if support is present. In our queri-funded qualitative study of barriers and facilitators to reductions in high-dose opioid therapy (as well as uptake of non-pharmacologic treatment), patients expressed frustration about perceived inadequate communication regarding the rationale for pain treatment plans; lack of their own and provider knowledge about tapering; and care fragmentation.(16) other va-based work revealed that patients view*

the possibility of worsened pain and the system abandoning them as major barriers to initiating tapers.(17) they felt that having access to tailored information and timely follow up on treatment plans were important facilitators. Providers reported struggling to enhance patients' motivation to engage with tapers and being daunted by the close and frequent follow-up that changes in pain treatment would entail. They discussed the availability of technology-enhanced, collaborative care approaches as strong facilitators.

2. *An effective web-based program could be useful in variably resourced settings. In a needs assessment conducted for this study, primary care providers (pcps) and veterans noted that the main barrier to opioid tapering was the lack of resources available to veterans between outpatient visits. The goal of this proposal is to address this gap by developing SUMMIT,an interactive, theory-informed, multi-component mobile website program to enable veterans to safely taper opioids. To expedite implementation, as advised by the office of connected care, we propose to develop SUMMIT as a web-based program that can be accessed with anonymized login credentials, does not store personal health or identifying information, and does not interact with the va health record (akin to va ptsd coach). SUMMIT, if shown to be effective, would be useful in augmenting the effort of well-resourced facilities that can afford dedicated provider time to tapering. But in the more common scenario in which clinicians have little time to devote to tapering, SUMMIT could be used as an enhancement to usual care, modeled after a landmark study by tannenbaum et al.(18) in this study, older patients on long-term benzodiazepine treatment were mailed a detailed 8-page pamphlet that included safety-related reasons they should taper benzodiazepines and instructions on tapering. At six months, 27% of the intervention group had discontinued benzodiazepines compared with 5% of the control group. While this study demonstrates that people can taper medications with relatively minimal support, based on our qualitative results(16) and our experience caring for veterans on LTOT, we believe that additional motivation and support will be required to be successful.*

3. *Intervention mapping (im) is a rigorous method of developing a multicomponent behavior intervention. Expert consensus recommends stepwise development of an intervention following a structured framework.(19) the widely-studied and applied im approach will serve as the framework for developing SUMMIT.(20) im was created to help health promoters develop the optimal intervention, based on planning, research, and theory, by creating a vocabulary for intervention planning, procedures for planning activities, and technical assistance with identifying theory-based determinants and methods for change. Im also provides a taxonomy of behavior change techniques (bcts) for use in supporting intervention content. In healthcare, im has been successfully applied to a wide range of different behaviors and populations.(21) particularly relevant to developing ehealth interventions, im lends itself to a user-centered design, which is essential to maximize acceptability, use, and adherence. We will use im to guide this proposal in two broad areas: (1) the identification of behavioral and environmental determinants related to opioid tapering, and (2) the selection of the most appropriate theoretical methods and practical applications to address the identified determinants.*

4. *Web-based applications are effective. Web-based programs, requiring no, or SUMMITed (synchronous or asynchronous) person-to-person contact, can be effective in changing behaviors as well as in treating chronic conditions. A recent review found that web-based interventions decreased illicit substance use after treatment [hedges' g (95% ci) = 0.31 (0.23 - 0.39)] and after six to 12 months of follow-up [hedges' g (95% ci) = 0.22 (0.07 - 0.37)].(22) a review of computerized interventions for depression and anxiety (common co-morbid conditions in veterans with chronic pain) commissioned by the va's evidence-based synthesis program reported large post treatment effects for patients diagnosed with generalized anxiety (standardized mean difference (smd) = 0.94) and major depression (smd = 0.82) and moderate treatment effects for those with depressive symptoms without a confirmed*

diagnosis of major depression (smd = 0.40).(23) of particular relevance to this proposal, several systematic reviews have confirmed that web-based programs are an effective adjunct to help patients manage chronic pain.(24-27) the most recent review found effect sizes (hedges' g) of -0.39 for pain interference, -0.33 for pain intensity, and -0.49 for catastrophizing.(28)

5. *Studies have found that multicomponent interventions are more effective than single component interventions.(29, 30) testing a multicomponent intervention "as a package"(31) will enable us to test the strongest possible program; however, this approach makes it difficult to understand the mechanism of action underlying any observed changes and does not provide a clear understanding of whether inclusion of all components is required to achieve the same benefit. To mitigate this limitation, we will follow best practices to enable future "deconstruction" of SUMMIT by: specifying the theoretical rationale for each bct; enumerating the specific theoretical constructs associated with each bct; classifying each bct according to the im taxonomy; measuring actual use of each component; supplementing quantitative measures with qualitative data to improve measures of actual use; and examining whether the amount of use of specific SUMMIT components is associated with change in specified theoretical constructs, and whether the latter mediate the relationship between treatment assignment and clinical outcome measures (see d.14.b and d.17.a).(31-36)*

6. *Incorporating the right design features is important to maximize retention. Though there are several important advantages to web-based health interventions, including their ability to dramatically increase access, offer a menu of options that can be selected according to each individual veteran's preferences, and tailor information based on individual user's needs and/or performance, attrition is a well-documented and prevalent downside.(37) several strategies have been shown to decrease attrition. These include: choosing bcts based on relevant theoretical constructs,(38) tailoring information,(39) provision of feedback, social networking and support,(40, 41) and use of "nudges" or persuasive techniques.(42) in a recent detailed review of adherence to web-based interventions, "dialogue support" was found to be the principle persuasion technique influencing adherence.(43) in this context, dialogue support includes offering praise, rewarding targeted behaviors, use of system reminders or prompts, providing suggestions to help reach target behaviors, inclusion of content that reminds patients of themselves,(39) using an attractive design, and ensuring that the system acts in a social manner (for example as a coach or instructor).(43) feedback is an effective component of dialogue support and can be successfully delivered using automated systems.*

7. *Motivating veterans to taper LTOT will be challenging. We acknowledge that motivating veterans on LTOT to taper will be difficult as many may be strongly biased to remain with the status quo. We will address this bias by including motivational interviewing (mi) as part of the intervention. Mi is a patient-centered approach that explores and develops patients' motivation and commitment to change within a collaborative, highly empathic patient-provider relationship. Characteristically, providers blend a combination of fundamental patient-centered counseling skills (e.g., reflective listening) with advanced strategic methods to elicit patient statements that favor change, called "change talk." Trained counselors help the patient develop and appreciate discrepancies between important life goals and current behavior; thus, the motivation, while facilitated by the counselor, comes from the patient. Mi has been demonstrated to significantly increase patients' intrinsic motivation for change and to increase self-efficacy for making behavioral changes across multiple conditions.(44-49) in this study, dr. Edmond (co-i) will conduct a single mi session with participants randomized to the intervention arm. The use of single session mi is supported by several studies.(50-53)*

8. *Innovation: how our vision for SUMMIT differs from currently available pain apps. Robust pain self-management skills are critical to enable patients with chronic pain to optimize qol. In view*

of this need, numerous web- and smartphone-based applications (apps) have been developed to increase competence and confidence is using these skills.(54, 55) while we recognize the value of these interventions, they are not designed to impact LTOT and therefore are unlikely to address the specific needs of veterans interested in tapering. Indeed, our qualitative work and preparatory interviews with patient-partners have emphasized the need to tailor the messaging and content of self-management strategies to issues relevant to LTOT. Based on the tannenbaum study cited above,(18) we infer that to impact behavior change with respect to opioid use, addressing the issue directly, clearly and transparently, as we propose to do in SUMMIT, will afford the highest likelihood of observing LTOT reductions. Thus, SUMMIT will differ from available apps in that 1) it will include approaches directly aimed at encouraging and supporting tapering, and 2) all self-management strategies included in the prototype will be tailored to the specific needs of those on LTOT. Phase 1 of the SUMMIT trial focused on development of the application; Phase 2 is focused on feasibility testing.

9. *Significance: while guidelines recommending against LTOT initiation should help prevent future harms, hundreds of thousands of veterans currently on LTOT are left vulnerable as there are insufficient resources to help them taper and/or ultimately discontinue LTOT. To afford a safe, veteran-centered tapering strategy to those currently prescribed LTOT, programs must be developed to extend the reach of face-to-face encounters with health professionals. Pcps, responsible for most of LTOT prescribing in VHA, are already overextended and spending additional time recommending and overseeing opioid tapers may be untenable. Thus, we are developing SUMMIT as an ancillary intervention to support, reinforce, and complement provider-initiated opioid tapering initiatives across the vha. To ensure rigor and successful future implementation, we will: 1) develop an evidence-based program with features proven to maximize engagement and retention; 2) ensure that the program includes mechanisms to address the diverse obstacles veterans report when consider opioid tapering (e.g., fear of pain flares and abandonment by the system); 3) employ a user-centered design process with meaningful input from veterans and pcps throughout the development and testing phases; and 4) adhere to recently published guidelines for mobile health interventions.(56) in addition, to ensure that SUMMIT is veteran-centered, veterans have played and will continue to play key roles in its development, testing, and execution.*

1.3. **Include rationale for including or excluding certain populations – in particular vulnerable populations.**
Not Applicable

2. **Objectives**

2.1. **Describe the study's purpose, specific aims, or objectives**.
The purpose of this research study is to evaluate the feasibility of a full-scale efficacy randomized control trail (RCT) of SUMMIT), a multi-component web program designed to enable Veterans to safely taper opioids.

2.2. **State the hypotheses to be tested.**
We hypothesize that the proposed feasibility trial will support a future definitive large-scale trial.

3. **Resources and Personnel**

3.1. **Include where and by whom the research will be conducted.**
The study will be conducted by the PI, at the CMCVAMC. Data analysis and support will be provided by the co-investigoars and collaborators at the West Haven VA.

3.2. **Provide a brief description of each individual's role in the study. Be sure to indicate who will have access to protected health information and who will be involved in recruiting subjects; obtaining informed consent; administering survey/interview**

procedures; and performing data analysis.

-The PI will have access to all study data, be involved with recruitment, obtaining informed consent and HIPAA authorization, and administering interviews.

-The Co-Investigator and the collaborators will meet monthly with the PI to discuss study design and oversee study progress. The co-investigators and collaborators will be involved with data analysis and will not have access to PHI.

-The research assistant, to be hired, will be involved with recruitment, obtaining informed consent and HIPAA authorization, and administering the initial study visit.

3.3. **If applicable provide information on any services that will be performed by contractors including what is being contracted out and with whom.**

N/A

3.4. **If applicable provide information on any Memoranda of Understandings (MOUs) or Data Use Agreements (DUAs) that are being entered into including with whom and for what reason.**

N/A

4. **Study Procedures**

4.1. **Study Design**

4.1.1. **Describe experimental design of the study. Include sequential and/or parallel phases of the study, including durations, and explain which interventions are standard of care.**

The study design is a 9-month, randomized, 2-arm, parallel, open-label feasibility trial. Eligible participants will be randomized to a brief single Motivational Interviewing (MI) session and SUMMIT versus a pain monitoring app. All participants will also be provided a referral to speak with a clinical pharmacy specialist about their medications and options for tapering.Feasibility and outcomes planned for a full-scale RCT will be collected at one-, three-, six-, and nine-months post-randomization. Opioid dose and adverse events (AEs) will be collected bi-weekly. We will send the link to the questionnaire to the participant if they have given permission to contact via email, otherwise we will send them the link via text, or read it aloud to them. Given the urgency to develop effective programs to support tapering efforts, we will perform interim analyses at three months. If positive, results of these analyses would expedite onset of the planned full-scale RCT.

Eligible patients on long term opioid treatment (LTOT) or on buprenorphine will be identified through VA Corporate Data Warehouse (CDW). Receipt of opioid medication will be defined as any dispense of a VA formulary category CN101 drug. Veterans having liquid methadone dispensed in the previous six months will be excluded. Because all methadone for the treatment of OUD is dispensed at federally licensed opioid treatment programs, we will cross check all methadone dispenses with stop code 523, the code used exclusively in those programs. For Veterans who remain eligible, a focused electronic medical record (EMR) review will be conducted to determine whether the Veteran is currently receiving liquid methadone or participating in a concurrent pain or opioid-related research study, and to check for evidence of hearing or visual impairments (not corrected with hearing aids or glasses), cognitive impairment or psychiatric condition. A list of eligible Veterans will be compiled into an Excel file and saved on the secured CHERP server. This list of potential subjects will NOT be printed out.

The study team will reach out via email to the primary care providers of Veterans who remain eligible after the above screening, to ensure the provider agrees with approaching the Veteran for possible enrollment.

Approved Veterans will then be mailed a letter informing them of the purpose of the study. The letter will notify potential participants that they will be telephoned by the project coordinator and will offer them the opportunity to refuse this contact by calling an answering machine and leaving a message. The project coordinator will telephone all patients who do not "opt out." If someone other than the participant answers the telephone, no personal health information (PHI) will be shared with the person who answers. Five attempts will made be to make contact with the potential participants. Veterans may also be informed of the opportunity to participate in the study by their primary care provider and be provided with a study letter. The study team will contact the Veteran within a week of provision of study letter. Participants will be assured that their participation is voluntary and that they can opt out from participating. During the telephone call, the remaining eligibility criteria will be verified.

Up to 64 patients will be recruited to participate in this research study. Due to COVID19, participants will undergo the informed consent process over the telephone, and provide oral consent.

All participants will be offered a referral to a clinical pharmacy specialist in the pain clinic to discuss options for medication management and opioid tapering. As part of the informed consent, patients will be reassured that the tapering steps will be conducted by their own pain care provider or with the assistance of the clinical pharmacy specialist..After obtaining consent, participants will be trained on how to complete baseline and outcome measures on their preferred device. ***Surveys will be sent to the participant via email through RedCap. As an alternative, we will register participants into the VA HealtheDialog text messages system in order to receive surveys and access the SUMMIT web application via link.*** *Baseline measures will be completed during this visit, prior to randomization, to ensure that participants are comfortable completing surveys electronically.*

Participants will be randomly assigned to the intervention or control group in a 1:1 ratio in eight blocks of eight using the Research Electronic Data Capture (REDCap) Randomization Module.

Randomization groups:
Experimental Intervention: Participants randomized to the experimental intervention will participate in a Motivational Interviewing (MI) session lasting between 30 and 60 minutes with a study coordinator. All MI sessions will be audiotaped using a VA-approved digital recorder and transcribed verbatim. Participants will subsequently be shown how to access SUMMIT through a web link via a set of unique anonymized login credentials and to navigate the components of SUMMIT on one or more devices, depending on their preference. They will then be trained on how to complete the outcome surveys ***on RedCap, which will be sent via email*** *.*

The SUMMIT application includes multiple modules for participants to learn about opioid tapering as well as other ways to manage their pain. As part of the application, participants will also have the option to connect with a peer support specialist at the VA who has previous experience with chronic pain and opioid tapering.

Control Intervention: Participants randomized to the control intervention will use an eHealth comparator: Manage My Pain(iPhone, Android). This app includes a pain monitoring functioning only, and thus will only minimally overlap, if at all, with SUMMIT's components. Control participants will not participate in a MI session. Participants will download the app and be shown how to use the Manage My Pain app and trained how to complete the outcome surveys

In order to help participants set up their mobile applications, the study coordinator will set up a video appointment through the VA's virtual care manager (VCM) and using the VA video connect (VVC) software. The appointment is coordinated using the participants email address, and through the video appointment the coordinator will help the participant set up their device.

4.1.2. **Include a description of how anticipated risk will be minimized and include an analysis of risk vs. potential benefit.**

Veterans with anxiety or concerns will be referred to their primary care physician. Each Veteran will be assigned an ID number that is not related to any PHI. The key containing the link between the study ID number and participant will be maintained on the CMCVAMC's secure server (\\vhaphifpccherp.v04.med.va.gov\shares2\Chhabra_Manik) on a separate folder from the collected data. Only Dr. Manik Chhabra (PI) and study staff will have access to this key.

Neither the SUMMIT app nor the Manage My Pain app will be collecting any personal health information. The SUMMIT app will collect aggregated data on usage of features of the app. The Manage My Pain app once downloaded requires the user to complete an end user agreement that specificies how any collected data will be used and shared. The app does aggregate non-personal information from all users, including pain records, age, geographic location, and gender, which is stripped of personal information. There is an option to sign up for an online account through the Manage My Pain app, which would collect additional information, however study participants will be advised not to do so.

4.1.3. **Provide description of the study population (delineate all categories of subjects – patients, providers, family members, employees, etc.). Include anticipated enrollment numbers.**

This projects involves the recruitment of 64 Veterans. Patient recruitment at the CMCVAMC will target male and female patients enrolled in long term opioid treatment (LTOT).

4.1.4. **As applicable, provide information on any added protections for vulnerable populations.**

N/A

4.1.5. **If applicable include information on data and specimen banking.**

N/A

5. **Recruitment Methods**

5.1. **State how many subjects will be needed.**

64 subjects

5.2. **Describe when, where, how and by whom potential subjects will be identified and recruited.**

Eligible Veterans will be identified through data-base review of eligibility. The study team will reach out to the Veteran's provider to ensure they agree with recruitment, and then the

Veteran willbe mailed a recruitment letter with study information and an invitation to participate. The letter will also notify potential participants that they will be telephoned by the project coordinator and will offer them the opportunity to refuse this contact by calling an answering machine and leaving a message. The project coordinator will telephone all patients who do not "opt out". Five attempts will be made by telephone. During screening phone call, inclusion/exclusion criteria will be confirmed. Study visits will be scheduled same day as clinical appointments when possible.

5.3. **Describe materials that will be used to recruit subjects, e.g., advertisements. Include materials as an appendix or separate attachment**
A recruitment letter will be used, as noted above in 5.2.

5.4. **Describe any payments to subjects, including the amount, timing (at the end of the study or pro-rated for partial study participation), method (e.g., cash, check, gift card), and whether subjects will experience a delay in receiving the payment.**
Participants will be compensated $50 for the baseline questionnaire, $5 per biweekly survey (up to 18 times over 9 months) and $25 per quarterly survey (up to 4 times over 9 months). Participants can be compensated up to $2400 total incentive. Patients will be paid via voucher or check from the VA.

6. **Informed Consent Procedures**

6.1. **Indicate if informed consent will be obtained and/or if you are requesting a waiver of informed consent or waiver of documentation of informed consent. If the research involves multiple phases, specify for which phases of the research the waiver(s) is being requested and/or the informed consent will be sought.**
Informed consent will be obtained. We will be obtaining an oral informed consent in part due to limitations as a result of COVID19. This is due to risks of obtaining in person consent for both patients and study staff. The patient will be contacted via telephone or VA Video Connect for the consent process, and the informed consent form will be read aloud to the participant to ensure full understanding of the purpose of the study, study procedures, as well as the risks and benefits of participating. Once the study coordinator confirms through questioning that the participant fully understands all aspects,oral consent will be documented. A copy will be mailed to the patient and be placed in the patient's chart.

6.2. **Describe who will be obtaining informed consent, if applicable, and any circumstances that may need to be addressed (e.g. subjects with impaired decision making ability and the use of a legally authorized representative, etc.)**
Study staff, such as the PI or the project coordinator will obtain informed consent.

6.3. **If applicable, indicate how local site study personnel will be trained regarding human subjects' protections requirements and how to obtain and document informed consent.**
All study staff will be trained/overseen by PI. All study staff will have completed relevant training regarding human subjects protection and how to obtain informed consent. All personnel are required to have CITI (Good Clinical Practices and Ethical Principles), VA Privacy and Information Security Awareness and Rules of Behavior, and Privacy and HIPAA Trainings. In addition, all study staff obtaining informed consent will have taken the VA Research Compliance Officer training.

7. **Inclusion/Exclusion Criteria**

7.1. **Describe the criteria that determine who will be included in or excluded from the study.**
Inclusion criteria for Veterans will be primary care patients who are dispensed ≥84 consecutive days of a stable dose of opioids (reflecting three consecutive 28-day

prescriptions) through primary care and who report stable levels of pain intensity over the past month. Patients will also need to have a smartphone with the ability to download a mobile application.

Exclusion criteria will be Veterans on liquid methadone or buprenorphine for opioid use disorder (OUD) and those who have transitioned to buprenorphine (transdermal or sublingual) for chronic pain, have hearing or visual impairments (not corrected with hearing aids or glasses), psychiatric conditions, cognitive impairments, or participating in a concurrent pain or opioid-related research study.

8. **Study Evaluations**

8.1. **Describe all evaluations to be conducted (including screening; tests/questionnaires that will be administered; any procedures that subjects will be required to complete) and data collection methods. Include materials as an appendix or separate attachment.**

The following questionnaires will be delivered through REDCap by the study coordinator at the outset of the study, and then every 6 weeks over the course of the study: Baseline Assessment, Daily Opioid Dose, Prescribed Opioids Difficulties Scale, PHQ-8, GAD-7, Modified Social Support Survey, Change Questionnaire, BIRS-24, PROMIS-29 Profile v2.0, and WHO 5-Item Well Being Scale. Participants will complete the surveys with the study coordinator, who will enter the responses intoREDCap.

9. **Data Analysis**

9.1. **Provide sample size determination and analysis (include anticipated rate of screen failures, study discontinuations, lost to follow-up etc.).**

The calculated number of participants to be enrolled in this feasibility study was based on the approach outlined by Cocks and Torgerson (85), which recommends using a 1-sided confidence interval (CI) to determine whether it is worthwhile proceeding with a full-scale trial. If the proportion of participants achieving the primary outcome is 20% or lower in the control group (14), the sample size required to detect a difference of 15% in the main trial (assuming 80% power, alpha = 0.05, two-sided test) is 276. (14, 85) A pilot sample size of 48 would produce a one-sided 90% CI that would exclude finding a 15% difference in the larger fully-powered trial. To account for the reasonably high drop-out rate, we will inflate the sample size by 25%. Thus, we will randomize 64 participants.

9.2. **Describe how, where and by whom the data will be analyzed.**

Quantitative statistics will be performed by SAS, version 9.4. and will be performed by Dr. Manik Chhabra (PI) and Dr. William Becker (co-I). As we are proposing a feasibility trial, most of the analyses are descriptive. We will use descriptive characteristics to describe the study population, all feasibility outcomes, and the distribution of the primary and secondary outcomes planned for the full-scale trial. We will ascertain the distributional characteristics, response rates as well as the percent of the missing data for all baseline and follow-up measures at each time point. Although not powered to detect significant between-group, we will compare differences in the primary and secondary outcomes to examine preliminary trends that may inform the design of the full-scale trial. We will use regression analyses to examine the association between group assignment and the primary and secondary outcomes. Group assignment and time will be modeled as fixed factors and participants as random factors. Separate models will be conducted for each outcome. We will perform an interim analysis at three months to evaluate trends in the recruitment rate, use of SUMMIT, and opioid dose reduction. These results may support earlier initiation of the planned full-scale RCT. Exploratory mediation analyses will be used to examine the processes underlying change. We will use the product of coefficients method to determine whether 1) "dose" (amount of use with specific SUMMIT components) and 2) change in specified theoretical constructs mediate the relationship between treatment assignment

and clinical outcome measures. (86) We will also examine the effect of compliance on change in theoretical constructs and the primary and secondary outcome measures using a Complier Average Causal Effect analysis. (87) To examine heterogeneity, exploratory moderating analyses will be performed by including an interaction term (moderator X intervention status) in a multiple linear regression model. We will construct separate models for the following five possible moderators: age, baseline opioid dose, duration of LTOT, prevalent comorbid mental illness, and baseline intrinsic motivation. Although we will not be sufficiently powered to perform definitive mediation or moderating analyses, the data generated from this feasibility study will determine which measures to include in the full-scale trial.

10. **Withdrawal of Subjects**

10.1. **Describe any anticipated circumstances under which subjects will be withdrawn from the research without their consent.**

Subjects diagnosed with opioid use disorder (OUD) or substance use disorder (SUD) during the study will be withdrawn and referred for treatment. The studyteam will notify their PCP if this is the case. Subjects exhibiting inappropriate behavior online or with a peer specialist may also be withdrawn.

10.2. **Describe the consequences of a subject's decision to withdraw from the research and the procedures for orderly termination of participation by the subject (e.g., the subject contacting the investigator for an end-of-study visit).**

No consequences for withdrawal. Once we are notified of a participant's decision to withdraw, we can continue to use information about them that has been collected up to that point. No information will be collected after a participant formally withdraws.

11. **Reporting**

11.1. **Include procedures for reporting unanticipated problems, serious adverse events, and protocol deviations.**

Protocol deviations, unanticipated/unexpected problems will be reported to the IRB within 5 business days of discovery. We will use the CMCVAMC serious-adverse event form for reporting SAEs, UADEs, and any other unanticipated/unexpected problems. We will also use the CMCVAMC Protocol Deviation form for reporting any protocol deviations. Any adverse event would be reported to the IRB at continuing review. Further, if the patient develops any concerns with their medication treatment plans, particularly effects related to their opioid tapers, these will be referred to their PCP.

12. **Privacy and Confidentiality**

12.1. **Describe whether the study will use or disclose subjects' Protected Health Information (PHI).**

For Veterans, we will need to obtain name, date of birth, complete mailing address, race, gender, and medical history. This information will be used only in our analysis and to contact the Veteran (mailing address); no information will be disclosed to others outside our study team.The applications being used by the study, likewise, will not use or disclose the participants PHI.

12.2. **Describe the steps that will be taken to secure the data (e.g., training, authorization of access, password protection, encryption, physical controls, Certificates of Confidentiality, and separation of identifiers and data)**

All study personnel will complete the required human subjects, HIPAA, and information security and privacy trainings at the VA. All paper/hard copy data, which includes subject log, informed consent forms, HIPAA authorization forms, and surveys will be maintained in study binders. The study binders in CMCVAMC will be kept in CHERP, 4100 Chester Ave, Suite 202 in a locked file cabinet. Any electronic data, which includes the subject log and the key linking participants to their ID number at CMCVAMC will be kept on the secured CMCVAMC server vhaphicherpnas (\\vhaphifpccherp.v04.

med.va.gov\shares2\Chhabra_Manik). The log and the key will be kept in separate folders on the server and will NOT be printed out. Study personnel with access to study data and who are no longer involved with the study will have access revoked and will be removed from the research staff form.

13. **Communication Plan for Multi-Site Studies or Studies being done at Non-CMCVAMC Locations**

☐ N/A; skip to question 14

13.1. **Include plan for ensuring all required local site approvals are obtained and notifying the Director of any facility where the research in being conducted but the facility is not engaged.**

All current documentation of VA IRB approvals will be stored in the VA secure server (\\vhaphifpccherp.v04.med.va.gov\shares2\Chhabra_Manik) and Dr. William Becker from the West Haven VA will upload any local site approval documents.

13.2. **Include plan for keeping all engaged sites informed of changes to the protocol, informed consent, and HIPAA authorization.**

Monthly team meetings will be held with the PI and study staff to discuss the study progress (including any changes to the protocol, informed consent, and HIPAA authorization).

13.3. **Include plan for informing local sites of any Serious Adverse Events, Unanticipated Problems, or interim results that may impact conduct of the study.**

Any SAEs, Unanticipated Problems or interim results that may impact conduct of the study will be immediately discussed with the other study site (West Haven VA) and reported to the CMCVAMC IRB within 5 business days of discovery. We will use the CMCVAMC serious-adverse event form for reporting SAEs, UADEs, and any other unanticipated/unexpected problems. We will also use the CMCVAMC Protocol Deviation form for reporting any protocol deviations. Any adverse event would be reported to the IRB at continuing review.

13.4. **Include plan for ensuring the study is conducted according to the IRB-approved protocol.**

As mentioned above (13.2), monthly team meetings will be held with the PI and study staff to discuss the study progress which help to ensure the study is being conducted according to the IRB-approved protocol.

13.5. **Include plan for notifying all local facility directors and LSIs when a multi-site study reaches the point that it no longer requires engagement of the local facility (e.g., all subsequent follow-up of subjects will be performed by the PI from another facility).**

Once the study concludes at the local facility (Philadelphia) – there will not be any additional follow-up of subjects from another facility (West Haven facility). Only data analysis will be occurring at the West Haven VA site after data collection has been completed at the Philadelphia VA.

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SECTION 17: KEYWORDS

(**NOTE:** Provide three (3) keywords. Use MeSH Headings only (Central Office Requirement). Enter one item per line. http://www.nlm.nih.gov/mesh/MBrowser.html)

1. *Long Term Opioid Use Disorder*
2. *Opioid Tapering Web-Tool*
3. *Motivational Interviewing*

SECTION 18: INSTITUTIONAL SUPPORT

(**NOTE:** If yes is marked next to any Service/Section listed below, you **MUST** obtain the signature of the Service Chief or Designee of any Service/Section involved in research. **OR**, a letter/e-mail should be provided to the investigator from the Service Chief or Designee of any Service/Section involved in this research.)

Laboratory	**Yes** ☐ **No** ☒	

		Signature OR Letter/E-mail
Pharmacy	**Yes** ☐ **No** ☒	**Signature OR Letter/E-mail**
Nuclear Medicine	**Yes** ☐ **No** ☒	**Signature OR Letter/E-mail**
Psychiatry	**Yes** ☐ **No** ☒	**Signature OR Letter/E-mail**
Medicine: David Stern	**Yes** ☒ **No** ☐	**Signature on hard copy in IRB 1 Office/emd**
Radiology	**Yes** ☐ **No** ☒	**Signature OR Letter/E-mail**
Nursing	**Yes** ☐ **No** ☒	**Signature OR Letter/E-mail**
Outpatient	**Yes** ☐ **No** ☒	**Signature OR Letter/E-mail**
Union	**Yes** ☐ **No** ☒	**Signature OR Letter/E-mail**
Lab Space	**Yes** ☐ **No** ☒	**Signature OR Letter/E-mail**
Other, specify ☐	**Yes** ☐ **No** ☒	**Signature OR Letter/E-mail**

SECTION 19: DATA MANAGEMENT AND ACCESS PLAN (DMAP)

***NOTE**: This Data Management and Access Plan (DMAP) should be used **for Unfunded** VA Research or VA Research Funded by Entities **Without** a Specific DMAP.*
IF THE FUNDING AGENCY HAS A DMAP, SUBMIT IT, INSTEAD OF THE BELOW.

Section 1 - Funding **–** *(Check applicable box and indicate funding source if present.)*	
☒ VHA Program Office **without** Specified DMAP Format	**Name of Program Office**: VA HSR&D
☐ External Funder **without** Specified DMAP Format	**Name of Funder**:
☐ **Unfunded**	
☐ **Not applicable**; see separate DMAP from funding source	

Section 2 - Public Access to Publications Resulting from the Research - *(Check all applicable boxes.)*

☒ The proposed research **is to be funded by VA.** Publications resulting from the research will be made available to the public through the National Library of Medicine (NLM) **PubMed Central** website within one year after the date of publication. *[Submission procedures are provided on the Office of Research and Development (ORD) website at http://www.research.va.gov/resources/policies/public_access.cfm.]*

☐ The proposed research **will not be funded by VA.**

☒ Publications will be made available to the public through **PubMed Central** within one year after the date of publication. *[See ORD website noted above.]*

☐ Publications **will be made available to the public** in another way. *[Briefly describe plans below.]*

☐ Publications will **not** be made available to the public. *[Provide a brief rationale below.]*

Additional details related to plans for public access to publications results from the research, as indicated in section 2 above.

Section 3 - Public Access to Final Data Sets Underlying Publications Resulting from the Research - *(Check all applicable boxes.)*

☒ Final data sets underlying publications resulting from the proposed research **will be shared** outside VA in **electronic format** through the mechanism(s) indicated in Items #6 through #10 below.

☐ Final data sets underlying publications resulting from the proposed research **will be shared** outside VA **ONLY in hard copy** through the mechanism(s) indicated in Items #6 through #10 below. *[Provide a brief rationale below].*

☐ Final data sets underlying publications resulting from the proposed research **will <u>not</u> be shared** outside VA, except as required under the Freedom of Information Act (FOIA) *[Provide the rationale below.]*

Additional rationale(s) for plans to access data sets underlying publications, as indicated in Section 3 above.

Section 4 - Mechanisms for Public Access to Final Data Sets Underlying Publications Resulting from the Research **–** *(Check all applicable boxes.)*

☐ As indicated in Item #5 above, final data sets underlying publications resulting from the proposed research **will <u>not</u> be shared** outside VA.

☐ The project involves **basic science research**. Final data sets underlying publications resulting from such research will be shared as described in the space below. *[Describe mechanisms for sharing, e.g., upon request, through a databank or repository, via a website]*

The research involves **human subjects**. Data sets based on information obtained from human subjects will be shared as follows. Check appropriate box.	☐ **Individually Identifiable Data** will be shared pursuant to valid HIPAA Authorization, Informed Consent, and an appropriate written agreement limiting use of the data to the conditions described in the authorization and consent.
	☒ **A Limited Dataset (LDS)** will be created and shared pursuant to a Data Use Agreement (DUA) that indicates adherence to any applicable Informed Consent provisions, appropriately limits use of the dataset and prohibits the recipient from identifying or re-identifying (or taking steps to identify or re-identify) any individual whose data are included in the dataset. *NOTE: An LDS does not necessarily imply de-identified data per HIPAA.*
	☒ **A De-identified, Anonymized Dataset** will be created and shared. *NOTE: ORO recommends that such sharing take place under a written agreement that adheres to any applicable Informed Consent provisions and prohibits the recipient from identifying or re-identifying (or taking steps to identify or re-identify) any individual whose data are included in the dataset. However, it is permissible for final datasets in machine-readable format to be submitted to and accessed from PubMed Central (and similar sites) provided that care is taken to ensure that the individuals cannot be re-identified using other publicly available information.*
It is <u>likely</u> that requests for data from outside researchers (or other entities) may correspond to one or both of the following **special conditions:**	☐ **Individually Identifiable Data**, excluding Veterans' names and 38 USC §7332-protected information, will be shared, <u>pursuant to a written request and IRB approved waiver of HIPAA authorization, with the approval of the Under Secretary for Health,</u> in accordance with VHA Handbook 1605.1 §13.b(1)(b) or §13.b(1)(c) or superseding versions of that Handbook. Note: Subject to all other listed requirements, Veterans' names may be shared with other Federal agencies (38 USC §5701), and with non-Federal investigators who provide the names and addresses of the individual subjects.
	☐ **Individually Identifiable Data,** including 38 USC 7332-protected information, will be shared, pursuant to the above requirements <u>and</u> a written assurance from the recipient that the information will be maintained in accordance with the security requirements of 38 CFR Part 1.466, or more stringent requirements, the information will not be re-disclosed except back to VA, and the information will not identify any individual patient in any report of the research or otherwise disclose patient identities.

Additional details on mechanisms for sharing final data sets as indicated in Section 4 above.

Section 5 - Briefly summarize **how, where, when, to whom, and the extent to which** data resulting from the research will be made available outside VA.

Section 5 answer: *A limited de-identified dataset will be made available on our CMCVAMC research website that is publicly available.*

Section 6 - Describe **how and where** data resulting from the research will be **stored and maintained** (e.g., data will be stored and maintained in a secure ORD data repository or resource; data will be stored on VA servers behind the VA firewall and backed up to a hard drive maintained and secured in the investigator's lab; etc.).

Section 6 answer: *The dataset will be housed on a server, administered by CHERP behind the VA firewall, access being granted only to those who apply directly to you, provide the necessary assurances that they will not re-identify the data, and submit to a clearance by the CMCVAMC Privacy Officer. The VA will not permit data to be stashed with NIH, not without a lot of data transfer approvals.*

Section 7 - Describe the mechanisms for ensuring the **protection of personal privacy,** the **confidentiality of individually identifiable information,** and the **security of proprietary data and information.**

Section 7 answer: *All data will be de-identified prior to being made available.*

Section 8 - Describe the **scientific and/or public purposes** for making the data available (i.e., how will scientists and/or the public benefit from making the data available) **and** explain how the data available for sharing will permit **validation of results** by the recipients (e.g., sufficient data and descriptors will be made available to confirm conclusions in the publication, duplicate statistical analysis, perform additional analyses, etc.).

Section 8 answer: *The scientific purpose of making this data available is to allow independent analysis of the data and to allow investigators to consider new analyses of the data that might further the study of opioid tapering among Veterans.*

Section 9 - Describe the mechanisms for ensuring the **protection of personal privacy,** the **confidentiality of individually identifiable information,** and the **security of proprietary data and information.**

Section 9 answer: ***See above -*** *All data will be de-identified prior to being made available.*

Section 10 - Describe the **scientific and/or public purposes** for making the data available (i.e., how will scientists and/or the public benefit from making the data available) **and** explain how the data available for sharing will permit **validation of results** by the recipients (e.g., sufficient data and descriptors will be made available to confirm conclusions in the publication, duplicate statistical analysis, perform additional analyses, etc.).

Section 10 answer: ***See above -*** *The scientific purpose of making this data available is to allow independent analysis of the data and to allow investigators to consider new analyses of the data that might further the study of opioid tapering among Veterans.*

Section 11 - **As Principal Investigator** for the proposed research, **I attest** to the accuracy of the information provided above, and **I** understand that –

- Final data sets must be maintained locally in accordance with VA Records Control Schedule 10-1 or until enterprise-level resources become available for long-term storage and access (unless otherwise required or permitted by the relevant VHA Program Office)
- Failure to implement this DMAP may result in restrictions to subsequent research activities

SECTION 21: ATTESTATION TO FOLLOW FEDERAL REGULATIONS

As the Principal Investigator for this project, I certify that I have read, understand, and accept the investigator responsibilities as outlined in VHA Handbook 1200.05, paragraph 5g and that these include but are not limited to the following:

- Giving first priority to the protection of human subjects; upholding professional and ethical standards and practices; and adhering to all applicable VA and other Federal requirements, include IRB and the local VA Facility's policies and procedures regarding the conduct of research and the protection of human subjects.

- Ensuring all investigators and other staffs participating in this human subjects research are qualified; have the appropriate training, education, and experience to perform procedures assigned to them; and that they have been appropriately credentialed and privileged as applicable per current local facility and VA requirements.

- Submitting all amendments to the project or changes in the informed consent to the IRB for review and approval prior to initiation, except when necessary to eliminate immediate hazard to the participants. Any changes implemented as a result of an immediate hazard will be promptly reported to the IRB as a project deviation and an amendment submitted if determined necessary.

- Obtaining and documenting legally effective informed consent of the subject or the subject's legally authorized representative (LAR), as well as a HIPAA authorization, unless the IRB approves an applicable waiver.

- Reporting problems, adverse events, and apparent serious or continuing noncompliance, including local research deaths, in accordance with VHA Handbook 1058.01, local VA Facility requirements, and IRB SOPs (to include the IRB Table of Reporting Requirements.)

- Ensuring appropriate research records are maintained that includes all information made or received by a VA Investigator over the entire lifecycle of the research activity and that these records are maintained in accordance with the VA Records Control Schedule and local policies and procedures.

- Providing continuing review and/or requested updates for the study as applicable in a timely manner and in accordance with the VA and IRB policies and procedures. This includes submission of a closure reports for both local sites and the overall study upon completion. noncompliance.

- Ensuring research does not start until final approval has been received from the IRB, and writte notification from the local Facility ACOS/R&D in accordance with local R&D Committee approval policies and procedures.

Signature or E-Signature of Principal Investigator, ONLY	Date Signed
Signature on hard copy in IRB 1 Office/emd	

SECTION 22: INSTITUTIONAL APPROVALS

(I have read this proposal and find it in compliance with federal, state and local policies and regulations. I have read and deemed the scientific quality of this proposal to be adequate and the proposal has scientific relevance to both the VA's mission and the facility's research program. Resources necessary for the performance of this proposed study are available and adequate.)

Signature or E-Signature of Section Chief:	**Date:**
Signature or E-Signature of Service Chief: **Signature on hard copy in IRB 1 Office/emd**	**Date:**
Signature or E-Signature of Chief of Staff: ***(Chief of Staff's signature needed for ACOS investigators only.)***	**Date:**