

**BETWEEN PERIL AND PROMISE: FACING THE DAN-
GERS OF VA'S SKYROCKETING USE OF PRE-
SCRIPTION PAINKILLERS TO TREAT VETERANS**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRTEENTH CONGRESS
FIRST SESSION

THURSDAY, OCTOBER 10, 2013

Serial No. 113-39

Printed for the use of the Committee on Veterans' Affairs



U.S. GOVERNMENT PRINTING OFFICE

85-864

WASHINGTON : 2014

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
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**BETWEEN PERIL AND PROMISE: FACING THE
DANGERS OF VA'S SKYROCKETING USE OF
PRESCRIPTION PAINKILLERS TO TREAT
VETERANS**

Thursday, October 10, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:59 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek, Huelskamp, Wenstrup, Brownley, Ruiz, Negrete McLeod, Kuster.

Also present: Representatives Miller, Bilirakis, Harris.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Mr. BENISHEK. Good morning. Thank you for being here today. The Subcommittee will come to order.

Before we begin, I want to ask unanimous consent for our colleague from Maryland, Dr. Andy Harris, to sit at the dais and participate in today's hearing. Without objection, so ordered.

And I am happy to see we have Mr. Miller here this morning, the Chairman of the Full Committee. Thank you for being here, Mr. Chairman.

With that, I would like to welcome you all to today's hearing, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans."

Today's subject is one of the most serious and significant we will discuss all year, and it is one that is particularly poignant and personal to me. I have spent 20 years serving our veterans as a physician at the Oscar D. Johnson VA Medical Center in Iron Mountain, Michigan. And in that capacity, I understand all too well what it means for a veteran and a patient to be in pain.

Pain can be an unrelenting enemy, one that thwarts an individual's ability to work and enjoy the activities they once loved, hinders their relationship with their family and friends, and impacts their capacity to be comfortable in their own home. On a daily basis, my veteran patients would confide in me about the pain they were in, and many ways in which they were hurting, and more than anything else their desperate desire to find relief.

Perhaps no where else is that more clear than in the heart-breaking testimony that we will hear shortly from two surviving spouses, Heather McDonald and Kimberly Green. Their husbands, Scott McDonald and Ricky Green, honorably served our Nation in

uniform and came home, as far too many of our returning veterans have, hurting and in pain. These men sought treatment from the department charged with caring for them, the VA, hoping to get the help they needed so they could once again take full and successful ownership of their lives without pain as their constant companion. Sadly, rather than getting the best care anywhere, Scott and Ricky were prescribed a disturbing array of pain, psychiatric, and sleeping medications without any clear consideration or special attention paid to how these powerful drugs were interacting with each other or affecting Scott and Ricky's physical and mental well being. The combined effects of these multiple medications ultimately took their lives.

We also will hear from two veterans, Joshua Renschler and Justin Minyard, who will give us a firsthand account of the struggles they faced with VA's apparent over-reliance on opiate-based medications for pain management. At one time, Joshua was prescribed 13 different medications. Despite his pleas that the medications were not working, he was never referred to a pain specialist. Justin was prescribed enough opiate pain medications on a daily basis to treat four terminally ill cancer patients. He eventually sought care outside of VA to find an effective treatment to manage his pain.

To say that I am disturbed by these accounts and by the multiple reports we hear everyday about the skyrocketing use of prescription painkillers, particularly opiates, to treat veterans in pain would be a major understatement. VA's band-aid approach to suppressing the symptoms of pain rather than treating their root cause must stop. VA maintains a pain management treatment model that makes primary care rather than specialty care the predominant treatment setting for veterans suffering from pain. Yet as I know from personal experience, the multifaceted nature of chronic pain, particularly when multiple medications are being prescribed, should not be managed by a primary care physician, but rather by a qualified pain specialist who is trained to understand the complexities of treating these conditions.

I want to be very clear that this hearing is not intended to vilify the many hardworking primary care providers working everyday to care for patients in pain at VA facilities across the Nation. I have been in their shoes. I know the challenges they face in providing the high quality care our veterans deserve. Rather, our intent here today, is to initiate better provider practices and most importantly better care coordination for our veterans and their loved ones so that no other family has to experience the pain, the suffering, or the loss that our witnesses on the first panel have already experienced.

It is critical for VA to take responsibility for its failures and rise to the challenge to change and take immediate action to adopt effective pain management policies, protocols, and practices.

We have already lost too many veterans on the homefront to battles with chronic pain. The stakes are too high for VA to continue to get it wrong.

This is a really important matter to me. In my own personal practice, I realized that I just do not know everything there is to know about pain. And that we always, always send people with

chronic pain to a specialist. To not do that is just inconceivable to me.

I will now yield to our Ranking Member, Julia Brownley, for any opening statement she may have.

[THE PREPARED STATEMENT OF HON. DAN BENISHEK APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chair. And good morning. I would like to thank everyone who is in attendance today for being here.

Chronic pain is a debilitating condition that affects veterans at a much higher rate than the civilian population. According to the Department of Veterans Affairs, in the newest cohort of veterans, chronic pain is the most common medical problem reported in veterans returning from the battlefield with estimates as high as 60 percent of those who seek treatment in the VA.

Modern warfare often leads to serious but survivable physical and neurological injuries, such as amputations, spinal cord injury, traumatic brain injury, gunshot wounds, and many more. Oftentimes, these same veterans experience mental health issues as well, such as Post-Traumatic Stress Disorder and depression. And while advances in medical technology have saved the lives of many wounded soldiers, many veterans of our armed forces are forced to live a life that is dominated by acute and chronic pain.

Providing safe, effective, adequate pain management is a crucial component of improving veterans health care. The treatment of chronic severe pain often involves physicians prescribing highly addictive painkillers, that if not properly monitored can lead to death. Testimony from our first panel highlights the dangers of prescription drugs and just how quickly veterans get trapped in a rapid downward spiral of addiction and pain.

I know that VA has a national pain management strategy, and I look forward to hearing from Dr. Jesse regarding the ramping up of pain clinics and services throughout the Veterans Health Administration. I am also very interested in progress being made with the Department of Defense on transitioning servicemembers and the management of medications between the agencies.

Finally, VA recognizes that chronic and acute pain among our veterans is a serious problem and in fact is a priority. I applaud them for taking the lead on this issue. But I am concerned that comprehensive pain care is not consistently provided throughout the VA's health care system.

I look forward to hearing from our witnesses. I thank you again for being here. It is important for this panel, and Members, and the public to hear your stories. Thank you, Mr. Chairman, and I now yield back.

[THE PREPARED STATEMENT OF HON. JULIA BROWNLEY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Ms. Brownley. I would like to yield to Chairman of the Full Committee, Mr. Miller from Florida.

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you, Dr. Benishek and Ms. Brownley both for having this very important hearing. And as you have already said, many of our servicemembers are returning home with serious injuries from the battlefield and very acute pain. And as they transition to veterans status, the pain often lingers and leads to chronic illness.

For these veterans, it is the pain level, not the veteran that sets the agenda for the day. It sets the tone for their families. And it keeps the veteran in many cases from fully participating in their daily lives and activities that they may have once had.

Yet when these veterans reach out and entrust the VA to relieve their pain, the treatment they often receive is the systemwide default of prescribing prescription painkillers. CBS News has recently reported that based on VA data, over the past 11 years, the number of patients treated by the VA is up 29 percent, while the narcotic prescriptions written by VA doctors and nurse practitioners are up 259 percent.

Look, veterans depend upon VA to uphold its mission of restoring the health of those who have borne battle. But instead of helping them manage their battles with pain, VA has opted instead to use a treatment that has the power to destroy rather than to restore their lives.

VA can and must change course and act now to reduce their reliance on the use of prescription drugs. The veterans and their loved ones must be listened to, must be followed up with closely, and supported with a treatment that can best help them regain happy and healthy lives. Anything less is unacceptable. And I yield back.

[THE PREPARED STATEMENT OF HON. JEFF MILLER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Chairman. I would like to now formally welcome our first panel to the witness table. As I mentioned earlier, joining us is Heather McDonald from South Vienna, Ohio; and Kimberly Stowe Green from Fort Smith, Arkansas. Mrs. Green is a veteran of the United States Air Force. Thank you, ma'am, for your service. And thank you both for being here to deliver what I know is going to be very difficult testimony for you.

Mrs. McDonald and Mrs. Green are joined by Joshua Renschler from Olympia, Washington; and Justin Minyard and Orlando Florida. Mr. Renschler and Mr. Minyard are both veterans of the United States Army and both continue to serve today as advocates for their fellow veterans. Thank you both for your service and for all the hard work that you continue to do.

We appreciate you all being here with us today to tell your stories. Mrs. McDonald, please proceed with your testimony. We like to keep it around five minutes so that everyone has an opportunity to be heard.

STATEMENTS OF HEATHER MCDONALD, SPOUSE OF SCOTT MCDONALD, SPC (DECEASED); KIMBERLY STOWE GREEN, SPOUSE OF RICKY GREEN, MSGT (RET)(DECEASED); JOSHUA RENSCHLER, SGT. (RET); AND JUSTIN MINYARD, 1SGT. (RET)

STATEMENT OF HEATHER MCDONALD

Mrs. MCDONALD. First and foremost, I want to thank you all for inviting us here today to speak. This is a cause that I know that we are incredibly passionate about.

After graduating from Belpre High School in 1995, Scott Alan McDonald took an oath to uphold the dignity and the honor of the United States Army. For 15 years, he served honorably in the uniform of his country and was proud to serve as a UH-60 Black Hawk mechanic and crew chief for a medevac unit. Bosnia, Panama, Iraq, and Afghanistan are only a few of the war torn countries he dedicated his life to changing. In his career, he experienced heartache, unimaginable violence, death, and the overall devastating effects of war. He saw many of his fellow soldiers give the ultimate sacrifice, narrowly escaping many times himself. He loved his country and what the American Flag stands for. He was a brother in arms to thousands of fellow soldiers, and a truly remarkable man that never met a stranger. Scott had larger than life expectations for his children and because of his commitment and honor in January of 2011 we married.

On April 30, 2011, Scott's career with the Army came full circle and he hung his uniform up for good. He began seeking the treatment from the VA for back pain and mental illness. The Chalmers P. Wylie Ambulatory Care Center in Columbus, Ohio immediately starting prescribing medications. Beginning with Ibuprofen, Neurontin, and Meloxicam, and graduating to Vicodin, Klonopin, Celexa, Zoloft, Valium, and Percocet. This is where the roller coaster began.

My husband was taking up to 15 pills a day within the first six months of treatment. Every time Scott came home from an appointment, he had different medications, different dosages, different directions on how to take them. And progressively over the course of a year and a half of starting his treatment, the medications had changed so many times by adding and changing that Scott began changing. We researched many of the drugs that he was prescribed online and saw the dangerous interactions that they cause. Yet my husband was conditioned to follow orders. And he did so.

On September 12, 2012, Scott attended another of his scheduled appointments. This is when they added Percocet. This was a much different medication than he was used to taking, and which they prescribed him not to exceed 500 milligrams of Acetaminophen. Again, my husband followed orders.

Approximately 01:00 hours on the 13th of September, I arrived home from my job. I found Scott disoriented and very lethargic. I woke him and asked him if he was okay. He told me he was fine and that he just took what the doctors told him to take. At approximately 07:30 I found my husband cold and unresponsive. At 35 years old this father of two was gone.

I ask myself why everyday. And when I asked the VA why more tests were not performed to make sure he was healthy enough,

they responded by saying, it is not routine to evaluate our soldiers' pain medication distribution. A simple, "I am in pain," constitutes a narcotic and, "This is not working," constitutes their change of medication.

I was sickened and disturbed by their response, and I decided at that point, no one else should die. I have no doubt that if the proper tests were being performed on our men and women, I would not be here today because my husband would be. I have no doubt that thousands of the soldiers that have fallen since coming home from War would be here today.

As the silent soldiers and the spouses of our military members, we almost expect the possibility they will not come home from War. But we cannot accept that they fight for their country, and after the battle is over, they come home and die in front of their children and their loved ones and this has got to stop.

When our men and women signed that contract they gave their bodies to their country. And I ask now, as the people that have the power and the ability to make these changes happen, to force regulations to change on behalf of all of the veterans out there that have died. And for their families, I beg you to reopen this issue and reevaluate the distribution of narcotics to our men and women when they come home. Because you do not only take the lives of these men and women, but you tarnish the lives of their families forever. They selflessly chose to wear the uniform the United States military, and when they come home, they should not be treated as numbers, nor should they be labeled as if they are no longer a productive or useful part of society. Thank you.

[THE PREPARED STATEMENT OF HEATHER McDONALD APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mrs. McDonald. I truly appreciate you being here and testifying. Mrs. Green, would you please begin?

STATEMENT OF KIMBERLY STOWE GREEN

Mrs. GREEN. Chairman Benishek, Ranking Minority Member Brownley, and all the distinguished Members of the Subcommittee, my name is Kimberly Green and I am honored to have been invited to speak to you today at this hearing. I am accompanied here today by my attorney Brad Miller, who is also a medical doctor. I respectfully request that my written statement be incorporated into the official records of this hearing.

I live in Fort Smith Arkansas. I served my country for 21 years in the United States Air Force serving both on active duty and reserve status. I retired as a Master Sergeant from the Arkansas Air National Guard. I am the widow of Ricky Green.

My husband served his country for 23 years, serving both on active duty status and in the Reserves. He was a military policeman and a paratrooper and he served with distinction in Desert Storm. He retired as a Sergeant First Class.

My husband Ricky Green died as a result of the VA's skyrocketing use of prescription painkillers. On behalf of my husband, myself, and our two grieving sons, I want to ask this Committee

to do all that it can to prevent other veterans from dying in the same manner that my husband died.

My husband died on October 29, 2011 at the age of 43, four days after lower back surgery. The Arkansas State Crime Lab and its medical examiner performed an autopsy and determined that the cause of death was mixed drug intoxication, complicating recent lumbar spine surgery. My husband died because of the prescription pain and sleeping medications that the VA and his doctors prescribed for him and dispensed to him out of the VA pharmacy.

In treating Ricky's service-connected back pain, the VA doctors wrote prescriptions for the following drugs: Oxycodone, Hydrocodone, and the generic versions of Valium, Zoloft, Ambien, Gabapentin, and Tramapol, among others. Ricky trusted the VA doctors and followed their orders.

The VA already has written guidelines for prescribing painkillers but these are not being followed. The clinical practice guidelines which have been in place since May of 2012 require physicians to closely monitor and evaluate patients who are being prescribed prescription painkillers for chronic pain and warn physicians about the dangers of drug interactions that can cause death. The guidelines also warn physicians to take special care in prescribing pain medications for patients such as my husband who had sleep apnea.

Unfortunately again, no such special precautions were taken for Ricky, who got a legal drug cocktail that included Oxycodone and Diazepam, which were reviewed by the VA and filled by the VA pharmacy on October 26, 2011.

I strongly believe that my husband was entitled to receive the quality of care that the VA and Department of Defense set forth in their guidelines. However, last year the VA's national program director for pain management admitted that VA has not fully implemented the guidelines.

I know that statistics show in Fayetteville, Arkansas where my husband was treated there is a high incidence of over-prescribing pain medications for veterans. In my husband's case, he asked the VA to reduce the opiate pain medications he was taking, but the VA did not listen.

I am proud of my husband. After serving his country for over 20 years in the military he went back to school and earned his college degree in criminal justice. Ricky survived serving in combat zones in his over 20 years of military service, but he could not survive the VA and its negligent treatment of him.

I have heard excuses. The guidelines are not standards of care, and some veterans who have died of overdoses were suicidal. These are excuses that the VA is making because it has failed to take the action needed to fully implement and follow its own written guidelines that have already been published. Let me be clear, the VA knew that Ricky was not suicidal. The VA knew that Ricky did not display drug seeking behavior. The VA knew that he wanted to reduce the amount of pain medication he was taking. It is all documented in Ricky's medical records.

Humana and the VA have teamed up on a program called Project Hero. Last year, this Committee heard the testimony of Brad Jones, Chief Operating Officer of Humana Healthcare Services. Mr. Jones contended that Humana and Project Hero provided a strong

care coordination element. This did not happen in my husband's case. No one at the VA or Humana monitored his drugs to ensure safety, nor questioned why he got all of the medications when he had a diagnosis of sleep apnea.

I would like this Committee to use its powers of investigation to uncover why Humana and Project Hero did not protect my husband Ricky from the lethal cocktail of drugs that killed him. Why cannot the powerful computer systems at both the VA and Humana that process the medical records of our veterans be programmed to monitor the kind of drug interactions and dangerous conditions like sleep apnea to alert both doctors and pharmacists when dangerous prescribing occurs, like that that killed Ricky?

It is my understanding that when unexpected death occurs, the VA does an analysis to find out why the death occurred. I want to know if such an analysis was ever done in my husband's case, and whether or not the VA will investigate my husband's death so that other veterans will not suffer the same fate?

I hope the VA, and if not the VA, then this Committee, will ask these questions, learn something to save the lives of our veterans in the future. This is the one way, the only way, that my husband will not have died in vain.

I will not be silent about any of this. My husband does not have a voice, therefore I am his voice. I want to see that this overdrugging of our veterans stops and that there is accountability for these physicians' actions. I respectfully request that this Committee demand that the VA follow its own written guidelines, demand that the VA put in place procedures that punish VA doctors and staff who do not follow the written guidelines and demand that the VA and its doctors put a stop to this epidemic of the VA's skyrocketing use of prescription painkillers to treat veterans. Thank you.

[THE PREPARED STATEMENT OF KIMBERLY STOWE GREEN APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you so much, Mrs. Green. I really appreciate your being here. Mr. Renschler, could you proceed?

STATEMENT OF JOSHUA RENSCHLER

Mr. RENSCHLER. Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, I am honored for the opportunity to speak to you today about my own experiences with the VA's pain management system, or lack thereof.

Not only am I retired from the United States Army in which I proudly served as an infantryman for five and a half years, but as stated earlier I currently walk alongside of other veterans struggling to navigate the difficult systems in trying to find a new normal life.

After I was medically retired from injuries sustained from a mortar blast in 2004, I left the Army in 2007 and entered immediately into the care of the VA in 2008. I was on eight different medications from the Department of Defense that took three years for Army doctors to balance a safe mix with limited side effects to allow me to have an opportunity to try to function. I entered into work at the only thing I knew how to do as an infantryman, I started working corrections.

With the VA care, my first practitioner informed me that many of the medications I was on were not on the VA's formulary and they had to find a new mix. They began experimenting on me. Despite the urging of my wife telling them that many of the medications they wanted to try again already failed through DoD, they did it anyway. Within 12 months of VA care, I was on 13 medications, many of which were to counter the effects of other medications, and I began to backslide in my recovery. It ended with me having a severe panic attack for the first time in my life while at work, resulting in the loss of my job, resulting in my family losing our house and our vehicle, and being virtually homeless, if it was not for our family stepping up and taking care of us.

It 2009, I began to suffer from debilitating back pain as a result of my injuries. The VA's answer to that was to add narcotics into the mix of my medications that I was on at the time. I was on Percocet, and what happened was, as I took that, the more I took it, the less it worked because my body became tolerant to it.

I continued to ask my VA doctors to find a proactive solution for the back pain rather than more medications, and the answer was an increase in the dosage to a level of 12 to 15 five-milligram tablets a day. When that was no longer effective, I finally saw a neurosurgeon who sent me to a physical therapist. I was excited for a proactive solution. However, when I received that care, it entailed me sitting in a chair while the physical therapist asked me questions about the pain and printed off a package of papers that included instructions on stretches to do at home on my own, and asked me to follow up in two weeks. That made me feel hopeless and infuriated.

When I began advocating strongly for my care at that point, my dosages maintained at the levels that they were, but they were augmented by other medications such as Morphine and Methadone. I began to not function well at all. I had children at the house and things were not going well at home. Finally, I was able to get an EMG and an MRI, which determined that I had severe nerve damage and resulted eventually in a fee service referral to a private hospital. When I went to that private neurosurgeon he asked me how long I had experienced the symptoms, and I had told him it had been over a year since it was that bad, and he was infuriated at the VA for allowing it to take place that long. He scheduled an urgent surgery that took place three days later and the result of the delay in my care meant that I have permanent nerve damage. I still have no feeling in my left leg to this day.

I continued to take this cocktail of medications that the VA prescribed me less the narcotics following the surgery. And there was no oversight. It took me three months to get an appointment with a primary care doctor that usually changed who the person was that I saw every three months when I got in there.

Finally I had a new prescriber in 2011, three years after I entered the system, who said many of these drugs are harmful to kidney and liver, let us get some blood work. The blood work determined that I had elevated liver enzymes to lethal levels. I immediately saw a hematologist who performed a biopsy and determined I had scarring of the liver and diagnosed me with non-alcoholic steatohepatitis. This prompted my wife and I to remove myself

from all of my medications, save the seizure medications and as needed migraines.

This makes life very difficult. But within six months my liver enzymes had returned to a high normal level. And I would rather be pill free and in pain than to die.

I continued to have struggles. In 2011, the back pain returned and I began pleading again for my own care and I was denied everywhere I went. I went back through the hoops of physical therapy, occupational therapy, who, by the way offered me a device to help me put my socks on in the morning. I was denied any other care that I was asked for. I turned to spending \$15,000 out of my own money to buy a therapeutic hot tub and a massage chair just hoping to find a way of managing my pain. I lived next door to a very nice lady who was a massage therapist who worked on me for free. These were the only ways I could manage my pain without the drugs.

There is no happy ending to this account, I apologize. I am currently taking narcotics again. I am prescribed levels that allow me to take six five-millimeter Oxycodone a day. I cannot take Percocet because of my liver.

Let me emphasize I did not make this trip here today to gain an advantage for myself. But I have walked alongside of countless veterans and I know this to be true: it is a hopeless situation when you are encountered with this type of debilitating pain. The VA is very quick to drop statistics on 22 soldiers a day ending their lives. But they do not really look internally and realize that the hopelessness that comes at the very end for a veteran is when he reaches a level of debilitating pain that puts him into a hopeless situation at home. Being 30 years old and having to rely on a cane and a wheelchair and not being able to hold my child without physical pain is a hopeless situation. And when I cry out to the VA, my only source of medical care, to help me with this situation and I am hit with a brick wall and a bottle of pills that does not end the hopelessness, and in fact it makes it a more hopeless situation and results in the loss of life of countless of our veterans.

I thank you for your time and your oversight on this matter, and I urge the VA to start looking internally for a solution to this epidemic.

[THE PREPARED STATEMENT OF JOSHUA RENSCHLER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Renschler, for your testimony. I truly appreciate your comments. Mr. Minyard, please begin.

STATEMENT OF JUSTIN MINYARD

Mr. MINYARD. My name is Justin Minyard and I would like to thank you for the opportunity to appear before the Committee and address this vital subject.

I am a medically retired member of the United States Army. Before retiring due to a series of spinal injuries, I was a first responder at the Pentagon on 9/11, and a special operations interrogator. I struggled with years of dependence on the opioid therapy, that was my only option made available to me for my chronic de-

bilitating back pain. Finally after years of searching, I found lasting pain relief through spinal cord stimulation, or SCS. Today, I am proud to say that I am not taking a single dose of opioid pain pills in the last two years. No veteran should have to struggle for as long as I did. Early access to interventions in the VA is critical.

I first developed chronic back pain when I was serving as a member of the Presidential Escort Third U.S. Infantry Old Guard stationed at Fort Myer. On 9/11, my unit was one of the first responders at the Pentagon. For the next 72 hours we searched for survivors, working on adrenaline to move huge pieces of rubble. As a result of these efforts, I sustained a serious back injury, damaged discs and ruptured vertebrae.

My back pain drastically impacted my life from September 11th onwards. In 2004 and 2007, I was deployed in the Middle East and reinjured my back during subsequent combat operations. When home on R&R, Army doctors told me my spine was rapidly deteriorating and I needed reconstructive back surgery. Despite knowing I should have the surgery, I wanted to complete the mission with my unit. My doctor responded, "If you insist on going, this is the only way that you will be able to make it through." Then he handed me a bottle of prescription opioid pain pills.

My pain fluctuated daily somewhere between a four and a nine on a one to ten pain scale. But I was able to mask that due to the high dose of pain pills. It was a very double edged sword. The pills allowed me to keep working, but they also allowed me to do further damage to my back.

August 4, 2008 was my breaking point. I came back to our team hour in Iraq after an extremely challenging three-day mission. I stepped out of my HUMVEE and my right leg simply gave out. I could not take another step and it was terrifying. I was subsequently Medevac'd on a helicopter to Balad Air Force Base.

Returning home, my life was not my life. I was in a great deal of pain, confined to a wheelchair, and struggling with severe PTSD. I also started an intense opioid pain medication management regimen. My life revolved around when is my next pill? When is my next dosage increase? And when can I get my next refill? At my worst point, I was taking enough pills daily to treat four terminally ill cancer patients.

I had enormous physical and mental effects on me. I was so high on the opioids that my eyes would often roll in the back of my head and if I was not babbling incoherently, I was drooling on myself.

My wife stayed by my side throughout the entire process, but for years I went without even telling her thank you for taking care of me. I was not the husband my wife deserved and I was not the father my daughter deserved, and it was a very dark and difficult part of my life, one of which I am extremely ashamed and regret today.

With no options offered by the medical services and after seeing a video of myself passed out with my daughter in my lap, I started to look for treatment on my own. I had a spinal fusion procedure that helped me regain some mobility, but did nothing to lessen my pain or dependence on opioid medication.

It was a major challenge navigating the bureaucracy of the VA and DoD health care systems. My wife had to advocate for me,

never taking no for an answer. Finally we found an interventional pain specialist at Fort Bragg conducting a trial study of SCS therapy. I credit both with turning my life around. My specialist explained how an implantable device could stop my brain from receiving pain signals. After a test drive, I had the permanent device implanted in less time than it takes to have a cavity filled. When the device was turned on, I was floored. With each adjustment to the device, I could feel the impulse moving through my body and hitting my targeted pain areas. All of a sudden, to push a button and have my pain drop significantly was life changing.

The relief that I felt from SCS allowed me to start tapering my medications. That process took time and was extremely difficult, but it was worth it. I am now at the point where I have not taken an opioid-based pain pill in more than two years.

The bottom line is that I consider myself extremely lucky that I was able to push through the maze of providers and find a doctor knowledgeable about SCS. The majority of soldiers are not so lucky. Soldiers who lack the resources and awareness to advocate for alternatives to opioids are left with the crushing reality of lifelong opioid dependence, or worse. A recent VA study spotlighted the horrific epidemic of suicide among veterans, 22 per day. We must increase awareness about alternatives to opioid medication in the VA system. The VA must work to create access to interventional pain specialist knowledgeable in state of the art pain management treatment. We must train more doctors in these techniques and devote more resources to raising awareness.

We should also be collecting data on long term outcomes of interventional therapies versus opioid therapies so we have the numbers to show that the techniques that helped me will help other soldiers as well. The VA is a great place to start because so many veterans come home and struggle just as I did.

I continue to struggle with the VA in getting timely appointments with the specialist to manage my SCS therapy. But my hope is that in the future, policies will be in place to help people like me manage their SCS therapy, and to help shield soldiers and their families from the devastating effects of opioid dependence.

Thank you very much for your time and for listening to my story.

[THE PREPARED STATEMENT OF JUSTIN MINYARD APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Minyard. We truly appreciate your comments.

I yield myself five minutes for questions. Thank you all once again. I guess I have a question, let me just start with Mrs. McDonald. Did your husband see the same person every time he went to the VA?

Mrs. McDONALD. No, sir.

Mr. BENISHEK. So was that person their regular primary care physician that they saw?

Mrs. McDONALD. Both his pain management and his mental health management prescription bottles had the same doctor's name on them. But it was a rarity that he either saw them, it was a rarity that he saw the same doctor twice. Many times he came home from appointments frustrated because he, especially in men-

tal health, had to basically relive the last 15 years and five deployments over, and over, and over again. And he never felt like that was ever going to be treatment for his PTSD. You know, like I said, almost immediately after seeking treatment, he was diagnosed with severe PTSD. In July of 2011, just months before he died, he was awarded 80 percent disability after never having an MRI, x-rays, nothing to prove where this pain came from.

Mr. BENISHEK. Mrs. Green, let me ask you the same question. Did your husband see the same person over and over again?

Mrs. GREEN. My husband had an assigned neurologist, a VA doctor, and then he also had a civilian doctor. So he had two neurologists. But he had other doctors that he did see at the Fort Smith VA Clinic. And he would see different health practitioners. So it could be a number of, a different number—

Mr. BENISHEK. Were you ever involved in asking the physician, did you ever go with him to his appointments and ask about all these medications?

Mrs. GREEN. I had, yes sir, I had attempted to go with him. They would not let me back with him into the room. Now I did see his—

Mr. BENISHEK. They would not let you go with him to see the doctor? Is that what you are saying?

Mrs. GREEN. No sir, they would not. Now I did see his doctor with him when he was, he had a spinal fusion in May of 2011, and I did see the doctor with him, and then the back surgery, I saw the doctor with him for the back surgery.

Mr. BENISHEK. So you never did, neither one of your husbands actually saw a pain specialist about—

Mrs. GREEN. No sir, my husband had never been referred to a pain specialist.

Mrs. McDONALD. I had, actually, just prior to my husband's death, when he went for his appointment on the 12th, I suggested to him that he talk to his doctor and allow me to talk to them. Because I feared that the amount of medication that he was on was what was preventing us from conceiving. Because he had completely deteriorated, not just as a person, but his health was going downhill. My husband was in stage two liver failure, which was only discovered by the coroner.

Mr. BENISHEK. Unbelievable. Mr. Renschler, is that your experience as well? Did you see the same person?

Mr. RENSCHLER. No sir, I did not see a pain specialist. And primary care, often as the deployment health team was attempting to shift focus, the primary care provider would often change from one appointment to the next.

Mr. BENISHEK. Mr. Minyard?

Mr. MINYARD. Sir just prior—

Mr. BENISHEK. I just want to know if you, did you see a regular, I mean, did you end up going, was this within the VA system, this pain—

Mr. MINYARD. My chronic pain treatment both was in with the DoD and the VA. I can tell you that before I was referred to an interventionalist pain specialist, I was already at the point where I was daily taking 240 milligrams of Oxycontin, 60 milligrams of Oxycodone, and 40 milligrams of Valium a day prescribed by my

general practitioner, the same doctor that prescribed medicine if I have a cold or the strep throat. And that also alternated between sometimes she decided to go with a 100 microgram Fentanyl patch, again which is typically used for patients that are not long for this world. So it was a long time——

Mr. BENISHEK. Did it seem, did any of you have the experience where the physician, or maybe you were not aware, that they were looking to get you to someone that could manage this better than they could and they just could not get the appointment? Or they just decided that they were going to do the management? Was there any, do any of you remember any——

Mr. MINYARD. In my situation, sir, my primary care provider made it clear to me that she was my primary care provider and it was her responsibility to manage my medication.

Mr. BENISHEK. All right.

Mr. MINYARD. If that can answer your question.

Mr. BENISHEK. All right. I think I am out of time now. I will yield to Ms. Brownley for five minutes in questions.

Ms. BROWNLEY. Thank you, Mr. Chair. And thank you all for being here, and thank you for your service to our country. And I think we all owe you, each and every one of you, a deep apology for not responding to your needs the way you have defended our country. And Mrs. McDonald and Mrs. Green, I include you in thanking you for your service to our country and being married to your spouse and supporting him through this process. That you, too, need to be thanked for your service. So thank you all. I think this is obviously a very, very important topic, and hearing your individual stories, I think is important for the American people to hear.

I wanted to ask a question, my first question anyway, and this question is more directed to Mr. Minyard and Mr. Renschler. And I was wondering about your experiences and maybe experiences from other wounded warriors that you may, more regarding the continuity of treatment from the Army to the VA, and perhaps from one VA facility to another VA facility?

Mr. RENSCHLER. I will answer that to the best of my knowledge. Again, I have walked alongside of countless veterans over the last several years in a volunteer capacity and walked them through, attempted to navigate the VA health care system to get the best care possible. In my experience, it takes quite often a door kicker mentality to get veterans the care that they need. We, I have hand walked them to a physician's door, to a social worker's door, to a mental health practitioner's door and said, "This person needs help today." And that is the way we have been able to make things happen in people's lives.

To answer as quick as possible, no. There is not good continuity of care from one facility to another. There is not good continuity of care from DoD to VA. You know, as I spoke on my specific experience leaving DoD and entering VA care, my medications were not only the VA formulary. So they completely changed my medication regime, put me on more harmful medications, which ended up causing me a backslide in my recovery which took the Army three years to establish.

As far as, there is a veteran that I work with currently that has left Portland VA facility in Oregon and moved into Washington State. And upon entering Washington State American Lake VA Hospital, he was told that his medications are not able to be purchased through the American Lake VA Hospital because they do not have the budget for the non-formulary medication that the other facility had. And this was, again, a medication that took six years to figure out the best thing for him. And they are not going to purchase it anymore, which is causing him a backslide in his pain management as well. So the short answer is no, there is not good continuity of care.

Ms. BROWNLEY. Thank you. And I think I said Mr. Green, I apologize. I meant Mr. Minyard, if you had any additional comments in terms of continuity of treatment?

Mr. MINYARD. Ma'am, with all due respect, I would not, in my opinion and through my experience, I would not place the word continuity anywhere in a sentence that contains the other nouns DoD and VA. To give you a quick answer. The systems to me—

Ms. BROWNLEY. Yeah. I hear you.

Mr. MINYARD. —do not work.

Ms. BROWNLEY. Thank you.

Mr. MINYARD. Yes, ma'am.

Ms. BROWNLEY. And then really to anyone who would like to respond, you know, can you talk a little bit to, about to what extent and with the VA facilities, has there been any kind of sort of comprehensive interdisciplinary approach to your situation or to others that you might, we talk about a primary provider, therapist, others who are working as a team?

Mrs. McDONALD. I guess I can say one thing about that. After my husband's death I did contact the VA almost immediately. I was, the VA itself told me that I needed to immediately start the process to claim my husband's death pension to help my family. What doing that immediately does, I do not know. I took 11 months to start receiving any retroactive pay from my husband's pension. I lost my home. I lost my car. When I asked them during the filing of the claim, the VA asked me whether I felt my husband's death was service-connected or not. First, that is not my decision. Every pill he put in his mouth was due to an ailment or injury he received either in theory due to his service for his country, so yes, that makes it service-connected. Why it took nine months for them to make a decision and a rating on that? No, I was simply told, "I am sorry, Mrs. McDonald, this is the process. It takes time." There is a huge backlog. I feel like the VA right now is proud of themselves because they are saying the backlog is going down. The amount of claims are lessening. Well, of course they are. Because they are dying. They are not receiving treatment anymore because they are not here to receive it.

You know, when I asked the VA, you know, why? Why was his health care not well managed? And the response they gave me was that there was nothing else that they could have done, and that his health care was well managed and properly maintained. No.

Ms. BROWNLEY. Thank you very much. And I yield back.

Mr. BENISHEK. Mr. Huelskamp?

Mr. HUELSKAMP. Thank you, Mr. Chairman. I would like to also apologize, as my colleague has done, for what has occurred here. I have a couple of follow up questions. The Chairman was asking, I think in terms of continuity of care. And I was also struck by the denial of Mrs. McDonald's for the ability to walk in with your husband and participation in those appointments. Is that what I understood correctly? That you requested and the VA would say no, you cannot come back and visit with—

Mrs. McDONALD. Many times I would go to the appointments with my husband in the very beginning of his treatment. I wanted to, first of all he was in denial that he even had PTSD, like most soldiers and veterans I think battle with that. Probably more than the pain itself is the denial behind the fact that they may actually have a mental health issue underlying a lot of the war that they have experienced. Once I was able to get him convinced that he needed, it actually took the help of another veteran to convince him he needed help. I did go for the first several months and I had to wait in the waiting room. I was told that due to privacy issues, I was not allowed to be there with my husband. Now in the civilian sector, doctors normally will allow a spouse to go back there just because, especially prescribing medication, once they have received that medication, they might not remember the orders that the doctor gave them afterwards of taking the medication. It was frustrating. I finally stopped going.

Mr. HUELSKAMP. Did your husband request that you come in there, and they denied that? I am just curious what the VA policy is.

Mrs. McDONALD. On the September 12th appointment, the day before he died, he requested that I be allowed to go with him to his, he was finally being scheduled to see a pain specialist at the Ohio State University Neurological Surgery Center for his back pain. A consultation, and they were going to allow me to be there. That would have been September 24, 2012, but Scott was deceased by the 13th.

Mr. HUELSKAMP. Okay. Mrs. Green, was it a similar experience?

Mrs. GREEN. Somewhat. I was denied the right to go in with my husband, and he did want me in there. But they refused because of privacy issues.

Mr. HUELSKAMP. Mr. Chairman, it sounds, I look forward to hearing what VA has to say.

Mrs. GREEN. This is going on, mm-hmm.

Mr. HUELSKAMP. Because you want to be in there, the patient would like to see you in there, and the VA, do you think it was a preference of the physician or the provider? Or do you think that was just their policy?

Mrs. GREEN. Sir, I cannot answer, I cannot speak, I do not know.

Mr. HUELSKAMP. All right, thank you. How big were these clinics in terms of how many providers were there? Were these pretty massive clinics, or were they small where you were receiving care?

Mrs. GREEN. The clinic at the VA in Fort Smith is not a huge facility. But they do, we do have a lot of returning servicemen and women, and it is utilized frequently from the Guard, a lot of transitioning soldiers. So, but it is not a very big facility.

Mr. HUELSKAMP. Mm-hmm. And Mrs. McDonald, when you were concerned on PTSD, what was the, how would they have handled that? You have to go see someone separately? Or you could bring it up to the primary care physician if your husband was willing? And do you know how they would have handled that?

Mrs. MCDONALD. I do not know how they would have handled it. You know, my primary concern of telling him, look, flat out, "I am going with you," my husband never accused me of having the ability to keep my mouth shut. I was going with him, regardless of what they said, because I had watched his medications fluctuate in such a way, especially for his PTSD, my husband was no longer Scott McDonald. I did not know who the man was that I was married to.

Mr. HUELSKAMP. Thank you.

Mrs. MCDONALD. He would become angry and violent. And in the months prior to his death, we had finally thought we had found a remedy, that he was back to himself. He was back to being a father and a husband. But he had been labeled 80 percent disabled.

Mr. HUELSKAMP. Okay.

Mrs. MCDONALD. Or he jokingly would say he did not mind being a soccer dad.

Mr. HUELSKAMP. All right.

Mrs. MCDONALD. But I could see that he was broken.

Mr. HUELSKAMP. Okay. All right. Thank you. I yield back, Mr. Chairman.

Mr. BENISHEK. Thank you, Mr. Huelskamp. I call upon Dr. Ruiz.

Mr. RUIZ. Thank you, Mr. Chairman. Thank you for your service. Thank you for all those days that you went wondering, and thank you for finding hope in your struggle to make sure that other people do not get treated like you did.

I am an emergency medicine doctor and I treat patients who come in when they are at their last wits, when they just cannot take it any more. When that pain is unbearable, they cannot see their doctor, or it is just relentless. Can you tell me about the experiences, have you, did you ever have those moments where you sought care for acute pain, acute on that chronic pain, at a different facility in the emergency department that was not affiliated with the VA?

Mrs. MCDONALD. As far as with my husband?

Mr. RUIZ. Yes.

Mrs. MCDONALD. No, because we quite frankly could not afford it. We utilized the VA because it is free health care for the first five years after separation from the military.

Mr. RUIZ. Okay.

Mrs. MCDONALD. And it is what we could afford.

Mr. RUIZ. How about the others?

Mr. RENSCHLER. The same answer. We honestly cannot afford for that to happen. We, it took us a long time to recover from the financial hardships of losing my job. And once my benefits started, I could not afford to seek treatment elsewhere. We had to put together, as I said, a pain management regime that worked for us. We paid out of pocket for a while for chiropractic care and we found somebody through church who would work on me chiropractically for free, and our neighbor is a massage therapist.

And we found things that worked for us just to get by. But you know, it would be really cool if the VA would take care of some of that too.

Mrs. GREEN. My husband always said that when he enlisted into the military the VA had promised him his free, or his health care. And when he was VA service-connected, he said he trusted the VA and that he was going to use the VA. And so his facilities that he utilized was the VA.

Mr. RUIZ. My understanding is that the VA will not cover acute emergencies outside of the VA in what they cover? Is that true or not true?

Mrs. GREEN. I cannot answer that.

Mr. RUIZ. Okay. My question also is referring to all those times that you mentioned that there was a doctor that would add a new medicine, or that would change the dose, and that there was no continuity of care, like it is not the same doctor. Sometimes that may occur outside of a VA system or not, or inside. I know in this case, it did occur on the inside. And sometimes that does occur on the outside. What was it like to get information from the VA to those doctors in terms of knowing what the medications they were on, and what is the dose, and what is the regimen that was prescribed? Because sometimes when you do not have that information, they see you for the very first time, and there is no continuity, there is no history. They just look at a list of maybe what you have been on before, and so they will prescribe you, just to handle that specific situation. How is the ability to acquire records or call your physician from the VA?

Mr. MINYARD. Sir, I can try to answer that. I think it would be easier if everybody in this room, we all worked together to try to raise the Titanic, than try to get my medical records from the VA to a civilian hospital. And to have a doctor from the VA call my civilian provider, that would be unheard of, sir. In my experience, it is extremely difficult to get. It is kind of a chain link process. It is extremely difficult for me to get my DoD records into the VA. If that happens in piecemeal, once they do get to the VA, and I do need to go see a civilian provider, I have yet to receive documents that I asked for 12 months ago. And I volunteered to come to the VA where the records are kept, take time from work, and photocopy them myself. And we are at 12 months and counting, sir. It is extremely difficult.

Mrs. McDONALD. I think for me, I was only able to obtain, and we are still in the process of obtaining my husband's full medical docket after the estate hearing, in which I was appointed the executor. I think the bigger question is, is why is there not more continuity between the doctors at the same VA? Why is my husband being prescribed the same medication and two weeks later sees another doctor who says, "do not take that," but then the same medications show up in our mailbox? My husband was just receiving pills left and right, that it seemed like with every months that passed the plastic bowl, mixing bowl that we kept all his meds in, had to become bigger. Because they just become so abundant. And nobody ever said, "stop taking this one, switch to this one." It was, "this does not come in that milligram, okay, so-and-so has you on," nobody was going through his records and saying, "this doctor al-

ready gave you this, so I am not going to go and do this.” So I think there needs to be a lot more communication amongst the doctors who work in the exact same area, in the exact same field, and treat the exact same patient.

Mr. RUIZ. I absolutely agree with you, and I think that is the primary question here is, what kind of safety mechanisms are in place to ensure that a prescription cannot be prescribed until they have a consultation with the appropriate pain specialist, which we know that they have, you have a lack of, in the VA, and the pharmacy, to start to have a different ability to look at the interactions between drugs.

There is a big push now, I know in the hospital that I work in at Eisenhower Medical Center, where every patient, the nurses, and the doctors have to get together and they have to look at the interactions and identify those interactions for every single drug that they take. I think these are approaches and policies that the VA may have, like you mentioned there are clinical guidelines. But it is the implementation, and what are the quality control measures that also look, not only at the actual science of those interactions but the patient/doctor relationship.

Not allowing the next of kin, the spouse, to be seen with the patient for privacy reasons, is one of the biggest hog washes I have ever heard. And the other thing is to make sure that we look at pain in a holistic manner. To look at the complexity of pain not only on the science, but also the effects of the interactions with family, their ability to function, their mental health, like you mentioned, and the perception of who they are as a human being. And I think that these are questions that we will be asking the VA and we will be looking thoroughly into.

So I thank you for giving voice to the voiceless. Although they are not voiceless, their voice lives in you. And I know that. Because I feel like your spouses are here, and I feel like all of your friends that are doing that are here with you. So thank you very much.

Mr. BENISHEK. Thank you, doctor. Now we will have five minutes from Dr. Wenstrup.

Mr. WENSTRUP. Thank you, Mr. Chairman. And I, like the others, applaud you for being here, and to have the courage to be here and to take up this new mission in life. Basically, the things that I was going to bring up my colleague, Dr. Ruiz, really pretty much covered. And as a caregiver, and as one that has given care in the DoD, I am an Army Reservist, I understand that side of it, and the complexities there with it. And it bothers me when we hear what we just heard, because this could not go on, I do not think very well in the civilian side, the things that are taking place.

And so my question to sort of piggyback on Dr. Ruiz is, when you went to the doctor, you or your spouse, did they ever take the time to review the current medicines while prescribing something new that you are aware of?

Mrs. GREEN. My husband went to the VA doctor in September, a month before his death, to request that his medications be reviewed. And how the VA, how the health care provider reviewed it was to tell him that he should continue taking all of his medications. And wrote that in the medical summary. And it is clear in

the medical summary of his medical records. And he followed the orders of the doctor.

Mr. WENSTRUP. Is that similar for all of you? I would imagine that—

Mr. RENSCHLER. I think she paints a pretty good picture of what it feels like and the transition I had to take for myself in learning how to advocate, and I learned it pretty good from my wife. She is about 5'5" but she is a pistol. When we would go into the hospital and the doctors would say, "you are going to take this pill," I would be like, "yes, sir, it is going to help me." As far as reviewing the medications, every visit, they would print off at the nurse's station a current list of medications. Not necessarily to go over them or to ask how they are doing, but I am sure that this comes down to a policy issue, this is how they are executing the policy to review those medications. At each visit, the doctor prints off a current list of medications and hands it to me as we are walking out the door.

You know, I think a big issue that I would like to raise as we are talking about this specifically is the oversight. You know, many of these medications have harmful side effects. And the problem that arises, I am sure in the civilian community, that primary care providers change and they move. But this happens really frequently at our VA facilities. It happens, they go from team to team. And when you are put on a new medication with harmful side effects and there is no oversight to say, "hey, how is this doing for you?" three days later, that is a dangerous practice.

Mr. WENSTRUP. That goes to my next question. When you were receiving your medications, was there ever a consultation with a pharmacist to discuss the medications that you are on?

Mr. RENSCHLER. That is another practice, at least at our facility, is that when you pick up your medications, if it is a new or renewal, we have to sit in front of the pharmacist who looks it up, and at our facility they say, "this is the medication that you are getting and these are some of the known side effects." And they print, for me, they have printed off a fact sheet for the medications and then prescribe them to me. So.

Mr. WENSTRUP. Were you ever offered a consultation with pain management specialists?

Mr. RENSCHLER. No.

Mr. WENSTRUP. Mr. Minyard?

Mr. MINYARD. Sir, I took it upon myself to try to track down the pain specialist in our VA. Nobody could tell me what office he was in. So I literally walked the three or four floors of the VA, office to office, asking who the pain specialist was.

Once I got there, I quickly realized it was an exercise in futility. Because his answers for my condition and my injuries were either go back on long term opioid-based treatment regimen, or he could do lumbar epidural shots. I mentioned that I had a spinal cord stimulator already implanted and it helped me, it was instrumental in stopping a dose of opioids that would have killed me very shortly. And he, this is, now to put this in perspective, this is the interventionalist pain specialist in charge of one of the largest VAs in Florida. The guy that we all are supposed to go to for pain management. He had never heard of a spinal cord stimulator. That

blows my mind. That to me is beyond unacceptable. And for me, as a patient to have to pull out a brochure and say, "This is what it does, doctor." And I did it very tactfully and very respectfully. But for me, I am an Army guy. And I am having to talk to a medical professional and explain a device that is used to treat pain, the field in which he has gone above and beyond to become educated in? And the most absurd part of it is, I was thrown out of the office.

The reception I got from him was, again, you are an Army guy, I am the pain specialist, how are you going to teach me anything? Here is your brochure. Thank you very much. Have a nice day. That was my situation. Which is absurd, sir, in my opinion.

Mr. WENSTRUP. I agree. Well my time is expired. I want to thank you all very much. I appreciate it.

Mr. BENISHEK. Thank you, doctor. Ms. Kuster?

Ms. KUSTER. Thank you very much, and thank you Mr. Chairman for holding this hearing. And to our colleagues, particularly our doctor colleagues, I want to say that we are fortunate to have their expertise on this panel.

I just want to say in addition to thanking you all for your courage to come forward today, and please know that you are giving voice to your spouses. And for you all, for your service, thank you, and for coming forward. I have been married for 27 years to a man who lives with chronic pain, not from military purposes, but I very much understand the story that all four of you have told, and it is something that I have lived with everyday and the psychological impact and the physical impact.

But I want to focus on, Mr. Minyard, your experience with this spinal cord stimulator. And just for me to understand as a new Member of Congress, how that type of answer to your prayers could be made available to more people in the VA system? And I know it is complicated managing pain. For my husband, he has tried every treatment that you have described and many that you have not. He now is getting hip replacement surgery, where people had talked about major back surgery. And in fact, this is one of the first times that I have seen him pain free. So I think it is complex in terms of the connections. But how to get from this opportunity that you had for more people across the spectrum, to have these types of cutting edge therapies that could make a tremendous difference in people's lives, do you have any suggestions for that?

Mr. MINYARD. Yes, ma'am. And I am very grateful for the question, and I will try to answer it as best as I can as a patient with the device that it works. I am obviously not an industry expert or anything like that, or a policy maker.

Ms. KUSTER. Sure, mm-hmm.

Mr. MINYARD. But the biggest stumbling block to getting this medical innovation, technology like this, that I have seen and when I deal with other veterans and other people that are dependent and addicted, as I was, to Oxycontin, is, or opioid pain medication, is that providers, as well as patients have to be educated. That is, for me, if I ran the world, that is where I would start. Because if you do not know about it, you cannot teach somebody about it. So if more doctors were made aware and learned about the technology, and it does not just have to be what I have, but it is medical innovation. Looking for a better, more effective way to treat veterans

and other chronic pain sufferers, not just veterans. So it is, in my opinion, again ma'am, it is not being satisfied with the status quo of we have been doing opioid pain medication for long term chronic pain treatment. It seems to be going okay, so let us stick with that. Why not strive to do something better?

And the ramifications of long term opioid-based pain medication, if you look at the, I spoke about this yesterday, a lot of times you hear the argument there is a cost benefit ratio. Pain pills are, I am assuming, much cheaper than technology like this. But cost benefit analysis is, that is not really realistic when you are looking at, if you want to do cost benefit analysis, we can do that. Let us go ahead and put, what cost are you going to put on my marriage? My ability to now know my daughter, who I did not know for three years because I was stoned and I was deployed? What value is there for me to be excited to read a book with my daughter at story time, at bedtime? What value do you place on me being happy and excited about my ten-year anniversary on Saturday? I, I did not think there was any way I could make it to ten years. If I was my wife, I would have divorced me 20 times ago.

But the point is, it has to, in my opinion, it has to start with education and the desire to look beyond the standard and the status quo. It seems to me every other, car industries for example, they do not settle for this year's model, is the best we are going to do, and we are good with it. They constantly strive to look for new innovations, better ways to sell their product. Why do we not do the same thing with patients? Look for more effective ways for them to live well, have a family, be a productive member of society, and manage their pain as opposed to their pain managing them, ma'am?

Ms. KUSTER. Thank you very much. My time is up. But in the civilian side there is a process, and I am sure Dr. Wenstrup is familiar with the quality assurance, and it is something that we could look into of trying to get to a place where these situations did not happen. So thank you so much for coming here today and sharing with us.

Mr. BENISHEK. Thank you. Mr. Bilirakis?

Mr. BILIRAKIS. Thank you, doctor. I appreciate it very much. And I want to thank you all for your service. I appreciate it. Thank you for your willingness to testify as well.

Mr. Minyard, I have one question. I understand that at one point you went to VA with a list of private sector providers in your area who were able to see you and could provide the treatment you needed, and were told by the VA that you could not access care in the community and would instead need to travel to another VA facility hours away. Is this true? And again, it would take months for you to get the next available appointment, which I think is unacceptable. Please describe that experience for us. And why did the VA tell you that you could not be seen in the community? I think this is a very important question. So please, if you will, thanks.

Mr. MINYARD. Yes, sir. Part of the technology I have and the pain therapy I have is treated by spinal cord stimulation. The Orlando VA, as I said earlier, the pain doctor there was not even aware of this treatment. And I went on Google Maps, looked up 60 providers within a ten-mile radius of the Orlando VA, civilian pro-

viders, that could give me the support I needed to maintain the device I use to manage my pain without opioids.

I went to the highest, I went, I started at the bottom and went up the chain of command at the Orlando VA, and then asked for the appeal to be sent up to Gainesville, saying why can I not, why with bonuses being paid to VA CEOs for outstanding performance when people are dying in the hospitals, why with big, you know, conventions being thrown that cost millions of dollars, why cannot somebody pay for me just to go down the street and get my device fixed? And they said no. It costs too much. We have a doctor in Gainesville, I live in Orlando, that deals with this type of thing.

So I said okay, can we get an appointment? And this was last May. They said, okay, we will put you on the list.

Mr. BILIRAKIS. So you have a doctor at the VA in Gainesville, that is affiliated—

Mr. MINYARD. In Gainesville.

Mr. BILIRAKIS. Okay.

Mr. MINYARD. I will see that doctor in June of 2014.

Mr. BILIRAKIS. June—

Mr. MINYARD. I made that appointment in May of 2013. So I am eagerly looking forward to it next year, sir.

Mr. BILIRAKIS. So in other words there are several, you said close to 60 providers, private sector providers in the area that could see you almost immediately?

Mr. MINYARD. Last count. And on top of that, sir, I know our time is getting short, but due to multiple TBI injuries, you know, one too many times being blown up, I have seizure disorder. The result of that is I have fairly frequent seizures, typically three to four every five months. So my license gets revoked every six months I have a seizure. So that was another case I brought up with the VA, saying you would rather me try to arrange a ride from Orlando to Gainesville, at the same time I have a full-time job which I was subsequently fired from because the VA kept canceling my appointments and that is another story. But knowing I did not have a drivers license, they still insisted that I was not allowed to go five miles from my home to a civilian doctor. Instead, I would wait until an appointment was available. And then, they actually called me and their words were, "We need you to arrange some transportation. Do you not have a wife?" My wife is a VP for a Fortune 500 company. She is taking care of me, my daughter, and progressed in her career unbelievably. So yes sir, I do have a wife. But I am not asking her to take time off to drive me to Gainesville when you can send me five minutes away. And that was that situation you are referring to, sir. If it did not happen to me, I would have trouble believing it, sir.

Mr. BILIRAKIS. All right, thank you. Anyone else want to comment on that on the panel? But also I would like if you do not mind, I would like to talk to you further after the hearing?

Mr. MINYARD. Yes, sir. It would be my pleasure.

Mr. BILIRAKIS. Okay. Please. Please. Anyone else want to comment on this particular issue?

Mrs. GREEN. My husband was referred for a sleep apnea test and there is a sleep facility in Fort Smith. And he, the referral was for Missouri. We had to take him to Missouri for his sleep apnea test.

Not once, but twice, when there is a sleep facility in Fort Smith, Arkansas. Twice.

Mr. BILIRAKIS. Thank you very much. I yield back the balance of my time. Thank you.

Mr. BENISHEK. Dr. Harris?

Mr. HARRIS. Thank you very much. I want to thank the Chair and the Ranking Member and other Members of the Committee to let me sit in on this. As you know, I am an anesthesiologist. So pain management, although not my subspecialty, is certainly related. And I have a couple, just a couple of very brief questions. Sergeant Renschler, let me ask you a question about the denial by the formulary of Lyrica. Which I find fascinating, because you know, Federal employees can get Lyrica. I mean, you can go on all kinds of health coverage to get Lyrica. But my question is very specific. My understanding is about your testimony the Chief of Neurosurgery said you should get Lyrica. And then it was denied by the pharmacy, by someone in the, did someone examine you from the pharmacy? Sit down, take a history, go over the indications, possible indications? Or was this just a paper denial as far as you know?

Mr. RENSCHLER. Sir, it is a disgusting situation and it went down like this. I went up to visit the Chief of Neurosurgery in the Seattle Medical Center. She came up with this medication option, said it might be a really great thing to improve my quality of life and reduce my dependence on opiate-based medications which is something that was a big goal for me. And it had very few side effects and it certainly was not damaging to the liver, so it was a great thing for me and my wife. When she put in, she did tell me it was non-formulary and it might be a battle to get it, but she was pretty confident that her rank would allow us to get this. It was denied. And she called me on the phone and told me it was denied but she was gathering the signatures from two other department heads to resubmit a request back to the pharmacy because when they responded to her they told her, "he should try things such as Lidocaine ointment and Gabapentin." And—

Mr. HARRIS. And again, just, because I think you have answered the question. It was recommended by someone who never met you—

Mr. RENSCHLER. Never met me, never evaluated me.

Mr. HARRIS. —did not know the specifics?

Mr. RENSCHLER. And did not know the specifics.

Mr. HARRIS. And my belief is, as I am sure you share, this was because Lyrica actually costs more than other medications, right? So this is a cost saving measure. It is just fascinating, that is fascinating to me. And just very briefly, Sergeant Minyard, let me just ask you because, you know, part of your testimony was pretty, as you have found out pain management can get pretty specific, require a lot, we require a high level of training.

Mr. MINYARD. Yes.

Mr. HARRIS. Because you could not find someone in the VA system who actually, nearby who could do what you had, which as you found out is pretty standard in the outside world.

Mr. MINYARD. Yes.

Mr. HARRIS. I mean, six or seven years ago, when I was giving anesthesia for people like you who were getting spinal cord stimulators implanted. When you were in overseas, though, were you getting epidural steroid injections in a tent in Iraq? I mean, I am an OB anesthesiologist. I have given thousands of epidurals to patients in labor. I would never dream of doing epidural steroids on a pain patient because you actually need some special training to do it properly. But is that what you were getting? Were you getting epidural steroid injections?

Mr. MINYARD. Yes, sir. I—

Mr. HARRIS. I mean, and again—

Mr. MINYARD. I do not want to sound—

Mr. HARRIS. —this is a VA hearing. It is not on DoD, obviously.

Mr. MINYARD. Yes, sir.

Mr. HARRIS. The DoD was responsible for delivering that. But I think the appreciation is, is that perhaps even systemwide, not even just the VA, maybe in the DoD, I mean there may be no appreciation for how very, for how the treatment of pain has changed over time. Multimodality. I mean, epidural steroids may well have been indicated in your case. But doing it in a tent in Iraq? I mean this—

Mr. MINYARD. Not even a tent, sir.

Mr. HARRIS. Oh, I am being generous—

Mr. MINYARD. Yes, sir.

Mr. HARRIS. —this was a tent.

Mr. MINYARD. I mean, what would happen, sir—

Mr. HARRIS. But you know what I mean? I am sure you did not have an interventional pain management specialist doing that intervention?

Mr. MINYARD. Sir, the docs that performed those, what would happen is, we would have, I would have my team's trucks rolled up outside the team house ready to go. As soon as all pre-combat checks were done, I went around the corner to a small enclosed area, three walls enclosed, and the RN that was attached to our trauma team would give me my epidural. And we would wait a few minutes to make sure everything was good, and then I would put on my combat kit, and roll on that mission. And I had eight of those.

Mr. HARRIS. I am going to apologize for the way the U.S. government handled that. Thank you very much, Mr. Chairman.

Mr. BENISHEK. Thank you, doctor. Well it was particularly frustrating to me to hear your many stories, one after another. But the challenges that you have addressed here seem to be remarkably similar for each of you. I hope that the administration officials that are here listened as closely as I did to the testimony. And if there are no further questions, the first panel is now excused. Thank you all so very much.

Now I will welcome the second panel to the witness table. Joining us on the second panel is Dr. Pamela Gray. Dr. Gray is a former provider at the Hampton VA Medical Center. Also in our second panel is Dr. Claudia Bahorik. Dr. Bahorik is a provider with VA's interim staffing program. In that capacity, she has worked at 13 different VA medical facilities across the country. She is also a disabled veteran, so thank you ma'am for your service. We are also

joined by Dr. Steven Scott, the Chief of Physical Medicine and Rehab Services at the James A. Haley Veterans Hospital in Tampa, Florida. Thank you all for being here and for your hard work on behalf of our servicemembers and veterans.

We will begin with Dr. Gray. Dr. Gray, please proceed with your testimony.

STATEMENTS OF PAMELA J. GRAY, M.D.; CLAUDIA J. BAHORIK, D.O.; AND STEVEN G. SCOTT, M.D., CHIEF OF PHYSICAL MEDICINE AND REHABILITATION SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF DR. PAMELA J. GRAY

Dr. GRAY. Thank you. At the outset, I would like to thank the Members of this Committee on Veterans' Affairs for offering me this opportunity. I am grateful for your time. I must also tell you that I am most honored to be in the presence of the four individuals who occupied these seats ahead of us. I would beg of this Committee to hear their stories and realize that they represent tens of thousands of similar stories. Tens of thousands.

I have included for your review today, a letter that I wrote to my State Senator. I do not mean at all for you to be bored by the trivial details of that letter. I use it as a jumping off point for you to hear the physician's side of what it was like, at least at one VA center in Hampton, Virginia, between 2008 and 2010 when I tried to work through the system and failed. As a result of trying to work through the system, and realizing the gravity of these complaints and the validity of my concerns, I offered myself up as a sacrificial lamb.

When you are employed as a physician, you are prohibited at a VA medical center from speaking out to the general public. You are to work through chain of command. I did so, and it fell on deaf ears. I went to my State Senator, knowing that the inevitable outcome would be to be terminated, which was indeed the case. But it was only through doing that, that my story was discovered. And I would like you to understand how I am here today.

I went through appropriate chain of command, went to service chiefs, chief of staff, director of the center, represented my VA as a VISN 1 through 11 conference on pain, I went through all the appropriate channels and failed. I am here because of the investigative reporting of a CBS News producer. And for that I am grateful.

I would pray of this Committee, no I would beg, I would beg of you to offer constructive intervention. Your flowery words of praise, thanks, condolence are heartfelt, I am quite sure. And they are eloquent. But if true change and action does not come out of this Committee, all here have failed.

With that in mind, I am going to just some highlights of my letter to my Senator. Not for details, and yes, there are names in that letter. And I chose to let them stay. I see no point in mentioning them in this testimony but they are in the written form. I do that because I spoke the truth then, and I speak the truth now.

I am a physician with 30 years experience. I am an internist and a rheumatologist. I closed my private practice and went to the VA in 2008. I never misrepresented myself. I am an internist, and a rheumatologist, and I was, had a dual appointment with internal medicine 30 percent, and primary care 70 percent. In the first hour of my first day, I was informed that I was head of pain management. In my ten years of post-graduate training, I had no pain management training. It is an entity unto itself. And it is a subspecialty that has subspecialty training. I was never asked if I was willing to assume this role, I was informed. So to those observations and questions that came before, I was pain management with zero training.

My concern about that was, it is not standard of care. If you are going to portray yourself as an obstetrician, you should have OB/GYN training. A surgeon should have surgical training. That is common sense. The VA in Hampton obviously did not realize that.

I tried to do what was asked of me. I thought it would be reasonable. They had no pain management, no rheumatologist. And so I decided to try and work through the system. I went through service chiefs, clinic nurses, telecare nurses, supervisors, when I found abberances in the way of treatment, musculoskeletal pain syndromes. I pointed out that ten to 20 percent of opioid users become addicted, we were creating addicts. All of this fell on deaf ears. The Chairman of the Department of Internal Medicine gave me this response to my query as why we were writing so many prescriptions for opioids, "think twice before refusing to write these narcotics. It is a time of economic downturn." I do not know if that was a threat of the loss of my job, or if it alluded to the possible diversion of narcotics. I do not know.

During my two-year period, I was coerced to writing drugs that I knew in my medical experience were wrong. When I would object, I was simply told to do it or else. The physicians are given three choices. One is acquiesce and keep your job. Two is quit; and three physicians quit during my two years there, one within 30 days of being hired due to objection to writing these massive amounts of opioids. I chose to work within the system, which led to termination, the third choice.

I documented in my notes, in 30 years of practice, I know how to write a note, I know how to be complete, I included the facts. I was being coerced by non-medical employees, non-M.D.s, to write for large amounts of opioids. When that was discovered in my medical note, which was an electronic medical record, I was ordered to delete the note or alter the note. I had reported the truth and I refused. The Chief of the Department of Primary Care altered my note, buried the note which documented the truth. And I had the proof, I had the original note, and then the subsequent note that was entered into the chart. And I reported that to the Office of Regional Counsel at McGuire in Richmond, Virginia. Nothing came of it. Again, I was trying to work through the system which was what was appropriate.

Upon representing my VA at the National Pain Conference, which was in 2009, I brought all of that information back to both Service Chiefs, the Chief of Staff, the Director. And in the two

years after that timeframe, nothing was implemented, absolutely nothing.

I became an advocate for several of the patients. There are patients who are smart enough to know about spinal stimulators, about alternate treatments. And as a result of trying to be a patient advocate, I was threatened with further action may result in disciplinary action to include removal. So again, the system failed me. I received death threats from patients. I was called before a probationary review board, not told of the charges against me, not allowed to review my records. And my Chief denied knowing anything about this review board when she herself had called for it.

So during my two years, I was forced to do work for which I had no professional training. I was ordered by supervisors to write large amounts of Schedule 2 narcotics for inappropriate medical circumstances. I had my medical records altered to hide factual documentation. I received sexual harassment by a male nurse, who would come to my office during lunch hour and threaten me if I did not write for the opioids. And when I reported it, I was asked if there were any other witnesses. Since there were no witnesses but the two of us during lunch hour, ergo it did not happen.

I was reprimanded for standing up for the rights of a patient. I was threatened to be reported to the National Data Bank, which is a mechanism for egregious complaints against physicians. And you have to reach a certain level of severity to be reported, and I did not. But they gave me that threat. And I was subjected to situations of entrapment, trying to get me to admit to things that were not true in an effort to build the case against me.

I underwent that board. I was never apprised of the findings. I was called to my boss' office and terminated.

I can see that I am over time. But I would like to beg, if I may offer the 11 patients that are at the end of this letter. And I will go through them quickly. The bottom line in all of them are they are on massive amounts of medication. You do not have to know anything about medicine, you do not have to know the difference between Morphine and Tramadol and Percocet, all you have to do is hear the quantities.

There was a 55-year old man, the first patient I saw in this musculoskeletal clinic, who had carpal tunnel. I bet you everyone here has had carpal tunnel symptoms. If you flex your hand for too long, these fingers will go a little numb. It is fixable with surgery. This gentleman has the surgery. He had none of the findings of chronic entrapment of the nerve. He had Morphine, Fentanyl patch, Tramadol, Percocet, he had been getting it since 2004, he had not been seen since 2004. He had had no labs checked since 2004. He had the opioids mailed to him. He did not even have to come in.

You had two veterans tell you about liver dysfunction as a result of these drugs. You must check the labs. There is not a civilian pain management, musculoskeletal clinic, rheumatologist, primary care, anything that would do this to a patient.

I can go through them all. I am over my time. This is representative.

[THE PREPARED STATEMENT OF PAMELA J. GRAY APPEARS IN THE APPENDIX]

Mr. BENISHEK. I truly appreciate your testimony, Dr. Gray. But time is a precious thing here in Congress—

Dr. GRAY. I understand.

Mr. BENISHEK. —and I just want to make sure that everyone has the opportunity to testify. We will certainly include the statement, your written statement in the record.

Dr. GRAY. Thank you.

Mr. BENISHEK. I appreciate your efforts here. Dr. Bahorik?

STATEMENT OF CLAUDIA J. BAHORIK

Dr. BAHORIK. I am here because no one else will speak out. My colleagues are afraid for their jobs. I am here as a physician who is concerned about the health and welfare of our vets. I also happen to be a physician acupuncturist, and a licensed physical therapist. I am here, too, because as he said, I am a disabled vet.

We have been asked to discuss the problem of narcotic prescriptions within the VA. I am here to tell you that the system is broken, that it is a set up for catastrophe, at least on the part of the veterans who get caught up in the pain game.

As a traveling physician, I have worked in 13 VA facilities from Guam to Maine, including the notorious VA in Jackson, Mississippi. Jackson serves as a perfect example of a system gone haywire. This was a system so cavalier that this VA facility did not think the Drug Enforcement Agency rules applied to it. So when they, DEA, stopped all the nurse practitioners from writing narcotics, the VA traveling docs were asked to help and I volunteered. I arrived to discover that I had been assigned the job of writing narcotic prescriptions for the vets that needed their monthly renewals. The first thing the head administrator told us was that we only had to review the charts, make sure they were stable, and write the prescriptions. He said he could do 30 charts a day while he was still playing top dog.

He did not understand why I objected, why I insisted I needed time to take a history, to examine the vets, and to review the chart. This is the same administrator that thought his own staff should write narcotic prescriptions on patients they never saw. He also paid medical residents at night to review charts on patients sight unseen so the pill mill could churn out more narcotics.

So they stuck me in a tiny exam room with no exam table, so I could not examine the vets. They gave me a nurse and we set out to screen the vets. What I found was a disgrace. I discovered that veterans' narcotic prescriptions were being renewed month after month, months on end, sometimes for one to two years without an examination of the body part that was in pain. They had been seen for routine medical problems, but the pain evaluation amounted to merely asking them to rate the pain on a scale of one to ten.

This was not just a few of the nurse practitioners whose patients I saw, it was the rule rather than the exception. Often, there were no x-rays, no recent MRIs, no tests, no specialist consultations for the pain problem. Just more and more narcotics on top of other medications.

There was no true attempt to screen for misuse or drug diversion. I found that urine tox screens were infrequently done and often they were positive for substances like cocaine and pot, or neg-

ative when they should have been positive. Many of the vets were misdiagnosed. Some had potentially serious conditions. Pain contracts were not being completed. When urine drug screening was done, no one even checked to see if the specimen was body temperature, or if the specimen was even from the veteran. No one was bothering to call the state databanks to see how many providers in the state were giving the people narcotics. I am here to tell you that this is not just a problem at Jackson, it is endemic throughout the VA where quick and cheap is rewarded over good and thorough.

Furthermore, it is uncommon for a doctor to refuse to write a narcotic prescription, only to have the vet go to the administration. What happens? The administrators call another doc and tell them to write the prescription. Or the vet will go to the emergency room to get their narcotics. Worse yet, doctors are being verbally abused, attacked, or injured when veterans who are on dangerous concoctions of mind altering substances are cut off. In Jackson, a doctor was shot and killed. Another had acid thrown in her face. In Delaware, two mental health workers were attacked. A vet who was denied narcotics ran his truck into the VA clinic in Lincoln, Maine. Another vet in Maine attempted to enter the VA with a gun to shoot the administrator. He became a case of suicide by cop.

Why is this happening? Unfortunately, we have given the veterans the impression that for whatever problem they have, we have a pill to help it. One or two pills for depression, one for anxiety, one or two for sleep, one for PTSD, then add a few more pills for problems like hypertension or diabetes, asthma, then add one or two or three prescriptions for narcotics. What happens if the vet adds some over the counter medications, or if he drinks alcohol? We have a prescription for chemical lobotomy, a veteran who is at risk for fatal interactions. Someone whose brain is bathed in a chemical soup.

The VA will show you guidelines and resources available to providers showing how much they are doing. These are the same administrators that create regulations, mandates, requirements that are so mind boggling that physicians are no longer captain of their ships. Basic principles of medicine are abandoned. Primary care providers are struggling to stay afloat in a system bogged down with mismanagement, bonuses that reward cheap care, not true quality care, and policies that make it nearly impossible to adequately and safely monitor the health care given to the brave men and women who served our country. Thank you.

[THE PREPARED STATEMENT OF CLAUDIA J. BAHORIK APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you for your testimony. Dr. Scott, would you please begin?

STATEMENT OF STEVEN G. SCOTT

Dr. SCOTT. I just want to begin by expressing my sincere sympathy to Mrs. McDonald and Mrs. Green who were here. And to you and your families, I just want to express that before I begin my testimony.

Good morning Chairman Benishek, Ranking Member Brownley, and Members of the Committee, thank you for the opportunity to participate in this oversight hearing and to discuss specifically the Department of Veterans, James A. Haley Veterans Hospital Chronic Pain Rehabilitation Program in Tampa, Florida that treats veterans experiencing acute and chronic pain. VA's chronic pain rehabilitation program was established in 1988. Our involvement in this program over the last 25 years, is a demonstration of our commitment to addressing pain management. We, recognizing that chronic pain can be very disabling and these veterans need our help.

Chronic pain is pain that does not resolve within three to six months. When chronic pain causes significant psychosocial dysfunction, then it is called chronic pain syndrome. Chronic pain syndrome is defined as chronic pain with significant psychosocial dysfunction. While pain may be the cause of these psychosocial problems, there is evidence that once established, these related problems linger even if the underlying pain is substantially reduced.

Unfortunately, many individuals with chronic pain syndrome attempt to fight these problems using increasing amounts of opioid analgesics. But these efforts are rarely successful. Due to the complexity of the syndrome, no single treatment approach is the answer. A multidisciplinary and multimodality approach is almost always necessary.

Tampa VA has both an inpatient and an outpatient chronic rehabilitation program, and has the only VA chronic pain program. The program is specifically designed to treat veterans and active duty military personnel with chronic pain. The program is evidence based, intensive, interdisciplinary, 19-day inpatient chronic pain treatment program that targets not only the pain intensity but also all the symptoms of chronic pain syndrome. The core philosophy of this program recognizes the complex interactions between the pathological, physiological, emotional, social, perceptual, cultural, situational components of chronic pain. Approximately half the patients submitted to this program are taking opioids and approximately half are not.

The program teaches pain self-management principles, where the participants assume responsibility for their daily functioning and learn to actually manage their pain. For most participants, this includes increasing their level of independent functioning; increasing their activity levels; reducing their emotional distress associated with chronic pain; eliminating their reliance on opioid analgesics or muscle relaxers; reducing pain intensity; improving marital, family, and social relationships, improving vocational and recreational opportunities; and improving their overall quality of life.

A unique aspect of this program is that all participants who take an opioid analgesic at admission are tapered off these medications during the course of the treatment. We have found that patients taken off these opioids, experience similar improvements to patients who are not taking opioids in all areas of treatment outcomes over time, including pain severity; activities of daily living; mobility; and all other psychosocial problems.

In its 25 years of existence, the program and its staff have received numerous awards. The program has been recognized as a

two-time Clinical Center of Excellence by the American Pain Society. It has also received the prestigious Secretary of Veterans Affairs Olin Teague Award for Clinical Excellence, and has been accredited six times by the Commission of Accreditation of Rehabilitation Facilities, or CARF. Their programs leaders have been actively involve in promoting systemwide enhancement of VA pain care. As the most specialized chronic inpatient pain treatment option in the VA health care system, the program has already accepted and treated referrals from all 50 states, Puerto Rico, and the United States Virgin Islands, and military installations from around the world.

In 2009, the Chronic Pain Program was selected to serve as VA's trading site for interdisciplinary pain programs. To date we have hosted 30 teams from across the country to observe the Tampa VA model system, and learn how to enhance pain treatment services at their facilities. The training program helps meet the 2009 VHA Pain Management Directive, mandating an interdisciplinary CARF accredited pain programs in each of the VISNs' integrated supported network. The positive effects of these training are seen in the increase from two CARF-accredited programs in 2009 to eight CARF-accredited programs in 2013, and it is anticipated that an additional 14 VA chronic pain programs will achieve CARF accreditation.

Mr. Chairman, VA is committed to providing a high quality of care that our veterans have earned and deserve. I appreciate the opportunity to appear before you today to discuss the Tampa VA chronic pain rehabilitation program, and I am grateful for your support in identifying and resolving challenges as we find new ways to care for veterans. I am prepared to respond to your questions that you may have.

[THE PREPARED STATEMENT OF STEVEN G. SCOTT APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Dr. Scott. I am going to yield myself five minutes to ask some questions. Dr. Gray, it is my understanding that each VA medical center is supposed to have a pain specialist. So I guess the pain specialist at your VA medical center was you, then, right? I mean, you were the one that was called the pain specialist even though you had no experience, is that correct?

Dr. GRAY. Correct.

Mr. BENISHEK. And now was it you that testified that your records were changed?

Dr. GRAY. Correct.

Mr. BENISHEK. You know, that is very much a fear that I have about the electronic medical records. Because I know myself at the VA, I experienced that as well. You know, I had a path report that said it was benign, and then the patient, that is why I sent the patient home for six weeks. And then when they came back, the same path report had mysteriously changed and become malignant. And yet, I had no evidence that there was a path report six weeks ago that said benign. So, you know, it makes you look bad. And this situation, where you are saying how the medical record is changed,

was there any evidence in the medical record, that it had been changed without your consent?

Dr. GRAY. Absolutely. Not that it was changed without my consent. Because I had been ordered by my superior to alter my notes, and I had documented the truth, I refused. I took it upon myself to print my note.

Mr. BENISHEK. Good idea.

Dr. GRAY. The electronic medical records cannot be entered into other than the treating physician or someone who has a pass level, and it could be a medical records person. My Chair, who ordered me to change my record, was Chief of Medical Records. She deleted the entire segment that she had ordered me to change. So the note started with my verbage, ended with my verbage, was signed with my signature. There was no record, and then reprinted, entered into the record as such. I printed that one, too.

Mr. BENISHEK. So you have a record of the—

Dr. GRAY. Yes, sir.

Mr. BENISHEK. —pre and the post?

Dr. GRAY. Yes, sir.

Mr. BENISHEK. Well I wish I would have copied that path report. To tell you the truth, this is a real scary thing for me because of the fact that, here we have got government controlled health care, where administrators are going to be changing the physician's notes to make themselves look good is a pretty scary situation in my estimation.

Dr. Bahorik, you relate a very similar story about being told how to treat patients by people that are not physicians, is that correct?

Dr. BAHORIK. Yes, it certainly is. Administrators that are not physicians are often in positions to supervise us and tell us what to do. Not only that, she was talking about pain specialists. For instance, at Wilmington in Delaware, the pain specialist is not a physician, it is a nurse practitioner who tells us what to do. And the other problem with a pain specialist is, if the person does get sent to a pain specialist they, once they start them on narcotics, they actually dump them back on primary care and expect us to continue the prescriptions. They just want to do their procedures and injections, and they do not want to bother with the mundane work of, or the day to day monitoring people on narcotics.

Mr. BENISHEK. Dr. Scott, let me ask you this question. It sounds as if you have a pretty dynamic pain specialty service there in the VA at Tampa. Do you have any experience with the way they manage pain elsewhere in the VA? I mean, it seems to me like you should be an example to the VA, as how pain management should occur. But it does not seem from the testimony we have had today that that is actually happening.

Dr. SCOTT. We are trying to, because we set up this, we are trying to get other centers to come and educate them at our center, sort of team to team like interactions. And we have had 30 of them that have actually come. This program is real unique because I actually have seen individuals, I have been in this program long enough, you know, it is 25 years so you can imagine, I have been 23 years at this program, that I have actually seen veterans from D-Day, you know, that have had chronic pain. I have seen veterans that have had chronic pain from Korea from frostbite and that. I

have seen veterans from Vietnam. I have seen veterans from Gulf War I. I have seen complex veterans that have polytrauma, chronic pain from this War. And in some of those invisible type wounds where they, you know, we have seen those too. And they have all been successful in this. And they have all done well. And we have a program that, when you do this CARF stuff, it is an outcome based. So we are constantly, everyday, everybody in the team is trying to improve. Improve the process, improve the program.

And over 25 years this thing has been polished off and is really a fine, I guess you would say, program that you could really try to model after. And that is what we are attempting to do, to educate more people out in the VA or elsewhere, by coming. We also try to do some research. We also try to do educational. We just do our best as we can. And but it has definitely a 25-year track records of excellent outcomes.

Mr. BENISHEK. Thank you, Dr. Scott. I am out of time. Ms. Brownley?

Ms. BROWNLEY. Thank you, Mr. Chair. And thank you to all of you for your testimony.

Dr. Gray, I wanted to ask you if you have any evidence at all that the story that you have told by trying to work through the system and do the right thing, if at the end of the day do you know if there was any kind of investigation by the VA to determine both sides of the story in your situation?

Dr. GRAY. No, ma'am. If I tell you the grounds for my dismissal were that I did not say good morning to a nurse. There was no addressing my issues. The Office of Inspector General, when I asked for a copy of the report as a result of my queries about physicians being bullied into overwriting opioids, they found that the waiting times for physical therapy were not excessive. That had never been my complaint. That had nothing to do with prescribing opioids.

So no, to my knowledge the issues were covered up, not addressed. And the entrapment issues that I alluded to were these trivial, trivial things that were used against me. They did not want to address the facts.

Ms. BROWNLEY. What happens in the VA when we know a patient is now an addict to their drug? I have heard over and over again today it is just different cocktails, more drugs. Is there a point in which that stops and ceases?

Dr. GRAY. No. No, ma'am.

Ms. BROWNLEY. Dr. Bahorik, you said in your opening comments you had background in both acupuncture and physical therapy?

Dr. BAHORIK. Yes, I am glad you brought that up. I have been an acupuncturist for a little over two years. And every facility I have gone to I have asked to be credentialed to do acupuncture, particularly for pain patients. And I have been denied. Not because I do not have credentials. I am licensed as a physician acupuncturist. Just because they do not want to open up a can of worms because patients are going to find out that the service is valuable, and then they would have to pay for someone. Same thing with chiropractors. They do not have enough chiropractors. They do not do alternative things like massage, or anything to that respect. Mr. Renschler mentioned that when he went to physical therapy they did nothing. Well as a physical therapist and after

having been to 13 facilities I can tell you that that is the absolute truth. Not only do they not do anything, patients cannot get in.

Ms. BROWN. Thank you. Dr. Scott, do you use acupuncture at all or massage therapy in any of your—

Dr. SCOTT. Yes, we credential people in acupuncture, and we also use massage, and we also use, have a chiropractor. We also have alternative things. And I also submitted some new research on CAM stuff, too, so we believe in that, too. And we believe it. We use it as part of our overall holistic approach to pain management. And I think that it is part of that whole, looking at this thing in more of a total thing than just a separate thing. So we do all of those things. And if the physical therapy, if we cannot, we use a lot of, if there is sometimes, if it is closer to home we use non-VA care. I mean, we basically use what is best for the patient. The—

Ms. BROWNLEY. You had mentioned about the training that you do. Do you train across the country in acupuncture so that others are licensed? Or massage therapy? Or—

Dr. SCOTT. We currently at the present time do not have a manual or I guess you would say a training program in those areas. We do have residency education, you know, and residency programs like neurology and physical medicine rehab that we train individuals or we can send them to places that get that training, too. But we do not have train the trainers, if that is what you mean, at our place.

Ms. BROWNLEY. And is the training, it sounds to me the way you have described it, the training is voluntary. That if people want to come and get trained, they come to your center. But you are not sort of overseeing centers across the country saying, trying to look at where they need to be trained, if people are up to speed in where they need to be?

Dr. SCOTT. Right. The 2009 pain directive says that every VISN should have what they call a tertiary and interdisciplinary team for pain. And we are trying to offer our 25 years of experience to facilitate that in the VISN area. But I do not have a, I am just a local pain director. I do not have any kind of a say on who comes and when they come. Except they are always invited.

Ms. BROWNLEY. Thank you. I have run out of time. I yield back.

Mr. BENISHEK. Thank you, Ms. Brownley. Dr. Wenstrup, you have five minutes.

Mr. WENSTRUP. Thank you, Mr. Chairman. My first question is, are providers at the VA protected in some way or free in some way from malpractice claims? Yes, doctor?

Dr. GRAY. Interesting. In a way, yes. Because basically you are suing the Federal government. I am glad you asked that, if I can go a little bit further?

Mr. WENSTRUP. Please.

Dr. GRAY. All you need to practice at a VA is a state license. So if you have a Florida license, you can come to Virginia and work at the VA. I went to my state Board of Medicine to ask for help in this matter. The State of Virginia, as many of the states do, has an outstanding program where via Internet you can find out in 30 seconds whether a patient has gone to multiple providers for opioids, whether they are double dipping inside the system and

outside the system. The answer I got from my administrators was we are the Federal government, we do not have to.

Mr. WENSTRUP. Yes, in Ohio we have a similar program so that you can check what medications patients are getting through multiple providers. And you know, I have contended in my practice, which my last day in private practice was in December, and I always contended when I was dealing with non-providers or people outside of our office, determining what patients should or should not get, I would speak to them and say, "Well, how does this patient come to see you then if you are making this decision?" And I usually would get what I wanted in that context. Because I do believe that unless you sit down with a patient, and you look them in the eye, and you put your hands on them, you should not be making their medical decisions. But that is another issue for another day.

Dr. GRAY. That is a real doctor, sir.

Mr. WENSTRUP. I am sorry?

Dr. GRAY. That is a real doctor.

Mr. WENSTRUP. Oh, well thank you, ma'am. But my question really for all of you, what within the VA system would really motivate any of the providers, or any administrator, to be exceptional, and to be efficient? And to really provide a high level of care? What is built into the system that motivates that? Because for an independent practitioner in the private sector, it is your reputation. It is a standard of care, it is your state medical board. And I am wondering what in the VA system provides that, or motivates one? If anything?

Dr. GRAY. That is private practice. I was a physician in private practice for 25 years before I went to the VA. And it is your pride. What you would have to do within the VA system, and again this is my two-year experience in one VA hospital, but you would have to interrupt the current system of reimbursement, let us say. Every one of my service chiefs, all of my superiors received a bonus, a raise, and a promotion.

Mr. WENSTRUP. On what matrix?

Dr. GRAY. It—

Mr. WENSTRUP. Going up?

Dr. GRAY. Correct. The theme here is do it as cheaply as possible, and this is my opinion, but do it as cheaply as possible. You well know these opioids cost pennies, just pennies. And I guess they think a human life is just pennies as well.

I established a therapeutic swimming program at zero cost to the VA because the facilities were in place. The van, the driver, the pool, I had patients willing and eager to participate. I got no response from my supervisors. It was cheaper to just give them opioids.

Mr. WENSTRUP. Dr. Scott?

Dr. SCOTT. Congressman, that is a very good question and I could answer it both from a clinical side as well as a personal side. It is providing good quality care and having good outcomes. I find that is what drives my staff to be very excellent, both in treating the war injured back, both treating this chronic pain program. I could sit down with any of my team and they have great pride in what they do, because the patients, they see the change, they see

the improvement, they see the outcomes. And they are so overwhelming in this program that they basically, they come to work loving the work. Not for the VA but for the patients, to fulfill our VA mission, here to serve those. And providing that high quality of care, and getting that atmosphere where everyone is important, everyone can contribute, everyone's suggestions are listened to and acted on. That is what makes a good quality, that is what makes the atmosphere a positive, that is what makes the outcome. It is not money. It is basically those. That is what I found over time. That is why this program has gone for 25 years, because we have had people that constantly see these outcomes that are so good. And it keeps driving them to continue to be better and for the next patient. And I just want to share that with you.

And for myself, the same thing. What drives me is not what they cannot do, what they can do. What drives me is just what some of the people said, when they feel helpless, hopeless, when they feel like basically pain is running their life, we get them control of their life. We get them control of their pain. And when they leave the program I give them a new mission, to go out and serve our country again. And basically it is a good feeling. And then when they do that and they come back, it is priceless. It is why we are here. It is our mission.

Mr. WENSTRUP. I applaud you for promoting that type of motivation. And for those that provide care under your tutelage, that they are taking that approach. That is personal pride and that is how I practice. But I do not think that everyone has that luxury right now, or performs in that manner. And I yield back.

Mr. BENISHEK. Mr. Bilirakis?

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. And I really appreciate you holding this hearing and allowing me to sit on the panel.

Dr. Scott, I want to thank you for all the quality health care you have provided over the years. I represent, as you know, the Tampa Bay area so I am very familiar with Haley. And you, sir, are a true patriot. So thank you very much. And I appreciate your testimony as well.

I understand from the testimony that approximately 30 teams from across the country have visited your facility to observe the model system and learn how to enhance pain treatment services at their facilities. Have these teams from VA, are the teams from VA or from the private sector? Are you aware of any programs similar to yours that have been established as a result of these visits? And what more can be done to increase the provision of programs like yours across the VA health system?

Dr. SCOTT. We have had 30 of them. They come and spend about two and a half days. And they spend it, first we have groups, we have small groups. We teach them one on one. They have multiple disciplines so we match them up with the different disciplines, too. We show them the whole structure of the program. We show the administrative aspect of the program. We have a tremendous outcome based type program. In other words, we do not measure pain with just a zero to ten level. We also measure all the different aspects of how you function with the pain. And so function is very important. So we have basically, we developed our own scale there,

you know, to actually measure pain. Not just a number, but how you interact with that pain, how you function with that pain. How you function with your wife, with your child, as was mentioned. That is just as important, too. And those things are all measurable. And we can then measure them when they come, when they go, when they leave, and we try to teach these teams that. Our goal is for them to go back and hopefully set up that tertiary interdisciplinary team that could take patients in the more complex level and manage that, too.

And then we are available if they want to come back again. If they want to communicate by phone, if they want to interact too. So our goal is to really try to facilitate and help the VA learn what we have learned for 25 years.

Mr. BILIRAKIS. Thank you. Thank you again for thinking outside the box. Of the veterans patients that received care through the chronic pain rehabilitation program last year, how many resided outside of your facility's catchment area? If you can answer that question?

Dr. SCOTT. Yeah, probably more than half come from outside. We basically have a, in our mission stuff we have a hundred mile radius. So if they are within a hundred miles, they come in, we can screen them in. If they are beyond a hundred miles, like I mentioned we have had them from Hawaii, we have them everywhere in the country, we basically have to screen by phone, by mail, by letter and that. And so we have different mechanisms. But it usually about, if I admit four, I admit four patients on a Monday, and discharge four. They are there three weeks. We have 12 patients there all the time. And generally I will have one from North Dakota, Nebraska, and maybe even up in New England, and then one from local. So we see them from all over. And that is one of the neat things, is the fact that they all, when they come together, they all band together like a bank of brothers and they support each other. And with that, then they leave and they continue on those relationships. And with those continued relationships they keep the compliance and they keep adding to the program over time.

So I think about, Dr. Bilirakis, I think it, I should say Congressman Bilirakis, it is about half and half, half local, half distant.

Mr. BILIRAKIS. How are we raising public awareness, you know, so the veterans across the country can be aware of this great program?

Dr. SCOTT. Well we try different things. And we are doing it, you know, we tried it through the professional channels with education and with research. We tried it with website, we actually had our own website for a while. We tried it with, on the Internet, a system that we have in the VA. We are constantly trying to get the word out as best we can about this program.

We are not completely up to full capacity all the time. We are at about 85 percent bed capacity. It takes an individual, just so you know because we monitor this stuff real closely, it takes us from the time of consult to time that comes in, less than about 30 days. So, and so we want to make sure the access is there and maintained. We want to make sure the beds are occupied and we want to make sure we are available to help any veteran in this country.

Mr. BILIRAKIS. Well thank you very much. Thank you very much, Mr. Chairman, for allowing me to sit on the panel. I appreciate it. Thank you all for your testimony.

Mr. BENISHEK. Dr. Harris?

Mr. HARRIS. Thank you very much. And I want to thank Dr. Gray and Dr. Bahorik for being here because, you know, we do hear that it is a problem when you complain against a physician working in the VA system, complaining about what is going on. Dr. Bahorik, you mentioned the Jackson facility. That is the one that was written up in the New York Times, a couple of prominent articles this year, right, about major problems with prescribing of controlled dangerous substances? And in some instances particularly involving, as I think you indicated you were involved with, you know, advanced practice nurses who prescribe and, you know, were not following DEA regulations? That is the same, that is the facility, right? That Jackson facility?

Dr. BAHORIK. That is the same facility, yes, it is.

Mr. HARRIS. That is what I thought. And you also mentioned there was a facility, I guess, I do not think it was that one, it must have been another one, where one of the advanced practice nurses actually was indicated to be the Chief of, the Director of Pain Medicine, or the Pain Specialist in the facility?

Dr. BAHORIK. Yes. A nurse practitioner is a Director of Pain Medicine. Well, she is actually the director. I think there is a director on paper that is not there—

Mr. HARRIS. Okay.

Dr. BAHORIK. —at the Wilmington VA Medical Center.

Mr. HARRIS. At Wilmington in Delaware?

Dr. BAHORIK. Yes.

Mr. HARRIS. Okay. And what was, do you know what that person's training is that would qualify that individual to be a pain specialist?

Dr. BAHORIK. No, I do not actually.

Mr. HARRIS. Okay.

Dr. BAHORIK. But I can tell you it is not as much as a physician.

Mr. HARRIS. Okay. And what is what is going to bring me up. Because you know there is this problem that is brewing in the VA about the nursing handbook that is going to say that all APRNs are supposed to achieve, become licensed independent practitioners. And that will basically certify that they can have independent practice of physicians. But your two, your recommendations, number ten and 12 are number ten, reverse the trend to replace physicians with cheaper extended care providers. Is that what you are talking about? A trend somewhere to go to less expensive, because the VA does pay midlevel providers less, less expensive midlevel providers?

Dr. BAHORIK. Yes, that is exactly what the trend is. And I feel that it is dangerous. I have been a number of places. I have seen problems with misdiagnoses. One of the things that really concerns me is these extended care providers were never intended to function independently. However, the VA has taken upon themselves to decide that they are equivalent in taking care of patients the same as a physician.

Mr. HARRIS. So that change to the nursing handbook would be of some concern? That would require—

Dr. BAHORIK. Yes, exactly, it would be.

Mr. HARRIS. Okay, that is what I thought. And number 12, recommendation 12 is return specialty care to the domain of physician specialists. Now this is intriguing to me because as you know advanced practice nurses claim specialty training that, and I know because I am practicing one of those specialties, that is far less training than a physician gets. But according to the VA under the new nursing handbook my understanding is if an advanced practice nurse claims specialty training and is certified, usually by a nursing group in that specialty, then they would have independent practice in the VA to practice that specialty?

Dr. BAHORIK. Yes, and that is what is happening. A lot of times when you send a patient to a specialist, you will get, most of the time you will get a report back from a physician assistant or a nurse practitioner. And there may or may not be any supervision by the specialist.

Mr. HARRIS. Okay. That is what I thought. Thank you very much. And I yield back my time.

Mr. BENISHEK. Ms. Brownley has another questions she would like to ask.

Ms. BROWNLEY. I just wanted to ask Dr. Gray perhaps that did you ever have an opportunity to refer one of your patients to this facility in Tampa?

Dr. GRAY. Thank you for asking that. I brought that model, the Tampa model, back to Hampton and asked if we could implement it. That was the result of the pain conference which was held in Florida and it was for VISNs 1 through 11. I was told we had no need of it, we had opioids. We certainly did not need anything like that. And if you try and refer outside of your VISN, the answer is no. So for us in Virginia we had Richmond, McGuire, where we could refer patients. And just as the gentleman referred to earlier, they can get an appointment. It will be 12 months, 14 months, 16 months from the date that you call for the appointment. And that is deemed adequate.

Ms. BROWNLEY. Thank you.

Mr. BENISHEK. Let me ask, follow up that. Who told you that, you could not refer, or could not bring that model back?

Dr. GRAY. The Chief of Medicine, the Chief of Primary Care, the Chief of Staff.

Mr. BENISHEK. Thank you. Well, I thank you all for being on this panel. And for your testimony today. You all are excused and we will welcome the third panel to the table. Thank you.

Dr. GRAY. Thank you.

Mr. BENISHEK. Thank you.

Joining us on the third panel today from the Department of VA is Dr. Robert Jesse, who is the Principal Deputy Under Secretary for Health for the Veterans Health Administration. And Dr. Jesse is accompanied by Dr. Robert Kerns, the National Director for Pain Research for the Veterans Health Administration. I would like to thank you both for being here today. Unfortunately, you have the job to explain what the VA is doing after we have had this testimony from the previous two panels, so I wish you luck with that. Dr. Jesse, please proceed with your testimony.

STATEMENT OF ROBERT L. JESSE, M.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT KERNS, PH.D., NATIONAL DIRECTOR FOR PAIN RESEARCH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. JESSE. Thank you, Chairman Benishek and Ranking Member Brownley, and Members of the Committee.

Before I start into formal remarks I would just like to address Mrs. McDonald and Mrs. Green. I am sorry, I cannot turn around and still be on the microphone. But there are no words that I can say to express how deeply I feel about both the suffering your husbands were going through and the suffering that you are going through now. But I would like to thank you for coming forward and telling your story. And if there is any way that we can honor their life, it is by keeping that story out there and by ensuring, by your holding us to the fire that we learn from it. Your comments about not letting this happen to other people are very, are taken. And I do so much appreciate your being here.

And likewise, to Mr. Renschler and Mr. Minyard, thank God you are still with us. And whatever we can do to restore your trust in the VA, please give us a chance.

So let me just start by extending those sympathies to all our Nation's veterans who suffer from chronic pain and from the many devastating ways in which that presents. The VA, let me be very clear, that we are strongly committed to ensure that veterans do have what they need to manage their pain. And that includes not just medications but to truly get to the root cause of this.

This is not an issue limited to veterans. Veterans are a population who are particularly challenged. But this is a national crisis. And in 2011 the Institute of Medicine published "Relieving Pain in America." This challenges tens of millions of Americans and it takes an incredible toll on morbidity, on mortality, on disability, and just has an incredible impact on not just the people suffering pain but their families and their communities.

The burden of pain amongst veterans is considerable. I think it was mentioned up to 60 percent, certainly around 50 percent, of the returning veterans from this War are affected to some extent by chronic pain. And they often require intensive strategies, as you heard from Dr. Scott, for the effective management of that pain. Sometimes that requires the use of opioids. These are proven therapies, particularly in severe pain, when other medications and modalities have not proven to be fully effective.

To be very clear, we all know that there are risks to these medications. There are risks to patients. As you heard from Dr. Gray, there are risks to providers who at times provide these medicines. And we all know that there are risks to the communities as well. And VA is working broadly across all segments with partners to try and ensure the effective use of opioid therapy when indicated for patients with chronic pain.

The VA has been at the forefront of health systems in this country in trying to deal with this issue. We began in 1998 with a national strategy for pain management. In 2000 the VA recognized pain as the fifth vital sign. This I think was an incredibly impor-

tant statement requiring providers to routinely screen and assess for pain as a vital indicator of health status. A year or so later the joint commission came up with a similar strategy.

The pain management directive, as you heard, was published in 2009. And that described a series of policies and procedures for the implementation of a step care model of pain that is the single standard of pain in the VA.

VA has worked closely with DoD. In 2010 we published evidence based guidelines, and we have continued that relationship through a number of strategies, including the health executive committee chartering a joint pain work group the singular goal of which is to ensure that the pain treatment strategies used in DoD are consistent with those used in VA so as servicemembers traverse from active duty into primary care there is not a disruption in their care, and you heard the devastating consequences of when that happens here today.

We are improving education and training on safe opioid therapy. This has an opioid safety initiative. This is actually finally giving us the kind of data that gives us the insight to see how these prescribing practices are occurring across the country. And when we have that data available to clinicians we can see significant successes in the reduction in the use of chronic opioids. We also have public safety initiatives. As there was discussion earlier, about participation in the state prescription monitoring programs. It was not that VA was, we did not have to do it, it was that we were not allowed to do it. And in 2011 we asked Congress for legislation that would permit us. In its wisdom, Congress granted that legislative relief in 2012 and now VA is participating, or will be participating in these state reporting boards. It is very important for both the patient's safety as well as the safety of communities.

We have expertise in this field. You have heard from Dr. Scott. I am here with Dr. Kerns so I am not going to go through all that right now. So I know that my time is up.

I do want to acknowledge, Mr. Chairman, that we are committed to improving veterans' health and well being. We know they have difficult problems. We know that they are suffering. And we are doing our, we are doing absolutely our best to and change a system from one that rewards an encounter and gives a prescription, to one that is built on healing relationships. This is crucial and vital to dealing with all of our patients and we certainly thank the efforts of this Committee and the Full Committee in meeting those goals. Thank you.

[THE PREPARED STATEMENT OF ROBERT L. JESSE APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thanks, Dr. Jesse. I yield myself five minutes to ask questions. I guess you had a standard answer, five minute talk there. I wish you would have responded a little bit to the testimony that we have had previously. Because frankly, I feel bad for you because you have to come here and defend the VA, and tell everyone how you are really working hard to fix the problem. But what I would like to know is what are you going to do about the situation where Dr. Gray described, where she was told to do something and then she did not do it, and then they changed the record?

What is going to happen with that? I mean, apparently nothing happened. Now so are you going to take that and do something about it?

Dr. JESSE. No I, first of all I was not aware of that until today. VA actually has——

Mr. BENISHEK. Do you think that is a good idea?

Dr. JESSE. No, it is absolutely not a good idea.

Mr. BENISHEK. If, yes. I will have to look into it. I do not know the situation. I have only heard this from Dr. Gray today.

Mr. BENISHEK. Right, right, right, and me, too.

Dr. JESSE. But as I said, for VA to change a record there is actually a formal process that is required to do that. So——

Mr. BENISHEK. Do you think a physician note should be changed? What are the circumstances that would allow an administrator to change the note of a doctor?

Dr. JESSE. As far as I am aware there would be none unless there are factual, untrue, unfactual issues in there. In fact——

Mr. BENISHEK. But doctor——

Dr. JESSE. —we do change notes all the time——

Mr. BENISHEK. —I appreciate your comments. But I would like if you can maybe answer me this, could you please figure out the policy for that? And maybe report back to me in maybe a month or so?

Dr. JESSE. I absolutely will, sir.

Mr. BENISHEK. The circumstance? Because, you know, I just do not think that that is very good policy. And I think Dr. Gray is pretty disappointed about the way she was treated. And I can see that the VA has to prove it, and all that. But——

Dr. JESSE. No, I——

Mr. BENISHEK. —I do not think that is sort of the behavior that we want to foster in the VA. If you could, could you do that for me——

Dr. JESSE. Absolutely.

Mr. BENISHEK. —maybe come back to the Committee in a month with a report?

Dr. JESSE. Absolutely.

Mr. BENISHEK. Okay. Now let me go on from there. The policy of having a pain specialist appointed at a VA hospital who has no previous experience in pain treatment, do you think that is a good policy to have? Now why was Dr. Gray appointed the pain specialist when she had no previous experience in pain? She is an internist and a rheumatologist. So she has some experience there.

Dr. JESSE. Yeah.

Mr. BENISHEK. But why would somebody like that, or a nurse practitioner, for example, be designated as the pain specialist? Why would that happen?

Dr. JESSE. I cannot explain why it happened in Dr. Gray's case but——

Mr. BENISHEK. Do you think that is a good policy?

Dr. JESSE. So I think there is——

Mr. BENISHEK. I know you are in a tough situation here because you have to defend the VA. But you see, what I am trying to get to is that these policies are indefensible. And they should be changed. And you sitting there and saying, we have got to do bet-

ter, you know, that is all well and good. But I would like to see some actual plans to make that happen.

Dr. JESSE. So there were, we have pain medicine specialists. That is a specialty within medicine, it has separate boards. And to confuse the terms of pain specialist, pain points of contact, and pain medicine specialist, I think we need to be clear about the language. A small facility, a CBOC, is not going to have on staff a pain medicine specialist—

Mr. BENISHEK. Well no, of course. But she apparently was more than just the pain point of contact. She was the pain specialist, according to what she said. She did not describe herself as the pain point of contact. I am a general surgeon and probably deal with a lot of pain. Maybe not as much chronic pain as the average family practitioner. But I usually have a system of where to refer. And so that one person is dealing with the pain treatment. And it is not just narcotics, it is a whole spectrum of care such as Dr. Scott mentioned.

Dr. JESSE. Well one of the key principles as the step care plan, as is outlined in the directive, is actually knowing where and when to refer. That is why that system was set up. So people are not trying to manage things that are outside their scope of capabilities.

Mr. BENISHEK. Well it sounds as if that Dr. Gray and the other doctor were encouraged not to refer people, but encouraged to use narcotics. Which, I do not know—

Dr. JESSE. Well that is indefensible. That is absolutely indefensible. And as physicians they should feel absolutely that they should refuse to do that.

Mr. BENISHEK. Well I am glad—

Dr. JESSE. I have, in my career in the VA I have never been forced or asked—

Mr. BENISHEK. I am glad to hear you say that, Dr. Jesse, frankly. So thank you for saying that. And I would then say to all physicians who work in the VA to stick to your guns and treat the patient as you think best, and please report this kind of stuff to us here. I think I am out of time. Thank you very much, doctor.

Dr. JESSE. May I follow—

Ms. BROWNLEY. See if Ms. Brownley wants you—

Dr. JESSE. Well, I am sorry, but not on my time. Maybe on someone else's.

Dr. JESSE. Okay.

Ms. BROWNLEY. So Dr. Jesse, I just want to understand your responsibility in the VA. Is your responsibility for quality of care? Or is your responsibility to oversee and make sure the system is working and you are really accountable? In today's hearing we are talking about pain management, that you are accountable for the VA and how they perform pain management?

Dr. JESSE. So I do not think that is an either/or question. I think ultimately the accountability is that all veterans receive absolutely the best possible care they can receive.

Ms. BROWNLEY. Okay.

Dr. JESSE. And that includes the ability to compare that care that they are receiving to some standard if there is one, to certain expectations, and certainly to the expectations of the patient.

Ms. BROWNLEY. Well I think in today's hearing I leave compelled that the system appears to be broken. I am going to have faith that there are pockets of excellence and in Tampa it looks like there is one certainly there, and there probably are in other parts of the country. But you know, how do you respond to the comments about we have a system of quick and cheap over good and thorough, and the basic principles of medicine have been abandoned? I mean—

Dr. JESSE. I would argue, and I am not one that would like to argue with other witnesses, but I do not believe that that is the case systemwide. The question by Dr. Wenstrup was asked, you know, what would motivate somebody to work in the VA if it is just quick and the simple? And the simple, or the very complex answer, is that we are there because we want to take good care of veterans. I am, I had a choice in 2000 between going into private practice, actually going to work in industry or working in the VA, and I chose to work in the VA. At that time it was not an excellent system, but I wanted to make it so. Today I think it is an excellent system. It is not outstanding. It still has problems. But we are making it better everyday. And the fundamental reason behind that is because the veterans actually really appreciated what we did for them. And a certain person by the name of Harold Jesse, who I was born on a Navy base, I grew up with my father who was a career Naval officer. I entrusted his care to the VA and I wanted to give back. And people work in the VA for those kinds of reasons, not because it is an easy come, easy go system.

Ms. BROWNLEY. And I am not questioning your commitment to that whatsoever.

Dr. JESSE. All right.

Ms. BROWNLEY. I absolutely am not. But it is, you know, how do we get your commitment permeated all the way down to each and every one of our veterans so that they are treated in the way that they need to be treated? And clearly walking away from this hearing I think we all have to agree that there are areas that we must look into, and there are areas that I think we just have to put on our chart, get to the bottom of it, and figure out ways in which we can improve upon it.

And I just, I wanted to also ask, Mrs. Green in your testimony asked about what the VA does after a death of one of our soldiers, a veteran.

Dr. JESSE. Mm-hmm.

Ms. BROWNLEY. And the analysis that is done thereafter. And so I wanted to follow up on that question to understand if that is happening after every death? And are we collecting data to determine the cause of death? And are we collecting it?

Dr. JESSE. So unexpected death is supposed to be studied. This is how we learn. You know, as physicians—

Ms. BROWNLEY. Well would it not in a pain management situation, where there is not any—

Dr. JESSE. Yeah.

Ms. BROWNLEY. —you know, you are not having heart problems or any other things—

Dr. JESSE. But, yeah, those are—

Ms. BROWNLEY. —would that more or less qualify under unusual—

Dr. JESSE. Absolutely, because those are unexpected deaths, as are the suicides. And one of the things where we really are making change is historically we have asked did we do everything that we should have? And often the answer is yes. But the real question is, did we do everything that we could have? And that requires a much deeper introspective view into each one of these cases. And we are beginning to change the culture that we really begin to get to that level of understanding and depth. Because that is where we are really going to be able to begin to change this equation.

Ms. BROWNLEY. Well it is a cultural change.

Dr. JESSE. Yes.

Ms. BROWNLEY. And cultural changes are hard, really, really hard.

Dr. JESSE. Yes.

Ms. BROWNLEY. But so, but are you collecting that data?

Dr. JESSE. So we have that data. We have in the past couple of years actually been collecting the data in a way that it becomes searchable so we can look at that. We also have the National Center for Patient Safety that does the root causes analysis. And they roll all of them up and look for commonalities across the systems where issues arise. And this is really key. Because often seeing it once does not really raise a red flag. But when you can look across the system and see it happening two, or three, or four times, then it does. And then we really need to understand how the system is allowing these things to happen. But it is only when people look, it is only when people like Dr. Gray raise issues and can do that in a way that they feel safe, and I apologize that that seemed to be contentious in her instance. But the ability for people to safely raise issues without being, getting into trouble for it, is the foundation of a just culture. And the only way that we are really going to change patient safety outcomes and improve health care.

Ms. BROWNLEY. Well I would certainly be interested to see what the data is and what any conclusions, you know, may come from it. Because I, I mean just anyway we can have that conversation another time.

Dr. JESSE. And we would be happy to do so.

Ms. BROWNLEY. Thank you for your testimony and I yield back.

Mr. BENISHEK. I appreciate your comments there, Dr. Jesse. And let me just say that I assume that Dr. Bahorik will not face any negative professional repercussions—

Dr. JESSE. No.

Mr. BENISHEK. —in the department as a result of her testimony here, is that correct?

Dr. JESSE. I would certainly hope not. And if she does, she should let me know.

Mr. BENISHEK. All right, thank you. Mr. Wenstrup?

Mr. WENSTRUP. Thank you, Mr. Chairman. You know, I want to applaud so many caregivers in the VA system.

Dr. JESSE. Thank you.

Mr. WENSTRUP. I know that in my private practice two of my partners give a couple of days a week to operate at the VA and they only have the interest of the patient in mind and that is why they are serving at the VA. And I think that is reflective of most at the VA. It is the system that I think we have to deal with and

have to address. And you know, the purpose of these hearings is to hear the truth and to right wrongs. And hopefully we will accomplish that with what we are doing here today.

To Dr. Kerns, you know, we hear the testimony today about the spinal cord stimulator, and I am sure you are very familiar with that with what you do, I would imagine, is would that be correct, sir?

Dr. KERNS. First of all, yes, let me echo the comments of others. I really do not want to miss the opportunity to express my sympathies to the people that were on the first panel in particular, and actually to the trouble that the physicians on the second panel have also experienced in the VA.

So yes, I am well aware of spinal cord stimulation. Just so you know, I am a psychologist, not a physician, so I am not a prescriber. But to the point about spinal cord stimulation, it is an evidenced based therapy for certain, but not all chronic pain, conditions, and only actually a small proportion likely benefit. It is a capacity that we are growing in VA. It is my understanding that as many as 40 of 152 core facilities actually do spinal cord implants, spinal cord stimulations. And a much larger proportion of facilities, certainly a majority, have pain medicine specialists who have the capacity to manage care for veterans who have received spinal cord stimulation either in the VA or outside the VA.

Mr. WENSTRUP. So of course your concern when you have the testimony earlier where he goes to the physician and he says, "I am not even familiar with the procedure," that is of concern. So from where you sit do you feel that you have everything you need to make providers aware of all the modalities that are available? And that you have the providers that can actually provide that type of care?

Mr. KERNS. So thank you for that question. I was also privileged to serve, actually, not as a representative of the VA, on the Institute of Medicine Committee that this Congress chartered. This is a key problem in the United States and in the VA. We (VA) are in fact a model of what we are trying to do in terms of improving education and actually training of providers in VA. So to one key example, I know there is interest of this Subcommittee about the interface between VA and Department of Defense. So there is a health executive committee chartered work group. And from that has emerged a very well funded joint incentive fund initiative that promotes education and training and consistency of pain care across the DoD/VA. I would also say there is a complementary initiative, well funded, to bring auricular acupuncture that has been developed in the battlefield in DoD into the VA and build that capacity as well. So these education and training initiatives are very important and timely as we work to address a national problem that most everybody from medical schools, nursing schools, other professional schools acknowledge is a failure to provide this education in our professional training schools. And I like the work that VA is doing in that regard.

Mr. WENSTRUP. Thank you, and I yield back.

Mr. BENISHEK. Thank you, Dr. Wenstrup.

Mr. HARRIS. Thank you very much, and thank you Mr. Chairman. You know, as a veteran I do know that and I appreciate that

the VA system is trying to do its best in difficult environments, within budgetary constraints, within personnel constraints, etcetera. But I want to ask specifically since one of the issues that came up since the hearing is on prescription narcotic overuse perhaps in the VA system, and you know one of the findings that was at the Jackson investigation back in earlier in this year, was this issue of, you know, advanced practice nurses, supervision of advanced practice nurses, whether it was adequate, there were all kinds of, and you have read the report, you know what I am talking about there.

And now, you know, one issue that has come up is this nursing handbook issue. Where instead of the VA kind of following along with Dr. Bahorik's recommendations are, which actually, you know, an attempt to provide better treatment for our veterans, including those in pain in the pain management system, is, you know, one of her recommendations, reverse the trend to replace physicians with cheaper extended care providers. But the nursing handbook change which would encourage all advanced practice nurses to become licensed independent providers, for instance let us say you had an advanced practice nurse who was named the pain specialist, or medicine, whatever the title is at the VA. But that person felt uncomfortable doing that, they felt uncomfortable in independent practice. They actually thought that it was appropriate to be collaborating or supervised by a specialist physician. The nursing handbook says they have to go work somewhere else. You either achieve independent practice, or you go work somewhere else. This is strange. Because in an environment like pain management, or in the environment on a care team, like in my specialty, anesthesiology. You know, the culture usually is that there is a culture of it is multidisciplinary, it is collaborative, and with recognition that there are a different level of providers with different levels of expertise. It seems to be doing exactly the opposite way with that thing.

So I am going to ask you, Dr. Jesse, do you feel given that this is under serious consideration, I know that the Ranking Member and chair have letters to you addressing concerns, and the AMVETS, and other groups, do you feel that the training is equivalent, or the ability to treat patients is equivalent, for the APRNs achieving licensed independent practice, and medical specialists?

Dr. JESSE. So—

Mr. HARRIS. —simple question. Do you roughly make—

Dr. JESSE. No, I do not equate them at all. But I want to be clear about something. The nursing handbook was a draft. It has not been approved. It is not—

Mr. HARRIS. Well I am, what I am getting to is, what is your opinion on it since you are going to be one of the decision makers, I understand?

Dr. JESSE. So the, I am a cardiologist. I do not believe that a nurse practitioner, I have very good nurse practitioners and PAs that work with us in cardiology, but we work as a team.

Mr. HARRIS. And you, but—

Dr. JESSE. Just as you work with—

Mr. HARRIS. Correct. But independent practice assumes not working as a team, that is why it is called independent practice. And in fact, under statute, in states that establish independent

practice, it specifically says, and I can quote from the statutes, that they work without involvement, requiring not physician involvement. That is what independent practice means—

Dr. JESSE. Right.

Mr. HARRIS. —in state statutes.

Dr. JESSE. Right.

Mr. HARRIS. No physician involvement. In the pain management program in the VA system, do you think that would be an improvement?

Dr. JESSE. No, not necessarily.

Mr. HARRIS. Okay, not necessarily. But under what circumstances would that be an improvement?

Dr. JESSE. So if we had a, if we had a VA facility that did not have inpatient surgery, outpatient surgery, but there were the need for some level of skills that a nurse anesthetist could bring, that would be useful to veterans so that they would not have to travel. Now in our system—

Mr. HARRIS. Dr. Jesse, I asked about pain management, not anesthesia. I specifically asked about pain management.

Dr. JESSE. But in those situations, whatever the nurse anesthetist could bring to that it would be useful to veterans. But they would still be working within the construct of a team, even if that team were conducted to one of the major medical centers. So again, this is, this handbook that you have seen is a very early draft. It is not agreed upon by the system. We will not move anything forward until we have had robust discussions with external stakeholders, including the societies. I know ASA is very interested in this. I know that the Family Practice folks are very interested, and AMA is very interested. And I can tell you that this will not move forward until we have had those discussions with all of the stakeholders.

Mr. HARRIS. Sure, and I appreciate that. And specifically with regard to pain management, you understand the complexity—

Dr. JESSE. Yes.

Mr. HARRIS. —of the DEA regulations—

Dr. JESSE. Oh, absolutely.

Mr. HARRIS. —and supervision requirement?

Dr. JESSE. Yes.

Mr. HARRIS. Because of course you do not have the ability of preemption with DEA law. Thank you very much, Dr. Jesse. And thank you very much for holding the hearing. And I want to thank the Committee for allowing me to participate.

Mr. BENISHEK. Thanks, Dr. Harris. If there are no further questions, I would excuse the third panel. Let me just say this. I think Mrs. McDonald brought it up at the very beginning, that this is not the end of it. Because there are many things that we will have to address here. Dr. Jesse, I look forward to working with you to answer some of the questions that were raised here and develop an overall plan within the VA to markedly improve the pain management system there. And I look forward to your reports. And hopefully we can just maybe get together for a couple of meetings outside the hearing venue—

Dr. JESSE. We would very much like that, sir.

Mr. BENISHEK. —make progress in this area. I want to thank again all the Members of the panels that have participated here. And thank you so much. I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered. I would like to also thank our witnesses again for joining us. The hearing is now adjourned.

[Whereupon, at 1:52 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Dan Benishek M.D.

Good morning and thank you all for being here today.

I welcome you all to today's hearing, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans"

Today's subject is one of the most serious and significant we will discuss all year. It is also one that is particularly poignant and personal to me.

I spent twenty years serving our veterans as a doctor at the Oscar G. Johnson VA Medical Center in Iron Mountain, Michigan.

In that capacity, I understand all too well what it means for a veteran and a patient to be in pain.

Pain can be an unrelenting enemy – one that thwarts an individual's ability to work and enjoy the activities they once loved, hinders their relationships with their family and friends, and impacts their capacity to be comfortable in their own home.

On a daily basis, my veteran patients would confide in me about the pain they were in, the many ways in which they were hurting, and – more than anything – their desperate desire to find relief.

Perhaps nowhere else is that more clear than in the heartbreaking testimony we will hear shortly from two surviving spouses, Heather McDonald and Kimberly Green.

Their husbands, Scott McDonald and Ricky Green, honorably served our Nation in uniform and came home -as far too many of our returning veterans do - hurting and in pain.

These men sought treatment from the Department charged with caring for them – the VA – hoping to get the help they needed so they could once again take full and successful ownerships of their own lives, without pain as their constant companion.

Sadly, rather than getting the best care anywhere, Scott and Rickey were prescribed a disturbing array of pain, psychiatric, and sleeping medications without any clear consideration or special attention paid to how these powerful drugs were interacting with each other or affecting Scott and Rickey's physical and mental well-being.

The combined effects of these multiple medications ultimately took their lives.

We will also hear from two veterans – Joshua Renschler and Justin Minyard – who will give us a first-hand account of the struggles they faced with VA's apparent overreliance on opioid-based medications for pain management.

At one time, Joshua was prescribed thirteen different medications. Despite his pleas that the medications weren't working, he was never referred to a pain specialist.

Justin was prescribed enough opioid pain medications on a daily basis to treat four terminally ill cancer patients. He eventually sought care outside of VA to find an effective treatment to manage his pain.

To say that I am disturbed by these accounts and by the multiple reports we hear every day about the skyrocketing use of prescription painkillers – particularly opioids – to treat veterans in pain would be a major understatement.

VA's band aid approach to suppressing the symptoms of pain rather than treating the root causes must stop.

VA maintains a pain management treatment model that makes primary care, rather than specialty care, the predominant treatment setting for veterans suffering from pain.

Yet – as I know from personal experience - the multifaceted nature of chronic pain, particularly when multiple medications are being prescribed, should not be managed by a primary care physician, but rather by a qualified pain specialist who is trained to understand the complexities of treating these conditions.

I want to be very clear that this hearing is not intended to vilify the many hard working primary care providers working every day to care for veterans in pain at

VA medical facilities across the country. I have been in their shoes and I know the challenges they face in providing the high-quality care our veterans deserve.

Rather, our intent here today is to initiate better provider practices and, most importantly, better care coordination for our veterans and their loved ones so that no other family has to experience the pain, the suffering, or the loss that our witnesses on the first panel have already experienced.

It is critical for VA to take responsibility for its failures and rise to the challenge to change and take immediate action to adopt effective pain management policies, protocols, and practices.

We have already lost too many veterans on the home front to battles with chronic pain.

The stakes are too high for VA to continue getting it wrong.

Prepared Statement of Hon. Julia Brownley

Good morning. I would like to thank everyone for attending today's hearing.

Chronic pain is a debilitating condition that affects veterans at a much higher rate than in the civilian population. According to the Department of Veterans Affairs, in the newest cohort of veterans, chronic pain is the most common medical problem reported in veterans returning from the battlefield with estimates as high as 60 percent for those who seek treatment at VA.

Modern warfare often leads to serious but survivable physical and neurological injuries such as amputations, spinal cord injury, traumatic brain injury, gunshot wounds, and more. Often times these same veterans experience mental health issues as well such as post-traumatic-stress disorder, anxiety, and depression. And while advances in medical technology have saved the lives of many wounded soldiers, many veterans of our Armed Forces are forced to live a life that is dominated by acute and chronic pain. Providing safe, effective, adequate pain management is a crucial component of improving veteran health care.

The treatment of chronic severe pain often involves physicians prescribing opioid analgesics, a highly addictive pain killer that if not properly monitored can lead to death. Testimony from our first panel highlights the dangers of opioid use and just how quickly veterans get trapped in a rapid downward spiral of addiction and pain.

I know that VA has a National Pain Management Strategy, and I look forward to hearing from Dr. Jesse regarding the ramping up of clinics and services throughout the Veterans Health Administration. I am also very interested in progress being made with the Department of Defense on transitioning servicemembers and the management of medications between the agencies.

Finally, VA recognizes that chronic and acute pain among our veterans is a serious problem and in fact, is a priority. I applaud them for taking the lead on this issue. But I am concerned that comprehensive pain care is not consistently provided throughout the VA's health care system.

I look forward to hearing from our witnesses today. Thank you, Mr. Chairman, and I now yield back.

Prepared Statement of Hon. Jeff Miller, Chairman

Thank you Dr. Benishek for holding this critical hearing to examine the Department of Veterans Affairs (VA) skyrocketing use of prescription painkillers to care for veterans with acute and chronic pain.

Many of our servicemembers are returning home from the battlefield with serious injuries and acute pain, and as they transition to veteran status, the pain often lingers and leads to chronic pain.

For these veterans, the pain level, not the veteran, sets the agenda for the day, sets the tone for their families, and keeps the veteran from fully participating in the life he or she once had.

Yet, when these veterans reach out and entrust the VA to relieve their pain, the treatment they often receive is the systemwide default prescribing of prescription painkillers.

According to a CBS News report, based on VA data, over the past eleven years the number of patients treated by the VA is up twenty nine percent, while narcotic prescriptions written by VA doctors and nurse practitioners are up two hundred and fifty nine percent.

The rapid rise in VA's use of prescription painkillers corresponds with data that indicates VA patients are dying of narcotic overdoses at twice the national average.

This is heart wrenching proof that VA's approach to pain management is failing and in need of an immediate overhaul.

These powerful prescriptions are not a cure-all and must not be doled out like a magic pill to fix chronic pain.

Veterans depend upon VA to uphold its mission of restoring the health of those who have borne the burdens of battle.

But instead of helping them manage their battles with pain in a healthy manner, VA has opted instead to use treatment that has the power to destroy, rather than restore their lives.

VA can and must change course and act now to reduce their reliance on the use of prescription painkillers.

We know there are pain care specialists who understand the complexities of treating these conditions, and VA must make them accessible to help veterans manage their pain without the disturbing risks of the long term use of prescription painkillers.

VA providers should be required to adhere to evidence-based prescription guidelines and be held accountable when those guidelines are not followed.

The veteran patient and their loved ones must be listened to, followed closely, and supported with a treatment plan that can best help them regain happy, healthy lives.

Anything less is unacceptable.

Prepared Statement of Heather McDonald

Scott Alan McDonald 5/24/77 9/13/12

After graduating from Belpre HS in 1995, Scott Alan McDonald took an oath to uphold the dignity and honor of the United States Army. For 15 years, he served honorably in the uniform of his country and was proud to serve as a UH- 60 Blackhawk mechanic and Crew Chief for a medivac unit.

Bosnia, Panama, Iraq, and Afghanistan were ust a few of the war torn countries that he dedicated his life to making a difference in. In his career he experienced heartache, unimaginable violence, death, and the overall devastating effects of war. He saw many of his fellow soldiers give their lives in the ultimate sacrifice to their country and narrowly escaped with his own life in tact.

He loved his country and what the American Flag stands for. He was a brother in arms to thousands of fellow soldiers and a truly remarkable man that never met a stranger. Scott had larger than life expectation for his daughters Yasmin and Reise. Because of his commitment to family and Honor, on Jan. 9, 2011 I married him.

On 30 April 2011, Scott's career with the Army had come full circle and he hung up his uniform for good. He began seeking treatment for Back and shoulder pain at the Chalmers P Whylie Ambulatory Care Center in Columbus, Ohio. Almost immediately he was placed on medication. Starting with ibuprofin, gabapentin, and meloxicam. After only a few visits he was refered to Mental Heath where he was then diagnosed with Severe Post-Tramatic Stress Disorder, adding several anti-depression and anxiety meds such as Zoloft and Valium. And this is were the roller coaster of drugs come into play.

Everytime Scott came home from an apt. He would have different meds. Progressivly over the year and half that he was recieving treatment, the medications changed many times often adding new meds, changing dosages and recommending that he takes the meds differently then the printed dosaging. We researched the drugs online and saw that there were many dangerous interaction involved with the medications he was on, but being that Scott had been conditioned to follow orders, he believed fully that his Dr.'s were doing all they could to help him. With every apt. the medication changed the side effects changed, and Scott himself was changing.

On 12 September 2012 Scott attended another oh his scheduled appointments. This time they had added a powerful narcotic, Percocet. This opiate drug was much different than the vicodine that he had previously been taking. The directions on the bottle said to not exceed 3000 mg of acetaminophen. Scott followed the orders. At 0730 on the 13th, less than 24 hrs after he was prescribed the Percocet, I found Scott on the couch. He was cold and unresponsive. I tried all I could and EMS also arrived but it was far to late for Scott. At 35 years old, this husband and father was gone! He left behind a wife, 2 daughters and many friends and family members who loved him very much.

Now the question is why? Why was this mans life tragectly cut short. It is well know how America's wounded warriors are being victimized by the huge backlog in their VA claims. Forcing families to wait months and in most cases Years to receive benefits that the earned. Nonetheless the Department of Veterans Affairs states that they are incredibly proud of the shrinking backlog, that it has begun issuing bonus to the buraucrats who meet the Departments numerical goals in case load reduction.

Keeping our men and woman doped up to keep them quiet and happy is not treatment. It is cruelty and torture and in too many cases It's manslaughter! For many American Service Members the VA is utilized as free healthcare to those who earned it thru their dedication and commitment to honor their country. In far too many cases , these service members become lost in the system and simply become a number and no longer viewed as productive members of society.

Tests that can save lives are not being performed. A simple " I am in pain" is a good enough evaluation to prescribe painkillers. And a patient claiming that a medication isn't working well enough , is grounds to change the medication.

In the civilian sector is routine and often mandatory to preform blood tests on patients that are just starting treatment or have been receiving treatment for a prolonged amount of time. I learned this thru speaking to Medical professionals at various local treatment facilities. This is how I learned about the LFT or liver function test commonly refered to as the Liver Enzyme Test. Being that the liver is responsible for a multitude of tasks including the metobolization on medications like narcotics but filtering out the toxins that are left behind it got me thinking, " Did doctors do this test for Scotty"?

So, I asked them! And they responded, but not with what I had hoped for.

" Liver function tests are NOT routine in the treatment of out veterans, and that my husbands healthcare was handled and well managed "

I was not only sickened by their response, but that day, I decided that no more shall die! Had they done the simple test, they would have discovered that due to the overwhelming amount of medications that Scott had been exposed to, his liver was inflammed and vurtually dying. But instead, it was only discovered by the coroner. I have no doubt that this test would have saved my husbands life, and Scott would be here today to watch his kids grow up to be beautiful young woman.

I have no doubt that a large percentage of the veteran overdose cases could have been prevented by this test. But instead they met a similar demise. Father's are gone, never to walk their daughters down the isle on her wedding day, or to throw a football with their sons. Children left without a mother to embrace them, and simply kiss the boo boo's..

There is nothing that I can say or do to bring Scott or the countless others back. There is nothing I can say or do to take away the pain we as family members have experienced. But there is so much that you, as Leaders can do. The regulations that involve our veterans need to be evaluated and changed. The irresponsible distribution of narcotics to our heros needs to STOP!!

So I Heather Renae McDonald, the proud wife of an American Hero who was taken too soon, stand here before you today to DEMAND that you take better care of our veterans. I stand before you to speak as an advocate for the countless widows, widowers, and children of those who lost a fight they didn't sign a contract to fight. I will stand with the many, and for those who have not found their voice to speak out, I vow to be your voice.

Together, we can still save thousands of lives. So I beg you, as the Leaders that have the ability and power to make these changes to do so.

If we do not act quickly, I fear that many more lives will be lost due to the malpractice and grotesk lack of proper care that the VA hands out.

When they signed that contract, they gave their bodies to their country, now you owe them their lives. These men and women deserve so much better. They deserve to live because they were committed and selflessly chose to wear the uniform of the UNITED STATES MILITARY .

Prepared Statement of Kimberly Stowe Green

Mr. Chairman (Dan Benishek), Ranking Minority Member (Julia Brownley), and all Distinguished Members of the Subcommittee:

Introduction

My name is Kimberly Green. I am honored to have been invited to speak to you today at this hearing entitled "Between Peril and Promise: Facing the Dangers of

VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans." I am accompanied here today by my attorney Brant Mittler who is also a medical doctor.

I respectfully request that my written statement be incorporated into the official records of this hearing.

The VA determined Ricky He was at first determined to be 50% disabled due to service related activities. And later the amount of disability was increased to 80%. Rickey was injured in the army during his training activities and from his paratrooper activities jumping out of planes and from his military police work in securing combat areas. The injuries to his back, knees and ankles caused him to have chronic pain later in his life.

I served my country for 21 years in the United States Air Force. I retired out of the military as a Master Sergeant. I am the widow of Ricky Green. My husband served his country for 23 years in the United States Army. He was a military policeman and paratrooper and he served with distinction in Desert Storm I. He retired out of the military as a Sergeant First Class.

I have no contracts or commercial ties to the VA or the federal government.

The VA's Skyrocketing Use of Prescription Painkillers Caused the Death of My Husband Ricky Green

My husband – Ricky Green – died as a result of the VA's skyrocketing use of prescription painkillers. On behalf of my husband, myself, and our two grieving sons, Andrew Evan Green, aged 21, and Alexander Michael Green, age 16, I want to ask this committee to do all that it can to prevent other veterans from dying in the same manner that my husband died.

My husband died on October 29, 2011 at the age of 43 after lower back surgery performed four days earlier on October 25, 2011. The Arkansas State Crime Lab and its Medical Examiner performed an autopsy and determined that the cause of death for my husband was Mixed Drug Intoxication complicating recent lumbar spine surgery. My husband died because of the prescription pain and sleeping medications that the VA and its doctors prescribed for him and dispensed to him out of the VA pharmacy.

I'm here to put names and faces on that sterile statistic of "mixed drug intoxication complicating recent lumbar spinal surgery".

The VA Already Has Written Guidelines for Prescribing Pain Killers but These Are Not Being Followed

The Veteran's Health Administration's National Pain Management Strategy, initiated November 12, 1998, established Pain Management as a national priority.

You can go to the VHA website today – <http://www.va.gov/painmanagement> – and see for yourself that the VA has written guidelines for prescribing pain medications. The two primary ones are (1) VHA Directive 2009–53 dated October 28, 2009 on Pain Management (<http://www.va.gov/painmanagement/docs/vha09paindirective.pdf>); and (2) the Veteran's Administration/Department of Defense Clinical Practice Guideline Management of Opioid Therapy for Chronic Pain dated May, 2010 (<http://www.healthquality.va.gov/COT-312-Full-er.pdf>). These guidelines include stepped care that involves primary care, secondary consultation, and interdisciplinary care and special measures to include testing, evaluating and monitoring to reduce the risks inherent in the use of prescription painkillers – and one of the most notable risks is accidental overdose. The problem is – these guidelines have not been fully implemented and are not being followed – they were repeatedly violated in my husband's case – and he had to pay with his life for that fact.

VHA Directive 2009–53 states at page A–3 that "[t]he potential for fatal overdose either by accident or in a suicidal attempt in patients suffering from multiple disorders or with polypharmacy must be considered in prescribing opioids and other medications." The potential for fatal overdose with these drugs was not adequately considered by the VA and its doctors treating my husband.

The Clinical Practice Guidelines require physicians to closely monitor and evaluate patients who are being prescribed prescription pain killers for chronic pain and these guidelines specially warn these physicians at page 24, and other places, about the dangers of drug-drug interactions that can cause death. The VA and its doctors prescribed and provided to my husband his medications – and the interactions among these drugs killed my husband.

During the course of his treatment at the VA, the VA and its doctors wrote my husband prescriptions, and VA pharmacies filled these prescriptions, for his chronic back pain which was service connected, for the following drugs: Oxycodone, Hydrocodone, Valium, Ambien, Zolof, Gabapentin, and Tramadol. My husband, Ricky Green, followed the orders of his VA doctors in taking these pain medications

– and these pain medications led to his death. He was not suicidal in taking these drugs – again he was just following his doctors’ orders.

The Clinical Practice Guidelines contain a section that requires physicians to take special care in prescribing pain medications for patients such as my husband who had sleep apnea. Unfortunately, again, no such special precautions were taken for my husband – and the guidelines were simply ignored – such that the drugs interacted with the sleep apnea to cause my husband to stop breathing and to die.

In my husband’s case, the VA and its doctors, over-prescribed my husband pain medications over a long period of time but after he had back surgery on October 25, 2011 related to the injuries he had incurred while on active duty he got a lethal drug cocktail that included oxycodone, and diazepam which were reviewed by the VA and filled by the VA pharmacy on October 26, 2011.

These two drugs – prescribed and provided by the VA and its doctors and pharmacist in violation of the Clinical Practice Guideline – together with the sleep apnea – are what produced according to the Arkansas State Medical Examiner produced “a significant stated of analgesia sedation, and respiratory depression” which led to my husband’s death. Ricky stopped breathing and died in his sleep on October 29, 2011.

I want to be clear in my testimony to this committee – I strongly believe that my husband was entitled to receive the quality of care that the VA, and DoD, set forth in writing in their own guidelines. However, these guidelines have not been fully implemented and are not being followed – and our veterans are suffering the consequences.

You do not have to take my word for it that these guidelines have not been implemented or followed. I was able to find on the internet the contents of a Cyber Seminar dated October 2, 2012 – about one year after my husband’s death – entitled “Overdose Among VA Patients Receiving Opioid Therapy for Pain; Risk Factors and Prevention.” (<http://www.hsrp.research.va.gov/for-researchers/cyber-seminars>). The introducer and participant at that seminar – a Dr. Bob Kerns – is a National Program Director for Pain Management and he is based at a VA Hospital in Connecticut. Here is a quote from him at that seminar: “... the VA/DoD Clinical Practice Guidelines. Its full implementation across the VA really has not been actualized or realized yet. So for those – there are a couple hundred people on the call that work facilities. I am guessing that many of you work in facilities that really have not thoroughly digested those guidelines and looked to implement the recommendations of the guidelines at a facility level, let alone at an individual level. And we should be doing that first....”

How long must our veterans be made to wait until these guidelines are fully implemented and begin saving the lives of our veterans?

If these guidelines would have been followed my husband would not have been prescribed drugs that caused him to have a mixed drug interaction and to stop breathing. If these guidelines would have been followed my husband would have been closely examined, monitored, and he would not have been provided the lethal cocktail of drugs that killed him.

Our Veterans Who Honorably Served Their Country Deserve Better Healthcare from the VA

I believe the VA and its doctors, rather than treating all of the underlying causes of my husband’s back pain, took the easier way out and overmedicated him with prescription pain killers. I believe this is happening far too much and I note that statistics have been compiled that show in Fayetteville, Arkansas – where my husband was treated – there is a high incidence of over-prescribing pain medications for veterans.

Treatment of the underlying medical conditions, physical therapy, counseling, monitoring, in-patient hospital stays – these are the kinds of things I believe our veterans need and are entitled to – not just the over-medication of prescription pain killers to mask their pain. In my husband’s case – he constantly asked the VA and its doctors to treat the root cause of his health problems – and to reduce the opiate pain medications he was being prescribed. The VA failed to do that in his case.

In Honor of My Husband

I am proud of my husband. After serving his country for over twenty years in the military he went back to school and earned his college degree in criminal justice. He had plans to go to law school so that he could be a voice for other veterans in their time of need. He was 43 years old when he died. He should have had a long life ahead of him. Ricky survived serving in combat zones in his over twenty years of military service, but he could not survive the VA and his negligent treatment of him.

This lethal cocktail of drugs – which again included Oxycodone and Diazepam among many other drugs – were prescribed by VA doctors and dispensed at the VA pharmacy. I have sent pictures of the bottles of the medicines my husband was taking to this subcommittee. These pill bottles – clear evidence of the negligence of the VA and its doctors – are now in safe keeping at the Sheriff's office in Fort Smith, Arkansas.

My husband was a hero and a great husband and father. He stood up for his country honorably when his country called for him. He trusted VA doctors. He deserved much better treatment than what he received at the VA. Now, because of what the VA has done to my husband, my husband and I will not be able to grow old together. He will not be with me at the college graduation ceremonies for our two sons. He will not be with me at the wedding ceremonies for our two sons. He will never see and come to know his grandchildren. The VA has taken the life of a great man. And the VA has left his family – including his wife and two sons – decimated and grief stricken.

I am here today to honor my husband's memory and to demand better treatment for the men and women – like my husband and I – who have honorably served our country in the military. The VA has written guidelines in place for the safe use of prescription pain killers – and the VA will have to follow these guidelines or more veterans will needlessly lose their lives – just like my husband did.

I am proud to do my part and to stand up and fight on behalf of my husband and not allow him or me to be a quiet victim of injustice. I have heard excuses – the guidelines are not standards of care and some veterans who die of overdoses were suicidal – these are excuses that the VA is making because it has failed to take the action needed to fully implement and follow the written guidelines that have already been published.

Let me be clear: the VA knew that Ricky was not suicidal, the VA knew that Ricky did not display drug seeking behavior. The VA knew Ricky want to reduce the amount of pain medication he was taking.

I think in my case – and in many other similar cases – the VA should admit what it has done wrong, make up for it, and most importantly – stop this kind of thing from happening in the future.

To those who have been injured or killed in the past by the VA and its doctors – these victims deserve just compensation.

More importantly – the VA and its doctors must avoid causing future victims – by doing the right thing and implementing, training, following, monitoring, and evaluating the VA and its doctors on the written guidelines for prescription pain medications that are already in place.

Prescription pain killers in high doses and over time are dangerous. There are better ways of treating our veterans.

The VA, Humana, and Project HERO

Humana and the VA have teamed up on a project called Project HERO. You can go to <http://www.humana-veterans.com/about-hvhs/project-hero.asp> to learn about this program. This website provides that “[t]he ultimate goal of Project HERO is to ensure that all health care delivered by the VA, either through VA providers or community partners, is of comparable quality and consistency for veterans.”

My husband was in the Project HERO program and it did him no good at all.

My understanding is that this Committee has heard the testimony of Brad Jones, Chief Operating Officer, Humana Healthcare Services, Inc., at a hearing on September 14, 2012. He claimed in his testimony that “[W]ith the exception of veterans participating in Project HERO and Project ARCH, veterans are left to navigate a confusing healthcare system on their own and become lost to the VA. The VA has no mechanism to track and monitor the care that Veterans receive in the community and there is no guarantee that these Veterans do not lose the quality, safety, and other protections that HERO and ARCH provide.”

Mr. Jones further testified that “lack of care coordination hinders the VA's ability to optimize its resources because there can be duplicative and conflictive treatment regimen. This not only results in wasted resources, but can also cause adverse medical outcomes.”

Mr. Jones contended that Humana and Project HERO provided a “strong care coordination element.”

This did not happen in my husband's case. His care was not coordinated. He was not provided the care he needed. He was not allowed the in-patient hospital care that he needed. And his prescription drugs were not coordinated and monitored to ensure safety.

No one at the VA or at Humana questioned why he got all of the medication that were prescribed when he had a diagnosis of sleep apnea.

Again – it is a case of written guidelines and programs – that are not implemented.

Questions That Deserve Answers from the Veteran's Administration and Humana

It is my understanding that when unexpected deaths occur, the VA does an analysis to find out why the death occurred. I want to know if such an analysis was ever done in my husband's case. I want to know if the VA has or will investigate the death of my husband and learn something from his death. Has the VA considered why my husband was forced out of the hospital one day after his back surgery instead of being allowed to stay three to five days as we had been told? Has the VA looked at the autopsy report so that it can see that the drugs it gave my husband killed him? Does the VA consider all the drugs that my husband Ricky Green was taking – with his diagnosis of sleep apnea – a quality problem and health care that fell below the standard of care and its own guideline? Does the VA understand that the interactions of all the drugs that they provided my husband killed him – and that these drug interactions are critical and must be taken into account before prescription pain killers are so cavalierly prescribed? Has the VA considered how dangerous it is to provide pain medications and sleeping pills to someone with sleep apnea such as my husband? And have the VA and Humana asked each other – who dropped the ball here – and why Project HERO did nothing at all to protect my husband. I would like this Committee to use its powers of investigation to uncover why Humana and Project HERO did not protect my husband Ricky Green from the lethal cocktail of drugs that killed him. Why can't the powerful computer systems at both the VA and Humana that process the medical records of our veterans be programmed to monitor the kinds of drug interactions and dangerous conditions like sleep apnea to alert both doctors and pharmacists when dangerous prescribing occurs like those that killed Ricky?

I hope the VA – and if not the VA then this Committee – will ask these questions, learn something, and save the lives of our veterans in the future. That is the one way – the only way – that my husband will not have died in vain.

Conclusion and Call for Action

I will NOT be silent about any of this. My husband doesn't have a voice therefore I am his voice. I want to see that this over drugging of our Veterans Stops AND that there IS accountability for these physicians actions. Prescribing sleeping pills, valium, tramadol, oxy, hydrocodone, to my husband was nothing but a death sentence. This is happening more and more and this has to STOP!

I want to leave you on this committee with a simple request – demand that the VA follow its own written guidelines, demand that the VA put in place procedures that punish VA doctors and staff who do not follow these written guidelines, and demand that the VA and its doctors put a stop to this epidemic of the VA's skyrocketing use of prescription painkillers to treat veterans.

Prepared Statement of Josh Renschler

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, I am honored to have the opportunity to speak to you today regarding my experiences with Pain Management treatment from the Department of Veterans Affairs. I proudly served in the United States Army as an Infantryman for 5 1/2 years. I am now the director of men's programming for a non-profit organization that assists service members, veterans and their families; who are struggling due to deployment related trauma. Based on my own experiences with the VA, and having witnessed first-hand the experiences of other veterans whom I have mentored; it is my belief that the VA has continually fallen short of providing veteran-centered care; the VA has completely missed the mark of meeting veteran's needs on an individual case by case basis as well as employing best practices to care for common injuries/illnesses. Pertaining to the VA's increasing use of opioids in pain management it is my belief that current practices are reckless and irresponsible at best. It is my intention to bring these issues into the light before this committee so they may be addressed by the VA in order to affect changes in policies and practices in order to improve care for all Veterans.

I was medically retired from the Army due to severe injuries from a mortar blast in Iraq and entered into the VA system in 2008. I was assigned to the Deployment Health Team at American Lake VA Hospital in Lakewood, WA and to the PolyTrauma Team from the Seattle VA Medical Center. At the time, I was on approximately 8 medications which treated me for sleep, migraines, pain, seizures and

anxiety. It had taken Army doctors 3 years to discover and balance an effective, safe medication mix. My VA primary care doctor told me that several of those medications were not on the VA formulary and that VA would not pay for them. My primary care provider at American Lake began experimenting with different medications on me, despite the urging of my wife due to the failure of these medications in the past. The side effects caused me so much difficulty that I began to backslide in my recovery. I was soon on 13 medications (some to simply counter the effects of others); and soon all my conditions worsened and I had a severe panic attack at work. As a result, I lost my job, costing my family our home and vehicle. As my back pain continued to worsen, my primary care provider simply increased the dose of Percocet until it was no longer effective even at the extreme dosing of 12–15 5mg tablets a day. Soon I was issued methadone and eventually morphine tablets to take in between dosing of Percocet. By mid-2009, these ridiculous dosages kept me from working. Though the pain was wildly out of control, visits to my primary care provider were 3 months apart and at each appointment I would beg for anything other than more meds. PolyTrauma finally granted a referral to see a Physical Therapist at American Lake; I was very excited to do something proactive. But the Physical Therapist simply asked me questions about my pain as he sat at a computer, and did nothing more than give me pages of instructions on stretching exercises to try at home and follow up with him in two weeks. As I then required the support of a cane just to walk, this left me feeling nearly hopeless. A little over a month later, an appointment with Neurosurgery finally led to an order for an MRI and EMG, which showed severe nerve damage and disc deterioration, and eventually a referral to a private Neurosurgeon. He was amazed that I was still walking and infuriated with the VA for allowing this to go on so long, and scheduled an urgent surgery 3 days later. By then (March 2010), due to the length of time the problems went unresolved; the nerve damage had become permanent. I still have no feeling in my left leg to this day.

From 2008–2011, I continued to take the “cocktail” of medications prescribed through the VA. I had never heard of a pain clinic and was never offered alternative therapies despite my pleading. (I did pay out of pocket as I could for Chiropractic care and massage therapy for some minor relief.) Over the course of these years, I was not once monitored for effects on Liver or Kidneys despite the high occurrence of Liver and Kidney issues with several of my medications. Finally, in early 2011 a new VA primary care doctor at the American Lake VA became very concerned and ordered a blood test that revealed extremely elevated Liver enzymes in dangerous levels. With a doubling of those levels over the next two months, I was referred to a Hematologist, who conducted a Liver biopsy. At this point my wife and I were very worried, so we began to slowly stop taking all but my seizure medications within 2 weeks; as we awaited my biopsy. Life became very difficult, but I didn’t wish to die. The biopsy showed minor scarring of the Liver; the problem was diagnosed as Non-Alcoholic Steatohepatitis. This led me to get off all but one of my medications; a subsequent blood test showed a drastic drop in my Liver enzymes to near safe levels (and they continued to drop over the next 6 months until reaching “high normal”).

By mid 2011, the nerve pain I’d experienced before the surgery began to come back, and the frustrating cycle all began over again with the unhelpful, uncaring Physical Therapy, and being sent to Occupational Therapy where I was given a “wedge pillow” to elevate my legs at bedtime and a device to help me put my socks on. My primary care doctor began treating my pain with oxycodone; I was now very restricted on what I could take due to my Liver issues. I demanded to see Neurosurgery and was given a referral to see the department head of Neurosurgery at the Seattle VA hospital. She informed me of a non-opiate medication called Lyrica that could drastically reduce my nerve pain and that had very few side-effects, but it was a non-formulary (expensive) medication. As she had anticipated, the pharmacy denied her request for the drug. Despite her subsequently getting recommendations from two other department heads in support of her resubmitted request, the VA pharmacy again denied it. Unwilling to go down the road of dangerous medications again, I spent \$12,000 for a therapeutic hot tub, \$3,000 for a massage chair, and began seeing a chiropractor regularly. This account has no happy ending. I am currently taking (6) 5mg oxycodone tablets daily, and I find no relief from pain laying, sitting, or standing and I have been begging and pleading with the VA to help me to little avail. Late in 2012, I did have the opportunity to try acupuncture through the VA; it was a 6-month wait for 6 appointments spread over 6 weeks. But as it was only available in Seattle, the hour long car ride defeated the minimal relief it provided. I still have not been offered a pain management clinic, though what I really need is a “hands-on” physical therapist, or a referral to a private hospital for another surgery.

Let me emphasize that I made this trip not to gain advantage for myself, but because I hope my testimony will help lead to changes in the way VA facilities handle pain-management. I hope that focusing on cases like mine will end irresponsible practices like prescribing medications that have potentially dangerous side effects with limited to no oversight of those medications. I hope it will result in much greater emphasis on pain-management and on improving overall quality of life, to include use of alternative therapies. And I hope that combat veterans experiencing chronic pain won't ever again be denied potentially helpful drugs simply because of their cost. I thank you for your time and for your careful oversight on this matter.

Prepared Statement of Justin Minyard

My name is Justin Minyard and I want to thank Chairman Benishek and Ranking Member Brownley for the opportunity to appear before the committee and address this vital subject.

I am a medically retired member of the U.S. Army. Before being forced to retire from the Army due to my debilitating back pain, I was a first responder at the Pentagon on 9/11 and a special operations interrogator in Afghanistan and Iraq. But due to injuries sustained in combat operations, I struggled with serious chronic pain and a dependence on the opioid medication that was the only option provided to me by the Armed Services healthcare system. Finally, after several years searching, I found lasting pain relief through spinal cord stimulation, or SCS. Today, I am proud to say that I have not taken a single dose of opioid pain medication in the last two years. No veteran should have to struggle for as long as I did – early access to interventionalists in the VA is critical.

Being free from opioid dependence has allowed me to serve as the founder of Operation Shifting Gears, a non-profit dedicated to serving injured or disabled veterans and as spokesperson for RaceAgainstPain.com, a community of chronic pain sufferers. I take it upon myself to personally encourage veterans and others suffering from chronic pain to explore options outside of opioid pain relief, such as spinal cord stimulation.

I first developed chronic back pain when I was serving as a member of the Presidential Escort, 3rd U.S. Infantry Old Guard, stationed at Fort Meyer. On 9/11, my unit was one of the first responders at the Pentagon. For the next 72 hours, we searched for survivors, working on adrenaline to move huge pieces of rubble. As a result of those efforts, I sustained a serious back injury – damaged discs and fractured vertebrae.

My back pain drastically impacted my life from September 11th onwards. I didn't seek treatment immediately, but instead took over-the-counter painkillers and tried to simply work through the pain. I volunteered to learn Arabic and become an interrogator. During my deployment to Afghanistan, I experienced another incident where I fell two stories out of the back of a helicopter, causing a disc to rupture and fracturing my vertebrae. I returned home due to the pain and had my first back surgery, a laminectomy, to replace one of the bulging discs and repair the fracture.

Despite the fact that my daughter Mackenzie was only three weeks old, it was 2007 and the army was in need of experienced interrogators like me to serve in Iraq, so I volunteered to go. While there, the weight of carrying a full 80–100 lb. combat load every day combined with a vehicle rollover caused further damage to my back. I came home and met with the army doctors, who told me that my spine was rapidly deteriorating and I needed reconstructive back surgery.

The physician left the room and I turned to my wife, Amy, and said, "What do you think we should do?" I knew she wanted me to stay home; I knew I should stay home. Mackenzie was only 5 months old at this point and Amy was working full-time. But I thought about my unit that was still in Iraq and the fact that I wanted to complete the mission we were sent there to do. So when my doctor came back in the room and I told him I was going to go against his advice and return to Iraq, he said, "If you insist on going back, this is really the only way you are going to be able to make it through." He handed me a prescription for opioids and I said, "Okay, if that's what we need to do, that's what we will do." I had the bottle in my hand and I was ready to go.

For the next 10 months in Iraq, I was able to do my job. My pain was fluctuating somewhere on a daily basis between a four and a nine on a 1-to-10 scale, but I was regularly taking about four to eight pills of high-dose opioid pain medication at the time. It was a very rough situation, but I was able to mask that with the opioid pain medications. That was a double-edged sword – the opioids allowed me to continue combat operations, but they allowed me to continue damaging my back as well. But

because of the way opioid pain medication works with your body, you build up a tolerance quickly and for me, in the middle of the desert, I didn't have a lot of other options for pain relief. I sought help from a Special Forces medic, who was able to call back to the States and request spinal cord epidural kits to be shipped to the base. So there I was, in an army tent in the middle of the desert, getting epidurals in order to continue working in Iraq.

August 4th, 2008 was my breaking point. I came back to the team house after an extremely challenging 3-day mission. I stepped out of my Humvee and my right leg simply gave out. I couldn't take another step. I learned later on that it was because of nerve damage that had occurred due to the compression putting pressure on the main nerve running through my right leg. It was terrifying – I arrived at the team house at about 5:00 in the afternoon and by 6:15 p.m., I was on a helicopter being medevac'd to Balad Air Force Base.

Coming back from Iraq, it quickly became evident that I had to be in a wheelchair. Because of the damage to my back, I couldn't walk more than 2 or 3 steps without some help. The first time I sat in the wheelchair, I felt like a different person. I felt like I had lost something.

My life when I returned back home was not my life. It was terrible. I was in a great deal of pain. I was dealing with mental issues like anxiety and depression.

I started an intense opioid pain medication regimen. The metaphor I think best gives people an idea of what it is like is: once I started on high-dose opioid pain pills; once that train left the station, it was going 1,000 miles an hour and wasn't making any stops. My life literally revolved around, "When is my next pill?," "When is my next refill?" and "When does my dose get increased?" If you wanted to talk to me about my job performance, if you wanted to talk to me about Friday night dinner plans, if you wanted to talk to me about plans for Christmas, I just didn't care. Unless you were going to tell me that you were going to give me a ride to the pharmacy or you were going to tell me that it was time to take my next pain pill, I didn't care. In fact, I would either ignore you or treat you very poorly.

At my worst point, I was taking enough opioid pain medication to treat four terminally ill cancer patients. That was on a daily basis. It had enormous physical and mental effects on me - people would often look at me and my eyes would be rolled into the back of my head. When I talked to people, I just wouldn't make any sense; it would all be incoherent. If I wasn't babbling incoherently, I would be asleep or simply drooling on myself.

I was on an insane amount of opioid pain medication. My dependency happened so fast. It felt like I blinked and then I looked up and my life revolved around getting my fix. I remember a point when I realized, "Okay this is starting to become a problem!" But soon after that, even that thought left my mind. My days drifted by like this: wake up: pain pill; have lunch: pain pill; in the afternoon: pain pill; and on and on. It was not a pleasant experience.

I am very ashamed about those years because I treated the people that mattered most to me very poorly. There were years that I went without telling my wife, who stayed by my side throughout the entire process, "Thank you for taking care of me." I was not the husband my wife deserved and I was not the father my daughter deserved. That was not the life I wanted. It was a very dark and difficult part of my life.

I continued to use a wheelchair but I didn't want to accept the diagnosis I had been given, which was that it was most likely going to be part of my life for the rest of my days. But, I was offered no choice by the medical services to address the cause of my injuries; only means to mask the effects with ever increasing amounts of opioids. I was finally forced to look on my own for options that were available that could possibly repair the damage and help me start walking again. That led me to my second back surgery at Duke University Hospital: a highly invasive, extremely painful anterior/posterior inter-body fusion in which surgeons inserted eight titanium rods that form a cage around my spine to support all of the damage to my back.

In preparing for the surgery, Duke actually had to call in a special pain management team to figure out how and what medication they were going to use that would be strong enough to overcome my body's tolerance to the high amounts of opioids I was already using. The pain management team said, "Surely we are reading this chart wrong. This guy hasn't really been on this amount of opioid pain medication for this long, has he?" They had to go back and do a case study to figure out what kind of anesthesia to prescribe.

That surgery was successful in that it allowed me to become more active and rely on the wheelchair less, but I was still in pain. I was still completely dependent on opioids and that was unacceptable to me. I hated having to rely on something else

to get through the day and I knew my years of dependence on pain medication were negatively impacting my family – and would likely lead to fatal medical side effects.

The defining point for me, when I realized I could not go on living a life dependent on opioid medication, was watching a home video of myself on Christmas morning. In the video, you see my daughter approach me while we were all together in the family room and ask me to help her open a present. As she was handing it to me, I was trying to hold on to it. And all of a sudden my neck muscles and head just kind of rolled back. My eyes rolled back in my head. I started drooling on myself. I don't think there could be much more of an impactful, defining moment where you realize something is wrong, so I started trying to find another solution.

Without help from the Government, it was a major challenge navigating the maze of providers and bureaucracy before finally being referred to an interventional pain specialist at Fort Bragg. My doctor, who happened to be conducting a clinical trial of SCS therapy, took a vested, personal interest in my case and I credit him with turning my life around.

The VA didn't make it easy for me to connect with people like him. My wife had to advocate for me, not taking "No" for an answer. But the VA hospitals and TRICARE should be doing everything they can to spread the word about his specialty: interventional pain management.

So the doctor said to me, "Have you heard about spinal cord stimulation (SCS)?" And I said, "Spinal cord what?" He explained the technology, made by Boston Scientific and others, to me. The implantable device would block my brain from receiving a pain signal and instead, mask that signal into a tingling feeling, as if a tuning fork is going off inside your body. He said, "It is a way for you to manage your pain and not have your pain manage you." He even explained that I would have the chance to test drive the device for one week before moving forward with the permanent implant and see if it would provide effective relief and that I was a good candidate for a clinical trial with SCS that was just starting at Fort Bragg.

Having the ability to test drive SCS was the ultimate selling point for me. Unlike my anterior/posterior inter-body fusion surgery, I could actually try this device with a minimally invasive procedure. I find that very rare in medical treatment.

So I immediately asked, "When can you get me in for a trial?" I came in for a trial a few weeks later and in less than the time it takes to get a cavity filled, I had the trial device implanted in a simple, outpatient surgery.

During the trial period, they placed the two leads in the area of my back where I needed the most pain relief. As soon as I woke up, they used the computer to manipulate the system and set up my pain management programs. The first time the stimulator was activated it felt incredible. As cliché as it sounds, I thought to myself, "This device is going to be a life changer." I was getting more pain relief from the one area the machine targeted in that moment than I had since I started on opioids years ago.

After that, the team went through my new Precision System's four different pain programs. At each point they asked, "Can you feel here? Can you feel here?" And I would tell him, "Can you move it left?" and I felt it. It's not unpleasant - it's like an internal massage moving across your back. With each keyboard click I heard, I could feel the impulse moving through my body and hitting the target pain area. Once it locks in to wherever your pain is, it's almost like magic. It's unbelievable because it is pain relief right where you need it. Not only does the SCS focus in on where you need it, but I was also given a remote that allows me to turn up the power to get even more relief in certain areas that are hurting on a given day. It is amazing to go for so many years struggling with pain relief and, all of a sudden, I can push a button and my pain can drop from a seven to a four.

I was floored. I wanted the permanent device implanted immediately. I said, "My test drive is done, I only need to go around the block once! I'm good."

But the bottom line is everyone has to do the trial. Mine was three days, and when I went back in to remove the trial, I couldn't wait to have the permanent version. I was counting down the minutes and calling the doctor's office every day, saying, "Let me know if someone cancels. I'll drive up there. I'll sleep in the doctor's office, because I know this spinal cord stimulator is going to be it for me."

Three weeks later, I had the permanent spinal cord stimulator implanted and that is where my life started to turn around. That was the defining moment. I was able to get the remote for my permanent SCS and start using it to manage my pain.

The relief I felt from SCS allowed me to start tapering down my medications. My goal was to ultimately be free of all opioids. That process took time and it was difficult, but it was completely worth it.

I am now at the point where I have not taken an opioid-based pain pill in more than 2 years. I actually have a medical directive that states that if I am taken to the hospital, I am not allowed to be administered a narcotic without my consent.

And if I am unconscious, my wife has to give consent. I have this because I went through this process and I don't need the medications, nor do I want them anymore. Like I said before, once you start...once on that train... it is a very, very, very fast and scary progression to the point where it is out of control.

I just want to leave you with something. There are a lot of soldiers in my situation. And not just soldiers, but a lot of people in this country who were pushed onto the opioid pain train, and now they're moving so fast and they can't get off of it. I consider myself extremely lucky that I was able to push through the maze of providers in TRICARE and find the doctor who knew the secret – at least for me. But there are many soldiers who are not so lucky; soldiers who lack the resources and awareness to advocate for alternatives to opioid pain regimens and are left to the crushing reality of lifelong opioid dependence or worse. A recent VA study spotlighted the horrific epidemic of suicide amongst veterans, 22 per day.

Pain is a pervasive condition with the impacts and burdens reaching far beyond the patient – to families, society, etc. According to NIH, when including healthcare costs, lost income, and lost productivity, pain costs almost \$100 billion per year. We must increase awareness about alternatives to opioid pain medication in the VA system. The VA must work to create accessible regional centers equipped with access to skilled interventional pain specialists. We must train more doctors in these techniques and devote more resources to raising awareness. We should also begin collecting data on long-term outcomes of interventional therapies versus opioid therapy so we have the numbers to show that the techniques that helped me will help other soldiers, too.

The VA is a great place to start, because so many veterans come home and struggle, just as I did. I continue to struggle with the VA in getting timely appointments with a specialist to manage my SCS therapy, but my hope is that in the future, policies will be in place to help people like me manage their SCS therapy and to help prevent soldiers and their families from the devastating effects of opioid dependence. Thank you all, so much, for listening to my story.

Prepared Statement of Pamela J. Gray, M.D.

October 10, 2013

At the outset I would like to thank the members of this committee on Veterans Affairs for offering me an opportunity to share my first hand experiences as a physician at a Veterans Hospital located in Hampton, Virginia.

I am presenting to you a letter I wrote to my State Senator in March 2010. The thoughts and observations in the letter were recorded with great clarity. I have included the names of individuals as in the original letter. As the truth was documented originally, so I chose to let it stand.

I beg of you to hear these words and act decisively to improve the healthcare delivery system for our deserving veterans.

Thanking you in advance for your attention.

Respectfully submitted,

Pamela J. Gray, M.D.

Dear Senator Webb,

I am writing to you to report my experiences with the delivery of medical care at the Hampton VAMC. My observations from April 2008 to March 2010 note the level of care is not consistent with community standards. As a physician working at the Hampton VA during that time period, I witnessed an abuse of authority which is a potential danger to public health and safety, specifically the overprescribing of opioids providing opportunity for diversion into the Hampton Community. As a result of reporting this information I have been terminated as of March 26, 2010. I am seeking whistleblower protection. The first contact via telephone to your office in Norfolk was December 2009. I am also asking you to contact the Office of the Inspector General on my behalf. I was initially contacted by Special Agent Molly Morgan on February 1, 2010, however, I am asking for further investigation as I feel my termination is reprisal for my concerns regarding prescribing of Schedule II narcotics.

I have been employed as a physician at the VAMC since April 28, 2008. I was hired in the capacity of 30% Rheumatology, 70% Primary Care. I have been informed by fellow physicians that in the six months prior to my arrival in multiple Primary Care Staff meetings, I was identified as a "pain specialist." I have no specialized training as a pain specialist nor did I ever identify myself as such. After

my arrival, I was informed I would manage difficult pain patients with musculoskeletal diagnoses being treated with large doses of Schedule II narcotics. As this is not a standard of care in the community, I sought to give a more appropriate level of care. I encountered resistance on the part of my service chiefs, clinic nurses, telecare nurses and nursing supervisors. My concern at this point was the overprescribing of opioids with the potential for diversion into the Hampton/Newport News communities. It is well documented that 10–20% of opioid users become addicted. The opportunity for diversion was of concern as this had been documented at the V.A. in Beckley, West Virginia. This was also well known by my service chiefs and the Chief of Staff as we had discussed it in full. I received no support for my efforts. I was told by the Chief of Medicine to “think twice before refusing to write narcotics in a time of economic downturn.”

I served on the Pain Committee upon appointment by the Director of the VAMC, Ms. Mims. There are multiple instances when I have been coerced or even ordered to write for Schedule II narcotics when it was against my medical judgment. Ms. Mims called me directly out of a Pain Committee meeting, ordering me to write opioids for a patient who had no objective findings to support a musculoskeletal diagnosis requiring such treatment. He was a thirty-eight (38) year old male with knee pain with normal exam and x-rays. Non-medical personnel tried to influence me to write for opioids, again for incorrect purposes. A patient care advocate, Mr. Waylon Murphy, and an Administrative Assistant, Roger Barkers, tried to persuade me to do so. This was documented in my medical notes. I was ordered to alter my notes by Dr. Karin Soobert, Chief of Primary Care. As I had documented factual truth, I refused. It is illegal to alter notes in a medical record; an addendum may be added but notes cannot be deleted. My note was deleted under the orders of Dr. Soobert, who is also Chair of Medical Records. I continued to lobby on behalf of the patients for a better level of care as well as improved work environment for the physicians, physician’s assistants and nurse practitioners who also felt pressure to write Schedule II narcotics against their better judgment. This was reported to Ruth November, J.D, Office of Regional Counsel, McGuire VAMC, Richmond, VA in April, 2009 (See email of same date).

Although pain management was not an area I wished to pursue, I served on the Pain Committee, represented our Medical Center at a National Pain Conference for VISN 1–11 and wrote the standard operating procedure for VAMC that is now in current use. I did everything which was asked of me by my two Service Chiefs and the Director. I brought all information back from the National Pain Conference to Dr. Soobert, Service Chief, and Dr. Arul, Chief of Staff. No change was implemented in one year.

As an advocate for a patient who was sent out of the Hampton V.A. Medical Center Emergency Room while he was having a CVA (cardiovascular accident or stroke), I sought neurologic consultation for the patient in July of 2009. The consult was refused three times. As a result of trying to protect the community image of the VAMC and care for the patient, I was threatened in writing that further such action “may result in disciplinary action to include removal” by Dr. Soobert. I have appealed her action and have been denied. The patient has filed suit against the VAMC Hampton.

In trying to improve patient care, I have received death threats from patients, coercion to practice poor medicine by non-medical personnel, have been found guilty of an ethics violation committed by another physician and now face a Professional Standards Board Review without being allowed to review any documents to be used against me. My service line chief who initiated the PSB denied knowing anything about the Board meeting. I am informed by Ms. Ruby Sheperd in Human Resources this originated directly as a result of Dr. Soobert’s request. Dr. Soobert denied knowledge of this and denied me access to my records for review prior to the Board.

In the twenty-three (23) months of my employment: 1) I have been forced to do work in which I have no professional training, 2) been ordered by supervisors and the Director to write large amounts of Schedule II narcotics in inappropriate medical circumstances, 3) have had my medical records altered to hide factual documentation, 4) have received sexual harassment by a male nurse, again, regarding opioids, 5) been reprimanded for advocating for a stroke victim’s right to care from the VAMC Hampton who, as a Marine veteran, was sent out of the Hampton VAMC Emergency Room as he was having a stroke, resulting in permanent brain injury, 6) been threatened to be reported to the National Data Bank for a non-reportable Level I Peer Review and 7) been subjected to situations involving entrapment by supervisors to “not stop writing for opioids in a time of economic downturn”/say defamatory remarks about ethnicity/say defamatory remarks about the Director, all of which I resisted as I found these actions reprehensible. I now am being asked to cover another physician’s clinic in Hampton in the clinic where I received the death

threats and had a male nurse scream at me for refusal to overprescribe opioids to hide the actions of a married doctor who has had a sexual relationship with a married nurse. Both have had their jobs protected. I am asked to participate in the cover up of a crime.

A Probationary Review Board to decide whether to terminate me was called on February 4, 2010. As of today, March 24, 2010, I have never been notified of its findings. One of the three physician members of the Committee referred a patient to me for ongoing care on March 10, 2010. I received a letter from the Union attorney on March 8, 2010 stating he had no knowledge of the outcome of the Board. The February 23, 2010 minutes of the Virginia Beach VAMC clinic where I had seen patients indicated I was to return to Virginia Beach April 2010. At 4:15, March 12, 2010 I received notification to come to Dr. Karin Soobert's office at the conclusion of my work. When I did not appear by 4:30, I received a second call telling me "not to forget to come to Dr. Soobert's office." When I arrived at 4:45 p.m. I was informed I was terminated. No cause was given. I was denied Union representation. I was told to sign the document placed in front of me. I asked to review it with a Union attorney. I was told to sign it "right now" and "turn in your badge." As it was then after close of business, I had no one to turn to for questions. In the termination note to follow, I was given Kellie Franks as the Human Resources person to contact. I called, leaving my cell phone number as a contact. I received no return call for one week. When she called she wanted to know what my questions were and she would call me back. Upon return call, I was given another contact name and number. When Evelyn Stephenson was contacted she informed me she did not know the answers to my questions (Cobra coverage, retirement funds, continuing Union dues, etc.) and that I should "go to the library [sic] and look it up." I have no answers to date. I was denied a written response.

Physicians in Primary Care at Hampton VAMC have three choices when prescribing large amounts of opioids. They may resign (3 excellent physicians did so in the past 12 months - Drs. Pagador, Hilland and Wozniak), do as they are told, or be terminated. Dr. Jamal Al-Zhara was terminated when he refused to alter records to hide emergency room errors. Dr. Soobert fired him and then prevented him from working at other VA Hospitals.

The Primary Care Physicians have no support from Administration including at the Director level. Examples of excess opioids includes:

- 55 year old male received Morphine MS Contin 30 mg twice daily, Tramadol 300 mg daily, Percocet 4 times daily, 1 Fentanyl patch 25 mg every 3 days for carpal tunnel since 2004, was not seen since 2004, had no labs checked since 2004, and had the opioids mailed to him.
- 64 year old, 102 pound female hospitalized for morphine/vodka overdose receiving 1800 tabs hydrocodone monthly concurrently with morphine sulphate (MS Contin) 100 mg tabs, 360 tabs monthly, and has received as many as 3,600 5 mg Oxycodone at monthly intervals
- 38 year old male, normal exam, normal x-rays ordered by Director Mims to continue filling his Percocet. Had been receiving 360 tabs every month.
- 39 year old male, working full time as farmer in Suffolk, VA receiving MS Contin, Duragesic patches, Percocet and Tramadol simultaneously for neck pain. Evidence of receiving Percocet from an outside, private primary physician and VAMC, never went to pain management consult but meds continued.
- 50 year old male, diagnosed with "low back pain" 10 years ago, last x-ray in 2004, wants more than Tylenol #3 (codeine) 4 per day, Tramadol 4 per day. Refused labs and x-rays, wants pain meds refilled.
- 55 year old male on morphine for "low back pain" 30 mg tabs 3 times per day, 240 tabs monthly mailed and Oxycodone 40 mg daily, 240 tabs monthly.
- 56 year old male wants Percocet for "chronic generalized pain." He wants 10 Percocet daily. I refuse. He reports me to administration. I am ordered by Dr. Karin Soobert to write the prescription. When I explain, she reports me for failure to follow orders. Contacted by Mr. Roger Barkers, Administrative Assistant, to write prescriptions.
- 52 year old male on morphine 300 mg CR, 2 tabs 3 times daily for Lupus. He does not have Lupus. He reported me to Roger Barkers who had Dr. Mowery see the patient and write the opioids. Patient on 1080 mg of morphine daily, 4 Oxycodone 80 mg twice daily for disease he does not have.
- 55 year old male demands morphine and Oxycodone because "I want them and you have to give them to me." Abusive. Police called. Another provider gives the meds the same day.
- 56 year old sleeps through appointment with me. I feel he is over-medicated. He is diagnosed with rheumatoid arthritis with no DMARD since 2000. On mor-

phine 90 mg daily, Oxycodone 10 mg daily, receiving 180 tabs morphine and 100 tabs Oxycodone monthly. I begin to taper on October 8, 2008, wife calls for in for more meds within 1 week. I was reported.

- 52 year old on Fentanyl patches. No CBC (complete blood count) since 2004, no LFT (liver function test) since 2007 and last urine drug screen 2008. Patches are mailed to him monthly for mild osteoarthritis. I alert Dr. Soobert this is not standard practice. I am terminated the following day.

Tens of thousands of examples exist. I have repeatedly alerted Dr. Karin Soobert, Chief of Primary care, Dr. Mary Kim Voss, Chief of Medicine and Dr. Arul, Chief of Staff that, due to fear of administrative reprisal, these are the rules, not the exception. The doctors are afraid to refuse the patients' demands. The amounts of Schedule II narcotics prescribed indicate diversion into the community is occurring.

I have consistently seen more patient than the other physicians. I am the only primary care physician to be over 100% booked in the history of the Primary Care at the VAMC Hampton. I have received the praise of my fellow physicians and nurses. It is my fondest desire to return to my position as a physician at the VAMC. There are fine physicians who wish to improve the level of care given to our veterans if given the opportunity and administrative support. Please assist me in bringing about the necessary changes to make this happen. I understand fully the gravity of these accusations and factual documentation exists for all.

Respectfully,

Pamela J. Gray, MD

Prepared Statement of Claudia J. Bahorik, D.O.

BACKGROUND INFORMATION

As a Board-Certified Family Physician for over twenty years and having worked in the medical field wearing various hats for over forty years, I feel more than qualified to enter an opinion on the current state of affairs regarding the narcotic situation at the VA primary care clinics. For the last 3½ years I have been a traveling primary care physician for the VA Interim Staffing Program. During this time, I worked as a physician directly providing medical care to veterans at thirteen different VA facilities. Additionally, I am a physician acupuncturist, a licensed physical therapist, and more importantly, I am a disabled veteran who also is a consumer of care at the VA.

SUMMARY

Although the VA can demonstrate they have guidelines and resources for the prescription of narcotics, on the grassroots level the primary care providers are struggling to stay afloat in a system flawed with errors, lacking oversight at all levels, and burdened by policies and politics that make it difficult to monitor and manage veterans with pain. These veterans, through the VA's own emphasis on pain, come to expect and demand narcotics, see pain control with narcotics as their "right," and bristle at attempts to limit use of these potent, addictive, and potentially lethal medications.

DISCUSSION:

The problem with narcotics is but the tip of the iceberg and the VA the Titanic headed full speed ahead for catastrophe. To quote a fellow physician, even a garbage dump looks good when you're flying at 50,000 feet.

Perhaps the narcotic fiasco run amuck will serve as the impetus to revamp a system steeped in tradition and run by a good ole boys club that protects its members even under legitimate fire. Take the recent hearings in Pittsburgh and the Legionnaire's problem. The VSN (division) director Mr. Moreland was rewarded with a \$63,000 bonus, which his superior Dr. Petzel found no problem with authorizing. An administrator from the Jackson, Mississippi VAMC when faced with serious charges is allowed to step down from his position and continue to see patients. Another administrator involved in Jackson narcotic disaster was reportedly transferred to a similar position at an unsuspecting VA in Tennessee. These are but a few recent examples of an administrative "shell game" played by those at the helm of the VA Health Care System.

Then there's the case of a physician assistant in Maine who was so unreliable and had so many complaints from staff and veterans that in an ordinary medical practice would have discharged him long ago. Around February of this year the VSN

decided to investigate and place the man on paid administrative leave. He had been missing work on a regular basis, absent during working hours and no one knew his whereabouts (it was rumored that he was teaching an unauthorized course at a local college over lunch and saw no problem making vets wait 1 ½ hours until he returned), and veterans were regularly requesting they be transferred to another provider.

This physician assistant would not obtain his own DEA license (drug enforcement agency) to prescribe narcotics (he told me he refused to pay for it, insisting the VA should pay for this license), instead, asked the physician in the adjacent office to write narcotic prescriptions on patients he had never met or examined (a violation of DEA prescribing policies). Then it was discovered that the physician assistant had been documenting that he had been doing extensive physical examinations on many vets who later complained to staff (and myself) that he never touched them (since most of the vets are also of Medicare age, this constitutes Medicare fraud). As far as I could ascertain, when I later covered his panel of vets, the only part of the physical exam for which he reliably performed per the veteran's admissions was the rectal exam.

As I worked with his former patient panel, it became obvious that not only had he not examined patients, he had ignored their complaints, in many cases had misdiagnosed veterans, and in some cases there was a potentially life-threatening delay in diagnosis. He had month after month seen to their narcotic prescriptions, yet never had examined the body part(s) for which they had a pain complaint. I discovered that the problems lists were incomplete or inaccurate, the medications lists were often not updated or accurate, and his notes worthless and unreliable.

As of about eight months later, this physician assistant was still on administrative leave, still getting paid, and the investigating committee could not make a determination as to his disposition. When a system cannot dispose of their own dead wood, how can one expect that system to effectively monitor and police itself?

This is but one example of failure to provide veterans with the high quality of care the VA likes to list on their flyers. In particular, the provision of veterans with narcotics in a rather cavalier fashion appears to be a systemic problem. I have been in thirteen VA facilities in the last 3 ½ years while employed as a traveling physician with what initially was known as the VA Physician Locums Program and now is the VA Interim Staffing Program. The program in its heyday, employed ninety physicians who also traveled around to other VA facilities throughout the country. How easy would it have been to survey these grassroots physicians, asking about the narcotics situation, particularly after many of us complained to our administration. I requested that our comments and concerns be passed along, but nothing was done. When our staff had telephone group conferences (few and far between), the problems we were experiencing with being expected to sign-off on narcotic prescriptions was brought up during at least two conferences. Again, nothing was done.

Suggestions were made to alert the facilities to the need to address our responsibilities as interim staffing and the facility expectations regarding continuing to write for narcotics, particularly when never having seen the veteran. We were all concerned that this violated the DEA policies and was a potential threat to the veterans and could result in DEA action against us. These comments never went any further, were not passed along to VACO (VA Central Office) who in their ignorance used us as a bunch of narcotic prostitutes.

This sounds rather far-fetched, but when the sparks hit the fan at Jackson, and it came out that the nurse practitioners were illegally writing narcotic prescriptions, VACO begged the VA locums staff to find physicians to immediately fly to Jackson to help with the situation. The only catch was that we were never informed that upon arrival we were going to be the narcotic pushers, and not do primary care, but get the drugs rolling.

The staff physicians had refused to write prescriptions for narcotics on patients they had never seen and the ER docs felt the same way. As one of the first two volunteers for this assignment, we were met by the administrator who informed us that even with his administrative duties he could manage reviewing thirty charts per day. He instructed us to simply look the chart over, see if the vet was "stable", and knock out the narcotic prescriptions that his veterans were clammering for since the nurse practitioners lost their ability to write due to DEA action. He saw no reason to do a physical examination and said we needed only a "face to face" visit to satisfy the DEA. When I pointed out that not only could I not physically or ethically be able to push through 30 vets on narcotics, but I needed sufficient time and space to perform examinations.

I was stuck in a section at Jackson, not far from the airport type screening at the front door (equipped with guards, metal detectors, and an X-ray screening device), and assigned my own swash-buckling narcotics police nurse, a male clerk, and

had the angry vets lined-up at my gates on a daily basis. I insisted on drug screens on every one prior to my even seeing them, and when they came back positive for illicit substances, or not positive for substances they should have been on, they were cut-off.

It was obvious that the administration was not in favor of my examining each vet, or reviewing each chart in a methodical fashion. My request from day one for an examination table was met with questions as to what purpose would I require an examination table for. To examine the vet properly was the response, yet my request went unanswered for one week until I threatened to climb back on the plane that very day if I didn't get the exam table. I got my table.

What I discovered at Jackson, by reviewing charts from a vast assortment of nurse practitioners, was typical of many of the VA facilities in which I have worked. Jackson perhaps was the worse example. I discovered that narcotic prescriptions were rubber-stamped month after month, sometimes for two years on end, without a reexamination of the body part(s) in pain. Sure, the veterans were seen by the provider, but the pain was addressed by merely asking if the vet had pain and to rate it using the infamous 1/10 rating scheme. This violates not only the standards the VA itself has posted (that is, if you can find these web-sites easily in the heat of battle), but the dictates of the DEA and ethical practice standards. Nearly every facility I have gone to for providing emergency coverage has the same recurring problems. Notes that are incomplete, poorly typed, difficult to read, and are rushed off to completion to satisfy time constraints administrators place on providers, so that billing can be completed immediately. No one seems to remember how to write a note, listing in order of importance the problems in a logical, clearly documented fashion. The art of note-writing had a purpose, that of assuring continuity of care is possible and reflecting the thoughts and impressions of the provider. If you compare the VA notes to those of outside physicians, our notes are a shameful disgrace. And yes, it does impact on the quality of care when I cannot pick up a chart and look at the last note or two and figure out what the veterans problems are, what the provider was thinking or planned. You would think this would be one of the measures of quality. It is not.

It became obvious that no one was supervising the nurse practitioners at Jackson, who essentially were practicing independently. As I reviewed the charts, I discovered notes that were incomplete regarding major health issues, conditions that were misdiagnosed, problem lists that were not up-to-date, medicine lists that were not current, tests were not being done, and in general, it appeared that they had fallen into a pattern of habit regarding the knee-jerk response to automatically refilling narcotic prescriptions. Often there were no recent consultations to specialists, no updated tests such as MRI's, and a lack of inquisitive investigation of pain complaints. Many times positive urine tox screens were ignored as well as drug screens that should have been negative. Drug screening was infrequent and if performed, was announced or anticipated by the routines of testing. There was no attention to the potential impact on poly-pharmacy on the health of veterans.

The same problems noted at Jackson were also noted at other VA facilities. Administrators expected that temporary or new providers would jump right into the mix, continue what the prior providers had started, and keep the veterans happy. After all, a happy vet is one that doesn't write damning letters to his Congressman about how the VA ignores his pain. These letters reportedly adversely affect that VSN's (division's) money flow from above.

Many facilities now shuffle the narcotic renewals from provider to provider when a position is left vacant, sometimes having administrators temporarily cover the narcotic prescriptions until a provider is replaced or returns. Again, these veterans are not seen in an actual face to face encounter, their charts are superficially scanned, and out pops a narcotic prescription ready to churn out of the VA pill mill.

The same problems exist at other VA facilities regarding documenting not only a veteran's pain complaints, but the medical encounter itself. Providers notes often are pages and pages of cut and paste, including a record of the exam using a repetitive template of basic findings, but little in the way of a pain-directed physical exam.

Notes are shamefully difficult to read, have incomplete listings of problems in the assessment section, and have sketchy plans outlined. The providers often are forced for the sake of time to address scores of pop-up "reminders" that have been triggered by the computer in order to appear as if they are providing what some administrator has identified as an indicator of quality care. These type of notes are conducive to mistakes. Several times I have seen a diagnose drop-off the radar because the medication expired for the problem and the provider doesn't have the time to review the scores of notations littering the path to discovery of all medical issues.

The one medication that never seems to be lost is the prescription for narcotics. Unfortunately, substance abuse may be listed on the main problem list, but it is often ignored when dealing with a pain complaint. Another factor that is often ignored is the potential interaction of multiple psychiatric medications prescribed. It is sort of the 'go ask Alice when she's ten feet tall' culture. There are pills for everything, and pushing pills is one thing the VA is good at – so good that the VA had been cited as being the biggest supplier of on-street legal drugs in the United States, and the largest consumer of narcotics in the world.

How did it get that way? It appears that about ten years ago the VA decided that pain was the fifth vital sign (after temperature, pulse, respiration and blood pressure). It became so ingrained that staff members were chastised if they did not ask about pain, even if the veteran had presented with no intention of discussing pain, they would be flagged. Now, not only do they ask about pain, but they must ask if you want something done about it that very day. It is no wonder medical problems fail to get addressed or are missed.

Pain management has become a double edged sword for the medical providers. You are damned if you don't prescribe narcotics and damned when you do and someone has an adverse outcome. Both cases result in complaints, and depending on how well placed the veteran is, those complaints can generate considerable aggravation for administration. Often I watched as a vet I had denied giving a prescription of narcotics to, although I had documented in great detail the rationale, as the vet would present to administration to have the non-clinical administrators order another provider to write for the medication (Jackson VAMC was quite good at this). The other scenario was the vets would go to the VA emergency room, and often just to get them out quickly, the prescription would be written.

Facilities encourage prescriptions of narcotics by denying alternative forms of treatment such as chiropractic (most facilities do not have a chiropractor or enough of them), massage, or acupuncture. The VA's vocational rehabilitation department spent \$8000 sending me to a physician acupuncture course two years ago, and I have yet to find a facility that will credential me so I can provide this service to vets. They give the excuse of having no one to supervise me. It makes no sense when acupuncture is less invasive than performing minor surgical procedures, cutting someone with a scalpel, or poking holes in skin to drain abscesses, all of which I am credentialed to do. The true issue is that they don't want to open a can of worms, i.e., be faced with having the vets demanding more of the same service. It is infinitely cheaper to dole out narcotics than it is to have veterans deal with pain through alternative measures. That is the bottom line.

Furthermore, the pharmacy gestapo controls the formulary, which is dictated in turn by the bonus a manager might receive if the costs are kept down. For instance, if you want to provide the non-formulary drug Lyrica for pain modulation, it typically is not approved by the pharmacist that oversees physician drug prescribing. You are instructed to use the older, less effective drug gabapentin first, document its lack of effect, then try a concoction of other pharmaceuticals all with central nervous system depressing effects first. If the veteran lives through the experimentation with chemicals coming at him from all directions and types of providers, maybe at some point they will relent and allow you to provide the drug.

Another example is Voltaren gel, a topical anti-inflammatory drug that can be rubbed into painful joints to control pain. It works and unfortunately for the veterans, it's non-formulary. Many vets are on so many drugs they should be putting omeprazole (Prilosec) in the water to counter the effects on their stomachs. Non-steroidal anti-inflammatory medications (NSAID's) are notorious for causing stomach ulcers, gastrointestinal bleeds, and even heart problems, yet these are the preferred first-line drugs that we are supposed to push – if one doesn't work, try another and another. Just add the omeprazole, the H2 blocker (like Zantac), or Cytotec that causes uncontrollable sudden bursts of diarrhea. Give them any number and combination of narcotics and mental health drugs, but don't allow the vet to use a topical substance, even on a trial basis, because it costs too much. Tell me, what is the cost of hospitalization for a GI bleed? Or the cost to society when a vet dies of a drug overdose?

No, the pharmacy is a dynasty, run by the new Ph.D.'s on the block, the Pharm.D. The pharmacists control the formulary, which is kept a secret and never, never published (the National formulary is published, however, each VSN can decide on what drugs to include or not include), since people might start to realize how few drugs and how old the drugs are that the VA allows on the formulary (and this is somehow up-to-date, high quality care?).

Not only do the pharmacists control the drugs, they now tell us how to practice medicine. It appears the VA has condoned such practices - pharmacists are cheaper than docs, maybe know the drugs' theoretical advantages, and are loving the in-

creased responsibility. Unfortunately, the VA leaders pushed us to this slippery slope in the name of cost-savings. When you think of it, why even have physicians when pharmacists take over management of hypertension, hyperlipidemia, diabetes in their “clinics,” – clinics in which they are given an entire block of time to deal with a few targeted medical disorders. Perhaps if the providers had such luxury there would be better control of chronic diseases, including pain management.

To cite an example, recently I had two pharmacists tell me they wouldn’t authorize the use of Voltaren gel for a vet who had numerous failures with other meds, stomach issues, and problems with narcotics. They instructed me, the physician, that I should have the veteran lose weight (as if that will happen magically overnight), exercise (which he couldn’t do much of due to his severe knee problem), refer him to physical therapy (which would do nothing for severe degenerative arthritis), and I should treat his “gout” because that might be causing his aches and pains. Twice I wrote back that the vet does not have gout (he had several joint aspirations proving this) and that an increase in uric acid (hyperuricemia) does not equate necessarily to a diagnosis of gout. Not only are the pharmacists telling us how to practice medicine, they are now diagnosing veterans.

What about the returning heroes coming back from the sandboxes in the Middle East? Often they are started on narcotics while deployed, just to keep them in the field. They arrive at our doors on medications for depression (who wouldn’t be depressed with the ridiculous number of back-to-back deployments), medications for anxiety such as Xanax, a medication to prevent the nightmares of PTSD, one or two pills to make them sleep (like zolpidem that makes them do things like sleep walking, night driving while asleep, asleep eating, or making crazy purchases on-line, none of which they remember upon waking), another anti-depressant when the first one isn’t quite performing the chemical lobotomy, perhaps a drug for attention deficit (it’s no wonder they can’t stay focused considering the drug soup bathing their brains), and to round off the cocktail they have been prescribed a narcotic or maybe even two for that ubiquitous pain complaint.

They present to facilities, young men typically, strung out on prescription cocktails, mentally shattered, and desperate for help. The VA dictates that, rightfully so, they need to be priority patients. However, they haven’t figured out how to assimilate another body into the mix when they can’t even accommodate the veterans currently on the roles. So administration begins another “shell game,” moving patients out of a provider’s panel into the officially unassigned category. The slot created on a panel allows them to put in the new OEF/OIF (Operation Enduring Freedom and Operation Iraqi Freedom) veteran for his initial appointment. Therefore, the providers panels are bulging, current veterans cannot get timely appointments, and if someone is sick and doesn’t have the luxury of having an outside physician, they are out of luck.

What happens when these hurting vets, soldiers with PTSD driving their miseries, are told there are no appointments even though there is a mandate (which they are aware of) directing facilities to get them in within so many days? One poor hero, desperate to get his PTSD treated, after too many rejections by the Wilmington VAMC, reportedly shot himself in the parking lot of the facility.

Walk-ins are definitely not welcome, nor is the system even user friendly if the providers do make room. Patients are expected to be “squeezed-in”, which only serves to make the provider run late (bad, a ding against the provider and the facility). Since time can’t be created, then the other veterans with appointments get short-changed in their face-to-face, now hurried appointments.

It would be too logical to pre-schedule slots that are reserved for sick visits. Even if that were done, the veterans cannot get through to their assigned offices on the telephone. Yes, the telephone system that links the VA facilities is archaic, inefficient, and contributes to the large number of vets getting frustrated after repetitively calling a VA answering service in Colorado (or some such place that might as well be on the moon) and be asked to leave a message – a message that some busy clinic clerk might get to some time that day. I have not found one VA facility in nearly four years of traveling as a gypsy doc for the VA who has a direct phone number to their assigned clinic that their patients can call in a normal fashion in order to be seen. So the response the VA has to this is to insist walk-ins must be seen that day. How this can be achieved is up to the staff who have no power to alter schedules, block-out time slots, or do anything creative without first going through levels of supervisors or one of the infamous, omni-present and omnipotent, sacred VA committees.

Oh, the VA has a solution. The pressure now is not to bring the vets in for a real appointment, providers are encouraged to try to do telephone appointments – a scheduled phone call of 15 minutes to do the same thing you would normally do in 30 minutes, sans the physical exam, without eyes on the patient, with minimal prep

time, and no scheduled time to write notes. It's no wonder sloppy is the norm. The providers end up staying later and later to catch-up, becoming more and more dissatisfied, and it is not rocket science to recognize that the providers mutate to the point of being pill-pushing automatons. VA survival tactics 101 – an ideal setting conducive to narcotics being passed merrily along with the rest of the mind-altering medications.

Is it going to get any better regarding the monitoring of narcotics? Probably it will until all the heat dies down, the newspapers get tired of the same story with a different twist, and the pressure returns to keep costs low. There are problems inherent in the system that impact on the way the narcotics are being prescribed. The providers are saddled with stifling paperwork, regulations and rules generated by persons who never treat patients, a computer system that is cumbersome and not user friendly, and no ability to control decisions that impact negatively on productivity.

Who ever heard of having a provider assigned to one exam room which also functions as a medical office? When a provider wants to see the next vet, he has to first change the paper of the exam table (maybe even wipe it down first), and then walk down to hall to fetch the patient. Five minutes wasted. The provider has to be a typist, a transcriptionist, the person who enters each and every drug a veteran receives from an outside physician in a labor-intensive fashion (it would be too logical to have the screening nurse do this chore), the one who enters each lab tests one by one (no clicking on panels for our docs), the person who enters a detailed consult to specialists (specialist who can decide to deny a consult based on how busy or motivated they are), or perform the lengthy questionnaire prior to entering an MRI (which a clerk could easily do).

The specialists also are the ones that are so pampered that they can agree to a consult only if the provider enters the testing that the specialist wants, that they will review, yet the provider has to take time to enter tests as if they were the specialist's secretary. Then it is up to the provider to make sure the vet attends the appointment. If they don't make the appointment, it's still the provider's burden of responsibility.

From the other side of the coin, as a disabled veteran I get medical care from the Lebanon VAMC in Pennsylvania. Recently, I went to see an ENT specialist for an ear infection causing hearing loss to the point I couldn't hear with my stethoscope. The surgeon was rude, refused to let me explain my problem in a succinct fashion, and instead insisted that he first wanted to read my chart (perhaps he should have done that before I entered the room for my 30 minute consult time slot he insisted on having since I hadn't been seen in over a year by ENT). After several minutes he rolled his chair over to the ENT (barber-like) chair where I sat, spun the examination chair rapidly, reached up and began to examine my right ear without having listened to what my new complaint was. He inquired, "So what is wrong with your right ear?" I explained that had he let me provide a history he might know I had a recurring problem with both ears. The treatment as I already knew from several such bouts, was to suction the residual debris from my ear canals. As he rapidly and vigorously moved the suction device in my ears he repetitively hurt me (he got too close to the ear drum). Every time I would reflexively flinch and every time he would chastise me for moving, regardless of the pain his less than gentle approach was creating. The final insult was when he berated me for waiting so long to come in (over a year), when in reality the problem have begun abruptly over the prior week.

Prior to that episode, I went to a VA doc for a complaint of feeling ill for a month, having symptoms of a kidney infection, and being concerned about my health. This fill-in ex-Navy physician, sat flipping through my thick paper chart (thick because the VA had all sorts of records from the illnesses caused by Anthrax immunizations), reached over and patted my hand, and asked, "Did you ever think of seeing a psychiatrist?"

A week later I was in the hospital with a mild stroke and a kidney infection.

Another VA surgeon performed a colonoscopy on me, never explained the procedure (doesn't matter than I am a physician), had me sign the consent, and then never bothered to tell me after the procedure what he did or didn't find. He just instructed the nurse to show me the photos from the colonoscopy and tell me the results. He was much too important as the Chief of Surgery to bother with mundane details.

Now if specialists treats me, a physician that way, how do they treat the run of the mill veterans? I hear complaints like this all the time about the insensitivity, the rushed consults, and the non-professional behaviors of specialists on the VA payroll. Being the sacred cows of the VA, they are untouchables.

Meanwhile, the provider is inundated with useless, repetitive computer messages known as “view alerts.” No one seems to know how to stop messages that tell us an appointment was made (we only need to know if one wasn’t made and why). Labs pop up as view alerts over and over again, the same labs, multiple labs presented separately in multiple view alerts, hundreds of view alerts. Then there are the mandatory staff meetings, time wasted that could be addressed through memos or e-mails. RN’s aren’t even allowed to enter unsigned orders to assist providers in performing duties, or are not allowed to do tasks within their scope of practice that could simplify the office procedures (like entering the orders for the endless medication renewal requests so that after reviewing the chart, the provider could more quickly sign the orders) and free up the provider to see patients.

Some nurses refuse to help providers with phone calls. Some nurses, like at Durham refused to do much to help the veterans. If I would ask them to flush a veterans ears (a facility that actually allowed the nurses to do this), they would answer that they needed to schedule an appointment. It didn’t matter that it was an elderly veteran who lived a distance away. They were out of the office 12:00 sharp and out the door at 4:30 come hell or high water, which the provider usually was overcome by at the end of the day.

Don’t expect that blood pressures listed in the charts are correct. For a matter of convenience the VA purchased all these expensive electronic BP machines that typically register higher than the true resting BP. You will never find the BP entered for both arms as you would in private practice, which is standard operating procedure for a patient with hypertension. A difference in pressure could indicate a blockage in one of the main arteries coming off the heart (this isn’t fantasy, I am a prime example of a subclavian blockage diagnosed only because I insisted the BP be taken in both arms). The machines automatically send the single BP to the electronic medical records, but apparently they aren’t set-up to manage two BP’s. Therefore, if the busy doctor wants a true reading he has to first scrounge around to find a manual cuff, find one that actually works or has all the parts, and then try to find a large cuff for the big arms. . . More wasted time that physicians’ could be using to think, to prevent disaster.

Yes, the VA physicians, nurse practitioners, and physician assistants are expected to be the supermen and women of the VA, yet have little input as to things that impact their day to day activities. Yes, the providers are not properly screening veterans taking narcotics, simply as a matter of sheer survival and keeping one’s head above water. Of course, it is their fault for putting up with the system, not trying to change it, but be forewarned that those who do speak up are likely to lose their jobs. People are rewarded for keeping their opinions under the radar, their hands hog-tied, and their jaws wired shut. Welcome to the world of the VA.

RECOMMENDATIONS REGARDING NARCOTIC PRESCRIPTION

1. **Provide an intensive training course for prescribers of narcotics** that is done in-house, not on a video monitor that providers can wander in and out of the training session ad lib (this was witnessed at a recent Tele-training course held by Wilmington VAMC). Provide written materials and references to all physicians, not merely the ones who were able to attend the live training. The course should be at the physician level, not watered down to include all personnel. Separate training should be done for nurses and staff having roles that intersect the provision of narcotics to veterans.

2. **Educate the veterans on options for and benefits of pain control with an emphasis on non-narcotic solutions.**

a. For veterans currently on regular large doses of narcotics, require mandatory attendance at educational seminars.

b. For veterans inappropriately prescribed or taking large amounts of narcotics concurrently with or without other central nervous system depressants, for veterans with a history of current or past substance abuse, provide an in-patient residence program. This program should promote healthy living concepts, introduce non-narcotic alternatives, provide an independent medical examination (a second opinion) of their pain complaints, and result in designing a comprehensive pain control program with minimal narcotic usage.

c. Acknowledge alternative forms of care by making a dedicated effort to provide such services.

1) Allow providers trained in alternative forms of care to deliver these services (for instance, I am a licensed physician acupuncturist and have not been allowed

(in the last two years that I have been licensed) by any VSN credentialing board to provide this service to veterans in lieu of prescribing narcotics).

2) Pay for chiropractic services on a "fee-basis" program if a chiropractor is not on staff. If not on staff, advertise and hire enough necessary to deliver these services.

3) Allow the VA physical therapists (who now are required to have Ph.D. degrees) to function as part of the pain management team and do more than simply sending the veteran out the door with a list of home exercises (Note: I also have been a licensed physical therapist for 40 years, with a Master's Degree as well!)

3. VA Pain Services should be directed by a full-time physician with special training in Pain Management.

a. Physician Assistants (PA's) and Nurse Practitioners (NP's) should not be the primary source of care in the Pain Management service when a veteran is referred by other providers for evaluation of a difficult pain management case.

b. Veterans managed by PA's and NP's should be evaluated on a regular basis by the Pain Management physician

c. Veterans placed on significant doses of narcotics by the Pain Service should not be allowed to transfer the prescription of these narcotics to primary care providers simply because it is beneath the dignity of the Pain Service to perform such mundane activities (this is the role their extended care providers can address).

4. **Physicians and extended care providers need to be responsible** for obtaining a complete pain history, performing a thorough examination pertaining to each body part in pain, ordering appropriate lab tests, studies (eg., X-rays, MRI's, CT's) and consultations.

a. Adequate time needs to be dedicated to the investigation of the pain complaint. This process is necessarily time-intensive and requires an appointment not riddled with other issues or concerns. That is, the session should not be part of a routine check-up for multiple medical issues, during which time multiple medication prescriptions need to be addressed and written, or when time is spent coordinating care with multiple outside physicians (as is commonplace).

b. Measures need to be taken to assure that the persons prescribing narcotics have proper training in physical assessment of musculoskeletal conditions. Perhaps giving providers extra training with the orthopedic service or on the pain service might be indicated.

c. Charts of veterans receiving narcotics should be randomly reviewed by peers, or the pain service if requested, to determine appropriateness of narcotic prescription.

d. Clinical Pharmacologists (Pharm D level) should also review narcotic prescriptions for appropriateness, likelihood of drug interactions (particularly in the presence of other mind-altering drugs).

5. **Dedicated monitoring should be required** of all persons taking narcotics (other than for a brief episode).

a. The urine drug (tox) screening process needs to be revised:

1) Veterans are familiar with criteria that military screening entails (witnessed drug screens, emptying pockets, leaving personal belongings out of the room)

2) Urine drugs screens needs to be both announced and unannounced, regardless of suspicion for diversion or abuse.

3) The screening needs to be taken seriously by both the staff and veteran. No excuses can be accepted when a request is made for providing a specimen.

4) The specimen needs to be collected in a manner consistent with accepted protocol, such as is used in pre-employment screening or post-accident screening by industry. For example, the veteran shall not have access to running water, the toilet water is dyed with a chemical designed to foil surreptitious dippers, and specimen containers should be specially designed for urine tox screening (such as to monitor pH and temperature). The veteran must empty their pockets, leave belongings outside the room, and preferably be monitored.

5) The issue of insufficient staffing must be addressed. This makes another case for the prescription of narcotics to be managed by providers at a facility equipped to properly monitor for drug misuse and other substance abuse.

b. Unannounced pill counts need to be performed, even in veterans not suspected of diversions or abuse, since no one can predict who will be the guilty culprit.

c. Although signing of Pain Contracts is not proven to be much of a deterrent, its use may serve to provide the veteran with the rules of engagement and serve as a warning that certain behaviors will not be tolerated.

d. The “lost prescription” story needs to be addressed up front. Veterans need to know they are responsible for keeping their controlled substances in a safe place.

e. The business of providing ‘bogus’ police reports as evidence of theft should be addressed initially upon signing the pain contract.

f. The practice of allowing veterans to “slip-up” and have a dirty urine should not be tolerated. These veterans should immediately be referred to Pain Management or a Suboxone program.

6. Safety issues need to be addressed regarding veterans who are prescribed narcotics, particularly when in combination with other centrally acting depressants or mind-altering drugs.

a. Veterans who are on other mind-altering drugs are at increased risk of accidental overdose and unwanted side effects.

b. Psychiatry should be responsible for assessing the appropriateness of all the mental health medications, particularly if narcotics are being prescribed.

c. Veterans should be offered alternative treatments for mental health disorders, including sleep problems and PTSD, such as intensive counseling programs and holistic approaches (relaxation exercises, melatonin, Herbals, acupuncture).

d. Pharm.D. pharmacists should also routinely earmark cases involving potentially interacting or additive medications for review on an on-going list.

e. A master list of each provider’s narcotic patients should be maintained and accessible to both provider and those engaged in monitoring.

f. The state’s narcotic data banks should be routinely accessed by either the provider or preferably the Pharm. D. This practice should be encouraged, since it is infrequently performed by busy providers who are currently expected to be a revolving door for veteran health care. By querying the data bank, veterans who doctor shop for narcotics can easily be spotted. For instance, earlier this year I discovered a vet that had been to 10 different providers who had written for narcotics for this vet between January and June.

g. There should be a nationwide central clearing house to which states be mandated to report all persons obtaining narcotic prescriptions. This data bank should be accessible to anyone providing an ongoing regimen of narcotics to an individual.

7. Safety issues need to be addressed regarding the persons who prescribe, interact and provide services related to the prescriptions of drugs.

a. Security at Community Based Outpatient Clinics (CBOC’s) is non-existent. Some CBOC’s have a system to silently alert the staff to a situation, but the keyboard must be accessible. Some CBOC’s have silent alarms under the provider’s desks, that go to the central office’s police station. By the time local police are notified and arrive, the situations has either resolved or had an adverse outcome.

b. Providers and staff are at increased risk of harm by disgruntled veterans – veterans who have problems with anger management, PTSD, anxiety, depression, and whose thought processes are chemically challenged by a cocktail of prescribed and possibly unprescribed substances. These veterans who have suffered unimaginable situations during their service to our country often lack the coping mechanisms, the internal restraints, or even the normal problem solving capabilities a non-medicated, mentally together individual would normally display.

c. Staff members have been assaulted, some killed, by veterans angry with care, whose demands are not met, or have been refused narcotic prescriptions.

1) In Jackson, Mississippi about 10 years ago a physician was shot and killed by a veteran who was denied pain medication.

2) Again in Jackson, two or three years ago a doctor had acid thrown in her face because a veteran was dissatisfied.

3) In Maine, a veteran reportedly became angry recently with not getting narcotics and ran his car into the side of their new CBOC building.

4) Another veteran angry about not getting his narcotics presented to the 'mother ship' in Maine reportedly hunting for the administrator to shoot. Instead, he was confronted by the police and a "suicide by cop" incident occurred.

5) Not long ago in Delaware two psychiatrists were reportedly attacked by a patient (it is rumored that both physicians have left the system)

5) I was told by a Phoenix VAMC staff member at the VA Intermin Staffing Program when I complained about concerns as to my safety while at Jackson, that this is not uncommon and a provider had been shot at the Phoenix VAMC.

6) The magnitude of the risk cannot be assessed since these statistics, if kept, are not available to staff.

7) Staff are not allowed to carry or have access to any type of protective device, such as a TASER or Mace. Instead, we are given silly little learning modules instructing us how to speak, act, or move to theoretically defuse volatile situations. One time I was forced to suggest that the all-female staff might grab the fire extinguisher to spray any violent perpetrator.

8) When potentially violent veterans or those who are known to have a history of violence or aggressive behavior directed against staff are identified, little effort on the part of administration is made to ensure the safety of staff. A complaint must be made to the "Disruptive Behavior Committee" after the fact, who will then decide on the final disposition of the complaint. The perception of the staff who were threatened or attacked seems to be overshadowed by the veterans "rights", of which there seem to be more of than the staff's rights when it comes to safety.

9) Often the vet will simply be reassigned to another provider at the facility, even though the vet will be coming into contact with the disparaged staff members.

10) The most potentially violent vets are as a last resort required to present for care at a VA hospital where a guard must be assigned to the veteran. In a remote CBOC this is not an option.

11) Even the provider asking the staff to call the local Police to stand-by during an encounter is met with administrative objections and this action has to be approved by someone who has no medical background, direct knowledge of the situation, and nothing to suffer if a veteran loses control.

12) In summary, the staff's concerns about potentially violent persons in the workplace needs to be honored with swift action designed to lessen the risk to staff.

9. One life lost is too many on either side of the coin.

GENERAL RECOMMENDATIONS

1. **Complete reorganization of the VA Health Care System**, eliminating the "top heavy" emphasis of the current organizational scheme.

2. **Elimination of bonuses paid to administrators at various levels that provide incentive to provide the cheapest medical care**, and **NOT** provide the most effective strategies for medical services, including pain management

3. **Across the board "retirement" of administrators who have been shuffled to other facilities in the face of controversy, as pawns in a real life "shell game"** that merely transposes problem administrators, and whitewashes solutions to problems that threaten the health of veterans.

4. **Return the baton of health care administration to the realm of those trained in medicine** - the physicians, nurses, extended care providers, and personnel in other medical specialties. Eliminate policies that allow non-medical personnel, including those without college education and no medical background, to oversee and implement policies that directly impact medical professionals.

5. **Identify, address, and eliminate the rules and regulations that have restricted the ability of medical professionals to practice** their profession according to the highest (not the cheapest) standards, including making medical decisions that impact upon the quality of health care, within the scope of their medical licenses.

6. **Upgrade the computer system** used by the VA - the sacred tail that wags the dog. Implement user-friendly touch screens on portable lap-tops, making the providers more efficient and mobile. Field-test programs and changes with users/providers who don't live in a world of techno-gobblygook, instead of just adding layers of patches and illogical, inefficient steps designed by IT (information technology)

geeks that do not consult or care to consult with the providers who are slowed by laborious and unnecessary steps in documentation. The system should be provider-driven for purposes of accurate, efficient note-keeping to direct medical care with the least amount of burden, not administrator-focused for the purposes of forcing provision of data to be used for purposes that shed a positive light on the top dogs and their potential bonuses.

7. **Return the provision of medical care to the realm of physicians**, who by nature of their extensive education and training, are the ones who not only know what constitutes quality care, but should be allowed to see to it that this care is provided to our veterans. Do not mistake the concept of quality medical care as being the cheapest care that can be provided to the masses.

8. **Analyze the VA sanctioned indicators of quality care** and determine if the measures used are merely ways to polish statistics to make the upper echelon appear to be the shining knights of the VA dynasty.

9. **Allow extended care providers, nurse practitioners and physician assistants, to practice according to their own practice acts.** Do not allow the VA to rewrite their job descriptions based on administrators' perceived ability to provide equivalent primary care, which equates to merely "adequate" health care (most of the time for non-complex cases) at a cheaper cost. Allow the physicians to follow the more medically complex cases, including oversight of all the pain management cases, and allow the extended care providers to do the routine nuts and bolts daily medical services. Currently the system is flip-flopped, with the NP's and PA's having smaller panels of patients than the physicians, who are expected to manage much larger panels, thus having less time to contemplate or effectively manage their clients complicated medical issues. Consequently, there is not even time to supervise or consult of the cases handled by extended care providers who largely function independently at the VA. Basically, the simpler cases should be handled by extended care providers and the more complex ones managed by physicians who should be given more time with these difficult cases.

10. **Reverse the trend to replace physicians with cheaper extended care providers.** Realign the team units to be directed by a physician who oversees that team's nurses and extended care providers along with ancillary staff. Currently the physicians are powerless due to the dictates of the administrative burdens. Implement methods to simplify and expedite day to day practices which historically have to pass through several layers of administration who jockey for control.

11. **Recognize that the heart and soul of the medical team is composed of the providers** of medical care. The current PACT approach (Patient Aligned Care Team) is based on a belief that the patient sits atop the health care team pyramid, when, in fact, the veterans are partners with the providers of medical care. The back to basics approach is based on the notion that the health care team is there to provide the best and most efficient care to the veteran, but the veteran does not have ownership of that team. The concept promulgated by the VA known as "Pain as the 5th Vital Sign" and that pain must be addressed regardless of other medical issues, is evidence of how terribly wrong a well-meaning system can become when care is driven by administrative demands and unreasonable expectations.

12. **Return specialty care to the domain of physician specialists.** Currently, many nurse practitioners and physician assistants perform specialty consults without physician intervention. The extended caregivers do not have equivalent training, their specialty training being largely on-the-job training. If there are not enough specialists, such as dermatologists and ENT physicians, contract the services out to medical experts and don't rely on cheap substitutes.

13. **Address the problem with the National VA Formulary** being so restrictive, loaded with cheap generics and limited drug choices in various categories. Currently each VSN's pharmacy decides which drugs they will supply, which is based on cost-saving practices that allow chiefs to obtain monetary rewards for limiting costs. Pharmacists are the persons currently making decisions about medical necessity of non-formulary medications, often basing their decisions on studies that they are instructed to quote to justify their sometimes inappropriate denials or decisions. Return physicians to the front-line of drug-prescribing. Make the facilities publish the medication lists on-line so the providers of medical care will know what drugs are available per category and veterans will know the limitations of the formulary. Currently, it is impossible to get the VSN pharmacy to print a list of drugs they authorize as "formulary" - their rationale being the list changes daily, which in this day and age of computers is a particularly feeble excuse. This practice really

equates to a veiled attempt by cost-cutters to maintain a wall of secrecy and whose practices are designed to exert control over providers.

14. **Emphasize non-medicinal oriented approach** to health care instead of focusing on which little pill can relieve a problem, and address what the veteran can do to help himself.

a. Do group visits for problems such as weight loss or chronic medical problems requiring education such as diabetes, hypertension, and hyperlipidemia – the ‘Big Three’ problems making up the nemesis of the VA.

b. Introduce alternative medicine approaches to be realistic options to facilities, such as acupuncture, chiropractic, massage, Tai Chi, and other such “mindfulness” oriented care.

c. Allow physical therapists to return to hands-on activities, not being forced by time constraints to be mere machine jockeys or mere distributors of exercises to do at home.

d. Allow physicians who are trained or to be trained in acupuncture and to utilize it according to the principles of established practice within their daily practices.

15. **Address Poly-Pharmacy** as a real problem with potentially real-life serious consequences. Realize the current system of “medicine reconciliation,” no matter how well-intentioned, just isn’t working. People are over-medicated because medication is cheaper than alternatives, less labor-intensive than a provider explaining rationale and alternatives (which are currently limited), and reinforced by the revolving door mentality (get them in and out as quickly as possible). Acknowledge that by farming out much care to inaccessible specialists (often due to limitation of training and experience by extended care providers), there is no one who truly is “Captain of the Ship” - the role primary care physicians were designed to fulfill. Medications are added to already long lists of medications willy-nilly, with computer-generated reminders of “poly-pharmacy” and warnings of potentially serious interactions often being ignored.

16. **Identify true measures of quality care** instead of relying on surrogates that are designed to make an administrator’s fiscal bottom line look good and perhaps contribute to his bonus. For instance, the current system rewards a provider based on whether they complete the computer-generated “Reminders” on-time or if they do the billing correctly and promptly, or do the endless and repetitive computer education modules on time (assigned by some well-intentioned administrator at the top who is far-removed from patient care). This says nothing about quality. Ignoring the fact that the veterans complaints have not been completely addressed, or all the interacting medical conditions were not taken into consideration, or that the physicians’ documentations of encounters are worse than a beginning medical student’s. These are examples of practices destined to result in harm to a veteran in the form of mistakes, misdiagnoses, delay of care, and adverse reactions, any of which could be life-threatening.

17. **Return to Basics**, providing all aspects of primary care at offices and eliminating unnecessary consultations of specialists and stopping the practice of making veterans travel distances for care within the boundaries of primary care.

A. Allow offices to perform simple point of care testing:

1. Ability to perform finger stick blood sugars (a test which is readily done in the home by patients but is not allowed in offices due to lack of common sense by the administrators and lack of guidelines defining these simple office procedures).

2. Ability to perform finger stick INR’s in the office to facilitate in-office management of anticoagulation

3. Ability to do simple hemocult testing (stool for Blood) in the office (CLIA waved testing) by nurses and providers without being subjected to onerous & ridiculous regulations that defy common sense.

4. Ability to use specially designed urine tox screen containers when obtaining specimens (for example, Monitor pH and temperature of urine)

B. Allow physicians, NP’s and PA’s to practice according to their training:

1. Provide necessary supplies for performing simple procedures, such as performing biopsies of suspicious skin lesions, minor laceration repair so that veterans do not have to wait unnecessarily long times for appointments with specialists and have to travel unnecessarily for procedures that can be office-based.

2. Train and accommodate providers who desire to do Joint injections, trigger point injections, or other simple procedures

3. Permit physicians who are trained in alternative medicine techniques to practice their skills (such as herbal therapy, acupuncture, manipulation). Develop an environment of support for providers who chose to use non-pharmacological approaches as part of their practices. Provide additional funding for training in alternative medicine.

C. Allow nurses to perform simple procedures they are trained to do without being hog-tied by regulations.

For example:

1. Perform screening and removal of cerumen (ear wax) from veterans to eliminate referral to specialists and not make the veteran wait for care or have to travel long distances to the VA hospitals.

2. Allow nurses to follow a predetermined policy for monitoring INR test results to facilitate anti-coagulation (which many elderly vets are on).

3. Allow nurses to remove sutures so vets do not have to unnecessarily travel long distances to specialists

4. Allow RN's to function as valuable team members, and provide medical technologists for drawing blood and obtaining and recording vital signs.

Do not put LPN's in medical technologist positions or fail to recognize their training prepares them to do more than most facilities are allowing (the problem is that there appears to be an emphasis on hiring more highly paid RN's and not using less expensive LPN's who can do most of what an out-patient office requires of nurses). Encourage the RN's to do more patient-oriented services, such as patient education.

18. Encourage providers to attend outside the VA medical education courses to learn the most up-to-date practices:

a. Provide ample education funds sufficient to attend at least one extensive medical review course per year (currently the VA only pays \$1000 per provider per year, which is a fraction of what non-VA providers are offered and does not cover the cost of a decent course).

b. Take the funding from the reported lavish junkets the administrators have sent themselves on in recent years and subsidize education, which will ultimately benefit veterans.

19. Eliminate waste at all levels. For example:

a. VSN administrator being paid a \$63,000 bonus for quality care when the facility had a Legionnaire's outbreak.

b. The Department of Veterans Affairs purchased pictures to spend leftover fiscal year dollars for \$562,000 (per the Washington Post) when the veterans themselves would gladly have contributed veteran-made artwork for free (Washington Post).

c. One facility purchased about 8 large flat-screen new televisions that were hung in the cafeteria which were not used as TV's but to flash a display of photos scanned repetitively, which supposedly were designed to calm the staff.

d. Eliminate blocking out an hour each week for an entire staff meeting, which takes providers away from patient care, and inefficiently transmitting information that could be passed-on by e-mail memos.

e. Eliminate indiscriminate purchase of expensive tele-health monitoring equipment which appears to be a priority over basic essentials such as decent suture removal kits, cerumen removal supplies, glucometers, point of care INR testing devices, minor surgical equipment, and liquid nitrogen.

f. One facility purchased off-brand wall mounted otoscopes for their new office (which likely were deemed more cost-effective by a bean-counter), but failed to realize that the standard otoscope tips don't fit the cheap knock-offs. To use them, the provider has to perform an exercise in finger dexterity, which slows the examination process.

g. One New Jersey new CBOC facility was supposed to have a temperature-controlled room to store medications (which was never set-up as planned). Consequently, when temperatures soared in the office above the safe level, several thousand dollars' worth of medications had to be destroyed. When the nurse manager

returned these to the pharmacy, a non-clinical administrative worker (with no medical training) berated the nurse for doing her job and attempting to prevent veterans from being given compromised medications.

h. Employees from multiple facilities complain about the inefficient and wasteful system for obtaining ID badges. This usually amounts to each employee making multiple trips to the VSN headquarters (aka the ‘mother ship’) information technology (IT) department when getting an ID badge. These appointments are tightly controlled by the IT staff, who make appointments for their convenience and not necessarily the convenience or needs of employees.

Furthermore, often the system is “down”, or if working, it can take hours of waiting to print one ID card. This process occurs after the employee is again fingerprinted (if it has been more than 3–6 months since the last badge was issued) – another time-consuming and expensive proposition). Several employees report driving 4–5 hours one-way from their CBOC (Community Based Out-Patient Clinic) only to be told they must return again and again-some as often as 5 times to obtain the sacred “PIV” ID badge. This badge designed is to travel with the employee from facility to facility, yet the various IT departments inappropriately inactivate the badges. This can become a costly process. For example, for each of the 70 doctors and extended care providers now in the VA Interim Staffing locums department, that means with each of 3–4 assignments per year there is a good likelihood that this process of wasted work days and IT employee hours will be repeated over and over again at a cost not even factored in to the scheme of things. No one is counting lost productivity, the cost of travel back and forth, and how this contributes to waste and interruption of care.

Curiously, this inept system has found me going to five different IT departments, making several trips at each facility resulting in a significant amount of time away from treating veterans.

This also means that five times I’ve been fingerprinted and my fingerprints run through the FBI system (or whoever checks our status). At what cost is this?

Does anyone do anything? Does anyone care?

i. Another gross waste is the time and money spent by each VA facility’s credentialing department. Of the now seventy physicians (previously ninety) who are part of the VA traveling physician corps (now called VA Interim Staffing), each physician has to be “re-credentialed” for each VA assignment. If each physician does three assignments per year that is 210 times per year references have to be contacted, 210 times per year the National Practitioner Data Bank is queried (not an insignificant cost for each query), and 210 times a huge number of staff have to track down the same information (all physicians and extended care providers) are initially credentialed upon hire).

The simple solution is for the VA Central Office (VACO) to issue a mandate that physicians or other ‘providers’ employed by the VA can be credentialed on a temporary basis at a facility that has an emergency need for staffing based on credentials from the parent facility. This loss of money had been going on during the over four years of this program’s existence in spite of numerous complaints by providers.

20. Make it easier to remove employees who are consistently not performing according to job standards.

a. Do not allow the practice of moving administrators around the VA system, relocating them in a secret “shell game” to other VSN’s (divisions)when performance has come into question.

b. Do not allow investigations to drag on through committee inertia or inability to take a stand on cases of abuse, or fraud.

One noteworthy case in New England involved a physician assistant accused of fraudulent medical records, poor work ethic, failure physically examine patients, and failure to monitor narcotics (some of the reported charges). At last report, the investigation was now into at least the 8th month, while the provider received full pay while on administrative leave (and reportedly also working in an ER at a local hospital outside the VA).

21. The VA is experiencing shortages of provider, which is at the core of the problems surrounding the VA, yet a program that was helping short-staffed facilities is in serious jeopardy.

a. The VA has its own corps of traveling physicians (some PA's), initially a great idea for getting temporary emergency medical coverage for VA facilities that needed providers to help deliver medical care to veterans who would otherwise go untreated.

b. Now due to micromanaging by the upper echelon and an emphasis on cost containment, the number of providers dropped from 90 to about 70, the focus is on cost-cutting, and the program now hires only part-time people who do not get benefits.

c. The VA Intermin Staffing Program now charges facilities, so there was a dramatic drop in the number of facilities requesting a VA locums provider (from well over a hundred facilities to about twenty).

d. So what happens to the vets because facilities do not have it budgeted to supply providers when short-staffed? They don't get care, or they are shuffled to another on-staff provider who already doesn't have the time to manage his/her panel. This contributes to the problem with failure to adequately manage pain medications.

e. What does the VACO offer as a solution to our program? Of course, hire another supervisor, an expensive Director of the VA Intermin Staffing Program. Great credentials, but did he ever do locums work? The program can't afford to keep trained, readily available physicians on their payroll, but they can add another layer of administration. As I mentioned previously, the system is far too top heavy and bogged down with committees that govern committees, and rules that sustain committees.

God Save Our Veterans! Apparently, no one else can.

Prepared Statement of Dr. Steven G. Scott, M.D.

Good morning, Chairman Benishek, Ranking Member Brownley and Members of the Committee. Thank you for the opportunity to participate in this oversight hearing and to discuss specifically the Department of Veterans Affairs' (VA) James A. Haley Veterans' Hospital's Chronic Pain Rehabilitation Program (CPRP) that treats Veterans experiencing acute and chronic pain.

For many individuals, chronic pain is much more than a lingering medical problem. It is instead a pervasive, unrelenting, and serious condition that affects every area of an individual's life including their mental health, physical health, family life, vocation, friendships, and even sleep. For these individuals, chronic pain is an unending daily battle where pain assumes command. Even the most rudimentary daily decisions - whether to go shopping; attend a medical appointment; see a friend - are based not on the individual's preferences, but instead on their level of pain. We call this constellation of pain related problems a "Chronic Pain Syndrome" or CPS. Estimates are that more than 25 percent of adults with chronic pain also have symptoms of CPS, and while pain may have been the cause of these problems, there is evidence that once established, these related problems linger even if the underlying pain is substantially reduced.

Unfortunately, many individuals with CPS attempt to fight these problems using increasing amounts of opioid analgesics. But, these efforts are rarely successful. Due to the complexity of CPS, no single treatment approach is the answer. A multi-disciplinary and multi-modality approach is almost always necessary.

CHRONIC PAIN REHABILITATION PROGRAM OVERVIEW

The James A. Haley Veterans' Hospital and Clinics in Tampa, Florida have both an inpatient and outpatient Chronic Pain Rehabilitation Program (CPRP). The Haley Veterans' Hospital has the only VA inpatient CPRP. The CPRP was designed to specifically treat Veterans and active duty military personnel with chronic pain syndrome (CPS). The CPRP is an evidence-based, intensive, interdisciplinary, 19-day inpatient chronic pain treatment program that targets not only pain intensity, but also all of the accompanying symptoms of CPS. The core philosophy of the CPRP recognizes the complex interactions between pathophysiological, emotional, social, perceptual, cultural, and situational components of chronic pain.

The CPRP teaches pain self-management practices where participants assume responsibility for their daily functioning and learn to actively manage their pain. For most participants this includes increasing their level of independent functioning, increasing activity levels, reducing the emotional distress associated with chronic pain, eliminating reliance on opioid analgesics and/or muscle relaxants, reducing pain intensity, improving marital, familial and social relationships, increasing vocational and recreational opportunities, and improving overall quality of life.

One of the unique aspects of the program is that all participants taking opioid analgesics at admission are tapered off these medications during the course of treatment. This practice began in 1988 when CPRP was established, and continues today. We do this because opioids essentially have no positive effects for this group of patients. Eliminating opioids for this group of individuals does not increase their pain nor increase their daily impairment. In fact, we have found that eliminating opioid reliance has virtually no effect on treatment outcomes. Individuals who discontinue these medications during treatment improve, as much or more than those who were not using opioid analgesics at admission¹.

CPRP TREATMENT COMPONENTS

The CPRP uses a variety of strategies to enhance self-management skills, increase activity, and reduce pain. These include daily goal-directed programs of individualized exercises, walking, pool therapy, occupational therapy, relaxation training, medical management, recreational therapy, and educational classes. Much of the skill enhancement and self-management training is provided by pain psychologists who serve as rehabilitation coaches and use individual cognitive and behavioral therapy techniques to reduce emotional distress, encourage self-reliance, enhance pain management skills and promote healthy lifestyles. Family members are involved in treatment when available and prior to discharge participants develop a plan of continued rehabilitation that can be implemented at home.

The typical participant in the CPRP is a male or female Veteran in their late 40s who has been fighting pain constantly for the last 15 years on average. They have tried virtually every known treatment, ranging from surgery to multiple medications or injections, and out of desperation may have become victims of a variety of pseudo treatments promising total pain relief at substantial individual cost. They are depressed, irritable, anxious and often angry with the medical establishment that they feel has failed them. Marital and family problems abound, separation or divorce is common, and friendships have dissolved. Typically they are unemployed or disabled and face a variety of financial challenges or crises. Many may misuse prescribed medications, alcohol, or other substances to try to cope. Although this cycle began with a single distinct pain, they now experience multiple pain problems many of which can develop or intensify due to their sedentary lifestyle and prolonged stress.

These same individuals, when offered hope, compassionate treatment, and the camaraderie of others in similar circumstances typically demonstrate remarkable improvements and resiliency during this 19-day inpatient program. When we used standardized measures to assess these changes, we see the following outcomes: reductions in pain severity, improvements in mood and sleep; increased strength, flexibility, and endurance; enhanced engagement with life and families; significant weight loss; and, increased confidence in their abilities to manage their lives despite elimination of opioid analgesics and other potentially harmful medications.² What we find after this treatment are individuals who are now laughing instead of frowning, seeking out contact with others instead of avoiding, and who are proud about their accomplishments. It is not rare to observe individuals who entered the program reliant on wheelchairs, walk out the door unaided at discharge.

CPRP RECOGNITION

In the CPRP's 25 years of existence, the program and its staff have received numerous accolades and awards. The CPRP has been recognized as a two-time Clinical Center of Excellence by the American Pain Society. The CPRP is one of only two programs that has twice won this prestigious award, the other being a program at Stanford University. The program has also received the prestigious Secretary of Veterans Affairs Olin E. Teague Award for clinical excellence and been accredited six times by the Commission on Accreditation of Rehabilitation Facilities (CARF). CPRP leaders have been actively involved in promoting system-wide enhancements in VA pain care, particularly for Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Veterans suffering from chronic pain in combination with other significant physical and emotional co-morbidities. As the most specialized chronic inpatient pain treatment option in the VA health care system, the program accepts referrals from all 50 states, Puerto Rico and the US Virgin Islands.

In 2009, the CPRP was selected to serve as the VA's national training site for interdisciplinary pain programs. Thirty teams from across the country have visited the James A. Haley Veterans' Hospital to observe the model system and learn how

¹Murphy J, Clark M, Banou E, Opioid Cessation and Multidimensional Outcomes After Interdisciplinary Chronic Pain Treatment. *Clin J Pain* 2013;29:109–117.

²Murphy J, et al (2013).

to enhance pain treatment services at their facilities. The training program has focused on helping these teams develop tertiary level, CARF-accredited pain programs in order to help meet the 2009 Veterans Health Administration Pain Management Directive 2009-053 mandating an interdisciplinary CARF option in each Veterans Integrated Support Network. The positive effects of these trainings are manifest by the increase from 2 CARF-accredited programs in 2009, both in the same VISN, to 8 CARF accredited programs in the VHA in 2013; 14 other VHA facilities are presently applying for CARF accreditation for a developed program or in the process of developing a CPRP with the intention of applying for CARF accreditation.

Conclusion

Mr. Chairman, VA is committed to providing the high quality of care that our Veterans have earned and deserve. I appreciate the opportunity to appear before you today to discuss the James A. Haley Veterans' Hospital's Chronic Pain Rehabilitation Program, and I am grateful for your support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. I am prepared to respond to any questions you may have.

Prepared Statement of Dr. Robert L. Jesse, M.D.

Good morning, Chairman Benishek, Ranking Member Brownley and Members of the Committee. Thank you for the opportunity to participate in this oversight hearing and to discuss the Department of Veterans Affairs' (VA) pain management programs and the use of medications, particularly opioids, to treat Veterans experiencing acute and chronic pain. I am accompanied today by Dr. Robert Kerns, VA National Director for Pain Research, Veterans Health Administration.

The issues related to pain and pain management are by no means exclusive to VA. As described in the 2011 Institute of Medicine (IOM) report, "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research"¹, pain is a public health challenge that affects millions of Americans and is rising in prevalence. Pain contributes to national rates of morbidity, mortality, and disability and there are costs of pain both on the toll it takes on people's lives and economically. The IOM estimated that chronic pain alone affects 100 million United States citizens and that the cost of pain in the United States is at least \$560-635 billion each year, which is the combined cost of lost productivity and the incremental cost of healthcare.

Studies show more than 50 percent of all Veterans enrolled and receiving care at VHA are affected by chronic pain, which is a much higher rate than in the general adult population. That makes pain management a very important clinical issue for VA. My testimony today will focus on how VA is providing comprehensive and patient-centered pain management services to improve the health of Veterans. The statement will highlight VA's current pain management strategies, the prevalence and use of opioid therapy to manage chronic pain in high risk veterans, the challenges of prescription drug diversion² and abuse among Veterans, and the actions VA is taking to improve the management of chronic pain, including the safe use of opioid analgesics, and the use of best practices across the VA health care system.

Prescription Drug Diversion and Abuse Challenges

Opioid analgesics may help many patients manage their severe pain when other medications and modalities are ineffective or are only partially effective. However, there may be risks to both individual patients as well as to the surrounding community when these agents are not prescribed or used appropriately. VA has embarked on a two pronged approach to addressing the challenge of prescription drug diversion and abuse among Veteran patients.

One approach is to improve the education and training in pain management and safe opioid prescribing for clinicians and the interdisciplinary teams that provide pain management care for Veterans. A complementary approach involves improving risk management through two systems initiatives. The first system initiative, the Opioid Safety Initiative, employs the tremendous advantages of VHA's electronic health record. This system-wide initiative identifies patients with one or a combination of risk factors, for example, high doses of opioids and opioids combined with sedatives to identify providers whose prescribing practices are misaligned with med-

¹Institute of Medicine. 2011. Relieving Pain in America: A Blueprint for Transforming Pain Prevention, Care, Education and Research. Washington, D.C.: The National Academies Press.

²Diversion is the use of prescription drugs for recreational purposes.

ical evidence/strong practices and to provide counseling, education and support for them to improve their care of Veterans with pain.

The second system-wide risk management approach to support the Veterans' and public's safety is promulgation of new regulations that enable VHA to participate in state Prescription Drug Monitoring Programs (PDMP). These programs, featuring appropriate health privacy protections, allow for the interaction between VA and state databases, so that providers in either can view electronic information about opioid prescriptions and be able to identify potentially vulnerable at-risk individuals. PDMPs can provide information to VA on prescribing and dispensing of controlled substances to Veterans outside the VA health care system. Participation in PDMPs will enable providers to identify patients who have received non-VA prescriptions for controlled substances, which in turn offers greater opportunity to discuss the effectiveness of these non-VA prescriptions in treating their pain or symptoms. More importantly, information that can be gathered through these programs will help both VA and private providers to prevent harm to patients that could occur if the provider was unaware that a controlled substance medication had been prescribed elsewhere already.

Current VA Pain Management Strategies

Chronic Pain in Veterans

The burden of pain on the Veteran population is considerable. We know that Veterans have much higher rates of chronic pain than the general population.³ Chronic pain is the most common medical problem in Veterans returning from the last decade of conflict (almost 60 percent).⁴ Many of these Veterans have survived serious, even extreme, injuries often associated with road-side bombs and other blast injuries. These events can cause damage to multiple bodily sites including amputations and spinal cord injuries. These Veterans also survived severe psychological trauma associated with exposure to the horrors of war on the battlefield. Many Veterans require a combination of strategies for the effective management of pain, including treatment with opioid analgesics, which are known to be effective for at least partially relieving pain caused by many different medical conditions and injuries. In 2010, VA and the Department of Defense (DoD) published evidence-based Clinical Practice Guidelines for the use of chronic opioid therapy in chronic pain. The guidelines reserve the use of chronic opioids for patients with moderate to severe pain who have not responded to, or responded only partially to, clinically indicated, evidence-based pain management strategies of lower risk, and who also may benefit from a trial of opioids to improve pain control in the service of improving function and quality of life.

We also know that the long-term use of opioids is associated with significant risks, particularly in vulnerable individuals, such as Veterans with Post-Traumatic Stress Disorder (PTSD), depression, Traumatic Brain Injury (TBI) and family stress – all common in Veterans returning from the battlefield, and in Veterans with addiction disorders. Chronic pain in Veterans is often accompanied by co-morbid mental health conditions (up to 50 percent in some cohorts) caused by the psychological trauma of war, as well as neurological disorders, such as TBI caused by blast and concussion injuries. In fact, one study documented that more than 40 percent of Veterans admitted to a polytrauma unit in VHA suffered all three conditions together – chronic pain, PTSD, and post-concussive syndrome.⁵

In addition to these newly injured Veterans suffering from chronic pain conditions and neuropsychological conditions, VA cares for millions of Veterans from earlier conflicts, who along with chronic pain and psychological conditions resulting from their earlier war injuries, are now developing the many diseases of aging, such as cancer, neuropathies, spinal disease, and arthritis, which cause chronic, often terrible pain. All these Veterans also deserve appropriate pain care, including, when indicated, the safe use of opioid analgesics.

VA cares for a Veteran population that suffers much higher rates of chronic pain than the civilian population, and also experiences much higher rates of comorbidities (PTSD, depression, TBI) and socioeconomic dynamics (family stress, dis-

³Gironda, R.J., Clark, M.E., Massengale, J.P., & Walker, R.L. (2006). Pain among veterans of Operations Enduring Freedom and Iraqi Freedom. *Pain Medicine*, 7, 339-343.

⁴Veterans Health Administration (2013). Analysis of VA health care utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans. Washington, DC: Department of Veterans Affairs.

⁵Lew, H.L., Otis, J.D., Tun, C., Kerns, R.D., Clark, M.E., & Cifu, D.X. (2009). Prevalence of chronic pain, posttraumatic stress disorder, and post-concussive syndrome in OEF/OIF veterans: The polytrauma clinical triad. *Journal of Rehabilitation Research and Development*, 46, 697-702.

ability, joblessness) that contribute to the complexity and challenges of pain management with opioids.⁶ Because more Veterans have the kind of severe and disabling pain conditions that require stronger treatments such as opioids, more of them have risks for overdose due to depression, PTSD and addiction.

In recognition of the seriousness of the impact of chronic pain on our Veterans' health and quality of life, VHA was among one of the first health systems in the country to establish a strong policy on chronic pain management and to implement a system-wide approach to addressing the risks of opioid analgesia. Our approach is outlined below.

VA National Pain Management Strategy and VHA Pain Management Directive

As part of the VA's National Pain Management Strategy,⁷ VHA Pain Management Directive 2009-053⁸ was published in October 2009 to provide uniform guidelines and procedures for providing pain management care. These include standards for pain assessment and treatment, including use of opioid therapy when appropriate, for evaluation of outcomes and quality of pain management, and for clinician competence and expertise in pain management. Since publication of the Pain Management Directive, a dissemination and implementation plan has been enacted that supports the following:

- Comprehensive staffing and training plans for providers and staff;
- Comprehensive patient/family education plans to empower Veterans in pain management;
- Development of new tools and resources to support the pain management strategy, and
- Enhanced efforts to strengthen communication between VA's Central Office (VACO) and leadership from facilities⁹ and Veterans Integrated Service Networks (VISNs).

Following the guidance of the VHA National Pain Management Strategy, and in compliance with generally accepted pain management standards of care, the Directive provides policy and procedures for the improvement of pain management through implementation of the Stepped Care Model for Pain Management (SCM-PM), the single standard of pain care for VHA, central to ensuring Veterans receive appropriate pain management services. The Directive also requires tracking opioid use and implementing strong practices in risk management to improve Veterans' safety.

Consistent with this model, a key objective is to expand capacity for specialty pain care services. Present data demonstrates an increase in this capacity over the past year, continuing this yearly trend since data were first analyzed in fiscal year (FY) 2005. Specifically, we know that:

- All VISNs are providing dedicated Pain Clinic services with dedicated Pain Clinics in about 95 percent of facilities.
- Through the third quarter of FY 2013, VHA provided Pain Clinic services to 104,388 unique Veterans (including both inpatient and outpatient pain clinic services). Compared to the same time period in FY 2012, this represents a 3.6 percent increase in the number of Veterans served in these specialty clinics.
- Total Pain Clinic encounters increased to 316,204 through the third quarter of FY 2013; up 2.6 percent over this same time period in FY 2012.
- Of the 95 percent of facilities with Pain Clinic Services, 84 percent have dedicated physician staff through the second quarter of FY 2013 (includes all physician specialty areas delivering Pain Clinic services by both VHA and In-House Contract Physician staff).
- Through the second quarter of FY 2013, 59 percent of facilities have physicians who specialize in Pain Medicine, and 44 percent of physician-delivered services VHA wide are provided by those who specialize in Pain Medicine. In the same period, 95 percent of Pain Clinic services were provided by VHA physicians, 3 percent by contract, and 2 percent by in-house fee physicians.
- Physician pain specialist staffing has increased slightly from 113 full-time equivalent employees in FY 2012 to 115 through the second quarter of FY 2013.

⁶ See citations 3 and 4.

⁷ The overall objective of the national strategy is to develop a comprehensive, multicultural, integrated, system-wide approach pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness.

⁸ www.va.gov/vhapublications/viewpublication.asp?pub-id=2781

⁹ The term "facilities" or "facility" refers to VA's 151 medical centers, hospitals, or healthcare systems.

- The current supply of physicians providing specialty Pain Clinic services per 100,000 unique patients, is 1.93, with an average of 2.22 support staff per physician (including administrative staff, advanced-practice providers, and other clinical staff).

Oversight and Accountability

Several key responsibilities are articulated in the Pain Management Directive. The Directive establishes a National Pain Management Program Office (NPMPO) in VACO that has the responsibility for policy development, coordination, oversight, and monitoring of VHA's National Pain Management Strategy. The Directive further authorizes the establishment of a multidisciplinary VHA National Pain Management Strategy Coordinating Committee that supports the Program Office in achieving its strategic goals and objectives. The Committee is comprised of 15 members to include: anesthesiology, employee education, geriatrics and extended care, mental health, neurology, nursing, pain management, patient education, pharmacy benefits management, primary care/internal medicine, quality performance, rehabilitation medicine, research, and women Veterans' health.

The Directive requires VISN Directors to ensure that all facilities establish and implement current pain management policies consistent with this Directive. VISN and facility pain management points of contact serve key roles as links between the NPMPO and VHA health care facilities. Facility directors are responsible for ensuring that accepted standards of pain care are met. The facilities establish multidisciplinary pain management committees to provide oversight, coordination, and monitoring of pain management activities and processes to facilitate the implementation of VA's Pain Management Strategy.

The NPMPO maintains records of VISN and facility compliance, along with other key organizational requirements contained in the Directive. All VISNs and facilities have appointed National Pain Office pain management points of contact, established multidisciplinary committees, and implemented pain management policies as required by the Directive.

Stepped Care Model for Pain Management

As mentioned earlier, SCM-PM is the single standard of pain care for VHA to ensure Veterans receive appropriate pain management services. Specifically, SCM-PM provides for assessment and management of pain conditions in the primary care setting. This is supported by timely access to secondary consultation from pain medicine, behavioral health, physical medicine and rehabilitation, specialty consultation, and care by coordination with palliative care, tertiary care, advanced diagnostic and medical management, and rehabilitation services for complex cases involving comorbidities such as mental health disorders and TBI.

In FY 2012, VHA made several important investments in implementing the SCM-PM. Major transformational initiatives support the objectives of building capacity for enhanced pain management in the primary care setting, including education of Veterans and caregivers in self-management, as well as promoting equitable and timely access to specialty pain care services.

There are other important efforts contributing to the implementation of SCM-PM in VHA facilities. Current initiatives focus on empowering Veterans in their pain management, and expanding capacity for Veterans to receive evidence-based psychological services as a component of a comprehensive and integrated plan for pain management. For example, during FY 2012, the VHA National Telemental Health Center expanded its capacity to deliver face-to-face, psychological services to Veterans remotely via high-speed videoconferencing links. This initiative not only emphasizes the delivery of cognitive behavior therapy for Veterans with chronic pain, but also promotes pain self-management, leading to reductions in pain and improvements in physical functioning and emotional well being.

Additionally, a Primary Care and Pain Management Task Force is developing a comprehensive strategic and tactical plan for promoting full implementation of the SCM-PM in the Primary Care setting, and it continues to work on several products in support of this effort. For instance, the Task Force is continuing to expand its network of facility-level Primary Care Pain Management points of contact (Pain Champions) who meet monthly, via teleconference, to identify and share strong practices that have led to improved pain care in primary care settings.

VA's pain management initiatives are designed to optimize timely sharing of new policies and guidance related to pain management standards of care. Of particular importance are VHA's continuing efforts to promote safe and effective use of opioid therapy for pain management, particularly those initiatives designed to mitigate risk for prescription pain medication misuse, abuse, addiction, and diversion.

Created in 2011, VA's Specialty Care Access Network–Extension of Community Healthcare Outcome (SCAN–ECHO) initiative allows pain specialists to train primary care providers in community based outpatient clinics (CBOCs) closer to Veterans' homes, particularly in rural and underserved geographic areas. Benefits of this program include reduced travel costs, improved quality of care, and increased provider and Veteran satisfaction. Multiple modules are available on VA's on-line Talent Management System (TMS), based on VA/DoD pain guidelines and approved for continuing education credits for physicians, nurses, pharmacists, and psychologists, thereby ensuring a standardized level of knowledge across pain care delivery. This initiative supports the implementation and evaluation of seven pain SCAN–ECHO regional training hubs. Each hub, designed to provide support for up to twenty Patient-Aligned Care Teams (PACT), is staffed by experts in pain management, and linked by real-time videoconferencing to PACT teams away from the medical center.

VHA has also implemented the Consult Management initiative, which uses E-Consults and phone consults, to change how specialty care services are delivered throughout VHA. E-Consult provides clinical support from provider to provider. E-Consult is an alternative to face-to-face visits, and is expected to improve access, communication, and coordination of care. Through a formal consult request, a provider requests a specialist to address a clinical problem or to answer a clinical question for a specific patient. Using information provided in the consult request and/or review of the patient's electronic health record (EHR), the consultant provides a documented response that addresses the request without a face-to-face visit. This method of consultation supports patient-centric care, reduces the burden of travel for the Veteran, and reduces overall travel and non-VA costs.

A particularly exciting initiative in its pilot phase of development is the pain management application for smart phones that will be used by Veterans and their care partners to develop pain self-management skills. This tool, called VA Pain Coach, will eventually interface with VHA's EHR, with appropriate privacy protections in a secure mobile application environment, allowing Veteran-reported information about pain, functioning, and other key elements to be securely stored and accessible to clinicians. VA Pain Coach, which is part of a suite of VA applications called "Clinic in Hand", is in the third month of a one-year pilot test with 1150 Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Veterans and their caregivers. In the future, a complementary initiative will build a clinician-facing application that will enhance the capacity of clinicians and Veterans to share in monitoring, decision making, treatment planning, and reassessment of pain management interventions.

VHA continues to work to strengthen its ability to meet the pain management needs of Veterans with complex chronic pain conditions with co-morbidities. Of particular importance are continued efforts to promote access to integrated care services for Veterans experiencing chronic pain and symptoms of PTSD, mild TBI, sleep disorders, and other common co-morbid conditions. In partnership with VHA's Mental Health Services, the ongoing Evidence-Based Psychotherapy initiative has been expanded to include an initiative on cognitive behavior therapy for chronic pain.

VHA's NPMPO also partners with Primary Care Services in support of its Post-Deployment Integrative Care Initiative. This field-based initiative, developed in 2008, supports integrated care clinical platforms for providing post-deployment services in VAMCs nationally. An example of this initiative is the PACT-based collaborative for post-deployment pain care. This initiative focuses on PACT and pain specialists in interdisciplinary collaborative care based on the Step Care Model of pain management. An additional monthly community of practice discussion, as well as a monthly call for a network of PACT Primary Care Pain Champions, were recently added focusing specifically on pain care in PACT settings to further the implementation of good pain care and rational opioid use.

VHA's capacity to provide Veterans with equitable access to specialty care services is strengthened by integrating other services important for pain management. For example, a partnership with Rehabilitation Services plans to build capacity for rehabilitation medicine services, including chiropractic services. Recently, the NPMPO contributed to a national educational conference, focusing on rehabilitation services, to promote models of integrated care that emphasize the role of rehabilitation specialists for pain management.

Further, the NPMPO continues to partner with Women Health Services to develop a strategic plan that will strengthen the capacity for women Veteran centered pain management services. In April 2012, VHA sponsored a Women's Health National audio conference on pain management for Women Veterans.

The NPMPO also partners with Pharmacy Benefits Management Services (PBM) and others in development of a comprehensive approach to promote the safe and ef-

fective use of long-term opioid therapy for Veterans. Of particular note was the promulgation of regulations permitting VA to participate with a growing number of states that have state Prescription Drug Monitoring Programs (PDMP). Thus, following state laws, VA providers can query PDMP databases about prescriptions from providers outside the VA, and can respond to queries from outside the VA about Veterans receiving controlled medications from the VA, leading to better communications with Veterans and all their caregivers about safe practices. The NPMPO also collaborates with PBM on the Opioid Safety Initiative which involves providing facility feedback on provider prescribing and facility utilization of opioids. This program was piloted in 4 VISNs and was implemented system-wide in August and September 2013.

VHA Pain Management Centers

The Under Secretary for Health chartered an Interdisciplinary Pain Management Center Work Group to provide guidance and oversight for VHA's efforts to develop VISN level tertiary care Pain Management Centers. These Centers have the capacity for providing advanced pain medicine diagnostics, surgical and interventional procedures, subspecialty pain care, and intensive, integrated chronic pain rehabilitation for Veterans with complex, co-morbid, or treatment refractory conditions. There are currently nine Commission for the Accreditation of Healthcare Facilities, or CARF, accredited pain rehabilitation centers in VHA. This includes one Center at the James Haley Veterans Hospital in Tampa, which is one of only two multidisciplinary pain management centers to be twice recognized by the American Pain Society as a Clinical Center of Excellence. The other is a program at Stanford University.

Finally, the DoD–VA Health Executive Council (HEC) Pain Management Work Group (PMWG) was chartered to develop a model system of integrated, timely, continuous, and expert pain management for Servicemembers and Veterans. The Work Group participates in VA/DoD Joint Strategic Planning (JSP) process to develop and implement the strategies and performance measures, as outlined in the JSP guidance, and shares responsibility in fostering increased communication regarding functional area between Departments. The Group also identifies and assesses further opportunities for the coordination and sharing of health related services and resource between the Departments. A key development is the HEC PMWG's sponsoring of two Joint Incentive Fund projects to improve Veterans' and Servicemembers' access to competent pain care in the SCM–PM: the Joint Pain and Education Project (JPEP), and the "Tiered Acupuncture Training Across Clinical Settings" (ATACS) projects. The latter project, ATACS, represents VHA's initiative to make evidence-based complementary and alternative medicine therapies widely available to our Veterans throughout VHA. A VHA and DoD network of medical acupuncturists are being identified and trained in Battlefield (auricular) Acupuncture by regional training conferences organized jointly by VHA and DoD. The goal of the project is for them to return to their facilities and VISNs with the skills to train local providers in Battlefield Acupuncture, which has been used successfully in DoD front-line clinics around the world. This initiative will provide Veterans with a wider array of pain management choices when they present with chronic pain.

Prevalence and Use of Opioid Therapy for the Management of Chronic Pain in Veterans

To monitor the use of opioids by patients in the VA health care system, VA tracks multi-drug therapy for pain in patients receiving chronic or long-acting opioid therapy for safety and effectiveness. This includes tracking of use of guideline recommended medications for chronic pain (i.e., certain anticonvulsants, tricyclic antidepressants (TCA), and serotonin and norepinephrine reuptake inhibitors (SNRI) which have been shown to be effective for treatment of some chronic pain conditions), and tracking of concurrent prescribing of opioids and certain sedative medications (e.g., benzodiazepines and barbiturates) which can contribute to over-sedation and overdose risk when taken with opioids and the other medications for pain listed above.

The prevalence of Veterans using opioids has been measured for Veterans using VHA health care services. For FY 2012, of the 5,779,668 patients seen in VA, 433,136 (7.5 percent) received prescriptions for more than 90 days supply of short acting opioid medications and 92,297 (1.6 percent) received at least one prescription for a long-acting opioid medication in the year. Thus, since chronic pain is the most common condition in all Veterans enrolled in VHA, more than 50 percent, a relatively small percentage of those Veterans are receiving opioid therapy, consistent with the DoD–VA Clinical Practice Guidelines which limit their use to patients with moderate to severe persistent pain that has not responded to other safer alter-

natives that are clinically appropriate. Of these 525,433 patients that received chronic or long-acting opioid therapy, 79,025 (15 percent) were also prescribed a TCA, 90,066 (17 percent) were also prescribed an SNRI, and 178,361 (34 percent) were also prescribed an anticonvulsant some time in FY 2012.

The co-prescription of TCAs and/or SNRIs with opioids is first line therapy for the more severe cases of pain related to nerve damage from disease (e.g., diabetes, cancer) or from injuries (e.g., battlefield blast and projectile injuries with or without limb amputation and spinal cord injury). The numbers above suggest that clinical teams are using medically indicated combinations of medications that are specifically needed for these more severe conditions, which themselves are often co-morbid with musculoskeletal pain such as injuries to joints, spine and muscles. Of note, these prescriptions may or may not have overlapped with the opioid prescription during the year.

In FY 2012, 193,644 (37 percent) of the patients prescribed chronic or long-acting opioid therapy received an overlapping prescription for a sedative medication. Notably, 272,719 (52 percent) of patients on chronic or long-acting opioid therapy also received non-medication-based rehabilitative treatments as part of their treatment plan (e.g., physical therapy (32 percent), chiropractic care (1 percent), programs to encourage physical activity (9 percent) or occupational therapy (17 percent), and 241,465 (46 percent) also received behavioral or psychosocial treatment for chronic pain or co-morbid mental health conditions.

These data, showing the use of non-medication treatments, suggest that Veterans are benefitting from VHA's efforts to create access to additional pain treatment modalities besides medication. This is consistent with VA's commitment to transform pain care to a biopsychosocial model¹⁰ that addresses all the factors that by research are demonstrated to affect Veterans' success in chronic pain treatment. Pursuant to this aim, a multi-modality, team-based, stepped care model, per VHA Directive 2009-053, is being implemented widely throughout VHA, and in coordination with DoD.

Improving Chronic Pain Management and Use of Best Practices in VHA

The strategies outlined earlier regarding VHA Pain Management Directive were developed and are being implemented to improve pain management outcomes for our patients. To achieve successful transformation of pain care in VHA several strategic goals must be met.

Health Care Provider Education and Training

First, as recognized by the IOM in its extensive 2011 review, "Pain in America" and the American Medical Association in its 2010 Report on Pain Medicine¹¹, and as articulated in VHA's Pain Management Directive in 2009-053, a formal commitment to pain management education and training for students and trainees in all clinical disciplines is required. For example, VHA, which provides training for a large proportion of medical students and residents, has the opportunity to establish a system-wide requirement for education and training of physicians in pain management, as recommended in the Directive.

The Joint Pain and Education Project, JPEP, mentioned earlier, has proposed training faculty in all VA training sites to pursue the implementation of such a curriculum, so that new generations of providers and other clinicians will themselves become the new teachers of good pain care. JPEP will target all levels of learner: the Veteran and his/her family and caregiver; the public; clinicians from all disciplines; specific providers and clinicians in practicing at each level of the SCM-PM: primary care, pain medicine specialty care, and other specialty care. VA is providing national leadership in developing interdisciplinary and discipline-specific competencies for pain management, in developing a system-wide approach to trainings, and in providing leadership roles in national projects to improve pain education and training.

Outcomes and Best Practices

In summary, there is growing evidence of the successful implementation of a Stepped Care Model for Pain Management in VHA. Importantly, Veterans receiving long term opioid therapy for management of chronic pain are increasingly likely to

¹⁰The Biopsychosocial Model takes the position that the causes and outcomes of many illnesses often involve the interaction of physical and pathophysiologic factors, psychological traits and states, and social-environmental factors. Effective treatment planning accounts for the salience of these factors in the precipitation and perpetuation of illness and illness-related disability.

¹¹Lippe PM, Brock C, David JJ, Crossno R, Gitlow S. The First National Pain Medicine Summit – Final Summary Report. *Pain Med* 2010;11(10):1447-68.

be receiving this therapy in the context of multidisciplinary and multimodal care that often incorporates physical and occupational therapy and mental health services. All VISNs provide specialty pain clinic services, and the number of Veterans who receive these services has grown steadily for the past five years. Nine facilities now provide CARF accredited pain rehabilitation services, a rapid increase in the availability of these higher specialized pain rehabilitation services for our most complex Veterans with debilitating chronic pain and comorbid mental health disorders.

VA learns from VISN and VA medical centers that are early adopters of implementing evidence based guidelines and best practices. The Minneapolis VAMC has had great success after their VISN leadership and Medical Center leadership organized multi-disciplinary team with pain providers, clinical pharmacist, psychologist, psychiatry, patient advocates and toxicologists. Interdisciplinary approaches were identified to address patients on the higher doses of opioid medications. The PACTs were encouraged to offer trials of non-opioid care and increase access to behavioral pain management resources as alternatives. Patients were assessed frequently to evaluate the trials of lower doses of medication and success of non-opioid alternative care. After implementing best practices, this medical center saw over a fifty percent decrease in the need to prescribe opioids for chronic pain management, in higher doses. The facilities' practices were shared nationally through educational teleconferences. VA applauds the work by this medical center and others like it to progress toward a standard of care for safer opioid prescribing

VA is working aggressively to promote the safe and effective use of long-term opioid therapy for Veterans with chronic pain for whom this important therapy is indicated. VA's Opioid Safety Initiative holds considerable promise for mitigating risk for harms among Veterans receiving this therapy, for promoting provider competence in safe prescribing of opioids, and in promoting Veteran-centered, evidence-based, and coordinated multidisciplinary pain care for Veterans with chronic pain. Early evidence of success in reducing overall opioid prescribing and average dose per day of opioid therapy is encouraging.

VA also has the opportunity to measure the impact of new policies and programs systematically and in a way that enhances the outcomes of interdisciplinary pain care for Veterans. VA's Office of Research and Development Pain Portfolio for FY 2013 consisted of 82 projects relevant to the treatment, diagnosis, and mechanisms underlying painful conditions experienced by Veterans, totaling approximately \$16.4 million (an increase of \$4.5 million from 2012).

VA recently funded a new research project that identifies a cohort of all Veterans in care in VHA with diagnosed painful musculoskeletal disorders. This database provides an important opportunity to examine pain care in VHA, including multidisciplinary pain care consistent with the SCM-PM, costs of care, and outcomes. VA is currently exploring the development of a prospective electronic system for supplementing this system by collection of Veteran reported outcomes. VA Pain Coach already described may provide an initial secure platform for this important initiative. Another opportunity is to partner with our DoD and National Institutes of Health colleagues to develop a registry of Veterans with painful conditions that can link with a similar system, called PASTOR Patient Reported Outcomes Measurement Information System (PROMIS), being developed in DoD military treatment facilities.

In addition to interagency collaborations mentioned earlier, VHA pain experts serve on the Interagency Pain Research Coordinating Committee (IPRCC). The IPRCC was tasked by the Undersecretary for Health at the Department of Health and Human Services to create a comprehensive population health-level strategy for pain prevention, treatment, management, and research.

Finally, on February 25, 2013, VHA submitted a notice in the Federal Register (FR Doc. 2013-04248) outlining a Pain Public Private Collaboration for the development of novel therapies to treat painful conditions. The goal is to partner VHA investigators with industry sponsors to develop or test new therapies for chronic pain

Conclusion

Mr. Chairman, we know our work to improve pain management programs and the use of medications will never be truly finished. However, we are confident that we are building more accessible, safe and effective programs and opportunities that will be responsive to the needs of our Veterans. We appreciate your support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. VA is committed to providing the high quality of care that our Veterans have earned and deserve, and we appreciate the opportunity to appear before you today. My colleagues and I are prepared to respond to any questions you may have.

Statements For The Record

THE AMERICAN LEGION

A CBS News Story¹ on September 19, 2013 reported that Army SPC Scott McDonald, a veteran of five tours of duty in Iraq, was found dead by his wife on his couch at home due to the nine different painkillers and psychiatric pills prescribed by the Department of Veterans Affairs (VA).

A second veteran, Army SPC Jeffery Waggoner, who was being treated by the Roseburg VA Medical Center for severe Post Traumatic Stress Disorder (PTSD), was prescribed “with a battery of drugs so generous that in the weeks leading up to the patient’s overdose in a Sleep Inn Motel, his medical records show, he only woke up only to take his medicine, which was a cocktail of 19 different medications,” according to a Center for Investigative Reporting article² in September 2013.

The overprescribing of pain medications is a tragic and dire situation many veterans face, which leads to further health problems and quality of life issues such as substance abuse disorders, depression, and in SPC McDonald’s and Waggoner’s cases, their lives.

The American Legion appreciates the committee for their concern in holding this hearing and utilizing their oversight authority to work to improve the lives of America’s veterans that depend on VA for their healthcare and treatment of pain symptoms. With proper care and medication management, even severely disabled veterans can still lead meaningful and productive lives. However, unless close scrutiny and care is exercised, even small problems with medications can spiral into much larger issues. All concerned parties must also be open minded, and consider other, alternative therapies to medication when considering long term care not only for pain management, but for other conditions including psychological disorders. By working together, the veterans of America, the service organizations such as The American Legion that serve them, as well as the concerned members of this committee and within the VA, a means to deal with the problem of pain management and mental health management that accounts for many factors to determine the best strategy for each, individual veteran can be developed.

Challenge of Prescription Drug Diversion and Abuse Among Veteran Patients

The American Legion believes that the misuse or abuse of prescription drugs amongst veteran patients is not necessarily due to veterans’ drug seeking and drug diversion behaviors but on several health care delivery system failures such as:

- Fragmentation within and between health care systems during service members’ time of transition and as a veteran with multiple systems of care;
- Inability to distinguish between traumatic brain injury, post-traumatic stress disorder and pain symptoms and overprescribing of pain medications to mental health patients
- Improvements needed in the management, oversight and clinical directives for VA providers’ prescribing of opiates

Fragmentation Within and Between Different Health Care Systems During Veterans Transition from the Military and as a Veteran

Compounding the concern of medication management leaving the military, veterans can be seen in multiple systems of care such as the DOD’s Military Health Care System, TRICARE, Medicare, Medicaid or in the private sector where different providers within of or external systems can concurrently prescribe or overprescribe pain medications. The only real check against conflicting prescriptions is the self-reporting of the veterans, which may be muddled by the very prescription drugs they need to manage their pain or symptoms.

While the State Drug Monitoring Program aims to reduce the number of controlled substances that are prescribed to individuals across multiple systems of care throughout the state, this database relies on providers to ensure medication reconciliation and information technology systems can provide this data to the state in real time. Currently, VA lacks a national information technology system and way to view all dispensing of medications to veterans through their VA Medical Centers, Community Based Outpatient Clinics and Consolidated Mail Out Pharmacy. In 2003, the VA submitted a pharmacy reengineering project to improve visibility over

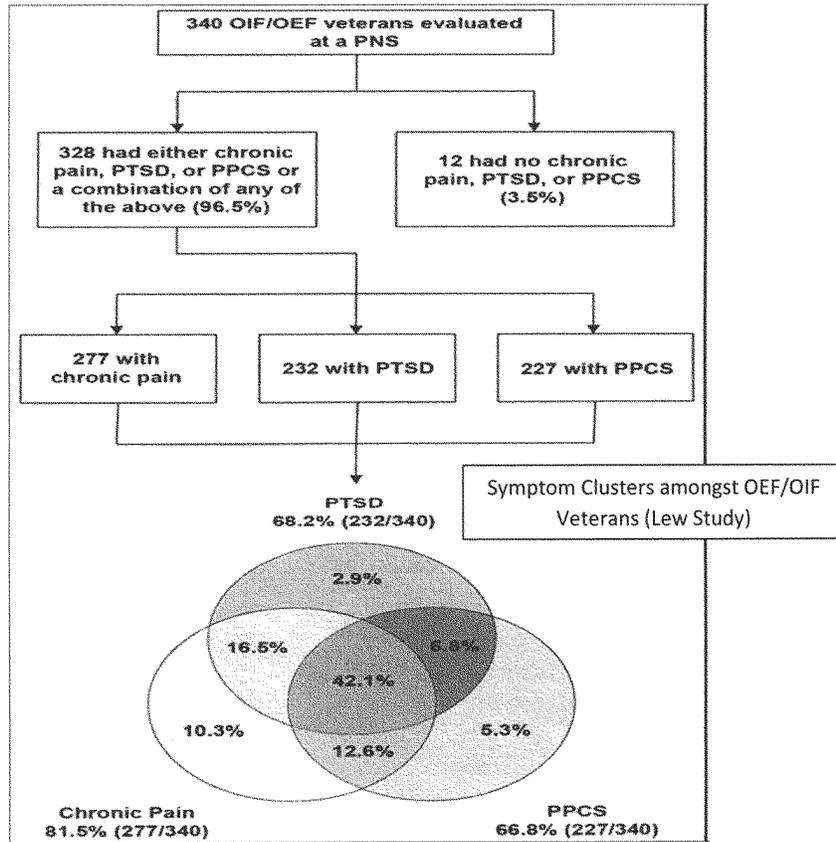
¹ <http://www.cbsnews.com/8301-18563-162-57603767/veterans-dying-from-overmedication/>

² <http://www.va.gov/oig/pubs/VAOIG-12-01872-258.pdf>

every inpatient and outpatient prescription dispensed which would enable providers in different VA hospitals and clinics to monitor risk for overprescribing of medications. However, the authorization and funding for this project was never approved, authorized or funded by VA's Office of Information Technology due to other competing IT projects.

Inability to Distinguish between Traumatic Brain Injury, Post Traumatic Stress Disorder and Pain Symptoms and Overprescribing of Pain Medications to Mental Health Patients

Three studies address the growing concern of pain management of veterans and improvements needed. First, in 2009, Dr. Henry L. Lew authored a research study titled "Prevalence of chronic pain, posttraumatic stress disorder, and persistent post-concussive symptoms in OIF/OEF veterans" in the Journal of Rehabilitation Research and Development. In the study, he found that within a sample of 340 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, 42.1 percent were diagnosed with multiple co-morbidities associated with the diagnosis of mild TBI, sleep disorders, substance abuse, psychiatric illness, visual disorders and cognitive disorders (see exhibit below). This inability of providers to know what constellation of symptoms and diagnoses makes treatment for these post deployment health care conditions more difficult.



Secondly, OEF/OIF veterans with mental health diagnoses³ were found to be significantly more likely to receive prescriptions for oxycodone, hydrocodone and other opioids than those with symptoms of pain and no mental health issue, according to a VA study released in March 2012⁴.

Dr. Karen Seal and colleagues at the San Francisco Veterans Affairs Medical Center's study, "Association of Mental Health Disorders with Prescription Opioids and High-Risk Opioid Use in US Veterans of Iraq and Afghanistan" published these findings in the Journal of the American Medical Association. The study sample consisted of 141,029 Iraq and Afghanistan veterans who were diagnosed with pain from 2005–2010 and found 15,676 (11 percent) of veterans with PTSD were prescribed opioids within the year for at least 20 consecutive days compared to 6.45 percent of veterans not diagnosed with any mental health disorder.

The study further commented on barriers to receiving mental health and the need for primary care clinicians to be trained in the co-morbidity of symptoms between PTSD and substance use disorder as well as the risk of prescribing both sedative and opioids and alternative therapies should be considered.

Third, Dr. Charles Hoge and Dr. Carl Castro's study, "Mild Traumatic Brain Injury in U.S. Soldiers Returning From Iraq" found that "evidence-based treatments for persistent post-concussive symptoms are lacking, results of diagnostic procedures for mild TBI or deployment related cognitive effects are inconclusive and management focuses largely on alleviating symptoms and reinforces the need for a multi-disciplinary approach centered in primary care. Further the study recommended the establishing of deployment health clinics to address the multiple physiological and physical symptoms and collaborative care approaches in primary care settings to improve intervention strategies.

Improvements needed in the management, oversight and clinical directives for VA providers' prescribing of opioid prescriptions

The VA Office of Inspector General (OIG) Office of Healthcare Inspections released a report on August 21, 2012 from an inspection of the VA Maine Healthcare System's Calais Community Based Outpatient Clinic on the prescribing of opioids for chronic pain. The OIG found that "providers did not adequately assess patients who were prescribed opioids for chronic pain; facility managers asked providers to write opioid prescriptions for patients whom the providers had not assessed and patients often obtained prescriptions from multiple providers due to staffing constraints."

The most disconcerting finding pointed out by the OIG was that "current VHA regulations do not require a provider to see a patient before writing an opioid prescription".

What The American Legion is Doing

TBI and PTSD Committee

The American Legion commissioned a TBI and PTSD Ad Hoc Committee in 2010 "to investigate the existing science and procedures and alternative methods for treating TBI and PTSD." During the three year study, the committee held six meetings and met with leading authorities in DOD, VA and personally interviewed veterans. One of the major reasons for formation of the committee was the overprescribing of medications and no new alternative therapies were being developed.

The committee examined the overlap of symptoms between TBI, PTSD and pain symptoms which could lead to misdiagnoses and treatment for the wrong medical condition. The committee found that "the primary treatment across the agencies and branches of services (active, reserve and guard) is pain management and medication to treat the symptoms; *there is every indication that the pharmacology approach is not the answer. Additionally, there is a need for DOD and VA to research TBI and PTSD research and treatments currently being used in the private sector, such as Hyperbaric Oxygen Therapy, Virtual Reality Therapy, other Complimentary and Alternative Medicines, instead of pharmacological treatments.*"

One service member that was interviewed by the TBI and PTSD Committee said that he was at the Warrior Transition Unit in Ft. Carson, Colorado and taking 18 different prescriptions for treatment of pain and other mental health symptoms. The service member was accepted into the National Intrepid Center of Excellence in Bethesda, MD and upon arrival the center said he would be taking half of the number of prescriptions. When he left the NICOE three weeks later, he was only taking nine

³ Primarily Posttraumatic Stress Disorder

⁴ <https://jamanetwork.com/issue.aspx?journalid=67&issueid=22492>

prescriptions but when he went back to the WTU in Ft. Carson, they put him back on his original 18 medications.

Any progress made at the Center of Excellence is being undercut by the inability of multiple programs serving the veteran health care needs to get on the same page.

American Legion Resolution and Position on Pain Management

The American Legion adopted a resolution⁵ to require federal funding for pain management research, treatment and therapies at the Department of Defense, Department of Veterans Affairs and at the National Institutes of Health be significantly increased and that the Congress and the President's administration re-double their efforts to ensure that an effective pain management program be uniformly established and implemented. The resolution also called on DOD and VA to increase their investment in pain management clinical research by improving and accelerating clinical trials at military and VA treatment facilities and affiliated university medical centers and research programs.

Veteran Testimonials

The American Legion reached out to our 2,600 accredited service officers and members regarding concerns they faced with pain management and medication management in VA. The following testimonials are real life anecdotes representing what we are hearing from American Legion members and veterans through our extensive network of service officers:

- **Veteran #1** - *Many pain meds do not work for me for whatever reason plus I'm a large person who lived with a lot of back pain for over 30 years before I allowed them to operate on my back—the surgery was very successful although I am still in some pain (but not near as much as I used to be). Anyway I was given oxycodone [sic] and a normal dose doesn't scratch the surface so I no longer take them because if I take a larger than normal dose I run the risk of bad reactions—once I was very paranoid for a couple of hours, another time I was flat stoned, and I don't remember too much about the third time but I know I was very light headed and uncomfortable for a couple of hours; so I flushed the rest of the prescription and do not take anything.*
- **Veteran #2** - *For a client with a long term prescribed therapy/treatment we have noted that doctors are now reducing the amounts provided and providing limited alternatives. Now, this may just again be a perception by the veteran but the veteran involved may be convinced he/she cannot accomplish daily living without the extended use of heavy/controlled meds. This becomes an explosive situation for a veteran utilizing/abusing/or addicted to the meds. In a case just recently the doctor advised the vet he would no longer get his 90 day supply of pain medications. This vet is combat wounded and suffers from severe PTSD. The immediate reaction was for the vet to almost become suicidal as he felt his conditions would no longer be adequately treated. He was told he would have to contact pain management and work on an alternative method for his chronic pain condition. Was this what he was actually told? We are unsure and find ourselves as advocates having to research the facts while we attempt to keep the vet calmed. We understand the intention is to begin limiting the use of heavier medications and we support this contention as we see a number of vets being "numbed" to handle the real or perceived pain. There are also two sides to every story but we are advocates and not medical professionals.*
- **Veteran #3** - *My main concern is in reference to what seems the VA's treating of the symptoms rather than the cause of the symptoms. Many of my veterans have complained that the VA isn't interested in finding and treating their problems and their solution is to dispense another pill instead of actual treatment. Another complaint is that clinicians seem to be reluctant to provide alternative treatments or therapies and don't give serious consideration or pursue using them. Most of these veterans aver that they are over medicated and are not receiving good proactive healthcare by their providers.*

Actions Needed to Improve the Management of Chronic Pain and the Utilization of Best Practices Across the VA Health Care System

The American Legion urges Congress, DOD and VA to take the following steps to strengthen programs and initiatives to reduce the administering and prescribing of pain medication to service members and veterans.

⁵Resolution No. 150 Support for Pain Management Research, Treatment and Therapies at DOD, VA, and NIH

- Pain management research, treatment and therapies at the Department of Defense, Department of Veterans Affairs and at the National Institutes of Health be significantly increased and that the Congress and the Administration re-double their efforts to ensure that an effective pain management program be uniformly established and implemented.
- DOD and VA increase their investment in pain management clinical research by improving and accelerating clinical trials at military and VA treatment facilities and affiliated university medical centers and research programs

The VA should carefully consider and look at new pain management and medication tracking requirements such as:

- Development of a more integrated care approach within primary care to address pain and the constellation of post deployment health illnesses and injuries to include pain specialists and pharmacists within VA's Primary Care Aligned Team model.
- VA should prioritize funding and development of Pharmacy Reengineering Program to coordinate all VA medications with a system that can track all medications between VA Medical Centers, Community Based Outpatient Clinics and Consolidated Mail Out Pharmacy to ensure opiates or other controlled substances are not overprescribed.
- VA should develop national procedures and directives to ensure that providers see veteran patients prior to prescribing opioids.
- VA should conduct a system-wide training of all providers and clinicians on reduction of pain medications and improved coordination, monitoring and oversight including parameters of numbers of medications and patients at risk that are taking several different medications.
- VA should develop national procedures and directives on the administration of pain medications to veterans specifically with mental health illness and develop training for primary care clinicians on treating pain symptoms concurrently.

Studying medication, as well as alternative treatments, is an important task to ensuring the system for providing health care for veterans remains the best resource for their health needs. As this issue continues to develop, The American Legion looks forward to working with the Committee, as well as DOD and VA, to find solutions. For additional information regarding this testimony, please contact Mr. Ian de Planque at The American Legion's Legislative Division, (202) 861-2700 or ideplanque@legion.org.

IRAQ & AFGHANISTAN VETERANS OF AMERICA

Statement of Jacqueline A. Maffucci, Ph.D., Research Director ¹

Chairman Benishek, Ranking Member Brownley, and Distinguished Members of the Subcommittee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA), I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding pain management practices, an important issue that affects the lives of thousands of service members and veterans.

IAVA is the nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and their supporters. Founded in 2004, our mission is critically important but simple – to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of nearly 270,000 members and supporters, we strive to help create a society that honors and supports veterans of all generations.

In partnership with other military and veteran service organizations, IAVA has worked tirelessly to see that veterans' and service members' health concerns are comprehensively addressed by the Department of Veterans Affairs (VA) and the Department of Defense (DoD). IAVA understands the necessity of integrated, effective, world-class healthcare for service members and veterans, and we will continue to advocate for the development of increased awareness, recognition and treatment of service-connected health concerns, chronic pain and pain management included.

According to a 2011 Institute of Medicine report, chronic pain affects approximately 100 million American adults. Nationally, the number of individuals diagnosed with chronic pain and the number of powerful narcotics prescribed to treat pain have increased in the last decade. Concurrently, prescription drug abuse is on the rise². The CDC has called prescription drug abuse an epidemic in the U.S, and the White House has developed a National Drug Control Strategy to address the

issue³. This is a national issue, and one from which our service members and veterans are not immune.

A recent report from the Center for Investigative Reporting found that over the last 12 years, there has been a 270 percent increase in Veterans Health Administration (VHA) prescriptions for four powerful opiates⁴. Given the last 12 years of conflict and the intense physical demands on our troops, it is no surprise that over half of the OEF/OIF veterans seeking VA medical care report chronic pain, nor is it a surprise that the majority of veterans seeking primary care treatment from the VA report pain as a major concern⁵.

Reports presented by the VHA on pain management illustrate the scope of pain and pain management practices within the VA and the unique potential causes of pain among veterans⁵. For Iraq and Afghanistan veterans, improved body armor and medical advancements has allowed for higher survival rates, but increased amputations and other lifelong impacts of nerve and skeletal damage, coupled with musculoskeletal concerns from the weight of wearing heavy body armor, highlight a need for successful pain management strategies for veterans of these conflicts. In 2012, the second most common reason for outpatient clinical visits and the fourth most common reason for hospitalization among active duty service members was musculoskeletal concerns⁶. With time and age, these injuries will most likely worsen⁶. This highlights the importance of comprehensive, integrated pain management protocols in military and veteran medical care.

Pain management is challenging in that pain manifests itself differently from patient to patient. Further, assessing pain and devising a management strategy can be very difficult, particularly given that this is a relatively new area of focus in the clinical research field. Related to this, the primary care physicians who see the bulk of patients with chronic pain have repeatedly reported that they feel underprepared to treat these patients due to a lack of training. In a 2013 study specific to VHA, this trend was echoed by the VHA providers who were surveyed as well⁷.

These same providers reported that barriers within VHA kept them from feeling prepared to treat chronic pain. These included formulary barriers, inability to access state prescription monitoring programs (which would allow them to see if patients have previously been prescribed controlled medications like opioids), and barriers to consulting with experts outside of the VA.

Chronic pain is also particularly prevalent in polytrauma cases, which are among the most complex medical cases to address. Pain often presents in consort with other conditions, such as depression, anxiety, PTSD, or TBI. Providers can be challenged to treat pain that is comorbid with other conditions because of the difficulty of managing multiple conditions. Some of these conditions may also limit the drugs available to the patient, making treatment options limited.

These issues constitute major challenges to pain management. Certainly part of a treatment program for chronic pain may include strong anti-pain medication, including opioids; but a schedule of treatment should not be limited to pharmaceutical remedies and should integrate a host of other proven therapies. This is why a stepped case management system can be very helpful. In this type of system, a primary care physician has the support of an integrated, multi-disciplinary team of providers to design and implement a comprehensive pain management plan for the patient.

The VA and DoD have been relatively proactive in how they approach management of chronic pain. Since 2000, VHA has instructed its providers to treat pain as the fifth vital sign⁸. Much like heart rate and blood pressure, inquiring about and documenting complaints of pain has been integrated into the physical exam. VA has also put more resources into research to understand pain assessment and treatment. And they have partnered with DoD to publish clinical practice guidelines and to restructure pain management protocols, recognizing that the responsibility for care often falls on the primary care physician while specialty support in the form of multidisciplinary pain management clinics may be relied upon as well.

Given the challenging nature of understanding pain, how it manifests, and how to best treat it, these have all been laudable initiatives on the part of VA and DoD. But the challenge remains to uniformly and effectively translate all of these efforts into practice. Too often we hear the stories of veterans who are prescribed what seems like an assortment of anti-psychotic drugs and/or opioids with very little oversight or follow-up. On the flip side, there are also stories of veterans with enormous pain and doctors who won't consider their requests for stronger medication to manage the pain.

One IAVA family member has expressed tragic exasperation with respect to the VA's current opioid drug usage practices. Her husband, who was prescribed nine different medications to address a range of health issues related to pain, anxiety, and depression, tragically passed away from what was labeled an accidental overdose by

the coroner. Since then, his widow has been fighting to include overmedication by the VA on his death certificate. The VA's response in this case has been to blame the widow, saying simply that she was trained to be a caregiver. But while she was indeed trained to provide care and assistance for her husband, that training did not include medication management.

In a similar case highlighted last month by CBS, a veteran with five tours of duty in Iraq and Afghanistan received a treatment plan from the VA with a total of eight prescriptions. When he was prescribed a ninth drug by the VA, he took the medicine as instructed. The next morning he was found by his wife; his death was classified as an accidental death due to overmedication.

It is not our job to second-guess the judgment of the doctors treating these patients, but it is our job to question the system that is providing overall care to our veterans and tracking this care. It is unacceptable to hear repeated stories like these, but they should drive us to look at the system as a whole and how it can be fundamentally improved.

In part, some of the challenges may be in the inherent differences between the VA and DoD systems of care, whether it be in their available formularies, uniformity of record keeping, use of medical terminology, or the interoperability, or lack thereof, of the medical record systems. Care for our service member and veteran population should involve one integrated approach and a successful pain management program requires a seamless transition between VA and DoD providers.

But beyond that, once a veteran is received into the VHA system, it's not just about putting out policies, clinical practice guidelines, and funding research. At the end of the day, the success will be seen in how those products are implemented into practice and how they are continually assessed for effectiveness. The key will be in education, integration, and assessment.

We can advance our knowledge of pain and pain management all we want, but it won't do our veterans any good if VA cannot efficiently and effectively integrate these findings into their management practices and have a plan in place to continually improve upon accepted practice with evidence-based findings.

Mr. Chairman, we again appreciate the opportunity to offer our views on this important topic and we look forward to continuing to work with each of you, your staff, and this subcommittee to improve the lives, health, and livelihoods of veterans and their families.

Thank you for your time and attention.

1 Dr. Jacqueline Maffucci, IAVA's Research Director, holds a Ph.D. in neuroscience from the University of Texas at Austin. She previously worked with Army staff and senior leaders to develop, implement, and monitor research programs and opportunities to address the health and wellness needs of service members.

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**NATIONAL ASSOCIATION FOR ALCOHOLISM AND DRUG ABUSE
COUNSELORS**

Pain Management Programs and the Use of Opioids to Treat Veterans

Current evidenced-based practice is supported through research and application showing that medication assisted treatment can be an effective means of treating individuals with opioid addiction.

NAADAC, the Association for Addiction Professionals, does not discount the significant positive medical uses of opioids to treat pain; however, NAADAC remains deeply concerned by the trend that has rendered opioids as the first choice for pain management by doctors. Behavioral therapeutic intervention, used in conjunction with medication assisted treatment, is far more effective in managing pain, as well as treating addiction, in terms of increasing the prospects for long-term recovery.

Given the inherent risk of dependence precipitated by opioids, NAADAC fully recommends that all non-opioid treatment options be explored before opioids are prescribed. In other words, NAADAC more strongly urges and supports the use of other clinical techniques and therapeutic interventions before the use of opioid administration for pain management.

Many veterans have been exposed to the use of prescription medication while serving in Afghanistan and Iraq and other service related involvement. In fact, it has been estimated that between 20 - 25 percent of troops stationed in these war zones have received prescriptions for sleep, anxiety, and depression, among some of the more prevalent issues being addressed. There is concern that the treatment community is creating a pill culture because of the large numbers of prescriptions being issued by the Departments of Defense and Veterans Affairs. This uptick in prescribed medication will continue to cause a higher likelihood of diversion incidences.

NAADAC would endorse and support a recommendation that all prescribers of pain and psychotropic medications be required to receive education and training in addictive disorders. This increased knowledge of the addiction process and evidenced-based therapeutic interventions, in addition to medication assisted treatment, would go a long way towards stemming the ever-increasing tide of overprescribing opioids before considering other options in pain management treatment.

“NAADAC’s Mission is to lead, unify, and empower addiction focused professionals to achieve excellence through education, advocacy, knowledge, standards of practice, ethics, professional development and research.” - NAADAC Mission Statement

NAADAC, the Association for Addiction Professionals, is the largest membership organization serving addiction counselors, educators and other addiction-focused health care professionals, who specialize in addiction prevention, treatment, research and education. With more than 9,000 members and over fifty affiliates, NAADAC’s members work to create healthier individuals, families and communities through prevention, intervention, treatment, continuing care and recovery support. NAADAC promotes excellence in care by promoting the highest quality and most up-to-date, science-based services to our addiction professionals and the clients, families and communities they serve. NAADAC does this by providing education, clinical training and certification. In the last eight years NAADAC has credentialed more than 15,000 counselors, playing an important role in sustaining quality health care services and protecting the well-being of the public.

WOUNDED WARRIOR PROJECT

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project to offer a perspective on VA treatment of veterans experiencing acute and chronic pain, and for convening a hearing on this very important subject.

Working with this generation of wounded, injured and ill veterans, we at Wounded Warrior Project (WWP) see daily the devastating impact of pain resulting from polytrauma and in-theater injury. In WWP’s surveying nearly 27 thousand wounded warriors this year, 63% of survey respondents had been hospitalized as a result of

their wounds or injuries,¹ with some 68% having suffered blast injuries and 17% bullet or shrapnel wounds.² Most of these warriors live with pain. In fact, two-thirds of the nearly 14 thousand respondents said they had moderate, severe, or very severe bodily pain.³ Some 80% said their pain interferes with work; among them, 30% said pain interfered with work “extremely” or “quite a bit.”⁴

Pain is the most frequent reason patients seek medical care in the United States.⁵ In general, studies of VA patients show that the pain veterans experience is significantly worse than that of the general public and is thought to be associated with greater exposure to trauma and psychological stress.⁶

Our troops’ post-9/11 combat experience is adding new chapters to medicine’s understanding of pain and pain-management. As is well understood, large numbers of combatants have survived polytraumatic injuries in Iraq and Afghanistan because of remarkable advances in modern military medicine and transport. But these warriors are at high risk of developing unremitting pain. Early study indicates that the prevalence of pain in soldiers with polytrauma is as high as 96%, and that high percentages of those suffering polytrauma experience pain-related impairment in physical and emotional function.⁷ (As we are learning, polytrauma pain is inherently complex, as multiple pathways may be affected, to include acute pain associated with surgery, centralized pain associated with spinal cord injury, headache due to traumatic brain injury, neuropathic pain due to nerve injury, and phantom pain associated with amputation.⁸ Post-traumatic stress disorder and traumatic brain injury, the largely invisible “signature wounds” of the war, not only have the effect of increasing warriors’ pain but of complicating treatment. As we heard from one VA psychologist at a tertiary VA medical center in the Midwest, “[Pain issues are] a MAJOR problem that seriously and negatively impact mental health care, and make my job a lot harder.”

While treating pain is one of medicine’s oldest challenges, “pain medicine” is a relatively new and evolving medical specialty.⁹ The Veterans Health Administration has certainly played an important role in attempting to develop a systematized approach to managing pain, beginning in 1998 with the formulation of a national pain strategy. VHA promoted the concept of “Pain as the 5th Vital Sign” in order to provide consistency in pain-assessments throughout the health care system. The initiative recognized the complexity of chronic pain management, especially for patients whose pain was compounded by PTSD, combat injuries, and substance use, and recognized further that such management was often beyond the expertise of a single practitioner.

Taking account of an earlier Inspector General finding that the extent of VA’s implementation of its national pain strategy had varied and that more work had been needed,¹⁰ Congress in 2008 directed VA to develop and implement a comprehensive policy on the management of pain experienced by VA patients.¹¹ In apparent response to the law, VHA in October 2009 published a directive on pain-management to provide policy and implementation procedures for improving pain management and to comply with generally accepted pain management standards of care. This directive reiterated that pain management is a “national priority,” a priority first articulated in the initial 1998 national pain strategy. The 2009 directive not only established a “stepped care” continuum model – beginning with primary care and advancing to timely access to interdisciplinary specialty consultation and collaboration, and finally to tertiary, interdisciplinary care requiring advanced diagnostics and

¹ Franklin, et al., 2013 Wounded Warrior Project Survey Report, 16 (July 23, 2013).

² Id., 22.

³ Id., 42.

⁴ Id., 42.

⁵ Office of the Army Surgeon General, Pain Management Task Force Final Report, “Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families,” E-1 (May 2010) . <http://www.dvcipm.org/files/reports/pain-task-force-final-report-may-2010.pdf/view>. Accessed October 1, 2013.

⁶ Id., 1.

⁷ War on Pain: New Strategies in Pain Management for Military Personnel and Veterans. (June 2011). Federal Practitioner. (28,2). Pg. 8.

⁸ Id., 8.

⁹ Office of the Army Surgeon General, Pain Management Task Force Final Report, “Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families,” E-1 (May 2010) , <http://www.dvcipm.org/files/reports/pain-task-force-final-report-may-2010.pdf/view>. Accessed October 1, 2013.

¹⁰ Report on the Veterans’ Health Care Policy Enhancements Act of 2008, H. Rep. 110-786 (July 29, 2008), accessed at <http://thomas.loc.gov/cgi-bin/cpquery/T?&report=hr786&dbname=110&>

¹¹ Section 501, Veterans’ Mental Health and Other Care Improvements Act of 2008, Public Law 110-387 (October 10, 2008)

CARF-accredited pain rehabilitation programs. Among its objectives, the national strategy is to create system-wide care standards for pain-management; establish skills in pain management; ensure performance of timely, regular and consistent pain-assessments in all VHA settings; and provide for an interdisciplinary, multi-mode approach to pain management that emphasizes optimal pain control, improved function, and quality of life. VISN directors are responsible for ensuring that all facilities establish and implement pain management policies consistent with the directive, and facility directors are responsible for meeting the objectives of the strategy, for fully implementing the stepped model of care, and for meeting the strategy's standards of pain care.¹² (In addition to this framework, VHA and DoD counterparts developed clinical practice guidelines for management of opioid therapy for chronic pain. The guidelines, first published in 2003, were intended to improve pain management, quality of life and quality of care. The guidelines were updated in May 2010 to reflect evidence-based practice.¹³)

Viewed as a statement of policy and an implementation directive, the National Strategy directive is praiseworthy. But the measure of such an initiative is the reality on the ground – more specifically, what is the experience of veterans who live with often-chronic pain?

Over the past week, we have engaged key WWP field staff from around the country to understand the VA pain-management experience of warriors with whom they work on a daily basis. The accounts they provided us reflect their engagement with warriors at dozens of VA medical facilities across the country. We have also interviewed a number of warriors (among them WWP staff) who have struggled with chronic pain to understand their experience directly, following up on a pain-management roundtable we convened two years ago. Several themes emerged. Notwithstanding a strategic objective of systemwide standards of care, the picture is one of variability of experience – from medical center to medical center, and even from warrior to warrior. Despite a policy directive that addresses implementation-procedure and establishes levels of responsibility, VHA does not appear to be proactively working to enforce its pain-management policies. And while VHA does have valuable resources with which to support implementation of pain-management strategies, inadequate training of clinicians and staff play a role in their not being used.

A starting point in managing a patient's pain is surely a full, competent pain assessment, and the national strategy directive identifies the performance of appropriate timely pain assessments consistently across the continuum as a core objective. Primary care is identified as a first step in that continuum, and when "a competent primary care provider workforce (including behavioral care)" cannot manage a pain condition, timely access to specialty consultation (step two) is required. The experience of our warriors suggests, however, that the fundamental objectives associated with these first steps are often not met. Specifically, our on-the-ground staff shared the following observations:

- Rather than being provided a full pain assessment, the common primary care experience is that a brief examination is provided and the remainder of the appointment is devoted to inputting (or updating) medication prescriptions. Staff report that "Medications are given with no treatment plan or direction other than 'take the medications.'"
- A senior benefits specialist on our team told us that "when I review medical records for veterans and see that they are on extensive pain medication I always ask if they have been referred to pain management for an assessment. The answer is usually 'no.'"
- A full pain assessment would include a review of a patient's electronic medical records (to include records of earlier treatment at other VA facilities) to better understand their pain care needs. That information is also vital to ensure that medications and techniques will be efficacious for a given veteran and that previously-failed approaches will not be re-instituted, as well as to avoid prescribing medications that may exacerbate underlying psychological or neurological conditions. Notwithstanding the importance of such review, patients frequently find that clinicians do not use VISTA to pull remote data and/or other pertinent and often critical prior medical records. (It was observed, in that regard, that "VA has a 'Cadillac e-record system,' but many clinicians and staff 'don't know how to drive it,' reflecting deficiencies in training and adherence to standards.)

¹² Department of Veterans Affairs, VHA Directive 2009–053 (October 28, 2009).

¹³ Department of Veterans Affairs and Department of Defense, Clinical Practice Guidelines: Management of Opioid Therapy for Chronic Pain (May 2010).

- Primary Care Managers routinely fail to present veterans with pain-relief options that are available and recommended for those presenting with chronic pain.
- The reality is that primary care is generally a hurried experience that does not allow time for questions, for development of a treatment plan, or for discussion of the appropriate time-frame for any particular pain treatment before consideration of trying something new.
- The primary care provider will send out requests for additional treatment, but those requests are not necessarily followed up. Specifically, warriors experience a lack of follow-through within the VA Medical Centers for setting up requested medical appointments and/or routine care follow up appointments. Compounding this frustration, the patient has no way to reach the provider, doctor or nurse without physically having an appointment.

Reliance on and monitoring of the use of opiate medication is, of course, an area of particular concern, and requires delicate case-by-case consideration. Understanding how variable care can be from facility to facility, we do not suggest that our teammates' observations necessarily describe consistent systemwide practice. At the same time, the observations of WWP staff from around the country strongly suggest that the following scenarios they have described are not at all uncommon:

- Narcotic medications are provided regularly with no treatment plan. These medications are provided on six-month intervals without follow up, and can be filled using the online system or over the telephonic system. These are shipped directly to the warrior's home.
- Illustrative of that experience, a benefits-specialist on our staff described having gone to a VA medical center to have a prescription for Tylenol 3 filled. He stated that the medication had worked in managing pain associated with his collapsed discs in his upper back and herniated discs in his lower spine. He reported that "I went to the pharmacy and was waiting for an hour. When I asked what was the hold-up, I was told they had to get the prescription from the locked cabinet where they kept the opiates. I was told that Tylenol 3 is not on the formulary and they had substituted oxycontin. Bottom line: I asked for a 'hand grenade,' they gave me an 'A-Bomb.'"
- If, on the other hand, warriors ask for narcotic medications they are most often not given them.

Describing his own experiences as well as those of other warriors with whom he has worked at a number of VA medical facilities across the country, one of our staff offered the following perspective:

"From my own experiences and of those relayed to me by my fellow wounded warriors, VA facilities vary wildly in how they approach pain management. Overlooking potential complications with their referrals seems to be a common mistake and often the assessments are not comprehensive. VA pain-management practices for warriors with polytrauma have been incredibly inconsistent, generally unsuited for a full recovery, and have not taken into account the warrior's other issues (such as PTSD). The system seems to operate completely on 'easy fixes' by overprescribing. I know several warriors who have become addicted to opiates as a result of mismanaged treatment plans and even turning to street drugs. One Marine I served with who was injured in 2005 has overdosed on prescribed medications, turned to heroin because of his addictions, and to this day relies on a VA referred methadone clinic. I have never heard of non-pharmaceutical options being offered directly, only of them being brought up by the warriors themselves to their physician. Despite resources for alternative treatments, I have not known the VA to directly point the warrior to them."

VHA's national pain management strategy reflects the important understanding that quality of life is a standard outcome measure of treatment effectiveness, including the treatment of pain. Consistent with that view, we applaud the emphasis the national strategy directive places on individualized plans of care – even as we convey our disappointment that the evidence we have compiled calls into question how much progress VA has made in instituting such individualized pain-care plans. As noted in the directive, however, one important element in such plans are non-pharmacologic interventions. In asking our field staff, however, how widely complementary therapies are available, we were advised, with two exceptions (one of whom had himself been prescribed acupuncture and massage therapy for severe back pain) that none was aware of any instance in which complementary therapies such as acupuncture or yoga had been offered.

While we see abundant evidence that there remain wide gaps in realizing the first two steps of the national strategy's stepped-care model, its third step – providing tertiary, interdisciplinary care may be even more distant. To the best of our knowledge, the Chronic Pain Rehabilitation Program at James A. Haley Veterans Medical Center (Tampa, FL) is the only VA program that currently meets the pain center criteria and is CARF-accredited. With chronic pain so widespread a concern among veterans, and particularly among our wounded warriors, it is difficult to understand so limited a deployment of tertiary resources.

Accounts of the experiences of warriors with whom we work underscore that much more progress must be made:

Toby Snell, a Marine from Washington state, sustained severe injuries from a car bomb in Iraq in 2006 and shared his story with WWP:

Toby was originally prescribed Vicodin by the Navy, which did not work for pain. Upon leaving the Marines, the VA again prescribed Vicodin despite his objections. He was referred to the Pain Management Clinic in the late 2007-early 2008 time-frame. He was told many times the pain was “in his head” but was ultimately prescribed 120mg extended release morphine/day. Medication still did not address his pain.

He was not allowed to see Ortho Surgery per his Primary Care doctor and the Pain Management doctors because he was told there was nothing they could do. He was, however, sent to the University of Washington School of Medicine for a second opinion in 2008, but the doctor there was not authorized to perform any diagnostic testing. As a result, she was unable to assist.

The VA then recommended a combination of morphine and fentanyl, but Toby refused because he was already very “out of it” due to the morphine and it wasn't working. He didn't want to add new meds.

In 2009, Toby self-reduced to 90mg/day with the help of Acupuncture. His Polytrauma doc had been trying to get fee-basis acupuncture for some time but had been denied until the VA hired their own provider.

In the Fall of 2011, the Wounded Warrior Regiment recommended Toby go to Operation Mend at UCLA. Toby finally made it to UCLA in March of 2013 after significant delays from the VA in providing Toby's medical records. Doctors there diagnosed him with significant damage in his sacroiliac joint and were able to conduct a 20 minute procedure to resolve the issue.

Ultimately, Toby wanted to get off of the morphine. A VA nurse told him that the only thing she could recommend was a “prison-like” detox facility intended for substance abusers.

Toby approached his VA Primary Care doctor who wanted to help, but clearly stated that he did not have experience in this field. The doctor recommended a slow/gradual approach but offered no additional specific guidance. As much as this doctor seemed to want to help, he was just not equipped to assist.

Over a 6 week period, Toby self-reduced from 90mg/day to 0mg/day. In the last few days/weeks, he was sick to his stomach and ultimately had to take other meds to control his nausea. At no point did the VA proactively assist in this process.

Ideally, Toby would have wanted them to treat the root cause of the pain rather than just trying to medicate. Additionally, at the time of the detox, he would have much preferred to be admitted to an “appropriate” in-patient facility that could have helped to monitor the weaning process as well as its effects on his other injuries (TBI, PTSD).

Each case is, of course, unique. But the profound frustration Toby described mirrors that of other veterans, for whom their battles with pain parallel their battles with seemingly rigid barriers encountered at some VA facilities.

A warrior in Houston, Brandon Price, for example, coping with back pain from an IED blast and knee pain from a gunshot wound, reported waiting over 3 years to get into a pain management program at the Houston VA. He was told he was ‘too young’ to be experiencing chronic pain and denied consults with the program until he worked with the Medical Center's patient advocate. He finally got into the program in Spring of 2013, but was told because of his delay in getting appropriate pain management care, he would have to go back to primary care to treat the severe muscle tension that was impairing their ability to treat his back pain. He will not be seen again in the program until January of next year. In the meantime, his primary care team try to help all they can and he appreciates their work, however they do not have the resources and expertise to treat his severe pain. In addition, they are not allowed to prescribe any narcotic pain medication, so even if it would be appropriate for treating his pain, he would have to wait to be seen again by the pain management program for such a prescription.

Our warriors' experiences and the observations of our teammates across the country do raise serious questions. What steps, for example, have been taken to address systems issues that may impede realization of pain-management policy goals?¹⁴ The gap between policy and practice, however, raises even broader questions. What, for example, does it mean for the Veterans Health Administration to describe pain management as a "national priority?" Given that declaration of "national priority," the recognition that the practice of pain-management in this country has been widely variable,¹⁵ and VA's important role in the education and training of a large percentage of our physician workforce, is there not a high burden on senior VHA leadership to ensure that the letter and spirit of its pain-management policy is actually implemented across the system? Does the term "priority" actually hold meaning, in an operational sense? Indeed, one might even ask whether the Veterans Health Administration has characterized so many subjects as "priorities" that it has become difficult to make any issue a real priority!

We pose these questions as an organization that works with and advocates for those whose sacrifices are immeasurable and to whom this country owes a profound debt that must include provision of timely, effective care for and rehabilitation of service-incurred wounds, injuries and illnesses. We do not suggest that managing chronic pain in warriors who, for example, have suffered polytrauma is easy or necessarily susceptible of resolution in a primary care clinic. Nor – to cite another critical challenge VHA has identified as a priority—is it necessarily easy to provide timely, effective mental health care to warriors who struggle with PTSD and often co-occurring behavioral health issues. But these surely must be real priorities – obligations that must be met ahead of others and met fully—for a health care system dedicated to the care of veterans.

These concerns lead us to urge this committee to continue to press VHA to make much more progress in the area of pain-management, but also to re-establish what the term "priority" means for the Veterans Health Administration, and to exercise whatever tools are needed to realize those highest priorities. They begin, in our view, with wounded warriors and their optimal timely care and rehabilitation. To fail to meet that obligation is, in our view, to fail all veterans.

VIETNAM VETERANS OF AMERICA

Chairman Benishek, Ranking Member Brownley, and Distinguished Members of the House Veterans' Affairs Subcommittee on Health, on behalf of President John Rowan, our Board of Directors, and our membership, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our statement for the record re: the Department of Veterans Affairs (VA) pain management programs and the use of medications, particularly opioids to treat veterans experiencing acute and chronic pain.

Our veterans, returning from two protracted wars, deserve the very best. Most agree that includes access to jobs, education, affordable housing, quality health care, and equal opportunity employment opportunities. After defending our freedom overseas, our soldiers, sailors, airmen and Marines are clearly facing a crisis at home. We need to ensure that those who have taken care of us abroad are taken care of once they transition back to civilian life.

One area that is often overlooked is the proper diagnosis and treatment for veterans suffering from chronic pain. While millions of Americans suffer from chronic pain, many are veterans who brought the unfortunate souvenir back from war. Despite the media attention given to post-traumatic stress disorder (PTSD), the number one malady suffered by America's active duty military personnel is musculo-

¹⁴The Report of (VA) Consensus Conference: Practice Recommendations for Treatment of Veterans with Comorbid TBI, Pain and PTSD (January 20, 2010) cited the need to support clinicians who provide interdisciplinary care, noting that "there is no consistent workload credit given to clinicians who take the time to manage or review cases with other providers" and the need for such credit to promote coordinated, collaborative care. The report also cited the importance of encouraging and offering incentives to providers to follow clinical practice guidelines regarding the use of non-formulary medications, noting the need for a "by-pass' around the sometimes complex non-formulary approval process" and the lack of a standardized protocol for such review and approvals. See Report at <http://www.ptsd.va.gov/professional/pages/handouts-pdf/TBI-PTSD-Pain-Practice-Recommend.pdf>.

¹⁵Office of the Army Surgeon General, Pain Management Task Force Final Report, "Providing a Standardized DoD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families." E-1 (May 2010) , <http://www.dvcipm.org/files/reports/pain-task-force-final-report-may-2010.pdf/view>. Accessed October 1, 2013.

skeletal. Given the number of physical injuries often experienced by troops, it is not surprising that chronic pain is a frequent problem among returning military personnel from Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF). Common sources of chronic pain for these troops are in the head (traumatic-brain injury or TBI) or post-concussion syndrome, legs (fractures, amputations), burns, shoulders, back, and knees. Other physical injuries include spinal-cord and eye injuries, as well as auditory trauma.

According to a May 2011 study by the American Pain Society, about nine in 10 Iraq and Afghanistan veterans who registered for care with the Department of Veterans Affairs are experiencing pain. More than half of these veterans have significant pain, the study asserted. In raw numbers, of the 291,205 who enrolled for VA health care between October 2003 and December 2008, 141,029 received a diagnosis of a painful condition not caused by cancer.

It's no secret that the best way to treat chronic, severe pain is by keeping it under control all the time, and for severe pain, the World Health Organization recommends strong opioids such as hydrocodone, as well as other such medications called adjuvant therapies, as needed for the particular kind of pain. In fact, a paper published in the March 7, 2012 *Journal of the American Medical Association* described the pattern of opioid prescription for returning OIF/OEF vets. Of the 291,205 who enrolled for VA health care between October 2003 and December 2008, 141,029 received a diagnosis of a painful condition not caused by cancer; and of that number, 15,676 received a prescription of an opioid drug that lasted at least 20 days.

And now in October 2013 we learn that the death rate from overdoses of such drugs at VA hospitals is twice the national average while the data also show the VA continues to prescribe increasing amounts of narcotic painkillers to many patients. Prescriptions for four opiates—hydrocodone, oxycodone, methadone and morphine—have surged by 270 percent in the past 12 years, according to data from the Center for Investigative Reporting (CIR) obtained through the Freedom of Information Act. CIR's analysis exposed the full scope of that increase, which far outpaced the growth in VA patients and varied dramatically across the nation among VA hospitals.

And chronic pain is not limited to America's newest generation of military personnel. It is also a significant malady among our older veterans, especially Vietnam veterans suffering from PTSD, hepatitis C, and those exposed to the herbicide Agent Orange. Given these morbidities, it may not be surprising to see a higher frequency of prescription opioids for these vets. Other common chronic pain complaints often include headache, low back pain, cancer pain, arthritis pain, neurogenic pain (pain resulting from damage to the peripheral nerves or to the central nervous system itself), psychogenic pain (pain not due to past disease or injury or any visible sign of damage inside or outside the nervous system). Frequently these veterans have two or more co-existing chronic pain conditions, including chronic fatigue syndrome, endometriosis, fibromyalgia, inflammatory bowel disease, interstitial cystitis, temporo-mandibular joint dysfunction, and vulvodynia. In addition, research suggests these chronic pain patients complain of cognitive impairment, such as forgetfulness, difficulty with attention, difficulty completing tasks, impaired memory, mental flexibility, verbal ability, speed of response in a cognitive task, and speed in executing structured tasks.

We can help veterans, both young and older, by ensuring they have access to improved treatments and medications to better manage their chronic pain. The fact is every person experiences pain differently and responds to treatments in different ways. Whether the pain stems from head trauma, spinal-cord and eye injuries or an amputation, there must be a variety of options available to treat the unique symptoms our veterans are experiencing. But the rise in prescription drug abuse threatens to stifle these options for fear of the further spread of abuse and misuse. We must not let that happen.

Make no mistake, prescription drug abuse is a major concern within the veteran community and VVA supports proactive measures to educate veterans of this threat and to encourage responsible prescribing to ensure these medicines stays out of the hands of those who abuse and misuse the drugs. But we cannot allow for the abuse dynamic to restrict veterans' access to the highest quality medications and treatments needed to relieve their pain.

Prescription medicines are not the only solution for every veteran. But for those who need them, they are critical. Together we can ensure our warriors can live long and productive lives, even if they have to manage pain. Access to quality health care and new options for treatment will protect the next generation of Americans coming back from war from experiencing the same challenges of past generations.

Whether a veteran has been wounded in combat, has experienced a non-battle injury, or is currently working through a recovery, chronic physical pain has the potential to play a significant role in their rehabilitation and reintegration process. In fact, managing the psychological and emotional effects of chronic pain can be just as challenging as the pain itself. Let us not stand in the way of our heroes fulfilling their dreams.

Vietnam Veterans of America

Funding Statement

October 10, 2013

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For further information, contact: Executive Director of Policy and Government Affairs, Vietnam Veterans of America. (301) 585-4000, extension 127

AMERICAN PSYCHIATRIC ASSOCIATION

On behalf of the American Psychiatric Association (APA), the medical specialty society representing over 35,000 psychiatric physicians and their patients nationwide, I welcome the opportunity to submit a statement for the record regarding the October 10th House Veterans Affairs' Subcommittee on Health hearing, "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Pain-killers to Treat Veterans."

The APA has for several years stressed the need for funding and workforce strength to support comprehensive mental health and substance use disorder treatment in the Veterans' Health Administration (VHA). The October 10th hearing highlighted a few issues which the APA has long advocated: improved prescription drug management programs (PDMPs) at the VHA as well as interoperability with state-run PDMPs, training of medical personnel on options for medically assisting substance use recovery, and the urgent need for non-opioid medications to treat chronic pain.

The focus of our statement is the veteran and returning military population, but issues such as medication diversion (taking a relative or friends' medication), medication seeking (doctor-shopping), improper prescribing, inadequate informatics on prescription utilization, and the need for better pain management as well as utilizing medical options to assist with substance use disorders are prevalent for the United States population as a whole.

In 2008, Congress directed the VHA to develop and implement a comprehensive policy on the management of pain experienced by VHA patients. Many VHA facilities are making significant progress on implementing the VA's mandate to improve pain management. In addition to this policy framework, VHA and Department of Defense (DoD) counterparts developed clinical practice guidelines for management of opioid therapy for chronic pain. The guidelines, first published in 2003, were intended to improve pain management, quality of life and quality of care. The guidelines were updated in May 2010 to reflect evidence-based practice. However, challenges still exist to fully implement evidence-based, comprehensive pain management as well as opioid addiction treatment.

Prescription Drug Management Plans (PDMPs)

Prescription Drug Management Plans help to identify and prevent potential misuse of prescription drugs, and assist in avoiding negative health outcomes for VA patients, including emergency treatment and accidental overdose. Thirty-eight states have PDMPs. Within the VHA itself, there is uneven utilization by providers of the VA's own health records program to verify prescription data for patients.

The APA has expressed concern that barriers to quality patient care as well as a patient safety are the limitations in VHA's ability to monitor prescriptions written for veterans outside of the VHA system. Prescription data coordination can assist

VHA physicians in identifying veterans who need intervention and treatment for substance use disorders as well as prevent intentional overdosing by alerting physicians to multiple prescriptions. The APA is encouraged by the Interim Final Rule on the VHA's prescription drug monitoring program effective on February 11, 2013, (VA-2013-VHA-0005-0001), which codified the VA's PDMP. The APA looks forward to the VHA's PDMP system's interoperability with state-run PDMPs. We note, however, that there are no national standards for state PDMP information sharing and interoperability between states is a hurdle to overcome.

Therefore, the APA respectfully requests that the VA enhance its collaboration with the Department of Justice, Department of Health and Human Services and state Attorneys General to expedite interoperability of the VA PDMP with state PDMP programs using the prescription monitoring information exchange (PMIX) computer architecture.

Recruitment and Retention of Psychiatrists

VHA Deputy Undersecretary Robert Petzel, M.D., stated in January 2013 before the House Veterans' Affairs Committee that the major workforce barrier to mental health and substance use treatment was the VHA's difficulty in hiring and retaining psychiatric physicians. Congressional testimony given by current and former psychiatric physicians in the VHA highlights non-competitive pay, uneven training, and long hiring processes as key barriers to developing and maintaining a robust psychiatric workforce.

The APA strongly encourages the VHA to further adjust the pay tables for psychiatric physicians to more accurately reflect the acuity of VHA need as well as to redress the imbalance that occurs when newly hired psychiatrists have compensation packages that are not aligned with the compensation of career VHA psychiatrists with years of experience and training. Such redress may improve the retention issues at VHA.

Recruitment of psychiatrists as specialty physicians remains an issue at the VHA. According to USAjobs.gov on September 17, there were 142 federal job vacancies for psychiatrists listed, of which 138 were for the VHA; 128 positions were for permanent hires. Of the 128 vacant full-time positions, only 33 (25%) were even eligible for medical school loan repayment under the VHA's Education Debt Reduction Programs (EDRP) program. Even if a VHA physician position is eligible for loan repayment, eligibility does not confer actual loan repayment. Under the EDRP program, a psychiatrist must apply for medical school loan forgiveness within six months of his or her hire date. VHA's HR departments are all too often unaware of this six-month stipulation, rendering some psychiatrists ineligible.

The APA is developing a recruitment and retention workforce proposal for psychiatrists at the VHA that would establish a medical school loan forgiveness program similar to that provided by the U.S. Army. The proposal would be a time limited opportunity to increase the number of psychiatrists in the VHA and would also require a VHA study on its impact. We look forward to working with Congress to enact this and related proposals to increase the supply of psychiatrists providing care to our nation's veterans.

Training the VHA Workforce: pain management and addiction treatment

Two issues overarch the VHA's nationwide ability to meet its Congressional mandate to provide comprehensive pain management services to our nation's veterans: evidence-based prescribing and pain management techniques for all veterans and enhanced availability of opioid-dependence treatment for those struggling with addiction.

The utilization of pain medication without benchmark pain assessments and accompanying treatment plan is inconsistent with good medical practice. Of particular concern is the prescription of multiple pain medications to veterans with multiple medical issues. Data suggest that some veterans with Post Traumatic Stress Disorder (PTSD) experience pain at a more intense level than their counterparts without PTSD. Veterans are subject to unique risk factors involving the misuse of prescribed controlled substances (Karen H. Seal et al., "Association of Mental Health Disorders With Prescription Opioids and High-Risk Opioid Use in US Veterans of Iraq and Afghanistan," 307 JAMA 940 (2012)). Many veterans being treated for opioid dependence also have co-occurring diagnosis such as depression or anxiety. Treatment of these co-occurring illnesses only underscores the need for more psychiatrists in the VHA.

Academic detailing or enhanced pharmacologic training provided by physicians to VHA medical personnel regarding evidence-based for treatment of pain and opioid dependence is necessary throughout the VHA. Certain Veterans Integrated Service Networks (VISNs), such as VISN 20, 21 and 6 have implemented short, in-service

training programs to change providers' practices in prescribing pain medication, particularly for those patients with co-occurring PTSD and depression.

All too often, veterans (and other Americans) take prescription pain medication for orthopedic or nerve injuries and become addicted to or dependent on opioid medications used for pain. For opioid-addiction treatment options, the APA strongly encourages the utilization of and more trained physicians, particularly by psychiatrists who are specially trained, in the use Suboxone and Buprenorphine in opioid-dependence treatment. These medications act as 'opioid antagonists' and can assist in the supervised withdrawal from opioids. The APA is a partner organization in two clinical mentoring and education initiatives funded by the Substance Abuse and Mental Health Services Administration (SAMHSA): Physicians' Clinical Support System-Buprenorphine (PCSS-B) and the Prescribers' Clinical Support System- Opioid Therapies (PCSS-O). Through the SAMHSA-funded grant, the APA has produced a series of webinars focused on the use of opioid therapies for treatment of opioid dependence and on the safe use of opioids in the treatment of chronic pain. The free webinars are available for psychiatrists, physicians of other specialties, other prescribers, residents, and other interested clinicians. Webinar recordings are available on this site. www.pcspb.org/educational-and-training-resources/special-topics and include:

- The Use of Buprenorphine to Treat Co-occurring Pain and Opioid Dependence in a Primary Care Setting
- Learning the Evidence Behind Alternative/Complementary Chronic Pain Management – Emphasis on Chronic Low Back Pain
- Patterns of Opioid Use, Misuse, and Abuse in the Military, VA, and US Population
- Enhancing Access to PDMPs Through Health Information Technology
- Identifying and Intervening With Problematic Medication Use Behaviors
- Assessing and Screening for Addiction in Chronic Pain Patients
- Psychological Management and Pharmacotherapy of Patients with Chronic Pain and Depression, Schizophrenia, and Post Traumatic Stress Disorder (PTSD)

Research on New Pain Medications

Federal agencies are currently involved in the development of new pain medications and methods to treat pain. The National Institute of Drug Abuse (NIDA) has been at the forefront of biomedical exploration. NIDA has, through an established testing program involving contract and grant mechanisms, developed several opiates pharmacotherapies that have been approved for use (Buprenorphine, Buprenorphine/Naloxone). Through interaction with leading substance abuse experts in academia, the pharmaceutical industry, and the Food and Drug Administration, NIDA has developed standardized outcome measures and success criteria for clinical pharmacotherapy trials, established clinical algorithms and standards for the conduct of exploratory clinical concept studies; human drug interaction studies; and Phase I, II, and III safety and efficacy studies. The Department of Defense, Veterans' Administration and the National Science Foundation are other major federal agencies investigating new pain medications and treatment.

The APA has vigorously supported enhanced federal research to encourage the development of a new class of pain medications that would not have the same potentially addictive effects as long term use of opioids. Sustained, robust federal investment must be a national priority in order to make significant progress on inventing novel medications and developing new mechanisms – biological or chemical - to control pain. NIDA's Clinical Trials Networks are currently testing on a few molecules of interest.

Pain management, addiction detection and effective treatment are significant priorities for our nation's veterans. These objectives require the better coordination of opioid and benzodiazepine prescribing inside and outside the VHA. We strongly support robust research and more training throughout VHA medical personnel of the uses of medications such Suboxone and Buprenorphine to assist in the treatment of addiction, along with the development of new non-opioid medications to treat pain. Above all, we believe that access to a well-trained workforce grounded in the highest quality care and respect for veterans and their families is of paramount importance. We stand ready to assist you in achieving these goals.

The APA appreciates the opportunity afforded by Chairman Benishek and Representative Brownley to provide this statement on behalf of its members. Should you have any questions or need further information, please do not hesitate to contact my staff, Lizbet Boroughs, at (703) 907-7800 or lboroughs@psych.org.

Sincerely,

Saul Levin, M.D., M.P.A.
CEO and Medical Director
American Psychiatric Association

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