

VA EFFORTS TO PREVENT AND COMBAT OPIOID OVERMEDICATION

HEARING BEFORE A SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE ONE HUNDRED FIFTEENTH CONGRESS FIRST SESSION

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VA EFFORTS TO PREVENT AND COMBAT OPIOID OVERMEDICATION

WEDNESDAY, NOVEMBER 15, 2017

SUBCOMMITTEE ON MILITARY CONSTRUCTION,
VETERANS AFFAIRS, AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 2:33 p.m. in room SD-124, Dirksen Senate Office Building, Hon. Jerry Moran (chairman) presiding.

Present: Senators Moran, Murkowski, Hoeven, Collins, Boozman, Capito, Schatz, Leahy, Tester, Udall, Baldwin, and Murphy.

OPENING STATEMENT OF SENATOR JERRY MORAN

Senator MORAN. Good afternoon. The subcommittee will come to order. I'm very interested and pleased that we're having this hearing. Senator Baldwin as well as Senator Capito were instrumental in encouraging me, although Senator Baldwin went through everybody I know to tell me I should do this.

[Laughter.]

Senator MORAN. I'm glad that I agree with all of them.

It worked. And this is a timely topic, timely all the time, but especially now. And so we're pleased to have our eighth subcommittee hearing of this year, and we want to have a conversation and a discussion about pain management at the Department of Veterans Affairs, and particularly how to prevent the overprescription of opioids.

In 2018, veterans were twice as likely—I'm sorry, 2011, veterans were twice as likely to die from accidental opioid overdose than non-veterans. In 2013, prescriptions for opioids increased by 270 percent over just 12 years, and the VA reported that more than 50 percent of veterans receiving care from the VA medical facilities were affected by chronic pain.

According to more recent data, over 63 percent of veterans receiving chronic opioid treatment from the VA also have a mental health diagnosis.

This subcommittee understands that the Department has been focused on creating and implementing better ways to monitor the prescription and usage of opioid medicines while embracing new and alternative pain management techniques to replace or in conjunction with this medication.

In July of last year, the first major Federal addiction legislation in 40 years, the Comprehensive Addiction and Recovery Act (CARA) was signed into law to address the opioid epidemic in this country. CARA included a bill led by Senators Baldwin and Capito

known as the Jason Simcakoski Memorial and Promise Act, or Jason's Law, named for Mr. Simcakoski's son. Mr. Simcakoski is a witness with us today.

Thank you for joining us.

In addition, the VA has its own opioid safety initiative to promote the safe and effective use of opioid therapy when clinically indicated. Today, we would like to hear from the Department about the progress that has been made in implementing Jason's Law and other initiatives and how this has changed prescribing behavior among clinicians at the VA as well as the rate of opioid use by veterans.

Earlier this summer, the VA Office of Inspector General completed a report on non-VA providers prescribing opioids to veterans, and found that veterans utilizing care outside the VA may be put at a more significant risk due to conflicting prescribing guidelines among different clinical settings, and a lack of information sharing between inside and outside providers in order to accurately maintain health records of the veteran.

According to the Inspector General (IG), non-VA providers, quote, "do not consistently have access to critical health care information regarding the veterans they are treating," unquote. And the inability to monitor opioid prescriptions written by a non-VA clinician and filled by a non-VA pharmacy is a challenge.

I understand that Senators Baldwin and Capito are once again at work to address this issue, and I support their effort. Today, I want the VA Office of Inspector General (OIG) to speak about these findings and how the Department can better serve their patients, particularly as more veterans are choosing to get their care outside the VA in community care.

I wish to thank my colleagues Baldwin and Capito, as I've done, for requesting this hearing, and I look forward to working with them and the other members of this subcommittee and our colleagues to see that we make progress in this regard and that the Department of Veterans Affairs is doing its job as to the best of their abilities.

As Members of Congress, we have no greater responsibility than responding to the need of our constituents, and I am grateful here to have Mr. Simcakoski present to speak directly to us about his experience with the VA. His courage is to be admired, and he is a significant advocate for his son, and his tireless commitment to his son's legacy are the reasons we're holding this hearing today.

I look forward to hearing about Jason's life and your thoughts on how to make the outcomes different for other veterans in the future.

In recent years, this committee has given the Department additional funding specifically for combating opioid abuse, supporting alternative treatments, and researching better methods of pain management. As I mentioned before, I wear two hats, as an appropriator charged with prioritizing the funding of the Department, as well as an authorizer with the ability to improve the laws that govern the VA process. I hope today's hearing facilitates a candid conversation about the improvements that the Department is making and needs to make and how Congress can support you with appropriate funding and needed changes in the law.

[The statement follows:]

PREPARED STATEMENT OF SENATOR JERRY MORAN

The Subcommittee will come to order. Good afternoon. Welcome to our eighth subcommittee hearing of 2017. Thank you all for being here today to discuss better ways to address pain management in the Department of Veterans Affairs and prevent the over prescription of opioids.

In 2011, veterans were twice as likely to die from accidental opioid overdoses as non-veterans. In 2013, prescriptions for opiates increased by 270 percent over just 12 years, and VA reported that more than 50 percent of veterans receiving care from VA medical facilities were affected by chronic pain. According to more recent data, over 63 percent of veterans receiving chronic opioid treatment from VA also have a mental health diagnosis.

This Subcommittee understands that the Department has been focused on creating and implementing better ways to monitor the prescribing and usage of opioid medicines while embracing new and alternative pain management techniques to be used in place of or in conjunction with medication. In July last year, the first major Federal addiction legislation in 40 years, the Comprehensive Addiction and Recovery Act (CARA), was signed into law to address the opioid epidemic in this country. CARA included a bill led by Senators Baldwin and Capito known as the Jason Simcakoski Memorial and Promise Act or Jason's law, named after Mr. Simcakoski's son. Mr. Simcakoski, thank you for being here with us today. In addition, VA has its own Opioid Safety Initiative to promote the safe and effective use of opioid therapy when clinically indicated.

Today, we would like to hear from the Department about the progress you have made implementing Jason's law and other initiatives, and how this has changed prescribing behavior among clinicians at VA as well as the rates of opioid use by veterans.

Earlier this summer, the VA Office of Inspector General completed a report on non-VA providers prescribing opioids to veterans and found that veterans utilizing care outside VA may be put at significant risk due to conflicting prescribing guidelines among the different clinical settings and the lack of information sharing between inside and outside providers in order to accurately maintain the health records of veterans. According to the Inspector General, non-VA providers "do not consistently have access to critical healthcare information regarding the veterans they are treating," and the inability to monitor opioid prescriptions written by non-VA clinicians and filled by non-VA pharmacies is a challenge. I understand that Senators Baldwin and Capito are once again at work to address this issue, and I support their effort. Today, I want VA OIG to speak about these findings and how the Department can better serve their patients, particularly as more veterans are choosing to get their care out in the community closer to home.

I wish to thank my colleagues Senators Baldwin and Capito for requesting we hold this hearing. You both have been champions uncovering issues within your local VA communities on this topic and also working with the Department to improve how it manages care. Thank you for commitment to making positive changes for our veterans.

As Members of Congress, we have no greater responsibility than responding to the needs of our constituents. I am grateful today to have Mr. Marvin Simcakoski present to speak directly to us about his experience with VA. Mr. Simcakoski's courage to be an advocate for his son and his tireless commitment to his son's legacy are the reasons we are holding this hearing today. I look forward to hearing about Jason's life and your thoughts on how to make sure outcomes are different for other veterans in the future. Thank you again for being here.

In recent years this Committee has given the Department additional funding specifically for combating opioid abuse, supporting alternative treatments, and researching better methods of pain management. As I've mentioned before, I wear two hats—as an appropriator charged with prioritizing the funding of the Department and as an authorizer with the ability to improve the laws that govern VA's processes. I hope today to facilitate a candid conversation about improvements the Department is making and needs to make, and how Congress can support you with appropriate funding and needed changes to the law.

I'd like to introduce our panel:

From the Department of Veterans Affairs: Dr. Laurence Meyer, M.D., Chief Officer for Specialty Care, and Dr. Friedhelm Sandbrink, M.D., Acting National Program Director for Pain Management; and also, the Honorable Michael L. Missal, Inspector General at the Department of Veterans Affairs; and Mr. Marvin Simcakoski

from Stevens Point, Wisconsin. He is the father of the late Jason Simcakoski, the namesake of the Jason Simcakoski Memorial and Promise Act passed last year.

Senator MORAN. I now turn to my colleague and the ranking member of this subcommittee, Senator Schatz.

STATEMENT OF SENATOR BRIAN SCHATZ

Senator SCHATZ. Thank you, Mr. Chairman.

And thank you to our witnesses for appearing before the subcommittee today to discuss VA's efforts to address the opioid epidemic. I want to especially recognize Senators Baldwin and Capito for asking for this important hearing.

There is no question that opioids are fueling a public health emergency. As the IG reported in July, overdose deaths involving prescription opioids have quadrupled since 1999, and this has hit our veterans especially hard. Behind these statistics are the heart-breaking stories of veterans like Marvin Simcakoski's son, Jason.

Last year, Congress took an important step forward on this front when we passed the Comprehensive Addiction and Recovery Act. This bill included Title IX, which is named after Jason Simcakoski, to give the VA clear statutory authority to reduce reliance on opioid medications, particularly in treating chronic pain. This includes establishing safer prescribing and monitoring habits and expanding efforts in complementary and integrative health treatment. I look forward to hearing from Dr. Meyer and Dr. Sandbrink on the status of implementing Jason's Law as well as what more needs to be done.

For example, I'm concerned that under Choice, we lose the ability to track all of the improvements made to address opioids in the VA because more than 35 percent of veterans are going outside of VA for care. We lose the transparency to see exactly how well our adjustments are working. Now, the VA is not alone here. This is a national public health crisis. And so we need more research to figure out how we can better help all patients and providers when it comes to chronic pain.

Last year, I introduced the STOP Pain Act with Senator Hatch, which directed the National Institutes of Health (NIH) to intensify and coordinate research about chronic pain and to develop alternatives to opioids to treat chronic pain. This year, I'm working on legislation for the NIH-directed STOP Pain Initiative, which would put real funding and hundreds of millions of dollars behind these efforts.

I know the VA also has new research and alternative treatment guidelines, and I would like to understand how these efforts can provide support for research into chronic pain and non-opioid alternatives to treat chronic pain.

Thank you, Mr. Chairman.

Senator MORAN. Senator Schatz, thank you very much.

We're pleased to be joined by the vice chairman of the full committee, Senator Leahy, and I recognize you if you have any opening comments.

STATEMENT OF SENATOR PATRICK J. LEAHY

Senator LEAHY. Thank you, Mr. Chairman. I appreciate that. You and I have discussed this before, and Senator Schatz and I

have. There is—every state and every community in the country has been hit with the opioid epidemic. None of us can say we've escaped it. It's hitting sons and daughters and mothers, fathers, friends, coworkers. It is impacting our veterans, our servicemembers.

We have over 16 years of war. We've asked members of our active reserve components to serve what's really an unprecedented number of deployments. We've left too many veterans broken and in pain. When we needed these brave men and women to return to battle, it was very easy just to prescribe opioids for pain management, but that's continuing when they return home. I think the military and the VA lean far too heavily on opioids to manage pain. It's an all too familiar story. Overprescribing opioid medications for chronic pain opens the door to addiction, overdose, suicide risk, and that devastates families and communities.

In 2011, the VA said veterans are twice as likely to die from overdose than the U.S. civilian population. Just think of that, twice as often. We continue to prescribe opioids to veterans and active duty military at an alarming rate. Among veterans, the number of prescriptions written for opioid pain killers increased 77 percent between 2004 and 2012.

Beginning in 2014, the VA, though, took the commonsense step of increasing patient education, alternative therapeutic approaches. Now, that resulted in 260,000 fewer patients receiving opioids this year, down from nearly 700,000 in 2012. But that means there are 400,000 more that are receiving—400,000 others that are receiving them. I think this brings about a dangerous, highly addictive drug because they've been overprescribed, and we created a unique challenge for our nation's veterans and their families.

Half of all returning veterans suffer chronic pain. More than 63 percent have a mental health diagnosis. They're more likely to suffer from chronic pain, the risk associated disability, psychological stress, and suicide.

And, Mr. Simcakoski, you know too well the tragic consequences. All of us wish we could bring back your son for you, but nobody more than you do. You deserve better. Every veteran deserves better. Some progress has been made since we passed the Comprehensive Addiction Recovery Act last year, but we have to do a lot more.

I have heard from several veterans in Vermont who are having difficulty accessing alternative treatments, acupuncture, chiropractic care, yoga, despite the efforts that the doctor had made, and they made it together, trying to settle on a non-opioid treatment. It shouldn't be easier to get a bottle of pills than it is to access the therapy you need right at home. That's not right. We have to do more. We have to do more to ensure both the VA and the private practices are communicating with each other so when a veteran makes use of a program like Choice, the history of pain management is taken into account.

And I'm glad we're moving away from the conversation on opioid addiction, and we're moving to talking about—instead of talking about incarceration. I highlighted that during a Senate Judiciary Committee hearing back in 2008 when the committee, Republicans and Democrats, went to Vermont to see what we're doing.

We're working together in the Senate Appropriations Committee. Mr. Chairman, I applaud you and Senator Schatz for this. To provide roughly \$1.4 billion in fiscal year 2018 to address the opioid crisis. That's an increase of more than \$137 million above the President's request, \$17 million above the House mark, and \$41 million above fiscal year 2017. You know, this subcommittee alone provides \$386 million to treat and prevent opioid dependency. We have a lot more to do.

I hope we can reach a bipartisan budget deal, but, Mr. Chairman, I do want to applaud you and Senator Schatz for having this. And as vice chairman of the overall committee, I will work with both of you to help.

Senator MORAN. Thank you, Mr. Vice Chairman. We look forward to working with you, and we, too, hope that there is a budget agreement related to the caps in short order, as December 8th is just a few days away.

Let me now introduce the panel. From the Department of Veterans Affairs is Dr. Laurence Meyer, Chief Officer for Specialty Care; and Dr. Friedhelm Sandbrink, Acting National Program Director for Pain Management; and also The Honorable Michael L. Missal, Inspector General at the Department of Veterans Affairs, welcome back; and Mr. Marvin Simcakoski, from Stevens Point, Wisconsin. He is the father of the late Jason Simcakoski, the namesake of the Jason Simcakoski Memorial and Promise Act passed last year.

Welcome to all of you. And I now recognize Dr. Meyer.

STATEMENT OF DR. LAURENCE MEYER, M.D., CHIEF OFFICER FOR SPECIALTY CARE

ACCOMPANIED BY DR. FRIEDHELM SANDBRINK, M.D., ACTING NATIONAL PROGRAM DIRECTOR FOR PAIN MANAGEMENT

Dr. MEYER. Good afternoon and thank you, Chairman Moran, Ranking Member Schatz, and members of the subcommittee. I thank you for the opportunity to testify about the use of opioids within the veteran community. I'm accompanied today by Dr. Friedhelm Sandbrink, Acting National Program Director for Pain Management.

Our job at the VA is not only to care for veterans we serve, but ultimately to keep them free from harm while receiving care at our facilities. I want to express my sincere sympathy to any veterans and their families for whom we have failed to uphold this standard. We're constantly striving to make improvement in care, and we're happy to discuss the progress we've made over the last four years.

Chronic pain management is challenging for veterans and clinicians. VA continues to focus efforts on identifying veteran-centric approaches that can be tailored to individual needs using medications as well as other modalities. Opioids can be effective treatment for some patients, but their use requires constant vigilance to minimize risks and adverse effects.

The VA launched a system-wide Opioid Safety Initiative (OSI), in August 2013, and has seen significant improvement in the use of opioids since then. Changes in prescribing and consumption are occurring at a steady pace, and the OSI dashboard metrics indicate all trends are moving in the desired direction.

A major challenge is patients already on long-term opioid therapy. Based on the VA/DoD opioid practice guidelines, opioid dosage adjustments in these patients should be individualized, and sudden opioid discontinuation should generally be avoided. This patient-centered process will give veterans time to adjust to new treatment options and to mitigate any patient dissatisfaction that may accompany these changes.

The VA has also actively developed and disseminated new practice guidelines to avoid starting veterans on inappropriate opioids for pain and to address those who have substance use disorder. The VA has also trained all of our prescribers about safe opioid prescribing and the heroin crisis in response to a presidential memorandum.

VA leadership has identified as its number one strategic goal to provide veterans personalized, proactive, patient-driven health care. Integrated health care is being made available to all veterans. VA is expanding its efforts in complementary and integrative health treatments through the creation of programs in each veteran's integrated service network. We are eagerly awaiting the final appointment of the Creating Options for Veterans' Expedited Recovery (COVER) Commission members to allow this commission to begin its important work.

Another risk management approach to support veterans and the public safety is VA participation in the state Prescription Drug Monitoring Programs (PDMPs). VA has implemented a regulatory change to enable VA prescribers to access information contained in these state databases. As of September 2017, 48 states and the District of Columbia have PDMPs that are fully activated to receive VA data transmissions, and this is occurring. Information available through these programs will help both VA and non-VA providers prevent harm to patients that could occur if the provider were unaware the controlled substance medication had been prescribed elsewhere.

In May 2014, a VA team developed and implemented the VA's Overdose Education and Naloxone Distribution program. As of October 30th, over 11,000 unique VA prescribers, stationed all across the VA health care systems, have prescribed over 112,000 naloxone kits to veteran patients on long-term opioids or who have opioid use disorder. As a result of the Comprehensive Addiction and Recovery Act, or CARA, copays do not apply to naloxone kits or training. Also in accordance with CARA, the Office of Patient Advocacy was established on July 11th of this year, and reports directly to the Under Secretary of Health.

VA is conducting reviews of clinicians' credentials during on- and off-boarding. These reviews explore potential risk areas related to any license violations which may impact their fitness for duty in or out of the VA.

Finally, we announced the STOP PAIN effort in direct response to the President's Commission report. This effort brings together a comprehensive toolkit of best practices from CARA, Pain Management, OSI, and other programs.

The VA continues to research alternatives and to implement programs to reduce the number of opioids prescribed and distributed.

Thank you, Senator Capito and Senator Baldwin, for requesting this hearing so we can bring this important issue to light. My colleague and I are prepared to respond to any questions you or the subcommittee may have.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF DR. LAURENCE MEYER, M.D.

Good afternoon, Chairman Moran, Ranking Member Schatz, and Members of the Subcommittee. Thank you for the opportunity to testify about the use of opioids within the Veteran community. I am accompanied today by Dr. Friedhelm Sandbrink, VA's Acting National Program Director for Pain Management.

Our job at VA is not only to care for the Veterans who we serve, but also to keep them free from harm while receiving care at our facilities. Any adverse consequence that a Veteran might experience while in, or as a result of, our care is a tragedy. I want to express my sincere sympathy to any Veteran and their families for whom we have failed to uphold this standard. We will always have room for improvement in care, and we are taking immediate action upon any opportunity to do so.

The president recently declared a public health emergency regarding the opioid crisis in our country, and VA is innovating and implementing new strategies rapidly to combat this national issue as it affects Veterans.

CHRONIC PAIN ACROSS THE NATION

Chronic pain affects the Veteran population, with almost 60 percent of returning Veterans who served in the Middle East and more than 50 percent of older Veterans in the VA healthcare system living with some form of chronic pain. The treatment of Veterans' pain is often very complex. Many of our Veterans have survived severe battlefield injuries, some repeated, resulting in life-long moderate to severe pain related to damage to their musculoskeletal system and permanent nerve damage, which can impact their physical abilities, emotional health, and central nervous system. It is important to note as well that there are limited clinical trial data supporting the use of opioids for chronic pain. VHA is committed to reducing overreliance on opioid medicines especially in light of the severe negative consequences risked by many patients on opioids.

VA'S PROGRESS IN PAIN MANAGEMENT

Chronic pain management is challenging for Veterans and clinicians. VA continues to focus on identifying Veteran-centric approaches that can be tailored to individual needs using medication and other modalities. Opioids can be an effective treatment for some patients, but their use requires constant vigilance to minimize risks and adverse effects. VA launched a system-wide Opioid Safety Initiative (OSI) in August 2013 and has seen significant improvement in the use of opioids. OSI has been designed to complement the Academic Detailing model. Academic Detailing is a proven method in changing clinicians' behavior when addressing a difficult medical problem in a population. Academic Detailing combines longitudinal monitoring of clinical practices, regular feedback to providers on performance, and education and training in safer and more effective pain management.

VA has actively developed and disseminated new practice guidelines to avoid starting new Veterans on inappropriate opioids for pain and low back pain and to address those who have substance use disorder. These guidelines were released in 2017 and 2015 respectively and are available at:

<https://www.healthquality.va.gov/guidelines/Pain/cot/>,
<https://www.healthquality.va.gov/guidelines/pain/lbp/index.asp>, and
<https://www.healthquality.va.gov/guidelines/MH/sud/>.

In March 2015, we launched the Opioid Therapy Risk Report (OTRR) tool, which provides detailed information on key risk factors of Veterans taking opioids to assist VA primary care clinicians with pain management treatment plans. We additionally added the Stratification Tool for Opioid Risk Mitigation (STORM), which uses predictive analytics to estimate risk of overdose or suicide in all patients on or considering opioid therapy and provides individually tailored recommendations for risk mitigation interventions and non-opioid pain management options. These tools are a core component of our reinvigorated focus on patient safety and effectiveness.

VA's own data, as well as the peer-reviewed medical literature, suggest that VA is making progress relative to the rest of the Nation. In December 2014, an independent study by RTI International health services researcher, Mark Edlund, MD, PhD, and colleagues, supported by a grant from the National Institute on Drug Abuse, was published in the journal *PAIN*¹. This study, using VHA pharmacy and administrative data, reviewed the duration of opioid therapy, the median daily dose of opioids, and the use of opioids in Veterans with substance use disorders and comorbid chronic non-cancer pain. Dr. Edlund and his colleagues found that:

- About 50 percent of Veterans with chronic non-cancer pain in this cohort received an opioid as part of treatment;
- Half of all Veterans receiving opioids for chronic non-cancer pain, are receiving them short-term (i.e., for less than 90 days per year);
- The daily opioid dose in VA is generally modest, with a median of 20 Morphine Equivalent Daily Dose (MEDD); and
- The use of high-volume opioids (in terms of total annual dose) is not increased in VA patients with substance use disorders as has been found to be the case in non-VA patients.

Although it is good to have this information, as confirmation of our efforts for several years, starting with the “high alert” opioid initiative in 2008 and including extensive educational and quality improvement initiatives, by no means is VA's work finished. By virtue of VA's central national role in medical student education and residency training of primary care physicians and providers, VA will be playing a major role in this transformation effort. We have already started with our robust education and training programs for primary care, such as Mini-Residency, Community of Practice calls, two Joint Incentive Fund training programs with the Department of Defense (DoD), and dissemination of the OSI Toolkit. The OSI Toolkit Task Force has published and promoted 16 evidenced-based documents and presentations to support the Academic Detailing model of the OSI. More information on the OSI Toolkit can be found here: https://www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_OSI.asp.

ALTERNATIVES TO OPIOIDS

VHA leadership has identified as its number one strategic goal “to provide Veterans personalized, proactive, patient-driven healthcare.” Integrated Health Care (IH), which includes Complementary and Integrative Medicine approaches, provides a framework that aligns with personalized, proactive, and patient-driven care. There is growing evidence for effectiveness of non-pharmacological approaches such as acupuncture, massage, and spinal manipulation as part of a comprehensive care plan for chronic pain, and psychological approaches such as Cognitive Behavioral Therapy for chronic pain are highly evidence-based. These are all being made available to Veterans.

VA is undertaking efforts across the system to increase use of non-opioid pain management strategies. These include:

- Lowering dependency on opioid prescribing by incorporating a team approach. VA has mandated that every facility set up an interdisciplinary pain team, including clinicians with expertise in addiction medicine, to help design and offer effective treatment plans for complex patients.
- Making use of a diverse array of non-opioid pain management options for Veterans, helping to minimize need for opioid prescriptions. For example, among patients receiving opioid therapy in the last four quarters, 36 percent also received physical therapy and 21 percent also received occupational therapy in that year. Forty-seven percent of patients prescribed opioids received psychosocial treatments in the last year and 73 percent also received other nonopioid pain pharmacotherapies. As VA implements a comprehensive approach to pain management, fewer Veterans are prescribed opioid therapy, and those that are receive a wide array of treatments, tailored to their needs and preferences, with a strong focus on rehabilitative and psychosocial interventions.
- Implementing both universal and targeted risk mitigation strategies for Veterans receiving opioid medication for pain to allow prescribing in the safest way possible. Veterans on chronic opioid therapy receive education on and discuss expected risks and benefits with their providers, provide written acknowledgment of their decision to receive chronic opioid therapy, are regularly monitored

¹Edlund MJ, Austen MA, Sullivan MD, Martin BC, Williams JS, Fortney JC, Hudson TJ. Patterns of opioid use for chronic noncancer pain in the Veterans Health Administration from 2009 to 2011. *Pain*. 2014 Nov;155(11):2337–43.

with urine drug screening, and VA checks their Prescription Drug Monitoring Program data. Those at risk of overdose or suicide also receive overdose education and naloxone prescriptions and develop personal safety plans with their provider to ensure that they are prepared in the case of crisis. VA's nationally available decision support tools, OTRR and STORM help clinicians target, apply, and monitor these risk mitigation interventions to ensure that patients regularly receive these safety interventions.

- Educating Veterans and providing tools to better and more safely manage their pain. VA has created a Patient/Family Management toolkit in the Veterans' Health Library and updated resources for pain management in My HealtheVet, the Veteran portal to their health record. A pain management app called Pain Coach is scheduled to be launched by the end of the year for use by patients receiving pain management treatments.

The VHA Office of Health Services Research and Development held a state-of-the-art (SOTA) conference titled "Non-pharmacological Approaches to Chronic Musculoskeletal Pain Management" in November 2016. Workgroups reached consensus recommendations on clinical and research priorities for the following treatment strategies: psychological/behavioral therapies; exercise/movement therapies; manual therapies; and models for delivering multi-modal pain care. Participants in the SOTA conference identified non-pharmacological therapies with sufficient evidence to be implemented across the VHA system as part of pain care. These recommended psychological/behavioral therapies include cognitive behavioral therapy, acceptance and commitment therapy, and mindfulness based stress reduction. Exercise and movement therapies include Yoga and Tai Chi, and manual therapies include manipulation, acupuncture, and massage. The Integrative Health Coordinating Center within the Office of Patient Centered Care and Cultural Transformation leads the expansion of complementary and integrative health modalities.

Veterans with chronic pain conditions, especially if severe and associated with medical and mental comorbidities, greatly benefit from a comprehensive approach that is founded on a biopsychosocial assessment and treatment, and thus addresses the needs of the whole person. Case management and coaching are effective tools within our pain treatment armamentarium to address the critical needs of Veterans with complex pain conditions. VHA offers Whole Health Coaching across VA and offers training to providers. The program is being rolled out system-wide. Whole Health Coaching addresses the psychological and social aspects of chronic pain by exploring the Veteran's reasons and motivation for pain management with an increased focus on functionality and doing "what matters most" to the Veteran. Whole Health providers partner with the Veteran to set personal goals for pain management that are individualized and motivational and then accompany the Veteran through the process of addressing and treating this pain.

In 2011, VA's Healthcare Analysis and Information Group published a report on Complementary and Integrative Medicine in VA. At that time, 89 percent of VHA facilities offered some form of Complementary and Integrative Medicine, however, there was extensive variability regarding the degree, level, and spectrum of services being offered in VHA. The top reasons for offering Complementary and Integrative Medicine included promotion of wellness, patient preferences, and adjunct to chronic disease management. The conditions most commonly treated with Complementary and Integrative Medicine include: stress management, anxiety disorders, post-traumatic stress disorder (PTSD), depression, and back pain.

VA recognizes the importance and benefits of recreational therapy in the rehabilitation of Veterans with disabilities. Currently, over 30 VA medical centers across the country participate in therapeutic riding programs. These programs use equine assisted therapeutic activities to promote healing and rehabilitation of Veterans with a variety of disabilities and medical conditions (e.g., traumatic brain injury, polytrauma). VA facilities participating in such programs utilize their local allocation of appropriated funds to contract for these services. Facilities are also able to use money in the General Post Fund, a trust fund administered by the Department, earmarked by the donor for this purpose to pay for these services.

A monthly IH community of practice conference call provides VHA facilities national updates, strong practices, and new developments in the field and research findings related to IH.

THE OPIOID SAFETY INITIATIVE (OSI)

OSI was chartered by the Under Secretary for Health in August 2012. OSI was piloted in several Veterans Integrated Service Networks (VISN). Based on the results of these pilot programs, OSI was implemented nationwide in August 2013. OSI's objective is to make the totality of opioid use visible at all levels in the organi-

zation. It includes key clinical indicators such as the number of unique pharmacy patients dispensed an opioid, unique patients on long-term opioids who receive a urine drug screen, the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events), and the average MEDD of opioids. Results of key clinical metrics measured by the OSI from Quarter 4, fiscal year (FY) 2012 (beginning in July 2012) to Quarter 4, fiscal year 2017 (ending in September 2017) are:

- 260,481 fewer patients receiving opioids (679,376 patients to 418,895 patients, a 38-percent reduction).
- 82,285 fewer patients receiving opioids and benzodiazepines together (122,633 patients to 40,348 patients, a 67-percent reduction).
- 192,742 fewer patients on long-term opioid therapy (438,329 to 245,587, a 44-percent reduction).
- The overall dosage of opioids is decreasing in the VA system as 33,565 fewer patients (59,499 patients to 25,934 patients, a 56-percent reduction) are receiving greater than or equal to 100 Morphine Equivalent Daily Dose.
- The percentage of patients on long-term opioid therapy with a Urine Drug Screen (UDS) completed in the last year to help guide treatment decision has increased from 37 percent to 88 percent (51-percent increase). Notably, a longitudinal analysis of VA data suggests that for every additional 1 percent of opioid-prescribed patients at a facility that receive monitoring using urine drug screening, patient level risk of suicide- or overdose-related healthcare events among those receiving opioid therapy decreased by 1 percent.
- The desired results of the Opioid Safety Initiative have been achieved during a time that VA has seen an overall growth of 157,923 patients (3,959,852 patients to 4,117,775 patients, a 4-percent increase) that have utilized VA outpatient pharmacy services.

The changes in prescribing and consumption are occurring at a modest pace, and the OSI dashboard metrics indicate the overall trends are moving in the desired direction. In accordance with the VA/DoD Clinical Practice Guideline of Opioid Therapy for Chronic Pain that was issued in February 2017,² initiation of long term opioid therapy for chronic non-cancer pain is not recommended, and instead non-opioid therapies are being utilized as first line therapies in a multimodal fashion. The challenge, however, is the patients already on long-term opioid therapy, with many on opioids for years, and often transferring care to VHA on opioid therapy. Based on the VA/DoD Opioid Practice guideline, opioid dosage adjustments in these patients should be individualized and sudden opioid discontinuation should be generally avoided. This patient-centered process will give Veterans time to adjust to new treatment options and to mitigate any patient dissatisfaction that may accompany these changes.

The opioid prescribing and risk mitigation parameters are all moving in the right direction, and VA expects this trend to continue as it renews its efforts to promote safe and effective pharmacologic and non-pharmacologic pain management therapies. Very effective programs yielding significant results have been identified and are being studied as strong practice leaders. VA has trained all VHA prescribers about safe opioid prescribing and the heroin crisis, in response to the Presidential Memorandum Addressing Prescription Drug Abuse and Heroin Use³ and the Comprehensive Addiction and Recovery Act of 2016 (CARA).

STATE PRESCRIPTION DRUG MONITORING PROGRAMS

Another risk management approach to support Veterans' and the public's safety is VHA participation in state Prescription Drug Monitoring Programs (PDMP). VA has implemented a regulatory change to enable VA prescribers to access information contained in these databases. These programs, with appropriate health privacy protections, allow for the interaction between VA and state databases so that providers

²Chou R, Deyo R, Devine B, Hansen R, Sullivan S, Jarvik JG, Blazina I, Dana T, Bougatsos C, Turner J. The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain. Evidence Report/Technology Assessment No. 218. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2012-00014-I.) AHRQ Publication No. 14-E005-EF. Rockville, MD: Agency for Healthcare Research and Quality; September 2014. Available at <https://www.effectivehealthcare.ahrq.gov/ehc/products/557/1988/chronic-pain-opioid-treatment-executive-141022.pdf> downloaded 2-24-2016.

³The White House Office of the Press Secretary. October 21, 2015. Presidential Memorandum Addressing Prescription Drug Abuse and Heroin Use-Available at <https://www.whitehouse.gov/the-pressoffice/2015/10/21/presidential-memorandum-addressing-prescription-drug-abuse-and-heroin> downloaded 2-24-2016.

can identify potentially vulnerable at-risk individuals. VA providers who register with the state PDMP can now access the state PDMP for information on prescribing and dispensing of controlled substances to Veterans outside the VA healthcare system. When all states are fully deployed, non-VA providers will also be able to identify their patients who may be receiving controlled substances from VA. Currently, VA transmits prescription data to all participating states. As of September 2017, 48 states and the District of Columbia are fully activated for PDMP data transmission, with two states that are not receiving transmissions from VA, Nebraska and Missouri. VA continues to work with Nebraska to establish transmissions, which were impacted by changes to the state's system, while Missouri does not have a statewide PDMP. In October 2016, VA released VHA Directive 1306, which requires PDMP use by controlled substance prescribers. Participation in PDMPs enables 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 available through these programs will help both VA and non-VA providers to prevent harm to patients that could occur if the provider was unaware that a controlled substance medication had been prescribed elsewhere already.

VA'S OPIOID EDUCATION AND NALOXONE DISTRIBUTION PROGRAM

In certain situations, opioids may be the best choice for pain, even for patients with risk factors for overdose or suicide. In such cases, it is crucial that patients and those around them know how to prevent, recognize and respond to an overdose. Naloxone is an antidote to opioid-induced respiratory depression, which can cause death. With opioid use, risks are involved, and VA is taking precautionary steps to mitigate these risks. In May 2014, a VHA team developed and implemented VA's Overdose Education and Naloxone Distribution (OEND) program. This program facilitates system processes and trains clinicians in opioid overdose education and prescription of naloxone for use in the case of overdose. VA clinicians have adopted this practice at a rapid pace. As of October 30, 2017, over 11,150 unique VA prescribers stationed across all VHA healthcare systems have prescribed over 112,183 naloxone kits to Veteran patients. Using advanced analytics, VA has been able to target OEND to Veteran patients at highest risk of overdose or suicide, prioritizing getting this potentially life-saving intervention to those with greatest need. As a result of the Comprehensive Addiction and Recovery Act of 2016, co-pays do not apply to naloxone kits or overdose education training, ensuring that at-risk Veterans do not decline this important training and rescue intervention out of concerns over cost.

PSYCHOTROPIC DRUG SAFETY INITIATIVE

The Psychotropic Drug Safety Initiative (PDSI) is a VHA nationwide psychopharmacology quality improvement (QI) program that improves the quality of mental healthcare for Veterans across VHA by improving the access to and quality of psychopharmacologic treatments for Veterans' mental health needs. The PDSI program supports VISN and facility psychopharmacology QI initiatives through development and monitoring of performance metrics, clinical decision support tools, and virtual learning collaborative and educational resources. Since it was chartered by the Under Secretary for Health in December 2013, the PDSI program has worked closely in partnership with other VA initiatives to address the opioid crisis and needs of Veterans for addiction treatment.

Reduction in inappropriate use of benzodiazepines has been a key focus of PDSI. This is important given the growth in use of benzodiazepines over the past decade that parallels the growth in use of opioids. When prescribed together, the risk of overdose death from benzodiazepines and opioids is greatly increased. Efforts through PDSI have had the following impact in reducing benzodiazepine use across VA:

- During Phase I PDSI efforts (fiscal year 2013–fiscal year 2015):
 - 42,000 fewer Veterans with PTSD received benzodiazepines;
 - 2000 fewer Veterans with dementia received benzodiazepines; and
 - 20,000 fewer elderly Veterans received benzodiazepines.
- During PDSI II efforts specifically focused on older Veterans in fiscal year 2015–fiscal year 2017:
 - Over 20,000 fewer older Veterans received outpatient prescriptions for benzodiazepines or sedative hypnotics; and
 - Over 5,700 fewer Veterans with dementia received a prescription for benzodiazepines.

PDSI has also directly addressed the need for Veterans with opioid use disorder to receive evidence-based medication-assisted treatment (MAT). Early PDSI efforts (fiscal year 2013–fiscal year 2015) saw a 12-percent increase in the proportion of patients with opioid use disorder treated with an opioid agonist therapy (national score increase from 27.9 percent to 31.2 percent). Starting in July 2017, PDSI focused on improving access to MAT for Veterans with opioid use disorder and alcohol use disorder. Every facility in the country has identified one of those two areas of prescribing as a priority for their local psychopharmacology QI work and efforts are underway now to improve addiction treatment for Veterans across the system.

CARA IMPLEMENTATION AND STOP PAIN

CARA was signed into law in July 2016 and is a comprehensive effort to address the opioid addiction epidemic. In accordance with this law, VHA is reducing reliance on opioid medication for chronic pain management, providing safer prescribing and monitoring practices, and moving towards a Veteran-centric, biopsychosocial care plan. CARA expands the comprehensive approach to Veteran care with enhanced patient and community interactions by improving access to the state prescription drug monitoring programs, conducting community meetings, and expanding the VA Patient Advocacy Program. The Office of Patient Advocacy was established on July 11, 2017, as directed by CARA Section 924. The new office reports directly to the Under Secretary for Health. The Office of Patient Advocacy is a national program office that promotes the delivery of exceptional advocacy services to advance and influence patient driven healthcare, ensures appropriate training, accurate reporting and trending, and carries out the responsibilities detailed in the legislation. VHA is expanding its efforts in complementary and integrative health treatments through the development and execution of a strategic plan to expand complementary health, the execution of pilot programs in each VISN, and supporting a commission to provide additional recommendations.

We are eagerly awaiting the final appointment of the Creating Options for Veterans' Expedited Recovery (COVER) Commission members, which will allow that Commission to begin its important work of exploring complementary and integrative treatment options. VHA has conducted reviews of the credentialing process during onboarding and off-boarding of clinicians. These reviews explore potential risk areas related to any license violations, which may impact their fitness for duty. CARA implementation continues to gain momentum through internal and external communications, pain management team implementations, program expansions, and education focusing on the health and safety of Veterans under our care.

We recently announced the STOP PAIN effort in direct response to New Jersey Governor Chris Christie's call as Chairman of the President's Commission on Combating Drug Addiction and the Opioid Crisis. This effort brings together a comprehensive tool kit of best practices from CARA, Pain Management, Opioid Safety Initiatives, Academic Detailing, Opioid Use Disorder, and MAT.

CONCLUSION

While VA continues to prescribe opioid for pain treatment, we are actively researching alternatives and ways to reduce the number of opioids prescribed and distributed. While we know we still have work to do to improve in this area, VA has been at the forefront of this effort, and we will continue to do so to better serve the needs of Veterans.

Thank you to Senator Capito and Senator Baldwin for requesting this hearing, and to the Chairman for holding it, so that we can bring this important issue to light. My colleague and I are prepared to respond to any questions you or the Subcommittee may have.

Senator MORAN. Thank you very much.

Mr. Missal.

STATEMENT OF HON. MICHAEL MISSAL, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. MISSAL. Mr. Chairman, Ranking Member Schatz, Vice Chairman Leahy, and members of the subcommittee, thank you for the opportunity to discuss the Office of Inspector General's work relating to preventing opioid abuse. As you know, opioid abuse has become a serious public health emergency for our nation that impacts individuals and families from all walks of life.

Our veterans have been particularly hard hit. It is not surprising that given the prevalence and complexity of chronic pain in the veteran population, overdose deaths among veterans occur at elevated rates when compared to the civilian population. With increasing opioid overdose deaths, the emphasis has appropriately shifted to opioid dose reduction, increased assessments, and closer monitoring of patients on chronic opioid therapy. My statement today will focus on the findings and recommendations from a recent report, "Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care."

Because of its persistent nature, chronic pain is particularly problematic to treat and is often refractory to conventional treatments. Within the veteran population, pain management becomes even more complicated because veterans' chronic pain is often accompanied by post-traumatic stress disorder, traumatic brain injury, substance abuse, depression, and various other combat injuries. Due to the complexity of chronic pain in the veteran population, VA deployed two initiatives in 2014 to improve the safety and management of chronic pain in veterans, the Opioid Safety Initiative and the enabling of VA providers to participate in state prescription drug monitoring programs.

While VA has responded aggressively to the opioid epidemic with the OSI, no such initiative is in place for veterans who are prescribed medications outside VA. Over the last several years, VA has implemented several Purchased Care programs to enable veterans to access medical care in the community, including the Veterans Choice program.

My office conducted a health care inspection to review opioid prescribing to high-risk veterans receiving VA Purchased Care. The purpose of the review was to identify the extent of opioid prescribing by non-VA providers and potential related patient safety issues. Prescriptions for veterans who are authorized care through Choice are required to be filled at a VA pharmacy in order for the cost of the medication to be paid by VA. However, a veteran can choose to fill the prescription outside VA and pay for the prescription with his or her own funds.

We found that with the expansion of community partnerships, a significant risk exists for patients who are prescribed opioids outside of VA. Specifically, gaps in health information exchanges between VA and non-VA providers can put patients at significant risk for serious medication interaction and unintentional or intentional overdose. Those especially at risk include patients suffering from chronic pain and mental illness who receive opioid prescriptions from non-VA clinical settings where opioid prescribing and monitoring guidelines may conflict with VA guidelines.

We confirmed that with the challenges related to health information sharing, non-VA providers do not consistently have access to critical health care information on the veterans they are treating. For example, access to an up-to-date list of medications and a relevant past medical history is important for any provider when caring for a patient, but especially so with high-risk veterans, such as those with chronic pain and mental illness. Similarly, without immediate sharing of information, VA providers may also not be

aware of treatment plans or new medications prescribed by non-VA providers.

These gaps in care coordination are particularly risky when treatment plans by either or both groups of providers include opioid therapy. Requiring that all opioid prescriptions be filled by a VA pharmacy will help ensure that VA providers have information about all opioids prescribed to a patient by all providers.

VA has made significant steps in battling the opioid crisis, but there is much more work to be done. Specifically, health information sharing between VA and non-VA providers has been a significant problem throughout the history of VA's Purchased Care programs. Rapid implementation of Choice limited opportunities to proactively design a streamlined and effective process for the coordination of care being provided to patients. OIG believes that the issues raised here today and included in our inspection report merit serious consideration as Congress and VA work together to revamp Choice.

Mr. Chairman, this concludes my statement. I'm happy to answer any questions you or other members of the subcommittee may have. Thank you.

[The statement follows:]

PREPARED STATEMENT OF HON. MICHAEL J. MISSAL

Mr. Chairman, Ranking Member Schatz, and Members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) work related to preventing opioid abuse. As you know, opioid abuse has become a serious public health emergency for our Nation that impacts individuals and families from all walks of life, and our veterans have been particularly hard hit. It is not surprising that, given the prevalence and complexity of chronic pain in the veteran population, overdose deaths among veterans occur at elevated rates when compared to the civilian population.¹ With increasing opioid overdose deaths, the emphasis has appropriately shifted to opioid dose reduction, increased assessments, and closer monitoring of patients on chronic opioid therapy. My statement today will focus on some of VA's recent efforts in this area and the findings and recommendations from our recent report, *Healthcare Inspection—Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care*.²

BACKGROUND

Because of its persistent nature, chronic pain is particularly problematic to treat and is often refractory to conventional treatments. Within the veteran population, pain management becomes even more complicated because veterans' chronic pain is often accompanied by post-traumatic stress disorder, traumatic brain injury, substance abuse, depression, and various other combat injuries. Due to the complexity of chronic pain in the veteran population, the Veterans Health Administration (VHA) developed and deployed two initiatives in 2014 to improve the safety and management of chronic pain in veterans: the Opioid Safety Initiative (OSI); and the enabling of VA providers to participate in state prescription drug monitoring programs (PDMP), which are state-run electronic databases used to track the prescribing and dispensing of controlled substance prescriptions to patients. The OSI includes specific opioid management guidelines, a toolkit for prescribers that focuses on patient education, guidance on alternative therapeutic approaches to chronic pain, and an emphasis on patient/provider collaborations to manage chronic pain. The OSI relies on data within VHA electronic health records (EHR) to identify patients who are prescribed opioids. This also allows identification of potentially life

¹ Bohnert AS, Ilgen MA, Galea S, McCarthy JF, Blow FC. Accidental poisoning mortality among patients in the Department of Veterans Affairs Health System. *Med Care*. Apr 2011 49(4):393-396

² Issued July 31, 2017. Available at: <https://www.va.gov/oig/pubs/VAOIG-17-01846-316.pdf>.

threatening concurrent benzodiazepine use.³ Veterans Integrated Service Network (VISN) and facility oversight committees are then able to make determinations as to which patients would be considered high risk. They can also identify providers whose prescribing practices are not consistent with the evidencebased OSI guidelines. Access to PDMPs allows VA providers to query state prescription drug monitoring databases to determine if non-VA providers have prescribed, and a patient has obtained, controlled substances outside the VA. OIG is currently looking at VA's compliance with several of these metrics within the OSI and we plan to publish our findings in 2018.

While VHA has responded aggressively to the opioid epidemic with the OSI, no such initiative is in place for veterans who are prescribed medications outside VA. Over the last several years, VA has implemented several purchased care programs to enable veterans to access medical care in the community, including the Veterans Choice Program (Choice), which was authorized by Congress under the Veterans Access, Choice, and Accountability Act of 2014.

OIG REPORT: OPIOID PRESCRIBING TO HIGH-RISK VETERANS RECEIVING VA PURCHASED CARE

The OIG conducted a healthcare inspection to review opioid prescribing to high-risk veterans receiving VA purchased care. The purpose of the review was to identify the extent of opioid prescribing by non-VA providers and potential related patient safety issues. We looked at the current volume of opioid prescriptions dispensed by VA pharmacies but written by providers participating in Choice. Prescriptions for veterans who are authorized care through Choice are required to be filled at a VA pharmacy in order for the cost of the medication to be paid by VA. However, a veteran can choose to fill the prescription outside the VA and pay for the prescriptions with his or her own funds. The potential for misuse of opioids increases when there is limited coordination between providers.

FINDINGS

OIG determined that 13,928 of the 877,253 veterans who were prescribed opioid medications during fiscal year 2016 received the prescription from Choice providers or a combination of Choice and VA providers and filled it in a VA pharmacy. Those 13,928 veterans received a total of 85,729 prescriptions from October 2015 through September 2016. This figure does not include opioid prescriptions written by non-VA providers and filled by non-VA pharmacies at the expense of the veteran. In these instances, where a nexus does not exist between the pharmacy and VA, the opioid medications will not automatically be recorded in the patient's VA EHR, and are therefore not subject to timely medication reconciliation or other care coordination or risk oversight by VA. More work is needed to understand the magnitude of veterans impacted by this lack of coordination and oversight.

OIG found that with the expansion of community partnerships, a significant risk exists for patients who are prescribed opioid prescriptions outside of VA. Specifically, gaps in health information exchanges between VA and non-VA providers can put certain patients at significant risk for serious medication interaction and unintentional or intentional overdose. Those especially at risk include patients suffering from chronic pain and mental illness who receive opioid prescriptions from non-VA clinical settings where opioid prescribing and monitoring guidelines may conflict with VA guidelines.

VA has acknowledged the importance of and the challenges inherent in care coordination with non-VA providers. In its "Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care," submitted to Congress on October 30, 2015, VHA, citing the Agency for Healthcare Research and Quality (AHRQ), stated: "... care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."⁴

When a patient is referred for care through one of VA's purchased care programs, an authorization for care from VA should include all information related to that patient that is relevant to the care being requested from the non-VA provider. OIG

³ Benzodiazepines belong to a class of drugs used to treat anxiety and in some cases for insomnia and muscle spasms. Chronic use can lead to physical and psychological dependence. Serious side effects including death can occur when combined with opioids. Jones, J. D., S. Mogali, et al. (2012). "Polydrug abuse: a review of opioid and benzodiazepine combination use." *Drug Alcohol Depend* 125(1–2): 8–18.

⁴ Section 3.3, p. 21, citing <https://www.ahrq.gov/professionals/preventionchroniccare/improve/coordination/index.html>. Accessed September 22, 2015.

confirmed that, with the challenges related to health information sharing, non-VA providers do not consistently have access to critical healthcare information on the veterans they are treating. For example, access to an up-to-date list of medications and a relevant past medical history is important for any provider when caring for a patient, but especially so with high-risk veterans such as those with chronic pain and mental illness.⁵ Similarly, without immediate sharing of information, VA providers may also not be aware of treatment plans or new medications prescribed by non-VA providers. These gaps in care coordination are particularly risky when treatment plans by either or both groups of providers include opioid therapy. VA has recently initiated the Community Viewer, a web-based application that allows community providers to access the VA EHR. OIG understands that this application will provide important information to community providers, which should result in more informed management decisions for those veterans receiving care outside of VA.

RECOMMENDATIONS

Requiring that all opioid prescriptions be submitted directly to and filled by a VA pharmacy will help ensure that VA providers have information about all opioids prescribed to a patient by all providers. A recent study⁶ of the impact of the OSI found overall reductions in the number of patients being prescribed high-dose opioids, and a reduction in the number of patients on concurrent chronic opioid therapy and benzodiazepines. The success of the OSI is in large part attributable to opioid prescription data in the VA EHR that allows for appropriate monitoring of patients, including oversight by facility providers, pharmacists, and VISN and facility Pain Management Committees. Comparable monitoring does not exist for opioid prescriptions written and filled outside of the VA system unless a non-VA provider or the patient makes the effort to notify VA or the VA provider routinely accesses the PDMP.⁷ In these instances, where proactive efforts are made, the patient's VA EHR can be updated appropriately.

While the ability to query PDMP databases is now available, VA providers are unlikely to access the PDMP unless they are prescribing controlled substances to a specific patient. Timely notification that veteran patients are receiving non-VA opioid prescriptions would prompt more immediate VA provider action when required. For example, if all routine non-VA opioid prescriptions were submitted directly to VA pharmacies, VA pharmacy staff could alert the VA provider of record that a non-VA opioid prescription was being dispensed. This would promote consistent pain management committee oversight by VA of opioid prescriptions prescribed by both VA and non-VA providers.

OIG recommended that the Under Secretary for Health:

- Require that all participating VA purchased care providers receive and review the evidence-based guidelines for prescribing opioids outlined in the Opioid Safety Initiative.
- Implement a process to ensure all purchased care consults for non-VA care include a complete up-to-date list of medications and medical history until a more permanent electronic record sharing solution can be implemented.
- Require non-VA providers to submit opioid prescriptions directly to a VA pharmacy for dispensing and recording of the prescriptions in the patient's VA electronic health record.
- Ensure that if facility leaders determine that a non-VA provider's opioid prescribing practices are in conflict with Opioid Safety Initiative guidelines, immediate action is taken to ensure the safety of all veterans receiving care from the non-VA provider.

⁵ The contracts in place with third party administrators who engage and manage Choice providers require that medical documentation, including information about prescribed medications, be submitted to VA within 14 days, but this standard is not routinely met. The failure by non-VA providers to provide timely documentation was exacerbated when VA entered into a contract modification with third party administrators which "decoupled" the payment to the providers from their obligation to provide records. We have previously reported on this issue (see appendix A for a list of relevant reports), and continue to recommend that VA enforce provisions in the contracts which require timely submission of complete clinical documentation.

⁶ Lin LA, Bohnert ASB, Kerns RD, Clay MA, Ganoczy D, Ilgen MA; Impact of the Opioid Safety Initiative on opioid-related prescribing in veterans. National Center for Biotechnology Information website, <https://www.ncbi.nlm.nih.gov/pubmed/28240996>. Accessed June 19, 2017.

⁷ The PDMP does not provide a fail-proof way to ensure access to prescription information. There are limitations to accessing the PDMP for patients who receive opioids in neighboring states or for providers who are not licensed by the state in which they care for patients. In addition, a provider would not likely access the PDMP when they are not prescribing controlled substances to the specific patient.

VHA concurred with the recommendations. At present, all four recommendations remain open. We will continue to follow up with VHA until they are implemented.⁸

CONCLUSION

VA has made some significant steps in battling the opioid crisis, but there is much work to be done. Specifically, health information sharing between VA and non-VA providers has been a significant problem throughout the history of VHA's purchased care programs. Rapid implementation of Choice, in particular, limited opportunities to proactively design a streamlined and effective process for the coordination of care being provided to patients. OIG believes that the issues raised here today and included in our inspection report merit serious consideration as Congress and VA work together to revamp Choice.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Subcommittee may have.

Senator MORAN. Thank you very much.

Mr. Simcakoski, thank you very much for being here, and we welcome your testimony.

STATEMENT OF MR. MARVIN SIMCAKOSKI

Mr. SIMCAKOSKI. My name is Marvin Simcakoski. And I am Jason Simcakoski's dad. My wife, Linda, is here with me today, and I speak out for our entire family, from Jason's daughter, Anaya, to his widow, Heather. We are all grateful for the bipartisan focus on the opioid epidemic facing our country, and especially our veterans. I'm grateful that you are holding this hearing today to hear from the VA on implementation of Jason's Law and some areas where the VA still needs improvement.

I'd like to tell you a little story about my son, Jason. He was proud to be a Marine and to serve his country. He always wanted to be number one at what he did, and he was very successful in the Marine Corps. Jason loved his fellow Marines.

While he was on base, Jason got his skull cracked open, and when he got out of the Marine Corps, he got help at the VA. I never expected that this help would ultimately lead to Jason's death. Quite simply, the VA gave him, gave Jason, too many drugs. As a family, we had a choice after Jason's death: we could either retreat into ourselves, just be angry, or we could channel our anger and our desire to fix this wrong so that no other family had to go through what we did.

The last time I testified before Congress, it was March 30, 2015. At that time, I said, "If after today's hearing nothing major gets changed, then I think people will lose faith in our government. Let's not let all of this fade away, let's make some historic changes that we can all be proud to be part of. Give these veteran men and women a fighting chance for a bright future instead of a cloudy one from being over meddled so that they know what it feels like to be normal."

Well, we did do something big, and we couldn't have done it without the two Senators sitting here today, Senator Tammy Baldwin and Senator Shelly Moore Capito, worked together along with Congressman Ron Kind and Gus Bilirakis to pass the Jason Simcakoski Memorial and Promise Act. Everyone put politics aside

⁸As an added layer of transparency, our public website now provides real-time data on the implementation status of OIG report recommendations. This information is available at: <https://www.va.gov/oig/apps/info/OversightReports.aspx> and <https://www.va.gov/oig/recommendationdashboard.asp>.

and actually focused on what was best for our veterans. I wish things around here could be like that.

I'm grateful that this committee is helping to make sure that Jason's Law is fully funded. So I want to thank you all here today. We need to make sure that the VA stays track on and that the money spent to implement Jason's Law is actually getting to where it needs to go.

Now that Jason's Law is in the books, we are moving forward with the reforms that needed to happen at the VA. However, while we are helping veterans who come to the VA, what about all the veterans who are using the Choice program? Our family is supporting the bipartisan bill that Senator Baldwin is putting forward to address the Inspector General's report from July that shows veterans receiving care outside the VA don't have the same opioid prescribing and monitoring guidelines that Jason's Law requires inside the VA. We need to stay vigilant, and I am going to work my hardest to see that this legislation also gets across the finish line.

As a family, we know it's very real and tragic the way devastating consequences of opioid addiction. I lost a son, others lost a brother, a husband, a father, and a friend when Jason lost his life. Nothing can replace his loss in our hearts, but as a family, we are determined to make a difference. We are committed to making sure that no other veteran or family has to experience this type of tragedy. I want veterans to have normal lives, not a life of dependence on any drug.

In the near future, we are going to be setting up a foundation in Jason's name to help veterans like Jason lead normal and fulfilling lives, free from addiction.

I want to thank you all again for your work on behalf of our nation's veterans and my family. I know Jason is proud of all the work we have done, and he is smiling down on all of us. I can also hear his voice telling us to keep going, and that is what we are going to do.

Thank you again.

[The statement follows:]

PREPARED STATEMENT OF MARV SIMCAKOSKI

My name is Marv Simcakoski, and I am Jason Simcakoski's Dad. My wife Linda is here with me today and I speak for our entire family, from Jason's daughter Anaya to his widow, Heather. We all are grateful for the bipartisan focus on the opioid epidemic facing our country, and especially our veterans. I'm grateful that you are holding this hearing today to hear from the VA on implementation of Jason's Law and some areas where the VA still needs improvement.

I'd like to tell you a little about my son, Jason. He was proud to be a Marine and to serve his country. He always wanted to be number one at what he did and he was very successful in the Marine Corps. Jason loved his fellow Marines. While he was on base Jason got his skull cracked opened and when he got out of the Marine Corps, he got help at the VA. I never expected that this help would ultimately lead to Jason's death. Quite simply, the VA gave Jason too many drugs.

Over the last couple of years of Jason's life, I really got to know and understand how Jason struggled with his addiction problem only to have it fueled time and time again by doctors at the VA. I argued with my son's doctors for years about how I could see they were over-medicating him. I was always told that I wasn't their patient, even though I was his Dad who truly cared about him a lot more than they did!

They had him on uppers like Adderall in the morning and then downers like clonazepam and lorazepam. I watched Jason go up and down because he worked with us in the family construction business. He would be all hyper in the morning

and then out of it in the late afternoon from all these meds that were killing him. When my son came home from one of his inpatient stays, the doctor had him on so many meds both Jason and I were confused by all the different meds he had to take. At one point, they had him on over 15 different medications, including opioids and benzodiazepines.

The VA helped create and fuel my son's addiction problems. I have seen the devastating consequences of addiction. It changes people. It changed my son.

Four days before my son died, he sent me a text while he was receiving inpatient treatment at the Tomah VA. He told me he couldn't take it anymore he was going crazy and he reached out to me to help him. I called various offices above his doctor and my son called me back and said within two hours someone was helping him. I met with his doctor the next day with my son and a patient advocate. When we all sat down in the room, his doctor turned and pointed to me and said that I caused her a lot of trouble. She said she spent 2 ½ hours in meetings because I went over her head and said she could have been taking care of my son. She also said I may know how to build houses and pound nails but I don't know anything about taking care of my son. This really hit me hard to have his doctor tell me I don't know how to take care of my son and I caused her a lot of trouble for trying to help my son who needed my help. The reason I called over her head is that my son wasn't receiving the care from her he needed.

August 30th 2014, was the hardest and most painful day of my life. There isn't a day that goes by when I don't relive that morning. I regret leaving my son in his room alone that morning only to get a call hours later that he had stopped breathing. I still can't get that thought out of my head; I wish I would have been there for him. I loved my son and still do with all my heart and I miss him badly.

As a family, we had a choice after Jason's death. We could either retreat into ourselves and just be angry or we could channel our anger and our desire to fix this wrong so that no other family has to go through what we did. The last time I testified before Congress, it was March 30th 2015. At that time, I said, "If after today's hearing, nothing major gets changed, then I think people will lose faith in our Government. Let's not let all of this fade away, let's make some historic changes that we can all be proud to be a part of. Give these veteran men and women a fighting chance for a bright future instead of a cloudy one from being over medded so they know what it feels like to be normal. I think this is going to be a great chance to have all government parties' work together to show the veterans they all really do care. After all, these people should be the most important priority to all of us because they are the real life heroes of this country! I am proud my son was veteran and he will always be my HERO!"

Well, we did do something big and we couldn't have done it without two Senators sitting here today. Senator Tammy Baldwin and Senator Shelly Moore Capito worked together, along with Congressmen Ron Kind and Gus Bilirakis to pass the Jason Simcakoski Memorial and Promise Act. Everyone put politics aside and actually focused on what was best for our veterans. I wish more things around here could be like that.

Jason's Law strengthens the VA's opioid prescribing guidelines and puts in place stronger oversight and accountability for the care they are providing our veterans. For me, one of the most important parts of the law was having an independent patient advocate at all the VA Medical Centers, someone who is actually independent and is looking out for the veteran, not their employer.

I'm grateful that this committee is helping to make sure that Jason's Law is fully funded, so I want to thank you all here today. We need to make sure that the VA stays track on and that the money spent to implement Jason's Law is actually getting to where it needs to go.

Now that Jason's Law is on the books, we are moving forward with the reforms that needed to happen at the VA. However, while we are helping veterans who come to the VA, what about all the veterans who are using the Choice Program? Our family is supporting the bipartisan bill that Senator Baldwin is putting forward to address the Inspector General's report from July that shows veterans receiving care outside the VA don't have the same opioid prescribing and monitoring guidelines that Jason's Law requires inside the VA. We need to stay vigilant and I am going to work my hardest to see that this legislation also gets across the finish line.

My wife and I are also staying active at the Tomah VA, where we have monthly meetings as part of the Veterans Experience Council. The Council takes feedback from Veterans and their families to help improve services at the VA. From once being told I didn't know what I was talking about to now having constructive meetings with people like Director Victoria Brahm to staff people who lead the pain management university—there is a world of difference at the Tomah VA. From an outsider's prospective, they are listening to people now and I'm never afraid to raise

concerns to question what they are doing. The Tomah VA isn't perfect and they still have work to do, but I have a lot of faith in Director Brahm. I've emailed her at 8pm at night with a veteran who needs help and she'll email me back within the hour telling me she's on it.

This is one way that my wife and I are staying involved in the VA, but we want to do more. As a family, we know in a very real and tragic way the devastating consequences of opioid addiction. I lost a son and others lost a brother, a husband, a father, and a friend when Jason lost his life.

Nothing can replace this loss in our hearts, but as a family, we are determined to make a difference. We are committed to making sure that no other veteran or family has to experience this type of tragedy. I want veterans to have normal lives, not a life dependent on any drug.

In the near future, we are going to be setting up a foundation in Jason's name to help veterans like Jason lead normal and fulfilling lives, free from addiction. I want to thank you all again for your work on behalf of our nation's veterans and my family. I know Jason is proud of the work we have done and he is smiling down on all of us. I can also hear his voice telling us to keep going and that is what we are going to do.

Thank you.

Senator MORAN. Thank you very much for your testimony. I have no doubt that while you're very proud of your son, you and Linda are proud of your son, he's very proud of you, and we're honored to have you with us today.

IMPLEMENTATION OF JASON'S LAW

Let me ask you this. I mean, your story and your family's experiences, it's devastating to all of us. We're—almost without exception, we're all parents, we love our kids, and we want good things to happen. We put faith in government, we put faith in the Department of Veterans Affairs, and sometimes our faith is not rewarded.

So we're pleased that Jason's Law has passed, and we're here today to make certain that its implementation is effective for individuals like your son, in the position of needing help from the Department of Veterans Affairs, and that they're cared for. And, again, your leadership is helpful, significant in that regard.

You indicated you testified in March of 2015. Can you describe for me, for us—and I know that you're actively involved in your local VA hospital, Tomah VA Medical Center. Could you describe for me how you think things are different today for a veteran that would be in the same circumstance your son was when he was there, how significantly different it is? You've heard Dr. Meyers' testimony about policies and procedures put in place. Do you see it different when you're in the hospital and when you talk to veterans and their family members at home?

Mr. SIMCAKOSKI. Yes, I do. And my wife and I, we meet once a month at Tomah. We're on the Veterans Experience Council. And the Director, Victoria Brahm, is the head of the council. And there are a lot of staff members that participate in the monthly meetings. And, you know, we go over and discuss things new things, you know, that we want to be put in place to help the veterans.

And also, you know, there have been significant changes since my son passed away. Well, first of all, there's a new Director, a new Chief of Staff, you know, and a lot of the other people that were problematic at the Tomah VA are gone now. But, you know, we see a better atmosphere there. People aren't afraid to talk anymore. Before, it was, you know, what I thought, it was more like a dictatorship run place, when my son was there, you know.

Even talking with the patient advocate, for example, she argued with me about my son's medications. And I asked her, I said, "So you're a doctor now, too?" because she thought that I didn't know anything. And she was sticking for the facility, which I thought she represented the patient.

Secondly, the doctors that were there at the time with my son, my son was afraid he was going to get kicked out of the facility because he didn't know how the doctor would feel because I went over his doctor's head because she wasn't doing anything to help my son at the time. My son sent his last text message to me was, "Dad, you have to help me. I can't take it anymore." And the doctor wasn't doing anything to help him. She made him take a prescription that was totally wrong for him and made him go crazy, and he told her that, and she told him that if he didn't take it, he was kicked out of the facility.

So, basically when I went over her head and talked to somebody else at the facility, next when I went back over there, she walked in the room with me, she said to me, you know, I'll still never forget that she said, "Mr. Simcakoski, you may know how to pound nails and build houses, but you don't know anything about your son. And you made it worse by going over my head." And I'm like, "No," I said, "I'm trying to help my son." And, my son kept us apart because he was afraid that he was going to be kicked out of there.

I mean, you don't get that, the atmosphere is pretty gone by the wayside now. Now you can bring things up. I mean, I can email Victoria Brahm at 7:00 at night on a veteran that contacts me that needs help, and she emails me back that same night and says, "I'll take care of it," and she's giving him a call the next day. So it's definitely a much better and positive atmosphere there now.

Senator MORAN. You do highlight something that I've seen. I mean, I have parents who come to me to tell me their son or daughter needs surgery or they don't believe they're getting the care they need from the VA, but their son or daughter tries to convince them not to talk to me, that visiting with me may have consequences in their care and treatment that they're receiving. And, again, you wouldn't expect that from anybody at the VA; you certainly wouldn't expect it from a patient advocate.

Do you, Mr. Simcakoski, do you and Linda, your wife—do you talk to, network with, other veteran families across the country? And what you've experienced in Wisconsin, is it anything that you know is happening elsewhere? So the improvements that you see, the attitude, the approach is different. Do you have a sense that that's beyond your own hospital or your own community, or do you know that?

Mr. SIMCAKOSKI. No, we get contacted from other veteran families. A lot of them contact us for help, and who do they talk to? Also a lot of them are congratulating us on the effort and thanking us for all the changes that have been made, not just in the VA, but in the private sector also. I know hospitals in our state that cut down on the amount of opioids and things like that given out to patients because of what happened to Jason.

And, some people were mad. Some people would say, "Hey, you know, we can't get the same pain meds now because of what happened with your son." I'm like, "Well, you know, I'm just trying to

save your life. If you don't like that, you know, that's up to you, but, "I said, "Look at what happened to our son. The ultimatum was death."

I mean, you can only go so high with medications, and, I mean, once you're maxed out, there's no place to go but, death. I mean, really. It's just like with alcohol or anything else. You can only take, tolerate—your system can only tolerate so much of it.

Senator MORAN. It's true in conversations that we have, case-work in our office, in which the complaint will be, "I no longer can get the medications that I need or have had in the past," so there's pushback because of the addiction.

Mr. SIMCAKOSKI. Right. Well, people have to realize that opioids don't help heal the process, they just mirror it, and sometimes it prolongs the process of the healing. I mean, I just had aortic aneurysm surgery in April, and, everybody said, "You've got to take pain meds," Well, I took two different days in the hospital and that was it, and then I took Tylenol, and I had major surgery. I mean, I'm cut all the way up. So, I mean, people can say what they want, but, you know, your system gets used to it.

That's just like chronic pain, you take chronic pain, and everybody has chronic pain. Well, I'm in the construction business my whole life. I've had walls knocked on me, on my neck, my back. I deal with chronic pain. I don't take a pain med every day. I learn to deal with it. I wake up slow and sore, but I get by, and I'm fine. I'm 60 years old, and I don't ever plan on taking them, period. And I know what my body is telling me.

So there are other alternatives. There's yoga, there's alternative therapy, which I think is, something great that, and the VA in Tomah is implementing a lot of different things right now for, other care besides pain meds. That's not the answer.

Senator MORAN. Thank you for your testimony today and for the role you're playing in changing the world for the better.

Mr. SIMCAKOSKI. Thank you.

Senator MORAN. You're welcome.

Senator Schatz.

Senator SCHATZ. Thank you, Mr. Simcakoski. I really appreciate everything you've done over the many years and the sacrifice that you've made.

PAIN MANAGEMENT

My first question, is for Dr. Meyer, and following up on this conversation. So you've changed your standard of care, you've tightened up the prescribing, you're tracking the opioids better. So the question I have is, what do you do about physical pain? And to what extent, when you look at this crisis, do you think of this as also a psychiatric problem; in other words, that some people are doing self-medicating related to other ailments that they have coming home, especially from combat missions? So what's the new standard of care in terms of pain management? How far along are you in terms of whatever research you think needs to be completed? What's the new gold standard?

I mean, I understand the first thing, the easy thing. Right? Is to reduce the availability of opioids, but what do we do about pain? And how do we prevent people from, if they are drug seeking and

they can't get the opioids at VA, that they go and chase it someplace else? So I'm wondering how we actually treat the veteran now that we've reduced the availability of the pain medication.

Dr. MEYER. Exactly. And I think it has to be tailored to each veteran and each patient independently. Back pain is different than neck pain or chronic headache after a closed head injury. And so you have to engage with that veteran and convince him or her to take all of the different modalities of pain and try and find out what works best for them. Often for low back pain, the active therapy is yoga, tai chi, and conventional physical therapy are all very good modalities. We also offer acupuncture, but that works for some, but not for everyone. And so the—

Senator SCHATZ. I want to just stop you there because, you know, I'm the son of a principal investigator, so I understand the need to kind of prove out all the alternative treatment modalities.

Dr. MEYER. Yes.

Senator SCHATZ. But I'm just wondering whether there's not a space before you do all your double-blind studies and establish that the stuff works, if you don't look at it another way, which is if you're—diversion, right? So maybe you don't get these people self-reporting that the pain is less, but if they're not taking opioids, that gets to be considered a positive outcome.

In other words, if someone does yoga or acupuncture or dance or art or whatever it is, that's success already, you don't have to get the clinical data to indicate that their pain is reduced. Am I making sense to you here?

Dr. MEYER. Yes. And I think we're doing that. We're both engaged in research, but also actively engaged in extending the reach of complementary and integrated health and making those modalities available everywhere and encouraging their use in individual cases across the board. We're also looking at studies to see what modalities work best where and extending those, and we're actively seeking better research to guide our future practice, but that's not stopping us from implementing these now.

OPIOID ABUSE AND PTSD

Senator SCHATZ. And so to what extent is—so this is sort of a different topic, but how much of this problem is not the person who comes in, gets overprescribed, and becomes an addict, but, rather, someone who's experiencing psychiatric or psychological pain and ends up self-medicating because they're trying to blot out whatever is going on with them in terms of their own personal psychiatric situation?

Dr. MEYER. So the scenario you describe of a veteran with both chronic pain and mental health issues or PTSD is very common in the VA, much more common than in the general civilian population, but it's across the board. And so that's another reason why it has to be—the treatment has to be tailored to the individual, often involving mental health. If somebody has already been on long-term opioids, they may well be dependent on those and, frankly, have an opioid use disorder that they're not willing to admit at this point. And so these become very intertwined.

Senator SCHATZ. Right.

Dr. MEYER. And you have to individualize that therapy. It can take a lot of engagement of individual veterans.

Senator SCHATZ. This is the last question. Is there a particular phenomenon—this is what has been described to me by combat veterans, and I don't know how to label it clinically, but it's the kind of heightened state that you're in when you're in combat, the adrenaline pumping, that sort of clarity, the "excitement" is the wrong word, but that heightened state of being alive, and the structure and the meaning that comes from that life, and then coming home and just not being able to match that.

And I don't know whether there's a clinical phenomenon that's been sort of—that's been named and categorized, but I just wonder whether that is something beyond the anecdotal, that actually you understand happens, and how you deal with that in terms of I guess it's probably psychiatric terms.

Dr. MEYER. Yes, that certainly can be part of the PTSD spectrum. I've seen it in people without PTSD as well. I've been a practicing physician in the VA for 35 years. And so, yes, I'm aware of it, and, yes, it is. It interacts with this whole issue of health.

Senator SCHATZ. Thank you.

Senator MORAN. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman. Let me start, Mr. Simcakoski, with thanking you so much for coming forward with Jason's story. And I just want to assure you that your advocacy has made a real difference, as is evident in the law that Senator Baldwin and Senator Capito authored. And your being here today will continue to help us make progress. So thank you for that.

OPIOID SAFETY INITIATIVE

Dr. Sandbrink, when I look at the statistics in Maine, they're very discouraging. Last year, 376 people died from overdoses. This year, we're on track for the exact same number, being if you look at where we are this year, it looks like we're going to have a very similar number of deaths, despite all of these efforts.

The VA in Maine has implemented an Opioid Safety Initiative that is intended to reduce the number of patients who are receiving in excess of 100 morphine equivalent dose. And the chart is encouraging in that it's going down in terms of the number of veterans receiving opioids. What I would like to know is, how do you track the number of opioids prescribed per veteran within the VA system and for those veterans who are being treated outside of the VA system?

Dr. SANDBRINK. So in regard to the veterans who we take care of within our system and within the Veterans Health Administration, as Dr. Meyer pointed out, the Opioid Safety Initiative, when it was initiated in August 2013, actually that's when it, you know, was expanded nationwide, includes a dashboard and the ability to track opioid prescribing in regard to multiple parameters. This is a dashboard that gives us an overall assessment of where we are in the Department of Veterans Affairs in regard to opioid prescribing. It can be then drilled down to our regional networks, or Veterans Integrated Service Network Liaisons (VISNs), to each facility, and then to each provider.

In regard to the parameters that we track, we have the total number of opioids, the opioid and benzos co-prescribing, the patients who are on high-dose opioid therapy, as well as the implementation of the risk mitigation strategies such as urine drug screens.

For instance, you know, I actually was in communication with the team lead at the main VA in Togus, and you had 186 patients I think on high-dose opioid prescribing, about 100 milligrams of morphine equivalent. The same numbers could be obtained from any other facility relatively easily within our dashboards. And we can track down at each facility who is the actual prescriber for each of these medications.

Senator COLLINS. So, Dr. Meyer, when you discover that a prescriber is an outlier, what do you do?

Dr. MEYER. So we have a program called Academic Detailing that's modeled after the obviously successful pharmaceutical company detail men that go around and advertise drugs. And so these dashboards are used to direct the activity of these generally PharmDs to go around and do one-to-one education. So those providers are individually identified and counseled. They become quickly aware that their prescribing practices are under review, and they are—the management of their patients is discussed with them and alternatives. That is incredibly successful, and we can show that as that gets implemented where it is targeted is you see a greater reduction and a greater appropriate use of safe prescribing practices.

It is inappropriate to cut off high-dose or even—you need to both engage the patient, give them alternative therapy for their mental health, for their pain, and then gradually taper them. We know that if you simply taper, especially abruptly taper, without providing that support, you increase both suicide and overdose because people seek drugs from alternative sources.

So what we've seen across the VA is we've implemented the combination of the dashboards, education, and this very specific Academic Detailing, is that we're seeing a very steady decline in every single VA with high-dose prescribing, and the charts are just amazing. It drops down in every facility. There's a lot of spread between facilities because that's the way they started, but each one is making what we feel now to be appropriate progress. And if there's a facility or a provider that's out of line, they get identified and educated.

Senator COLLINS. Thank you.

Senator MORAN. Senator Baldwin.

Senator BALDWIN. Thanks to the committee chair and ranking member for holding this hearing and particularly to all of the members relating to the action our committee has taken to fully fund the provisions of CARA that are the Jason Simcakoski Memorial and Promise Act.

Marv, I want to again thank you for being here and sharing Jason's story, and for yours and Linda's and Heather's and Anaya's continued commitment to the care that veterans receive and turning your tragedy into hope for others.

VA PATIENT ADVOCACY

You shared a story in your answers to the chairman's questions about the role of the Office of Patient Advocacy, and I think those are really important. And, you know, we tend, in looking at the Jason Simcakoski Law, Jason's bill, to focus on the retraining of prescribers and the ability to track their prescribing in real time, et cetera, but the role of a patient advocate is really critical. And I wonder if you can explain a little bit in more detail what was happening, what wasn't working right, with the patient advocate role in the Tomah VA. And then I'm going to ask Dr. Meyer a question about the new Office of Patient Advocacy and its stand-up right now.

Mr. SIMCAKOSKI. Well, you know, like I said, the patient advocate at the time when my son was in the VA in Tomah, my wife and I didn't feel like they were representing the patients' best interests at all. It seemed like they were working for that facility and answering to that facility's Director or Chief of Staff. And, to me, I mean, it was troubling because, we're trying to—we're going to this person because, that's who the patient—was supposed to be working for the patient and, instead, it seemed like it was completely a different case.

In our son's case, I know it was because I said, we just didn't get along at all because of the way, we were treated. Basically our family was treated like, we didn't know anything and we were dumb, and this person knew what they were talking about medically and about our son, which I don't even know at the time if she even met our son.

But, yeah, it wasn't a good situation. And, I mean, obviously something has to change. And that's why, the patient advocate office should be not with the facility that they work for, it should be an independent office, so that that person doesn't have to worry about consequences from helping that patient at that facility.

Senator BALDWIN. If I recall the sort of chain of command, the patient advocate was answering to or supervised or directed by the supervising physician who was actually treating Jason that was sort of the chain of command rather than an independent advocacy.

Mr. SIMCAKOSKI. That's correct, yes.

Senator BALDWIN. Okay. Dr. Meyer, can you please provide us with an update on how the new Office of Patient Advocacy is working to improve communication with veterans and their families, to provide education and training that would empower patients, and making sure that office has the resources and tools that they need to assist veterans, particularly those recovering from opioid addiction and struggling with chronic pain?

Dr. MEYER. So I can tell you what I do know. And the Office was established I believe in June or July. It's stated in my testimony, I believe July 11th. And I do know that it's established. I have talked to them, and I know they're active. I'm aware of the memos that go out, but they are independent from the Pain Service and from me. They do respond directly to the Under Secretary. So it is a high-level office.

Something I was just talking to Mr. Simcakoski about before, that what I haven't personally done is call a local VA and assure

that the connection is made and find out what would happen if I did that. And I think that's something that I should take responsibility for doing, but I haven't done yet. I'm sorry.

Senator MORAN. Senator Boozman.

OVERPRESCRIPTION OF OPIOIDS

Senator BOOZMAN. Thank you, Mr. Chairman. Opioid overprescription abuse is truly a severe problem in Arkansas, as we discussed, and is so much so throughout the country. According to a recent report by CDC, Arkansas has the unwelcome distinction of being second only to Alabama in its writing of opioid prescriptions.

A few months ago, the Arkansas Health Department shared a sobering statistic that I want to share with you all. In 2016, 235.9 million opioid pills were sold in Arkansas, three opioid prescriptions for every Arkansan. That is enough for every man, woman, and child in the state to take 80 pills. And so because of that, as all of us here really do take this issue very, very seriously.

I was pleased that just yesterday the University of Arkansas Agriculture Extension Service received a \$322,000 grant from USDA to develop complementary and alternative pain management interventions to reduce opioid abuse and misuse among rural Arkansas residents. The project will focus on bridging the access gap and on increasing awareness of opioid risk and treatment alternatives.

Arkansas has also received funding from the Health and Human Services for nine community health centers in 2016–2017 to help combat the opioid epidemic. Health care centers like the ones in Arkansas have seen a 55 percent increase in the number of veterans they serve from 2008 to 2016, in large part, due to the implementation of the Choice program in 2014.

All of these are great examples of how all corners of the Federal Government are working to stem the tide of opioid overprescription abuse, which can benefit veterans.

I guess the question is, how is the VA working with other Federal agencies to address the opioid epidemic? How are we working together? And for Arkansas, it's especially important to address the unique needs of rural pain sufferers, many of which are veterans. What are you doing specifically to address the pain management needs of veterans in rural areas?

Dr. MEYER. So thank you, Senator Boozman. First, the VA does sit on the intergovernmental task—the White House called task force on opioid management. So I'm actively engaged in that, and I represent the Under Secretary in that. So we are trying to coordinate responses so we don't allow any piece of the puzzle between HHS, DOD, Border and Customs to fall down in between the cracks. And we're working to, for example, make sure that we all have better PDMP access is an easy example. So I hope that continues and can be as successful as all of us, you know, imagined it might be.

With respect to rural veterans, the VA does have the Office of Rural Health, and so portions of that funding go to a lot of different areas, but one of them is for training providers in rural areas in both pain management and in substance use, is an easy example. We're very aware of the needs for rural veterans, and ironically,

the Choice Act or the new proposed CARA legislation does not always solve those issues because there are regional shortages of all providers, both in and out of the VA, and that's someplace where telehealth can help.

And so the provision of direct-to-home telehealth is something the VA is expanding enormously. The goal for next year is to have 5 percent of all veterans have at least one touch by the health care system not in a VA hospital or clinic. It could be—it could in a library if that's where they have broadband because not all veterans have broadband. But this can be delivered on a cell phone.

VA ADAPTIVE SPORTS PROGRAM

Senator BOOZMAN. How about—and very quickly because we're running out of time—how about adaptive—how about other alternatives like adaptive sports and things either at the center or out in the communities? Tell us what you're doing in that regard.

Dr. MEYER. We can certainly refer people out for alternative therapies in the communities where they're available. I am not familiar with adaptive sports specifically as an option in rural areas, but we can. Does that answer the question?

Senator BOOZMAN. No, I think so. I think—

Dr. MEYER. I'm trying to cut it short.

Senator BOOZMAN. No, I understand.

Dr. MEYER. I can go on.

Senator BOOZMAN. No, no, I understand. I guess the thing I would say, I think those things are really very, very important, the camaraderie, the sense of achievement, you know, doing something different.

But, again, thank you, Mr. Chairman.

Senator MORAN. Senator Tester.

Senator TESTER. Yeah, thank you, Mr. Chairman and ranking member. I want to thank all the panelists for being here today.

VA ENVIRONMENT OF CARE

Mr. Simcakoski, thank you for being here. I've got to tell you, your story was gut-wrenching. I appreciate you being here. It's a tough situation, and I appreciate you and your wife being good parents.

By your testimony, you indicated that the patient advocate was the problem, and the chain of command of the patient advocate was the problem. And were there other things that were a problem other than that?

Mr. SIMCAKOSKI. Yes, there was. That was just one of the many problems. They didn't have a crash cart on the floor. The nurse wasn't—didn't know what to do. She panicked. My son was left for about 15, 20 minutes without anybody doing anything to help him. They didn't know if he was dead or alive. They didn't have a defibrillator on the floor.

Senator TESTER. Got you.

Mr. SIMCAKOSKI. There were numerous sorts of things—

Senator TESTER. So let me go over here to Dr. Meyer.

Dr. Meyer, are a crash cart, a defibrillator on the floor, are those things standard operating procedure in VA hospitals?

Dr. MEYER. Yes. And we do have programs, the Environment of Care, that should be overseeing that at all places. I've not gone back and looked and seen what happened at that VA on that occasion, I can tell you.

Senator TESTER. Okay. It might be important to go back and review and make sure that the checks and balances that are in this system are actually working. I don't know, how long have you been with the VA?

Dr. MEYER. I've been at the Salt Lake VA for about 35 years.

Senator TESTER. Yeah, so you've got a little bit of experience.

Dr. MEYER. Oh, yeah.

Senator TESTER. So I think, you know, really getting to the bottom to make sure—what happened to this family should never happen. And we all know opioids are bad news. I had a friend that had throat cancer that if they wouldn't have grabbed him and hauled him off to treatment, he'd have committed suicide, there's no doubt in my mind about it, or he'd have just died.

I want to talk to you, Mike, and thanks for being here. You reported on two case summaries. Would you classify those two case summaries as being typical?

Mr. MISSAL. I think the description of each of them is not untypical of what we find. They both showed that veterans with a number of issues getting care in both VA and outside VA. We don't know how many there are, but we would think they're very similar to other issues that we have out there.

TRACKING OPIOID PRESCRIPTIONS

Senator TESTER. You talked about prescriptions, if we really want to be able to track them, need to be prescribed by the VA. To be honest with you, in rural areas of this country, it becomes pretty tough to do, especially when you need whatever prescription it is yesterday. And it's one of the challenges that we really have I believe with unfettered access to the Choice program and not being able to monitor these folks to be able to determine what's being done to them, prescription drugs taken.

Assuming that every drug can't be given out by the VA, which I don't believe is possible, what other move—what other moves should we make in that regard?

Mr. MISSAL. I think coordination of care is the real key here, and I think that's the challenge VA is going to face. As more veterans are getting care out in the community, to the extent that there is not coordination between the providers and the pharmacies, you're putting veterans at greater risk.

Senator TESTER. And that—okay. And that coordinator would be a VA doctor?

Mr. MISSAL. It could be a VA doctor. VA does have mail-order pharmacies as well, so you don't have to have one around the corner from you. So there are alternatives that VA can use.

ALTERNATIVE AND COMPLEMENTARY THERAPIES

Senator TESTER. Okay. Sounds good.

And this is for you, Dr. Meyer or Dr. Sandbrink. You talked about alternative treatments. Do you have a number of how many

alternative treatments you're looking at right now to replace opioids?

Dr. MEYER. You mean in terms of encounters or modalities?

Senator TESTER. Yeah, how many, Mr. Simcakoski talked about yoga.

Dr. MEYER. Yeah.

Senator TESTER. Look, there are other things out—I mean, I've read that marijuana can help. How many different alternative—

Dr. MEYER. There are probably at least 20 total. They're not all available at every site.

Dr. SANDBRINK. So in November 2016, the Health Services Research & Development arm of the VA, the research arm, had what is called a state-of-the-art conference in regard to nonpharmacological treatments for pain—

Senator TESTER. Yeah.

Dr. SANDBRINK. Nonpharmacologic and nonintervention treatments.

Senator TESTER. Yeah.

Dr. SANDBRINK. And they collected basically the information and evidence since this report about the promising or potentially helpful modalities, and it was categorized into psychological modalities, which include CBT, cognitive behavioral therapy, acceptance and commitment therapy, mindfulness therapy, mindfulness-based stress reduction—

Senator TESTER. Marijuana?

Dr. SANDBRINK. Marijuana is not based on that evidence since this report. The other that I want to mention were yoga and tai chi and exercise programs and the movement therapies, and then spinal manipulation, massage, and acupuncture.

Senator TESTER. So if I might, Mr. Chairman, just one thing, and that is, I think that the ranking member makes a good point. You need to really get them tricked out so you can use them if you're going to have a replacement, you can study them to death.

The other point is, that this is what Mr. Simcakoski talked about is how you have teach people how to deal with pain without drugs is really important, and it can be done because we've all done it at some point in time in our lives. And so I would just encourage that.

Thank you, Mr. Chairman.

Thanks to the panelists.

Senator MORAN. Senator Murkowski.

ALTERNATIVE THERAPIES

Senator MURKOWSKI. Thank you, Mr. Chairman.

Gentlemen, I want to continue along the same lines that Senator Tester was pursuing in terms of some of the alternatives to opioids. And I was recalling that some time ago we were dealing with a VA that was pretty limiting in terms of alternatives that were available for our veterans, and I had recalled several different discussions with young guys who were returning at that time from Iraq, and bodies beat up pretty hard by being in vehicles that didn't have much suspension and wearing heavy body armor. And rather than being given chiropractic care or physical therapy, the prescription was just take the pill.

And at that time, you'll recall, the number of visits that were allowable for that veteran were—the chiropractic visits were limited. I think they were like 11 visits or was less than a dozen, which to me was incredible. So we go ahead and we'll prescribe the pill, but we're not going to help you kind of manipulate and move that body and help that body recover.

So we're talking about a whole host of different alternatives, which I think is great, whether it's chiropractic or acupuncture or equine-assisted therapeutic activities, I'm all over this, I think it's great. But are we in the same situation that we were several years back where we are limiting the number? We've got some arbitrary number out there that says, okay, when you hit 20 appointments of acupuncture or 25 chiropractic visits, you're done. And recognizing again that for many of the people in my state, going to a VA facility is not a possibility. So they're going to be going out onto the community for this.

How is this going to work? And what can you—how can you assure me that this level of care, which in many cases, physical therapy can go on for months and months and months and months, how do we address that?

Dr. MEYER. So thank you. Yeah, I think your state is predominantly rural, as is Senator Tester's. It's not unique.

Senator MURKOWSKI. Mm-hmm.

Dr. MEYER. And you have a very hard situation there.

What we've tried to do and are trying to do as we negotiate the care and the community aspects of the Choice Act is we're responsible for overseeing that care, and we're trying to come up with the best ways to do that, and this certainly involves pain, but it involves all kinds of stuff. And so we are not going to be limiting people to an episode, but neither do we want to approve one at a time over and over again because that becomes a bureaucratic nightmare.

And so what we're trying to establish is episodes of care that might be, let's say, 15 or 20 episodes of chiropractic care, but then they could be extended. So you wouldn't have to go back and approve every one, but neither do you get a blank check. I don't think it would be responsible either from the point of view of the taxpayer or from overseeing veterans' care to simply turn somebody over and not make sure that care was needed and effective.

So we're trying to walk the line, and I can't say what the limit is at all, I don't think we've established one for chiropractic care, but—

Senator MURKOWSKI. Well, I used chiropractic as an example, and I think it's a good one.

Dr. MEYER. Yeah. Mm-hmm.

Senator MURKOWSKI. And I think it also recognizes the fact that everybody is different, everybody is going to heal different. Some people are not as good at their physical therapy as they should be. And so when we have kind of that arbitrary limit, if you will—and I understand that you can have some level of oversight that says, okay, after this many visits, you have to get kind of a re-up, if you will.

But I will tell you, as one who was in physical therapy for many, many months after a pretty serious recreational injury, nothing

like our veterans would ever do, to be on a physical therapy bed and have the person next to me crying, not because she was in pain, but because she was being told by her physical therapist that her number of treatments was up with her coverage, and she couldn't get any more. And she said, "I'm not done, I still hurt, I still need you."

And I don't want our veterans to be in that same situation where they feel they can't get that continued care, there is this gap. So you've taken them off the opioids, which is the place that they should be trying to go, but we need to make sure that we're working with them. And I fear that as we're moving into this Choice where you have different issues and different places and rural states are clearly going to see this impact that we've set up a tough situation for those vets who cannot get that care in a VA facility.

Thank you, Mr. Chairman. My time is expired.

VA CHIROPRACTIC CARE

Senator MORAN. I want to use the opportunity of Senator Murkowski's line of questioning to highlight that back in my House days, we passed legislation requiring the VA to implement chiropractic care within each VISN. In my view, the VA was slow in its implementation of that and didn't seem to embrace that concept. The Senate has now passed legislation requiring chiropractic care in every VA hospital. My understanding is the VA is about half-way—that bill has not yet become law, but the VA has about half of their hospitals that provide chiropractic care. But the point that the Senator from Alaska raises, there are circumstances in which there is no chiropractic care at all, let alone the number of visits that a patient, a veteran, can see. Am I missing something, Dr. Meyer?

Dr. MEYER. I think your characterization—I don't have the numbers at my fingertips, but I think it's globally accurate. And the VA is in the process of upping its game in chiropractic care. I know that it's also dangerous to extrapolate from one VA, but in my own VA, I was both a requestor and an approver at different times of extended services. So specifically for physical therapy, we had patients in Idaho, and, you know, we would say they've had their 12 visits, let's re-up, it's working. And so I know that occurred in at least one VA routinely.

Senator MORAN. Thank you very much.

Senator Udall.

Senator UDALL. Thank you, Mr. Chairman and Ranking Member Schatz, for holding this hearing. Incredibly important.

VA INFORMATION SHARING WITH COMMUNITY PROVIDERS

Mr. Inspector General, you seem to conclude in your report that significant steps have been made and moved forward in the Veterans Administration to resolve this, but the thing that seemed to worry you the most is that health care information sharing between the VA and the non-VA providers has been a significant problem throughout the history of the VHA's Purchased Care program. And so you've made recommendations about this.

My questions are to the VA. What steps have you taken, knowing these recommendations have come in, to better tackle this problem

of the Choice program being set up and having providers getting opioids out here, and then also getting opioid prescriptions within the VA? What specifically have you done to resolve this?

Dr. MEYER. So that's actually handled by two different offices. But I'm aware of the work and I think I can speak to it. One is that we've established—I believe in Mr. Missal's written testimony he mentioned the Community Viewer, which is now in existence and is rapidly being rolled out. So that allows outside providers to see the VA records of that veteran. And once that's fully implemented, I think it will be the best solution.

Senator UDALL. When will that be fully implemented?

Dr. MEYER. I'm not sure of the time scale. I hope in this calendar year. I think that's a fair estimation. And I can get back to you on that as a follow-up question.

Senator UDALL. Okay.

Dr. MEYER. I'm sorry, I just don't have that. However, we already have implemented an automatic request and note generator that when the consult is made, pulls elements out of our electronic record that includes recent lab tests, prescription records, problem lists, and recent notes, and that it's usually about a 20-page packet that goes to the outside provider at the time of the request. So that helps them on their side.

We're also trying to get better access to their records, but providers use all different kinds of systems outside the VA. I don't think care coordination between providers and different systems is unique to the VA and those not. It's seen across the health care spectrum.

So I'd like to think that the VA is doing at least as good a job, if not better, than some others. And we're aggressively tackling it. So I hope that we really have the access of outside providers to VA records solved this calendar year or, excuse me, 2018.

Senator UDALL. Yeah. Mr. Inspector General, have they done enough? Have they moved quickly enough? Are these the kinds of things that you believe will resolve this?

Mr. MISSAL. These are the things that are going to help. You can always do more. One of the recommendations we had in the report was that the medication histories be provided to the outside providers so they can see what this veteran has had before, and it assists the provider in the care that they would be giving.

And so we're going to be checking. They have agreed to implement that, and we will ensure that they fulfill it and do it in a sustainable way. But this is one of the big challenges, and while care in the community certainly has its benefits, it creates other challenges as well. And in our opinion, coordination of care may be the biggest challenge, and it's not going to be easy to resolve.

OPIOIDS AND THE NATIVE AMERICAN POPULATION

Senator UDALL. In New Mexico, we not only have the rural health care issue we've talked about, but we also have a huge issue in terms of Native Americans and Native American veterans. What is the Veterans Administration doing to approach that particular issue, Native American veterans and dealing with the opioid crisis?

Dr. MEYER. So New Mexico I think has been a leader in rural health. And the Extended Health Care Option (ECHO) program

was developed down there, as I'm sure you know, and so the VA has been heavily involved with that specific program. And, indeed, I was just in Albuquerque for the national meeting of that recently.

We're using, as I mentioned, I think to Senator Tester, we're using—or was it Senator Boozman? The telehealth modalities extensively, and then the ECHO program uses teleconferencing to allow education of providers in more rural areas. Now, the issue is we do have clinics out there, but we still need to make our reach farther.

And so the Native American population in Utah or, excuse me, in New Mexico does tend to be extremely rural, and in other areas, it's urban. And so they do have different demographics and different prevalence of some diseases. And I think we're aggressively working on pain, on hepatitis C, on other issues that are more prominent in Native American populations. And we're, you know, again, the Indian Health Service actually uses a different version of our health system, and I know they are considering merging with the same electronic health record that we and the DOD anticipate using. And so if that comes to pass, it will make care coordination even easier.

Senator UDALL. Yeah. Thank you very much. And thank you for your work on this.

Senator MORAN. Senator Capito.

Senator CAPITO. Thank you, Mr. Chairman, and I thank the ranking member.

And I want to thank my colleague Senator Baldwin for working on this issue with the Simcakoski family.

And it's nice to see both of you again, and thank you for your advocacy and your bravery really for just keeping it up, keeping it going.

I have a couple questions, and the more I sit here, the more questions I get, because I don't think that what's going on at the VA in terms of conflicts or in not being able to get enough data about opioids is any different than what's going on in the general public. Sometimes we use the VA as a good example of, "Well, let's do this in the general public," and sometimes we use the general public to say, "Let's try this at the VA."

VA COMMUNITY CARE PRESCRIPTION PRACTICES

When my colleague from Arkansas said that they had the second highest opioid prescribing rate, I'm not proud to say that we used to have that distinction in West Virginia. In 2006, we prescribed 129.9 per hundred people; and it's down to 1996, which is still not so great. But it does show you that if you begin to monitor and if you begin to keep track and you have accurate records and you shine a light on this, you can improve the situation and you can make a difference. And so I would say that that's an important takeaway from this.

But here's where my concern is: if you have a veteran who goes to community care and is prescribed an opioid, first of all, I think we obviously have to fix the loophole that the VA records should be able to reflect that, if at all possible. My understanding is they have to fill that prescription at the VA, is that correct?

Dr. MEYER. So what we're actively implementing in response to the Inspector General, and also in response to Senator Tester's concern about availability, is that if somebody is writing—and we battered back and forth numbers—less than seven days of an opioid, they can get it at an outside pharmacy, but they can get the first seven days elsewhere. Then following that, they need to use one of the VA's mail-order pharmacies. And that makes it available. But I would point out that the VA uses the state PDMPs, and the pharmacies do, and the VA providers are required to check that as well for, in all cases, for chronic prescriptions. So we do have that kind of exchange.

STATE PRESCRIPTION DRUG MONITORING PROGRAMS

Senator CAPITO. Do you in every VA, are you monitoring what's going on at the state monitoring drug program?

Dr. MEYER. Yes. I can't say that every single provider every single time follows each state and VA guidelines, but we're working on it.

Senator CAPITO. Right. So if you have a VA that straddles different states—

Dr. MEYER. Of which there are many.

Senator CAPITO. Do they avail themselves of every state?

Dr. MEYER. Yes. So I—

Senator CAPITO. That didn't sound so affirmative there.

Dr. MEYER. I can give you—but it's hard.

Senator CAPITO. I know. I know. Because it's reflected in the general public. That's been part of the problem.

Dr. MEYER. North Florida/South Georgia, we have to write because you have to be licensed in South Georgia.

Senator CAPITO. Right.

Dr. MEYER. You have to write a consult, somebody who is licensed. There are two different pieces of legislation going through, and the VA has submitted suggestions to that legislation to allow us to check even in states in which we're not licensed and to allow surrogates to check for us.

Senator CAPITO. Absolutely have to do that.

Dr. MEYER. My preference would be for an automated system to allow that check-in and have it imported into our medical record automatically. That would greatly relieve the reliance on the mechanics of the provider.

Senator CAPITO. Right.

Dr. MEYER. A MD getting in, which is a considerable administrative workload.

Senator CAPITO. Well, we should be able to do that. I mean, we need to do that because, as you said, a lot of VAs straddle different and I understand the licensing issues, but I also understand that in pursuit, sometimes the veteran is no different than the general population in the pursuit of medications that maybe they can't get one place, they're going to find out a way to get it. One of the ways I realized they were doing in West Virginia for a time was instead of using their insurance card or their credit card, they're paying cash, and it's not going into the system because it's not set up for that. And I hope we've gotten rid of that loophole as well.

ADVERSE DRUG INTERACTIONS

I'll just close and say that Andrew White was a young veteran who returned home to his family in late 2007. He went to the VA in Huntington, West Virginia. It wasn't opioids so much, but it was conflicting medicines. He was on a whole cocktail of a lot of different medicines and in tremendous pain, PTSD. He couldn't figure out what was wrong with him. He became a different person. And one day he didn't wake up in his own home. And I'm convinced, as his parents are convinced, and the VA has looked at this, too, that the combination of what he was taking was just too much for him.

And so I know you've worked hard at the VA to try to look at different conflicts. And this sort of melds into opioids, but it doesn't necessarily mean that it's an opioid prescription. It can be the opioid prescription on top of everything else. So I think we can do better. I appreciate your efforts. I do think that if you look at what's going on in the charts of states like mine and Arkansas where you see improvements, those are the same places you can make improvements through the VA, and our veterans are certainly well deserving of that.

Thank you.

Senator MURPHY. Thank you very much, Mr. Chairman.

Thank you all for your testimony.

Mr. Simcakoski, thank you very much for being here and sharing your story with us. And thanks to Senators Baldwin and Capito for all their great work on this.

ALTERNATIVE THERAPIES

So in the private sector, one of the biggest barriers to this conversion away from dependency on pain medication is the willingness or the lack of willingness on behalf of the insurers to pay for alternatives. And so there's a supply issue. There's just not enough access there on the private sector side when it comes to all of these alternative pain therapies that we've talked about here today. And maybe you've answered this in response to other questions, but is there a capacity issue in the VA? If you continue to be successful in moving patients away from opioid treatment, is there any capacity issue with respect to physical therapy or acupuncture or chiropractic, all of the different places that you might go?

Dr. MEYER. Yes, there is. And we're seeking to expand those options as actively as we can. We have shortages in many of the physicians. We also have shortages in many of the other health professions. Not all VAs have a full suite of complementary and integrated health, and so they need to go to the VISN centers. And has been pointed out, in rural areas that can be basically prohibitive for one way or another. So, and in some cases they're not available in the communities either. So the VA is working to expand access.

Senator MURPHY. And what do you need from Congress in order to expedite that improvement of access?

Dr. MEYER. So the complementary and integrated health teams are expanding in tracking that. They do have support to do that, but it is just simply a slow process. I think you can continue to encourage that and monitor that, and that's always actually appreciated.

PAIN MANAGEMENT TEAMS

Senator MURPHY. Mr. Missal, you had a section of your testimony related to breakdowns in the coordination of care. And one of the problems especially with multimodal therapy is that, you know, it takes a different degree of coordination to get to all of those appointments, to organize transportation, a lot easier to take a pill and go to the prescription—to go to the pharmacy once.

Can you just drill down a little bit more on what you found needs to be done better when it comes to coordination, in particular, the amount of coordination necessary to help veterans who are in multimodal therapy? There's a study at the clinic in San Antonio that identified a lot of these barriers that existed to multimodal therapy.

Mr. MISSAL. Right. Part of what VA is trying to do now is to do more of a team approach, to have pain management specialists on those teams. And what they're going to have to do then is get it out to the community. That's why the more they can coordinate their care, the more information sharing. And so that would involve education, it would involve training, and also technology. As was pointed out, right now there are so many different kinds of health records out there that don't talk to one another. So the more they can figure out the back end in terms of getting the records that can better speak to one another or to be better shared, the more effective it's going to be.

Senator MORAN. Senator Schatz.

MEDICINAL MARIJUANA

Senator SCHATZ. Thank you, Mr. Chairman. I think this question is for Dr. Sandbrink. I would like to insert for the record a summary of a study conducted from 1999 to 2010. It's in the Journal of the American Medical Association, October 2014 issue. And here is the abstract.

I'll just summarize the results. Three states have medical cannabis laws effective prior to 1999. Ten states enacted medical cannabis laws between 1999 and 2010. Now, here's the most important thing. States with medical cannabis laws had a 24.8 percent lower mean annual opioid overdose mortality rate compared with states without medical cannabis laws. So 25 percent reduction when medical cannabis is available in terms of opioid deaths.

Now, I know that this isn't the end of the scientific inquiry, but this is pretty compelling data to me. And I also understand that the VA is a Federal agency. So I want to set aside the question of statute, and I want to ask you your clinical opinion. Do you view this data as persuasive in terms of what appears to be an inverse relationship between the availability of medical cannabis and the overuse and eventually overdose related to opioids?

Dr. SANDBRINK. Yeah, thank you very much. Clearly, there is an association, there is some kind of correlation going on that was pointed out in that study.

Senator SCHATZ. Could you summarize it for me? I want to hear it in your words because I'm not the clinician here.

Dr. SANDBRINK. You know, as you just summarized for those states that have implemented cannabis laws and implemented the

availability of cannabis for medical purposes, that there has been a 25 percent reduction, about 25 percent reduction, of overdose deaths. In that regard, obviously, that's a very important finding. I think we need to understand what is truly providing this what seems to be a protection or reduction of overdose deaths. I think there are, and I think there is increased evidence for medicine.

Senator SCHATZ. Well, do we? I mean—sorry to interrupt for a moment. You do? You need to do the academic and scientific inquiry to try to figure out really what's going on here right? At the physiological level or psychiatric or whatever. But I'm not sure we need to know exactly why it's working to use it for policy-making purposes. Do you see what I'm saying?

Dr. SANDBRINK. Yes.

Senator SCHATZ. I see you nodding, Dr. Meyer. Would you like to weigh in without getting yourself in trouble?

[Laughter.]

Dr. MEYER. I walk that line a lot. So again thank you. I don't think we can wait to have the perfect evidence for everything. I would concur with you. And if you have evidence that something is working, you don't need to figure out why it's working I'm talking in very general terms here in order to employ it. The VA is in the position of being required to follow the statutory law. And so, as Federal employees, we're prohibited from recommending marijuana.

I think one of the things that we do in the practice of pain medicine and medicine in general, including mental health, is that we can, while we can't recommend medical marijuana, we don't have to, for example, stop opioids because it's being used. And so if people would—if Congress would change regulations, we would have more freedom both to investigate and to give therapy.

Senator SCHATZ. To prescribe or recommend.

Dr. MEYER. Yes.

Senator SCHATZ. And this would be—I assume that until you go through an FDA process and all the rest of it, you're not—most doctors are not prepared, you know, really to treat it like medicine, but you probably would be comfortable to treat it like yoga or like physical therapy or like any of these other—you know, Senator Tester was getting to this point. It's sort of betwixt and between in terms of, is it medicine? You know, maybe not. Does it help? Almost certainly. And so where do you put that as a doc?

Dr. MEYER. Or even as we would with herbal medicine, for example. I think that might be a better example for right now in this case. So, yeah.

Senator SCHATZ. Thank you.

Senator MORAN. Senator Baldwin.

VA OPIOID SAFETY TRAINING

Senator BALDWIN. Thank you. I just have a couple of closing questions, and I appreciate the opportunity to have another quick round on this, to really focus squarely on the gaps that exist. And, you know, earlier today, Senator Capito and myself, the chairman, also Senator Tester, others of our colleagues on a bipartisan basis, introduced legislation to further some of the recommendations con-

tained, Mr. Missal, in the Inspector General report released earlier this year.

We've talked about a lot of the essential and critical components of Jason's Law in the VA, the training of prescribers, implementing the latest CDC guidelines that focus both on drug interactions as well as the safest opioid prescribing practices, implementation of Patient Advocacy Office, the Patient Advocacy Office, and strengthening that in all of our VA health institutions, pain management teams, and real-time tracking of prescribing.

Now, certainly in terms of gaps that have been identified in the Veterans Choice program and other community care programs, we can't necessarily take all of those components that I view as critical and, you know, for example, real-time tracking of prescribing. But you've prioritized, you've identified some of the most important. You haven't talked as much about training and basically requiring an understanding of the VA's adoption of the CDC latest guidelines, but that's a key part of this. So I wonder if you could expand on that.

Mr. MISSAL. Sure. One of our recommendations in the report is that all non-VA providers need to receive and review the OSI guidelines. Within those guidelines, it does talk about many of the things that you mention, including education and training. And so when we make recommendations, we do it because we've identified an issue and we think this is going to be an appropriate solution. VA has agreed to do that. So we will be monitoring their progress to implement that. And I think many of the things you talked about would be included in there and perhaps in some of our other recommendations, and we're going to be watching this very carefully to make sure they get implemented.

Senator BALDWIN. Okay. And, Mr. Chairman, if I could just end on a note where you began. We're very pleased that you have a seat both at the authorizing table and the appropriating table on this, and I have appreciated your leadership. I know that this isn't the only gap that has been identified in terms of creating a seamless passage for our veterans between VA care or care within VA facilities and care in the community or Veterans Choice. I am glad that you are tackling that with our colleagues on the authorizing side. And I hope, as a sponsor of this important, more narrowly focused piece, that you'll share that with your colleagues on the authorizing side, too.

Senator MORAN. Senator Baldwin, thank you for your lobbying efforts.

[Laughter.]

DEPARTMENT OF VETERANS AFFAIRS BUDGET

Senator MORAN. It allows me the opportunity to indicate that we are the committee, or subcommittee, members should know the Choice program expires when the funding for this year comes to a conclusion. That's currently estimated to be at the end of December. The VA is not always perfect in its estimates. And while our CR expires December the 8th, the question is, where are we after December the 8th? And I don't have a clear understanding where that is.

But in addition to the expiration of the program—let me outline why I think that's significant. One, veterans would no longer be able to use Choice. Two, the intermediaries, the providers, the TriWest in our case, the Health—Health—HealthNet. How can I forget their names? HealthNet. Those people may go away. Their networks would disappear, and restarting Choice again becomes much more complicated than if we can continue the program.

So Congress has a lot of burdens on its back at the moment, one, to get us out of the CR, and to do that, will give us the money we need to fully fund Choice into the future and keep Choice alive and well. Mr. Missal may have a lot less concerns about what's going on in community care if the program no longer exists. In my view, veterans in Kansas and across the country will be misserved, underserved, in the absence of community care.

We also have another challenge, and this is where the Budget Control Act (BCA) caps come into play, in this as well as many other instances. The plan, and I think it's the right one, is to consolidate all community care under one program so that Choice and the community care programs that the VA already had before Choice become one pot of money. And from my perspective, a good change that will occur, that is planned to occur, is that mandatory spending will go away, be replaced by discretionary spending, and this subcommittee and the Appropriations Committee, and ultimately the entire Senate and Congress, will then have control over how we spend money in community care, a broader category than the mandatory spending of Choice and the community—discretionary spending under community care.

So we need to be working with our leadership in the Senate and the House and with the administration in getting us to a point that when December the 8th comes, we have a plan in place, and I hope it's not another CR perhaps beyond a few days, to deal with the expiration of Choice and the creation of a community care account within the VA to deal with all community care programs in that one account, and then becomes the jurisdiction of this subcommittee, at least for the appropriations process.

Incidentally, your lobbying has been successful, and Senator McCain and I and others are working with the authorizing committee to introduce an extension, a reauthorization of the Choice program, and our draft of that bill already includes the Capito-Baldwin legislation that we've described today.

VA COMMUNITY CARE COORDINATORS

It also, Dr. Meyer, includes requiring the VA to have a community, a care coordinator within the VA to monitor and to manage the care of a veteran when he or she is receiving care outside the VA so that there is a VA person within your hospital in Utah who is monitoring the care.

And I think it goes to part of the solution that Mr. Missal has sought, is somebody needs to be paying attention to where that veteran is, where the prescriptions are being filled, and in what circumstances they're being played in a sense with the inside the VA, outside the VA, and private pay. I don't know that we can get to the private pay, but maybe.

And a large part of what I think Mr. Missal has highlighted for us and Mr. Missal, I'm just going to say this privately, as we left, I think you're doing your job very well. Then it dawned on me that every time I have a town hall meeting, I listen to all the complaints, and as I walk out door, someone whispers in my ear, "I think you're doing a good job." So I decided to say it publicly.
[Laughter.]

VA ELECTRONIC MEDICAL RECORDS

Senator MORAN. It is, I think, a very important task you have, and I think you are performing that task admirably, but I think a significant component to this—and here we go back to what I was saying earlier about a CR and the BCA caps—we also have an issue here of electronic medical records, and we are up against a timeframe in which the VA and its coordination with the Department of Defense in implementing a new contract for electronic medical records across the system, there are efficiencies and economies of scale that occur when we do this in conjunction with the Department of Defense.

The Department of Defense is starting in Washington State. We need to appropriate the money. The money that is needed to implement that contract will exceed the budget control caps. And, again, for another reason, as it relates to our care and treatment of veterans, we need to get something done in December so that the VA can further its contracting obligations and get electronic health records implemented in conjunction with the Department of Defense in the cost saving way that I think makes sense in a timely fashion.

And I think it comes back again to the testimony that we've had today, the nature of this hearing, which is that then has a consequence upon the VA's ability to monitor the prescribing and the use of opioids and other prescriptions that it will otherwise not have. Not only is that computer system, those electronic health records, to coordinate with DOD and the VA so we have a more continuous seamless system in which you leave the DOD and come to the VA, but also to coordinate within the VA medical health records, and now the issue that arises because of your report, how do we coordinate? How do we have electronic medical records that are compatible with the medical records system outside the VA when we contract with an outside provider? That's where I don't want to discourage us from doing everything we can today, but it seems to me that electronic medical records are a significant key to solving the issues that you raise in your report. Am I missing something?

Mr. MISSAL. No, I think you said that extremely well.

Senator MORAN. That's what I complimented, so you would answer the question that way. Thank you.

[Laughter.]

Senator MORAN. Let me just ask a couple questions, then we'll conclude this hearing.

HIGHLY ADDICTIVE PRESCRIPTION DRUGS

In particular, I want to know if while we're focused on opioids, I want to make sure we're not missing something else. So is there

another drug? Is there something else that we ought to be worried about so that if we ultimately get opioids under control and they're managed and utilized in the appropriate way, have we missed some other thing that's either with us today or coming in a direction that is dangerous and harmful to veterans as a drug?

Dr. MEYER. So there are other drugs with the potential for abuse, certainly benzodiazepines, amphetamines, some of the muscle relaxants do come to mind. Many of those are also subject to the same electronic oversight that we give. Certainly, we're including benzodiazepines in.

Senator MORAN. So the policies that the VA is implementing related to opioids really is broader. When we use the word "opioid," we're talking about a broader category of dangerous prescription drugs? Okay.

Dr. MEYER. The OSI is specifically focused on opioids, but we're not blind to that. And we have not seen an uptick in other drugs' prescribing. Opioids are clearly the big problem.

Senator MORAN. Let me ask a question that then raises at least to me, which is, If we're diminishing the use of opioids within the VA, are we increasing the use of something else that is dangerous in its place?

Dr. MEYER. No.

Senator MORAN. Good.

Mr. Missal, did your investigation, your IG report, only deal with opioids, or it was broader in scope than that one particular drug?

Mr. MISSAL. We focused in on opioids, but obviously some of the fixes for opioids then could be applied to other drugs as well when you get into the coordination of care because then that means all the other drugs being utilized, including opioids, would be included.

NON-VA PRESCRIBING PRACTICES

Senator MORAN. Do we have any statistics that demonstrate that a veteran has, as a result of opioid or other drug addiction and abuse, has died in the category of community care? Are there examples of circumstances of death, where the prescription occurred outside the VA?

Mr. MISSAL. I don't have that information in front of me, but this is not a problem just limited to VA. It occurs throughout the United States.

Senator MORAN. I didn't ask my question very well. My question is we've heard from Mr. Simcakoski and what his family has endured within the VA. We're now focused on community care. Are there instances of death that resulted from prescriptions of opioids, the use of opioids, because of the circumstances you describe in your report; in other words, prescriptions that are within community care?

Mr. MISSAL. Right. Given the extensiveness of care in the community at more than 30 percent, I don't have a specific example here, but there likely are a number of instances where the prescribing practices, and perhaps not having all the information, did result in a tragic situation.

Senator MORAN. Did you examine your report in this instance is about community care and your recommendations on how the VA needs to improve its oversight and practices within community

care. Have you looked at the VA, I need to refresh my memory. Have you looked at the VA for opioid policies and implementation of this law within the VA, exclusive of community care?

Mr. MISSAL. Not specifically, but we do have a report coming out on pain management and VA's approach to it. So it's going to be much broader than opioids. It's going to be covering a lot of different medications. And we should have that out in 2018.

OPIOID PRESCRIBING ACCOUNTABILITY

Senator MORAN. Thank you. Do we have examples of where individuals within the VA or community providers outside the VA, through Choice or community programs, have been fired as a result of their behavior, their activities, in regard to opioid prescription and utilization?

Dr. MEYER. I'm aware of such cases in the VA. Those are, of course, an HR issue, but that has happened. I would think that we can't really fire an outside provider, but what we can do is seek to contract with them, and also, if appropriate, report them. I believe there are outside providers again, so that's done through essentially a contracting office using a third-party arrangement, and I'd be very surprised if that hadn't happened.

Senator MORAN. If you would, Dr. Meyer, report back to the committee of the indications of the number of instances in which a contract has been terminated because of bad behavior related to prescribing utilization of opioids and other harmful drugs. Does that make sense?

Dr. MEYER. I will, yes, it does, and yes.

Senator MORAN. My point there is I want to make certain that the VA is making certain there is a consequence to the behavior that we're trying to get at, and if there is a problem, then that contract provider, even though it may be through HealthNet or TriWest, those people ought not be involved in the Choice program. We do not, I'm a supporter of Choice, as is most Members of the Senate. We do not want to taint that program because of bad behavior. It needs to be eliminated, not tolerated.

Dr. MEYER. I would add that's opioids and other behavior as well, sir.

Senator MORAN. Thank you.

Mr. MISSAL. Mr. Chairman, one of the recommendations in our report is that VA needs to examine that, and if there are any providers outside of VA who are practicing inconsistent with the OSI, the Opioid Safety Initiative, then they should be removed as a provider, and VA agreed to that recommendation, so they'll be in the process of doing that.

Senator MORAN. Great. You asked my question so much better than I did, and that's the information I'm looking for, is apparently what you've already agreed to do in response to the IG report.

And it's somewhat related to this question, but I was interested to know if there are already ongoing investigations into, unrelated in a sense, responding to the IG report, is the VA on the ball sufficiently to be investigating this behavior of inappropriate prescribing of opioids and other dangerous drugs? Thank you.

I think I'm coming to a conclusion.

Mr. Schatz, do you have anything else?

Senator SCHATZ. No.

Senator MORAN. I think I'm done.

VA CARE COORDINATION TEAMS

I did mean to ask you, Dr. Meyer, I mentioned that our reauthorization of the Choice program would include care coordinator teams, require that within the VA to monitor and to be responsible for a veteran who is receiving care outside the VA. In your professional opinion, does that concept have merit?

Dr. MEYER. Yes. So in my professional opinion, there are a couple of faces to that challenge. One is the coordination of care that we've been talking about, and the other is the oversight of the quality of that care. And neither one of those offices are automatically stood up. And I would also point out that when we do then send that care out, as we will have to take on these additional functions, and that's work that remains within the VA, and additional work entailed basically by sending somebody out. And so that will need to be moved into our work stream. So I think your solution is a good first step. It may take still more.

Senator MORAN. I would—I don't know that this was in your purview, but I would refer the VA back to the ARCH program. It was the pilot program that predated Choice in I think four locations across the country. There were pilot programs to demonstrate how community care could or should work, and in those instances, there was someone within the VA who monitored the care for those veterans in the ARCH program, and it—my experience is only with the one pilot program in Kansas. If the Senator from Maine was here, she would be talking about the value of that program in Maine. I would just refer the VA to look at how that was done. The data and information gained from that pilot program, in my view, could help determine what that program should look like in a broader sense.

Dr. MEYER. This is a program at scale. This now represents about 30 percent of all of our care, so this is a lot more than one coordinator. This has to be a system.

Senator MORAN. Understood.

I always try to give the witnesses an opportunity to inform the subcommittee of anything that they wish they would have said or regret saying.

[Laughter.]

Senator MORAN. If you have anything you would like to add for the record, clarify for the record, we'd be glad to hear from any of you before I conclude the hearing.

Mr. MISSAL. I would just like to thank you for holding this hearing. Even though our report is relatively limited in terms of our just focus on opioids, our hope is that it has messages that are broader. We put out reports so it gets attention. Holding hearings like this get attention. And we think this will have a great benefit going forward.

Senator MORAN. Mr. Missal, I've suggested, at least to myself, that you and I have a regular meeting in which you tell me what you're looking at and what you're finding, and while I told myself I haven't accomplished that yet, and I look forward to a greater regularity of which we utilize the information that you garner, and

perhaps you utilize our ability to highlight those recommendations and help us monitor to make certain that those recommendations that are agreed to by the VA are actually implemented.

Mr. MISSAL. I'm happy to do so.

Senator MORAN. Thank you.

Dr. MEYER. And I would add my thanks to you for holding the hearing, and also to Jason's family, the Simcakoskis, for their continued work on this and advocacy, and to Senators Baldwin and Capito for getting us rolling with CARA and keeping us moving on that.

Senator MORAN. Mr. Simcakoski, thank you very much, Doctor you mentioned the bipartisan nature and your goal of seeing whether government actually works. And all of us at this table and those that were here earlier, we wish this process worked better, we wish there was more bipartisanship, we wish we were locking arms and solving problems. There are always going to be differences of how we do it, that's not the issue here, but the goodwill desire to see that there's a result rather than score political points, and I'm often—your circumstance highlights the importance of this.

My walk down to the Vietnam Wall or the Lincoln Memorial and go by the World War II Memorial or the Korean War Memorial reminds me of the sacrifice that so many people made had nothing to do with Democrats or Republicans, and we need to roll-model ourselves after your son and his service and those who served with him, the calling that they had, which is sometimes seemingly so different than the calling we seem to think we have.

And so I hope at the end of my time in public service that there's a little bit less cynicism about the way this process is. And I think all of us here want to contribute to reducing the cynicism and proving to you that the American government is still something that matters to the American people. So thank you.

Mr. SIMCAKOSKI. All right. Thank you all also.

ADDITIONAL COMMITTEE QUESTIONS

Senator MORAN. I do want to reiterate the need for the Department to stay on top of this issue, to continue to monitor the prescribing process, remain innovative in your responses, to make sure that we do everything to reduce opioid use. We owe that to the men and women who serve our country. Thank you for your service at the Department of Veterans Affairs, and we look forward to good things happening for all veterans.

I again thank our witnesses for being here. I would remind the subcommittee members that if they have any questions that haven't been asked today, they can submit them for the record. They should be turned in to the subcommittee staff no later than Wednesday, November 22nd. That way you won't have to spend Thanksgiving preparing those questions, or your staffs will not.

QUESTION SUBMITTED TO DR. FRIEDHELM SANDBRINK

QUESTION SUBMITTED BY SENATOR SUSAN M. COLLINS

Question. In 2014, I worked to ensure that our service members and veterans could participate in safe prescription drug disposal programs throughout the Department of Defense and VA. This effort provides veterans a reliable, safe, accessible, and accountable method to dispose of unneeded medications while reducing

the risk of overdose, misuse, or diversion. Could you provide the committee with an update on VA's drug take back programs and their impact on combating opioid abuse?

Answer. Veterans Health Administration (VHA) appreciates Senator Collins' efforts to ensure Veterans' needs were addressed when the Drug Enforcement Administration (DEA) published the Final Rule on Disposal of Controlled Substances. It is VHA policy that each Department of Veterans Affairs (VA) medical facility (including associated VA community clinics) must implement at least one practical, accessible, and secure option for patient disposal of controlled substances medications when appropriate and in applicable settings. All VHA facilities have mail back envelopes for distribution to Veterans free of charge. In addition, over 100 facilities have on-site receptacles that Veterans may use to dispose of their unwanted/unneeded medications. As of September 30, 2017, Veterans have returned over 107,000 pounds (53 tons) of unwanted/unneeded medication using these services. Removal of this medication from Veterans' homes reduces the risk of diversion as well as intentional and unintentional overdoses and poisonings. All returned medications are destroyed in an environmentally responsible manner and in compliance with all DEA regulations through the use of a third-party vendor. Information on these services for Veterans, as well as medication safety in the home, is posted on the VA website at: <https://www.pbm.va.gov/vacenterformedicationsafety/vacenterformedicationsafetyprescriptionsafety.asp>. In addition, VHA partnered with the Department of Defense to produce a public safety announcement on this important topic. It is hosted on YouTube at: <https://www.youtube.com/watch?v=77-ZbwhVm4s>.

SUBCOMMITTEE RECESS

Senator MORAN. And I also want to take this opportunity—this probably is our last hearing for the calendar year of 2017. I'm sorry, the calendar year of 2017. I appreciate the relationship and cooperation with Senator Schatz. And I particularly want to thank both our minority and majority staff. We've had eight hearings this year. It's work. Most of the burden falls upon the people behind me. And I'm very grateful for their commitment to see that good things happen both in our military as well as our veteran—Department of Veterans Affairs, and serve those who need our help within the military, and those who need our help within the veteran community.

And with that, I conclude the hearing. Thank you.

[Whereupon, at 4:30 p.m., Wednesday, November 15, the subcommittee was recessed, to reconvene subject to the call of the Chair.]