



**THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON**

October 30, 2024

The Honorable Jon Tester
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the requirements of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, P.L. 115-182 § 131, I enclose the Department of Veterans Affairs (VA) annual report outlining the ongoing efforts to ensure community providers engage in safe opioid prescribing practices. The report details processes implemented to allow providers to review a Veteran's prescription history and the number of community providers familiar with VA's Opioid Safety Initiative. VA remains committed to honoring the Nation's Veterans by ensuring a safe environment to deliver exceptional health care.

In addition, as required by 38 U.S.C. § 116, I enclose a statement of cost for preparing the report. I am providing this report to the leaders of the House and Senate Committees on Veterans' Affairs.

Sincerely,

A handwritten signature in black ink, appearing to read "DMcDonough", written in a cursive style.

Denis McDonough

Enclosures

DEPARTMENT OF VETERANS AFFAIRS



Congressionally Mandated Report: Establishment of Processes to Ensure Safe Opioid Prescribing Practices by Non-VA Health Care Providers

October 2024

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Executive Summary

In this report, the Department of Veterans Affairs (VA) outlines the ongoing steps VA is taking to implement all the requirements of section 131 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, P.L. 115-182. In addition, the report provides an overview of the processes VA has in place to ensure community providers engage in safe opioid prescribing practices. For example, in March 2024, VA further strengthened its review of community care provider opioid prescribing practices by streamlining its monitoring processes to ensure the recommendations of the VA Opioid Safety Initiative (OSI) are followed and Veterans receive high quality care.

VA modified the existing structured review of the community care provider opioid prescribing practices with enhanced reporting capabilities through an automated dashboard, new intake forms, and clear guidance on roles and responsibilities to document evidence of the application of VA OSI risk mitigation strategies. In the past year, VA also established an integrated project team (IPT) to address findings and recommendations from the recently published Office of Inspector General reports.

Background

On June 6, 2018, the President signed into law the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, P.L. 115-182. The VA MISSION Act strengthens the ability of VA to deliver quality health care and timely services that Veterans have earned, whether in VA facilities or through a community provider. VA tracks the following requirements of section 131 of the VA MISSION Act of 2018:

- Ensure that covered health care providers are provided a copy of the VA Opioid Safety Initiative (OSI) and certify that they have reviewed the evidence-based guidelines for prescribing opioids as set forth in the initiative.
- Implement a process to ensure that a Veteran's relevant medical history and list of prescriptions is shared with community providers.
- Require covered health care providers to submit to VA the medical records of any care or services furnished to a Veteran, including records of any prescriptions for opioids, in the timeframe and format specified by VA.
- Record prescriptions in Veterans' electronic health records (EHR) and enable other monitoring of the prescriptions as outlined in the VA OSI.
- Ensure that the opioid prescribing practices of covered health care providers do not conflict with or are otherwise inconsistent with the standards of appropriate and safe care, do not violate the requirements of the covered health care provider's medical license, or do not place Veterans at risk and that they take action as appropriate.
- Ensure that network contracts with Third Party Administrators (TPA) that provide community care contain, among other things, language authorizing VA and TPAs to take appropriate actions up to and including the removal of community health care providers.

VA Community Provider Review of Evidence-Based Opioid Guidelines

VA's provider network of more than 1.4 million community providers requires significant oversight and management. While these providers do not work directly for VA, the care they deliver has direct impact on the Veterans we serve. VA relies upon its TPAs to help recruit and manage these providers, and expects our TPAs to assure some quality control. However, TPAs often have little ability to influence the behavior of the providers. VA continues to make progress in monitoring the safety and quality of care its community care partners provide, but work is still ongoing.

As of this writing, VA is not yet compliant with the requirement of section 131(a) to ensure that all covered health care providers receive the VA OSI and certify that they have reviewed the evidence-based guidelines set forth in the VA OSI.

Through its Training Finder Real-time Affiliate-Integrated Network (TRAIN), an online external learning management system, VHA provides access to VA OSI guidelines and other training courses to all community providers. However, VA cannot enforce training completion as a requirement for receiving community care referrals through the TPAs. Section 131(a) of the VA MISSION Act of 2018 requires that all covered health care providers be provided with a copy of the VA OSI and certify that they have reviewed the evidence-based guidelines for prescribing opioids set forth by the VA OSI. As of March 2024, 18,316 community providers have certified that they completed a review of the VA OSI guidelines.

Many of these providers will transition from Veterans Care Agreements (VCAs) to the Community Care Network (CCN) contract, and the contractors will ensure their provider handbooks include a copy of the VA OSI and providers will certify they have reviewed it as part of their CCN training requirements. For providers who use VCAs, VA provides an online VA OSI training module for providers to review and certify. VA communicates the expectation for prompt completion of VA OSI training.

Medical Records and Medication History

VA implemented processes to share with covered health care professionals the available and relevant medical history of the Veteran and a list of all medications prescribed to the Veteran. VA also put in place requirements for community providers to submit medical records of any care or services furnished, including records of any prescriptions for opioids.

VA uses three main tools to share all relevant medical information with community providers when authorizing care. These tools are:

- **Veterans Health Information Exchange (VHIE):** VHIE is used by health care providers to access seamlessly and securely the information they need to coordinate Veterans' care. VA and other participating provider organizations can request and receive electronic health information safely and securely through a secure gateway called the Joint Health Information Exchange, or Joint HIE. VHIE ensures community providers have the most up to date and accurate information to treat patients.
- **Health Share Referral Manager (HSRM):** HSRM enables VA and community

providers to upload and share essential clinical documents, including images, notes, and tests. HSRM is a product that allows for standardized referrals with medical documentation and bidirectional communication. HSRM also is used to create offline referrals, thus ensuring that providers who are still adopting HSRM can continue to send and receive important medical information. When an HSRM offline referral is used, a documentation package, including a referral, is attached, and sent through secure fax or secure email.

- Referral Documentation (REFDOC) Tool: REFDOC automates a process for reviewing a Veteran's relevant medical history. In REFDOC, VA can provide important demographic information, lab and progress notes, and other important records, as necessary. This history includes information on outpatient medications dispensed by VA within the last 12 months, current medications prescribed by non-VA sources, and notes on provider consent to long-term opioid prescriptions for pain management.

In addition, VA has a provider letter within Oracle Health. Like the VistA-based REFDOC tool, when using the provider letter, VA can provide important demographic information, lab and progress notes, and other important records, as necessary. This history includes information on outpatient medications dispensed by VA within the last 12 months, current medications prescribed by non-VA sources, and notes on provider consent to long-term opioid prescriptions for pain management.

Medical Documentation

Community providers participating in CCN and under VCAs are contractually obligated to submit all medical documentation, including documentation of products dispensed and prescriptions associated with an episode of care with a claim, within specified timeframes. The TPAs—Optum and TriWest—are required to educate the CCN providers on medical documentation submission requirements.

Initial medical documentation is medical documentation associated with the first appointment of a Standard Episode of Care (SEOC). Final medical documentation is medical documentation that covers the entire SEOC. Initial medical documentation for outpatient care must be returned within 30 days of the initial appointment. Final outpatient medical documentation must be returned within 30 days of the completion of the SEOC. Medical documentation must be returned within 30 days for inpatient care and will consist, at a minimum, of a discharge summary. Any medical documentation requested by VA for appropriate urgent follow up must be provided to VA upon request.

The collected documentation is added to the Veteran's EHR and is available for review by a Veteran's VA provider. In cases where the contractors or providers do not submit clinical documents within the specified timeframe required, local VA staff contact the provider to request the documentation. VA provided guidance to the field on documentation requests as part of its memorandum on October 1, 2021, titled Revised Administrative Closure of Community Care Consults Process. In addition, CCN contracts limit retail pharmacies to fill urgent/emergent opioid medications for a maximum of a 7-day supply (or less if state limits are more restrictive) without refills.

All opioid prescriptions over a 7-day supply that are processed by a VA pharmacy are captured in the Veteran's EHR.

VA Review of Community Providers' Opioid Prescribing Practices

VA has multiple approaches to review community providers' opioid prescribing patterns, described in the following subsections.

Standardized Opioid Prescription Provider Review

The Veterans Integrated Service Networks (VISNs) have been reviewing and reporting on VA and community provider prescribing practices since 2019. When VISNs identify concerns regarding prescription patterns of a community provider, VA coordinates peer-review of the non-VA provider, including collaboration with TPAs, as necessary, to ensure that providers prescribe opioids in a manner consistent with the VA OSI.

From March 1, 2023, through February 29, 2024, 17 of the 18 VISNs completed at least 1 multidisciplinary committee review on the opioid prescribing practices of community providers. About 1,035 community providers were initially reviewed for their opioid prescribing practices (as identified using the process below). Of those community providers reviewed, approximately 16% underwent further review by VA quality and patient safety staff.

In March 2024, VA further strengthened its criteria and processes for review of community care provider opioid prescribing practices. VA established a standardized provider review process, including the release of the MISSION Act Section 131 Review of Community Care Provider Opioid Prescribing Practices memorandum on March 12, 2024, which entails a reasonable workload for VA medical staff performing the reviews and meets the needs of VA. The guidance for this standardized process was developed using a multidisciplinary approach that included the viewpoints of subject matter experts from VA National Pharmacy Benefits Management, Pain Management, Opioid Safety, and Prescription Drug Monitoring Program (PMOP), Office of Integrated Veteran Care program offices, VISN Community Care, Integrated Veteran Care Management, Integrated Field Operations, and web tool experts.

In this revised process, each step allows for facilities to have clearly defined roles and responsibilities, while providing VA medical centers (VAMC) and VISNs with the flexibility to make decisions that make the most sense for their facilities. VA creates a list of providers whose prescribing behaviors are considered to be high-risk (for example, Veterans who are prescribed an opioid and benzodiazepine, morphine equivalent daily dose ≥ 90 mg and have started new long-term opioid therapy). These high-risk behaviors can lead to overdose and development of opioid use disorder. VA identified these focus areas (triggers) as the best approach to flag and initiate provider reviews and have data collected on these areas across VA. In the new process, VA uses three specific VA OSI metrics to create a list of providers for in-depth reviews, including metrics on providers: (1) obtained consent from the Veteran, (2) conducted periodic urine drug screens to assess for prescribed medications and other controlled prescription and illicit drugs, and (3) searched

prescription drug monitoring programs in their state to ensure that Veterans are not prescribed opioids by another provider.

In support of this revised guidance, VA also built new resources to support and automate the newly updated processes. The first of these new resources is a Microsoft Power App that is now the data collection mechanism moving forward. The Microsoft Power App is automated, thus allowing VHA to provide quarterly reports to VISN leadership for increased oversight. A redesigned SharePoint site containing resource documents with further background and instructions on review guidelines provides further communications to the field. Moreover, VA built out the Opioid Community Prescriber Review Q&A Dashboard, monitored by the Office of Integrated Veteran Care. This dashboard is a centralized location for users to search frequently asked questions and submit questions about the community opioid provider process.

These updates will produce additional data points that can be used in the future to provide high quality insights on the review process. Equally important, VA has now standardized the opioid prescriber review process and automated the reporting for transparent documentation from the VAMCs to the VISN Directors.

As a result of the newly implemented guidance and resources, VA has seen an uptick in the number of provider reports submitted. From March 2024 to June 2024 alone, there have been over 700 provider reviews submitted. In comparison, 776 reports were submitted over the twelve-month period ranging from March 2022 to February 2023. In addition, all 18 VISNs are submitting within reporting requirements, and there has been a 2% decrease in the number of providers referred for additional review with a potential quality issue (PQI) submitted. A review does not indicate a confirmed issue, but rather potential high risk prescribing practices that need to be evaluated.

Leveraging VA Pharmacy Prescribing Practices

VA developed procedures at the pharmacy and provider level to ensure that safe prescribing practices are followed in community care regarding opioids. Both community care and VA pharmacists perform multiple system checks to identify prescribing behaviors of providers, drug-drug interactions, prescriptions that may be refilled too soon and real-time point-of-sales review. CCN contractually requires TPAs to independently identify, evaluate, track, find trends and report interventions to resolve any potential quality and or patient safety issues and process to completion within established Quality Assurance Surveillance Plan measures.

Safety and Quality Reporting

Separate from proactive efforts by VA to review community care provider opioid prescribing and pharmacy reviews described previously herein, a VAMC or VISN can submit a Joint Patient Safety Reporting form, which is a centralized reporting system used within VHA to report all patient safety events. If the care was provided by a TPA CCN community care provider, the staff member also can submit a PQI form associated with the applicable TPA, thus initiating the TPA investigative review

process. Once the PQI form is submitted to the TPA, the TPA peer review committee will review the case and make the final determination. When actions on a provider or facility will significantly impact access to care, the TPA will reach out to coordinate those actions with VA.

Actions Against Community Providers Who Do Not Follow Safe Opioid Prescribing Practices

VA is taking appropriate actions to exclude or limit community providers when their opioid prescribing practices conflict with the standards of appropriate and safe care; violate the requirements of a medical license; or may place Veterans at risk. The appropriate TPA performs an extensive quality review when a significant concern arises for a specific provider. The TPA uses a peer review process to evaluate and investigate reported potential quality of care and patient safety concerns to resolution (for example, egregious substandard care jeopardizing quality of care and/or Veteran safety).

VAMCs review VCA providers according to local review policy procedures. In the event a community provider is found to have prescribing practices that jeopardize safe Veteran care, VA will place a provider hold on the provider's Provider Profile Management System profile, and the provider will not receive further referrals or authorizations. This formal provider hold process may be used for TPA network providers as well while TPAs are conducting their contractually required investigative review process. Any active authorizations are reviewed for alternate care coordination needs based on clinical determination. Guidance for care coordination for active patients under a deactivated provider is delineated within IVC Field Guidebook.

In addition, VA established a credentialing process for onboarding VCA and CCN providers. VA credentials VCA providers and has credentialing requirements in CCN contracts for TPAs. There is also an established process to report community care provider concerns for quality of care and/or patient safety issues.

VA's Efforts to Address Office of Inspector General Concerns

VA continues to review and enforce requirements for covered health care providers to receive the VA OSI and certify they have reviewed the evidence-based prescribing guidelines. Following two recently published Office of Inspector General (OIG) reports, "Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans" and "Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Healthcare System in Topeka and Leavenworth," VA established an IPT to address OIG's findings and recommendations. This IPT includes clinical and administrative leadership from VHA's Office of Integrated Veteran Care and has accomplished several actions to date to address OIG's findings, including:

- Partnering with the VA CCN TPAs to confirm roles and responsibilities between VA and the TPA in tracking CCN provider certification of VA OSI guideline review.
- Investigating contractual and internal system limitations in tracking

- community provider completion of the OSI training in VHA TRAIN.
- Consulting with the CCN Next Generation project team to ensure lessons learned are applied so the CCN Next Generation contract clearly defines TPA roles and responsibilities in tracking community provider certification of OSI guideline review.

VA will continue to assess potentials solutions to OIG findings and recommendations and provide updates in future reports.

Conclusion

VA will continue to promote safe opioid prescribing practices through multiple approaches for community providers who care for Veterans and continue to refine the process to review opioid provider prescription practices.

Department of Veterans Affairs
October 2024