



Department of Veterans Affairs
Office of Inspector General

News Release

Washington, DC 20420
(202) 461-4683

FOR IMMEDIATE RELEASE
August 1, 2017

VA Office of Inspector General Releases Inspection Report on Opioid Prescribing *Conflicting VA and Community Care Monitoring Guidelines Increase Risks to Veterans*

WASHINGTON – The VA Office of Inspector General (OIG) issued its Healthcare Inspection report, *Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care*, identifying the immediate need for improved care coordination between VA and non-VA healthcare providers prescribing opioids to veterans. The inspection reviewed opioid prescribing to high-risk veterans, such as those with chronic pain and co-occurring mental health illnesses, receiving VA purchased care from the Veterans Choice and other non-VA community provider programs.

With the prevalence and complexity of chronic pain among veterans, this population has been significantly impacted by the nation’s opioid crisis. Fragmented care coordination between VA and non-VA providers, as well as differing clinical standards for managing pain, places certain veterans at increased risk for overdose or complications associated with prolonged opioid use.

“Veterans receiving opioid prescriptions from VA-referred clinical settings may be at greater risk for overdose and other harm because medication information is not being consistently shared,” said Michael J. Missal, Inspector General, U.S. Department of Veterans Affairs. “That has to change. Healthcare providers serving veterans should be following consistent guidelines for prescribing opioids and sharing information that ensures quality care for high-risk veterans.”

VA’s Opioid Safety Initiative provides VA healthcare providers a framework to evaluate, treat, and manage patients with chronic pain or long-term opioid therapy. However, community providers are not obligated to adhere to these guidelines. This can present significant patient safety and care management challenges when community care providers’ prescribing and monitoring practices conflict with the VA’s evidence-based guidelines.

The OIG report recommends that non-VA providers be required to submit prescriptions for opioids directly to VA pharmacies so that these prescriptions can be tracked and coordinated with medications prescribed by VA care providers; to review evidence-based guidelines for prescribing opioids; and to include in care consults an updated list of the patient’s medications. The VA concurred with the recommendations and submitted action plans to implement them.

The OIG conducts oversight of VA and its programs and operations, providing independent and objective reporting to the VA Secretary and the Congress for the purpose of preventing and detecting fraud, waste, and abuse, and bringing about positive change in the integrity, efficiency, and effectiveness of VA. To report potential criminal activity, fraud, waste, mismanagement, or other abuse, contact the VA OIG Hotline at vaoighotline@va.gov or www.va.gov/oig/hotline/default.asp. ###