

**STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON MILITARY CONSTRUCTION,
VETERANS AFFAIRS, AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
HEARING ON
“VA EFFORTS TO PREVENT
AND COMBAT OPIOID OVERMEDICATION”**

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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

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 3962011;4):393-396

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

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 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 evidence-based 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

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.

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 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.

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

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.

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.

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.

- 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.

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.

⁸ As 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/recommendation-dashboard.asp>.