FULFILLING OUR PROMISES
TO THE MEN AND WOMEN WHO SERVED

National Service & Legislative Headquarters
807 Maine Avenue, S.W.
Washington, D.C. 20024-2410
Phone (202) 554-3501
Fax (202) 554-3581
www.dav.org

STATEMENT OF
JOY J. ILEM
DAV DEPUTY NATIONAL LEGISLATIVE DIRECTOR
SUBMITTED FOR THE RECORD TO THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
WASHINGTON, DC 20515
APRIL 30, 2014

Chairman Sanders, Ranking Member Burr and Members of the Committee:

DAV (Disabled American Veterans), an organization of 1.2 million wartime veterans who were wounded, injured or made ill due to their military service, appreciates this opportunity to offer testimony for the record of your hearing to examine overmedication and its problems and solutions in the Department of Veterans Affairs (VA).

Less than a month ago, VA formally directed its 21 Veterans Integrated Service Networks (VISN) to launch a new and intensive opioid safety initiative. The stated goals are to reduce harm to veterans from unsafe medications and dosages, but to adequately control veterans' pain. While DAV offers no opposition to this initiative, our experience in recent years in several local instances with VA physicians who decided to abruptly discontinue prescribed opioids for our members without offering them alternatives does not lend confidence that this initiative will be carried out with sensitivity to the needs of veterans to tolerably manage their pain in absence of such drugs. Some of our members who contacted DAV had been prescribed these drugs for decades, and were tolerating their pain well, but were offered little to no alternatives when VA physicians decided to abruptly end such prescribing. In situations such as these, we are concerned that these veterans will turn to alcohol or illicit drugs in search of pain relief, or will be left to needlessly suffer.

As we understand it, VA's opioid safety initiative contains nine goals. The initial goals (to be accomplished within six months, according to the directive) would establish systems to educate VA prescribers about safely and effectively prescribing opioids; increase the usage of urinalysis to detect presence of opioids in veterans' urine; provide VA prescribers potential access to state prescription databases to identify veterans who are in receipt of opioids from private prescribers; and establish "tapering programs" for certain veterans using opioids along with other drugs.

The second set of VA goals, to be achieved over the next nine months, includes central development of a "risk stratification toolkit" to be deployed locally in VA facilities

to enable physicians to assess veterans using opioids who should not be treated with them, or identify those who can be given reduced doses at a safer level. Another goal calls for each VISN to implement a uniform tapering program for certain "high-risk" opioids, with an overall objective of VA's achieving a 75 percent reduction in the use of certain opioids by not later than December 15, 2014.

The third set of VA goals, to be achieved over a year or possibly longer, requires all VA facilities to identify veterans who are prescribed opioids above a stated dosage ceiling (200 milligrams of morphine equivalents per day). VA Central Office will collate this data and provide it to VISNs and facilities, which will be required to conduct appropriateness reviews with prescribers who are identified as providing veterans dosages higher than the dosage ceiling. Another goal is for all VA facilities to provide at least two unspecified complementary and alternative medicine (CAM) modalities in the treatment of chronic pain. These modalities are to be put in place by March 15, 2015.

The last goal is to establish a mental health component within the Patient Aligned Care Team approach to delivering VA care to veterans with a history of prescribed opioid use, focusing on establishing a three-facility trial of deploying "interdisciplinary medication risk management teams," to identify "strong practices that can be operationalized across the VHA Healthcare System," to achieve further reductions in the use of prescribed opioids.

The above description of VA's initiative is oversimplified and summarized for the Committee's use, but constitutes our understanding of its purpose based on our review of the directive and information we have received from VA practitioners who remain concerned about this new program's effectiveness and its impact on veterans in pain. To our knowledge neither DAV nor the remainder of the veterans service organization community have had a comprehensive briefing by VA on this new program, its purpose and justification, and how it will be implemented and monitored. It is also our understanding that, although already issued to VISNs and facilities, the directive is being reconsidered based on numerous concerns that have arisen since, and may be amended.

While we have not received a national resolution from our membership on the topic of opioid reduction in VA health care, as indicated above, many of our members who were wounded, injured or made ill due to military service during wartime suffer from chronic pain from numerous causes other than malignancy (the only stated exception to this initiative), and presumably will be targeted by this new policy. The directive suggests that the use of CAM combined with integration of a specialized, and as yet untested, new mental health treatment model can substitute for existing prescribing practices by VA physicians who are dealing over time in primary and specialty care with veterans suffering from chronic pain and chronic pain syndrome.

In a confounding countertrend, the Veterans Benefits Administration recently announced in the *Federal Register* that it has determined justification is sufficient to award service-connected ratings to veterans suffering from chronic pain and chronic

pain syndrome, as discrete disabilities. DAV fully supports this broader authority to recognize that chronic pain is real, damaging and even debilitating. Also, this decision on rating veterans with chronic pain would suggest that chronic pain is a significant disabling condition from the vantage point of the VA division that awards disability compensation, whereas based on this new opioid reduction directive, another division of VA may see it quite differently.

DAV is also concerned about VA's potential participation in state drug monitoring programs. Many of these activities were stimulated by law enforcement, not public health authorities, in a search for illicit prescribing practices by private physicians, and trafficking in controlled substances by people who defraud physicians. While we appreciate VA's legitimate interest in protecting against abuse and overuse of opioids, we are concerned about potential unintended consequences of VA's approach to these state monitoring programs and recommend close oversight by the Committee to ensure its purposes are limited to the health and safety of veterans and of their health care.

DAV would never advocate for broad use of narcotics as a first line, or only line, of treatment for wounded, injured and ill veterans with chronic pain or chronic pain syndrome; however, the intent of VA's new initiative seems dedicated first to a drastic reduction in the use of painkiller drugs over other purposes, and may not keep uppermost the needs of veterans who suffer from chronic pain as a clinically legitimate treatment population.

DAV strongly supports bringing significant CAM treatments into VA health care, particularly for younger veterans who do not want traditional health care, prescription medications or typical mental health treatments; however, if VA intends to use CAM as a substitute for, or replacement of, legally prescribed opioid medications in a known and older population, we urge VA to ensure the effects of shifting veterans away from these medications is closely followed in clinical care, lest these veterans resort to the abuse of alcohol or other drugs to compensate for the loss of painkillers that actually work for them. Additionally, VA facilities' selection of CAM models may not have the desired effect intended by this directive. For example, a study in the *Journal of the American Medical Association* ("Acupuncture for the Treatment of Cocaine Addiction: A Randomized Controlled Trial," January 27, 2010) that followed treatment of a large group of cocaine users diverted to acupuncture therapy as a substitute did not demonstrate effectiveness in reducing the use of cocaine in that population. In fact, the study "does not support the use of acupuncture as a stand-alone treatment for cocaine addiction or in contexts in which patients receive only minimal concurrent psychosocial treatment." Numerous other published studies replicate this finding on acupuncture, and are reported on VA's Health Services Research and Development webpage, http://www.hsrd.research.va.gov/publications/esp/acupuncture.cfm. In our view, VA health care officials should carefully study the efficacy of CAM modalities as exchanges for prescribed opioids for pain to ensure they can accomplish the results intended, and that CAM modalities selected by facilities are efficacious for these purposes, are evidence-based, and are accompanied by appropriate other treatment resources.

Mr. Chairman, perhaps most important to the purposes of this hearing, DAV is concerned that the required rapid implementation of this new directive will not be standardized and uniform across the vast VA system. In fact, the directive itself allows for local deviations and modifications, by "providing opportunity for customization to meet local needs." The alternative approaches that are offered in the directive are vague, and may lead to wide variations, or only limited local implementation. In DAV's view, the directive should mandate interdisciplinary pain management teams be established at each facility, and ensure these teams are functional, before launching such an aggressive tapering program. The structure and function of such teams should be specified and mandatory. Without more specificity, a "pain management team" may simply become a single provider designated in a facility whose primary (or imposed) clinical role would be to reduce the prescribing of opiates to veterans, without providing viable alternatives to address their pain.

We believe any alternative treatments accompanying this plan should be specified and required in the directive. This availability should include psychological pain management treatments and other alternative treatments, including but not limited to specialized counseling, chiropractic care, and CAM approaches that are evidence-based. Even when some of these services are made "available," a veteran with chronic pain may only be given a limited course of treatment, or be made to choose one or the other but not both to meet pain care needs. This would be an unfortunate and unsafe way to deal with opioid reduction due to its impact on the health of individual veterans. As an advocate for these veterans, especially those who were wounded, injured and ill due to military service, such an outcome would be unacceptable.

During VA's initiative to implement a national formulary 15 years ago, many prescribers complained that they were disallowed from prescribing preferred, standard medications they had used for years in their practices because they were not a part of the then-new national formulary. In order for VA physicians to procure off-formulary drugs under the policy, VA established a national procedure in which the prescriber had to submit an explicit justification for use of a particular drug in an individual veteran's case, before a local or VISN VA pharmacy prescribing board, to gain approval of the deviation. This process at the time was seen as time consuming, a dampening influence, an interference of professional practice, and a difficult bureaucratic barrier. The formulary change accomplished the VA's goal of producing cost savings, but it came at the expense of many veterans who needed to adjust to new medications without warning and in some cases against the interests of their prescribing physicians. We hope and trust this new initiative will not carry similar consequences for the veterans it is going to affect.

Finally, also about 15 years ago, it is helpful to recall that VA took the national and even international lead on establishing pain as the "fifth vital sign." Hospitals and physician practices all over the world now use this concept in evaluating patients' pain level and developing interventions for pain as an important treatment goal on its own merit. Pain is the number one reason people, including wounded, injured and ill veterans, seek health care. DAV hopes VA will be able to carry out this new initiative to

reduce opioid prescribing recalling its stewardship of pain management in western medicine, without rushing to judgment that veterans under VA care are atypically overprescribed narcotic medications. We understand from practitioners in VA facilities that, already, the pressure on, and monitoring of, providers to decrease their prescribing of opioids in pain management is leading to significant reductions in such prescribing, with no good alternatives available for affected veterans who are suffering from chronic pain. This is a troubling development, and we hope the Committee will thoroughly review this situation, not only during this hearing but on a recurring basis, to ensure that veterans experiencing pain remain VA's primary focus.

Mr. Chairman and Members, this concludes DAV's statement. Again, DAV appreciates the indulgence of the Committee in permitting the submission of this testimony.