

United States Senate

December 8, 2015

The Honorable Robert A. McDonald
Secretary
Department of Veterans Affairs
810 Vermont Avenue, Northwest
Washington, DC 20420

Dear Secretary McDonald:

I am writing you in regard to the Department of Veterans Affairs' (VA) current policy on the prescription practices and guidelines for controlled substances. I am deeply concerned about the epidemic of opioid addiction and overdose death that is devastating families both in Indiana and across the country. In light of the Drug Enforcement Administration's inspection of Marion, Indiana Veteran Affairs Medical Center, I am particularly interested in the VA's efforts to ensure that all of its prescribers comply with the Controlled Substances Act requirements and are using evidence based practices for prescribing controlled substances.

Addiction, especially the recent increase in prescription drug abuse and heroin use, impacts Hoosiers in all corners of our state from our largest cities to rural communities. As Senator, I have met with too many families who are struggling to find appropriate treatment services for a loved one in need. The epidemic has touched our children, adults, and even our veterans.

While there is no easy solution, there are steps that we can take to enhance our prevention efforts so that fewer families will suffer from addiction or the untimely death of a loved one. That is why in 2014, I introduced the Heroin and Prescription Opioid Abuse Prevention, Education, and Enforcement Act, with Senator Kelly Ayotte (R-NH), and reintroduced similar legislation in April of this year. Our bill establishes an interagency task force to develop best practice guidelines for prescribing opioid pain medication and would further enable the development of state prescription drug monitoring programs. Since introducing this legislation, I have been working with my colleagues, federal agency partners, as well as state and local officials to advance these policy priorities.

More Americans now die every year from drug overdoses than they do in motor vehicle crashes and the majority of those overdoses involve prescription medications. To address this crisis this October, the President issued a Presidential Memorandum directing Federal Departments and Agencies to ensure that health care professional who prescribe opioids are properly trained in opioid prescribing. Your leadership has been recognized to lead a research initiative to evaluate non-opioid alternative approaches to pain management. Further, the Department of Defense and Department of Veteran Affairs have been tasked with developing a standardized pain management curriculum for widespread use in education and training programs.

- What type of policy and/or process improvement initiatives has the Veteran Health Administration implemented in order to comply with the Controlled Substance Act or Presidential Memorandum?

- What are the challenges to implementing initiatives to address this crisis and ensure the highest level of patient safety?
- What expanded role will the VA's Complementary and Alternative Medicine (CAM) Department play in the comprehensive evidence based pain management of our Veterans?
- Are these CAM capabilities available in Indiana? If not, is there a planned timeline for implementation?
- Do you have an internal and external mechanism to receive complaints and suggestions at all VA facilities in Indiana? How are they managed to ensure that Senior Executives are notified of these reports? Do you have a specific metric that causes immediate processing to the highest levels of leadership?
- Have there been complaints about opioid prescribing practices in Indiana? If so, what were the complaints? Were they substantiated? What action was taken to address the complaints?

It is my understanding that the VHA Handbook 1108.1, *Controlled Substances*, is scheduled for recertification. It is my hope that this update will include measures that will provide the highest security measures for controlled substances, clarify policies governing the most secure supply chain, and outline roles and responsibilities for personnel responsible for these substances. Specifically, I am interested in the following:

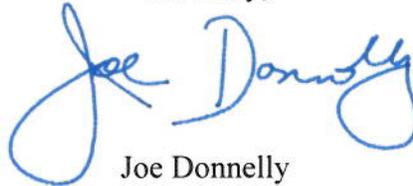
- Are there universal policies that govern controlled substances across the Veteran Health Administration or are they locally controlled by facility and/or state?
- How does the Veteran Health Administration ensure all of their providers with prescriptive authority for controlled substances receive continued medical education for prescribing controlled substances and recognizing addiction behaviors?
- How does the VHA ensure their practicing clinicians are in compliance with the Controlled Substance Act?
- Have there been any incidences where a VAMC or CBOC in Indiana has been found to be not in compliance with rules and regulations governing controlled substances?
- Is there a VA policy for follow-up internal review following the completion of a DEA investigation?
- How does the prescribing rate at the Marion VA facility compare to the prescribing rates at other VA hospitals serving a similar panel of enrollees?
- Does the Office of Inspector General review controlled substance prescription practices during their routine reviews of facilities?
- Does the local Quality Assurance Reviews address evidence based practices for opioid prescription practices?

INSPECT, Indiana's prescription drug monitoring program (PDMP), is an important component of Indiana's strategy to prevent prescription drug abuse and diversion. I am a strong supporter of utilizing PDMPs to their fullest potential as a resource for healthcare providers, public health officials, and law enforcement. However, PDMPs can only be an effective tool if they include information that is as up-to-date and complete as possible.

- Does the Veteran Health Administration have a universal policy that gives all medical providers the electronic capability and/or responsibility to verify a patient's current medications (i.e. controlled substances)? If not, how does the VHA ensure that patients are not receiving multiple prescriptions for controlled substances at different locations?
- When are medical providers and pharmacists required to check the respective state's PDMP before prescribing or issuing controlled substances?
- Do any Veteran Administration Medical Centers in Indiana provide data to INSPECT, Indiana's prescription drug monitoring program?
- What barriers exist for centers in Indiana that currently are not providing data to INSPECT?

Thank you for your leadership and consideration of this critically important issue. I look forward to your response to the questions I have provided.

Sincerely,

A handwritten signature in blue ink that reads "Joe Donnelly". The signature is fluid and cursive, with the first name "Joe" and last name "Donnelly" clearly legible.

Joe Donnelly
United States Senator