JUNE 10, 2015

PRESCRIPTION MISMANAGEMENT AND THE RISK OF VETERAN SUICIDE

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

ONE HUNDRED FOURTEENTH CONGRESS, FIRST SESSION

HEARING CONTENTS:

MEMBER STATEMENTS:

Rep. Mike Coffman (R-CO) *[no pdf available, 23:58 of the webcast]*
Chairman, Subcommittee on Oversight and Investigations

Rep. Ann Kuster (D-NH) *[no pdf available, 29:25 of the webcast]*
Ranking Member, Subcommittee on Oversight and Investigations

WITNESSES:

Dr. Carolyn Clancy *[view pdf]*
Interim Under Secretary for Health, U.S. Department of Veterans Affairs
Written testimony submitted on behalf of the three Department of Veterans Affairs witnesses

Mr. Michael Valentino *[part of VA's written testimony presented by Dr. Clancy]*
Director, Natural Resources and Environment, U.S. Government Accountability Office

Dr. Harold Kudler *[part of VA's written testimony presented by Dr. Clancy]*
Chief Consultant, Mental Health Services, Veterans Health Administration
U.S. Department of Veterans Affairs

Mr. Randall Williamson *[view pdf]*
Director, Health Care Issues, Government Accountability Office

Dr. Jacqueline Maffucci *[view pdf]*
Research Director, Iraq and Afghanistan Veterans of America

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STATEMENT OF

DR. CAROLYN CLANCY

INTERIM UNDER SECRETARY FOR HEALTH

VETERANS HEALTH ADMINISTRATION

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

Subcommittee on Oversight and Investigations

COMMITTEE ON VETERANS' AFFAIRS

United States HOUSE OF REPRESENTATIVES

June 10, 2015

Good morning, Chairman Coffman, Ranking Member Kuster, and Members of the Committee. Thank you for the opportunity to discuss the provision of mental health care to Veterans, particularly those who are at risk for suicide. I am accompanied today by Dr. Harold Kudler, Acting Chief Consultant for Mental Health Services and Mr. Michael Valentino, Chief Consultant of Pharmacy Benefits Management Services. My written statement will discuss VA's many initiatives enhancing the appropriate use of prescription medications as well as VA programs caring for individuals who experience mental and substance use disorders, including programs for suicide prevention.

Opioid Safety Initiative

Chronic pain, which is a major health problem for Servicemembers and Veterans, is also a national public health problem as outlined in the 2011 study by the Institute of Medicine (IOM). At least 100 million Americans suffer from some form of chronic pain. The IOM study describes in detail many concerns about pain management, including system-wide deficits in the training of our Nation's health care professionals in pain management and the problems caused by a fragmented health care system. The over-use and misuse of opioids for pain management in the United States are a consequence of a health care system that continues to struggle with these challenges. About 30% of the U.S. adult population experiences chronic pain, a large number to manage. The problem of chronic pain in the VA is even more daunting with 50% to 60% of

Veteran patients experiencing chronic pain due to battle field and other service related injuries. It is important to note that nationally, most patient deaths from overdose are unintended. Many Veterans have also incurred head injuries, collectively referred to as traumatic brain injuries (TBI), which can compound psychological injuries such as post-traumatic stress disorder resulting from their experiences. The combination of pain, a head injury and mental health disorder can further degrade quality of life for Veterans and their families, increasing the risk for overdose, substance abuse, and suicide.

The VA health care system has identified and broadly responded to the many challenges of pain management through policies supporting clinical monitoring, education and training of health professionals and teams, and expansion of clinical resources and programs. The Opioid Safety Initiative (OSI) was implemented system-wide in August 2013 and is producing the desired results. The goal of the OSI is to make the totality of opioid use visible at all levels in the organization. The OSI includes key clinical indicators such as the number of unique pharmacy patients dispensed an opioid, unique patients on long-term opioids who receive a urine drug screen, the number of patients receiving an opioid and a benzodiazepine (which puts them at a higher risk of adverse events) and the average morphine equivalent daily dose (MEDD) of opioids. Results of key clinical metrics measured by the OSI from Quarter 4 Fiscal Year 2012 (beginning in July 2012) to Quarter 2 Fiscal Year (FY) 2015 (ending in March 2015) are:

o 109,862 fewer patients receiving opioids

o 33,871 fewer patients receiving opioids and benzodiazepines together

o 74,995 more patients on opioids that have had a urine drug screen to help guide treatment decisions

o 91,760 fewer patients on long-term opioid therapy

o The overall dosage of opioids is decreasing in the VA system as 12,278 fewer patients are receiving greater than or equal to 100 Morphine Equivalent Daily Dosing.

o The desired results of the Opioid Safety Initiative have been achieved during a time that VA has seen an overall growth of 90,488 patients that have utilized VA outpatient pharmacy services.

Special Medication Concerns

Psychotropic Drug Safety Initiative

In an effort to ensure our Veterans receive safe, effective and evidence-based psychopharmacologic treatments, the VHA launched the Psychotropic Drug Safety Initiative (PDSI) in December of 2013. The PDSI is a VHA nation-wide quality improvement initiative coordinated through the Office of Mental Health Operations (OMHO) in collaboration with

Mental Health Services (MHS) and Pharmacy Benefits Management (PBM). Every VAMC in the country has been required to participate through local or VISN-wide quality improvement initiatives. The PDSI aims to address possible overprescribing, possible problems in clinical management, misalignment between prescribing and diagnosis, and meeting specific mental health needs through pharmacotherapy. The key aspects of this program include developing measures and sharing data with VISNs and facilities, providing feedback and support for local quality improvement action planning, supporting a collaborative community of practice, and disseminating information about psychotropic prescribing.

The PDSI program utilizes a dashboard that contains indicators of prescribing practices intended to facilitate quality improvement by helping providers prioritize patients to review. The PDSI program also conducts twice monthly QI collaborative conference calls. Even though this program has only been operational for just over a year, it has already demonstrated a positive impact. As of the end of quarter 1 of FY2015, we have seen significant improvement in the national score of 14 of the 20 PDSI measures. For example, the proportion of Veterans with alcohol use disorder who received pharmacotherapy treatment rose over 1% nationally, which means 5,902 additional Veterans received these evidence-based treatments. Similarly, the proportion of Veterans with opiate use disorder who received opiate agonist therapy increased nearly 2% nationally, with an additional 2,420 Veterans receiving these evidence-based treatments. We have also noted a 2% decrease nationally in the proportion of Veterans with PTSD receiving benzodiazepines and a 1% decrease in the proportion of Veterans with PTSD and no psychosis diagnosis who received an antipsychotic medication.

Academic Detailing Initiative

On March 27th 2015, I mandated national implementation of an Academic Detailing Initiative in every network by June 30th, 2015. Based on the results of a 3-year pilot, I believe Academic Detailing holds the promise of continued progress personalizing Veterans' pain management and assure medication safety in our most vulnerable Veterans with Mental Health concerns. This program was designed to allow specially trained clinical pharmacists to assess individual providers' prescribing practices and meet with them one-on-one over a period of time to identify any treatment gaps. The goal of these meetings is to aligning individual prescribing practices with published medical evidence where gaps exist. Clinical pharmacists from 16 of the 21 networks are engaged in training for academic detailing interventions; 130 clinical pharmacists have already completed the required training for delivering the behavior change interventions with prescribers. Thus far, 1534 interventions of academic detailers have been recorded. The topics covered in these interventions include pain and opioid use in 872 interventions, 389 for Opioid Overdose Education and Naloxone Distribution and 174 for benzodiazepine safety.

Overdose Education and Naloxone Distribution (OEND)

VHA has also undertaken a national initiative to make overdose education and naloxone rescue kits available to patients at risk of accidental or intentional overdose. Naloxone can reverse an opioid overdose, preventing overdose death and morbidity when administered in a timely manner. Distribution of overdose rescue training and naloxone kits is a novel intervention within health care settings, and it is being rapidly adopted by VA. To date, 822 VHA providers have begun prescribing these kits to at risk patients, with over 4250 patients receiving training and kits. Already, Veterans have reported reversing 70 opioid overdoses with the naloxone VHA prescribed, representing potential lives saved from these efforts.

VHA has developed a predictive model and clinical decision-support tool to identify patients with opioid prescriptions at risk of suicide-related events and overdose. This tool is being pilot tested and optimized with pain and mental health specialists.

VHA has continued efforts to ensure that effective substance use disorder treatments are available for patients with substance use disorders, knowing that they have an elevated risk for suicide and overdose. Greater engagement in VHA substance use disorder programs is associated with lower suicide attempt risk and reduced criminal behavior in Veterans initiating substance use disorder treatment. VHA continues to increase availability of specialty substance use treatment, increasing the number of patients treated per year with specialty treatment services and with opioid agonist treatment for opioid use disorders.

National Take-Back Initiative

In September 2014, the Drug Enforcement Administration (DEA) published a final rule for the Secure and Responsible Drug Disposal Act of 2010 in the Federal Register, effective October 9, 2014. This Rule provides three voluntary methods for ultimate users (e.g. Veterans) to dispose of their unwanted/unneeded medications in a secure and responsible manner: 1- Mail Back Packages, 2- On-site Collection Receptacles, and 3- Take Back Events.

VA has been aggressively planning and implementing drug disposal options for Veterans. A Directive, which is currently in concurrence, will require VA medical centers to implement at least one practical, accessible, and secure disposal method, when appropriate and in compliance with DEA regulations. In April 2015, Mail Back Envelopes were provided to all VA facilities for distribution to Veterans. Guidance on envelope distribution to maximize Veteran engagement and use was also provided and as of May 31st, 2015, 369 envelopes, which contained approximately 160 pounds of unwanted/unneeded medication, have been returned to a vendor for environmentally responsible destruction.

VA is also piloting the use of on-site collection receptacles in 6 VA medical centers. The pilot involves pharmacy and Security & Law Enforcement staff with different sites of care including ambulatory care, community living centers and residential treatment programs. Data will be gathered on Veteran usage, feedback, safety, costs, and resource utilization to evaluate decisions going forward. Thus far, both Veterans and staff report a high level of satisfaction with this service and approximately 800 pounds of unwanted/unneeded medication have been collected

and destroyed. Removal of this medication from Veterans' homes reduces the risk of diversion as well as intentional and unintentional overdoses and poisonings.

Mental Health Overview

Since September 11, 2001, more than two million Servicemembers have deployed to Iraq or Afghanistan. Long deployments and intense combat conditions require comprehensive support for the emotional and mental health of Veterans and their families. Accordingly, VA continues to develop and expand its mental health and substance use disorder programs as an integrated system of care. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from 927,052 in Fiscal Year (FY) 2006 to more than 1.5 million in FY 2014. We anticipate that VA's requirements for providing mental health care will continue to grow for a decade or more after current operational missions have come to an end. VA believes this increase is partly attributable to proactive screening to identify Veterans who may have symptoms of depression, post-traumatic stress disorder (PTSD), substance use disorder, or those who have experienced military sexual trauma. In addition, VA has partnered with the Department of Defense (DoD) to develop the VA/DoD Integrated Mental Health Strategy to advance a coordinated public health model to improve access, quality, effectiveness, and efficiency of mental health services for Servicemembers, National Guard and Reserve, Veterans, and their families.

VA has many entry points for VHA mental health care. These entry points include medical centers, Community Based Outpatient Clinics (CBOCs), Vet Centers providing readjustment counseling, a Veterans Crisis Line, VA staff on college and university campuses, and other outreach efforts. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increases in staff toward mental health services.

VA has expanded access to mental health services with longer clinic hours, telemental heath capability to deliver services, and standards that mandate immediate access to mental health services to Veterans in crisis. In an effort to increase access to mental health care and reduce any stigma associated with seeking such care, VA has integrated mental health into primary care settings. From the beginning of FY 2008 through March 2015, VA has provided more than 4.7 million Primary Care-Mental Health Integration (PC-MHI) clinic visits to more than 1,137,000 unique patients. This improves access by bringing care closer to where the Veteran can most easily receive these services, and improves quality of care by increasing the coordination of all aspects of care, both physical and mental. In addition, a second round of VA Community Mental Health Summits has recently been completed at virtually all major VA facilities across the nation and analysis of feedback from VA and Community participants is underway. Based on 2013 Summit recommendations, Community Mental Health Points of Contact have been identified at every VA Medical Center. The Community MH POC provides ready access to information about VA eligibility and available clinical services, ensures warm handoffs at critical points of transition between systems of care, and provides ongoing liaison between VA and Community Partners. At each of the 2014 Summits, featured presentations included best practices in support of military and Veteran families in populating the National Resource Directory to enhance

referrals to VA and community resources across America for use by any Servicemembers, Veterans, family members, referring clinicians or other stakeholders.

VA has made deployment of evidence-based therapies a critical element of its approach to mental health care and offers a continuum of recovery-oriented, patient-centered services across outpatient, residential, and inpatient settings. State-of-the-art treatment, including both psychotherapies and biomedical treatments, are available for the full range of mental health problems, including Post- Traumatic Stress Disorder (PTSD), substance use disorders, and suicidality. While VA is primarily focused on evidence-based treatments, we are also assessing complementary and alternative treatment methodologies that need further research, such as meditation and acupuncture in the care of PTSD. For example, a recently published clinical trial suggests that mindfulness techniques were as effective in treating depression as antidepressants. VA has trained over 6,100 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD, Cognitive Processing Therapy and Prolonged Exposure Therapy, as indicated in the VA/DoD Clinical Practice Guideline for PTSD[1][1]. VA operates the National Center for PTSD, which guides a national PTSD mentoring program, working with every specialty PTSD program across the VA health care system. The Center has begun a PTSD consultation program for any VA practitioners (including primary care practitioners and Homeless Program coordinators) who request consultation regarding a Veteran in treatment with PTSD. So far, the consultation program has provided over 2,600 consultations and triaged an additional 165 requests from the Suicide Risk Management Consultation Program. Starting in January 2015, the PTSD Consultation program has expanded so that providers outside of VA can now consult with the program as well as VA providers.

Specialized mental health centers of excellence (CoE) are another essential component of VA's response to meeting the mental health needs of Veterans. These centers, including 10 Mental Illness Research, Education and Clinical Centers (MIRECC), the National Center for PTSD and four additional centers strive to improve the health and well-being of Veterans through world-class, cutting-edge science, education and clinical care. The centers are designed to be incubators for new investigators, new clinicians, new treatments, new ways of educating staff and patients, and new ways of delivering care.

We know that there have been issues with Veteran access to care. We take those concerns seriously and continue to work to address them. In addition, receiving direct feedback from Veterans concerning their care is vitally important. During Quarter 4 of FY 2013, as part of VHA's effort to seek direct input from Veterans in understanding their perceptions regarding access to care, we conducted a survey of over 40,000 Veterans who were receiving mental health care. The replication of that survey for FY2015 is currently underway and approximately 50,000 Veterans who have received mental health services will be surveyed by the end of July 2015 about their perceptions of mental health services. These results, and other outreach to Veterans, aid us as we strive to improve the timeliness of appointments; reminders for appointments; accessibility, engagement, and responsiveness of clinicians; availability and agreement with clinician on desired treatment frequency; helpfulness of mental health treatment; and treatment with respect and dignity.

Programs and Resources for Suicide Prevention

Overall, Veterans are at higher risk for suicide than the general U.S. population, notably Veterans with PTSD, pain, sleep disorders, depression, and substance use disorders. VA recognizes that even one Veteran suicide is too many. We are committed to ensuring the safety of our Veterans, especially when they are in crisis. Our suicide prevention program is based on enhancing Veterans' access to high-quality mental health care and programs specifically designed to help prevent Veteran suicide.

In 2011, the age-adjusted rate of suicide in the U.S. general population was 12.32 per 100,000 persons per year. At just over 12 for every 100,000 U.S. residents, the 2011 rate of suicide has increased by approximately 15 percent since 2001. Rates of suicide in the United States are higher among males, middle-aged adults, residents in rural areas, and those with mental health conditions.

The most recent available data show that suicide rates are generally lower among Veterans who use VHA services than among Veterans who do not use VHA services. In 2011, the rate of suicide among those who use VHA services was 35.5 per 100,000 persons per year; a decrease of approximately 6 percent since 2001. Rates of suicide among those who use VHA services have remained relatively stable; ranging from 35.5 to 37.5 per 100,000 persons per year over the past 4 years. Despite evidence of increased risk among middle-aged adults (35-64 years) in the U.S. general population, rates of suicide among middle-aged adults who use VHA services have decreased by more than 16 percent between the years 1999-2010. Decreases in suicide rates and improvements in outcomes were also observed for some other high-risk groups. Between 2001 and 2010, rates of suicide decreased by more than 28 percent among VHA users with a mental health or substance abuse diagnosis, and the proportion of VHA users who die from suicide within 12 months of a survived suicide attempt has decreased by approximately 45 percent during the same time period. Available data suggest suicide risk is not evenly distributed across all Veteran groups. More than 70% of all Veteran suicides occur among adults aged 50 years and older. Recent analyses of VA data (2000-2010) also identified significant increases in rates of suicide among male Veterans between the ages of 18 and 29 years and there is evidence of increased risk for suicide among female Veterans of all ages when compared to females in the U.S. general population.

The Veterans Crisis Line/Military Crisis Line

In partnership with the Substance Abuse and Mental Health Services Administration's National Suicide Prevention Lifeline, the Veterans Crisis Line/Military Crisis Line (VCL/MCL) connects Veterans and Servicemembers in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline (1-800-273-TALK (8255), then press 1) that offers 24/7 emergency assistance. August 2014 marked seven years since the establishment of the initial program, which was later rebranded to show its direct support for Servicemembers. It has expanded to include a chat service and texting option. As of the end of March 2015, the VCL/MCL has rescued 48,000 actively suicidal Veterans. As of March 2015, VCL/MCL has

received over 1,746,000 calls, over 217,000 chat connections, and over 35,000 texts; it has also made over 282,000 referrals to Suicide Prevention Coordinators. Based on the 2012 Presidential Executive Order, we expanded the capacity of the Veterans Crisis Line by 50 percent.

Suicide Prevention Coordinators

VA has a network of over 300 Suicide Prevention Coordinators (SPC) located at every VA medical center and the largest CBOCs throughout the country. Overall, SPCs facilitate implementation of suicide prevention strategies within their respective medical centers and clinics to help ensure that all appropriate measures are being taken to prevent suicide in the Veteran patient population, particularly Veterans identified as being at high risk for suicidal behavior, and the SPCs engage in outreach to other Veterans, family members, and community partners.

SPCs are responsible for implementing VA's *Operation S.A.V.E* (Signs of suicidal thinking, Ask the questions, Verify the experience with the Veteran, and Expedite or Escort to Help). This is a one-to-two hour in-person training program provided by VA SPCs to Veterans and those who serve Veterans to help prevent suicide. Suicide prevention training is provided for every new VHA employee during Employee Orientation. Our goal is to increase mental health awareness wherever Veterans and their family members are present and to continuously enhance and expand our response to their needs.

SPCs participate in outreach activities, meetings with state and local suicide prevention groups with Active Duty/National Guard and Reserve units as well as college campuses. Each SPC is required to complete five or more outreach activities in his or her local community each month. To ensure that high-risk Veterans are being monitored appropriately, SPCs manage a Category I Patient Record Flag (PRF) with a corresponding High-Risk List. The primary purpose of the High Risk for Suicide PRF is to communicate, consistent with appropriate privacy protections, to VA staff that a Veteran is at high risk for suicide, and the presence of a flag should be considered when making treatment decisions. SPCs ensure that all Veterans identified as high risk for suicide have completed a safety plan that is documented in their medical record, and that the Veteran is provided a copy of his or her safety plan.

The Joint Suicide Data Repository

In 2010, DoD and VA launched a Joint Suicide Data Repository (SDR) as a shared resource for improving our understanding of patterns and characteristics of suicide among Veterans and Servicemembers. The combined DoD and VA search of data available in the National Death Index represents the single largest mortality search of a population with a history of military service on record. The DoD/VA Joint SDR is overseen by the Defense Suicide Prevention Office and VA's Suicide Prevention Program.

On February 1, 2013, VA released a report on Veteran suicides including data from the SDR, a result of the most comprehensive review of Veteran suicide rates ever undertaken by VA. With assistance from state partners providing real-time data for SDR, VA is now better able to assess the effectiveness of its suicide prevention programs and identify specific populations that need targeted interventions. This new information will assist VA in identifying where at-risk Veterans may be located and improving the Department's ability to target specific suicide interventions and outreach activities in order to reach Veterans early and proactively. These data will also help VA continue to examine the effectiveness of suicide prevention programs being implemented in specific geographic locations (e.g., rural areas), as well as care settings, such as primary care, in order to replicate effective programs in other areas. VA continues to receive state data that is being included in the SDR. VA plans to update the suicide data report later this year.

VA's National Efforts

Suicide prevention efforts must extend to reach Veterans who may not seek assistance. Therefore, VA has focused on increased targeted outreach efforts throughout the country to Veterans and their family members with significant emphasis on safety. We encourage Veterans and their families to learn more about mental illness and to take precautions particularly during times of stress.

VA has sponsored public service announcements, rebranded and optimized the VCL/MCL Web site for mobile access and viewing, and developed social and traditional media advertisements designed to inform Veterans and their families of VA's VCL/MCL resources. During National Suicide Prevention Month in September 2014, VA launched its new outreach campaign theme for this year, "The Power of 1," which emphasizes that just one person, one conversation, or one small act can make a big difference to a Veteran or Servicemember in crisis.

Furthermore, VA is engaged in ongoing research to determine the most effective mental health treatments and suicide prevention strategies. VA has also established the Mental Health Innovations Integrated Project Team that is working to implement early intervention strategies for specific high-risk groups. Through early intervention, VA hopes to reduce the risk of suicide for Veterans in these high-risk groups.

Another national suicide prevention initiative is VA's Behavioral Health Autopsy Program (BHAP). BHAP is designed to enhance suicide prevention efforts by systematically collecting information for all deaths by suicide reported to VHA clinicians and Suicide Prevention Coordinators. BHAP is a multiphase quality improvement initiative that consists of standardized chart reviews for all Veterans' suicides known to VHA staff and interviews with bereaved family members. Medical chart reviews of suicide decedents offer important clinical information concerning Veterans' VHA service utilization.

In addition, VA established an online Community Provider Toolkit for individuals outside of VA who provide care to Veterans. This provides an important resource in the wake of the Veterans

Access, Choice, and Accountability Act of 2014. This Web site features key tools to support the mental health services provided to Veterans including information on connecting with VA, understanding military culture and experience, and working with patients with a variety of mental health conditions.

Readjustment Counseling Service

VA's Readjustment Counseling Service (RCS) provides a wide range of readjustment counseling services to eligible Veterans and active duty Servicemembers who have served in combat zones and their families. RCS also provides comprehensive readjustment counseling for eligible Veterans and Servicemembers who experienced military sexual trauma, as well as offering bereavement counseling to immediate family members of Servicemembers who died while on active duty. These services are provided in a safe and confidential environment through a national network of 300 community-based Vet Centers located in all 50 states (as well as the District of Columbia, American Samoa, Guam, and Puerto Rico), Mobile Vet Centers, and the Vet Center Combat Call Center (877-WAR-VETS or 877-927-8387). In FY 2013, Vet Centers provided over 1.5 million visits to Veterans, active duty Servicemembers, and their families. The Vet Center program has provided services to over 30 percent of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Veterans who have left active duty. As the President announced in August 2014, the First Lady and Second Lady's Joining Forces initiative is promoting awareness of Vet Centers for combat Veterans, Servicemembers, and their families.

Research

VHA is engaged in multiple research projects related to mental health, suicide and violence, as well as optimizing pharmacological and non-pharmacological interventions for pain and psychiatric conditions. Several current studies are addressing opioid use, including:

· An ongoing study, titled "Impact of Interventions to Reduce Violence and Substance Abuse among VA Patients" that focuses on the use of new intervention approaches targeting the use of violence prevention skills and means of sustaining substance use remission.

· A recently funded study focused on Justice-involved Veterans (i.e. those detained by or under the supervision of the criminal justice system) that aims to improve utilization of VHA mental health/ substance abuse disorder (SUD) care.

· An ongoing study seeking to provide guidance on indications for opioid reassessment in primary care.

· An ongoing study examining a program called "Comprehensive Opioid Management in Patient Aligned Care Teams" that uses a web-enabled electronic, interactive voice response telephone

monitoring and care management system to facilitate patient engagement, conduct regular opioid monitoring and provide relevant education.

· An ongoing study examining opioid prescribing in VHA before and after the Opioid Safety Initiative.

In addition, the Pain Workgroup of the SUD, Quality Enhancement Research Initiative (QUERI) is working to increase utilization of non-pharmacological, evidence-based pain management in specialty SUD treatment settings, and to improve the understanding and measurement of opioid misuse in SUD specialty care.

Closing Statement

Mr. Chairman, VA is committed to providing timely, high quality care that our Veterans have earned and deserve, and we continue to take every available action and create new opportunities to improve suicide prevention services.

[1] http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf

United States Government Accountability Office

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

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VA HEALTH CARE

Improvements Needed to the Monitoring of Antidepressant Use for Major Depressive Disorder and the Accuracy of Suicide Data

Statement of Randall B. Williamson
Director, Health Care

June 10, 2015

VA HEALTH CARE

Improvements Needed to the Monitoring of Antidepressant Use for Major Depressive Disorder and the Accuracy of Suicide Data

GAO Highlights

Highlights of GAO-15-648T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

In 2013, VA estimated that about 1.5 million veterans required mental health care, including for MDD. MDD is a debilitating mental illness related to reduced quality of life and increased risk for suicide. VA also plays a role in suicide risk assessment and prevention.

This testimony addresses the extent to which (1) veterans with MDD who are prescribed an antidepressant receive recommended care and (2) VAMCs are collecting information on veteran suicides as required by VA. The testimony is based on GAO's November 2014 report, *VA Health Care: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data* (GAO-15-55). For that report GAO analyzed VA data, interviewed VA officials, and conducted site visits to six VAMCs selected based on geography and population served. GAO also reviewed randomly selected medical records for five veterans from each of the six VAMCs, for veterans diagnosed with MDD and prescribed an antidepressant in 2012, as well as all completed BHAP templates. The results cannot be generalized across VA. GAO followed up in May 2015 to determine the status of GAO's previous recommendations.

What GAO Recommends

GAO recommended that VA implement processes to assess deviations from recommended care; identify and address MDD coding issues; and implement processes to improve veteran suicide data. VA has made progress on these recommendations and has fully implemented one.

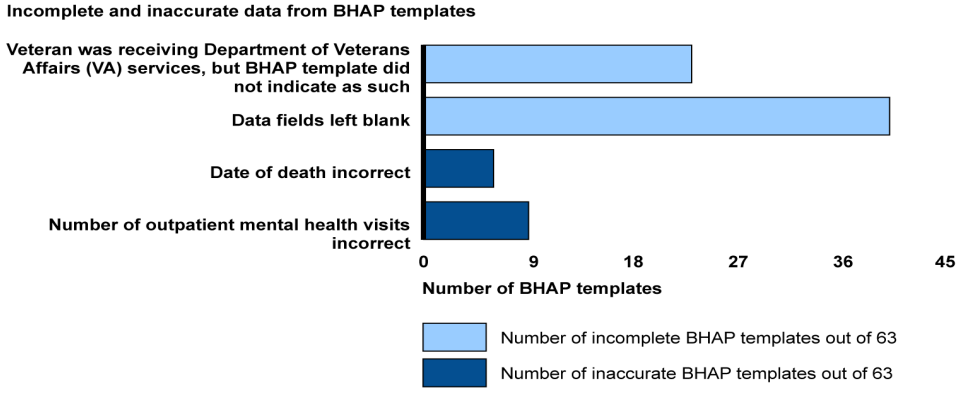
View GAO-15-648T. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

Department of Veterans Affairs (VA) policy states that antidepressant treatment must be consistent with VA's current clinical practice guideline (CPG) for major depressive disorder (MDD); however, GAO's recent review of 30 veterans' medical records found that most contained deviations. For example, although the CPG recommends that veterans' depressive symptoms be assessed at 4-6 weeks after initiation of antidepressant treatment using a standardized assessment tool, 26 of the 30 veterans were not assessed in this manner within this time frame. Additionally, 10 veterans did not receive follow up within the time frame recommended in the CPG. GAO found that VA (1) does not have a system-wide process in place to identify and fully assess the extent to which veterans with MDD who have been prescribed antidepressants are receiving care as recommended in the CPG and (2) does not know whether appropriate actions are being taken by VA medical centers (VAMC) to mitigate potentially significant risks to veterans. GAO also found that VA's data may underestimate the prevalence of MDD among veterans being treated through VA as a result of imprecise coding by clinicians, further complicating VA's ability to know if veterans with MDD are receiving care consistent with the CPG.

GAO's recent work has found that the demographic and clinical data that VA collects on veteran suicides were not always complete, accurate, or consistent. VA's Behavioral Health Autopsy Program (BHAP) is a quality initiative to improve VA's suicide prevention efforts by identifying information that VA can use to develop policy to help prevent future suicides. The BHAP templates are a mechanism by which VA collects suicide data from VAMCs' review of veteran medical records. GAO's review of the 63 completed BHAP templates at five VAMCs found that (1) over half of the templates that VAMCs submitted to VA had incomplete or inaccurate data, and (2) VAMCs submitted inconsistent information because they interpreted VA's guidance differently. Lack of complete, accurate, and consistent data—coupled with GAO's finding of poor oversight of the review of BHAP templates—can inhibit VA's ability to identify, evaluate, and improve ways to better inform its suicide prevention efforts.

Number of Behavioral Health Autopsy Program (BHAP) Post-Mortem Chart Analysis Templates with Incomplete or Inaccurate Data



Source: GAO analysis of VA data. | GAO-15-648T

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee:

I am pleased to be here to discuss our recent work on the monitoring of veterans with major depressive disorder (MDD) who were prescribed an antidepressant and data collection efforts by the Department of Veterans Affairs (VA) on veteran suicides. In 2013, VA estimated that about 1.5 million veterans required mental health services, including for MDD. MDD is a particularly debilitating mental illness and is associated with reduced quality of life, reduced productivity, and increased risk for suicide.[1] These negative effects underscore the importance for veterans of timely, evidence-based assessment for and treatment of MDD, which may include medications such as antidepressants, psychotherapy, or a combination of both. Based on our previous analysis of VA data from veterans' medical records and administrative sources, 532,222 veterans had a diagnosis of MDD from fiscal years 2009 through 2013, and among those veterans, about 499,000 (94 percent) veterans were prescribed at least one antidepressant by a VA provider.[2] According to VA, the prevalence of MDD among veterans being treated in VA primary care settings is higher than that among the general population.

In addition to providing ongoing care to veterans with MDD, VA plays a role in suicide risk assessment and prevention among veterans. According to VA in a June 2013 report, about one-quarter of the 18 to 22 veterans who die by suicide each day were receiving care through

[1]MDD is characterized by the presence of depressed mood or loss of interest or pleasure along with other symptoms for a period of at least 2 weeks that represent a change in previous functioning. These symptoms include significant weight loss; insomnia or excessive sleeping; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate, or indecisiveness; and recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, Va: American Psychiatric Association, 2013).

[2]Veterans were classified as having a diagnosis of MDD if, in at least one fiscal year included in our review, they had two or more outpatient encounters or at least one inpatient hospital stay with a diagnosis of MDD. The 532,222 veterans diagnosed with MDD represent about 10 percent of veterans who received health care services through VA. This estimate is based on published Congressional Research Service data on the number of veterans who received health care services through VA from fiscal years 2009 through 2013 (roughly 5.5 million).

VA.[3] Research has identified numerous risk factors for suicide among veterans, which include substance use disorder, physical impairments, previous suicide attempts, and depression. Additionally, life stressors, such as marital or financial problems, contribute to a veteran's risk of suicide.

Given the debilitating effects that depression can have on veterans' quality of life, VA's monitoring of veterans with MDD is critical to ensuring that they receive care that is associated with positive health care outcomes. Additionally, the relatively high veteran suicide rate makes it important that VA use data that it collects related to veteran suicides to drive its prevention efforts. Today I will address two areas: the extent to which (1) veterans with MDD who are prescribed an antidepressant receive recommended care, and (2) VA medical centers (VAMC) are collecting information on veteran suicides as required by VA.

My statement is based on a GAO report released in November 2014 examining VA's monitoring of veterans with MDD who have been prescribed an antidepressant and the use of suicide data within VA.[4] For our work examining the care received by veterans with MDD who are prescribed an antidepressant, we reviewed VA policy documents and interviewed VA Central Office officials responsible for developing and implementing VA mental health policy. We also conducted site visits to six VAMCs, which we selected for variation in complexity of health care services offered, geographic location, and number of veterans using mental health services.[5] We reviewed a random, nongeneralizeable sample of medical records for 5 veterans treated at each of the 6 VAMCs—for a total of 30 veterans—to assess the extent to which the antidepressant treatment-related care VAMCs provided was consistent with three evidence-based treatment recommendations included in VA

[3]VA/Department of Defense (DOD) Assessment and Management of Risk for Suicide Working Group, *VA/DOD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide* (June 2013).

[4]GAO, *VA Health Care: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data*, GAO-15-55 (Washington, D.C.: Nov. 12, 2014).

[5]These six VAMCs were located in Canandaigua, New York; Gainesville, Florida; Iowa City, Iowa; Philadelphia, Pennsylvania; Phoenix, Arizona; and Reno, Nevada. In contrast to the other site visits, which were completed in person, we completed the site visits to the VAMCs located in Gainesville, Florida, and Reno, Nevada, through telephone interviews.

guidelines.[6] Results from our medical record review cannot be generalized to the VAMC or across VAMCs. For our work examining the data that VA requires VAMCs to collect on veteran suicides, we reviewed VA policies, guidance, and documents related to VA's suicide prevention efforts to identify the data collected by VA staff on veteran suicides. We also interviewed VA Central Office and VAMC officials responsible for VA's suicide prevention program, obtained documents and interviewed officials regarding the collection of veteran suicide data, and compared data obtained from VAMCs to information included in the veterans' medical records and information we obtained from VA Central Office.[7] Results from our review of veteran suicide data can be generalized to the VAMCs we visited, but cannot be generalized to other VAMCs. In May 2015, in preparation for this statement, we met with VA officials to discuss the status of VA's implementation of action plans to address the six recommendations included in our November 2014 report.

The work on which this statement is based was conducted, with updates in May 2015, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Further details on our scope and methodology are included in our report.

Background

VA provides care to veterans with mental health needs in VAMC primary and specialty care clinics. The *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook (Handbook), which defines VA's minimum clinical requirements for mental health services, requires that VA facilities provide evidence-based treatment through the administration

[6]The 30 veterans we selected were diagnosed with MDD and had a new treatment episode of an antidepressant in calendar year 2012. For our review we selected three evidence-based treatment recommendations for inclusion in our review that had among the highest strength of research evidence, were sufficiently specific to enable us to determine the extent to which VA providers were following the recommendation, and would not require clinical judgment to determine the extent to which VA providers were following the recommendation.

[7]We reviewed completed information on veteran suicides from five of the VAMCs included in our review. One VAMC reported having no veteran suicides as of the date of our site visit; therefore, our analysis of suicide data does not include this VAMC.

of medication, when indicated, consistent with the MDD clinical practice guideline (CPG) recommendations.[8] The CPG is guidance intended by VA to reduce current practice variation between clinicians and provide facilities with a structured framework to help improve patient outcomes, but should not take the place of the clinician's clinical judgment. The MDD CPG includes approximately 200 evidence-based recommendations to provide information and assist in decision making for clinicians who provide care for adults with MDD. CPG recommendations describe, for example, the use of standardized assessments of veterans' depressive symptoms as part of an evidence-based treatment plan.[9]

In June 2006, VA began implementing several initiatives aimed at suicide prevention, including appointing a National Suicide Prevention Coordinator, developing data collection systems to increase understanding of suicide among veterans and inform VA suicide prevention programs, and instituting suicide prevention programs in all VAMCs.[10] VA Central Office uses several mechanisms to collect data on veteran suicides to help improve its suicide prevention efforts, including the Behavioral Health Autopsy Program (BHAP).[11] The BHAP initiative, which began in December 2012, is a quality improvement initiative

[8]The MDD CPG is formally known as the *VA/DOD Clinical Practice Guideline for Management of Major Depressive Disorder* (May 2009). The MDD CPG was issued by the joint VA/DOD Evidence-Based Practice Work Group in 2009. Formed in 1999 and composed of VA and DOD officials, the VA/DOD Evidence-Based Practice Work Group makes decisions about which CPGs for specific conditions will be developed and oversees their development.

[9]According to the MDD CPG, veterans with MDD treated with antidepressants should be closely observed, particularly at the beginning of treatment and following dosage changes, to maximize veterans' recovery and to mitigate any negative treatment effects, including worsening of depressive symptoms.

[10]The Handbook requires VAMCs to have a suicide prevention coordinator whose responsibilities include establishing and maintaining a list of veterans assessed to be at high risk for suicide; monitoring these veterans; responding to referrals from staff and the Veterans Crisis Line; and collecting and reporting information on veterans who die by suicide and who attempt suicide.

[11]VA also collects data through the following mechanisms: Suicide Prevention Application Network, in which VAMCs submit information on the number of veterans that completed suicides, the number of suicide attempts, and indicators of suicide prevention efforts; suicide behavior reports, which clinicians must complete when they learn that a veteran attempted or completed suicide and add to the veteran's medical record; and root cause analyses that are completed by VAMC patient safety managers for suicide attempts and completed suicides under certain circumstances.

intended to improve VA's suicide prevention efforts by identifying demographic, clinical, and other related information on veteran suicides that VA Central Office can use to develop policy and procedures to help prevent future veteran deaths.[12] VA Central Office officials explained that the BHAP initiative allows them to collect more systematic and comprehensive information about suicides, including information gleaned from interviews of family members of those veterans who die by suicide. VA Central Office has provided suicide prevention coordinators with a BHAP guide on how to complete the fields in the BHAP template.

Veterans in Our Review Often Did Not Receive Recommended Care, and VA Lacks Methods to Track Whether Recommended Care Is Provided

Our recent work, based on the three CPG recommendations we selected, has found almost all of the 30 veterans with MDD in our review who had been prescribed antidepressants received care that deviated from the MDD CPG recommendations. For example, we found that although the CPG recommends that veterans' depressive symptoms be assessed at 4-6 weeks after initiation of antidepressant treatment using a standard assessment tool to determine the efficacy of the treatment, 26 of the 30 veterans were not assessed using such a tool within this time frame. Additionally, 10 veterans did not receive follow up within the time frame recommended in the CPG. Table 1 below depicts the specific recommendations we reviewed and the number of veterans that did not receive care consistent with the corresponding CPG recommendation.

[12]Veteran suicide data for the BHAP initiative are submitted by VAMCs to VA's Center of Excellence for Suicide Prevention. The Center of Excellence was created by VA Central Office, and for the purposes of our testimony, we refer to the Center of Excellence as part of VA Central Office.

Table 1: Number of Veterans in GAO's Sample Not Receiving Care As Recommended in the Clinical Practice Guideline (CPG) for Major Depressive Disorder (MDD)

CPG recommendation	Number of veterans not receiving care as recommended in the CPG for MDD
To enhance antidepressant treatment, veterans should be educated on when to take the medication, possible side effects, risks, and the expected duration of treatment, among other things	6 of 30 veterans lacked documentation of patient education when the medication was prescribed
Standardized assessments of depressive symptoms, such as the Patient Health Questionnaire-9, should be used to monitor treatment at 4-6 weeks after initiation of treatment and after each change in treatment	26 of 30 veterans were not assessed using a standardized assessment tool at 4-6 weeks after initiation of treatment 18 of 30 veterans were not assessed using a standardized assessment tool at any encounter[a] 10 of 30 veterans did not have a follow-up encounter that occurred 4-6 weeks after initiation of treatment[b]
A plan should be developed that addresses the duration of antidepressant treatment, among other things	1 veteran of 30 did not have a planned date for follow up and plan for future care documented in the veteran's medical record at the initial encounter

Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-15-648T

Note: We included 30 veterans in our review. Our review began with the encounter during which a VA clinician ordered an antidepressant to treat depressive symptoms (initial encounter) and five follow-up encounters with a VA clinician, or sooner if the veteran did not have five follow-up encounters. Our review was limited to encounters during which the antidepressant treatment was reviewed, including encounters during which side effects and treatment effect were assessed, but no change was made to medication orders.

[a]Of the 30 veterans included in our review, only 6 were assessed using a standardized assessment at the initial encounter where antidepressant medication was prescribed. VA Central Office officials explained that they would expect a standardized assessment to be conducted at the start of an antidepressant to establish a baseline score.

[b]Three veterans did not receive a follow-up encounter at all. Two veterans did not show for scheduled appointments that were within the CPG recommended time frame. Five veterans did not have a follow-up encounter until after 6 weeks.

We also found that VA does not always know the extent to which veterans with MDD who have been prescribed antidepressants are receiving care as recommended in the CPG, and some clinicians at VAMCs we visited described instances in which they generally do not follow the CPG recommendations. For example, officials from two VAMCs we visited explained that they do not routinely use the nine item Patient

Health Questionnaire (PHQ-9).[13] According to officials at one of these VAMCs, the standard of care is to conduct a clinical interview and observation. However, the CPG recommendation states that the PHQ-9 combined with a clinical interview should be used to obtain the necessary information about symptoms and symptom severity. It also states that the PHQ-9 improves diagnostic accuracy and aids treatment decisions by quantifying symptom severity. Additionally, we found that VA Central Office has not developed a mechanism to determine the extent to which mental health care delivery in VAMCs conforms to the recommendations in the MDD CPG. While deviations from recommended practice may be appropriate in many cases due to clinician discretion, VA has not fully assessed whether these examples are acceptable deviations from the CPG. VA Central Office and some VAMCs have implemented limited methods to determine the extent to which veterans are receiving care that is consistent with some of the CPG recommendations.[14] However, without a system-wide process in place to identify and fully assess whether the care provided is consistent with the CPG, VA does not know the extent to which veterans with MDD who have been prescribed antidepressants are receiving care as recommended in the CPG and whether appropriate actions are taken by VAMCs to mitigate potentially significant risks to veterans. The CPG is intended to reduce practice variation and help improve patient outcomes, but without an understanding of the extent to which veterans are receiving care that is consistent with the CPG, we concluded that VA may be unable to ensure that it meets the intent of the CPG and improves veteran health outcomes.

To ensure that veterans are receiving care in accordance with the MDD CPG, we recommended that VA implement processes to review data on veterans with MDD who were prescribed antidepressants to evaluate the level of risk of any deviations from recommended care and remedy those that could impede veterans' recovery. VA concurred with our

[13]The PHQ-9 is a diagnostic tool, which uses the nine MDD diagnosis symptoms as criteria to help clinicians make a criteria-based diagnosis of depressive disorders and measure depression severity to aid treatment decisions.

[14]These methods include (1) a psychopharmacology quality improvement initiative that began in fiscal year 2014 consisting of a series of prescribing practice metrics such as the proportion of veterans with depression prescribed three or more concurrent antidepressant medications for 60 or more continuous days, and (2) a software system called the Behavioral Health Laboratory that some VAMCs have implemented to help ensure that veterans with MDD who are prescribed antidepressants receive care consistent with the CPG when the veteran is treated in a primary care clinic.

recommendations and stated that VA would examine associations between treatment practices and indicators of veteran recovery or adverse outcomes. VA Central Office officials reviewed whether a cohort of veterans with MDD received treatment with an antidepressant that was in line with MDD CPG recommendations.[15] However, in choosing CPG recommendations to review, VA officials told us that they chose the recommendations for review based on the ease of obtaining the needed data and because the antidepressant medication coverage measure is nationally recognized, rather than based on a methodical review of all of the CPG recommendations to identify those that may put veterans at risk and could impede veterans' recovery if not followed, as we recommended in our November 2014 report. Therefore, it is not clear whether the CPG recommendations that VA chose to review were among those that may put veterans at risk and could impede recovery if not followed. Moreover, VA has not indicated whether it has implemented a process that will review CPG recommendations on an ongoing basis to identify deviations that place veterans at risk and impede recovery. This recommendation remains open pending further VA action.

Diagnostic coding discrepancies further complicate VA's ability to know if veterans with MDD are receiving care consistent with the CPG. Specifically, we found that for 11 of the 30 veterans' medical records we reviewed the clinician coded the encounter as "depression not otherwise specified," a less specific code than MDD, even though the clinician documented a diagnosis of MDD in the veteran's medical record. Therefore, VA's data may not fully reflect the extent to which veterans have MDD due to a lack of diagnostic coding precision by clinicians, or the extent to which such discrepancies may permeate VA data.[16] As a result, VA's ability to monitor veterans with MDD and assess its performance in treating veterans as recommended in the MDD CPG and measuring health outcomes for veterans is further limited because VA may not be fully aware of the population of veterans with MDD.

[15]To do this, VA reviewed (1) the extent to which veterans received antidepressant medication coverage for at least 84 days during a 12-week period; (2) rates of psychiatric hospitalization; and (3) the association between the receipt of guideline-consistent care and changes in depression symptoms documented using PHQ-9 scores.

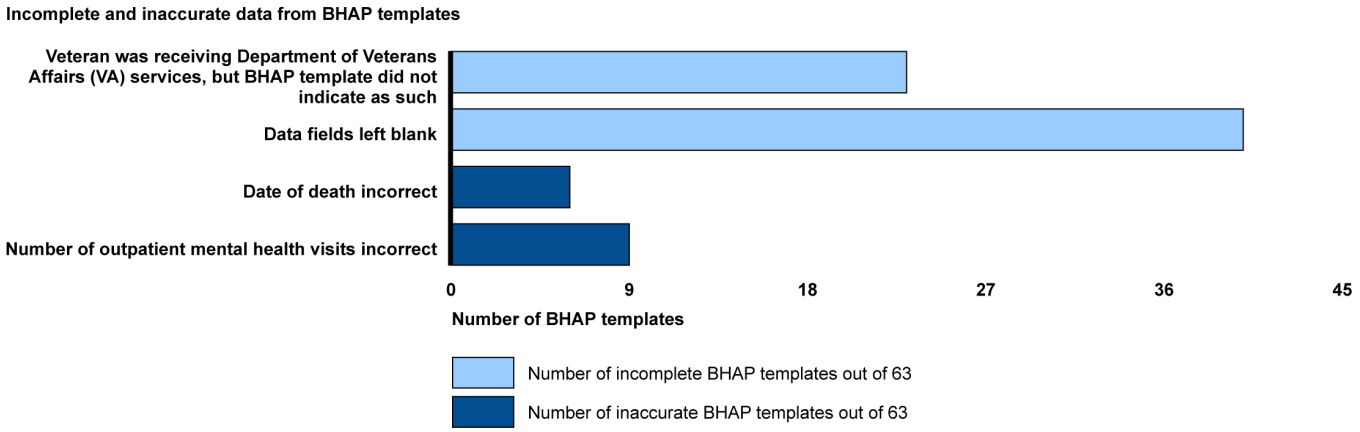
[16]VA's data on the number of veterans with MDD are based on the diagnostic codes associated with patient encounters.

To address this shortcoming, our report recommended that VA (1) identify the extent to which there is imprecise diagnostic coding of MDD by examining encounters with a diagnostic code of "depression not otherwise specified" and (2) determine and address the factor(s) contributing to imprecise coding. VA concurred with our recommendations and stated that they would examine patterns of diagnostic coding among veterans with new episodes of depression by evaluating diagnosis patterns and treatment settings, as well as conduct chart reviews for a sample of veterans to examine the diagnosis in the veteran's medical record and the diagnostic code used for the encounter. VA's review of the accuracy of diagnostic codes is ongoing. Additionally, during the course of our review, VA Central Office officials reported that they had discovered a software mapping error in VA's medical record system where selection of MDD as a diagnosis when using a keyword search function may mistakenly result in the selection of the "depression not otherwise specified" diagnostic code. While this error has been resolved, according to VA officials the solution would only apply to encounters going forward and would not retroactively correct any previous coding discrepancies. As a result, any such instances would still be coded in VA's system as "depression not otherwise specified," even though these veterans were diagnosed with MDD, and therefore data VA collected prior to resolving the software error may still not fully reflect the number of veterans with MDD.

Data VA Collects on Veteran Suicides Were Not Always Complete, Accurate, or Consistent

Our recent work has found that demographic, clinical, and other data submitted to VA Central Office on veteran suicides were not always completely or correctly entered into the BHAP Post-Mortem Chart Analysis templates (BHAP templates)—a mechanism by which VA Central Office collects veteran suicide data from VAMCs' review of veterans' medical records. We found that over half of the 63 BHAP templates we examined had incomplete or inaccurate information (see fig. 1).

Figure 1: Number of Behavioral Health Autopsy Program (BHAP) Post-Mortem Chart Analysis Templates with Incomplete or Inaccurate Data



Source: GAO analysis of VA data. | GAO-15-648T

It is important that VA have complete, accurate, and consistent data because VA Central Office uses this information to compile internal reports as part of VA's quality improvement efforts for its suicide prevention program, and unreliable data limits VA Central Office's ability to develop policy and procedures aimed at preventing veteran deaths.[17] VA Central Office used veteran enrollment information when compiling the BHAP report in March 2014. Specifically, VA Central Office included clinical data in the BHAP report only for veterans utilizing VA services. However, we found that clinical data for 23 of the 63 BHAP templates we reviewed would not be included in the report because of missing data, such as not indicating whether the veteran was enrolled in VA health care services, even though the veteran had a VA medical record.

Additionally, 40 of the 63 BHAP templates we reviewed included various data fields where no response was provided, resulting in incomplete data. For example, for 19 templates, VAMC staff did not enter requested data as to whether the veteran had all or some of 15 active psychiatric symptoms within 12 months prior to the veteran's date of death. These missing fields are counted as "no" in the report, meaning that the veteran

[17]Department of Veterans Affairs, *Behavioral Health Autopsy Program Interim Summary, December 1, 2012 – February 27, 2014* (Mar. 13, 2014). This report includes information on veterans who die by suicide, both with and without a history of VA health care service utilization.

did not have these symptoms. For at least one BHAP template we reviewed, the nonresponse for the question about the psychiatric symptom of isolation would have counted as “no” in the report; however, officials from the responsible VAMC told us that the veteran did have this symptom. Furthermore, we found that VAMCs did not always submit BHAP templates for all veteran suicides known to the facility, as required by the BHAP guide, and VA Central Office does not have a process in place to determine whether it is receiving the BHAP templates for all known veteran suicides. For example, one VAMC had completed 13 BHAP templates at the time of our site visit but had not submitted them; however, neither the VAMC nor VA Central Office were aware that these templates had not been submitted until after we requested them from VA Central Office.

We also found numerous instances of inaccurate data in the 63 BHAP templates we reviewed. For example, we found 6 BHAP templates that included a date of death that was incorrect based on information in the veteran’s medical record. The difference in the dates of death in the veterans’ medical records and the dates of death in the BHAP templates ranged from 1 day to 1 year. The accuracy of the date of death recorded in the BHAP template is important because it is used as a point of reference to calculate other fields, such as the number of mental health visits in the last 30 days. Without accurate information, VA cannot use this information to determine whether policies or procedures need to be changed to ensure that veterans at high risk for suicide are being seen more frequently by a mental health provider to help prevent suicides in the future.

We also found several situations where VAMCs interpreted and applied instructions for completing the BHAP templates differently, resulting in inconsistent data being reported across VAMCs. For example, one VAMC included a visit to an immunization clinic as the veteran’s final visit, while another VAMC did not include this type of visit, even though this was the last time the veteran was seen in person. The BHAP guide indicates that the final visit should be the last time the veteran had in-person contact with any VAMC staff, but the BHAP guide does not identify the different types of visits that should be counted. Additionally, VA policy and guidance states that the BHAP template should be completed for all suicides known to the facility, but at the five VAMCs we visited, these data were not always being reported. VA policy and instructions do not explicitly state that veterans not being seen by VA also should be included, and in the absence of this declaration, some VAMCs interpreted the instructions to mean that only veterans being seen by VA should be

included in the data submitted. Therefore, two VAMCs have submitted data only for veterans being treated by VA, while the others include data on all known veteran suicides—whether they have been treated by VA or not. When VAMCs do not provide consistent data, VA Central Office will receive and use inconsistent data in preparing its trend reports, such as BHAP reports, which are intended to be used to improve suicide prevention efforts.

Further, we found that VA did not have an established process for reviewing the accuracy of BHAP templates, and for the sites we covered in our review, BHAP templates were not being reviewed by VA officials at any level for accuracy, completeness, and consistency. Therefore, our findings at five VAMCs could be symptomatic of a nationwide problem, and other VAMCs may also be submitting incomplete, inaccurate, or inconsistent suicide-related information and VA may not be getting the data it needs across the department to make appropriate resource decisions and develop new policy. We also found that VA lacks sufficient controls, such as automated data checks, to ensure the quality of the existing BHAP data. Not reviewing the data is inconsistent with internal control standards for the federal government, which state that agencies should have controls over information processes, including procedures and standards to ensure the completeness and accuracy of processed data.[18]

To improve VA's efforts to inform its suicide prevention activities, we made three recommendations in our November 2014 report that directed VA to (1) clarify guidance on how to complete the BHAP templates to ensure that VAMCs are submitting consistent data on veteran suicides, (2) ensure that VAMCs have a process in place to review data on veteran suicides for completeness, accuracy, and consistency before the data are submitted to VA Central Office, and (3) implement processes to review data on veteran suicides submitted by VAMCs for accuracy and completeness. VA agreed with our recommendations and, to date, has made some progress in addressing these recommendations.

[18]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

- VA has issued clarifying guidance to suicide prevention coordinators and VA officials reported that suicide prevention coordinators expressed being more comfortable with filling out the BHAP templates. We closed the first recommendation as implemented.
- The last two recommendations remain unimplemented pending VA's completion of planned actions.
  - To ensure that the BHAP data are accurate, complete, and consistent, VA created a checkbox in the BHAP template to indicate that the data were checked by VAMC leadership. VA's initial random checks indicate the checkbox is being used and VAMC leadership is reviewing entries resulting in better consistency of the data. VA plans to run monthly reviews to determine compliance.
  - Additionally, VA created a software program to compare data from the BHAP templates to the data entered into another suicide prevention database maintained by VA. VA officials plan for this review to become part of the quarterly routine review process and information about missing cases will be sent back to the VAMCs for correction on a quarterly basis.

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you might have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Randall B. Williamson, Director, Health Care at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Marcia A. Mann, Assistant Director; Emily Binek; Cathleen Hamann; Sarah Resavy; and Jennifer Whitworth.

Statement of Jacqueline A. Maffucci, Ph.D.[1]

Research Director, Iraq and Afghanistan Veterans Of America

before the

House Veterans' Affairs Committee

Subcommittee on Oversight and Investigations

for the hearing titled:

Prescription Management and the Risk of Veteran Suicide

June 10, 2015

Chairman Coffman, Ranking Member Brown, and Distinguished Members of the Subcommittee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our nearly 400,000 members and supporters, I would like to extend our gratitude for the opportunity to share our views and recommendations regarding prescription management and the potential risk of veteran suicide. In 2014 IAVA launched its Campaign to Combat Suicide. In February of this year, with your help we celebrated the signing of the Clay Hunt SAV Act into law. This was a first step on a long road to address the challenges of combating suicide among our service members and veterans. The issue that we have been invited to talk about today is a complex one because it encompasses two topics: providing care for veterans who are seeking relief from chronic pain and other conditions, and recognizing that there is potential for misuse of these powerful drugs intended to provide relief. And while these drugs are extremely powerful, they can also be extremely effective for a veteran who has not found relief elsewhere.

According to a 2011 Institute of Medicine report[2], chronic pain affects approximately 100 million American adults and this number is growing. Given the last 14 years of conflict and the very physical daily demands on our troops, we've seen a similar trend among service members and veterans. Over 60 percent of the OEF/OIF veterans seeking VA medical care seek care for musculoskeletal ailments[3] and this is the most common category for disability compensation. Within IAVA's own community, two out of three respondents to our member survey reported experiencing chronic pain as a result of their service. Additionally, one in five were using prescribed opioid medications.

Among this newest generation of veterans, medical advancements have allowed for higher survival rates from complex injuries, but this also increases the likelihood for lifelong impacts of nerve and skeletal damage. Treatment of pain in these instances can be even more complex,

because co-occurrence with other conditions, such as depression, anxiety, PTSD, or TBI may limit treatment options for the veteran.

For clinicians, assessing pain and devising a management strategy can be very difficult as well, particularly given that this is a relatively new area of focus in the clinical research field. Related to this, the primary care physicians, who see the bulk of patients with chronic pain, have repeatedly reported that they feel underprepared to treat these patients due to a lack of training. In a 2013 study specific to VHA, this was echoed by the VHA providers surveyed[4].

Adding to the challenge are studies showing that untreated pain can actually put an individual at higher risk for suicide[5], and yet we also know that prescription medications can provide a means for suicide attempts, with over half of all non-fatal suicide events among veterans resulting from overdose or intentional poisoning[6]. This highlights the challenges that clinicians face every day when treating patients with complex injuries that might include physical and psychological ailments. It also demonstrates the importance of comprehensive, integrated pain management for military and veteran medical care.

The VA and DoD have both invested in moving the needle forward in this area, investing in research on pain and pain management, publishing an evidence-based Clinical Practice Guideline, implementing an opioid safety initiative, and introducing a stepped-case management system where primary care physicians have the support of an integrated, multi-disciplinary team of providers to design and implement a comprehensive treatment plan for the patient.

However, there is certainly room for improvement. With approximately 22 veterans dying by suicide every day, and more attempting suicide[7], reducing instances of overmedication and limiting access to powerful prescription medications that can be used to intentionally overdose must be included in a comprehensive approach to addressing the issue. A recent study showed that while patients receiving opioid therapy are at an increased risk for attempting suicide, following some of the critical care guidelines recommended in the VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain reduced this risk significantly[8].

This shows the critical need not only for policies and guidelines, but full implementation of those guidelines. VA's 2009 Directive on Pain Management, which outlines the stepped care approach to pain management, expired in October 2014. While IAVA understands that it expired in date only and the policy remains active, we are also extremely discouraged that the update to this important policy has not been prioritized and the new policy is still pending. We urge the VA to prioritize this to insure that the guidance provided by this important policy is not lost. Once reinstated, the challenge remains to uniformly and effectively implement this guidance at all VA facilities.

IAVA also would like to emphasize the importance of minimizing the risk of overdose and over-medication through the creation of formulary take-back programs and the use of state prescription monitoring programs within the VA.

Last year, a change to DEA regulation expanded the authorization for drug drop-off sites to pharmacies, hospitals, clinics and other authorized collectors. This important change in law gave VA and DoD the ability to stand up formulary take back programs in their hospitals. This is a critical mechanism for means control, removing unused prescriptions from the general populations to limit the possibility of misuse and abuse, and yet, no action has been made to move this forward.

While the VA is working to fully implement its participation in state prescription drug monitoring programs, IAVA urges the VA to move faster. Full implementation is critical to increase visibility across VA and non-VA clinicians so that they can be more informed as they work with their patients to provide safe and effective care.

Too often we hear the stories of veterans who are prescribed what seems like an assortment of anti-psychotic drugs and/or opioids with very little oversight or follow-up. On the flip side, there are also stories of veterans with enormous pain and doctors who won't consider their requests for stronger medication to manage the pain. These are tough challenges and IAVA remains committed to working with the VA and Congress to address them.

Again, we appreciate the opportunity to offer our views on this important topic, and we look forward to continuing to work with each of you, your staff, and this Committee to improve the lives of veterans and their families.

Thank you for your time and attention.

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[1] Dr. Jacqueline Maffucci, IAVA's Research Director, holds a Ph.D. in neuroscience from The University of Texas at Austin. She previously worked with Army staff and senior leaders to develop, implement, and monitor research programs and opportunities to address the health and wellness needs of service members.

[2] Institute of Medicine. (July 2011). Relieving Pain in America.

[3] Department of Veterans'Affairs. (June 2015). VA Health Care Utilization Among OEF/OIF/OND Veterans Cumulative from 1st Qtr FY 2002-1st Qtr FY 2015

[4] Lincoln LE et al. (2013) Barriers and Facilitators to Chronic Non-Cancer Pain Management in Primary Care. *J. Palliative Care & Medicine*.

[5] Ilgen MA et al. (2013). Noncancer pain conditions and risk of suicide. *JAMA Psychiatry*.

[6] Kemp J. and Bossarte R. (2012). Suicide Data Report 2012. Department of Veterans Affairs.

[7] Ibid.

[8] Im JJ et al. (2015). Association of Care Practices with Suicide Attempts in US Veterans Prescribed Opioid Medications for Chronic Pain Management. *J Gen Intern Med*.