STATEMENT OF
ILSE WIECHERS, MD MPP, MHS
ACTING DEPUTY ASSISTANT UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON

"MEDICATION MANAGEMENT IN VA HEALTH CARE"

DECEMBER 3, 2025

Chairman Moran, Ranking Member Blumenthal, and other Members of the Committee: thank you for inviting us here today to discuss our efforts to ensure safe, effective, and Veteran-centered medication management, as well as three draft bills that would affect VA programs and services. I am Dr. Ilse Wiechers, Acting Deputy Assistant Under Secretary for Health for Patient Care Services within the Veterans Health Administration. Joining me today is Dr. Tom Emmendorfer, Executive Director, Pharmacy Benefits Management Services.

We appreciate the Committee's attention to the issue of polypharmacy—defined as the concurrent use of multiple medications—and its potential risks, including adverse drug interactions and adverse drug events. Veterans often present with complex health conditions, including chronic pain, posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and substance use disorders (SUD). These conditions frequently require multifaceted treatment approaches, which can lead to complex medication regimens. While polypharmacy may be clinically appropriate for some Veterans in some contexts, VA recognizes the risks associated with excessive or poorly coordinated prescribing. We have taken a proactive, data-driven approach to address these risks while ensuring that Veterans receive the care they need.

Medication Management Within VA

VA's medication management strategy is supported by a centralized, evidence-based national formulary that ensures consistency, safety, and cost-efficiency across all

VA medical facilities. Formulary decisions are based on real-world evidence, clinical value, and safety, rather than market incentives. Non-formulary medications remain accessible through a transparent, standardized request process. This system allows VA to negotiate national contracts, reduce geographic variability, and improve outcomes through centralized oversight and analytics.

Medication reconciliation is a cornerstone of VA's patient safety efforts. This process ensures that Veterans' medication lists are accurate and up to date across all care settings, including from community care providers and other Federal providers. VA emphasizes collaboration among providers, patients, and caregivers, and leverages secure messaging, online portals, and mobile apps to support communication and reduce discrepancies.

VA has implemented several nationally recognized initiatives to reduce unnecessary medication use and promote safer prescribing. The VIONE program, launched in 2016, is a system-wide deprescribing initiative that empowers clinicians to evaluate medications based on whether they are Vital, Important, Optional, Not indicated, and Every medication has a reason (VIONE). Since its launch in 2016, the program has eliminated over 3.4 million unnecessary or potentially inappropriate prescriptions for more than 1.26 million Veterans. To build on this success, VA recently issued a Request for Information to industry to identify innovative software solutions that can further support individualized medication review and deprescribing, which is the planned and supervised process of reducing or stopping medications that are no longer appropriate or wanted with the goal of improving health outcomes.

Opioid Safety and Prescribing Practices

VA's Opioid Safety Initiative (OSI), launched in 2013, has led to a 68% reduction in the number of Veterans receiving opioids, a 90% reduction in concurrent opioid and benzodiazepine prescriptions, and an 86% decrease in new long-term opioid therapy starts. The OSI is supported by tools such as the Stratification Tool for Opioid Risk Mitigation, which uses predictive analytics to identify Veterans at high risk of overdose or suicide and prompts interdisciplinary case reviews to improve care coordination.

These reviews have been associated with significant reductions in all-cause mortality and repeat overdose events.

VA integrates data from Prescription Drug Monitoring Programs (PDMP) and internal dashboards to track prescribing patterns and ensure compliance with clinical guidelines. Risk mitigation strategies, including urine drug screening and informed consent, are embedded in clinical workflows. VA also distributes naloxone, a medication that rapidly reverses opioid overdoses, widely and provides overdose education to Veterans and caregivers. Naloxone is available free of charge through VA pharmacies, mobile units, and community outreach events.

Complementing these efforts, VA operates the Overdose Education and Naloxone Distribution (OEND) program to prevent opioid overdose deaths. The OEND program educates Veterans and caregivers on recognizing and responding to overdoses and ensures broad access to naloxone. As of September 30, 2025, VA has dispensed more than 1,863,901 naloxone prescriptions.

Psychotropic Medication Oversight

VA has implemented the Psychotropic Drug Safety Initiative (PDSI), a decade-long quality improvement program focused on optimizing psychotropic prescribing. This initiative has significantly reduced potentially inappropriate prescribing, including a reduction in benzodiazepine use among Veterans with PTSD as well as SUDs. PDSI continues to evolve, and current priorities include: (1) improving monitoring of Veterans prescribed stimulant and antipsychotic medications, (2) reducing antipsychotic use among Veterans with dementia, and (3) reducing benzodiazepine use among older Veterans.

Mental Health and Pain Management

VA prioritizes evidence-based psychotherapies as first-line treatments for PTSD and other mental health conditions. These include Cognitive Processing Therapy, Prolonged Exposure Therapy, and Written Exposure Therapy, all of which are available across VA’s specialized PTSD programs. The Model of Accelerated Services Delivery offers intensive therapy formats that reduce the time to recovery, while the Concurrent

Treatment of PTSD and SUDs using Prolonged Exposure integrates care for Veterans with dual diagnoses.

VA also supports non-pharmacologic pain management through its Whole Health model, which includes complementary and integrative health modalities such as acupuncture, yoga, tai chi, and mindfulness. These services are available in person and via telehealth, expanding access to Veterans in rural and underserved areas.

Pharmacogenomics and Clinical Decision Support

VA uses pharmacogenomics (PGx) by integrating genetic testing data into medical records to inform and optimize medication management for Veterans to prevent adverse drug events and to avoid ineffective medications. In 2019 the VA National Pharmacogenomics Program (formerly known as PHASER) was established. In fiscal year (FY) 2023 the Expanding Clinical Pharmacist Practitioners in Pharmacogenomics program was established to further enhance PGx testing capabilities by leveraging Clinical Pharmacist Practitioners to bridge knowledge gaps and foster the integration of PGx test results into clinical care. This program increased the number of facilities offering PGx testing from 45 in 2023 to 153 in 2025, thereby increasing testing to nearly 4,500 new tests ordered per month with more than 125,000 tests completed to date. These tests inform prescribing decisions for almost 100 commonly used medications, including those used to treat depression, pain, selected cancers, and cardiovascular conditions as well as other conditions. PGx data is integrated into the electronic health record, and clinical decision support tools generate alerts for drug-gene interactions, enabling real-time, prescribing guided by Veterans' pharmacogenomic test results. VA is planning on offering PGx testing at all VA medical centers by the end of calendar year 2026.

VA’s Medication Order Check Health Care Application provides automated alerts for drug-drug interactions, therapeutic duplications, inappropriate dosing, and pharmacogenomic risks. These alerts support safer prescribing and are reviewed by pharmacists before medications are dispensed.

Academic Detailing and Provider Education

VA's academic detailing program delivers structured, tailored education to clinicians focused on evidence-based medication management. Trained pharmacy specialists conduct interactive sessions—both in-person and virtual—providing up-to-date, unbiased information addressing medication safety, efficacy, and cost-effectiveness. Educational tools such as provider handouts and patient materials reinforce these messages. Targeting high-impact prescribers managing large panels of patients with PTSD and chronic pain, academic detailing has demonstrated measurable success in reducing risky opioid prescribing, lowering co-prescription of opioids and benzodiazepines, and increasing distribution of naloxone. Academic Detailing has been implemented nationally but can vary from site to site. Facilities with greater participation in academic detailing show more rapid improvements in prescribing practices.

Department of War (DOW) to VA Transition and Community Care

VA and DOW have established robust systems to ensure continuity of care during the critical transition period from military to civilian life. VHA Directive 1108.15, Continuation of Mental Health Medications Initiated by Department of War Authorized Providers, mandates the continuation of DoW-prescribed medications during transition, with exceptions only when a medication is clinically unsafe or inappropriate. VA Liaisons, Military2VA Case Managers, and the Solid Start Program provide proactive outreach and care coordination. In 2025, VA launched a national case management program for transitioning Service members with opioid use disorder, leveraging DoW data to ensure timely intervention and engagement in evidence-based treatment.

Pending Legislation

Having detailed the clinical initiatives that guide VA's medication management and patient safety efforts, I will now address the Department's views on the three bills on today's agenda.

S. XXXX End Veterans Overdose Act of 2025

Summary: Section 2(a) of the bill would require VA to make covered medications available at VA pharmacies to any covered Veteran or caregiver of a covered Veteran at no charge and without a prescription.

Section 2(b) would require VA to ensure that any Veteran or caregiver of a covered Veteran who receives a covered medication under subsection (a) also receives drug information on the use of such medication.

Section 2(c) would state that, in carrying out this section, VA may only collect the personally identifiable information (PII) needed for prescribing covered medication, and any PII collected under this section could only be used solely for the purpose of delivering, evaluating, and enhancing the quality of health care. VA could not use any PII collected under this section for the purpose of preventing a Veteran from employment.

Section 2(d) would require VA, not later than 2 years after the date on which VA first makes covered medications available to covered Veterans and caregivers under this section, and annually thereafter, to submit to Congress a report on this section. VA would need to include in these reports the number of covered Veterans and caregivers of covered Veterans who received covered medications under this section; an assessment of the feasibility and advisability of expanding the authority under this section to provide covered medications to immediate family members of covered Veterans; an assessment of the feasibility of expanding the authority under this section to include non-Department health care providers through the Veterans Community Care Program, an assessment of trends in the utilization of covered medications under this section, and any other recommendations with respect to the authority under this section.

Section 2(e) would define various terms. The term “caregiver” would mean a family caregiver of a Veteran participating in the program of comprehensive assistance for family caregivers under 38 U.S.C. § 1720G(a) or a caregiver of a Veteran participating in the program of general caregiver support services under 38 U.S.C. § 1720G(b). The term “covered medication” would mean any opioid overdose rescue medication, such as naloxone. The term “covered veteran” would have the meaning given that term in 38 U.S.C. § 1703(b), which generally refers to Veterans enrolled in VA health care or those eligible to receive care without needing to enroll.

Position: VA supports this bill, subject to amendments and the availability of appropriations.

Views: VA supports the intent of the bill to expand access to opioid overdose rescue medications for Veterans. Currently, 38 U.S.C. § 1710(g)(3)(B) already exempts from copayment requirements for medical services for eligible Veterans with respect to education on the use of opioid antagonists to reverse the effects of overdoses of specific medications or substances. Similarly, 38 U.S.C. § 1722A(a)(4) already exempts enrolled Veterans from medication copayment requirements for opioid antagonists furnished to Veterans who are at high-risk for overdose of a specific medication or substance to reverse the effect of such an overdose.

Naloxone acts quickly to reverse opioid overdose, restoring breathing and buying crucial time for emergency responders. It is safe and effective, is not a controlled substance, and VA emphasizes education about its use, overdose risk signs, safe medication storage, and disposal.

To expand access to opioid antagonists, like naloxone VA has permitted standing orders (or prescriptions), for any Veteran at risk of overdose. All over-the-counter medications, like naloxone, dispensed by VHA require a prescription, which allows for accountability of procured pharmaceuticals and stewardship of Government resources. While we are concerned that the bill would prohibit VA from using prescriptions, which could increase the risk for waste and fraud, the VA stands ready to work with the Committee to mitigate these concerns and increase the availability of overdose reversal medications, like naloxone, to save lives.

Naloxone is already available free of charge to enrolled Veterans in various forms, including nasal sprays. VA distributes naloxone not only through VA pharmacies but also at Community Resource and Referral Centers, resource fairs, and mobile medical units. Veterans can request naloxone by speaking to a provider, contacting a pharmacist (who can then facilitate a naloxone order from the Veteran's provider if a standing order does not exist), or messaging their care team through the VA Mobile App or VA's website.

VA provides education to caregivers about the availability and use of naloxone, as indicated, and if a caregiver expresses an interest in naloxone for a Veteran, the local Caregiver Support Team notifies the Veteran's provider of the request, helping to ensure continuity of care for the Veteran.

Cost Estimate: VA does not have a cost estimate for this bill.

S. XXXX Protecting Veteran Access to Telemedicine Services Act

Summary: Section 2 of the bill would add a new section 1730D to title 38, United States Code (U.S.C.), regarding the delivery, distribution, and dispensation of controlled medications through telemedicine. The proposed subsection (a) of this statute would state that, pursuant to 38 U.S.C. § 1730C and the requirements of the Controlled Substances Act (CSA), 21 U.S.C. § 801 et seq, covered health care professionals could use telemedicine through the use of an interactive telecommunications system, including an audio-only telecommunications system, to deliver, distribute, or dispense to eligible patients a controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 301 et seq, regardless of whether the professional has conducted an in-person medical examination under the following three circumstances: first, if the covered health care professional (A) is acting in the usual course of professional practice, (B) is authorized to prescribe the basic class of such controlled substance under an active, current, full, and unrestricted state license, registration, or certification, and (C) subject to subsection (b), at the time of the telemedicine visit of the patient, the provider both has reviewed VA's electronic health record database, including the internal prescription database, and the PDMP for the state in which the patient is located (if such a PDMP exists) for at least the 1-year period preceding the date of the visit, as well as provided documentation of such review and all attempts to access such databases and program, including successful and unsuccessful attempts; second, if the substance is delivered, distributed, or dispensed for a legitimate medical purpose; and third, the patient has been seen in-person by

another health care professional of the Department or a non-Department provider under referral from the Department, during the 2-year period preceding the telemedicine visit.

Proposed section 1730D(b) would limit covered health care professionals, when they are unable to review VA's electronic health record database (including the internal prescription database) and the PDMP for the State in which the patient is located, to providing no more than a seven-day supply until the covered health care professional is able to review such databases and program. If the database or PDMP required to be reviewed is inaccessible for an extended period, covered health care professional could provide consecutive 7-day supplies of a controlled substance until the database or program is accessible.

Proposed section 1730D(c) would state the authority under this section could only be used to supply a controlled substance for not more than a 6-month period.

Proposed section 1730D(d) would allow VA to waive the third requirement under subsection (a) (that the patient have been seen in-person during the previous 2 years) for patients newly enrolled in VA care or under other circumstances as VA determines necessary.

Proposed section 1730D(e) would require VA to ensure that the authority under this section is used to prevent interruptions to patient care and not as a replacement for routine in-person patient care.

Proposed section 1730D(f) would require VA to establish in regulations guidelines and a process for the delivery, distribution, and dispensation of a controlled substance pursuant to subsection (a). These regulations would have to include parameters for prescribing controlled substance to Veterans under this section,

Proposed section 1730D(g) would provide that nothing in this section could be construed to remove, limit, or otherwise affect any obligation of a covered health care professional under the CSA.

Proposed section 1730D(h) would require VA to submit to Congress an annual report that addresses the use of the authority under this section in each Veterans Integrated Service Network.

Proposed section 1730D(i) would provide that this authority would terminate on the date that is 5 years after the date of enactment.

Proposed section 1730D(j) would define the terms “controlled substance,” “deliver,” “dispense,” and “distribute” by reference to section 102 of the CSA. It would also define the term “covered health care professional” to mean a health care professional who is either a VA employee appointed under 38 U.S.C. §§ 7306, 7401, 7405, 7406, or 7408; or under title 5 or operating from a VA facility (including a VA clinic); who is authorized by VA to provide health care under chapter 17; who is required to adhere to all standards for quality relating to the provision of health care in accordance with applicable VA policies; who has an active, current, full, and unrestricted license, registration, or certification or meets qualification standards set forth by VA within a specified time frame; and, with respect to health care professionals listed under 38 U.S.C. § 7402(b) (which includes physicians, dentists, nurses, and other providers), has the qualifications for such profession as set forth by VA. The term would also include contractors furnishing care in a Department facility or clinic and health professions trainees appointed under 38 U.S.C. § 7405 who are under the clinical supervision of a health care professional described above.

Position: VA supports this bill, subject to amendments.

Views: VA greatly appreciates the Committee’s engagement and attention on this issue, as well as the willingness to discuss technical issues VA has identified with the bill. We believe these discussions have been productive, and we look forward to continuing to work together as the Committee considers and advances this legislation. VA wants to ensure this new authority effectively addresses the two significant barriers VA has experienced in ensuring providers can furnish care, including prescribing controlled substances, to Veterans through telehealth: restrictions within the CSA, and variability in state law prescribing requirements. These barriers have created significant access challenges for care delivery. As currently written, this bill appears to be intended to address the first of these barriers but not the second. VA recommends amendments to ensure both barriers are addressed. The Drug Enforcement Administration (DEA) and the Department of Health and Human Services (HHS) published a final rule authorizing VA providers to prescribe controlled substances via telemedicine (90 FR 6523), due to

become effective December 31, 2025 (90 FR 13410). While VA supports DEA's rule, it would only address one barrier, and Congress enacting legislation to provide this authority would provide an even stronger basis in law to support the delivery of care Veterans and other beneficiaries have earned.

While VA strongly supports the goal of this bill, amendments would be required to ensure it sufficiently addresses the first access barrier, and further amendments would be needed to address the second barrier.

As context for the second access barrier, the practice of telemedicine, as defined in the CSA, generally requires compliance with applicable Federal and state laws. These requirements concerning applicable state laws create ambiguity and legal concerns for VA health care professionals who could be subject to different state laws. Applicable state laws could be interpreted under the CSA as those in the provider's state of licensure; the provider's state of practice; the provider's state of registration with the DEA; the patient's state of residence; or the patient's location at the time of the clinical encounter. If one or more of these states' laws apply, a covered health care provider might be required to operationalize multiple practice standards; provide similar Veterans with different services; modify the treatment of a single Veteran based on the location at the time of a visit; or be prohibited from prescribing medically appropriate treatment at all.

VA included a legislative proposal in the FY 2024 and FY 2025 President's Budget request to address the risk of variable state laws to Veteran access to care, while ensuring that providers remain subject to the CSA's requirements that prescriptions be for legitimate medical purposes and prescribed in the usual course of practice. Where these requirements are defined by state law, VA's proposal would have authorized VA health care professionals to prescribe necessary controlled substances for their patients when adhering to national prescribing standards, regardless of a Veteran's location in the country and variable state laws.

VA has published a final rule (90 FR 47595) asserting the preemption of certain state laws regarding the prescribing of controlled substances at 38 C.F.R. § 17.417(b)(3); this final rule became effective November 3, 2025. While VA has asserted this authority pursuant to 38 U.S.C. § 1730C, similar to our discussion

regarding the DEA and HHS rule, we believe Congress specifically amending that statute to assert this authority would provide a clearer and stronger legal basis for the preemption of state law.

Authorizing VA health care professionals to follow a single, understandable Federal framework for telehealth-controlled substance prescribing would enable VA to maximally leverage telehealth to expand access, reach vulnerable Veterans in rural communities, and deliver consistent services to all Veterans, wherever they are in the country.

Again, VA greatly appreciates the Committee's interest in addressing access risks for Veterans. We stand ready to provide any further necessary technical assistance on this bill.

Cost Estimate: VA estimates there are no costs associated with the bill, if amended.

S. XXXX Written Informed Consent Act

Summary: Section 2 of this bill would require VA to update Veterans Health Administration (VHA) Directive 1005, dated May 13, 2020, and titled "Informed Consent for Long-Term Opioid Therapy for Pain," to apply to antipsychotic, stimulant, antidepressant, anxiolytic, and narcotic medications.

Position: VA cites concerns with this bill.

Views: While VA shares the goal of ensuring Veterans are fully informed about their treatment options, we have significant concerns that the bill, as currently drafted, would impose burdensome and unnecessary requirements, impairing access to timely, effective care without improving safety or patient understanding and potentially worsen patient outcomes.

VA maintains an unwavering commitment to the health and safety of America's Veterans. A critical component of this commitment is ensuring that informed consent

practices are consistently and rigorously applied across all VA health care facilities in accordance with VA statutory and regulatory authority and policy requirements. VA supports continuous quality improvement in medication prescribing and informed consent practices and as such, rescinded VHA Directive 1005 dated May 13, 2020, through VHA Directive 1004.01(3), titled “Informed Consent for Clinical Treatments and Procedures,” effective December 12, 2023. Consequently, it is unclear what legal effect, if any, the bill would have if enacted.

Under new VHA Directive 1004.01(3) and 38 C.F.R. § 17.32, VA practitioners are already required to conduct and document an informed consent discussion with every Veteran, or the Veteran’s surrogate when the Veteran lacks decision-making capacity, for any medical treatment or procedure recommended to them, including prescribed medications. This process includes a thorough explanation of the clinical indications, risks, benefits, and alternatives, enabling Veterans or their surrogates to make voluntary and informed decisions about their care.

Signature consent, which involves obtaining both the Veteran’s or surrogate’s and practitioner’s signatures on a formal VA consent form, is reserved for treatments and procedures that meet high-risk criteria as defined by regulation and policy. These determinations are made using evidence-based criteria developed by national VA medical and pharmacy subject matter experts. Additionally, practitioners may determine, on a case-by-case basis, that a medication warrants signature consent for a specific Veteran based on an individualized clinical assessment.

The draft bill appears to mandate signature consent for approximately 100 medications approved by the Food and Drug Administration, many of which are routinely prescribed and do not meet the high-risk threshold. For these medications, the current practice of informed consent discussion and documentation in the electronic health record is both clinically appropriate and sufficient to protect Veterans’ rights and safety. Requiring signature consent in these cases would not enhance patient outcomes and could, in fact, have adverse effects.

VA is concerned that the proposed requirements could mislead Veterans or their surrogates by implying that certain medications are inherently high-risk when they are not, potentially deterring Veterans from accepting clinically appropriate treatments. The

bill could also impair access to care, particularly for Veterans in rural or underserved areas, by introducing logistical barriers and delays in the prescribing process. Requiring signature consent could undermine clinical judgment by discouraging the use of effective medications due to the administrative burden associated with signature consent. The bill appears to assume that signature consent improves patient-centered outcomes such as understanding, satisfaction, or safety, especially when compared to other commonly prescribed outpatient medications, but that is not necessarily the case.

Moreover, VA is concerned that the additional requirements could increase the risk of negative outcomes, including suicide, by delaying access to essential psychiatric and pain management medications. VA supports continuous quality improvement in medication prescribing and informed consent practices. Rather than imposing rigid signature requirements, VA is engaged in several initiatives to improve medication safety. For example, VA is continuing implementation of the Mobile Informed Consent initiative, which enables practitioners to send real-time, evidence-based, easy-to-understand educational materials to Veterans as part of the informed consent process. VA is also conducting system-wide quality improvement campaigns focused on psychotropic prescribing through the Psychotropic Drug Safety Initiative.

Cost Estimate: VA does not have a cost estimate for this bill.

Conclusion

VA is committed to ensuring that every prescription advances—not undermines—the health of Veterans. We are proud of the progress made through initiatives like VIONE, OSI, and PDSI, but we recognize that more work remains. VA will continue its medication review efforts, improve access to innovative and non-pharmacologic treatments, and enhance consistency in prescribing practices through data-driven oversight and provider education.

We appreciate the Committee's oversight and support as we continue to put Veterans first by ensuring they receive the safest, most effective, and most compassionate care possible. We are prepared to answer any questions you may have.