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MEDICATION MANAGEMENT IN VA HEALTHCARE

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DECEMBER 3, 2025

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MEDICATION MANAGEMENT IN VA HEALTHCARE

WEDNESDAY, DECEMBER 3, 2025

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 4 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Tuberville, Sheehy, Blumenthal, Hirono, Hassan, and King.

OPENING STATEMENT OF HON. JERRY MORAN, CHAIRMAN, U.S. SENATOR FROM KANSAS

Chairman MORAN. Good afternoon and welcome. I know that Senator Blumenthal is running a few minutes late, but on his way, and I assume that we'll have a number of our colleagues join us. We have a vote at 4:30, so we'll have to figure out that circumstance as well.

I appreciate our witnesses joining us today and for the important work that you all do to support our veterans and their families. As we know, our Nation owes veterans the assurance of receiving safe, high quality, and effective care through the Department of Veterans Affairs. This includes making certain that the medications that are being prescribed are designed to support their recovery from trauma, pain, and mental health challenges, and are being paired correctly with the right support system. This responsibility is central to this Committee's mission, and it is the focus of today's discussion.

Recent reporting by *The Wall Street Journal* has raised concerns about the use of multiple central nervous system medications among veterans, often referred to as "combat cocktail." These stories raise the question of how widespread these practices are, their origins, how the VA is addressing this issue, and what VA's oversight and accountability mechanisms are in these instances. Medication is critical to the overall care and well-being of many veterans and nothing from today's hearing should suggest that veterans should hesitate to seek treatment or that evidence-based medications are unsafe or unwelcome in any way.

Over the past decade, the VA has made significant progress in reducing opioid prescriptions through promoting safer options, expanding programs that support holistic health, and implementing new oversight measures to identify high risk medication combina-

tions. This hearing, however, provides an opportunity to assess progress, discuss effective strategies, and identify gaps that still remain. Veterans deserve the trust in the system, and that's exactly why we're here today.

This includes understanding how the VA trains clinicians, monitors prescribing practices, and implements policy to make certain veterans have access to non-medication options like therapy, pain management, and community programs, along with discussing whether private sector models or technologies can offer insights and ultimately help the VA to better serve veterans.

Today we'll hear from VA officials who oversee prescribing practices and mental health policies across the system. The goal is simple: simply want to understand the scope of this issue and determine what steps the VA and Congress can take to guarantee that veterans receive safe, effective, and personalized care. The men and women who have served our Nation deserve nothing less.

As I indicated, Senator Blumenthal is expected to join us shortly and we are going to proceed with the first panel. Testifying on the first panel today, which is on my sheet the second panel, is Dr. Julie Kroviak, Principal Deputy Assistant Inspector General for the Healthcare Inspections, U.S. Department of Veterans Affairs; Alyssa Hundrup, Director, Health Care at U.S. Government Accountability Office; and Erin Fletcher, Wounded Warrior Project.

I appreciate our witnesses willing to testify, and we'll begin. Ms. Hundrup?

PANEL I

STATEMENT OF ALYSSA HUNDRUP, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. HUNDRUP. Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, thank you for the opportunity to discuss our work related to medication management at VA.

My testimony today covers various related GAO report findings and recommendations. Effective medication management is essential to ensure veterans receive safe and comprehensive treatment. This is particularly important for veterans experiencing mental health conditions, which have been a persistent and growing issue. Many veterans also live with chronic pain, often because of injuries from their military service.

Veterans may receive medications such as antidepressants or mood stabilizers, as well as opioids for pain management. Some veterans have multiple chronic and mental health conditions, which may necessitate the use of numerous medications, increasing the risk of polypharmacy. If managed improperly, polypharmacy can lead to adverse health outcomes or even overdose or death. As such, it is critical that VA ensure it is offering effective treatment, including medication as well as non-pharmacological options such as therapy to reduce the risk of negative outcomes.

In 2019, we examined VA providers' treatment plan decisions for veterans with mental health conditions. We found veterans received a range of treatments including talk therapy, one or more psychiatric medications such as anti-anxiety or anti-depressants, or

a combination of the two. At that time, VA did not have guidance on or monitor providers' documentation of required treatment options in the plans. So, we made two recommendations to address these issues.

Since then, VA agreed with and took action to implement the recommendations. Specifically, VA providers are now required to record mental health treatment plans as separate easily identifiable documents in medical records. The plans are to clearly show what treatment is being provided, the different treatments that were considered, and whether any changes may need to be further considered going forward.

VA also developed an approach for monitoring the consideration of different evidence-based treatments, including both the prescribing of medications and therapy options. With this approach, VA is in a better position to ensure providers are considering all available options and providing the most appropriate treatment to each veteran. Importantly, with this information, VA is also in a position to evaluate the prevalence and appropriateness of polypharmacy and minimize the risks that it can bring including overdose or death.

Additionally, we've examined issues related to VA's implementation of its Opioid Safety Initiative. At the time of our report, VA had reduced opioid prescribing rates, but we found VA did not consistently follow some risk mitigation strategies, such as conducting annual urine drug screening or requiring informed consent for long-term prescribing. We made recommendations to address these issues and VA has implemented them.

For example, VA created a planning tool for primary care providers related to reviewing and documenting each of the risk mitigation strategies in veterans' medical records. With this tool, VA can better ensure providers are following the strategies. In light of the very serious risks that opioids pose, including addiction and overdose, it is critical that VA ensure it is maintaining careful oversight of prescribing so that it is done in a safe and effective manner.

Lastly, the availability of mental health services is especially important for service members transitioning out of the military as this is a particularly vulnerable time. The transition period can bring stressors related to housing, employment, and family reintegration, and these veterans are susceptible to mental health conditions. In our 2024 report, examining mental health services for transitioning service members, we found VA and DoD identified a number of helpful touch points such as pre-separation counseling, but the two departments have not assessed the effectiveness of their collective efforts, and we recommended they do so.

VA has also agreed with this recommendation and stated that it will coordinate with DoD to establish a plan of action to implement it, including identifying any gaps in services or duplicative efforts. It's important for VA to take action to address our recommendation, and we will carefully monitor the steps that VA takes going forward.

Addressing our recommendation will help to ensure that departments the are most effectively offering mental health services to service members and veterans as they readjust to civilian life. This

concludes my prepared statement. I'd be happy to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Hundrup appears on pages 37–56 of the Appendix.]

Chairman MORAN. Dr. Kroviak, welcome, and thank you for your testimony.

STATEMENT OF JULIE KROVIAK, MD, PRINCIPAL DEPUTY ASSISTANT INSPECTOR GENERAL IN THE ROLE OF ACTING ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. KROVIAK. Chairman Moran, Members of the Committee, I am pleased to testify about the oversight conducted by the Office of Inspector General regarding VA's medication management practices.

A fundamental healthcare activity is a medication reconciliation process involving providers, patients, and their caregivers, that ensures they are aware of all medications that patient is prescribed and taking, including over the counter and supplements.

Medication reconciliation required by VA can be time and labor intensive, but it helps verify that patients are taking their medications as prescribed, and that each medication's risk and potential side effects are understood. It can also reveal or prevent duplicative treatments, contraindications due to allergies, and potentially dangerous drug interactions.

Medication reconciliation is most critical during care transitions, such as when a patient is discharged from a hospital, moves between different levels of care, or receives VA and community care. For those patients with chronic or difficult to treat conditions including mental health conditions, the risk of polypharmacy, being prescribed multiple medications, is real, but it does not always mean a patient is receiving poor care.

Veterans are at higher risk for psychotropic polypharmacy, that is, being prescribed more than two medications that affect mind, mood, and behavior. This can occur because of their distinct military experiences that lead to complex and treatment-resistant mental health diagnoses.

The OIG has noted deficiencies in medication management in several of our reports on VA healthcare. We uncovered non-compliance with required processes for patients being discharged from acute mental health care settings. For example, only 37 percent of electronic health records at the Philadelphia VA included clear discharge medication instructions, which are essential to prevent medication errors post-hospitalization, and ensuring continued recovery.

Patients must also be educated on potential risks associated with their prescriptions. Many anti-depressants, for instance, carry "black box" warnings due to their increased risk of suicidal thoughts, particularly in young adults. One tragic case reviewed by the OIG revealed serious deficiencies when a young veteran who ultimately died by suicide was prescribed an anti-depressant without being educated on the risks, and was not provided timely follow-up care to evaluate responses to this new medication. This case

highlights the critical value of patient education and timely follow-up care.

In addition to challenges with safe prescribing within VA, the OIG is concerned with safe prescribing for veterans receiving community care. A significant, troubling area remains the oversight of opioid prescriptions written by community care providers. VA is required to ensure community providers review and acknowledge VA's Opioid Safety Initiative (OSI) guidelines. However, we found inadequate oversight of VA's third-party administrators' certification that community providers reviewed these guidelines. When community providers are not even aware of VA's expectations for safe opioid prescribing, VA cannot guarantee the safety of those veterans referred to the community for chronic and acute pain management.

Our review of the VA Eastern Kansas Health Care System highlighted further inadequacies in coordination and oversight of medication management involving community providers. Among other issues related to patient safety for veterans referred to the community, we found incomplete documentation verifying safe opioid prescribing practices and a lack of documented medication reconciliation by community providers.

In conclusion, VA's dedicated clinical staff work tirelessly to provide high quality care tailored to each veteran's needs. Such care can involve multiple treatment modalities and medications. Patients and caregivers must be empowered to manage their care with accurate medication instructions and understanding of treatment expectations and knowledge of potential side effects for each medication.

The OIG is committed to independent oversight. Our teams of dedicated medical professionals are uniquely positioned to assess and drive meaningful improvements in the quality of care delivered by both VA and community providers. Chairman Moran, Ranking Member Blumenthal, and Committee members, I am happy to take any questions you may have.

[The prepared statement of Dr. Kroviak appears on pages 57–62 of the Appendix.]

Chairman MORAN. Thank you, Doctor. Erin Fletcher, welcome again. Your testimony will be received.

STATEMENT OF ERIN FLETCHER, PSY.D., WARRIOR CARE NETWORK DIRECTOR, WOUNDED WARRIOR PROJECT

Dr. FLETCHER. Thank you. Chairman Moran, Ranking Member Blumenthal, and distinguished Committee members, thank you for today's hearing and for the honor to join you on behalf of Wounded Warrior Project and the warriors and families we serve.

Our vision to foster the most successful, well-adjusted generation of wounded service members in our Nation's history, brings with it the responsibility to identify, address, and serve the mental health needs of veterans who reach out for help. In our most recent Warrior Survey, 77 percent of warriors reported PTSD and more than half presented with moderate to severe PTSD symptoms at the time of the survey. Nearly two in three reported one or more mental health conditions, and for many of the warriors we support,

mental health challenges can be worsened further by poor sleep, chronic pain, and feelings of isolation.

Recent reporting about polypharmacy has highlighted how overmedication can be one of the many challenges veterans face on their road to recovery. Poor access to therapy, canceled appointments, and stigma can also frustrate even those who are most motivated to find care. But there is reason for hope and we can frame strategies for improvement around stopping overmedication, increasing access to care, and embracing innovation. Regarding overmedication, recent research has shown that 28 percent of post-9/11 veterans receiving VA mental health care, met criteria for central nervous system polypharmacy.

One way to help reverse these trends will be for Congress and VA to continue their investment in precision medicine. By moving beyond one-size-fits-all care, precision medicine enables more accurate decisions that improve outcomes and reduce unnecessary or ineffective treatments. Congress helped launch VA's initiative for precision mental health to identify and validate brain and mental health biomarkers, and translate those findings into improved clinical care for veterans. With consistent support and funding, as well as expansion to consider low level blast injuries, this initiative can transform the way medication can supplement evidence-based therapy.

Increasing access to care will help move away from what some veterans observe to be a medication first approach at VA, in which prescriptions are offered before therapy or without consistent access to evidence-based treatments. But as our country is struggling with training enough providers to meet increasing demand for mental healthcare, we can broaden our perspective on access. Veterans increasingly express interest in non-pharmacological and complementary therapies to supplement their clinical treatment. Mindfulness, yoga, acupuncture, Tai Chi, and other integrative approaches provide coping skills, stress reduction, and support between therapy sessions.

Congress and VA can help extend more access to approaches like these by renewing commitment to VA's whole health program. Even with over 100 whole health locations, availability still widely varies across VA facilities. Without a consistent centralized implementation model, many veterans remain unaware of available resources or encounter barriers in accessing them. Moreover, capacity constraints and frontline clinical treatment make access to these services even harder to obtain. These barriers can lead veterans relying solely on pharmacological interventions.

Last, innovation can help set new strategies to ensure veterans have access to evidence-based treatment. Forward thinking approaches to case management are one area where we can drive change. We found success with offering veterans regular touch points to reduce frustration, ease confusion, and help them stay engaged while they navigate the clinical system. In a VA context, one example that we have found extremely effective is the post-9/11 Military2VA (M2VA) Case Management Program.

This Public-Private Partnership (P3) model allows VAs to place liaisons at certain partnership sites as veterans complete specialized treatment within the community. For example, VA liaisons are

onsite at our Warrior Care Network academic medical centers where veterans receive intensive outpatient care. The VA liaisons help veterans obtain VA medical records, schedule follow-up appointments at VA after discharge, and serve as a direct point of contact should the veteran have questions about their VA care in the future.

At these sites, 90 percent of participating veterans return to VA for ongoing care, which is evidence that structured, proactive, and collaborative transition support helps prevent veterans from falling through the cracks and help maintain gains achieved in treatment.

In conclusion, I'd like to recognize that VA is our biggest and most important partner in helping veterans access the care and support they need. It is critical that we give VA the tools it needs to succeed, and with Congress's help, VA has made progress in recent years to reduce over prescriptions, improve oversight, embrace innovation, and strengthen its mental healthcare system. We are hopeful that the challenges being discussed today will be the focus of even more effort to ensure that veterans receive the best possible support when seeking mental health care.

Thank you for this invitation to testify and I welcome your questions.

[The prepared statement of Dr. Fletcher appears on pages 63–70 of the Appendix.]

Chairman MORAN. Thank you very much.

Before we go to questions, let me turn to the Ranking Member Senator Blumenthal for his opening statement.

HON. RICHARD BLUMENTHAL,
RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you. Thank you, Mr. Chairman, and my apologies for my lateness. I'm going to put my statement in the record. But let me just thank you and thank the witnesses for being here today.

[The opening statement of Senator Blumenthal appears on pages 31–33 of the Appendix.]

Polypharmacy often is a symptom of long wait times for care or other factors that may result in multiple medications that conflict with each other or cause damage to the individual. Insufficient clinical capacity, fragmented care and lack of accessible alternatives to medication may lead to overreliance or mismanagement of pharmaceuticals. And unfortunately, what we've seen is longer waiting times for access to care.

Reports indicate that there is a serious deviation from VA's commitment to evidence-based veteran-centered mental healthcare. And I have written to Secretary Collins about it. I'm going to put that letter in the record as well.

[The letter referred to appears on pages 87–88 of the Appendix.]

The VA has lost a lot of its staff, which could account for those delays, and it needs to be in the position to have the resources to restore its mental health care network. And let me just say finally, by way of this introductory statement that, Dr. Fletcher, I was concerned that the VA has instituted a copayment for holistic treat-

ment like yoga, fitness classes, meditation, whole health coaching that allow veterans to rely on treatment other than just medication. And I think that is really counterproductive.

So, I look forward to our questions and again, my thanks, Mr. Chairman.

Chairman MORAN. You're welcome, Senator Blumenthal. Let me begin with a broad question to each of you. In part, what precipitated this hearing was the reporting from *The Wall Street Journal* that highlighted troubling examples of veteran medication experiences. From each of your perspectives, how closely do those cases align with what your office or organization is seeing and where do they differ?

In other words, tell me whether what you see is what is reported in that article and what we should know about that. Start with you, Ms. Hundrup.

Ms. HUNDRUP. Thank you. So, in our work, we had found there's a number of factors that influence providers' decisions to prescribe. They ranged from the resources at a medical center, to complexity of the conditions, the comfort level with prescribing, as well as the availability and the types of treatment. So there's really a lot that can influence it.

At the time of our work, which was based on fiscal year 2018 data, so it's a little bit dated, there were 37 percent of veterans with at least one mental health condition that were prescribed a psychiatric medication, either alone or in combination with therapy. And focusing on those with PTSD, veterans taking two or more classes of medications ranged from 32 percent for those seeing a primary care provider to upwards of 61 percent for those seeing both primary and specialty care providers.

Now, as has been stated, polypharmacy in and of itself isn't necessarily problematic. So in preparation for this hearing, we were looking to see if there was updated data on where the VA is in terms of polypharmacy. Again, not to say that polypharmacy alone is bad, but it does increase risks. Updated data were not available. So I would encourage the VA to make those data available and it is worth examination.

What we did recommend is making sure the treatment plans have clear identifiable information so that they can monitor that and see where there are risks and mitigate those risks, such as if a provider is doing a lot of prescribing and you see a lot happening, you can look into that and see if that is appropriate to make sure that they're mitigating any risks or taking action if that may be the case.

Chairman MORAN. Is that a suggestion so that we could compare what takes place at the VA with other healthcare providers?

Ms. HUNDRUP. Well, just to have a number to update where we are, you know, a lot has changed since 2018. So just to understand veterans, for example, with PTSD or other mental health conditions, what kinds of prescribing is occurring, what kinds of classes of psychiatric medications are they getting? For a while there was a lot of concern about opioids in combination with benzodiazepines. I know that had been reduced greatly and that was something that the VA made great strides in. But where are we today? Has that continued to decrease? I think some of these allegations in the arti-

cle, we just don't have the data, so we don't know. So I think the first order of business is really seeing updated data.

Chairman MORAN. Fresh data. Okay, thank you. Doctor, anything to add or suggest?

Dr. KROVIAK. I was actually quite disappointed in the article. I think it is devastating to read about the patient experiences. Those are real. Yes, I found the article disappointing. The cases were devastating. The patient experiences are real. But what I didn't, and I wouldn't expect to have seen in the article is what the medical record showed, what the provider and healthcare team, what their response would've been, and how they supported the patient. These were complicated patients. It's easy to understand that from reading the article, that VA treats very complicated patients.

I was also very disappointed that the suggestion is that the VA providers are handing out medications to avoid providing adequate care. That's not what we've seen. We've been in every facility, CBOC, Vet Center, CLC; this is not what we're seeing. We are seeing compassionate, dedicated providers managing incredibly complicated patients.

Chairman MORAN. Great to hear. Thank you. Dr. Fletcher?

Dr. FLETCHER. Yes. Thank you for the opportunity. So what we hear from the warriors we serve is that they often encounter medication recommendations before therapy is offered or even accessible. And so we know this doesn't happen everywhere, but we've heard it consistently enough that it suggests an opportunity to increase access to first line psychotherapies and more shared decision-making in the treatment planning process.

Chairman MORAN. Is what you're saying different than what Dr. Kroviak was saying?

Dr. FLETCHER. No, I think there's a lot of similarities. A lot of similarities, yes.

Chairman MORAN. Senator Blumenthal.

Senator BLUMENTHAL. Thank you. Dr. Fletcher, to what extent have waiting times for mental health appointments been due to diminished staff, and I'll ask the same question of our other witnesses as well?

Dr. FLETCHER. Thank you for that question. So what we've heard, again, from the warriors we serve is that they are experiencing access to care difficulties and that can create problems. We know that warriors with the best outcomes have access to evidence-based treatment, are well-informed about the medications that they are taking, and again, are active participants in the treatment planning process.

Senator BLUMENTHAL. Dr. Kroviak?

Dr. KROVIAK. Yes, we are aware of shortages in mental health providers and access to care within mental health and health in VA. That's not unique to the VA healthcare system. So, the wait times we're seeing in VA are also reflected in the wait times that veterans are experiencing when being referred to the community. So, it is a much bigger problem than just VA.

Senator BLUMENTHAL. It's not unique. But what is maybe unique, certainly unusual to the VA healthcare system, is that it is discouraging talented mental health professionals from coming to the VA through policies of furloughs and firings. Would you agree?

Dr. KROVIAK. So, I will say through our cyclical reviews, where we go out to facilities not for cause, but to try to get a feel for culture and quality of care practices, we are getting more feedback that morale is going down because of the uncertainty within the Federal Government. So yes, while they aren't participating in the DRP or didn't participate in the DRP or other programs, clinical staff were exempted from that, but they are still losing clinical staff because of morale.

Senator BLUMENTHAL. Morale going down means——

Dr. KROVIAK. Correct.

Senator BLUMENTHAL [continuing]. That fewer talented and skilled professionals are going to come to the VA or stay, they're going to be leaving if morale——

Dr. KROVIAK. Yes, I have to say, these are discussions we have with leaders. We are not asking them to validate the data—they're just sharing in a conversation the concerns at the local level.

Senator BLUMENTHAL. Did you have anything, Ms. Hundrup?

Ms. HUNDRUP. I would just quickly echo what Dr. Kroviak said about the nationwide shortages applying to both VA and inside as well as outside. Also, it is important to distinguish between care within VA and outside care. For the VA, there is a timeliness standard for care in a VA facility. They don't have that for receiving care in the community, which means that VA is limited in its understanding of how long it's taking for a veteran to be seen in the community or what the challenges are or how best to address them.

And we do have an outstanding recommendation for VA to establish a timeliness standard, which would help give us more information about the differences. And of course, timeliness of care is an access to care issue because the longer a veteran has to wait can exacerbate health issues. Thank you.

Senator BLUMENTHAL. And of course, *The Wall Street Journal* article the Chairman referred to a little while ago, "Combat Cocktail: How America Overmedicates its Veterans", I think indicates that the care for them, mental health care or other kinds of care is really important to prevent the overmedication that often results from the cocktail of pharmaceutical drugs that may be prescribed sometimes wrongly or inadvertently. And I wonder if you can say Dr. Fletcher, whether there should be stronger safeguards oversight to prevent that kind of problem?

Dr. FLETCHER. I thank you for that. What we hear from our warriors is that they want to spend more time with their providers. They want to fully, you know, process through their trauma, their symptoms. They want to be informed about the medications that they're being prescribed. We know that consistent follow-up increases chances of treatment adherence and treatment compliance. Consistent follow-up allows providers and veterans to identify medications that may not be working properly, avoid symptoms, you know, side effects that become too uncomfortable. That consistent oversight is important to successful clinical outcomes.

Senator BLUMENTHAL. Well, again, my time is about to expire. Let me just say that I appreciated both the OIG and the GAO findings, which I think are tremendously important. Just as one example, 33 percent of VHA facilities were not in full compliance with

requirements to have a pain management team. That seems like a really basic failing. And again, you can't have pain management without the personnel to do it. And I think unfortunately, the VA is sacrificing that tremendously important capability. Thank you, Mr. Chairman.

Chairman MORAN. Senator Tuberville.

HON. TOMMY TUBERVILLE,
U.S. SENATOR FROM ALABAMA

Senator TUBERVILLE. Thank you, Mr. Chairman. Thanks for being here. Good to see you all. Very important issue. We have a lot of problems in my State of Alabama with overprescribing at times. Doctor, you and Ms. Hundrup spoke about enhancing oversight at the VA and medical management related issues, especially a better hold on medical professionals accountable for overprescribing harmful medications. Do we have a plan for that? Both of you, could you all answer?

Dr. KROVIAK. So, ultimately, the plan is VA's, but what our oversight work has shown that a lot of critical leaders in the VISN, which is a body that exists to oversee the facilities, do not have defined roles, and responsibilities, and clear lines of authority. So, VA has a plethora of directives and policies that, you know, are based in evidence.

However, it's the consistent application of those policies and practices where we find most of the issues that we report on. With structured oversight roles within the VISN, where leaders know what is their responsibility, it is written down and they own it, and that certain staff and procedures and practices, they are accountable to that leader can really help enforce—we feel it could really help enforce the more consistent application of these directives and policies and practices that they have plenty of.

Senator TUBERVILLE. Thank you. Ms. Hundrup?

Ms. HUNDRUP. I would also, again, echo Dr. Kroviak. I think we have many similar findings and share the same sentiments, but I would just add that in our work, I think by having VA more clearly document the treatment plans that are in a mental health care plan and have them be easily identifiable as well as document what evidence-based treatment options were considered. Obviously, in many, many cases it's very complex. There's not a straightforward answer.

There does have to be adjustments very specific to the individual that change over time. And these are complex cases, so you might have multiple medications involved. But by having that documented and clear in the record, it sets up VA to be in a position to monitor that. And they had committed to reviewing individual providers' plans, you know, a sample of plans on a biannual basis just to make sure. I think as Dr. Kroviak said, some of the policies are only as good as they're implemented.

So, you know, I would be interested to see what VA is doing to continue to monitor and look for outliers and then take action with providers that may not have the best education or may not be making the best decisions for their veterans.

Senator TUBERVILLE. Do you all think we should have oversight on foreign manufactured drugs that we give our veterans? Is there any thought on that?

Dr. FLETCHER. Thank you for that question. I think where the Warrior Project we stand on this is, we want our veterans to be as informed as possible about the medications that they're taking. We want treatment recommendations to evidence-based research informed and prescribed in the safest manner possible.

Dr. KROVIAK. I don't have a specific comment on the oversight. You said meds manufactured over——

Senator TUBERVILLE. Foreign manufactured.

Dr. KROVIAK. Yes, I mean, again——

Senator TUBERVILLE. Which most of them are by the way anyway, I would think.

Dr. KROVIAK. Right. I mean, this whole medication reconciliation process that I've emphasized in my testimony is really more about the interaction between the prescriber, the provider, and the patient. I think that's where all of this sort of action has to happen to where everybody's on the same page. It's really outside of the VA to where the question you're asking would be, you know, put into play and absolutely I would not, you know, speak against increased scrutiny over the safety of the medications that we're buying and prescribing.

Ms. HUNDRUP. I would just echo that. That's not something that I have familiarity with, but I think that's an important topic that VA should be closely looking at.

Senator TUBERVILLE. Thank you. I got 45 seconds. Ms. Fletcher, I hosted a field hearing in Montevallo, Alabama this spring talking about HBOT and psychedelic-assisted therapy. Do you think that expanded access through FDA approval of these types of therapies could and would help address the polypharmacy issue?

Dr. FLETCHER. Thank you for that question. I think that access and research into alternative treatments is something that a lot of the warriors that we serve would be interested in. We hear oftentimes that they're coming to us saying that they've tried more traditional therapies and are more eager to pursue the non-traditional therapies when they haven't found that success. But again, we would want these treatment recommendations to again, be based on patient safety and evidence-informed.

Senator TUBERVILLE. Thank you. Thank you, Mr. Chairman.

Chairman MORAN. Senator Hirono.

HON. MAZIE K. HIRONO,
U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Mr. Chairman. Thank you very much for the panel. So, we have millions of veterans, millions of veterans, and a rather large percentage of them have PTSD. And according to *The Wall Street Journal* article, nearly 60 percent of VA patients with PTSD, and I don't know what that translates to into numbers, but they say that's over half a million patients. Are each of these veterans with PTSD supposed to have an individual treatment plan? I don't know who to ask this question to. Yes? No?

Dr. FLETCHER. Yes. I think that having an individualized approach to treatment yields better outcomes.

Senator HIRONO. I know. That's not my question, though. Do each of these, over half a million, let's just focus on the veterans with PTSD, do they each have a treatment plan and who's supposed to come up with a treatment plan for each of those veterans?

Dr. KROVIAK. If they're diagnosed with PTSD and being treated, then they are required to have a treatment plan that is created and monitored by their healthcare team.

Senator HIRONO. And Dr. Fletcher, you deal directly with the veterans of the two other panel members. So, do they have individualized treatment plans?

Dr. FLETCHER. I would say that that varies across veterans and across——

Senator HIRONO. I'm sorry, what?

Dr. FLETCHER. I would say that that varies. I can't speak necessarily for all of the veterans. We typically hear that when they're afforded the opportunity to have the access to this evidence-based treatment that it can be individualized, but it's not always.

Senator HIRONO. Well, when you think about the number of veterans we have and their medical needs and they go to VA, it's just astronomical. The needs are astronomical. And at a time when there have been pretty significant cuts to VA, which always had a shortage of providers. Isn't that true? I mean, in Hawaii they're always trying to hire people for the VA. So, there's always been a shortage. It's been exacerbated with this regime. Isn't that so? That shortage? Somebody?

Dr. KROVIAK. So, the OIG publishes a report annually on critical staffing shortages, and for the past 8 to 10 years, I can't remember exactly, but this year, yes, you are correct. We've noticed the most significant increases in those——

Senator HIRONO. So, at the same time as, I think Dr. Fletcher, no—GAO, I think you said that there needs to be yes, more oversight. And when you have the staffing cuts, etc., who's supposed to provide the oversight that you are recommending? This is for Ms. Hundrup, am I pronouncing your name correct?

Ms. HUNDRUP. Yes, that's correct.

Senator HIRONO. So, you say more oversight is needed, but there are massive cuts to VA. Who's supposed to provide the oversight for the medical care of the veterans?

Ms. HUNDRUP. Right. I think that that's where there is a level of oversight to ensure, because as I mentioned, if you have a policy or requirement, it's only as good as——

Senator HIRONO. But do we? You're saying that they need more oversight, but there isn't more oversight. In fact, I would say there's less, because there are cuts. There have been cuts to the VA's capacity to provide care. So, what I'm seeing is that I commend you all for pointing out the needs, but how are the needs supposed to be met when the VA is actually making pretty significant cuts to an already strapped healthcare system, the biggest healthcare system in the country? I mean, I don't know how the veterans are supposed to receive the kind of care they need when there are cuts to the provider base.

Ms. Fletcher, I was intrigued by your saying that veterans would like to have alternative kinds of care, and is that a fruitful avenue for us to support and pursue if we're not going to have all the men-

tal health providers that are necessary, you know, non-traditional services? Are we doing something to provide those kinds of programs?

Dr. FLETCHER. I think that there is absolute value in pursuing research to support these alternative therapies. What we've typically heard, again, is most of the warriors that we serve are willing to avail themselves to the frontline treatments that are already available. What we hear is they seek these alternative therapies when what they've tried hasn't worked. And we always want—and so a commitment to innovation in mental health care is absolutely needed.

Senator HIRONO. Do you think that that is a fruitful way to go, but because the VA system lacks providers, especially I would say mental health providers, maybe primary care providers, but if we can create an environment where alternative kinds of support can be provided, is that a fruitful way for us to proceed? Dr. Fletcher?

Dr. FLETCHER. Yes, I do believe there's value in pursuing alternative therapies.

Senator HIRONO. Well, that may be one of the ways to go when we lack resources. Thank you, Mr. Chairman.

Chairman MORAN. You're welcome. Senator Sheehy.

HON. TIM SHEEHY,
U.S. SENATOR FROM MONTANA

Senator SHEEHY. Thank you all for coming today. Appreciate your commitment to this important cause. As a combat veteran myself, married to a combat veteran, I take very personal stake in all these matters and thank you for your commitment to the cause. You know, I think to respond to some of my colleagues' comments there, all the more reason why the community care model was introduced and is more critical now than ever, which is the VA has perpetually been underresourced especially in rural states like Montana, where you cannot have a VA clinic in every town.

And when most towns are two to three hours apart, when it's a five-hour drive, from Plentywood to Helena, the expectation that a VA clinic will be available within reasonable driving distance in a negative 30-degree snowstorm, is unlikely. And taking advantage of the community care options and investing in community care, especially in our rural states, is just as important now more than ever.

You made a great point today Dr. Fletcher, and I want to reinforce, and that's the alternative care model. That we're seeing so many veterans now flying to Mexico, flying to the Middle East, going to Turkey to get psychedelic treatment. That they're finding immediate relief from PTSD, from TBI. They're finding it to be safer, healthier, and far more effective for them and their families. And yet that type of treatment is not only not provided by the VA or our healthcare system at all, it's been stigmatized and in some cases treated as illegal, even though it's working far better.

And I think whether it's acupuncture or dry needling or yoga, meditation, sleep therapy, or alternative psychedelics, we need to be open-minded about how we can adopt these therapies. And unfortunately, this isn't a knock on the VA, but the government is not inherently going to be an innovative, entrepreneurial, creative

place. It's just not. It's opposed to the DNA of a government bureaucracy. And we shouldn't fight that. We should welcome that and say, outside groups like Wounded Warrior Project, like other nonprofit organizations can be those hotbeds of innovation.

And we should be able to welcome those in and welcome their creative thought process. Because at the end of the day, it's about the outcomes, not the process. Veterans not victims, patients not bureaucracy, and outcomes over process. And at the end of the day, that's what we have to focus on. So, thanks for your comments there.

Ms. Hundrup, I want to go back to a comment you made, I think it was incredibly relevant. I'd like your thoughts on that. You said, you know, no matter what the legislation or the policies are, if they're not executed properly, none of that matters. And I think that that is government in a nutshell at the end of the day. We can all pass laws, but if the people that we employ to enact those policies aren't the right ones or are not doing it properly, it's going to fail.

This written informed consent law we're trying to pass, I think has broad support across the veteran, the nonprofit, and the healthcare industries, and in communities. I'd like your thought on should this pass, how we ensure that when it passes, if it passes, we enact it properly, and the outcome is what we want?

Ms. HUNDRUP. Yes. I think informed consent is important because it's an explicit way to ensure the patient knows about the risks of the medications they may be taking. In the case of the Opioid Safety Initiative, we did find that the informed consent was lacking and recommended that VA take steps. In implementing our recommendation, they implemented a tool so in the medical record, there's a flag to show whether or not informed consent for long-term opioid therapy was discussed and signed by the patient.

So, I would suggest perhaps a similar approach where in that medical record, if it is expanded to other psychiatric or other medications for informed consent, there could be a similar flag that in prescribing it, it blips up on the medical record and they can then have that discussion with the patient, including the date that that was had.

Senator SHEEHY. Do you feel the VA is currently structured to be able to effectively implement this rule should we pass it?

Ms. HUNDRUP. I will acknowledge it's been a while since we looked at this, but I understand that tool was in place in their medical records. Now, I will acknowledge a lot is happening with the medical records right now and the transition. But should what we understood to take place when they implemented our recommendation in 2020 still be there and still be utilized. I think it's worth asking.

I think my understanding is it could be a simple process to add that and that providers would be continuing to do that. I've not heard any cases where it has been lacking, but again, it's up to each provider in that medical record to document that for that individual veteran.

Senator SHEEHY. Now on its face, unrelated, but all things relate to this, do you think this is yet another reason why we must reemphasize electronic health records, linking DoD health records that

have a seamless pass through to VA health records so we do not have to continue to waste billions of dollars in years and lives losing medical records from years in service, from combat injuries that have been meticulously documented by the DoD, and then we throw them in the trash and rebuild them from scratch for the VA, which takes years, missing treatments, missing symptoms, and failing our veterans.

Is it finally time for us to have a DoD to VA health record that is seamless and there's no delay and there's no ledge that people fall off of?

Ms. HUNDRUP. Absolutely.

Senator SHEEHY. Thank you.

Chairman MORAN. Senator Sheehy, you might want to tell our colleagues about the plan for a roundtable that you've asked me to conduct to have a conversation about a topic that you described in some of your questioning. So, next Tuesday at 2 o'clock, you might tell us what you have in mind.

Senator SHEEHY. Thank you, Chairman. Yes, we're going to talk about our alternative treatment ecosystem. After I was wounded, I was privileged to undergo some processes at Walter Reed, which were eye-opening for me. A lot of the alternative treatments that we've talked about: psychedelics, sleep therapy, yoga, etc. But specifically, the availability of psychedelics and how we can bring those into the VA system, into the broader veteran healthcare ecosystem as we're seeing really a tremendous caseload of feedback from veterans and patients who've benefited from that treatment, very specifically, and come back and testify that these treatments are having an incredible impact on them, and the side effects, at least so far are minimal to negligible.

So, thank you for giving me an opportunity to bring that up. It's going to be hopefully, a pretty insightful session. Thank you.

Chairman MORAN. You're welcome. Thank you for your leadership and interest in this topic and Committee. We have not invited every Committee member, but you're all invited. We invited everybody who's on this Committee that has been engaged in this psychedelic treatment aspect of pursuing policy, but anybody and all are welcome to come and it's next Tuesday at 2 o'clock.

Now, Senator King.

HON. ANGUS S. KING, JR.,
U.S. SENATOR FROM MAINE

Senator KING. Thank you, Mr. Chairman. I want to emphasize what Senator Sheehy just said. As I looked over my notes and my questions, it all comes back to decent electronic medical records. You talked about coordination with community care, good electronic medical records, coordination with veterans coming out of the Defense department, decent electronic medical records. And everything comes back to that.

I mean, the overprescribing or prescribing polypharmacy where there's conflicts and danger, that's where you get—that won't happen if you have decent medical records. So, every practitioner that sees a veteran sees the same information about what they're taking, what they've been prescribed, what their history is, all that necessary background.

So, the development of electronic medical records for the Department of Defense and the VA has been an absolute debacle. And we're spending billions of dollars, it's still not working. It's been tested. People don't like it. I've never understood, frankly, why we didn't use the same system that's already on the shelf for thousands of hospitals across the country. Why are we inventing a whole new system for these patients? But sorry about the speech, but Senator Sheehy provoked it, because he's absolutely right.

A personal story. Just recently, I talked to an elderly friend, and in our conversation, I realized that she was much sharper and more engaged and with it than had been the case just a month or two before. And I didn't really think too much about it until I later talked to her husband who said she had a fall, she had a broken knee, she went into the hospital, her physicians looked at her prescription record and changed the prescriptions, and she's a different person.

Nothing else happened other than taking her off certain drugs, putting her on others, and adjusting the volume, if you will. And so this was totally obvious, and all it was, was somebody seeing cohesively what the prescription record was. And I'm sure that's happening with thousands of veterans.

One question I have is, this seems to be a prime area where AI could help. AI could tell you whether there are contradictions and problems. I mean, I think that's one area. Everybody's talking about AI and all the problems. But this is something where AI could quickly and instantly analyze. It would have every drug in the world and you put in, "What would happen if this person is taking these three drugs and I prescribe this?" It would give you an instant answer. Isn't that true? You're nodding. Nodding doesn't show up in the record. You have to say, "Yes, Senator. That was a brilliant comment."

[Laughter.]

Ms. HUNDRUP. Yes, Senator. That is not a topic we've looked at in-depth, but I do think you're absolutely right. And in terms of just even some of the record sharing, we do understand from VA in terms of them stating their intent to implement our recommendations that they do anticipate using medical technologies like AI. So, I think just to loop back to the need for oversight and the need for more people, I do think there is promise that AI could alleviate some of that.

We're very early, and that's not something that GAO has looked at specifically, so I need to stop there, but I think it has a lot of promise.

Senator KING. One of my questions is, is there any part of the VA routine that involves an annual checkup of your medications? Is that something the VA does routinely? It seems to me that would be a useful tool.

Dr. KROVIAK. I can take that question. So, within an EHR, including the old CPRS that VA uses and the new Cerner record, when you prescribe a new medication, the software itself is taking that one medication against the list of medications a patient is already prescribed or against a known list of allergies the patient has reported.

So, what you're saying is happening in even the most basic EHR function. The issue is an alert can pop up that describes the risk level of that interaction. So, the provider in that moment has to make a determination like, "Yes, I know this risk exists, but I'm taking the risk because it's worth whatever outcome or treatment plan I've established." So, what you're saying is happening. It doesn't require new technology.

Senator KING. There are regular reviews of medication?

Dr. KROVIAK. Every time you see a patient, this medication reconciliation process should be happening between provider and patient, but the software that they're using when you enter a new medication will run it against the inventory of what's already being prescribed to make sure those interactions aren't happening that you're worried about.

Senator KING. And one of the things you mentioned was the possible lack of communication and coordination with community care?

Dr. KROVIAK. Yes.

Senator KING. That's correct? So, that's a gap we should be paying attention to?

Dr. KROVIAK. It's a massive gap that we've reported on frequently. There is a technological solution—one day when all EHRs communicate with each other. That's the ultimate solution. We are nowhere near that.

Senator KING. And there's no excuse for being nowhere near that in this day and age. But I deeply appreciate your testimony and I hope you'll follow-up as a result of our questions and what the Committee is after. Let us know what we can do to help. That's our job here. And you can be our eyes and ears in the field and say, "Here's a gap. Here's a problem. Here's where either oversight by this Committee or legislation by this Committee could help to fill those kinds of gaps."

Thank you very much for your testimony. Thank you, Mr. Chairman.

Chairman MORAN. Senator Hassan.

HON. MARGARET WOOD HASSAN,
U.S. SENATOR FROM NEW HAMPSHIRE

Senator HASSAN. Well, thanks, Mr. Chairman and Ranking Member Blumenthal. And to our witnesses, thank you for your support of veterans.

Ms. Hundrup, I wanted to start with you. As you highlighted in your testimony, veterans often experience hardships in the transition period where they leave the military and reenter civilian life. As you know, the GAO recommended that the DoD and VA's Joint Executive Committee, which oversees the coordination of healthcare and benefits between the military and the VA, assess the effectiveness of DoDs and VA's efforts to facilitate access to mental health services for these transitioning service members.

So, can you discuss why it's important to make these kinds of assessments and how they can help lead to potentially improving the healthcare that our veterans are receiving during this critical time?

Ms. HUNDRUP. Yes, thank you. So, in our work, we identified a number of helpful touchpoints across the transition continuum, which is 1 year before separation to 1 year after. However, there

was often some confusion about which program they need to use or how it works. Sometimes a lack of awareness. Some of the programs we found were late. So, for example, there were two programs, Solid Start and inTransition, both noble programs with good intent, but they were identifying the veterans two to three months after separation, which is already very late in the process.

Senator HASSAN. Yes.

Ms. HUNDRUP. And there was also potential duplication getting similar phone calls, which was just resulting in confusion on the part of the veteran maybe being overwhelmed, not knowing. So, not only was it late in the process, but looking across, there are a lot of different programs. I think each individually has, again, noble goals and provides critical services. But looking across, there was, you know, maybe some places that were a little too late.

Senator HASSAN. But as we look at assessing this, especially for mental health care, what is the value of this assessment in terms of mental health access?

Ms. HUNDRUP. So, the value of this assessment will be to look across and identify the timing, whether there are gaps, whether certain things could be done earlier, whether, for instance, the Separation Health Assessment is supposed to have a mental health assessment that's not happening now.

So, I think they could identify what is happening, where there are gaps, maybe there's overlap or duplication, and really look systematically across, which I think could result in some savings on the part of DoD or VA or both. And they can take those savings and shift them. So, services really coming at the right time in a clear manner for the veteran that are more understandable. So, I think it's going to result in a more cohesive, holistic approach.

Senator HASSAN. And I think that's, you know, critically important, as somebody who advocated it and worked on the Solid Start Program. The idea was day one of the transition, there would be these things in place, right? And that means that the organizations have to start planning before the veteran separates.

Dr. Kroviak, let me kind of follow up in a way on what Senator King was just talking about, because one of the issues you've raised is medication management for veterans who are receiving community care. And you've discussed, it's really important that veterans who receive community care have their opioid prescriptions coordinated and monitored by the VA. The coordination and oversight obviously can be lifesaving for veterans struggling with pain and mental health conditions.

In 2023, the Inspector General's office looked into VA oversight of community care opioid prescriptions and found, "Gaps in care coordination documentation and the use of risk mitigation strategies for system patients receiving community care." In your testimony, you stated that two of the seven recommendations from that 2023 report still haven't been implemented.

So, what problems remain in terms of ensuring the community care providers and the VA are working together to ensure that veterans, especially those who are being prescribed opioids, are getting the safest, best care that they can, and what can we do in Congress to help?

Dr. KROVIAK. Yes, so I think those two recommendations you're referencing are specific to that information sharing. And we have been working with IVC, which is the Integrated Veteran Care program office that runs community care. It is a struggle to ensure that communication and oversight of that effective sharing of information, and it will require likely changes to the contract, modifications to the contract that VA has with the TPAs currently. They are up to renew that contract in the coming year. They're taking our considerations and concerns very seriously, and we meet with them quarterly to discuss how we can move forward with ensuring these things happen.

Senator HASSAN. Well, let us know if we can be helpful in that way and urging forward.

Dr. KROVIAK. Of course. Thank you.

Senator HASSAN. I'm just about out of time, so I'll follow up in writing, but I continue to be really concerned about the issue of veterans, especially with mental health issues being given the right kind of follow up instructions about their medications when they're discharged. So, I'll follow up with a question in writing for you on that. Thanks, Mr. Chair.

Chairman MORAN. Senator Hassan, thank you.

We have another panel and we have not yet called the 4:30 vote, so we might be in good shape for the hearing to conclude. I'll quit talking to improve the chances, except I don't have time to ask these questions. But I'm very interested, Dr. Kroviak, in community care. And it seems like other Members of this Committee are. I don't know whether the problem—I suppose, because we don't have the information, the coordination. We don't know whether there has been real life problems for the veterans or whether it's lack of ability to demonstrate whether that exists or not.

So, I'll follow up with my staff and you to have that conversation like, are veterans at real risk or we don't know. And it's not just a paperwork issue, I don't mean just, because records are important, information matters. And I'm interested, of course, in the Eastern Kansas report that you alluded to and want to hear more about that.

And then I think it was you, Dr. Fletcher, that maybe said something about prescription first image. I want to know whether the prescription first image has a basis in fact, or whether it's just something that is said. And then also there is an impression that the VA has been successful in overprescribing opioids and I'd like to know the facts about that belief.

And so those are the things I want to follow up and I'll ask my staff and you to have those conversations. I thank you. I knew if I did this, that Senator Blumenthal would think he was entitled as well [laughter].

Senator BLUMENTHAL. Just a really quick question which I neglected to ask before, Ms. Hundrup. *The Wall Street Journal* article says, "Only 15 percent of veterans diagnosed with depression, PTSD, or anxiety are offered psychotherapy in lieu of medication according to a 2019 report by the Government Accountability Office." Is that percentage still accurate?

Ms. HUNDRUP. Unfortunately, I don't have updated data on where we are with that, which is to my earlier point, as I think

it's worth following up with VA since publicly available data on that are not out there.

Senator BLUMENTHAL. If you could follow up, I would appreciate it. But you know of no reason that that number has changed?

Ms. HUNDRUP. I don't know that that would necessarily change, no.

Senator BLUMENTHAL. Thank you. Thanks Mr. Chairman.

Chairman MORAN. Senator Blumenthal, thank you. Thank you all very much for your testimony. Appreciate your commitment to this cause. And with that you are dismissed, quickly. And I welcome our second panel, quickly.

Testifying today on the second panel is Dr. Ilse Wiechers, Deputy Director, Office of Mental Health, U.S. Department of Veterans Affairs, and she is accompanied by Tom Emmendorfer, Executive Director of Pharmacy Benefits Management, U.S. Department of Veterans Affairs.

Thank you both very much for your presence and Dr. Wiechers, you are recognized for your testimony.

PANEL II

STATEMENT OF ILSE WIECHERS, MD, MPP, MHS, ACTING DEPUTY ASSISTANT UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY THOMAS EMMENDORFER, PHARM.D., EXECUTIVE DIRECTOR, PHARMACY BENEFITS MANAGEMENT (PBM) SERVICES

Dr. WIECHERS. Good afternoon, Chairman Moran, Ranking Member Blumenthal, and Members of the Committee. I am Dr. Ilse Wiechers, Acting Deputy Assistant Under Secretary for Health for Patient Care Services at the Veterans Health Administration. I'm joined today by Dr. Tom Emmendorfer, Executive Director of Pharmacy Benefits Management Services. Thank you for the opportunity to speak with you about how VA ensures safe, effective, and veteran-centered medication management, and to share our views on the three bills under consideration today.

As a practicing VA psychiatrist for over 15 years now, I'm aware of the complexity of medication management for our Nation's veterans. Many veterans live with multiple chronic conditions like PTSD, chronic pain, and substance use disorders, which often require complex treatment plans.

While multiple medications may be necessary, we recognize the risks of polypharmacy and are committed to reducing unnecessary or unsafe prescribing. VA has built a strong foundation for safe medication use through our national formulary and evidence-based prescribing practices. We use real world data, not market incentives to guide decisions.

One example is our use of pharmacogenomics, which helps tailor medications to a veteran's genetic profile. This approach is improving outcomes in reducing adverse drug events. We have also made significant progress in opioid safety. Since launching our Opioid Safety Initiative in 2013, we have reduced opioid prescribing by 68

percent and cut concurrent opioid and benzodiazepine prescribing by 90 percent.

Tools like the STORM—Stratification Tool for Opioid Risk Mitigation—dashboard help us identify veterans at high risk and coordinate care to prevent overdoses. VA has continued to make it easier for veterans to obtain the life-saving medication Naloxone. We distribute Naloxone widely: over 1.8 million prescriptions to date, as well as providing overdose education to veterans and the caregivers. Naloxone is available free of charge to enrolled veterans in various forms. It can be accessed through VA pharmacies, mobile units, community events, and even by messaging care teams through the VA app or website.

In addition, we are continuing to advance the Psychotropic Drug Safety Initiative or PDSI, a decade long quality improvement effort focused on safer prescribing of medications for mental health conditions. PDSI has helped reduce inappropriate use of benzodiazepines and anti-psychotics, especially among veterans with PTSD and substance use disorder.

Despite these successful initiatives, we acknowledge there is more work to be done. That's why VA recently issued a request for information to identify innovative software solutions that can support individualized medication review and de-prescribing. This is part of our broader effort to address polypharmacy and ensure that every medication has a clear evidence-based purpose.

Now, I will turn briefly to the legislation before the Committee noting that our full views are detailed in my written statement. VA supports the End Veterans Overdose Act subject to amendments. We agree with the goal of expanding access to Naloxone, but we are concerned about removing prescription requirements entirely. Prescriptions help ensure accountability and stewardship of government resources. That said, we've already taken steps to make Naloxone widely accessible, including permitting the use of standing orders or prescriptions for any veterans at risk of overdose. We remain committed to increasing the availability of overdose reversal medications like Naloxone to save lives.

VA supports the Protecting Veteran Access to Telemedicine Services Act also with amendments. 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. VA recommends amendments to ensure this new authority effectively addresses the two significant barriers VA has experienced and ensuring providers can furnish care, including prescribing controlled substances to veterans through telehealth, restrictions with the CSA—Controlled Substances Act—and within the CSA, and variability in state law prescribing requirements. A clear federal framework would help us deliver consistent care to veterans wherever they live.

VA has concerns with the Written Informed Consent Act. While we support the goal of informed decision-making, requiring signature consent for a broad range of medications could lead to unintended consequences, such as a delay in access to care and increased stigma to mental health treatment that might deter veterans from accepting needed care. Our current policies already re-

quire completion of informed consent discussions and documentation in the electronic health record that is tailored to clinical risk.

In closing, VA is committed to ensuring safe, effective, and veteran-centered medication management that helps improve the lives of our Nation's heroes. We're proud of the progress we've made, but we know there's more to do. We'll continue to refine our practices, expand access to innovative treatments, and put veterans first in everything we do.

Thank you for your time and your continued support. We look forward to your questions.

[The prepared statement of Dr. Wiechers appears on pages 71–84 of the Appendix.]

Chairman MORAN. Thank you. Let me turn to Senator Blumenthal. We need to ask questions in light of the scheduler vote——

Senator KING. Mr. Chairman, I have to leave unfortunately for another meeting, but I want to compliment the department for the dramatic reduction of opioids prescribing. I think that's——

Senator BLUMENTHAL. I'm happy to yield to you, Senator King, if you want to ask.

Senator KING. No, that's all I wanted to comment. Thank you very much.

Senator BLUMENTHAL. Thank you. Let me ask Dr. Wiechers, I noticed that you are on the faculty at Yale, so you're familiar with our VA facility in Connecticut. And as you know, Secretary Collins has repeatedly stated that access to VA care has not been affected by staffing reductions. But the VA's own data, in my view, tells a different story.

Wait times for new mental health appointments have increased sharply since January. In my home State, Connecticut, for example, the most recent data shows the current wait time for a new patient mental health appointment at the Orange VA Clinic in Connecticut, an outpatient facility specializing in mental health, is 208 days, nearly six months.

Let me ask you, given these kinds of wait times, how does the VA plan to prevent overreliance on medication when veterans can't access these timely appointments and what steps are necessary to address this issue?

Dr. WIECHERS. Thank you for the question, Senator. I agree that access to timely mental health care is one of our top priorities. We continue to actively be recruiting and hiring mental health providers across the system. We are working to address the access challenges that you have noted. And it does vary from facility to facility.

So, acknowledge that there are differences based on location, but we're doing work now to identify areas of ways we can improve our efficiencies so that our workflow and our ability to see patients and get them access quickly——

Senator BLUMENTHAL. You don't dispute the data showing those wait times?

Dr. WIECHERS. I acknowledge that there are wait times at some facilities that are beyond what our expectation and standard——

Senator BLUMENTHAL. I've also heard credible reports that some VA psychologists are being instructed to cap the number of sessions they can offer patients, even when in their professional judgments additional sessions are clinically necessary. I don't know how you justify that kind of practice.

Dr. WIECHERS. There is no cap on the number of psychotherapy appointments that a veteran can have. There's no national policy. That wouldn't be——

Senator BLUMENTHAL. So, you dispute that there are any caps that psychologists have been instructed to impose?

Dr. WIECHERS. We support the implementation of evidence-based psychotherapies. Many of those evidence-based psychotherapies are a course of treatment that occurs sometimes 8 to 12 treatments, sometimes 12 to 20 treatments. The individual provider working with that veteran is the one who is determining that course of treatment and when it's appropriate to complete that work. But there is no cap set. There is no policy indicating a cap in the number of treatments available. It is a decision——

Senator BLUMENTHAL. So, the answer to my question is yes, you dispute that any instructions have been provided that there should be a cap imposed by psychologists?

Dr. WIECHERS. There's no national policy instructing to have a cap in——

Senator BLUMENTHAL. Well, were psychologist ever told they have to impose caps?

Dr. WIECHERS. I can't speak to what every individual psychotherapist across the country has been told by someone, but I can say that we don't have a policy that states that and that I wouldn't support it.

Senator BLUMENTHAL. Well, I would just tell you, I'm going to cut through the verbiage in the interest of time. We've been told by multiple sources that caps have been imposed on psychologists. So, if you're not hearing it, I think the VA leadership needs to do a better job of listening to the psychologists and others who are actually providing care. In the interest of time, I'm going to yield.

Chairman MORAN. Thank you, Senator Blumenthal. I'd suggest Dr. Wiechers, that you take Senator Blumenthal's commentary to heart and actually explore within the VA whether there's a policy or a written national policy, whether there's a practice that is limiting the ability for the treatment that the provider believes is necessary in some fashion. That makes sense to you?

Dr. WIECHERS. That does make sense to me. And Senator Blumenthal, I'd like to continue the conversation with you and your staff further so I can make sure I understand what you're hearing better.

Senator BLUMENTHAL. I would welcome that opportunity. And I just want to say this is not personal to you. I recognize you are not in charge of the VA healthcare system and both of you have long histories of service in the VA, which I appreciate. I thank you for your service and I know you have ultimately the goal of serving our veterans. And I want to be helpful to you in serving that goal.

Dr. WIECHERS. Thank you, sir.

Chairman MORAN. Dr. Emmendorfer, let me ask you maybe a question. I was able to attend the launch of the PHASER pilot pro-

gram in 2019, I think it was. It was at the National Press Club, with Secretary Wilkie, and which introduced the idea of using a patient's DNA to prevent medication side effects and reduce the use of ineffective medications. I understand that program is successful. I'd like to have that confirmed and is now available in nearly every VA medical center.

How is the VA training providers to use this? How is the VA integrating the results into the VA's electronic health records? Tell me about this program and whether it matters.

Dr. EMMENDORFER. Thank you, Senator, and I am happy to report that it is a success. As a matter of fact, earlier this week, we just learned that one more VA medical facility has implemented the pharmacogenomics program, and we expect the remaining seven VA medical facilities to implement pharmacogenomic testing by the end of the calendar year 2026.

For the training, we have over 1,000 VA providers that have participated in the continuing education program on pharmacogenomics. And then we also have our Academic Detailing Services program, which has especially trained pharmacists that have conducted outreach with, I believe, around 7,000 providers to help promote pharmacogenomics. It's well integrated into our electronic health record, so it's part of the clinical decision support system.

There's about 100 medications that are evidence-based with the pharmacogenomic testing. And so at the time of prescribing, the computer system, our electronic health record, will flag an alert on the pharmacogenomic testing, and that helps guide appropriate medication selection and therapy. So, we're very proud of the program.

Chairman MORAN. Tell me, as the layman on so many things, what does the DNA tell us? What does it indicate? What is it capable of indicating to avoid in the treatment of a patient?

Dr. EMMENDORFER. Yes, so it's helpful with the DNA because it will tell us as healthcare providers how we would expect that medication to behave when it's in your system and being metabolized by your body. And that information really helps us make that upfront selection of the medication. So, in the past where you may have to do some trials and then if the patient's trial on the medication wasn't optimal, and then you may have to taper and stop that medication and then try another medication. The pharmacogenomics takes that guesswork out upfront.

Chairman MORAN. Thank you. Senator Blumenthal, anything you want to cover before I——

Senator BLUMENTHAL. I would like to submit some additional questions for the record.

Chairman MORAN. You also indicated you had something to submit for the record, I think.

Senator BLUMENTHAL. I'm going to submit my statement and the letter that I wrote to Secretary Collins.

Chairman MORAN. Without objection.

Chairman MORAN. I'm sorry to cut this hearing short. Senator Blumenthal and I probably have access to more conversations with you, and I see you nodding your heads, and then we'll follow up with our staff to make sure that anything that we may have missed because of the vote is covered.

Chairman MORAN. With no other questions, I want to once again, thank you for your testimony. I thank our Committee members for their participation and for our audience. Each member has five legislative days in which to submit statements or questions for the record.

Any Senator who would like to submit a question for the record to today's witnesses should do so in a timely manner. And likewise, I ask our witnesses to respond to any questions that they receive from this effort following today's hearing in a timely manner as well.

And with that, our Committee hearing is adjourned.

[Whereupon, at 5:18 p.m., the hearing was adjourned.]

A P P E N D I X

Opening Statement

Opening Statement
Ranking Member Richard Blumenthal
Senate Veterans' Affairs Committee
Medication Management in VA Healthcare
December 3, 2025

- Today, we will be addressing an issue integral to veterans' health – safe and effective medication management.

- The issue of polypharmacy is often a symptom of long wait times, insufficient clinical capacity, fragmented care, and the lack of accessible alternatives to medication – leading to the overreliance or mismanagement of pharmaceuticals.

- In many areas of the country, veterans are waiting weeks - sometimes months - for therapy appointments because VA does not have enough mental health staff.

- When a veteran can finally get in the door, we are hearing reports that some facilities are capping the number of therapy sessions they can receive.

- If these reports are accurate, they represent a serious deviation from VA's commitment to evidence-based, veteran-centered mental health care.

- I recently sent a letter to Secretary Collins demanding answers after multiple Connecticut VA clinics began reporting wait times more than 100 days for new patient mental health appointments. This is completely unacceptable.

- Delays like these are not just an inconvenience. They have direct, dramatic, and devastating impacts on the lives of veterans.

- For a veteran managing PTSD, depression, or a substance use disorder, long wait times can be dangerous, destabilizing, and contribute directly to overreliance on medication without the addition of regular therapy.

- In another move antithetical to the principles of medication management, Secretary Collins recently decided to force many veterans to begin paying copays for whole health services.

- These services – including yoga and fitness classes, meditation, and whole health coaching – are part of a holistic treatment approach that allows veterans to not rely solely on medication to address mental or physical health conditions.

- I was baffled to hear the Department is no longer allowing many veterans to access these services cost-free, disincentivizing them from taking a whole health approach to their well-being.

- In addition to these challenges, Congress continues to receive troubling reports from OIG and GAO about medication management for veterans who use the community care network.

- Many community providers are failing to complete required training on opioid prescribing and are not reliably reporting controlled substance prescriptions to state prescription drug monitoring programs.

- And community providers are often not returning medical records to VA in a timely manner—or at all.

- When records don't come back, VA clinicians are left prescribing in the dark. That is dangerous, and it puts veterans' lives at risk.

- Because of the toxic work environment this Administration has created at VA, providers are leaving in droves – meaning more veterans will now be subject to the fragmented care that occurs in the community.

- Polypharmacy issues - like those we will hear about today - will only increase if this Administration continues its plans to stretch VA providers thin and send more care into the private sector.

- Today, I expect candid answers and concrete plans from VA leadership on how it will address this growing challenge.

- Polypharmacy is a complex issue, but its underlying causes are solvable – we need VA to commit to rebuilding its mental health workforce, to encouraging veterans to take a holistic approach to their wellbeing, and to enforcing training and documentation standards for community providers.

- Thank you, Mr. Chairman.

Prepared Statements

United States Government Accountability Office

Testimony
Before the Committee on Veterans' Affairs, U.S. Senate

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VA HEALTH CARE

Status of Key Recommendations Related to Mental Health and Medication Management

Statement of Alyssa M. Hundrup, Director, Health Care

GAO-26-108786

GAO Highlights

VA HEALTH CARE

Status of Key Recommendations Related to Mental Health and Medication Management

GAO-26-108786 December 2025

A testimony before the Committee on Veterans' Affairs, U.S. Senate.

For more information, contact: Alyssa M. Hundrup at hundrupa@gao.gov

What GAO Found

The Department of Veterans Affairs (VA) provides health care services to over 9 million enrolled veterans, and thousands of military service members transition to its care each year. Mental health conditions are a persistent issue for veterans, and many veterans also live with chronic pain. These conditions are often treated with medications that must be managed carefully. For example, opioids can be prescribed for pain, but these carry the risk of addiction and overdose.

VA has implemented four key GAO recommendations to strengthen its oversight of mental health treatment plans and to help ensure its providers follow strategies for mitigating the risk of opioids.

- **Mental health treatment plans.** Veterans with mental health conditions may be offered various treatment options, including medication or therapy, or a combination of both. The Veterans Health Administration (VHA) requires specialty providers, such as psychiatrists, to document in mental health treatment plans that evidence-based treatment options were considered. In June 2019, GAO found VHA did not have guidance for these requirements nor monitor whether the providers followed them. VA concurred with GAO's two recommendations to address these issues and, in 2020, implemented both. For example, VA initiated reviews of selected charts biannually to ensure providers meet mental health treatment planning expectations.
- **Opioid safety risk mitigation strategies.** In response to concerns about opioid use, VA launched its Opioid Safety Initiative in 2013 to help ensure veterans are prescribed and use opioids in a safe and effective manner. As part of this initiative, VHA developed risk mitigation strategies for providers to follow when prescribing opioids to veterans, such as conducting urine drug screening. In May 2018, GAO found VHA providers at selected medical facilities did not consistently follow some risk mitigation strategies. Further, not all facilities had access to trained providers to educate other providers in ensuring opioid safety. GAO made two recommendations to address these issues. VA concurred and, in 2019 and 2020, implemented each recommendation. For example, VA created a planning tool that gives providers information on risk mitigation strategies, such as the patient's last urine screening.

VA has not addressed GAO's recommendation to the Department of Defense-VA Joint Executive Committee to assess the effectiveness of mental health services for transitioning service members and veterans. This Committee oversees the two departments' coordination for health care and benefits, including programs that may assist service members and veterans during the transition. In 2024, GAO found that the Committee had identified a number of mental health touchpoints for transitioning service members. However, the Committee had not assessed the effectiveness of the departments' efforts in facilitating access to such mental health touchpoints and made a recommendation that it do so. VA concurred with this recommendation, but as of November 2025, this recommendation has not yet been implemented.

Why GAO Did This Study

Effective medication management is of the utmost importance to ensure U.S. veterans receive safe and comprehensive treatment as part of their health care. This is particularly important for the growing number of veterans receiving treatment for mental health conditions and for vulnerable populations, such as those transitioning out of the military.

Concerns have been raised about the adverse effects of polypharmacy among veterans, which is the use of more than one medication. For example, research suggests that prescribing both benzodiazepines—a type of medication used to treat anxiety or post-traumatic stress disorder—and opioids to treat chronic pain can increase veterans' risk of death from suicide.

GAO has reported on opportunities for VA to enhance its oversight of various issues related to medication management for veterans, including those with mental health conditions and those transitioning out of the military. This statement describes a selection of this work, including recommendations GAO has made related to (1) mental health treatment plans, (2) opioid safety, and (3) access to mental health services for transitioning service members and veterans.

This statement is based primarily on three GAO reports issued between May 2018 and July 2024 (GAO-18-380, GAO-19-465, and GAO-24-106189). GAO also reviewed available research related to VA prescribing practices and steps the agency has taken to address five selected recommendations GAO made across these reports.

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee:

Thank you for the opportunity to discuss issues related to the Department of Veterans' Affairs (VA) medication management. Effective medication management is of the utmost importance to ensure our nation's veterans receive safe and comprehensive treatment as part of their health care, including for mental health conditions.

Mental health conditions have been a persistent and growing issue for our nation's veterans.[1] From 2006 through 2023, the number of veterans who received mental health care from the Veterans Health Administration (VHA) more than doubled, according to VHA officials. Veterans with mental health conditions can receive treatment through psychotropic medications, such as anti-depressants or mood stabilizers. Treatments may also include non-pharmacologic therapy, such as talk therapy, or using a combination of medication and therapy.

Additionally, more than a third of veterans lived with chronic pain in 2023, often because of injuries from their military service, according to VA. One common treatment for chronic pain is the use of opioid medications, which can result in addiction as well as potentially overdose and death, if not managed appropriately.[2] Our past work has shown that veterans are particularly at risk for developing substance use disorders and they are 1.5 times more likely to die from opioid overdose than the general population.[3] In response to concerns about opioid use, VA launched its Opioid Safety Initiative in 2013 to help ensure veterans are prescribed and use opioid pain medications in a safe and effective manner.

[1]For the purposes of our report, mental health conditions include various conditions such as anxiety-related disorders, depression-related disorders, and post-traumatic stress disorder, as well as substance use disorders such as alcohol use disorder.

[2]Drug misuse—the use of illicit drugs and the misuse of prescription drugs, including opioids—has been a persistent and long-standing public health issue in the U.S. In September 2025, the Department of Health and Human Services renewed, as it has done since the initial 2017 determination, the declaration of the opioid crisis as a public health emergency. We added national efforts to prevent, respond to, and recover from drug misuse to our High-Risk List in 2021. See GAO, *High-Risk Series: Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness*, GAO-25-107743 (Washington, D.C.: Feb. 25, 2025) for our most recent update on progress federal agencies have made on this issue.

[3]See GAO, *Veterans Health Care: Services for Substance Use Disorders, and Efforts to Address Access Issues in Rural Areas*, GAO-20-35 (Washington, D.C.: Dec. 2, 2019).

Media reports have highlighted concerns about polypharmacy among veterans, which is the use of more than one medication that may have adverse effects when combined.[4] Polypharmacy can result in overdose or death. Research suggests that prescribing both opioids and benzodiazepines—a type of medication used to treat anxiety or post-traumatic stress disorder—can increase veterans' risk of death from suicide.[5] However, some veterans have multiple chronic and mental health conditions, which may necessitate the use of numerous medications, increasing the risk of polypharmacy. For example, some veterans with post-traumatic stress disorder (PTSD) may be prescribed more than one medication, such as medicines to improve sleep and anxiety, which, if managed improperly, could lead to adverse health outcomes or even overdose or death. As such, it is critical that VA ensure it is offering effective treatment options, including both medication and non-pharmacologic options, to reduce the risk of adverse health outcomes.

Furthermore, some populations of veterans are particularly vulnerable to developing mental health conditions. One such population includes the thousands of military service members transitioning back to civilian life annually. The transition period can bring challenges, such as the loss of a sense of purpose, familial and financial strain, and difficulty readjusting to social and civilian life.[6] Research has shown that during the transition period, service members are particularly vulnerable to mental health conditions. For example, the suicide rate is about 2.5 times higher for veterans in the first year of separation than for active-duty service

[4]For example, see Shalini Ramachandran and Betsy McKay, "Combat Cocktail: How We Overmedicate Veterans," *Wall Street Journal*, August 2, 2025.

[5]National Academies of Sciences, Engineering, and Medicine, *Veterans, Prescription Opioids and Benzodiazepines, and Mortality, 2007–2019: Three Target Trial Emulations* (Washington, D.C.: 2025).

[6]More than 210,000 service members separated in fiscal year 2023, according to data from the Department of Defense (DOD). DOD separation data include active-duty service members from the Army, Air Force, Marines, Navy, and Coast Guard. They also include Reserve and National Guard separations from active duty greater than 180 days or on contingency operations orders over 30 days.

members.[7] VA, in coordination with the Department of Defense (DOD), has a number of programs and processes, such as pre-separation counseling and health assessments, to provide mental health services to service members and veterans as they transition out of the military.

Over the past several years, we have reported on opportunities for VA to enhance its oversight of various issues related to medication management for veterans, including those with mental health conditions and vulnerable populations, such as those transitioning out of the military. My testimony today summarizes selected findings from a selection of this body of work, including key recommendations we have made related to

1. providing guidance on and monitoring mental health treatment plans for veterans;
2. ensuring provider adherence with key opioid risk mitigation strategies; and
3. assessing transitioning service members' and veterans' access to mental health services.

This statement is based on work we issued between May 2018 and July 2024 reviewing prescribing practices for mental health conditions, opioid safety, and access to mental health services for transitioning service members.[8] Detailed information on the objectives, scope, and methodology of this work can be found in each issued report. This statement is also based on our review of available research related to VA

[7]See Yu-Chu Shen, Jesse M. Cunha, Thomas V. Williams, "Time-Varying Associations of Suicide with Deployments, Mental Health Conditions, and Stressful Life Events Among Current and Former U.S. Military Personnel: A Retrospective Multivariate Analysis," *Lancet Psychiatry*, vol. 3, no. 11 (2016):1039-1048. This study showed that the suicide rate remained about 2.5 times higher for veterans in the first 3 years of separation compared with the active-duty population. This risk for death by suicide can remain elevated for years following the transition period.

[8]See GAO, *VA Mental Health: VHA Improved Certain Prescribing Practices, but Needs to Strengthen Treatment Plan Oversight*, GAO-19-465 (Washington, D.C.: June 17, 2019); *VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed*, GAO-18-380 (Washington, D.C.: May 29, 2018); and *DOD and VA Health Care: Actions Needed to Better Facilitate Access to Mental Health Services During Military to Civilian Transitions*, GAO-24-106189 (Washington, D.C.: July 15, 2024).

prescribing practices and information on the agency's efforts to implement five key recommendations GAO made in these reports.[9]

We conducted the work on which this statement is based 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.

Background

VA operates one of the nation's largest health care systems. Its health care system is organized into 18 regional networks, called Veterans Integrated Service Networks, that oversee 170 VA medical centers and more than 1,000 outpatient facilities. These networks serve over 9 million enrolled veterans.[10] These facilities, in turn, deliver a wide range of health care services to veterans including traditional hospital-based services (e.g., surgery and pharmacy) and specialty services (e.g., psychiatry). To meet the needs of the veterans it serves, VA is also authorized to pay for eligible veterans to receive medical care from providers in the community.[11]

VA Mental Health Treatment

According to VA data, 31 percent of all users of VHA services in 2023 had a confirmed mental health diagnosis.[12] VA also found that 14 percent of

[9]See, for example, Alessandra A. Pratt et al., "The Impact of Comorbid Chronic Pain on Pharmacotherapy for Veterans with Post-Traumatic Stress Disorder," *Journal of Clinical Medicine,* vol. 12, no.14 (2023): 4763, and Kenda R. Stewart Steffensmeier et al., "What's Gender Got to Do With It: Accounting for Differences in Incident Guideline Discordant Prescribing for PTSD Among Women and Men Veterans, *Journal of Clinical Psychiatry,* vol. 85, no. 2 (2024).

[10]We have made over 200 recommendations since 2010 for VA to improve its oversight of the safety, quality, and timeliness of veterans' health care. As a result of these longstanding issues, we added VA health care to the GAO High-Risk List in 2015, and noted that inadequate oversight and accountability was an area of concern. See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

[11]See VA MISSION Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393, 1395-1404 (2018).

[12]Department of Veterans Affairs, *From Science to Practice: Mental Health Conditions Among VHA Patients* (Washington, D.C.: April 2024).

all users of VHA services in that year had a PTSD diagnosis.[13] Veterans with PTSD or other mental health conditions may be offered a variety of treatment options. This includes non-pharmacologic therapy, such as talk therapy, and pharmacologic therapy, such as medication, or a combination of both.

In our prior work, VA medical center officials we interviewed reported that various factors contribute to providers' decisions to prescribe psychotropic medications and offer non-pharmacologic therapy to veterans.[14] Specifically, these officials from multiple VA medical centers cited each of the following factors: VA medical center resources, the complexity of veterans' mental health conditions, the comfort level of providers with treating conditions or prescribing medications, the veterans' preferences, and the logistics of receiving mental health treatment.

VA Mental Health Treatment Planning Requirements

Having a treatment plan for each veteran with a diagnosed mental health condition is essential for ensuring that the veteran receives coordinated, individualized care that reflects the VA provider's consideration of all appropriate treatment options in alignment with the veteran's specific clinical needs and recovery goals. VHA has established certain requirements for mental health specialists' documentation of mental health care treatment plans. The Joint Commission—an independent, not-for-profit organization that accredits and certifies health care organizations including VA medical centers—is to periodically review the documentation of such plans to ensure that they align with the Commission's standards.

- **VHA policies to document mental health treatment plans.** In 2008, VHA issued its mental health services handbook to define minimum clinical requirements for mental health services at VA medical centers, requiring that specialist mental health providers, such as psychiatrists, document mental health treatment plans in veterans' electronic

[13]VA's data from 2023 are consistent with our prior reporting, which found that PTSD was one of the most prevalent mental health conditions, with 12 percent of veterans using VHA services in 2018 having a PTSD diagnosis. We reported that the other most highly prevalent mental health conditions included major depressive disorder (15 percent) and generalized anxiety disorder (3 percent). See GAO-19-465.

[14]GAO-19-465.

medical records.[15] The mental health services handbook specifies that plans should include documentation that different evidence-based treatment options were considered by mental health providers and that approaches to monitor the outcomes of care were developed.[16]

- **The Joint Commission standards for mental health care settings.** As part of the accreditation process for VA medical centers, the Joint Commission assesses mental health treatment plans developed by specialty care providers based on various standards. These standards focus on specific patient and organization functions that are essential to providing safe and high-quality care, including plans for treatment provided in mental health care settings.

VA Opioid Safety Initiative and Risk Mitigation Strategies

VA launched its Opioid Safety Initiative in 2013 to improve the safety and care of veterans who are prescribed opioids for pain. Part of its efforts include using non-pharmacologic pain relief alternatives, such as acupuncture or yoga, for veterans. As part of this initiative, VHA developed three opioid risk mitigation strategies for its providers to follow when prescribing opioid pain medications to veterans.

- **Annual urine drug screening for veterans on long-term opioid therapy.** Providers should generally ensure that an annual urine drug screening has been conducted for veterans who are on long-term opioid therapy prior to initiating or renewing an opioid prescription.[17]
- **Annual prescription drug monitoring program (PDMP) query.** PDMPs are state-run electronic databases used to track dispensing of prescriptions for controlled substances, identify suspected misuse or diversion, and identify trends in drug utilization. In 2016, VHA began requiring that providers query these programs at least annually when

[15]According to VHA officials, the mental health services handbook's planning requirements for mental health treatment do not apply to mental health providers who create treatment plans in a primary care setting through the primary care-mental health integration (PC-MHI) model.

[16]Evidence-based treatments are those that have been scientifically studied and proven to be effective for the treatment of a mental health condition. The mental health services handbook includes additional mental health treatment plan requirements that elaborate on this component, such as that mental health treatment plans must consider treatment options intended to reduce symptoms, improve functioning, prevent relapses or recurrences of episodes of illness, and be attentive to the veteran's values and preferences.

[17]VHA defines long-term opioid therapy as having had a 90-day supply or more of opioids in the last 6 months.

prescribing opioids to determine if the veteran has obtained opioid medications or other controlled substances from a non-VA provider.[18]

- **Informed consent for long-term opioid therapy.** In 2014, VHA issued a policy requiring that providers educate their patients on the risks associated with the use of prescription opioids and obtain veterans' formal acknowledgment of these risks in writing.[19]

Military to Civilian Transition

The transition from military to civilian life can be a particularly vulnerable period for veterans. Upon entering civilian life, veterans may have difficulty translating their military skills to a civilian job, and they may struggle to find employment, housing, and the other benefits that were provided as part of their military service. VA's research has identified many transition-related challenges—such as homelessness, family reintegration, employment, post-traumatic stress disorder, and substance misuse—that can increase the risk for suicide during the first year after separation.[20]

[18]Veterans Health Administration, *Querying State Prescription Drug Monitoring Programs*, VHA Directive 1306 (Washington, D.C.: Oct. 19, 2016). This requirement is subject to limitations imposed by states, which can impact VHA providers' access to the state databases. According to VHA policy, providers should follow state regulations for queries if these regulations are more stringent than VHA's policy.

[19]In December 2023, VA issued an updated policy related to informed consent for clinical treatments and procedures that incorporated the requirements of the 2014 policy on long-term opioid therapy for pain. See Veterans Health Administration, *Informed Consent for Clinical Treatments and Procedures*, VHA Directive 1004.01(3) (Washington, D.C.: December 12, 2023).

[20]Academic research also found that certain demographic characteristics, such as length of time in service and level of education, can exacerbate these challenges. For example, see Chandru Ravindran, et al., "Association of Suicide Risk with Transition to Civilian Life," *JAMA Network Open*, vol. 3, no. 9 (2020).

Providing Guidance on and Monitoring Providers' Documentation of Required Treatment Options in Mental Health Treatment Plans

In our 2019 report, we examined various issues related to VHA health care providers' treatment decisions for veterans with mental health conditions.[21] In our review, we found veterans with these conditions received a range of treatments, including non-pharmacologic therapy, psychotropic medications from one or more classes, or a combination of the two.[22] We found VHA did not have guidance or monitor providers' documentation of required treatment options in mental health treatment plans, and we made two recommendations to address these issues. VHA agreed with and has implemented each of the two recommendations.

Guidance on documenting mental health treatment plans. In our 2019 report, we found that VHA did not have guidance that specified its expectation that mental health providers in specialty care document treatment plans in an easily identifiable way within veterans' medical records. According to VHA officials responsible for overseeing mental health services, specialty mental health providers should be documenting treatment plans in notes that are easily identifiable and separate from other health information. In a nongeneralizable review of medical records, we found that a majority had a mental health treatment plan recorded in a progress note. However, we viewed several examples where the treatment plan was not the only information recorded within the progress note, making it difficult to readily identify the mental health treatment plan itself.

It is important to document each veteran's treatment plan in such a manner so that the provider, or any other providers who may become involved in the veteran's treatment, can readily refer to the plan as they evaluate progress. Providers need to be able to readily access veterans' mental health treatment plans to ensure that treatment is being provided as ordered, understand why certain treatments were decided against, and assess whether treatment changes are needed.

[21]GAO-19-465.

[22]A medication may be classified by the chemical type of the active ingredient or by the way it is used to treat a particular condition. Psychotropic medication classes include, among others, (1) antidepressants, (2) antipsychotics, (3) anxiolytics, and (4) mood stabilizers. Our 2019 review found that among veterans who were diagnosed with at least one mental health condition and used VHA services in fiscal year 2018, 10 percent received psychotropic medication only, 27 percent received both psychotropic medication and non-pharmacologic therapy, 18 percent did not receive psychotropic medication or non-pharmacologic therapy, and 45 percent received non-pharmacologic therapy.

In our 2019 report, we recommended that VHA disseminate guidance for Veterans Integrated Service Networks and VA medical centers that more clearly reflects its expectation that mental health providers in specialty care should record mental health treatment plans within veterans' medical records in an easily identifiable way. VHA concurred with this recommendation and implemented it in 2020. VA provided us with a 2019 memorandum regarding mental health treatment planning. The memorandum explicitly states the requirement for mental health providers in specialty care to record mental health treatment plans as a separate, easily identifiable document in the medical record. Treatment plans are expected to ensure that it is clear what treatment is being provided, the different treatments that were considered, and any ongoing assessments used to determine whether any treatment changes are needed for the patient, according to this memorandum.[23]

Monitoring the consideration of evidence-based practices. In our 2019 report, we also found that VHA had not developed an approach for monitoring whether specialty mental health providers were documenting their consideration of different evidence-based treatment options within mental health treatment plans. The documentation of these considerations, including whether veterans are offered psychotropic medications or non-pharmacologic therapy, is required by VHA's mental health services handbook. However, in our review of a nongeneralizable sample of medical records, none of the records had documented treatment plans that showed consideration of different evidence-based treatment options for the veterans' mental health condition.

VHA officials told us at the time that VHA relied on the Joint Commission to assess specialty mental health treatment plans as part of the organization's accreditation process for each VA medical center. However, the Joint Commission's standards did not include an assessment of whether providers considered different treatment options. As a result, VHA could not ensure that specialty providers were considering all available treatment options and providing the most

[23]In April 2023, VHA issued a revision of its Uniform Mental Health Services policy to ensure every veteran receiving mental health care has an easily accessible and individualized treatment plan. VA's revised policy states that a veteran's plan should be readily identifiable in the veteran's electronic health record as a single, comprehensive, and integrated mental health treatment plan, following the veteran from one treatment setting to another rather than existing as separate plans, which could contribute to polypharmacy or other risks. Veterans Health Administration, *Uniform Mental Health Services in VHA Medical Points of Service*, VHA Directive 1160.01 (Washington, D.C.: Apr. 27, 2023.)

appropriate treatments to each veteran. It is important for specialty providers to consider mental health treatment options that are evidence-based to ensure veterans are receiving the most effective treatment. For example, the VA/DOD Clinical Practice Guideline for Management of PTSD and acute stress disorder recommends that veterans with PTSD receive individual psychotherapy over pharmacologic interventions.[24]

In our 2019 report, we recommended that VHA develop and implement an approach for monitoring treatment plans for veterans with mental health conditions to ensure that such plans include documentation that different evidence-based treatment options were considered. VHA concurred with this recommendation. In 2020, VHA implemented the recommendation, providing us with a memorandum regarding mental health treatment planning. The memorandum stated the requirement for mental health providers in specialty care to record mental health treatment plans that include, among other things, an indication that different treatments were considered. The memorandum also required VA medical centers to implement ongoing chart reviews to ensure providers meet treatment planning expectations. Specifically, the memorandum required all VA medical centers to ensure that each licensed independent specialty provider has 5 treatment plans reviewed biannually. By monitoring clearly documented treatment plans, VHA is better positioned to ensure specialty providers consider all appropriate treatment options and make modifications to that treatment as necessary in a coordinated way.

Ensuring Provider Adherence to Required Opioid Safety Risk Mitigation Strategies

In our 2018 report, we examined issues related to VA's implementation of its Opioid Safety Initiative.[25] At the time of our report, VA had seen reductions in opioid prescribing rates for veterans since implementing its initiative in 2013. For example, VA data showed the percentage of patients dispensed an opioid decreased from about 17 percent to about 10 percent from fiscal year 2013 to the first quarter of fiscal year 2018. However, in our review, we found VHA providers at selected medical facilities did not consistently follow some opioid risk mitigation strategies, and we identified a number of factors that may have contributed to this

[24]See Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (Washington, D.C.: June 2023).

[25]GAO-18-380.

inconsistency. We made two recommendations to address these issues.[26] VA agreed with our recommendations and implemented them in 2019 and 2020.

Provider adherence to risk mitigation strategies. In our 2018 report, we found that VHA providers at selected medical facilities did not consistently follow the three key opioid risk mitigation strategies. These strategies were intended to help ensure that providers were safely prescribing opioid medications to patients at VHA medical facilities. Overall, based on our review of a non-generalizable sample of medical files for veterans at five selected facilities, we found that 75 percent of the medical files in our sample documented an annual urine screening, 26 percent indicated the veteran's names had been queried in a PDMP, and 70 percent showed informed consent from the veteran.

To help improve implementation of the opioid risk mitigation strategies, we recommended that VHA medical facilities take steps to better ensure provider adherence to the strategies. VA concurred with this recommendation and in November 2019 implemented it through a series of actions. For example, VHA created a planning tool for primary care providers related to risk mitigation strategies in electronic medical records. This tool includes the date of the last urine drug screening, the date of the last PDMP check, and the date informed consent was signed. By taking actions such as this, VHA can better ensure providers are following the opioid risk mitigation strategies and that veterans are prescribed opioids in a safe and effective manner.

Required staff to support providers in ensuring opioid safety. In our 2018 report, we also identified a number of factors that may have contributed to inconsistent provider adherence to the three key opioid risk mitigation strategies. Specifically, at the time of our review, not all VA medical facilities had access to academic detailing services, despite this VHA requirement. Academic detailing is a program in which trained clinical pharmacists are available to educate providers about evidence-based care related to the appropriate treatment of relevant medical

[26]See GAO-18-380. We made three additional recommendations in this report related to VA documenting actions it takes towards achieving the goals of the Opioid Safety Initiative, clearly defining measurable outcomes for any goals that have not been met, and tracking the use of a tool providers can use prior to initiating opioid therapy. VA concurred with these recommendations and took action between 2019 and 2021 to implement each of the three recommendations.

conditions.[27] According to VHA, academic detailing services can help ensure that providers follow opioid risk mitigation strategies. In our review, we found that most of the 18 Veterans Integrated Service Networks had established an academic detailing program; however, four had not.

We also found that four of five selected facilities did not have a pain champion at the time of our review, as required.[28] A pain champion is a part-time position that can help providers adhere to opioid risk mitigation strategies. Pain champions are generally primary care providers knowledgeable about pain care who can serve as a resource for other primary care providers by promoting safe and effective pain care. According to VHA officials, pain champions play a critical role in opioid safety and can help providers remedy gaps in pain care management for individual patients, such as incomplete opioid risk mitigation strategies.

In our 2018 report we recommended that VA ensure that all Veterans Integrated Service Networks have an academic detailing program and that all VA medical facilities have a designated primary care pain champion as required. VA concurred with our recommendation and in June 2020 implemented it. Specifically, officials from all 18 Veterans Integrated Service Networks attested that they had fully implemented an academic detailing program and that every medical facility had designated a pain champion. The availability of such resources will help provide important information to providers about evidence-based clinical practice guideline recommendations, such as non-pharmacological alternatives.

[27]At the time of our review, VHA required that all Veterans Integrated Service Networks fully implement an academic detailing program, defined as having at least three full time equivalent detailers. According to VA officials, such detailers were responsible for educating providers at all facilities as well as reviewing facility-level data on prescribing patterns and identifying potential areas of improvement.

[28]At the time of our review, VHA policy required each medical facility to maintain a 0.25-0.50 full-time equivalent pain champion serving in primary care. See VHA Memorandum, *System-wide Implementation of Academic Detailing and Pain Program Champions* (Washington, D.C.: Mar. 27, 2015).

Assessing Access to Mental Health Services for Transitioning Service Members and Veterans

In our 2024 report, we examined issues related to mental health services for transitioning service members and veterans.[29] In particular, we examined the DOD-VA Joint Executive Committee's assessment of mental health services across the transition continuum, which the committee defines as 1 year before and 1 year after separation.[30] This committee serves as the primary federal interagency body for overseeing military transition assistance activities, including coordination with providing health care for service members and veterans across the transition continuum. In our report, we found that the DOD-VA Joint Executive Committee had not assessed the effectiveness of the departments' efforts overall in facilitating access to mental health services for transitioning service members.

As described in our report, officials told us that the Committee directed the Transition Executive Committee (its subcommittee focused on transitioning from the military) to identify DOD and VA mental health-related programs and processes across the transition continuum in 2022.[31] The Transition Executive Committee identified a number of DOD and VA programs and processes, such as pre-separation counseling and health assessments, that may provide mental health touchpoints for service members during this time.[32]

However, officials responsible for the review told us that they limited their review to producing an inventory of available mental health resources,

[29]GAO-24-106189.

[30]See GAO-24-106189. In this report, we also examined the Department of Defense's inTransition program—a program that assists service members who may need support with mental health services during their separation from military service. We made four recommendations to DOD's Defense Health Agency to improve oversight of this program, including that DOD revise inTransition's enrollment criteria and outreach policy. As of November 2025, these recommendations remain open.

[31]The Transition Executive Committee provides oversight and direction related to transition assistance to service members and veterans. The National Defense Authorization Act for Fiscal Year 2024 added the Transition Executive Committee as a statutory committee of the DOD-VA Joint Executive Committee. Prior to this legislation, the Transition Executive Committee operated as a directed committee of the DOD-VA Joint Executive Committee's co-chairs. Pub. L No. 118-31, div. A, tit. XVIII, § 1805, 137 Stat. 136, 687 (2023).

[32]The Transition Executive Committee identified multiple DOD and VA programs and processes that may provide mental health touchpoints for service members prior to separation. Such programs include Transition Assistance Program pre-separation counseling, the Enterprise Individualized Self-Assessment, inTransition, pre- and post-separation VA health care registration, and the Separation Health Assessment.

and they did not assess the effectiveness of these resources. Specifically, the officials said that they did not evaluate whether or how these programs and processes collectively facilitate continuous access to mental health services across the transition continuum.

Such an assessment would provide the Committee with a more comprehensive understanding of how and when service members and veterans can access mental health services, including access to pharmacologic and non-pharmacologic treatments, across the transition continuum. As we noted in our report, this would better position the Committee to identify and address issues with any service gaps, overlap, or duplication. For example, as described in our report, we found that service members and veterans may be unaware of the various programs offering touchpoints, unable to distinguish the difference between them, and could be confused by multiple programs.

In our 2024 report, we recommended that the DOD-VA Joint Executive Committee assess the effectiveness of DOD and VA programs and processes overall in facilitating access to mental health services across the transition continuum, and then recommend any needed changes to DOD and VA. Such changes could include those to address any identified gaps or unnecessary duplication or overlap. VA concurred with our recommendation, but as of November 2025, has yet to implement it.[33] To implement our recommendation, VA stated that the DOD-VA Joint Executive Committee will ensure the proper executive subcommittees are coordinated and establish plans of action, milestones, and metrics to identify gaps or duplicative efforts. Conducting such an assessment would help VA better ensure that veterans have access to the mental health support they may need, when they need it, especially as they readjust to civilian life after serving in the military.

In closing, ensuring effective oversight of medication management for veterans is an issue of vital importance given the risks that some treatments, such as polypharmacy, can lead to dangerous outcomes for the veterans themselves. This is particularly important for those who may be vulnerable, including the growing number of veterans with mental

[33]DOD did not provide formal comments on our July 2024 report. However, in October 2024, DOD responded that it concurred with this recommendation. Its response stated that the DOD-VA Joint Executive Committee will ensure that appropriate executive subcommittees are aligned and that plans of action, milestones, and metrics are established to identify gaps or redundancies in services. DOD estimated completion of planned actions in response to this recommendation by December 2025.

health conditions and those who are transitioning from active military service to civilian life. Importantly, VA has taken a number of actions, including implementing our recommendations related to providing guidance on and monitoring mental health treatment plans for veterans. Such action will better allow VHA to oversee provider prescribing practices, including evaluating the prevalence and appropriateness of polypharmacy, to ensure that veterans receive the most efficacious treatments.

Similarly, in implementing our recommendations related to its Opioid Safety Initiative, VA has strengthened its ability to ensure provider adherence with key opioid risk mitigation strategies. In light of the risks that opioids pose, including addiction and potential overdose, it is critical that VA maintain careful oversight of providers' adherence to its risk mitigation strategies to ensure veterans are prescribed opioids in a safe and effective manner.

It remains important for VA to take action to address our recommendation to assess the overall effectiveness of DOD and VA programs and processes in facilitating access to mental health services across the transition continuum. We are encouraged that VA has stated that the DOD-VA Joint Executive Committee will establish plans of action, and we will continue to monitor steps the departments take through the committee to implement our recommendation. Addressing our recommendation will help to ensure the departments are providing critical mental health services to this particularly vulnerable population.

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Alyssa M. Hundrup at hundrupa@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony include Amy Leone (Assistant Director), Rebecca Rust Williamson (Assistant Director), and Erika Huber (Analyst-in-Charge). Other contributors include Nan Bozzolo, Monica Perez Nelson, Ethiene Salgado-Rodriguez, and Cathy Whitmore.

Related GAO Reports

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DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

STATEMENT OF JULIE KROVIAK, MD
PRINCIPAL DEPUTY ASSISTANT INSPECTOR GENERAL, IN THE ROLE OF
ACTING ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS
OFFICE OF INSPECTOR GENERAL
US DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
US SENATE
HEARING ON
MEDICATION MANAGEMENT IN VA HEALTH CARE
DECEMBER 3, 2025

Chairman Moran, Ranking Member Blumenthal, members of the Committee, thank you for the opportunity to testify on oversight conducted by the Office of Inspector General (OIG) regarding the Department of Veterans Affairs' (VA) medication management practices.

One of the most fundamental activities in healthcare management is ensuring providers and patients are informed of all medications that a patient is prescribed and taking. This process of medication reconciliation—where a provider and a patient or caregiver carefully review prescription and over-the-counter medications, and supplements—can be time-consuming and labor intensive. Ultimately, it ensures not only that patients are taking their medications as prescribed, but that potential drug interactions are eliminated or discussed, and patients are educated about the potential side effects. This critical discussion can reveal or prevent misunderstandings, duplicative treatments, contraindications due to allergies, and potentially dangerous drug interactions. Medication reconciliation is most critical during transitions of care, such as at discharge or when a patient moves between different levels of care, or receives care from VA and community providers. These transitions increase the risk of medication-related errors due to miscommunication. To reduce this risk, healthcare teams must ensure that, at each transition point, the patient or caregiver clearly understands the treatment plan.

Older patients and those with multiple chronic conditions are often prescribed many medications. Polypharmacy, or the prescribing of numerous medications to a patient, is common in patients being treated for complex and treatment-resistant mental health conditions. Veterans are at greater risk than the general population for *psychotropic* polypharmacy—the concurrent use of two or more medications that affect the mind, mood, and behavior—due to their unique military experiences that often lead to complex mental health diagnoses. Polypharmacy, psychotropic or otherwise, is not in itself a sign of an error or an oversight, but it does increase the risk of adverse outcomes.

The OIG has published numerous healthcare inspections and other reports that highlight the challenges VA faces in caring for veterans with complex mental health needs who are also prescribed multiple psychotropic medications. This statement will describe several findings in those reports specific to critical deficiencies in medication management of these veterans.

PATIENTS DISCHARGED FROM ACUTE MENTAL HEALTH CARE SETTINGS MUST RECEIVE CLEAR MEDICATION INSTRUCTIONS

Patients admitted to mental health units are at high risk for suicide in the months following discharge, with approximately 40 percent of suicidal behaviors occurring within 90 days of completion of inpatient care.[1] For this reason, the OIG's mental health inspection program examines staff compliance with required processes designed to ensure that patients discharged from an acute inpatient mental health unit receive appropriate education and instructions regarding their medications. In the four acute inpatient unit inspections completed by the OIG since September 2024, the OIG teams have found repeated noncompliance with these practices.[2] For example, at the VA Philadelphia Healthcare System in Pennsylvania, inspectors found that only 22 percent of electronic health records (EHRs) reviewed included required discussion with patients about medication risks and benefits and only 37 percent had discharge instructions documenting the reason for the medication.[3] Only 61 percent of the EHRs had discharge instructions free of technical medical abbreviations, which can be difficult for patients, caregivers, or family members to understand. Additionally, 45 percent of the EHRs included discharge instructions in which generic and brand names were used interchangeably without clarification that they refer to the same medication. The OIG made several recommendations to improve medication treatment and discharge instructions to help prevent veterans from making medication errors at home following hospitalization. While the facility has taken satisfactory actions to address several recommendations, the OIG will monitor their compliance until all of the report's recommendations can be closed.[4]

VA PROVIDERS MUST EDUCATE PATIENTS ON THE RISKS ASSOCIATED WITH PRESCRIBED MEDICATIONS

All medications carry some risk. Providers are obligated to inform their patients about potential risks and benefits of medications and collaborate with patients to determine the best management plan. All prescription antidepressant medications carry a "black box" warning, the strongest warning issued by the

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[1] Forte, Alberto MD et al., "Suicidal Risk Following Hospital Discharge: A Review," *Harvard Review of Psychiatry*, 27, no. 4 (July/August, 2019): 209–216, https://journals.lww.com/hrpjournal/fulltext/2019/07000/suicidal_risk_following_hospital_discharge__a.1.aspx.

[2] All mental health inspection reports published by the OIG as of the hearing date can be found on the OIG's webpage.

[3] VA OIG, *Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*, June 26, 2025.

[4] The OIG follows up on open recommendations at quarterly intervals commencing 90 calendar days from the date of the report's issuance to determine what corrective action VA has taken to address the findings. VA is provided 30 calendar days to respond. This process continues until all recommendations are implemented with supporting documentation indicating sustained compliance of corrective actions.

Food and Drug Administration, for a potential increased risk of suicidal thoughts and behaviors, particularly in children and young adults. These warnings are not intended to limit use of these medications when treatment is needed, but rather to ensure providers and patients are aware of these risks and patients are educated to recognize and respond to specific symptoms that can be life-threatening. The following summary illustrates the serious consequences that can result when patients are not adequately informed.

In 2022, a veteran, in their twenties, presented at the VA Tuscaloosa Healthcare System and screened positive for traumatic brain injury, posttraumatic stress disorder, and depression.[5] A nurse practitioner diagnosed the patient with unspecified trauma- and stressor-related disorder, and prescribed mirtazapine for depression. About fifty days after beginning the medication, the patient died by suicide.

The OIG conducted a healthcare inspection to evaluate allegations related to the patient's care and found that the nurse practitioner did not directly inform the patient about the increased risk of suicidal thoughts and behaviors associated with mirtazapine, despite this medication having a black box warning for increased risk of suicide in young adults.[6] This failure to educate the patient regarding the boxed warning of the medication's specific risks likely resulted in the patient's insufficient awareness of the need to self-monitor for suicidal thoughts and seek medical attention.

Additionally, the OIG found that the nurse practitioner did not address the need for close monitoring after initiating mirtazapine. When interviewed, the nurse practitioner said the patient was told to call the clinic, a suicide crisis hotline, or present to a walk-in clinic if experiencing suicidal ideation or a worsening of mental health symptoms, however these instructions were not documented and the patient was scheduled for an appointment four months later. The failure to closely monitor the patient after initiating mirtazapine prevented a timely evaluation of worsening symptoms or emerging adverse medication effects, including suicidal thoughts and behaviors.

In total, the OIG made 14 recommendations in this report, including several directed at the medication management and quality assurance processes. Notably, the recommendation for the facility director to create "processes to ensure that providers provide patient education about applicable boxed warnings when prescribing psychiatric medication" remains open.

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[5] VA OIG, *Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama*, September 26, 2024.

[6] US Food and Drug Administration, "REMERON® (mirtazapine) tablets, for oral use." VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, August 14, 2009, amended September 17, 2021. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1004.01(2), Informed Consent for Clinical Treatments and Procedures, December 12, 2023, amended May 1, 2024. Unless otherwise specified, the 2024 directive contains the same or similar language regarding informed consent discussion as the rescinded 2021 handbook. At the time of the patient's care, VHA required that "all treatment and procedures require the prior, voluntary informed consent of the patient," including "the expected benefits and known risks associated with the recommended treatment or procedure."

VETERANS MUST RECEIVE PROPER MEDICATION MANAGEMENT AND QUALITY OVERSIGHT FROM COMMUNITY CARE PROVIDERS

The OIG's Office of Healthcare Inspections has reported on the many challenges VA faces in providing seamless coordination and quality oversight for veterans referred to the community for care. Meeting veterans' healthcare needs in the community requires coordinating highly skilled multidisciplinary teams through efficient processes that prioritize the safety and timely delivery of that care. Oversight of care delivered in the community requires a different level of monitoring and communication than care provided within Veterans Health Administration (VHA) facilities. These findings highlight clear gaps in VA's contracts and processes, particularly in ensuring that community providers deliver and document health care in accordance with VA's standards. From the findings discussed below, the OIG has issued recommendations that can inform future community care procurement efforts.

VA Did Not Provide Necessary Oversight of Opioid Prescriptions Written by Community Care Providers

Veterans are at an elevated risk of opioid overdose, often due to higher rates of chronic pain and co-occurring mental health conditions such as posttraumatic stress disorder and military sexual trauma.[7] When veterans receive care in the community, opioid prescriptions must be tracked and coordinated with VA. The failure to do so puts patients at increased risk of opioid misuse and overdose.

The MISSION Act of 2018 requires VA to ensure that community providers who prescribe opioids to veterans receive and certify their review of VA's Opioid Safety Initiative (OSI) guidelines.[8] VA also requires these providers to query state prescription drug monitoring programs to determine whether veterans have existing opioid prescriptions before issuing a new one.

An OIG healthcare inspection team assessed care coordination for patients of the VA Eastern Kansas Health Care System (VA Eastern Kansas) who received community care and were dually prescribed opioids and benzodiazepines from community care network providers.[9] The inspection team also reviewed compliance with public law and VHA policies and guidelines specific to the oversight of community providers' opioid prescribing practices. The OIG found issues related to incomplete and delayed community provider documentation, including the use of OSI prescribing risk-mitigation strategies, prescriptions dispensed at VA versus community pharmacies, and lack of medication

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[7] John Hudak, "Assessing and improving the government's response to the veterans' opioid crisis," Brookings Institution (July 2020); VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, May 2022.
[8] P.L. 115-182. The VA MISSION Act of 2018 is also known as the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018. It established a permanent community care program for veterans.
[9] VA OIG, *Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and Leavenworth*, September 26, 2023.

reconciliation and VHA medication profile updates.[10] Additionally, the team identified two examples in which patients received multiple controlled substance prescriptions from a mix of providers from VA Eastern Kansas, other VA facilities, and the community care network. The OIG found the veterans integrated service network director and medical center staff were not conducting oversight of the community providers' opioid prescribing practices as required under the MISSION Act and as recommended by the OIG in 2019. In addition, they were not reporting concerns of unsafe community care network provider practices to the third-party administrators.

The OIG made seven recommendations to the under secretary for health related to community care provider documentation, evidence of network providers' training and use of OSI risk-mitigation strategies, state prescription drug monitoring program queries, and the capture of community-provider-prescribed medications in EHRs. The OIG made two recommendations to the VISN director related to ensuring VA Eastern Kansas has processes to conduct oversight of community care network providers' prescribing practices. The OIG made four recommendations to the VA Eastern Kansas director related to documenting OSI risk-mitigation strategies, capturing community-provider-prescribed medications in the EHR, filling vacant pain management positions, and educating staff on reporting patient safety concerns involving community care providers. Two recommendations to the under secretary for health remain open, regarding the need for community care providers to document prescriptions and the use of opioid risk mitigation strategies and to conduct and document state prescription drug monitoring program queries.

CONCLUSION

Every day, qualified and dedicated clinical staff provide high-quality, compassionate care to veterans with complex clinical needs. Each veteran's experiences and challenges are unique, and addressing their medical and mental health needs requires an individualized approach that considers their best interests and their treatment preferences. When medications are prescribed, the instructions, indications, expected outcomes, and potential side effects must be clearly communicated among veterans, their caregivers, and the healthcare teams supporting their recovery.

The OIG remains steadfast in its mission to provide independent oversight of VA, ensuring veterans, their families, and caregivers receive the high-quality services and benefits they have earned. With its team of dedicated medical professionals, the Office of Healthcare Inspections is uniquely positioned to drive meaningful impacts to care by continuing to issue evidence-based reports and recommendations to enhance the quality of care veterans receive from VA and community providers.

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[10] A separate OIG team assessed whether (1) VA ensured community providers received and certified their review of the OSI guidelines, (2) a sample of community providers conducted the required queries, and (3) the medical records of sampled veterans included opioid prescriptions, as required by the MISSION Act. Two recommendations to improve compliance with MISSION Act requirements and OSI guidelines remain open. VA OIG, *Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans*, September 26, 2023.

Chairman Moran, Ranking Member Blumenthal, and members of the Committee, this concludes my statement. The OIG looks forward to working with you and this Congress to advance the provision of care to veterans. I would be happy to answer any questions you may have.

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WOUNDED WARRIOR PROJECT

WOUNDED WARRIOR PROJECT

Statement of:
Erin Fletcher, Psy.D
Director, Warrior Care Network

On

"Medication Management in VA Health Care"

Committee on Veterans' Affairs
United States Senate

December 3, 2025

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Senate Committee on Veterans' Affairs, thank you for the opportunity to submit this written testimony to examine medication management within the Department of Veterans Affairs (VA) and its central role in ensuring safe, effective, and personalized mental health care for our nation's veterans. We are grateful for your continued commitment to addressing challenges that deeply affect veterans and their family members, caregivers, and survivors.

For more than 20 years, Wounded Warrior Project (WWP) has remained dedicated to our mission to honor and empower wounded warriors. Today, more than 250,000 post-9/11 veterans and family members are registered with WWP, engaging with programs that span mental health care, social connection and support, financial wellness, independence, and whole health recovery. Mental and brain health are our largest programming investments and reflect the critical importance of addressing the lasting, invisible wounds of war.

Our Mental Health Continuum of Support offers a range of programs designed to meet the diverse mental health care needs of warriors. It brings together internal resources and services to assist warriors on their journey to long-term recovery. Rather than prescribing a fixed path to recovery, the system allows for consideration of individual needs to determine the order and frequency of appropriate program engagement. Our commitment to using validated scales and measurements helps us monitor symptoms, assess care needs, and track outcomes effectively. Any warrior who has a setback may be re-evaluated and referred back to one or more programs for additional care. The goal is to provide the appropriate amount of care a warrior may need to get to his or her highest possible level of resilience, psychological well-being, and healing, which can lead to breakthroughs in reaching real world goals like maintaining a job with steady income, sustaining healthy relationships with family and friends, decreasing isolation, and increasing one's sense of belonging.

For context, nearly 6 in 10 (58.7%) veterans who have registered for WWP and answered our annual survey are enrolled in VA healthcare. Nearly 8 in 10 (78.8%) have a service-connected disability rating of 70 or higher. Despite these commonalities, every warrior's healthcare journey is unique, and not all seek new or additional care and support through WWP for the same reasons. For example, veterans and Service members with some of the greatest needs are treated through our Warrior Care Network, a two-week intensive outpatient mental health program in which warriors receive a year's worth of mental health treatment. Warriors treated through this program often experience fast, lasting relief from PTSD and other mental health challenges aided by eased anxiety and depression, improved sleep, and stronger relationships. Most warriors enrolled in the program are several years after their index trauma, underscoring the lasting impact of these injuries and the critical need for ongoing research, program development, and sustained investment in support services.

Our work in mental health has helped shape our perspective and helped identify trends with veterans who present to WWP after seeking care at VA. Although VA has made substantial progress in many areas, opportunities still exist to further improve medication management – particularly in mental health settings – for veterans. We offer the following observations and reflections to recognize these advancements and to identify areas to further support veterans' recovery through coordinated, evidence-based medication management.

I. ***Polypharmacy***

Through our Mental Health Continuum of Support programming, WWP regularly receives feedback on VA care from veterans who seek new or complementary help from our organization and our partners. Veterans often describe a "medication-first" approach at VA in which prescriptions are offered before therapy or without consistent access to evidence-based treatments. Many veterans share that appointments are not as frequent or as long as desired. Some indicate feeling rushed through therapy and medication management appointments, which can have detrimental impacts on the therapy relationship and the veteran's desire to continue with treatment. Some veterans also report difficulty adhering to mental health medications due to unpleasant side effects and limited understanding of why the medication is needed or how it helps. Anecdotally, warriors tell us that they appreciate getting medication education and a second opinion from psychiatrists who can also help explain their care and how prescribed medications support their overall treatment plans and recovery. This feedback highlights the importance of coordinated interdisciplinary medication management between patient and provider.

These anecdotes are consistent with broader research on mental health and medication management. In 2023, a VA-supported study found that 28 percent of post-9/11 veterans receiving VA mental-health care met the criteria for "central nervous system (CNS) polypharmacy," defined as five or more CNS medications prescribed concurrently.[1] Of the over 90,000 veterans included in the study, more than 90 percent were diagnosed with PTSD, depression, headache, or a combination thereof, underscoring the high comorbidity burden

[1] Alicia A. Swan et al., *Comorbidity and Polypharmacy Impact Neurobehavioral Symptoms and Symptom Validity Failure Among Post-9/11 Veterans with Mild Traumatic Brain Injury*, FRONTIERS IN NEUROL. (July 2023), *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC10395329/.

within this population.[2] A 2016 comprehensive study also highlights that CNS polypharmacy is associated with increased risk for suicide-related behaviors and drug or alcohol overdose.[3] Collectively, this research underscores the need for cautious prescribing, integrated care, and using polypharmacy as a flag for intervention to mitigate burden of adversity in this population. And yet despite these findings, veterans served by WWP continue to report medication combinations, often referred to as a "combat cocktail," as a familiar part of their VA care experience.[4]

For many veterans, chronic pain has become an aggravating factor in their ability to manage and balance symptoms and medication. More insight into how opioid prescriptions interact with psychiatric medications can help provide hope and relief. Encouraging news emerged in response to an April 2024 congressional inquiry on access to non-opioid alternatives, wherein VA reported a significant decline in opioid use among veterans enrolled in VA care since 2018.[5] Building on these improvements, WWP supports the *Veterans Heroin Overdose Preventative Examination* (HOPE) Act (H.R. 5919), which would direct VA to conduct a review of veteran deaths from opioid overdoses over the past five years, including prescribed and non-prescribed opiate misuse, and other contributing factors to opioid overdoses among veterans. The bill also requires VA to outline steps being taken on a federal level to address the opioid crisis, including tracking, collecting, and disposing of unused prescriptions, and to publish recommendations to improve the safety and well-being of veterans.

The national shortage of mental-health prescribers, across both VA and community care, is an additional challenge. These shortages often require that facilities designate primary-care providers as responsible for managing complex psychiatric regimens, instead of mental health professionals. By extension, these shortages also contribute to infrequent or brief follow-up appointments which limit opportunities for meaningful discussion between veterans and their providers. As noted previously, a common concern from veterans using VA for mental health is that care is less frequent and the appointments are shorter than desired. This has the unfortunate effect of leaving the veteran feeling like their providers are not accessible and is compounded by the feeling that therapy sessions are not conducive to processing trauma, given their length and frequency – often one 30-minute session per month. We have also received feedback that some providers lack military cultural competency, which complicates discussions related to trauma and symptom history.

To strengthen clinical outcomes for veterans with PTSD and related conditions, VA may wish to consider placing additional emphasis on first-line, evidence-based psychotherapies, such as Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), before initiating medication (when deemed clinically appropriate or at the request of the veteran). There may also

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[2] *Id.*
[3] Garen A. Collett et al., *Prevalence of Central Nervous System Polypharmacy and Associations with Overdose and Suicide-Related Behaviors in Iraq and Afghanistan War Veterans in VA Care 2010–2011*, DRUGS REAL WORLD OUTCOMES (Jan. 2016), *available at* https://pmc.ncbi.nlm.nih.gov/articles/PMC4819457/.
[4] *See, e.g.*, Shalini Ramachandran et al., *'Combat Cocktail': How America Overmedicates Veterans*, WALL ST. J., July 31, 2025, *available at* https://www.wsj.com/health/healthcare/veterans-affairs-ptsd-polypharmacy/.
[5] *See* Press Release, Sen. Kevin Cramer, Letter to VA Requests Update on Non-Opioid Pain Management Options for Veterans (Apr. 18, 2024), https://www.cramer.senate.gov/news/press-releases/letter-to-va-secretary-requests-update-on-non-opioid-pain-management-options-for-veterans.

be value in exploring the use of CNS polypharmacy as a "trigger tool" for referral to an interdisciplinary treatment team, allowing medical experts to collaboratively review medication regimens, optimize treatment plans, and assess appropriate non-pharmacological options.[6] Additionally, continued efforts to expand and incentivize the recruitment of high-quality mental-health providers and prescribers – along with strengthened medication education and shared decision-making practices – would help ensure veterans receive informed, individualized care that supports long-term mental-health outcomes. Continuing efforts to ensure access to better skilled pain management providers would also help build and maintain pathways away from opioid use that can aggravate mental health outcomes.

II. ***Transition Challenges Between Department of Defense (DoD) and VA Healthcare***

For many veterans, the transition from active duty to veteran status represents a period of destabilization. In a survey of nearly 10,000 recently separated veterans, "health concerns were most salient for newly separated veterans, with many veterans reporting that they had chronic physical (53%) or mental (33%) health conditions and were less satisfied with their health than either their work or social relationships."[7] Veterans engaged in WWP programs have also reported challenges as they transition from DoD to the VA healthcare system. These include difficulty maintaining continuity of medications, delays in refills or dosage adjustments, lack of parity between electronic health record systems, and unclear points of contact.

In its 2024 National Veteran Suicide Prevention Annual Report, VA's Office of Suicide Prevention found that veterans who have recently transitioned are at a higher risk for suicide than the general veteran population, particularly those who have dealt with mental health or substance use issues prior to separation. This, combined with the fact that only 7 of the 17.6 veterans who die by suicide every day receive VA care, underscores the critical need to ensure those transitioning back to civilian life are provided with a simple and efficient path to the VA care and benefits that they have earned, and may very well help to save their lives.

Wounded Warrior Project believes a healthy transition is an essential part of creating a healthy veteran. We also believe that this process requires collaboration between VA, DoD, and the community to ensure that all the unique needs of each transitioning Service members are met. WWP supports the *Servicemember to Veteran Health Care Connection Act of 2025* (S.585) and its intent to better foster collaboration between DoD and VA during the transition process, simplify VA health care enrollment, and increase proactive outreach to those veterans who have yet to engage with VA services. The bill would also require that Service members participating in the DoD Transition Assistance Program (TAP) be informed about this pre-registration process and how to complete enrollment after separation. This legislation would also improve efforts to connect veterans to VA services after discharge, requiring VA to conduct proactive outreach as part of the VA Solid Start program and beyond, both encouraging and assisting veterans to complete the enrollment process.

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[6] *See* Collett at FN 3.

[7] Dawne S. Vogt et al., *U.S. Military Veterans' Health and Well-being in the First Year After Service*, AM. J. PREV. MED. (Mar. 2020), *available at* https://pubmed.ncbi.nlm.nih.gov/31902684/.

Public-private partnership can also drive progress. VA's Post-9/11 Military2VA (M2VA) Case Management Program assists transitioning Service members by providing personalized navigation through VA care, benefits, and reintegration resources. Through this program, VA has collaborated with the DoD and military treatment facilities (MTFs) to transition the health care of injured or ill Service members and veterans to VA medical facilities through dedicated Liaisons – nurses and social workers – who coordinate the transfer of health care between systems.

Beyond these services, VA has more limited but equally impactful capability to share Public-Private Partnership (P3) VA Liaisons at certain partnership sites to VA for Veterans as they complete specialized treatment in the community. As one of those partners, WWP has seen some of our strongest outcomes at locations where VA Liaisons are integrated with our Warrior Care Network academic medical centers. At these sites, 90 percent of participating veterans return to VA for ongoing care, evidence that structured, proactive, and collaborative transition support helps prevent veterans from falling through the cracks. With this record of success, we encourage Congress and VA to explore options for bringing this approach to wider scale so that more benefit from individualized navigation and support where it is most appropriate.

III. ***Pharmacogenomic Testing and Precision Medicine***

VA can and should help drive innovation in mental and brain health, where needs are especially pronounced among the veterans it serves. WWP commends VA's forward-leaning efforts through programs like the Pharmacogenomics testing for Veterans (PHASER), which aims to enhance the quality of life for veterans by ensuring they receive the most effective and safe medications tailored to their genetic makeup. The PHASER program offers specific genetic testing called pharmacogenomics, or PGx, which determines how a patient responds to medications given their DNA profile. It analyzes genetics to help providers identify which medications are likely to work best, reducing trial-and-error prescribing, minimizing side effects, and improving treatment outcomes by guiding the right drug at the right dose.[8]

The PHASER program is particularly beneficial for veterans with chronic conditions, mental health challenges, pain management challenges, and those taking multiple medications. The program has already demonstrated that precision prescribing can significantly reduce harmful drug–gene mismatches and improve medication safety with nearly 50% of participating veterans prescribed medications informed by genetic variability.[9] With a scalable infrastructure that spans this entire national network, including clinical decision support, PGx-trained pharmacists, and tele-PGx services, VA is uniquely positioned to transform polypharmacy management by helping ensure the right medication and dose for each veteran, the *first* time. Continued investment could allow PHASER to mature across all VA medical centers and outpatient clinics, expanding access, strengthening evidence-based prescribing, and driving down preventable medication toxicity across the enterprise.

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[8] *See, e.g.*, U.S. DEP'T OF VET. AFF., PHASER, at https://www.va.gov/phoenix-health-care/programs/phaser/ (last visited Dec. 1, 2025).

[9] *See, e.g.*, DEEPAK VOORA, U.S. DEP'T OF VET. AFF., VA NATIONAL PHARMACOGENOMICS PROGRAM (JAN. 2023), at https://cpicpgx.org/wp-content/uploads/2023/01/VooraCPIC2023sharing.pdf (last visited Dec. 1, 2025).

Currently, awareness and implementation of pharmacogenomic testing through PHASER vary considerably across VA facilities, leading some veterans to seek the testing through outside entities at their own expense. Through our programs, WWP has supported a small number of veterans by covering the cost to inform medication evaluation, and many have experienced meaningful improvements as a result. In each case, the veteran had been told that VA either did not offer or did not cover the testing, underscoring the need for consistent and expanded access across the system.

We believe there is strong potential to expand pharmacogenomics as part of a broader mental health modernization effort. In most areas of medicine, clinicians rely on diagnostic information before initiating treatment. For example, providers do not administer intravenous antibiotics without first obtaining a blood panel to identify the infection and guide the plan of care. Yet, in mental health care, clinicians often must make medication decisions without comparable diagnostic tools, despite the significant side effects associated with many CNS and antipsychotic medications. In sum, we encourage VA to expand the PHASER program and ensure wider access to pharmacogenomic testing to help provide precise, targeted care that supports more effective treatment outcomes for veterans.

Pharmacogenomics is only one facet of precision medicine – an overall healthcare approach that tailors prevention, diagnosis, and treatment to the unique biological, genetic, and clinical characteristics of each individual. By moving beyond one-size-fits-all care, precision medicine enables more accurate decisions that improve outcomes and reduce unnecessary or ineffective treatments. These developments are opening a new frontier in individualized, data-driven care, advancing our ability to deliver safer, more effective treatments today while laying the foundation for tomorrow's innovations.

Research in this field remains emergent, particularly for PTSD and major depressive disorder (MDD), where validated genetic profiles for medication selection are still evolving. Looking ahead, greater attention will be needed to develop risk indicators for repeated low-level blast exposure, the effects of substance use disorder (SUD) on neuroplasticity, and the implications of non-fatal overdose on long-term brain health. Advancing our understanding in these areas will require continued research investment.

To that end, WWP supports continued investment in VA's precision medicine capabilities. As part of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* (P.L. 116-171 § 305, VA launched the Scott Hannon Initiative for Precision Mental Health (SHIPMH) to identify and validate brain and mental health biomarkers and translate those findings into improved clinical care for veterans. SHIPMH brings together leading experts and major VA research programs to build a comprehensive, data-driven understanding of mental and brain health using advanced tools such as machine learning algorithms to give a complete 360° diagnostic of brain health. By expanding data sharing and integrating biomarker research into practice, SHIPMH's first clinical use case focuses on pharmacogenetic testing to guide safer, more individualized treatment for opioid use disorder.

The *Precision Brain Health Research Act* (S.800) would build upon SHIPMH by expanding the scope of precision mental health research to include additional risk factors,

conditions, and biological indicators that are especially relevant to military service – such as repeated low-level blast exposure, long-term neurobiological impacts of trauma, and other service-related brain health variables that SHIPMH does not yet fully address. While SHIPMH focuses on identifying biomarkers and translating them into clinical tools, the *Precision Brain Health Research Act* strengthens this foundation by directing broader, coordinated research efforts across VA and its partners, enhancing data integration, and accelerating the development of new diagnostic and treatment pathways. Together, they advance a more comprehensive precision-medicine framework capable of addressing complex, service-connected brain and mental health challenges with greater accuracy and individualized care.

We believe the passage of the *Precision Brain Health Research Act* is an important step forward in shaping the future of modern medical care and represents an exciting new horizon. By advancing research, pharmacogenomics, and individualized assessment tools, VA can improve detection of adverse health impacts and enable more targeted treatment pathways for affected veterans.

IV. Complementary, Integrative and Emerging Therapies

Veterans increasingly express interest in non-pharmacological and complementary therapies to supplement their clinical treatment. Mindfulness, yoga, acupuncture, tai chi, and other integrative approaches provide coping tools, stress reduction, and support between therapy sessions. We receive regular feedback that many veterans want to incorporate these holistic therapies into their mental-health care. To that end, WWP appreciates the creation of the provision of Complementary and Integrative Health (CIH), which has notably expanded access to these services through telehealth, community partnerships, and volunteers in support of the overall expansion of the VA's Whole Health Program. And yet, even with over 100 Whole Health locations, availability still varies widely across VA facilities. Without a consistent, centralized implementation model, many veterans remain unaware of available services or encounter barriers in accessing them. Moreover, capacity constraints in front-line clinical treatment make access to these services even harder to obtain. These barriers can leave veterans relying solely on pharmacological interventions.

After exhausting multiple traditional options, some veterans have expressed desire to learn more about emerging treatments. Early research, including work conducted through WWP's Warrior Care Network partners, suggests that carefully structured integration of emerging therapies with evidence-based protocols can improve mental-health outcomes. While this research continues to evolve, the horizon is bright. We see encouraging breakthroughs with cutting-edge interventions such as repetitive transcranial magnetic stimulation (rTMS), transcranial direct current stimulation (tDCS), and stellate ganglion blocks (SGB). These approaches hold the potential to reshape the landscape of PTSD care. Realizing the full promise of these innovations will require continued research and thoughtful integration into care delivery models, ensuring veterans have access to the most advanced and effective treatments available.

Perhaps the most powerful example of this momentum is psychedelic assisted therapy (PAT). At WWP, we have observed that certain veterans who have been hesitant to engage with traditional mental-health models are open to exploring this modality. To that end, WWP

supports the *Innovative Therapies Centers of Excellence Act of 2025* (H.R. 2623) which positions VA as a true pioneer in education, clinical, and cutting-edge research activities focused on psychedelic-assisted therapies for conditions like PTSD, chronic pain, and substance use disorder.

Moreover, WWP was pleased to help launch the Veteran Alliance for Leadership, Outreach, and Recovery (VALOR) Coalition alongside partners at Veterans Exploring Treatment Solutions (VETS), the Navy Seal Foundation, and the Green Beret Foundation. VALOR is a first-of-its-kind coalition uniting veteran-serving organizations, policy advocates, and scientists to transform mental healthcare for those who have served. The coalition aims to accelerate access to evidence-based mental health treatments, expand psychedelic research, and eliminate policy barriers that prevent veterans from receiving the care they deserve. VALOR's newly formed Scientific Advisory Council will guide scientific priorities, shape research agendas, and provide expert input on legislative, regulatory, and policy initiatives.[10] The work of the Scientific Advisory Council will help VALOR ensure that veterans and their families benefit from the safest, most effective, and most ethical approaches to emerging treatments. As VALOR partners and Scientific Advisory Council members continue their work, we will be eager to share recommendations for legislative and regulatory changes that can help bring emerging life-changing and life-saving therapies to more veterans in a safe and responsible manner.

Collectively, these innovations represent an opportunity to move beyond a one-size-fits-all model and advance toward a more personalized, precision-medicine approach to veteran mental-health care. WWP supports continued research, clinical trials, and careful evaluation of emerging modalities to inform safe, evidence-guided pathways for veterans seeking new options. We encourage VA to strengthen the integration of complementary, integrative, and emerging therapies within individualized treatment plans. We also encourage expanded access to care, so veterans receive coordinated, holistic care that aligns with their preferences and supports long-term recovery.

V. Conclusion

Wounded Warrior Project deeply appreciates the Committee's leadership in examining medication management across VA. We recognize and applaud VA's progress in recent years to reduce overprescriptions, improve oversight, embrace innovation, and strengthen its mental-health care system. Together, we share a common goal: ensuring every veteran receives safe, effective, continuous, and personalized mental-health care. Concerns raised in our testimony today related to polypharmacy, access to therapy, transition-of-care processes, precision-medicine availability, and the integration of alternative, complementary, and emerging therapies highlight opportunities for continued, shared progress. We thank the Committee for its attention to these critical issues and stand ready to support your work in any way we can as we collectively strive to honor and empower the veterans who have sacrificed so much for our nation.

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[10] Press Release, VALOR Coalition, VALOR Inaugurates Scientific Advisory Council, https://supportvalor.org/updates/press-release-veterans-exploring-treatment-solutions-vets-inaugurates-valor-coalitions-scientific-advisory-council/.

STATEMENT OF
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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.

Submission for the Record

United States Senate
WASHINGTON, DC 20510

November 13, 2025

The Honorable Doug Collins
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Collins,

I write to express my serious concern regarding the increasing and unacceptable wait times for new patient mental health appointments across Department of Veterans Affairs (VA) medical facilities in Connecticut. Veterans seeking care for mental health conditions—many of whom are in acute distress—deserve timely access to treatment. The reports of significant delays are deeply troubling and raise urgent questions about the Department's management of mental health access.

My staff has heard reports from veterans and their families who have been forced to wait weeks or even months for an initial mental health appointment. Such delays are not only inconsistent with VA's stated access-to-care standards but also pose serious risks to the health and safety of those who served our nation.

The Senate Veterans Affairs Committee Minority staff have been tracking patient wait times once a week since January 2025 from VA's Access to Care website. I am particularly alarmed by the following findings based on VA's own wait-time data at the following facilities:

- **Orange VA Clinic**—only 3 weeks since May 2025 had a wait time under 100 days for a new patient mental health appointment.
- **Willimantic VA Clinic**– several weeks in September and October had wait times over 100 days for a new patient mental health appointment
- **McGuirk, Winsted, Stamford, Waterbury and Danbury VA Clinics**—all consistently have wait times well above 50 days for a new patient mental health appointment

These examples in Connecticut are not isolated and are likely indicative of a broader systemic issue that must be addressed immediately. We can see this from the drastic increase in wait times for a new patient mental health appointment since the beginning of the year. Extreme examples include the Orange VA Clinic, which had a wait time of 43 days on January 29, the Willimantic VA Clinic, which had a wait time of 41 days on February 18, the Winsted VA Clinic, which had a wait time of 19 days on March 23, and the Stamford VA Clinic, which had a wait time of 10 days on April 14. These are the earliest recorded wait times the VA website produced for each of these clinics, all under 50 days and well below 100 days. The substantial rise in new patient mental health appointment wait times across Connecticut during the past year raises serious concerns.

Accordingly, I request that the Department provide the following information within **30 days** of receipt of this letter:

1. A detailed explanation of the factors contributing to increased wait times for new mental health appointments, including staffing shortages, resource allocation, or scheduling inefficiencies.
2. The Department's current plan of action to restore timely access, including short-term mitigation steps and long-term solutions to both new and existing patient mental health appointments.
3. Data on current national average wait times for new and existing mental health appointments across all VA medical centers and outpatient clinics.
4. An update on efforts to expand telehealth to ensure that veterans are not left without timely treatment.

The Department's mission is to provide care and support worthy of the sacrifice of America's veterans. Persistent barriers to mental health care are unacceptable and demand swift corrective action. Congress will continue to exercise oversight to ensure that VA fulfills this critical responsibility.

I appreciate your prompt attention to this matter and look forward to your response.

Sincerely,

Richard Blumenthal
Ranking Member
Senate Committee on Veterans' Affairs

Questions for the Record

Department of Veterans Affairs (VA)
Questions for the Record
Committee on Veterans' Affairs
United States Senate
Medication Management in VA Health Care

December 3, 2025

Questions for the Record from Chairman Jerry Moran:

Question 1: How does VA train mental health providers, especially newer clinicians, on deprescribing principles and managing polypharmacy for complex conditions such as PTSD, TBI, and depression?

VA Response: VA trains mental health providers on a range of prescribing principles including deprescribing and polypharmacy through multiple initiatives and processes, such as: (1) the Psychotropic Drug Safety Initiative in the Office of Mental Health; (2) Academic Detailing services through the Office of Pharmacy Benefits Management; (3) clinical practice guidelines for common mental health disorders affecting Veterans; (4) continuing medical education; and (5) ongoing professional practice evaluation and supervision for all providers.

1. Since 2013, the VA Psychotropic Drug Safety Initiative (PDSI) has been the centerpiece for VA's efforts to ensure safe psychotropic prescribing. PDSI is a Nationwide quality-improvement program that uses population-level data, dashboards, and targeted clinical interventions to make psychotropic prescribing safer and more evidence-based, by focusing on high-risk psychotropic medications and combinations of medications. PDSI supports clinicians in optimizing, monitoring, and deprescribing psychotropic medications when risks outweigh benefits. The initiative operates nationally, with every VA facility participating, and has evolved through multiple phases that target different psychotropic safety priorities over time. Current PDSI efforts related to polypharmacy and deprescribing are focusing on benzodiazepine prescribing for Veterans with posttraumatic stress disorder (PTSD), antipsychotic prescribing for Veterans with dementia, and monitoring Veterans prescribed stimulant medications.

2. VA Academic Detailing is an evidence-based, clinician-to-clinician outreach service that delivers tailored, one-on-one or small-group education to frontline providers to promote guideline-concordant, safer prescribing, and care. It is run nationally through VA Pharmacy Benefits Management and focuses on high-impact topics like psychotropic safety, pain, and opioid risk mitigation. Academic Detailing campaigns have provided pocket cards, guides, and population health patient-panel reviews to reduce opioids, benzodiazepines, stimulants, and antipsychotic polypharmacy. VA's use of Academic Detailing as a guideline concordant implementation strategy has resulted in reduction

in adverse events, and reduction in morbidity and mortality in Veteran populations to improve safe prescribing practices.

3. VA reinforces polypharmacy and deprescribing principles through the VA/ Department of War (DoW) Clinical Practice Guidelines. VA and DoW develop joint clinical practice guidelines through a structured, evidence-based process led by the VA/DoW Evidence-Based Practice Work Group, which uses multidisciplinary expert panels that include Veterans. The process is designed to meet National Academy of Medicine standards for clinical practice guidelines. These guidelines form the basis for quality improvement and educational efforts.

4. VA delivers continuing medical education to mental health providers through a mix of national web-based platforms, live webinars and conferences, and embedded local education and supervision. These mechanisms are designed to be free, multidisciplinary, and closely aligned with VA/DoW guidelines and national mental health and suicide prevention priorities. Examples of these trainings include, A Rational Approach to Benzodiazepine Prescribing and Deprescribing (September 4, 2025) and The Effect of Selective Serotonin Reuptake Inhibitor Prescribing on the Risk of Adverse Outcomes among Veterans with PTSD (December 4, 2025).

5. Professional practice evaluations in VA use a structured, data-driven process. Ongoing Professional Practice Evaluations (OPPE) are used to continuously monitor each licensed independent practitioner's clinical performance and to inform decisions about renewal or modification of clinical privileges. OPPE runs throughout a provider's regular privileging cycle and is distinct from the initial, time-limited Focused Professional Practice Evaluation that occurs when new privileges are first granted. OPPE criteria are specific to the provider's specialty and scope of practice, with an emphasis on appropriateness of care, patient safety, and desired outcomes. Mental health prescriber OPPE criteria focus on medication reconciliation and shared decision making when prescribing.

Question 2: What safeguards has VA implemented to prevent uncoordinated prescribing for veterans with multiple mental health conditions, and where are there still gaps?

VA Response: VA has developed multiple safeguards including clinical programs and electronic tools to coordinate prescribing for Veterans with multiple mental health conditions.

VA's electronic health record (EHR) system, CPRS/VistA, using the Medication Order Check Healthcare Application, and Federal EHR, using medication Clinical Decision Support, provide automated alerts for drug-drug interactions, therapeutic duplications, inappropriate dosing, and pharmacogenomic risks for prescribers.

VA uses a team-based approach to mental health care through the Behavioral Health Interdisciplinary Program (BHIP). BHIP teams consist of mental health prescribers, social workers, therapists, nurses, and administrative personnel. A central part of BHIP model is the Mental Health Treatment Coordinator (MHTC) who is designated to serve as the central point for coordinating all mental health services during a Veteran's episode of care. MHTCs work closely with medical and BHIP providers to manage panels, track needs and progress, and ensure Veterans receive the right care at the right time. MHTCs reduce the risk of fragmented or uncoordinated prescribing and support a more consolidated, coherent treatment plan.

Question 3: For veterans receiving care from multiple providers, what tools or policy changes is VA using to better coordinate medication decisions across the system?

VA Response: Veterans Health Administration (VHA) Directive 1310(1), Medical Management of Enrolled Veterans Receiving Self-Directed Care from External Health Care Providers, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=9461, includes requirements for the coordination of care, to include medication management between VA and external health care providers that provide health care to Veterans not paid for by VA. The directive provides content addressing medication reconciliation, prescribing, monitoring, and follow-up.

VHA Directive 1345, Medication Reconciliation, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=9702, requires medication reconciliation at every episode or transition in care where medications will be administered, prescribed, modified, or may influence the care given. Medication reconciliation ensures Veterans' medication lists are accurate and up-to-date across all care settings, including from VA and non-VA providers.

VA emphasizes collaboration among providers, patients, and caregivers, and leverages secure messaging, online portals, and mobile applications to support communication and reduce discrepancies. Additionally, VA's Medication Order Check Healthcare Application provides automated alerts for drug-drug interactions, therapeutic duplications, inappropriate dosing, and pharmacogenomic risks.

Question 4: How does VA monitor prescribing patterns to identify inappropriate polypharmacy, and what are the most common breakdowns in real-world practice?

VA Response: The most common breakdown in practice is a lack of visibility to all medications the patient is prescribed. For example, when non-VA providers fill prescriptions without VA benefits or when Veterans take over-the-counter supplements, VA relies on the Veteran to disclose those medication updates to clinicians.

To mitigate the risk from this situation, VA uses multiple tools to monitor prescribing patterns to identify inappropriate polypharmacy. The EHR includes real-time alerts for

drug interactions and duplications. VA's Opioid Safety Initiative (OSI) is supported by tools such as the Stratification Tool for Opioid Risk Mitigation (STORM), 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 requires clinicians to query Prescription Drug Monitoring Programs (PDMP) as outlined in policy. VA leverages internal dashboards to monitor and measure compliance with VA's established policy requirements. VA's PDSI optimizes psychotropic prescribing. This initiative has significantly reduced potentially inappropriate prescribing, including a reduction in benzodiazepine use among Veterans with PTSD and substance use disorders. Also, VA has a system-wide deprescribing initiative that empowers clinicians to evaluate medications based on whether the medications are vital, important, optional, or not indicated and ensure that every medication has a reason VA will be piloting smart clinical software that helps prescribers simplify complex medication regimens — improving Veteran safety and reducing harmful side effects. The initial Feasibility Pilot will consist of 10 sites to examine software function and fit into clinical workflows and will conclude at the end of 2026. The outcomes of the feasibility pilot will inform future expansion efforts.

Directive 1306(2), Querying State Prescription Drug Monitoring Programs, https://ba.va.gov/policy?p=paKMOE0000000Hb44AE, establishes responsibilities requiring VHA health care providers to query state PDMPs to support safe and effective prescribing of controlled substances. With few exceptions, the Directive requires that PDMP queries be performed prior to initiating therapy with a controlled substance and more often when clinically indicated. A PDMP query must be done at least annually for VA patients who are receiving prescriptions for controlled substances.

Question 5: What systems does VA have in place to verify which medications a veteran is taking, including over-the-counter medications and non-VA prescriptions?

VA Response: VHA Directive 1345, Medication Reconciliation, https://ba.va.gov/policy?p=paKMOE00000005XQ4AY, requires medication reconciliation at every episode or transition in care where medications will be administered, prescribed, modified, or may influence the care given. This process ensures Veterans' medication lists are accurate and up-to-date across all care settings. As part of the medication reconciliation process, clinicians ask about non-VA prescription(s), over-the-counter medications, or supplements the Veteran is taking and document them in the EHR. VA Rx Refill and My HealtheVet allow Veterans to view and update their medication list online, including non-VA and over-the-counter medications.

Question 6: What solutions, if any, is VA exploring to improve the accuracy of a patient's medication profile to better inform providers of a patient's current medication regimen?

VA Response: On March 16, 2026, VHA awarded a contract to support addressing polypharmacy through the deployment of advanced clinical decision-support software. This initiative leverages AI and technology to reduce adverse drug interactions and enhance outcomes for those with complex physical and mental health needs such as PTSD. This initiative is part of VHA's broader strategy to improve medication management, address potential risks from overprescribing, and put Veterans first. The initiative and contract are structured to evaluate the feasibility pilot at 10 VHA sites (to be completed by end of 2026) guided by an implementation science framework ensuring rigorous evaluation and practical operational learning. The outcomes of the feasibility pilot will inform future expansion efforts.

In addition to this initiative, VA is prioritizing safe, evidence-based prescribing to reduce unnecessary polypharmacy and strengthen informed consent. VA trains clinicians in evidence-based prescribing, deprescribing, and polypharmacy management through multiple national programs. These include the Psychotropic Drug Safety Initiative, educational outreach, nationally adopted clinical practice guidelines; continuing medical education; and ongoing professional practice evaluation and supervision. Comprehensive Medication Management conducted by clinical pharmacist practitioners supports reduction in polypharmacy through adjusting regimens and helping Veterans understand medication risks. Together, these measures improve safety and support Veterans in managing their medications.

Question 7: How does VA make certain that prescriptions, especially multiple psychoactive medications, are regularly reviewed by qualified mental-health and pharmacy professionals, rather than being managed in a fragmented way?

VA Response: VA uses multiple safeguards, including clinical programs such as BHIP teams and MHTCs, as well as electronic tools, to coordinate prescribing for Veterans with multiple mental health conditions.

VHA Directive, 1345 Medication Reconciliation, https://ba.va.gov/policy?p=paKMOE00000005XQ4AY, requires medication reconciliation at every episode or transition in care where medications will be administered, prescribed, modified, or may influence the care given. This process ensures that Veterans' medication lists are accurate and up-to-date across all care settings.

Questions for the Record from Ranking Member Richard Blumenthal:

Question 1: What steps is VA taking to ensure community care providers are held to the same medication management standards as VA providers – including completing the required opioid safety training and reporting relevant prescriptions to state prescription drug monitoring programs?

VA Response: Through the Joint Health Information Exchange (HIE), VA securely shares medication data with non-VA providers. Care coordinators and pharmacists also work directly with community providers to align treatment plans and avoid unnecessary

medications. It is the responsibility of the community care provider to check the state's PDMP in accordance with their state's requirements and Third-Party Administrators (TPA) provider agreement prior to prescribing a controlled substance. Community Care Network (CCN) providers must follow the VHA Formulary Management Process (VHA Directive 1108.08) at:
https://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=9889

Both TPAs, Optum and TriWest, published updates to their provider manuals, documenting the contractual requirement to query state PDMPs prior to prescribing opioids and highlighting the need to document this action. VA contracted with TPAs to include the VA OSI guidelines into their direct TPA provider contracts and manuals. By including the VA OSI guidelines into the TPA provider contracts and manuals, the community provider is legally required to attest to having received and reviewed the VA OSI guidelines.

Additionally, the CCN Next Generation contracts require all opioid-prescribing providers to complete and attest to take the OSI training course available on VA's learning management platform. The TPAs will be required to notify VA of providers that have and have not taken the training.

Question 1A: What changes has VA made to ensure community care providers complete the required opioid safety training?

VA Response: In addition to the requirements for TPAs listed above, providers who prescribe opioids must complete the Community Care Provider–Opioid Safety Initiative training course, as mandated by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018), section 131 (VHA Training Finder Real-time Affiliate-Integrated Network (TRAIN) ID # 1086479), and retain a copy of their completion certificate. Each provider is required to complete the VA's online Community Care Provider Opioid Safety Initiative training once. VA's Office of Integrated Veteran Care disseminates guidance to providers regarding the OSI training and monitors its completion.

VA will conduct targeted outreach to Veteran Care Agreement (VCA) providers with active DEAs who are non-compliant with Opioid Safety Initiative (OSI) requirements in advance of CCN NG roll-out, including those who have not completed the required VA-specific opioid safety training. Through this outreach, VA aims to close training gaps, reinforce safe prescribing practices, and ensure all participating providers meet the clinical standards necessary to deliver safe, coordinated care to Veterans. This focused engagement supports compliance, strengthens provider readiness, and reduces risks associated with opioid prescribing by non-VA Health Care Providers.

With the Community Care Network (CCN) Next Generation contracts, VA has introduced a new requirement for all DEA-registered and state-licensed opioid-prescribing providers to self-attest to compliance with VA opioid safety standards and mandates electronic capture and transmission of this data to VA. It adds new compliance,

documentation, and provider-reporting obligations not present in the legacy Community Care Network contracts.

This change is in alignment with the Consolidated Appropriations Act of 2023 (MATE Act), which requires all DEA registrants authorized to prescribe Schedule II–V controlled substances to attest to completion of at least 8 hours of opioid and substance-use disorder education. In addition to the federal requirement, VA mandates completion of VA-specific opioid safety training. This VA-specific training requirement ensures that prescribers are equipped to address the unique pain-management, mental-health, and opioid-related risks prevalent within the Veteran population, supporting safer and more effective care delivery.

Question 1B: What is the current opioid safety training completion rate among community care providers?

VA Response:

There are approximately 1.5 million Non-VA Health Care Providers supporting Veteran care in the community. Of those, 702,130 have active DEA licenses (46.8%). Through CCN, all providers that have an active DEA are required to complete the training, there is no expectation of 100% overall participation for those providers that do not have a DEA. Of those with an active DEA, 2.02% have certified they have completed a review of the VA OSI guidelines through VA's TRAIN, an online external learning management system. This percentage is variable as the network is not static, so both the denominator and the volume of training certifications completed change over time.

Question 2: If VA is committed to increasing access to non-pharmacological options for veterans, why is the Department now charging many veterans for whole health services, including yoga and fitness classes, meditation, and whole health coaching?

VA Response: VA is committed to delivering non-pharmacologic approaches for well-being, and these services will continue to be offered to any Veteran who is interested.

VA does not have statutory authority to keep Whole Health and well-being services non-billable. Assigning a $15 copayment ensures equity and compliance across the system and alignment with current Federal law

Starting October 1, 2025, VA updated its billing practices for Whole Health and well-being services to ensure consistency with Federal law. Veterans in Priority Groups 6, 7, and 8, who are or may already be responsible for outpatient copayments, pay a $15 copayment for Whole Health and well-being services.

This charge applies only to Veterans who are already subject to outpatient copayments. Veterans exempt from copayments, such as those with service-connected conditions

rated 50% or higher, those receiving care for a service-connected condition, or those meeting other statutory or regulatory exemptions, are not affected. Review of fiscal year (FY) 2025 data showed fewer than 5% of Veterans would be impacted by this change.

Question 2A: Please provide participation data for VA's whole health programs from before and after the reinstitution of copays.

VA Response: The change in copayment status took effect October 1, 2025. Therefore, there are limited data to date on use of Whole Health programs since reinstitution of copayments. We have provided a 2-month view of Whole Health and well-being program used in FY 2026 (October 15 - December 15, 2025) compared to this same time period in FY 2025.

Whole Health and well-being services - (National data timeframe: October 15 to December 15, 2025).

FY 2025: Total unique Veterans: 45,311; Total visits: 126,321.

FY 2026: Total unique Veterans: 43,613; Total visits: 128,058.

Question 3: How many VA facilities are currently in full compliance with requirements to have a pain management team?

VA Response: Out of 139 facilities (referring to administrative parent facilities consisting of Health Care System or VA Medical Center), 78 (56%) facilities are compliant with minimal Pain Management Team (PMT) clinical requirements are compliant with minimal Pain Management Team (PMT) clinical requirements.

Question 3A: How many vacancies are there currently among pain management team staff at VA? How has this number changed over the past two years?

VA Response: As of December 1, 2025, VHA had 100 vacant pain management positions in comparison with 68 vacancies in December 2024 and 78 vacancies in December 2023. This indicates an increase of 32 vacant positions from December 2024 to December 2025.

Questions for the Record from Senator Mazie Hirono:

Question 1: How does VA handle medication management through the transition, particularly when it comes to those with prescriptions for opioids?

VA Response: VA providers conduct medication reconciliation as outlined in VHA Directive 1345, Medication Reconciliation, https://ba.va.gov/policy?p=paKMOE00000005XQ4AY, which requires medication reconciliation is conducted at every episode or transition in care where medications will

be administered, prescribed, modified, or may influence the care given. The provider, pharmacist, or other authorized personnel verify medication lists and utilize standardized handoff tools within the EHR to help ensure continuity and prevent duplication or omissions.

Additionally, VA and DoW 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 (https://ba.va.gov/policy?p=paKMOE00000008xY4AQ), 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 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.

Question 1A: How does prescription and mental health care management during the transition differ in the case of administrative separation related to substance abuse, if the servicemember receives an other-than-honorable discharge?

VA Response: VA policy directs VA providers to continue DoW-initiated mental health medications for fully eligible Veterans when clinically appropriate, supporting sustained pharmacotherapy across the transition from DoW to VA care. When a Service member separates with an other-than-honorable discharge and lacks general VA eligibility, that continuity framework applies only to the extent they qualify for emergent suicide care (under 38 U.S.C. § 1720J) or limited mental or behavioral health care to include treatment for substance use disorders (under 38 U.S.C. § 1720I). In some cases, VA can provide additional services if the Veteran is found to have a service-connected disability or if they have a favorable character-of-discharge (COD) determination, even if the Veteran is not eligible for broader compensation.

VA does not treat all other-than-honorable discharges as automatically "dishonorable" for VA purposes. VA reviews the circumstances of service and reason for discharge to decide if the service qualifies as "under conditions other than dishonorable." A favorable COD determination means the person meets VA's basic discharge requirement for benefits.

Question 1B: Has DOD been a willing partner when it comes to considering or implementing additional guardrails for separating servicemembers with opioid prescriptions, given what a vulnerable time the transition typically is?

VA Response: Yes, DoW has been a willing and engaged partner in exploring options for continuity of care for separating Services members on opioid prescriptions. DoW participates in joint working groups, such as the Joint Executive Committee, Health Executive Committee, and policy initiatives with VA to enhance care continuity, including medication management for controlled substances like opioids. Examples include

shared protocols under the DoW-VA Pharmacy Enterprise and warm hand-off initiatives through the Health Executive Committee.

Question 1C: Are there additional components to the standard "warm handoff" that would help ensure consistent prescription access for opioids and mental health medications?

VA Response: VA recently implemented a new Case Management Protocol that utilizes a VHA STORM sub-report to support transition. VA STORM is a suite of clinical decision support tools that use VA medical record data and predictive modeling to promote patient-centered care to help improve opioid safety. The STORM reports gather information from across VA and update nightly so that the information is available regardless of location of care delivery. The data displayed on these reports are actionable and patient-specific to facilitate care coordination for Veterans. Key features of STORM reports include identifying patients at elevated risk for adverse events such as suicide and drug overdose, listing risk factors that place these patients at elevated risk such as mental health diagnoses, suggesting risk mitigation strategies, and displaying a patient's upcoming appointments and current treatment providers. Any Veteran enrolled in VHA health care with a medical record indicating they have received services within the past 2 years and have filled a VA prescription for an opioid is included in the STORM reports. As determined by the provider, using STORM report outputs, a Veteran may be connected to other programs and services to address their non-clinical needs.

The new Case Management Protocols pull information from DoW medical records to identify VA patients who were treated for opioid use disorder diagnoses while in the military. VA patients treated for opioid use disorder while they were in the military are presented on the STORM decision support system and reviewed by a national case manager who works with the Veterans' health care providers to ensure that they are offered effective services for their conditions. This decision support system uses data sharing between DoW and VA to ensure prompt VA attention to high-risk conditions and care needs identified before the service-member left DoW.

Question 2A: In your opening statement you described medication reconciliation as "a cornerstone of VA's patient safety efforts." How soon after the transition can a separating servicemember with multiple active medications expect to go through the medication reconciliation process, particularly those who sought private sector care during their transition?

VA Response: A Service member can go through a medication reconciliation review as soon as he or she receives any sort of care at VA. VHA Directive 1345, Medication Reconciliation (https://ba.va.gov/policy?p=paKMOE00000005XQ4AY) requires medication reconciliation to occur at every episode or transition in care where medications will be administered, prescribed, modified, or may influence the care given within VA.

Question 2B: If a veteran is prescribed multiple medications, particularly for mental health or PTSD, how frequently does VA recommend their primary care provider reconcile any medication prescribed across providers?

VA Response: VA recommends a medication reconciliation every time medications will be administered, prescribed, modified, or may influence the care given.

Question 2C: How does VA ensure community care providers are regularly reviewing and reconciling medication for veterans with multiple prescriptions, especially medications prescribed for mental health conditions or PTSD?

VA uses a standardized process to generate a community care referral packet that is sent to community providers along with the VA authorization. In addition to medical records pertinent to the services being requested, the referral packet includes a list of the Veteran's current medications for the community provider's review. It is within the community provider's professional scope of practice to review the medication list and reconcile when prescribing new medications. Except for urgent/emergent prescriptions, any routine prescriptions written by community providers are submitted to the VA pharmacy and are fulfilled according to VHA Directive 1345, Medication Reconciliation, which requires medication reconciliation at every episode or transition in care where medications will be administered, prescribed, modified, or may influence the care given. Medication reconciliation ensures Veterans' medication lists are accurate and up-to-date across all care settings, including from VA and non-VA providers.

Question 3A: Per the Department's October 2025 report to Congress titled "Establishment of Processes to Ensure Safe Opioid Prescribing Practices by Non-VA Health Care Providers," approximately 6.3% of community providers initially reviewed for their opioid prescribing practices underwent further review. Of those that underwent additional review, how many providers were subject to actions to exclude or limit their participation in VA's Community Care program?

VA Response: The 6.3% of community providers who underwent further review of their opioid prescribing practices resulted in 10 providers being terminated from the CCN.

Question 3B: Are holds on providers' ability to receive further referrals or authorizations permanent in this case? If not, what level of re-evaluation occurs before a provider is able to take veteran patients again?

VA Response: Providers that are terminated from CCN are permanently removed from the network.

Question 4A: Additionally, the Department's October 2025 report provided no detail related to VA's oversight of Community Care providers neglecting to query state prescription drug monitoring programs (PDMPs) before prescribing opioids. Has anything changed in the Department's oversight of this particular issue with Optum and TriWest or directly with community providers?

VA Response: Since the October 2025 report was issued, TPAs published updates to their provider manuals, describing the contractual requirement to query states' PDMPs prior to prescribing opioids.

For CCN Next Gen, community providers will be required to document their query to the state PDMP in the medical record.

Question 4B: How does the Department plan to ensure community providers are querying PDMPs regularly and documenting their queries?

VA Response: Please see the response to Question 4A. Additionally, the CCN Next Generation Request for Proposal, published December 15, 2025, added a contractual requirement that the PDMP checks are documented.

Questions for the Record from Senator Jim Banks:

Question 1: Please provide annual data for FY 2020 through 2024 on the number of veterans prescribed two or more central nervous system drugs concurrently. Provide any other related polypharmacy data during this period that VA determines relevant.

VA Response: The number of Veterans using VA services who filled prescriptions for two or more core central nervous system (CNS) medications at the end of each FY for years 2020 through 2024 are provided in Table 1 below.

VA notes that this is the total number of Veterans with CNS-active prescriptions fills. The total number of Veterans served by VA over this time has increased as well, as shown in the two figures on page 13. VA uses a definition of "Core" CNS medications found in Beers Criteria. Beers Criteria are the leading evidence-based criteria for medication combinations, which may pose a risk to older adults.[1] This list of CNS medications includes antidepressants, antipsychotics, anticonvulsants, mood stabilizers, benzodiazepine, opioids, and skeletal muscle relaxants.

Table 1. Number of Veterans with Filled Prescriptions for Two or More CNS-Active Medications on the Last Day of Each Year

Fiscal Year	Number of Veterans
2020	662,849
2021	653,332

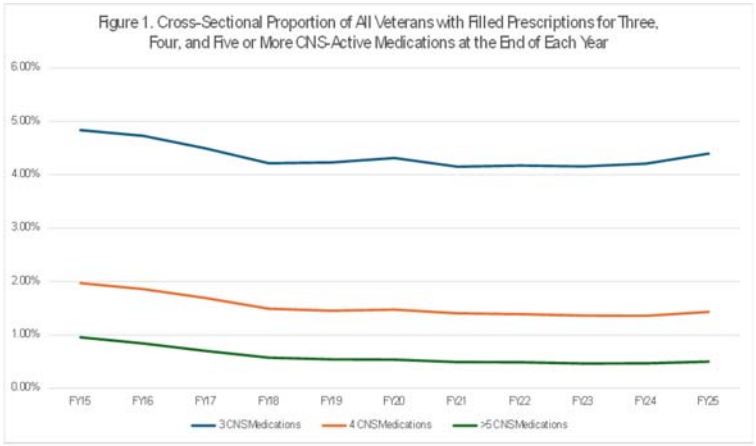
[1] American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *Journal of the American Geriatrics Society*. 2023;71(7):2052-2081. doi:10.1111/jgs.18372.

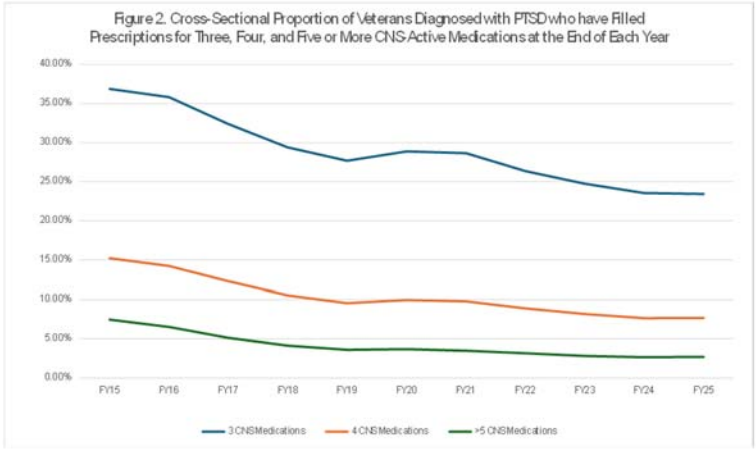
2022	656,940
2023	676,724
2024	713,732
2025	772,143

When evaluating rates of CNS polypharmacy among Veterans, VA analyzes the proportion of Veterans with three, four, and five or more core CNS-active medication prescriptions filled among all Veterans with a prescription filled by VA. The research literature on polypharmacy varies, but the most common definition used is five or more CNS-active medications.[2] VA notes that clinical practice guidelines for the treatment of common mental health disorders among Veterans, such as major depression and PTSD, supports the use or two concurrent psychotropic medications for these conditions. For many Veterans with complex mental health needs, treatment with multiple CNS-active medications is appropriate, guideline-recommended, and needed to optimize mental health. CNS-active medications are also guideline recommended for treatment of chronic pain and/or neurological conditions, which commonly co-occur with mental health conditions in Veterans.

The proportions of Veterans with CNS polypharmacy are decreasing. Since FY 2015, the proportion of Veterans with three, four, and five or more CNS-active medications has decreased, as seen in Figure 1 below. When Veterans with a diagnosis of PTSD are evaluated, the trend of decreasing polypharmacy is greater, as seen in Figure 2 below.

[2] Maust DT, Kim HM, Chiang C, et al. Prevalence of central nervous system–active polypharmacy among older adults with dementia in the US. *JAMA*. 2021;325(10):952-961. doi:10.1001/jama.2020.27825.





Department of Veterans Affairs
June 2026

Senator Maggie Hassan
Questions for the Record
Senate Veterans' Affairs Committee
Medication Management in VA Health Care
December 3, 2025

Questions for Dr. Julie Kroviak – Principal Deputy Assistant Inspector General for Healthcare Inspections, Office of Inspector General, VA

1. What can the VA do to help veterans who are discharged from in-patient mental health care stay safe, especially with regard to properly educating them about their medications?
   Answer: As noted in our recommendations, healthcare teams should work to ensure the patient or caregiver clearly understands the treatment plan. VA staff can do this by complying with VA processes. Patient education should include education on the medication's benefits and risks; ensure the medication instructions are clear, free of technical or medical jargon; and avoid the interchangeable use of generic and trade names for medications. Staff should also document these discussions.

2. In addition, what can Congress do to help with this issue?
   Answer: Congress can help address this concern by continuing to conduct oversight on the issue, and members and Congressional staff can ask VHA leaders at the national, VISN, and local level how they are ensuring VHA staff compliance with relevant processes.

Sen. Cassidy
Questions for the Record
Senate Veterans' Affairs Committee
VA Medication Management
December 3, 2025

Questions for Julie Kroviak, MD, Principal Deputy Assistant Inspector General for Healthcare Inspections, U.S. Department of Veterans Affairs

In your testimony, you described the issue of polypharmacy – where a veteran patient receives numerous medications – and you made recommendations for increased oversight and coordination between VA direct care and community care.

One of the reasons overmedication is occurring is the high rate of turnover among physicians and other medical professionals in the VA. This causes a disruption in the physician-patient relationship for which quality care depends.

This is further complicated when the same veteran patient is visiting providers under both the VA direct care and community care for the same mental health illness.

However, because there is insufficient documentation sharing between community care providers and the VA, it can lead to a triangulation problem where neither provider has the full medical history of the veteran patient. In other words, the care is not linear.

- What actions can the VA take to reduce turnover of medical professionals at VA medical centers so that veterans can continue to see the same doctor who can continue to treat the same mental health illness?
  Answer: VA faces long-standing challenges competing with private sector compensation to recruit and retain providers. VA should use all available authorities to ensure potential qualified candidates and current providers are offered the most competitive compensation packages as permitted by law.

- How can we more effectively streamline documentation sharing between community care and the VA so that medical professionals have access to the full applicable medical history of the veteran patient necessary to provide quality and effective mental health care?
  Answer: OIG reports have highlighted repeated noncompliance with VA processes and procedures that require VA staff to request and document the attempts to retrieve medical records from community providers and upload them into VA's medical records. Unique challenges exist with the exchange of diagnostic imaging between community and VA providers. VA OIG is aware that VHA is actively exploring and piloting technological solutions to both issues, but as of now, the OIG is not aware of a permanent solution. In December 2025, VA issued a request of proposal on its Community Care Network Next Generation – Medical contract that may address issues related to accountability and

oversight of timely medical record exchange. Updates/questions should be directed to VA.

The VA Accessing Telehealth through Local Area Stations (ATLAS) program helps to connect veterans in rural areas with the VA by setting up shops in rural areas with technological equipment to connect virtually.

- How could this program be reformed so that veterans can continue to have a patient-physician relationship with the same medical professional no matter where they live?
  Answer: The OIG has conducted no work related to the ATLAS program.

Earlier this year, Senator Hirono and I introduced the bipartisan *VetPAC Act of 2025* that would create a new Veterans Health Administration Policy Advisor Commission (VetPAC) to facilitate an independent commission to improve veteran patient health care delivery and address challenges within the VHA by conducting regular assessments and reports to Congress.

One of the issues VetPAC will address, among others, is addressing staffing retention concerns for VHA medical staff.

- Where should VetPAC start to evaluate VA medical professional turnover, and do you agree the commission can help address this issue for our veterans?
  Answer: The OIG does not take a position on this legislation; however, should the Commission be stood up, the OIG would stand ready to work with it to improve VA's provision of care to veterans.

Statements for the Record

American College of Clinical Pharmacy

Statement for the Record to the U.S. Senate Committee on Veterans' Affairs:

Medication Management in VA Healthcare

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The American College of Clinical Pharmacy (ACCP) appreciates the opportunity to provide the following statement for the record related to the December 3, 2025 U.S. Senate Committee on Veterans' Affairs (VA) hearing titled: *Medication Management in VA Healthcare*.

ACCP is a professional and scientific society that provides leadership, education, advocacy, and resources enabling clinical pharmacists to achieve excellence in patient care practice and research. ACCP's membership is composed of over 16,000 clinical pharmacists, residents, fellows, students, scientists, educators and others who are committed to excellence in clinical pharmacy practice and evidence-based pharmacotherapy.

The Veterans Health Administration (VHA) has been a leader in effectively utilizing the skills and talents of clinical pharmacists to the benefit of our veterans' health. In 2010, the VA established the Clinical Pharmacy Practice Office (CPPO) to advance access to services by these highly trained health professionals. In addition, the VA has fully integrated clinical pharmacists into its Patient-Aligned Care Teams (PACT), a leading model for providing patient-driven, personalized and team-based care to our veteran population.

Clinical pharmacists practice in a variety of healthcare settings including medical clinics, integrated health systems, hospitals, community-based pharmacies and others. In these settings, they work collaboratively with physicians and other providers to ensure that patients receive the best care possible. As medication experts, clinical pharmacists are regularly consulted by the healthcare team for specific recommendations about the appropriateness of prescription medicines and other aspects of medication therapy that their education and training have prepared them to address.

Comprehensive medication management (CMM) is a direct patient care service provided by clinical pharmacists working as formal members of the patient's health care team. CMM has been demonstrated to significantly improve patient outcomes and reduce harm caused by inappropriate medication use.[1]

The integration of Clinical Pharmacist Practitioners (CPPs) providing CMM within the VHA also helps address key drivers of burnout among health care team members and providers.

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[1] McFarland MS, Finks SW, Smith L, Buck ML, Ourth H, Brummel A; Medications Right Institute. Medication Optimization: Integration of Comprehensive Medication Management into Practice. Am Health Drug Benefits. 2021 Sep;14(3):111-114. PMID: 35261714; PMCID: PMC8845520.

In one of the largest and most comprehensive evaluations of the integration of clinical pharmacists into team-based care, VHA findings revealed that the clinical pharmacists positively impact drivers of burnout, reinforcing past research.[2]

VA National Pharmacogenomics Program

Pharmacogenomics (PGx) is the study of how a patient's genetic profile determines their responses to specific medications. When integrated into CMM, PGx testing allows for targeted treatment decisions based on the unique characteristics of the patient's unique genetic profile.

ACCP applauds VHA's recognition of the unique value that qualified clinical pharmacists provide in leveraging advanced technologies to the treatment and therapy of complex conditions. As medication therapies and genomics continue to evolve, programs like Pharmacogenomics testing for Veterans (PHASER) will help advance unique, precise and personalized approaches to medication therapies.

Clinical Pharmacy, Mental Health and Substance Abuse Disorder

ACCP is committed to advancing an individualized, patient-centered approach to patient care that considers patient variability in physiology, drug metabolism and other underlying medical conditions. Given the role that opioid medications play in pain management and opioid use disorder, clinical pharmacists have both an opportunity and an obligation to participate in the care of patients by promoting rational pharmacotherapy of opioids and multimodal analgesia and enhancing access to Medications for Opioid Use Disorder (mOUD) or Medication Assisted Treatment (MAT).

As communities across the country struggle to respond to the opioid epidemic, a comprehensive strategy must be prioritized that appropriately integrates clinical pharmacists - the health professionals best suited to optimize medication use – into teams caring for these patients. Medication optimization is critical to a comprehensive patient-centered approach to management of pain and other chronic conditions. Clinical pharmacists are essential team members in a modern, interprofessional approach to acute and chronic pain.

Clinical pharmacists provide direct patient care as part of interprofessional teams across a variety of practice settings. The VA's PACTs include primary care providers (PCPs), nurses, and other clinicians, including clinical pharmacists and advanced practice nurses working

[2] McFarland MS, Ourth H, Boggle D. Evaluation of team experience with the clinical pharmacist practitioner providing comprehensive medication management in the Veterans Health Administration. J Gen Intern Med. DOI 10.1007/s11606-025-09920-w

collaboratively to implement individualized care plans for patients with complex, chronic conditions including chronic pain and mental health disorders. Pharmacists at the VA are also involved in innovative team-based approaches to MOUD or MAT. As a part of their work, VA pharmacists are now incorporating pain management into their training programs for pharmacy students and residents, preparing the next generation of healthcare providers to better manage these conditions.

Optimizing Medications Through Telehealth: Protecting Veteran Access to Telemedicine Services Act of 2025

The widespread adoption of telehealth has demonstrated[3] its long-term value, particularly for patients with mobility issues and those in rural and/or medically underserved areas. To ensure the broadest possible patient access and the highest quality of care, we urge Congress to pass H.R.1107 – the Protecting Veteran Access to Telemedicine Services Act of 2025. This legislation will improve healthcare accessibility, convenience, and efficiency by enabling remote consultations, reducing travel requirements, and facilitating timely medical interventions.

Conclusion

There is convincing evidence that Clinical Pharmacy Practitioners (CPPs) in the VA improve access, clinical outcomes, and cost effectiveness when properly deployed for direct patient care. It is critical to note that increasing access to clinical pharmacy services through the VA's PACTs could serve as a solution to unburdening primary care providers by reducing primary care provider revisit rates.[4] We would welcome the opportunity to provide additional information, data, and connections to successful practices that provide comprehensive medication management (CMM) and pharmacogenomics services as part of an effort to optimize the use of medications for America's veterans.

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[3] Thomas AM, Baker JW, Hoffman TJ, et al. Clinical pharmacy specialists providing consistent comprehensive medication management with increased efficacy through telemedicine during the COVID19 pandemic. J Am Coll Clin Pharm. 2021;4:934-938. doi: 10.1002/jac5.1494.

[4] McFarland MS, Nelson J, Ourth H, et al. Optimizing the primary care clinical pharmacy specialist: Increasing patient access and quality of care within the Veterans Health Administration. J Am Coll Clin Pharm. 2020;3:494-500. doi 10.1002/jac5.1177

STATEMENT FOR THE RECORD
OF
DR. MARIE BLACK
HEALTH POLICY ANALYST
VETERANS' AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
ON
"MEDICATION MANAGEMENT IN VA HEALTHCARE"

DECEMBER 3, 2025

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"MEDICATION MANAGEMENT IN VA HEALTHCARE"

December 3, 2025

Chairman Moran, Ranking Member Blumenthal, and distinguished members of this Committee, on behalf of National Commander Dan K. Wiley and more than 1.5 million dues-paying members of The American Legion, we thank you for the opportunity to offer our testimony for the record on medication management at the U.S. Department of Veterans Affairs, including proposed reforms like *The Protect Veteran Access to Telemedicine Services Act* and the *Written Informed Consent Act*.

The American Legion is guided by active Legionnaires who dedicate their time and resources to serve veterans, servicemembers, their families, and caregivers. Our positions are grounded in more than 106 years of advocacy, beginning at the post level. Every time The American Legion testifies, we bring the veteran community's voice directly to Congress. The American Legion remains committed to ensuring veterans receive the high-quality healthcare they have earned, and we have long played a vital oversight role at VA. Today, that role is more critical than ever.

The American Legion is a resolution-based organization, and the following resolutions support and inform our recommendations below: Resolution No. 19: *Improving Telehealth Access*,[1] and Resolution No. 18: *Written Informed Consent*.[2]

In every year since 2001, more than 6,000 veterans have died by suicide annually, and according to the VA's 2024 National Veteran Suicide Report more than 40% of these suicides occurred while the veteran was utilizing care at VA. Success in combatting this epidemic have been mixed, despite increased Congressional attention and dramatic increases in funding at VA. Psychopharmacological interventions, are one of the few "evidenced-based" treatment modalities recognized by the VA for mental health treatment but are often ineffective and can result in adverse treatment outcomes. In just one example, VA's website has a comparison tool of different modalities for treating post-traumatic stress (PTS). When listing selective serotonin reuptake inhibitors (SSRIs) and/or serotonin-norepinephrine reuptake inhibitors (SNRIs) against other treatments, VA states, "36 out of every 100 people who receive medications will have meaningful

[1] "Resolution No. 19 (2021): Improving Telehealth Access" The American Legion Digital Archive, https://archive.legion.org/node/3578

[2] "Resolution No. 18 (2023): Written Informed Consent," The American Legion Digital Archive, https://archive.legion.org/node/15022

symptom improvement after about 3 months." By any objective measure, a 36% "success" rate is failing, particularly when accounting for potential negative side effects and failures in prescribing safety that have consistently been identified by the VA's Office of Inspector General.

This is why controls and oversight of medication management at VA is critical to the health and safety of 6.1+ million veterans under VA care. When functioning properly, VA policies and safety protocols prevent harm, reduces suicide risk, and strengthens trust in VA. When it doesn't, and when the VA does not follow laws related to informed consent, outlined in 38 CFR 17.32, consequences can be deadly. Modern conflicts have left many veterans dealing with chronic pain, post-traumatic stress (PTS), and traumatic brain injuries (TBI), which are often treated using complex medication regimens that in many cases have little or no efficacy for the treatment of such injuries. These veterans are at much greater risk when communication or oversight breaks down, and when clinicians are too quick to diagnose and prescribe rather than properly screening for TBIs or toxic exposure injuries and identifying the true root cause of the veteran's mental health struggles.

The simultaneous use of multiple medications (polypharma) is pervasive among the veteran population and broadly recognized as one of the top ten common causes of deaths in the United States.[3] During the 1990s and 2000s, prescription opioids were widely used within the VA, with nearly one-fifth of veterans receiving opioid prescriptions by the mid-2000s.[4][5] While these medications can reduce pain, they also carry high risks when not carefully monitored. Poor oversight contributes to addiction, medication interactions, and overdose.

With more veterans using community care, coordination between VA and non-VA providers is also critical. Studies have shown that veterans receiving opioids from Medicare Part D pharmacies often experienced prescription overlaps with VA-prescribed opioids, raising the risk of overdose. More than half of these veterans received prescriptions from both systems, double prescribing that could have been prevented with stronger medication safeguards.[6]
Informed consent plays a huge role in this problem, as evidenced by the VA's Office of Inspector General (OIG) September 2024 report "Mismanaged Mental Health Care for a Patient Who Died by Suicide."[7] The report discussed the case of veteran Hunter Whitley, whose mental health nurse practitioner's (MHNP) "failure to provide the patient education regarding mirtazapine's boxed warning likely resulted in the patient's insufficient awareness of the need to self-monitor for

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[3] VA News, "VIONE changes the way VA handles prescriptions," The Department of Veterans Affairs, January 25, 2020. https://news.va.gov/70709/vione-changes-way-va-handles-prescriptions/.
[4] "Understanding the Opioid Overdose Epidemic." Centers for Disease Control and Prevention, June 9, 2025. https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html.
[5] Communications, DAV. "How-and Why-the VA Changed How It Treats Veterans' Chronic Pain." DAV, September 15, 2025. https://www.dav.org/learn-more/news/2025/how-and-why-the-va-changed-how-it-treats-veterans-chronic-pain.
[6] Carico, Ron, Xinhua Zhao, Carolyn T. Thorpe, Joshua M. Thorpe, Florentina E. Sileanu, John P. Cashy, Jennifer A. Hale et al. "Receipt of overlapping opioid and benzodiazepine prescriptions among veterans dually enrolled in Medicare Part D and the Department of Veterans Affairs: a cross-sectional study." *Annals of internal medicine* 169, no. 9 (2018): 593-601. https://pubmed.ncbi.nlm.nih.gov/30304353/.
[7] "Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama." Department of Veterans Affairs Office of Inspector General. September 26, 2024. https://www.vaoig.gov/reports/hotline-healthcare-inspection/mismanaged-mental-health-care-patient-who-died-suicide-and

suicidal thoughts and seek supportive resources." In 2025, VA OIG published a report for the VA System in Massachusetts, which identified failures to provide evidence of "required discussion with veterans on the risks and benefits of prescribed medications" in a significant number of veteran healthcare records.[8] Two other 2025 reports for systems in Virginia and Pennsylvania echoed these concerns.

VA claims there has been progress to reduce opioid prescriptions by an estimated 67% since 2012,[9] but according to the VA's OIG, consistent implementation of informed consent, especially for psychotropic medications with Box Warnings for suicide risk from the Food and Drug Administration, remains elusive. Veterans continue to experience abrupt or poorly managed opioid tapering; polypharmacy without adequate monitoring; gaps between pain management, addiction treatment, mental health care, and insufficient informed-consent processes for high-risk medications.

Both draft bills address these systemic issues within VA medication management that contribute to opioid addiction, treatment lapses, and veteran suicide. The American Legion strongly supports both proposals, with one minor amendment.

DRAFT – The Written Informed Consent Act

To direct the Secretary of Veterans Affairs to expand a directive of the Veterans Health Administration regarding informed consent to apply to certain types of medications.

In May 2020, VHA issued Directive 1005 to require written informed consent for long-term opioid therapy. The Written Informed Consent Act introduced on 2 December, 2025, expands this requirement to include other medications, many of which host FDA Box Warnings for suicide risk: antipsychotics, stimulants, antidepressants, anxiolytics, and narcotics.

Each of these medication classes carries long-term risks that veterans must be fully informed about. Antipsychotics can cause metabolic changes and weight gain. Stimulants can cause cardiac complications and sleep issues. Antidepressants can cause impaired sexual function, weight gain, and emotional blunting. Anxiolytics carry a high risk of dependence, cognitive impairment, and chronic fatigue. Narcotics can cause gastrointestinal complications, weaken immune function, and carry a high risk of addiction. Again, many of these drugs have warnings for suicidal thoughts and behaviors, so with that in mind, we have a responsibility not only to our veterans, but their families to ensure they fully understand the potential risks that accompany treatments.

The American Legion has documented numerous cases in which Legionnaires were not adequately informed about the risks of medication. In one notable example, a veteran undergoing cancer treatment was not warned about narcotic effects on driving ability and experienced a serious car

[8] "Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds." Department of Veterans Affairs Office of Inspector General. March 5, 2025. https://www.vaoig.gov/reports/mental-health-inspection-program/mental-health-inspection-va-central-western-massachusetts

[9] VA News, "VA Reduces number of Veterans prescribed opioids by 67% since 2012." September 21, 2023. https://news.va.gov/press-room/va-reduces-opioids-by-67-since-2012/#:~:text=Table_title:%20VA%20reduces%20number%20of%20Veterans%20prescribed,%7C%202012:%2076%2C444%20%7C%202023:%2014%2C733%20%7C

accident. Another veteran in our Washington, D.C. office who deals with chronic PTSD, back, and leg injuries was - at one point - prescribed seven daily medications, resulting in increased suicidal ideation and, ultimately, a failed suicide attempt.

With polypharmacy so prevalent, VA must adopt all reasonable measures to ensure veterans understand their treatment plans, risks, and alternatives to ensure these cases are rare or nonexistent.

The American Legion supports this legislation through *Resolution No. 18: Written Informed Consent*, which urges VA to conduct regular state Prescription Drug Monitoring Program (PDMP) checks, prevent adverse medication interactions, and implement prompt follow-up wellness checks for veterans prescribed Black Box Warning medications.

DRAFT – The Protect Veteran Access to Telemedicine Services Act

To amend title 38, United States Code, to authorize certain VA health professionals to deliver or dispense controlled substances via telemedicine under certain conditions.

Approximately 2.7 million rural veterans are enrolled in VHA care. Many live in designated Health Professional Shortage Areas (HPSAs) where provider scarcity, facility closures, and geographic barriers make it difficult to access care. A 1-to-2,500 physician-to-patient ratio in some areas makes it nearly impossible to get timely appointments.[10]

Telemedicine dramatically expands access to care by increasing the number of available prescribers and offering safe, secure medication without forcing veterans to spend hours on the road.

During the COVID-19 pandemic, emergency authorities temporarily relaxed in-person evaluation requirements under the *Ryan Haight Act* and the *Controlled Substances Act*. This allowed VA providers to prescribe controlled medications via telemedicine practices that proved to be highly safe, effective, and necessary. Three emergency extensions were subsequently approved by DEA/HHS, with the current extension expiring on December 31, 2025.[11] As this deadline approaches, the potential for uncertainty looms large. Veterans and clinicians cannot operate under shifting requirements that change from year to year. Codifying these authorities would preserve access for rural and mobility-impaired veterans, prevent dangerous lapses in medication refills, reduce travel burdens and associated stress, and ensure continuity of chronic-care treatment.

One American Legion service officer shared that cross-state tele-prescribing privileges are vital for a veteran traveling between states who relies on the VA Traveling Veteran Program. Telehealth

[10] "Rural Health Care Workforce Development." Department of Veterans Affairs, Last updated May 2023, https://www.ruralhealth.va.gov/docs/ORH1458-010_Workforce_508c.pdf.
[11] "Better Communication and Oversight Could Improve How the Pain Management, Opioid Safety, and Prescription Drug Monitoring Program Manages Funds." Oversight.gov, May 25, 2025. https://www.oversight.gov/reports/audit/better-communication-and-oversight-could-improve-how-pain-management-opioid-safety.

enabled the veteran to maintain communication with their assigned provider without treatment gaps.

However, The American Legion is concerned with consistent care coordination. We urge the committee to consider a modest amendment to require one in-person appointment per calendar year.

The American Legion supports this draft legislation, with a proposed amendment, through *Resolution No. 19: Improving Telehealth Access,* which urges Congress to permanently allow VA health professionals to practice telemedicine across state lines within the scope of their federal duties.

CONCLUSION

Chairman Moran, Ranking Member Blumenthal, and distinguished members of the Committee, The American Legion thanks you for your leadership on these critical issues and for the opportunity to provide this testimony.

We stand ready to continue working with the Committee, VA, and our nation's veterans to ensure consistent, safe, and high-quality care. Questions concerning this testimony can be directed to Logan Barber, Legislative Associate, at lbarber@legion.org.

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STATEMENT FOR THE RECORD

AMERICAN PSYCHIATRIC ASSOCIATION

FOR THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

IN ADVANCE OF

DECEMBER 3, 2025

LEGISLATIVE HEARING

The American Psychiatric Association (APA), the national medical specialty society representing over 39,200 psychiatrists, appreciates the opportunity to submit this statement for the record to the Senate Committee on Veterans' Affairs. We commend the Committee's continued leadership in advancing policies that support timely, high-quality, and accessible mental health care for our nation's veterans, and respectfully offer the feedback below on the legislation set to be considered.

Protecting Veteran Access to Telemedicine Services Act

The APA strongly supports the Protecting Veteran Access to Telemedicine Services Act, legislation that would permanently extend a pandemic-related exemption to the Ryan Haight Act by allowing Department of Veterans Affairs (VA) clinicians to prescribe medically necessary controlled substances to veterans via telemedicine, even if an in-person examination has not occurred. Telehealth has proven to be an effective, evidence-based means of expanding access, improving continuity of treatment, and supporting timely interventions for those managing complex psychiatric and substance use conditions. As of 2024, 73 VA facilities faced a severe shortage of psychiatrists, highlighting the importance of the use of telemental health services. By ensuring that VA physicians, including psychiatrists, can deliver telehealth services without unnecessary restrictions, this legislation protects continuity of care and prevents treatment disruptions. The APA urges prompt support of this House passed legislation to preserve these essential flexibilities before they expire at the end of the year.

Saving Our Veterans' Lives Act

The APA also strongly supports the Saving Our Veterans' Lives Act, which seeks to establish a VA program to provide free firearm lockboxes to eligible veterans as a practical and effective means of reducing veteran suicide. This important legislation recognizes that firearms are the most common method used in veteran suicides, and that putting time and space between at-risk individuals and lethal means is one of the most evidence-based strategies for suicide prevention. Providing secure firearm storage options at no cost would empower veterans and their families to take proactive steps toward safety without stigma or intrusion into personal rights. Importantly, in addition to distributing lockboxes, the legislation would fund a public education campaign and require the development of an informational video on secure firearm storage, ensuring that suicide prevention messaging is consistent, accessible, and culturally sensitive to the veteran community. We urge the Committee to move swiftly on this measure and to continue supporting programs that expand access to mental health services and reduce suicide risk across the veteran population.

Written Informed Consent Act

The APA shares the Committee's commitment to ensuring that veterans are fully informed about their treatment options and appreciates the intent of the Written Informed Consent Act to enhance transparency and promote patient safety. However, as currently drafted, the legislation could have unintended consequences for both veterans and physicians. Additional written requirements may not enhance safety but could increase documentation burdens, discourage clinicians from treating complex patients, and heighten burnout among an already strained VA workforce. Moreover, an additional requirement of informed consent to access mental health medications could create a layer of stigma for patients and delay treatment. We welcome the opportunity to work with the Committee to identify

targeted approaches that balance patient autonomy with clinical efficiency, such as focusing written consent requirements on specific high-risk situations, while maintaining flexibility for physicians to exercise their best medical judgment. Mandating written consent for entire classes of medications, many of which are prescribed routinely for behavioral health conditions, risks creating administrative barriers that may delay timely treatment and divert valuable clinical time away from direct patient care. Informed consent should remain a clinical and patient-centered process, guided by professional judgment and existing VA protocols, which already require physicians to discuss the risks, benefits, and alternatives of treatment with their patients.

The APA thanks the Committee for its continued commitment to improving veterans' mental health care. We stand ready to collaborate and support the Committee's efforts to advance evidence-based solutions that strengthen access, quality, and safety in mental health services for all who have served.

Statement of the

Fleet Reserve Association

On

H.R. 4837, the Written Informed Consent Act

Presented to the

United States Senate

Veterans' Affairs Committee

By

Theodosius Lawson
Director, Legislative Programs

December 1, 2025

Chairman Moran, Ranking Member Blumenthal, and distinguished Members of the Committee:

The Fleet Reserve Association (FRA) appreciates the opportunity to submit this statement in strong support of H.R. 4837, the Written Informed Consent Act. Founded in 1924, FRA is the oldest and largest association serving the interests of the U.S. Navy, Marine Corps, and Coast Guard. FRA has a long history of advocating for sea service personnel. Our guiding principles of "Loyalty, Protection and Service" drive our work to ensure veterans receive the quality care and protections they have earned through honorable service.

FRA has championed veterans' health reforms for nearly a century, from post-World War II benefits expansions to modern mental health initiatives. Today, as we face a veteran suicide crisis, H.R. 4837 stands as a vital step forward in safeguarding our members' well-being.

A Brief History of Informed Consent in Veterans' Healthcare

Informed consent has deep roots in protecting service members and veterans from harm. The principle gained global force after World War II horrors, like unethical experiments, leading to the 1947 Nuremberg Code's call for voluntary, informed agreement to medical procedures. In the U.S., the 1957 Salgo court case established "informed consent" as law, requiring doctors to explain risks and options clearly.

For veterans, the Department of Veterans Affairs (VA) built on this in 2020 with Directive 1005, mandating written consent for long-term opioid prescriptions. This responded to the opioid crisis, where VA scripts contributed to a roughly 35 percent rise in veteran overdoses from 2010 to 2020. Now, H.R. 4837 extends these safeguards to other high-risk drugs, addressing gaps exposed by ongoing mental health challenges.

The Importance of Informed Consent for Veterans

Informed consent is more than paperwork; it's a promise of respect and partnership. It empowers veterans to make choices aligned with their values, builds trust in VA providers, and reduces risks from treatments. Without it, veterans may face hidden dangers, like addiction or worsened mental health, eroding the confidence needed for healing.

Studies show clear wins: Shared decisions boost treatment adherence by up to 15 percent and satisfaction by 10 to 20 percent. Research on enhanced consent processes indicates that veterans feel more empowered when risks and alternatives are clearly explained, with many opting for non-drug options like therapy. For our sea service community, often dealing with PTSD, chronic pain, and isolation, these protections honor their service by treating them as informed partners, not just patients.

H.R. 4837: Key Provisions and Veteran Support

H.R. 4837, introduced by Rep. Gus Bilirakis, updates VA Directive 1005 to require written informed consent for five high-risk medication categories: antipsychotics, stimulants, antidepressants, anxiolytics, and narcotics. Veterans must get clear, documented info on benefits, risks, alternatives (like therapy), and their right to refuse.

This bill enjoys broad backing from the veteran community. FRA members and other advocates echo this call, emphasizing the need for transparency in psychotropic prescribing. Nationally, with 17 veteran suicides daily and about 25 percent tied to recent prescriptions, enhanced consent rules are seen as a key tool to prevent tragedies.

Specific Benefits for Targeted Medications

H.R. 4837 targets drugs central to veteran care but linked to serious risks. Here's why written consent will make a real difference:

- **Antidepressants and Anxiolytics (e.g., SSRIs like sertraline, benzodiazepines like lorazepam):** FDA black-box warnings note an increased risk of suicidality, up to twofold in the first months of use, especially for younger veterans. Consent will highlight therapy options, potentially cutting med-related suicides by 5 to 10 percent and boosting non-drug adherence by up to 15 percent.
- **Antipsychotics (e.g., risperidone for PTSD-related psychosis):** These carry dependency and metabolic risks; informed veterans in related studies shifted to counseling up to 20 percent more often, reducing long-term side effects.
- **Stimulants (e.g., Adderall for ADHD):** Overuse leads to heart issues; clear risk talks could lower misuse by 10 to 15 percent, per VA data trends, freeing resources for holistic care.
- **Narcotics (expanding beyond long-term opioids):** Short-term use still risks addiction; the opioid directive already cut initiations by about 20 percent, extending this could save $50 to 100 million yearly in complications.

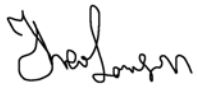
Overall, the bill could reach tens of thousands of veterans annually receiving these VA prescriptions, estimated at over 1 million psychotropic scripts yearly fostering 80 to 90 percent satisfaction in prescribing and easing the suicide burden.

CONCLUSION:

The Fleet Reserve Association urges swift Senate passage of H.R. 4837. This commonsense reform upholds the Nuremberg legacy, prevents tragedies like those in the opioid crisis, and delivers the transparent care our shipmates deserve. By passing this bill, Congress can save lives, strengthen VA trust, and affirm that no veteran faces treatment blindfolded.

FRA stands ready to work with the Committee on implementation and stands with you in service to those who served. Thank you for your leadership.

Respectfully submitted,



Theodosius Lawson
Director, Legislative Programs
Fleet Reserve Association

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GRUNT STYLE US 1776 GS THIS WE'LL DEFEND

FOUNDATION

STATEMENT FOR THE RECORD
SUBMITTED BY THE GRUNT STYLE FOUNDATION TO THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
'MEDICATION MANAGEMENT and POLY PHARMACY' HEARING
119TH CONGRESS, FIRST SESSION

December 3, 2025

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee:

The veteran suicide epidemic has taken the lives of more than 155,000 veterans since 2001. Since 2015, an average of 6,500 veterans have died by suicide each year, and according to the U.S. Department of Veterans Affairs (VA) 2024 Annual Suicide Report, 40% of these suicides occurred while veterans were under the care of the VA.

One of the most critical indicators of concern can be found in the suicide rates for 18-to-34 year-old veterans, which have more than doubled since 2001, a 102% increase. These unabated increases and tragic outcomes continue to frustrate veterans, families, advocates, experts, and lawmakers alike, in spite of the fact that the VA's spending on veteran mental health and suicide prevention has steadily increased, with the VA spending $16.6 billion on mental health in 2024, including $559 million on suicide prevention.

While the VA has made progress in some regards, this progress could be described as modest at best. Any meaningful efforts to impact the total numbers of veteran suicides or suicide rates will continue to falter without addressing the role of medications in these deaths.

It is our hope our testimony will:

- Provide a detailed understanding as to the role medications and VA prescribing practices are playing in veteran suicides;
- Provide substantive recommendations to make VA prescribing practices safer and smarter; thereby reducing veteran suicide rates by more than 25%;
- Present a hypothesis as to why this crisis has not been solved, in spite of the first Congressional hearings on medications and veteran suicides were first hosted more than fifteen years ago.

The Grunt Style Foundation thanks the Senate Veterans Affairs Committee for the invitation to submit testimony for this hearing, and we thank Chairman Moran and Ranking Member Blumenthal for taking a leadership role to oversee safer medication prescribing reforms VA-wide. We believe Congressional oversight will be required to ensure reforms are made, as there may be real or perceived guild-based conflicts of interest, which may impede the VA's Office of Mental Health from fixing this crisis on its own.

Finally, we are proud to thank Senator Sheehy for introducing the Written Consent Act in the US Senate, and to Representatives Gus Bilirakis, Jack Bergman and Keith Self for introducing HR 4837 in the House. We applaud every senator, Democratic, Republican or Independent alike, for supporting this common sense legislation – legislation which will make prescribing safer and smarter for clinicians, and veterans, and will save lives.

The Faces of Preventable Harm

On November 13, 2022, Hunter Whitley, a U.S. Marine Corps veteran, shot himself to death in his apartment while attending college at the University of Alabama. Hunter was 23 years old. A month before his death, Hunter was prescribed the antidepressant mirtazapine, but according to an investigation by the VA's Office of Inspector General (OIG), the mental health nurse practitioner who prescribed this drug to Hunter "did not discuss mirtazapine's boxed warning of increased risk of suicidal ideation or behavior for young adults."

On April 13, 2023, five months to the day after Hunter's death, Connor Brumfield, U.S. Army veteran, killed himself in his apartment while attending college at Montana Tech. Connor was 22 years old. Eight days – and eight pills, taken as prescribed – before his death, Connor visited his local VA clinic in Butte, Montana for a vision test. While there, Connor was screened for depression, where he tested positive for "moderate depression." This was Connor's first and only appointment, which lasted a little over an hour. The geriatric specialist nurse practitioner Connor met with diagnosed him with a psychiatric disorder, depression, and prescribed the antidepressant bupropion (Wellbutrin) to treat it. This in spite of Connor having a mild traumatic brain injury (TBI), Connor was prescribed the drug, Wellbutrin, which is also contraindicated for patients with TBIs.

As was the case in Hunter Whitley's death, a legal review of Connor's records found that the VA failed to discuss the Food and Drug Administration's (FDA) Black Box Warning to monitor for suicidal thoughts and behaviors associated with the use of Wellbutrin for young adults under the age of 24. Each of the antidepressants prescribed to Hunter and Connor had this warning for the 18-24 year-old age group:

"***WARNING: SUICIDAL THOUGHTS AND BEHAVIORS:*** *Increased risk of suicidal thoughts and behavior in pediatric and young adult patients taking antidepressants.*"

Systemic Failures in VA Medication Safety Practices

Hunter and Connor's suicides are just two tragedies, which serve as the tragic represention of systemic issues within the VA's Office of Mental Health (OMH) and the VA mental health care system: the overprescribing and unsafe prescribing of psychotropic medications to our Nation's veterans. These failures are all solvable, but before the issues can be meaningfully addressed, they must be acknowledged:

1. **Overprescription of Psychotropic Medications to Veterans Under VA Care**

Problem:

Nearly 70% of veterans under VA care are prescribed psychotropic medications, 3.5x the rate of the civilian population; and more than 28% of veterans under VA care are prescribed antidepressants, a rate more than double of their civilian counterparts. Through one lens, these prescription rates might be seen as the success indicators of a health system providing an unprecedented level of care, treatment and engagement with a patient population. This would be a great thing, if many of these evidence based pharmacological mental health treatments were as safe and effective as we'd been told. As such, with prescription rates unprecedented in any other patient population, we should not only expect, but demand to see veteran suicide rates dropping over time precipitously for a population where 7 in 10 patients are prescribed a pharmacological mental health treatment modality.

Unfortunately, and as was presented in the 2010 House Veterans Affairs Commitee Hearing: *Exploring the Relationship Between Medications and Veteran Suicides*, many of these medications may be involved in a doubling or tripling for the risk of suicides or attempts. An example of VA data cited during the hearing: A retrospective study of "887,000 VA patients treated for depression" "found that completed suicide rates were approximately twice the base rate following antidepressant starts in VA clinical settings." (Valenstein, et al. 2009).

A litany of more recent studies have continued to show the same, to include findings of a "2.5x higher risk for suicide attempts when taking antidepressants compared to placebo" (Hengartner, et al 2019).

Solution:

Deploy the VA Whole Health Program as the VA's leader in mental health programming, and look to alternative modalities in lieu of treatments that have been found to, or have the potential to increase the risk of suicidal thoughts, behaviors, attempts and completed suicides.

The VA OMH's paradigm of care is centered almost exclusively around pharmacologically focused solutions, and this has largely been the approach since former leaders of the American Psychiatric Association (APA) began leading VA mental health programming, as early as 1946.

When the VA has one specialty, psychiatry, leading VA mental health programming with a one size fits all specialty approach to mental health, this paradigm of care will and has become the dominant approach to VA mental health care. It is for these reasons, among others, that we see the unprecedented prescription rates, and subsequent adverse events we see occurring to the VA patient population everyday, and this should drive us to deploy a more holistic approach to health and mental health at the VA.

By properly resourcing the VA Whole Health Program and by placing the leaders of this program at the top of the VA's mental health organizational chart, we will see a complete transformation in VA mental health. A transformation that it will be patient-led, and

empowered by Whole Health specialists trained to help veterans reach their health goals throughout their lifetimes.

2. **Poly Pharma & Multi-Drug Cocktails**

Problem:

"Patients prescribed more than 3 central nervous system (CNS) acting drugs at a time results in diminishing patient outcomes." – Quote from VA mental health leader

As the Wall Street Journal detailed in their July 31, 2025 investigative report: *'Combat Cocktail': How America Overmedicates Veterans*, the VA continues to have a problem with prescribing multi-drug cocktails to veterans under their care. One of the veterans the Journal report profiles is Army veteran Scott Griffin, who at times was prescribed nine CNS medications at once, and how this veterans' foray into poly pharma resulted in him putting a gun into his mouth.

When surveying veterans, one can readily find an endless list of stories from patients who were prescribed five, ten, and even fifteen or more medications at a time – in the case of this writer, six at a time.

These examples of poly pharma are indefensible, as there are no studies to show that the prescribing of three, five, ten or more CNS medications at once results in better patient outcomes. Instead we consistently find the inverse.

A 2016, associative study of Iraq and Afghanistan veterans who experienced polypharma under VA care, found that "Suicide-related behavior and drug/alcohol overdose were significantly associated with CNS polypharmacy." (Collett et al, 2016).

Solution:

While the VA should be applauded for their efforts towards reducing polypharma rates VA wide, two actions can be taken to address polypharma concerns:

A. Retrain Prescribers and Mental Health Clinicians on Adverse Medication Events and Akathisia: In early January of 2022, two veterans treated by the Chico VA Outpatient Clinic shot and killed their mothers within 48 hours of each other. Both were told by clinic staff they could not be seen immediately and both had been prescribed several CNS medications at a time, as was detailed in a ProPublica series on these tragedies.

   Within the pages of the VA's OIG report regarding Navy veteran Julia Larsen's case, one can find a horrific prescribing cascade of medications, many of which are known to cause psychosis, mania, agitation and other adverse events. According to the OIG report, early in Ms. Larsen's care, the report shows she'd been prescribed an antidepressant. Not long after, she was prescribed a stimulant. Soon after, Ms. Larsen was institutionalized, and after a psychiatrist issued her a bi-polar diagnosis, which she refused, her poly pharma medication cascade increased dramatically. The tragedies, which occurred to these two families were preventable – had the VA properly staffed and trained the members

of their clinic, and had the clinicians been able to properly identify adverse medication events occurring in both veterans.

B. Change VA's Definition of "Polypharma": to align with populations outside of the VA. If VA mental health leaders are willing to acknowledge that more than three CNS medications prescribed at a time results in diminishing outcomes, one would think that three medications should constitute "polypharma" within the VA, not five medications at a time as is currently recognized.

3. Systemic VA Failures to Provide and Document Informed Consent

Problem:

The same day the VA's OIG published their findings on Hunter Whitley's death, it also published the results of a "Mental Health Inspection of the VA Augusta Health Care System in Georgia," which found that 27% of veteran electronic health records (EHRs) did not show any evidence that prescribers discussed the risks and benefits of medication treatments with their patients.

Six months later, on March 5, 2025, the VA OIG published results of its "Mental Health Inspection of the VA Central Western Massachusetts Healthcare System." Investigators found that 30% of EHRs did not show documentation of discussions with patients of "risks and benefits of medication treatment."

Three months later, on June 6 and June 26, 2025 respectively, the VA OIG published reports of its Mental Health Inspections of the VA Philadelphia Healthcare System in Pennsylvania and the VA Salem Health System in Virginia. In both cases the VA investigators found that "most EHRs did not have evidence of required discussions with veterans on the risks and benefits of prescribed medications."

The VA OIG reports, accompanied with the personal stories of Hunter Whitley, Connor Brumfield, and countless other veterans under VA care, tells a story of a systemic failure by the VA to provide informed consent to their patients, and of violating 38 CFR 17.32, the federal law outlining informed consent practices for all treatments to veterans under VA care.

Solution:

Written Informed Consent Act: In August of 2025, U.S. Representatives Gus Bilirakis, Jack Bergman and Keith Self introduced the Written Consent Act in the US House. On December 2, 2025, Senator Tim Sheehy introduced companion legislation in the U.S. Senate.

Though less than half a page long, the Written Consent Act will save lives. It does so by expanding to several classes of psychiatric drugs, the written informed consent policy that currently exists in the VA for the prescribing of opiates for long-term pain management, a policy established under the Obama administration in 2014 and expanded and updated under the Trump administration in 2020.

The bill will require prescribers to obtain written informed consent for other classes of high-risk medications, including antipsychotics, antidepressants, anxiolytics

(benzodiazepines), stimulants and narcotics. Many of the drugs in these classes already carry black box warnings for suicidal thoughts and behaviors, and the inserts regularly describe other possible serious adverse drug events. For U.S. veterans, passage of the Written Informed Consent Act is one of the most significant lifesaving actions lawmakers can take.

4. **Systemic Medication Safety Training Failures**:

Problem:

VA clinicians are currently incapable of providing informed consent to patients, as have not been properly trained on common adverse psychotropic medication events, such as suicide risk profiles; dependency and withdrawal issues related to antidepressants and other psychotropics; Post-SSRI Sexual Dysfunction (PSSD), etc.

June of 2025: Primary care doctor informs veteran patient that antidepressants treat depression by correcting a chemical imbalance, similar to the way insulin treats diabetics. This claim is false, and is not supported by scientific studies. Sadly, this is the result of misinformation provided to doctors in medical schools, a claim which was disproven by a meta-analysis study by Moncrieff, et al in 2022.

August 2025: Psychiatrist suggests antidepressant as first treatment option for veteran, without offering psychotherapy or other options first. The patient informs the psychiatrist that they experienced "horrific year-long withdrawal from an SSRI," and the psychiatrist replies to the patient's antidepressant withdrawal experience: "I've never heard of that before."

Solution:

Host annual VA-wide training standdown for all VA prescribers and mental health counselors on adverse medication events and akathisia. On November 5, 2025, the Lansing Area Veterans Coalition, the Battle Creek VA Medical Center, the Michigan Veterans Affairs Agency, the Grunt Style Foundation, MISSD.co, the Michigan Commanders Group, Medicating Normal and others partnered with Central Michigan University to host a training that provided 4 CEU/CME credits to attendees at the Michigan State Capitol. MISSD.co, along with experts in the field of mental health hosted an "Akathisia 101" training; a film screening of the documentary Medicating Normal was hosted, along with a post-screening panel discussion with experts, surviving families and veterans with lived experiences.

This training could be deployed throughout the VA, and would save lives by simply educating prescribers and counselors on the signs and symptoms of adverse medication events, and would also help reduce cases of polypharma.

5. **Data Release and Public Disclosure of the VA Overprescribing Epidemic:** Psychotropic medications never mentioned in any of the VA's past annual suicide reports

Problem:

In the history of the VA's Annual Suicide Reports, there has never been a single mention of "psychiatric drug", "psychotropic", "antidepressant", "antipsychotic", "stimulant",

"anxiolytic", or any psychiatric drug class or brand name in the role of veteran suicides. The only example that can be found is in the 2024 VA suicide Report, which discusses a 29.2% increase in suicide rates for veterans with "Sedative Use Disorder." "Benzodiazepines", are used in the report as an example of medications related to Sedative Use Disorder.

This is troubling, as the report fails to discuss the VA's efforts since 2012 to reduce the number of veterans inappropriately prescribed benzodiazepines long-term for the treatment of post-traumatic stress disorder, from 29% in 2012, to less than 7% prescribed today. This is alarming, because tapering patients off of benzodiazepines is known to be dangerous, as some patients can take years tapering from their medication, and in some cases patients are trapped on these drugs permanently. So rather than discussing this issue through the lens of inappropriately prescribed benzodiazepines – veterans are instead victim blamed with another substance use disorder label.

Solution:

Publicly release all VA prescribing data: prescription rates, polypharma rates, duration of prescriptions, toxicology reporting, etc. All of this data should be made public on the VA's website, and an entire section of the VA's annual suicide reports should be dedicated to the discussion of medications and prescribing practices through the lens of suicide risk.

If this mental health treatment modality used for 7 in 10 veterans under VA care was a statistic VA leaders were proud of, we would also expect to see these prescription rates and outcomes championed and discussed throughout the VA's annual suicide reports – and not being forced into the public realm through Freedom of Information Act Requests. Rather than being a source of pride within VA walls, these statistics and ensuing OIG investigations appear to be a source of liability and concern for the VA, and this issue is one that can be easily addressed through public disclosures.

While one should expect any one of the concerns outlined above to result in adverse outcomes to our Nation's veterans; but **combined we conservatively estimate these practices may contribute to 25% of all veteran suicides.**

History of VA OMH Medication Oversight and Legislative Actions

The role of medications in veteran suicides has been an issue of exploration by Congress since at least 2010, when the House Veterans Affairs Committee held hearings: *Exploring the Relationship Between Medication and Veteran Suicide*.

Dr. Annelle Primm, of the American Psychiatric Association testified that the APA would ***"urge caution against hasty legislative actions that might limit access to these vital treatments***. The ***existing evidence does not conclusively support a direct causal relationship between antidepressants and increased suicide risk.***" The VA's message was largely the same, in that they did not want to stigmatize mental health medications for veterans who needed them.

Unfortunately, this would be just the first publicly identifiable example of VA mental health leaders from the VA's Office of Mental Health working alongside the APA to deter Congress from investigating this issue, or introducing legislation to solve unsafe prescribing practices at the VA.

In 2016, the HVAC held a bill markup hearing where draft written consent legislation by Congresswoman Julia Brownley was debated. The legislation was to "direct the Secretary of Veterans Affairs to establish a list of drugs that require an increased level of informed consent."

Again, the VA and APA both testified against the draft legislation, alongside another group who'd received a great deal of funding and support from pharmaceutical companies. OMH leaders claimed informed consent concerns were already being addressed by 38 CFR 17.32, VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures. The VA claimed that "No medical treatment or procedure can be provided in VHA to any patient without the patient's full and informed consent first having been obtained and documented. Providers are required to appropriately document the informed consent in the patients' electronic health records." As was previously discussed, VA OIG inspections and investigations have continued to find informed consent discussions are not occurring, and informed consent discussions are not even being documented in "many" electronic health records VA wide.

The VA testified that the legislation could "significantly impede VA's ability to provide prompt care," and that it "would add an undue time burden on Veterans and their care providers."

Representative Brownley's draft bill was never introduced.

In 2021, another written consent bill was drafted, and again internal communications show the APA working to block the legislation.

In 2025, HR 4837, the Written Consent Act was finally introduced by Representatives Bilirakis, Bergman and Self. Since the legislation was introduced, veteran advocates have learned that OMH leaders have met with multiple legislative offices, again deterring representatives and senators from moving forward with written consent legislation for psychotropic medications.

The question that must be asked is why? Why does the APA and VA OMH work so closely on proposed legislation that would provide greater information and safety protocols for veteran patients prescribed high risk medications? It appears the reason could be that in many cases, at minimum they may be the same people leading the decision making and that VA mental health leaders may be prioritizing the APAs legislative priorities over safety concerns of veterans under VA care.

Dr. Tamara Campbell: is the current VA Chief of Mental Health, Executive Director of VA's OMH. At the same time, she also currently serves as the "APA Representative" to the Ohio Psychiatric Physicians Association (the state level chapter of the APA). Prior to this, Dr. Campbell was the president of the Ohio Psychiatric Physicians Association.

Dr. Marsden McGuire: Between 2017 and October of 2025, Dr. McGuire served as the Director, Continuum of Care and General Mental Health in OMH, and as the former Acting Assistant Deputy Under Secretary for Health for Patient Care Services from July 2018 to February 2019. While serving as part of the OMH's leadership team, Dr. McGuire also served as the President of the Maryland Psychiatric Society (Maryland's APA state chapter) from 2019 to 2020.

Dr. Ilse Wiechers – Acting Deputy Assistant Under Secretary for Health for Patient Care Services, Deputy Executive Director, VA Office of Mental Health and OMH's legislative policy lead, also served as one of four lead editors of "A Psychiatrists Guide to Advocacy," a book she co-edited alongside the former CEO of the APA, the former head of federal relations and advocacy for the APA, and another psychiatrist from the Uniformed Services University.

This textbook trains psychiatrists how to use motivational interviewing to influence others; how to take on leadership positions in the state and federal government and to support "good policies" and laws, and to "block bad policies" and laws, among other actions.

In the case of the Written Consent Act, it seems this training manual that a senior leader in the Veterans Health Administration helped to create, is now being used against the seventeen national veterans organizations supporting legislation to make prescribing practices safer at the VA.

In the past two years, VA leaders have been made acutely aware of this ongoing crisis, yet no meaningful action has been taken. In spite of briefings by the Grunt Style Foundation being provided to former VA Secretary McDonough, meetings with former Under Secretary of Health Elnahal, as well as with VA's former Chief Medical Officer, Dr. Erica Scavella, now Assistant Under Secretary for Health, and multiple meetings between Dr. Ilse Wiechers, advocates and mental health leaders from the Michigan Veterans Affairs Agency (MVAA).

We believe the primary reason for this is not only because of financial conflicts of the drug industry and their influence over Congress and the VA, but also intellectual – and what are at minimum intellectual conflicts of interests between leaders in the VA's Office of Mental Health (psychiatry) and the American Psychiatric Association.

Conflicts of Interest: VA Mental Health Leaders and the APA

We hope the overview provided above can be helpful in shaping future oversight hearings into the VA's overprescribing concerns and prescribing practices, as these issues detailed here are merely the wavetops, and do not fully encapsulate the current beneath the surface, but we look forward to continuing our work with the Committee to make meaningful reforms to provide greater safety and improved outcomes to veterans under the VA's care.

DRAFT BILL – The Written Informed Consent Act. *To direct VA to expand VHA Directive 1005 regarding informed consent to include additional categories of long-term high-risk medications.*

The Grunt Style Foundation applauds Senator Tim Sheehy for introducing legislation to expand the May 2020, VHA issued Directive 1005 to require written informed consent for long-term opioid therapy. The simplicity of the Written Consent Act should also be applauded, for making small changes to expand written consent for antidepressants, anxiolytics, antipsychotics, stimulants and narcotics, which will result in greatly increased outcomes for veterans prescribed psychotropic medications.

We thank all senators and representatives who support this legislation, and we look forward to ensuring all veterans are provided informed consent, and that they understand not only the risks of various treatments, but alternative modalities that may help veterans who may not benefit from many commonly prescribed psychotropic medications.

Conclusion

The Grunt Style Foundation sincerely appreciates the opportunity to express our views before this Committee. Please find the summary below of the issues discussed, and suggested courses of action to make prescribing practices safer and smarter at the U.S. Department of Veterans Affairs:

1. Overprescribing of Psychotropic Medications in VA Care

- Nearly **70% of veterans under VA care receive psychotropic medications**, **3.5×** the civilian rate.
- **Antidepressant prescribing exceeds civilian rates by more than double**, yet suicide rates have *not* fallen proportionately—indicating that high-volume prescribing has **not translated into improved outcomes**.
- Evidence cited in congressional hearings shows antidepressants can **double or triple suicide and attempt risk in some populations**, especially young adults.

Core Issue: The VA treatment model is heavily pharmacology-first, psychiatry-led, and slow to adopt alternative modalities even when medications show limited or adverse impact.
Recommended Reform: Empower Whole Health as the default or co-equal model of care to reduce inappropriate reliance on pharmaceuticals and increase non-pharmacological support pathways.

2. Polypharmacy & Multi-Drug "Combat Cocktails"

- VA clinicians frequently prescribe **3–10+ simultaneous CNS-acting drugs**, despite little evidence that multi-drug cocktails improve outcomes.
- At least one study of Iraq/Afghanistan veterans linked polypharmacy to **significantly higher rates of suicide and overdose**.
- Veterans frequently report cascaded medications—added to treat side-effects caused by previous medications—rather than deprescribing or root-cause review.

Recommended Reform:

- Mandatory national retraining for prescribers on polypharmacy risk, akathisia, and adverse medication recognition.
- Redefine *polypharmacy* as **3 or more CNS drugs**, not 5.

3. Informed Consent Failures: Legal Requirement Not Followed

VA OIG inspections across multiple facilities found that 27–30% of electronic patient records lacked evidence of required discussions on risks/benefits of prescribed psychiatric medications, meaning veterans are routinely medicated without legally compliant informed consent.

The consequences are visible in preventable deaths like Hunter Whitley (23) and Connor Brumfield (22)—both prescribed antidepressants carrying black-box warnings for young adults without discussion of suicide-risk warnings or TBI contraindications.

Recommended Reform:

- **Pass the Written Informed Consent Act.** Requires *written* consent for antidepressants, anxiolytics, antipsychotics, stimulants & narcotics—just as VA already requires for long-term opioids. *Half-page legislation, high-impact, immediately implementable.*

4. Training Deficits & Outdated Beliefs about Antidepressants

Many VA clinicians still report no knowledge of withdrawal syndromes, akathisia, or black-box risk profiles. Some believe disproven serotonin-imbalance theories when counseling patients. This makes informed consent impossible in practice.

Recommended Reform:

- Annual *VA-wide* adverse-events and akathisia training.
- Required competencies for prescribers prior to independent authority.

5. Transparency Failure: VA Suicide Reports Never Discuss Medication Role

Despite being the dominant treatment pathway for **7 in 10 veterans**, VA suicide reports have **never included discussion of specific psychiatric drug classes**, prescribing patterns, or medication-related suicide risk.

Recommended Reform:

- Public reporting of psychotropic prescribing, polypharmacy, tapering, toxicology outcomes, and suicide-related medication correlations. If the VA is confident in psychotropic efficacy and safety, transparency should be a point of pride—not concealed.

The Grunt Style Foundation appreciates the opportunity to present this testimony. We stand ready to assist the Committee as it considers the actions required to address unsafe prescribing practices and improve the safety of veterans across the VA system.

Biography

Derek Blumke is the Veteran Impact Fellow at the Grunt Style Foundation. In this role, he leads the *War Cry for Change* initiative, which focuses on reducing the overprescribing of psychotropic medications to veterans. His work centers on educating the public about the risks associated with inappropriate prescribing and advancing reforms that promote safer, better-informed mental health care for veterans.

Blumke is a veteran of the United States Air Force and deployed with AC-130H Spectre Gunships. He co-founded Student Veterans of America and served as its president. He later became a Founding Committee Member of the National Action Alliance for Suicide Prevention, and a founding director of the VA's VITAL Initiative, a national mental health program for VA. He has also served as an editor for Veterans and Military Families at the mental health website *Mad in America*.

Across his portfolio, Blumke advocates for policy changes that strengthen patient-informed consent, establish clearer prescribing guidelines, and improve transparency in VA prescribing and toxicology data. His goal is to reduce veteran suicide by advancing a more responsible and evidence-driven approach to mental health treatment.

The Honorable David J. Shulkin MD

Ninth Secretary, US Department of Veterans Affairs

601 Pennsylvania Ave, NW

1007

Washington, DC 2004

December 1, 2025

Submitted as Written Testimony to the U.S. Senate Veterans' Affairs Committee:

I am submitting this written submission below that is from my blog post that was published on written informed consent in June of this year. I am deeply appreciative of your time and effort being spent to consider this important issue for our nation's heroes.

Every day, veterans are prescribed medications that may increase their likelihood of worsening outcomes, suicide, self-harm, or addiction. Too often, this happens without veterans being fully informed of these risks. To improve pharmaceutical safety, the VA should standardize the practice of Written Informed Consent (WIC) for all high risk medications to help reduce the risk of inappropriate prescribing and its adverse consequences.

Written Informed Consent is a process where a veteran (or their caregiver) receives a summary of the risks, benefits, and alternative treatments and is given the chance to ask questions prior to having the prescription filled. This approach represents a cornerstone of ethical medical practice that empowers veterans and fundamentally can improve health outcomes.

To understand the urgency of this issue, it is critical to understand the threat posed to these veterans and those who care for them. The risks associated with opioids (addiction, overdoses, and erratic behaviors) are generally understood. However, benzodiazepines and other high-risk medications are far less understood. Since 2010, research has shown that there are significant risks associated with benzodiazepines for the treatment of PTSD. This includes risks such as increased

aggression, disinhibition, and worsening of substance abuse. These risks alone would warrant the maximum level of informed consent, but the dangers extend even further. A veteran with PTSD is 60% more likely than a veteran without PTSD to be arrested for a violent crime. Additionally, a veteran co-prescribed benzodiazepines and opioids is more likely to die prematurely from multiple causes and specifically from suicide. Furthermore, a veteran taking benzodiazepines for PTSD may worsen their symptoms and interfere with cognitive therapies.

The VA currently employs written informed consent for some medications but has not applied this practice consistently across all high risk drugs. VHA's Handbook 1004.01, and VHA Directive 1005 requires written informed consent for long-term opioid therapy, defined as opioid use for 90 or more days to treat non-cancer pain. VA has demonstrated strong results with this practice. From 2012 to 2023, as part of the VA's Opioid Safety Initiative (OSI), which employed written informed consent, reduced opioid prescriptions by 67%. However, even with this limited scope requirement for informed consent across the VA, a Government Accountability Office study found that among 53 veterans prescribed long-term opioid therapy, 12 veterans did not have the required written informed consent, indicating gaps in adherence to this policy. More significantly, the VA's current written informed consent requirements do not extend to benzodiazepines and other high-risk psychotropic medications, despite their well-documented dangers for veterans with PTSD.

In Wisconsin however, broad use of WIC for high risk medications has been in place at VA for years and has resulted in significant reductions of high-risk medications. This practice demonstrates that WIC could be standardized across the entire VA.

The value of written informed consent for high-risk medications extends across multiple dimensions of healthcare quality and patient safety. Written consent ensures veterans are provided with the information necessary to make truly informed decisions about their care. When veterans understand the full spectrum of potential outcomes, they can weigh these against their personal values, life circumstances, and treatment goals. This leads to treatment decisions that are not only medically sound but also personally meaningful and sustainable.

From a clinical perspective, the informed consent process creates opportunities to enhance VA providers to thoroughly review the evidence base for their prescribing decisions, potentially identifying safer alternatives or non-pharmacological interventions that might be equally effective. This systematic review process can reduce prescribing errors and inappropriate medication use, while the documentation requirement creates a clear record of the decision-making process that can inform future care decisions.

Written informed consent also serves as a powerful risk mitigation tool. By ensuring that patients understand potential adverse effects, the process can improve medication adherence and monitoring of side effects. Veterans who are aware of warning signs are more likely to seek timely medical attention when problems arise, potentially preventing serious complications. The process also builds trust between veterans and their healthcare providers. When clinicians take the time to thoroughly explain treatment options and genuinely solicit patient input, it demonstrates a collaborative approach to care can that can lead to better communication, improved treatment adherence, and more positive health outcomes overall. For veterans who may have experienced trauma or injury in military service, shared decision making can have profound psychological benefits that extend well beyond the specific medication decision at hand.

Medications, especially those that affect the brain, come with risks and dangers that are known even when they are not fully understood. Veterans deserve to fully understand these risks before choosing a course of treatment. Implementing standardized Written Informed Consent for high-risk medications is both a moral imperative and a proven strategy for improving veteran health outcomes.

Thank your for your consideration of this matter.

Sincerely,

David Shulkin MD

David Shulkin MD

Jewish War Veterans of the USA (JWV)

Kenneth Greenberg, National Executive Director

Statement for the Record

Senate Committee on Veterans Affairs Hearing

H.R. 4837 - Written Informed Consent Act

December 3, 2025

Overview – JWV Summary Support for the Written Informed Consent Act

JWV supports H.R. 4837, the Written Informed Consent Act, which improves veterans' understanding of the risks associated with certain pharmaceuticals to address persistent high rates of veteran suicides. Specifically, the bill requires that veterans provide written informed consent for Black Box medications included in the VA formulary. The U.S. Food and Drug Administration requires Black Box warnings for medicines with a high potential for serious safety risks. Often, these warnings communicate rare but dangerous side effects or essential instructions for the safe use of the drug.

Many of the Black Box medications are prescribed to veterans, and suicidal ideation is commonly one of their primary side effects. VHA Handbook states: "Veterans must be informed of the side effects and the treatment options for medications and treatments they are prescribed." The Veterans' Written Informed Act improves the education veterans receive about certain risks associated with Black Box medications by requiring all veterans to provide written informed consent that they understand the dangers of these drugs.

Background

On August 1, 2025, U.S. Representatives Bilirakis, Bergman, and Self introduced H.R. 4837, known as the "Written Informed Consent Act." This legislative proposal aims to improve and expand the Veterans Health Administration's (VHA) existing informed consent policies to cover a broader range of medications. As the name indicates, the bill requires explicit written informed consent for certain classes of drugs that are commonly used to treat various conditions among veterans. Currently, the VHA Directive 1005, established in May 2020, mandates informed consent specifically for long-term opioid therapy. The new Bill seeks to update and broaden this directive to include additional psychotropic and potentially life-altering medications.

Provisions

The Bill directs the Secretary of Veterans Affairs to modify VHA Directive 1005 to ensure that informed consent policies are applied to a new set of medications.

Medications: The Bill identifies specific categories of drugs that will require written informed consent: - Antipsychotics - Stimulants - Antidepressants - Anxiolytics - Narcotics

Impact: The legislation underscores the importance of transparency and ensures that veterans are fully informed before consenting to potentially powerful medications, thus promoting patient autonomy and safety.

The bill reflects a critical shift towards more comprehensive care protocols within the VHA, emphasizing the importance of ethical medical practices and informed patient decision-making.

The main stakeholders affected by H.R. 4837 include veterans receiving care, healthcare providers within the Veterans Health Administration, and veterans' families.

Veterans receiving VHA care will experience greater autonomy and safety in their treatment. They will be better informed about the benefits, side effects, and potential risks of a broader range of medications, contributing to their overall well-being.

Healthcare Providers: VHA medical professionals, including doctors, nurses, and pharmacists, will need to adapt to the updated consent procedures, which may entail additional administrative responsibilities and training to ensure effective communication.

Veterans' Families: Families and caregivers will be more involved in decision-making, providing additional support and ensuring veterans have the information needed to make well-informed decisions about their medication.

For healthcare providers and policy analysts, this bill presents an opportunity to review and improve current policies related to patient consent, ensuring adherence to best practices in patient care and ethical transparency.

Expanded and Updated Directive

The most critical aspect of H.R. 4837 lies in its clear articulation of which medications fall under the expanded informed consent directive. Understanding these key points helps clarify the bill's intentions:

Informed Consent Directive: Initially focused solely on long-term opioid therapy, the updated directive will now include:

- Antipsychotic medications are used in managing psychiatric conditions such as schizophrenia.
- Stimulant drugs are often prescribed for ADHD or narcolepsy.
- Antidepressants are utilized in the treatment of depression and anxiety disorders.
- Anxiolytics, prescribed for anxiety management.
- Narcotic medications, known for pain relief but carrying a risk of addiction.

These updates aim to ensure that patients fully comprehend their treatment options, potential

side effects, and any associated risks. Such knowledge empowers patients to make informed decisions that align with their health priorities.

The Written Informed Consent Act highlights the ever-increasing need for transparency in medical practices, particularly concerning medications that have a profound impact on a patient's mental and physical health. Here's why this bill is important:

Enhancing Patient Rights: It reinforces the commitment to ensuring veterans are active participants in their healthcare decisions, thereby promoting dignity and respect in medical care.

- **Addressing Safety Concerns**: Given the potential side effects and dependencies associated with the new list of medications, informed consent is a critical step in preventing adverse outcomes and improving safety.
- **Legal and Ethical Implications**: By aligning with ethical medical practices, the Bill ensures compliance with broader legal standards, decreasing the likelihood of malpractice and legal disputes.
- **Broader Health Initiatives**: The Bill reflects broader health initiatives aiming for holistic and integrative care approaches, fostering better health outcomes and veteran satisfaction with their healthcare.

Conclusion

H.R. 4837, the Written Informed Consent Act, represents a substantial advancement in healthcare policies impacting veterans. Mandating written informed consent for a broader array of medications ensures that veterans can engage in their treatment processes with full knowledge of their options. For stakeholders, staying informed about this legislative development is critical. Those in the healthcare sector should prepare for procedural updates by educating staff and developing comprehensive strategies to integrate these changes into everyday practice. JWV urges the Senate and House Veterans Affairs Committees to pass the bill and to seek swift floor action in both chambers.

Please refer questions or comments to the JWV National Executive Director at kgreenberg@jwv.org.

JWV thanks Legal Codify Publishing for the use of its article dated August 28, 2025, in this statement.

STATEMENT OF

ANTHONY HAYES, CHIEF GROWTH OFFICER

NAVIS CLINICAL LABORATORIES

STATEMENT FOR THE RECORD

UNITED STATES SENATE

COMMITTEE ON VETERANS' AFFAIRS

The issue of polypharmacy is personal to me. A close family member who served our country struggled with PTSD and was prescribed multiple medications from different clinicians. No one had complete visibility into the combinations or interactions, and over time, that lack of clarity contributed to a decline that ended in tragedy. Sadly, what happened in my family mirrors what so many veterans and their families are forced to navigate every day: too many medications, too many prescribers, and not enough real visibility into what is actively being metabolized in a veteran's body.

The Wall Street Journal's "Combat Cocktail" article captured this exact challenge. Veterans regularly receive medications for PTSD, chronic pain, sleep disturbances, depression, and metabolic disease from multiple clinicians across multiple care settings. These regimens often overlap, interact, and shift over time, creating complexity that no single provider can reliably track. National data reinforce the seriousness of the problem: up to 30 percent of hospital admissions in older adults are medication-related1, 1.5 million emergency-department visits each year are tied to adverse drug events[2], and roughly 16 percent of all 30-day readmissions are medication-related[3]. About 40 percent of these events are preventable[4].

This is even more pronounced among veterans. In 2019, VA data showed that nearly 60 percent of veterans with PTSD, more than 520,000 people, were taking two or more CNS medications simultaneously, and roughly 7 percent were on five or more[6]. These combinations have been associated in VA and related studies with higher risks of overdose, destabilization, and suicide-related behavior, particularly when psychoactive medications are prescribed across different clinics without complete cross-visibility.

We see these challenges every day. Earlier this year, we tested a veteran in his early thirties who had been struggling with worsening panic, depression, and emotional volatility. His chart listed two behavioral-health medications, and his toxicology screen confirmed two. His exposure profile told a different story. He was actually taking five psychoactive medications, prescribed by multiple clinicians, all interacting in ways no single provider could see. Once his care team had accurate exposure data, they adjusted his regimen. His symptoms stabilized. His family said they finally got him back.

We supported another veteran, an older Army retiree, who was unknowingly taking two different blood thinners from two other clinics. He followed the instructions exactly. His chart didn't reflect the duplication. His toxicology panel didn't detect it. His exposure test did. He had been slowly bleeding internally, and the accurate medication profile allowed his clinicians to intervene immediately. One corrected prescription changed everything.

These are not rare events; they are structural consequences of a system in which clinicians lack a reliable way to verify what a veteran is actually taking. Across studies and in our experience, approximately half of patients have discrepancies[7] between what is prescribed and what is actually in their system. Inaccurate medication lists have been repeatedly identified as a significant safety issue, and recent oversight reports have raised concerns about unresolved "active medication list issues" within the VA's EHR transition. When combined with frequent medication changes and complex behavioral health needs, the risk compounds rapidly.

The Navis polypharmacy test was purpose-built to address these gaps. It detects more than 120 prescription and over-the-counter medications and supplements from a single noninvasive sample. It aligns drug-drug interactions to the patient's diagnoses for clinical relevance. This is not toxicology, and it is not a behavioral-monitoring tool. It is a clinical diagnostic tool that provides objective clarity about what medications are actually present, whether they are interacting, and whether the list in the chart aligns with reality.

The most effective workflow begins with establishing a baseline upon a veteran's entry into care, followed by retesting 7 to 14 days after discharge. This window is when many adverse events occur, partly because approximately 70 percent of patients leave the hospital with at least one new medication[10]. Hospital teams commonly spend 45 minutes or more interviewing a patient to assemble a medication list. Yet studies show that more than half, and often as much as 65 to 95 percent, of these lists are inaccurate[8] at intake. Objective exposure data allows clinicians to reconcile the record, correct duplications or omissions, identify interactions early, and intervene before harm occurs. We interface directly with the VA's electronic health record system, so results flow into the veteran's chart and are visible to every provider involved in the patient's care.

In outpatient behavioral-health settings, quarterly testing has proven especially valuable for high-risk veterans who see multiple specialists and experience frequent medication adjustments. Regular monitoring provides a current picture of what the veteran is actively metabolizing, reduces cross-prescriber blind spots, and supports safer, better-coordinated treatment decisions. These benefits also extend to veterans with Alzheimer's or cognitive impairment, individuals with significant chronic-disease burdens, and anyone struggling with medication complexity or polypharmacy-related risks.

The challenges described in the "Combat Cocktail" article are deeply concerning, but they are not inevitable. They are the result of limited visibility, which appropriate diagnostic tools and workflows can address. Veterans deserve coordinated, informed, and proactive medication management. Objective exposure testing provides clinicians with clarity when it matters most.

Thank you for the opportunity to provide this testimony. I stand ready to support the Committee and the Department of Veterans Affairs with any additional data, reports, or resources you may need.

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Statement for the Record

Submitted to the United States Senate Committee on Veterans' Affairs
Hearing: **"Medication Management in VA Healthcare"**
December 3, 2025

Submitted by:
David Zakariaie, Chief Executive Officer
Senseye, Inc.
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Austin, Texas

Introduction

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee: Thank you for the opportunity to submit this Statement for the Record for the Committee's hearing on "Medication Management in VA Healthcare." Senseye shares the Committee's commitment to strengthening the clinical safety, precision, and effectiveness of mental and behavioral health care provided to Veterans and has developed the first objective mental health-specific diagnostic technology that will aid VA Healthcare providers in diagnosing and treating its Veterans more effectively and efficiently.

Under current Standard of Care procedures, mental health disorders are diagnosed without objective measurements, the functional equivalent of trying to diagnose a heart attack without an EKG or diabetes without an A1C blood test. Clinicians are frustrated that current tools (e.g., PHQ-9, CAPS-5) are subjective, time-consuming, and often inaccurate. Published studies have shown that misdiagnosis rates for some conditions, particularly PTSD, are as high as 90% [1–5], frequently driving well-intentioned, yet ineffective treatment, which can result in unnecessary healthcare costs. Even when correctly diagnosed, measuring the effectiveness of treatments for PTSD, depression, or anxiety in clinical practice relies on self-report questionnaires that can be influenced by variations in scoring and interpretation. Senseye's mission is to provide clinicians and patients with objective, state-of-the-art, FDA-authorized diagnostic tools to address these challenges.

The Challenge: Lack of Objective Measurement in Medication Management

VA clinicians and other healthcare providers face a persistent challenge in medication management for behavioral health. Diagnosis and follow-up depend heavily on patient self-reporting and clinical interviews. These approaches are important but are also time-consuming, subjective, and frequently incomplete. When medications are used, such as antidepressants, anxiolytics, or emerging psychedelic-assisted therapies, providers do not currently have an objective biomarker that reflects treatment response or physiological change.

This limitation can lead to uncertainty in medication titration, delays in identifying adverse reactions, and difficulties in evaluating which treatments are most effective for specific Veteran populations.

Technology Overview

Senseye is a Software-as-a-Medical-Device (SaMD) company developing the **first and only objective diagnostic test for mental health,** initially for PTSD and subsequently for depression and anxiety (hereinafter "the device"). Senseye provides a ten-minute, smartphone-based assessment that uses artificial intelligence to measure and analyze nervous system disruptions resulting from mental health dysfunction. These disruptions, which cause changes in a person's "fight-or-flight" response and ability to rest and regulate their heart rate, are measured by the device via multiple ocular metrics such as pupil dilation, saccadic movement, blink dynamics, and gaze patterns, as well as heart rate and heart rate variability.

The nervous system disruptions measured by the Senseye device to test for PTSD, depression, and anxiety are rooted in neuroscience; these conditions share overlapping neurobiological, cognitive, and physiological features [6] which manifest through ocular metrics like pupil size and eye movements [7–12]. The linkage between changes in ocular metrics and the conditions that drive them demonstrates scientific validity in using these features to detect the presence and severity for PTSD, depression, and anxiety. By quantifying nervous system disruptions, Senseye provides an objective, physiologically based test that can be used before, during, and after treatment for assessing the presence and severity of PTSD, MDD, and GAD.

Senseye is developing this device under **rigorous quality and design standards to support FDA authorization**.

Senseye's objective assessment also presents a unique opportunity for drug development use cases. Without reliance on interpretation of patient-reported answers, the device is designed to **reduce potential bias in studies, lower variability in results, and provide confirmation of severity changes observed in primary endpoints**. The result is a quantitative assessment that gives clinicians reliable information to support diagnostic decisions and to monitor how well treatments are working.

Additionally, current gold-standard assessments such as the CAPS-5 are typically limited to use 1x/month, while the Senseye device will allow for use multiple times per month, providing more contemporaneous data on drug effects.

Research conducted with leading institutions, including VA, shows:

- Diagnostic accuracy is well above the current real-world standard of care (PCL-5) and is expected to be greater than 80% sensitivity and specificity at FDA approval, compared to a full clinical interview and CAPS-5.
- Strong correlation between Senseye biomarker scores and CAPS-5 scores.
- Clear potential for use as a secondary endpoint in clinical trials that evaluate medication effectiveness.

Relevance to VA Medication Management

Senseye gives VA clinicians an objective tool to support medication decision-making. Specifically, it can:

- Provide an objective and accurate diagnostic test result.
- Provide physiological evidence of treatment response or non-response.
- Support titration decisions by identifying early improvement or deterioration.
- Strengthen VA's ability to evaluate the effectiveness of newer medications, including psychedelic-assisted therapies, through standardized, unbiased secondary endpoint data.

Senseye complements providers' clinical judgment by adding a quantitative data point to guide more precise and individualized medication management.

Alignment with FDA and VA Research Initiatives

Senseye is advancing through the FDA De Novo pathway for its PTSD Diagnostic Test, the PMA Pathway for its PTSD/GAD/MDD panel diagnostic, and the Innovative Science and Technology Approaches for New Drugs (ISTAND) qualification program for its use in drug trials. ISTAND supports new methods that can serve as validated endpoints in clinical trials. This is particularly important for behavioral health, where objective physiological markers are limited.

Having recognized the need for objective measurement in medication and treatment management, VA is increasingly involved in clinical trials and research on advanced treatments for PTSD and depression, as reflected in VA's participation in Senseye's Phase 2 trials. Upcoming Phase 3 trials will offer an expanded enrollment opportunity for VA patients. However, more than mere participation is needed to address the urgent problems affecting Veterans and their families. VA clinicians need to know whether innovative approaches are working, both on a spot basis and over a defined period. VA needs to know that the funds being used to treat Veterans are supporting methods that are both effective and efficient. Veterans need to know with a great degree of certainty that the VA is not overmedicating or undertreating their condition. VA should prioritize its investment and collaboration efforts so that the combination of proper diagnosis and treatment, together with objective assessments, will allow Veterans to trust the care they receive.

Senseye aims to directly contribute to these improvements by providing an objective test that supports clinical trial design, safety monitoring, cost-effective treatments, and verifiable outcomes.

Conclusion

The Department of Veterans Affairs has made extraordinary progress in advancing behavioral health care and suicide prevention. The next step in this advancement is the integration of objective physiological measurement tools that support safer and more effective medication management and care for Veterans and their families.

Senseye appreciates the Committee's leadership in examining this important topic and stands ready to support the Committee and VA in evaluating and implementing evidence-based solutions that improve care for those who proudly served our nation.

We would welcome the opportunity to testify in-person at a future hearing focused on private sector innovations that can expand the tools available to VA.

Thank you for including this Statement for the Record.

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STATEMENT OF

MEGGAN COLEMAN, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

FOR THE RECORD

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

Medication Management in VA Healthcare

WASHINGTON, D.C. December 3, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I would like to thank you for the opportunity to speak on this subject.

Research consistently shows that polypharmacy—taking multiple medications simultaneously—is highly prevalent among veterans, particularly those managing conditions like post-traumatic stress disorder (PTSD), chronic pain, or multiple health issues[1]. Approximately half of veterans experience general polypharmacy, and more than a third are prescribed numerous psychotropic medications. Veterans with PTSD are at particular risk, with nearly 48 percent receiving polypharmacy involving psychotropic drugs, compared to about 22 percent among those without PTSD. Many older veterans take more than five medications, and some may take over fifteen at once.[2] Additionally, the use of multiple sedative and psychoactive drugs has increased over time, with a notable rise in polysedative prescribing—combining sleep aids, antipsychotics, and anti-anxiety medications—between 2004 and 2011[3]. The co-prescription of opioids and

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benzodiazepines remains particularly concerning as this combination is known to significantly heighten the risk of overdose and suicide.

The consequences of these prescribing patterns are serious. Studies indicate that veterans on long-term opioids or benzodiazepines face a substantially higher risk of suicide and unintentional overdose.[4] At the same time, those on three or more psychoactive medications have more than double the risk of both outcomes. While the Department of Veterans affairs (VA) has successfully reduced benzodiazepine use among PTSD patients—from about 31 percent in 2009 to 11 percent in 2019—certain groups such as older and female veterans continue to be disproportionately affected. Systemic issues also exacerbate these risks. VA's Electronic Health Record (EHR) system transition has introduced medication-tracking and coding errors, and gaps in oversight of community care prescribing have led to inconsistent use of special-authorization drugs. Together, these trends highlight the urgent need for stronger medication management systems, improved prescribing oversight, and expanded access to safe, evidence-based alternatives to minimize dependence on high-risk drug combinations.

A recent investigation by *The Wall Street Journal* included interviews with more than 50 veterans, VA practitioners, researchers, and former officials to gather firsthand accounts of prescribing practices, veterans' experiences, and institutional behavior.[5] They revealed that many veterans diagnosed with PTSD and related conditions were being prescribed multiple central nervous system (CNS) medications simultaneously. When these combinations are not carefully monitored, they can lead to severe sedation, metabolic issues, and an increased risk of suicidal thoughts or behaviors. These findings highlight ongoing concerns raised by veterans and advocacy organizations, suggesting that some VA prescribing practices may depend too heavily on medications instead of focusing on safer, evidence-based alternatives or shared decision-making approaches.

This situation has both clinical and public trust implications. Veterans deserve transparent and well-documented informed consent when they are prescribed medications that carry known risks, such as addiction, overdose interactions, cognitive or motor impairment, and in some cases worsening mood. They should also have access to effective alternative treatment options. Recognizing these risks, several pieces of legislation introduced this year aim to enhance safeguards around medication management, informed consent, and patient choice. These efforts are designed to ensure that treatment of veterans prioritizes safety, transparency, and respect for their autonomy.

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[4] Collett, G. A., Song, K., Jaramillo, C. A., Potter, J. S., Finley, E. P., & Pugh, M. J. (2016). Prevalence of Central Nervous System Polypharmacy and Associations with Overdose and Suicide-Related Behaviors in Iraq and Afghanistan War Veterans in VA Care 2010-2011. *Drugs - real world outcomes*, *3*(1), 45–52. https://doi.org/10.1007/s40801-015-0055-0
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[5] Ramachandran, Shalini, and Betsey McKay. (2025). "'Combat Cocktail': How America Overmedicates Veterans" *The Wall Street Journal*, July 31, 2025. https://www.wsj.com/health/healthcare/veterans-affairs-ptsd-polypharmacy-3c9673ac

VFW Members' Experiences

Through a recent partnership with the Grunt Style Foundation, the VFW has worked to call attention to this problem through a variety of public efforts, calling on veterans to share their stories. These efforts included a Veterans Harm Reduction Summit hosted on Capitol Hill last spring, alongside Disabled American Veterans, where veterans came to share their stories and promote potential solutions.

One veteran who spoke at a press conference during the summit was VFW Washington Office Executive Director Ryan Gallucci, an Iraq War veteran. In 2010, he requested a non-stimulant medication from VA to treat his attention-deficit/hyperactivity disorder (ADHD) due to concerns about his long-term heart health. He was prescribed atomoxetine, a serotonin-norepinephrine reuptake inhibitor (SNRI) sold under the brand name Strattera. With limited information about its risks, he assumed it was safe.

However, within a month, he began experiencing daily panic attacks, and after a couple of drinks to celebrate Veterans Day, he blacked out. Those around him reported that he had become manic and aggressive. With the help of his now-wife, he realized that the medication was likely to blame and was able to stop taking it. After discontinuing the drug, his symptoms subsided.

Further research revealed that his reaction was not uncommon. Strattera currently has a black box warning indicating serious side effects, including suicidal thoughts, mania, aggression, and even heart issues. He recounted this traumatic experience during a press conference in June this year, where the VFW called on Congress to mandate informed written consent for psychotropic medications like Strattera. He stated that if he had been required to review these risks with his doctor and provide written consent, he would have refused the medication.

At the summit, former VFW-SVA Legislative Fellow Angela Peacock also shared her experiences of not coping with personality changes resulting from a cocktail of medications after her service in Iraq, and the challenges of following safe deprescribing guidelines to avoid catastrophic harm that can come from trying to wean off these drugs. Peacock was one of the first veterans to bring this issue to the forefront during her fellowship with the VFW in 2019. She has also been a featured speaker on this topic around the country, and her story is part of the documentary "Medicating Normal," which seeks to raise awareness of the potential harm of overprescribing psychiatric medication.

Numerous other veterans have reported to the VFW that they were not adequately counseled by their VA providers about what to expect from psychotropic medications. VFW's National Veterans Service received an inquiry from a veteran in California who was prescribed two selective serotonin reuptake inhibitors (SSRIs) by VA, which resulted in an emergency room visit. The veteran also reported difficulty accessing consistent mental health care and therapy. Following this incident, they requested that their mental health treatment be managed through a community care referral to ensure continuity and reduce the risk of future crisis visits. This event occurred between late 2024 and early 2025.

Marine Corps veteran John Jowers recently shared his story at a Texas Senate Committee on State Affairs hearing this past March. He described his experience of battling severe mental and physical injuries for more than 13 years. During that time, he was prescribed several medications, at one point taking nearly 10,000 pills a year. This resulted in frequent hospital visits due to side effects and drug interactions.

Four years ago, Jowers began using legal hemp-derived products, and within two months he was able to stop taking all prescription medications except for his diabetes treatment. He reported that his drug interactions ceased, and he regained his health, clarity, and purpose as a husband, father, and veteran. Jowers emphasized his support for strong regulations for this alternative treatment to ensure product safety, but he cautioned that an outright ban on hemp-derived products would be devastating for many veterans. Before using these products, he struggled with suicidal thoughts and attempts, but credits hemp-derived consumables with helping save his life. He urged lawmakers to preserve veterans' freedom to choose safe and effective treatments that have enabled many to reclaim their well-being and stability.

VFW Texas State Commander Dave Walden shared that after returning from combat in Iraq, he was prescribed a cocktail of more than 20 medications a day by VA. Like many Texas veterans, he found himself trapped in a pharmaceutical fog—overmedicated, struggling to function, and disconnected from daily life. Veterans across the state reported similar experiences, often leading to dangerous drug interactions that frequently went unnoticed.

Joshua Starks, a former Infantry Officer in the Oklahoma National Guard's 45th Infantry Brigade Combat Team, served two combat tours in Afghanistan from 2011–2012, leading multiple combat outposts during a period of heavy casualties, constant enemy attacks, and severe personnel shortages that left his unit exhausted and traumatized. After returning back to the United States, several of his fellow soldiers sought mental health care at VA, but found the enrollment process difficult and the care lacking. He knows of several who gave up and died by suicide. Starks himself reached a breaking point after a dangerous dissociative flashback while driving his young son to school, prompting him to seek care from VA. Unfortunately, he endured months-long delays, repeated misdiagnoses, and emotionally numbing medications without receiving real coping tools. Ultimately, he sought help outside of VA by participating in outdoor programs, meditation, cognitive behavioral therapy, and neurofeedback therapy. These finally helped him manage his PTSD, though not before he lost his marriage, friendships, and his military career. Grateful for the support of the VFW and fellow veterans, he is now pursuing a degree in social work to help ensure other veterans receive the care he struggled so long to find.

These experiences highlight a larger issue within the VA system, which is the potential for overprescribing and the urgent need for alternative and more personalized options for those who have served. Commander Walden emphasized that veterans who once defended American freedoms now find themselves fighting for the freedom to make informed health care choices. He urged lawmakers to recognize that those trusted with the nation's most advanced weapons systems should also be trusted to make responsible decisions about their own care. For many veterans, this debate is not about politics, it is about reclaiming health, autonomy, and dignity after years of dependence on medications that caused more harm than good.

Legislative Solutions

According to VA, more than 40 percent of veterans receiving VA health care have a service-connected disability related to mental health. The VFW acknowledges the increasing demand for alternative, evidence-based treatments for PTSD and other mental health conditions. Currently, most veterans seeking care are prescribed SSRIs or SNRIs, along with various forms of psychotherapy.

To address the concerns expressed by numerous VFW members, we support two critical pieces of legislation introduced in the House. H.R. 2623, *Innovative Therapies Centers of Excellence Act of 2025*, would establish five specialized VA medical centers focused on developing and evaluating advanced treatments for PTSD. Some of the promising therapies under consideration include stellate ganglion block, hyperbaric oxygen therapy, ketamine infusion, MDMA-assisted therapy, medical cannabis, and other plant-based alternatives. This legislation would enhance VA's ability to provide safe, scientifically validated alternatives to traditional medication-heavy treatment models. By creating a limited number of well-governed centers of excellence, VA would be able to conduct rigorous clinical trials, train clinicians, and implement new therapies in a controlled, data-driven manner, thereby reducing reliance on multiple medications.

To ensure the legislation's success, we recommend establishing clear outcome metrics, such as symptom improvement and functional recovery, as well as standardized informed consent procedures. Additionally, it emphasizes the importance of data sharing across VA systems and creating pathways to scale successful programs nationwide.

While current treatments may be effective for some individuals, others experience only temporary relief, adverse side effects, or challenges when discontinuing medications. To promote transparency and safety, the VFW supports the requirement of written informed consent before beginning long-term treatment with high-risk psychiatric drugs. H.R. 4837, *Written Informed Consent Act*, would expand these requirements to include additional medication categories such as benzodiazepines, stimulants, antipsychotics, and sedative-hypnotics. This legislation would ensure that veterans receive clear and consistent information about the potential risks, benefits, and available alternatives to medication, along with a defined plan for monitoring, tapering, and follow-up.

With nearly 2.5 million veterans using its mental health services, VA is in a unique position to lead the nation in advancing innovative, data-informed mental health care that prioritizes patient choice, safety, and trust. Just as VA has pioneered telemedicine, cardiovascular care, and prosthetics, it could now do the same for PTSD treatment.

Recommended Oversight, Monitoring, and Patient Safety Enhancements

To enhance accountability and promote safer prescribing practices, the legislation previously mentioned could introduce stronger oversight, monitoring, and patient safety measures within VA. One proposed approach is to mandate written informed consent for certain high-risk medication classes, along with a clear monitoring and tapering plan to ensure safe and coordinated care. Establishing prescribing thresholds, such as when opioids are prescribed

alongside benzodiazepines or when a veteran is prescribed three or more CNS depressants, could trigger pharmacy or medication-safety reviews as a precautionary measure.

Additionally, providing public, facility-level reporting on prescribing practices and outcomes at VA could improve transparency, public awareness, and facilitate learning across locations. For example, reporting from the VA Center for Medication Safety (VA MedSAFE) could be made available to the public. This program focuses on research and evaluation of adverse drug events and polypharmacy to develop strategies to improve medication safety for veterans.

Finally, conducting independent evaluations of VA Center of Excellence for Mental Illness Research, Education, and Clinical Centers (MIRECCs) could help assess whether newer treatments are effectively reducing medication burden, and improving mental health and suicidality outcomes. Together, these recommendations would enhance veteran safety, promote data-driven oversight, and foster greater trust in VA prescribing practices.

Data Gaps and Suicide Prevention

Significant gaps in publicly available VA data persist, especially concerning medication prescribing patterns, the prevalence of polypharmacy, the co-prescription of high-risk drugs such as opioids and benzodiazepines, and variations among facilities. These gaps hinder our ability to understand how prescribing practices may impact veteran suicide risks. While VA operates internal medication safety programs like VA MedSAFE, the absence of data on facility-level prescribing practices, the long-term co-prescription of CNS agents, and related adverse events restricts external oversight and independent research.

To address these gaps, VA should provide annual public reports that detail prescribing patterns by drug class. These reports should include the number of veterans receiving two or more CNS-active medications concurrently, as well as the rates of documented adverse drug events and overdoses.

Provisions of the VFW-championed *Not Just a Number Act* were passed in January as part of the *Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act*, to require VA to include more of its benefits usage data in its annual suicide prevention reporting. However, additional data is still required to achieve its objectives fully.

Equally important is the need for a mandatory linkage between prescribing data and suicide prevention outcomes utilizing transparent, peer-reviewed analytic frameworks. This approach would help Congress, researchers, and the public better understand the potential relationships between medication combinations and veteran suicides. Establishing standardized metrics and a publicly accessible data dictionary would ensure that VA analyses can be replicated and verified by independent experts. Additionally, funding for external research partnerships with organizations such as the National Institutes of Health, the Centers for Disease Control and Prevention, and academic institutions should be prioritized to evaluate not just correlations but also causal mechanisms behind adverse outcomes.

By implementing these suggestions, VA could transition from internal reporting to true data transparency. This would enable policymakers, clinicians, and researchers to identify risks earlier, improve prescribing practices, and ultimately prevent avoidable veteran deaths. The approach is clear: veterans should never be treated as mere statistics, and their safety relies on data systems that are open, accountable, and actionable.

VFW Recommendations

We owe our veterans transparent, evidence-based care that respects their autonomy and minimizes preventable risks. *The Wall Street Journal* reporting serves as a clear warning that patterns of polypharmacy extend beyond clinical issues. They raise important questions about public accountability, research, and policy. Congress should require VA to take the following actions:

- Expand access to evidence-based alternative treatments for PTSD through dedicated centers of excellence.
- Establish strong written informed consent protections.
- Publicly report prescribing patterns and adverse events while supporting independent evaluations.
- Publish all available data on psychotropic medications and their effects on patients.
- Ensure that doctors are adequately trained in deprescribing.
- Implement the *Not Just a Number Act* reporting to provide additional data on VA benefits usage as it compares to suicide risks.

Chairman Moran and Ranking Member Blumenthal, this concludes my testimony. I thank you for the opportunity to provide remarks on this important issue.

TESTIMONY FOR THE RECORD OF

JOHN SPAGNOLA

VETERANS STRATEGIC SOLUTIONS, PRESIDENT

FOR THE

U. S. SENATE COMMITTEE ON VETERANS' AFFAIRS

119th UNITED STATES CONGRESS, FIRST SESSION

LEGISLATIVE HEARING

3 DECEMBER 2025

Senator Jerry Moran and distinguished members of the Senate Veterans Affairs Committee, it is my pleasure to submit this testimony for the record concerning the following draft legislation, the ***Written Informed Consent Act***.

The purpose of this proposed legislation is to strengthen protections for veterans and ensure that they fully understand the risks and benefits of specific medications prescribed by VA physicians. A cost-effective solution to accomplish this goal would be to direct the Secretary of Veterans Affairs to expand Veterans Health Administration Directive 1005, "*Informed Consent for Long-term Opioid Therapy for Pain*", dated 13 May 2020 (see also: VHA's Handbook 1004.01 (5), *Informed Consent for Clinical Treatments and Procedures,* amended September 17, 2021) to include the following high-risk medications which carry FDA warnings:

1. Antipsychotics,
2. Stimulants,
3. Antidepressants,
4. Anxiolytics, and
5. Narcotics

The Problem: Imagine a fragile veteran, taking one or more of these powerful and risky medications, who is not prepared for possible side effects such as: vision problems (blurred or unfocused); hallucinations (seeing things or hearing voices); depression; anger issues; severe fatigue; being unable to think/function coherently, etc. These symptoms could push them over the edge into a possible suicidal situation due to fear or confusion. Furthermore, they may be unable to work or support themselves and their families, they may also be dealing with alcohol or drug addiction, or they might exhibit violent or unpredictable behavior. Historically, the VA has spent millions of dollars on veteran suicide prevention programs with little to no success in saving veteran lives.

Current solutions are not working, and continuing to repeat failed actions/programs and wasting finite financial resources is the definition of insanity. It is time to try something simple, different, and cost-effective.

As a first step, we need to enforce what is already a part of the VHA Handbook: "*Veterans must be informed of the side effects and the treatment options of medications and treatments they are prescribed.*"

The VA often uses Verbal Informed Consent, which, because it cannot be monitored or reliably verified, is not enforceable. This oversight causes our veterans and their families to be subject to a lack of vital information about medication side effects, as well as their right to be aware of, and possibly choose other medications or alternative treatment options.

Currently, the VA's Written Informed Consent requirements exclude many high-risk medications, including benzodiazepines, putting uninformed veterans, and potentially their families, at dangerous, unnecessary risk.

The VA's own Office of Inspector General has identified numerous deficiencies in the informed consent process as it is currently practiced, which could be addressed by putting this proposed legislation into practice across the VA Health Care system.

According to "*Rights and Responsibilities of VA Patients,*" VA patients have the right to "receive a complete and understandable explanation of their illness, treatment options, expected outcomes, and potential risks." Unfortunately, this admirable goal is not consistently met across the VA Health Care system. This is the flaw that this draft legislation is meant to address.

Unfortunately, the problem of veteran suicide, which is both a national tragedy as well as a disgrace, has been a long-standing problem in the United States. Although billions of dollars have been spent trying to find a solution to this problem, there seems to be no end in sight, and veterans are paying the ultimate price for their honorable service.

Veterans continue to be prescribed multiple prescriptions, many with dangerous side effects, and suicidal ideation is at the top of the list. Without proper warnings from the VA's health care providers regarding the many risks associated with the five specific classes of medications (antipsychotics, stimulants, antidepressants, anxiolytics, & narcotics), veterans and their families are being exposed to unknown risks, including suicidal ideation, addiction, anger management issues, hallucinations, etc.

Properly informed veterans are much more likely to adhere to their medication protocols and to deal with possibly alarming side effects calmly. This more collaborative approach to veteran health care, which often requires the use of some of these high-risk medications, is a win-win for both veterans and their physicians, leading to more positive health outcomes.

To be clear, there is no intention to control or interfere with any medications that are prescribed by VA doctors. There is no question that physicians are the medical experts who recommend patient care medications, but the patient also has rights, including fully understanding, questioning, and/or even refusing those recommendations. This kind of collaborative, two-way relationship shows true respect between VA physicians and their veteran patients.

It is understood that this type of open communication between doctors and their patients may be slightly more time-consuming, but the possible result, fewer veteran suicides, is certainly worth the extra effort. This level of information is especially critical in cases where a veteran may be taking multiple medications simultaneously.

Even though all prescription medications include inserts, and there have been some improvements, they are not written for the ordinary, everyday layperson. Also, since you do not even get the insert until after the VA pharmacy has filled the prescription, it is already too late to ask questions and/or discuss alternative or possible side effects. Veterans need this information while they are with their doctor, so they can decide if the benefits of the medication outweigh the risks.

Veterans are entitled to have access to safe, necessary, and effective medications without limiting pharmaceutical treatments while simultaneously preventing serious negative consequences. Written Informed Consent adds a needed layer of protection to both veterans and their physicians.

Simply put, the premise of this proposed legislation is to save veteran lives by providing them with the critical information they need to fully understand their medications and be ready to deal with any possible side effects. A fully and properly informed patient is much more likely to adhere to their medication regimen and less likely to be needlessly panicked if/when they experience alarming side effects. All veterans utilizing the VA health care have the right to safe, medically necessary, and effective medications. The piece that is missing is ensuring they have all the information required to not only participate in their own health care, but to make informed decisions regarding those medications.

Written Informed Consent will help ensure that physicians are providing all vital information, including risks and side effects, considering all available evidence-based treatment options and medications to each veteran as a means of minimizing or eliminating the potential risk of suicide.

Thank you for this opportunity to share my comments on this critical issue.

*** See attachment at the end of this document, "VA's Informed Consent Form for Opioids***

John Spagnola, Veterans Strategic Solutions

Mr. Spagnola is an experienced Chief Executive Officer and President of Veterans Strategic Solutions. He has a demonstrated history of collaborating with like-minded organizations, including Veteran Service Organizations and social/medical associations, to achieve mutually beneficial goals.

Spagnola's mission is to help establish beneficial legislation through the formation of tactical alliances and coalitions, irrespective of political affiliation. Through his efforts, he endeavors to enlighten, inform, and increase awareness of critical veteran issues, thereby improving veterans' lives through beneficial legislation.

Mr. Spagnola is a business leader with a background in strategic planning, public speaking, fundraising, and public relations. He earned a BA in Political Science and Psychology from the University of New Hampshire. He is based in Florida and has skills that include event planning and out-of-the-box problem-solving.

Department of Veterans Affairs

Consent for Long-Term Opioid Therapy for Pain

A. IDENTIFICATION

1. Patient Name, Social Security Number, and Date of Birth:

Name: Last, First, Middle | **Last four digits of SSN** | **Date of Birth**

2. Decision-making capacity:

The patient HAS decision-making capacity (skip to item 3).

The patient DOES NOT HAVE decision-making capacity. Enter surrogate name and relationship to the patient. (If the patient's surrogate is not established or available, refer to Handbook 1004.01 for guidance).

Name: Last, First, Middle | Relationship

3. Name of the treatment: Long-Term Opioid Therapy for Pain

4. Practitioner obtaining consent:

Name: Last, First, Middle

5. Supervising practitioner: (if applicable)

Name: Last, First, Middle

6. Additional practitioner(s) performing or supervising the treatment: (if not listed above)

B. INFORMATION ABOUT THE TREATMENT

7. Reason for long-term opioid therapy (diagnosis, condition, or indication):

8. Location of pain:

9. Goal(s) of long-term opioid therapy (e.g., pain score, functional abilities such as go back to work, climb stairs, walk short distances, sleep through the night, do daily household chores, start a light exercise program):

10. Name of current or initial opioid medication(s):

11. Brief description of the treatment:

Opioids are very strong medicines and so it is very important to weigh their risks and benefits when considering them and other treatment alternatives for long-term, non-cancer pain. When opioids are prescribed, ongoing strategies to decrease your risk may include utilizing the lowest dose for the shortest time possible. In addition, your health care team will monitor side effects as well as whether opioids are helping or possibly harming you.

Your healthcare team will monitor when you renew and refill your prescription within VA. Consistent with state law, they will also monitor this outside of VA. All states have prescription drug monitoring programs (PDMP) that track patterns of prescription drug use. VA and these programs may obtain and share information about you without your specific consent.

For your safety, your healthcare team may also count your pills, ask you about your symptoms, and talk with you about testing your urine or blood. Urine drug testing (or in some cases blood testing) is part of the pain care plan when opioids are prescribed. Urine drug tests (or blood tests) will show which substances and medicines you have been taking. This can help determine if there are added risks for side effects or overdose from opioids when they are used with other medicines or substances (e.g., marijuana, street drugs, and alcohol). Your provider will order urine or blood drug tests with your oral informed consent (separate from this consent).

If you or your provider make a decision that the risks of opioids outweigh the benefits or that opioids are no longer the right treatment for you, your provider will work with you to taper the medicine to minimize withdrawal symptoms. You may be asked to sign a new consent form if you seek opioid pain care from another VA provider, if the treatment plan for your opioid prescription significantly changes, or If your condition or diagnosis changes so that a new informed consent conversation is needed to make new decisions about your treatment.

As part of this informed consent discussion, your healthcare team will review a patient information guide with you called "Safe and Responsible Use of Opioids for Chronic Pain" to make sure that you know how to take your medication, understand the potential risks of taking opioids for chronic pain, and alternatives to opioids for pain management. Your healthcare team will give you a copy of the guide so that you can use it as a reference

The guide includes information about:

- Opioid medicines
- Your pain care plan involving specific types of treatments and activities
- Alternatives to opioids for pain management
- Possible side effects of opioid medicines
- How to take opioids in a safe and responsible way

12. Potential benefits of the treatment:

Opioids are more effective in reducing acute pain than chronic pain.

- They usually only "take the edge off" chronic pain for a short time
- Daily use of opioids can actually make your pain worse over time

13. Known risks and side effects of the treatment:

Opioids are no longer recommended for the routine management of chronic pain.

No matter how much you take, opioids will not take the pain away.

- Any dose can be risky, even a small dose
- Higher doses usually cause more side effects, without reducing your pain

Possible opioid side effects include:

- Sleepiness or mental confusion (slow thinking)
- Bad dreams or hallucinations
- Constipation
- Sweating
- Nausea and vomiting
- Itching (possible allergic reaction)
- Decreased sex hormones (including for women, irregular or no menstrual periods; for men, less ability to have an erection)
- Bone loss/brittle bones
- Dry mouth, tooth decay
- Worsening pain
- Opioid Use Disorder (when moderate or severe is also known as "addiction")
- Respiratory depression (slow or shallow breathing)
- Overdose and death

13. Other risks of opioid therapy:

1) Increased pain:
- For some people, opioids may increase pain
- If this happens, a change in your pain treatment plan may be needed

2) Withdrawal symptoms can happen when a person takes opioids for more than a few weeks then stops taking the opioid, lowers the dose too quickly, or takes a drug that reverses the effects of the opioid (e.g., naloxone). Some common withdrawal symptoms are:
- Runny nose
- Chills
- Body aches
- Diarrhea
- Sweating
- Nervousness
- Nausea
- Vomiting
- Mental distress
- Trouble sleeping

3) Impaired driving or impaired ability to safely use machinery:
- Sleepiness and confusion are common side effects from opioids
- Do not drive or operate machinery if you feel sleepy or confused
- Alcohol and other sedating medicines can increase these symptoms

4) Tolerance:
- When opioids are taken daily, your body gets used to the medication
- Over time, the opioid will be less effective at lowering your pain

5) Dependence:
- Means your body will depend on the opioid to feel normal
- Anyone taking opioids can develop dependence
- The risk goes up the longer you take opioids and with higher doses
- Treatments are available for opioid dependence

6) Opioid use disorder:
- Can happen even when opioids are taken as prescribed and it can be life-threatening
- Medication-assisted treatment for opioid use disorder (that is, medications and counseling) can relieve pain and other opioid withdrawal symptoms, decrease opioid craving, and reduce the risk of overdose and death
- Medicines for opioid use disorder include buprenorphine, extended-release injectable naltrexone, and (when administered daily through an Opioid Treatment Program) methadone

7) Drug interactions- problems when drugs are taken together. Opioid side effects can be increased by:
- Drinking small amounts of alcohol
- Some over-the counter medications
- Some herbal remedies
- Other prescription medications
- Street drugs

8) Risks in pregnancy:
- Continued use of opioids during pregnancy can cause your baby to have withdrawal symptoms after birth. Your baby may need to stay in the hospital longer after birth
- Stopping opioids <u>suddenly</u> if you are pregnant and physically dependent on opioids can lead to complications during pregnancy.
- Studies have not shown a clear risk for birth defects with opioid use during pregnancy. If there is an increased risk for birth defects in pregnancy with opioid use, it is likely small

9) Respiratory depression
- Any opioid use increases risk for respiratory depression (slow or shallow breathing)

10) Overdose and death
- Any opioid use increases risk for possible overdose and death

14. Alternatives to the treatment:

You have the option <u>not</u> to take opioids. Other treatments can be used as part of your pain care plan. Alternatives include:

1) Self-care
- General Health Activities
  - Develop or maintain supportive relationships
  - Get a good night's sleep every night
  - Eat healthy foods including fruits and vegetables
  - Move your body every day and do activities you enjoy
  - Stop smoking and using other tobacco products
  - Try meditation or other relaxing activities
- Pain Management Strategies
  - Improve your posture: stand or sit up straight
  - If you are overweight, lose weight. Consider enrolling in a weight management program
  - Practice yoga, exercise, stretching, and/or Tai Chi
  - Learn and practice deep breathing and relaxation exercises
  - Use heat or cold packs on the painful areas
  - Attend pain management classes and join support groups

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     - Learn and practice deep breathing and relaxation exercises
     - Use heat or cold packs on the painful areas
     - Attend pain management classes and join support groups
2) Non-medication Treatments
   - Behavioral Therapies
     - Learn to react to pain in a way that helps you function better and reduce your pain. For example: Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), mindfulness-based therapies including meditation
   - Acupuncture
   - Spinal Manipulation (Chiropractic therapy)
   - Physical Therapy and Occupational Therapy
   - Nerve stimulation (like a Transcutaneous Electrical Nerve Stimulator [TENS unit])
3) Non-opioid Medication Treatments
   - Topical Treatments
   - Gels, creams, ointments, or patches that are applied to the skin on a painful area. For example: diclofenac gel, methyl salicylate cream/ointment, lidocaine patch or ointment
   - Oral Treatments
   - Anti-inflammatory medicines – for muscle/bone pain
   - Nonsteroidal anti-inflammatory drugs (NSAIDs). For example: ibuprofen, naproxen, meloxicam, etodolac, celecoxib
   - Antidepressant medicines – for muscle/bone and nerve pain
   - Tricyclic antidepressants (TCA). For example: nortriptyline, desipramine, amitriptyline, imipramine
   - Serotonin norepinephrine reuptake inhibitors (SNRI). For example: duloxetine, venlafaxine
   - Anticonvulsant medicines – for nerve pain. For example: gabapentin, pregabalin
4) Other Treatment Options
   - You may benefit from more specialized treatments available in some primary care clinics or from some pain clinics
     - These treatments may include trigger point injections in areas of localized pain and muscle spasms, or steroid injections for joint pain
   - Pain clinics may provide epidural steroid injections and several types of pain blocks that can help some patients with spine conditions.
   - Rarely, spinal cord stimulation devices or spine surgery may be considered
     - These interventional pain procedures are for pain conditions that have not or are not likely to respond to other treatments
     - They are often used with the treatments listed above

16. Additional Information:

17. Comments:

C. SIGNATURES

Practitioner obtaining consent:

- All relevant aspects of the treatment and its alternatives (including no treatment) have been discussed with the patient
- (or surrogate) in language that s/he could understand. This discussion included the nature, indications, benefits, risks, side effects, monitoring, and likelihood of success of each alternative that was considered
- I have discussed all of the information contained in the education document "Safe and Responsible Use of Opioids for Chronic Pain " with the patient (or surrogate) and have provided the patient a copy
- If I am prescribing methadone for chronic pain I have given the patient the methadone information sheet
- The patient (or surrogate) demonstrated comprehension of the discussion
- I have given the patient (or surrogate) an opportunity to ask questions
- I did not use threats, inducements, misleading information, or make any attempt to coerce the patient/surrogate to consent to this
- treatment
- I have offered the patient (or surrogate) the opportunity to review and receive a printed copy of the consent form
- If the patient is a woman of childbearing age (ages 15-50), I have discussed the patient's pregnancy status and pregnancy intentions
  - If the patient is not considering pregnancy, I have discussed (or referred the patient for) contraceptive counseling
  - If the patient is considering pregnancy, I have discussed (or referred the patient for) preconception counseling

Signature _____ Date _____ Time _____

Patient or surrogate:

- Someone has explained the treatment, what it is for, and how it could help or harm me
- Someone has explained things that could go wrong, including serious side effects and death
- Someone has told me about other treatments that might be done instead, and what would happen if I have no treatment
- I have discussed the information in the document "Safe and Responsible Use of Opioids for Chronic Pain" with my provider
- I understand the importance of:
  - Telling my provider about side effects
  - Telling my provider about changes in my pain and daily function
  - Getting my opioids from only my VA provider and no one else
  - Not giving away (or selling) my opioids to other people
  - Storing my opioids in a safe place away from children, family, friends, and pets
  - Safely getting rid of opioids I do not need
  - Not drinking alcohol or taking illegal street drugs when I am on opioids
  - For women, telling my provider if I think I might be pregnant, know I am pregnant, or am planning to become pregnant.
- I plan to use my medications responsibly, and take them as prescribed
- I understand how to refill my opioid prescription or get a new prescription. I understand that my VA pharmacy may be closed on weekends, holidays, and after regular clinic hours. I understand that my provider might not give me early medication refills or replace doses that are lost or stolen
- I understand that my provider will order urine drug tests. I understand that the results of these tests or my refusal to be tested may cause my provider to talk to me about changing my opioid treatment plan
- I understand that I may have to taper opioids if my provider decides that it is unsafe for me to continue
- Someone has answered all my questions
- Someone has given me information about how to contact the clinic, if there is a problem and who to call in an emergency
- I know I may refuse or change my mind about having treatment. If I do refuse or change my mind, I will not lose my healthcare or any other VA benefits
- I have been offered the opportunity to review and receive a copy of my consent form
- I choose to have this treatment

Signature _____ Date _____ Time _____

Witnesses: No witness is needed if the patient or surrogate signs their name. Two witnesses are needed only when the patient's signature is indicated with an "X" or some other identifying mark.

Witness Name (Please Print) _____

Witness Signature _____ Date _____ Time _____

Witness Name (Please Print) _____

Witness Signature _____ Date _____ Time _____