

# U.S. Sen. Baldwin: Joins colleagues to demand VA step up and protect veterans from prescription drug abuse

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WASHINGTON, D.C. – U.S. Senator Tammy Baldwin (D-WI) joined five of her colleagues in pressing the Department of Veterans Affairs (VA) to take swift action to protect veterans seeking opioid prescriptions following [concerning reports](#) that found some providers of veterans' health care are not meeting VA prescription opioids safety standards.

“We write today to discuss our concerns with the Department of Veterans Affairs’ oversight of non-VA providers who prescribe opioids to veterans,” **the Senators wrote in a letter to VA Secretary Denis McDonough.** “In Fiscal Year 2022, the Department spent more than \$27 billion in the community for health care services for veterans. VA must ensure the dollars it spends result in high-quality, safe care for veterans.”

In 2017, the Department of Health and Human Services declared opioid deaths a public health emergency. At the time, studies indicated veterans were twice as likely to die from accidental opioid overdoses. To combat this, Congress included a provision in the [VA MISSION Act of 2018](#) to ensure non-VA providers were informed of VA best practices and evidence-based guidelines when prescribing opioids under VA’s Opioid Safety Initiative (OSI). Congress also required third-party administrators responsible for contracting with VA community care providers to check their states prescription drug monitoring program to mitigate prescription drug abuse and overdose by veterans using VA community care.

However, a [recent report](#) from the VA Office of Inspector General (OIG) found the third-party administrators failed to provide adequate oversight of whether Veterans Community Care Network health care providers were completing and certifying VA's OSI training module. The OIG also found that approximately 14,700 of 18,200 non-VA providers in the Community Care Network who prescribed opioids to veterans in fiscal year 2021 had not completed VA's OSI training module and did not certify their mandated review of VA's guidelines. An [additional VA OIG report](#) found a similar lapse in oversight resulted in patients being overprescribed opioids from both VA and Community Care Network providers—increasing veterans' risk of sedation and overdose.

**The Senators continued,** “It is clear VA and its contracted third-party administrators failed to do their due diligence in ensuring the health and safety of the veterans in their care...As stated many times before, we feel if there is an issue at one location, it will likely occur elsewhere. The Department must work not only to address the shortcomings outlined in these OIG reports but also to ensure lessons learned are implemented system-wide.”

Continuing their efforts to protect veterans and ensure they are being provided high-quality care, the Senators urged VA to provide an update on their implementation of recommendations from the OIG reports. These recommendations include issuing formal guidance to VA pharmacy staff regarding best practices related to prescription drug monitoring programs after receiving controlled substance prescriptions from community providers, and strengthening its own monitoring controls over third-party administrators. The lawmakers concluded their letter by urging VA to move swiftly to address their concerns and protect veterans.

“It is the responsibility of VA to ensure the veterans in its care, or that of its community partners, are being provided high-quality care,” **concluded the Senators.** “We urge VA to act to ensure our nation's veterans are not put at risk when seeking care in the community...VA can outsource the work - but it cannot outsource the responsibility for taking care of our veterans.”

The letter was led by Senator Jon Tester (D-MT), and co-signed by Senators Patty Murray (D-WA), Mazie Hirono (D-HI), Angus King (I-MA), and Jacky Rosen (D-NV).