GAO reviewed facility data and prescribing. At the selected facilities, geography and rates of opioid facilities to obtain diversity in through March 2017. GAO selected the medical facilities from March 2016 prescribed opioids at five selected VHA GAO reviewed a random, interviewed VHA officials. In addition, related to OSI efforts and goals and GAO reviewed data and documents mitigation strategies. To do this work, providers adhere to key opioid risk mitigation strategies. To the extent that these factors affect all VHA facilities, VHA also did not establish measures of safety or effectiveness under this goal. These limitations prevent VHA from fully evaluating progress and accurately determining the extent to which its efforts to help ensure safe and effective prescribing of opioids have been successful.

In a review of a nongeneralizable sample of 103 veterans’ medical records at five selected VHA medical facilities, GAO found that VHA providers did not always adhere to key opioid risk mitigation strategies, which are required by VHA policy or relevant to OSI goals. For example, among 53 veterans who were prescribed long-term opioid therapy (defined as a 90-day supply in the last 6 months), GAO found that

- 40 veterans did not have their names queried in a state-run prescription drug monitoring program database. The databases are used to identify patients who are receiving multiple prescriptions that may place them at greater risk for misusing opioids or overdosing;
- 21 veterans did not have a urine drug screening within the year prior to having their prescription filled. The screenings are used to determine whether veterans are taking their opioid medications as prescribed; and
- 12 veterans did not provide written informed consent. Informed consent is a formal acknowledgement that the veteran has been educated on the risks and benefits of opioid use prior to initiating long-term opioid therapy.

GAO found several factors that may have contributed to inconsistent adherence to key opioid risk mitigation strategies at the selected VHA facilities. For example, four of the five selected facilities did not have a pain champion (a primary care position required by VHA that can help providers adhere to opioid risk mitigation strategies), and not all facilities had access to academic detailing, a program in which trained clinical pharmacists work one-on-one with providers to better inform them about evidence-based care related to the appropriate treatment of relevant medical conditions. In addition, three of the five facilities did not consistently review veterans’ medical records to ensure provider adherence to these strategies. To the extent that these factors affect all VHA facilities, VHA will continue to face challenges ensuring that its providers prescribe opioids in a safe and effective manner.