United States Government Accountability Office

GAO

Report to the Ranking Member, Committee on Veterans' Affairs, House of Representatives

November 2012

DOD AND VA HEALTH CARE

Medication Needs during Transitions May Not Be Managed for All Servicemembers

To access this report electronically, scan this QR Code.

Don't have a QR code reader? Several are available for free online.

GAO-13-26

November 2012

DOD AND VA HEALTH CARE

Medication Needs during Transitions May Not Be Managed for All Servicemembers

GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-13-26, a report to the Ranking Member, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Medication management is critical to effective continuity of care for servicemembers transitioning out of the military. Psychiatric and pain medications may be of particular concern because of potential adverse health effects if not taken as intended.

GAO was asked to provide information on the process used by DOD and VA to help servicemembers manage their psychiatric and pain medications during transitions. In this report, GAO examined (1) the extent to which servicemembers transitioned out of the DOD health care system with psychiatric or pain medications and subsequently received care from VA and (2) efforts DOD and VA have in place to help ensure servicemembers' psychiatric and pain medication needs are met during transitions of care. GAO focused on active duty servicemembers, Reservists, and National Guard members who discharged from military service and Reservists and National Guard members who demobilized in fiscal years 2009 through 2011. GAO also reviewed DOD and VA documents, including transition policies, and interviewed DOD and VA officials from headquarters and six DOD and VA facilities, selected on the basis of size, geographic location, patient characteristics, and other factors.

What GAO Recommends

GAO recommends that DOD develop a transition policy for medications that applies to all servicemembers and that DOD and VA identify and apply best practices for managing servicemembers' medication needs during transitions of care. DOD and VA concurred with the recommendations.

View GAO-13-26. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

About 1 in 12 (approximately 94,000) servicemembers discharged from military service and Reservists and National Guard members demobilized in fiscal years 2009 through 2011 had a psychiatric or pain medication, and almost half of these servicemembers subsequently received care from the Department of Veterans Affairs (VA) within 9 months. The percentage of servicemembers discharged or demobilized with psychiatric or pain medications increased slightly across the 3 fiscal years, from about 7 percent in fiscal year 2009 to about 9 percent in fiscal year 2011. The most common psychiatric medications for servicemembers discharged or demobilized from fiscal years 2009 through 2011 included antidepressants, while the most common pain medications included nonsteroidal anti-inflammatories, such as prescription-strength ibuprofen, and an opioid—oxycodone acetaminophen. Although not all discharged or demobilized servicemembers receive care from VA, GAO found that almost half of servicemembers with psychiatric or pain medications in fiscal years 2009 through 2011 subsequently received care from VA within 9 months.

The Department of Defense's (DOD) and VA's efforts may not help all servicemembers manage their medication needs during transitions of care. DOD does not have a formal policy for transitioning medication needs for all servicemembers, and the efforts available to all servicemembers are limited. For example, DOD officials identified the medical assessment as the effort DOD has in place to help all servicemembers transition their medical needs prior to discharge. This assessment is a key opportunity for assisting all servicemembers with managing medications; however, DOD cannot ensure that certain best practices, such as developing a plan for how to obtain medications during the transition and providing current medication lists at the point of discharge, are included during these assessments. In addition to efforts that may assist all servicemembers, DOD and VA provide specific servicemember groups with more thorough and direct assistance in transitioning their health care, including medications. For example, servicemembers with complex health care needs may receive additional assistance through military case management services. Finally, some DOD military treatment facilities and VA medical centers have efforts that can help manage servicemembers' medication needs, but these may not be available at all facilities. Many of the programs available only to specific groups or to servicemembers accessing certain DOD or VA facilities incorporate identified best practices for transitions of care, such as sharing medical information between providers, scheduling VA appointments and providing servicemembers with medication lists prior to discharge. Identifying best practices and implementing them across the departments could better ensure overall continuity of care, including medication management, for servicemembers transitioning between health care providers, and could reduce their potential for adverse health effects from misusing or discontinuing psychiatric or pain medications.

Contents

Figures

Abbreviations

DOD	Department of Defense
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
PTSD	post-traumatic stress disorder
VA	Department of Veterans Affairs
WTU	Warrior Transition Unit

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

November 2, 2012

The Honorable Bob Filner
Ranking Member
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Filner:

Medication management—ensuring that medications are used appropriately and regimens are adhered to—is critical to effective continuity of care for those servicemembers who are transitioning out of the military and changing health care providers. Management of psychiatric and pain medications may be of particular concern because of the prevalence of the conditions for which these medications are prescribed among servicemembers and the potential adverse health effects if not taken as intended. Literature indicates that between 20 and 40 percent of servicemembers returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF)[1] suffer from deployment-related mental health conditions, including post-traumatic stress disorder (PTSD), depression, and substance abuse.[2] Mental health conditions may be managed with various therapies, including medications, such as antidepressants and antianxiety medications. Pain is a serious and highly prevalent condition, according to a report from the Department of Veterans Affairs (VA) and the Department of Defense (DOD); among returning OEF/OIF servicemembers, pain is the most frequently presented complaint.[3] Pain also may be managed with various therapies, including medications such as opioids.

[1]Military operations in Iraq as of September 1, 2010, are referred to as Operation New Dawn (OND).

[2]See K. H. Seal et al., "VA Mental Health Services Utilization in Iraq and Afghanistan Veterans in the First Year of Receiving New Mental Health Diagnoses," *Journal of Traumatic Stress*, vol. 23, no. 1 (2010).

[3]Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain* (May 2010).

Individuals may experience serious adverse health effects when psychiatric and pain medications are abruptly discontinued. For example, when certain psychiatric medications are abruptly discontinued, an individual may experience problems such as relapses in psychotic episodes, return of anxiety symptoms, and exacerbation of depression symptoms. Similarly, when some pain medications, such as opioids, are not gradually reduced, an individual may experience withdrawal symptoms such as nausea, insomnia, and anxiety. Certain types of psychiatric and pain medications should be gradually tapered off under a doctor's supervision.

The transition out of the DOD health care system, which can start when servicemembers discharge from the military and continue until they are cared for by receiving health care providers, such as VA, is a vulnerable point in terms of providing seamless care. Transitions between health care systems may increase the likelihood of patients deviating from their treatment plans. Specifically, such transitions may increase the likelihood of patients discharged with medications not adhering to their medication regimens, for example by misusing or inappropriately discontinuing use of a medication their providers prescribed prior to discharge.

You expressed interest in obtaining information on the process used by DOD and VA to help servicemembers manage their psychiatric and pain medications during transitions from DOD to VA. In this report, we provide information on

1. the extent to which servicemembers transitioned out of the DOD health care system with psychiatric or pain medications and subsequently received care from VA and
2. the efforts DOD and VA have in place to help ensure servicemembers' psychiatric and pain medication needs are met during transitions of care.

As requested, we also compared DOD's and VA's formularies for psychiatric and pain medications. (See app. II.)

To determine the extent to which servicemembers transitioned out of the DOD health care system with psychiatric or pain medications and subsequently received care from VA, we obtained data from DOD's

Defense Manpower Data Center and Defense Health Cost Assessment and Program Evaluation on the number of servicemembers who were discharged from military service[4] and Reservists and National Guard members who were demobilized with psychiatric or pain medications (prescribed prior to discharge or demobilization) in fiscal years 2009, 2010, and 2011.[5] In this report, we included servicemembers who discharged—active duty servicemembers, Reservists, and National Guard members—and Reservists and National Guard members who demobilized, because both of these populations can transition out of the DOD health care system and could be eligible for VA care. We then obtained data from VA's National Data System on how many of these servicemembers subsequently received health care from VA within 9 months of their discharge or demobilization date. We selected the 9-month time frame to provide consistent data across each of the 3 fiscal years—the most current available VA data at the time of our review were from June 2012, 9 months after the end of fiscal year 2011. Data on servicemembers who subsequently received care from VA do not describe the full population of servicemembers who received care after being discharged from military service or demobilized as not all servicemembers subsequently seek and receive care from VA. We assessed the reliability of the data in several ways, including discussing with DOD and VA officials their methodology and data-collection techniques and conducting our own review of their programming and methodological approaches using data file documentation, code book and file dictionaries, and programming logs.

To identify the efforts DOD and VA have in place to help ensure servicemembers' psychiatric and pain medication needs are met during transitions of care, we reviewed documents and interviewed officials from DOD, the Department of the Army,[6] and VA. We reviewed documents, such as department policies related to health care and medication transitions. We interviewed officials from DOD, Army, and VA

[4]Servicemembers may discharge from the military under several circumstances, including expiration of term of service, medical retirement, and career retirement.

[5]The number of servicemembers with pain or psychiatric medications is not equivalent to the number of servicemembers with related conditions because psychiatric and pain medications may be prescribed for other conditions.

[6]We focused our review on the Army, rather than other military service branches, because the Army has the largest number of OEF/OIF/OND servicemembers.

headquarters offices that have oversight of, and set policies related to, the provision of health care, including psychiatric and pain care and prescription medication benefits, and that have roles in assisting servicemembers with their health care as they transition out of DOD. For example, we interviewed officials from DOD's TRICARE Management Activity's Clinical Quality Office, Pharmacoeconomic Center, and Case Management Program; and the Office of the Surgeon General of the Army. We also interviewed officials from VA's VA/DOD Collaboration Office and the Veterans Health Administration's Pharmacy Benefits Management Services, Liaisons for Healthcare Program, and OEF/OIF/OND Care Management Program. In addition, we interviewed officials, including providers and case managers, from local Army military treatment facilities and VA medical centers, as well as servicemembers and veterans, through six site visits. We selected sites to visit to obtain a diverse sample on the basis of criteria such as facility size, patient complexity, presence or absence of a VA Liaison for Healthcare, and Army and VA region, and to ensure military treatment facility proximity to a VA medical center. On the basis of these criteria we selected the following facilities: (1) Walter Reed National Military Medical Center (Bethesda, Md.); (2) Washington D.C. VA Medical Center; (3) Bayne-Jones Army Community Hospital (Fort Polk, La.); (4) Alexandria VA Medical Center (Pineville, La.); (5) Weed Army Community Hospital (Fort Irwin, Calif.); and (6) Loma Linda (Calif.) VA Medical Center. Finally, we interviewed officials from selected veterans service organizations—the American Legion, Military Officers Association of America, and Wounded Warrior Project—to obtain their perspectives on transition policies and programs.

We focused our review on efforts that department officials and local military treatment facility and VA medical center officials identified as having a role in helping servicemembers manage their medications as they transition from DOD to VA. We also focused on the transition efforts used by servicemembers transitioning between outpatient settings, rather than inpatient settings, because medication management between outpatient settings is a vulnerable point in terms of providing seamless care. The transition efforts we identified may not be exhaustive because some servicemembers may have received help through efforts that were not identified by the officials we interviewed or through efforts that may not have been related to the health care aspects of their transition. We did not review the effectiveness of the efforts identified.

Additionally, we reviewed relevant literature on transitions of care and medication adherence, including effective approaches for transitioning health care needs and strategies for promoting patient adherence to medication treatment plans. For example, we reviewed literature from the National Transitions of Care Coalition, a nonprofit organization that works to address gaps that affect safety and quality of care for transitioning patients, to identify best practices within DOD's and VA's transition efforts.

We conducted this performance audit from January 2012 to October 2012 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. See appendix I for a complete description of our scope and methodology.

Background

DOD and VA provide health care, including medications for psychiatric and pain conditions, to servicemembers and veterans through their respective health care systems. Due to concerns about the continuity of care for servicemembers transitioning between the two health care systems, the departments have made efforts to coordinate transitions of care from DOD to VA. Medication management is a key component of transitions of care, and although servicemembers may misuse or discontinue their use of medications at any time, including while they are under a provider's care, literature suggests there is greater risk for these issues during transition periods.[7]

[7]See for example, E. A. Coleman, et al., "The Care Transitions Intervention: results of a randomized controlled trial," *Archives of Internal Medicine*, vol. 166, no. 17 (2006).

DOD Health Care

DOD provides health care to active duty servicemembers; Reservists and National Guard members on active duty;[8] and other beneficiaries, such as family members and retired servicemembers. Through TRICARE and a direct-care system of military treatment facilities operated by the Departments of the Army, Navy, and Air Force, DOD offers comprehensive health care coverage, including outpatient and inpatient care, preventive care, prescription medication coverage, and mental health care.[9] Beneficiaries also can obtain care from civilian health care providers.

TRICARE beneficiaries may obtain prescription medications through military treatment facility pharmacies, network and nonnetwork retail pharmacies, and the TRICARE mail-order pharmacy. DOD is required by law to make all clinically appropriate medications available to servicemembers, and, with the exception of several classes of medications, such as smoking-cessation and weight-loss medications, DOD makes all Food and Drug Administration-approved medications available.[10] DOD's formulary includes a list of medications that all military treatment facilities must provide and a list of medications that military treatment facilities may elect to provide on the basis of the types of services offered at that facility (e.g., cancer medications).[11] DOD also can classify medications "nonformulary" on the basis of its evaluation of their cost and clinical effectiveness. Nonformulary medications are available to beneficiaries at a higher cost, unless the provider can establish medical necessity.

When discharging or demobilizing, some servicemembers are eligible for transitional health care benefits through TRICARE. For example, the Transitional Assistance Management Program provides 180 days of

[8]Reservists and National Guard members on active duty for more than 30 days are covered by TRICARE. They also may be eligible for TRICARE coverage prior to active duty and after active duty and may be eligible to purchase TRICARE coverage when they return to inactive status. See GAO, *Defense Health Care: DOD Lacks Assurance That Selected Reserve Members Are Informed about TRICARE Reserve Select*, GAO-11-551 (Washington, D.C.: June 3, 2011).

[9]According to DOD, as of September 2012, there were 244 military treatment facilities.

[10]See 10 U.S.C. § 1074g(a)(3); 32 C.F.R. §§ 199.4(g), 199.21(h)(3)(iii).

[11]A formulary is a list of medications, grouped by medication class, that a health care system's providers are expected to use when prescribing medications.

benefits to certain eligible servicemembers, including Reservists and National Guard members.[12] These servicemembers could therefore be eligible for both DOD and VA health care during this period.[13]

VA Health Care

Veterans who served in active military duty and who were discharged or released under conditions other than dishonorable are generally eligible for VA health care.[14] Reservists and National Guard members also may be eligible for VA health care if they were called to active duty by a federal order and completed the full period for which they were called. Reservists and National Guard members also can be eligible for VA health care when they demobilize from combat operations, even if they have not separated from military service. In general, veterans must enroll in VA health care to receive VA's medical benefits package—a set of services that includes a full range of hospital and outpatient services, prescription medications, and noninstitutional long-term care services.[15] VA provides health care services at various types of facilities, including VA medical centers.[16]

Veterans may obtain prescription medications through VA's mail-order pharmacy and medical center pharmacies. VA has a national formulary that provides access to medications for eligible beneficiaries. VA makes

[12]Reservists and National Guard members can transition from DOD health care both when they discharge from the military, under circumstances such as retirement, and when they separate from active duty.

[13]Similarly, retired servicemembers also could be eligible for both TRICARE and VA benefits.

[14]Any veteran who has served in a combat theater after November 11, 1998, including OEF/OIF/OND veterans, and who was discharged or released from active military duty on or after January 28, 2003, has up to 5 years from the date of the veteran's most recent discharge or release from active duty service to enroll in VA's health care system and receive VA health care services. See 38 U.S.C. § 1710(e)(1)(D),(e)(3). For those veterans who do not enroll during their enhanced eligibility period, eligibility for enrollment and subsequent care is based on other factors such as compensable service-connected disability, VA pension status, catastrophic disability determination, or financial circumstances.

[15]VA's enrollment system includes eight categories for enrollment, with priority generally based on service-connected disability, low income, and other recognized statuses such as former prisoners of war. See 38 U.S.C. § 1705; 38 C.F.R. § 17.36.

[16]According to VA, as of June 2012, there were 152 medical centers.

decisions about whether to add medications to its formulary on the basis of clinical and cost effectiveness and, like DOD, provides access to nonformulary medications when a physician attests that there is a compelling clinical reason to do so through its nonformulary request process.[17] Veterans also may receive health care funded by sources other than VA, including private insurance, Medicare, and Medicaid.

Transitions of Care

The process and length of time for transitioning servicemembers' health care from DOD to VA or another health care system varies. For instance, some servicemembers separate from the military and have their first appointment at VA the following week. Others may take more time to transition to VA, waiting months or years before scheduling their first appointment. Furthermore, some servicemembers may not transition their care to VA at all and instead seek care from other health care providers.

As GAO has previously reported, DOD and VA have created a number of clinical and nonclinical programs to assist servicemembers during transitions between the two departments.[18] For example, to improve case management during transitions,[19] there are programs such as Army Warrior Transition Units (WTU)[20] and the VA OEF/OIF/OND Care

[17]Each VA medical center is responsible for establishing a process to adjudicate nonformulary medication requests that ensures decisions are evidence-based in accordance with certain prescribing criteria. Medical centers are required to adjudicate nonformularly medication requests within 96 hours.

[18]GAO, *DOD and VA Health Care: Federal Recovery Coordination Program Continues to Expand but Faces Significant Challenges*, GAO-11-250 (Washington, D.C.: Mar. 23, 2011); *VA and DOD Health Care: Progress Made on Implementation of 2003 President's Task Force Recommendations on Collaboration and Coordination, but More Remains to Be Done*, GAO-08-495R (Washington, D.C.: Apr. 30, 2008); *DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers,* GAO-07-1256T (Washington, D.C.: Sept. 26, 2007); *DOD and VA Outpatient Pharmacy Data: Computable Data Are Exchanged for Some Shared Patients, but Additional Steps Could Facilitate Exchanging These Data for All Shared Patients,* GAO-07-554R (Washington, D.C.: Apr. 30, 2007).

[19]According to the Case Management Society of America, case management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

[20]WTUs provide a comprehensive program of medical care, rehabilitation, professional development, and personal goals for wounded, ill, and injured servicemembers to help them remain in the Army or transition to civilian life.

Management Program.[21] DOD and VA also have longstanding efforts to improve the two departments' health information exchange capabilities. For exchanging health information, the departments have relied on a patchwork of initiatives involving existing DOD and VA systems to increase electronic health record interoperability, including an initiative to share electronic health information, such as outpatient pharmacy data, on separated servicemembers. GAO has reported on challenges DOD and VA have faced in their data-sharing efforts—for example, challenges in planning, staffing, and budgeting—and that the departments are still working to overcome many of these issues.[22]

Medication management is a key component of successful transitions of care.[23] According to the National Transitions of Care Coalition—a nonprofit organization that produces tools and resources to assist with transitions of care—transitions should include education and counseling about medication adherence, medication lists at discharge, and a plan for how to get medications during transitions.

Reasons for Medication Challenges during Transitions

Ensuring that patients take medications as prescribed is a challenge that is well-documented in literature. Research shows that patients may not adhere to their prescribed medication regimens—for example by misusing or inappropriately discontinuing medications.[24]

[21]The OEF/OIF/OND Care Management Program is located at every VA medical center and provides case management services to any OEF/OIF/OND veteran who is identified as high risk or who requests case management.

[22]See, for example, GAO, *Electronic Health Records: DOD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs*, GAO-11-265 (Washington, D.C.: Feb. 2, 2011); *Electronic Health Records: DOD and VA Interoperability Efforts Are Ongoing; Program Office Needs to Implement Recommended Improvements*, GAO-10-332 (Washington, D.C.: Jan. 28, 2010); and *Electronic Health Records: DOD and VA Have Increased Their Sharing of Health Information, but More Work Remains,* GAO-08-954 (Washington, D.C.: July 28, 2008).

[23]Other key components of successful transitions of care include identifying a clinician to coordinate patients' transitions, coaching and education to support self-management, and information sharing between providers (including a discharge summary). See National Transitions of Care Coalition, *Care Transition Bundle: Seven Essential Intervention Categories and Crosswalk* (Washington, D.C.: Feb. 28, 2011).

[24]See for example, RAND, *A Review of Barriers to Medication Adherence: A Framework for Driving Policy Options* (Santa Monica, Calif.: 2009).

Patients can misuse their medications by taking medications in ways other than how they were prescribed. This can include taking more than was prescribed, for instance if a servicemember decides to increase his or her dose of pain medication without the supervision of a physician. It may also include cutting pills in an effort to reduce the dose or make the prescription last longer, which can change the absorption of certain medications such as extended-release formulations. Both of those scenarios can potentially lead to adverse effects, including overdose and death.

Patients may inappropriately discontinue their use of medications—including psychiatric and pain medications—for a variety of reasons, according to literature.[25] In particular, patients may stop taking their medications because they do not think the medication is working; some providers indicated this might be more likely to happen with servicemembers who are on pain medications such as nonsteroidal anti-inflammatory medications. Symptoms associated with a mental health condition, such as paranoia associated with PTSD, which is prevalent among returning servicemembers, also may make a discontinuation more likely.

Although patients may misuse or inappropriately discontinue their use of medications at any time, including while they are under a provider's care, literature suggests there is greater risk for these issues during transition periods. For example, some servicemembers may make their health care a lower priority when they return to their civilian responsibilities. Others may experience delays setting up appointments with health care providers and, as a result, discontinue use of medications.

[25]See, for example, World Health Organization, *Adherence to Long-Term Therapies: Evidence for Action* (Geneva, Switzerland: 2003).

About 1 in 12 Transitioning Servicemembers Had Psychiatric or Pain Medications; Almost Half Subsequently Received VA Care

About 1 in 12 (approximately 94,000) servicemembers discharged and Reservists and National Guard members demobilized from fiscal years 2009 through 2011 had a psychiatric or pain medication, and almost half of these servicemembers subsequently received care from VA within 9 months. Both the percentage and total number of servicemembers discharged and demobilized with psychiatric or pain medications increased slightly across the 3 fiscal years. Servicemembers who were discharged from military service were more likely to have psychiatric or pain medications than Reservists and National Guard members who demobilized. (See table 1.)

Table 1: Servicemembers Discharged and Reservists and National Guard Members Demobilized with Psychiatric or Pain Medications, Fiscal Years 2009 through 2011

Fiscal year	Total	With psychiatric medications	With pain medications	With both psychiatric and pain medications	Total with psychiatric or pain medications
2009	**407,078**	12,352 (3.0%)	13,681 (3.4%)	3,914 (1.0%)	**29,947 (7.4%)**
2010	**407,305**	13,061 (3.2%)	13,509 (3.3%)	4,169 (1.0%)	**30,739 (7.5%)**
2011	**378,277**	15,105 (4.0%)	14,836 (3.9%)	5,127 (1.4%)	**35,068 (9.3%)**
Total (2009-2011)[a]	**1,128,845**	**40,009 (3.5%)**	**41,417 (3.7%)**	**13,033 (1.2%)**	**94,459 (8.4%)**
Servicemembers who discharged from military service	**888,113**[b]	36,896 (4.2%)	34,884 (3.9%)	11,939 (1.3%)	**83,719 (9.4%)**
Reservists and National Guard members who demobilized	**240,732**	3,113 (1.3%)	6,533 (2.7%)	1,094 (0.5%)	**10,740 (4.5%)**

Source: GAO analysis of DOD data.

Notes: Servicemembers discharged refer to active duty servicemembers, Reservists, and National Guard members who discharged from military service generally under conditions other than dishonorable.

Each of the medication categories—psychiatric medications, pain medications, and both psychiatric and pain medications—is mutually exclusive. For example, a servicemember with psychiatric medications but not pain medications is counted only in the "with psychiatric medications" column. A servicemember with both psychiatric and pain medications is counted only in the "with both psychiatric and pain medications" column.

Data on psychiatric and pain medications refer to prescriptions for psychiatric and pain medications that were filled, not all prescriptions that were written.

[a]The number of servicemembers in each fiscal year does not sum to the total number of servicemembers across all 3 fiscal years because servicemembers discharged from the military or demobilized in more than 1 fiscal year are counted only once in the total.

[b]The total number of servicemembers who discharged from military service includes 486,467 active duty servicemembers, 371,995 Reservists and National Guard members, and 29,651 servicemembers who discharged from military service as both an active duty servicemember and a Reservist or National Guard member during the 3 fiscal years.

The most common psychiatric medications for servicemembers discharged and Reservists and National Guard members demobilized from fiscal years 2009 through 2011 included sertraline (used to treat depression, PTSD, and anxiety disorders), while the most common pain medications included prescription-strength ibuprofen (used to treat mild to moderate pain) and oxycodone acetaminophen (used to treat moderate to severe pain). (See table 2.)

Table 2: Most Common Psychiatric and Pain Medications for Servicemembers Discharged and Reservists and National Guard Members Demobilized, Fiscal Years 2009 through 2011

Generic name (medication class)	Percentage of total psychiatric or pain medications at discharge or demobilization	Examples of conditions or symptoms for which medication is commonly prescribed
Psychiatric medications		
1. Sertraline (antidepressant)	12.4	Depression, PTSD, and anxiety disorders
2. Citalopram (antidepressant)	10.5	Depression
3. Trazodone (antidepressant)	7.5	Depression
4. Buproprion (antidepressant)	6.8	Depression
5. Quetiapine (atypical antipsychotic)	6.0	Depression
Pain medications		
1. Ibuprofen (nonsteroidal anti-inflammatory)	19.0	Mild to moderate pain
2. Naproxen (nonsteroidal anti-inflammatory)	12.9	Mild to moderate pain
3. Meloxicam (nonsteroidal anti-inflammatory)	12.7	Mild to moderate pain
4. Celecoxib (nonsteroidal anti-inflammatory)	7.4	Mild to moderate pain
5. Oxycodone acetaminophen (opioid)	7.1	Moderate to severe pain

Source: GAO analysis of DOD data.

Notes: Servicemembers discharged refer to active duty servicemembers, Reservists, and National Guard members who discharged from military service generally under conditions other than dishonorable.

Data on psychiatric and pain medications refer to prescriptions for psychiatric and pain medications that were filled, not all prescriptions that were written.

Officials stated that appropriate medication management varies across pain and psychiatric medications. For example, they noted that discontinuation of a nonsteroidal anti-inflammatory pain medication, such as ibuprofen, can typically be done by the servicemember without the supervision of a provider; patients do not typically become physically dependent on these medications and therefore these medications do not cause withdrawal symptoms when they are discontinued. In contrast, officials told us that people taking pain medications such as oxycodone acetaminophen, an opioid, for several weeks and people taking any of the psychiatric medications, including quetiapine, an antipsychotic, should

only discontinue use of the medications under the supervision of a health care provider because of potential side effects.

Although not all servicemembers who are discharged from military service or demobilized receive care from VA, we found that almost half of servicemembers with psychiatric or pain medications in fiscal years 2009 through 2011 subsequently received care from VA within 9 months. (See table 3.) Among these servicemembers, the average number of days between a servicemember's date of discharge or demobilization and first VA appointment was 81 days (about 3 months). Across the 3 fiscal years of data we reviewed, we found that about one-third of servicemembers received care at VA within 1 month.

Table 3: Servicemembers Discharged and Reservists and National Guard Members Demobilized with Psychiatric or Pain Medications from Fiscal Years 2009 through 2011 Who Subsequently Received Care from VA

Fiscal year	Total with psychiatric or pain medications	With psychiatric medications who subsequently received care from VA	With pain medications who subsequently received care from VA	With both psychiatric and pain medications who subsequently received care from VA	Total with psychiatric or pain medications who subsequently received care from VA
2009	**29,947**	5,754	5,418	2,475	**13,647 (45.6%)**
2010	**30,739**	6,556	5,391	2,668	**14,615 (47.5%)**
2011	**35,068**	7,670	5,680	3,263	**16,613 (47.4%)**
Total (2009-2011)[a]	**94,459**	**19,720**	**16,200**	**8,311**	**44,231 (46.8%)**

Source: GAO analysis of DOD and VA data.

Notes: Servicemembers discharged refer to active duty servicemembers, Reservists, and National Guard members who discharged from military service generally under conditions other than dishonorable.

Data on psychiatric and pain medications refer to prescriptions for psychiatric and pain medications that were filled, not all prescriptions that were written.

We limited our analysis to servicemembers who received care from VA within 9 months of discharge or demobilization to provide consistent data across each of the 3 fiscal years—the most current available data at the time of our review was from June 2012, 9 months after the end of fiscal year 2011.

[a]The number of servicemembers in each fiscal year does not sum to the total number of servicemembers across all 3 fiscal years because servicemembers discharged from the military or demobilized in more than 1 fiscal year are counted only once in the total.

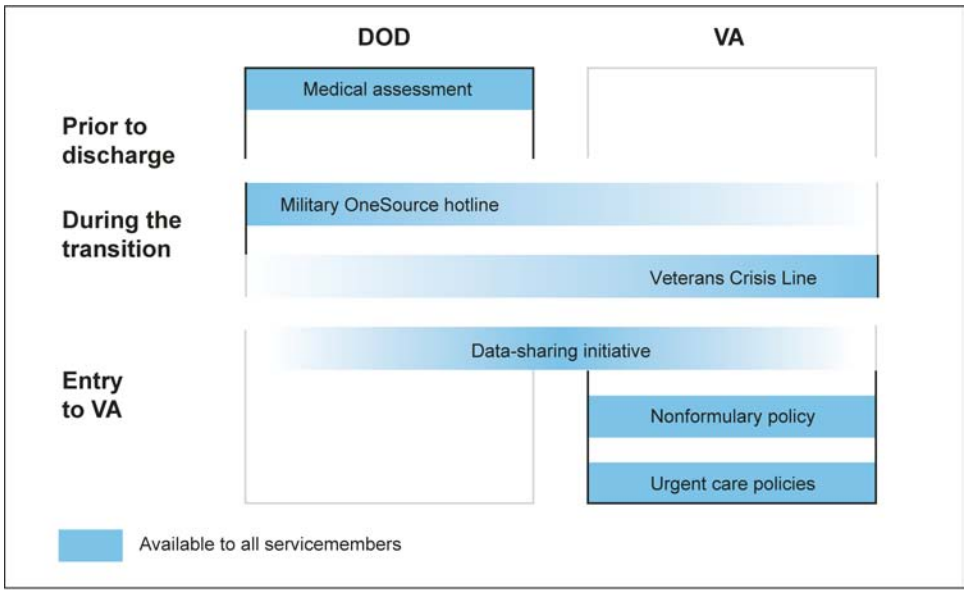
DOD's and VA's Efforts May Not Help All Servicemembers Manage Their Medication Needs during Transitions of Care

Efforts DOD and VA have in place that are directed to all servicemembers are limited in their ability to help servicemembers manage their medication needs during transitions of care. However, certain groups are eligible for additional assistance transitioning their health care, including medication management. Additionally, some DOD military treatment facilities and VA medical centers have efforts that can help manage servicemembers' medication needs, but the efforts may not be available at all facilities.

DOD and VA Efforts Directed at All Servicemembers Are Limited in Their Ability to Help Manage Transitional Medication Needs

DOD and VA have several efforts that may help servicemembers manage their medications during transitions, but these efforts are limited in terms of their ability to ensure that all servicemembers have the necessary help during this period. Although DOD does not have a formal policy for transitioning medication needs for all servicemembers, the two departments have broader policies, programs, and procedures that provide assistance to servicemembers with aspects of their transition more generally. Additionally, there are components of these efforts that may help servicemembers manage their medications during the transition from DOD to VA, but none of them are focused specifically on medication management. These efforts can occur at several phases of the transition: prior to a servicemember's discharge from the military; during the transition between the two departments; and once a veteran seeks care at a VA facility. (See fig. 1.)

Figure 1: DOD and VA Efforts Available to All Servicemembers That May Help Servicemembers Manage Their Medications during Transitions of Care



Source: GAO analysis of DOD and VA information.

Prior to Discharge

Prior to discharge, DOD officials identified the medical assessment—an interview between the discharging servicemember and a physician, physician assistant, or nurse practitioner occurring prior to separation—as the medical effort DOD has in place to help servicemembers transition their medical needs as they discharge from the military.[26] The assessment is not designed to address medication management; rather, its purpose is to document servicemembers' health at the time of separation and to record injuries or illnesses incurred during military service. The assessment does, however, include a review of current medications. Additionally, if the health care provider conducting the medical assessment believes a physical exam is appropriate, or if the

[26]For Reservists and National Guard members demobilizing, the post-deployment health assessment—the DOD process for assessing the medical condition of servicemembers after demobilization—may identify servicemembers who need medical assistance and may trigger a referral for care. Reservists and National Guard members may receive VA care prior to separating from the military.

servicemember requests one, the servicemember will receive one—commonly referred to as a separation physical.[27]

Although the medical assessment may help servicemembers manage their medications during transitions, its ability to do so is limited. First, although the assessment includes a review of medications prior to discharge, the assessment may not include certain best practices for transitioning medication needs, such as developing a plan for how to get medications during the transition and providing a medication list. Second, the medical assessment and separation physical can occur up to 6 months before a servicemember's separation date, and therefore may not be the servicemember's final medical appointments in the military, making it difficult for the provider to counsel the servicemember on medication management during the transition. Counseling about medication management is a critical component of successful transitions of care.

During the Transition

DOD and VA each have a telephone hotline—DOD's Military OneSource and VA's Veterans Crisis Line—available to help servicemembers and veterans with a variety of issues, including medication management. Specifically, Military OneSource provides resources and information to servicemembers and veterans on a range of topics—including health care, education, career training, finance, and family support—and VA's Veterans Crisis Line is available for servicemembers and veterans to call to connect with local VA medical centers. Although Military OneSource and VA's Veterans Crisis Line are available for servicemembers and veterans to call at any time,[28] providers told us these hotlines are particularly useful during transitions of care. For instance, some DOD providers said they tell servicemembers to call Military OneSource if they need assistance during their transition. Similarly, a VA nurse who responds to referrals from VA's Veterans Crisis Line said that she frequently receives referrals from the hotline from veterans who have

[27]The requirements for a separation physical vary among the military services. In the Army, retirees are required to have a separation physical, but servicemembers who are separating at the end of their term of service are not required to have a physical. Servicemembers in the Army also may waive the separation physical if they have undergone a physical examination within 12 months of separation.

[28]According to DOD officials, Military OneSource received approximately 1,500 calls daily in May 2012. The national coordinator of VA's Veterans Crisis Line said the hotline receives more than 1,000 calls daily.

problems with their medications, such as when they have let their medications lapse after discharging from the military and their symptoms have reemerged or they have experienced withdrawal symptoms. The national coordinator of VA's Veterans Crisis Line told us hotline responders estimate that they receive about one call per day from a transitioning veteran with a medication issue.

Entry to VA

For servicemembers who transition to VA, there are departmental policies that can assist with medication needs upon entry into VA's health care system, including VA's nonformulary policy, DOD and VA's data-sharing initiative, and VA's policies for providing urgent care. Specifically, VA's nonformulary policy—allowing providers to prescribe medications not on VA's formulary if they establish clinical necessity—can help newly transitioned veterans avoid medication discontinuations due to differences in DOD's and VA's formularies. VA providers said they will typically continue existing medication therapies for patients who are new to VA, even if the medication is not on VA's formulary, as long as the medication is effective and the veteran is stable on the medication. VA providers said their nonformulary requests are rarely denied and they have been able to keep new patients on nonformulary medications, or switch them to formulary medications when appropriate. A draft VA policy documents that VA providers are permitted to change previously prescribed DOD medications to medications on VA's formulary for servicemembers who have separated from military service.[29] Some VA providers said they may change a new VA patient's nonformulary medication to a VA formulary medication, but usually not when the patient is first entering VA, noting that it is important to establish relationships with patients before changing their medications. When comparing DOD's and VA's formularies for psychiatric and pain medications, we found that more than 50 percent of the psychiatric and pain medications on DOD's formulary as of March 12, 2012, were also on VA's formulary, and these medications represented the most utilized psychiatric and pain medications on DOD's formulary in fiscal year 2011. Specifically, the medications on DOD's formulary that were also on VA's formulary represented 90 and 96 percent of the total number of prescriptions for

[29]The draft policy also states that VA providers should continue DOD medication regimens for active duty servicemembers who are receiving care at VA. It clarifies that once a servicemember separates from the military, VA providers are permitted to change medications as appropriate. VA officials told us that they anticipate the policy will be released in December 2012.

psychiatric and pain medications, respectively. (See app. II for our comparison of DOD's and VA's formularies for psychiatric and pain medications.)

Additionally, to help servicemembers transition to VA, DOD and VA have a data-sharing initiative that allows DOD to electronically share historical health information, including outpatient pharmacy data, on separated servicemembers with VA on a monthly basis. Through this initiative, known as the Federal Health Information Exchange, DOD transmits certain information into a shared repository that VA can access and pull into its own record system, available at all VA facilities.[30] The purpose of the data-sharing initiative is to improve the safety and quality of care provided at VA and to reduce costs by avoiding duplicative services. Moreover, sharing of pharmacy data is important for medication management during transitions because it improves continuity of care. Although some VA providers access and use shared pharmacy data, others told us they were not aware that they could access DOD data through VA's system, or could not always find DOD data, and as a result had determined that looking for it typically was not worthwhile. DOD and VA officials said that the data-sharing initiative is fully operational and accessible at every VA facility. They said providers who do not use it may not be familiar with how to access data or aware of what information is available. They added that the information may not be as useful to providers if veterans sought care from a private provider before coming to VA because in those cases DOD's data are not the veterans' most recent health information.

VA also has national policies in place to prioritize patients with urgent health care needs and to provide such care on an expedited basis. Following these policies, each VA medical center we visited had procedures to accommodate "walk-in" patients—those who do not have an appointment—who had not previously received care at VA and had an urgent medical need. VA providers told us they ensure such patients are seen the same day they walk in to the facility and, in the case of an urgent medication need, are given enough medication to cover the period

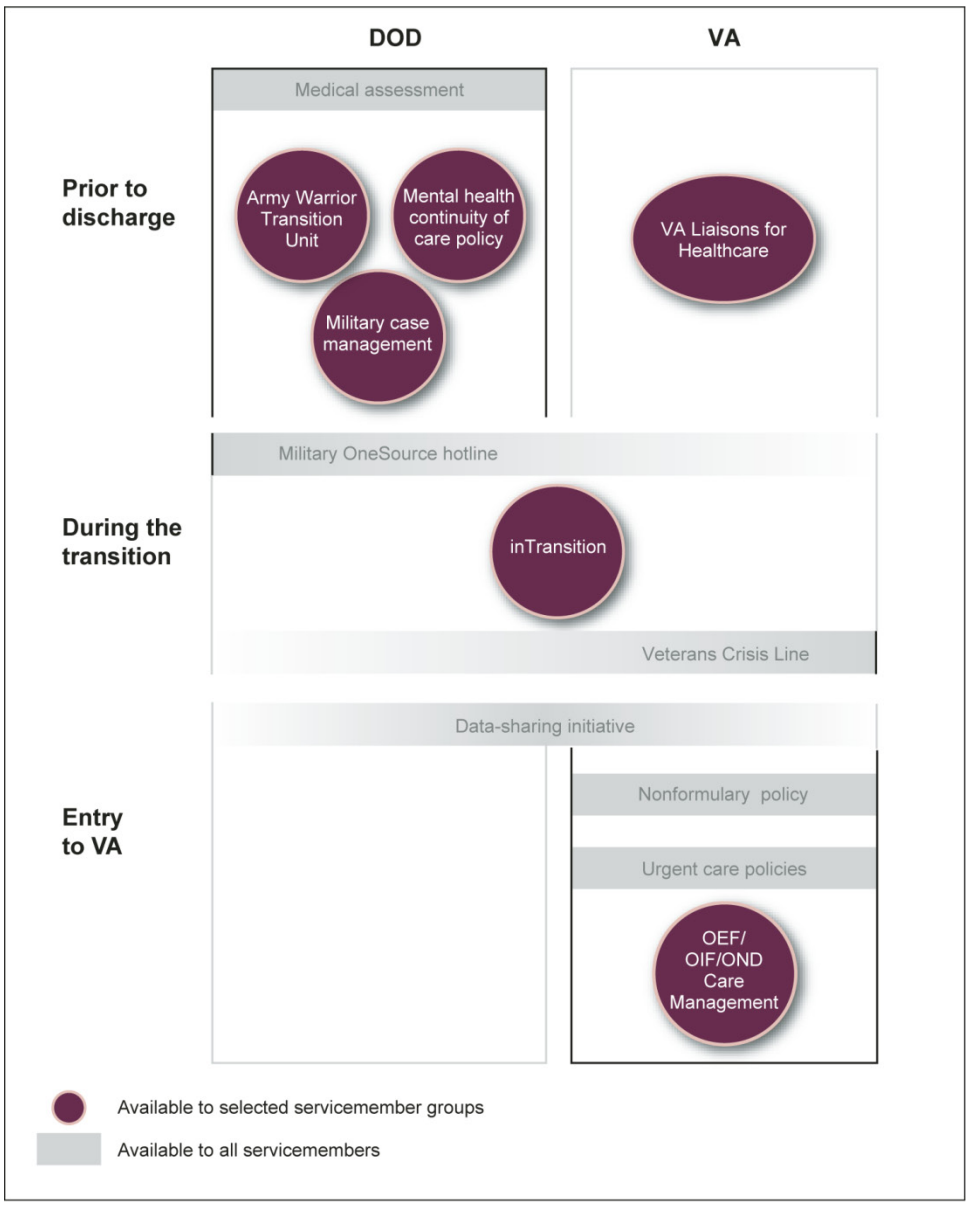
[30]DOD and VA also share electronic health information through the Bidirectional Health Information Exchange, which allows providers at both departments access to view information on shared patients who receive care from both DOD and VA. This initiative may help transition health care needs for Reservists and National Guard members who may receive VA care prior to separating from the military.

until they can come in for a full assessment. Providers told us they generally are able to provide any type of medication on a short-term basis, including nonformulary medications and less commonly prescribed medications, as long as patients are able to document their use of a particular medication. VA providers told us that such walk-ins are common and that walk-in procedures are in place so that any veteran who is eligible for care will not be left with an unmet need. The National Transitions of Care Coalition states that providing timely access to healthcare providers is a critical component of safe and effective transitions of care.

DOD and VA Provide Additional Assistance to Meet Transitional Medication Needs for Specific Servicemember Groups

In addition to the efforts available to all servicemembers, DOD and VA have developed efforts for specific servicemember groups—such as servicemembers with more complex health care needs or with mental health conditions—that are designed to provide more thorough and direct assistance with transitioning their health care, including components to help address medication needs. (See fig. 2.)

Figure 2: DOD and VA Efforts Targeted to Specific Servicemember Groups That Provide Additional Assistance to Help Manage Medication Needs during Transitions of Care



Source: GAO analysis of DOD and VA information.

Prior to Discharge

Prior to discharge, DOD and VA have several additional efforts available to servicemembers with complex health care needs or mental health conditions that provide assistance with transitioning their medication needs—including case management services and access to staff whose primary focus is helping servicemembers connect with VA health care services.

For example, servicemembers with complex health care needs may receive case management services through military case managers or Army WTUs, to help coordinate their medical care as they transition out of the military, including medication management.[31] Military case management services are available to servicemembers who have catastrophic or multiple medical needs, which could include managing medications. Family issues, seeing multiple providers, and a history of noncompliance are also indicators of a need for military case management. Military case managers are required to help connect separating servicemembers with new health care providers and to assist them with transitioning their health care needs, including medications. For example, military case managers are required to fill out the VA referral form and submit it, along with a discharge plan and medical record, to the VA representative at the military treatment facility or the receiving VA medical center.[32]

Additionally, transitioning servicemembers in the Army with complex health care needs may receive assistance through Army WTUs. The Army WTU program is available to wounded Army servicemembers whose injuries preclude them from contributing to their unit's mission or whose injuries are severe enough to require case management in order to properly rehabilitate. According to Army officials, WTUs served nearly 19,000 servicemembers during fiscal year 2011. WTUs are designed to help servicemembers remain in the Army or transition to civilian life, guided by a Comprehensive Transition Plan to facilitate their process of recovery and transition. Servicemembers are also assisted by a "Triad of

[31]Military case managers and WTUs provide similar services for servicemembers with complex health care needs, and DOD officials told us that unit commanders and military clinicians use judgment in determining which is most appropriate for a servicemember. Military case managers are also available to retirees and dependents, while WTUs are limited to active duty servicemembers, Reservists, and National Guard members.

[32]See Department of Defense, TRICARE Management Activity, *Medical Management Guide* (Washington, D.C.: 2009).

Care" team—composed of a nurse case manager, primary care manager, and squad leader. WTU policy requires nurse case managers to ensure a "warm handoff" to the VA either by connecting the servicemember with a VA representative stationed at the military treatment facility, or by assisting the servicemember with the VA enrollment process and contacting the receiving VA to coordinate follow-up care.[33] For example, the primary care and nurse case managers at facilities we visited without a VA representative on site told us they complete a VA referral form to identify any needs for specialty care, such as mental health care. As members of the Triad of Care team with the authority to prescribe medications, primary care managers—who are typically physicians—also can help WTU servicemembers prepare to manage their medications during a transition. For instance, a primary care manager we spoke with said that she ensures servicemembers have adequate supplies of medications to cover their transition periods and counsels servicemembers about the importance of adhering to their medication regimens.[34]

Some military case managers, WTU nurse case managers, and WTU primary care managers we spoke with told us they take additional measures when helping a servicemember transition to VA, including giving the servicemember a hard copy of his or her medical record, providing a list of his or her current medications, and writing a discharge summary that describes the servicemember's medical history and current status. In addition, some military case managers and WTU nurse case managers said servicemembers who have separated from the military sometimes contact them with questions about their health care—including medications. For example, servicemembers call them with questions about how to schedule appointments at their local VA facility because they need medications even though these individuals are no longer formally receiving military case management services. Sharing copies of medical records, providing a medication list, completing a discharge summary, and having a clearly identified practitioner to facilitate and

[33]See Department of Defense, Department of the Army, *Comprehensive Transition Plan: Policy and CTP-Guidance (CTP-G)* (Washington, D.C.: 2011).

[34]Squad leaders also help servicemembers prepare to transition out of the Army by providing nonclinical assistance, such as ensuring that servicemembers attend required briefings and vocational trainings prior to their separation from the military.

coordinate a patient's care are all best practices for transitions between health care providers.[35]

In addition to DOD military case management and Army WTUs, VA also provides assistance to servicemembers with complex health care needs prior to discharge through VA's Liaisons for Healthcare program. The liaisons are VA employees stationed at military treatment facilities who help ensure a smooth transition for servicemembers from those facilities to VA.[36] For instance, at the military treatment facility we visited with VA liaisons, the liaisons we spoke with said they would alert receiving VA medical centers about potential increased risks of medication discontinuation for patients for whom they had concerns. VA liaisons work with military case managers and WTU nurse case managers at military treatment facilities. Specifically, military case managers and WTU nurse case managers at military treatment facilities with VA liaisons are able to work directly with these liaisons to schedule appointments and share medical information, eliminating the need to contact the receiving VA medical centers. VA liaisons told us that although servicemembers are typically referred to them by military or WTU case managers, they also can assist servicemembers at their military treatment facility who do not receive military or WTU case management services. According to VA, VA liaisons assisted with approximately 6,500 referrals to VA and provided 28,500 educational consultations to servicemembers, families, and military providers in fiscal year 2011. Providers told us that servicemembers who receive assistance from a military case manager, WTU nurse case manager, or VA liaison are more likely than servicemembers who transition without this assistance to have a smooth transition from DOD to VA, including the transition of their medications.

[35]See National Transitions of Care Coalition, *Care Transition Bundle: Seven Essential Intervention Categories* (Washington, D.C.: Feb. 28, 2011); A. M. Spehar et al., "Seamless Care: Safe Patient Transitions from Hospital to Home," *Advances in Patient Safety: From Research to Implementation* (Rockville, Md.: 2005); and T. Bodenheimer, "Coordinating Care: A Perilous Journey through the Health Care System," *New England Journal of Medicine,* vol. 358, no. 10 (2008):1064-1071.

[36]According to VA officials, VA's formula for determining which military treatment facilities receive liaisons includes the total number of VA referrals made by each facility and patient acuity, among other factors. As of September 2012, there were 33 VA liaisons stationed at 18 military treatment facilities. VA officials said that the program has been approved to expand to 43 liaisons at 21 military treatment facilities in fiscal year 2013.

Additionally, in March 2012, DOD released a policy to ensure continuity of care for servicemembers receiving mental health care that outlines how to appropriately transition care between providers, including addressing psychiatric medication needs.[37] For instance, the policy directs the DOD provider to contact, as appropriate, the receiving provider to communicate the patient's history, current status, needs during the transition period—which could include medications—and to establish a follow-up appointment to better ensure continuity of care. It also states that the DOD provider should add a final summary of treatment in the patient's medical record. As with other DOD policies, this policy directs the individual military services to develop their own detailed policies in line with the general guidance for transitioning servicemembers' mental health care.

These efforts—military case management, WTUs, VA Liaisons for Healthcare, and DOD's mental health continuity of care policy—all include elements that experts have identified as best practices for transitions of care, such as sharing medical information directly between providers and scheduling appointments with a receiving provider prior to discharge.[38]

During the Transition

During the transition, servicemembers receiving mental health services are eligible for additional assistance through the inTransition program—a DOD program, with support from VA, established in 2010 to offer specialized coaching and assistance to servicemembers receiving mental health care as they transition between health care providers. The program is available to servicemembers who are transitioning within DOD and those who are separating from the military. Servicemembers can be identified for inTransition services either by self-referral or physician-referral. Coaches for inTransition are directed to contact servicemembers at least once a week and are trained in motivational interviewing to encourage servicemembers to continue their mental health care treatment, which could include medications. Although many of the DOD and VA providers we spoke with were unfamiliar with the inTransition program, one DOD mental health care provider said she believes the inTransition program is a useful resource and she shares the inTransition information with her patients prior to their discharge. Similarly, a National

[37]DOD refers to mental health care as behavioral health care. For consistency throughout this report and other GAO reports, we use the term mental health care.

[38]See National Transitions of Care Coalition, *Care Transition Bundle*.

Guard member we interviewed during one of our site visits told us he was not familiar with the program but said it would be helpful if someone checked in on him after he demobilized and left active duty, as he sometimes forgets to take his medications because of the memory loss he experiences from an injury. According to the director of the inTransition program, the program provided coaching services to approximately 1,800 servicemembers and veterans from February 1, 2010, through March 31, 2012. Coaching and education about how to self-manage one's care during a transition are also consistent with best practices.[39]

Entry to VA

Upon entry to VA, the OEF/OIF/OND Care Management Program can assist veterans with complex health care needs. Located at every VA medical center, the goal of the program is to coordinate patient care activities and ensure that OEF/OIF/OND veterans are receiving necessary care. Specifically, care management teams, which include program managers and case managers, work together to coordinate the care for veterans who need case management services and to receive patients when they arrive at VA. OEF/OIF/OND case managers also are required to contact veterans who have been referred by WTUs or military case managers prior to their first VA appointment. One veteran we interviewed during our site visits said he spoke with an OEF/OIF/OND case manager after his discharge, but prior to his first VA appointment. He described how he had run out of his medications—and had been cutting his psychiatric medication so it would last longer—and the case manager told him to come to a VA facility that day to see a provider and get his medications. Some case managers told us they also alert providers about any special needs, such as nonformulary medications, prior to a veteran's first appointment. Prior to discharge, OEF/OIF/OND program managers also serve as VA contacts for all WTU nurse case managers, military case managers, and VA liaisons working with transitioning servicemembers. Although military case managers, WTU nurse case managers, and VA liaisons are the primary way veterans get connected to the OEF/OIF/OND Care Management Program, the program is also available to any OEF/OIF/OND veteran who arrives at a VA facility. Program managers are responsible for ensuring that every veteran of these conflicts is screened for case management services, and

[39]See National Transitions of Care Coalition, *Care Transition Bundle*; T. Bodenheimer, "Coordinating Care"; and E. A. Coleman et al., "The Care Transitions Intervention."

veterans can request the services regardless of their screening results. According to VA officials, the OEF/OIF/OND Care Management Program was providing services to approximately 50,000 servicemembers and veterans at the end of fiscal year 2011.

Local DOD and VA Facility Efforts Can Help Meet Servicemembers' Transitional Medication Needs but May Not Be Available at All Facilities

Some DOD military treatment facilities and VA medical centers have developed local policies and procedures that can help servicemembers transition their care and manage their medications. For example, some military treatment facilities provide medication lists to servicemembers prior to discharge, and some VA medical centers conduct outreach to military treatment facilities. However, these efforts are not part of formal department-wide policies and are implemented at the discretion of individual facilities.

Two of the three military treatment facilities we visited had local policies that require providers to give patients a current medication list at the end of each appointment, including their last medical appointment prior to discharge. For instance, the list at one facility includes the medication name, dosage, directions for use, date of last fill, number of refills, and prescribing physician. Medication lists can assist servicemembers with medication management during transitions of care, including by helping to remind them to take their medications and to adhere to prescribed treatment regimens. Medication lists also can improve continuity of care during transitions by providing documentation of a patient's current medications. At the military treatment facility we visited that does not have this type of policy, case managers and providers told us they sometimes provide this type of information to servicemembers even though it is not required at their facility. The National Transitions of Care Coalition has identified medication lists as a best practice during transitions to ensure safe use of medications and adherence to patients' plans of care. Additionally, The Joint Commission, an accrediting body for health care organizations, includes medication lists in one of its patient safety goals.

In another example of local efforts to help meet transitional medication needs, officials from two VA medical centers we visited said they send staff to military treatment facilities or military bases without VA Liaisons for Healthcare to educate servicemembers about VA health care. According to officials at these VA medical centers, having a point of contact at VA increases the likelihood that servicemembers will call VA for care and may make them less likely to experience a discontinuation in their medication use. For instance, officials at one medical center we visited said they send OEF/OIF/OND care management staff to National

Guard demobilization events to help National Guard members returning from combat begin the process of enrolling in VA health care. Officials at another medical center said they send OEF/OIF/OND care management staff to a nearby Army military treatment facility that does not have a VA Liaison for Healthcare so they can act as informal VA liaisons, educating servicemembers about VA health care and providing VA enrollment forms. These activities also provide servicemembers with a VA point of contact during their transitions. Officials at these medical centers said these efforts improve the transition of care between DOD and VA and can reduce the likelihood of a veteran discontinuing medication use. Additionally, two veterans we spoke with described the benefit of having VA staff reach out to them while they were still on active duty. Specifically, one veteran told us an OEF/OIF/OND case manager called him prior to discharging from the Army to help him schedule his first appointment at VA and that this connection helped ensure he had a smooth transition of his health care, including his medications. While OEF/OIF/OND Care Management program materials suggest that OEF/OIF/OND Care Management staff are encouraged to conduct outreach to active duty servicemembers, this type of outreach is not required by VA policy. Instead, this type of outreach is directed by local VA medical centers.

Conclusions

Continuity of health care, especially with respect to medication management, is important for servicemembers who are transitioning out of the military and changing health care providers. Ensuring psychiatric and pain medications are continued during transitions is particularly important given the potential adverse health effects that can be experienced in response to misusing or abruptly discontinuing them. Given that DOD may be the last provider of health care prior to discharge, the department has primary responsibility for preparing servicemembers for transitions of care. DOD's medical assessment is a key opportunity for assisting all servicemembers with managing medications, but there is no assurance that best practices, such as providing current medication lists at the point of discharge, are included in these assessments. Additionally, although DOD and VA have several other efforts that implement one or more best practices for managing medications during transitions, these efforts are available only to specific groups or to servicemembers accessing certain DOD or VA facilities. DOD does not have a department-wide policy to help ensure that all transitioning servicemembers' medication needs are managed. Without such a policy, DOD cannot ensure, for example, that the basic step of providing current medication lists at the point of discharge is implemented across all its military

facilities, including for the approximately 50 percent of servicemembers discharged with psychiatric or pain medications who do not connect with VA providers in a timely manner, if at all. As such, the departments cannot be assured that servicemembers' medication needs are sufficiently met during transitions. Furthermore, best practices implemented locally or in specialized programs—such as scheduling VA appointments prior to discharge for WTU servicemembers—could benefit a broader population of servicemembers. Identifying best practices and implementing them across the departments could better ensure overall continuity of care, including medication management, for servicemembers transitioning between health care providers.

Recommendations for Executive Action

To help ensure appropriate medication management for all servicemembers during transitions, we recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness to develop a formal DOD transition policy for medications that applies to all servicemembers, including a requirement that all servicemembers be provided a current medication list prior to transitioning out of the military and changing health care providers.

We also recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, and the Secretary of Veterans Affairs direct the Under Secretary for Health, to work together to identify and apply best practices for managing servicemembers' medication needs during transitions of care, including assessing the extent to which practices currently available within existing transition policies and programs that are targeted to specific servicemember and veteran groups can be made more widely available.

Agency Comments and Our Evaluation

We provided a draft of this report to DOD and VA for comment. Both departments concurred with our recommendations, and the departments' responses are reprinted in appendixes III and IV. In its response, DOD provided comments on the medication list component of our recommendation for it to develop a transition policy for medications that applies to all servicemembers. DOD stated that servicemembers may receive a copy of their medical records, which would include a list of current medications. However, DOD does not provide all servicemembers a copy of their medical records. DOD also indicated that medication

information for servicemembers is already shared with VA through the Bidirectional Health Information Exchange. However, as we noted in our report, this data-sharing initiative is limited to shared patients—such as servicemembers who receive care from both DOD and VA prior to separating from the military. Moreover, not all servicemembers discharged from DOD subsequently receive care from VA. We believe that it is important that all servicemembers transitioning out of the DOD health care system be provided with a medication list at discharge, which is important for helping to ensure medications are used appropriately and that there is continuity of care for servicemembers changing health care providers.

In response to our recommendation that DOD and VA work together to identify and apply best practices for managing servicemembers' medication needs during transitions of care, DOD specified that it would work with VA to identify best practices such as reducing medication errors. As DOD identifies and applies best practices, it should focus on practices that will help manage servicemembers' medication needs during transitions of care. As we have identified in our report, some of these best practices are currently available within existing transition policies and programs and could be made more widely available. Additionally, VA stated that its Veterans Health Administration has several efforts under way to address the challenges associated with the medication needs of transitioning servicemembers. VA also provided technical comments, which we have incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 12 days from the report date. At that time, we will send copies of this report to the Secretary of Defense, Secretary of Veterans Affairs, and appropriate congressional committees. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.

Sincerely yours,

Debra A. Draper
Director, Health Care

Appendix I: Scope and Methodology

To determine the extent to which servicemembers transitioned out of the Department of Defense (DOD) health care system with psychiatric or pain medications, we obtained data from DOD's Defense Manpower Data Center and Defense Health Cost Assessment and Program Evaluation on the number of servicemembers who discharged and Reservists and National Guard members who demobilized with psychiatric or pain medications in fiscal years 2009, 2010, and 2011. The Defense Manpower Data Center provided us with a list of active duty servicemembers, Reservists, and National Guard members who discharged or were released (including retirees) from military service generally under conditions other than dishonorable and a list of Reservists and National Guard members who demobilized. We included servicemembers who discharged and Reservists and National Guard members who demobilized because servicemembers in both of these populations can transition out of the DOD health care system and could be eligible for VA care. For servicemembers who had multiple discharge or demobilization dates within a fiscal year, we used the latest date. DOD's Pharmacoeconomic Center provided us with a list of psychiatric and pain medications.[1] DOD's Defense Health Cost Assessment and Program Evaluation then reviewed TRICARE claims files for discharged and demobilized servicemembers to determine if they had a current psychiatric or pain medication when they discharged or demobilized. Data from the claims files identifies prescriptions that were filled, not all prescriptions that were written. Furthermore, because some psychiatric and pain medications may be prescribed for conditions other than mental health or pain conditions, the number of servicemembers with psychiatric or pain medications is not equivalent to the number of servicemembers with related conditions.

To determine how many of those servicemembers discharged from military service and Reservists and National Guard members demobilized with psychiatric or pain medications subsequently received care at the Department of Veterans Affairs (VA), we obtained data from VA's National Data System on how many of these servicemembers subsequently received health care from VA. We provided VA with the list of servicemembers who discharged from military service or demobilized

[1]DOD's Pharmacoeconomic Center excluded psychiatric and pain medications that were available over-the-counter, were bulk medications used by pharmacists for compounding, and were provided through certain routes of administration, such as intravenous pain medications.

with a psychiatric or pain medication in fiscal years 2009, 2010, or 2011. VA compared the data to its electronic medical records to identify which servicemembers received care at VA within 9 months of their discharge or demobilization date. We selected the 9-month time frame to provide consistent data across each of the 3 fiscal years—the most current available VA data at the time of our review were from June 2012, 9 months after the end of fiscal year 2011. Data on servicemembers who subsequently received care from VA do not describe the full population of servicemembers who received care after being discharged from military service or demobilized. Not all servicemembers subsequently seek and receive care from VA; some receive care from other sources, such as private providers.

We assessed the reliability of the data in several ways, including discussing with DOD and VA officials their methodology and data-collection techniques and conducting our own review of their programming and methodological approaches using data file documentation, code book and file dictionaries, and programming logs.

To identify the efforts DOD and VA have in place to help ensure that servicemembers' psychiatric and pain medication needs are met during transitions of care, we reviewed documents and interviewed officials from DOD, the Department of the Army, and VA. We focused our review on the Army, rather than the other military services, because it had the largest number of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF)[2] servicemembers. We reviewed documents including DOD, Army, and VA policies related to health care and medication transitions. For example, we reviewed the Army Surgeon General Pain Management Task Force Report, VA's National Pain Management Strategy, and VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.[3] We interviewed officials from DOD, Army, and VA headquarters offices that have oversight of, and set

[2]Military operations in Iraq as of September 1, 2010, are referred to as Operation New Dawn (OND).

[3]See Office of the Army Surgeon General, Pain Management Task Force, *Providing a Standardized DOD and VHA Vision and Approach to Pain Management to Optimize the Care for Warriors and their Families* (May 2010); Department of Veterans Affairs, *Pain Management*, VHA Directive 2009-053 (Washington, D.C.: Oct. 28, 2009); and Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain* (May 2010).

policies related to, the provision of health care, including mental health and pain care and prescription-medication benefits, and that have roles in assisting servicemembers with their health care as they transition out of DOD. Specifically, we interviewed officials from

- DOD's TRICARE Management Activity's Clinical Quality Office, Pharmacoeconomic Center, and Case Management Program; Reserve Medical Programs; Defense Health Information Management System; and inTransition Program;
- Office of the Surgeon General of the Army; Army National Guard; and Army Pain Management Program; and
- VA's VA/DOD Collaboration Office and Veterans Health Administration's Pharmacy Benefits Management Services, Veterans Crisis Line, inTransition Program, Office of Health Information, Pain Management Program, Liaisons for Healthcare Program, and OEF/OIF/OND Care Management Program.

We also interviewed officials, including providers and case managers, from Army military treatment facilities and VA medical centers, as well as servicemembers and veterans, through six site visits to obtain their perspectives about how the departments' efforts to transition servicemembers with medication needs are being implemented and to identify local efforts to assist servicemembers with medication management during transitions. We selected sites to obtain a diverse sample based on facility size, patient complexity, presence or absence of a VA Liaison for Healthcare, and Army and VA region, and to ensure military treatment facility proximity to a VA medical center. On the basis of these criteria we selected the following facilities: (1) Walter Reed National Military Medical Center (Bethesda, Md.); (2) Washington D.C. VA Medical Center; (3) Bayne-Jones Army Community Hospital (Fort Polk, La.); (4) Alexandria VA Medical Center (Pineville, La.); (5) Weed Army Community Hospital (Fort Irwin, Calif.); and (6) Loma Linda (Calif.) VA Medical Center. Finally, we also interviewed officials from selected veterans service organizations—the American Legion, Military Officers Association of America, and Wounded Warrior Project—to get their perspectives on transition policies and programs and where there are opportunities to improve the handoff from DOD to VA.

We focused our review on efforts that department officials and local military treatment facility and VA medical center officials identified as having a role in helping servicemembers manage their medications as they transition from DOD to VA. We also focused on the transition efforts used for servicemembers transitioning between outpatient settings, rather than inpatient settings, because medication management between outpatient settings is a vulnerable point in terms of providing seamless care. We may not report an exhaustive list of all efforts because some servicemembers may have received help through efforts that were not identified by the officials we interviewed or through efforts that may not have been related to the health care aspects of their transition. We did not review the effectiveness of the efforts identified.

Additionally, we reviewed relevant literature on transitions of care and medication adherence, including effective approaches for transitioning health care needs and strategies for promoting patient adherence to medication treatment plans. For example, we reviewed literature from the National Transitions of Care Coalition, a nonprofit organization that works to address gaps that affect safety and quality of care for transitioning patients, to identify best practices within DOD's and VA's transition efforts.

We conducted this performance audit from January 2012 to October 2012 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.

Appendix II: Formulary Comparison

In comparing DOD's and VA's formularies for psychiatric and pain medications, we determined which psychiatric and pain medications on DOD's formulary were also on VA's formulary.[1] DOD's Pharmacoeconomic Center provided us with a list of the psychiatric and pain medications on DOD's formulary, as of March 12, 2012.[2] We compared this list with VA's full formulary, found on VA's Veterans Health Administration's Pharmacy Benefits Management Services website, as recommended by VA pharmacy officials.[3] We compared medications using generic names; we did not compare medications based on differences in strength or dosage form, such as whether the medication is a liquid or a tablet.[4] DOD also provided data on the number of prescriptions filled for psychiatric and pain medications by active duty servicemembers to provide additional context for our comparison. We spoke with knowledgeable DOD pharmacy officials about the data, including their methodology for identifying psychiatric and pain medications, and with DOD and VA officials about our methodology for comparing the formularies. On the basis of these discussions, we determined the data to be sufficiently reliable for our purposes.

We found that 57 percent of the psychiatric and pain medications on DOD's formulary were also on VA's formulary, and these medications represented the most utilized psychiatric and pain medications on DOD's formulary. (See table 4.) Specifically, the medications on DOD's formulary that were also on VA's formulary—62 psychiatric medications and 31 pain medications—represented 90 and 96 percent of the total number of

[1]Because we focused on transitions of care from DOD to VA, we did not determine which medications on VA's formulary were not on DOD's formulary.

[2]DOD's Pharmacoeconomic Center excluded psychiatric and pain medications that were available over-the-counter, were bulk medications used by pharmacists for compounding, and were provided through certain routes of administration, such as intravenous pain medications.

[3]VA, "VA National Formulary," accessed March 16, 2012, http://www.pbm.va.gov/NationalFormulary.aspx. VA officials confirmed that there had been no changes to the formulary between March 12, 2012, and March 16, 2012.

[4]According to DOD and VA pharmacists, differences in dosage form do not typically correspond to clinically significant differences. However, in some cases, different dosage forms may be prescribed for different clinical indications and may have significant implications for patients. For instance, some opioids are prescribed in an immediate-release formulation for breakthrough pain, whereas a long-acting formulation may be prescribed for chronic pain.

prescriptions for psychiatric and pain medications, respectively, filled by active duty servicemembers in fiscal year 2011.

DOD and VA pharmacy officials said that some of the differences in DOD's and VA's formularies are due to differences in the structure of the departments' health care systems. For example, DOD's formulary covers prescriptions written by both military and civilian providers and, as a result, DOD officials said that the department needs to have a broader formulary to account for differences in prescribing practices among different providers. In contrast, VA has a closed system and provides prescriptions written by its own providers, which VA officials said allows VA to have more direct control over the medications that are prescribed to its patient population. VA officials also emphasized that VA regularly provides nonformulary medications to veterans through its nonformulary request process that allows providers to prescribe medications not on VA's formulary if they can establish clinical necessity.[5] VA providers at the three sites we visited told us that they find the nonformulary request process easy to use and that their nonformulary requests are rarely denied.

[5]Each VA medical center is responsible for establishing a process to adjudicate nonformulary medication requests that ensures decisions are evidence-based in accordance with certain prescribing criteria. Medical centers are required to adjudicate nonformularly medication requests within 96 hours.

Table 4: Comparison of DOD's and VA's Formularies for Psychiatric and Pain Medications, March 2012

Medication on DOD's formulary[a]	Medication on VA's formulary	Percentage of DOD prescriptions filled by active duty servicemembers, fiscal year 2011
Psychiatric		
Sertraline Hydrochloride	✓	10.7%
Citalopram Hydrobromide	✓	8.8
Bupropion Hydrochloride	✓	7.5
Diazepam	✓	7.0
Trazodone Hydrochloride	✓	6.9
Clonazepam	✓	5.5
Venlafaxine Hydrochloride	✓	5.3
Fluoxetine Hydrochloride	✓	5.2
Amphet Asp Amphet D Amphet		4.6
Quetiapine Fumarate	✓	4.4
Amitriptyline Hydrochloride	✓	3.5
Topiramate	✓	3.5
Alprazolam	✓	2.8
Lorazepam	✓	2.5
Methylphenidate Hydrochloride	✓	2.2
Paroxetine Hydrochloride	✓	2.2
Mirtazapine	✓	1.8
Duloxetine Hydrochloride		1.7
Aripiprazole	✓	1.5
Buspirone Hydrochloride	✓	1.4
Divalproex Sodium	✓	1.4
Nortriptyline Hydrochloride	✓	1.2
Lamotrigine	✓	1.1
Risperidone	✓	0.8
Modafinil		0.7
Olanzapine	✓	0.5
Levetiracetam	✓	0.5
Atomoxetine Hydrochloride		0.5
Lithium Carbonate	✓	0.4
Oxcarbazepine		0.4
Armodafinil		0.3

Medication on DOD's formulary[a]	Medication on VA's formulary	Percentage of DOD prescriptions filled by active duty servicemembers, fiscal year 2011
Dextroamphetamine Sulfate	✓	0.3
Doxepin Hcl	✓	0.3
Ziprasidone Hydrochloride	✓	0.3
Carbamazepine	✓	0.2
Desvenlafaxine Succinate		0.2
Lisdexamfetamine Dimesylate		0.1
Zonisamide		0.1
Phenytoin Sodium Extended	✓	0.1[b]
Imipramine Hydrochloride	✓	0.1
Milnacipran Hydrochloride		0.1
Fluvoxamine Maleate		0.1
Primidone	✓	< 0.1
Desipramine Hydrochloride	✓	< 0.1
Sodium Oxybate		< 0.1
Asenapine Maleate		< 0.1
Haloperidol	✓	< 0.1
Chlorpromazine Hydrochloride	✓	< 0.1
Chlordiazepoxide Hydrochloride	✓	< 0.1
Lacosamide		< 0.1
Clomipramine Hydrochloride	✓	< 0.1
Phenelzine Sulfate	✓	< 0.1
Clorazepate Dipotassium		< 0.1
Nefazodone Hydrochloride		< 0.1
Paliperidone	✓	< 0.1
Dexmethylphenidate Hydrochloride		< 0.1
Guanfacine Hydrochloride		< 0.1
Oxazepam		< 0.1
Olanzapine Fluoxetine Hydrochloride	✓[c]	< 0.1
Clozapine	✓	< 0.1
Perphenazine	✓	< 0.1
Phenobarbital	✓	< 0.1
Valproic Acid	✓	< 0.1
Imipramine Pamoate	✓	< 0.1

Medication on DOD's formulary[a]	Medication on VA's formulary	Percentage of DOD prescriptions filled by active duty servicemembers, fiscal year 2011
Phenytoin	✓	< 0.1
Protriptyline Hydrochloride		< 0.1
Vilazodone Hydrochloride		< 0.1
Amitriptyline Hydrochloride Chlordiazepoxide	✓[c]	< 0.1
Paroxetine Mesylate	✓	< 0.1
Loxapine Succinate	✓	< 0.1
Lurasidone Hydrochloride		< 0.1
Perphenazine Amitriptyline	✓[c]	< 0.1
Pimozide	✓	< 0.1
Bupropion Hydrobromide	✓	< 0.1
Thiothixene	✓	< 0.1
Selegiline	✓	< 0.1
Fluphenazine Hydrochloride	✓	< 0.1
Valproate Sodium		< 0.1
Maprotiline Hydrochloride		< 0.1
Methamphetamine Hydrochloride		< 0.1
Isocarboxazid		< 0.1
Ethosuximide		< 0.1
Lithium Citrate	✓	< 0.1
Tranylcypromine Sulfate	✓	< 0.1
Thioridazine Hydrochloride		< 0.1
Trifluoperazine Hydrochloride	✓	< 0.1
Clonidine Hydrochloride	✓	< 0.1
Amoxapine		< 0.1
Haloperidol Lactate	✓	< 0.1
Clobazam		0.0
Ethotoin		0.0
Felbamate	✓	0.0
Mephobarbital		0.0
Meprobamate		0.0
Methsuximide		0.0
Molindone Hydrochloride	✓	0.0
Rufinamide		0.0

Medication on DOD's formulary[a]	Medication on VA's formulary	Percentage of DOD prescriptions filled by active duty servicemembers, fiscal year 2011
Trimipramine Maleate		0.0
Vigabatrin		0.0
Subtotal psychiatric 99	**62 (63%)**	**100%[d]**
Pain		
Ibuprofen	✓	27.8
Hydrocodone Bit Acetaminophen	✓	14.0
Oxycodone Hydrochloride Acetaminophen	✓	13.8
Naproxen	✓	11.4
Tramadol Hydrochloride	✓	6.5
Cyclobenzaprine Hydrochloride	✓	6.5
Meloxicam	✓	5.0
Celecoxib		2.7
Gabapentin	✓	2.3
Acetaminophen With Codeine	✓	2.0
Oxycodone Hydrochloride	✓	1.7
Diclofenac Sodium	✓	1.0
Indomethacin	✓	0.8
Morphine Sulfate	✓	0.5
Piroxicam	✓	0.4
Naproxen Sodium	✓	0.3
Hydromorphone Hydrochloride	✓	0.3
Ketorolac Tromethamine	✓	0.3
Etodolac	✓	0.2
Tramadol Hydrochloride Acetaminophen		0.2
Buprenorphine Hydrochloride Naloxone	✓	0.1
Diclofenac Epolamine		0.1
Fentanyl	✓	0.1
Oxymorphone Hydrochloride		0.1
Hydrocodone Ibuprofen		0.1
Methadone Hcl	✓	0.1
Nabumetone		0.1
Meperidine Hydrochloride	✓	0.1

Medication on DOD's formulary[a]	Medication on VA's formulary	Percentage of DOD prescriptions filled by active duty servicemembers, fiscal year 2011
Oxaprozin		0.1
Diclofenac Potassium	✓	0.1
Sulindac	✓	< 0.1
Diclofenac Sodium Misoprostol		< 0.1
Diflunisal		< 0.1
Tapentadol Hydrochloride		< 0.1
Codeine Sulfate	✓	< 0.1
Buprenorphine	✓	< 0.1
Ketoprofen		< 0.1
Tolmetin Sodium		< 0.1
Salsalate	✓	< 0.1
Dihydrocodeine Aspirin Caffeine		< 0.1
Naproxen Esomeprazole Magnesium		< 0.1
Buprenorphine Hydrochloride	✓	< 0.1
Mefenamic Acid		< 0.1
Butorphanol Tartrate	✓	< 0.1
Codeine Butalbital Acetaminophen Caffeine		< 0.1
Flurbiprofen	✓	< 0.1
Morphine Sulfate/Naltrexone		< 0.1
Pentazocine Hydrochloride Naloxone Hydrochloride		< 0.1
Fentanyl Citrate	✓	< 0.1
Dihydrocodeine Bitartrate Acetaminophen Caffeine		< 0.1
Oxycodone Hydrochloride Oxycodone Terephthalate Aspirin		< 0.1
Pentazocine Hydrochloride Acetaminophen		< 0.1
Fenoprofen Calcium		< 0.1
Ibuprofen Oxycodone Hydrochloride		< 0.1
Meclofenamate Sodium		< 0.1
Oxycodone Hydrochloride Aspirin		< 0.1
Codeine Butalbital Aspirin Caffeine		< 0.1
Choline Sal Magnesium Salicylate		< 0.1
Levorphanol Tartrate		< 0.1

Medication on DOD's formulary[a]	Medication on VA's formulary	Percentage of DOD prescriptions filled by active duty servicemembers, fiscal year 2011
Meperidine Hydrochloride Prometh Hydrochloride		< 0.1
Aspirin Codeine Phosphate		< 0.1
Carisoprodol Codeine Phosphate Aspirin		< 0.1
Ibuprofen Famotidine		0.0
Lansoprazole Naproxen		0.0
Magnesium Salicylate		0.0
Subtotal pain 65	**31 (48%)**	**100%[d]**
Total 164	**93 (57%)**	

Source: GAO analysis of DOD and VA data.

[a]This analysis does not include psychiatric or pain medications on DOD's formulary that were available over-the-counter, were bulk medications used by pharmacists for compounding, and were provided through certain routes of administration, such as intravenous pain medications.

[b]Prescriptions for phenytoin sodium extended includes prescriptions for phenytoin sodium.

[c]VA generally does not include combination medications on its formulary. However, VA officials told us that their providers can prescribe several medications together, which can be equivalent to the combination medication. Therefore, in cases where VA's formulary includes the individual medications that make up a particular combination medication, we have marked it as being on VA's formulary.

[d]Percentages do not sum to 100 due to rounding.

Appendix III: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

OCT 15 2012

Ms. Debra Draper
Director, Defense Health Care Team
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC 20548

Dear Ms. Draper:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report GAO-13-26, "VA AND DOD HEALTH CARE: Medication Needs During Transitions May Not Be Managed for All Servicemembers," dated September 21, 2012 (GAO Code 291003). DoD appreciates the opportunity to comment on the draft report. DoD concurs with both recommendations.

Please direct any questions to the points of contact on this matter, Mr. Kenneth E. Cox (Functional) and Mr. Gunther J. Zimmerman (Audit Liaison). Mr. Cox may be reached at (703) 681-4258, or Kenneth.Cox@tma.osd.mil. Mr. Zimmerman may be reached at (703) 681-3492, ext. 4065, or Gunther.Zimmerman@tma.osd.mil.

Sincerely,

Jonathan Woodson, M.D.

Enclosures:
1. Overall Comments

GOVERNMENT ACCOUNTABILITY OFFICE
Draft Report Dated September 21, 2012
GAO-13-26 (GAO CODE 291003)

"DOD AND VA HEALTH CARE: MEDICATION NEEDS DURING TRANSITIONS MAY NOT BE MANAGED FOR ALL SERVICEMEMBERS"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATION

RECOMMENDATION 1: The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness to develop a formal DOD transition policy for medications that applies to all servicemembers, including a requirement that all servicemembers be provided a current medication list prior to transitioning out of military and changing health care providers.

DoD RESPONSE: DoD concurs with comment to the recommendation. A manual, stand-alone process for providing every servicemember a list of current medications would be extremely burdensome, and may not result in substantially improved health care outcomes. However, DoD agrees that it has the same responsibility for providing global access to health information for "healthy" separating servicemembers as for the injured and ill. Thus, every Service member may receive a current list of active prescriptions during separation processing as part of the personal copy of the medical records. Additionally, that list is available to every potential Department of Veterans Affairs (VA) provider who may see the patient next through the Bi-directional Health Information Exchange (BHIE) system. The BHIE system makes available the complete text of visit notes and a listing of all diagnoses since 2005. These notes may include summaries with detailed care plans for complicated cases. The first VA provider to see a newly separated patient thus has a quite robust set of data already to review before seeing the patient. Should there be any questions, the name and telephone numbers to contact the last DoD providers who saw the patient are there. While not able to anticipate the next VA provider in most cases, the DoD has provided as much information as possible via BHIE and made it very easy for personal communication between providers to take place whenever necessary. DoD has established a work group to update its current Service Treatment Record guidance to account for numerous ways AHLTA is already used and to standardize future documentation in the electronic health record. DoD will use this updated guidance to leverage this technical capability to its fullest extent and promote standardization in how prescriptions are entered in to AHLTA.

RECOMMENDATION 2: The GAO recommends that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness and the Secretary of Veteran Affairs direct the Under Secretary of Health to work together to identify and apply best practices for managing servicemembers' medication needs during transitions of care, including assessing the extent to which practices currently available within existing transition policies and programs that are targeted to specific servicembember and veteran groups can be made more widely available.

DoD RESPONSE: DoD concurs with the recommendation. DoD will work with VA to identify best practices to reduce medication errors, adverse effects, number of total medications needed, and improve patient outcomes.

Appendix IV: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

October 19, 2012

Ms. Debra Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"DOD AND VA HEALTH CARE: Medication Needs during Transitions May Not Be Managed for All Servicemembers"*** (GAO-13-26). VA generally agrees with GAO's conclusions and concurs with GAO's recommendation to the Department.

The enclosure specifically addresses GAO's Recommendation 2 and provides technical comments to the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

John R. Gingrich
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"DOD AND VA HEALTH CARE: Medication Needs during Transitions May Not Be Managed for All Servicemembers"
(GAO-13-26)

Recommendation 2: We also recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness and the Secretary of Veterans Affairs direct the Under Secretary for Health to work together to identify and apply best practices for managing servicemembers' medication needs during transitions of care, including assessing the extent to which practices currently available within existing transition policies and programs that are targeted to specific servicemember and veteran groups can be made more widely available.

VA Comment: Concur. Addressing the medication needs of transitioning Servicemembers is important to the Veterans Health Administration (VHA). The Government Accountability Office report identifies a number of challenges such as how to address serious adverse effects if psychiatric and pain medications are abruptly discontinued and how best to transition health care between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) regarding formulary and information management, training, and development of tools. VHA has been working to address the challenges as described in the review, and will continue its efforts. For example, VHA has several committees and workgroups where VHA has already developed collegial relationships with counterparts in DoD, as well as the Indian Health Service (IHS). We will encourage the continuation of these efforts. The current efforts and accomplishments include:

- The National Alliance for Patient Medication Information Standardization (NAPMIS) includes representatives from VHA, DoD, and the Department of Veterans Affairs (VA) Office of Information and Technology (OIT). NAPMIS has helped develop the "Essential Medication List" that outlines the basic medication information that must be available in any medication list for the purposes of coordinating and managing patient medication information.

- The VHA Inter-Professional Medication Information Education Workgroup includes representatives from VHA, DoD, and IHS staff works to develop training and tools necessary to manage information between health care teams, patients, and caregivers as they transition between care settings. This includes the transitions involving DoD and VA.

- VHA's 2012 Medication Use Crisis conference, a multi-program, multi-Federal agency conference with DoD participation, included a presentation by the VA Liaison for Healthcare program office. Participants in the conference discussed how to communicate with patients about understanding their medications and how to get the full benefit of their medication therapy, improve therapeutic outcomes, reduce medication errors and adverse drug events, enhance coordination of patient

1

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"DOD AND VA HEALTH CARE: Medication Needs during Transitions May Not Be Managed for All Servicemembers"
(GAO-13-26)

centered care to improve Veterans' and Servicemembers quality of life, and reduce overall healthcare costs. There was also a presentation by the Office of Mental Health, Pain, and Addiction Services on, "Misuse of Meds: Addiction, Pain, and Mental Illness". This will continue on in fiscal year 2013 as a quarterly virtual conference series with DoD and IHS officials invited to attend and participate on the planning committee.

- VHA's My HealtheVet (MHV) team works with appropriate DoD officials to support transitioning Servicemembers accessing their medication information through "Medication Play It Safe" and "Ask A Pharmacist."

- VHA will request that the Interagency Care and Coordination Committee Community of Practice task a group of VHA and DoD staff to collaborate and design a process that will help to expand our current activities so as to make them mainstream.

- Representatives from VA's Medication Reconciliation program were invited to present at the VA Liaison for Healthcare program's annual training on VA's formulary and policies governing returning Servicemembers.

VHA has a number of internal initiatives and examples are provided below. Results of these initiatives will be shared with our Federal partners as appropriate.

- VHA clinicians and staff have access to a VA Medication Reconciliation Share Point Site with templates and documentation where best practices regarding medication information management are shared. We have sent examples of products to our Federal partners upon request.

- VHA has established internal workgroups charged to improve documentation and monitoring, as well as education of both patients and staff to improve patient care for transitioning Servicemembers. Examples are the Medication Reconciliation Documentation and Monitoring Workgroup and the Medication Staff and Patient Education Workgroup, both of which meets monthly in a virtual format. We have shared our products with our Federal partners.

- VistAWeb or the Computerized Patient Record System provides information to VHA clinicians and staff about medications currently prescribed for active uty/transitioning Servicemembers that receive care at VA facilities.

Servicemembers who elect to receive care with VHA are assigned to Primary Care Patient Aligned Care Teams (PACT). PACT provides patient-centric, longitudinal,

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"DOD AND VA HEALTH CARE: Medication Needs during Transitions May Not Be Managed for All Servicemembers"
(GAO-13-26)

team-based care that focuses on ensuring access, care management, and coordination for chronic illness as well as prevention, healthy living, and wellness services. PACT members caring for Veterans returning from recent combat include mental health personnel and social workers to enhance sensitivity to the mental health needs and readjustment issues prevalent in this population, including the management of chronic pain syndromes. PACT providers partner with the Veteran and other VA services in prescribing medications consistent with VA prescribing guidelines. As patients receive care from their assigned PACT, staff reviews current medications to promote patient safety and appropriateness of care. VHA has established policies for Veterans without an assigned primary care provider to receive care without delay via the Emergency Department or Urgent Care Clinics.

VHA is also planning to review existing transition policies and programs in 2013 as part of the VA Medication Information Management Initiative. The purpose would be to focus on how to achieve more patient-centered medication information management.

3

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Janina Austin, Assistant Director; Jennie Apter; Lisa Motley; Leslie Powell; Dan Ries; and Karin Wallestad made key contributions to this report.