VA Veterans Opioid Oversight Report

Opioid Safety, MME Metrics, Tapering Practices, and Veteran Outcomes

Prepared for Congressional Oversight Discussion

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Pain Awareness - Right to Treatment

Core principle: High-risk veterans should receive more support and individualized care, not automatic tapering, abandonment, or denial of effective treatment.

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I. Executive Summary

Veterans living with chronic pain are not a generic patient population. Many carry service-connected injuries, traumatic brain injury, PTSD, depression, anxiety, substance-use risk, sleep disorders, mobility limitations, and increased suicide risk. These overlapping conditions do not make veterans less deserving of pain treatment. They make individualized care, mental-health support, suicide-prevention safeguards, and careful medical judgment even more critical.

Over the past decade, the Department of Veterans Affairs implemented major opioid-reduction initiatives, including the Opioid Safety Initiative, prescribing dashboards, MME-based monitoring, opioid/benzodiazepine reduction efforts, high-dose opioid metrics, tapering tools, and risk-stratification systems such as STORM, the Stratification Tool for Opioid Risk Mitigation. These systems were designed to reduce overdose risk and improve opioid safety. However, congressional oversight is needed to determine whether these policies were implemented, and continue to be implemented, in a way that protected veterans — or whether some veterans were destabilized by policy-driven tapering, abrupt discontinuation, rigid dose thresholds, inadequate follow-up, or loss of access to effective pain care.[1][2]

The concern is not that opioid safety should be ignored. The concern is that opioid safety cannot be measured only by reduced prescribing numbers. A reduction in opioid prescriptions does not automatically prove improved patient outcomes. If veterans are tapered without adequate mental-health care, pain care, informed consent, suicide-risk screening, monitoring, and timely follow-up, the result may be greater harm rather than greater safety.

VA's own risk-stratification research recognized that veterans prescribed opioids may have multiple overlapping risk factors, including prior overdose or suicide-related events, mental-health diagnoses, substance-use disorder diagnoses, opioid dose, sedative co-prescribing, emergency-room use, inpatient mental-health treatment, and medical comorbidities. The VA clearly knew many veterans affected by opioid policy were medically and psychologically complex. The central question is whether that complexity triggered more coordinated care — or whether it became part of a system that justified tapering, scrutiny, and institutional risk management.

Later federal guidance from HHS, CDC, and VA/DoD warned against rapid tapering, abrupt discontinuation, rigid dose thresholds, and patient abandonment. Veteran-specific research has also raised serious concerns about overdose and suicide risk following opioid discontinuation, especially among veterans treated with opioids for longer periods. GAO reports have further documented gaps in

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1 U.S. Department of Veterans Affairs, "VA reduces prescription opioid use by 64% during past eight years," July 30, 2020, reporting a 64% reduction in VA prescription opioid use from FY2012 to FY2020 Q3 and related reductions in long-term opioid therapy, opioid/benzodiazepine co-prescribing, and high-dose opioid prescribing.

2 Oliva, E. M., Bowe, T., Tavakoli, S., et al., "Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide," Psychological Services 14, no. 1 (2017): 34-49.

VA opioid safety implementation, mental-health integration, scheduling, community care, and oversight.[3][4][5][6][7][8]

This report asks Congress to examine whether VA opioid-reduction policies, MME metrics, tapering practices, and risk-scoring systems protected veterans as intended. It also asks whether veterans identified as “high-risk” received more support, better care coordination, stronger mental-health access, and safer pain management — or whether they were placed at greater risk by a system focused too heavily on reducing opioid numbers.

The guiding principle should be simple:

> **When the VA identifies a veteran as high-risk, that risk should trigger more care, not less care.**

Veterans should not be reduced to MME numbers, dashboard targets, or risk scores. They deserve individualized medical judgment, informed consent, timely mental-health support, suicide-prevention safeguards, responsible pain care, and protection from abandonment.

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3 U.S. Department of Health and Human Services, Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, October 2019. HHS warned against rapid tapering or sudden discontinuation because of withdrawal, worsening pain, psychological distress, suicidal thoughts, and potential transition to illicit opioid sources.

4 Centers for Disease Control and Prevention, CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022, MMWR Recomm Rep. 2022;71(3):1-95. The CDC stated the guideline should not be applied as inflexible standards of care or used to justify rapid tapering, abrupt discontinuation, patient dismissal, or abandonment.

5 U.S. Department of Veterans Affairs and Department of Defense, VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain, Version 4.0, 2022.

6 Oliva, E. M., Bowe, T., Manhapra, A., et al., "Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation," BMJ 368 (2020): m283. This observational study found associations between stopping opioid prescriptions and overdose or suicide deaths, with risk increasing by longer prior opioid-treatment duration; it should not be read as proving causation in every individual case.

7 Cowan, Benjamin W., and Joshua C. Tibbitts, "The Opioid Safety Initiative and Veteran Suicides," NBER Working Paper No. 29139, August 2021, DOI: 10.3386/w29139. As a working paper, it should be cited carefully as an estimate and oversight concern rather than final proof of causation.

8 U.S. Government Accountability Office, VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed, GAO-18-380, May 29, 2018.

II. Why This Matters to Congressman Fallon

This issue is directly relevant to Congressman Pat Fallon's office because it sits at the intersection of veterans' health care, military service, mental-health access, suicide prevention, federal oversight, and the proper limits of bureaucratic control over medical decision-making.[9]

Congressman Fallon's work on military personnel and veterans' issues makes this report especially important. Veterans living with chronic pain are often not only dealing with pain exclusively. Many also live with PTSD, traumatic brain injury, depression, anxiety, sleep disorders, mobility limitations, substance-use risk, and elevated suicide risk. These conditions are frequently tied to military service, service-connected injuries, combat exposure, training injuries, or the long-term physical and psychological burden of serving the country.

For that reason, VA opioid policy cannot be qualitatively evaluated only by counting how many opioid prescriptions were reduced. The more important question is whether veterans were made safer, healthier, and more supported — or whether some were placed at greater risk through forced tapering, abrupt discontinuation, rigid dose thresholds, delayed follow-up, inadequate mental-health access, or treatment decisions driven by dashboards and risk scores rather than individualized medical judgment.[10][11][12]

This report also raises serious federal oversight concerns. The VA is a federal health-care system. When federal opioid policy, VA performance metrics, MME thresholds, prescribing dashboards, or risk-stratification tools influence clinical decisions, Congress has a responsibility to ask whether those systems are protecting veterans or unintentionally harming them.

The concern is not whether opioid safety matters. Opioid safety does matter. Diversion, overdose risk, dangerous co-prescribing, and unlawful prescribing should be taken seriously. But opioid safety must not become a one-sided policy goal where reduced prescribing is treated as success even when veterans lose access to effective pain care, mental-health support, or suicide-prevention safeguards.

This issue also aligns with broader principles of limited government and medical freedom. Medical care should be guided by the doctor-patient relationship, informed consent, individual risk-benefit analysis,

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9 Rep. Pat Fallon, "Rep. Fallon Appointed Chairman of Military Personnel Subcommittee," official congressional press release; House Armed Services Committee, Military Personnel Subcommittee jurisdiction statement.

10 U.S. Department of Veterans Affairs, "VA reduces prescription opioid use by 64% during past eight years," July 30, 2020, reporting a 64% reduction in VA prescription opioid use from FY2012 to FY2020 Q3 and related reductions in long-term opioid therapy, opioid/benzodiazepine co-prescribing, and high-dose opioid prescribing.

11 Centers for Disease Control and Prevention, CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022, MMWR Recomm Rep. 2022;71(3):1-95. The CDC stated the guideline should not be applied as inflexible standards of care or used to justify rapid tapering, abrupt discontinuation, patient dismissal, or abandonment.

12 Oliva, E. M., Bowe, T., Tavakoli, S., et al., "Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide," Psychological Services 14, no. 1 (2017): 34-49.

and patient-specific clinical judgment. Federal agencies, dashboards, and generalized dose thresholds should not replace the judgment of physicians who understand the veteran's medical history, pain condition, mental-health needs, functional status, and treatment response.

This matter also has a Texas connection. P.A.R.T. Texas and P.A.R.T. USA have been working to advance chronic-pain patient protections, physician autonomy, medical freedom, and safeguards against bureaucratic interference in lawful medical care. Texas grassroots efforts, including chronic-pain resolutions and platform language supporting physician autonomy and patient protections, show that this issue is not isolated. It is part of a broader concern that legitimate patients and responsible doctors have been harmed by policies that confuse medical care with drug enforcement.

For Congressman Fallon's office, this report offers an opportunity to examine a serious question with national importance:

Did VA opioid-reduction policy protect veterans — or did it create incentives that caused some veterans with chronic pain, mental-health conditions, and suicide risk to receive less care when they needed more?

Veterans should not be treated as liabilities because they are medically complex. A veteran identified as high-risk should not be pushed away from care. High risk should trigger stronger support, better monitoring, timely mental-health treatment, careful pain management, and coordinated follow-up.

Congressional oversight is needed to ensure that federal opioid policy does not reduce veterans to MME numbers, dashboard targets, or risk scores. Veterans deserve individualized care, access to appropriate pain treatment, mental-health support, suicide-prevention protections, and a system that values their lives over bureaucratic metrics.

III. Veterans Are Not a Generic Patient Population

Veterans living with chronic pain often carry more than one medical burden. Many are not simply patients with pain; they are patients whose pain may be connected to military service, training injuries, combat exposure, physical trauma, traumatic brain injury, orthopedic damage, nerve injury, degenerative conditions, or years of physical strain placed on the body through service.

For many veterans, chronic pain also overlaps with mental-health conditions. PTSD, depression, anxiety, sleep disturbance, substance-use risk, traumatic brain injury, and suicide risk may exist alongside severe physical pain. These conditions can interact with one another. Pain can worsen depression and sleep deprivation. PTSD can make pain harder to manage. Untreated pain can increase isolation, hopelessness, and suicide risk. Substance-use risk can complicate treatment, but it does not erase the veteran's need for pain care, mental-health care, or humane medical support.[13]

This is why veterans cannot safely be treated through a one-size-fits-all opioid policy. A veteran with chronic pain, PTSD, depression, or prior suicide-related risk should not automatically be viewed as a reason to deny or discontinue pain treatment. Those factors should instead trigger closer monitoring, better coordination, and stronger support.

> **A high-risk veteran is not a failed patient. A high-risk veteran is a patient who needs a stronger care plan.**

The VA's own risk-stratification work recognizes this complexity. The STORM model was designed to identify veterans prescribed opioids who were at risk for overdose or suicide-related events. It did not look only at opioid dose. It included multiple domains, including previous overdose or suicide-related events, emergency-room use, inpatient mental-health treatment, substance-use disorder diagnoses, mental-health diagnoses, prescription-related factors, and medical comorbidities.[14]

The existence of this model demonstrates that the VA knew the veterans affected by opioid policy were often clinically complex. The system was not dealing with a simple question of "opioids versus no opioids." It was dealing with veterans whose physical pain, mental-health history, medical conditions, and suicide risk had to be considered together.

High-risk patients are endangered when complexity is treated as a reason to reduce care instead of improve care. If a veteran is flagged because of PTSD, depression, substance-use risk, sedative co-prescribing, prior emergency care, or a suicide-related event, the safest response should not be automatic tapering or abandonment. The safest response should be a coordinated plan that includes the treating physician, mental-health support, pain management, informed consent, careful follow-up, and, where needed, suicide-prevention resources.

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13 Centers for Disease Control and Prevention, CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022, MMWR Recomm Rep. 2022;71(3):1-95. The CDC stated the guideline should not be applied as inflexible standards of care or used to justify rapid tapering, abrupt discontinuation, patient dismissal, or abandonment.

14 Oliva, E. M., Bowe, T., Tavakoli, S., et al., "Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide," Psychological Services 14, no. 1 (2017): 34-49.

Veterans should not be punished for being medically complicated. They should not be forced into rigid tapering because their risk profile looks difficult on paper. They should not be left without pain care because they also need mental-health care. And they should not be made afraid that disclosing depression, PTSD, or suicidal thoughts will cause their medication to be cut off.

A responsible VA opioid policy must recognize the whole veteran. It must distinguish between unlawful diversion and lawful medical treatment. It must distinguish between risk that requires monitoring and risk that requires abandonment. It must distinguish between opioid safety and opioid elimination.

Veterans with chronic pain deserve care plans that are individualized, medically justified, and supported by timely access to mental-health services, suicide-prevention safeguards, and pain-management options. Their treatment should be based on clinical need, not merely on MME numbers, dashboards, or generalized federal pressure to reduce prescribing.

IV. The VA's Opioid Safety Initiative, MME Metrics, and the Limits of Dose-Based Policy

The Department of Veterans Affairs began major opioid-reduction efforts before the 2016 CDC opioid guideline became the central national reference point for opioid prescribing policy. The VA's Opioid Safety Initiative, launched systemwide in 2013, focused on reducing opioid-related risk across the Veterans Health Administration. Its stated goals included improving opioid safety, reducing high-risk prescribing, increasing monitoring, and encouraging safer pain-management practices.[15]

On paper, those goals appear reasonable. Veterans should be protected from overdose, dangerous medication combinations, unsafe prescribing, and lack of monitoring. No responsible policy should ignore overdose risk, opioid/benzodiazepine co-prescribing, substance-use concerns, or the need for careful follow-up.

The problem is that opioid safety can become distorted when success is measured primarily by reduced prescribing numbers, without considering patient outcomes after the fact.

Under VA opioid-reduction efforts, prescribing dashboards and systemwide metrics tracked categories such as the number of veterans dispensed opioids, long-term opioid therapy, high-dose opioid therapy, opioid/benzodiazepine overlap, and morphine milligram equivalent measurements. These metrics created a system where dose reduction and prescription reduction could be treated as evidence of improvement.

But reduced opioid prescribing is not, by itself, proof that veterans are safer.

A veteran may be safer if opioid therapy is reduced carefully, voluntarily, gradually, and with adequate alternative treatment, mental-health care, pain management, informed consent, and follow-up. But a veteran may be placed at greater risk if opioid therapy is reduced abruptly, involuntarily, without sufficient support, or because of pressure to meet systemwide targets rather than because the veteran's individual medical condition warrants the change.

This distinction is central to congressional oversight.

The VA publicly reported large reductions in prescription opioid use, long-term opioid therapy, opioid/benzodiazepine co-prescribing, and high-dose opioid therapy. Those reductions were presented as major opioid-safety achievements. However, Congress should ask whether the VA measured the outcomes that matter most to veterans: pain control, function, mental-health stability, suicide risk, overdose risk after discontinuation, emergency-room use, illicit opioid exposure, patient abandonment, and access to replacement care.[16]

A dashboard can count prescriptions. It cannot fully measure whether a veteran lost the ability to function, sleep, work, attend appointments, care for family, or maintain hope.

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15 U.S. Government Accountability Office, VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed, GAO-18-380, May 29, 2018.

16 U.S. Department of Veterans Affairs, "VA reduces prescription opioid use by 64% during past eight years," July 30, 2020, reporting a 64% reduction in VA prescription opioid use from FY2012 to FY2020 Q3 and related reductions in long-term opioid therapy, opioid/benzodiazepine co-prescribing, and high-dose opioid prescribing.

MME-based metrics can be useful as rough reference tools when clinicians compare opioid doses or identify possible safety concerns. But MME was never designed to be a rigid ceiling that replaces individualized medical judgment. When MME thresholds become operational targets, they can create pressure to reduce medication even when a patient is stable, functional, and carefully monitored.[17]

MME-based policy also has a scientific limitation: it can create the false impression that patients are biologically interchangeable. They are not.

Morphine milligram equivalent calculations may compare medications on paper, but they do not fully account for individual biology. Veterans may metabolize medications differently. They may have different levels of opioid tolerance, different genetic metabolism patterns, different liver or kidney function, different co-prescribed medications, different pain conditions, different injury histories, and different responses to treatment. A dose that may be excessive or unsafe for one patient may be clinically necessary, stable, and carefully monitored for another.

This is why MME should never be treated as a substitute for individualized medical judgment. A number on a chart cannot fully measure pain severity, function, tolerance, metabolism, quality of life, mental-health stability, or whether a veteran is actually safer after a medication change.

MME also cannot measure the treating physician's knowledge, training, specialty experience, or long-term understanding of the patient. A pain-management specialist, neurologist, orthopedic specialist, primary-care physician, or other treating clinician may understand details that no dashboard can capture: the veteran's diagnosis, treatment history, failed therapies, medication tolerance, functional improvement, mental-health stability, daily limitations, family support, injury pattern, and response to prior dose changes.

That clinical knowledge is why the doctor-patient relationship matters. A generalized MME threshold cannot replace a physician who has evaluated the patient, reviewed the medical history, observed the patient's function, considered risks and benefits, and made a case-specific medical judgment.

MME assumes comparability on paper, but veterans are not interchangeable. The same disease, injury, or condition may affect two veterans very differently. A medication regimen that is inappropriate for one patient may be medically necessary and carefully monitored for another. Chronic pain conditions, traumatic injuries, nerve damage, spinal disorders, PTSD, traumatic brain injury, depression, sleep disorders, and other service-connected conditions do not affect every veteran in the same way.

For that reason, MME should be used, at most, as a prompt for clinical review — not as a substitute for individualized care. A number cannot know the patient. A dashboard cannot replace the physician. A threshold cannot account for the full reality of a veteran's body, history, function, and medical needs.

When policy assumes that every patient should fit the same dose threshold, it ignores biological variation and undermines individualized care. For veterans with complex service-connected injuries, chronic pain, PTSD, traumatic brain injury, depression, sleep disturbance, and multiple medications, that kind of one-size-fits-all approach is especially dangerous.[18][19][20]

For veterans, this risk is especially serious. A veteran may have severe chronic pain alongside PTSD, depression, anxiety, sleep disturbance, traumatic brain injury, or suicide risk. Reducing pain medication

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17 Centers for Disease Control and Prevention, CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022, MMWR Recomm Rep. 2022;71(3):1-95. The CDC stated the guideline should not be applied as inflexible standards of care or used to justify rapid tapering, abrupt discontinuation, patient dismissal, or abandonment.

without adequate safeguards may worsen the very conditions that increase risk. If pain worsens, sleep collapses, mobility declines, depression deepens, or the veteran feels abandoned, the policy may increase danger rather than reduce it.

The VA's opioid-reduction framework also operated within a health-care system already facing access, staffing, scheduling, and coordination challenges. If opioid tapering depends on timely mental-health care, suicide-prevention support, non-opioid pain treatment, physical therapy, behavioral health, community care, or specialist follow-up, then those services must actually be available. A tapering policy is not safe merely because it recommends support on paper. It is safe only if that support reaches the veteran in real time.

This is why Congress should not evaluate VA opioid policy only by asking whether opioid numbers decreased. Congress should ask whether veterans were protected during and after those reductions.

Key oversight questions include:

1. Were veterans tapered because of individualized clinical need, or because of systemwide pressure to reduce opioid numbers?
2. Were MME thresholds used as warnings for review, or as de facto limits?
3. Were stable veterans forced or pressured into tapering despite functioning well on existing treatment?
4. Were veterans screened for suicide risk before tapering or discontinuation?
5. Were mental-health services available before, during, and after tapering?
6. Were veterans given informed consent about tapering risks?
7. Were adverse outcomes tracked after opioid reduction or discontinuation?
8. Were rural veterans, medically complex veterans, or veterans with PTSD and depression disproportionately harmed?
9. Did VA measure pain, function, quality of life, suicide risk, overdose risk, emergency care, and patient abandonment — or mainly prescription counts?
10. Did physicians retain clinical discretion, or did dashboards and performance metrics influence medical decisions?
11. Did VA account for individual biology, metabolism, tolerance, comorbidities, physician expertise, specialty training, doctor-patient knowledge, and patient-specific treatment response before pressuring dose reduction?

The central issue is not whether opioid risk should be managed. It should be. The issue is whether opioid risk was managed in a way that respected the whole veteran. Specifically, did the VA's harm-reduction efforts cause harm to its patients?

A responsible opioid-safety policy must protect veterans from overdose and dangerous prescribing, but it must also protect them from untreated pain, forced tapering, abandonment, mental-health

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18 U.S. Government Accountability Office, Veterans Health Care: Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services, GAO-23-105372.

19 U.S. Government Accountability Office, Veterans Health: Improvements Needed to Achieve Successful Appointment Scheduling Modernization, GAO-25-106851, May 22, 2025.

20 U.S. Government Accountability Office, Veterans Health Care: Opportunities to Improve Access to Care Through the Veterans Community Care Program, GAO-25-108101, February 12, 2025.

destabilization, and suicide risk. Safety cannot mean simply reducing prescriptions. Safety must mean protecting the veteran's life, stability, dignity, function, and access to care.

MME can help identify a point for clinical review. It should not become an automatic trigger for forced tapering, denial of care, pharmacy refusal, or physician scrutiny without patient-specific medical analysis.

Congress should therefore examine whether the VA's Opioid Safety Initiative and related MME-based reduction efforts measured true patient safety — or whether reduced prescribing became the primary marker of success while veteran harm was undercounted, overlooked, or treated as outside the dashboard.

V. STORM: The VA Knew High-Risk Veterans Were Clinically Complex

The Veterans Health Administration developed the Stratification Tool for Opioid Risk Mitigation, known as STORM, as a clinical decision-support tool for patients prescribed opioids. STORM was designed to identify veterans at increased risk for overdose or suicide-related events and to help clinicians prioritize review, monitoring, and risk-mitigation interventions.[21]

This matters because STORM shows that the VA's own opioid-safety framework recognized something essential: veterans prescribed opioids are not all the same. Their risk cannot be understood by opioid dose alone.

STORM did not simply identify veterans based on MME. It incorporated multiple categories of risk, including prior overdose or suicide-related events, emergency-room use, inpatient mental-health treatment, substance-use disorder diagnoses, mental-health diagnoses, prescription-related factors, sedative co-prescribing, opioid dose, and medical comorbidities. In other words, STORM recognized that overdose and suicide risk can arise from the interaction of physical pain, mental-health conditions, substance-use history, prescription combinations, prior crisis events, and broader medical complexity.[22]

That point is extremely important for congressional oversight.

If the VA had the ability to identify veterans as high-risk because of PTSD, depression, bipolar disorder, substance-use disorder, prior overdose or suicide-related events, emergency-room use, inpatient mental-health treatment, sedative co-prescribing, and medical comorbidities, then the VA also had an obligation to ensure that those veterans were not simply pushed toward opioid reduction without sufficient support.

High-risk identification should trigger high-support care.

STORM was not supposed to be a tool for abandonment. It was not supposed to reduce veterans to risk scores. It was designed to help clinicians see risk factors and risk-mitigation strategies so they could make better, more informed decisions. The proper purpose of such a tool should be to improve safety, strengthen monitoring, and connect veterans to needed care.

The danger arises if risk scoring is used, directly or indirectly, to justify reducing treatment rather than improving care. A veteran with PTSD, depression, prior suicidal ideation, substance-use risk, or complex medical history may appear "high-risk" in a data system. But that does not mean the veteran should be denied pain treatment or rapidly tapered. It means the veteran needs a more careful plan.

A high-risk veteran may need more frequent visits, better medication review, naloxone education, mental-health support, substance-use treatment when appropriate, family or caregiver involvement, safer prescribing practices, physical therapy, pain specialty support, and close follow-up. That is very different from using risk as a reason to push the veteran out of care.

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21 Oliva, E. M., Bowe, T., Tavakoli, S., et al., "Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide," Psychological Services 14, no. 1 (2017): 34-49.

22 Oliva, E. M., Bowe, T., Tavakoli, S., et al., "Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide," Psychological Services 14, no. 1 (2017): 34-49.

It should be noted that a high-risk, complex patient will require not merely more contact with health-care providers. Rather, more experienced providers, such as a physician, should physically see them and assess the patient instead of directing care through a team of less skilled providers.

STORM also reinforces why MME alone is an inadequate measure of patient safety. A veteran on a higher opioid dose may not have the same risk profile as another veteran on a lower dose with severe depression, sedative co-prescribing, recent emergency care, prior overdose, or suicidal ideation. The VA's own risk model recognized that risk is multifactorial. Therefore, VA policy should not treat dose alone as the dominant marker of safety.[23]

This is where congressional oversight is needed. Congress should ask how STORM and similar tools were used in practice. Did high-risk veterans receive more coordinated care, or did they become targets for opioid reduction? Were clinicians given enough time and resources to act on STORM information? Did STORM lead to better follow-up, mental-health access, and risk mitigation? Or did it operate inside a system where the strongest measurable incentive was still reduced opioid prescribing?

The distinction matters.

A risk score can be useful if it helps clinicians protect a veteran. It can be harmful if it becomes another bureaucratic label that follows the veteran without ensuring actual care.

The VA's own STORM research makes clear that veterans at risk for overdose or suicide-related events often have overlapping medical, psychiatric, prescription, and social complexity. That evidence supports the central argument of this report: veterans identified as high-risk should receive more individualized care, not less.

Congress should require VA to explain how risk-stratification tools were implemented, whether veterans identified as high-risk were connected to timely care, and whether adverse outcomes after opioid tapering or discontinuation were tracked. Without that oversight, a tool intended to improve safety could become part of a system that identifies risk without ensuring support.

The question is not whether the VA could identify risk. The question is whether the VA responded to that risk in a way that protected veterans.

23 Oliva, E. M., Bowe, T., Tavakoli, S., et al., "Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide," Psychological Services 14, no. 1 (2017): 34-49.

VI. Federal Guidance Later Warned Against Rapid Tapering and Abrupt Discontinuation

Federal opioid policy did not remain static. Over time, federal agencies and clinical guideline authors increasingly recognized that opioid reduction can cause serious harm when it is done too quickly, too rigidly, or without patient-centered safeguards.

That matters because many veterans were affected by opioid-reduction pressure before these warnings became widely emphasized.

The 2010 VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain included tapering language that encouraged relatively aggressive dose reduction. In its tapering protocol, the guideline stated that, for patients who were not addicted, clinicians could taper by 20% to 50% per week of the original dose. Although the same section recognized that tapering should be individualized and that some patients may require slower tapers, the existence of such aggressive taper language is important historical context.[24]

Later federal guidance moved in a much more cautious direction.

In 2019, the U.S. Department of Health and Human Services issued a tapering guide warning that opioids should not be tapered rapidly or discontinued suddenly because of the risk of significant withdrawal. HHS warned that rapid tapering or sudden discontinuation can cause acute withdrawal symptoms, worsening pain, serious psychological distress, and thoughts of suicide. HHS also warned that some patients may seek other opioid sources, including illicit opioids, to treat pain or withdrawal when prescribed opioids are abruptly reduced or stopped.[25]

This was a major federal correction.

It confirmed that opioid reduction is not automatically safe simply because the dose goes down. If a patient is physically dependent after long-term treatment, rapid dose reduction can be medically dangerous. If pain worsens and mental health deteriorates, the patient may become less stable, not more stable.

The CDC's 2022 opioid guideline also warned against misapplication of opioid guidance. CDC acknowledged that prior recommendations had been misused as rigid rules, resulting in rapid tapers, abrupt discontinuation, patient dismissal, untreated or undertreated pain, withdrawal symptoms, psychological distress, overdose, and suicidal ideation or behavior. CDC emphasized that its recommendations should not be treated as inflexible standards of care or used to replace individualized clinical judgment.[26]

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24 U.S. Department of Veterans Affairs and Department of Defense, VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, 2010. The tapering protocol included historical language allowing tapering by 20% to 50% per week for certain patients while also recognizing the need for individualization.

25 U.S. Department of Health and Human Services, Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, October 2019. HHS warned against rapid tapering or sudden discontinuation because of withdrawal, worsening pain, psychological distress, suicidal thoughts, and potential transition to illicit opioid sources.

The 2022 VA/DoD guideline likewise moved away from abrupt or rigid approaches. It emphasized individualized care and warned against abrupt discontinuation unless there are immediate safety concerns. The VA's own tapering tool also recognized that suicide risk must be addressed before tapering. It instructed clinicians to activate suicide-prevention planning when appropriate and to consult mental-health providers before beginning tapering in veterans at high suicide risk or who are actively suicidal.[27][28]

Together, these sources show that federal policy eventually recognized a critical truth: tapering is not a neutral administrative act. It is a medical intervention that can carry serious risk.

This is especially important for veterans. Many veterans prescribed opioids for chronic pain have long treatment histories, multiple diagnoses, mental-health conditions, sleep problems, and suicide-risk factors. For these veterans, tapering may require months or years, careful monitoring, mental-health support, family or caregiver involvement when appropriate, non-opioid pain treatment, and a clear plan to prevent abandonment.

The question for congressional oversight is whether VA opioid-reduction practices were consistent with these later safety warnings.

Congress should ask:

1. Were veterans tapered under older, more aggressive tapering assumptions before later federal warnings were issued?
2. Did VA identify veterans who were already stable and functional on opioid therapy before recommending tapering?
3. Were veterans warned of the risks of rapid tapering, withdrawal, worsened pain, mental-health destabilization, overdose, and suicide?
4. Were veterans given meaningful informed consent before tapering began?
5. Did VA require mental-health review before tapering veterans with suicide risk, severe depression, PTSD, or recent crisis events?
6. Were tapering plans voluntary and individualized, or driven by systemwide opioid-reduction pressure?
7. Were veterans ever dismissed, abandoned, or made to feel they had no choice but to accept dose reduction?
8. Did VA track adverse outcomes after tapering or discontinuation?
9. Were rural veterans or veterans with limited access to mental-health care placed at increased or specific risk?

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26 Centers for Disease Control and Prevention, CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022, MMWR Recomm Rep. 2022;71(3):1-95. The CDC stated the guideline should not be applied as inflexible standards of care or used to justify rapid tapering, abrupt discontinuation, patient dismissal, or abandonment.

27 U.S. Department of Veterans Affairs and Department of Defense, VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain, Version 4.0, 2022.

28 U.S. Department of Veterans Affairs, PBM Academic Detailing Service, Opioid Taper Decision Tool: A VA Clinician's Guide. The tool emphasizes individualized taper decisions, follow-up/support, patient communication, mental-health considerations, and suicide-prevention planning when indicated.

10. Did VA update its practices quickly enough after HHS, CDC, and VA/DoD cautioned against rapid tapering and abrupt discontinuation?

These questions are not theoretical. They point directly to veteran safety.

If federal agencies now warn that rapid tapering, sudden discontinuation, rigid thresholds, and patient abandonment can cause harm, then Congress should examine whether earlier VA opioid-reduction efforts caused preventable harm before those warnings were fully incorporated into practice.

This does not mean opioid therapy should never be reduced. In some cases, tapering may be medically appropriate. But appropriate tapering must be individualized, gradual when possible, clinically justified, carefully monitored, and supported by adequate pain care and mental-health care.

The lesson from later federal guidance is clear: opioid safety cannot be achieved by forcing numbers down. True safety requires protecting the patient during every stage of care.

For veterans, that means no forced tapering without individualized review. No abrupt discontinuation without urgent medical justification. No abandonment. No rigid MME rule replacing physician judgment. No reduction plan that ignores suicide risk, mental-health access, or the veteran's actual ability to function.

Veterans deserve an opioid policy that learns from federal warnings instead of repeating the mistakes those warnings were meant to correct.

VII. Veteran-Specific Evidence of Harm

The concern that opioid reduction can harm veterans is not theoretical. Veteran-specific research and federal data raise serious questions about whether opioid discontinuation, forced or pressured tapering, and policy-driven prescribing reductions may have increased risk for some veterans rather than reduced it.

The Department of Veterans Affairs has treated opioid reduction as a major opioid-safety success. VA publicly reported large reductions in the number of veterans receiving prescription opioids, long-term opioid therapy, high-dose opioid therapy, and opioid/benzodiazepine combinations. Those numbers may show that prescribing declined. But they do not, by themselves, prove that veterans were safer.[29]

To determine whether opioid policy protected veterans, Congress must look beyond prescription counts and examine actual outcomes: overdose, suicide, suicide attempts, mental-health crisis, emergency-room use, illicit opioid exposure, worsening pain, loss of function, patient abandonment, and access to replacement care.

A major veteran-specific BMJ study by Oliva and colleagues examined associations between discontinuing opioid prescriptions, length of opioid treatment, and overdose or suicide deaths in U.S. veterans. The study found that stopping opioid prescriptions was associated with increased risk of overdose or suicide death, and that risk increased as the duration of prior opioid treatment increased.[30]

This finding is critical. It does not mean every opioid discontinuation caused a death. But it does mean that stopping opioids in veterans — especially veterans who had been treated for longer periods — cannot be treated as automatically protective. Discontinuation may create risk, and that risk must be monitored, documented, and mitigated.

This is especially important for veterans who have been on long-term opioid therapy. Long-term treatment can create physical dependence, tolerance, and complex stability issues. If medication is reduced or stopped too quickly, the veteran may experience withdrawal, worsened pain, sleep disruption, emotional distress, loss of function, or increased vulnerability to unsafe alternatives. In veterans already living with PTSD, depression, anxiety, traumatic brain injury, substance-use risk, or suicidal ideation, destabilization can be dangerous.

The BMJ study therefore supports a key oversight question:

Did VA track what happened to veterans after opioids were stopped?

Congress should ask whether VA monitored overdose deaths, suicide deaths, suicide attempts, psychiatric emergencies, emergency-room visits, illicit opioid exposure, and loss of care after opioid discontinuation

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29 U.S. Department of Veterans Affairs, "VA reduces prescription opioid use by 64% during past eight years," July 30, 2020, reporting a 64% reduction in VA prescription opioid use from FY2012 to FY2020 Q3 and related reductions in long-term opioid therapy, opioid/benzodiazepine co-prescribing, and high-dose opioid prescribing.

30 Oliva, E. M., Bowe, T., Manhapra, A., et al., "Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation," BMJ 368 (2020): m283. This observational study found associations between stopping opioid prescriptions and overdose or suicide deaths, with risk increasing by longer prior opioid-treatment duration; it should not be read as proving causation in every individual case.

or tapering. If the VA measured reductions in prescribing but did not adequately measure harm after reduction, then the safety picture is incomplete.

The NBER working paper by Cowan and Tibbitts adds another serious concern. The authors examined the VA's Opioid Safety Initiative and veteran suicides. Their analysis estimated that the Opioid Safety Initiative was associated with an increase in veteran suicide rates relative to civilian rates, with the strongest estimated effect among rural veterans. Because this is a working paper, it should be cited carefully and not overstated as final settled proof. But it is highly relevant to congressional oversight because it directly raises the possibility that a federal opioid-reduction initiative may have had unintended consequences for veteran suicide risk.[31]

That concern is especially serious for rural veterans. Rural veterans may have fewer pain specialists, fewer mental-health providers, longer travel distances, fewer community-care options, and more difficulty getting timely follow-up. If opioid reduction occurs in a setting where replacement care is delayed or unavailable, rural veterans may face greater danger than veterans with easier access to services.

The VA's own suicide-prevention reporting confirms that veteran suicide remains an ongoing national crisis. The most recent VA suicide-prevention report shows that thousands of veterans continue to die by suicide each year. VA also recognizes that health problems and pain are relevant suicide-risk factors, and pain has been identified among the risk factors reported in veteran suicide-prevention data.[32]

This matters because chronic pain policy cannot be separated from veteran suicide prevention.

A veteran in severe pain is not merely a prescribing statistic. A veteran in severe pain may be isolated, sleep-deprived, depressed, physically limited, financially strained, and afraid of losing the only treatment that has allowed some level of function. If that veteran is told medication will be reduced or stopped without adequate alternatives, the result may be fear, hopelessness, withdrawal, destabilization, or crisis.

That does not mean every veteran should remain on opioids indefinitely. It means decisions must be individualized, medically justified, and supported by real safeguards. The risk of continuing opioid therapy must be weighed against the risk of reducing or stopping therapy. For some veterans, the risk of destabilization may be greater than the risk of carefully monitored continuation.

Federal policy too often treats opioid risk as though it flows only from prescribing. But veteran-specific evidence shows that risk can also flow from discontinuation.

That distinction matters.

If a veteran is stable, functional, compliant, and carefully monitored on an opioid regimen, forced reduction may create harm. If a veteran is high-risk because of PTSD, depression, suicide history, substance-use risk, or medical complexity, abrupt or unsupported tapering may increase danger. If a veteran has limited access to mental-health care, pain care, or follow-up, tapering may be especially unsafe.

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31 Cowan, Benjamin W., and Joshua C. Tibbitts, "The Opioid Safety Initiative and Veteran Suicides," NBER Working Paper No. 29139, August 2021, DOI: 10.3386/w29139. As a working paper, it should be cited carefully as an estimate and oversight concern rather than final proof of causation.

32 U.S. Department of Veterans Affairs, 2025 National Veteran Suicide Prevention Annual Report, released February 2025, covering suicide data through 2023 and reinforcing the continuing need for connection, support, and suicide-prevention efforts.

Congress should therefore require VA to answer specific outcome questions:

1. How many veterans were tapered or discontinued from opioid therapy after implementation of the Opioid Safety Initiative?
2. How many veterans experienced overdose, suicide attempt, suicide death, psychiatric hospitalization, emergency-room visit, or crisis-line contact after tapering or discontinuation?
3. Did VA track outcomes separately for veterans on long-term opioid therapy?
4. Did VA track outcomes by taper speed?
5. Did VA track outcomes for rural veterans?
6. Did VA track outcomes for veterans with PTSD, depression, substance-use disorder, traumatic brain injury, prior overdose, or prior suicide-related events?
7. Did VA distinguish voluntary tapering from forced, pressured, or policy-driven tapering?
8. Did VA ensure mental-health care and suicide-prevention planning before tapering high-risk veterans?
9. Did VA track whether veterans turned to illicit opioids, emergency care, or non-VA care after discontinuation?
10. Did VA measure pain, function, quality of life, and patient stability after opioid reduction?

These questions are necessary because opioid reduction cannot be assumed to equal safety. For veterans, safety must mean more than fewer prescriptions. Safety must mean fewer deaths, fewer overdoses, fewer suicides, fewer crises, better pain control, better function, and stronger connection to care.

The evidence now available is enough to justify congressional oversight. VA opioid policy may have been designed to reduce harm, but Congress must determine whether implementation caused preventable harm for some veterans, especially those already at elevated risk.

The central lesson is clear:

> **Stopping opioids is not automatically safe. Reducing MME is not automatically patient-centered. Lower prescribing numbers are not automatically proof of better care.**

For veterans with chronic pain and mental-health risk, the true measure of safety is whether the veteran lived, functioned, remained connected to care, and received support instead of abandonment.

VIII. GAO Oversight Findings: Safety Systems Were Not Always Reliable

The VA's opioid-reduction policies depended on the assumption that risk could be identified, monitored, and managed through clinical safeguards. Those safeguards included prescription monitoring, urine drug screening, informed consent, pain management support, academic detailing, mental-health access, suicide-prevention planning, community care, scheduling, and follow-up.

That assumption only works if the safety systems are actually functioning.

GAO reports raise serious concerns that VA systems were not always reliable enough to support the level of risk created by opioid tapering, discontinuation, and systemwide prescribing reduction.

In GAO-18-380, GAO reviewed VA opioid safety efforts and found that the Veterans Health Administration had made progress in reducing opioid prescribing, but still needed further efforts to assess progress and reduce risk. This is important because it shows that prescription reductions alone did not prove the system had fully implemented the safety measures needed to protect veterans.[33]

GAO identified gaps in opioid safety practices, including incomplete documentation of state prescription drug monitoring program checks, urine drug screening, and written informed consent for some veterans on long-term opioid therapy. GAO also identified facility-level gaps related to pain champions, academic detailing, and implementation of opioid safety goals.[34]

These findings matter because opioid reduction can create serious risk when it occurs without reliable monitoring, informed consent, and follow-up. If a veteran is being tapered, discontinued, or pressured to reduce medication, the system must be able to document that the veteran was evaluated, informed, monitored, supported, and connected to appropriate care.

The VA's opioid safety framework also depended on the availability of mental-health services. This is especially important because veterans affected by opioid policy may also have PTSD, depression, anxiety, substance-use risk, traumatic brain injury, suicide risk, or prior overdose/suicide-related events.

GAO has reported persistent challenges in fully integrating mental-health services into primary care. This matters because integrated mental-health care is supposed to help identify and address anxiety, depression, medication adherence concerns, suicide risk, and other issues that may affect treatment safety. If mental-health integration is incomplete or staffing challenges interfere with access, then opioid tapering policies may place veterans at risk without the support those policies assume exists.[35]

This is not a minor administrative issue. For a high-risk veteran, delayed access to mental-health care can be dangerous. If a veteran is losing pain control, experiencing withdrawal, sleeping poorly, becoming depressed, or expressing suicidal thoughts, timely mental-health access is not optional. It is part of patient safety, standard of care, and duty of care.

GAO has also continued to identify VA scheduling, wait-time, referral, and community-care concerns. These findings are relevant because opioid tapering or discontinuation is often justified on the

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33 U.S. Government Accountability Office, VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed, GAO-18-380, May 29, 2018.

34 U.S. Government Accountability Office, VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed, GAO-18-380, May 29, 2018.

35 U.S. Government Accountability Office, Veterans Health Care: Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services, GAO-23-105372.

assumption that other treatment options will be available. But if physical therapy, behavioral health, pain specialty care, mental-health appointments, community-care referrals, or follow-up visits are delayed, then the veteran may be left with reduced medication but no timely replacement care.[3637]

Past investigative reporting has raised concerns that VA may have allowed clinicians with serious medical-error histories to resign quietly, while negative information was allegedly removed from personnel files or not fully reported to the National Practitioner Data Bank. Whether those specific practices have been corrected is a matter for congressional oversight. The larger patient-safety question is clear: VA must not protect institutional reputation at the expense of veterans, state licensing boards, future patients, or public safety.

That is not safe tapering. That is a care gap.

A written policy may say that tapering should be supported. A VA tool may say that mental-health review should occur before tapering a suicidal veteran. A guideline may say that care should be individualized. But congressional oversight must examine whether those safeguards actually reached veterans in practice.

The difference between policy on paper and care in real life is where harm can occur.

A veteran may be told that opioids are being reduced because the VA is following safety policy. But if that veteran cannot access timely mental-health care, cannot obtain pain specialty support, cannot get community care scheduled, cannot reach the prescribing clinician, or cannot obtain adequate follow-up during withdrawal or worsening pain, then the safety policy has failed the patient.

GAO's findings support a central concern of this report: VA opioid reduction should not be evaluated only by whether prescribing declined. It must be evaluated by whether the safety infrastructure around the veteran actually worked.

Congress should ask whether VA had reliable systems to ensure that veterans affected by opioid reduction received:

1. Documented informed consent;
2. Prescription drug monitoring review when appropriate;
3. Urine drug screening when clinically indicated;
4. Individualized risk-benefit analysis;
5. Suicide-risk screening and safety planning;
6. Mental-health consultation for high-risk veterans;
7. Pain management support;
8. Non-opioid treatment options that were actually accessible;
9. Timely follow-up during tapering;
10. Community-care referrals without harmful delays;
11. Monitoring for overdose, suicide attempts, suicide death, emergency care, worsening pain, and patient abandonment.

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36 U.S. Government Accountability Office, Veterans Health: Improvements Needed to Achieve Successful Appointment Scheduling Modernization, GAO-25-106851, May 22, 2025.

37 U.S. Government Accountability Office, Veterans Health Care: Opportunities to Improve Access to Care Through the Veterans Community Care Program, GAO-25-108101, February 12, 2025.

If those systems were incomplete, understaffed, delayed, or inconsistently implemented, then VA opioid reduction may have exposed veterans to preventable harm.

The oversight issue is therefore not only whether the VA had opioid safety policies. The issue is whether the VA had enough capacity, staffing, accountability, and follow-through to make those policies safe for real veterans.

Veterans should not be forced to rely on promises of support that are not available when they need it. A taper plan without timely care is not a safety plan. A risk score without follow-up is not protection. A dashboard showing fewer prescriptions is not proof that veterans are alive, stable, functioning, and connected to care.

GAO's findings show why Congress must look beyond VA opioid reduction statistics and examine whether the systems meant to protect veterans were strong enough to carry the weight placed on them.

IX. Congressional Oversight Questions

Congressional oversight is needed because VA opioid-reduction policies, MME metrics, tapering practices, risk-scoring systems, and access-to-care limitations may have created unintended harm for veterans living with chronic pain and complex medical needs.[38394041424344]

The central question is not whether opioid safety matters. It does. The central question is whether VA opioid policy protected veterans in practice — or whether it reduced prescribing numbers while failing to adequately measure pain, function, mental-health stability, overdose risk, suicide risk, illicit drug exposure, and patient abandonment.

Congress should require VA to answer clear, patient-centered oversight questions.

A. Questions About Opioid Reduction and Tapering

1. How many veterans were tapered from opioid therapy after implementation of the VA Opioid Safety Initiative?
2. How many veterans had opioid therapy discontinued entirely?

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38 U.S. Department of Veterans Affairs, "VA reduces prescription opioid use by 64% during past eight years," July 30, 2020, reporting a 64% reduction in VA prescription opioid use from FY2012 to FY2020 Q3 and related reductions in long-term opioid therapy, opioid/benzodiazepine co-prescribing, and high-dose opioid prescribing.

39 Oliva, E. M., Bowe, T., Tavakoli, S., et al., "Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide," Psychological Services 14, no. 1 (2017): 34-49.

40 Centers for Disease Control and Prevention, CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022, MMWR Recomm Rep. 2022;71(3):1-95. The CDC stated the guideline should not be applied as inflexible standards of care or used to justify rapid tapering, abrupt discontinuation, patient dismissal, or abandonment.

41 U.S. Department of Health and Human Services, Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, October 2019. HHS warned against rapid tapering or sudden discontinuation because of withdrawal, worsening pain, psychological distress, suicidal thoughts, and potential transition to illicit opioid sources.

42 Oliva, E. M., Bowe, T., Manhapra, A., et al., "Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation," BMJ 368 (2020): m283. This observational study found associations between stopping opioid prescriptions and overdose or suicide deaths, with risk increasing by longer prior opioid-treatment duration; it should not be read as proving causation in every individual case.

43 Cowan, Benjamin W., and Joshua C. Tibbitts, "The Opioid Safety Initiative and Veteran Suicides," NBER Working Paper No. 29139, August 2021, DOI: 10.3386/w29139. As a working paper, it should be cited carefully as an estimate and oversight concern rather than final proof of causation.

44 U.S. Government Accountability Office, VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed, GAO-18-380, May 29, 2018.

3. How many veterans were tapered from long-term opioid therapy?
4. How many veterans were tapered from doses above specific MME thresholds?
5. How many tapers were voluntary, and how many were initiated because of VA policy, facility pressure, prescribing dashboards, risk scores, or provider concern about scrutiny?
6. Did VA distinguish between clinically necessary tapering and tapering driven by systemwide opioid-reduction goals?
7. Did VA track taper speed, including rapid tapers, gradual tapers, and abrupt discontinuations?
8. Did VA identify whether veterans were stable, functional, and compliant before tapering began?
9. Were veterans given individualized risk-benefit reviews before tapering or discontinuation?
10. Were veterans informed of the risks of withdrawal, worsened pain, psychological distress, overdose risk, illicit opioid exposure, and suicide risk before tapering?

B. Questions About Outcomes After Tapering or Discontinuation

1. Did VA track overdose deaths after opioid tapering or discontinuation?
2. Did VA track suicide deaths after opioid tapering or discontinuation?
3. Did VA track suicide attempts, suicidal ideation, psychiatric hospitalization, crisis-line contact, or emergency-room visits after tapering or discontinuation?
4. Did VA track worsening pain, loss of function, sleep disruption, depression, anxiety, or inability to perform daily activities after tapering?
5. Did VA track whether veterans sought opioids outside the medical system after discontinuation?
6. Did VA track whether veterans left VA care after opioid reduction?
7. Did VA track whether veterans lost access to pain management after their prescribing clinician left, retired, transferred, or stopped treating chronic pain?
8. Did VA compare outcomes for veterans whose opioids were continued under monitoring versus veterans whose opioids were reduced or discontinued?
9. Did VA separately analyze outcomes for veterans on long-term opioid therapy before tapering?
10. Did VA separately analyze outcomes for veterans who had been on opioid therapy for years before discontinuation?

C. Questions About Suicide Risk and Mental-Health Support

1. Were veterans screened for suicide risk before opioid tapering or discontinuation?
2. Were veterans with PTSD, depression, bipolar disorder, traumatic brain injury, substance-use disorder, or prior suicide-related events given mental-health review before tapering?
3. Did VA require mental-health consultation before tapering veterans identified as high-risk or actively suicidal?
4. Were suicide-prevention plans documented before tapering high-risk veterans?
5. Did VA ensure that veterans had timely access to mental-health care during tapering?
6. Did VA track whether veterans experienced increased depression, hopelessness, or suicidal ideation during tapering?
7. Did VA track whether veterans feared reporting depression or suicidal thoughts because they believed their medication would be reduced or discontinued?
8. Were family members or caregivers involved when appropriate and authorized by the veteran?
9. Were veterans forced to authorize caregiver involvement in order to receive continued treatment?
10. Did VA ensure follow-up after missed appointments, signs of crisis, withdrawal symptoms, or worsening pain?
11. Did VA track whether pain itself was a suicide-risk factor in veterans affected by opioid reduction?

D. Questions About STORM and Risk-Scoring Systems

1. How was STORM used in clinical practice?
2. Were veterans identified as high-risk by STORM connected to more care, or were they more likely to be tapered or scrutinized?
3. Were higher-level providers assigned to high-risk, medically complex patients?
4. Did VA track whether STORM-identified high-risk veterans received timely mental-health services, pain care, naloxone education, substance-use support, and follow-up?
5. Were STORM scores used directly or indirectly to pressure prescribing changes?
6. Did clinicians have sufficient time, staffing, and resources to act on STORM information?
7. Did VA evaluate whether STORM improved patient outcomes, or only whether risk factors were identified?
8. Did VA track adverse outcomes among veterans flagged by STORM after opioid tapering or discontinuation?
9. Did VA ensure that risk scores were not treated as performance measures or reasons to avoid treating complex veterans?
10. Did VA communicate to clinicians that high-risk identification should trigger support rather than abandonment?
11. Did VA evaluate whether STORM or similar tools unintentionally encouraged risk avoidance by providers?

E. Questions About MME Metrics and Dose Thresholds

1. Were MME thresholds used as clinical review prompts, or as de facto prescribing limits?
2. Were physicians pressured to reduce veterans below certain MME levels regardless of patient stability?
3. During the implementation of opioid reduction, were physicians restricted, punished, admonished, corrected, or released from service or contract for using their best medical judgment in continuing to prescribe opioids when they deemed it necessary?
4. Did VA account for individual biology, metabolism, tolerance, comorbidities, and treatment response before recommending dose reduction?
5. Did VA account for physician training, specialty experience, and the treating clinician's knowledge of the veteran?
6. Did VA track whether stable veterans were harmed after being reduced below a threshold?
7. Did VA evaluate whether MME-based metrics discouraged clinicians from treating chronic pain patients?
8. Did VA review whether MME thresholds were applied differently across facilities?
9. Did VA ensure that MME calculations were not treated as substitutes for individualized medical judgment?
10. Did VA compare patient outcomes by dose reduction rather than only by prescribing reduction?
11. Did VA evaluate whether MME-focused policy contributed to patient abandonment, physician fear, or reduced access to pain care?

F. Questions About Access to Pain Care and Mental-Health Care

1. Were veterans able to access timely pain management before, during, and after tapering?
2. Were veterans able to access timely mental-health care before, during, and after tapering?
3. Were non-opioid pain treatments actually available, or only recommended on paper?
4. Were physical therapy, behavioral health, interventional pain care, specialty care, and community care available without harmful delays?

5. Did VA track wait times for replacement care after opioid reduction?
6. Did the VA track call logs, messages to providers, and provider reach-back to patients who requested care?
7. Has VA opioid-reduction policy inadvertently medically discriminated against disabled veterans, including veterans whose disabilities make travel, repeated appointments, urine drug screening, specialty visits, or forced treatment changes more difficult?
8. Did VA track whether veterans were left with reduced medication but no meaningful alternative treatment?
9. Did rural veterans face longer delays or fewer treatment options?
10. Did community-care referral delays interfere with safe tapering?
11. Did VA track whether staffing shortages affected safe opioid management?
12. Did VA evaluate whether reduced access to trained pain clinicians increased veteran risk?

G. Questions About Physician Autonomy and Provider Fear

1. Did VA physicians feel pressure to reduce opioid prescribing because of dashboards, audits, performance measures, investigations, or fear of scrutiny?
2. Did VA evaluate whether opioid policy discouraged doctors from treating chronic pain patients?
3. Did VA track whether clinicians transferred, discharged, or refused complex pain patients because they were considered too risky?
4. Did VA distinguish responsible pain treatment from unlawful prescribing or diversion?
5. Did federal enforcement pressure affect the willingness of physicians to treat veterans with chronic pain?
6. Did fear of investigation, licensure consequences, prosecution, professional ruin, or asset loss contribute to reduced access to pain care?
7. Did VA provide safe-harbor protections for clinicians practicing individualized, documented, medically appropriate pain care?
8. Did VA ensure physicians could continue stable opioid therapy when medically justified?
9. Did VA protect the doctor-patient relationship from being overridden by generalized federal metrics?
10. Did VA encourage more qualified clinicians to enter pain care, or did the policy environment push them away?
11. Are there any whistleblower complaints by health-care providers about deleterious effects of opioid-reduction policy implementation on poor patient outcomes?

H. Questions About Whether VA Measured True Safety

1. Did VA define success mainly by reduced opioid prescribing?
2. Did VA measure whether veterans were more stable, functional, and connected to care after opioid reduction?
3. Did VA measure pain control, quality of life, sleep, mobility, mental-health stability, and ability to perform daily activities?
4. Did VA measure whether opioid reduction increased emergency care, psychiatric crisis, overdose, suicide, or illicit drug exposure?
5. Did VA measure patient abandonment?
6. Did VA measure whether veterans trusted the VA after opioid reduction?
7. Did VA track complaints from veterans who felt forced, abandoned, or destabilized?
8. Did VA analyze whether prescribing reductions happened faster than access to replacement care improved?
9. Did VA compare opioid reduction outcomes against overdose and suicide trends?

10. Did VA publicly report adverse outcomes with the same seriousness that it reported prescribing reductions?

I. Questions About Provider Accountability, Credentialing, and Transparency

1. Has VA fully corrected prior transparency and provider-accountability concerns involving clinicians with serious medical-error histories?
2. Does VA report adverse privileging actions, serious quality-of-care concerns, malpractice-related findings, and provider misconduct to the National Practitioner Data Bank when required?
3. Does VA report appropriate provider misconduct or license concerns to state medical boards and nursing boards?
4. Has VA ever removed or concealed negative provider-history information through settlement agreements, resignation agreements, or personnel-file changes?
5. Are veterans informed when a provider has a serious history that may affect patient safety?
6. Does VA hire or retain providers with prior disciplinary histories, license restrictions, malpractice concerns, or adverse privileging actions?
7. What safeguards does VA use to ensure providers with prior issues are not placed in positions where veterans are at risk?
8. How often does VA re-review credentialing and privileging after complaints, adverse events, malpractice claims, or patient-safety incidents?
9. Does VA protect veterans at least as strongly as civilian systems are expected to protect patients?
10. Does VA prioritize institutional reputation over patient safety when resolving provider misconduct or medical-error cases?

J. Questions About Financial Incentives, Grants, and Opioid-Reduction Metrics

1. Have VA facilities, military treatment centers, academic medical centers, military physicians, VA-affiliated researchers, or treatment programs received grants, contracts, or financial incentives aimed at reducing opioid prescribing?
2. If so, how much money has been awarded systemwide?
3. What agencies, institutions, or programs awarded the funding?
4. Were doctors, providers, researchers, or facilities evaluated based on reduced opioid prescribing rates?
5. Were any incentive programs created to decrease opioid prescription rates?
6. Did any grant, contract, or incentive define success primarily by reduced opioid use?
7. Were patient outcomes measured, including pain control, functional recovery, quality of life, mental-health stability, disability impact, suicide risk, overdose risk, and patient-reported experience?
8. Were long-term outcomes measured after opioid reduction?
9. Were veterans or patients harmed by opioid-reduction goals that did not adequately account for individualized medical need?
10. Did opioid-reduction funding or incentives create a “pay-to-reduce” environment where researchers or facilities financially benefited from lowering opioid use while patients bore the risk?
11. Did any opioid-sparing research or incentive program include safeguards to ensure patients who still required opioid therapy were not stigmatized, undertreated, or denied appropriate care?

The issue is not whether opioid-sparing research is valuable. The issue is whether financial incentives or grant success metrics may unintentionally prioritize reduced opioid use over individualized patient outcomes.

Even if VA is legally obligated to provide appropriate care, Congress should examine whether veterans experience a lower practical standard of care because of access delays, internal accountability barriers, provider shortages, inadequate reporting, or institutional self-protection.

Do veterans and current service members receive care that meets the same standard of care and duty of care expected in civilian health systems, and if not, what legal, regulatory, staffing, access, or accountability gaps allow a lower practical standard to exist?

These questions are necessary because the VA cannot prove opioid safety by showing only that fewer prescriptions were written. Congress should require VA to show whether veterans were actually safer.

The proper measure of success is not simply a lower prescription count. The proper measure is whether veterans remained alive, stable, functioning, supported, and connected to appropriate care.

X. Policy Recommendations

Congress should require the Department of Veterans Affairs to reform opioid policy so that veteran safety is measured by patient outcomes, not merely by reduced prescribing numbers. Opioid safety should include prevention of overdose and diversion, but it must also include protection from untreated pain, forced tapering, patient abandonment, mental-health destabilization, suicide risk, and loss of access to legitimate medical care.[454647]

The goal should be a balanced system: one that prevents unsafe prescribing while preserving individualized, medically appropriate pain treatment for veterans who need it.

VA policy should not presume that opioid tapering is the correct goal for veterans who are receiving effective, medically appropriate pain treatment. If a veteran's medication is working, the veteran is stable or benefiting, and the treating clinician determines that continued therapy is medically appropriate, then the policy should protect continued treatment with appropriate monitoring.

A veteran should not be tapered, reduced, or discontinued from medication solely because of MME level, prescribing dashboards, generalized opioid-reduction goals, facility pressure, provider fear, or the veteran's classification as "high-risk."

High-risk status should not mean automatic tapering. High-risk status should mean increased support.

A. Prohibit MME Thresholds as Automatic Taper or Denial Triggers

VA should be prohibited from using MME thresholds as automatic triggers for forced tapering, medication denial, pharmacy refusal, disciplinary review, or physician scrutiny without individualized clinical analysis.

MME may be used as a tool for review. It should not be used as a substitute for medical judgment.

Any policy involving MME should clearly state that dose calculations do not account for every relevant clinical factor, including patient biology, metabolism, tolerance, comorbidities, treatment history, functional benefit, failed therapies, mental-health stability, physician expertise, specialty training, or the doctor-patient relationship.

A veteran should not lose effective treatment simply because the dose appears high on paper. A dose that may be unsafe for one patient may be clinically necessary, stable, and carefully monitored for another.

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45 Centers for Disease Control and Prevention, CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022, MMWR Recomm Rep. 2022;71(3):1-95. The CDC stated the guideline should not be applied as inflexible standards of care or used to justify rapid tapering, abrupt discontinuation, patient dismissal, or abandonment.

46 U.S. Department of Health and Human Services, Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, October 2019. HHS warned against rapid tapering or sudden discontinuation because of withdrawal, worsening pain, psychological distress, suicidal thoughts, and potential transition to illicit opioid sources.

47 U.S. Department of Veterans Affairs and Department of Defense, VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain, Version 4.0, 2022.

B. Protect Continued Therapy When Medically Appropriate

VA should explicitly protect continued opioid therapy when the treating clinician determines that the veteran is benefiting, stable, monitored, and medically appropriate for continued treatment.

The purpose of opioid policy should not be to force every veteran toward dose reduction. The purpose should be to ensure that each veteran receives the safest effective care based on individual medical need.

Continued therapy should remain available when:

1. The veteran has a documented pain condition;
2. The medication provides functional benefit or meaningful pain relief;
3. The veteran is following the treatment plan;
4. Risks are being monitored;
5. The treating clinician determines that continuation is medically appropriate;
6. Alternative treatments have failed, are unavailable, are contraindicated, or are insufficient;
7. Tapering would create a greater risk than carefully monitored continuation.

For some veterans, the safest medical plan may be continued medication with closer monitoring, more frequent follow-up, mental-health support, medication review, naloxone education when appropriate, and coordination between providers.

The goal is not to force veterans off medication that works. The goal is to keep veterans alive, stable, functional, supported, and safely treated inside legitimate medical care.

C. Require Individualized Clinical Review Before Any Dose Reduction or Discontinuation

Before reducing or discontinuing opioid therapy, VA should require a documented individualized review that considers:

1. The veteran's diagnosis and pain condition;
2. Duration of opioid therapy;
3. Functional status;
4. Prior treatment failures;
5. Current stability or instability;
6. Mental-health conditions;
7. Suicide-risk factors;
8. Substance-use history;
9. Co-prescribed medications;
10. Medical comorbidities;
11. Rural access barriers;
12. Availability of replacement care;
13. The treating clinician's medical judgment;
14. The veteran's informed preferences and goals;
15. Whether continued therapy with monitoring is safer than tapering.

A stable veteran should not be forced into tapering solely because of a number, dashboard target, generalized policy preference, or fear of scrutiny.

D. Limit Tapering to Medically Justified Circumstances

Tapering should be considered only when it is medically justified, requested by the veteran, or required because of a clear and immediate safety concern.

Examples may include a serious medication interaction, evidence of dangerous misuse, severe adverse effects, overdose concern, patient request, or other documented clinical reason. Even then, tapering should be individualized, gradual when possible, supported by informed consent, and accompanied by real access to mental-health care, pain care, follow-up, and crisis support.

Tapering should not be used as a punishment. It should not be used as a quota tool. It should not be used simply because a veteran is difficult, complex, high-risk, rural, disabled, or above a generalized MME threshold.

If a veteran needs closer monitoring, the answer should be closer monitoring — not automatic medication loss.

E. Require Informed Consent and Patient-Specific Planning

VA should require meaningful informed consent before non-emergency dose reduction or discontinuation.

Veterans should be informed of potential risks, including withdrawal, worsened pain, sleep disruption, mental-health destabilization, overdose risk after loss of tolerance, illicit opioid exposure, and suicide risk.

Any change in therapy should be individualized and adjusted based on patient response. Veterans should have a clear process to report worsening symptoms and request reassessment.

The veteran should not be left believing the decision has already been made by a dashboard, a policy target, or a number on a chart.

F. Require Mental-Health and Suicide-Risk Safeguards

For veterans with PTSD, depression, bipolar disorder, traumatic brain injury, substance-use disorder, prior overdose, prior suicide attempt, suicidal ideation, severe anxiety, or other serious risk factors, VA should require documented mental-health review before any non-emergency taper or discontinuation.

For veterans identified as high suicide risk or actively suicidal, tapering should not begin unless urgent medical circumstances require it and mental-health consultation, safety planning, and close follow-up are in place.

High-risk veterans should receive stronger support, including access to mental-health care, suicide-prevention resources, more frequent follow-up when needed, and coordinated care between pain management, primary care, pharmacy, and mental-health providers.

G. Monitoring Should Be Individualized and Adjustable

Monitoring should be based on the veteran's actual risk, behavior, stability, and medical needs — not on a permanent label.

Congress should require VA to examine how a high-risk label affects a veteran's care. A high-risk designation should be informative, not punitive. It should guide clinicians toward better support, more appropriate monitoring, and timely treatment, not create a permanent label that leads to reduced care, suspicion, avoidance, or automatic tapering.

Veterans with additional risk factors may need closer monitoring, more frequent visits, mental-health support, medication review, urine drug screening when clinically appropriate, prescription monitoring, or coordinated care. But closer monitoring should not be treated as punishment, and it should not automatically mean tapering or discontinuation.

If a veteran follows the treatment agreement, remains stable, participates in care, completes appropriate monitoring, and shows improved or managed risk over time, then the level of monitoring should be reassessed and reduced when clinically appropriate.

A veteran should not be trapped forever under maximum scrutiny if the veteran has demonstrated stability and responsible participation in care.

The purpose of monitoring should be to keep the veteran safely in care, not to create a pathway toward abandonment.

H. Track Adverse Outcomes After Dose Reduction or Discontinuation

VA should be required to track and publicly report adverse outcomes after opioid tapering, dose reduction, or discontinuation, including:

1. Overdose death;
2. Suicide death;
3. Suicide attempt;
4. Suicidal ideation;
5. Psychiatric hospitalization;
6. Emergency-room visits;
7. Crisis-line contact;
8. Illicit opioid exposure;
9. Withdrawal-related crisis;
10. Worsening pain;
11. Loss of function;
12. Patient abandonment or loss of care;
13. Requests for reinstatement or adjustment of therapy.

These outcomes should be tracked by taper speed, duration of prior opioid therapy, rural status, mental-health diagnosis, substance-use diagnosis, age, sex, race, disability status, and facility.

VA should not be permitted to report prescribing reductions as safety successes without also reporting patient outcomes after those reductions.

I. Protect the Doctor-Patient Relationship and Physician Clinical Judgment

VA policy should explicitly protect the treating clinician's ability to continue opioid therapy when medically justified, documented, and monitored.

Physicians should not be pressured to reduce opioids solely to satisfy dashboards, prescribing targets, generalized MME thresholds, or fear of scrutiny.

VA should distinguish lawful, medically appropriate pain treatment from diversion, criminal conduct, or reckless prescribing. Responsible doctors should not be driven out of pain care by fear of investigation, prosecution, professional ruin, asset loss, or imprisonment.

A safer system encourages trained physicians to treat pain responsibly. It does not scare them away from patients who need care.

J. Create Safe-Harbor Protections for Responsible Pain Care

Congress should consider safe-harbor protections for clinicians who provide individualized, documented, medically appropriate pain treatment.

Safe-harbor protections could apply when the clinician:

1. Documents diagnosis and treatment rationale;
2. Conducts individualized risk-benefit review;
3. Uses monitoring when clinically appropriate;
4. Reviews relevant medication risks;
5. Screens for mental-health and suicide risk when indicated;
6. Provides informed consent;
7. Coordinates care when needed;
8. Adjusts treatment based on patient response;
9. Continues effective therapy when medically justified;
10. Does not engage in diversion, fraud, or unlawful prescribing.

This would help keep responsible physicians in pain care while preserving enforcement authority against actual misconduct.

K. Ensure Replacement Care Is Real Before Any Non-Emergency Taper

VA should not recommend or require tapering based on the assumption that alternative care exists unless that care is actually available to the veteran.

Before any non-emergency taper, VA should document whether the veteran has timely access to:

1. Mental-health care;
2. Suicide-prevention support;
3. Pain management;
4. Primary care follow-up;
5. Physical therapy;
6. Behavioral health;
7. Substance-use treatment when appropriate;
8. Specialist care;
9. Community care when VA access is delayed;
10. Emergency support if symptoms worsen.

A taper plan without timely access to replacement care is not a safety plan.

If replacement care is not available, continued monitored treatment may be safer than reducing medication and leaving the veteran unsupported.

L. Create a Dedicated Rural Veteran Pain and Mental-Health Access Program

Congress should require VA to create or expand a dedicated rural veteran pain and mental-health access program, including traveling clinicians, mobile care teams, telehealth support, and transportation assistance.

Many rural veterans are disabled, medically fragile, homebound, or unable to travel long distances for care. Veterans who served this country should not lose access to pain treatment, mental-health care, monitoring, or follow-up simply because they cannot easily reach a VA facility.

VA should establish designated funding for rural outreach care that allows qualified clinicians to travel to veterans when clinically appropriate. This should include access to pain-care providers, mental-health professionals, primary-care support, medication review, and suicide-prevention resources.

When in-person facility visits are necessary for testing, imaging, procedures, urine drug screening, specialist evaluation, or other required care, VA should provide transportation support so rural and disabled veterans are not effectively denied care because of distance, disability, or lack of mobility.

A veteran should not be forced into unsafe tapering or discontinuation because replacement care is geographically unavailable. If VA policy requires monitoring, then VA must make monitoring reachable.

M. Require Independent Specialty Peer Review

Any review of pain treatment, opioid continuation, tapering, discontinuation, or alleged inappropriate prescribing should include independent specialty peer review outside the immediate VA chain of command.[48][49][50]

The reviewing clinicians should be qualified in the relevant field. Pain-management decisions should be reviewed by clinicians with pain-management expertise. Mental-health decisions should be reviewed by qualified mental-health professionals. Substance-use concerns should be reviewed by professionals with relevant substance-use treatment expertise.

A physician outside the relevant specialty should not be treated as automatically qualified to judge complex specialty care. An emergency-room physician should not be the sole reviewer of a pain-management specialist's long-term chronic-pain plan. A clinician without mental-health expertise should not be the sole reviewer of psychiatric stability, suicide risk, PTSD, depression, or behavioral-health treatment.

Peer review must be meaningful. It should be performed by clinicians who understand the condition, the treatment field, the risks of continuation, the risks of discontinuation, and the realities of caring for medically complex veterans.

This review process should protect veterans from inappropriate forced tapering while also preserving appropriate oversight for unsafe or unlawful prescribing.

N. Audit STORM and Other Risk-Scoring Tools for Unintended Consequences

Congress should require VA to audit how STORM and similar risk-scoring tools were used in practice.

An anonymized, systemwide VA quality-of-life and quality-of-care assessment tool should be used to evaluate the patient's individualized experience within the VA system. Such a tool should measure whether veterans feel heard, supported, monitored, respected, and connected to care after being identified as high-risk or affected by opioid-reduction policy.

The audit should determine whether veterans identified as high-risk received more support, better monitoring, and timely care — or whether they were more likely to be tapered, discontinued, avoided by providers, or treated as liabilities.

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48 U.S. Government Accountability Office, Veterans Health Care: Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services, GAO-23-105372.

49 U.S. Government Accountability Office, Veterans Health: Improvements Needed to Achieve Successful Appointment Scheduling Modernization, GAO-25-106851, May 22, 2025.

50 U.S. Government Accountability Office, Veterans Health Care: Opportunities to Improve Access to Care Through the Veterans Community Care Program, GAO-25-108101, February 12, 2025.

Risk tools should never become tools of abandonment. They should be used to connect veterans to care.

O. Protect Rural Veterans From Disproportionate Harm

VA should separately analyze the impact of opioid reduction on rural veterans.

Rural veterans may face longer travel distances, fewer pain specialists, fewer mental-health providers, limited community-care options, and delayed follow-up. These access barriers can make tapering more dangerous.

VA should be required to ensure that rural veterans have timely access to mental-health care, pain management, telehealth when appropriate, pharmacy support, home-based care when needed, transportation support, and crisis intervention before and during any medication change.

Congress should also examine whether VA opioid-reduction policy has had a discriminatory practical effect on disabled veterans. Disabled veterans may face greater barriers to repeated appointments, travel, urine drug testing, specialty visits, forced treatment changes, physical therapy requirements, or access to replacement care. A policy that appears neutral on paper may disproportionately burden disabled veterans if it fails to account for mobility limits, transportation barriers, rural isolation, service-connected injuries, mental-health conditions, or complex medical needs.

P. Require Patient-Outcome Metrics, Not Just Prescription Metrics

VA opioid policy should be evaluated using patient-centered outcomes, including:

1. Pain control;
2. Function;
3. Sleep;
4. Mobility;
5. Mental-health stability;
6. Suicide risk;
7. Overdose risk;
8. Emergency-room use;
9. Ability to work or perform daily activities;
10. Patient trust and connection to care;
11. Quality of life;
12. Continued access to legitimate medical treatment.

Reduced prescribing should not be treated as the main measure of success.

Q. Preserve Legitimate Access to Pain Treatment

Congress should ensure that veterans are not pushed out of lawful medical care and into unsafe alternatives.

Policies that restrict access without preserving safe medical pathways may increase harm. Veterans with untreated pain may become desperate, isolated, destabilized, or exposed to illicit drugs. Some may face increased risk of overdose or suicide.

The safest system is one that keeps veterans inside legitimate medical care, where they can be monitored, supported, and treated by qualified clinicians.

R. Require VA Reporting to Congress

VA should be required to report to Congress on:

1. Opioid tapering, dose reduction, and discontinuation rates;
2. Outcomes after tapering, reduction, and discontinuation;
3. Use of MME thresholds;
4. Use of STORM and risk-scoring tools;
5. Mental-health access before and during any medication change;
6. Suicide-risk safeguards;
7. Rural veteran outcomes;
8. Community-care delays;
9. Provider shortages;
10. Patient complaints and abandonment reports;
11. Facility-level variation;
12. Corrective actions taken;
13. Continued-therapy cases where ongoing treatment was medically justified;
14. Monitoring intensity and whether monitoring was reduced after demonstrated stability.

This reporting should include both national and facility-level data.

S. Establish a Veteran Pain and Safety Review Process

Congress should consider requiring VA to establish a review process for veterans who believe they were harmed by forced tapering, abrupt discontinuation, denial of pain care, refusal to continue medically appropriate therapy, or loss of access to opioid therapy despite medical need.

Such a process should include clinicians with pain-management expertise, mental-health professionals, patient advocates, and veteran representation.

The purpose should not be to guarantee any specific medication. The purpose should be to ensure that veterans receive individualized review, fair process, specialty-informed evaluation, and medically appropriate care.

T. Standard of Care and Duty of Care Review

Congress should require a review of whether veterans and current service members receive care that meets the same standard of care and duty of care expected in civilian health systems. This review should examine whether VA policies, access delays, staffing shortages, sovereign-immunity barriers, internal reporting systems, or limited patient remedies create a lower practical standard of care for veterans, especially disabled veterans and veterans with complex pain, mental-health, or mobility needs.

Veterans should not receive a lower practical standard of care because they are treated in a federal system. Those who served, including those who were drafted and had no meaningful choice but to serve, should not be left with fewer protections than the civilian public.

U. Provider Accountability, NPDB, and State Board Reporting

Congress should require VA to verify that all serious provider misconduct, adverse privileging actions, malpractice-related findings, serious quality-of-care concerns, and settlement-related provider accountability issues are properly reported to the National Practitioner Data Bank and appropriate state licensing boards. VA should not be permitted to remove or conceal negative provider-history information in a way that prevents state regulators, future employers, or patients from identifying serious safety concerns.

Veterans should not be treated by a system that protects institutional reputation over patient safety.

V. VA Credentialing and Hiring Safeguards

Congress should review VA credentialing and hiring safeguards to determine whether VA has hired or retained providers with prior disciplinary histories, license restrictions, malpractice concerns, adverse privileging actions, or serious medical-error histories. The review should distinguish isolated cases from systemic issues, but should require VA to show that veterans are protected by rigorous credentialing, privileging, reporting, and re-review processes.

Congress should determine whether VA hiring practices protect veterans at least as strongly as civilian health systems are expected to protect patients.

W. Financial Incentives, Research Grants, and Opioid-Reduction Metrics

Congress should examine whether military physicians, VA-affiliated researchers, academic medical centers, treatment centers, or trauma-care programs have financially benefited from grants, contracts, or incentive programs designed to reduce opioid prescribing. If such funding exists, Congress should ask how much money has been awarded systemwide, how patient outcomes were measured, whether success was defined by reduced opioid use alone, and whether pain relief, function, disability, quality of life, mental-health stability, suicide risk, and patient-reported outcomes were also measured.

Were there any incentive programs for doctors, providers, facilities, researchers, or health systems to decrease opioid prescription rates, and if so, did those incentives prioritize patient outcomes or prescription reduction metrics?

This report does not oppose research into safer or opioid-sparing pain treatment. The concern is whether opioid-reduction funding or incentives create pressure to treat reduced prescribing as success even when individual patients may still need opioid therapy.

X. Final Policy Principle

The guiding principle should be clear:

> **A veteran identified as high-risk should receive more care, not less care.**

High risk should mean increased support, appropriate monitoring, mental-health access, suicide-prevention resources, and individualized treatment. It should not mean abandonment, forced tapering, automatic discontinuation, or loss of therapies that are working.

For many veterans, the appropriate response to risk may be continued medication with closer monitoring, not medication removal. Monitoring should also be adjustable. If a veteran remains compliant, stable, engaged in care, and medically appropriate for continued therapy, monitoring intensity should be reassessed and reduced when clinically justified.

VA opioid policy should protect veterans from overdose, diversion, and unsafe prescribing. But it must also protect veterans from untreated pain, forced tapering, abandonment, mental-health crisis, illicit drug exposure, overdose after discontinuation, and suicide.

> **True safety is not achieved when a dashboard shows fewer prescriptions.**

True safety is achieved when veterans remain alive, stable, functioning, supported, and connected to appropriate medical care.

XI. Conclusion

Veterans who live with chronic pain deserve more than policy slogans, dashboard targets, and generalized assumptions about opioid prescribing. They deserve individualized medical care, mental-health support, suicide-prevention safeguards, access to trained clinicians, and a system that recognizes the full reality of their service-connected injuries, medical conditions, and lived experience.

This report does not argue that opioid safety should be ignored. Opioid safety matters. Veterans should be protected from overdose, dangerous prescribing, harmful medication combinations, diversion, and lack of monitoring. But true safety cannot be measured only by how many prescriptions were reduced.

A lower prescription count does not automatically mean fewer deaths, fewer overdoses, fewer suicides, less suffering, better function, or better care.

The VA's opioid-reduction efforts, MME metrics, prescribing dashboards, tapering practices, and risk-scoring systems were built around the goal of reducing risk. But congressional oversight is needed to determine whether those systems worked as intended — or whether some veterans were harmed when reduced prescribing became a primary marker of success.[51][52]

The evidence gathered for this report raises serious concerns. VA opioid policy operated in a system where many veterans already faced chronic pain, PTSD, depression, traumatic brain injury, substance-use risk, suicide risk, rural access barriers, and complex medical needs. VA's own STORM research recognized that veterans prescribed opioids may have overlapping overdose/suicide risk factors, mental-health diagnoses, substance-use disorders, prescription-related risks, and medical comorbidities.[53]

That knowledge should have triggered more care.

For some veterans, however, opioid reduction may have meant less care: less pain control, less stability, less trust, fewer willing clinicians, delayed replacement treatment, fear of disclosure, or loss of access to therapy that had been helping them function.

That is the concern Congress must examine.

A veteran identified as high-risk should not be treated as a liability. High risk should not mean automatic tapering, abandonment, or denial of medication. High risk should mean stronger support, closer monitoring when needed, timely mental-health care, suicide-prevention planning, specialty-informed review, and continued access to medically appropriate treatment.

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51 U.S. Department of Veterans Affairs, "VA reduces prescription opioid use by 64% during past eight years," July 30, 2020, reporting a 64% reduction in VA prescription opioid use from FY2012 to FY2020 Q3 and related reductions in long-term opioid therapy, opioid/benzodiazepine co-prescribing, and high-dose opioid prescribing.

52 Centers for Disease Control and Prevention, CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022, MMWR Recomm Rep. 2022;71(3):1-95. The CDC stated the guideline should not be applied as inflexible standards of care or used to justify rapid tapering, abrupt discontinuation, patient dismissal, or abandonment.

53 Oliva, E. M., Bowe, T., Tavakoli, S., et al., "Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide," Psychological Services 14, no. 1 (2017): 34-49.

The doctor-patient relationship must remain central. A dashboard cannot know the veteran. An MME number cannot measure biology, tolerance, metabolism, function, trauma history, failed therapies, mental-health stability, or the treating physician's clinical judgment. A risk score cannot replace care.

Nor can these tools account for the fact that the same diagnosis does not affect every veteran the same way. Two veterans may have the same condition, injury, or disease, but experience different pain levels, limitations, medication responses, side effects, risks, and outcomes. A policy that treats them as interchangeable ignores the reality of human biology and undermines individualized medicine.

The safest system is not one that drives veterans and physicians away from lawful pain treatment. The safest system is one that keeps veterans inside legitimate medical care, where they can be evaluated, monitored, supported, and treated by clinicians who understand their conditions.

Congress should require VA to answer whether opioid-reduction policies actually improved veteran outcomes. VA should be required to report not only how many prescriptions were reduced, but what happened afterward: overdose deaths, suicide deaths, suicide attempts, emergency care, psychiatric crises, illicit drug exposure, worsening pain, loss of function, rural access problems, provider shortages, and patient abandonment.[545556575859]

If opioid policy reduced prescribing but increased suffering, crisis, overdose risk, or suicide risk, then the policy failed the veterans it was supposed to protect.

Veterans served this country. They should not have to fight a federal health-care system for individualized care, pain treatment, mental-health support, or the right to be treated as human beings rather than numbers.

At the end of the day, those who have served, and those who are still serving, have put themselves between the American people and danger. They have given their bodies, minds, time, health, and futures in service to this country. The least this country can do is ensure they receive the best care possible —

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54 Oliva, E. M., Bowe, T., Manhapra, A., et al., "Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in US veterans: observational evaluation," BMJ 368 (2020): m283. This observational study found associations between stopping opioid prescriptions and overdose or suicide deaths, with risk increasing by longer prior opioid-treatment duration; it should not be read as proving causation in every individual case.

55 Cowan, Benjamin W., and Joshua C. Tibbitts, "The Opioid Safety Initiative and Veteran Suicides," NBER Working Paper No. 29139, August 2021, DOI: 10.3386/w29139. As a working paper, it should be cited carefully as an estimate and oversight concern rather than final proof of causation.

56 U.S. Government Accountability Office, VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed, GAO-18-380, May 29, 2018.

57 U.S. Government Accountability Office, Veterans Health Care: Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services, GAO-23-105372.

58 U.S. Government Accountability Office, Veterans Health: Improvements Needed to Achieve Successful Appointment Scheduling Modernization, GAO-25-106851, May 22, 2025.

59 U.S. Government Accountability Office, Veterans Health Care: Opportunities to Improve Access to Care Through the Veterans Community Care Program, GAO-25-108101, February 12, 2025.

care that does not abandon them, frighten them, reduce them to numbers, or leave them alone after they have carried burdens on behalf of the nation.

No veteran, and no current service member, entered military service expecting that after facing threats abroad, they would come home and have to fight another battle within their own borders — against pain, trauma, disability, bureaucracy, and a health-care system that too often leaves them feeling abandoned.

They did not serve this country so they could later be reduced to a number, treated with suspicion, or forced to fight for care inside the very system meant to support them.

That is not the American way.

The American way should be to honor service with care, accountability, and dignity. It should mean that when veterans return home carrying injuries in their bodies and wounds in their minds, this country does not leave them alone to suffer. It stands with them.

Veterans should not receive a lower practical standard of care because they are treated inside a federal system. Whether they volunteered or were drafted, whether they served in combat or in support roles, and whether their wounds are visible or invisible, they are entitled to care that meets the dignity of their service. A system that gives the general public stronger practical protections than veterans is not honoring service. It is failing it.

The guiding principle for reform should be simple:

A veteran identified as high-risk should receive more care, not less care.

A veteran stable on effective treatment should not be forced off medication because of a dashboard, MME threshold, or generalized policy goal.

A veteran in rural America should not lose care because treatment is too far away.

A veteran with PTSD, depression, traumatic injury, or suicide risk should not be abandoned in the name of safety.

And a physician who provides responsible, documented, medically appropriate pain care should not be driven away by fear.

True safety means veterans remain alive, stable, functioning, supported, and connected to care.

That is the standard VA opioid policy should be held to. That is the standard Congress should demand.

References and Source Links

The following source titles are clickable links for verification and staff review. In Microsoft Word, hold Ctrl and click a linked source title if Word requires it.

No.	Source	Link
1	U.S. Department of Veterans Affairs	VA reduces prescription opioid use by 64% during past eight years
2	Centers for Disease Control and Prevention	CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022
3	U.S. Department of Health and Human Services	HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics
4	U.S. Department of Veterans Affairs / Department of Defense	VA/DoD Clinical Practice Guideline: Use of Opioids in the Management of Chronic Pain (2022)
5	U.S. Department of Veterans Affairs / Department of Defense	VA/DoD Clinical Practice Guideline: Management of Opioid Therapy for Chronic Pain (2010)
6	VA PBM Academic Detailing Service	Opioid Taper Decision Tool: A VA Clinician's Guide
7	Psychological Services / American Psychological Association	Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM)
8	U.S. Government Accountability Office	GAO-18-380: VA Health Care: Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed
9	The BMJ	Oliva et al. (2020): Associations between stopping prescriptions for opioids, length of opioid treatment, and overdose or suicide deaths in U.S. veterans
10	National Bureau of Economic Research	Cowan and Tibbitts: The Opioid Safety Initiative and Veteran Suicides, NBER Working Paper No. 29139
11	U.S. Department of Veterans Affairs	Veteran Suicide Data and Reporting / 2025 National Veteran Suicide Prevention Annual Report

12	U.S. Government Accountability Office	GAO-23-105372: Veterans Health Care: Staffing Challenges Persist for Fully Integrating Mental Health and Primary Care Services
13	U.S. Government Accountability Office	GAO-24-106023: VA Health Care: Organization of the Office of Mental Health and Suicide Prevention
14	U.S. Government Accountability Office	GAO-25-106851: Veterans Health: Improvements Needed to Achieve Successful Appointment Scheduling Modernization
15	U.S. Government Accountability Office	GAO-25-108101: Veterans Health Care: Opportunities to Improve Access to Care Through the Veterans Community Care Program
16	House Armed Services Committee	Military Personnel Subcommittee Jurisdiction
17	USA Today	VA conceals shoddy care and health workers' mistakes
18	Axios	Report: VA hid records of serious medical errors
19	National Practitioner Data Bank / HRSA	NPDB Guidebook: Reporting Adverse Clinical Privileges Actions
20	Electronic Code of Federal Regulations	45 CFR § 60.12: Reporting adverse actions taken against clinical privileges
21	U.S. Department of Veterans Affairs	VHA Directive 1100.20: Credentialing of Health Care Providers
22	UT Health San Antonio	New TRC4 grant aims to reduce opioid treatment for burn victims by 90%

Note: These links supplement the report footnotes. The footnotes remain the formal citation support, while this list gives readers a convenient way to open the source documents directly.