

**Testimony of Kimberly Stowe Green before the Subcommittee on Health,
House Committee on Veterans' Affairs, United States House of
Representatives.**

Washington, D.C.
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Mr. Chairman (Dan Benishek), Ranking Minority Member (Julia Brownley), and all Distinguished Members of the Subcommittee:

Introduction

My name is Kimberly Green. I am honored to have been invited to speak to you today at this hearing entitled "Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans." I am accompanied here today by my attorney Brant Mittler who is also a medical doctor.

I respectfully request that my written statement be incorporated into the official records of this hearing.

The VA determined Ricky He was at first determined to be 50% disabled due to service related activities. And later the amount of disability was increased to 80%. Rickey was injured in the army during his training activities and from his paratrooper activities jumping out of planes and from his military police work in securing combat areas. The injuries to his back, knees and ankles caused him to have chronic pain later in his life.

I served my country for 21 years in the United States Air Force. I retired out of the military as a Master Sergeant. I am the widow of Ricky Green. My husband served his country for 23 years in the United States Army. He was a military policeman and paratrooper and he served with distinction in Desert Storm I. He retired out of the military as a Sergeant First Class.

I have no contracts or commercial ties to the VA or the federal government.

The VA's Skyrocketing Use of Prescription Painkillers Caused the Death of My Husband Ricky Green

My husband – Ricky Green – died as a result of the VA’s skyrocketing use of prescription painkillers. On behalf of my husband, myself, and our two grieving sons, Andrew Evan Green, aged 21, and Alexander Michael Green, age 16, I want to ask this committee to do all that it can to prevent other veterans from dying in the same manner that my husband died.

My husband died on October 29, 2011 at the age of 43 after lower back surgery performed four days earlier on October 25, 2011. The Arkansas State Crime Lab and its Medical Examiner performed an autopsy and determined that the cause of death for my husband was Mixed Drug Intoxication complicating recent lumbar spine surgery. My husband died because of the prescription pain and sleeping medications that the VA and its doctors prescribed for him and dispensed to him out of the VA pharmacy.

I’m here to put names and faces on that sterile statistic of “mixed drug intoxication complicating recent lumbar spinal surgery”.

The VA Already Has Written Guidelines for Prescribing Pain Killers but These Are Not Being Followed

The Veteran’s Health Administration’s National Pain Management Strategy, initiated November 12, 1998, established Pain Management as a national priority.

You can go to the VHA website today – <http://www.va.gov/painmanagement> – and see for yourself that the VA has written guidelines for prescribing pain medications. The two primary ones are (1) VHA Directive 2009-53 dated October 28, 2009 on Pain Management (<http://www.va.gov/painmanagement/docs/vha09paindirective.pdf>); and (2) the Veteran’s Administration/Department of Defense Clinical Practice Guideline Management of Opioid Therapy for Chronic Pain dated May, 2010 (http://www.healthquality.va.gov/COT_312_Full-er.pdf). These guidelines include stepped care that involves primary care, secondary consultation, and interdisciplinary care and special measures to include testing, evaluating and monitoring to reduce the risks inherent in the use of prescription painkillers – and one of the most notable risks is accidental overdose. The problem is – these guidelines have not been fully implemented and are not being followed – they were repeatedly violated in my husband’s case – and he had to pay with his life for that fact.

VHA Directive 2009-53 states at page A-3 that “[t]he potential for fatal overdose either by accident or in a suicidal attempt in patients suffering from multiple disorders or with polypharmacy must be considered in prescribing opioids and other medications.” The potential for fatal overdose with these drugs was not adequately considered by the VA and its doctors treating my husband.

The Clinical Practice Guidelines require physicians to closely monitor and evaluate patients who are being prescribed prescription pain killers for chronic pain and these guidelines specially warn these physicians at page 24, and other places, about the dangers of drug-drug interactions that can cause death. The VA and its doctors prescribed and provided to my husband his medications – and the interactions among these drugs killed my husband.

During the course of his treatment at the VA, the VA and its doctors wrote my husband prescriptions, and VA pharmacies filled these prescriptions, for his chronic back pain which was service connected, for the following drugs: Oxycodone, Hydrocodone, Valium, Ambien, Zoloft, Gabapentin, and Tramadol. My husband, Ricky Green, followed the orders of his VA doctors in taking these pain medications – and these pain medications led to his death. He was not suicidal in taking these drugs – again he was just following his doctors’ orders.

The Clinical Practice Guidelines contain a section that requires physicians to take special care in prescribing pain medications for patients such as my husband who had sleep apnea. Unfortunately, again, no such special precautions were taken for my husband – and the guidelines were simply ignored – such that the drugs interacted with the sleep apnea to cause my husband to stop breathing and to die.

In my husband’s case, the VA and its doctors, over-prescribed my husband pain medications over a long period of time but after he had back surgery on October 25, 2011 related to the injuries he had incurred while on active duty he got a lethal drug cocktail that included oxycodone, and diazepam which were reviewed by the VA and filled by the VA pharmacy on October 26, 2011.

These two drugs – prescribed and provided by the VA and its doctors and pharmacist in violation of the Clinical Practice Guideline – together with the sleep apnea – are what produced according to the Arkansas State Medical Examiner produced “a significant stated of analgesia sedation, and respiratory depression” which led to my husband’s death. Ricky stopped breathing and died in his sleep on October 29, 2011.

I want to be clear in my testimony to this committee – I strongly believe that my husband was entitled to receive the quality of care that the VA, and DoD, set forth in writing in their own guidelines. However, these guidelines have not been fully implemented and are not being followed – and our veterans are suffering the consequences.

You do not have to take my word for it that these guidelines have not been implemented or followed. I was able to find on the internet the contents of a Cyber Seminar dated October 2, 2012 – about one year after my husband’s death – entitled “Overdose Among VA Patients Receiving Opioid Therapy for Pain; Risk Factors and Prevention.” (http://www.hsrdr.research.va.gov/for_researchers/cyber_seminars). The introducer and participant at that seminar – a Dr. Bob Kerns – is a National Program Director for Pain Management and he is based at a VA Hospital in Connecticut. Here is a quote from him at that seminar: “... the VA/DoD Clinical Practice Guidelines. Its full implementation across the VA really has not been actualized or realized yet. So for those – there are a couple hundred people on the call that work facilities. I am guessing that many of you work in facilities that really have not thoroughly digested those guidelines and looked to implement the recommendations of the guidelines at a facility level, let alone at an individual level. And we should be doing that first....”

How long must our veterans be made to wait until these guidelines are fully implemented and begin saving the lives of our veterans?

If these guidelines would have been followed my husband would not have been prescribed drugs that caused him to have a mixed drug interaction and to stop breathing. If these guidelines would have been followed my husband would have been closely examined, monitored, and he would not have been provided the lethal cocktail of drugs that killed him.

Our Veterans Who Honorably Served Their Country Deserve Better Healthcare from the VA

I believe the VA and its doctors, rather than treating all of the underlying causes of my husband’s back pain, took the easier way out and overmedicated him with prescription pain killers. I believe this is happening far too much and I note that statistics have been compiled that show in Fayetteville, Arkansas – where my

husband was treated – there is a high incidence of over-prescribing pain medications for veterans.

Treatment of the underlying medical conditions, physical therapy, counseling, monitoring, in-patient hospital stays – these are the kinds of things I believe our veterans need and are entitled to – not just the over-medication of prescription pain killers to mask their pain. In my husband’s case – he constantly asked the VA and its doctors to treat the root cause of his health problems – and to reduce the opiate pain medications he was being prescribed. The VA failed to do that in his case.

In Honor of My Husband

I am proud of my husband. After serving his country for over twenty years in the military he went back to school and earned his college degree in criminal justice. He had plans to go to law school so that he could be a voice for other veterans in their time of need. He was 43 years old when he died. He should have had a long life ahead of him. Ricky survived serving in combat zones in his over twenty years of military service, but he could not survive the VA and his negligent treatment of him.

This lethal cocktail of drugs –which again included Oxycodone and Diazepam among many other drugs – were prescribed by VA doctors and dispensed at the VA pharmacy. I have sent pictures of the bottles of the medicines my husband was taking to this subcommittee. These pill bottles – clear evidence of the negligence of the VA and its doctors – are now in safe keeping at the Sheriff’s office in Fort Smith, Arkansas.

My husband was a hero and a great husband and father. He stood up for his country honorably when his country called for him. He trusted VA doctors. He deserved much better treatment than what he received at the VA. Now, because of what the VA has done to my husband, my husband and I will not be able to grow old together. He will not be with me at the college graduation ceremonies for our two sons. He will not be with me at the wedding ceremonies for our two sons. He will never see and come to know his grandchildren. The VA has taken the life of a great man. And the VA has left his family – including his wife and two sons – decimated and grief stricken.

I am here today to honor my husband’s memory and to demand better treatment for the men and women – like my husband and I – who have honorably served our country in the military. The VA has written guidelines in place for the safe use of

prescription pain killers – and the VA will have to follow these guidelines or more veterans will needlessly lose their lives – just like my husband did.

I am proud to do my part and to stand up and fight on behalf of my husband and not allow him or me to be a quiet victim of injustice. I have heard excuses – the guidelines are not standards of care and some veterans who die of overdoses were suicidal – these are excuses that the VA is making because it has failed to take the action needed to fully implement and follow the written guidelines that have already been published.

Let me be clear: the VA knew that Ricky was not suicidal, the VA knew that Ricky did not display drug seeking behavior. The VA knew Ricky want to reduce the amount of pain medication he was taking.

I think in my case – and in many other similar cases – the VA should admit what it has done wrong, make up for it, and most importantly – stop this kind of thing from happening in the future.

To those who have been injured or killed in the past by the VA and its doctors – these victims deserve just compensation.

More importantly – the VA and its doctors must avoid causing future victims – by doing the right thing and implementing, training, following, monitoring, and evaluating the VA and its doctors on the written guidelines for prescription pain medications that are already in place.

Prescription pain killers in high doses and over time are dangerous. There are better ways of treating our veterans.

The VA, Humana, and Project HERO

Humana and the VA have teamed up on a project called Project HERO. You can go to <http://www.humana-veterans.com/about-hvhs/project-hero.asp> to learn about this program. This website provides that “[t]he ultimate goal of Project HERO is to ensure that all health care delivered by the VA, either through VA providers or community partners, is of comparable quality and consistency for veterans.”

My husband was in the Project HERO program and it did him no good at all.

My understanding is that this Committee has heard the testimony of Brad Jones, Chief Operating Officer, Humana Healthcare Services, Inc., at a hearing on September 14, 2012. He claimed in his testimony that “[W]ith the exception of veterans participating in Project HERO and Project ARCH, veterans are left to navigate a confusing healthcare system on their own and become lost to the VA. The VA has no mechanism to track and monitor the care that Veterans receive in the community and there is no guarantee that these Veterans do not lose the quality, safety, and other protections that HERO and ARCH provide.”

Mr. Jones further testified that “lack of care coordination hinders the VA’s ability to optimize its resources because there can be duplicative and conflictive treatment regimen. This not only results in wasted resources, but can also cause adverse medical outcomes.”

Mr. Jones contended that Humana and Project HERO provided a “strong care coordination element.”

This did not happen in my husband’s case. His care was not coordinated. He was not provided the care he needed. He was not allowed the in-patient hospital care that he needed. And his prescription drugs were not coordinated and monitored to ensure safety.

No one at the VA or at Humana questioned why he got all of the medication that were prescribed when he had a diagnosis of sleep apnea.

Again – it is a case of written guidelines and programs – that are not implemented.

Questions That Deserve Answers from the Veteran’s Administration and Humana

It is my understanding that when unexpected deaths occur, the VA does an analysis to find out why the death occurred. I want to know if such an analysis was ever done in my husband’s case. I want to know if the VA has or will investigate the death of my husband and learn something from his death. Has the VA considered why my husband was forced out of the hospital one day after his back surgery instead of being allowed to stay three to five days as we had been told? Has the VA looked at the autopsy report so that it can see that the drugs it gave my husband killed him? Does the VA consider all the drugs that my husband Ricky Green was taking – with his diagnosis of sleep apnea – a quality problem and health care that fell below the standard of care and its own guideline? Does the VA understand that the interactions of all the drugs that they provided my husband

killed him – and that these drug interactions are critical and must be taken into account before prescription pain killers are so cavalierly prescribed? Has the VA considered how dangerous it is to provide pain medications and sleeping pills to someone with sleep apnea such as my husband? And have the VA and Humana asked each other – who dropped the ball here – and why Project HERO did nothing at all to protect my husband. I would like this Committee to use its powers of investigation to uncover why Humana and Project HERO did not protect my husband Ricky Green from the lethal cocktail of drugs that killed him. Why can't the powerful computer systems at both the VA and Humana that process the medical records of our veterans be programmed to monitor the kinds of drug interactions and dangerous conditions like sleep apnea to alert both doctors and pharmacists when dangerous prescribing occurs like those that killed Ricky?

I hope the VA – and if not the VA then this Committee – will ask these questions, learn something, and save the lives of our veterans in the future. That is the one way – the only way – that my husband will not have died in vain.

Conclusion and Call for Action

I will NOT be silent about any of this. My husband doesn't have a voice therefore I am his voice. I want to see that this over drugging of our Veterans Stops AND that there IS accountability for these physicians actions. Prescribing sleeping pills, valium, tramadol, oxy, hydrocodone, to my husband was nothing but a death sentence. This is happening more and more and this has to STOP!

I want to leave you on this committee with a simple request – demand that the VA follow its own written guidelines, demand that the VA put in place procedures that punish VA doctors and staff who do not follow these written guidelines, and demand that the VA and its doctors put a stop to this epidemic of the VA's skyrocketing use of prescription painkillers to treat veterans.