On August 30, 2014, U.S. Marine Veteran Jason Simcakoski died in the Tomah Veterans Affairs' Medical Center as a result of mixed drug toxicity.

U.S. Senators Tammy Baldwin and Shelly Moore Capito's bipartisan Jason Simcakoski Memorial Opioid Safety Act would provide VA with the tools it needs to help prevent this tragedy from occurring to other veterans and their families.

Opioid Therapy and Pain Management

At the heart of the **Jason Simcakoski Memorial Opioid Safety Act** are provisions to strengthen VA's opioid prescribing guidelines and improve pain management services.

- ***VA/DoD Clinical Practice Guidelines:*** This legislation would require VA and DoD to jointly update the VA/DoD Clinical Practice Guidelines for Management of Opioid Therapy for Chronic Pain.
- ***VA Pain Management and Safe Opioid Education***: This bill would require VA opioid prescribers to have pain management and safe opioid prescribing education and training, including training on the updated guidelines.
- ***VA's Opioid Therapy Risk Report tool***: The bill would improve, through use of VA's existing Opioid Therapy Risk Report tool, real-time tracking of, and access to, data on the opioid use of veterans in order to prevent over-medication.
- ***Countering Overdoses:*** This proposal would require increased availability and use of opioid receptor antagonists, which are used to counter the effects of opioid overdoses.
- ***VA and DoD Collaboration:*** This legislation would require the working group on Pain Management Therapy within the VA/DoD Joint Executive Committee also to address appropriate opioid therapy.
- ***Pain Management Boards***: This bill would establish boards in each VISN to oversee compliance with VA's guidance on pain management. The Board would also carry out educational forums on pain management and treatment.
- ***Reports and Investigation:*** This bill would hold the VA accountable for appropriate care and quality standards through annual VA and GAO reports to Congress, and trigger an investigation if prescribing rates at a facility are found to be a dangerous outlier.

Patient Advocacy

- ***Community Meetings on Improving VA Care:*** This proposal would require community meetings at VA facilities on improving health care administered by VA.
- ***Office of Patient Advocacy:*** This legislation would establish an office of Patient Advocacy within the Office of the Under Secretary for Health. It would also refocus the current program's purpose so that Patient Advocates work on behalf of veterans to address concerns with their health care.
- ***Awareness of Patient Advocacy Program:*** This bill would require VA to display the purposes of the Patient Advocacy Program and the contact information for each health care facility's patient advocate in a well-travelled area of each VA hospital and clinic.

Complementary and Integrative Health

- ***Research and Education on Complementary and Integrative Health:*** This proposal would require VA to develop a plan to expand research and education on, and delivery of complementary and integrative health services into the health care services provided to veterans and to conduct a pilot program to deliver such services.

VA Hiring and Internal Audits

- ***VA Reviews of License Violations:*** This proposal would require VA to increase information sharing with state licensing boards when VA identifies provider medical practice violations and when hiring providers.
- ***VA Self-Analysis:*** This legislation would require the VA Secretary to appoint an independent and interdisciplinary office within the Office of the Secretary to carry out internal audits and self-analysis to improve the furnishing of benefits and health care to veterans and their families.