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COMMITTEES:
BUDGET
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FOREIGN RELATIONS
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

United States Senate

WASHINGTON, DC 20510

February 10, 2015

The Honorable Johnny Isakson
Chairman
Senate Committee on Veterans' Affairs
Russell Senate Office Building, Room 412
Washington, D.C. 20510

The Honorable Richard Blumenthal
Ranking Member
Senate Committee on Veterans' Affairs
Russell Senate Office Building, Room 412
Washington, D.C. 20510

Dear Chairman Isakson and Ranking Member Blumenthal:

I write to request that the Committee include language in its report accompanying H.R. 203, the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, to require yearly third-party evaluations of Department of Veterans Affairs (VA) doctors' opioid prescription practices. The SAV Act makes important and necessary changes to improve the mental health care of our veterans and brings suicide prevention to the forefront of VA mental health treatment. As the reported events at the Department of Veterans Affairs Medical Center (VAMC) in Tomah, Wisconsin illustrate, substance abuse often accompanies our veterans' struggles with mental health disorders. Accordingly, I believe that the SAV Act should ensure that there is proper oversight over the prescribers of opioids in order to avoid another incident similar to what reportedly occurred at the Tomah VAMC.

The reported opioid prescription practices at the Tomah VAMC are concerning. According to reports, "in 2004, the Tomah VA dispensed 50,000 oxycodone pills to roughly 25,000 veterans. By 2012, that number had grown to 712,000."[1] Accounts from the facility referenced veterans who were "doped-up" on so many opiates that they were "zombified" and veterans colloquially referred to the Tomah VAMC as "Candy Land."[2] One psychiatrist in particular, who also served as the hospital's chief of staff, earned the nickname "Candy Man" for his opioid prescription practices.[3] Tragically, two veterans who received treatment at the facility died of reported drug overdoses.[4]

The VA Office of Inspector General (OIG) received 32 allegations of malfeasance at the Tomah VAMC and subsequently initiated an inspection of the facility, which it completed in March 2014. The inspection focused on the prescription practices of two officials, "Dr. Z" and another medical professional at the facility labeled "Y." Data compiled by the inspection

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[1] Aaron Glantz, *Opiates handed out like candy to 'doped-up' veterans at Wisconsin VA*, THE CENTER FOR INVESTIGATIVE REPORTING, Jan. 8, 2015, http://www.revealnews.org/article-legacy/opiates-handed-out-like-candy-to-doped-up-veterans-at-wisconsin-va.
[2] *Id.*
[3] *Id.*
[4] *Id.*

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showed that medical professional Y prescribed to 182 unique patients an average of over 29,000 milligrams of opioids per patient.[5] That same data showed that Dr. Z prescribed to 128 unique patients an average of over 25,000 milligrams of opioids per patients.[6] The inspection found that Dr. Z and medical professional Y's opioid prescription practices were "at considerable variance compared with most opioid prescribers" in the region.[7]

Although the inspection cleared Dr. Z and medical professional Y of wrongdoing, it noted that Dr. Z and medical professional Y's opioid prescription practices "raised potentially serious concerns" that should be brought to the attention of VA leadership.[8] The report was not publically released when the inspection was completed. Instead, the public learned about the report's findings only after media outlets reported on the widespread opioid over-prescription to veterans at the Tomah VAMC.

As you know, on May 14, 2014, the VA OIG released a report entitled, "Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy."[9] The report described both the prevalence of VA patients who filled any take home opioid prescriptions in FY 2012 and compiled baseline data metrics on these opioid patients. The report also looked at dispensing habits of VA facilities, including early refill requests, and screening procedures the hospitals had in place for opioid patients.

Notably, the report found that 13.1 percent of patients prescribed opioids had an active substance use issue. Further, the report found that the VA is not adequately screening for potential opioid abuse or protecting high risk patients, like those with substance abuse, who are prescribed such drugs. I believe that an annual review of opioid prescription practices will help to identify instances of opioid over-prescription in a timely manner and will allow the VA to make informed decisions that protect the well-being of our veterans.

The media accounts from the Tomah VAMC, the March 2014 VA OIG inspection of the Tomah facility, and the May 2014 system-wide inspection illustrate that effective oversight of the opioid prescription practices of VA doctors is lacking. Accordingly, annual third-party evaluations of the opioid prescription practices of VA doctors are warranted to ensure that our veterans receive the mental health care they deserve.

I respectfully request that the Committee include the following suggested language in its report accompanying H.R. 203:

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[5] U.S. Department of Veterans Affairs, Office of Inspector General. Administrative Closure. *Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority at the Tomah Medical Center*. MCI# 2011-04212-HI-0267, Mar. 12, 2014, at 8.
[6] *Id.*
[7] *Id.* at 9
[8] *Id.*
[9] U.S. Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections, *Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy*, May 14, 2014, http://www.va.gov/oig/pubs/VAOIG-14-00895-163.pdf.

"Regarding Section 2, "*the Committee intends that the required 'evaluations of mental health care and suicide prevention programs' described in this provision will include a review of opioid prescription trends by doctors in the VA system. The review of opioid prescription practices shall include, but not be limited to: (1) an evaluation of VA opioid prescription patterns of take-home opioids, including frequency of written prescriptions for opioids, amount of opioids prescribed, and medications (type and amount) that are concurrently prescribed with opioids to patients; (2) an evaluation of VA dispensing patterns, including data on early refill requests and how often those early refill requests are granted; (3) a description of both the prevalence of VA patients who filled any take-home opioid prescriptions at a VA facility in the given fiscal year and those patients' baseline characteristics; (4) an assessment on whether VA facilities are adequately following VA/Department of Defense (DOD) Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain (CPG) screening and monitoring guidelines for patients prescribed opioids; and (5) an assessment of VA patterns for prescribing opioid treatment for patients suffering from mental health disorders.*"

I commend the both of you for your leadership in securing passage of the SAV Act in the Senate and thank you for your consideration of my request.

Sincerely,

Ron Johnson
United States Senator