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DEPARTMENT OF VETERANS AFFAIRS
BEFORE A JOINT FIELD HEARING OF
THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
AND
THE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
ON THE OPERATIONS OF THE TOMAH VA MEDICAL CENTER
TOMAH, WISCONSIN

MARCH 30, 2015

Messrs. Chairmen and Members of the Congress, thank you for the opportunity to testify today on the Office of Inspector General's (OIG) inspection of allegations related to the prescribing practices of staff at the Tomah VA Medical Center (VAMC), in Tomah, Wisconsin, conducted from October 2011 through March 2014. I am accompanied by Alan Mallinger, M.D., Senior Physician, Office of Healthcare Inspections. I will provide a brief summary of the OIG's work, which is outlined in the administrative closure that was posted on the OIG website on February 6, 2015.

BACKGROUND

In March 2011, the OIG Hotline received a complaint regarding prescription practices at the Tomah VAMC. After review, we referred the allegations to the Director, Veterans Integrated Service Network (VISN) 12, VA Great Lakes Health Care System, who has managerial oversight of the Tomah VAMC. A copy of this referral was also sent to the office of the Veterans Health Administration (VHA) Chief of Staff. The VISN 12 Director provided a detailed response to the allegations on June 22, 2011, that stated 16 allegations involving over 30 patients were unsubstantiated. The VISN 12 Director substantiated two allegations involving two patients. As a result of this review, the VISN Director initiated an action plan to:

- Review refill policies at Tomah VAMC.
- Review Tomah policies regarding lab testing of patients on narcotics.
- Evaluate practice trends and approaches to pain to ensure the needed variety of pain approaches is available to Tomah patients.
- Work with the Chief of Staff to evaluate pain approaches and the effectiveness of such.

Based on the VISN 12 Director's fact-finding efforts and commitment to take corrective action, we closed the complaint.

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On August 25, 2011, the OIG Hotline received a new anonymous complaint with similar allegations, including a statement that the same letter had been sent to all Wisconsin Senators and Representatives. On September 29, 2011, Representative Ron Kind forwarded the same complaint to the OIG Hotline. On October 7, 2011, the Office of Healthcare Inspections accepted the case for review. Over the course of the next 3 years, the OIG Office of Healthcare Inspections conducted an extensive inspection of the allegations involving the OIG's Office of Investigations, the Drug Enforcement Agency, and Tomah and Milwaukee municipal police to determine if there was evidence of narcotic abuse at the Tomah VAMC. We reviewed patient medical records, protected peer reviews of providers' practice, and pharmacy records. We conducted an undercover surveillance operation and reviewed email messages and associated files originating from 17 individuals. We interviewed at that time current and former VA employees and conducted a site visit that included touring the outpatient pharmacy to assess security.

We could not substantiate the majority of allegations made in the complaints that the OIG received. Although the allegations dealing with general overuse of narcotics at the facility may have had some merit, they did not constitute proof of wrongdoing. We did not find any conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies. We administratively closed the inspection on March 14, 2014. VHA Central Office senior officials were advised 3 days earlier about the Tomah inspection. While the decision to close this inspection administratively has since been questioned, at the time we believed that given the totality of the facts—paramount of which was that the allegations were not substantiated and the impact disclosure of unfounded allegations could have on an individual's reputation and privacy—an administrative closure was appropriate.

We noted several issues of concern and made suggestions to address these concerns to the VAMC Director and the VISN 12 Director. We conducted a telephone briefing with the Tomah VAMC Director, VISN 12 Quality Management Officer, and the Organizational Improvement Analyst for the Tomah VAMC on July 3, 2014; and met in person with the VISN 12 Director on July 16, 2014, to discuss the following suggestions:

- The Facility Director should implement a vehicle by which clinicians and staff can openly and constructively communicate concerns and rationale when disagreements arise concerning dispensing of opioid prescriptions.
- The Facility Director should review the reporting structure in the context of safeguarding bi-directional clinical discourse from actual or perceived administrative constraint.

- The Facility Director should ensure development of guidance, parameters, processes, or a specialty clinic-based mechanism to assist clinicians and staff with managing complex patients requesting early opioid refills.
- The Facility Director should consider some variant of the tumor board model as one potential avenue by which to foster collaborative interdisciplinary management when presented with very complex clinical pain cases.
- The VISN should conduct further evaluation and monitoring of relative and case-specific opioid prescribing at Tomah VAMC on both a facility and individual clinician level.

The OIG currently has several inspections ongoing at the Tomah VAMC concerning allegations of poor patient care. When our work is completed, we will publish the results on our website. However, due to privacy concerns and other restrictions on the release of protected information, those reports will not mention names and sensitive information may be redacted or omitted. I can assure you that the OIG's review will be a comprehensive review of the facts based on a thorough review of all information available.

We have included a list of reviews conducted by the OIG since 2011 related to opioid prescribing practices, including a national review issued on May 14, 2014, *Healthcare Inspection – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients of Opioid Therapy*. In this report, we found that VA was not following its own policies and procedures in six key areas: acetaminophen prescription practices; follow-up evaluations of patients on take-home opioids; concurrent substance use treatment with urine drug tests; prescribing and dispensing of benzodiazepines concurrently with opioids; routine and random urine drug tests prior to and during take-home opioid therapy; and medication reconciliation. We note that VA has taken actions to implement a number of the recommendations in this report, but VA must be vigilant in monitoring facility compliance with opioid prescription policies and completing outstanding recommendations.

CONCLUSION

The OIG's healthcare inspection at the Tomah VAMC was painstaking and exhaustive. At the end of a 2 and ½ year review, we concluded that opioid prescribing practices of some Tomah VAMC staff were at the outer boundary of acceptable prescribing practice, found no evidence that illegal activity was occurring, and closed the inspection administratively. This in no way should suggest that we are unconcerned about the proliferation of opioid prescribing at the Tomah VAMC or other VHA facilities. In fact, the OIG has been concerned for some time with opioid prescribing practices across the VHA health care system and in May 2014 made six recommendations in our national report for corrective actions. We are committed to completing our ongoing healthcare inspections at the Tomah VAMC with great care and diligence, and will provide our results to VA and Congress as soon as we are completed.

APPENDIX A

VA Office of Inspector General
Reporting on Opioid Prescription Practices

December 9, 2014	Alleged Inappropriate Opioid Prescribing Practices, Chillicothe VA Medical Center, Chillicothe, Ohio http://www.va.gov/oig/pubs/VAOIG-14-00351-53.pdf
July 17, 2014	Quality of Care and Staff Safety Concerns at the Huntsville Community Based Outpatient Clinic, Huntsville, Alabama http://www.va.gov/oig/pubs/VAOIG-14-01322-215.pdf
June 25, 2014	Medication Management Issues in a High Risk Patient, Tuscaloosa VA Medical Center, Tuscaloosa, Alabama http://www.va.gov/oig/pubs/VAOIG-13-02665-197.pdf
June 9, 2014	Quality of Care Concerns Hospice/Palliative Care Program, Western New York Healthcare System, Buffalo, New York www.va.gov/oig/pubs/VAOIG-13-04195-180.pdf
May 14, 2014	VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy http://www.va.gov/oig/pubs/VAOIG-14-00895-163.pdf
November 7, 2013	Alleged Improper Opioid Prescription Renewal Practices, San Francisco VA Medical Center, San Francisco, California http://www.va.gov/oig/pubs/VAOIG-13-00133-12.pdf
August 21, 2012	Management of Chronic Opioid Therapy at a VA Maine Healthcare System Community Based Outpatient Clinic http://www.va.gov/oig/pubs/VAOIG-12-01872-258.pdf
August 10, 2012	Patient's Medication Management, Lincoln Community Based Outpatient Clinic, Lincoln, Nebraska http://www.va.gov/oig/pubs/VAOIG-12-02274-244.pdf
August 19, 2011	Alleged Improper Care and Prescribing Practices for a Veteran, Tyler VA Primary Care Clinic Tyler, Texas http://www.va.gov/oig/54/reports/VAOIG-11-01996-253.pdf
June 15, 2011	Prescribing Practices in the Pain Management Clinic at John D. Dingell VA Medical Center, Detroit, Michigan http://www.va.gov/oig/54/reports/VAOIG-11-00057-195.pdf