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DEPARTMENT OF VETERANS' AFFAIRS
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
US HOUSE OF REPRESENTATIVES
AND
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
HEARING ON
TOMAH DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER**

March 30, 2015

Good afternoon Chairman Miller and Chairman Johnson, and other Members of the Congress. Thank you for the opportunity to appear before you today at Tomah to discuss quality of care issues at the Tomah VA. I am accompanied today by Dr. Mallinger. Dr. Mallinger has published over 100 articles in peer reviewed journals, held prestigious positions in Psychiatry and Pharmacology at several prominent medical schools, and led research programs in Psychiatry at the NIH. He has worked in the Office of Healthcare Inspections for the last four years.

In 2010, VA and DoD published a Clinical Practice Guideline: *Management of Opioid Therapy for Chronic Pain*. Our National Review, *VA Patterns of Dispensing Take Home Opioids and Monitoring Patients on Opioid Therapy*, which was requested by the Senate Veterans Affairs Committee and published in May of 2014, includes the following statement: "Opioids are powerful medications that can help manage pain when prescribed for the right condition and when used properly. However, if prescribed inappropriately or if used improperly, they can cause serious harm, including overdose and death." This national review which mirrored the time frame of our work in Tomah, demonstrates that in 2012, VA providers were in general non-compliance with guideline requirements. Whether it be the use of urine drug screens and follow up visits (37% compliance with guideline), the practice of refilling prescriptions at least 7 days early (23% early refills), the concomitant use of benzodiazepines and narcotic medications (92% of chronic opioid population), or ensuring that veterans with substance use disorder and chronic pain receive concurrent treatment for their substance use disorder and urinary drug testing (10.5% compliance), the data in this report makes clear that VA as a system of care, was managing this patient population very poorly. The report states, "The concurrent use of benzodiazepines and opioids can be dangerous because opioids and benzodiazepines can depress the central nervous system and thereby affect heart rhythm, slow respiration, and even lead to death." The report also highlights the risk of liver toxicity as several combination medications, include a narcotic and acetaminophen. Among the chronic opioid user population, 45% of veterans were prescribed at least one daily dose of 4 grams or more of acetaminophen, placing them at significant risk for liver failure.

Who are these patients? One in sixteen served in Operation Enduring Freedom or Operation Iraqi Freedom, one in three was diagnosed with a mood disorder, one in five with PTSD, and one in seven with substance use disorder.

My written statement reviews the timeline of events related to the Tomah administrative closure. In summary, it was alleged that narcotic medication was being used as the primary treatment for PTSD, that specific patients were receiving poor quality of medical care, that numerous patients were dying of narcotic overdose, that Tomah providers were contemplating the amputation of a veteran's leg as treatment for his pain syndrome, and that there was inappropriate interference with the administration of the pharmacy service by Tomah management. The administrative closure's first four pages detail the steps OIG staff took to determine if these allegations had factual support. We reviewed numerous medical charts and peer reviews, we interviewed many current and former employees, we contacted the local Tomah police, Milwaukee police and the DEA. We pulled the email of 17 employees. The OIG Office of Investigations examined aspects of these allegations. We found that the allegations that led us to Tomah could not be substantiated. We did find examples of the failure to comply with the DoD/VA chronic pain guideline, consistent with the national data discussed today. Given that the data we collected did not support the allegations that led us to Tomah, knowing that our national report would highlight the many deficiencies in VA provider's compliance with these guidelines, I chose to administratively close this report. To ensure that the deficiencies we identified were corrected by VHA, Office of Healthcare Inspections staff met with the director of Tomah and the VISN director. Both gentlemen were familiar with the individuals and issues we described at Tomah. These leaders discussed the changes that had been instituted and future planned actions to address the deficiencies we identified.

The Office of Healthcare Inspections reviews aspects of hospital performance on a three year cycle and reports the results of each review in a Combined Assessment Program report. A review of medical center compliance with current VHA stroke guidance is a part of the current review. Upon the completion of data collection and analysis, a summary report with recommendations will be presented to the Undersecretary for Health, and then published. I will be pleased to answer your questions.