Congress of the United States
Washington, DC 20510

January 14, 2015

Via Electronic Transmission

The Honorable Richard J. Griffin
Deputy Inspector General
Office of Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Deputy Inspector General Griffin:

We are deeply troubled by reports that veterans at the Tomah, Wisconsin, Veterans Affairs Medical Center (VAMC) continue to receive questionable care. It is disturbing to hear veterans and individuals working at the Tomah VAMC describe the medical center as "a system that's gone completely haywire."[1] Specifically, some veterans label the Tomah VAMC as "Candy Land" due to the amount of narcotic painkillers being prescribed.[2] Nothing is more important than ensuring that our men and women in uniform receive high quality care.

In March 2014, your office completed an inspection at the Tomah VAMC.[3] According to documents, that review centered on a series of allegations concerning the amount of narcotic painkillers prescribed to patients, among other allegations.[4] The inspection found that the rate of opioid prescriptions at Tomah was alarming enough that issues were brought to the attention of VA leadership.[5] The inspection further noted that the Tomah VAMC ranked highest in the Veterans Integrated Service Networks (VISN) for the total morphine equivalents per unique patients treated with opioids.[6]

These initial allegations were administratively closed by your office and we understand the following suggestions were brought to the attention of the facility director at Tomah VAMC and VISN management:

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[1] Aaron Glantz. "Opiates handed out like candy to 'doped-up' veterans at Wisconsin VA." The Center for Investigating Reporting. Jan. 12, 2015. Accessed at: http://www.jsonline.com/news/wisconsin/opiates-handed-out-like-candy-to-doped-up-veterans-at-wisconsin-va-b99423091z1-288223591.html
[2] *Id.*
[3] 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.
[4] *Id.*
[5] *Id.*
[6] *Id.*

- 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.[7]
- The facility director should review the reporting structure in the context of safeguarding bidirectional clinical discourse from actual or perceived administrative constraint.[8]
- 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 opioids refills.[9]
- 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.[10]
- 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.[11]

It is concerning that even after this inspection, similar allegations and problems continue at the Tomah VAMC. Due to the recent concerns raised, we request that your office conduct a comprehensive investigation of the Tomah VAMC. In an effort to understand what your office has done since that inspection, please respond to the following questions:

1) Since closing the March 2014 inspection, has your office reviewed whether the Tomah VAMC and the VISN have responded to the five suggestions? If so, what were the responses?

2) At this time, does your office have any current inspections or investigations open at the Tomah VAMC? If so, please identify and explain these inspections and/or investigations.

3) The March 2014 inspection stated that some patients at the Tomah VAMC were receiving prescriptions from physicians of incorrect specialties. Has the Tomah VAMC implemented new procedures to ensure patients are referred to the proper specialists before opiate prescriptions are written?

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[7] 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. At page 10.
[8] 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. At page 11.
[9] *Id.*
[10] *Id.*
[11] *Id.*

4) Pharmacy staff "uniformly indicated that they were reluctant to question any prescription ordered" by one particular doctor or "any aberrant behavior by his patients." Has the VA-OIG received complaints of a lack of communication between doctors and pharmacy staff since your last report? If so, please explain what the VA-OIG is doing to address these complaints.

5) Was the IG inspection provided to Congress? If not, why not?

Please provide a written response as soon as possible but no later than 5 p.m. on Jan. 27, 2015.

Thank you for your attention to this important matter. If you have any questions regarding these issues, please contact Brian Downey on the Senate HSGAC staff at (202) 224-4751 or Caroline Robinson in Congressman Duffy's office at (202) 225-3365.

Sincerely,

Ron Johnson
Chairman
Homeland Security and Governmental Affairs

Sean Duffy
United States Representative