DEPARTMENT OF VETERANS AFFAIRS
VA Great Lakes Health Care System
500 E. Veterans Street
Tomah, WI 54660

May 1, 2014

The Honorable Tammy Baldwin
Member, United States Senate
Suite 1920
633 W. Wisconsin Avenue
Milwaukee, WI 53203

Dear Senator Baldwin:

Thank you for allowing us the opportunity to respond to the concerns outlined in your letter, dated April 7, 2014, on behalf of an anonymous constituent concerning his allegations about general prescribing patterns at Tomah Veterans Affairs Medical Center (VAMC). Your letter was forwarded to Dr. David Skripka, the Associate Chief of Staff for Mental Health, who assisted in reviewing and investigating these allegations. I offer the following in response:

Your constituent's first allegations stated "a large percentage of Veterans being treated for substance abuse are for substances including opiates, benzodiazepines, and stimulants which were originally prescribed by VA providers"; and "these same Veterans continue to be prescribed these substances of abuse while in active treatment". Dr. Skripka and other staff performed chart reviews of every patient enrolled in Tomah VAMC's residential treatment program for substance abuse in calendar year 2014. (January 1 to April 8 of 2014). Of the 65 patients enrolled this year, 14 patients were being treated for abuse or addiction to opiates, benzodiazepines, and/or stimulants in any form. Four of those 14 Veterans were being treated with opioid replacement therapies such as buprenorphine or methadone that are recommended for opioid use disorders; buprenorphine and methadone were not included in the findings that follow.

Of those 14 patients, only one began the abuse/addiction of a drug class after a VA provider prescribed a medicine from that class. That same patient was also the only one of the 14 patients who was currently prescribed a medication from a drug class that was part of their addiction treatment.

The Veteran cited above is a Veteran over the age of 60 with multiple complex medical problems including arthritis, kidney failure, and liver transplant. His primary addiction was to alcohol, but he had also reported overusing both prescribed and nonprescribed opiate pain medications at the time of a hospitalization. His hospital

team and outpatient primary care provider collaborated and decided the most appropriate option was to continue treating his pain using a modified regimen that still included opiates, with additional monitoring. That new pain medication regimen was then continued during his residential substance abuse treatment.

Some background may be in order before addressing the other allegations. The Departments of Veterans Affairs and Defense have published clinical practice guidelines for the management of Post Traumatic Stress Disorder (PTSD), most recently in 2010. Although the published studies in this area are very limited, those guidelines do recommend that benzodiazepines be considered relatively contraindicated for treatment of PTSD. The following statement is taken from the cover of the clinical guidelines for PTSD noted above:

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) guidelines are based on the best information available at the time of publication. They are designed to provide information and assist in decision-making. They are not intended to define a standard of care and should not be construed as one. Also, they should not be interpreted as prescribing an exclusive course of management. Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations that are unique to an institution or type of practice. Every healthcare professional who is making use of these guidelines is responsible for evaluating the appropriateness of applying them in any particular clinical situation.

There continues to be some professional debate and controversy relating to benzodiazepines in PTSD, both in terms of general guidelines and in how those guidelines are applied to individual cases. However, the responsibility for individual treatment decisions ultimately lies with the attending physician or other provider responsible for a Veteran's care. Their decisions should be informed by the circumstances, needs, and preferences of that individual patient, and all the informational tools available at the time.

Your constituent alleges that prescribing benzodiazepines for Veterans with PTSD is a standard practice, and that employees are pressured by management to prescribe substances, apparently benzodiazepines, not compatible with national guidelines. Dr. Skripka indicates that he has directed the mid-level providers that he supervises in the residential substance abuse program to follow certain general principles in their prescribing. These include avoiding changes in pre-existing medication regimens when Veterans enter the program, unless those changes are coordinated with and approved by the outpatient providers who will be resuming clinical responsibility when the Veteran is discharged after 30 or 60 days. This direction has been given to avoid a scenario where there is an abrupt change in medication that might be reversed when they return to their primary outpatient provider. Medical providers across Tomah VAMC have also been directed to speak with patients directly before making changes to medications.

Dr. Skripka otherwise strongly denies any institutional or management direction to medical providers indicating they are to initiate or otherwise prescribe benzodiazepines to Veterans as a whole, or to Veterans with PTSD as a whole. He requests that your constituent communicate any specific examples to me directly.

Your constituent alleged that there are a "high" number of instances in which controlled substances are prescribed prior to alternatives being trialed. Dr. Skripka indicated difficulty responding with specific data to such a broad statement, as this includes many types of treatments prescribed for many different conditions by many types of providers. He indicates that there are some conditions for which an initial trial of a controlled substance is appropriate, and also agrees that he has seen cases where he believes appropriate alternative measures that could have been appropriate were not tried first. He believes some of the data tools described below may be helpful, and otherwise encourages your constituent to communicate specific examples that are concerning through the VA channels available.

Dr. Skripka did want to acknowledge the overall importance of this issue, and the areas where Tomah VAMC is focusing our improvement efforts. Aggregate measures gathered by the VA at the national level have shown that Veterans at Tomah VAMC with PTSD receive a benzodiazepine or sleeping medication more often than the mean for other VA Medical Centers. However, those measures did not offer the ability to analyze or drill down further, or to distinguish the reason that benzodiazepines are prescribed. A recent Veterns Health Administration (VHA) "Psychopharmacology" initiative has been underway in recent months, and promises to offer tools for all VA Medical Centers to review and "drill down" data relating to prescribing patterns, and to compare themselves to other medical centers. Tomah VAMC participated in this initiative earlier this year, and worked with a Veterans Integrated Service Network (VISN) 12, VA Great Lakes Healthcare System pilot project to offer additional analysis of benzodiazepine prescriptions. This tool can enable theTomah VAMC to obtain aggregate information and analyze cases with Veterans receiving various treatments, including benzodiazepines, correlated with certain diagnoses. This tool also permits us to institute targeted education or monitoring as indicated. Tomah VAMC will be reporting efforts in this area to the VA Office of Mental Health Operations.

The Opioid Safety Initiative (OSI) is another VHA initiative, intended to identify patients who are taking long-term opioids in a dose that is considered to be in excess of the norm. The Tomah VAMC Pain Management Committee is charged with implementing the OSI by evaluating the patient's use of opioids and providing recommendations for their ongoing use or discontinuance. The Pain Committee is a multidisciplinary committee made up of two physicians, two clinical pharmacists, a nurse practitioner, a clinical nurse specialist, and a psychologist. A comprehensive medical record review is conducted by the committee and recommendations are made in-person to the prescribing provider. This committee is reviewing two to three cases per week and started in February 2014.

In the future, I would strongly encourage your constituent to report their concerns directly so that we may address specific examples and give us the chance to work with their issues at the lowest possible level first.

Thank you again for this opportunity to address your constituent's concerns with treatment at the Tomah VAMC. If you have additional questions, please contact David Skripka, M.D., Associate Chief of Staff for Mental Health at (608) 372-1631.

Sincerely,

Mario V. DeSanctis, FACHE
Medical Center Director