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COMMITTEES:
HEALTH, EDUCATION, LABOR, AND PENSIONS
BUDGET
SPECIAL COMMITTEE ON AGING
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

United States Senate

WASHINGTON, DC 20510

January 22, 2015

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

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

Dear Chairman Isakson and Ranking Member Blumenthal:

I am writing to request that you hold a hearing to address the failure of the Department of Veterans Affairs (VA) to stop improper opioid prescribing practices and associated abuse of administrative authority at the Tomah VA Medical Center. Additionally, I am concerned that these problems are not unique to the Tomah facility; therefore, I request that the hearing also examine the problem of overmedication across the VA network, particularly the use of opioids for mental health treatment. While I applaud the committee for investigating the problem of overmedication in a hearing last Congress, I believe that more needs to be done to ensure that our nation's veterans receive the timely, safe, and highest-quality care that they have earned.

There are significant risks associated with the use of opioids, and these addictive medications should not be casually prescribed or absent strict monitoring. I support the VA's recent efforts to reduce the use of opioids, like the Opioid Safety Initiative, but believe that more immediate steps must be taken, including the prompt expansion of alternative medical care for veterans and strengthened oversight of mental health treatment throughout the VA. Indeed, I called for these actions last Congress, supporting S.1950, a comprehensive veterans bill that included efforts to reduce dependency on narcotic painkillers and improve mental health care.

The Tomah VA provides a deeply disturbing case study of overmedication at the VA. A March 2014 OIG report that looked into allegations of extremely high levels of opioid painkiller prescriptions detailed amounts at "considerable variance" compared to other Veterans Integrated Service Network (VISN) 12 facilities and prescribers. Indeed, out of the seven VISN 12 facilities, the Tomah VA had by far the highest per patient dosage rate. In addition, out of more than 3,200 VISN 12 providers, three physicians at the Tomah VA were the highest, fifth highest, and seventh highest opioid prescribers, accounting for 33% of all opioid prescriptions in VISN 12. Despite these alarming numbers, the OIG did not find evidence of wrongdoing, stating only that "allegations dealing with general overuse of narcotics at the facility may have had some merit." In fact, according to the OIG, these troubling practices were within the bounds of the

acceptable VA standard of care. This is particularly troubling in light of the tragic and ultimately fatal overdose of former Marine Jason Simcakoski, who died as a patient at the Tomah VA last fall, and other veterans who reportedly became addicted to drugs as a result of the prescribing practices at Tomah. Clearly, it is past time for the VA standard of care to be thoroughly revised.

At my urging, last week Secretary McDonald launched a broad and thorough investigation of the operation of the Tomah VA. In addition, last summer, I raised concerns about the prescribing practices at Tomah directly to the Tomah facility, to VISN 12 and to VA's headquarters. While the VA did take some steps in Fall 2014 to make changes at Tomah, it is clear that the Department of Veterans Affairs has failed to adequately address the serious problems at this facility. Therefore, to supplement this internal review, the Senate Committee on Veterans' Affairs should exercise its oversight as well. Thank you for your consideration of my request and all that you do in support of our nation's veterans.

Sincerely,

Tammy Baldwin
United States Senator