THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

April 28, 2023

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-21-000033 Temple, Texas

Dear Mr. Kerner:

Enclosed is the supplemental report as requested in your November 1, 2022, email to the Department of Veterans Affairs. The supplemental report provides additional information related to the Office of Special Counsel (OSC) File No. DI-21-000033 report submitted to OSC on the investigation at the Olin E. Teague Veterans' Hospital in Temple, Texas.

Thank you for the opportunity to respond.

Sincerely,

Denis McDonough

Enclosure

Department of Veterans Affairs

Supplemental Report for the Office of Special Counsel

VA Central Texas Veterans Health Care System

Temple/Austin Campuses

Temple, Texas

OSC File Numbers DI-21-000470, DI-21-000503

Addendum to OSC File Number DI-21-000033

April 2023

The Department of Veterans Affairs (VA), Office of the Secretary, received an email from the Office of Special Counsel (OSC) on November 1, 2022, regarding VA's investigation, led by the Veterans Integrated Service Network (VISN) 17, into whistleblower allegations related to conduct that may constitute a violation of law, rule or regulation and a substantial and specific danger to public health or safety at the VA Central Texas Veterans Health Care System (hereafter Temple) in Temple, Texas.

Recommendation #1 to Central Texas

Regarding allegation 1, the agency recommended that the VA Central Texas Healthcare System (CTVHCS) review the current published SOP related to the prescription of buprenorphine.

a. *Has the agency completed this review, and if so, does the current SOP conform with national standards of practice?*

VA Response

Central Texas Veterans Health Care Memorandum MCP 116A-009, Buprenorphine/Naloxone Therapy for Opioid Use Disorder, dated June 25, 2019, was rescinded on October 26, 2022, and replaced with MCP 116-009, removing the requirement for physicians to have completed Drug Enforcement Agency (DEA)/Substance Abuse Mental Health Services Administration training and hold DEA waivers. MCP 116-009 was approved and presented at the Clinical Executive Council meeting held the week of April 2, 2023.

Recommendation #2 to Central Texas

Related to the agency's conclusion in allegation 2, the agency recommended that the CTVAHCS review the high rate of community referrals from the pain management clinic. Specifically, the agency recommended an investigation of the Pain Management Clinic's potential competency and training gaps to explain the high percentage of referrals to the community, with the goal of maximizing quality of care and mitigating the percentage of community referral.

a. Has the agency completed this review, and if so, what were the results?
b. Do the agency's current service agreements for community care adhere to relevant governing authorities, policies, and directives?

VA Response

During the review period there was inefficiency in the lack of sharing the radiofrequency ablation (RFA) equipment. The unit was housed in the Austin clinic and insofar as the Austin provider only did interventions 2 days per week, it was available to be transported to Temple for use the other 3 days but was not. A new RFA set has been acquired for the Temple clinic rendering the sharing issue moot.

Regarding competency and training gaps, all Pain Management Services physicians, including the current Acting Chief, have completed the Talent Management System (TMS) course VA 31108 "Pain Management and Opioid Safety" and as referenced below, the Consult Toolbox training.

Central Texas has the attached May 22, 2022, Integrated Pain Management Service Agreement in place. The facility follows guidelines set at the national level, pursuant to the VA MISSION Act of 2018.

Recommendation #3 to Central Texas

Regarding the findings in allegation 5, the agency determined that there was a question of consistency regarding the interpretation of "Best Medical Interests" criteria related to referral for community care and recommended further investigation into the facility's interpretation of this concept to ensure alignment with the Mission Act.

a. *Has the agency completed this investigation and if so, what were the results?*

VA Response

To ensure consistent application of the referral process, Pain Medicine Service providers and Care in the Community staff completed TMS course VA4622567 "Consult Toolbox Curriculum Module 2: Ordering a Consult in the Consult Toolbox."

Department of Veterans Affairs
April 2023

Integrated Pain Management Service Agreement
Central Texas Veterans Health Care System Healthcare System

I. Preamble

A. The Central Texas Veterans Health Care System (CTVHCS) offers comprehensive pain management consultative services that deliver interventional pain management procedures as well as pharmacotherapy, including opioid management, and integrative pain management modalities, such as acupuncture and chiropractic treatments, as part of the VHA Whole Health Initiative. The biopsychosocial approach to pain management within this Service Agreement reflects the current evolution occurring in the VA healthcare system from one of simply managing pain to providing a comprehensive pain rehabilitation plan, empowering Veterans to take control of their lives and health to promote a healthier lifestyle and improve their quality of life.

B. Some degree of functional restoration is always possible. Non-pharmacologic and non-interventional measures should be provided for any pain conditions prior to referral for specialty pain management services.

C. According to the Medical Center Memorandum on Patient Rights (004VES-002, October 2, 2019):

> Patients have the right to have their pain assessed and to receive treatment to manage their pain. Patients and their treatment team will develop a pain management plan together. Patients are expected to guide the treatment process by communicating their pain, needs, preferences, and the effectiveness of treatment received and by working in collaboration with the team to optimize their treatment.

D. This Service Agreement is based on the Stepped Care Model of Pain Management as described in VHA Directive 2009-053 from October 28, 2009, and the CTVHCS Pain Management Policy, MCP 011-001. Any future revisions of this Directive will serve as a basis for implementation of this Service Agreement.

E. Consultation is available for both inpatient and outpatient pain management. This includes consultation for patients in palliative care.

II. Services Included:

The following Services are a party to this agreement:

- Ambulatory Care
- Medicine
- Surgical
- Anesthesia
- Mental Health and Behavioral Medicine
- Physical Medicine and Rehabilitation
- Pharmacy
- Nursing
- Whole Health and Integrated Health
- Care in the Community
- Geriatrics and Extended Care

III. Objectives:

A. To integrate the consultation process for comprehensive, interdisciplinary pain management to Veterans.

B. To implement the VHA stepped-care approach to pain management, which involves educating Veterans in self-management skills and providing pain management in all appropriate settings, including primary care and specialty care.

C. To transition Veterans with chronic pain from a pain management strategy to a Recovery Model of care, focusing on functional restoration and improvement in quality of life.

IV. Expected Response Time:

Response to consults will be within VA guidelines.

V. Requirements:

A. Consult process:

1. Primary Care providers and Specialty Clinic providers will enter a consult order for the Integrated Pain Management Clinic.

    a. Providers must document a focused evaluation pertinent to the pain site within 6 months of the consult in any VA or community setting to rule out emergent and urgent conditions based on focalizing neurologic findings. Referrals from Community Care may refer to the non-VA documentation of such.

    b. All requests for acupuncture, chiropractic care, interventional pain management, and consultation for medication management for chronic pain will be submitted to this clinic for consultation.

    c. Acupuncture and Chiropractic care will not automatically be authorized concurrently – Veterans may need to complete a course of one treatment before being authorized for the other in most cases. Veterans may be referred to Pain Management concurrently with the other services.

    d. While patients will be encouraged to participate in Whole Health Coaching, this is not a requirement.

2. Patients will be referred to Community Care if they meet Mission Act criteria for drive time and wait time, or if they require a service that is not available at CTVHCS.

B. Pharmacotherapy: Consultations to the Pain Clinic to optimize pharmacotherapy can be requested if conservative measures and initial pharmacotherapy are ineffective, or if referring providers have concerns about opioid safety that Clinical Pharmacy Pain Management is unable to address.

Referring providers must be mindful of the fact that abruptly weaning or stopping opioids increases the risk of overdose and suicide.

1. The Pain Management Section will assist with tapering or rotation of medications, with the goal of stabilizing patients on safe and effective analgesic regimens that improve function and quality of life. In some cases, long-term full- or partial-agonist opioid therapy may be recommended, based on careful consideration of the risks and benefits, as well as an understanding of the patient's goals of care. This is based on the Interagency Taskforce on Best Practices for Pain Management recommendations that:

    a. Weaning or stopping opioids should be done based on a shared decision with the patient with regard to the treatment goals and the risks and benefits of continuing opioids vs. weaning them.

    b. Consultation with pain management and behavioral health can be incorporated as part of treatment planning and implementation.

2. Buprenorphine (with or without naloxone), should be considered, as this is the first-line treatment for OUD or Complex Persistent Opioid Dependence due to Long-Term Opioid Therapy. Buprenorphine is effective for both analgesia and for OUD treatment and can be managed in either Specialty or Primary Care.

3. Naloxone: This medication is a critical opioid risk-mitigation tool and should be prescribed for any patients who are prescribed opioids, or have a history of OUD, unless there is a true contraindication. Naloxone may be ordered through Naloxone Education and Use Note template.

4. Inpatient consultation: Providers may request bedside consultation for acute pain management of hospitalized patients due to acute, evolving processes, such as in the perioperative setting. An Inpatient Pain Management consult order must be entered and the Pain Management Section must be contacted by telephone. For hospitalized patients who are stable and with a history of chronic pain, an outpatient Integrated Pain Management consultation may be placed prior to discharge.

C. Pain Management outside of Whole Health and Integrated Health Service. Separate consults can be entered for the following:

1. Physical Medicine and Rehabilitation Service

    a. Physiatry (Rehab MD Physician) which will determine if Skilled Therapy Services are needed (PT, OT and KT).
    b. TENS unit through Physical Therapy Section

2. Whole Health Service

    a. Introduction to Whole Health

b. Yoga

3. Mental Health and Behavioral Medicine

   a. Cognitive Behavioral Therapy for Chronic Pain

D. Coordination of care:

1. The providers in the Integrative Pain Clinic will assess patients and collaborate with the Veteran to develop an Individualized Treatment Plan based on the patient's Personal Health Inventory and Personal Health Plan. This plan may include:

   a. Health Coaching

   b. Complementary and Integrative Health approaches, including Mind-Body approaches, Acupuncture, Chiropractic care, Tai Chi, Yoga, and others.

   c. Interventional pain management procedures.

   d. Pharmacotherapy.

   e. Rehabilitative approaches, including Physical, Occupational and Kinesiotherapy Services.

   f. Behavioral approaches, including Cognitive Behavioral Therapy for Chronic Pain.

   g. Nutritional approaches

2. Pain Clinic providers may present cases they believe constitute higher risks and complexity due to the Veteran's comorbidities and polypharmacy with the members of the Interdisciplinary Pain Management Team (PMT) at an Interdisciplinary Team (IDT) meeting, which occurs no less than once monthly.

   a. The PMT consists of the following members:

      i. Pain Specialist
      ii. Behavioral Health Specialist with expertise in Pain Management.
      iii. Rehabilitation Specialist
      iv. Addiction Specialist
      v. Clinical Pharmacy Specialist
      vi. Social Worker

   b. After discussing these cases at the IDT meeting, the PMT may decide to follow the patient as a team or may recommend a treatment plan that can be implemented by specific members of the team or the referring provider.

c. Criteria for longitudinal care are as follows:

   i. History of chronic pain with comorbid substance use disorders or complex persistent opioid dependence due to long-term opioid therapy.

   ii. High risk of suicide

   iii. Frequent hospitalization due to uncontrolled pain

   iv. History of multiple interventions, including surgical management, with persistent pain.

   v. High risk as determined by STORM and CAN scores.

d. In cases that require longitudinal care, the Veteran will be seen by all appropriate members of the PMT for individual assessments and discussed at another IDT meeting within 60 days.

e. Referring providers will be invited to participate in the IDT meetings to be involved in treatment planning for their patient and afforded the opportunity to ask questions and have concerns addressed.

3. Patients will be followed in the Pain Clinic longitudinally if clinically indicated, in collaboration with the PMT. Criteria for discharge include:

   a. Sustained improvement in pain and function.

   b. Adherence to treatment plan, including:

      i. Receiving prescribed medications only from VA providers.

      ii. Taking medications strictly as directed

      iii. Urine drug testing results that are consistent with prescribed medications.

   c. Engagement in self-management approaches.

   d. No complications or hospitalizations for 3 months.

4. Transition of Care: Care of patients will transition from the Pain Management Clinic to Primary Care when the meets all discharge criteria. Primary Care would then be responsible for prescription of medications.

   a. If the Primary Care provider does not agree with the recommended medication regimen, they must provide an alternative treatment plan that is equally safe, effective, and acceptable to the patient.

b. Risk Mitigation: PACT providers will implement risk mitigation strategies in collaboration with PACT nurses, Clinical Pharmacists, and Intensive Case Management or other Care Coordinators, when indicated, including:

   i. Keeping informed consent for long-term opioid therapy current.

   ii. Querying the Prescription Drug Monitoring Program

   iii. Checking urine drug screen

   iv. Educating patients and care givers or family members on overdose and prescribing naloxone.

c. Ongoing Collaboration: Referring provider may re-consult any member of the Pain Management Team at any time for a change in status or risk.

E. Communication:

1. The consult result note will be utilized to communicate recommendations and treatment plan back to the referring clinician. Involvement of the PACT RN Case Manager and daily PACT team huddles are highly recommended to improve communication and continuity of care for these complex patients.

2. Other channels of communication can be used for urgent concerns, including e-mail, telephone, and instant messaging.

3. Intensive Case Management and other Care Coordination may be indicated for some Veterans. The Care Coordinators will facilitate communication between the different specialty clinics and the Veteran's PACT team.

VI. Monitor & Evaluation of this agreement

A. All stakeholders will remain in open communication regarding the effectiveness of this agreement.

B. This agreement will be renewed within three years of date of final signature or sooner as deemed necessary by all stakeholders.

VII. Attachments: None