DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420
FEB 0 1 2016

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-3745

Dear Ms. Lerner:

I am responding to your request for supplemental information on the Department of Veterans Affairs (VA) North Texas Health Care System (VANTHCS) in Dallas, Texas (hereafter, the Medical Center), and at the Sam Rayburn Memorial Veterans Center in Bonham, Texas, regarding the status of the corrective actions taken in response to the three recommendations made in VA's October 20, 2015, original report.

This supplemental report shows that action on our first and third recommendations is complete, and that action on the second is scheduled to be completed on March 1, 2016. This report makes no additional recommendations to the Medical Center.

If you have any other questions, I would be pleased to address them. Thank you for the opportunity to respond.

Sincerely,

David J. Shulkin, M.D.

Enclosure

Office of the Medical Inspector
Supplemental Report
to the
Office of Special Counsel
North Texas Health Care System
Dallas, Texas
OSC File No. DI-14-3745
2016-D-31

BACKGROUND

The Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) investigate allegations lodged with the Office of Special Counsel (OSC) of inappropriate opioid management at the Department of Veterans Affairs (VA) North Texas Health Care System (VANTHCS) in Dallas, Texas (hereafter, the Medical Center), and at the Sam Rayburn Memorial Veterans Center (the Bonham Center) in Bonham, Texas. Specifically, the whistleblower alleged that narcotic prescriptions are routinely refilled automatically without following proper procedures, including a reevaluation of the patient's continued need, completion by the patient of a Controlled Pain Medication (Opioid) Agreement, urine toxicology screening, and use of the Texas Department of Public Safety online prescription monitoring program.

Based on its investigation, VA made three recommendations. These recommendations were endorsed by the Secretary of VA and the I/USH. This supplemental report outlines the actions the Medical Center has taken in response to the original report recommendations.

RECOMMENDATIONS AND ACTIONS

Recommendation 1: Review patients of Provider 1 and Provider 4 who were concomitantly prescribed opioids and benzodiazepines to determine if the continued opioid therapy was clinically appropriate. Depending on the results of this review, take appropriate action.

Resolution: As noted in the original report, the percentage of patients cared for by Provider 1 and Provider 4 who were taking opioids and benzodiazepines concomitantly was greater than the national percentage of patients receiving those medications together. We also noted in the original report that this finding did not account for possible differences in provider patient population or in provider responsibilities and did not establish or address whether the concomitant use of these medications was clinically appropriate or inappropriate in any particular case. Based on this identification of a trend and not based on the identification of an incident of inappropriate prescribing or care, we recommended a review of the electronic medical records of some of Provider 1's and Provider 4's patients receiving opioids and benzodiazepines concomitantly.

The Medical Center Assistant Chief of Staff for Primary Care, who manages patients receiving opioids and benzodiazepines, reviewed the electronic medical records of eight of Provider 1's patients and six of Provider 4's patients for whom those providers concomitantly prescribed opioids and benzodiazepines. These patients were Provider 1 and Provider 4's entire population of patients who received opioids and benzodiazepines concomitantly. In all 14 cases, the reviewer found that the management of opioids and benzodiazepines was clinically appropriate and that there are no lapses in the patients' continued care.
Action Completed November 19, 2015

Recommendation 2: Continue to develop a comprehensive pain management and long-term opioid use program that includes an opioid oversight process using Opioid Safety Initiative (OSI) Dashboard data.

Resolution: The prescribing providers follow the policy stated in Medical Center Memorandum No. 112A-06, *Chronic Opioid Use,* to provide comprehensive pain management care to patients treated with opioids. A tool to deliver OSI provider-specific scorecard data from the OSI dashboard database has been requested by the Chief of Staff and is expected to be implemented by March 1, 2016. Until this is in place, Section Chiefs will continue to distribute their service-specific Opioid Safety summary reports on a quarterly basis.
Action pending with resolution by March 1, 2016.

Recommendation 3: Revise VANTHCS MEMORANDUM 112A-06 to conform with VHA Directive 1005.

Resolution: The Medical Center has adopted nationally standardized patient information guide and informed consent form to comply with VHA Directive 1005. Medical Center leadership approved the revisions in conformance to that Directive on December 23, 2015, and incorporated them into VANTHCS MEMORANDUM 112A-06.
Action Completed December 23, 2015.