Dear Ms. Alexander,

I would like to thank you for your assistance in this extremely important Veteran care issue. Clear enforced standards/protocol and consistency is greatly needed in dealing with the opioid epidemic that we face at the VA. Patient safety is obtained when every provider is working from guidelines that are enforced and every provider is doing all the additional steps (UDT, Fentanyl levels, State drug prescription monitoring, evaluation of mental health status) to ensure safe prescribing of opiates. I continue to find provider apathy when additional options have been available for years and still are not used, when the results would be of great benefit.

My hope is that clear enforced steps are mandated to all providers at every level at the VA nationwide. Provider compliance must finally be addressed. It is only then, that safer opiate prescribing is obtained and every Veteran will benefit from these set of standards. Prescribing opiates is one step but safe opiate prescribing involves a number of available additional steps to ensure to our best ability, it is done safely. This would benefit the Veterans, we serve, and the VA as well.

Sincerely,

Dr. John Bonchak

Ms. Lynn Alexander, Attorney Disclosure Unit

Re: OSC File No. DI-14-3745

I received the following reports provided by you through my Attorney, Stephanie Bernstein which include:

1. Letter to Ms. Lerner from Robert Nabors dated 11/18/15
2. Letter to Ms. Lerner from David Shulkin dated 11/1/16
3. Report to the Office of Special Counsel dated 10/20/15

My comments are as follows:

1. The VHA should have a uniform national policy regarding prescribing of opioids based on comprehensive guidelines that are enforced and not just used as a suggestion or recommendation.
   All providers need to be on the same page in primary care setting when dealing with pain management issues since the primary care physician is not a pain management specialist. This would assure that from primary care provider to primary care provider there would be uniform and continuity of care.
2. The VHA needs to have a published national policy on querying and reporting to State PDMPs. VHA should mandate that all VA providers prescribing controlled medications access the PDMP system prior to prescribing. Ongoing monitoring should continue to assure that the patient is not multi-sourcing or receiving dual care that could place the patient at risk of harmful drug-drug interaction or potential addiction.
   Dallas/Bonham VA does not report to Texas PDMP the controlled medications dispensed by the VA pharmacy. The private sector cannot monitor VA controlled medications at all.
   The VHA should find a way to provide this information to the State PDMP because many of the patients utilize dual care through the VA and private sector.
   The VA and private sector physicians should have access to abutting states and to any state PDMP systems due to VA patients crossing state lines.
3. The present Consent for Long-Term Opioid Therapy for Chronic pain clearly informs the patient "not drinking alcohol or taking illegal street drugs when I am on opiates". Street drugs such as cannabis, cocaine, methamphetamine, etc. are still illegal in the State of Texas, by Federal Law and in Federal Medical facilities. A patient receiving opioid medication and tests positive on urine drug screen (cannabis) is noted in the Report that it is the "clinical determination left to the clinical judgement of the treating physician" to continue opioid medication. See page 11 under conclusion. I question this physician judgement. I find it concerning that VA would allow a patient that uses illegal drugs to receive opioid medications. To allow physicians to use their "own judgement" can destabilize VA guidelines and policy. For example, most recently, I received a patient from another provider that had clear documentation in the patient's records that the patient was a chronic cannabis user-(addicted for many years) and continued to receive opioid medication. Because the patient was using an illegal substance, the patient's opioid medication was stopped. There is no way to access benefit vs. risk of opioid medication while the patient continues to use an illegal drug. The correct judgement in these cases is to offer the patient addiction therapy, ween the patient off of opioid medication and offer other pain treatment options. This exact problem is ongoing through present date.

Page 12 under Findings, I find it concerning that the Report did not consider the fact that the patient who was receiving controlled medications in the private sector and VA and using cannabis may have been a contributing factor in the patient's death.

4. Page 13 under Conclusion it is stated "there is no VHA or Medical Center requirement to test for it (fentanyl). Why? Fentanyl is 100 times as potent as morphine. Fentanyl monitoring is by blood sampling rather than urine testing, so, if a measurement of fentanyl in a patient prescribed this medication is desired, an additional order other than the routine one for a UDT must be given. This medication needs to be monitored very closely in the clinical setting. Fentanyl is becoming the most overused and abused drug (legally and illegally) leading to a dramatic increases in overdose and deaths nationwide. Details on proper use, safe handling, application and disposal is of utmost importance and the VA should have a very clear and definitive policy with the use of this drug.
5. Page 14 second paragraph, In patient's chronically medicated with opioids a UDT Should Be compulsory and not a recommendation left to the provider's clinical decision making. So, if a provider choses to not do a UDT, this is perceived by the VA as not being fully implemented? How can you document if the patient is taking his/her medication as prescribed and not using other controlled or illegal drugs if UDT is not utilized? For a physician to not order a UDT is just pure apathy.
6. Page 15 last paragraph, To this date, "The Medical Center does not communicate individual provider's performance with regard to opioid prescribing practices in an easily understandable fashion to the Bonham Center providers"
7. Page 17 under recommendations #2, A comprehensive pain management and long term opioid use program with the Dallas VA pain clinic is less than optimal. They take no involvement in prescribing and monitoring chronic opioid medication. The use of chronic opioid medication is left to the decision and monitoring of the primary care provider that include MD, DO, PA, and NP who are not trained or certified as pain specialists. This places the primary care provider in a difficult position in the care of chronic pain patient and especially the patient that requires over 100 morphine equivalent medication. Perhaps all patients requiring chronic opioid medication should be evaluated by a pain specialist at least yearly for ongoing medication use and any other pain control options available. All patients requiring more than 100 morphine equivalents need to be under the care of a pain specialist. Dallas VA pain clinic's main interest is doing injections. Why is it required to have Xray/CT/MRI exams done (within 1 year) before they see the patient for consultation? Why not see the patient and if the patient needs to have additional tests, this should be ordered by the pain specialist. Delay after delay, the patient becomes upset and provider does not have the needed information and even the Pain psychology department will not see the patient unless actively enrolled in the pain clinic. All these delays add up causing for a delay in patient care and diagnosis/treatment.
8. It is well known that many or the VA patients are overmedicated and chronic use and misuse of opioid medications have led to addiction and death. The VHA needs to have a rational, clearly defined policy for opioid use that is followed by all providers and enforceable. Clinical judgement comes into play when assessing whether the patient would benefit from opioid therapy and if the answer is yes, then every provider needs to follow the same protocol for safe and effective treatment.

9. The VHA does not issue our medical license. Each State has enforceable rules on the prescribing of controlled medications which must be followed for licensure. The VHA needs to follow suit and coordinate with the Sates so that there are no differences between the two and the physician is able to comply at both levels. The goal should be a joint effort with the States and VHA in using and enforcing safe opioid prescribing policies.
10. In closing, the first thing we learn in medical school is to do no harm. We are constantly reminded of the toll the nation has taken in terms of increases in opioid abuse, overdoses and death running parallel to increase prescribing of opioids for pain. The CDC reminds us by terming the rise in prescription opioid abuse as an "epidemic". We, as physicians, must do a better job. By using uniform, clear and understandable policies and prescribing practices for the physician to follow and set goals and personal responsibility for the patient, this will be a good first step in addressing this epidemic.

DR. JOHN BENCHNK