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United States Senate

WASHINGTON, DC 20510

January 13, 2015

The Honorable Robert A. McDonald
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary McDonald:

I am writing to request that you take immediate action to address extremely troubling reports of improper opiate prescribing practices and abuse of administrative authority at the Tomah VA Medical Center. I raised these concerns on behalf of a constituent in April and June of last year, sending letters to the Tomah VA and the VA Office of Inspector General (OIG), respectively. In addition, the OIG issued a March 2014 report that raised a number of serious concerns, yet action to address these problems has not been taken. Therefore, I believe it is time for you to intervene and conduct a broad and thorough investigation of the operation of the Tomah VA and ensure that the facility is providing the highest-quality care to Wisconsin veterans.

The March 2014 OIG report that looked into the aforementioned allegations revealed evidence of extremely high levels of opiate painkiller prescriptions at the Tomah VA during fiscal year 2012, detailing 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 opiate prescribers, accounting for 33% of all opiate 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."

I am also concerned by reports of an administrative culture of intimidation and dysfunction at the Tomah VA. According to the OIG report, four pharmacists left the Tomah VA because of "concerns with the facility's expectations for dispensing opiods and other controlled substances." Despite this finding, the OIG did not substantiate allegations of abuse of authority. While I understand that patient populations and their medical needs vary by facility, I am troubled at the OIG's reluctance to recognize a clearly significant problem at the Tomah VA. Coupled with personal accounts from veteran patients, their families, and former employees, the allegations investigated by the OIG—both those substantiated and those unsubstantiated, but otherwise validated by evidence—require action.

Additionally, while the OIG report evaluated multiple accusations raised by a series of whistleblowers, it was limited in focus and therefore not a thorough investigation into Tomah VA operations. The veterans that rely on this facility deserve a comprehensive and immediate investigation that determines the full scope of the problem and leads to action.

Mr. Secretary, I applaud your reliance on a single metric for evaluating the VA's work: the quality of the outcome for the veteran. While the concerns raised at the Tomah facility are alarming, it bears noting that I believe that the overwhelming majority of Wisconsin VA employees strive every day to provide quality and timely care to our veterans. To achieve and maintain that standard, it is imperative that you take action to address the issues affecting veterans and employees at the Tomah VA. I look forward to working with you toward that goal.

Sincerely,

Tammy Baldwin
United States Senator