U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED FIFTEENTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

May 17, 2017

The Honorable David J. Shulkin
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shulkin,

We appreciate the VA Office of Medical Inspector (OMI) fulfilling the Committee's request for an investigation into the allegations about blind scheduling and inappropriate tapering of opioids at the Peru, Indiana Community Based Outpatient Clinic. As you know, the OMI investigation substantiated several concerns about the quality of care and the culture within the VA Northern Indiana Health System (VANIHS). After an in-depth review of the findings, we have several follow-up questions.

1. The report states that the provider in question failed to have face-to-face appointments and complete physical assessments of veterans before tapering their prescriptions. According to the OMI, this was in direct violation of an Indiana law that was adopted by the medical center in its policy.
    a. Is the provider mentioned in the report currently on staff at the VANIHS? If so, please explain any administrative action that was taken against her.
    b. Were her practice privileges suspended or is a suspension being considered?
    c. Will this provider be reported to the state licensing board for her actions?
    d. Why were reports from the patient advocacy office about the lack of communication and continuity of care not acted on by leadership?
        i. What other options did veterans have if leadership failed to address their concerns reported to patient advocacy?
    e. How is it acceptable for a doctor to remove veterans from their medications without the proper follow-up assessment?
    f. Were any external peer reviews done regarding these cases? If so, please provide all such reviews.
    g. What plans are in place to ensure this and other providers are held accountable for failing to appropriately prescribe opioids to veterans?

2. According to the OMI report, the physician who inappropriately managed veterans on opioids is in a leadership position at the facility that would presumably oversee the practitioner who was blind scheduling. Furthermore, this provider is allegedly in charge of administering the Opioid Safety Initiative (OSI). If this is accurate, please explain if this provider is still in charge of overseeing VANIHS clinics and their implementation of the OSI when she was found to be noncompliant with medical center policies regarding the prescription of opioids.

3. Although the OMI was unable to substantiate the findings regarding one veteran's death being the result of inappropriate tapering, please inform the Committee of the rate and dosage at which opioids were being tapered regarding this veteran and whether VA believes they were appropriate for a person with cardiac disease.

4. The report highlighted the fact that another provider at the Peru clinic was blind scheduling veterans without their knowledge.
    a. Please explain the extent that each employee involved was held accountable for blind scheduling veterans and failing to follow VHA directives related to scheduling.
    b. Did the facility certify that it was in compliance with all related laws, regulations, and rules regarding scheduling for the years this blind scheduling occurred?
    c. Was any medical insurance billed for these appointments related to blind scheduling?
    d. Did this blind scheduling affect Veterans Equitable Resource Allocation funding to the facility? If so, how was it affected?
    e. Is this provider currently providing direct patient care?
    f. How was this allowed to happen for two years without being identified and addressed?

5. According to a recent article,[1] Mr. Michael Hershman, the Director of VANIHS, had not received a copy of the OMI report at the time of the article's publication. We are concerned by his comment, particularly that he has not received a copy of a report that concerns quality of care issues at the facility he oversees.
    a. Has Mr. Hershman now obtained a copy of the OMI report? If not, why not?
    b. How can Mr. Hershman follow-up on the recommendations from the OMI and make improvements at the facility without the report?

Please provide this information, unredacted, to the Committee by **Friday, June 2, 2017.** The documents provided must in a digital format that does not disable printing. The deliverables opened by this request will not be closed until the Committee is sufficiently satisfied with the responses provided. If you have any questions, please do not hesitate to have your staff contact Mr. Jon Hodnette, Majority Staff Director, Subcommittee on Oversight & Investigations at (202) 225-3569.

Sincerely,

DAVID P. ROE, M.D.
Chairman

JACKIE WALORSKI
Member of Congress

JIM BANKS
Member

DPR/tb

[1] Available at: http://www.journalgazette.net/news/local/indiana/20170510/issues-found-at-peru-va-clinic.