



## United States Senate

WASHINGTON, DC 20510-0504

<http://feinstein.senate.gov>

January 6, 2016

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

Dear Secretary McDonald,

I am writing today regarding a report by the Office of Inspector General concerning the medical care a San Diego veteran of the U.S. Marine Corps received prior to tragically committing suicide. This report revealed that the marine received opioid medications for 22 months without follow-up medical care. Furthermore, it found that he was not referred to medical care for symptoms of traumatic brain injury and post-traumatic headaches identified at a disability rating exam, though these conditions statistically put him at risk of self-harm.

This case is deeply troubling and a powerful reminder of how important it is for medical practitioners to provide patients with regular follow-up care when prescribing opioids. The Centers for Disease Control and Prevention report that drug overdose is now the nation's leading cause of death among Americans between the age of 25 and 64. In fact, the agency estimates that approximately 44 Americans die every day from opioid overdose. Suicide is also a leading cause of death for this age group. Recent data released by the department estimates that roughly 22 veterans take their own lives every day.

I recognize the department has taken important steps to improve its oversight of opioids and coordination of mental health care and that it has responded positively to the recommendations made by the Deputy Inspector General. However, given the national epidemic of opioid overdose deaths and veteran suicides, I recommend that the San Diego and other California Medical Centers consider taking the following actions based on the lessons that can be learned from this tragedy:

- Institute a pilot “audit and feedback program” to evaluate opioid use and follow-up care. Audit and feedback programs have been shown to be an

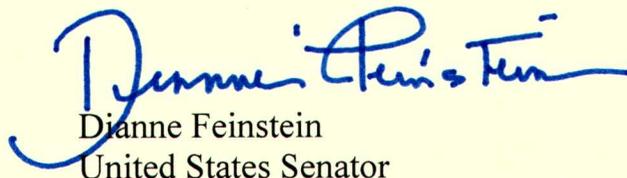
important tool in both assessing and improving the quality and safety of health care;

- Require the department's medical facilities to participate in the state's Prescription Drug Monitoring Program;
- Ensure adherence to the department's Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including increased and regular communication between the primary care provider and the patient regarding the risks and management of opioid treatment;
- Develop an automated reminder in the department's computer system for instances when patients are requesting opioid refills and have not received medical care consistent with the department's guidelines; and
- Carefully assess veterans with conditions or symptoms that may indicate a mental health diagnosis or a potential for opioid misuse, especially when a veteran is using opioids on a long-term basis.

It is important for the department to do as much as feasibly possible to ensure veterans are provided access to mental health care. One of the challenges of diagnosing and treating veterans who are at risk of suicide is that illnesses like post-traumatic stress disorder and depression can impair the ability of veterans to actively seek medical care. Additionally, there remains a social stigma that exists within the military associated with seeking care, which must be broken or circumvented. I realize that clinicians have limits to how much they can do to ensure patients make and keep appointments, but I believe we owe it to our veterans to continually figure out how to do more.

Thank you for your attention to my recommendations. I appreciate the commitment of your department's clinicians and health care professionals and look forward to working with you to reduce the number of opioid overdoses and suicides that occur each year.

Sincerely,



Dianne Feinstein  
United States Senator

DF/tc