

VA: Putting Veterans First?

American veterans called to duty for the service of their country have been promised treatment for medical conditions incurred during, or resulting from, their service as compensation for risk to life and limb. However, recent cost cutting initiatives within the VA appear to be undermining that basic principle. Veteran patient care seems to take a back seat to cost containment. A few examples from Veterans Integrated Service Network 2 (VISN 2) in upstate New York illustrate this point.

Bad Drug Policy #1: In an effort to reduce pharmacy expenditures, VISN 2 officials decided in July 1997 to institute a drug substitution policy that had been opposed repeatedly by both pharmacists and cardiologists at the Stratton VAMC in Albany. The risks to certain patients as a result of this policy include acute myocardial infarction (heart attack) and death. The policy required an anti-hypertensive/anti-anginal agent called amlodipine (Norvasc) to be switched automatically to another, called felodipine (Plendil). Of the two agents, only amlodipine is FDA-approved for the treatment of angina (chest pain which can lead to heart attack). Clinical studies have also established that the use of amlodipine in those patients with congestive heart failure (CHF) was safe.

Many of the patients slated for the automatic switch to felodipine had complicated conditions, which included angina, congestive heart failure and hypertension. Felodipine is not FDA-approved for angina and is not safe nor recommended for pa-

tients with CHF.

The automatic switching began, and the fears of those in opposition to the policy became reality with startling reports of patients' being hospitalized as a direct result of the switch. Those reports apparently failed to persuade network administrators to change their position on the substitution policy. Shockingly, after five such adverse drug events (ADEs) were reported to the FDA, the policy was suddenly and inexplicably expanded nationally.

Why did the national formulary advisors, responsible for negotiating cost containment contracts, institute such a policy when critical questions by experts in cardiology remained unanswered?

In the July 1998 issue of U.S. MEDICINE, Kay Fowells, the VISN 2 pharmacy manager who supported the switch, was interviewed. She disclosed that 1,000 veteran patients in VISN 2 had been switched to felodipine. According to her calculations, she expected an adverse drug event rate of 4 per cent per year. The VISN 2 rate of ADEs at that time did not exceed 4 per cent, but did not include unreported events. My understanding of Ms. Fowells' reasoning is that as long as the reporting of adverse events did not exceed 4 per cent, it was acceptable. Unfortunately, the majority of the events in question are acute myocardial infarctions and deaths.

Are we to believe that deaths associated with a controversial policy are acceptable if they only occur in 4 per cent of patients? Ms. Fowells further indicates that, "We

would expect that whenever you convert patients from whatever type of drug it is, not all are going to be suited for that drug and you may have to switch back." Unfortunately, myocardial infarction resulting in death does not allow adequate opportunity to switch back. It seems that the nature of adverse events should be taken further into consideration.

John Ogden, chief consultant for VA pharmacy benefits management, has indicated that the policy was implemented for cost reasons. An ABC news affiliate investigative report in July 1998 identified one veteran in VISN 2 who experienced acute myocardial infarction when he was taken off amlodipine (Norvasc) and switched to felodipine.

The patient was fortunate to survive his drug misadventure, and was switched back to amlodipine and discharged in stable condition. His amlodipine prescription was again automatically switched to felodipine, presumably after the questionable policy was expanded nationally. The patient required emergency room treatment and re-hospitalization.

As a result of congressional pressures, a long-awaited drug utilization review is being drafted by the Pharmacy Benefits Management group (PBM) but apparently will focus only on hypertension and not the cases complicated by angina and CHF. This type of review clearly cannot answer the question of whether or not we have harmed patients by implementing across the board drug switching policies, aimed at cutting costs.

How many adverse drug reaction reports remain unreported? We need to know how

many veterans were hurt!

Bad policy #2: A veteran who is service connected for sexual dysfunction resulting from injuries sustained in Vietnam has been repeatedly denied by the VA for treatment with sildenafil (Viagra). Following nationally mandated appeals procedures, the patient was declared to be compensable for the service connected disability, yet the VA refused to permit him to receive a test dose of sildenafil (Viagra).

While other VAs in the country provide Viagra under criteria for non-formulary use, VISN 2 maintains a strict "No Buy Policy," in spite of compensability and service connection.

In view of this policy, the patient requested permission to procure treatment in another VISN where the drug is available. This request was flatly rejected. The result of these decisions was to deny potentially helpful treatment to this man, who lost sexual function as a direct result of service to his country.

It appears to me that VISN 2 and the National PBM group for VA formulary policy place special interests and cost containment ahead of patient care and safety. Nationally, veterans' organizations are asking why the promise for healthcare in exchange for risks to life and limb is not being honored?

Has the VA decided that it will choose which illnesses are worthy of treatment and eliminate treatments that are labeled too costly or unimportant? Apparently it has.

ANTHONY R. MARIANO, R.Ph.
Pharmacy Manager
Stratton VAMC
Albany, New York