Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Inappropriate Prescription and Staffing Practices Hampton VA Medical Center Hampton, Virginia

Report No. 10-01167-06 **October 12, 2010**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

In January 2010, Senator Jim Webb's office contacted the Office of Inspector General with multiple allegations regarding inappropriate prescribing practices, pain management, staffing, and other quality of care issues in primary care (PC) at the Hampton VA Medical Center, Hampton, Virginia (the medical center).

We did not substantiate that PC providers were forced to write prescriptions for patients not under their care. However, we did find that if providers refuse to write narcotic prescriptions for their assigned patients, the patients can request a new provider. We recommended that the medical center ensure that all prescribing providers are trained in VA Patient Centered Medical Home model and the process for prescribing medications for temporary or newly assigned patients.

We did not substantiate that patients who test positive for drugs are not referred to rehabilitative care, that medical records are altered or deleted to cover up the truth, or that five physicians left the medical center because of pressure to write large numbers of narcotic prescriptions.

We substantiated that the Physical Therapy (PT) department was understaffed. However, we did not substantiate that there was a 6 month backlog of appointments or that PT staff were not trained in pain management. We recommended that the medical center evaluate all options for recruitment and retention of qualified physical therapists.

We did not substantiate that the medical center does not have a neurologist on staff or that there is a large backup for orthopedic appointments.

We did substantiate that medical center staff had been threatened by patients. We found that medical center managers have taken appropriate steps to protect staff. We did not substantiate that staff had been threatened by administrators.

The Veterans Integrated Service Network and Medical Center Directors agreed with the findings and recommendations. The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Mid-Atlantic Health Care Network (10N6)

SUBJECT: Healthcare Inspection – Alleged Inappropriate Prescription and Staffing Practices, Hampton VA Medical Center, Hampton, Virginia

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of multiple allegations regarding inappropriate prescription practices, staffing, pain management and other quality of care issues in primary care (PC) at the Hampton VA Medical Center (the medical center) in Hampton, Virginia.

Background

The medical center, a 468-bed facility, serves a 15-county area in eastern Virginia and a 10-county area in northeastern North Carolina. This area, commonly referred to as the Tidewater Area, has a veteran population of more than 220,000. A teaching hospital providing a full range of patient care services, the medical center features state-of-the-art technology as well as education and research. The medical center is part of Veterans Integrated Service Network (VISN) 6.

On January 7, 2010, Senator Jim Webb's office contacted the OIG's Office of Investigations with allegations of inappropriate prescribing practices and other quality of care issues in PC at the medical center. The allegations were as follows:

- Physicians are forced by administrators/staff to write prescriptions for narcotics for patients not under their care.
- Medical records are altered/deleted to cover up these incidents.
- Patients who test positive for drugs are not referred to Rehabilitation Medicine Centers for treatment. Narcotic prescriptions are written for these patients.
- Five physicians have left the medical center in the last 2 years because of the pressure to write large numbers of narcotic prescriptions.

- Staff has been threatened professionally by administrators and personally by veterans when they try and not write inappropriate narcotic prescriptions.
- The Physical Therapy (PT) department is understaffed; consequently, there is a 6-month back-log of appointments.
- The staff in PT are not trained in pain management.
- The medical center does not have a neurologist on staff so patients must receive care on a fee basis or go to Portsmouth Naval Medical Center. They cannot go to Hunter Holmes McGuire VA Medical Center for treatment.
- Recently the medical center hired an orthopedic doctor but the back-log for appointments is tremendous.
- Veterans are diverting/selling controlled and non-controlled pharmaceuticals prescribed by medical center providers.

On February 1–2, 2010, a Special Agent from the Office of Investigations (OI) accompanied by a Health System Specialist from OHI conducted a site visit at the medical center. Interviews were conducted with leadership, PC providers, physical medicine & rehabilitation services (PM&RS) providers, pharmacists, and mental health providers. During the interviews, one complainant provided supportive documentation that included patients' names and encounter dates. Documentation was reviewed, including a comprehensive medical record review.

OI determined that there was no evidence of drug diversion and that the other allegations were not criminal in nature; and closed their case. OHI assumed responsibility for investigating allegations related to health care.

Scope and Methodology

OHI conducted an onsite inspection March 24–25, 2010. We reviewed pertinent documents which included Veterans Health Administration (VHA) and medical center policies and procedures, Joint Commission standards, committee minutes, quality management documents, and selected administrative and related management documents.

Other allegations presented by the complainant were beyond the scope of an OHI review.

We conducted interviews of PC management staff and medical staff leadership, members of the PM&RS Committee, PC providers and staff, and the Patient Advocate. We reviewed additional patient medical records as patient names were provided by interviewees.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Inappropriate Prescription Practices and Management of Patients with Chronic Pain Issues in the Primary Care Setting

Allegation (a): ***Physicians are forced by administrators and staff to write prescriptions for patients not under their care.***

We did not substantiate that PC providers were forced to write prescriptions for patients not under their care. We interviewed 15 PC providers and 4 stated that they were pressured to write narcotic prescriptions for patients that were not assigned to them. The Chief Of Staff (COS) and Chief of PC referred to the professional standard that ultimately it is the PC provider who makes the clinical decision to prescribe or not; and that some clinicians are more comfortable than others in providing care for the complex veteran patient with chronic pain. After extensive interviews with all stakeholders, it is clear that among some PC providers there is a perception of pressure to write narcotic prescriptions and a fear of retaliation if they fail to do so.

The complainant alleged that *narcotic prescriptions are patient driven and the practice has been to force doctors to write them.* Historically, the delivery of PC services in VHA facilities was provider centered; now VHA has initiated the Patient Centered Medical Home (PCMH) Model,[1] which is a patient-driven, team-based approach that delivers efficient, comprehensive, and continuous care through active communication and coordination of health care services. PCMH depends on a core and expanded team of health care personnel who work with the patient to plan for their overall health. One of the goals for patients with chronic pain is to facilitate integration of chronic pain management seamlessly into PC practice sites. A second goal is to expand educational resources available to PC providers on management of chronic pain. A third goal is to initiate systems redesign projects on management of controlled substance prescriptions written for chronic pain.

VHA policy[2] states that PC gives eligible veterans access to health care professionals familiar with their needs. It provides long-term patient provider relationships, coordinates care across a spectrum of health care services, educates, and offers disease prevention programs. The PC standards begin with continuity; each veteran must be assigned a single PC provider. A second standard is accessibility and timeliness; when clinically indicated, patients must have access to their PC team for face-to-face encounters for urgent or new medical issues.

At the medical center, the reality of attempting to comply with existing standards and policies as well as meet new standards introduced by the PCMH initiative has resulted in providers caring for chronic pain patients they are not familiar with, or in some cases, not

[1] VHA Primary Care Program Office web site, http://www1.va.gov/PrimaryCare/pcmh/, accessed March 29, 2010.
[2] VHA Directive 2006–031, *Primary Care Standards*, May 17, 2006.

comfortable treating. For example, the medical center allows dissatisfied patients to request a change of provider. The patient is assigned a new provider; meanwhile, another provider in a different PC clinic is asked to provide care temporarily until a new provider is assigned. We reviewed patient complaints concerning PC providers over the last year. The majority of complainants were patients with chronic pain issues. The most common complaint concerned reduction in pain medications or refusal by the provider to write a renewal of a narcotic prescription. In addition, we reviewed medical records that showed that narcotic refills were provided by the temporary providers with documented instructions to the patient to comply with necessary laboratory studies and medical appointments.

We interviewed the Patient Advocate who explained that he works with providers and attempts to mediate between the patient and their provider when a complaint has been made. One of his responsibilities is to educate the patient about clinical decisions that the patient may not agree with or understand. He denied pressuring the providers to write prescriptions for narcotics.

Allegation (b): ***Patients who test positive for drugs are not referred to Rehabilitation Medicine Centers for treatment. Narcotic prescriptions are written for these patients.***

We did not substantiate this allegation. We reviewed 14 medical records of patients named by the complainant or other PC providers as patients with chronic pain issues. We found that these patients were referred within the medical center to PM&RS and/or the pain clinic; or referred to the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia; or referred to a fee–basis provider in the local community.

In October 2009, VHA National Pain Management Strategy was promulgated with the issuance of a new pain management policy based on generally accepted pain management standards of care.[3] The policy provides guidance to facilities for the use of a stepped-care model of pain care with the management of most pain occurring in the PC setting. The PC provider is supported with access to consultations, diagnostic and rehabilitation services, education programs, collaboration with integrative mental health-PC teams, and post-deployment programs.

The medical center's pain committee is actively implementing the new policy. Since February 2010, PM&RS management review meetings have taken place to review and monitor PM&RS consults and waiting times. Establishment of an interdisciplinary group to consult with PC providers that treat chronic pain patients has been proposed.

[3] VHA Directive 2009–053, *Pain Management*, October 28, 2009.

Allegation (c): ***Medical records are altered or deleted to cover up the truth.***

The complainant alleged that patient progress notes in the electronic medical record were altered to cover up the truth. We did not substantiate this allegation. In December 2008, a provider received an e-mail from a supervisor notifying the provider that a review of the provider's progress notes showed a percentage of them to be noncompliant with VHA policy[4] on medical record documentation and, at times, unprofessional. The notes included names of administrative staff not involved in the patient's care, derogatory comments concerning administrative staff, and omissions of the provision of patient care. The provider refused to amend the identified notes.

VHA policy requires that medical record documentation be honest and candid with regard to medical conditions, without being derogatory or critical of patients or staff. Individual employee names are included in health record documentation to identify practitioners for continuing care. Each patient encounter must reference the chief complaint and/or reason for the patient visit and, as appropriate, relevant history, examination findings, and prior diagnostic test results; assessment, clinical impression, or diagnosis; plan for care; and date and identity of the treating health care professional.

The medical center determined that the identified notes contained information that was outside of the VHA requirements and redacted the notes, leaving in place the clinically relevant information which was accessible to all treating providers. Access to the contents of the original notes was restricted to a limited number of medical center staff.

Allegation (d): ***Five physicians have left the medical facility in the last two years because of the pressure to write large numbers of prescriptions.***

We did not substantiate this allegation. The complainant provided only one name of a physician that allegedly left because of pressure to provide narcotics to patients. We asked all of the interviewees if they were aware of providers who left because of this issue. Four providers said they knew of physicians that left because of the prescription issue. However, they were able to provide only one name. We were unable to interview that provider. Sixteen providers left the medical center from December 2008 through March 2010. Three of the providers had documented concerns with prescribing narcotics for patients with chronic pain issues. Of those three providers, two had documented other issues that contributed to their leaving such as disagreements with management decisions and/or medical center administrative requirements.

[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006

Allegation (e): ***Staff has been threatened professionally by administration and personally by veterans when they try and not write inappropriate narcotic prescriptions.***

We substantiated that several staff, including a provider who worked with chronic pain patients, had been threatened by patients. In December 2008, a patient was denied a narcotic refill due to the detection of illicit drugs found on a routine urine drug screen. The patient allegedly threatened the provider. We were informed that some providers' personal vehicles had been damaged. The medical center took actions to protect the staff and patients, which included the use of the patient record flag system to identify patients whose behavior may pose a threat either to staff or patient, or compromise the delivery of quality health care;[5] increased police presence when known violent patients are in the building; and training staff to deal with patient threats.

We did not substantiate that staff has been threatened by administrators. Some providers told us that they perceived the peer review process to be punitive rather than a quality improvement tool. We examined 170 peer reviews of 70 providers conducted from January through December 2009. We did not discern a pattern of discrimination towards any individual provider and found no evidence that peer reviews were used as a punitive measure.

Issue 2: Staffing

Allegation (a): ***The PT department is understaffed. Consequently, there is a six month backlog of appointments.***

We substantiated that the PT Department was understaffed. The COS acknowledged a chronic shortage of physical therapists at the medical center. The COS and Chief of PM&RS stated they reviewed requests for higher pay grades for physical therapists and/or incentive awards but ultimately denied the requests. As a result, two of the three VA physical therapists resigned or relocated. The COS told us that the PM&RS budget for 2010 included five full-time physical therapy staff, but currently they have only one full time VA physical therapist on board. Recruiting efforts for physical therapists have not been successful.

We did not substantiate that there was a 6-month backlog of appointments. Medical center management actively monitors wait times and PT staff had reduced the backlog of appointments prior to the departure of two physical therapists. As of April 2010, surgery patients were able to receive an appointment for PM&RS immediately. Other patients waited 2 to 6 weeks for an appointment either in the medical center or by fee-basis referral.

[5] VHA Directive 2003–048, *National Patient Record Flags*, August 28, 2003.

Allegation (b): ***The staff in PT is not trained in pain management.***

We did not substantiate this allegation. We reviewed the functional statement and competency standards for the physical therapist currently employed at the medical center. We found that the standards were appropriate for the position and that the physical therapist is competent in the use of pain treatment therapies, including the Trans-Epidermal Nerve Stimulator.

Allegation (c): ***The medical center does not have a neurologist on staff so patients must receive care on a fee-basis or go to Portsmouth Naval Hospital because they have a contract with the medical center, and Hampton patients cannot go to Hunter Holmes McGuire VA Medical Center for treatment.***

We did not substantiate this allegation. The medical center is staffed for 1.5 Full Time Equivalent Employee Neurologist staff positions. The medical center has a formal agreement with the nearby Naval Medical Center in Portsmouth, Virginia, for the provision of healthcare to veterans, including neurology services. We reviewed 14 medical records of patients with chronic pain issues for evidence of referrals and found that 2 of the patients were referred to McGuire VA Medical Center for pain management, while the remaining 12 patients received referrals to specialty clinics at the medical center and to the Naval Medical Center.

Allegation (d): ***Recently the center hired an orthopedic doctor, but the back log for appointments is tremendous.***

We did not substantiate this allegation. An orthopedic physician assistant has been on staff since May 2003. Contract/Fee Orthopedists have been utilized from 2005 through 2009, when the medical center hired two part-time orthopedic physicians. In addition, orthopedic services are available at the Naval Medical Center. For the past year, 100 percent of new patients have received an orthopedic appointment in less than 31 days from referral, while 99.9 percent of established patients have received and appointment within 31 days.

Conclusions

The perception of some providers that the decision to prescribe or not prescribe narcotics to a patient was not ultimately a professional clinical decision for the provider to make, has hampered the implementation of the PCMH model of care and the VHA Pain Management Strategy by the medical center. Management has identified many opportunities for improvement of PM&RS, which can be enhanced by ensuring that all prescribing providers are trained in VHA standards and local policies for treatment of patients with chronic pain.

Understaffing of physical therapists could impact the medical center's ability to fully implement VHA policies, which call for timely access to specialty consultation in pain medicine, physical medicine, and rehabilitation. Efforts to fully staff the PT Department must be undertaken.

Recommendations

Recommendation 1. We recommended that all prescribing providers are trained in the PCMH model and the process for prescribing medications for temporary or newly assigned patients.

Recommendation 2. We recommended that the medical center evaluate all options for recruitment and retention of qualified physical therapists.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans (see Appendixes A and B, pages 9–12, for the Director's comments). We will follow up on the planned actions until they are complete.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 27, 2010

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **Healthcare Inspection – Alleged Inappropriate Prescription and Staffing Practices, Hampton VA Medical Center, Hampton, Virginia**

To: Director, Washington DC Office of Healthcare Inspections (54DC)

I concur with the response by the Medical Center Director and with the recommendation for improvement identified in the report.

(*original signed by*:)
Daniel F. Hoffmann, FACHE
Network Director, VISN 6

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 27, 2010

From: Director, Hampton VA Medical Center (590/00)

Subject: **Healthcare Inspection – Alleged Inappropriate Prescription and Staffing Practices, Hampton VA Medical Center, Hampton, Virginia**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. This is to acknowledge receipt and thorough review of the Office of Inspector General Healthcare Inspection – Alleged Inappropriate Prescription and Staffing Practices draft report. I concur with the recommendation for improvement identified in the report.

2. The response and action plan for the recommendation is enclosed.

3. Should you have any questions regarding the comments or implementation plan, please contact me at (757) 722-9961, extension 3100.

(*original signed by*:)
Deanne M. Seekins, MBA
Medical Center Director

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1: We recommended that the medical center ensure that all prescribing providers are trained in the PCMH model and the process for prescribing medications for temporary or newly assigned patients.

Concur **Completion Date:** September 22, 2010

A. Primary Care Providers were reeducated on the PACT (Patient Aligned Care Team) model, formerly PCMH, by September 22, 2010.

B. Primary Care Providers were educated on the standard operating procedure for prescribing medications in Primary Care by September 22, 2010, as follows:

SOP

1. For new patients, the primary care provider (PCP) will personally evaluate and assess the patient to include review of any existing records, nurse screening and vital signs taken, and perform an adequate history and physical examination prior to prescribing any medication, with documentation of the indication, medical decision making and plan for follow up care.

2. For temporarily assigned patients (i.e. those patients assigned to other PCP's in their absence or unavailability), the PCP will personally evaluate and assess the patient to include review of any existing records, nurse screening and vital signs taken, and perform an adequate history and physical examination prior to prescribing any medication, with documentation of the indication, medical decision-making and plan for follow up care.

3. For unscheduled (walk-in) and telephone encounter patients, the PCP will review any existing records and personally perform an adequate history and physical examination as indicated prior to prescribing any medication. The PCP will prescribe only clinically justified medication, with

documentation of the indication, medical decision-making and plan for follow-up care.

Recommendation 2: We recommended that the medical center evaluate all options for recruitment and retention of qualified physical therapists.

Concur **Completion Date:** December 31, 2010

From October 2008, various aggressive recruitment efforts for staff Physical Therapist (PT) at GS-9/11 were done, which resulted in one successful recruitment in 2010. To fill the other staff vacancy, we are continuing aggressive recruitment efforts including contact with affiliated academic institutions. Currently this position is filled with a contract physiotherapist.

In August 2010, one applicant was interviewed for the supervisory PT position. No selection was made. Continuous advertisement is ongoing. The supervisory PT position is being re-announced.

Salary differences and variations have been studied. The Medical Center Director was briefed on the salary survey on September 22, 2010. Appropriate increases to the current salary level will be made by November 2010. Management is exploring options to upgrade the supervisory position from GS-12 to GS-13. A proposal to VACO to create a separate PM&RS Service will be submitted by October 31, 2010. The creation of a separate PM&RS Service will assist with the efforts to upgrade the position from GS-12 to GS-13.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Gail Bozzelli, RN Washington, DC Office of Healthcare Inspections (202) 461-4672
Acknowledgments	Jerome E. Herbers, MD Randall Snow, JD Judith Thomas, RN Molly Morgan, Washington, DC Office of Investigations

Appendix D

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