Administrative Closure
A Alleged Inappropriate Opiates Prescribing Practices
Lexington VA Medical Center (596)
Lexington, KY
MCI# 2014-00703-HI-0374

The VA Office of Inspector General Office of Healthcare Inspections reviewed allegations from a [(b)(3):5 U.S.C. App 3 (IG Act);(b)(6)] at the Lexington VA Medical Center (the facility) regarding inappropriate prescribing practices at that facility.

We interviewed the complainant. [(b)(6)] clarified that [(b)(6)] concerns were limited to one provider, [(b)(6)], who has since been appointed the [(b)(6)] [(b)(6)]. The complainant revealed that when [(b)(6)] moved to [(b)(6)] [(b)(6)] and his patients were distributed among other PCPs, [(b)(6)] had concerns about those patients assigned to [(b)(6)]. [(b)(6)] indicated that [(b)(6)] thought that too many of his patients were on opiates at too high doses, and some patients had contraindications to being prescribed opioid medications.

As an example, the complainant provided the name of a patient who had been on [(b)(6)] [(b)(6)]'s panel prior to the patient's death on September 1, 2013. We contacted the Madison County, KY, Coroner's Office and spoke with the assigned medical examiner. He reported that toxicology results for this patient were all in the normal range at the time of death, and the patient did not die of an opiate overdose. We also reviewed the medical record for this patient and did not find evidence of inappropriate care by [(b)(6)].

We conducted a site visit at the facility December 2-4, 2013. We interviewed administrative and clinical Primary Care staff as well as the Chief of Pharmacy, the board-certified pain anesthesiologist who chairs the pain committee, and the psychologist for the pain team. We also reviewed Veteran's Health Administration (VHA) and local policies, facility data for long and short acting opioid prescriptions for the 4th quarter of fiscal year 2013, and reviewed selected charts of [(b)(6)]'s patients as described below.

We evaluated documentation provided by the facility including data from VHA's Opioid Safety Initiative Dashboard, which permits provider level comparison to VHA, Veterans Integrated Service Network, and facility averages for several metrics related to opiates, and offers data at the individual patient level. We used this data to identify those patients on the highest doses of several high-volume opiates, and those charts were reviewed. We also received a list of all of the patients who were prescribed hydrocodone from the Chief of Pharmacy, and patients with the highest doses were reviewed.

From this analysis, we identified [(b)(6)]'s patients who were on the highest doses of opioids and reviewed the electronic health record of 20 of these patients. We

found that these patients were monitored for medication compliance through urine drug screens as well as participation in Kentucky's prescription monitoring program.[1] In several cases in which patients were not following medical recommendations or were taking illicit drugs, (b)(6) warned them that their prescriptions would be terminated and took appropriate follow-up actions.

Everyone we interviewed reported that opiate use is a long standing, well known problem in the Appalachian area. The facility has initiated several actions to reduce inappropriate opioid use by patients, such as limiting short-acting opiate prescriptions to 100 pills per month. As the pain clinic is staffed by anesthesia providers and primarily focuses on interventional procedures, the facility has been working on developing other options to alleviate a patient's chronic pain. A new interdisciplinary pain team started providing electronic consultation five months ago. In January 2014, the facility will be enrolling patients in pain school, an interdisciplinary educational program focusing on self-management of pain. The facility also has plans to pilot alternative medicine clinics such as acupuncture and yoga classes.

In July 2013, the facility's Pharmacy and Therapeutics Committee discussed patients who were outliers based on daily dose of prescribed long-acting opiates (morphine, oxycodone, or methadone). Patients who were deemed to be on very high doses were referred to the Pain Committee for review and recommendations. After review, few changes were recommended by the committee. We were told that the facility plans to continue these reviews semi-annually.

The determination of the appropriate dosage of opiates is complex, and the dosage prescribed by reasonable providers may vary. The facility's board-certified pain anesthesiologist is familiar with the opioid prescribing practice throughout the facility in his capacity as pain clinic director, Pain Committee chair, and pain team leader. We asked him about the dosages of opioid medication in the cases that he reviewed, specifically whether they were appropriate for the underlying diagnoses; he responded that in his opinion, these dosages were appropriate.

We found that a higher proportion of (b)(6)'s patients are on opioid medications than most other PCPs at this facility. However, our review did not support the allegation that (b)(6)'s patients were mismanaged or that medications he prescribed were contraindicated. We found that practices were in accordance with local policies.

The facility initiated appropriate actions prior to our review and we found no evidence of patient harm. Also of note, we found the facility seemed receptive to suggestions made while we were onsite. For example, they expressed interest in the suggestion to include

[1] Kentucky All Schedule Prescription Electronic Reporting (KASPER) https://ekasper.chfs.ky.gov/FAQ/FAQ.htm Accessed 12/23/13. Facility providers are required to review data for their patients at least every 3 months.

medication related metrics into the Ongoing Professional Practice Evaluations for PCPs. This is not a VHA requirement, but was suggested as something to strengthen oversight.

Based on this review, I am administratively closing this case.

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Assistant Inspector General for
Healthcare Inspections 12/31/13