Allegations of Abuse of Controlled Substances Prescriptive Authority
James A. Haley VA Medical Center, Tampa, FL
Project No. 2008-02841-HI-0178
Administrative Closure
February 6, 2009

BACKGROUND

A pharmacist at the James A Haley VA Medical Center, Tampa, FL (the medical center) contacted the St. Petersburg Office of Investigations and alleged that a primary care physician's prescribing practices for controlled substances greatly exceeded that of his peers. The pharmacist also expressed concerns about the risk of possible overdose and diversion of controlled substances by patients. The Office of Investigations requested that the Office of Healthcare Inspections determine if the physician's controlled substances prescriptive practices resulted in harm or potential harm to veterans.

INSPECTION PROCESS

We reviewed policies, procedures, documents, and medical records prior to making a site visit to the medical center. During the site visit, we interviewed the Chief of Staff (COS) and other physician managers in Primary Care and Pain Management Services. We also interviewed the Chief of Pharmacy, the pharmacist that made the allegations, the Chief of Quality Management, the Patient Safety Officer, and the Medical Center Director. Our inspection focused on patient safety and quality of care issues, as well as actions taken to monitor and correct the physician's patient care and prescriptive practices.

INSPECTION RESULTS

We found that the provider prescribed controlled substances at a significantly higher rate than his peers. We also found that the provider's current prescriptive practices were under close scrutiny by pharmacists and other physicians in Primary Care and Pain Management. We learned that efforts to mentor the physician over the last two years have not resulted in a change in practice patterns. The physician had been counseled on numerous occasions, yet remained resistant to suggested changes in his practice patterns. The physician was forced to consult Pain Management Services on two different patients just prior to our site visit.

As a result of the issues with this provider, the medical center initiated several processes to monitor physicians prescribing controlled substances and improve patient safety and quality of care for all patients receiving controlled substances. These interventions included:

- Obtaining physician profile data on a regular basis.

9-6

- Reviewing provider practice patterns.
- Tracking and trending of patient complaints.
- Developing a physician mentoring program.
- Making changes in the Chronic Opioid Use Policy to limit amounts that can be prescribed by primary care providers, and ensure Pain Management Services is consulted for patients with chronic pain management needs.

While there was a potential for harm to patients, we did not find any patients that were harmed, nor did we identify any patient safety issues.

RECOMMENDATIONS

Medical center management was already aware of the issues in this allegation and had taken actions prior to our site visit. While on site, we recommended that the Professional Standards Board (PSB) be notified of this physician's prescribing practices. The COS and Medical Center Director agreed with our recommendation and provided us with documentation of initial PSB notification and action plans. Therefore we are administratively closing this case.

(Signature on file)

Carol Torczon, RN, MSN, ACNP
Associate Director, St Petersburg Office of Healthcare Inspections
Office of Inspector General

12/08/08