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

Administrative Closure
VA Montana Healthcare System
Miles City and Glendive Community Based Outpatient Clinics

The VA Office of Inspector General Office (OIG) Office of Healthcare Inspections reviewed actions taken by the VA Montana Healthcare System to address allegations of misuse of the System's opioid use policies on the part of a staff physician.

A man in his thirties was seen at the Miles City/Glendive CBOC in December 2009, receiving prescriptions authorizing large quantities of narcotic. The patient died unexpectedly three day later. The county coroner listed the cause of death as "unintentional overdose." No immediate investigative actions were reported as taken, the case being assigned to a single peer reviewer nearly four months later. In May 2010 the peer reviewer concluded

(b)(3):38 U.S.C. 5705,(b)(6)

In October 2010 the facility Director issued a charge letter convening an administrative investigative board (AIB) to determine whether non-compliance with VA opioid policies affected the patient's care in December 2009.

The AIB report, issued in November 2010,

(b)(6)

In November 2010 the subject doctor was presented the opportunity to respond to the May 2010 and August 2010 peer review findings. Although the System's Chief of Staff reported having a "direct conversation in November 2010 with (subject doctor)"

(b)(3):38 U.S.C. 5705,(b)(6)

and telling (subject doctor) "that it was his responsibility to review the record before prescribing" there was no

documentation of this meeting. When asked in May 2011 whether additional measures had been taken in response to the Peer Review Committee's (b)(3):38 U.S.C. 5705 determination regarding the subject doctor, the System Director responded, "there is no further documentation to submit."

Approximately seven months after the Chief of Staff's reported conversation with the subject doctor, and following OHI inquiries of the Director as to the System's

(b)(3):38 U.S.C. 5705,(b)(6)

Implemented and/or planned measures included a focused professional practice evaluation of and narcotic management training for the subject doctor, as well as comprehensive review and periodic monitoring of narcotic prescribing formalized for all providers.

Conclusion

We concluded that both the System's initial peer review and subsequent AIB were flawed. Further, the initial response of System leadership to the Peer Review Committee's reasoned determination of (b)(3):38 U.S.C. 5705,(b)(6)

(b)(3):38 U.S.C. 5705,(b)(6)

(b)(3):38 U.S.C. 5705,(b)(6) However, in response to OIG oversight, the System initiated appropriate actions and implemented necessary procedures.

(b)(6)

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