



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection Summary Report:
Evaluation of Medication
Management in Veterans
Health Administration
Facilities, Fiscal Year 2020



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Figure 1. *Veterans Affairs Building, Washington, DC.*

Source: <https://www.gsa.gov/> (accessed June 24, 2021).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
OIG	Office of Inspector General
OMHSP	Office of Mental Health and Suicide Prevention
PMOP	Pain Management, Opioid Safety, and Prescription Drug Monitoring
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years. The OIG selects and evaluates specific areas of focus each year.

The purpose of this report's evaluation was to determine whether VHA facility leaders and clinicians complied with selected medication management program requirements and guidelines for processes related to long-term opioid use for pain.

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. These inspections involved interviews with key staff and evaluations of clinical and administrative processes. The OIG also selected and reviewed electronic health records at five additional facilities but did not conduct site visits or issue individual reports to these facilities because of COVID-19 restrictions.¹ The results in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG reviews.² The findings may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG observed compliance with pain screening but identified weaknesses with

- aberrant behavior risk assessments,
- concurrent benzodiazepine therapy,
- urine drug testing,
- informed consent,
- patient follow-up, and
- quality measure oversight.

¹ The five facilities were: VA Central Iowa Health Care System in Des Moines; VA Black Hills Health Care System in Fort Meade, South Dakota; Iowa City VA Health Care System in Iowa; Minneapolis VA Health Care System in Minnesota; and VA Nebraska-Western Iowa Health Care System in Omaha.

² Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

Conclusion

The OIG conducted detailed inspections at 36 VHA facilities to ensure staff implemented selected medication management processes. The OIG subsequently issued seven recommendations for improvement to the Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders. The intent is for VHA leaders to use these recommendations to help guide improvements in operations and clinical care at the facility level. The recommendations address findings that may eventually interfere with the delivery of quality health care.

VA Comments

The Deputy Under Secretary for Health, Performing the Delegable Duties of Under Secretary for Health concurred in principle with the comprehensive healthcare inspection findings and recommendations (see appendix C, page 16, and the responses within the body of the report for the full text of the executive's comments) and provided action plans to ensure consistent care processes that will likely lead to improved outcomes. The OIG will follow up on the planned actions for the open recommendations until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

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Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

The purpose of this report's evaluation was to determine whether VHA facility leaders and clinicians acted in accordance with selected requirements and guidelines related to long-term opioid use for pain. Opioid medications are known to cause dependence, tolerance, abuse, and accidental overdose.¹ The opioid crisis is a national public health emergency with, on average, 130 Americans dying every day from an opioid overdose.² Long-term opioid use is of particular concern in the veteran population where there are incidences of posttraumatic stress disorder, major depressive disorder, alcohol use, substance abuse, and suicide attempts.³ These disorders, coupled with long-term opioid use, can potentially lead to an increased risk of overdose compared to the general population.⁴

To determine whether clinicians were compliant with VHA's requirements and guidelines for the management of pain with long-term opioid therapy, the OIG assessed the provision of care in the following areas:

- Completion of initial screening for pain
- Assessment of aberrant behavior risk
- Avoidance of concurrent therapy with benzodiazepines
- Completion of urine drug testing with intervention, when indicated
- Documentation of informed consent
- Timely follow-up with patients included required elements

VHA also requires facilities to establish a multidisciplinary pain management committee "to provide oversight, coordination, and monitoring of pain management activities and processes." Monitoring measures may include, but are not limited to, "adherence to published clinical

¹ "Opioid Overdose," World Health Organization, accessed August 16, 2021, https://www.who.int/substance_abuse/information-sheet/en/.

² "Understanding the Epidemic," Centers for Disease Control and Prevention, accessed August 16, 2021, <https://www.cdc.gov/drugoverdose/epidemic>.

³ *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*, Version 3.0. February 2017.

⁴ *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

practice guidelines, timeliness of pain treatment, adequacy of pain control, medication safety, appropriate use of stepped care treatment...patient satisfaction, physical and psychosocial functioning, and quality of life.”⁵ The OIG examined the following indicators of program oversight and evaluation:

- Performance of pain management committee activities
- Monitoring of quality measures
- Following the quality improvement process

The results in this summary report are a snapshot of national-level VHA performance at the time of the fiscal year 2020 OIG reviews.⁶ The findings in this report may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

⁵ VHA Directive 2009-053, *Pain Management*, October 28, 2009.

⁶ Fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020.

Methodology

To determine whether VHA facilities complied with selected requirements and guidelines related to long-term opioid use for pain, the OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs).

The OIG interviewed key staff and reviewed clinical and administrative processes. The OIG also randomly selected and reviewed the electronic health records of 998 outpatients who had newly dispensed (no VA dispensing in the previous six months) long-term opioids for pain through VA, for daily or intermittent use, for 90 or more calendar days from July 1, 2018, through June 30, 2019.⁷ The OIG also selected and reviewed electronic health records at five additional facilities but did not conduct site visits or issue individual reports to these facilities because of COVID-19 restrictions.⁸

Unless otherwise noted, the OIG published individual CHIP reports for each facility. For this report, the OIG analyzed data from the individual facility reviews to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. The comments and action plans submitted by the Acting Under Secretary for Health in response to the recommendations appear within the report. The OIG accepted the action plans that the Acting Under Secretary for Health developed based on the reasons for noncompliance.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁹ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspections in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁷ Patients with any type of cancer, without a pain diagnosis, who are on hospice or palliative care six months prior to or during the study period, or prescribed opioids only by community/Choice providers were excluded.

⁸ The five facilities were: VA Central Iowa Health Care System in Des Moines; VA Black Hills Health Care System in Fort Meade, South Dakota; Iowa City VA Health Care System in Iowa; Minneapolis VA Health Care System in Minnesota; and VA Nebraska-Western Iowa Health Care System in Omaha.

⁹ Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

VA recommends routine assessments of pain and the completion of an opioid risk assessment before initiating patients on long-term opioid therapy and recommends against the therapy for patients with untreated substance use disorders. VA also recommends avoiding drugs capable of inducing fatal interactions, such as opioids with benzodiazepines.¹⁰ Healthcare providers are required to conduct initial and random ongoing urine drug testing during opioid therapy.¹¹ To achieve VHA's vision of providing patient-driven healthcare, providers are also required to obtain informed consent from patients and provide education on the risks, benefits, and alternatives prior to initiating long-term opioid therapy.¹² Lastly, when prescribing opioid therapy for chronic pain, VA recommends that providers evaluate patients for improvement in pain and opioid-related adverse events at least every three months and more frequently as doses increase.¹³

Findings and Recommendations

The OIG observed compliance with pain screening. However, across the facilities inspected in fiscal year 2020, the OIG identified weaknesses with

- aberrant behavior risk assessments,
- concurrent benzodiazepine therapy,
- urine drug testing,
- informed consent,
- patient follow-up, and
- quality measure oversight.

VA guidelines recommend that providers complete a behavior risk assessment that includes the patient's history of substance abuse, psychological disease, and aberrant drug-related behaviors

¹⁰ "Benzodiazepines (Street Names: Benzos, Downers, Nerve Pills, Tranks)," U.S. Drug Enforcement Administration, accessed October 6, 2021, https://www.deadiversion.usdoj.gov/drug_chem_info/benzo.pdf. "Benzodiazepines are a class of drugs that produce central nervous system (CNS) depression and that are most commonly used to treat insomnia and anxiety."

¹¹ *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*; Department of Veterans Affairs, *Pain Management, Opioid Safety, VA Educational Guide (2014)*, July 2014.

¹² VHA Directive 1005(1), *Informed Consent for Long-Term Opioid Therapy for Pain*, May 6, 2014, amended November 13, 2018. (This directive was rescinded on May 13, 2020, and replaced with VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain*. The two documents contain similar language related to informed consent.)

¹³ *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

prior to initiating long-term opioid therapy.¹⁴ The OIG estimated that providers did not assess 46 percent of patients for behavior risks, based on the electronic health records reviewed.¹⁵ This may have resulted in providers prescribing opioids for patients at high risk for misuse. Reasons for noncompliance included managers' reported belief that facility efforts met requirements and lack of oversight.¹⁶

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facility providers complete aberrant behavior risk assessments on all patients prior to initiating long-term opioid therapy.

¹⁴ *Pain Management, Opioid Safety, VA Educational Guide (2014)*. Examples of aberrant drug related behaviors include "lost prescriptions, multiple requests for early refills, unauthorized dose escalation, apparent intoxication, frequent accidents etc." *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

¹⁵ The OIG estimated that 95 percent of the time, the true compliance rate is between 47.1 and 62.7 percent, which is statistically significantly below the 90 percent benchmark.

¹⁶ Managers specifically reported the following rationales for not meeting the requirement: variability in interpreting the requirement, not anticipating chronic long-term opioid therapy, screening by licensed practical nurses and/or urine drug testing in lieu of additional evaluation, assessments documented by other clinicians which were sometimes outside of the required timeframe, and lack of a standardized template to capture required elements for documentation.

Under Secretary for Health concurred in principle

Target date for completion: November 2022

Under Secretary for Health response: VHA’s Pain Management, Opioid Safety, and Prescription Drug Monitoring (PMOP) Program Office, in collaboration with VHA’s Office of Assistant Under Secretary for Health for Operations, will make certain that facility providers complete aberrant behavior risk assessments on all patients that do not meet reasonable exceptions as established by policy. For example, some reasonable exceptions are patients receiving opioid medications in hospice or palliative care settings. The PMOP program will establish a working group of stakeholders to determine any exceptions. Membership will include VHA stakeholders to include the Office of Mental Health and Suicide Prevention (OMHSP), Primary Care Service, and field representatives from the Veterans Integrated Service Networks (VISNs) and Facilities.

VHA PMOP Program Office and its collaborative working group stakeholders interpret this recommendation to ensure facility providers complete aberrant risk behavior assessments on patients prior to establishing that opioid therapy qualifies as “long-term” per VHA policy; not to conduct the assessment prior to initiating opioid therapy that may or may not extend to the 90-day timeframe. Per current policy, Directive 1005, the definition of long-term opioid therapy for pain is the medically indicated use of opioids on a daily or intermittent basis for 90 or more calendar days to treat non-cancer pain.

VA/DoD clinical practice guidelines recommend avoiding co-administration of drugs that could induce fatal interactions, such as an opioid and benzodiazepine combination.¹⁷ For patients already prescribed benzodiazepines, the OIG estimated that providers did not justify adding opioid therapy in 28 percent of the electronic health records reviewed.¹⁸ Co-administration of an opioid and benzodiazepine may have resulted in an increased risk of harm and potentially fatal drug interactions. When asked why noncompliance occurred, facility managers reported that they believed efforts met requirements and there was lack of oversight and attention to detail.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that facility providers document justification for prescribing opioids and benzodiazepines concurrently.

¹⁷ VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.

¹⁸ The OIG estimated that 95 percent of the time, the true compliance rate is between 61.4 and 83.1 percent, which is statistically significantly below the 90 percent benchmark.

Under Secretary for Health concurred in principle

Target date for completion: November 2022

Under Secretary for Health response: VHA’s PMOP Program Office, in collaboration with VHA’s Office of Assistant Under Secretary for Health for Operations, will make certain that facility providers document justification for prescribing opioids and benzodiazepines concurrently, unless exceptions apply such as, patients receiving opioid medication in hospice or palliative care settings. The PMOP program will establish a working group of stakeholders to determine any exceptions. Membership will include VHA stakeholders to include the OMHSP, Primary Care Service, and field representatives from the VISNs and Facilities.

VA/DoD clinical practice guidelines recommend that providers conduct a “UDT [urine drug test] prior to initiating or continuing LOT [long-term opioid therapy] and periodically thereafter.”¹⁹ Additionally, according to VHA, “all test results requiring action must be communicated by the ordering provider, or designee, to patients.”²⁰ The OIG estimated that providers did not conduct initial urine drug testing for 28 percent of patients, based on the electronic health records reviewed.²¹ Further, the OIG estimated that providers failed to follow up with 15 percent of patients who had problematic urine test results.²² This may have resulted in providers’ inability to identify whether patients had substance use disorders, were potential diversion risks, or adhered to the prescribed medication regimen. Reasons for noncompliance included managers and staff’s reported belief that facility efforts met requirements, staffing issues, and lack of attention to detail and oversight.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facility providers consistently conduct urine drug testing as recommended for patients on long-term opioid therapy.

¹⁹ VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain.

²⁰ VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

²¹ The OIG estimated that 95 percent of the time, the true compliance rate is between 67.2 and 78.0 percent, which is statistically significantly below the 90 percent benchmark.

²² The OIG estimated that 95 percent of the time, the true compliance rate is between 81.8 and 87.9 percent, which is statistically significantly below the 90 percent benchmark.

Under Secretary for Health concurred in principle

Target date for completion: November 2022

Under Secretary for Health response: VHA's PMOP Program Office, in collaboration with VHA's Office of Assistant Under Secretary for Health for Operations, will make certain that facility providers consistently conduct urine drug testing as recommended for patients on long-term opioid therapy, unless exceptions apply such as patients receiving opioid medication in hospice or palliative care settings or patients who cannot make urine. The PMOP program will establish a working group of stakeholders to determine any exceptions. Membership will include VHA stakeholders to include the OMHSP, Primary Care Service, and field representatives from the VISNs and Facilities.

Informed consent, Urine Drug Screen, and Prescription Drug Monitoring Program query compliance will be incorporated into the Primary Care physician and Pain physician Ongoing Professional Practice Evaluation/Focused Professional Practice Evaluation, set for implementation in Fiscal Year 2023.

Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that facility providers communicate problematic urine test results to patients.

Under Secretary for Health concurred in principle

Target date for completion: November 2022

Under Secretary for Health response: VHA's PMOP Program Office, in collaboration with VHA's Office of Assistant Under Secretary for Health for Operations, will make certain that facility providers communicate problematic urine test results to patients unless exceptions apply, such as patients receiving opioid medication in hospice or palliative care settings. The PMOP program will establish a working group of stakeholders to determine any exceptions. Membership will include VHA stakeholders to include the OMHSP, Primary Care Service, and field representatives from the VISNs and Facilities. Please note, VHA PMOP Program Office and its collaborative working group stakeholders interpret this recommendation to apply to problematic urine drug results for patients on long-term opioid therapy.

VHA requires providers to obtain and document informed consent prior to the initiation of long-term opioid therapy. VHA also requires that the informed consent conversation cover the risks

and benefits of opioid therapy, as well as alternative therapies.²³ The OIG estimated that providers did not obtain and document informed consent prior to initiating long-term opioid therapy for 36 percent of the patients reviewed.²⁴ Therefore, patients may have received treatment without knowledge of the alternative therapies and associated risks, including opioid dependence, tolerance, addiction, and fatal overdose. Reasons for noncompliance included managers' reported belief that facility efforts met requirements and lack of attention to detail.²⁵

Recommendation 5

5. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facility providers obtain and document informed consent for patients prior to initiating long-term opioid therapy.

Under Secretary for Health concurred in principle

Target date for completion: November 2022

Under Secretary for Health response: VHA's PMOP Program Office, in collaboration with VHA's Office of Assistant Under Secretary for Health for Operations, will make certain that facility providers consistently obtain and document informed consent, for patients prior to establishing that opioid therapy qualifies as "long-term" per VHA policy unless exceptions apply, such as patients receiving opioid medication in hospice or palliative care settings. Per VHA's policy on informed consent, the requirement for written informed consent does not apply to patients enrolled in hospice, or patients receiving long-term opioid therapy for cancer pain, for whom oral informed consent is required, and specific documentation of informed consent for opioid therapy is not required. The PMOP program will establish a working group of stakeholders to determine any exceptions. Membership will include VHA stakeholders: OMHSP, Primary Care Service, and field representatives from the VISNs and Facilities.

VA/DoD clinical practice guidelines also recommend that providers follow up with patients within three months after initiating long-term opioid therapy.²⁶ Additionally, VHA requires providers to assess patients' adherence to their pain management plan of care and the

²³ VHA Directive 1005(1), *Informed Consent for Long-Term Opioid Therapy for Pain*, May 6, 2014, amended November 13, 2018. (This directive was rescinded on May 13, 2020, and replaced with VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain*. The two documents contain similar language related to informed consent.)

²⁴ The OIG estimated that 95 percent of the time, the true compliance rate is between 58.2 and 69.3 percent, which is statistically significantly below the 90 percent benchmark.

²⁵ Managers specifically reported that there was unclear guidance from the directive, confusion between state and VHA requirements, discrepancies between facility policy and VHA requirements, and that they assumed consent was only needed on initiation of opioid therapy.

²⁶ *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

effectiveness of interventions.²⁷ The OIG estimated that 21 percent of electronic health records reviewed lacked evidence that providers followed up with patients three months after initiating long-term opioid therapy.²⁸ Further, the OIG estimated that 18 percent of electronic health records reviewed did not have evidence that providers assessed patients' adherence to their pain management plan of care or the effectiveness of the interventions provided.²⁹ Failure to conduct follow-ups can result in missed opportunities to assess patients' adherence to the therapy plan, effectiveness of treatment, and risks of continued opioid therapy.³⁰ Reasons for noncompliance included managers' reported belief that facility efforts met requirements and staffing issues.³¹

Recommendation 6

6. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that facility providers follow up with patients within three months after initiating opioid therapy to assess adherence to the pain management plan of care and effectiveness of interventions.

Under Secretary for Health concurred in principle

Target date for completion: November 2022

Under Secretary for Health response: VHA's PMOP Program Office, in collaboration with VHA's Office of Assistant Under Secretary for Health for Operations, will make certain that facility providers consistently follow up with patients within three months after initiating opioid therapy to assess adherence to the pain management plan of care and effectiveness of interventions provided unless exceptions apply, such as patients receiving opioid medications in hospice or palliative care settings or patients who cannot make urine. The PMOP program will establish a working group of stakeholders to determine any exceptions. Membership will include VHA stakeholders to include the OMHSP, Primary Care Service, and field representatives from the VISNs and Facilities.

²⁷ VHA Directive 2009-053, *Pain Management*, October 28, 2009.

²⁸ The OIG estimated that 95 percent of the time, the true compliance rate is between 73.4 and 82.8 percent, which is statistically significantly below the 90 percent benchmark.

²⁹ Regarding adherence to the plan of care, the OIG estimated that 95 percent of the time, the true compliance rate is between 76.1 and 88.1 percent, which is statistically significantly below the 90 percent benchmark. For intervention effectiveness, the OIG estimated that 95 percent of the time, the true compliance rate is between 77.9 and 87.5 percent, which is statistically significantly below the 90 percent benchmark.

³⁰ VHA Directive 2009-053; *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*.

³¹ Managers specifically reported that they believed performing risk reviews in combination with patient feedback was sufficient for frequent follow-ups, assumed the use of business days versus calendar days was acceptable, and focused on major issues rather than documenting pain management.

VHA requires each medical center to have a multidisciplinary pain management committee to “provide oversight, coordination, and monitoring of pain management activities and processes” and to monitor the “quality of pain assessment and the effectiveness of pain management interventions.”³² The OIG found that 36 percent of the committees responsible for monitoring the quality of pain assessment and effectiveness of pain management interventions did not have measures in place to monitor quality or effectiveness. This could result in the committees’ inability to determine deficiencies and provide recommendations to facility leaders to improve pain management outcomes. Reasons for noncompliance included managers’ reported belief that facility efforts met requirements and lack of attention to detail.

Recommendation 7

7. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that facilities monitor the quality of pain assessment and effectiveness of pain management interventions.

Under Secretary for Health concurred in principle

Target date for completion: November 2022

Under Secretary for Health response: VHA’s PMOP Program Office, in collaboration with VHA’s Office of Assistant Under Secretary for Health for Operations, will establish a working group of stakeholders to evaluate and make recommendations on an approach for facilities to monitor the quality of pain assessment and the effectiveness of pain management interventions. To close this recommendation, the PMOP will provide recommendations and propose next steps to VHA leadership. Membership will include VHA stakeholders: OMHSP, Primary Care Service, and field representatives from the VISNs and Facilities.

³² VHA Directive 2009-053.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines seven OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient safety issues or adverse events. The intent is for VHA leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy	<ul style="list-style-type: none"> • Provision of pain management using long-term opioid therapy • Program oversight and evaluation 	<ul style="list-style-type: none"> • Facility providers complete aberrant behavior risk assessments on all patients prior to initiating long-term opioid therapy. • Facility providers document justification for prescribing opioids and benzodiazepines concurrently. • Facility providers consistently conduct urine drug testing as recommended for patients on long-term opioid therapy. • Facility providers communicate problematic urine test results to patients. • Facility providers obtain and document informed consent for patients prior to initiating long-term opioid therapy. 	<ul style="list-style-type: none"> • None

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Long-Term Opioid Therapy (continued)		<ul style="list-style-type: none"> • Facility providers follow up with patients within three months after initiating opioid therapy to assess adherence to the pain management plan of care and effectiveness of interventions. • Facilities monitor the quality of pain assessment and effectiveness of pain management interventions. 	

Appendix B: Parent Facilities Inspected

**Table B.1. Parent Facilities Inspected
(October 1, 2019, through September 30, 2020)**

Names	City
Ann Arbor VA Medical Center	Ann Arbor, MI
Charlie Norwood VA Medical Center	Augusta, GA
Battle Creek VA Medical Center	Battle Creek, MI
Birmingham VA Medical Center	Birmingham, AL
Boise VA Medical Center	Boise, ID
Ralph H. Johnson VA Medical Center	Charleston, SC
Jesse Brown VA Medical Center	Chicago, IL
Chillicothe VA Medical Center	Chillicothe, OH
Cincinnati VA Medical Center	Cincinnati, OH
Harry S. Truman Memorial Veterans' Hospital	Columbia, MO
Columbia VA Health Care System	Columbia, SC
VA Illiana Health Care System	Danville, IL
Dayton VA Medical Center	Dayton, OH
Atlanta VA Health Care System	Decatur, GA
John D. Dingell VA Medical Center	Detroit, MI
Carl Vinson VA Medical Center	Dublin, GA
Edward Hines, Jr. VA Hospital	Hines, IL
Oscar G. Johnson VA Medical Center	Iron Mountain, MI
Kansas City VA Medical Center	Kansas City, MO
William S. Middleton Memorial Veterans Hospital	Madison, WI
Marion VA Medical Center	Marion, IL
VA Northern Indiana Health Care System	Marion, IN
Milwaukee VA Medical Center	Milwaukee, WI
Central Alabama Veterans Health Care System	Montgomery, AL
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
John J. Pershing VA Medical Center	Poplar Bluff, MO
VA Portland Health Care System	Portland, OR
Roseburg VA Health Care System	Roseburg, OR
Aleda E. Lutz VA Medical Center	Saginaw, MI

Names	City
VA Puget Sound Health Care System	Seattle, WA
Mann-Grandstaff VA Medical Center	Spokane, WA
VA St. Louis Health Care System	St. Louis, MO
Tomah VA Medical Center	Tomah, WI
VA Eastern Kansas Health Care System	Topeka, KS
Tuscaloosa VA Medical Center	Tuscaloosa, AL
Robert J. Dole VA Medical Center	Wichita, KS

Source: VA OIG.

Appendix C: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: December 9, 2021

From: Deputy Under Secretary for Health, Performing the Delegable Duties of Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020 (OIG 2021-01507-HI-1151) (VIEWS # 6278293)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020. The Veterans Health Administration concurs in principle with all seven recommendations and provides an action plan.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D.

OIG Contact and Staff Acknowledgments

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