Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Improper Care and Prescribing Practices for a Veteran

Tyler VA Primary Care Clinic
Tyler, Texas

Report No. 11-01996-253 **August 19, 2011**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an evaluation in response to allegations by a complainant. Allegations included inadequate medical and mental health care, including improper prescribing practices at the Tyler VA Primary Care Clinic in Tyler, TX. The complainant further alleged that the patient had dementia and facility providers disregarded her concerns.

We did not substantiate the allegations of inadequate medical and mental health care.

We substantiated the allegation that facility providers improperly prescribed opioids and alprazolam to the patient. Specifically, we identified the following deficiencies in prescribing practices: (a) inconsistent documentation of pain assessments, (b) absence of a written opioid treatment agreement or urine drug tests, (c) no consideration of non-pharmalogical approaches for pain management, and (d) absence of evaluations of opioid therapy effectiveness. However, we could neither substantiate nor refute the allegation that prescribing practices contributed to his overdose and death. We found no evidence to support the allegation that the patient had dementia or otherwise lacked decision-making capacity.

We did not substantiate the allegation that providers disregarded the complainant's concerns.

We recommended that the System Director ensures that providers consistently document pain assessments for patients on opioid therapy and monitor and evaluate these patients in accordance with VHA and system pain management policies.

The Veterans Integrated Service Network and System Directors concurred with our recommendation and provided an acceptable action plan. We will follow up on the planned action until it is completed.

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

TO: Director, VA Heart of Texas Health Care Network (10N17)

SUBJECT: Healthcare Inspection – Alleged Improper Care and Prescribing Practices for a Veteran, Tyler VA Primary Care Clinic, Tyler, Texas

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an evaluation in response to allegations by a complainant. The complainant alleged inadequate medical and mental health care, including improper prescribing practices at the Tyler VA Primary Care Clinic (the facility) in Tyler, TX. The complainant further alleged that facility providers disregarded her concerns. The purpose of the review was to determine whether the allegations had merit.

Background

The facility is part of the VA North Texas Health Care System (the system) in Dallas, TX, within Veterans Integrated Service Network (VISN) 17. It is 98 miles from the system referral center in Dallas and serves more than 36,000 veterans in Woods, Henderson, Smith, Van Zandt, and Rusk counties. The facility provides primary care, pharmacy, mental health, Tele-Move, and Tele-Retinal services.

The system's pain management policy calls for an individualized pain control plan if initial interventions are not adequate. This plan requires ongoing assessments of the effectiveness of pain management interventions.[1] Prescribing practices for opioid[2] therapy should include the following as appropriate for each patient:

- Initial and ongoing pain assessments.
- Written opioid treatment agreements.
- Periodic urine drug tests (UDTs).
- Consideration of non-pharmacological approaches for chronic pain management.
- Evaluation of opioid therapy effectiveness.

[1] VA North Texas Health Care System Memorandum 112A-01, *Pain Management*, March 3, 2008.
[2] Opioids are medications with effects similar to those of opium and opium derivatives and are used to treat moderate and severe pain. The term is often used as a synonym of "narcotics."

The system policy adheres to the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.[3]

In March 2011, the complainant contacted the OIG Hotline Division regarding a patient's treatment at the facility. The complainant alleged that facility clinicians:

- Failed to provide the patient adequate medical and mental health care.
- Improperly prescribed opioid medications and alprazolam for the patient, who allegedly had dementia, which contributed to his overdose and death.
- Disregarded her concerns.

Scope and Methodology

We reviewed VHA and system policies governing pain management. We also reviewed the patient's medical record, as well as autopsy and toxicology reports. In addition, we interviewed the patient's last primary care provider (PCP).

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The patient was a man in his early 60's with a history of chronic low back pain, myocardial infarction (heart attack) with pacemaker insertion, sleep disorders, and hypothyroidism (underactive thyroid). During 1993–2009, he received outpatient care at three VA medical centers. Additionally, the patient received care from non-VA providers during 2001–2008 and had reportedly received home oxygen therapy.

In 2004 and 2007, requests were submitted for pain management and mental health consultations at the system referral center in Dallas. The patient did not keep any of the appointments scheduled with these consultants.

The patient had two PCPs at the facility. The first PCP followed him from May 2006 through July 2008 and documented pain assessments in 4 of 13 clinic visits. The PCP did not order UDTs and no opioid treatment agreement was documented. During this period, the patient made frequent phone calls and unscheduled visits requesting refills for pain medications, and he usually received the requested medications.

In 2006, the patient began to receive opioids (hydromorphone then oxycodone) for low back pain, quetiapine for mood enhancement, and diazepam for anxiety. In early 2007, at the patient's request, the PCP prescribed a muscle relaxant (carisoprodol) and another opioid (fentanyl). In April, he received a sedative (temazepam) for insomnia.

In August 2008, the patient's care was transferred to a second PCP. This PCP documented pain assessments in 3 of 10 clinic visits. The PCP did not order UDTs and no opioid treatment

[3] VA/DOD Clinical Practices Guideline, *Management of Opioid Therapy for Chronic Pain*, May 2010

agreement was documented but did reduce doses of opiod medications. In September 2008, he prescribed an anti-anxiety medication (alprazolam). During 2008–2009, the patient received opioids or sedatives every 3 to 6 weeks.

The PCP documented that the patient reported not taking his medications at all or taking more doses than were prescribed. The patient continued to make frequent phone calls and unscheduled visits for pain medication refills.

The patient died in early May 2009, 10 days after his last appointment with the second PCP. According to the autopsy report, the principal cause of death was hydromorphone toxicity (overdose).

Inspection Results

We did not substantiate the allegations of inadequate medical and mental health care. We reviewed the medical records from the three VA medical centers where the patient was treated during 1993–2009. The patient had regular primary care visits and was referred for pain management and mental health specialty care.

We substantiated the allegation that facility providers improperly prescribed opioids and alprazolam to the patient. Specifically, we identified the following deficiencies in prescribing practices: (a) inconsistent documentation of pain assessments, (b) absence of a written opioid treatment agreement, (c) no consideration of non-pharmalogical approaches for pain management, and (d) absence of evaluations of opioid therapy effectiveness. However, we could neither substantiate nor refute the allegation that prescribing practices contributed to his overdose and death. The patient was taking hydromorphone and alprazolam for more than 9 months prior to his death.

During the course of our review, the complainant submitted additional documents from 2006 showing that a non-VA provider had considered the patient to be incompetent. This opinion was not accompanied by any examination details, and these documents were never incorporated into the VHA medical record. We could not verify whether this assessment of incompetence was ever brought to the attention of any VHA PCP. Further, there is nothing in the medical record to suggest that the patient ever lacked the ability to make his own medical decisions. We found no evidence to support the complainant's assertion that the patient had dementia or otherwise lacked decision-making capacity.

We did not substantiate the allegation that providers disregarded the complainant's concerns. During the last 2 years of the patient's life, there was no evidence in the medical record that any family member was involved in this patient's care, and we found no record of family complaints.

Conclusions

We concluded that the patient received adequate medical and mental health care.

We determined that facility providers did not fully adhere to proper prescribing practices. However, we could neither substantiate nor refute the allegation that these deficiencies in

prescribing practices contributed to his overdose and death. We found no evidence to support the complainant's allegation that the patient had dementia or otherwise lacked decision-making capacity**.**

We did not substantiate the allegation that providers disregarded the complainant's concerns.

Recommendation

We recommended that the System Director ensures that providers consistently document pain assessments for patients on opioid therapy and monitor and evaluate these patients in accordance with VHA and system pain management policies.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 5–7, for the Directors' comments.) We will follow up on the planned action until it is completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 9, 2011

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **Healthcare Inspection – Alleged Improper Care and Prescribing Practices, Tyler VA Primary Care Clinic, Tyler, Texas**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Thru: Director, VHA Management Review Service (10A4A4)

1. Thank you for allowing me to respond to this Healthcare Inspection for Alleged Improper Care and Prescribing Practices at the Tyler VA Primary Care Clinic, Tyler, Texas.

2. I concur with the recommendations and have ensured that action plans have been developed.

3. If you have further questions regarding this inspection, please contact Judy Finley, Quality Management Officer at 817-385-3761 or Denise B. Elliott, VISN 17 HSS at 817-385-3734.

(*original signed by*:)
Lawrence A. Biro
Director, VA Heart of Texas Health Care Network (10N17)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 4, 2011

From: Mark Doskocil, FACHE

Acting Director, VA North Texas Health Care System (549/00)

Subject: **Healthcare Inspection – Alleged Inappropriate Prescribing Practices, Tyler VA Primary Care Clinic, Tyler, Texas**

To: Mr. Lawrence Biro

Director, VA Heart of Texas Health Care Network (10N17)

I concur with the findings noted in this report. Action plans have been developed and monitoring will be conducted on a regular basis.

Should you require any additional information, please contact Patricia Bowling, Chief, Clinical Quality Management, 214-857-2327.

(*original signed by*:)
Mr. Mark Doskocil, FACHE
Acting Director, VA North Texas Health Care System (549/00)

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 Recommendation

We recommended that the System Director requires that prescribing practices be strengthened to ensure that providers consistently document pain assessments and that patients on opioid therapy are appropriately monitored and evaluated in accordance with VHA and system pain management policies.

Concur

Target Completion Date: 12/8/2011

Facility's Response:

Providers and Nursing staff are to be educated on proper documentation of pain assessments, usage of IMED and the pain contract requirements for Opiods, alternative methods of pain management, and the local Pain Management MCM and Directive. Effectiveness of pain management will be monitored on a monthly basis, through departmental medical record audits as well as Medical Records Committee reviews.

Status: Open

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Daisy Arugay, MT Douglas Henao, RD Jerome Herbers, MD Mary Toy, RN

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Heart of Texas Health Care Network (10N17)
Director, VA North Texas Health Care System (549/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: John Cornyn, Kay Bailey Hutchison
U.S. House of Representatives: Bill Flores, Louie Gohmert, Eddie Bernice Johnson, Samuel Johnson, Kenny Marchant, Silvestre Reyes, Peter Sessions

This report is available at http://www.va.gov/oig/publications/reports-list.asp.