



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 15-01669-246

Healthcare Inspection

Patient Deaths, Opioid Prescribing Practices, and Consult Management VA Greater Los Angeles Healthcare System, Los Angeles, California

May 23, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General conducted a healthcare inspection to evaluate allegations related to patient deaths from drug overdose, inappropriate opioid prescribing practices, and improper consult management at the VA Greater Los Angeles Healthcare System (system), Los Angeles, CA.

Specifically, a complainant alleged that seven patients died from drug overdoses in an 8-month period at the New Directions (a non-VA organization providing services to homeless veterans) housing facility located on the system's Sepulveda campus, and that system psychiatrists prescribed inordinate doses of opioid medications without reasonable cause or oversight. The complainant also alleged that cardiology consults were being canceled or discontinued improperly.

We did not substantiate the allegation that seven patients died from drug overdoses during an 8-month period at the New Directions housing facility. We were unable to obtain the names of the seven patients from the complainant; therefore, we reviewed the electronic health records of six patients who the system reported as having died while living in the New Directions housing facility located on the Sepulveda campus from its opening in September 2013 to August 2014. We reviewed coroner reports for the six patients; one report indicated that one of the six patients died from multiple drug intoxication. We determined that the drugs associated with this patient's death had not been ordered by system providers.

We did not substantiate that system psychiatrists prescribed inordinate amounts of opioids without oversight. A query of the Veterans Health Administration's (VHA) pharmacy database revealed four patients who had been prescribed opioids at the upper range of the recommended daily dose. The opioid regimens for these patients were appropriate under the circumstances. None of these patients suffered an adverse event. Proper system controls were in place to track the opioid prescriptions for these and other patients. We obtained data showing the system had a lower percentage of patients on larger amounts of opioids than the VHA national average.

We substantiated the allegation that cardiology consults were canceled or discontinued by non-physician staff members, including nurses, technicians, and administrative personnel. However, this was an acceptable practice under certain circumstances. Of the 49 consults we reviewed that were canceled or discontinued by non-physician cardiology staff, 5 were inappropriately canceled or discontinued. We did not find documented evidence in the electronic health record of patient harm in these five patients, however patients can be put at increased risk of harm when consults are inappropriately canceled or discontinued.

We recommended that the System Director ensure staff conduct a review of canceled or discontinued cardiology consults to determine if patients suffered harm as a result of inappropriate consult closure and confer with the Office of Chief Counsel regarding disclosure as necessary. We also recommended that system staff comply with current VHA policies regarding consult management.

Comments

The Veterans Integrated Service Network and System Directors concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 14–17 for the full text of the comments.) We consider recommendation 1 closed. We will follow up on the planned actions for the remaining open recommendation until they are completed.



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

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate allegations related to patient deaths from drug overdose, inappropriate opioid prescribing practices, and improper consult management at the VA Greater Los Angeles Healthcare System (system), Los Angeles, CA.

Background

The system comprises two campuses, a 688-bed tertiary care parent facility in West Los Angeles and a long-term care facility in Sepulveda, and nine community based outpatient clinics, all located in California. The system provides primary, specialty, outpatient, medical, surgical, mental health (MH), rehabilitative, and long-term care services.

The system serves a population of approximately 90,568 enrolled veterans in a primary service area that includes Los Angeles, Santa Barbara, San Luis Obispo, Ventura, and Kern counties in California. The system is part of Veterans Integrated Service Network (VISN) 22.

The Sepulveda VA Medical Center (SMC), located 15 miles north of the parent facility in Los Angeles, provides primary, general medical, MH, dental, rehabilitation and long-term care, and specialty services. SMC consists of 26 long-term care and 14 hospice beds. In fiscal year 2014, SMC served 34,458 unique patients with a cumulative 264,843 outpatient visits.

New Directions Program

The New Directions (ND) program provides housing and a variety of other services to homeless patients in the Los Angeles area. Services include MH therapy, substance abuse support, counseling, remedial education, job training and placement, and legal advice. In 2013, an ND housing facility became operational at the SMC campus with 147 individual studio apartment units for veterans in two separate buildings; each building contains offices where ND staff provide onsite support services, community rooms, and computer rooms. The housing area also includes courtyards with garden areas. Although the ND housing facility is located on VA grounds, the system does not manage or provide oversight for the ND program or staff.

Homeless Patient Aligned Care Team

In March 2014, the system established the SMC Homeless Patient Aligned Care Team (H-PACT) in response to multiple ND resident deaths that occurred in 2013 and 2014. The H-PACT included a primary care physician, registered nurse, MH physician, psychologist, and a social worker. The H-PACT routinely met with ND staff to discuss the care and issues related to ND housing residents who were enrolled in and receiving VHA care.

U.S. Deaths Related to Opioid Overdose

Deaths from prescription opioids have reached epidemic levels according to the Centers for Disease Control and Prevention.¹ Overdose deaths involving prescription opioids have quadrupled since 1999. In 2015, more than 22,000 people died from overdoses involving prescription opioids.² These prescription opioids include: codeine, hydrocodone, oxycodone, morphine, hydromorphone, methadone, tramadol, and fentanyl. Medications that have a short duration of action, such as hydrocodone and oxycodone, are more likely to be abused compared to long acting medications like methadone. As these drugs have different potencies, clinicians standardize prescriptions into the Morphine Equivalent Daily Dose (MEDD)³ to change patients from one opioid to another.⁴

Opioid Prescribing Guidelines

Many opioid prescribing guidelines recommend that clinicians avoid doses greater than 90 MEDD.⁵ One study involving a population of VA patients found a linear increase in overdose death rates with greater opioid doses.⁶ Guidelines generally recommend using opioid risk assessment tools, informed consent agreements, and urine drug testing to mitigate risks of overdose deaths and inappropriate use.

Veterans Health Administration Opioid Prescribing Guidance

In 2010, VA and the Department of Defense published a joint Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain (Guideline).⁷ The Guideline provides clinicians who prescribe opioids with evidence-based best practices on the management of chronic pain.

In 2013, the Veterans Health Administration (VHA) launched the Opioid Safety Initiative to promote an interdisciplinary approach to pain relief. In July 2014, the group developed and published an evidence-based toolkit to guide providers.⁸ The Opioid

¹ Centers for Disease Control and Prevention. <http://www.cdc.gov/drugoverdose/epidemic/index.html>. Accessed June 2, 2015.

² Centers for Disease Control and Prevention. <https://www.cdc.gov/drugoverdose/data/analysis.html>. Accessed March 27, 2017.

³ The MEDD is used to translate the dose and route of each opioid medication the patient has received over the last 24 hours to a parenteral (administered other than through the digestive tract such as by intravenous or intramuscular injection) morphine equivalent using a standard conversion table.

⁴ Bohnert A, Valenstein M, Bair MJ, et al. Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths. *JAMA*. 2011; 305(13):1315–21.

⁵ Nuckols TK, Anderson L, Popescu I, et al. Opioid Prescribing: A Systematic Review and Critical Appraisal of Guidelines for Chronic Pain. *Ann Intern Med*. 2014; 160: 38–47.

⁶ Bohnert A, Valenstein M, Bair MJ, et al. Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths. *JAMA*. 2011; 305(13):1315–21.

⁷ VA/DoD *Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*, Version 2.0 May 2010.

⁸ Opioid Safety Initiative. http://www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_OSI.asp. Accessed July 30, 2015.

Safety Initiative provides data on key items that influence a patient's risk of overdose or misuse such as dates of last primary care and pain clinic visits and MEDD prescribed. The data are used to generate the Opiate Therapy Risk Report, with details down to the individual provider level at each facility.

Allegations: The complainant initially contacted the OIG Hotline in June 2014 but was not available subsequently to clarify the allegations. Based upon our understanding of the complainant's initial contacts, we evaluated the following concerns:

- Seven patients died from drug overdoses in an 8-month period at the ND housing facility located at the SMC campus.⁹
- System psychiatrists prescribed inordinate doses of opioids without reasonable cause or oversight.
- System staff improperly canceled or discontinued cardiology consults.

Scope and Methodology

We initiated our review in January 2015 and completed our work in January 2016. We conducted a site visit April 13–14, 2015, which included both entrance and exit briefings with the Acting Director. We interviewed system leadership including the then-Chief of Staff and Deputy Chief of Staff, psychiatrists, a psychologist, social workers, a primary care provider (PCP), the Controlled Substance Oversight Committee Chairperson, and staff from cardiology, pharmacy, police, clinical informatics, and ND. We also spoke with the VA National Opioid Safety Initiative staff, including the VA Acting Chief Consultant of Pharmacy, and communicated with the Deputy National Mental Health Program Director.

We reviewed the electronic health records (EHR) of the six patients who the system reported as having died at the time they were residents in the ND housing facility located on SMC campus from its opening in September 2013 to August 2014.

We reviewed relevant VHA and system policies and procedures, peer reviews related to opioid prescribing, pharmacy drug profiles, VA police reports, California Controlled Substance Utilization Review and Evaluation System drug information,¹⁰ and coroner reports. We reviewed national, VISN, and system data on opioid prescribing practices for pain. We reviewed the EHRs of 4 patients who received prescriptions in the upper range for recommended daily doses of opioids during the period from January 2013 through June 2014. We also examined 49 cardiology consults that were canceled or discontinued by non-physician staff.

⁹ The allegation did not specifically define the “8-month” time frame.

¹⁰ Controlled Substance Utilization Review and Evaluation System is a database of controlled substances that are dispensed in California. Opioid prescribers access the database to obtain a patient's controlled substance history. The goal of the program is to reduce drug abuse in California. <https://oag.ca.gov/cur-es-pdmp>.

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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 Summaries

Alleged Patient Deaths from Drug Overdose: Patients 1–6

Patient 1

The patient was in his late 50s at the time of his death in 2013. He had a history of homelessness, mental health issues, and multiple medical conditions. In 2008, he was involved in a motor vehicle accident with resultant knee and neck pain. He had been receiving care at another VA facility, which included treatment of his chronic pain with opioid medication, until mid-2013 when he sought care at the system. A month after transferring his care to the system, the patient reported needing additional doses of his opioid medication for his chronic pain.

He moved into an ND apartment located on the SMC campus about the same time he transferred his care to the system. The following month, the patient was taken to the system's Emergency Department (ED) by police for alcohol intoxication while on ND grounds. According to the VA police report, an ND case manager reported that while visiting the patient prior to the patient's ED visit, he had observed visitors providing the patient with some unknown pills. The day after discharge from the ED, the patient told a different ND case manager that he took the wrong pills and felt like he might die but declined her offer to contact paramedics. He requested the ND case manager come by his room the next day. The ND case manager went to the patient's room the following day and when he did not respond, contacted the building manager to gain entry into the apartment. They found the patient unresponsive on the floor. Paramedics pronounced the patient dead on their arrival. The coroner's report indicated the patient's death was due to multiple drug intoxication. The toxicology screen was positive for morphine, amphetamine, and methamphetamine and negative for alcohol or hydrocodone. The patient's VA EHR did not show orders for any of the medications listed on the toxicology screen up to a year prior to the patient's death.

Patient 2

The patient was in his mid-50s at the time of his death in 2014. He had a history of multiple medical conditions and had been taking a long-acting opioid daily for about 2 years prior to his death. In 2013, he moved into an ND apartment located on the SMC campus and established care at the SMC for continued long-acting opioid dosing.

According to the VA police report, in early 2014, the building manager and ND case manager conducted a welfare check and found the patient unresponsive on his bed. The VA police were called, and they found that the patient had expired. Toxicology results revealed a long-acting opioid level that was consistent with chronic maintenance therapy. The medical examiner attributed the patient's death to a medical condition. Opioid medications were not found to be a contributing cause of death.

Patient 3

The patient was in his mid-60s at the time of his death in 2014. He had a history of mental health issues and multiple medical conditions. He was admitted to the ND program in early 2014 to undergo substance abuse treatment. He moved into an ND apartment located on the SMC campus, and followed up with a VA psychiatrist who restarted him on medications. In mid-2014, the patient left ND on a pass early in the morning to visit his family. He was due back that evening but did not return. The next day, he committed suicide, about 60 miles away from ND. The coroner determined the cause of death to be from hanging. The patient had low levels of alcohol in his blood but tested negative for drugs including opioids.

Patient 4

The patient was in his late 50s at the time of his death in 2013. He had a history of multiple medical conditions and had been prescribed opioid medications at various times. At the time the patient moved into an ND apartment located on the SMC campus, he was on an opioid medication used for the treatment of moderate pain. According to a VA police report, approximately 2 months after his move to ND, an employee entered the patient's apartment and found him unresponsive on his bed. The patient was pronounced dead at the scene by paramedics. The coroner determined that the patient's death was due to natural causes with negative toxicology results, including opioids.

Patient 5

The patient was in his mid-40s at the time of his death in 2013. He had a history of mental health issues and multiple medical conditions. VHA records indicated that he had not been prescribed and did not receive opioid pain medications from the system. In late 2013, he moved into an ND apartment located on the SMC campus. He followed up with his system PCP a few weeks later for a routine visit.

Approximately 1 month later, the patient was visited by his ND case worker and complained of not feeling well and seemed "woozy." The patient declined medical evaluation. The ND case worker returned the next morning and discovered the patient on the floor. The patient was pronounced dead by paramedics. The coroner's report documented blunt head and neck trauma with lacerations and contusions of the face, subdural (brain) hemorrhage, and a fracture of the neck vertebrae. Based on the characteristics of the injuries, the coroner determined the patient died of an accidental fall. Per the toxicology screen report, opioids were not detectable.

Patient 6

The patient was in his late 50s at the time of his death in 2014. He had a history of multiple medical conditions. In late 2013, he moved into an ND apartment located on the SMC campus. Three days later, he saw his system PCP who prescribed an opioid medication for 15 days for back pain. About 3 weeks later, he saw his PCP again. He was given an opioid medication to be taken twice a day for another 10 days. The next

month, he told his doctor that he did not need any more opioid medication, as his back pain had improved.

In early 2014, a family member observed that the patient was having difficulty breathing and was unresponsive. The family member called 911. Emergency responders administered aid but concluded that the patient had likely died before their arrival. The coroner attributed the cause of death to a medical condition. The coroner determined that toxicology screening was not indicated.

Patients Prescribed \geq 200 MEDD by a Psychiatrist Between January 2013 and June 2014: Patients 7–10

Patient 7

The patient was in his mid-60s with a history of mental health issues and multiple medical conditions. In early 2014, he presented to the system's ED and was later admitted to the Behavioral Health Unit. He had a behavioral flag¹¹ for receiving overlapping prescriptions of opioids from non-VA providers. After a 2-week hospitalization, the psychiatrist who discharged the patient continued an opioid medication, which was the same dose the patient had been taking prior to admission. The patient did not receive any additional opioid prescriptions from a psychiatrist.

Patient 8

The patient was in his late 50s with a history of multiple medical conditions. From 2012 to mid-2014, his psychiatrist had been consistently prescribing an opioid medication without changes in dosage. A 2014 clinical warning note detailed the patient's refusal to provide a urine specimen for a toxicology screen and sign an opioid informed consent. The note documented overlapping VA and non-VA opioid prescriptions with prior negative urine toxicology tests for opioids raising concerns for possible drug diversion. The patient was seen again by the pain clinic provider in mid-2014, who ordered a urine drug screen that did not show opioids. The pain clinic provider reviewed the clinical history and recommended non-opioid based management. The following month, the psychiatrist informed the patient that he would no longer prescribe opioid pain medication. The patient's non-VA PCP assumed primary management of the patient's pain.

Patient 9

The patient was in his mid-50s with a history of mental health issues and multiple medical conditions. He had been on an opioid medication (opioid 1) since 1996, and was transitioned to a second opioid medication (opioid 2) in 2001. His psychiatrist had been prescribing opioid 2 since that time. In mid-2014, the patient decided to decrease

¹¹ A behavioral flag is a patient record flag entered into the EHR for safety of patients, employees, and visitors.

his opioid 2 dose without consulting his psychiatrist. The patient subsequently complained of withdrawal symptoms, and his psychiatrist increased his dose. Over the years, the psychiatrist would assess the patient's level of pain at each visit and adjust his dose accordingly. Occasionally, the psychiatrist would prescribe a small amount of short-acting opioids for acute injuries.

Patient 10

The patient was in his mid-30s with a history of mental health issues who had been receiving an opioid medication for opioid dependence from his psychiatrist. In early 2014, he reported that his opioid medication was stolen. Another psychiatrist refilled the same dosage for 1 day until the patient could follow up with his primary psychiatrist.

Inspection Results

Issue 1: Deaths from Drug Overdose

We did not substantiate the allegation that seven patients died from drug overdoses during an 8-month period at the ND housing facility located on the SMC campus. We were unable to obtain the patient names from the complainant. We reviewed the EHRs of six patients who the system reported as having died while living in ND housing located on the SMC campus in 2013 and 2014. We reviewed the coroner reports for these patients including toxicology results, VA police reports, and the patients' VHA drug profiles. The coroners found that, of the six patients reviewed, one death was related to "multiple drug intoxication." According to that patient's EHR, system providers did not prescribe any of the drugs listed in his toxicology report.

Issue 2: Psychiatrists' Opioid Prescribing Practices Without Oversight

System Psychiatrists' Prescribing Practices

We did not substantiate the allegation that psychiatrists were prescribing inordinate doses of opioids.

We queried the VHA pharmacy database for the period January 2013 to June 2014 using a cut-off of 200 MEDD, which was the upper range of recommended daily dosing according to most clinical guidelines.¹² VISN 22 uses ≥ 200 MEDD as the required cut-off for reporting the VISN dashboard (Pain Score Card). We identified four patients who received ≥ 200 MEDD of opioids from system psychiatrists (Patients 7–10). Different psychiatrists prescribed the medications in each case.

In all four patient cases, despite being prescribed opioids in the upper ranges, the prescription of these doses and the clinicians' actions remained within practice

¹² VA/DoD *Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*, Version 2.0 May 2010. See also, Nuckols TK, Anderson L, Popescu I, et al. Opioid Prescribing: A Systematic Review and Critical Appraisal of Guidelines for Chronic Pain. *Ann Intern Med.* 2014; 160: 38–47.

guidelines. Patient 7 had a one-time refill of opioid prescriptions after a hospitalization, and Patient 10 had a refill to replace a reported stolen medication. Patient 8 demonstrated signs of misusing his medications, and his psychiatrist worked with the pain clinic and the patient's PCP to discontinue the prescription. Patient 9's psychiatrist had a therapeutic relationship with the patient for more than 15 years. Although Patient 9 was on a large dose of opioids, he required minimal dosing changes over the years; when acute issues arose, he was given small amounts of short-acting opioids until the problem resolved. Patients 9 and 10 were both on a long-acting opioid medication that is commonly used to treat chronic pain and opioid addiction.

Oversight for Psychiatrists' Prescribing Practice

We did not substantiate the allegation that system psychiatrists were prescribing opioids without oversight. We found that the system had a process in place for monitoring provider-specific pain medication prescribing practices.

Additionally, VISN 22 maintains a dashboard that actively monitors whether providers at each facility are following the Guideline.¹³ Some of the monitoring measurements include percentages of patients who:

- are receiving ≥ 200 MEDD (target is 3 percent or less)
- are prescribed a benzodiazepine with opioid¹⁴
- have a urine drug screen, opioid informed consent, and state monitoring report in the past year.

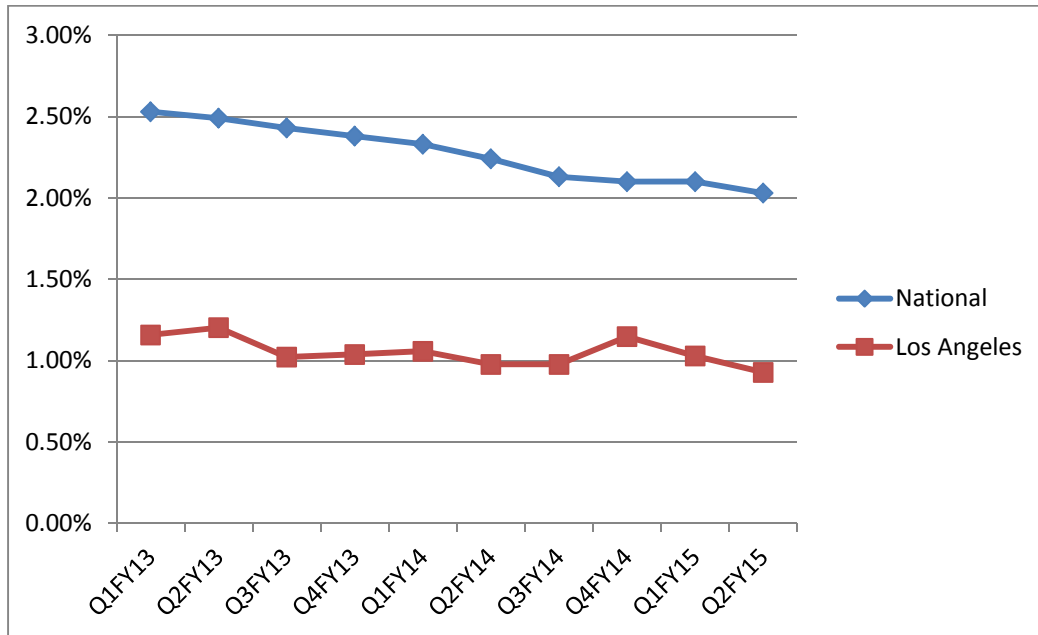
We found that the system Controlled Substance Oversight Committee Chairperson tracks opioid prescribing-related data, reviews individual cases, and provides interventions to alert providers about potential risks. Any concerns about opioid prescribing practices are reported to the Quality Management Service.

We received data from the system from the first quarter of fiscal year 2013 through the second quarter of fiscal year 2015 demonstrating the system consistently had fewer patients on ≥ 200 MEDD compared to the VHA national average. Data for the system also demonstrated a gradually decreasing trend in the number of patients on opioids. The following figure demonstrates the trends in patients receiving opioids ≥ 200 MEDD at the system and nationally.

¹³ VA/DoD *Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*, Version 2.0, May 2010.

¹⁴ The concurrent use of an opioid pain medication and benzodiazepine medication significantly increases the risk of adverse outcomes. One of the four patients we reviewed who received ≥ 200 MEDD from a psychiatrist had concurrent benzodiazepine prescriptions by the same VA psychiatrist. The patient was monitored by the psychiatrist and received a stable dose of the benzodiazepine for many years.

Figure: Percentage of VHA National and System Opioid Patients With ≥ 200 MEDD From Q1 FY 2013 Through Q2 FY 2015



Source: VHA, VAOIG

Issue 3: Improper Closure of Consults

We substantiated the allegation that system staff, including nurses and other non-physician staff, closed out (canceled or discontinued) cardiology consults. However, the system Deputy Chief of Staff for Clinical Informatics and Operations and the Chief of Cardiology informed us that non-physician¹⁵ staff may close out consults under the following conditions:

- under the direction of a physician or nurse practitioner,
- if it is a duplicate consult, or
- if the patient died and the consult was no longer indicated.

Prior to April 2014, the system did not have a formal policy on outpatient consultations. However, the system issued a policy in 2013 that addressed the management of “no-show” patients (patients who do not attend and do not call to cancel an appointment). The policy includes specific instructions for first no-show and second consecutive no-show patients. In general, the policy allows two no-shows prior to canceling the consult.¹⁶

¹⁵ Non-physicians include registered nurses, technicians, clerical, and administrative staff.

¹⁶ Greater Los Angeles Policy 00-11-37, *Management of “No-Show” Patients*, September 2013.

The system provided a list of 18,114 consults that were canceled or discontinued by non-physician cardiology staff from September 2012 through June 2014. We excluded patients:

- who had consults outside the study period (from January 2013 through June 2014);
- who had duplicate orders;
- who had completed examinations; and
- “mock consults.”¹⁷

Of the remaining 4,743 consults, we randomly selected 50 cardiology consults that were canceled¹⁸ or discontinued¹⁹ for review to determine whether they were closed appropriately.²⁰ If inappropriately closed, we reviewed the patient’s EHR to determine if the patient experienced clinical impact.

We found that nurses, technicians, and administrative staff discontinued or canceled 49 consults. A physician appropriately canceled one consult. The table below describes the type of staff and number of consults canceled or discontinued.

Table. Canceled/Discontinued Consults

Staff Type	Number of Consults	Percent
MD	1	2
Nurses	13	26
Technicians	13	26
Administrative staff	21	42
Unknown Position	2	4

Source: OIG analysis of facility cardiology consult data from September 2012 through June 2014

Of the 49 consults, 5 were inappropriately canceled or discontinued. Although our review of the five corresponding EHRs did not reveal evidence of patient harm, we could not apply this finding to cardiology consults that we did not review. Staff did not consistently follow procedure for notifying patients who failed to show for their scheduled appointments and did not reschedule. The system policy required clerical staff to send a “no-show” letter or postcard to the patient with instructions to call to

¹⁷ Mock consults are those using fictitious patient information for teaching purposes.

¹⁸ The consulting service may cancel/deny a consult if the requesting provider did not ask an appropriate consult question or provide sufficient information. The consult is returned to the requesting provider.

¹⁹ The sending or receiving provider may discontinue a consult that is no longer wanted or needed. A consult may be discontinued after two no-shows or if the patient does not respond to system staff’s efforts to schedule.

²⁰ Our study period was from January 2013 through June 2014.

reschedule the appointment.²¹ None of the five patients were notified to reschedule their appointments.

During an interview, a system leader told us that the system had already begun to address this issue by automating the notification process and reminding Services to review and close out consults timely.

Conclusions

We did not substantiate the allegation that seven patients died from drug overdoses during an 8-month period at the ND housing facility located on the SMC campus. Our review of coroner reports for the six residents who died while living in the ND housing facility located on the SMC campus in 2013 and 2014 showed that one of the six ND patients died from multiple drug intoxication. We determined that the drugs associated with this patient's death had not been ordered by system providers. The coroner reports did not attribute drug overdose as the cause of death for the other five patients.

We did not substantiate the allegation that system psychiatrists prescribed inordinate amounts of opioids without oversight. VHA, VISN 22, and system data showed that providers were below the VHA national average for prescribing large amount of opioids. We identified four patients who received opioids ≥ 200 MEDD from January 2013 to June 2014. In each case, the prescribed regimen was within practice guidelines and did not result in an adverse outcome. The system had a Controlled Substance Oversight Committee that monitored providers' opioid prescribing practices.

We substantiated the allegation that cardiology consults were canceled or discontinued by non-physician staff, including nurses, technicians, and administrative personnel. However, this practice was acceptable under certain circumstances. We determined that non-physician cardiology staff inappropriately canceled or discontinued 5 of the 50 randomly selected consults that we reviewed, and did not consistently follow system procedures for notifying patients to reschedule missed appointments. Our review did not reveal evidence of patient harm for these five patients. Although our review did not find evidence of patient harm for the 10 percent of consults that were inappropriately canceled or discontinued, we could not apply this finding to cardiology consults that we did not review.

Recommendations

1. We recommended that the System Director ensure staff conduct a review of canceled or discontinued cardiology consults to determine if patients suffered harm as a result of inappropriate consult closure and confer with the Office of Chief Counsel regarding disclosure as necessary.

²¹ Greater Los Angeles Policy 00-11-37, *Management of "No-Show" Patients*, September 2013.

2. We recommended that the System Director ensure system staff comply with current Veterans Health Administration policies regarding consult management.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

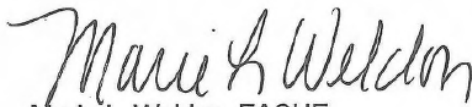
Date: January 23, 2017

From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles Healthcare System, Los Angeles, California

To: Director, Los Angeles Office of Healthcare Inspections (54LA)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, "Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles Healthcare System, Los Angeles, California."
2. If you have any questions or need further information, please contact Jimmie Bates, Quality Management Officer for VISN 22 at (562) 826 5963.



Marie L. Weldon, FACHE
Network Director, VISN 22

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 10, 2017

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subj: Healthcare Inspection—Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles Healthcare System, Los Angeles, California

To: Director, Desert Pacific Healthcare Network (10N22)

1. Attached you will find the facility response to Recommendations 1 and 2 for OIG report entitled, “Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles Healthcare System, Los Angeles, California.”
2. If you have any questions or need further information, please contact Therese Cortez, Chief, Quality Management at (310) 478 3711 x41389.



Ann Brown, FACHE
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the System Director ensure staff conduct a review of canceled or discontinued cardiology consults to determine if patients suffered harm as a result of inappropriate consult closure and confer with the Office of Chief Counsel regarding disclosure as necessary.

Concur

Target date for completion: Completed January 2017

Facility response: GLA reviewed the five consults identified by OIG as inappropriately canceled or discontinued due to patient no-shows and determined no evidence of patient harm occurred.

The national directives released in 2016 on consult processes and outpatient scheduling have provided GLA clear procedures for consult management. GLA has actively communicated these current national policies to providers and scheduling staff on the appropriate procedures for consult management.

In an active effort to ensure GLA follows current VHA guidance on consult management, a review of canceled or discontinued cardiology consults was conducted to determine if patients suffered harm as a result of inappropriate consult closure. For FY17 Q1 (October 1, 2016 to December 31, 2016), there were 753 Cardiology consults that were Discontinued or Canceled by non-licensed independent practitioners (LIP). 50 of these Cardiology consults were randomly selected for administrative and clinical review. 48 were appropriately discontinued by authorized staff. 2 were identified as being discontinued inappropriately. Both of the consult closures were due to patient factors – no show (only 1 no show) or non-response to scheduling attempts (no LIP guidance). There was no evidence of harm as a result of the discontinued or canceled consult.

Also, intrinsic to the VA Electronic Medical Record (CPRS), any cancellations or discontinuations of consults generate an alert back to the requesting provider. This systematic alert process ensures collaborative communication to ensure that if a consult is needed, the ordering provider would receive an alert that the consult was discontinued and could submit a new consult for the patient as appropriate.

Additionally, no-show letters are auto-generated and sent to the patient.

OIG Comment: based on information provided, we consider this recommendation closed.

Recommendation 2. We recommended that the System Director ensure system staff comply with current Veterans Health Administration policies regarding consult management.

Concur

Target date for completion: April 2017

Facility response: The GLA Consult Management Committee provides oversight of consult management. This includes ensuring communicating current national policies on consult management and developing appropriate procedures for discontinuation and standardization of scheduling documentation. This committee is comprised of members from clinical, administrative, and technical roles and reports to the Medical Executive Council.

Health Administration Services includes scheduling staff and oversees scheduling training. All Medical Staff Assistants (MSAs) are required to complete training with the MSA Academy, an 8 hour training session that includes a consult module. GLA is in the process of transitioning the 8 hour academy to a 71 hour academy based on national requirements. Each consult requires a licensed independent practitioner (LIP) to review and provide discontinuation guidance either at the time of screening (prior to initial scheduling) or after the requisite number of scheduling attempts have been made. If discontinuation guidance is not documented, the MSA will notify the LIP requesting review of the consult and document the request in the consult. The consult remains in active status until such time as the LIP provide discontinuation guidance and that guidance has been met or the patient contacts the clinic for scheduling or denial of the appointment.

GLA also created a Consult Management Dashboard that was adopted as a Region 1 level application used by numerous facilities. This tool allows for regular monitoring and improvement of facility consult performance and results.

Also, intrinsic to the VA Electronic Medical Record (CPRS), any cancellations or discontinuations of consults generate an alert back to the requesting provider. This systematic alert process ensures collaborative communication to ensure that if a consult is needed, the ordering provider would receive an alert that the consult was discontinued and could submit a new consult for the patient as appropriate.

GLA issued guidance to the providers and scheduling staff on appropriate procedures with consult management following issuance of the current VHA Directive on Consult Processes and Procedures. GLA will continue to conduct ongoing monitoring review of consults to ensure compliance with current VHA policies. A review of 30 randomly selected consults will be audited each month for compliance with consult management requirements until the target of 90% has been sustained for 3 consecutive months. The results will be monitored and reported to the Consult Management Committee and Medical Executive Council for ongoing compliance.

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