DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Inappropriate Controlled Substance Prescribing Practices at a Veterans Integrated Service Network 20 Medical Facility

HEALTHCARE INSPECTION | REPORT # 16-05323-200 | JULY 5, 2018

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a complaint that a primary care provider (PCP1) at a Veteran Integrated Service Network (VISN) 20 medical facility (Facility)[1] continued to prescribe controlled substances[2] to a patient at high risk[3] for overdose. The specific allegations are listed below:

- PCP1 was told the patient was also getting controlled substances from non-VA pharmacies.
- Family members reported concerns that the patient was abusing controlled substances.
- Providers warned PCP1 of his prescribing practices.
- The patient had a history of benzodiazepine abuse.
- PCP1 was no longer the patient's designated PCP but continued to prescribe him controlled substances.
- PCP1 had a reputation among Facility staff of prescribing controlled substances "recklessly."

The OIG also reviewed the Facility's oversight of controlled substance prescribing.

The OIG substantiated that PCP1 continued to prescribe controlled substances despite knowledge that the patient was also obtaining controlled substances from non-VA pharmacies. OIG inspectors found electronic health record (EHR) documentation of prescription drug monitoring program (PDMP) reports that revealed controlled substance prescriptions from non-VA pharmacies in two states. In addition, OIG inspectors found EHR documentation of urine drug screens positive for controlled substances not prescribed by PCP1. However, Facility policy and Veterans Health Administration (VHA) Opioid Safety Initiative (OSI) guidelines did not include recommendations for how to amend prescribing practices based on results of PDMP queries and positive results of urine drug screens.

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[1] The name of the Facility is not being disclosed to protect the privacy rights of the subject of the report pursuant to 38 U.S.C., Section 7332, *Confidentiality of Certain Medical Records,* January 3, 2012.

[2] Under the Controlled Substances Act of 1970, 21 U.S. Code § 812, drugs are classified by their potential for abuse. OIG interpreted controlled substances in the context of this report to mean opioid and/or benzodiazepine medications.

[3] OIG considered patients at increased risk for opioid overdose to include individuals with a history of opioid overdose, history of substance abuse disorder, higher opioid dosages (greater than or equal to 50 MEDD), or concurrent benzodiazepine use. https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf. (The website was accessed on April 19, 2017.)

The OIG substantiated that family members reported concerns to Facility staff that the patient was abusing controlled substances. The OIG team found EHR documentation of contacts from the patient's family members to Facility staff regarding controlled substance misuse, drug seeking behavior, and prescription medication overdose episodes requiring emergency care. During a review of the patient's EHR, OIG staff also found documentation of contacts from law enforcement agencies pertaining to behavior and arrests related to intoxication from controlled substances. Facility staff notified PCP1 of the contacts from family members and law enforcement, usually through signature notification in the patient's EHR.

The OIG did not substantiate that providers warned PCP1 about his prescribing practices. OIG inspectors found EHR entries in which Facility providers from primary care, mental health (MH), and pharmacy documented opinions regarding the patient's misuse of prescribed drugs, risk for lethality, and recommendations to "proceed cautiously" with prescribing. However, the OIG team did not find evidence in the EHR or during interviews that providers directly warned PCP1 of his prescribing practices. Facility staff from primary care, MH, and pharmacy services reported that given PCP1's high-level positions in administration and on committees, they did not feel comfortable confronting PCP1 or reporting PCP1's prescribing practices up the chain of command. In addition, PCP1 informed the OIG team that he did not solicit feedback regarding his prescribing practices and that he could recall only one occasion in which he received feedback from a staff member.

The OIG substantiated that the patient had a history of benzodiazepine abuse. The patient had a documented history of polysubstance abuse; specifically, the patient had diagnoses of alcohol, opioid, and anxiolytic (benzodiazepine) use disorders. PCP1 documented discussions with the patient acknowledging substance abuse issues in the EHR. PCP1 continued to prescribe controlled substances for the patient during substance abuse treatment and recovery, and immediately following overdose episodes.

The OIG substantiated that PCP1 was no longer the patient's designated PCP and continued to prescribe controlled substances to the patient. The 2010 *VA and Department of Defense (VA/DOD) Clinical Practice Guidelines for Management of Opioid Therapy for Chronic Pain* state that patients on chronic opioid therapy should have one designated provider who accepts primary responsibility for their overall medical care. In addition, the Facility's Pain Management policy requires the patient's care provider to be the principal manager of the pain management plan. In mid-2015, PCP1 assumed a Facility leadership role and Facility staff reassigned his patients to other providers at the community based outpatient clinic (CBOC). PCP1 was no longer the patient's assigned PCP although he continued to prescribe controlled substances to the patient, despite the fact that the newly assigned PCP and MH providers' treatment plans for the patient explicitly avoided controlled substances.

The OIG could not substantiate that PCP1 had a reputation among Facility staff for prescribing controlled substances "recklessly," as initially alleged. During the course of the OIG inspection,

the complainant became known to the OIG team and acknowledged that he/she was unable to describe PCP1's general prescribing practices as reckless because the concerns that prompted the OIG complaint were related to one patient. In addition, staff members the OIG team interviewed expressed widely divergent views of PCP1's controlled substance prescribing, ranging from "no concern" to "dangerous." Some of the staff members who expressed prescribing concerns noted that PCP1's practice had improved over time with implementation of the OSI and that PCP1 generally prescribed controlled substances in small quantities, mitigating the risk associated with the medications.

During the OIG review, OIG inspectors determined that PCP1 continued to prescribe controlled substances for the patient, despite the patient's nonadherence to a controlled substance treatment agreement signed in 2013. In addition, although the Facility revised its policy, the revised Medical Center Memorandum (MCM) was not in alignment with VHA Directive 1005, *Consent of Long-Term Opioid Therapy for Pain*, 2014, issued May 6, 2014, that required a specific consent form. The OIG reviewed the Facility's processes, policies, and procedures pertaining to controlled substance prescribing oversight and identified limitations in the Facility leaders' abilities to effectively oversee opioid prescribing in a high-risk patient. Specifically, the OIG team noted

- Limitations in the way staff utilized databases to review OSI metrics assessing controlled substance prescribing,
- Inconsistent provider interpretation of and lack of formal policy for a Category II patient record flag (PRF) that the Facility used to alert providers about controlled substance/drug seeking behavior, and
- Limited mechanisms for reporting concerns relating to a Facility leader's controlled substance prescribing practices.

The Facility used a VISN 20 database to review opioid prescribing data. The Facility used these databases to look for providers who were global outliers in controlled substance prescribing practices and therefore, lacked systematic processes for reviewing controlled substance prescribing for individual patients, which included high-risk patients.

A Category II PRF that the Facility, used to alert providers about controlled substance/drug seeking behavior, was placed in the patient's EHR in 2013. The only recommendation in the Category II PRF was to assist ED providers with "setting limits" and a plan to review the patient's case in five years. PCP1 acknowledged the Category II PRF, but informed OIG inspectors that the PRF did not influence his prescribing practices because it only pertained to care in the ED. The Facility Board that is responsible for controlled substances safety (Board) placed and monitored the Category II PRFs. The OIG found that the Board's role, responsibilities, and authority for placing, monitoring, and removing Category II PRFs were not well defined, and the Board lacked established protocols and procedures.

PCP1 held a variety of leadership positions in the Facility. Many individuals who expressed concerns pertaining to PCP1's controlled substance prescribing for the patient reported directly to PCP1 in the Facility's chain of command. Staff from primary care, MH, and pharmacy services reported that given PCP1's high-level positions in administration and on committees, they did not feel comfortable confronting PCP1 regarding his prescribing practices or going around PCP1 and reporting up the chain of command.

The OIG also found deficiencies in the protected peer review process. In 2013 and 2016, Facility staff conducted protected peer reviews on controlled substance prescribing. The OIG team found peer review process deviations from VHA and Facility policy. In general, both VHA and Facility policies require a percentage of Level 1 and all Level 2 and 3 peer reviews to be reviewed by the Peer Review Committee (PRC). The PRC reviews the episode of care and makes a determination of the final Level of Care. The OIG team found that the Facility's peer review process involved sending the initial peer review to the Service Chief for assessment prior to the PRC. The Service Chief reviewed the 2013 peer review and assigned a different rating from the initial rating. The PRC concurred with the Service Chief rating, and the recommendations made by the initial peer reviewer to facilitate safe opioid prescribing were not implemented.

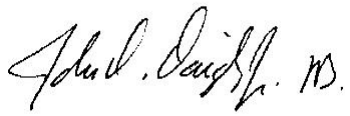
In 2016, the Facility completed both a peer review and a quality review looking at controlled substance prescribing practices. VHA requires that a peer reviewer's responsibilities include abstaining or withdrawing from participation in a case if a conflict of interest exists, or for any other reason, the reviewer is unable to conduct an objective, impartial, accurate, and informed review. A subordinate of the subject of the peer review, who expressed dissatisfaction with his/her performance rating and the subject's leadership, completed the initial peer review in 2016. The quality reviewer did not submit a written report of the conclusions. The quality reviewer informed the OIG team that he/she looked for duplicate prescriptions, multiple prescribers (including assignment to prescriber), and timely renewals and found no deficiencies.

In summary, the OIG found that PCP1 placed the patient at risk by prescribing controlled substances despite multiple indicators of misuse and knowledge of negative sequelae from controlled substance use, which included multiple overdose events. Facility policy and VHA OSI guidelines related to PDMP queries and urine drug screens did not influence PCP1's prescribing practices. The Facility collected PDMP and urine drug screening data but did not have policies recommending changes in provider prescribing practices based on the data. OIG staff were informed that the Facility policy did not include recommendations to allow for flexibility and the application of a provider's clinical judgement. Although policies should allow latitude for clinical judgement, no policy may cover all possible circumstances. The OIG team determined that PCP1 failed to exercise reasonable clinical judgement and continued to prescribe controlled substances to this high-risk patient and did not consistently document justification for deviations from safe practices in the EHR. Additionally, PCP1 did not confer with other practitioners or subject matter experts regarding management of this patient.

The OIG made one recommendation to the VISN Director to review the patient's care and the provider's practice and seven recommendations to the Facility Director related to prescribing practices and peer review processes.

Comments

The VISN and Facility Directors concurred with the OIG's recommendations and provided acceptable action plans. (See Appendixes A and B, pages 27–33 for the Directors' comments.) Based on information provided, the OIG team considers recommendations 4, 7, and 8 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



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Contents

Abbreviations

CBOC	community based outpatient clinic
CDC	Centers for Disease Control and Prevention
COS	Chief of Staff
DOD	Department of Defense
ED	Emergency Department
EHR	electronic health record
FY	fiscal year
HRR	High Risk Registry
MCM	Medical Center Memorandum
MEDD	morphine equivalent daily dose
MH	mental health
OIG	Office of Inspector General
OPCA	opioid pain care agreements
OSI	Opioid Safety Initiative
OTRR	National Opioid Therapy Risk Report
PCP	primary care provider
PDMP	prescription drug monitoring program
PRF	Peer Review Committee
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a complaint that a primary care provider (PCP1) at a Veteran Integrated Service Network (VISN) 20 medical facility (Facility)[4] continued to prescribe controlled substances[5] to a patient at high-risk[6] for overdose.

Background

Controlled Substances

Opioid medications (opioids) are controlled substances that reduce feelings of pain. The effect of opioids on a patient can be influenced by the dosage prescribed, a patient's tolerance to opioids, and other medication taken by the patient. Opioid use in the management of chronic pain[7] can be an effective treatment option, but can also be associated with serious adverse effects including overdose, death, and addiction. The Centers for Disease Control and Prevention (CDC) recently published the "CDC Guideline for Prescribing Opioids for Chronic Pain" that recommends providers avoid prescribing more than 90 morphine equivalents daily dose (MEDD), and justify decisions to prescribe more than 90 MEDD.

Overdose deaths involving prescription opioids have quadrupled since 1999. In 2014, more than 14,000 people died from overdoses involving prescription opioids.[8] Clinicians should carefully weigh the benefits of long-term opioid therapy against the potential harmful effects to patients.

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[5] Under the Controlled Substances Act of 1970, 21 U.S. Code § 812, drugs are classified by their potential for abuse. The OIG interpreted controlled substances in the context of this report to mean opioid and/or benzodiazepine medications.

[6] Within the context of this report, the OIG considered patients at high-risk for opioid overdose to include individuals with a history of opioid overdose, history of substance abuse disorder, higher opioid dosages (greater than or equal to 50 morphine equivalent daily dose), or concurrent benzodiazepine use. Centers for Disease Control and Prevention. https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf. (The website was accessed on April 19, 2017 and August 15, 2017.)

[7] According to VHA Directive 2009-053, *Pain Management*, October 28, 2009: "…management of chronic pain diseases and disorders that may be expected to persist for more than 90 days, and in some instances, the patient's lifetime."

[8] Centers for Disease Control and Prevention. http://www.cdc.gov/drugoverdose/data/overdose.html. (The website was accessed on January 25, 2017.)

Benzodiazepines are controlled substances used to treat physical and psychological conditions including anxiety. Due to their sedative properties, benzodiazepines have the potential for abuse, especially when used simultaneously with alcohol or opiates.[9] [10] The concurrent use of opioids and benzodiazepines is a concern because a patient may be at a greater risk for a fatal overdose.[11]

Substance Use Disorders

Substance use disorders occur when a patient's recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[12] The fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders*[13] states that an individual with substance use disorder, "…may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects."

The Facility's Medical Center Memorandum (MCM) on opioid agreements alerts providers to potential indicators of addiction and substance abuse in patients on opioids and other controlled substances. Some examples include patients'

- Obtaining controlled substances from multiple sources,
- Multiple requests for early fills and/or reports of lost/stolen/damaged medication,
- Unsanctioned dose escalations or use of medication to treat other symptoms,
- Positive drug screen for illegal substances or prescription medications other than prescribed or refusing or forgetting to provide periodic drug screens,
- Repeated aggressive/threatening or belligerent behavior in the VA clinic involving opioid/controlled substance requests,
- Motor vehicle accident (MVA) or arrest related to opioid or illegal drug use or alcohol intoxication, and

[9] Opiates are drugs derived from opium, while opioids generally refer to the synthetic form of the drug. In this report, the terms are used interchangeably.

[10] Center for Substance Abuse Research. *Benzodiazepines*. http://www.cesar.umd.edu/cesar/drugs/benzos.asp. (The website was accessed on August 16, 2017.)

[11] Patients likely to be prescribed both opioids and benzodiazepines are those with post-traumatic stress disorder. U.S. Department of Veterans Affairs, *Pain Management Opioid Safety: VA Educational Guide (2014)*.

[12] Substance Abuse and Mental Health Services Administration. *Mental and Substance Use Disorders*. https://www.samhsa.gov/disorders/substance-use. (The website was accessed on August 16, 2017.)

[13] The DSM-5 is a diagnostic manual used by clinicians that contains descriptions and symptoms of all mental disorders classified by the American Psychiatric Association (APA).

- Intentional or unintentional overdose.

VA Opioid Safety Efforts

In May 2010, VA and the Department of Defense (DOD) issued the *VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain* (Guideline).[14] The Guideline

1. Addresses assessment and evaluation of chronic pain and appropriateness of opioid therapy,
2. Presents and discusses formal treatment plans and treatment agreements, and
3. Provides guidance on assessing response to treatment, and determinations of adherence or abuse (aberrant drug-related behaviors).[15]

In addition, prescribers were advised to consider the use of written opioid pain care agreements (OPCAs) and periodic urine drug testing.[16] OPCAs generally list the expectations of providers and patients for the safe management of long-term opioid therapy, such as following dosing recommendations, completing random urine drug testing, and having only one opioid prescriber to prevent multiple prescriptions.

Due to concerns that local OPCAs may contain language considered threatening to the patient-physician therapeutic relationship, Veterans Health Administration (VHA) established policy in May 2014 regarding informed consent for long-term opioid therapy that would take the place of local OPCAs. The National Pain Management Program and the National Center for Ethics in Health Care jointly developed, with input from other national program offices and VHA medical facility staff, a patient information guide and a form titled, "Consent for Long-Term Opioid Therapy for Pain" (consent). Prior to initiating long-term opioid therapy, prescribers must complete the informed consent process whereby they discuss the risks, benefits, and alternatives of the treatment with patients.

Opioid Safety Initiative

In 2013, VHA developed two system-wide initiatives to improve the safety and management of chronic pain in veterans. The two initiatives were the Opioid Safety Initiative (OSI) and the

[14] *VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain,* May 2010.

[15] Aberrant drug related behaviors may include patient claims of lost prescriptions, multiple requests for early refills, unauthorized dose escalation, and any history of positive urine drug screens for illicit drugs.

[16] The OIG used the terms urine drug test(ing) and urine drug screen(ing) interchangeably. These terms appear in the Guideline and Opioid Safety Initiative (OSI) policy and education materials. The OIG used these terms consistently with the cited references.

participation of VHA providers in state prescription drug monitoring programs (PDMP).[17] On April 2, 2014, the VA Under Secretary for Health issued a memorandum outlining the OSI framework that included

- Educating providers on urine drug screens (UDS) and PDMP,
- Increasing the use of UDS,
- Establishing tapering programs for patients using the combination of benzodiazepines and opioids and for high-risk opioids,
- Developing tools to identify higher risk patients,
- Identifying patients on greater than 200 MEDD,
- Offering at least two Complementary and Alternative Medicine (CAM) modalities in the treatment of chronic pain at all facilities, and
- Developing models of MH and primary care collaboration to manage prescribing of opioids and benzodiazepines in patients with chronic pain.

In a December 10, 2014 OSI Updates memorandum, the Acting Deputy Under Secretary for Health provided additional guidance to VISN directors that included timelines for complying with the goals.

Facility Policies on Pain Management and Controlled Substance Prescribing

The Facility's pain management policy requires that the patient's care provider is the principal manager of the patient's pain management plan. Other practitioners/programs are available for patient evaluation and for treatment/recommendations.

As early as November 2012, the Facility's agreement for controlled substances (Agreement) delineated provider responsibilities when prescribing long-term opioid therapy. The provider is responsible to

- Review the Agreement with any patient who is prescribed controlled substances for more than 180 consecutive days,
- Request that the patient sign the Agreement if the patient wishes to continue to receive the prescribed medication, and

[17] PDMPs are state-run electronic databases used to track the prescribing and dispensing of controlled substances to patients.

- Enter a progress note documenting the establishment of the Agreement and ensure the patient understands the terms of the Agreement.

In 2016, the Facility amended the requirement to complete the Agreement for any patient prescribed controlled substances for 90 consecutive days and added additional provider responsibilities to the Agreement:

- Complete an Opioid Consent on iMed.[18]
- Order UDS as a monitor of use of medications and document the safety of the treatment plan.
- Examine patients prescribed controlled substances on a regular basis to evaluate the risk-benefit of the treatment plan.
- Use the state PDMP to evaluate patients' safe use of the prescribed medications.

The policy mandated a response by the provider when patients did not adhere to the Agreement. This policy allowed for flexibility in the type of response, although it required some type of response.[19] The Agreement stated that allowing a patient who has not adhered to the Agreement to continue to receive opioids (especially if the non-adherence took place on multiple occasions) substantially weakens the value/usefulness of the Agreement, leads to poor and potentially unsafe care, and may incur liability for the clinician and institution.

The policy also delineated institutional oversight responsibilities for the Pharmacy and Therapeutics Committee. Committee members were tasked with performing periodic Drug Utilization Reviews to monitor policy compliance and deliver feedback to the Chief of Staff (COS) and Service Chiefs.

Patient Record Flag

A patient record flag (PRF) is an immediately identifiable electronic alert in the patient's electronic health record (EHR) intended to enhance the delivery of safe and appropriate health care by alerting VHA employees of critical patient care information in the initial moments of the patient encounter. Category I PRFs are distributed throughout VHA and include High-Risk for Suicide, Violent or Disruptive Behavior, and Missing and Wandering Patient. Category II PRFs are system-specific. The Facility developed a Category II PRF used to alert providers about

[18] iMed is a software application that helps clinicians manage the informed consent process electronically.

[19] Options included reminding the patient of the terms of the agreement, refusal to provide early refills for lost or stolen medications, utilization of prospective renewal processes, intensification of monitoring, consultation with addiction specialists, and discontinuation of controlled substance prescriptions.

patients' controlled substance/drug seeking behavior. The COS assigned a program, service, or committee to maintain each type of PRF.[20]

Peer Review

A peer review conducted as part of a system's quality management program is a confidential, non-punitive process for evaluating health care provided by an individual provider. A peer review is a critical review performed by a provider's peer or group of peers. A peer is a health care professional who has similar or more advanced education, training, experience, licensure, or clinical privileges or scope of practice to the provider being reviewed. Peer reviewers assess actions taken by another provider relative to an episode of care. Episodes of care are referred for peer review by providers or facility leaders who have clinical or administrative concerns about the care.[21]

The basic steps of the peer review process include:

1. Initial review: Evaluation of a provider's selected episode of care conducted by a peer reviewer who makes an initial Level of Care decision as described below:

- Level 1–most experienced, competent providers would have managed the case in a similar manner.
- Level 2–most experienced, competent providers might have managed the case differently.
- Level 3–most experienced, competent providers would have managed the case differently.[22]

2. Secondary review: Review of a percentage of initial Level 1 and all initial Levels 2 and 3 decisions by the facility's multidisciplinary Peer Review Committee (PRC), which assigns the final Level of Care and determines the need to recommend specific actions to the individual provider.[23]

3. Recommended actions: Confidential communication of the results of the peer review is given to the provider along with any recommended actions to improve performance.[24]

[20] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. This directive expired December 31, 2015 and has not yet been replaced. Facility MCM on patient record flags.

[21] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This directive expired June 30, 2015 and has not yet been updated.

[22] VHA Directive 2010-025.

[23] VHA Directive 2010-025.

[24] VHA Directive 2010-025.

Allegations

On September 13, 2016, the OIG received an anonymous complaint alleging that PCP1 continued to prescribe controlled substances to a patient at high-risk[25] for overdose. The specific allegations are listed below:

- PCP1 was told the patient was also getting controlled substances from non-VA pharmacies.
- Family members reported concerns that the patient was abusing controlled substances.
- Providers warned PCP1 of his prescribing practices.
- The patient had a history of benzodiazepine abuse.
- PCP1 was no longer the patient's designated PCP, but continued to prescribe him controlled substances.
- PCP1 had a reputation among Facility staff of prescribing controlled substances "recklessly."

OIG notified the Facility of the allegations on September 15, 2016 and OIG initiated a healthcare inspection on September 23, 2016 to review PCP1's prescribing practices and the Facility's oversight of controlled substance prescribing. The OIG team also reviewed the Facility's oversight of controlled substance prescribing.

[25] The OIG considered a patient at increased risk for opioid overdose to include individuals with a history of opioid overdose, history of substance abuse disorder, higher opioid dosages (greater than or equal to 50 MEDD), or concurrent benzodiazepine use. https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf. (The website was accessed on January 25, 2017.)

Scope and Methodology

The OIG initiated its review in September 2016 and conducted a site visit February 13–17, 2017. The review period for the identified patient covered 2012–2016.

The OIG team interviewed PCP1, the Facility's Primary Care Service Chief, Acting Chief of Pharmacy, Risk Manager, Suicide Prevention Coordinator, Acting COS, Chief of Quality, Safety, and Value (QSV), Pain Clinic Director, Chair of the OSI Subcommittee, primary care and MH providers, pharmacists, a data analyst, and other staff with relevant knowledge.

The OIG reviewed relevant VHA directives and Facility policies, VA/DOD guidelines, medical literature, the patient's EHR, peer reviews, credentialing and privileging data, committee meeting minutes, and patient advocate reports. The OIG team reviewed controlled substance prescribing data from VISN 20 Corporate Data Warehouse[26] from Quarter 3 fiscal year (FY) 2015 to Quarter 3 FY 2016.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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

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

[26] Corporate Data Warehouse is a centralized data repository that contains VA clinical, administrative, and financial data.

Case Summary

In 2012, the patient was less than 25 years old when assigned to PCP1 at a Facility CBOC. At the initial appointment, PCP1 diagnosed the patient with post-traumatic stress disorder, depression with anxiety, and low back pain. PCP1 prescribed an opioid for pain and a benzodiazepine for "panic attacks." PCP1 did not document a long-term treatment plan for opioid use. The patient saw a psychologist the same day who recommended an antidepressant to aid in managing anxiety and careful monitoring for substance abuse. Over the ensuing weeks, the psychologist alerted PCP1 to the patient's ongoing alcohol abuse and prior recommendations to closely monitor the patient for potential substance abuse.

Although the patient moved out of state a month later, PCP1 maintained telephone contact and continued to prescribe pain medication for the patient. In the fall of 2012, police arrested the patient for driving under the influence (DUI), which resulted in an admission to another VA medical center for suicidal ideation because of statements made during the arrest.

About the same time, PCP1 documented in the EHR that the patient received an opioid prescription from the other VA medical center; PCP1 also ordered two early renewals for both opioids and benzodiazepines. On one occasion, the patient called PCP1 claiming medication was not received. The pharmacy verified that the medication was sent to the correct address and that someone signed for the package. PCP1 documented that he accepted this was suggestive of abuse, but he believed the patient.

In late 2012, Facility staff admitted the patient for suicidal ideation. On admission, the patient appeared intoxicated and requested medication for back pain. The discharging provider documented concern regarding the patient's outpatient use of a "large dose" of a benzodiazepine as well as concern for potential opioid abuse and suggested the patient's PCP weigh risks and benefits of the medication. The discharging provider discontinued the benzodiazepine prior to discharge. The day following discharge, PCP1 noted that the patient had back pain and several recent personal stressors and prescribed an opioid and two different benzodiazepines.

Later that month, physicians at a non-VA hospital diagnosed the patient with an opioid overdose and pneumonia. The patient's family informed Facility staff of the overdose episode and EHR documentation showed PCP1 was aware of the information. Subsequent to acknowledging the information from the family contact, PCP1 saw the patient in the clinic. PCP1's note did not reference the overdose, only treatment for pneumonia. PCP1 prescribed both an opioid and a benzodiazepine at this visit, which occurred three days after the overdose event.

In early 2013, physicians at a non-VA hospital diagnosed the patient with benzodiazepine withdrawal. The following day, the patient and a family member saw PCP1. PCP1 documented that he discussed the patient's abuse of substances and drug seeking behavior and reviewed the principles of chronic pain management with the patient. PCP1 prescribed the patient a

nonsteroidal anti-inflammatory medication and a small number of less potent opioids; he did not prescribe additional benzodiazepines.

One month later, PCP1 re-prescribed the patient a more potent opioid because the patient informed him that it was more effective in treating pain. PCP1 declined to prescribe benzodiazepines when the patient reported drinking alcohol to reduce anxiety. PCP1 instead offered to prescribe a different medication for anxiety and advised the patient to seek MH services.

The following month, PCP1 saw the patient, who reported taking anxiety medication, drinking most evenings, and taking opioids more frequently than prescribed. The patient stated that the back pain was unchanged. PCP1 increased the opioid dose, prescribed a Transcutaneous Electrical Nerve Stimulation (TENS) unit for pain, and a medication for sleep. Because the patient was resistant to starting counseling and reluctant to start a different anxiety medication, PCP1 resumed the patient's benzodiazepine prescription to manage anxiety during the patient's job interviews.

Approximately a month later, the patient was seen in the Facility's Emergency Department (ED) "demanding" opioids. An ED provider placed a referral to the Controlled Substance Safety Alert Board. Later that day, the patient arrived at the CBOC wielding a knife and "demanding" opioids and benzodiazepines to replace allegedly stolen medications. Although the patient left the clinic when directed to do so by Facility staff, the patient threatened to keep "blowing up the phones" to obtain his medications. The Board reviewed the patient's case and in mid-2013, issued a Category II PRF in the EHR.

Over a three-month period in 2013, the patient's family member called Facility staff numerous times to discuss issues with substance abuse. Law enforcement also called Facility staff to report contacts and arrests related to substance abuse. A provider covering for PCP1 refused to renew controlled substances because the patient was "misusing" medications and was "at high-risk for death." PCP1 received these messages and met with the patient; at which time, PCP1 again discontinued treatment with benzodiazepines and implemented an Agreement for opioids with the patient.

In late 2013, VA police found the patient unconscious in a car in the Facility parking lot and transported the patient to the Facility ED where the patient "responded positively to Narcan."[27] ED physicians diagnosed the patient with opioid intoxication. The patient's UDS was positive for benzodiazepines, which PCP1 had not prescribed. The patient saw PCP1 the day after discharge. PCP1 discussed the dangerous pattern of misusing prescribed medications and informed the patient that opioid treatment would be discontinued with further evidence of benzodiazepine use. PCP1 renewed the patient's opioid medication.

[27] Narcan® is a prescription medication used for the treatment of an opioid overdose.

A month later, the patient received a DUI related to the use of prescription medication. The following day the patient was transported via ambulance to a non-VA ED for suicidal ideation with altered mental status. The diagnosis was opioid overdose. Following the ED visit, the patient telephoned PCP1 claiming that the police confiscated all opioid and benzodiazepine medications. PCP1 offered the following options: come to the Facility ED, go to a non-VA urgent care, or start a trial of a medication to help with withdrawal symptoms. The patient opted to go "cold turkey."[28]

A few weeks later, the patient was suspected of being under the influence of "opiates and benzos,"[29] was booked into jail, and placed on a suicide watch. PCP1 signed the EHR note acknowledging receipt of this information. PCP1 informed the patient that he would not prescribe any controlled substances and that when the patient was engaged in a treatment program, PCP1 would work with the treatment team to determine which medications were indicated.

In early 2014, the patient enrolled in the Facility's outpatient Substance Abuse Treatment Program (SATP). After a few days in the SATP, the patient saw PCP1, as the patient was concerned about withdrawal symptoms and pain. PCP1 agreed to provide an opioid prescription until the patient was fully engaged in SATP. PCP1 ordered two early renewals of opioids while the patient was enrolled in the SATP.

A month later, the patient was seen by an addiction psychiatry fellow and diagnosed with opioid use disorder. The plan was to stop all illicit substances and prescribed opioids and benzodiazepines with subsequent induction of Suboxone® in an inpatient setting.[30] A few weeks later, the patient was admitted to an inpatient Residential Rehabilitation Treatment Program (RRTP). However, the patient was discharged after approximately two months, prior to completion of treatment, for verbal aggression towards a staff member. The patient was provided with a 10-day supply of Suboxone® at discharge and instructed to follow-up with his/her Suboxone® providers as an outpatient.

The patient was involved in an MVA two weeks after discharge from the RRTP. Evaluation at a non-VA ED resulted in a diagnosis of benzodiazepine overdose. On the day of discharge, the patient was taken by ambulance to a different non-VA ED where staff described the patient as

[28] Cold turkey in this context means using no medications.

[29] Benzos is another term for benzodiazepine.

[30] Suboxone® is a Food and Drug Administration-approved opioid medication for the treatment of opioid dependence. Suboxone® is a combination medication composed of an opioid (buprenorphine) and another medication (naloxone) that blocks the effects of opioids to prevent the medication from being misused. Suboxone® may be referred to as buprenorphine/naloxone, the generic names for its components. Naloxone is not absorbed orally and is added as a deterrent for intravenous abuse. Facility providers used the names buprenorphine and Suboxone® interchangeably in the EHR.

agitated, combative, injuring staff, and requiring a substantial amount of medication to control behavior. The patient subsequently required intubation (a breathing tube was inserted) and an intensive care unit admission. The patient was eventually transferred to the Facility and discharged with a prescription for Suboxone® and an appointment for the SATP clinic. Facility providers attributed the patient's agitation and aggression to the use of benzodiazepines prescribed by non-VA providers in the outpatient setting.

Two days after discharge from the Facility, the patient's family notified VA staff that the patient was receiving medications from outside facilities. The patient's addiction psychiatrist reviewed a PDMP report that confirmed multiple prescriptions for controlled substances including benzodiazepines. Upon discovery that the patient was still taking benzodiazepines, the addiction psychiatrist discontinued Suboxone®, because the combination of Suboxone® and benzodiazepines could be fatal. PCP1 acknowledged this information through signature of an EHR note.

The following month, the patient spoke with PCP1 by telephone and acknowledged doctor shopping to obtain a number of prescriptions, mostly for benzodiazepines, outside the Facility. The patient intended to continue doing this if the VA did not provide pain medication. PCP1 documented that he told the patient this was addictive behavior and that PCP1 supported the psychiatrist's decision to discontinue Suboxone® because it was dangerous to combine Suboxone® with benzodiazepines. The patient continued to obtain benzodiazepines from outside pharmacies.

The same month, the patient informed a case manager "all my problems started again because of benzos. I don't want to be on them anymore." PCP1 signed the note acknowledging receipt of this information. A few days later, the patient saw PCP1 and reported feeling anxious and struggling with sobriety in the context of personal stressors. PCP1 prescribed a five-day supply of a benzodiazepine which he noted the patient had "used and not abused in the past." That same day, the patient was seen at a non-VA healthcare system for "anxiety" and received a benzodiazepine prescription.

Later that month, a Facility pharmacist ran a PDMP report that showed the patient had multiple new outside prescriptions for benzodiazepines. Although PCP1 signed the pharmacist's note acknowledging receipt of the PDMP information, he prescribed additional benzodiazepines for the patient the same day.

The patient reported to the addiction psychiatrist drinking to intoxication at least twice a week, taking opioids prescribed by a non-VA provider, continuing to use benzodiazepines obtained from PCP1 and other sources, and using marijuana. The psychiatrist opined that the patient continued to be at high-risk due to ongoing substance abuse and a history of acting out behavior,

especially when disinhibited by alcohol and sedative hypnotics.[31] A few days after the patient's visit with the psychiatrist, PCP1 spoke with the patient by telephone. The patient reported feeling stressed because a court date was postponed. PCP1 ordered a prescription for a higher dosage of benzodiazepines.

A month later, the addiction psychiatrist and other Opiate Treatment Program staff met to discuss the patient. They noted that the patient appeared to be intoxicated while meeting with a case manager and UDSs indicated multiple non-prescribed substances. Opiate Treatment Program staff consulted with PCP1 to initiate tapering of the patient's benzodiazepine in preparation for his/her admission into the RRTP.

The patient was admitted to the RRTP for 20 days. Staff scheduled the patient for an outpatient appointment to discuss continuation of Suboxone®, but the patient missed the appointment. After the missed appointment, the patient had a prescription for a benzodiazepine filled at an outside pharmacy. The patient presented to the Facility ED two days later, and an ED provider prescribed a benzodiazepine.

A few weeks later, PCP1 spoke with the patient by telephone. The patient reported poor sleep and stress related to a pending court date. The patient agreed to abstain from alcohol and avoid "narcotics," and PCP1 prescribed benzodiazepines.[32] The next month, the patient was involved in an MVA. Upon discharge, non-VA hospital providers prescribed opioids. PCP1 prescribed both opiates and benzodiazepines when the patient claimed to have lost the medications during the MVA.

In the fall of 2014, the patient telephoned PCP1 on three separate occasions to report that either medications were not received in the mail or the medications were damaged during shipping. PCP1 issued early controlled substance renewals on all three occasions. PCP1 informed the patient that the multiple requests for early refills gave the appearance that the patient was a drug abuser attempting to obtain additional medication. However, PCP1 documented that the patient's requests for early fills of controlled substances were "infrequent."

In late 2014, the patient received a probation violation, resulting in a court advisement to complete SATP in early 2015. The patient informed his/her SATP social worker of a history of abusing medications and indicated that benzodiazepines were the drug of choice. The patient stated that PCP1's plan was to taper and then discontinue opioids and benzodiazepines, but indicated an intent to seek those medications in the "underground economy" when that happened. The social worker conveyed this information to PCP1.

[31] Sedative-hypnotics are medications that suppress the central nervous system and are typically used to treat a patient's anxiety and insomnia.

[32] The term narcotic generally refers to a class of drugs that have addictive potential and induce euphoria. This includes prescription medications such as opioids and benzodiazepines.

During the course of treatment in SATP, PCP1 ordered two early renewals of benzodiazepines and opioids, because the patient reportedly lost the medication. During a treatment session that occurred two days following one early renewal, the patient presented to a treatment group and appeared intoxicated. The SATP social worker called PCP1 to discuss how medical care and MH care goals could intersect to best serve the patient.

Two months later, the patient was incarcerated. The SATP social worker spoke with PCP1 regarding the plan for detoxification post incarceration. PCP1 stated that he would not renew opioids. The patient was discharged from jail directly to the RRTP. An addiction psychiatrist documented the patient admitted that benzodiazepine use had been problematic and that the patient "should not have [benzodiazepines] prescribed ... again."

In the summer of 2015, Facility staff assigned the patient to a new PCP (PCP2).[33] At the first appointment, PCP2 acknowledged the patient's substance abuse and recommended non-opioid treatment for back pain.

Approximately six weeks later, the patient had a UDS that was positive for alcohol metabolites, and an SATP psychologist discussed the results with the patient. The patient did not agree that alcohol use jeopardized progress in substance abuse treatment and indicated a belief that abstinence from alcohol was only required by the courts.

In late 2015, the patient sent an email to PCP2 and complained about being "labeled as an addict." The patient requested "low mg [milligram] anxiety/sleep aid" and reported not feeling comfortable with providers other than PCP1. PCP2 wrote a note in the patient's EHR stating that PCP1 saw the patient the month before and deferred follow-up to PCP1.

The patient also opted to discontinue care with his/her psychiatrist in late 2015, citing a preference for MH medication prescribing from PCP1. PCP1 wrote a note acknowledging that he was not currently assigned as the patient's PCP. The psychiatrist documented that the patient wanted to receive care from PCP1 because the patient believed PCP1 would prescribe controlled substances and that the psychiatrist would not give controlled substances because of the Category II PRF.

In late 2015, the patient was incarcerated. The patient transitioned to house arrest and was required to attend 90 court-ordered meetings in 90 days. The patient did not want to attend VA groups as well as court mandated meetings, so the patient requested discharge from the SATP in early 2016.

Seven months later, the patient contacted the Veterans Crisis Line (VCL) to say that he/she was not going to be alive in the morning. The patient reportedly stole a family member's car, used a

[33] PCP1 was detailed to a leadership position for 14 months from 2015 to 2016, and his patients were assigned to other providers during this period.

family member's credit card, forged a check, and had three DUI's due to benzodiazepine use. VCL staff initiated a rescue. EHR documentation does not include a VA inpatient evaluation for suicidal ideation.

Five days after the VCL contact, the patient saw PCP1 and complained of persistent pain symptoms from an MVA that occurred two days earlier. The patient informed PCP1 about the VCL call and an outside prescription for a benzodiazepine. PCP1 prescribed an opioid. The following day, the patient's family member called the patient's assigned CBOC and told a registered nurse (RN) the patient had already taken all of the prescribed opioids. The RN asked the patient to come in to the CBOC for a pill count, but the patient refused and terminated the call. The RN called back but was unable to reach the patient after several attempts. The clinic RN contacted emergency services for a wellness check; however, the patient's EHR does not contain documentation regarding subsequent contact with emergency services.

PCP1 telephoned the patient later that day, who claimed a family member dumped his/her medication; PCP1 renewed the opioid. The clinic RN received records from a non-VA healthcare system noting that the patient presented to the ED the previous day requesting opioids for left knee pain resulting from a hiking accident. The non-VA medical records also indicated that the patient had been to two additional health systems in the past three days "demanding" benzodiazepines and had to be escorted out by security. The RN notified PCP1 about this information. In addition, a Facility pharmacist submitted a PDMP query for an eight-month period in 2016, which noted 20 prescriptions for controlled substances from 12 different providers filled at 10 different pharmacies. The pharmacist alerted PCP1 to this information and requested he "review the PDMP record and advise." PCP1 signed the note acknowledging receipt of the information.

A member of the patient's family contacted the Patient Advocate regarding concerns about PCP1 prescribing opioids and benzodiazepines to the patient. The Primary Care Clinical Director and PCP2 were alerted to the family member's concerns. PCP2 noted that he would "assume care if and when PCP1 no longer fulfills that role."

PCP1 wrote that based on the information in the PDMP, he was going to stop the new opioid prescription. However, he changed his mind because he spoke to the patient, and the patient was under the "impression that VA had routine access to all prescriptions no matter where prescribed, hence the patient denied hiding any information." Based on this conversation and "careful correlation with documented injuries," PCP1 renewed the opioid.

PCP1 filled an opioid prescription again in the fall of 2016. No additional prescriptions were in the EHR for controlled substances from PCP1 for the remainder of 2016.

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Inspection Results

Issue 1: PCP1's Controlled Substance Prescribing Practices

PCP1 Was Told the Patient Was Also Getting Controlled Substances from Non-VA Pharmacies

The OIG substantiated that PCP1 continued to prescribe controlled substances for the patient despite knowledge that the patient was also obtaining controlled substances from non-VA pharmacies. The OIG inspectors found

- EHR documentation of four PDMPs citing evidence that the patient received controlled substances at non-VA pharmacies in other states;
- EHR documentation of 10 encounters from non-VA facilities in which the patient received controlled substances; and
- EHR documentation of eight UDSs positive for controlled substances not prescribed by PCP1.

Facility policy and VHA OSI guidelines related to PDMP queries and UDS did not influence PCP1's prescribing practices. The Facility collected PDMP and UDS data but did not have policies recommending how to amend provider prescribing practices based on the data. The OIG inspectors were informed that the Facility policy did not include recommendations to allow for flexibility and the application of providers' clinical judgement.

Family Members Reported Concerns That the Patient Was Abusing Controlled Substances

The OIG substantiated that family members reported concerns to Facility staff that the patient was abusing controlled substances. From 2012 to 2016, OIG inspectors found EHR documentation of 23 contacts from the patient's family members to Facility staff regarding

- Opioid and benzodiazepine misuse, such as taking more medication than prescribed;
- Drug seeking behavior including pursuit of controlled substance prescriptions from non-VA providers;
- Controlled substance overdose episodes requiring emergency care; and
- Legal issues related to controlled substance abuse.

A family member directly reported concerns to PCP1 on one occasion, and PCP1 acknowledged (via EHR co-signature) at least 14 other contacts from family members regarding concerns about

the patient's misuse of controlled substances. PCP1 informed OIG inspectors that he noted the family reports in the EHR but had concerns about the credibility of the family members' statements and could not discuss the issues with the family because the patient declined to give him permission. Therefore, the family statements documented in the EHR did not cause him to change his prescribing practices.

During the OIG EHR review, OIG inspectors also found documentation of four contacts from law enforcement agencies pertaining to the patient's behavior and arrests related to intoxication. These contacts specifically noted that the patient appeared "heavily medicated" on two separate occasions and included information related to an arrest for DUI of opioids and benzodiazepines. PCP1 acknowledged receipt of three of the four contacts via EHR signature.

Providers Warned PCP1 of His Prescribing Practices

The OIG did not substantiate that providers warned PCP1 of his prescribing practices. The OIG team found 17 EHR entries in which providers from primary care, MH, and pharmacy services documented opinions regarding the patient's misuse of prescribed medications, risk for lethality, and recommendations to proceed cautiously with prescribing. However, OIG inspectors did not find evidence in the EHR or during interviews that providers directly warned PCP1 of his prescribing practices. Facility staff from primary care, MH, and pharmacy services reported that given PCP1's high-level positions in administration and on committees, they did not feel comfortable confronting PCP1 or reporting PCP1's prescribing practices up the chain of command. In addition, PCP1 informed OIG inspectors that he did not solicit feedback regarding his prescribing practices and that he could recall only one occasion in which he received feedback from a staff member. He did report that a primary care nurse advised him to "be careful of this one [patient]."

The Patient Had a History of Benzodiazepine Abuse

The OIG substantiated that the patient had a history of benzodiazepine abuse. The patient had a documented history of polysubstance abuse, specifically, alcohol, opioid, and anxiolytic (benzodiazepine) use disorders in the EHR. PCP1 documented discussions with the patient acknowledging substance abuse issues in the EHR.

From 2012 to 2015, the patient had admissions to the SATP and to the RRTP. PCP1 continued to prescribe controlled substances (including early renewals for lost medication) for the patient during substance abuse treatment and recovery, and immediately following overdose episodes.

PCP1 Continued to Prescribe Controlled Substances When He Was No Longer the Patient's Designated PCP

The OIG substantiated that PCP1 continued to prescribe controlled substances when he was no longer the patient's designated PCP. Guidelines recommended that patients on chronic opioid

therapy should have one designated provider who accepts primary responsibility for their overall medical care.[34][35] In addition, the Facility's pain management policy required the patient's care provider to be the principal manager of the pain management plan. Other practitioners/programs were available for patient evaluation and for treatment/recommendations. In mid-2015, PCP1 assumed a Facility leadership role, and he moved from a CBOC to the main Facility. Facility staff reassigned PCP1's patients to other providers at the CBOC. PCP1 was no longer the patient's assigned PCP although he continued to prescribe controlled substances to the patient, despite the fact that the newly assigned PCP2 and MH providers' treatment plans for the patient explicitly avoided controlled substances.

PCP1 informed OIG inspectors during an interview that he continued to treat the patient because of their longstanding relationship and that the patient lost his/her driver's license and was unable to access the CBOC where he/she was assigned to PCP2. Primary care staff told OIG inspectors that the patient's dual providers created friction in terms of contradictory treatment plans and staff confusion regarding the appropriate point of contact for questions and concerns.

PCP1 Had a Reputation among Facility Staff of Prescribing Narcotics "Recklessly"

The OIG could not substantiate that PCP1 had a reputation among Facility staff for prescribing controlled substances "recklessly," as initially alleged. During the course of the review, the complainant became known to the OIG team and upon questioning acknowledged that he/she was unable to describe PCP1's general prescribing practices as reckless because the concerns that prompted the OIG complaint were related to one patient. In addition, the OIG team interviewed staff members who expressed widely divergent views of PCP1's controlled substance prescribing, which ranged from "no concern" to "dangerous." Some of the staff members who expressed prescribing concerns noted that PCP1's practice improved over time with implementation of the OSI and that PCP1 generally prescribed controlled substances in small quantities, mitigating some of risk associated with the medications.

Incidental Finding: Violations of the Agreement

During the review, OIG inspectors found that PCP1 continued to prescribe controlled substances for the patient, despite patient nonadherence to an Agreement signed in 2013.

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[34] PCP2, once assigned in the Primary Care Management Module, would be considered the patient's provider and the person responsible for treatment decisions and coordination of care.

[35] *VA/DOD Clinical Practice Guidelines for Management of Opioid Therapy for Chronic Pain* provides education and guidance to primary care clinicians who are interested in knowing more about this approach to the management of chronic pain.

Agreement violations included the acquisition of controlled substances from sources outside of the Facility and non-compliance with documented treatment plans. The OIG team found documentation of 15 early renewals of opioids and 12 early renewals of benzodiazepines for 'lost' or 'stolen' medications ordered by PCP1 after the patient signed the Agreement.

The Facility's policy pertaining to controlled substances treatment agreements allows for flexibility in decision making, although the policy mandates a response on the part of the clinician when the Agreement is violated. The policy lists specific options for violation of the Agreement and directs the clinician to enter a note into the EHR describing the clinical situation and the rationale for the chosen option.

PCP1 did not consistently adhere to this policy. OIG inspectors found multiple documented early renewals for episodes of lost medication without an associated PCP1 response to the violation or documented rationale for early renewal other than the patient's explanation for the loss of medication.

During an interview, PCP1 stated that he attempted to mitigate risk by prescribing controlled substances on a contract basis and prescribed small amounts of medication with a requirement for frequent refills.

PCP1 also stated that he evaluated the information obtained from the PDMPs and UDSs based on the patient's explanation. He stated he was "uncomfortable but ok" because the patient's "explanation and commitment to not do that again was to me at the time believable."

In addition, OIG inspectors noted that the Facility revised its policy on the opioid agreement: however, the revised policy was not in alignment with VHA Directive 1005 Consent of Long-Term Opioid Therapy for Pain, 2014 that required a specific consent form.[36]

Issue 2: System's Oversight of Controlled Substance Prescribing

The OIG reviewed the Facility's processes, policies, and procedures pertaining to controlled substance prescribing and identified limitations in the Facility's ability to effectively oversee providers' controlled substance prescribing.

OSI Data Monitoring

The Facility used two databases to review OSI metrics: a VISN 20 database referred to as the "Dashboard" or High-Risk Registry (HRR) and the National Opioid Therapy Risk Report (OTRR). These tools allowed users to drill down to facility-, provider-, and patient-level data and included items such as opioid and benzodiazepine prescriptions and dosages, UDS results,

[36] VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain*, May 6, 2014.

and the presence of PDMP queries and informed consents. The Facility did not utilize these tools in a way that would have captured PCP1's prescribing practices for the patient.

The Facility used these databases to look for providers who were global outliers in controlled substance prescribing practices; and therefore, missed providers with irregular prescribing for individual patients. The VISN 20 Opioid Safety Review Board mines OTRR data and targets providers for counseling who are two standard deviations above the mean for the percentage of patients on their panel with a prescription for opioids. The OIG team reviewed data from VISN 20 Corporate Data Warehouse and found PCP1's overall prescribing practices were consistent with VISN 20 data for other providers with respect to the percentage of patients prescribed an opioid. PCP1 informed OIG inspectors that he was not contacted or counseled regarding his prescribing practices. Providers can request a review from the VISN 20 Opioid Safety Review Board, although PCP1 informed OIG inspectors that he did not request a review of his opioid prescribing practice for the patient.

CBOC managers reviewed HRR provider opioid prescribing data for the purpose of performance pay[37] determination. They looked at the percentage of patients who had completed iMed consents, annual UDS, and face-to-face encounters with PCPs. HRR pulls provider panel data from the VISN 20 Corporate Data Warehouse; and therefore, is specific to providers with assigned patient panels.[38] Data were not easily available for non-paneled providers who prescribed controlled substances, and a request for an ad hoc report had to be generated to obtain this information. PCP1 did not have an assigned patient panel for 13 months from 2015 through 2016 due to his leadership duties, and OIG inspectors found no evidence that facility managers performed an HRR opioid prescribing review for PCP1.[39] However, such a review would not have identified prescribing issues for the patient. Similar to the VISN 20 Opioid Safety Review Board review, CBOC managers looked at provider practice patterns and not at prescribing for individual patients.

Staff informed OIG inspectors that the Facility had no process in place for reviewing opioid prescribing for individual patients, including high-risk patients, unless requested by the provider. In early 2015, the Facility performed reviews of patients on greater than 200 MEDD, as required by the OSI. By the end of 2015, members of the Project Improvement Team reported significant progress had not been made in reducing the number of patients on high-dose opioids. Because of this, opioid safety efforts shifted to focus on initiatives to influence providers to participate in safe prescribing practices. One such effort was the development of tools within the EHR to alert

[37] Performance pay is a component of compensation paid to recognize the achievement of specific goals and performance objectives prescribed on an FY basis by an appropriate management official.

[38] A Primary Care Panel is the group of patients assigned to a specific primary care provider. A paneled provider is a provider who has been assigned a group of patients.

[39] PCP1 fell under the executive career field performance appraisal system and opioid prescribing (or clinical parameters in general) was not utilized for these performance evaluations.

providers to information that may influence prescribing for individual patients. For instance, when a provider signs an opioid prescription, they are alerted to recent PDMP and UDS results. However, there was no requirement for the provider to consider the information in the alerts when making prescribing decisions. PCP1 continued to prescribe for a patient with positive UDS for non-prescribed substances, and PDMP queries demonstrated the patient's receipt of controlled substances from outside of the Facility.

Category II PRF

The Facility Board that is responsible for controlled substances safety (Board) is charged with issuing Category II PRFs to alert providers about a patient's controlled substance/drug seeking behavior. Reports of controlled substance seeking behavior may be made to the Board through an electronic reporting system that is available to all staff. Prescribers generate the majority of referrals. The Board is comprised of a multidisciplinary team that reviews the EHR for evidence of controlled substance seeking behavior demonstrated by patients and makes recommendations as "designees" of the COS to providers regarding risk mitigation of controlled substance seeking behavior. If the Board activates the Category II PRF, staff members receive an alert upon accessing the patient's EHR regarding the history of a patient's drug seeking behavior. During the OIG interviews, providers and pharmacists stated that the Category II PRF was a helpful tool when providing care to patients on controlled substances. However, the OIG team found inconsistent provider interpretation of and lack of a well-defined process for the Category II PRFs.

In 2013, Facility staff placed a Category II PRF in the patient's EHR. The only recommendation in the patient's Category II PRF was to assist ED providers with "setting limits" with a plan to review his case in five years. One MH provider documented in the EHR that he/she would not prescribe controlled substances to the patient because of the Category II PRF. The Facility pharmacists told OIG inspectors that the Category II PRF was one reason they ran PDMP reports for the patient that led to the discovery of controlled substance prescriptions from outside the VA. PCP1 acknowledged the Category II PRF, but informed OIG inspectors that the PRF did not influence his prescribing because he believed it pertained only to controlled substance prescribing in the ED.

OIG inspectors found the Board's role, responsibilities, and authority for assessing, placing, and removing Category II PRFs were not well defined, and the Board lacked established protocols and procedures.[40] For instance, there was no process in place for routine review of the patient's record to monitor compliance with the recommendations in the Category II PRF, other than a

[40] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. "Each facility must have clearly written definitions and entry criteria" (consistent with VHA Directive 2010-053) for all Category I (VHA-wide) and Category II (system-specific) flags.

standard five-year assessment to determine if the PRF should remain in place. In addition, since mid-2016, the Board has not had a permanent chairperson. The Facility suspended the Board in early 2017 after the interim chairperson resigned from this position. The Facility reinstated the Board a month later, although it still lacked a permanent chairperson.

Reporting Concerns Relating to a Facility Leader's Controlled Substance Prescribing

PCP1 held several leadership positions in the Facility. One mechanism to address concerns about a provider's controlled substance prescribing is to report the concerns directly to a supervisor. However, PCP1 was the direct supervisor for the providers who cross-covered PCP1 for the patient and who expressed concerns about PCP1's prescribing practices. CBOC nursing staff reported concerns to the CBOC Practice Manager, who also reported directly to PCP1. One provider informed OIG inspectors that it seemed "out of line" to speak with PCP1 directly.

Staff from primary care, MH, and pharmacy services reported that given PCP1's high-level positions in administration and on committees, they did not feel comfortable reporting PCP1's prescribing practices up the chain of command.[41] In 2016, a family member expressed concerns to a Patient Advocate and an RN about PCP1's controlled substance prescribing on the patient's safety and well-being. The Patient Advocate referred the patient's case to a provider peer group. The Facility had multiple peer groups that support PCPs who desire and voluntarily request assistance with the management of complex pain patients. A peer group reviews a patient's history and makes treatment recommendations that are placed in the patient's EHR. Providers are not required to implement the treatment plan that the peer group recommends, and the peer group does not conduct follow-up with the provider or patient. A peer group representative contacted PCP1; PCP1 declined the review. The same week, a Facility pharmacist ran a PDMP query that revealed the patient obtained controlled substances from multiple facilities. Following these events, a Patient Advocate, a Pharmacist, and a PCP alerted the Primary Care Service Chief[42] to concerns about PCP1's controlled substances prescribing for the patient. During an interview, the Primary Care Service Chief stated that he was not aware of a history of this prescribing pattern by PCP1 until the 2016 notifications.

Protected Peer Reviews

Facility Peer Review Process in 2013 and 2016

Facility staff conducted peer reviews on providers' controlled substance prescribing in 2013 and 2016. The OIG team found peer review process deviations from VHA and Facility policy. Both

[41] The chain of command in this case was Practice Manager, Primary Care Service Chief, and Chief of Staff.

[42] The Primary Care Service Chief was PCP1's supervisor.

VHA and Facility policies require that once an initial protected peer review is completed and an initial Level of Care is assigned, a percentage of Level 1 and all Level 2 and 3 peer reviews are reviewed by the PRC. The PRC reviews the episode of care and makes the final determination of the Level of Care. Notification of the PRC's final determination is sent to the provider's Service Chief who communicates the result and the PRC's recommendations to the provider in a non-punitive and non-disciplinary manner.

OIG inspectors found that at the Facility, after the initial peer reviewer assigned a Level of Care, the Service Chief reviewed the peer review to ensure accuracy and to determine if it met policy criteria. The Service Chief confirmed the initial peer reviewer understood the issues and the requirements for the assigned level. If the Service Chief disagreed with the review, he/she could enter a Level of Care and rationale for the different level assignment. Both the initial peer review and Service Chief reviews were forwarded to the PRC, and the Service Chief presented the case to the PRC. The addition of the Service Chief review prior to PRC is not consistent with VHA or Facility peer review policies.

2013 Peer Review

In 2013, the initial peer reviewer[43] assigned the case a certain level. The Service Chief assigned a different level, and the PRC concurred with the Service Chief. The PRC did not implement the initial peer reviewer's recommendations outlining safe prescribing practices. The OIG team found a similar format for the 2016 peer review.

2016 Peer Review

In 2016, after being alerted to concerns about controlled substance prescribing, the Service Chief[44] initiated a second peer review and a general quality review.

The OIG team identified problematic issues with the 2016 peer review. VHA requires that a peer reviewer's responsibilities include abstaining or withdrawing from participation in a peer review if a conflict of interest exists, or for any other reason, the reviewer is unable to conduct an objective, impartial, accurate, and informed review. A subordinate of the subject of the peer review, who expressed dissatisfaction with his/her performance rating and the subject's leadership, completed the initial peer review in 2016. Therefore, the peer review may not have been an impartial review.

[43] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 defines a peer reviewer as "a health care professional who can make a fair and credible assessment of the actions taken by the provider relative to the episode of care under review."

[44] The same Service Chief reviewed both the 2013 and 2016 peer review.

2016 Controlled Substance Review

To further evaluate opioid prescribing practices, Facility managers developed a two-part quality review. For the first part of the quality review, Pharmacy Service provided a list of patients, who received opioid prescriptions in the past 30 days, to risk management staff. Risk management staff selected a random sample of 25 cases that were reviewed and rated.

For the second part of the quality review, the Facility reviewed the EHRs of 10 of the 25 patients selected by risk management. The reviewer was asked to determine if the prescriptions were "appropriate." The reviewer specifically looked for duplicate prescriptions, multiple prescribers (including prescriber assignment), timely renewals, and if prescriptions were "outlandish" in either dosages or quantities. The reviewer did not review PDMPs. The reviewer did not document the findings of any of the reviews, which hindered OIG inspectors' abilities to adequately evaluate the findings.

Conclusion

The OIG found that PCP1 continued to prescribe controlled substances to a high-risk patient despite numerous indicators of the patient's misuse and negative sequelae from controlled substance use, including multiple overdose events. Specifically, the OIG substantiated that PCP1 continued to prescribe controlled substances for the patient despite knowledge that the patient was also obtaining controlled substances from non-VA pharmacies, multiple contacts from family members and law enforcement pertaining to the patient's abuse of controlled substances, and knowledge of the patient's history of polysubstance abuse. OIG inspectors also substantiated that PCP1 continued to prescribe controlled substances when he was no longer the patient's designated PCP.

The OIG found EHR entries in which providers from primary care, MH, and pharmacy services documented opinions regarding the patient's misuse of prescribed drugs, risk for lethality, and recommendations to "proceed cautiously" with prescribing. However, OIG inspectors did not find evidence that providers directly warned PCP1 of his prescribing practices in the EHR or during interviews.

The OIG could not substantiate that PCP1 had a reputation among Facility staff for prescribing controlled substances "recklessly," as initially alleged. During the course of the inspection, the complainant became known to the OIG team and acknowledged that he/she was unable to describe PCP1's general prescribing practices as reckless because the concerns that prompted the OIG complaint were related to one patient. In addition, the OIG team interviewed Facility staff members who expressed widely divergent views of PCP1's controlled substance prescribing, ranging from "no concern" to "dangerous." Some of the staff members who expressed prescribing concerns noted that PCP1's practice had improved over time with implementation of the OSI and that PCP1 generally prescribed controlled substances in small quantities, mitigating the risk associated with the medications.

Although not an allegation, PCP1 continued to prescribe controlled substances for the patient after violations of the Agreement and did not follow Facility policy that mandates a documented response on the part of the provider when the Agreement is violated. OIG inspectors also noted that the Facility's policy did not consistently reflect the shift from "Agreements" to "Consent for Long-Term Opioid Therapy for Pain" as outlined in VHA Directive 1005.

The OIG identified limitations in the Facility's ability to effectively oversee providers' opioid prescribing in high-risk patients. Facility policy and VHA OSI guidelines related to PDMP queries and UDS did not influence PCP1's prescribing practices. The Facility collected PDMP and UDS data but did not have policies recommending changes in providers' prescribing practices based on the data.

The Facility did not have regular processes in place for reviewing controlled substance prescribing for individual patients, including high-risk patients. The patient's EHR was not flagged for review of controlled substance prescribing despite the patient's history of multiple overdoses, polysubstance abuse with admissions for substance abuse treatment, and multiple admissions for suicidal ideation and contacts with the VCL, generally in the context of intoxication.

In 2013, the patient had a Category II PRF placed in the EHR. PCP1 acknowledged the existence of the Category II PRF but informed OIG inspectors that the PRF did not influence his prescribing practices. In addition, OIG inspectors found the Board's role, responsibility, and authority for assessing, placing, and removing Category II PRFs was not well defined. In addition, since mid-2016, the Board has not had a permanent chairperson. The Facility suspended the Board in early 2017 after the interim chairperson resigned from this position. The Facility reinstated the Board a month later, although it lacked a permanent chairperson.

Efforts by staff to report prescribing concerns fell short. Facility staff informed OIG inspectors that given PCP1's high-level positions in administration and on committees, they did not feel comfortable confronting PCP1 or reporting PCP1's prescribing practices up the chain of command.

Facility staff conducted peer reviews regarding controlled substance prescription practices on two occasions with no actionable outcomes. Contributing factors included potential reviewer bias, lack of comprehensive review of prescribing patterns, and lack of access to and knowledge of the first peer review during the second review process. In addition, OIG inspectors found the Facility's peer review process involved sending the completed initial peer review to the Service Chief for assessment prior to the PRC, which is a deviation from VHA and Facility policies. A quality review of overall controlled substance prescribing practice was also performed, although not documented, and OIG inspectors were unable to determine the factors that led to the absence of findings in the review.

The OIG recognizes the value of shared decision-making and the utility of a provider's clinical judgement in the determination to use opioid therapy to treat pain. However, shared

decision-making and clinical judgement must be exercised in the context of patient safety. As many high-risk patients on controlled substances have complex pain and psychosocial comorbidities, input from pain specialists and MH providers can be invaluable in these determinations. It would also be beneficial for the Facility to have a review process that is multidisciplinary.

The OIG made eight recommendations.

Recommendations 1–8

1. The Veterans Integrated Service Network 20 Director conducts a management review of the care of the patient who is the subject of this report, and confers with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action.

2. The Facility Director implements a systematic approach to review prescribing of controlled substances to individuals at high-risk for substance abuse or misuse.

3. The Facility Director strengthens processes that foster interdisciplinary collaboration for the management of patients with complex clinical pain and allows referrals from all Facility staff.

4. The Facility Director ensures that policy and practice is consistent with Veterans Health Administration Directive 1005, *Informed Consent for Long-term Opioid Therapy for Pain*.

5. The Facility Director ensures provider accountability for compliance with Veterans Health Administration and Facility controlled substance policies, including opioid informed consent policies.

6. The Facility Director strengthens the Facility Board that is responsible for controlled substances safety, including clarification of roles, responsibilities, and authority; and the development of clearly written definitions and entry criteria for Category II patient record flags in accordance with Veterans Health Administration policy.

7. The Facility Director maintains full compliance with the Veterans Health Administration's peer review directive, including but not limited to the selection of impartial reviewers and removing the service chief level review from the Facility peer review process.

8. The Facility Director performs a focused professional practice evaluation on primary care provider 1's opioid prescribing practices in high-risk patients.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: .April 5, 2018

From: Director, Northwest Network (10N20)

Subj: Healthcare Inspection— *Alleged Inappropriate Controlled Substance Prescribing Practices at a Veterans Integrated Service Network 20 Medical Facility*

To: Director, Hotline Coordination, OIG Office of Healthcare Inspections (54HL)

Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to provide a status report on follow-up to the findings from the Healthcare Inspection—*Alleged Inappropriate Controlled Substance Prescribing Practices at a Veterans Integrated Service Network 20 Medical Facility*.
2. Attached please find the facility concurrence and response to the findings from the review.
3. I concur with the findings, recommendations, and submitted action plans.

(Original signed by:)

Michael J. Murphy

Comments to OIG's Report

Recommendation 1

The Veterans Integrated Service Network 20 Director conducts a management review of the care of the patient who is the subject of this report, and confers with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action to take.

Concur.

Target date for completion: June 1, 2018

Director Comments

The Network Director will direct the Chief Medical Officer to oversee the management review by appropriate clinical staff and coordinate with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action.

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Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: .April 4, 2018

From: Facility Director

Subj: Healthcare Inspection— *Alleged Inappropriate Controlled Substance Prescribing Practices at a Veterans Integrated Service Network 20 Medical Facility*

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to review the report of the Office of Inspector General Healthcare Inspection of *Controlled Substance Prescribing Practices at a Veterans Integrated Service Network 20 Medical Facility*.
2. We concur with the findings and recommendations and will ensure that actions to correct them are completed as described.

(Original signed by:)

Facility Director

Comments to OIG's Report

Recommendation 2

The Facility Director implements a systematic approach to review prescribing of controlled substances to individuals at high-risk for substance abuse or misuse.

Concur.

Target date for completion: June 30, 2018

Director Comments

The existing Facility Board that is responsible for controlled substances safety (Board) members (Chief of Staff, Deputy Chief of Staff, and Care Coordination Manager) have been meeting and reviewing 100% of cases referred for concerns regarding potential controlled substance abuse or misuse. Currently, any clinical staff member may make a referral to the Board by placing a consult in the EHR. In addition, cases may be referred outside of the EHR by the Pain Committee, Peer Review Committee, VISN20 Opioid Safety Review Board, Patient Advocate, or Executive leadership. Moving forward, the Facility will also ensure all staff are aware that they may refer cases anonymously to the Board by notifying Risk Management or by placing a patient safety event report in the system. Broad education about these pathways for referral is planned for general medical staff and clinical staff meetings.

As an additional safety mechanism, the Board will conduct a monthly automated pull from the VHA Support Service Center (VSSC) Opioid Therapy Risk Report (OTRR) to capture those with Risk Index for Overdose or Serious Opioid-induced Respiratory Depression (RIOSORD) class of 8-10 who may not have been identified otherwise.

In March 2018, the first meeting of an expanded Board was held, including additional members from Primary Care, Mental Health (Substance Abuse Treatment Program), Pharmacy, and Pain Clinic to provide subject matter expertise and additional manpower to conduct reviews.

The Board will monitor the number of patients being reviewed, number of reassessments, and outcomes of the reviews. This data will be reported to Pain Committee monthly for three months and then quarterly thereafter.

Recommendation 3

The Facility Director strengthens processes that foster interdisciplinary collaboration for the management of patients with complex clinical pain and allows referrals from all Facility staff.

Concur.

Target date for completion: June 30, 2018

Director Comments

All facility staff can refer patients with complex pain concerns to the Pain Clinic through the clinic's electronic medical record consult. Veterans are referred to the Pain Clinic via the Controlled Substance Safety Alert consult mentioned above. For FY17 the Pain Clinic completed 1141 referrals. These referrals included pain education groups, e-consults, and individual treatments. On average, the clinic receives 100-200 referrals a month. Average wait time for new patients if 29.1 days and for established patients is 11.8 days.

Pain Clinic staff ensure the facility staff are aware of the process of referrals by regularly attending clinical team and committee meetings. The Pain Clinic plans to partner with Executive Leadership team on a robust communication plan regarding their new range of services, which includes a presentation to the medical staff.

In addition, over the next 3 years the Facility will integrate formal health coaching, with dedicated health coaches for Veterans and health educators for staff, and we will begin offering additional alternative approaches to pain treatment such as chiropractic and acupuncture care. These enhanced and new programs will ensure improved interdisciplinary collaboration and significantly increased capacity, with opportunities for all staff to make referrals for care and consultation. The psychologist, social worker, pain nurse practitioner, addiction psychiatrist, and pharmacist are currently in the recruitment process.

Recommendation 4

The Facility Director ensures that policy and practice is consistent with Veterans Health Administration Directive 1005, *Informed Consent for Long-term Opioid Therapy for Pain*.

Concur.

Target date for completion: Completed

Director Comments

The Pharmacy and Therapeutics Committee co-chairs have revised MCM to be consistent with Veterans Health Administration Directive 1005, *Informed Consent for Long-term Opioid Therapy for Pain*. Executive Council for Medical Staff review and concurrence will be complete by the target date.

OIG Comment

The Facility provided sufficient supporting documentation, and the OIG considers this recommendation closed.

Recommendation 5

The Facility Director ensures provider accountability for compliance with Veterans Health Administration and Facility controlled substance policies, including opioid informed consent policies.

Concur.

Target date for completion: June 30, 2018

Director Comments

The Facility Primary Care Division has implemented a semi-annual OPPE [Ongoing Professional Practice Evaluation] process to monitor completion rates for opioid informed consent, urine drug screen testing, and review of state Prescription Drug Monitoring Program (PDMP) results for all chronic opioid patients assigned to each provider. Primary care clinical practice managers will provide feedback to clinicians as needed about any practices that are not compliant with policies. In addition, OPPE chart audits will be used to identify unexpected findings on urine drug screen testing or PDMP reviews. If unexpected findings are present, chart audits will also evaluate if the findings were addressed appropriately.

The Chief of Primary Care will review the OPPE results and ensure any fall-outs are addressed. An FPPE [Focused Professional Practice Evaluation] may be triggered for clinicians who remain out of compliance after counseling.

Recommendation 6

The Facility Director strengthens the Facility's Board that is responsible for controlled substances safety, including clarification of roles, responsibilities, and authority, and the development of clearly written definitions and entry criteria for Category II patient record flags in accordance with Veterans Health Administration policy.

Concur.

Target date for completion: June 30, 2018

Director Comments

The Board has updated the written Standard Operating Procedure (SOP) to include specific roles, responsibilities and authority, clearly written processes for referrals to the Board, and clear criteria for category II patient record flags. Board review process will also cover clinical recommendations and referrals to specialty clinics (e.g. Pain, SATP) as appropriate.

We will provide three months of minutes to show evidence of Board's process.

Recommendation 7

The Facility Director maintains full compliance with the Veterans Health Administration's peer review directive, including but not limited to the selection of impartial reviewers and removing the service chief level review from the Facility peer review process.

Concur.

Target date for completion: Completed

Director Comments

The peer review process has been modified to be in full compliance of the Veterans Health Administration Directive Peer Review for Quality Management. The instructions for selecting a peer reviewer were revised to ensure reviewers are impartial. The Peer Review Committee no longer receives the service chief level determination.

The facility submits the revised Peer Review Committee agenda, the revised email notification to Peer Review Committee Members, and a screen shot of the Peer Review database and requests closure of this recommendation.

OIG Comment

The Facility provided sufficient supporting documentation, and the OIG considers this recommendation closed.

Recommendation 8

The Facility Director performs a focused professional practice evaluation on primary care provider 1's opioid prescribing practices in high-risk patients.

Concur.

Target date for completion: Completed

Director Comments

The facility conducted a 100% review of this provider's opioid prescribing for the last three months on a focused professional practice evaluation (FPPE), that included a question regarding opioid prescribing.

After review of the FPPE, the primary care service chief recommended moving to OPPE.

OIG Comment

The Facility provided sufficient supporting documentation, and the OIG considers this recommendation closed.

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