DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Pharmacy Process Concerns and Improper Staff Communication at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia

HEALTHCARE INSPECTION | REPORT #20-01102-266 | SEPTEMBER 24, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations related to the prior authorization drug request process at the Hunter Holmes McGuire VA Medical Center (facility) in Richmond, Virginia.[1] Specifically, it was alleged that the Facility Pharmacy Services'

- Prior authorization drug request consult template did not allow prescribers sufficient space to document treatment rationale,
- Pharmacy and Therapeutics Committee did not include adequate mental health representation,
- Prior authorization drug request process caused delays in patients receiving medications, and
- Problems with Mental Health Service were not addressed by facility leaders aware of the concerns.[2]

It was further alleged that pharmacists canceled medication orders without communicating with the patient or prescriber and increased the risk of adverse events, and the number of denied drug requests was "very large." In addition to the allegation related to facility leaders' failure to address issues with the Mental Health Service, the OIG was concerned that facility leaders did not effectively address prescriber and pharmacist improper documentation about medication decisions in patients' electronic health records.

The OIG substantiated that the prior authorization drug request consult template included a limited space for prescribers to enter treatment rationale. However, the consult process included an option to document unlimited supplemental information, although prescribers did not always know about this option.

The OIG found that Pharmacy Services staff did not provide consistent training on the prior authorization drug process and procedures, but instead expected facility pharmacists assigned to prescribers' teams to provide on-the-job training as needed. Without consistent training on the prior authorization drug process and procedures, not all requesting prescribers may be aware of the consult option to enter supplemental information, the most efficient way for them to provide

[1] VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019. The VA prior authorization drug request process is an evidence-based restriction placed on designated medications "to guide the use of select drugs, or drug related supplies, that require close monitoring to ensure appropriate use." Prescribers submit a request that includes rationale for use to a pharmacy representative who makes the approval determination.

[2] Richmond VA Medical Center, Richmond, VA, *Pharmacy and Therapeutics Charter,* August 25, 2015. The Pharmacy and Therapeutics Committee is responsible for assuring appropriate drug therapy use in compliance with regulatory and accreditation standards, including review of medication use as it relates to safety and cost.

treatment rationale to the pharmacist reviewer. If prescribers do not have adequate information regarding the supplemental field option, it could result in a prescriber's incomplete provision of information for the consideration of a pharmacy reviewer, which could contribute to delayed or disapproved request determinations.

The OIG did not substantiate that the Pharmacy and Therapeutics Committee lacked adequate mental health representation because a psychiatrist was assigned continuously since 2016. The OIG determined that there was a three-month gap of Pharmacy and Therapeutics Committee mental health representative participation in 2019 because of staff assignment changes. The Director, Pharmacy Services and a Pharmacy and Therapeutics Committee cochair recommended a replacement mental health representative to the Chief, Mental Health; however, the recommended representative was not selected. The Chief, Mental Health informed the Pharmacy and Therapeutics Committee cochair that the recommended mental health representative had existing commitments that prevented selection.

The OIG found that the relationship between Pharmacy and Therapeutics Committee leaders and the mental health representative was problematic and noncollaborative. Pharmacy and Therapeutics Committee leaders told the OIG team that the mental health representative, a psychiatrist, was not actively involved in meeting discussions and often did not attend a full meeting. When interviewed by the OIG, the psychiatrist reported continuing to learn Pharmacy and Therapeutics Committee processes and described a perception of poor cooperation from Pharmacy Services staff but did not believe that raising the issue would be effective because of a Pharmacy and Therapeutics Committee cochair's authority. The psychiatrist also reported to the OIG that patient care demands interfered with participation in meetings for the entire scheduled time. Given the Pharmacy and Therapeutics Committee's significant role in medication-related decisions that affect both Mental Health and Pharmacy Services, a positive working relationship is critical to communication and conflict resolution.

The OIG did not determine that the prior authorization drug request or appeals process delayed treatment. The OIG found that facility prior authorization drug request and appeal reviews were typically completed within 96 hours, as required by Veterans Health Administration (VHA) policy. The appeals process included an option for prescribers to request an expedited process for completion in less than 96 hours. However, when asked by the OIG, five of eight prescribers who were interviewed were unfamiliar with or erroneously understood the process for expediting an appeal. The national consult template did not include appeal instructions and some, but not all, facility pharmacist reviewers included appeals instructions in their consult completion when a medication was denied. As noted above, Pharmacy Services staff did not provide an overall prior authorization drug request training. The requesting prescribers' lack of familiarity with the correct process for expediting appeals and the absence of written guidance regarding the appeals procedures could result in the requesting prescribers' failure to participate effectively in the process on behalf of their patients.

Mental health prescribers reported modifying their prescribing practices to avoid pharmacy processes, such as the prior authorization drug request process, that they viewed as time-consuming or labor-intensive. Given that the prior authorization drug request process is evidence-based and intended to address patient-specific needs, the OIG recognizes that prescribers' change of practice may enhance patient safety. However, the OIG cautions that prescribers' potential frustration and consequent avoidance of the required process should not impede the prescribers' pursuit of the most effective treatment plan based upon medical knowledge and experience. The OIG would expect clinical leaders to monitor and address prescribers' frustrations and promote engagement in the prior authorization drug request process.

The OIG found that a mental health prescriber (Mental Health Prescriber) may have contributed to one patient not receiving medications by failing to communicate with the reviewing pharmacist when the pharmacist requested additional information.[3] The medication at issue was denied. The Mental Health Prescriber did not notify the patient of the medication denial, as required by facility policy. The OIG did not find evidence of adverse clinical outcomes documented in the patient's electronic health record that may have resulted from the denied mental health medication order.[4]

Starting in January 2019, facility leaders were aware of unprofessional communications between Mental Health and Pharmacy Services staff related to the prior authorization drug request process. While some corrective actions were taken, the OIG found that these actions taken did not effectively resolve the problems.

The OIG found that although aware of critical comments in addition to disagreeing opinions improperly documented in patients' electronic health records documentation since November 2019, neither the Chief, Mental Health nor the Director, Pharmacy Services suggested additional criteria to monitor electronic health records for appropriate documentation. The OIG believes that facility leaders did not consider this option due to their initial awareness of only the Mental Health Prescriber's improper electronic health record documentation and their assumption that supervisory intervention addressed the problem. The unresolved issues contributed to an ongoing lack of collaboration and tension between mental health prescribers and pharmacists that may hinder quality patient care.

The Chief of Staff stated that the problems between Mental Health and Pharmacy Services staff related to the prior authorization drug request process appeared to be interpersonal and not patient safety-related and therefore asked that Mental Health and Pharmacy Services leaders address the concerns. The Pharmacy and Therapeutics Committee cochair and the Mental Health

[3] The pharmacist reached out to the prescriber for more information about the medication and the next day, the Mental Health Prescriber submitted a prior authorization drug request.

[4] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for a higher level of care.

Prescriber's supervisor met but described the meeting as ineffective in resolving the issues because there was contempt and nothing changed. The Deputy Chief, Mental Health (Deputy Chief) stated that efforts to resolve the issues were complicated by Pharmacy Services leaders' history of frustration related to working with the Mental Health Prescriber. The Deputy Chief presented prescriber concerns related to use of the prior authorization drug request for specific medication combinations at a Pharmacy and Therapeutics Committee meeting. The Deputy Chief described the Pharmacy and Therapeutics Committee as not receptive to differing opinions. The Pharmacy and Therapeutics Committee cochair informed the Deputy Chief and two psychiatrists that a review of the literature provided to the Pharmacy and Therapeutics Committee the previous day did not sufficiently support the argument for approval.

The OIG did not find evidence that facility leaders requested assistance from Veterans Integrated Service Network (VISN) leaders or the National Center for Organizational Development to address the ongoing problematic behaviors between the services. During the OIG team's February 2020 site visit, Pharmacy Services leaders, the Deputy Chief, and the Mental Health Prescriber reported ongoing tension between the Services.

Although the Mental Health Prescriber's supervisor and the Deputy Chief spoke with the Mental Health Prescriber about improper documentation, the Mental Health Prescriber later entered information into the electronic health record that incorrectly suggested the Pharmacy Services staff was responsible to inform the patient of medication status in the patient's electronic health record.[5] The OIG found that facility leaders did not effectively address that the Mental Health Prescriber improperly documented critical comments in addition to disagreeing opinions within patients' electronic health records. Further, the OIG found that Pharmacy Services staff, including leaders, sent disrespectful emails about Mental Health Service staff. Facility leaders' failure to effectively resolve ongoing collaboration issues between the Mental Health and Pharmacy Services staff may have perpetuated critical communication demonstrated in electronic health record documentation and email exchanges.

As discussed above, the OIG substantiated that a pharmacist canceled medication orders without communicating with a patient; however, facility policy requires the requesting prescriber, not the pharmacist, to notify the patient of this medication information. The OIG did not substantiate that pharmacists canceled medication orders without communicating with the requesting prescriber. The OIG found that pharmacists contacted prescribers when in need of additional information and prescribers were notified of consult completion through the electronic health record.

[5] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the timeframe of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020.

The OIG did not substantiate that facility pharmacist reviewers denied a large number of prior authorization drug requests when compared to other VISN 6 facilities. Of seven facilities, the OIG found that the facility had the second lowest denial rate in VISN 6. The OIG found that the facility's prior authorization drug request denial rate was lower than most VISN and national VHA facilities.

The OIG made five recommendations to the Facility Director related to prescriber education on prior authorization drug request consultation procedures, promotion of mental health prescribers' pursuit of the most effective treatment plan for each patient, a review of staff improper electronic health record entries and email, and evaluation of ways to improve the workplace relationships between Mental Health and Pharmacy Services.

Comments

The VISN and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to allow time for the facility to submit documentation of actions taken and to ensure they have been effective and sustained.

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Abbreviations

OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations related to the pharmacy and facility prior authorization drug request process at the Hunter Holmes McGuire VA Medical Center (facility) in Richmond, Virginia.[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 6, is a 349-bed tertiary care medical center and includes four community-based outpatient clinics. The facility offers care in medicine, surgery, neurology, rehabilitation medicine, mental health, substance use, spinal cord injury, and palliative care. The facility served over 68,500 patients from October 1, 2018, through September 30, 2019, and is affiliated with the Medical College of Virginia and Virginia Commonwealth University.

Prior Authorization Drug Request Process

The VA national formulary lists prescription medications and related supplies required to be available at all VA medical facilities. VA restricts some formulary medications using criteria established "to guide the use of select drugs, or drug related supplies, that require close monitoring to ensure appropriate use." Prior authorization of a medication is a type of evidence-based restriction.[2]

Facility policy requires that prescribers submit an electronic health record consult request to Pharmacy Services when a medication requires prior authorization.[3] The consult request must include the name of the medication, dose, and rationale for use. The chief of staff designates a pharmacy representative to review prior authorization drug requests. Pharmacists are required to complete the consult with the request determination within 96 hours, and upon completion, an electronic health record alert is automatically generated to the requesting prescriber.[4]

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[1] The term "pre-authorization for medications" was used in the allegations to refer to the process that VHA calls "prior authorization drug request." For this report, the OIG will use the term prior authorization drug request.

[2] VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

[3] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016. VHA defines a consult as a two-way communication between providers, made in the electronic medical record, on behalf of a patient.

[4] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the timeframe of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020. The new policy included similar language regarding the requirement that the requesting prescriber submit a consult in the patient's electronic health record.

Prior OIG Reports

In a 2019 report, *Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*, the OIG recommended that VHA review guidance for mental health clinical pharmacists' responsibilities for communication with the collaborating licensed independent practitioner who has prescribing authority.[5] As of March 25, 2020, the recommendation was closed.

In a September 2019 report, *Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center*, the OIG made six recommendations related to Pharmacy Services deficiencies; however, the recommendations were not directly relevant to the current inspection.[6]

In a July 2020 report, *Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center,* the OIG made 10 recommendations. Four recommendations addressed facility leaders' adherence to VHA policies regarding disclosure of adverse events, summary suspension of licensed independent practitioners, credentialing and privileging, and state licensing board reporting. As of August 2, 2020, all recommendations remained open.[7]

Allegations and Related Concern

On November 20, 2019, the OIG received allegations and subsequently identified a related concern:

1. The Facility Pharmacy Services'
    - Prior authorization drug request consult template did not allow prescribers sufficient space to document treatment rationale,
    - Pharmacy and Therapeutics Committee (Committee) did not include adequate mental health representation,[8]
    - Prior authorization drug request process caused delays in patients receiving medications, and

[5] VA OIG, *Review of Mental Health Clinical Pharmacists in Veterans Health Administration Facilities*, Report No. 18-00037-154, June 27, 2019. The mental health clinical pharmacists reviewed in this report provided clinical pharmacy services in direct patient care settings which is a different focus than the current inspection.

[6] VA OIG, *Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia*, Report No. 18-04679-239, September 27, 2019.

[7] VA OIG, *Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center*, Report No. 9-07600-215, July 29, 2020.

[8] Richmond VA Medical Center, Richmond, VA, *Pharmacy and Therapeutics Charter,* August 25, 2015. This charter was revised December 23, 2019. The Committee is responsible for assuring appropriate drug therapy use in compliance with regulatory and accreditation standards, including review of medication use as it relates to safety and cost.

- Problems with Mental Health Service were not addressed by facility leaders aware of the concerns.
    - Additionally, the OIG was concerned that facility leaders did not effectively address prescriber and pharmacist improper documentation about medication decisions in patients' electronic health records.

2. Pharmacists canceled medication orders without communicating with the patient or prescriber and increased the risk of adverse events.

3. The number of denied drug requests was "very large."

Scope and Methodology

The OIG initiated the inspection on January 6, 2020, and conducted a site visit from February 10, through February 13, 2020.

The OIG team interviewed the complainant; leaders from Pharmacy Benefits Management, VISN 6, the facility, and Mental Health and Pharmacy Services; facility pharmacists and outpatient prescribers; members of the Committee; and Health Information Management Services personnel.

The OIG reviewed VHA and facility policies and procedures related to Mental Health, Pharmacy, and Health Information Management Services. The OIG reviewed facility organizational charts, bylaws, service line agreements, professional performance evaluations, the prior authorization drug request consult template, and relevant electronic mail (email). Additionally, the OIG reviewed applicable facility committee charters and meeting minutes from December 1, 2018, through November 30, 2019.

The OIG reviewed VISN and facility prior authorization drug request data from December 1, 2018, through November 30, 2019. The OIG also reviewed patient electronic health records for the 15 appealed prior authorization drug requests that occurred December 1, 2018, through November 30, 2019.[9] Additionally, the OIG reviewed the electronic health records of five patients identified in the allegations.[10]

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).

[9] When a pharmacy reviewer denies a prior authorization drug request, prescribers can submit an appeal for reconsideration of the prior authorization drug request that a Committee subgroup reviews.

[10] The allegations included five patients' names but one of the electronic health records did not reflect pharmacy involvement. Therefore, the OIG team excluded the patient from analysis.

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, §7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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.

Inspection Results

1. Prior Authorization Drug Request Process Issues

The OIG substantiated that the prior authorization drug request consult template included a limited space for prescribers to enter treatment rationale. However, the consult process included an option to document unlimited supplemental information, although prescribers did not always know about this option. The OIG did not substantiate that the Committee failed to include mental health representation although mental health representation did not participate for three months due to staff assignment changes. The OIG found the relationship between the Committee's leaders and mental health representative was problematic and noncollaborative.

The OIG did not substantiate that delays in patient care occurred due to the prior authorization request process but found that a mental health prescriber (Mental Health Prescriber) may have contributed to one patient not receiving medications by failing to respond to the reviewing pharmacist's requests for additional information. Further, the Mental Health Prescriber did not notify the patient of the medication denial, as required by facility policy.[11]

The OIG substantiated that starting in January 2019, facility leaders were aware of problems between Mental Health and Pharmacy Services staff related to the prior authorization drug request process. The OIG did not substantiate that leaders failed to take corrective actions; but found the actions taken did not effectively resolve the problems. In addition to the prior authorization drug request process problems, the OIG noted improper documentation by the Mental Health Prescriber in patients' electronic health records. Further, the OIG found that Pharmacy Services leaders authored disrespectful email exchanges with Pharmacy Services staff about Mental Health Service staff.

Consult Documentation Space

VHA requires standardization and management of consultation processes to ensure timely and clinically appropriate patient care. Additionally, clinical leaders are responsible for ensuring adherence to consult-related national program office guidance.[12]

[11] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the timeframe of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020. The new policy included similar language regarding the requirement that the requesting prescriber contact the patient to identify a medication substitution when the prior authorization drug request is denied.

[12] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016, amended June 28, 2019.

The OIG found that the facility prior authorization drug request consult template included Pharmacy Benefits Management nationally required components.[13] Although the consult components were predetermined, a facility Health Information Management Services supervisor demonstrated to the OIG that a prescriber could provide unlimited information in a supplementary space prior to consult completion.[14]

In interviews with the OIG team, a pharmacy leader and a staff pharmacist reported that in addition to the consult information, the pharmacist reviewer based approval decisions on an electronic health record review and communication with the requesting prescriber, as needed. A pharmacist reviewer told the OIG that most follow-up communication to requesting prescribers occurred by instant message or telephone, which prescribers confirmed.[15]

Facility policy requires prescribers to document treatment rationale "in sufficient detail" to justify why another medication is not appropriate and must list all failed therapeutic alternatives in the prior authorization drug request.[16] The OIG found that although the consult template space for treatment rationale was limited, prescribers had the consult option to enter supplemental information to further explain rationale for the request. In OIG interviews, 9 of 11 prescribers described sufficient space in the consult to document treatment rationale for medication requests.[17] When asked by the OIG, 4 of the 11 prescribers reported being aware of the option to enter supplemental information into the consult. The Director, Pharmacy Services told the OIG that years ago prescribers received formal prior authorization drug request training, but currently, facility pharmacists assigned to prescribers' teams were expected to provide on-the-job training as needed.

[13] VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019. Pharmacy Benefits Management is a program office of senior pharmacy leaders that, among other duties, coordinates the VA national formulary process. In an interview with the OIG team, a Pharmacy Benefits Management leader approximated that the template was implemented in 2017.

[14] Once the prescriber completes all required template elements, a new, editable consult screen opens displaying the template information and space for prescriber entry of required information such as the recommended follow-up appointment date. The prescriber can enter an unlimited amount of new information in that consult screen.

[15] In October 2018, VA initiated a software application that did not retain instant messages. Therefore, the OIG could not evaluate instant message communications. The OIG did not find evidence of pharmacist reviewer follow-up communication in electronic mail review.

[16] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the time frame of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020. The new policy included similar language regarding the requirement that the requesting prescriber submit a consult in the patient's electronic health record.

[17] The OIG team interviewed a total of 13 prescribers—10 mental health and 3 non-mental health prescribers. The Mental Health Prescriber and one prescriber who reported not using the facility consult were excluded from this analysis. Of the nine prescribers who stated there was sufficient space, six were mental health prescribers and three were non-mental health prescribers.

The OIG found that without consistent training on the prior authorization drug process and procedures, not all requesting prescribers may be aware of the consult option to enter supplemental information, the most efficient way for them to provide treatment rationale to the pharmacist reviewer. Prescribers' lack of knowledge regarding the supplemental information field option may have resulted in a prescriber's incomplete provision of information for pharmacy reviewer consideration, and may have contributed to delayed or disapproved request determinations.

Mental Health Representation

The OIG did not substantiate that the Committee lacked adequate mental health representation because a psychiatrist was assigned continuously since 2016. The OIG determined that there was a three-month gap of Committee mental health representative participation in 2019 because of staff assignment changes.

The Chief of Staff is responsible for appointing multidisciplinary Committee members based on recommendations from respective service line chiefs. The Committee must include a mental health representative as a voting member.[18] When interviewed by OIG, a psychiatrist reported serving as a Committee member starting in 2016 through March 2019. The OIG found that the psychiatrist did not attend meetings from January 2019 through March 2019, which the psychiatrist told the OIG team was due to a reduction in work hours beginning in January 2019.[19] The psychiatrist stepped down from the Committee upon assignment to a community-based outpatient clinic in March 2019.

The Director, Pharmacy Services and a Committee cochair informed the OIG that they recommended a replacement mental health representative to the Chief of Mental Health; however, the recommended representative was not selected. In an email exchange, the Chief, Mental Health informed the Committee cochair that the recommended mental health representative had existing commitments that prevented selection. The Chief, Mental Health informed the OIG that a replacement psychiatrist was chosen when volunteers were solicited in a psychiatry meeting. The psychiatrist began attending Committee meetings in April 2019 and remained on the Committee as of May 13, 2020. In a review of Committee meeting minutes from April through November 2019, the OIG found that the psychiatrist attended seven of the eight Committee meetings.

Committee leaders told the OIG team that the psychiatrist was not actively involved in meeting discussions and often did not attend a full meeting. When interviewed by OIG, the psychiatrist

[18] Richmond VA Medical Center, Richmond, VA, *Pharmacy and Therapeutics Charter,* August 25, 2015. This charter was revised December 23, 2019. The revised charter included similar language regarding the Committee requirement to include a mental health representative.

[19] The OIG reviewed Committee minutes recorded during December 2018 through November 2019.

reported continuing to learn Committee processes and described a perception of poor cooperation from Pharmacy Services staff but did not believe that raising the issue would be effective because of a Committee cochair's authority. The psychiatrist also reported to the OIG that patient care demands interfered with participation in meetings for the entire scheduled time.

When interviewed by the OIG, a primary pharmacist reviewer reported consulting other pharmacists when unfamiliar with specialized prior authorization drug requests. A mental health clinical pharmacist confirmed that the primary pharmacist reviewer sent complex mental health prior authorization drug requests for review. Additionally, the OIG found evidence in email and electronic health record review that the mental health clinical pharmacist reviewed initial prior authorization drug requests. The Director, Pharmacy Services told the OIG that the Committee appeals subgroup did not include a mental health prescriber (see appeals process discussion on next page). The psychiatrist who served on the Committee reported participating in one Committee-wide mental health-related vote since assigned but was not consulted by the Committee on mental health prescriber appeals.

The OIG found that although there was a three-month period when a mental health representative was absent from the Committee, another psychiatrist was then assigned. Given the Committee's significant role in medication-related decisions that affect both Mental Health and Pharmacy Services, a positive working relationship is critical to communication and conflict resolution.

Prior Authorization Drug Request Delays

The OIG reviewed Pharmacy Benefits Management prior authorization drug request reports and patients' electronic health records whose prior authorization drug requests were appealed from December 1, 2018, through November 30, 2019. The OIG did not determine that the prior authorization drug request or appeals process delayed treatment. However, the OIG found that for one of the four patients identified in the allegations, the Mental Health Prescriber may have contributed to the patient not receiving medication by failing to communicate with the reviewing pharmacist when the pharmacist requested additional information.

VHA and Facility Pharmacy Processes and Timeliness

VHA requires completion of prior authorization drug requests and requesting prescriber notification within 96 hours of the request. Additionally, a Pharmacy Benefits Management subject matter expert told the OIG that urgent prior authorization drug requests are to be immediately completed. VHA requires that each VISN director oversee a process for facilities to report prior authorization drug request and appeals data, including the number of requests and

appeals not completed within 96 hours. For requests and appeals completed in over 96 hours, facilities must provide the VISN with completion time, reason for delay, and outcome.[20]

The Director, Pharmacy Services told the OIG that a requesting prescriber may submit an appeal regarding the denied request decision and that the appeal request is reviewed by a Committee subgroup that included three physicians.[21] In an interview with the OIG team, the Chief of Staff reported adjudicating when a requesting prescriber disagrees with the appeal determination. The April 2020 updated facility policy outlines the role of the Committee appeals subgroup; however, the policy in effect for this inspection review period of December 1, 2018, through November 30, 2019, did not include that information. Neither facility policy includes information about the adjudication role of the Chief of Staff.[22]

Pharmacy Benefits Management reports for prior authorization drug request consults from December 1, 2018, through November 30, 2019, reflected that facility pharmacy reviewers completed 99.7 percent of prior authorization drug request consults within the 96-hour required time frame. Pharmacists also completed 13 of 15 prior authorization drug request appeals consults within 96 hours.[23]

According to the Committee cochairs, the Committee subgroup that reviewed appeals could expedite the process when requested by the prescriber for completion in less than 96 hours. However, when asked by the OIG, five of eight prescribers were unfamiliar with or erroneously understood the process for expediting an appeal.[24] Four of the five prescribers who were unclear on the process were mental health prescribers. A Committee cochair told the OIG that the national consult template did not include appeal instructions. Some, but not all, facility pharmacist reviewers included appeals instructions in their consult completions when a medication was denied. The requesting prescribers' lack of familiarity with the correct process for expediting appeals and the absence of written guidance regarding the appeals procedures could result in the requesting prescribers' failure to participate effectively in the process on behalf of their patients.

[20] VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

[21] The Committee subgroup included the physician Committee cochair as one of the three physicians.

[22] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the timeframe of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020.

[23] Nine of the 15 appeals were submitted by mental health prescribers. One appeal over 96 hours was delayed due to difficulty reaching the patient for additional information. For the second delayed appeal, in response to the requesting prescriber's notification of concern, the Director, Pharmacy Services approved the request and the patient's medication was ordered within the required time frame. However, the pharmacist failed to administratively close the consult within 96 hours, as required.

[24] Of the eight prescribers asked, five were mental health prescribers and three were non-mental health prescribers.

The OIG found that Pharmacy Services staff provided medication-specific prior authorization drug request guidance through email to the Mental Health Service during 2019. As discussed above, the Director, Pharmacy Services told the OIG that although there was not an overall prior authorization drug request process training, facility pharmacists assigned to prescribers' teams are available and expected to provide information as needed as part of on-the-job training.

When asked by the OIG, seven mental health prescribers reported modifying their prescribing practices to avoid pharmacy processes, such as the prior authorization drug request process, that they may view as time-consuming or labor-intensive. Given that the prior authorization drug request process is evidence-based and intended to address patient-specific needs, the OIG recognizes that prescribers' change of practice may enhance patient safety. However, the OIG cautions that prescribers' potential frustration and consequent avoidance of the required process should not impede the prescribers' pursuit of the most effective treatment plan based upon medical knowledge and experience. The OIG would expect clinical leaders to monitor and address prescribers' frustrations and promote engagement in the prior authorization drug request process.

Communication Delay

The Mental Health Prescriber may have contributed to one patient not receiving medication by failing to communicate with the reviewing pharmacist when the pharmacist requested additional information. Further, the Mental Health Prescriber did not notify the patient of the medication denial or communicate with the patient until the patient called two months later.

Facility policy required that the requesting prescriber (1) contact the pharmacist immediately if the clinical status of a patient requires urgent review of a medication request, and (2) respond to requests for additional justification within 96 hours to prevent consult discontinuation.[25] Facility policy requires that the requesting prescriber contact the patient and identify a medication substitution when the prior authorization drug request is denied.[26]

The OIG reviewed the following events that occurred over a three-day period in late 2019:

[25] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the timeframe of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020. The new policy included similar language regarding the requesting prescriber's requirement to respond but shortened the timeframe from 96 to 48 hours.

[26] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the time frame of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020. The new policy included similar language regarding the requirement that the requesting prescriber contact the patient to identify a medication substitution when the prior authorization drug request is denied.

Day 1

- During a patient's outpatient psychiatric appointment, the Mental Health Prescriber placed a liquid-form medication order; the patient was scheduled for a follow-up appointment in approximately one month.
- The Committee pharmacist cochair messaged the Mental Health Prescriber requesting additional information after being notified by Pharmacy Services staff of the medication order, and the Mental Health Prescriber did not respond that day.
- An outpatient pharmacist flagged the medication order, requesting that the Mental Health Prescriber enter a prior authorization drug request.

Day 2

- The Mental Health Prescriber entered a prior authorization drug request for the liquid-form medication.
- The outpatient pharmacist discontinued the original liquid-form medication order.
- The Mental Health Prescriber responded to the Committee pharmacist cochair's instant message from the day before and provided one subsequent response related to rationale for the medication use. The Committee pharmacist cochair requested additional information via two additional instant messages within an hour but the Mental Health Prescriber did not respond anymore that day.

Day 3

- The Mental Health Prescriber sent an email to the Director, Pharmacy Services, Committee physician cochair, and Committee pharmacist cochair regarding this patient's medication.
- The Committee pharmacist cochair replied that the Mental Health Prescriber would not "dialogue with me about how to come up with a more appropriate pharmacotherapy option," and did a review of the patient's electronic health record to understand the patient's concerns.
- A mental health clinical pharmacist reviewed the prior authorization drug request.
- The mental health clinical pharmacist documented denial of the liquid-form medication request based on information provided in the consult and the patient's electronic health record.

The OIG did not find electronic health record documentation that the Mental Health Prescriber contacted the patient regarding the medication denial, as expected by facility policy.[27] The patient canceled the next month's appointment and next spoke with the Mental Health Prescriber in early 2020, after the patient called "in regards to mental health medication that was supposed to be delivered." The Mental Health Prescriber documented that "the pharmacy discontinued the order for [medication] of their own [*sic*] without informing [the patient]. [Patient] remains unchanged." The Mental Health Prescriber ordered the patient a nonrestricted form of the medication and noted a plan for a six week follow-up; however, an appointment was not scheduled.

The patient presented for an appointment with a psychologist seven weeks after speaking with the Mental Health Prescriber in early 2020, and reported not yet starting the medication. The patient canceled the next appointment with the psychologist, and an administrative staff member mailed a reschedule request. As of late spring 2020, the patient's electronic health record did not include documentation of additional contact or future appointments. The OIG did not find evidence of adverse clinical outcomes that may have resulted from the denied mental health medication order.[28]

The OIG found that facility prior authorization drug request and appeal reviews were typically completed within 96 hours, as required by VHA policy.[29] The OIG determined that the prior authorization drug request or appeals processes did not delay patients' treatment; however, the Mental Health Prescriber's failure to provide the pharmacist reviewer with requested supplemental information about the patient's medication concerns may have contributed to an almost two-month delay in medication delivery to one of the four patients identified in the allegations.

Facility Leaders' Actions

As noted above, facility leaders were aware of problems between Mental Health and Pharmacy Services staff related to the prior authorization drug request process starting in January 2019. The OIG did not substantiate that leaders failed to take corrective actions; however, the OIG found that those actions did not effectively resolve the problems.

VHA requires facility directors to ensure implementation of and adherence to the formulary process. Chiefs of staff are required to establish a process to review provider-initiated appeals for

[27] As discussed later in the report, the Mental Health Prescriber inconsistently documented patient notification of medication denials.

[28] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for a higher level of care.

[29] VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

denied prior authorization drug requests.[30] Clinical service chiefs are responsible for the clinical management of electronic health records.[31] The OIG found that although aware of the critical comments in addition to disagreeing opinions improperly documented in patients' electronic health records documentation since November 2019, neither the Chief, Mental Health nor the Director, Pharmacy Services suggested additional criteria to monitor electronic health records for appropriate documentation. The OIG believes that facility leaders did not consider this option due to their initial awareness of only the Mental Health Prescriber's improper electronic health record documentation and their assumption that supervisory intervention addressed the problem.

In January 2019, the Committee cochair informed the Mental Health Prescriber's supervisor about concerns regarding unprofessional communications between the Mental Health Prescriber and pharmacists and requested conflict mediation.[32] In an interview with the OIG team, the Chief of Staff recalled that around February 2019, the Director, Pharmacy Services reported mental health prescribers' concerns related to the prior authorization drug request process and improper communication with Pharmacy Services staff. Additionally, the OIG found that in November 2019, the Committee cochair electronically mailed an adjudication request to the Chief of Staff that contained the Mental Health Prescriber's concerns related to the prior authorization drug request process. The Chief of Staff told the OIG team that the concerns appeared to be interpersonal and not patient safety-related and therefore asked that Mental Health and Pharmacy Services leaders address the concerns.

In February 2019, a Committee cochair requested a meeting to discuss concerns with the Mental Health Prescriber's supervisor who replied that a face-to-face meeting was a good idea but due to patient care schedule, a meeting could not be held until April 2019. The Committee cochair and the Mental Health Prescriber's supervisor informed the OIG that the meeting was ineffective in resolving the issues because there was contempt and nothing changed.

In July 2019, the Mental Health Prescriber notified the Deputy Chief, Mental Health (Deputy Chief) of ongoing concerns with Pharmacy Services staff in email. The Mental Health Prescriber responded to the Deputy Chief's offer to forward the email to the Chief, Mental Health with concern about confidentiality, but ultimately deferred to the Deputy Chief's decision. The OIG did not find evidence that the Deputy Chief forwarded the information to the Chief, Mental Health. The Deputy Chief reported to the OIG likely having notified the Chief, Mental Health but being unable to recall if and when that occurred. The Mental Health Prescriber told the OIG that the Deputy Chief was unsuccessful in resolving the issues and told the Mental Health

[30] VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

[31] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[32] VA Directive 5978, *Alternative Dispute Resolution*, February 7, 2013. Mediation is an alternative dispute resolution process involving assistance from a trained, neutral mediator to assist two or more parties in finding a mutually acceptable solution to their dispute.

Prescriber not to report concerns due to the Pharmacy Services leaders' influence at the facility. The Deputy Chief told the OIG that efforts to resolve the issues were complicated by Pharmacy Services leaders' history of frustration related to working with the Mental Health Prescriber.

The Deputy Chief presented prescriber concerns related to use of the prior authorization drug request for specific medication combinations at a November 7, 2019, Committee meeting.[33] Meeting minutes included information required from the requesting prescriber for the prior authorization drug request submission. In an interview with the OIG, the Deputy Chief described the Committee as not receptive to differing opinions. On November 8, 2019, a Committee cochair electronically mailed the Deputy Chief and two psychiatrists that a review of the literature provided to the Committee the previous day did not sufficiently support the argument for approval. The Committee cochair reiterated the prior authorization drug requirements for the specific medication combinations and encouraged prescribing alternatives.

The OIG found that facility leaders were aware of concerns related to the prior authorization drug request process, issues between the Mental Health and Pharmacy Services, and improper communication in the electronic health record as early as January 2019. Mental Health and Pharmacy Services leaders took some actions to address the issues, however, they did not result in improved communication or resolution of the poor working relationship between the Pharmacy Services staff and the Mental Health Prescriber. The OIG did not find evidence that facility leaders requested assistance from VISN leaders or the National Center for Organizational Development to address the ongoing problematic behaviors between the services.[34]

Related Concern: Improper Documentation

VA's core values include integrity, commitment, advocacy, respect, and excellence. VA defines respect as, "Treat all those I serve and with whom I work with dignity and respect. Show respect to earn it."[35] Healthcare professionals document patient data or observations, actions, or instructions in patients' electronic health records.[36] VHA requires the electronic health record to reflect accurate and clinically relevant statements and prohibits entry of derogatory or critical comments.[37] The facility's Medical Records Committee reviews electronic health record

[33] The meeting discussion was related to prior authorization drug request use for concurrent serotonin-norepinephrine uptake inhibitor and selective serotonin reuptake inhibitor prescriptions.

[34] The VHA National Center for Organizational Development provides organizational health services, including individual and organizational assessments, consultation and intervention, and supportive services. https://www.va.gov/NCOD/. (This website was accessed on May 5, 2020.)

[35] VA Mission, Vision, Core Values & Goals. https://www.va.gov/about_va/mission.asp. (The website was accessed on May 5, 2020.)

[36] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[37] VHA Handbook 1907.01.

documentation for "completeness, legibility, authentication, accuracy, and timely completion."[38] Service chiefs are responsible for contributing additional review criteria for their service based on "documentation requirements that may be new, problematic, or the focus of an external audit."[39] Additionally, facility policy states that disrespectful conduct is a breach of ethical behavior requirements.[40]

The facility's Chief, Health Information Management Services told the OIG that staff documentation in the electronic health record should not include opinions about another staff member's actions; however, the Medical Records Committee did not routinely review electronic health records for improper entries. The OIG team found that in late 2019, the Mental Health Prescriber documented concerns in the electronic health record about a pharmacist discontinuing a patient's medication order given what clinical factors the Mental Health Prescriber considered in the treatment recommendation.[41] The Mental Health Prescriber also documented a request that the Committee review the medication order discontinuation and included Mental Health and Pharmacy Services leaders as additional signers.

Two days later, as described above, the Mental Health Prescriber's supervisor and the Deputy Chief, Mental Health spoke with the Mental Health Prescriber about improper documentation and communication with Pharmacy Services staff and developed a plan for the Mental Health Prescriber's supervisor to be involved in the Mental Health Prescriber's communication with Pharmacy Services staff. In early 2020, however, the Mental Health Prescriber entered information into the electronic health record that incorrectly suggested the Pharmacy Services staff was responsible to inform the patient of medication status in the patient's electronic health record.[42] As noted above, according to the facility policy, the prescribing provider has the responsibility to inform the patient.

Additionally, in 3 of 15 electronic health records for patients with appealed prior authorization drug request denials, the OIG found that the Mental Health Prescriber documented critical comments in addition to disagreeing opinions related to Pharmacy Services staff decisions.[43] Specifically, the Mental Health Prescriber documented, "pharmacy has coopted care of this patient," "current procedures over-rule the provider responsible," and noted in an electronic

[38] Richmond VA Medical Center, *Medical Records Committee Charter,* July 21, 2015. The medical records committee assists with electronic health record planning, use, and development and oversight of service record reviews and documentation standards compliance.

[39] Richmond VA Medical Center, *Medical Records Committee Charter,* July 21, 2015.

[40] Medical Center Memorandum 00-022, *Organizational Code of Ethics and Ethical Behavior*, September 3, 2019.

[41] The patient is also discussed above regarding a delay in receiving medication.

[42] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the timeframe of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020.

[43] One patient name occurred both in the review of the prior authorization drug request appeals and in the names provided in the allegations; therefore, it was not recounted in the appeals.

health record correspondence to a patient regarding a medication delay that, "[t]his has to do with the pharmacy. I have addressed it to their leadership."

Despite facility leaders' awareness of improper electronic health record documentation, the OIG found that as of May 28, 2020, neither the Chief, Mental Health nor the Director, Pharmacy Services suggested additional criteria to monitor electronic health records for appropriate documentation. Further, the OIG found multiple examples from February 2019 through February 2020 of email between Pharmacy Services staff members, including some authored by Pharmacy Services leaders, that contained disrespectful comments related to Mental Health Service staff. Additionally, patients' confidence in facility staff may erode upon review of their electronic health record containing the improper documentation.

2. Medication Orders Canceled Without Communication

As discussed above, the OIG substantiated that the pharmacist canceled medication orders without communicating with a patient; however, facility policy requires the requesting prescriber and not the pharmacist to notify the patient of this medication information. The OIG did not substantiate that pharmacists canceled medication orders without communicating with the requesting prescriber. The OIG found that pharmacists contacted prescribers when in need of additional information and prescribers were notified of consult completion through the electronic health record.

Facility policy requires that the requesting prescriber contact the patient and identify an alternative medication when the prior authorization drug request is denied.[44] When asked by the OIG, four of five facility prescribers reported that the requesting prescriber is responsible for communicating medication information to the patient. One of the five prescribers reported to the OIG notifying the patient at the time of the request but stated the patient was notified of the final decision when presenting to the pharmacy the same day.

The OIG found electronic health record documentation that the Mental Health Prescriber notified one of four patients about a medication denial. A second patient called the Mental Health Prescriber and reported not receiving a medication and a pharmacist reviewer approved the medication upon the Mental Health Prescriber's request. The OIG did not find evidence that the Mental Health Prescriber notified two other patients regarding medication denials.

[44] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the timeframe of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020. The new policy included similar language regarding the requirement that the requesting prescriber contact the patient to identify a medication substitution when the prior authorization drug request is denied.

The OIG also reviewed 15 patient electronic health records containing appealed, prior authorization drug request denials from December 1, 2018, through November 30, 2019.[45] The OIG found that in 6 of 15 electronic health records, the requesting prescriber documented patient notification of the prior authorization drug request denial. In 5 of 15 electronic health records, the OIG did not find documentation indicating that the requesting prescriber notified the patient of the denial. For 2 of 15 electronic health records, the OIG did not find documented patient notification of the initial prior authorization drug request denial, however the appeal was overturned and the medication approved.

VHA describes the consult as a means of communication between providers.[46] Facility policy requires prescribers to enter an electronic consult for a prior authorization drug request. The pharmacist reviewer must use established national, VISN 6, and facility guidelines when reviewing prior authorization drug requests. Additionally, the requesting prescriber is required to respond to any follow-up inquiry by the pharmacist within 96 hours to prevent a prior authorization drug request from being discontinued.[47] When the pharmacist reviewer completes the consult, the prescriber is notified of the decision and recommendations through the patient's electronic health record. The requesting prescriber must ensure the prior authorization drug request is approved and then enter the prescription.[48]

When interviewed by the OIG, pharmacist reviewers reported communicating with the requesting prescriber through instant messaging and email when additional information was needed to complete the prior authorization drug request consult. For two of the four patients identified in the allegations, the OIG found that the Mental Health Prescriber initiated an email discussion of medication concerns to which pharmacists responded via email. Additionally, the pharmacist's completion of the prior authorization drug request consult in the electronic health record notified the prescriber of the decision through an alert.

Pharmacy Services staff told the OIG team that if the information provided in the consult is not sufficient, the pharmacist reviewer attempts to reach the prescriber to obtain additional information and reviews the patient's electronic health record to make a determination. In

[45] Two patient names occurred both in the review of the prior authorization drug request appeals and in the names provided in the allegations so were not recounted in the appeals.

[46] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016.

[47] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the timeframe of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020. The new policy included similar language regarding the requesting prescriber's requirement to respond but shortened the timeframe from 96 to 48 hours.

[48] Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control*, December 14, 2018. This policy was in effect during the timeframe of the events discussed in this report; it was rescinded and replaced by Medical Center Memorandum 119-010, *Therapeutic Order and Drug Use Control,* April 9, 2020. The new policy included similar language regarding the requirement that the requesting prescriber ensure the request is approved and prescription has been entered into the electronic health record.

interviews with the OIG, five prescribers who were asked about notifications, confirmed receiving notification of decisions regarding prior authorization drug requests through the patient's electronic health record.

3. Drug Requests Denial

The OIG did not substantiate that facility pharmacist reviewers denied a large number of prior authorization drug requests when compared to other VISN 6 facilities.[49] Of seven facilities, the OIG found that the facility had the second lowest denial rate in VISN 6. The OIG found that the facility's prior authorization drug request denial rate was lower than most VISN and national VHA facilities.

Medications that require prior authorization drug requests are determined at the national, VISN, or facility level, depending on the medication designation.[50] The OIG reviewed Pharmacy Benefits Management reports regarding the percentage of denied prior authorization drug requests at the facility compared to other VISN 6 facilities and aggregated VHA national data during December 1, 2018, to November 30, 2019. As shown in table 1, the OIG found that the facility had the second lowest denial rate in VISN 6, at 5.6 percent. Additionally, VHA's national average denial rate of 12.8 percent was significantly higher than the facility's 5.6 percent denial rate.

[49] Pharmacist Benefits Management leaders told the OIG team that the prior authorization drug requests data could not be sorted by mental health submissions but only by clinic or provider name. Each medical center used distinct clinic names, which made a review by clinic name impracticable. Therefore, the OIG team reviewed the VISN facilities' prior authorization drug requests generally and the facility's mental health prior authorization drug requests.

[50] VHA Directive 1108.08(1), *VHA Formulary Management Process*, November 2, 2016, amended August 29, 2019.

Table 1. VISN 6 and National Prior Authorization Drug Request Denial Rates

VISN 6 Facility	Prior Authorization Drug Requests	Prior Authorization Drug Request Did Not Meet Criteria (Denied)	Percentage Denied (%)
Salem, VA	4,435	382	8.6
Asheville, NC	10,003	851	8.5
Fayetteville, NC	6,235	516	8.3
Salisbury, NC	15,270	1,181	7.7
Hampton, VA	9,433	650	6.9
Richmond, VA	**13,628**	**758**	**5.6**
Durham, NC	9,004	471	5.2
VISN Totals	68,008	4,809	7.1

Source: Pharmacy Benefits Management Prior Authorization Drug Requests: All Consults Summary Report, VISN 6, December 1, 2018, to November 30, 2019.

The OIG determined that requesting prescribers had the option to appeal denied prior authorization drug requests. The OIG reviewed appealed prior authorization drug request denials at the facility from December 1, 2018, through November 30, 2019. Of 15 initially denied prior authorization drug requests, pharmacists overturned and approved 6 of them during the appeals process. Mental health prescribers initiated the request in five of the six appeals that were overturned and approved upon the Committee subgroup's review of patient information.[51] When interviewed by the OIG team, the VISN Pharmacy Executive denied concerns related to facility prior authorization drug request data, including denied requests. The VISN Pharmacy Executive also denied being aware of any negative impact on patient outcomes due to the facility's prior authorization drug request determinations.

Conclusion

The OIG substantiated that the prior authorization drug request consult template included a limited space for prescribers to enter treatment rationale. Not all prescribers were aware that the consult included an entry option to document unlimited supplemental information. Facility leaders did not provide consistent prior authorization drug process and procedures training, which may have contributed to requesting prescribers' lack of awareness of the most efficient process for providing treatment rationale. As a result, pharmacist reviewers may have delayed determinations or denied medications due to receiving incomplete information.

[51] The Committee subgroup approved three of the appeals with subsequent Committee reviews of the patients' medication response and needs, one with changes to the patient's other medication, and one as the prescriber requested originally.

The OIG did not substantiate that the Committee lacked adequate mental health representation because a psychiatrist was assigned continuously since 2016. However, the relationship between the Committee and a new mental health representative assigned after the previous representative's three-month absence was problematic and noncollaborative, which may have hindered conflict resolution.

The OIG did not substantiate that the prior authorization drug request and appeals process caused delays in treatment for patients whose prescribed medications required prior authorization drug request consults. When asked by the OIG, seven mental health prescribers reported modifying their prescribing practices to avoid pharmacy processes, such as the prior authorization drug request process, that they may view as time-consuming or labor-intensive. Given that the prior authorization drug request process is evidence-based and intended to address patient-specific needs, the OIG recognizes that prescribers' change of practice may enhance patient safety. However, the OIG cautions that prescribers' potential frustration and consequent avoidance of the required process should not impede the prescribers' pursuit of the most effective treatment plan based upon medical knowledge and experience.

The Mental Health Prescriber may have contributed to one patient not receiving a medication by failing to communicate with the reviewing pharmacist when the pharmacist requested additional information. Facility leaders took actions to resolve problems between Mental Health and Pharmacy Services staff, but the actions did not effectively resolve the problems. The Mental Health Prescriber improperly documented critical comments in addition to disagreeing opinions within patients' electronic health records. The OIG also found that Pharmacy Services staff sent disrespectful emails about Mental Health Service staff. Facility leaders were aware of staff's improper electronic health record entries but had not suggested monitoring for appropriate documentation.

The OIG substantiated that the pharmacist canceled medication orders without communicating with a patient; however, the requesting prescriber, not the pharmacist, is required to notify the patient of medication denials. The OIG did not substantiate that pharmacists canceled medication orders without communicating with the requesting prescriber. Pharmacist reviewers reported communicated with requesting prescribers when in need of additional information during the review process. Additionally, when pharmacist reviewers completed the prior authorization drug request consult, requesting prescribers received electronic health record notification.

The OIG did not substantiate that facility pharmacist reviewers denied a large number of prior authorization drug requests when compared to other VISN 6 facilities. The OIG found that the facility's prior authorization drug request denial rate was lower than most VISN and national VHA facilities. The OIG determined that requesting prescribers had the option to appeal denied prior authorization drug requests.

Recommendations 1–5

1. The Hunter Holmes McGuire VA Medical Center Director ensures prescriber education on prior authorization drug request consultation procedures including consult documentation options, urgency level communication, patient notification, and appeals processes.

2. The Hunter Holmes McGuire VA Medical Center Director promotes mental health prescribers' utilization of the prior authorization drug request process in consideration of the medication plan most effective for each patient.

3. The Hunter Holmes McGuire VA Medical Center Director ensures that electronic health records are reviewed for improper entries, and takes action as indicated.

4. The Hunter Holmes McGuire VA Medical Center Director conducts a review of staff improper electronic health record entries and electronic mail and consults with Office of Human Resources to determine if administrative action is warranted, and takes action as appropriate.

5. The Hunter Holmes McGuire VA Medical Center Director evaluates ways to improve the workplace relationships between Mental Health and Pharmacy Services staff, including consultation with the Veterans Integrated Services Network or the National Center for Organizational Development, and takes actions as appropriate.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 2, 2020

From: Director, VA Mid-Atlantic Health Care Network (10N06)

Subj: Healthcare Inspection—Pharmacy Process Concerns and Improper Staff Communication at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia (652)

To: Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I reviewed the report and the response of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia.

2. If you have further questions, please contact the VISN 6 Quality Manager Officer.

(*Original signed by*:)

Deanne M. Seekins, MBA, VHA-CM
VA Mid-Atlantic Health Care Network Director, VISN 6

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 31, 2020

From: Executive Director, Central Virginia VA Health Care System (CVHCS)(652/00)

Subj: Healthcare Inspection—Pharmacy Process Concerns and Improper Staff Communication at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia

To: Director, VA Mid-Atlantic Health Care Network (10N06)

1. The Executive Director, CVHCS, reviewed the draft of the subject report and concurs with the findings.
2. A plan for corrective actions to include a timeline for completion and sustainment of improvements has been implemented.

(*Original signed by*:)

J. Ronald Johnson, MHA, FACHE
Executive Director, Central Virginia VA Health Care System

Facility Director Response

Recommendation 1

The Hunter Holmes McGuire VA Medical Center Director ensures prescriber education on prior authorization drug request consultation procedures including consult documentation options, urgency level communication, patient notification, and appeals processes.

Concur.

Target date for completion: December 31, 2020

Director Comments

Pharmacy Service will develop a training document for prescriber education on prior authorization drug request consultation procedures including the consult documentation options, urgency level communication, patient notification, and appeals processes. All Mental Health prescribing providers will receive this training.

Recommendation 2

The Hunter Holmes McGuire VA Medical Center Director promotes mental health prescribers' utilization of the prior authorization drug request process in consideration of the medication plan most effective for each patient.

Concur.

Target date for completion: December 31, 2020

Director Comments

The Pharmacy and Therapeutics (P&T) Committee will review all prior authorization drug request appeals in the P&T committee. All appeals and supporting rationale will be documented in the P&T minutes.

Recommendation 3

The Hunter Holmes McGuire VA Medical Center Director ensures that electronic health records are reviewed for improper entries, and takes action as indicated.

Concur.

Target date for completion: December 31, 2020

Director Comments

The Medical Records Committee will complete a random audit of electronic health record documentation each month for improper entries and identify the Service Chief for action for improper entries. Results will be presented to the Medical Executive Council (MEC).

Recommendation 4

The Hunter Holmes McGuire VA Medical Center Director conducts a review of staff improper electronic health record entries and electronic mail and consults with Office of Human Resources to determine if administrative action is warranted, and takes action as appropriate.

Concur.

Target date for completion: December 31, 2020

Director Comments

The Medical Records Department will provide refresher training to all staff on professional interactions as well as appropriate medical records documentation. All staff will be encouraged to notify their service chief of any improper electronic health record entries and electronic mail. The Service Chief will consult Office of Human Resources (OHR) to determine if administrative action is warranted. In addition, electronic health records will be evaluated monthly by the medical records committee for improper entries. Any identified improper documentation will be sent to the Service Chief for OHR consultation for further action, if warranted.

Recommendation 5

The Hunter Holmes McGuire VA Medical Center Director evaluates ways to improve the workplace relationships between Mental Health and Pharmacy Services staff, including consultation with the Veterans Integrated Services Network or the National Center for Organizational Development, and takes actions as appropriate.

Concur.

Target date for completion: December 31, 2020

Director Comments

Pharmacy and Mental Health leadership will provide a monthly joint meeting with both Mental Health and Pharmacy Providers. Topics discussed will include any mental health prescribing issues including the role of the pharmacy providers in medication prescription process. In addition, the VISN 6 High Reliability Organization (HRO) Lead will complete Just Culture and HRO Training at a future meeting to the attendees.

OIG Contact and Staff Acknowledgments

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