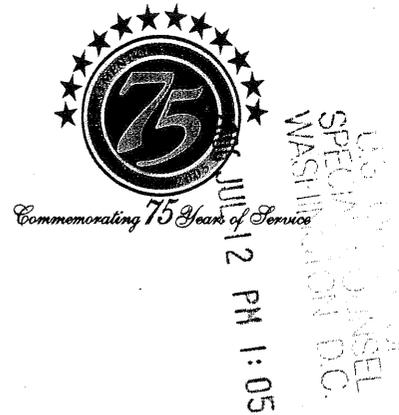




THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

July 7, 2006



Ms. Catherine A. McMullen
Chief, Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036-4505

Dear Ms. McMullen:

This is to advise you that the Office of the Inspector General has concluded its review of the Murfreesboro CMOP, your file number OSC DI-05-0068. A copy of our findings is enclosed for your convenience.

If you have any questions regarding this matter, please contact Ken Greenberg, Executive Secretary, at (202) 273-4869.

Sincerely yours,

R. James Nicholson

Enclosure

6/21/2006

**Whistleblower Disclosure
MCI #2006-02169-HL-0651**

1. Summary of the information with respect to which the investigation was initiated.

Prescriptions filled on the super-tote line at the Department of Veterans Affairs, Mid-South Consolidated Mail Outpatient Pharmacy (CMOP) in Murfreesboro, TN, were not being routinely verified by a pharmacist before they were sent to patients. According to the whistle blower, the failure to properly verify prescriptions violated general principles of pharmacy law, the applicable Veterans Health Administration Manual, and the instructions of both the National CMOP Director and the Chief Consultant for the Pharmacy Benefits Management Strategic Healthcare Group.

2. A description of the conduct of the investigation.

VHA Pharmacy Service conducted an Administrative Board of Investigation from March to June 2005, that included a review of this allegation.

3. A summary of any evidence obtained from the investigation.

VHA initiated a pilot project in the latter part of 1999, early 2000, that included having pharmacy technicians at the CMOPs fill the prescriptions and a pharmacist check every prescription to ensure accuracy before the prescriptions are mailed to the patients. The Murfreesboro CMOP did not comply with the requirement that all prescriptions are checked for accuracy by a pharmacist. Murfreesboro management said they did not have the right ratio of technicians to pharmacists to comply with the requirement. When VHA managers were made aware of this deficiency in November 2002, they told the CMOP Director to stop the pilot and comply with the requirement for a pharmacist to check all prescriptions. In November 2004, VHA managers found that the CMOP Director had failed to comply with this directive and took personnel action against the CMOP Director. The CMOP Director is no longer with the VA. The problem has been corrected and the Murfreesboro CMOP is in compliance with VHA policy.

4. A listing of any violation or apparent violation of any law, rule, or regulation.

VHA Handbook 1108.05 May 30, 2006 states that "*All outpatient prescriptions must be filled under the supervision of a licensed pharmacist and checked by a licensed pharmacist prior to issuance to the patient or the patient's agent.*"

5. A description of any action taken or planned as a result of the investigation.

The CMOP Director was issued a Reprimand on July 22, 2005, for failure to timely carry out instructions. The Reprimand states "...you were directed by John Ogden, VA Chief Consultant, Pharmacy Benefits Management and Timothy Stroup, National CMOP Director, to discontinue a pilot program of Technician Prescription Validation and fully implement Pharmacist Validation for all prescriptions containing legend or controlled substance medications. The implementation of this direct order was delayed until November 2004."

From: Greenberg, Ken [mailto:ken.greenberg@va.gov]
Sent: Wednesday, September 06, 2006 3:26 PM
To: Biggs, Tracy
Cc: Carrington, Belinda L
Subject: RE: supplemental information

Good Afternoon Tracy --

You asked for additional information on the ABI and what happened to the CMOP Director as he was no longer with VA. Please see below for the additional information. Thanks Ken 202 273 8320

Additional Information for OSC on
CMOP Super Tote Issue at Murfreesboro, TN
MCI # 2006-02169-HL-0651

The Administrative Board of Investigation was conducted by three senior Veterans Health Administration officials (one human resources professional and two pharmacy professionals) from March to June 2005. The super tote issue review examined testimony and supplemental information from eight CMOP employees.

The CMOP Director is no longer with VA; police reports note that he died from what appeared to be a self-inflicted gunshot wound on November 30, 2005.

From: Biggs, Tracy [mailto:TBiggs@osc.gov]
Sent: Wednesday, September 06, 2006 9:20 AM
To: Greenberg, Ken
Subject: supplemental information

Good morning Ken,

I am writing to check the status of the supplemental information on the report we discussed. Will we receive it this week?

Thank you.

Tracy Biggs

9/14/2006