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**Analysis of Disclosures, Agency Investigation and Report, Whistleblower Comments, and
Comments of the Special Counsel**

Summary of OSC File No. DI-05-0068

The U.S. Department of Veterans Affairs, charged with caring for this nation's veterans, has identified and corrected a serious violation of pharmaceutical regulations. The whistleblower alleged that the super-tote line at the U.S. Department of Veterans Affairs (VA), Mid-South Consolidated Mail Outpatient Pharmacy (CMOP) in Murfreesboro, Tennessee, routinely failed to have a pharmacist verify the accuracy of the prescriptions before mailing them to patients. The whistleblower alleged that the failure to conduct regular reviews by pharmacists was a violation of law, the Veterans Health Administration (VHA) manual, the instructions of the National CMOP Director and the Chief Consultant for Pharmacy Benefits Management Strategic Healthcare Group.

The agency substantiated the allegations and took disciplinary action against the CMOP Director. CMOP Murfreesboro is now operating in compliance with applicable regulations and guidelines.

The Whistleblower's Disclosures

The whistleblower, who requested anonymity, alleged that prescriptions filled by the Mid-South CMOP were not being verified by pharmacists before they were sent to patients. The allegations focus on prescriptions filled on the super-tote line at the Mid-South CMOP. The facility uses "super-totes" as one method for assembling and processing prescriptions in preparation for distribution by mail to patients. Each super-tote contains prescription drugs for approximately thirty different patients, and according to the whistleblower, thousands of prescriptions filled by the Mid-South CMOP pass through the super-tote line daily, accounting for approximately fifteen percent of the Mid-South CMOP's volume.

The whistleblower explained that all prescriptions must be checked to ensure that the drug in the bottle matches the drug identified on the label, that the dosage is correct, that it is the drug prescribed for the patient, that it can be taken with other drugs taken by the patient, and that the instructions provided with the prescription are correct. The whistleblower maintained that because the technicians do not have the education and training pharmacists have, they cannot conduct the review necessary.

The whistleblower provided OSC with evidence that prescriptions were being verified by technicians rather than pharmacists. Indeed, the whistleblower alleged that there were no pharmacists involved in the process of filling and dispensing prescription drugs on the super-tote line at the Mid-South CMOP. According to the whistleblower, the practice of having technicians check prescriptions violated the general principles of pharmacy law and the instructions of both

the National CMOP Director and the Chief Consultant for the Pharmacy Benefits Management Strategic Healthcare Group. This practice also appeared to violate the VHA Manual which required that licensed pharmacists be provided for supervision as well as the performance of professional functions.

OSC initially referred this allegation to the Honorable Richard J. Griffin, VA Inspector General, on December 14, 2004, requesting information related to the whistleblower's allegation. In order to avoid interference with an ongoing criminal investigation, OSC granted the VA Office of the Inspector General (VA OIG) several lengthy extensions based upon that office's representation that this allegation was being investigated as a potential criminal violation. In March 2006, the VA OIG informed OSC, that it would no longer request extensions. Nor did the VA OIG provide OSC with the information requested about the investigation. Thus, on April 24, 2006, this matter was referred to the Secretary of Veterans' Affairs for investigation pursuant to 5 U.S.C. § 1213.

The Report of the Department of Veterans' Affairs

The Veterans Health Administration Pharmacy Service convened an Administrative Board of Investigation (ABI) which conducted its investigation from March to June 2005. The ABI consisted of three senior Veterans Health Administration officials (one Human Resources professional, and two pharmacy professionals). During the course of the investigation, the ABI reviewed testimony and supplemental information from eight CMOP employees. The investigation substantiated a violation of VHA Handbook 1108.05 which sets forth the requirement that a licensed pharmacist must supervise and review the filling of all outpatient prescriptions prior to distribution to patients.

Under a pilot program initiated by VHA in early 2000, pharmacy technicians at CMOP were given the responsibility of filling prescriptions. A pharmacist would then check the prescriptions to ensure that they had been filled properly before they were mailed to the patients. The investigation found that Murfreesboro did not comply with the requirement that a pharmacist review the prescriptions. CMOP management officials contended that the failure to comply was due to inadequate staffing.

According to the report, in November 2002, when VHA managers became aware that prescriptions were not being reviewed properly, they instructed the CMOP Director to stop the pilot project and comply with the requirement that a pharmacist ensure the accuracy of all prescriptions. In November 2004, VHA managers discovered that the CMOP Director had failed to comply with the directive that had been issued in November 2002, and with the review requirement. VHA reprimanded the Director on July 22, 2005, for failure to carry out instructions.

The report states that the facility now operates in compliance with VHA requirements. Finally, the report notes that the Director is no longer at the facility because he subsequently passed away.

The Whistleblower's Comments

The whistleblower did not comment on the agency report.

Conclusion

Based on the representations made in the agency report and as stated above, I have determined that the agency report contains all of the information required by statute and that its findings appear to be reasonable.