Department of Veterans Affairs
Office of Inspector General

Audit of
Veterans Health Administration's
Management of Non-Controlled Drugs

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VA Office of Inspector General
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To Report Suspected Wrongdoing in VA Programs and Operations

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Abbreviations

AR/WS	Automatic Replenishment/Ward Stock Dispensing
CMOP	Consolidated Mail Outpatient Pharmacy
DEA	Drug Enforcement Administration
GAO	Government Accountability Office
IV	Intravenous Dispensing
NABP	National Association of Boards of Pharmacy
NADDI	National Association of Drug Diversion Investigators
OIG	Office of Inspector General
OP	Outpatient Dispensing
PBM	Pharmacy Benefits Management Service
SMO	Supply Management On-Line
UD	Unit Dose
VHA	Veterans Health Administration
VistA	Veterans Health Information System and Technology Architecture
VISN	Veterans Integrated Service Network

Executive Summary

Results in Brief

The Office of Inspector General (OIG) conducted an audit to determine how accurately the Veterans Health Administration (VHA) could account for inventories of non-controlled drugs at increased risk for waste and diversion in its health care facilities (facilities). VHA needs to improve its ability to account for non-controlled drugs to reduce the risk of waste and diversion. VHA cannot accurately account for its non-controlled drug inventories because it has neither implemented nor enforced sufficient controls to ensure pharmacy inventory practices are standardized and pharmacy data is accurate.

Pharmacy managers from VA health care facilities included in our inventory analysis reported a range of local practices that affect the completeness and accuracy of pharmacy data captured in VHA's Veterans Health Information System and Technology Architecture (VistA), as well as the accuracy of annual physical inventory data. Local pharmacy personnel are not consistently recording information on transactions in VistA, such as pharmacy stock transfers, drug dispensing, and drug returns. Furthermore, VistA lacks the capability to account for drugs that are dispensed by a VHA Consolidated Mail Outpatient Pharmacy (CMOP) but are returned to and restocked by a facility because the drugs cannot be delivered to the veteran. Pharmacy managers told us that this VistA limitation can contribute to their facility's positive inventory discrepancy. A positive inventory discrepancy occurs when a facility's ending inventory is higher than it should have been given the quantities of drugs purchased and dispensed. We found that 24 of the 31 facilities we reviewed had a positive inventory discrepancy for at least one of the five drugs we reviewed. This condition is a major concern since drug losses associated with diversion could go undetected.

VHA has not instituted adequate controls to ensure that pharmacy personnel accurately and consistently record drug transactions in VistA. VHA has not developed procedures to monitor drugs that are at higher risk for diversion. VHA needs to develop procedures to capture information in its inventory records on returned quantities of CMOP dispensed drugs that are restocked by facilities. While VHA requires its facilities to conduct annual physical inventories of non-controlled drugs, it neither ensures inventory data is accurate nor uses the data as a tool to identify drug loss or possible drug diversion.

VHA has also not taken steps to require that non-controlled drugs are monitored. Further, VHA has not maximized the use of existing inventory data to increase accountability over non-controlled drugs. However, some facilities are taking actions and using various tools to improve accountability over selected non-controlled drugs. To increase accountability, VHA needs to improve the completeness of its pharmacy data and its annual physical inventory reports. In addition, VHA needs to provide its facilities

with guidance on how to develop procedures to monitor non-controlled drugs. Without improved accountability, non-controlled drugs are at increased risk for waste and diversion.

Background

Prescription drugs are generally categorized as controlled or non-controlled. Non-controlled drugs make up the bulk of VHA facility-level spending on pharmaceuticals and accounted for about $1.3 billion in fiscal year (FY) 2008 compared to $67 million facilities spent on controlled drugs. Non-controlled drugs are not subject to stringent inventory and oversight controls despite the fact that some are expensive while others contain active ingredients that can be used to manufacture illicit drugs. In contrast, controlled drugs, which include painkillers such as oxycodone, are identified as such by the Drug Enforcement Administration and are tightly regulated under the Controlled Substances Act of 1970. VHA requires its facilities to store controlled substances in separate secure vaults and to conduct routine physical counts of each drug to reduce the risk for diversion.

Prescription medications are dispensed directly to veterans by facility inpatient and outpatient pharmacies. Veterans may also receive their medications in the mail either from a facility or from a CMOP. Information on facility-level drug dispensing, as well as the transfer of drug stocks, is captured in VistA. Data on facility-level drug purchases is captured in the pharmaceutical prime vendor Supply Management On-line (SMO) database.

We selected five drugs for review. Four of these drugs—Sustiva, Zyprexa, Ultram, and Levitra—are considered at increased risk for diversion. We also included the anti-clotting drug Plavix in our analysis because it is the drug most frequently purchased by VHA. To determine to what extent VHA could account for the total inventory available for each of these drugs from 2007 to 2008, we calculated an inventory discrepancy for each drug at 31 randomly selected facilities. These facilities were selected from the 157 facilities that provide both inpatient and outpatient pharmacy services. We also conducted site visits to 6 of the 31 facilities and surveyed pharmacy managers from these facilities. We suspended our inventory analysis after determining pharmacy data was incomplete and therefore, not reliable. We also determined that annual physical inventory reports were not accurate because some drugs were not included in the inventory count at some facilities. Further, data is not available to measure the accuracy of physical inventory reports. While the results of our inventory analysis cannot be extrapolated to all facilities, our findings related to internal control weaknesses affecting the reliability of VistA data on pharmacy transactions and facility-level annual pharmacy inventory reports are system-wide.

Findings

Drug Transactions Not Accurately and Consistently Recorded. VistA does not have the capability to capture all information on pharmacy transactions automatically. Information on quantities of transferred drugs and returned drugs, for example, must be manually entered into VistA. Pharmacy managers told us that pharmacy personnel do not always enter information into VistA on quantities of drugs transferred to secondary locations, such as an inpatient ward. Unless pharmacy personnel consistently and accurately enter information on transferred drugs and adjust the quantity of medications that were previously recorded as being dispensed, a facility's dispensing data will be inaccurate.

Pharmacy managers also reported that pharmacy personnel return drugs to inventory without entering the information in VistA, despite VHA guidance to do so. In addition, we confirmed VistA does not have the capability to account for CMOP dispensed drugs that are returned to and restocked by a facility. Pharmacy Benefits Management (PBM) Service officials, however, told us that they have concerns about the use of drugs returned in the mail because conditions such as extreme heat or cold can affect a drug's integrity. VHA needs to issue a policy on facilities' use of drugs returned in the mail, and if facilities restock returned drugs, VHA needs to develop standardized procedures to capture information in its inventory records on restocked CMOP dispensed drugs. Inaccurate inventory data limits VHA's ability to detect losses due to diversion.

Pharmacy dispensing data is also incomplete because some pharmacy personnel may be inappropriately using the prescription label reprint function in VistA to dispense drugs. The quantity of drugs dispensed using the reprint function is only captured if the original prescription was never released to the patient. According PBM officials, pharmacy personnel should not use the VistA reprint function to dispense drugs. Pharmacy managers from the six facilities we visited told us that pharmacy personnel are using the reprint function to dispense drugs to patients, which can affect the accuracy of outpatient dispensing data captured in VistA. There are no controls in VistA, such as an electronic sign off by a pharmacy supervisor, to track why a reprint label is being initiated and to ensure that the function is not being inappropriately used to dispense drugs. VHA needs to establish procedures to monitor and control the use of the reprint function.

Lack of Policy to Monitor High-Risk Non-Controlled Drugs. VHA policy requiring its facilities to monitor at least 20 non-controlled drugs for diversion expired in 2003. VHA has not established standardized monitoring requirements for non-controlled drugs or provided guidance to its facilities on which non-controlled drugs are at increased risk for diversion. In response to our questionnaire, 36 percent of pharmacy managers from facilities providing inpatient and outpatient pharmacy services reported that they lack adequate information on how to develop processes to monitor non-controlled drugs for diversion. However, some pharmacy managers are taking steps to monitor non-controlled drugs in the absence of a VHA policy. Eighty percent of pharmacy managers

reported that they monitor at least one non-controlled drug for diversion and the majority of these pharmacy managers (63 percent) reported that they monitor one to five drugs. Almost half of the pharmacy managers who reported monitoring non-controlled drugs for diversion used inventories as a way to monitor these drugs. According to questionnaire responses, most of these inventories are conducted at least quarterly.

Physical Inventories Not Fully Utilized to Account for Non-Controlled Drugs. VHA is also not fully utilizing annual physical inventories to account for non-controlled drugs, and we found that physical inventory data for some facilities is not accurate. According to PBM officials, the purpose of the annual physical pharmacy inventory is not to account for inventories of specific drugs, but to measure how efficiently facilities are managing inventory turnover, an indicator of whether a facility has too much or too little on-hand inventory. None of the pharmacy managers at the six sites we visited were able to provide us with documentation demonstrating their compliance with VHA's requirement to ensure that annual physical inventories are accurate. Pharmacy managers at 11 of 31 facilities reported that their inventory discrepancies may be the result of inaccurate physical inventory data.

In 2007, VHA did not ensure that three of its facilities conducted annual physical inventories. Also, VHA does not require its facilities to maintain their annual physical inventory reports for a period of time, nor does it require them to record inventory results in a standardized electronic format. Thirty-five facilities were either unable to provide us with their inventory reports or the reports were only available in hardcopy format. Retaining standardized electronic inventory data would allow VHA to develop reports to monitor the inventories of specific non-controlled drugs nationally or regionally. Complete and standardized annual physical inventory data is needed to help VHA establish accountability over its non-controlled drug inventories.

Conclusion

VHA cannot accurately account for its non-controlled drug inventories because it lacks effective controls and reliable information to do so. The accurate and complete data needed to account for these drugs is not available, and VistA lacks the capability to capture information on some drugs that are returned to a facility and restocked. VHA's information limitations negatively impact its ability to accurately account for and monitor its inventories of non-controlled drugs and impair its ability to identify instances of drug waste and diversion. Without accurate and complete information, VHA cannot ensure its non-controlled drug inventories are appropriately safeguarded, increasing the risk of waste and diversion. The implementation and enforcement of sufficient controls to ensure accurate and complete information is imperative to VHA's ability to account for and safeguard non-controlled drug inventories.

Recommendations

1. We recommend the Under Secretary for Health develop procedures to identify high risk non-controlled drugs and require pharmacy managers to monitor those drugs by establishing standardized inventory discrepancy rates that if exceeded require further investigation.
2. We recommend the Under Secretary for Health develop appropriate internal controls to ensure pharmacy managers and staff accurately and consistently record drug-dispensing activity in VistA.
3. We recommend the Under Secretary for Health require that information on drug stocks transferred within a VA health care facility and drugs dispensed by and returned to a facility's stock is accurately and consistently recorded in VistA.
4. We recommend the Under Secretary for Health establish a policy on VA health care facilities' use of drugs returned in the mail; and if returned drugs are restocked by facilities, develop procedures to ensure information on returned quantities of CMOP dispensed drugs that are restocked is consistently captured in inventory records using standardized procedures.
5. We recommend the Under Secretary for Health develop policy to limit access to the VistA label reprint function to appropriate pharmacy personnel and develop standard procedures to capture information on drugs dispensed using the reprint function.
6. We recommend the Under Secretary for Health develop standardized electronic annual physical inventory reporting formats; develop standards to ensure that annual physical inventory reports are reasonably accurate; and establish a procedure to hold VA health care facility pharmacy managers accountable for the accuracy of annual physical inventory reports.

Management Comments and OIG Response

The Acting Under Secretary for Health agreed with the findings and recommendations in the report and provided acceptable implementation plans (see Appendix B for the full text of comments). VHA will develop processes that identify and monitor high-risk non-controlled drug inventories including the designation of universal inventory discrepancy rates that, if exceeded, will require follow-up investigation. VHA will also emphasize the importance of accurately and consistently recording drug dispensing activity in VistA, and will identify internal monitoring controls to ensure that facilities are complying with documentation requirements.

VHA will reinforce the importance of fully utilizing existing capabilities in VistA to record and monitor the transfer of drug stocks within a facility and also issue guidance that drugs returned to the pharmacy after leaving VA custody must not be returned to stock and should be destroyed. VHA will develop procedures for returning and disposing

of CMOP dispensed drugs and will reiterate the importance of adjusting inventory data to account for drugs returned in the mail as undeliverable and destroyed.

VHA will develop a policy to limit access to the VistA label reprint function, standard procedures to capture information on drugs dispensed using the reprint function, and standardized electronic formats to ensure that annual physical inventory reports are reasonably accurate. VHA will also establish procedures to hold health care facility managers accountable for report accuracy.

We consider these planned actions acceptable, and we will follow up on their implementation until all proposed actions are completed.

(original signed by:)

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for Auditing

Introduction

Purpose

The Office of Inspector General (OIG) conducted an audit to determine how accurately the Veterans Health Administration (VHA) could account for inventories of non-controlled drugs at increased risk for waste and diversion in its health care facilities.

Background

VHA Pharmacy Workload and Prescription Drug Spending. In fiscal year (FY) 2008, VA health care facilities (facilities) filled about 141 million prescriptions. Non-controlled drugs make up the bulk of VHA's facility-level drug expenditures. During FY 2008, facilities spent about $1.3 billion on non-controlled drugs compared to $67 million on controlled drugs. Some non-controlled drugs have an increased risk for diversion because of their high cost or street value. VHA purchases most of its non-controlled drugs through a national contract awarded in 2004 to the McKesson Corporation, the pharmaceutical prime vendor.

Controlled vs. Non-Controlled Drugs. Prescription drugs are generally categorized as controlled or non-controlled. Non-controlled drugs are not subject to stringent inventory and oversight controls despite the fact that some are expensive while others contain active ingredients that can be used to manufacture illicit drugs. In contrast, controlled drugs, which include painkillers such as oxycodone, are identified as such by the Drug Enforcement Administration (DEA) and are tightly regulated under the Controlled Substances Act of 1970. VHA requires its facilities to store controlled substances in separate secure vaults and to conduct routine physical counts of each drug to reduce the risk for abuse and diversion.

Prior Reviews. From 2005 to 2008, the VA OIG's Office of Investigations investigated 32 allegations of facility-level non-controlled drug diversions. About half of these investigations are now closed, and some of them resulted in convictions. For example, over a 6-month period in FY 2006, a VA employee diverted about $51,000 worth of non-controlled drugs including Zyprexa, used to treat mental health conditions such as schizophrenia, and the cholesterol treating drug Lipitor.

The need for increased oversight of non-controlled drugs was discussed in the OIG report, *Review of VA Medical Facility Compliance with Controls over Prescription Drugs* (Report 05-00877-17, November 1, 2006). According to this report, inventory management needed improvement at 16 facilities, and it was recommended that VHA make better use of automated inventory management systems to account for non-controlled drugs. The report also noted that compliance with accountability controls can potentially decrease a facility's risk of drug diversion.

Program Office Responsibilities. VHA's Pharmacy Benefits Management (PBM) Services is responsible for developing policies to improve the safety and efficiency of facility inpatient and outpatient pharmacies. VHA's Chief Logistics Office provides guidance on pharmacy inventory management to local and regional pharmacy managers across VHA's Veterans Integrated Service Networks (VISN). According to VHA Handbook 1761.2, *VHA Inventory Management,* the Chief Logistics Office is responsible for providing guidance on monitoring compliance with pharmacy policies and procedures. The Chief Network Office is responsible for enforcing pharmacy inventory management policy.

Requirements for Monitoring Facility Pharmacy Inventories. VHA's Chief Logistics Office requires facilities to conduct annual physical inventories of all pharmaceutical items, including non-controlled drugs. According to VHA Handbook 1761.2, facilities must complete physical inventories and submit the total dollar value of these inventories to PBM by February 28 of each year. PBM aggregates inventory data regionally and forwards the data to VISN pharmacy managers. PBM also forwards nationally aggregated data to the Chief Logistics Office for monitoring purposes.

PBM's *Guidelines for Conducting Annual Inventories* require facility pharmacy managers to complete physical inventories of their pharmacies within a 24-hour period and conduct a random check of at least 25 inventory items for completeness and accuracy. According to PBM's guidelines, facility pharmacy managers can use physical inventory data to manage their stocks of drugs by using the data to identify inventory shortages and overages.

Drug Dispensing Process and Information Systems. Prescription medications are dispensed directly to veterans through a facility's inpatient or outpatient pharmacy. As outpatients, veterans may pick up filled prescriptions from a facility's outpatient pharmacy or the facility may mail the filled prescription directly to the veteran. Veterans may also have their medications mailed directly to them from a VHA Consolidated Mail Outpatient Pharmacy (CMOP).

Information on facility-level drug dispensing as well as the transfer of drug stocks is captured in VHA's Veterans Health Information System and Technology Architecture (VistA). Information on outpatient and inpatient drug dispensing and the transfer of drugs is captured in four VistA databases—Outpatient Dispensing (OP), Unit Dose (UD), Intravenous Dispensing (IV), and Automatic Replenishment/Ward Stock Dispensing (AR/WS). Data on facility-level drug purchases is captured in the pharmaceutical prime vendor's Supply Management On-Line (SMO) database. Some information from SMO—such as information on drug prices and drug names—can be uploaded to VistA using VHA's Drug Accountability Software.

Scope and Methodology

To determine how accurately VHA can account for non-controlled drugs, we selected five drugs for review. We selected Sustiva, Zyprexa, Ultram, and Levitra because these drugs are considered to be at increased risk for diversion. We also included the anti-clotting drug Plavix in our review because it is the drug most frequently purchased by VHA.

To determine to what extent VHA could account for the total inventories available for each of the five reviewed drugs from 2007 to 2008, we calculated an inventory discrepancy for each drug at 31 randomly selected facilities. These facilities were selected from the 157 facilities that provide both inpatient and outpatient pharmacy services. We suspended our inventory analysis after determining the pharmacy data was incomplete and therefore, not reliable.

We also determined that annual pharmacy inventory reports were not accurate because some drugs were not included in the inventory count at some facilities. Although the results of our inventory discrepancy analysis cannot be extrapolated to all facilities, our findings related to internal control weaknesses affecting the reliability of VistA data on pharmacy transactions and facility-level annual pharmacy inventory reports are system-wide. When this data is viewed in context with other available evidence, we believe the opinions, conclusions, and recommendations in this report are valid.

To identify non-controlled drugs that are considered at high risk for diversion, we interviewed Federal and private drug diversion experts. We analyzed VHA national and local pharmacy management policies and used an on-line questionnaire to survey pharmacy managers from the 157 facilities. The questionnaire was designed to obtain information on how many facilities are monitoring non-controlled drugs, actions local pharmacy managers are taking to monitor non-controlled drugs, and factors that affect pharmacy managers' ability to monitor inventories of non-controlled drugs.

We obtained a 100 percent response rate. We also conducted site visits to six geographically diverse facilities where we interviewed local pharmacy managers and observed pharmacy procedures. These facilities were located in Fayetteville, NC; New York, NY; Long Beach, CA; Wichita, KS; Seattle, WA; and Spokane, WA. We interviewed representatives from a national health maintenance organization (HMO) and a large national retail pharmacy chain to learn about private sector efforts to monitor non-controlled drugs for waste and diversion.

We conducted this performance audit from April 2008 to February 2009, in accordance with generally accepted government auditing standards. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective (see Appendix A for a more detailed discussion of our scope and methodology including our data reliability assessments).

Results and Conclusions

Accountability for Non-Controlled Drugs Needs to Improve

VHA cannot accurately account for its non-controlled drug inventories, because it has neither implemented nor enforced sufficient controls to ensure pharmacy inventory practices are standardized and pharmacy data is accurate. Pharmacy managers from facilities included in our inventory analysis reported a range of local practices that affect the completeness of pharmacy data captured in VistA, as well as the accuracy of annual physical inventory data. VHA has not instituted adequate controls to ensure that pharmacy personnel accurately and consistently record drug transactions in VistA. Also, VHA has not developed procedures to monitor drugs that may be at higher risk for waste and diversion. While VHA requires its facilities to conduct annual physical inventories of non-controlled drugs, it neither ensures inventory data is accurate nor uses the data as a tool to identify drug loss or possible drug diversion. Without improved accountability, non-controlled drugs are at increased risk for waste and diversion.

Public Law 97-255, the *Federal Managers Financial Integrity Act of 1982*, requires Federal agencies to establish internal controls to provide reasonable assurance that Federal property such as non-controlled drug inventories are appropriately safeguarded. According to the Government Accountability Office's (GAO) *Standards for Internal Control in the Federal Government* (GAO/AMID-00-21.3.1, November 1999), strong internal controls are the first line of defense in ensuring that agency assets are safeguarded. Agency management is responsible for developing suitable policies and procedures for internal controls.

According to VHA officials, the current VistA system cannot provide information to account for a facility's on-hand inventory accurately, because it does not have the capability to maintain a perpetual inventory. A perpetual pharmacy inventory system provides real-time information by accounting for current stock balances, all drug purchases, and all drug dispensing. In response to our questionnaire, 67 percent of pharmacy managers, from facilities providing inpatient and outpatient pharmacy services, reported VHA's pharmacy information system does not have the capability to monitor the non-controlled drug inventories closely enough to detect diversion. Non-controlled drugs, particularly those that are high cost or have a high street value, may be more vulnerable to diversion because of the broad awareness that VHA's pharmacy information system lacks the capability to track non-controlled drug inventories in detail.

In 2003, VHA launched the Pharmacy Re-Engineering project to make improvements to VistA. While we did not evaluate the design of the re-engineered system or results of system tests, PBM officials told us that this new system is expected to address deficiencies in VistA. Originally slated for completion in 2005, the project's timeline has been extended to 2011. However, PBM officials told us the project may not be completed until 2014.

While awaiting implementation of the Pharmacy Re-Engineering project, VHA needs to take immediate action to address limitations in its current inventory management system to improve its ability to account for and monitor non-controlled drug inventories. VHA should coordinate with VA's Office of Information and Technology to ensure that the Pharmacy Re-Engineering project will address the internal control weaknesses and data inaccuracies we discuss in this report and that the project timeline is met.

Drug Transactions Not Accurately and Consistently Recorded. Although VHA has established some procedures in its user manuals regarding the use of VistA to record pharmacy transactions, controls are not in place to ensure that accurate and complete information on drug transactions is captured. Information on transferred stocks of drugs and drug returns must be manually entered into VistA. We found that local pharmacy personnel are not consistently recording information in VistA on transactions such as pharmacy stock transfers and drug returns. Also, some dispensing data may be incomplete because some pharmacy personnel are inappropriately using the prescription label reprint function in VistA to dispense drugs. These factors impacted the completeness of the data used to conduct our analyses and may account for the inventory discrepancies we calculated. As a result, facilities' actual inventory discrepancies may be higher or lower.

Data on Transferred Non-Controlled Drug Inventories Not Consistently Captured. Pharmacy managers from 9 of the 31 facilities included in our analysis reported that pharmacy personnel do not always enter information on quantities of drugs transferred to secondary locations into the VistA AR/WS database. They stated that this incomplete or missing data may account for the negative inventory discrepancies we calculated for their facilities. Information on transferred stocks of drugs must be manually entered into the AR/WS database. VHA Handbook 1108.6, *Inpatient Pharmacy Services–Administration of Medication Management Systems,* provides guidance to pharmacy personnel on using the AR/WS database to record information on quantities of medications transferred to secondary locations, such as an emergency room or inpatient ward.

At one of the sites we visited, the facility pharmacy manager told us that AR/WS is not used at all to capture information on stocks of drugs transferred to a State Veterans Home. Rather than using AR/WS, pharmacy personnel at this site captured information on medications transferred to the State Veterans Home in a database that did not interface with VistA. Based on data provided by the facility, we estimate about 18 percent of the facility's total available inventory of Zyprexa was not accounted for in VistA. Dispensing data on non-controlled drug inventories will be understated at facilities where pharmacy personnel are not consistently and accurately entering information on transferred stocks of medications in the AR/WS database.

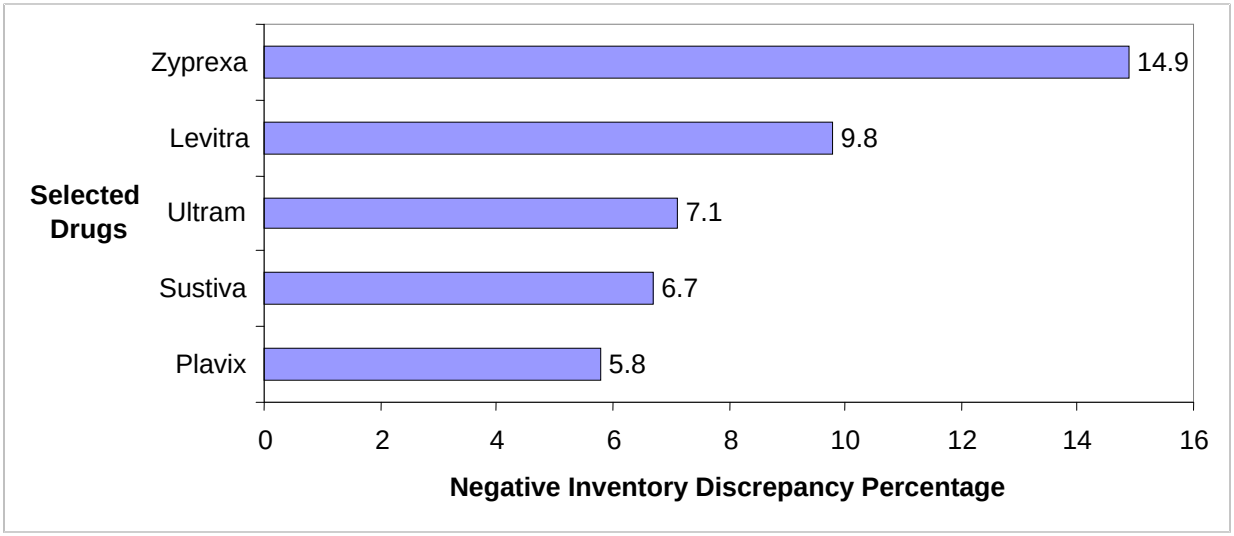
Label Reprint Function Inappropriately Used to Dispense Drugs. VistA has the capability to reprint prescription labels, which is appropriately used in cases when the original label is damaged. According to PBM officials, pharmacy personnel generally should not use the VistA reprint function to dispense drugs. However, pharmacy

managers from the six facilities we visited told us that pharmacy personnel are using the reprint function to dispense drugs to patients, which can affect the accuracy of outpatient dispensing data captured in VistA.

VistA does not have any controls in place, such as an electronic sign off by a pharmacy supervisor, to track why a reprint label is being initiated and to ensure that the function is not being inappropriately used to dispense drugs. The quantity of drugs dispensed using the reprint function is not always captured in the VistA OP database. In fact, the quantity of drugs dispensed using the reprint function is only captured in the VistA OP database if the original prescription was not released to the patient. This can occur when a prescription cannot be filled by a CMOP because the drug is not available and the facility fills the prescription instead. In such cases, facility pharmacy personnel could use the reprint function to print another prescription label to fill the patient's prescription rejected by the CMOP. VHA needs to establish procedures to monitor and appropriately control reprint activity.

We calculated a negative inventory discrepancy for at least one of the five selected drugs at 31 facilities, meaning the ending inventory was lower than it should have been given the quantities of drugs purchased and dispensed by the facility. These inventory discrepancies may be caused by local practices related to how information is captured on pharmacy stock transfers and the use of the prescription label reprint function. We estimated from our review of five non-controlled drugs that 31 facilities were unable to account for a total of 379,339 units, valued at about $700,000, or 8 percent of their total available inventory of 4.9 million units, valued at about $6 million. Considered in terms of individual drugs, facilities included in our analysis experienced average negative inventory discrepancies ranging from about 6 percent for Plavix to 15 percent for Zyprexa. Exhibit 1 shows the range of average negative inventory discrepancies for the reviewed drugs.

Exhibit 1. Average Negative Inventory Discrepancies for Five Non-Controlled Drugs

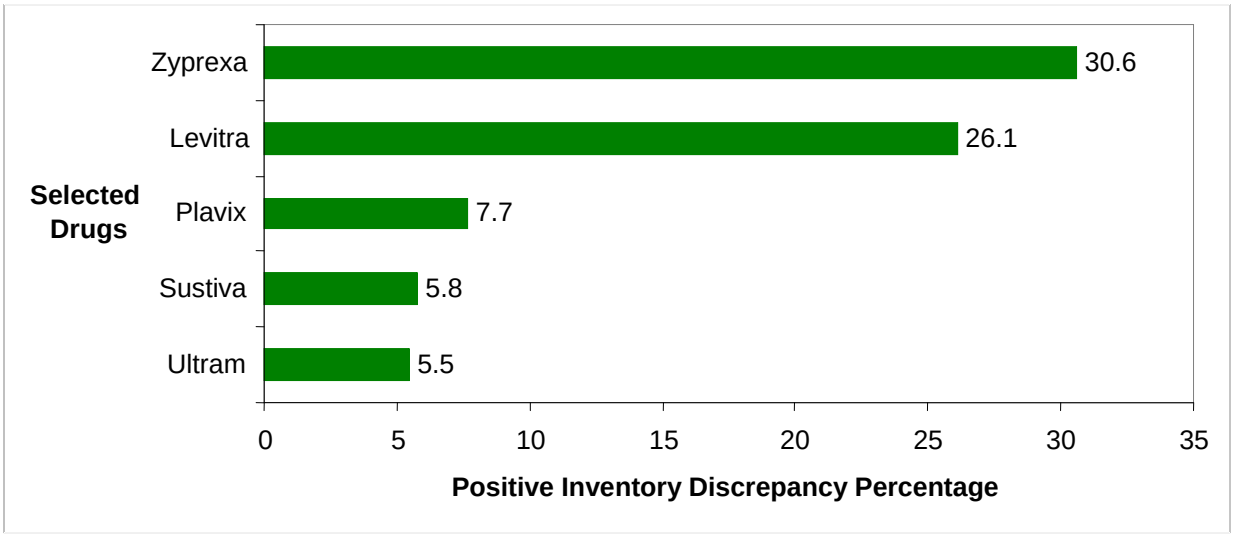


Data on Drugs Returned to Stock Not Consistently Captured. We also found that facilities are not consistently capturing information on quantities of drugs originally dispensed by the facility and returned to the same facility's pharmacy inventory for reuse. Pharmacy managers from seven facilities included in our analysis told us that some pharmacy personnel may be returning drugs to inventory without adjusting balances in VistA. VHA's *Outpatient Pharmacy Managers User Manual,* states pharmacy personnel should manually enter information into VistA on the quantity of non-controlled medications returned to the pharmacy's stock for future dispensing. This return to stock function corrects VistA data on the quantity of a given drug dispensed to date. Unless pharmacy personnel adjust the quantity of medications that were previously recorded as being dispensed, a facility's dispensing data will be inflated.

We calculated a positive inventory discrepancy for at least one of the five selected drugs at 24 facilities, meaning the ending inventory was higher than it should have been given the quantities of drugs purchased and dispensed by the facility. We estimated from our review that these facilities had 876,555 units available for dispensing, yet records showed these facilities dispensed 909,785 units and had 53,696 units in ending inventory. This represents an excess of 86,926 units, which was 10 percent more of the five drugs than the facilities should have had available to dispense.

We calculated average positive inventory discrepancies for each drug that ranged from 6 percent for Ultram to as high as 31 percent for Zyprexa. Positive inventory discrepancies are a major concern since drug losses associated with diversion could go undetected and be attributed to poor inventory recordkeeping practices. Exhibit 2 shows the range of average positive inventory discrepancies for the reviewed drug.

Exhibit 2. Average Positive Inventory Discrepancies for Five Non-Controlled Drugs



These positive inventory discrepancies may be a result of not capturing information on returned drugs in VistA. While the return to stock function in VistA corrects the inventory count for medications dispensed and returned to stock by the same facility,

VistA does not have the capability to account for CMOP dispensed drugs that are restocked by a facility. Pharmacy managers told us that it is a local decision whether to restock returned drugs originally dispensed by a CMOP, and managers at two sites we visited reported routinely restocking returned drugs dispensed by a CMOP. Pharmacy managers from both of these sites told us their positive inventory discrepancies were caused by not being able to capture information in VistA on drugs returned to stock that were originally dispensed by a CMOP.

We confirmed that the VistA system does not have the capability to account for returned quantities of these non-controlled drugs. PBM officials, however, told us that they have concerns about the use of drugs returned in the mail because conditions such as extreme heat or cold that these drugs may be exposed to during shipment can affect a drug's integrity. VHA needs to issue a policy on facilities' use of drugs returned in the mail, and if facilities restock returned drugs, VHA needs to develop standardized procedures to capture information in its inventory records on restocked CMOP dispensed drugs.

Lack of Policy to Monitor High-Risk Non-Controlled Drugs. VHA does not currently require its facilities to monitor any non-controlled drugs. VHA Directive 98-020, *Drug Accountability Software Version 3.0*, which required facilities to monitor at least 20 non-controlled drugs for possible diversion, expired in 2003. VHA does not currently provide facilities with technical guidance on how to monitor non-controlled drugs to detect diversion, and VHA has not taken steps to improve the usefulness of its annual physical inventory information to improve accountability over non-controlled drugs.

Some Facilities Taking Steps to Monitor Non-Controlled Drugs. In response to our questionnaire, 36 percent of pharmacy managers reported that they lack adequate information on how to develop processes to monitor non-controlled drugs for diversion. Pharmacy managers at some facilities are taking steps to monitor non-controlled drugs in the absence of a comprehensive VHA policy. Eighty percent of pharmacy managers reported that they monitor at least one non-controlled drug for diversion and the majority of these pharmacy managers (63 percent) reported that they monitor one to five drugs. Almost half of the pharmacy managers, who reported monitoring non-controlled drugs for diversion, used inventories as a way to monitor these drugs. According to questionnaire responses, most facilities conduct inventories of some drugs at least quarterly.

Other actions pharmacy managers frequently reported taking to monitor non-controlled drugs for diversion included comparing data on drug purchasing and dispensing to identify unaccounted for drugs and tracking selected non-controlled drugs through VistA software that was designed to perpetually track inventories of controlled substances. To increase accountability over non-controlled drugs at increased risk for diversion, VHA needs to identify and monitor these drugs.

During our site visits, we observed and learned about actions pharmacy managers were taking to increase monitoring of non-controlled drugs. For example, pharmacy managers at one facility we visited started using the VistA Drug Accountability Software in

May 2008 to monitor the same five drugs we analyzed. At another facility we visited, pharmacy managers issued a local policy in August 2008 to increase monitoring of non-controlled drugs. They would, for example, select five non-controlled drugs to monitor closely each year. This facility also stores non-controlled drugs at increased risk for diversion in a secure storage area, such as a locked vault. Efforts were being taken at the other four facilities we visited to increase monitoring of some non-controlled drugs. For example, at three facilities we observed that some non-controlled drugs considered at higher risk for diversion were stored in a vault or secured room. At another facility, pharmacy managers reported that they monitor some non-controlled drugs by periodically comparing purchasing records against dispensing reports to identify any abnormalities.

Private Sector Actions to Monitor Non-Controlled Drugs. We interviewed representatives from a national HMO and large national retail pharmacy chain to identify current private sector policies and procedures used to monitor inventories of high-risk non-controlled drugs. Both monitor some non-controlled drugs for diversion. For example, the HMO tracks high cost drugs, while the national retail pharmacy tracks drugs at high risk for diversion, based on a listing of high risk drugs developed by the National Association of Drug Diversion Investigators (NADDI). Both compare purchasing and dispensing data to calculate inventory discrepancies every month. Representatives told us that when purchases for a drug exceed drug-dispensing rates in consecutive months an investigation may be initiated. However, representatives stated they take into account the size of a pharmacy; the volume of the drug being dispensed; as well as the timing of the purchases to determine if drug diversion is in fact occurring. They reported that they do not use a standard inventory shrinkage rate, which would account for losses such as waste caused by the accidental spilling of bottles of medications and theft. We were unable to identify an industry-wide standard inventory shrinkage rate for non-controlled drugs.

Physical Inventories Not Fully Utilized to Account for Non-Controlled Drugs. VHA has not taken steps to improve the usefulness of its annual physical inventory information to improve accountability over non-controlled drugs. According to PBM officials, the purpose of the annual physical inventory is not to account for inventories of specific drugs, but to measure how efficiently facilities are managing inventory turnover, an indicator of whether a facility has too much or too little on-hand inventory. However, according to VHA's guidance, an annual physical inventory may be used to identify missing inventory or potential drug diversion. While physical inventory data could be a useful tool for VHA to monitor selected non-controlled drugs nationally or regionally, VHA needs to take steps to improve the accuracy of this information.

VHA requires pharmacy managers to verify that physical inventories are conducted completely and accurately by conducting random checks of at least 25 items. None of the pharmacy managers at the six sites we visited were able to provide us with documentation demonstrating their compliance with VHA's requirement to ensure that annual physical inventories are accurate. Furthermore, pharmacy managers from 11 of 31 facilities told us that their inventory discrepancies may be the result of inaccurate physical inventory data. VHA does not require its facilities to maintain their annual

physical inventory reports for a period of time, nor does it require its facilities to record inventory results in a standardized electronic format. Thirty-five facilities were unable to provide us with their inventory reports or the inventory reports were only available in hardcopy format.

We determined the risk for error was too high to rely on these manual reports for purposes of this analysis. Retaining standardized electronic inventory data would allow VHA to develop reports to monitor the inventories of specific drugs nationally or regionally. Complete and standardized annual physical inventory data is needed to help VHA establish accountability over its non-controlled drug inventories.

Conclusion

VHA cannot accurately account for its non-controlled drug inventories because it lacks effective controls and reliable information to do so. The accurate and complete data needed to account for these drugs is not available, and VistA lacks the capability to capture information on some drugs that are returned to a facility and restocked. VHA's information limitations negatively impact its ability to accurately account for and monitor its inventories of non-controlled drugs and impair its ability to identify instances of drug waste and diversion. Without accurate and complete information, VHA cannot ensure its non-controlled drug inventories are appropriately safeguarded, increasing the risk of waste and diversion. The implementation and enforcement of sufficient controls to ensure accurate and complete information is imperative to VHA's ability to account for and safeguard non-controlled drug inventories.

Recommendations

1. We recommend the Under Secretary for Health develop procedures to identify high risk non-controlled drugs and require pharmacy managers to monitor those drugs by establishing standardized inventory discrepancy rates that if exceeded require further investigation.
2. We recommend the Under Secretary for Health develop appropriate internal controls to ensure pharmacy managers and staff accurately and consistently record drug-dispensing activity in VistA.
3. We recommend the Under Secretary for Health require that information on drug stocks transferred within a VA health care facility and drugs dispensed by and returned to a facility's stock is accurately and consistently recorded in VistA.
4. We recommend the Under Secretary for Health establish a policy on VA health care facilities' use of drugs returned in the mail; and if returned drugs are restocked by facilities, develop procedures to ensure information on returned quantities of CMOP dispensed drugs that are restocked is consistently captured in inventory records using standardized procedures.

5. We recommended the Under Secretary for Health develop policy to limit access to the VistA label reprint function to appropriate pharmacy personnel and develop standard procedures to capture information on drugs dispensed using the reprint function.
6. We recommended the Under Secretary for Health develop standardized electronic annual physical inventory reporting formats; develop standards to ensure that annual physical inventory reports are reasonably accurate; and establish a procedure to hold VA health care facility pharmacy managers accountable for the accuracy of annual physical inventory reports.

Management Comments and OIG Response

The Acting Under Secretary for Health agreed with the findings and recommendations in the report and provided acceptable implementation plans (see Appendix B for the full text of comments). VHA will develop processes that identify and monitor high-risk non-controlled drug inventories including the designation of universal inventory discrepancy rates that, if exceeded, will require follow-up investigation. VHA will also emphasize the importance of accurately and consistently recording drug dispensing activity in VistA, and will identify internal monitoring controls to ensure that facilities are complying with documentation requirements.

VHA will reinforce the importance of fully utilizing existing capabilities in VistA to record and monitor the transfer of drug stocks within a facility and also issue guidance that drugs returned to the pharmacy after leaving VA custody must not be returned to stock and should be destroyed. VHA will develop procedures for returning and disposing of CMOP dispensed drugs and will reiterate the importance of adjusting inventory data to account for drugs returned in the mail as undeliverable and destroyed.

VHA will develop a policy to limit access to the VistA label reprint function, standard procedures to capture information on drugs dispensed using the reprint function, and standardized electronic formats to ensure that annual physical inventory reports are reasonably accurate. VHA will also establish procedures to hold health care facility managers accountable for report accuracy.

We consider these planned actions acceptable, and we will follow up on their implementation until all proposed actions are completed.

Appendix A

Additional Information on Audit Scope and Methodology

To identify non-controlled drugs at increased risk for diversion, we reviewed relevant studies published by Federal agencies such as DEA and private sector organizations such as the NADDI and the National Association of Boards of Pharmacy (NABP). We interviewed Federal drug diversion experts from DEA, the Food and Drug Administration, National Institute of Drug Abuse, and the Substance Abuse and Mental Health Services Administration. In addition, we interviewed experts from the private sector including representatives from NADDI and NABP.

Based on our interviews and reviews of investigations and published research, we identified four drugs consistently cited as at increased risk for diversion: Sustiva, Zyprexa, Ultram, and Levitra. We also included the anti-clotting drug Plavix in our analysis because it is the drug most frequently purchased by VHA. Exhibit 3 provides further information on the drugs we included in our analysis.

Exhibit 3. Non-Controlled Drugs Selected for Inventory Analysis

Trade Name	Generic Name	Criteria for Selection	Facility Total Purchases (Feb 2007 – Feb 2008)	Therapeutic Use
Zyprexa	Olanzapine	High risk for diversion and high unit cost	$27.6 million	Mental/mood conditions such as schizophrenia and bipolar mania
Levitra	Vardenafil	High risk for diversion	$673,000	Erectile dysfunction
Ultram	Tramadol	High risk for diversion	$862,000	Pain control
Sustiva	Efavirenz	High risk for diversion and high unit cost	$3.2 million	HIV infection
Plavix	Clopidogrel	Highest volume drug purchased by VHA	$20 million	Cardiac conditions such as heart attack, unpredictable severe constricting chest pain, and prevention of blood clots in the brain

Source: Drug Manufacturer Information and OIG Analysis

Inventory Analysis. VHA operates 157 facilities that offer both inpatient and outpatient pharmacy services. We requested 2007 and 2008 annual physical inventory data from each facility. Sixty-six facilities were not included in our analysis for a range of reasons. For example, 26 facilities could only provide us with inventory data in hardcopy format. We determined that manually entering large amounts of data into our data analysis software would introduce an unreasonable amount of error and did not include these facilities in our analysis. Furthermore, 27 facilities failed to comply with VHA's

requirement to conduct their inventories within a 24-hour period. We did not include these facilities in our review because we were unable to reconcile beginning inventory data captured over multiple days with ending inventory data that was not captured over a similar period of time. Exhibit 4 provides further details on reasons why some facilities were excluded from our inventory discrepancy analysis based on their annual physical inventory reports.

Exhibit 4. Annual Physical Inventory

Factors Excluding VA Health Care Facilities from Review	Unique Facilities
Facilities that did not conduct a 2007 inventory	3
Facilities that could not provide a 2007 or 2008 inventory	9
Facilities that did not conduct a 2008 inventory before the February 29 deadline	1
Facilities conducted inventories over multiple dates	27
Facilities that provided either a 2007 or 2008 hardcopy inventory	26
Total number of facilities excluded from OIG review	66

To calculate a total available inventory discrepancy percentage, we included in our analysis the total quantity of each of the five selected drugs available for dispensing during a 12-month period from 2007 to 2008. We calculated each facility's total available inventory by taking the reported ending balance of each facility's 2007 inventory and adding the number of units purchased for each of the five selected drugs during the year. We then subtracted the number of units dispensed through the facility's inpatient and outpatient pharmacies to determine an OIG calculated inventory. We compared our calculated inventory to the facility's reported 2008 ending physical inventory and determined a total available inventory discrepancy for each drug at each facility. We then divided the facility's inventory discrepancy by the total available facility inventory to calculate a total available inventory discrepancy percentage for each drug at each facility.

We found both positive and negative inventory discrepancies. A negative inventory discrepancy was observed when a facility's reported ending inventory was lower than our calculated ending inventory based on the quantity of drugs a facility purchased and dispensed. A positive inventory discrepancy was observed when a facility's reported ending inventory was higher than our calculated ending inventory based on the quantity of drugs a facility purchased and dispensed.

Data Reliability. We conducted tests to assess the reliability of data that we planned to use in our inventory discrepancy analysis. To test drug-purchasing data, we compared data provided by the OIG Austin Data Analysis Division with information from the prime vendor's SMO database and found that facility level purchasing data was reliable for the purposes of our audit. We were unable to test the reliability of annual physical inventory data because VHA's VistA information system does not have the capability to maintain

perpetual inventory information and as a result, we were not able to compare each facility's annual physical inventory reports to another source of inventory data. We were not able to assess the reliability of dispensing data extracted from VistA because facilities do not keep hard paper logs of dispensed non-controlled drugs. Furthermore, pharmacy dispensing data is generated from prescriptions entered electronically by VHA clinicians into VHA's Computerized Patient Record System that operates as part of the VistA information system.

We took steps to assess the reliability of specific data we used in our inventory discrepancy analyses. We shared the results of our inventory analyses with pharmacy managers from each facility included in our analysis. We asked each facility pharmacy manager to review the data that we used to conduct our analysis for accuracy and completeness. Some of these pharmacy managers reported that limitations in the VistA information system, as well as local procedures, may affect the completeness and reliability of VistA generated dispensing information. We confirmed during our site visits that VistA limitations and local procedures were impacting the completeness and reliability of pharmacy information captured in VistA as well as annual physical inventory reports. We concluded that pharmacy dispensing data captured in VistA and annual physical inventory data were not reliable and suspended our inventory discrepancy analysis at 31 randomly chosen facilities. Exhibit 5 provides details on the facilities included in our analysis.

Exhibit 5. VA Health Care Facilities Included in Inventory Analysis

No.	VA Health Care Facility	Location	Station	VISN
1	Edith Nourse Rogers Memorial Veterans Hospital	Bedford, MA	518	1
2	Manchester VA Medical Center (VAMC)	Manchester, NH	608	1
3	Manhattan Campus of the VA New York Harbor (Health Care System) HCS	New York, NY	630	3
4	Erie VAMC	Erie, PA	562	4
5	Philadelphia VAMC	Philadelphia, PA	642	4
6	Fayetteville VAMC	Fayetteville, NC	565	6
7	Salem VAMC	Salem, VA	658	6
8	Atlanta VAMC	Decatur, GA	508	7
9	Central Alabama Veterans HCS	Montgomery, AL	619	7
10	Carl Vinson VAMC	Dublin, GA	557	7
11	West Palm Beach VAMC	West Palm Beach, FL	548	8
12	Huntington VAMC	Huntington, WV	581	9
13	VA Ann Arbor HCS	Ann Arbor, MI	506	11
14	Robert J. Dole VAMC	Wichita, KS	589A7	15

Exhibit 5. VA Health Care Facilities Included in Inventory Analysis (cont'd)

No.	VA Health Care Facility	Location	Station	VISN
15	Jack C. Montgomery VAMC	Muskogee, OK	623	16
16	Overton Brooks VAMC	Shreveport, LA	667	16
17	New Mexico VA HCS	Albuquerque, NM	501	18
18	Northern Arizona VA HCS	Prescott, AZ	649	18
19	Cheyenne VAMC	Cheyenne, WY	442	19
20	Jonathan M. Wainwright Memorial VAMC	Walla Walla, WA	687	20
21	Spokane VAMC	Spokane, WA	668	20
22	VA Puget Sound HCS	Seattle, WA	663	20
23	VA Puget Sound HCS	Tacoma, WA	663A4	20
24	VA Palo Alto HCS	Palo Alto, CA	640	21
25	VA Palo Alto HCS	Livermore, CA	640A4	21
26	VA Sierra Nevada HCS	Reno, NV	654	21
27	VA Long Beach VAMC	Long Beach, CA	600	22
28	VA Southern Nevada HCS	Las Vegas, NV	593	22
29	VAMC Saint Cloud	Saint Cloud, MN	656	23
30	VA Black Hills HCS	Fort Meade, SD	568	23
31	VA Black Hills HCS	Hot Springs, SD	568A4	23

Appendix B

Acting Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: JUN 02 2009

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report: **Audit of the Veterans Health Administration's Management of Non-Controlled Drugs** (Project No. 2008001322-R1-0130/WebCIMS 426747)

To: Assistant Inspector General for Audit (52)

1. I have reviewed this draft report and concur with your auditors' findings and recommendations. You have pointed out an acknowledged need for stronger, more universally applied internal controls of high-risk non-controlled drug inventories, and involved VHA program offices have already begun to coordinate specific actions to address issues raised in the report. VHA's plan of corrective action in response to each recommendation is attached.

2. A key preliminary step has been taken by VHA's Pharmacy Benefits Management (PBM) Service to develop systematic processes for all pharmacy managers to use in identifying and monitoring high-risk non-controlled drugs, including the designation of universal discrepancy rates that will provide guidance as to whether further investigation might be warranted. PBM will also develop national procedures for disposition of returned mail-out drugs and utilize established communication venues to reiterate to Chiefs of Pharmacy the importance of adjusting inventories to reflect the destruction of these undeliverable drugs.

3. In addition, by the end of September 2009, PBM anticipates completion of a policy to limit personnel access to the VistA label reprint function, development of standard procedures to capture information on drugs dispensed using the reprint system, development of standardized electronic formats and standards for use in mandated annual physical inventory reports, and establishment of an oversight procedure to better ensure the accuracy of facility physical inventory reports. At the same time, a copy of this report will be distributed to all Veterans Integrated Service Networks and facilities once it is finalized, and PBM and the Office of the Deputy Under Secretary for Health for Operations and Management staff will again reiterate key monitoring requirements through established channels of communication with the field, including national conference calls and Web site informational exchanges.

4. Thank you for the opportunity to comment on this report. If additional assistance is required, please have a member of your staff contact Margaret M. Seleski, Director, Management Review Service at 461-8470.

Gerald M. Cross, MD, FAACP

Attachment

VA FORM MAR 1989 2105

Appendix B

VETERANS HEALTH ADMINISTRATION
Action Plan Response
OIG Draft Report: Audit of the Veterans Health Administration's Management of Non-Controlled Drugs (Project No. 2008-01322-R1-0130)

Recommendations/ Actions	Status	Completion Date

1. We recommend that the Under Secretary for Health develop procedures to identify high risk non-controlled drugs and require pharmacy managers to monitor those drugs by establishing standardized inventory discrepancy rates that if exceeded require further investigation.
Concur

VHA's Pharmacy Benefits Management (PBM) Service will develop processes and systems that can be utilized by pharmacy managers to identify and monitor non-controlled drug inventories that are specifically designated as high-risk. The primary focus will be to standardize processes for nationwide application, including the designation of universal inventory discrepancy rates that, if exceeded, will require follow-up investigation.

PBM will also recommend an implementation timeline for the new requirements to become operational throughout the system, a process that Veterans Integrated Service Network (VISN) Pharmacist Executives will oversee in coordination with staff from the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM), as well as PBM staff.

In Process — June 30, 2009 and Ongoing

2. We recommend that the Under Secretary for Health develop appropriate internal controls to ensure pharmacy managers and staff accurately and consistently record drug dispensing activity in VistA.
Concur

As noted in the report, VHA has established policies that identify internal controls and consistent recording of drug dispensing activities in VistA. Your findings reflect that facilities are not consistently complying with established policy.

To address this concern, PBM staff will re-emphasize the importance of this requirement through established communication modes, including regularly scheduled conference calls with facility Pharmacy Service Chiefs. In follow-up, PBM staff will also develop a facility-level survey instrument to gauge compliance improvement. The Office of the DUSHOM staff will work with VISN clinical staff to identify internal monitoring controls that can be utilized to ensure that facilities are complying with this documentation requirement.

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VHA Action Plan/OIG Draft Report: Audit of the Veterans Health Administration's Management of Non-Controlled Drugs

Long-term plans for facilitating facility compliance with internal controls for inventory management are included in the requirements for the Pharmacy Re-Engineering project (PRE). PRE is under the management and direction of the Assistant Secretary for Information Technology. The new inventory system was originally planned for implementation in 2008, but has experienced several delays. It has now been pushed back to 2011, at the earliest.

Planned June 30, 2009 and Ongoing

3. We recommend the Under Secretary for Health require that information on drug stocks transferred within a VA health care facility and drugs dispensed by and returned to a facility's stock is accurately and consistently recorded in VistA.
Concur

PBM staff will coordinate with staff in the DUSHOM office to reiterate to VISN and field facility staff the importance of fully utilizing existing capabilities of the Automatic Replenishment/Ward Stock package to record and monitor the transfer of drug stocks within their health care facilities. PBM will also issue guidance to the field emphasizing that drugs returned to the pharmacy after leaving VA custody must not be returned to stock. Instead, the drugs must be destroyed, and there must be documentation to that effect.

In Process June 30, 2009 and Ongoing

4. We recommend the Under Secretary for Health establish a policy on VA health care facilities' use of drugs returned in the mail; and if returned, drugs are restocked by facilities, develop procedures to ensure information on returned quantities of CMOP dispensed drugs that are restocked is consistently captured in inventory records using standardized procedures.
Concur

PBM will develop procedures for returning and disposing of Consolidated Mail Outpatient Pharmacy (CMOP) dispensed drugs and will consider whether an official policy on facility disposition of drugs returned in the mail is additionally warranted. In the meantime, PBM staff will use established modes of communication with the field, including regularly-scheduled conference calls with Chiefs of Pharmacy, to focus on the importance of adjusting inventories to account for drugs returned in the mail as undeliverable and destroyed.

Planned June 30, 2009 and Ongoing

Page 3

VHA Action Plan/OIG Draft Report: Audit of the Veterans Health Administration's Management of Non-Controlled Drugs

5. We recommend the Under Secretary for Health develop policy to limit access to the VistA label reprint function to appropriate pharmacy personnel and develop standard procedures to capture information on drugs dispensed using the reprint function.
Concur

PBM will develop a policy to limit access to the VistA label reprint function to appropriate pharmacy personnel and will develop standard procedures to capture information on drugs dispensed using the reprint function. PBM will also submit a New Service Request to the Office of Information and Technology to support the policy to limit access.

Planned June 30, 2009 and Ongoing

6. We recommend that the Under Secretary for Health develop standardized electronic annual physical inventory reporting formats, develop standards to ensure that annual physical inventory reports are reasonably accurate; and establish a procedure to hold VA health care facility pharmacy managers accountable for the accuracy of annual physical inventory reports.
Concur

PBM will develop standardized electronic formats, develop standards to ensure that annual physical inventory reports are reasonably accurate, and establish a procedure to hold health care facility managers accountable for the accuracy of annual physical inventory reports.

Planned September 30, 2009

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Nick Dahl (781) 687-3120
Acknowledgments	Irene J. Barnett Michael Cannata John Cintolo Matthew Kidd Jennifer Leonard James McCarthy Steven Rosenthal

Appendix D

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