US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

**VETERANS HEALTH ADMINISTRATION**

# Incomplete Implementation of Corrective Actions to Address Pharmacy Service Concerns at the VA Central Western Massachusetts Healthcare System in Leeds

**Healthcare Inspection** | **23-01965-217** | **August 21, 2024**

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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess whether leaders implemented corrective actions to address pharmacy-related concerns at the VA Central Western Massachusetts Healthcare System (system) in Leeds.[1]

In early 2023, the OIG received five allegations related to prescription processing delays and inadequate pharmacy staff training, and requested the Veterans Integrated Service Network (VISN) Director to respond to the allegations. According to the response, an external review, performed by individuals associated with another VISN, partially substantiated or substantiated four of the five allegations and made 12 recommendations.[2] The System Associate Director (Associate Director) adopted the recommendations as 12 corrective actions and, in late-July, tasked the chief of pharmacy with implementation of 11 of the 12 recommendations.[3] Of the 12 corrective actions, 3 were due to be implemented by July 28, 5 by August 31, and 4 by September 29, 2023. The OIG opened a hotline in September to determine whether system leaders had implemented the corrective actions.

The OIG reviewed system documentation supporting implementation of the corrective actions and determined that 11 of the 12 corrective actions were incomplete. The OIG found that

- Three corrective actions required development of standard operating procedures for completion; however, the OIG found that the standard operating procedures were insufficient to address the concerns identified by the external review.
- Five of the corrective actions were related to training pharmacy staff and supervisors; however, the OIG found that pharmacy staff did not receive training.
- Two corrective actions required a staffing coverage plan to be developed; however, the OIG found the coverage plans were not feasible.
- One corrective action required a gap analysis to ensure that select pharmacy practices complied with Veterans Health Administration requirements; however, the OIG reviewed the gap analysis and found that it lacked documentation supporting how the Pharmacy Service was meeting each item analyzed.

[1] Leaders included the Associate Director, acting Associate Director, Chief of Staff, and chief of pharmacy. Through interviews, the OIG learned the Associate Director began a detailed position as the acting System Director on July 24, 2023, but is referred to as the Associate Director throughout the report. A system leader became the acting Associate Director on July 24, 2023.

[2] The external reviewers did not substantiate one of the five allegations.

[3] During the OIG inspection, the Associate Director reported failing to include corrective action 12 in the communication with the Chief of Pharmacy.

Only one corrective action, to establish a plan for procurement technician coverage, had been completed; specifically, the plan assigned pharmacy supervisors as procurement technician backup. However, through interviews, the OIG learned of pharmacy supervisor vacancies and determined this would challenge the feasibility of the plan.

The OIG determined that the chief of pharmacy perceived the corrective actions as a disciplinary tool rather than an opportunity to improve pharmacy services and that this impacted implementation of the corrective actions.[4] The chief of pharmacy told the OIG that the corrective actions tasked by the Associate Director were "punitive" and an attempt to remove the chief of pharmacy from the position. The chief of pharmacy added that the corrective actions, such as developing standard operating procedures and other documents, were unnecessary as there were national guidelines for pharmacy services, but completed the corrective actions by the due dates "so that I wouldn't be disciplined."

The OIG also determined that system leaders, specifically the Associate Director and the acting Associate Director, as the chief of pharmacy's supervisors, did not provide effective and timely oversight to ensure completion of the corrective actions; and although not required, missed opportunities to involve the VISN Pharmacist Executive (VPE) to assist system staff during implementation to achieve compliance, instead waiting until corrective action deadlines had passed.[5] The OIG found that the Associate Director missed an opportunity to communicate the findings of the external review and recommendations to the VPE, diminishing the effectiveness of the VPE to assist system staff with implementing the corrective actions.[6] The Associate Director told the OIG that based on experiences with staff from another VISN office, the Associate Director had expected the VPE's involvement to be limited, but reported the VPE would be contacted sooner in the future.

In July 2023, the acting Associate Director of the system took over supervision of the chief of pharmacy.[7] The acting Associate Director explained to the OIG having not reviewed whether the corrective actions were implemented until after the deadlines had passed to allow the chief of pharmacy "the full extent of time to produce everything required" due to the concerns of

[4] VHA Directive, 1108.07(1), *General Pharmacy Service Requirements*, November 28, 2022, amended October 4, 2023. According to VHA policy, the chief of pharmacy is responsible for implementing VHA pharmacy requirements to promote a safe and efficient service that includes a medication management system and patient-centered customer service.

[5] VHA Directive, 1108.07(1). A VPE assists VA medical facilities with pharmacy practice compliance including "[m]edication procurement, security, storage, distribution/dispensing, inventory management and disposal" and education and training. The VPE also ensures that "facility action plans are developed and acted upon" when pharmacy recommendations are identified by oversight groups.

[6] The VPE was not included in the VISN response to the OIG.

[7] The acting Associate Director covered when the system's Associate Director became the acting System Director. The system's Pharmacy Service was organizationally aligned under the associate director position until October 2023, when the Pharmacy Service was re-aligned under the chief of staff position.

perceived punitive intentions raised by the chief of pharmacy. While reviewing the documents supporting completion of the corrective actions, the acting Associate Director identified the need for pharmacy expertise to review the supporting documents, but did not engage the VPE because supervision of the chief of pharmacy transitioned to the Chief of Staff in October. Approximately a week after assuming supervision of the chief of pharmacy, the Chief of Staff consulted with the VPE to review documents submitted by the chief of pharmacy to support completion of the corrective actions. After reviewing the documents, the VPE told the OIG that some of the recommendations were met, some were partially met, and some were not met. As of March 2024, the VPE continued to be in contact with system pharmacy staff for updates on progress with implementation of the corrective actions.

The OIG concluded that until system leaders ensure thorough completion of the corrective actions, prescription processing delays and improperly trained pharmacy staff likely remain.

The OIG made three recommendations to the VISN Director related to the completion of the corrective actions; ensuring pharmacy staff and supervisors receive training and guidance; and ensuring that leaders, whose actions contributed to the incomplete corrective actions and ineffective oversight, receive administrative action, as appropriate.

## VA Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes B and C). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

# Contents

# Abbreviations

| | |
|---|---|
| OIG | Office of Inspector General |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |
| VPE | VISN Pharmacist Executive |

# Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess whether leaders implemented corrective actions to address pharmacy-related concerns at the VA Central Western Massachusetts Healthcare System (system) in Leeds.[1]

## Background

The system, part of Veterans Integrated Service Network (VISN) 1, provides psychiatric, substance abuse, and posttraumatic stress disorder services, and primary and secondary medical care to approximately 90,000 patients in central and western Massachusetts. The system includes the Edward P. Boland VA Medical Center in Leeds and six community-based outpatient clinics.[2] The Veterans Health Administration (VHA) classifies the system as a level 3 complexity.[3]

The system's Pharmacy Service, managed by the chief of pharmacy, operates three pharmacies in the Leeds, Worcester, and Springfield locations, and utilizes pharmacy technicians, pharmacy procurement technicians, and clinical pharmacists in pharmacy operations.[4]

### Pharmacy Oversight

According to VHA policy, the chief of pharmacy is responsible for implementing VHA pharmacy requirements to promote a safe and efficient service that includes a medication management system and patient-centered customer service.[5] The chief of pharmacy serves as the

[1] Leaders included the Associate Director, acting Associate Director, Chief of Staff, and chief of pharmacy. Through interviews, the OIG learned the Associate Director began a detailed position as the acting System Director on July 24, 2023, but is referred to as the Associate Director throughout the report. A system leader became the acting Associate Director on July 24, 2023.

[2] The Edward P. Boland VA Medical Center operates 85 psychiatric beds and 30 community living center beds on campus, and a 16-bed Behavioral Health Rehabilitation Residential Treatment Program located off-campus in Northampton. Community-based outpatient clinics are located in Fitchburg, Springfield, Greenfield, and Pittsfield, and two clinics are in Worcester.

[3] VHA Office of Productivity, Efficiency, and Staffing (OPES), "Facility Complexity Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes each medical facility by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex; level 3 facilities are the least complex.

[4] "Under the supervision of a pharmacist, pharmacy technicians perform routine pharmacy functions including filling, preparation and dispensing of prescriptions . . . management of automated dispensing equipment (ADE), inventory management and multiple types of customer contact services." A pharmacy procurement technician is a pharmacy technician responsible for ordering medications and supplies. VHA Handbook 5005/159, *Staffing, Appendix G28. Pharmacy Technician Qualification Standard*, November 7, 2023.

[5] VHA Directive, 1108.07(1), *General Pharmacy Service Requirements*, November 28, 2022, amended October 4, 2023.

pharmacy subject matter expert, is responsible for the management of pharmacy systems, and empowers and engages a workforce that ensures staff educational needs are met.[6]

The medical facility director ensures overall compliance with the general pharmacy management directive and takes corrective action for non-compliance.[7] Additional responsibilities include ensuring the chief of pharmacy addresses any recommendations identified by government oversight offices, including the OIG and other external and internal pharmacy operations oversight groups, and that the VISN Pharmacist Executive (VPE) is updated on the status of recommendations.[8]

## Prior OIG Report

In an August 2023 report, the OIG surveyed VHA facilities to determine severe occupational staffing shortages for fiscal year 2023.[9] The OIG found a 19 percent increase in self-reported severe occupational staffing shortages as compared to the previous year. Within the system, severe occupational staffing shortages were reported in five clinical positions, including pharmacy technicians and pharmacists. Severe staffing shortages in pharmacy were not unique to the system, as pharmacy technicians and pharmacists were the 15th and 21st most reported severe occupational staffing shortages across 282 VHA occupations. From fiscal year 2022 to fiscal year 2023, the pharmacy technician occupation had the second highest increase in the number of facilities identifying the occupation as a severe staffing shortage. The OIG made no recommendations but emphasized the importance of VHA's continued assessment of severe occupational staffing shortages given the increases from fiscal year 2022 to fiscal year 2023, and encouraged VHA's efforts to complete work on open recommendations from an August 2021 OIG report on VHA's staffing models.[10]

## Allegations and Related Concerns

In late February 2023, the OIG received five allegations related to prescription processing delays and inadequate staff training in the system's Pharmacy Service. The OIG sent the allegations to the VISN Director in April and requested a response. The VISN Director provided a response to the OIG in July, which showed that, in May, the System Associate Director (Associate Director)

[6] VHA Directive, 1108.07(1).

[7] VHA Directive, 1108.07(1).

[8] VHA Directive, 1108.07(1).

[9] VA OIG, *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*, Report No. 23-00659-186, August 22, 2023; Fiscal years for federal agencies include an annual period of October 1 of one calendar year through September 30 of the following year. Congressional Budget Office, "*Common Budgetary Terms Explained*," accessed November 27, 2023, https://www.cbo.gov/publication/57660.

[10] VA OIG, *Review of Veterans Health Administration Staffing Models*, Report No. 20-01508-214, August 19, 2021. As of January 24, 2024, three recommendations remain open.

initiated an external review of the five allegations, performed by individuals associated with another VISN. The external reviewers did not substantiate one allegation, partially substantiated two allegations, and substantiated two allegations (see table 1), and made 12 recommendations.[11]

**Table 1. Allegations and Findings**

| Allegation | External Review Finding |
|---|---|
| **Allegation 1** Patient care is and has been significantly delayed. | Partially Substantiated* |
| **Allegation 2** Prescription orders are three weeks behind. | Not Substantiated |
| **Allegation 3** Community care faxes are several months behind. | Substantiated |
| **Allegation 4** Outpatient orders are going out one week behind or are missed completely. | Partially Substantiated |
| **Allegation 5** New staff are not being trained properly. | Substantiated |

*Source: OIG table showing VISN response excerpts.*
**The external reviewers found delays in community care prescription processing in the Northampton pharmacy location.*

The Associate Director adopted the recommendations as 12 corrective actions and, on July 24, tasked the chief of pharmacy with implementation of 11 of the 12 corrective actions.[12] Specifically, of the 12 corrective actions, 3 were to be implemented by July 28, 5 by August 31, and 4 by September 29. Table 2 lists the 12 corrective actions and corresponding due dates.

**Table 2. Twelve Corrective Actions**

| Corrective Action | Due Date |
|---|---|
| 1. Develop a standardized process and operating procedure for the ongoing management of community care prescriptions across VA Central Western Massachusetts to include processing of prescriptions within seven days and a process for prescriptions requiring follow-up. | August 31, 2023 |
| 2. Designate pharmacy staff across VA Central Western Massachusetts to complete community care prescription processing daily to include electronic, hard copy, and faxed prescriptions. | July 28, 2023 |
| 3. Complete new and ongoing training and competencies on all pharmacist staff involved in the completion of community care prescription processing. | August 31, 2023 |
| 4. Develop a process for addressing refill mail slips. | August 31, 2023 |

[11] At the time of the external review, Pharmacy Service was overseen by the incumbent of the associate director position. The Associate Director tasked the external reviewers with one additional allegation that resulted in eight recommendations to improve pharmacy leadership and staffing. The OIG did not review the additional allegation and corresponding recommendations.

[12] During the OIG inspection, the Associate Director reported failing to include corrective action 12 in the communication with the Chief of Pharmacy.

| Corrective Action | Due Date |
|---|---|
| 5. Assign refill mail slips to a specific technician role and ensure staff are aware of the assignment and staff are trained on how to process refill requests. | July 28, 2023 |
| 6. Conduct a gap analysis to ensure pharmacy procurement practices, pharmacy return mail practices, and expired medication for return and destruction are in compliance with VHA Directive 1108.07. | September 29, 2023 |
| 7. Develop a standardized process and operating procedure for the management of medications and supplies on backorder. | August 31, 2023 |
| 8. Provide staff education on proper cancellation of refills, management of backordered items, and consolidated mail outpatient pharmacy rejects. | August 31, 2023 |
| 9. Ensure backup coverage is in place for consolidated mail outpatient pharmacy rejects in the event a procurement technician is unavailable to complete. | July 28, 2023 |
| 10. Develop a comprehensive pharmacy procurement technician training program or coordinate with another site for formal training with established procurement technicians to include currently available electronic training for pharmacy procurement. | September 29, 2023 |
| 11. Develop and implement a new technician service-level orientation and training plan. | September 29, 2023 |
| 12. Develop and implement a new supervisor service-level orientation and training plan. | September 29, 2023 |

*Source: OIG table showing VISN response excerpts.*

The OIG questioned the ambitious plan of implementing the 12 corrective actions given the relatively short time frame and opened a hotline to determine whether system leaders had completed implementation. During the inspection, the OIG identified deficiencies in oversight of implementation of the corrective actions.

# Scope and Methodology

The OIG initiated the inspection on September 11, 2023, and conducted a site visit November 13–14. The OIG interviewed and corresponded with system leaders and VISN and system pharmacy leaders, supervisors, and staff.[13]

The OIG reviewed relevant VHA and system pharmacy policies and procedures, system patient safety reports and action plans, VISN and system emails, system staff and supervisor competencies and training records, and other human resources documents.

[13] The OIG interviewed the VISN 1 Pharmacist Executive (VPE), Associate Director, acting Associate Director, Chief of Staff, chief of pharmacy, pharmacy supervisors, and pharmacy staff.

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

The OIG substantiates 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, as amended, 5 U.S.C. §§ 401–424. 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

## Incomplete Corrective Actions and Contributing Factors

The OIG reviewed documentation provided by system leaders to support implementation of the corrective actions and determined that system leaders did not complete 11 of the 12 corrective actions (see appendix A).[14]

The system provided three standard operating procedures to demonstrate closure for corrective actions 1, 4, and 7; however, upon review, the OIG found that the standard operating procedures were insufficient to address the concerns identified by the external review. The system provided documentation for corrective actions 3, 8, 10, 11, and 12 involving training pharmacy staff and supervisors; however, the OIG found that the documentation did not support that the training was provided to pharmacy staff. Moreover, pharmacy staff reported to the OIG having not received training and system leaders provided documentation that pharmacy procurement technician and pharmacy supervisor training had not been completed. The system provided staffing coverage plans that were developed to complete corrective actions 2 and 5; however, the OIG found

[14] The OIG determined only corrective action 9, to establish a plan for procurement technician coverage, had been completed. The system established a coverage plan that tasked pharmacy supervisors with backup coverage responsibility. However, the OIG determined that the system's pharmacy supervisor vacancies would have precluded effective coverage; The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

through interviews with pharmacy staff that the coverage plans were not feasible. Further, pharmacy staff reported to the OIG being unaware of the coverage plans. To support completion of corrective action 6, the system provided documentation of a gap analysis; however, the OIG found it to be incomplete and absent of documentation to support how the Pharmacy Service was meeting the items for analysis. During interviews, pharmacy staff reported there have been no changes in pharmacy processes and operations since facility leaders reported the corrective actions were completed.

## Failures by the Chief of Pharmacy

The OIG determined the chief of pharmacy perceived the corrective actions as a disciplinary tool rather than an opportunity to improve pharmacy services and that this impacted implementation of the corrective actions.

According to the chief of pharmacy, the corrective actions were not necessary and were "punitive" in nature. The chief of pharmacy described having not been involved by the Associate Director in the development of the corrective actions and expressed the perception that the Associate Director tasked the corrective actions within a short time frame with the intent of removing the chief of pharmacy from the position. Additionally, the chief of pharmacy told the OIG that VA Pharmacy Benefits Management and the VPE provided pharmacy oversight and therefore, oversight should not be provided by the Associate Director, who did not have pharmacy expertise.[15] The chief of pharmacy added that new standard operating procedures and other documents were not needed to be developed because there were national guidelines for pharmacy services. Despite these beliefs, the chief of pharmacy reported implementing the corrective actions and turning in documents to complete the corrective actions by the assigned due dates "so that I wouldn't be disciplined." The chief of pharmacy reported that after the due dates, system leaders continued to request additional documentation to support closure of the corrective actions. However, the chief of pharmacy reported not providing additional documentation because all the supporting documents had already been provided and the belief that the request for additional documentation was punitive and unnecessary.[16]

[15] The chief of pharmacy's belief in this oversight responsibility is contrary to what is delineated in VHA policy. "Pharmacy Benefits Management Services (12PBM)," VA Patient Care Services, accessed January 2, 2024, https://vaww.patientcare.va.gov/PCS/PBM.asp. (This site is not publicly accessible.) VA Pharmacy Benefits Management provides leadership for pharmacy activities throughout VHA; VHA Directive, 1108.07(1). A VPE assists VA medical facilities with pharmacy practice compliance including "[m]edication procurement, security, storage, distribution/dispensing, inventory management and disposal" and education and training. The VPE also ensures that "facility action plans are developed and acted upon" when pharmacy recommendations are identified by oversight groups.

[16] The requested supporting documentation included verification that developed training occurred, documentation of coverage plans, and evidence a self-assessment was completed. In early December, the Chief of Staff provided documentation to the OIG that the chief of pharmacy had been moved to another position for 120 days and that two other pharmacists would be temporarily assuming the chief of pharmacy duties consecutively.

## Ineffective Oversight by System Leaders

The OIG determined that system leaders, specifically the Associate Director and the acting Associate Director, as the chief of pharmacy's supervisors, did not provide effective and timely oversight to ensure completion of the corrective actions; and although not required, missed opportunities to involve the VPE to assist system staff during implementation to achieve compliance, instead waiting until corrective action deadlines had passed. Additionally, the OIG found that the Associate Director missed an opportunity to communicate the external review findings and recommendations to the VPE, diminishing the effectiveness of the VPE to assist system staff with implementing the corrective actions.

Through interviews, the OIG learned that on July 24, 2023, a system leader became the acting Associate Director, taking over supervision responsibility of the Pharmacy Service while the Associate Director served in the capacity of acting System Director. In interviews, the OIG also learned the 12 corrective actions were due to be completed during the acting Associate Director's supervision. The acting Associate Director and Chief of Staff told the OIG that on October 8, 2023, system leadership was realigned and the Chief of Staff assumed responsibility for the Pharmacy Service.[17]

When interviewed by the OIG, the acting Associate Director recalled deciding to wait to review the chief of pharmacy's documentation until the end of September, despite knowing the corrective actions had staggered completion due dates from the end of July to the end of September. According to the acting Associate Director, the rationale for delaying the review of documentation was to provide the chief of pharmacy "the full extent of time to produce everything required" due to concerns raised by the chief of pharmacy regarding the perceived punitive intent of the corrective actions. The acting Associate Director reported being concerned upon review of the supporting documentation that the corrective actions had not been completed and that pharmacy subject matter expertise was required to understand and further review the supporting documentation. However, the acting Associate Director reported to the OIG not reaching out for subject matter expert assistance because oversight of the corrective actions was transitioning to the Chief of Staff.

The OIG learned through interviews that the Associate Director did not communicate the external review findings and recommendations to the VPE due to an expectation that the VPE's involvement would be limited.[18] The Associate Director explained this expectation was based on experiences with staff from another VISN office and recognized that in the future, the VPE should be contacted sooner. The Chief of Staff told the OIG that in October 2023, about a week

[17] The OIG received documentation that the Chief of Staff was on leave from mid-January until late February and has been on intermittent leave since late March 2024. The Deputy Chief of Staff is the acting Chief of Staff and has oversight of the Pharmacy Service.

[18] The VPE was not included in the VISN response to the OIG.

after taking over supervision duties of the Pharmacy Service when the Pharmacy Service was organizationally realigned, the Chief of Staff requested the VPE review documents submitted by the chief of pharmacy to support the completion of the corrective actions. The VPE explained to the OIG being in a consultative role and completing "a 25,000 feet review" of the corrective actions. The VPE reported that, upon reviewing the documents to support completion of the corrective actions, the VPE informed the Chief of Staff that some of the recommendations were met, some were partially met, and some were not met.[19] The Chief of Staff told the OIG of plans to involve the VPE as a subject matter expert in monitoring and completion of the corrective actions.[20] As of March 2024, the VPE reported to the OIG being in contact with system staff for updates on progress.

The OIG concluded system leaders did not sufficiently ensure completion of any of the 12 corrective actions. System leaders did not provide timely and effective oversight and missed an opportunity to involve the VPE sooner. The OIG would have expected system leaders to have been more proactive in seeking out pharmacy consultation from the VPE. While the Chief of Staff eventually included the VPE, and system leaders and the VPE have plans to be more collaborative in the future, system leaders missed opportunities to consult with the VPE during the implementation and subsequent review of the corrective actions. The OIG concluded that until system leaders ensure thorough completion of the corrective actions, prescription processing delays and improperly trained pharmacy staff likely remain.

# Conclusion

The OIG determined that because 11 of the 12 corrective actions were not completed, patients may continue to experience delays with Pharmacy Service. The OIG found the chief of pharmacy's perception that the corrective actions were not necessary undermined implementation. The OIG also found system leaders did not provide adequate oversight of completion of the corrective actions. The acting Associate Director's decision to delay a thorough review of documentation supporting completion of corrective actions created a missed opportunity for prompt intervention. System leaders missed opportunities to include the VPE for consultation during the external review and monitoring completion of the corrective actions.

[19] Both a system leader and the VPE confirmed consultation occurred but when asked could not provide information about which corrective actions were reviewed and what was determined.

[20] In December 2023, the chief of pharmacy had been detailed to another position.

# Recommendations 1–3

1. The Veterans Integrated Service Network Director ensures thorough completion of the VA Central Western Massachusetts Healthcare System pharmacy corrective actions, and takes action as needed.

2. The Veterans Integrated Service Network Director ensures that pharmacy supervisors and staff at the VA Central Western Massachusetts Healthcare System receive the necessary training and written guidance to complete the corrective actions, and monitors for compliance.

3. The Veterans Integrated Service Network Director ensures that leaders, whose actions contributed to the incomplete corrective actions and ineffective oversight, receive administrative action, as appropriate.

# Appendix A: OIG Evaluation of Corrective Actions

**Table A.1. Corrective Action Status and OIG Determination and Rationale**

| Corrective Action | System Determination of Completion Status and Date | OIG Determination | OIG Rationale |
|---|---|---|---|
| 1. Develop a standardized process and operating procedure for the ongoing management of community care prescriptions across VA Central Western Massachusetts to include processing of prescriptions within seven days and a process for prescriptions requiring follow-up. | Completed October 11, 2023 | Partially Complete | A standardized procedure was created but did not clearly state responsibility for follow-up of unapproved non-formulary medication requests and did not include a plan or instructions for how the process will be managed. |
| 2. Designate pharmacy staff across VA Central Western Massachusetts to complete community care prescription processing daily to include electronic, hard copy, and faxed prescriptions. | Completed October 11, 2023 | Partially Complete | System pharmacy leaders hired a designated community care pharmacist and planned to hire a community care pharmacy technician. System pharmacy staff reported that when the community care pharmacist was not at work, coverage was insufficient to ensure community care prescriptions were processed daily. |
| 3. Complete new and ongoing training and competencies on all pharmacist staff involved in the completion of community care prescription processing. | Completed November 3, 2023 | Partially Complete | Competency documents were provided but did not demonstrate training, and staff reported being instructed to sign the documents without receiving training. |
| 4. Develop a process for addressing refill mail slips. | Completed October 11, 2023 | Partially Complete | A standardized procedure was created but did not include how refill mail slips were to be entered into the system or the time frame required. |
| 5. Assign refill mail slips to a specific technician role and ensure staff are aware of the assignment and staff | Completed October 11, 2023 | Partially Complete | This duty was assigned to the pharmacy technician covering a specific task within the pharmacy but |

| Corrective Action | System Determination of Completion Status and Date | OIG Determination | OIG Rationale |
|---|---|---|---|
| are trained on how to process refill requests. | | | some system pharmacy staff reported they were not aware of who was assigned the duty. The work assignment did not account for staffing shortages. |
| 6. Conduct a gap analysis to ensure pharmacy procurement practices, pharmacy return mail practices, and expired medication for return and destruction are in compliance with VHA Directive 1108.07. | Completed November 3, 2023 | Partially Complete | The gap analysis document was submitted with all elements marked as meeting the requirements or not applicable. Documentation supporting the determination was not included. |
| 7. Develop a standardized process and operating procedure for the management of medications and supplies on backorder. | Completed October 11, 2023 | Partially Complete | A standardized procedure was created but did not include actions to take to ensure a prompt response from a prescriber or patient notification requirements. |
| 8. Provide staff education on proper cancellation of refills, management of back-ordered items, and consolidated mail outpatient pharmacy rejects. | Completed November 3, 2023 | Incomplete | The documentation provided did not demonstrate evidence that training occurred. |
| 9. Ensure backup coverage is in place for consolidated mail outpatient pharmacy rejects in the event a procurement technician is unavailable to complete. | Completed November 3, 2023 | Complete | A backup coverage plan was developed and communicated to the pharmacy procurement technicians but did not account for the number of vacant positions, which could impact the effectiveness of the coverage plan. |
| 10. Develop a comprehensive pharmacy procurement technician training program or coordinate with another site for formal training with established procurement technicians to include | Incomplete* November 3, 2023 | Incomplete | System reported item as incomplete. |

| Corrective Action | System Determination of Completion Status and Date | OIG Determination | OIG Rationale |
|---|---|---|---|
| currently available electronic training for pharmacy procurement. | | | |
| 11. Develop and implement a new technician service-level orientation and training plan. | Completed<br>November 3, 2023 | Partially Complete | Orientation and training materials were developed but no training plan was in place. New staff reported they did not receive adequate training or orientation when starting their position. |
| 12. Develop and implement a new supervisor service-level orientation and training plan. | Incomplete*<br>November 3, 2023 | Incomplete | System reported item as incomplete. |

*Source: OIG analysis of system provided documents related to corrective action item implementation.*
**The Chief of Staff reported this item was incomplete and the chief of pharmacy reported it was complete. Because the Chief of Staff was responsible for determining implementation of the corrective actions, the OIG included the Chief of Staff's determination.*

# Appendix B: VISN Director Memorandum

## Department of Veterans Affairs Memorandum

Date: July 9, 2024

From: Director, VA New England Healthcare System (10N1)

Subj: Healthcare Inspection—Incomplete Implementation of Corrective Actions to Address Pharmacy Service Concerns at VA Central Western Massachusetts Healthcare System in Leeds

To: Director, Office of Healthcare Inspections (54HL04)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. The VA New England Healthcare System, VISN 1, is committed to honoring our Veterans and ensuring they receive high-quality healthcare services. We appreciate the assessment provided by the Office of Inspector General and the opportunity to review and comment on the report "Incomplete Implementation of Corrective Actions to Address Pharmacy Service Concerns at the VA Central Western Massachusetts Healthcare System in Leeds."

2. Based on the thorough review of the report by myself and VISN 1 Leadership, I concur with the recommendations.

3. If there are any questions regarding responses or additional information required, please contact the VISN 1Quality Management Officer.

(*Original signed by:*)

Ryan Lilly, MPA
VISN 1 Network Director
VA New England Healthcare System

[OIG comment: The OIG received the above memorandum from VHA on July 10, 2024.]

# VISN Director Response

## Recommendation 1

The Veterans Integrated Service Network Director ensures thorough completion of the VA Central Western Massachusetts Healthcare System pharmacy corrective actions, and takes action as needed.

_X _Concur

____Nonconcur

Target date for completion: December 31, 2024

### Director Comments

The VISN Pharmacy Executive in conjunction with the local pharmacy executive team and local leadership team, will ensure completion of the corrective action plan by December 31, 2024. The tracking of completion shall be reported through the governance structure starting with the VA Central Western Massachusetts Healthcare Delivery Council, resulting in a monthly report to VISN Chief Medical Officer, or designee.

## Recommendation 2

The Veterans Integrated Service Network Director ensures that pharmacy supervisors and staff at the VA Central Western Massachusetts Healthcare System receive the necessary training and written guidance to complete the corrective actions, and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: December 31, 2024

### Director Comments

The Veterans Integrated Service Network Director concurs in principle with the recommendation and will ensure the VA Central Western Massachusetts Healthcare System provide retraining of all existing pharmacy staff, with evidence for training of onboarding staff. Retraining has already been initiated and is led by the VISN Pharmacy Executive. Completion of training will be reported up to the VISN Medical Officer or designee, monthly until existing staff have been trained, and a process for onboarding training has been established.

## Recommendation 3

The Veterans Integrated Service Network Director ensures that leaders, whose actions contributed to the incomplete corrective actions and ineffective oversight, receive administrative action, as appropriate.

_X _Concur

____Nonconcur

Target date for completion: July 31, 2024

### Director Comments

The Veterans Integrated Service Network Director will consult with VISN HR staff and VHA Workforce Management and Consulting to determine if any administrative action is warranted for any leader whose actions contributed to the incomplete corrective actions and ineffective oversight.

### OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

# Appendix C: Facility Director Memorandum

## Department of Veterans Affairs Memorandum

Date: July 11, 2024

From: Director, VA Central Western Massachusetts Healthcare System (CWM) (631)

Subj: Healthcare Inspection—Incomplete Implementation of Corrective Actions to Address Pharmacy Service Concerns at VA Central Western Massachusetts Healthcare System in Leeds

To: Director, VA New England Healthcare System (10N1)

I would like to thank the Office of Inspector General for the opportunity to review the draft report of the Incomplete Implementation of Corrective Actions to Address Pharmacy Service Concerns at VA Central Western Massachusetts Healthcare System in Leeds.

I have reviewed and concur with the recommendations pertaining to our pharmacy service and will ensure the corrective actions are completed and sustained through our governance structure.

I appreciate the Office of Inspector General's partnership in our continuous improvement efforts.

If there are any questions regarding responses or additional information required, please contact Chief of Quality Management for the VA Central Western Massachusetts Healthcare System.

(*Original signed by*:)

Jonathan Kerr
Interim Executive Director, VA CWM

[OIG comment: The OIG received the above memorandum from VHA on July 11, 2024.]

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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