THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

October 7, 2024

The Honorable Hampton Dellinger
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-24-000447

Dear Mr. Dellinger:

I am responding to your March 5, 2024, letter to the Department of Veterans Affairs (VA) regarding whistleblower allegations that the Central Texas VA Healthcare System (hereinafter Temple) in Temple, Texas, engaged in conduct that may constitute violation of a law, rule, or regulation; engaged in gross mismanagement; or created a substantial and specific danger to public health or safety.

The Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. VA conducted a site investigation on April 30, 2024 – May 2, 2024.

We do substantiate one and do not substantiate three of the whistleblower's allegations. We make nine recommendations to Temple and two recommendations to the Veterans Health Administration. The signed report will be sent to the respective offices with a request for an action plan.

Thank you for the opportunity to respond.

Sincerely,

Denis McDonough

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-24-000447

Central Texas VA Healthcare System
Temple, Texas

Report Date: September 26, 2024

Content Manager 2024-C-9

Executive Summary

The Office of the Secretary of the Department of Veterans Affairs (VA) received a letter from the Office of Special Counsel on March 5, 2024, requesting formal resolution. Subsequently, the Under Secretary for Health directed the Office of the Medical Inspector (OMI) to assemble and lead a VA team to investigate allegations concerning the Central Texas VA Healthcare System (CTVAHCS) (hereinafter Temple) located in Temple, Texas. The whistleblower, who consented to the release of his name, alleged that an employee engaged in conduct that may constitute violation of a law, rule, or regulation; engaged in gross mismanagement; or created a substantial and specific danger to public health or safety. We conducted an in-person investigation on April 30, 2024, through May 2, 2024, to investigate these allegations.

Specific Allegations of the Whistleblower

1. *CTVAHCS Chief of Staff, Associate Chief of Staff, and Director of Operations have refused to adhere to and enforce national directives, policies, and standard operating procedures (SOP) for the processing of DME prescriptions, including, but not limited to VHA Directive 1173.2 "Responsibilities, Prosthetic and Sensory Aids Service," VHA Directive 1173.06, "Wheeled Mobility Devices," VHA Office of Community Care, Request for Service Form 10-10172 Standard Operating Procedures; Safe Patient Handling and Mobility Technology to Support Veterans in Home Settings, SOPs; and PSAS Business Practice Guidelines for Consult Management.*

2. *Due to the noncompliance of these officials, PSAS consistently expends agency funds on improper equipment orders.*

3. *Patient care is delayed because patients are not receiving prescribed DME on a timely basis.*

4. *Any other, related allegations of wrongdoing discovered during the investigation of the foregoing allegations.*

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place and **do not substantiate** allegations when the facts and findings showed the allegations are unfounded. We are **unable to substantiate** allegations when the available evidence was insufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of the findings, we make the following conclusions and recommendations:

Conclusion for Allegation 1

- We **do not substantiate** the Chief of Staff (COS), Deputy COS, and the Medical Center Director have refused to adhere to and enforce national directives, policies, and SOP for the processing of durable medical equipment (DME) prescriptions.

- Temple leadership has taken multiple steps to try and resolve concerns in compliance with national policies, reaching out to Veterans Integrated Service Network 17 and to the Prosthetic and Sensory Aids Service (PSAS) National Program Office (NPO) for guidance.

- Temple PSAS closed consults for home DME from both VA prescribers and eligible entities based on perceived inadequate assessment of education, training, and home environment.

- PSAS closed consults for VA prescribers and eligible entities based on perceived failure to provide detailed descriptions of DME specifics on their consult.

- We find guidance in PSAS Business Practice Guidelines (BPG) for PSAS Consult Management regarding detailed descriptions (for example vendor, make, and model) unreasonable and potentially a reason for delay of services.

Recommendations to Temple

1. Educate Temple PSAS staff, including the Chief, that Veterans Health Administration (VHA) Directive 1173, Prosthetic and Sensory Aids Service, dated March 27, 2023. and Safe Patient Handling and Mobility Technology SOP, dated July 18, 2019, both support the use of an interdisciplinary team approach for evaluation, education, and training of patients on DME, and develop plans to operationalize such interdisciplinary teams.

2. Reschedule the postponed in-depth review and education by the combined PSAS and Physical Medicine and Rehabilitation (PMR) NPOs.

Recommendation to VHA

1. Clarify guidance in PSAS BPG for PSAS Consult Management that the detailed description for DME is the responsibility of all care team members to include PSAS representatives, not just those providers or eligible entities submitting a PSAS consult.

Conclusions for Allegation 2

- We **do not substantiate** that PSAS consistently expends agency funds on improper orders.

- We noted approximately $100,000 in excess or improper equipment stored in the Temple contract warehouse in September 2021 and $84,000 at the end of fiscal

year (FY) 2022 due to rejection or non-delivery. These values represent approximately 0.2% of the total Temple PSAS annual budget.

Recommendation to Temple

None.

Conclusions for Allegation 3

- We **substantiate** patient care was delayed in the delivery of DME. In 7 of 10 examples provided to us, documentation was adequate to fulfill the request, yet the consults were cancelled.

- As noted previously, the Chief of PSAS failed to note the role of an interdisciplinary team, to include specialty care and PSAS staff, in the evaluation, education, and training of patients on DME in questioning the request for a new hospital bed for a veteran with a pontine stroke, causing a delay in providing necessary medical equipment.

- The Chief of PSAS failed to follow procedures defined in Central Texas Veterans Healthcare System (CTVHCS) SOP 117-21-02, Major Medical and Special Equipment Committee (MMSEC), dated July 1, 2021, in the same case.

- The Chief of PSAS is outside their scope by offering medical treatment suggestions to VA health care providers and questioning the quality of the justification from a clinical perspective.

- VHA Directive 1173.06, Wheeled Mobility Devices (WMD), dated December 13, 2021, provides guidance for the Wheeled Mobility Clinic (WMC) Team lead or prescribing VA health care provider to assess for misuse of WMD by the Veteran, placing them in a potentially adversarial position of enforcement versus a therapeutic relationship.

- Temple PSAS SharePoint site included an out of date link from calendar year 2009 that needs to be updated.

Recommendations to Temple

3. See Allegation 1, Recommendation 1.

4. During the rescheduled PSAS and PMR NPO review, include a review of the appropriateness of consults closed by PSAS FY 2023 to present and provide related training to ordering providers and PSAS.

5. Enforce SOP 117-21-02 with a focus on MMSEC team responsibilities and add Care in the Community representation to the MMSEC.

6. Ensure the Chief of PSAS is aware of and complies with their responsibilities under VHA Directive 1173, paragraph 2i through 2i(17), and that these responsibilities do not include offering medical treatment suggestions to VA health care providers or questioning the quality of the justification from a clinical perspective.

7. PSAS provide in-service training to providers on the new Temple PSAS SharePoint after removing out of date SharePoint website link.

Recommendation to VHA

2. Provide guidance on interpretation of VHA Directive 1173.06 regarding responsibilities of the WMC Team lead or prescribing VA health care provider, particularly paragraph 18 and its associated note.

Conclusions for Additional Findings

- CTVHCS Medical Center Policy 674-121-001 is not an actual policy that has been signed by the Medical Center Director.

- PSAS is providing incorrect interpretations of policy which impacts clinical decisions on DME.

Recommendations to Temple

8. Conduct a review of policies currently in use by PSAS to validate accuracy.

9. Ensure all staff are aware of the correct guidance relating to use of VA Federal Supply Schedule for DME and exceptions to this policy.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel concerns that alleged conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; and a substantial or specific danger to public safety occurred. We reviewed the allegations and determined the merits of each. We discovered evidence of delays in supplying DME to Veterans. There are recommendations contained in this report for Temple to follow VHA Directives, facility policy, and for VHA to review business practice guidelines and wheeled mobility device policy.

Table of Contents

I. Introduction

The Office of the Secretary of the Department of Veterans Affairs (VA) received a letter from the Office of Special Counsel on March 5, 2024, requesting formal resolution. Subsequently, the Under Secretary for Health directed the Office of the Medical Inspector (OMI) to assemble and lead a VA team to investigate allegations concerning the Central Texas VA Healthcare System (CTVAHCS) (hereinafter Temple) located in Temple, Texas. The whistleblower, who consented to the release of his name, alleged that an employee engaged in conduct that may constitute violation of a law, rule, or regulation; engaged in gross mismanagement; or created a substantial and specific danger to public health or safety. We conducted an in-person investigation on April 30, 2024, through May 2, 2024, to investigate these allegations.

II. Facility Profile

Temple, which is part of Veterans Integrated Service Network (VISN) 17, is a level 1a high complexity facility that serves Veterans in 39 counties in Central Texas.[1] Temple has two medical centers located in Temple and Waco, Texas; one stand-alone outpatient clinic in Austin, Texas; four community-based outpatient clinics located in Brownwood, Bryan/College Station, Cedar Park, and Palestine; and a rural outreach clinic in La Grange, Texas. Additionally, Temple has a Temple VA Clinic annex in the community that houses six patient aligned care teams and a sleep center in Killeen, Texas.[2]

III. Specific Allegations of the Whistleblower

1. *CTVAHCS Chief of Staff, Associate Chief of Staff, and Director of Operations have refused to adhere to and enforce national directives, policies, and standard operating procedures (SOP) for the processing of DME prescriptions, including, but not limited to VHA Directive 1173.2 "Responsibilities, Prosthetic and Sensory Aids Service," VHA Directive 1173.06, "Wheeled Mobility Devices," VHA Office of Community Care, Request for Service Form 10-10172 Standard Operating Procedures; Safe Patient Handling and Mobility Technology to Support Veterans in Home Settings, SOPs; and PSAS Business Practice Guidelines for Consult Management.*

2. *Due to the noncompliance of these officials, PSAS consistently expends agency funds on improper equipment orders.*

1 Complexity 1a facilities have a high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs. VHA Facility Complexity Model Fact Sheet, undated. Available at: http://raft.vssc.med.va.gov/SelfPacedDocuments/FY23, last accessed June 24, 2024. ***Note**: This is an internal VA website that is not available to the public.*
2 VHA Support Service Center, Trip Pack-Operational Statistics Table, Temple, Texas. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx, last accessed June 20, 2024. ***Note**: This is an internal VA website that is not available to the public.*

3. *Patient care is delayed because patients are not receiving prescribed DME on a timely basis.*

4. *Any other, related allegations of wrongdoing discovered during the investigation of the foregoing allegations.*

IV. Conduct of Investigation

The VA team conducting the investigation consisted of a Senior Medical Investigator and a Clinical Program Manager, both from OMI; a Clinical Program Manager from VHA Prosthetic and Sensory Aids Service (PSAS); and a virtual Employee and Labor Relations Consultant (as needed). We reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in attachment A. We interviewed the whistleblower on April 22, 2024.

We conducted an entrance brief on April 30, 2024, with the following VISN 17 and Temple leadership:

- Chief Medical Officer, VISN 17
- Director, VISN 17
- Deputy Quality Manager, VISN 17
- Executive Assistant, VISN 17
- Medical Center Director
- Chief of Staff (COS)
- Deputy COS
- Associate Director
- Chief, Quality Safety and Value
- Deputy Chief, Quality Safety and Value
- Compliance Officer
- Executive Assistant to the Deputy Director
- Deputy Executive Director
- Assistant Director
- Executive Assistant to the Associate Director

We interviewed the following Temple employees:

- Medical Center Director
- COS
- Deputy COS

- Assistant Director
- Chief, PSAS
- Chief Financial Officer
- Compliance Officer (acting)
- Nurse Manager, Patient Safety
- Chief, Quality Safety and Value
- Chief, Physical Medicine and Rehabilitation (PMR) Service
- Supervisory Prosthetics Representative
- Request for Service (RFS) Coordinator
- Physiatrists (2)
- Occupational Therapists (2)
- Chief, Care in the Community (CITC) (acting)
- Orthotist-Prosthetist
- Chief Oncology
- Prosthetic Purchasing Agent
- Prosthetic Representatives (2)
- Primary Care Physician
- Prosthetics Rep, VISN 17

We conducted an exit brief on May 2, 2024, with the following VISN 17 and Temple leadership:

- Medical Center Director
- COS
- Assistant Director
- Chief, Quality Safety and Value
- Assistant Chief, Quality Safety and Value
- Executive Assistant to the Medical Center Director
- Deputy Chief Nurse Executive
- Executive Assistant to the Deputy Director
- Deputy Executive Director, Temple
- Deputy Quality Manager, VISN 17
- Quality Manager Officer, VISN 17

- Deputy COS

V. Background, Findings, Conclusions, and Recommendations

Allegation 1

CTVAHCS Chief of Staff, Associate Chief of Staff, and Director of Operations have refused to adhere to and enforce national directives, policies, and standard operating procedures (SOP) for the processing of DME prescriptions, including, but not limited to VHA Directive 1173.2 "Responsibilities, Prosthetic and Sensory Aids Service," VHA Directive 1173.06, "Wheeled Mobility Devices," VHA Office of Community Care, Request for Service Form 10-10172 Standard Operating Procedures; Safe Patient Handling and Mobility Technology to Support Veterans in Home Settings, SOPs; and PSAS Business Practice Guidelines for Consult Management.

Background

The Centers for Medicaid and Medicare Services defines "Durable medical equipment" as equipment that meets the requirement defined in 42 C.F.R. § 414.202 as follows:

> *"(1) Can withstand repeated use.*
>
> *(2) Effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years.*
>
> *(3) Is primarily and customarily used to serve a medical purpose.*
>
> *(4) Generally, is not useful to a person in the absence of illness or injury.*
>
> *(5) Is appropriate for use in a patient's home."*[3]

We did not find VHA Directive 1173.2, "Responsibilities, Prosthetic and Sensory Aids Service," as written in in the allegation. VHA Handbook 1173.2, Furnishing Prosthetic Appliances and Services is no longer in effect. However, we believe VHA Directive 1173, Prosthetic and Sensory Aids Service, dated March 27, 2023, is the correct reference and is hereinafter referred to in this report.

VHA Directive 1173, paragraph 2i through 2i(17) states: *"The VA medical facility PSAS Chief is responsible for:*

> *(1) Representing the VA medical facility on all topics related to PSAS.*
>
> *(2) Educating Veterans and clinicians on all PSAS programs and the administrative requirements for each.*

3 Code of Federal Regulations, Title 42, Chapter IV, Subchapter B, Part 414, Subpart D, § 414.202, last amended September 17, 2024. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.202, last accessed September 23, 2024.

(3) Collaborating with clinical staff to resolve PSAS administrative consult issues and ensure the streamlined provision of PSAS devices and benefits.

(4) Providing clinical staff information about devices that VA medical facility PSAS is authorized to purchase and PSAS programs available to Veterans.

(5) Assigning a VA medical facility COR [Contracting Officer Representative] for all VA medical facility-level PSAS contracts to monitor ongoing contractual compliance for all PSAS service contracts by accreditation standards and other associated governing bodies.

(6) Ensuring PSAS transactions and expenditures for PSAS items and services are recorded appropriately within the NPPD [National Prosthetic Patient Database].

(7) Monitoring the VA medical facility PSAS budget and communicating all needs or excess through appropriate fiscal and VISN channels.

(8) Ensuring PSAS staff are educated on and adhere to all PSAS BPG [Business Practice Guidelines].…

(9) Ensuring adherence to all PSAS administrative consult management procedures as outlined in the PSAS BPG to ensure the timely and accurate provision of devices and benefits to Veterans.

(10) Ensuring proper administration of all PSAS benefit programs, including the Automobile Adaptive Equipment (AAE) program, Home Improvements and Structural Alterations (HISA) program and Clothing Allowance in accordance with eligibility requirements and VHA regulations.…

(11) Ensuring the completion of all VA medical facility PSAS assigned VA medical facility field corrections and recall actions initiated in VHA Alerts and Recalls application within the expected timeframe. ***NOTE****: Recall actions are VA medical facility assignments made on an item that was issued by PSAS and may be in Veteran possession where the manufacturer has issued a recall or field correction.*

(12) Ensuring VA medical facility PSAS staff abide by all applicable financial policies for procurement of prosthetic devices.…

(13) Ensuring all PSAS performance metrics are routinely monitored to ensure VA medical facility compliance.

(14) Advocating for PSAS programs at VA medical facilities.

(15) Developing action plans to address recommendations identified by external and internal oversight groups (e.g., VSOs, VA Office of Inspector General,

The Joint Commission, Payment Integrity Information Act, Commission on Accreditation of Rehabilitation Facilities (CARF)).

(16) Partnering with the VPR [VISN Prosthetics Representative] and VA medical facility leadership and clinical staff to implement all applicable PSAS policies, programmatic changes and action plans for identified areas of concern resulting from internal and external audits to ensure streamlined and consistent service delivery.

(17) Ensuring the completion of supplemental claim reviews for all administrative appeals received within 30 calendar days of receiving VA Form 20-0995."[4]

Additionally, VHA Directive 1173, paragraph 2j(1) through 2j(8) states, the prescribing VA health care provider or eligible entity (a non-VA provider who has the authority to request devices and equipment through VA) is responsible for:

"(1) Evaluating Veterans and determining whether they require an item or service under PSAS programs.

(2) Providing clinical justification for the prescribed item or service as required by the corresponding regulations. ***NOTE****: Please refer to Appendix A [of VHA Directive 1173] for further information on regulatory authorities governing PSAS benefits, devices and equipment.*

(3) Performing and documenting in the Veteran's electronic health record (EHR) an evaluation of the Veteran to establish any clinical requirements under PSAS programs, including a justification for a PSAS item or service.…

(4) Ensuring the environment where items or equipment provided under PSAS programs will be used is considered or assessed to ensure it meets the Veteran's needs (e.g., HISA program or home medical equipment home assessment, AAE program vehicle assessment). ***NOTE****: Not all items or equipment provided by PSAS will require a home assessment if the home environment is not relevant to the safe and effective function of the items or equipment.*

(5) Coordinating equipment trials for the Veteran, if indicated, documenting trial results in the EHR and determining whether the trialed item or service is optimal for the Veteran's needs. ***NOTE****: Not all items will require an equipment trial. The determination on whether an item must be trialed is based upon manufacturer or clinical requirements.*

(6) Collaborating with administrative or clinical staff to provide additional information or clarification on requested PSAS program items and benefits to ensure timely delivery.

4 VHA Directive 1173, Prosthetic and Sensory Aids Service, dated March 27, 2023.

*(7) Ensuring the Veteran is provided training and education to ensure safe and efficient use of PSAS program items or benefits, including discussing Veteran responsibilities. **NOTE**: Education and training may be provided by personnel in specialty clinics that distribute items and equipment to the Veteran or other members of the clinical team.*

(8) Serving as the point of contact for Veterans when their conditions or circumstances change in such a way that may impact their use of PSAS programs, including conducting routine follow-up appointments with Veterans based on their needs (e.g., phone, telehealth, in-person visit)."[5]

VHA Directive 1173, paragraph 6a through 6c states that:

"a. PSAS is an essential component of health care delivery in VA that provides comprehensive support to optimize Veterans' health and independence. PSAS develops patient-centered protocols for the procurement and distribution of items and benefits to Veterans that support and are aligned with clinical standards of care. PSAS staff consult relevant clinical standard operating procedures and provide items and equipment under prosthetic programs.

b. Items and benefits provided include, but are not limited to, sensory aids, such as hearing and blind aids; mobility aids, such as walkers and wheelchairs; communication and assistive devices; orthotic and prosthetic devices; home respiratory therapy, such as home oxygen services; recreational and rehabilitative equipment; surgical implants; durable medical equipment and prosthetic item repairs; and service dog insurance.

c. Additionally, PSAS administers several Veteran benefits programs such as AAE, HISA and Clothing Allowance."[6]

VHA Directive 1173.06, Wheeled Mobility Devices (WMD), dated December 13, 2021, paragraph 4, states: *"It is VHA policy that WMDs are provided to maximize the health, mobility, function and quality of life for Veterans. It is VHA policy for VA to maintain the operation of WMDs."*[7]

Additionally, VHA Directive 1173.06, paragraph 5k through 5k(18) states: the Wheeled Mobility Clinic Team lead or prescribing VA health care provider is expected to

"… evaluate, fit, train and follow-up with the Veteran for wheeled mobility and knowledge, in clinic, face-to-face, and using the VA telehealth platform. Knowledge must be commensurate with the complexity of each Veteran's clinical needs. Such prescribing VA health care providers may include Physiatrists, Occupational therapists, Physical Therapists, Kinesiotherapists and Recreation Therapists with

5 Ibid.
6 Ibid.
7 VHA Directive 1173.06, Wheeled Mobility Devices (WMD), dated December 13, 2021.

expertise in prescribing wheelchairs. The WMC [Wheeled Mobility Clinic] Team Lead or Prescribing VA Health Care Provider is responsible for:

(1) Completing a preliminary needs assessment with review of past medical history, diagnosis, prognosis and WMD previously issued to the Veteran and documenting in the Veteran's EHR.

(2) Performing and documenting in the Veteran's EHR, a comprehensive functional evaluation of the Veteran to determine the needed WMD and any related equipment needs.

(3) Documenting the Veteran's goals, clinical rehabilitation goals, and metrics and outcome measures. ***NOTE****: It is recommended that an outcome measurement tool be used initially and at an appropriate follow-up interval (e.g., Functional Mobility Assessment).*

(4) Providing a comprehensive wheeled mobility assessment, which may include a trial of various devices, configurations and options, and wheeled mobility management trial to determine if the Veteran can safely drive, control and operate the WMD.

(5) Assessing transportation needs, including any need and ability of the Veteran and their care provider to safely transport the Veteran and WMD (e.g., vehicle modifications, vehicle lift, public transportation), and prescribing equipment or referring the Veteran for further evaluation.

(6) Assessing the environment where the WMD will be used to ensure it will meet the needs of the Veteran (e.g., residence ingress or egress through ramp or vertical platform lift access, threshold and door width clearance, access to electrical power outlets for charging power mobility devices and sheltered storage from the weather).

(7) Determining the need for manufacturer's representative or vendor assistance at a specific WMC. Manufacturer's representative or vendors must be registered according to national and VA medical facility standards and have a specific purpose for any WMC visits. Vendors must not have standing invitations and do not have prescriptive authority.

(8) Communicating with the Veteran, caregiver or assistant in order to share assessment findings, results, discuss mobility options, Veteran expectations, training, collaborate on mutually agreed goals and develop a treatment plan.

(9) Coordinating WMD trials for the Veteran as needed and determining whether the device is optimal for the Veteran's needs.

(10) Completing documentation of a prescription, including a justification for the WMD and all associated accessories in the patient's EHR.

(11) Coordinating with clinical and administrative staff to ensure timeliness of WMD issuance, accuracy and overall continuity of care.

(12) Reviewing all quotes for custom seating and mobility products in collaboration with VA medical facility PSAS staff to ensure accuracy.

(13) Documenting the WMD trial education and entire fitting process in the EHR.

(14) Providing the Veteran, caregiver or assistant with a manufacturer's user guide, and discussing content including roles and responsibilities, safe and efficient use of WMD and routine maintenance and care of the WMD. This includes discussing Veteran responsibilities including storage, and safe and acceptable use of WMDs.

(15) Scheduling follow up for Veterans receiving WMDs in order to document outcomes based on the evaluation and determine if the goals and expectations documented during the evaluation were achieved. The timeframe, frequency and method of follow up are determined on an individual basis for each Veteran.

(16) Serving as the point of contact for Veterans when their conditions or circumstances change in such a way that may impact their use of the WMD. This includes recommending routine follow ups to Veterans based on their needs, (e.g., phone, telehealth, in person visit) for reassessment of WMD, seating function, and safety.

(17) Ensuring that additional follow-up modifications that are recommended by the prescribing health care provider are completed by either the prescribing VA health care provider or by qualified support personnel under the instruction and supervision of the prescribing VA health care provider.

(18) Reevaluating Veteran circumstances if WMD misuse is suspected. ***NOTE****: If the prescribing VA health care provider or WMC team agrees or independently suspects misuse, then the prescribing VA health care provider will reevaluate the Veteran's circumstances to determine whether that specific WMD continues to be the most appropriate device, or whether an alternative WMD may be more suitable.*

NOTE*: Major Medical Equipment (MME) Committees at VA medical facilities may provide advice or guidance on complex cases but must not substitute for WMCs or assume these responsibilities in the place of WMC."*[8]

Safe Patient Handling and Mobility Technology to support Veterans in Home Settings (SPHMT) SOP, dated July 18, 2019, states:

8 Ibid.

"… *A clinician or an interdisciplinary team must evaluate the Veteran's functional status with consideration of his or her unique medical needs to determine the equipment necessary to support safe mobility in home settings. The type and quantity of SPHMT provided is determined by the clinician or interdisciplinary team based on the Veteran's comprehensive medical needs and compatibility of SPHMT options with the home environment.*

The evaluation can be performed either in a facility by a VA clinician, VA interdisciplinary team or in the home setting by a VA clinician, VA interdisciplinary team or VA contracted community home health care provider(s). Members of the interdisciplinary team can include but are not limited to: SPHM facility coordinator, physicians, mid-level providers (i.e., physician assistant or nurse practitioner), registered nurses (RN) and nursing staff, wound/ostomy specialists, social workers, case managers, and PSAS representatives."[9]

VHA PSAS BPG for PSAS Consult Management, dated May 2017, and updated August 1, 2021, states a PSAS Consult is considered an administrative consult. It is the method for a VA clinician to prescribe and request a PSAS appliance or service for an individual patient. An accountable individual supervising PSAS employees (for example, PSAS Chief, PSAS Assistant Chief, PSAS Supervisor, or other Service Chief Supervising PSAS) will partner with facility-level Clinical Access Coordinators and designated clinical partners to ensure consult service requests include a section for the provider to identify the accessories and consumable supplies for the requested device. There is no expectation that the requesting provider is to provide an exhaustive list of all necessary supplies, but to indicate the need for such via the PSAS consult.[10]

Further, the BPG state:

- *"Consults submitted to PSAS must contain a detailed description of the device or service required and an appropriate clinical justification for the request (at a minimum) to facilitate the issuance or procurement of the device/service. A consult would be considered to have a detailed description if it contains sufficient information (e.g., vendor, size, specs etc.) for the consult to be actionable by a PSAS Staff member.*

- *The Diagnostic Code (ICD [International Classification of Diseases] Code) used must be appropriate to the condition for which the device or service is requested and if there are any questions or questionable ICD Code usage, defer to the*

9 Safe Patient Handling and Mobility Technology to support Veterans in Home Settings (SPHMT) SOP, dated July 18, 2019. Available at: https://dvagov.sharepoint.com/sites/VHAProsthetics/safe%20patient%20handling/forms/allitems.aspx, last accessed September 23, 2024. ***Note****: This is an internal VA SharePoint website that is not available to the public.*
10 Prosthetic and Sensory Aids Service (PSAS) Business Practice Guidelines (BPG) for PSAS Consult Management, dated May 2017. Available at: https://dvagov.sharepoint.com/sites/VHAPREIntranet/Org/ProsDocs/Forms/AllItems.aspx, last accessed September 23, 2024. ***Note****: This is an internal VA SharePoint website that is not available to the public.*

Chief of PSAS and Sensory Aids (PSAS) for follow-up/guidance with the requesting Clinician."[11]

If the consult includes the statements *"Veteran wants" or "Veteran requests,"* it will be returned to the requesting provider seeking appropriate medical justification. If none is provided within 1 week, then the consult should be closed using NR013 code (Item not medically indicated as determined by a clinician). In this case, the closed consult informs the clinician a new consult is required.[12]

Temple developed a Standard Work Document for CITC, dated April 3, 2023, to standardize fulfilment of RFS from Community Providers. The document specifically states PSAS fulfills RFS using the following procedures:

1. Receive requests completed with the essential elements contained in the Field Guidebook Chapter 3.5. Extraneous elements and fields will not be required unless specifically negotiated with CITC.

2. RFS' without the essential elements may be returned to CITC.

3. RFS' meeting the Field Guide definition will be accepted.

4. Prosthetics may determine appropriate brand/model/vendor.

This work document is operationalized through completion of VA Form 10-10172, Community Care Provider Request for Service, dated May 2021. This form contains a specific section on DME education and training (if applicable) which states: Failure to thoroughly complete the RFS for DME will result in delayed patient care and prevent VA from DME fulfillment. Before DME will be issued, education, training, and fitting of DME (as applicable to the specific DME ordered) must be completed. If applicable education, training, and fitting are not completed, the form indicates the requested DME will be mailed to requesting provider's address to coordinate an alternative time for proper instruction on DME use.

Findings

The management of the DME process involves coordination between multiple departments, primarily (but not limited to) PSAS, PMR Service, Specialty Care Services, primary care, and CITC. In calendar year (CY) 2021, Temple, and VISN 17 requested a site visit from VHA PSAS National Program Office (NPO) and VHA Office of Community Care to assist with this coordination. A virtual program review took place between August and November of CY 2021, followed by a site visit on December 6, 2021. The primary purpose of the virtual review and site visit was to review operating effectiveness of the facility PSAS and CITC for DME requests and fulfillment, process evaluation for RFS, routine consult management, urgent and emergent contract awareness, TriWest claims and billings, delegation of authority, provider education and communication for

11 Ibid.
12 Ibid.

care coordination, and some specific commodity topics such as, wound vac therapy, therapeutic footwear, and life vests. As such, 14 challenges were identified. They are:

1. RFS, VA Form 10-10172;
2. Delegation of Authority (DOA);
3. Community Provider Orders;
4. Consult Management Activity;
5. PSAS Review for Education and Training and Treatment Plan Documentation;
6. STAT consults entered to PSAS;
7. Informal Requests to PSAS via Notes on Consults or Emails;
8. TriWest Contract Changes for Region 4;
9. Routine vs. Urgent and Emergent;
10. TriWest Claims and Denials;
11. Conversations about Therapeutic Footwear, Wound Vac, Life Vest, etc.;
12. Care Coordination Partnership between PSAS and CITC;
13. Care Coordination Partnership between CITC and Community Providers; and
14. Quality Management Review of PSAS.[13]

Each identified challenge had associated recommendations. The program offices involved in this virtual site visit did not require an action plan to address the observations. However, Temple developed a tracking spreadsheet indicating monitoring of all 14 recommendations. Five recommendations are closed and 9 remain open as of April 15, 2024.

Notable actions taken as a result of the recommendations include: the COS modified the RFS DOA assignments to include Specialty Services in addition to the primary care providers and established regular meetings between PSAS and CITC, and between PSAS and PMR to improve communication and processes. The COS also developed a standard work document for RFS that outlines the work performed by CITC RN, Prosthetics, CITC Service, Specialty Clinics, and the COS. Additionally, Temple leadership tasked the Systems Redesign Office to assist in development of a process

13 Prosthetic and Sensory Aids Service in collaboration with Office of Community Care Central Texas Healthcare System (V17) (674), Summary of Virtual Site Visit and Recommendations, dated December 6, 2021. Available at: https://dvagov.sharepoint.com/sites/ctx/ELC/CCSC/CommitteeDocuments/Forms/By%20Year.aspx, last accessed September 23, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public.*

for obtaining a hospital bed for home use. This process was agreed upon by multiple services (such as primary care, PMR, and prosthetics) in CY 2022, and updated April 3, 2023.

VHA Directive 1173, paragraph 2j(4) directs that a prescribing VA health care provider or eligible entity is responsible for:

> "*Ensuring the environment where items or equipment provided under PSAS programs will be used is considered or assessed to ensure it meets the Veteran's needs (e.g., HISA [Home Improvements and Structural Alterations] program or home medical equipment home assessment, AAE [Automobile Adaptive Equipment] program vehicle assessment)*." However, the additional note that follows states: "***NOTE**: Not all items or equipment provided by PSAS will require a home assessment if the home environment is not relevant to the safe and effective function of the items or equipment*."[14]

Interviewees informed us that the primary concerns from the PSAS Department are education and training of the patient on DME and the assessment of the patient's home, based on VHA Directive 1173, paragraph 2j(4) as noted above. Interviewees told us PSAS staff frequently puts consults in a pending status or closes consults if they deem training, education, and the home environment assessment for DME are inadequate. We reviewed the consult template in the Computerized Patient Record System (CPRS) and determined that there is a section for documenting and attesting completion of education and training. This documentation is also on VA Form 10-10172. PSAS staff contends the provider (such as PMR or primary care) should complete the home environment evaluations as described in VHA Directive 1173 and SPHMT SOP." However, VHA Directive 1173 and the PSAS SOP do not require that home environment evaluations must be conducted by only PMR or primary care providers. In fact, both documents note the role of interdisciplinary teams to include specialty care and PSAS staff in the evaluation, education, and training of patients on DME.

Additionally, multiple interviewees informed us that PSAS closes consults based on the requesting providers' failure to provide DME specifics such as make and model, pursuant to the PSAS BPG for PSAS Consult Management. The guidelines state:

> "*Consults submitted to PSAS must contain a detailed description of the device or service required and an appropriate clinical justification for the request (at a minimum) to facilitate the issuance or procurement of the device/service. A consult would be considered to have a detailed description if it contains sufficient information (e.g., vendor, size, specs etc.) for the consult to be actionable by a PSAS staff member*."[15]

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14 VHA Directive 1173, Prosthetic and Sensory Aids Service, dated March 27, 2023.
15 Prosthetic and Sensory Aids Service (PSAS) Business Practice Guidelines (BPG) for PSAS Consult Management, dated May 2017. Available at: https://dvagov.sharepoint.com/sites/VHAPREIntranet/Org/ProsDocs/Forms/AllItems.aspx, last accessed September 23, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public.*

Conclusions for Allegation 1

- We **do not substantiate** the COS, Deputy COS, and the Medical Center Director have refused to adhere to and enforce national directives, policies, and SOP for the processing of DME prescriptions.

- Temple leadership has taken multiple steps to try and resolve concerns in compliance with national policies, reaching out to VISN 17 and to the PSAS NPO for guidance.

- Temple PSAS closed consults for home DME from both VA prescribers and eligible entities based on perceived inadequate assessment of education, training, and home environment.

- PSAS closed consults for VA prescribers and eligible entities based on perceived failure to provide detailed descriptions of DME specifics on their consult.

- We find guidance in PSAS BPG for PSAS Consult Management regarding detailed descriptions (for example vendor, make, and model) unreasonable and potentially a reason for delay of services.

Recommendations to Temple

1. Educate Temple PSAS staff, including the Chief, that VHA Directive 1173 and SPHMT SOP both support the use of an interdisciplinary team approach for evaluation, education, and training of patients on DME, and develop plans to operationalize such interdisciplinary teams.

2. Reschedule the postponed in-depth review and education by the combined PSAS and PMR NPOs.

Recommendation to VHA

1. Clarify guidance in PSAS BPG for PSAS Consult Management that the detailed description for DME is the responsibility of all care team members to include PSAS representatives, not just those providers or eligible entities submitting a PSAS consult.

Allegation 2

Due to the noncompliance of these officials, PSAS consistently expends agency funds on improper equipment orders.

Findings

As noted above in Allegation 1, we do not find the officials named to be non-compliant with the listed documents. Regarding funding, Temple PSAS had a $52 million budget in fiscal year (FY) 2024 for DME and is on target to spend $62 million. According to the

whistleblower, Temple has an estimated $1 million in unused DME over the past 3 years because VA prescribers and eligible entities failed to provide adequate information.[16] We were unable to confirm the estimate. Ordered and unused DME, due to Veteran rejection or inability to deliver, is stored by the delivery contractor (Eagle Home) in their warehouse. Attempts are made to reissue the DME to another Veteran. If this is not possible, PSAS Logistics completes a report of survey and the DME is turned in as excess. The General Services Administration attempts to sell the item with proceeds returned to VA but usually at an extreme reduction compared to the original cost. We reviewed data from Eagle Home from September 15, 2021, and noted they were storing a total of $107,858.66 in excess DME. The excess DME that Eagle Home was storing at the end of FY 2022 was $83,937; however, it is unclear how long some items have been in the warehouse.

Conclusions for Allegation 2

- We **do not substantiate** that PSAS consistently expends agency funds on improper orders.

- We noted approximately $100,000 in excess or improper equipment stored in the Temple contract warehouse in September 2021 and $84,000 at the end of FY 2022 due to rejection or non-delivery. These values represent approximately 0.2% of the total Temple PSAS annual budget.

Recommendation to Temple

None.

Allegation 3

Patient care is delayed because patients are not receiving prescribed DME on a timely basis.

Background

VA Functional Organization Manual, version 8, Description of Organizations Structure, Mission, Function, Task and Authorities, Volume 1, Administrations, dated CY 2023, subsection VHA-12RPS Rehabilitation and Prosthetic Services, Overview, states, in part, the service:

- *"Provides medical and rehabilitative preventive strategies, and acute and chronic management of disorders that alter Veterans' functional status. This treating specialty delivered by physicians (Physiatrists or Physical Medicine & Rehabilitation physicians) and other core disciplines (physical therapy, occupational therapy, speech pathology, kinesiotherapy) emphasizes restoration and optimization of function through physical modalities, therapeutic exercise and*

16 Less than 1% of the total FY 2024 budget assuming an average cost of $333,000 per FY.

interventions, adaptive equipment, modification of the environment, education and assistive devices.

- *Leads the world as the comprehensive provider of prosthetic devices and sensory aids. VA provides clinically appropriate and commercially available, state of the art prosthetic equipment, sensory aids and devices to Veterans across the continuum of patient care. Such items include artificial limbs and bracing, wheeled mobility and seating systems, sensory-neural aids (e.g., hearing aids, eyeglasses), cognitive prosthetic devices, items specific to women's health, surgical implants and devices surgically placed in the Veteran (e.g., hips and pacemakers), home respiratory care, recreational and sports equipment."*[17]

CTVHCS SOP 117-21-02, Major Medical and Special Equipment Committee (MMSEC), dated July 1, 2021, states that the MMSEC Team is responsible for:

- *"Review requests of Major Equipment, Special Items, and/or Experimental Appliances/Devices;*
- *Review Prescriptions written by Clinical Providers/Physicians to ensure that the requested items are necessary for the treatment or rehabilitation of the Veteran;*
- *Arrange for home visits if needed to make a final determination on Veteran's needs (KT [Kinesiotherapy] and OT [Occupational Therapy] Team Members will assist with coordination);*
- *Arrange for the training of the Veteran and/or Family/Caregiver in the use and operation of equipment if required."*[18]

Findings

We reviewed 10 examples submitted by the whistleblower and noted that in 7 of the cases, the information provided by the prescribing provider requesting DME appears adequate. All cases provided were closed by PSAS without ordering the DME with the rationale there was too little information to proceed; these instances delayed Veteran care.

In one especially concerning example, we noted an RFS for an infusion pump for home chemotherapy was closed. The home infusion pump for chemotherapy was delayed three months; however, we did find evidence in CPRS the Veteran continued to receive outpatient chemotherapy in the community.

17 VA Functional Organization Manual, version 8, Description of Organizations Structure, Mission, Function, Task and Authorities, Volume 1, Administrations, dated 2023. Available at: https://department.va.gov/wp-content/uploads/2024/06/va-functional-organizational-manual-volume-1.pdf, last accessed June 24, 2024. ***Note**: This is an internal VA website that is not available to the public*.
18 CTVHCS SOP 117-21-02, Major Medical and Special Equipment Committee (MMSEC), dated July 1, 2021. Available at: https://dvagov.sharepoint.com/sites/ctx/memorandum/SOP%20Repository/Forms/AllItems.aspx, last accessed September 23, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public*.

Another example came in an email from the Chief of PSAS (a non-clinician) dated April 25, 2024, Subject *"Hospital Bed Order from PMRS Physiatry,"* which stated:

> *"This is an example of a specialty bed order from PMRS Physiatry to Prosthetics. It appears PMRS Physiatry is asking Prosthetics to perform the coordination so the Veteran may be referred from PMRS Physiatry to PMRS Major Medical Clinic? Veteran already has a bed and is within the manufacturer's specifications, and it appears a new bed is requested for foot contractures. Does a new bed need to be purchased for foot contractures or can PMRS provide therapies and/or ADLs like night splints? If a new bed is needed, Prosthetics needs to know Make, Model, etc. in order to purchase the bed."*

In this case, the Veteran is a 43-year-old who suffered a Pontine stroke (a disruption to the Pons, the largest component of the brain stem) 3 years prior, leaving him unable to move, or communicate, but with full cognitive function.[19] This Veteran's wife cares for him at home supported by home health providers. The family also has small children. PSAS closed this hospital bed consult for *"Insufficient information for provision of hospital bed."* We noted the PSAS BPG for PSAS Consult Management states: *"A consult would be considered to have a detailed description if it contains sufficient information (e.g., vendor, size, specs etc.) for the consult to be actionable by a PSAS staff member."* We reviewed the CPRS consult note for this Veteran that contained an extensive assessment, justification, vendor, size, and specification suggestions, as described below:

> *"Item required: Specialty Hospital Bed Justification:*
>
> *Recommending the patient be evaluated for a different specialty hospital bed by the Major Medical Equipment Committee. The patient is currently experiencing significant issues with their current bed that are impacting their comfort, safety, and overall quality of care. A different bed may better address these concerns and improve the patient's overall well-being.*
>
> *The recommended bed should have a longer sleep surface length (88 inches or longer) to accommodate the patient's plantarflexion contractures and provide adequate positioning to prevent injury and discomfort. Additionally, the bed should have full rails to prevent falls, especially given the patient's limited mobility and need for head elevation. Furthermore, the bed should have features for regular turning to prevent pressure ulcers and maintain skin integrity. These features are essential to improve the patient's quality of sleep and overall well-being, as well as reduce the burden on his family and caregivers. I suggest considering a specialty bariatric/pulmonary bed, such as the Progressa or Compella bariatric SmartBed hospital bed, which can address the specific needs and challenges faced by the patient. The bed should also include an adjusted footboard (Flex-A Foot system*

19 NIH, National Library of Medicine, National Center for Biotechnical Information, Pontine Infarction, dated May 29, 2023. Available at: https://www.ncbi.nlm.nih.gov/books/NBK554418/, last accessed June 24, 2024.

type) to accommodate the patient's fixed plantarflexion contractures and prevent skin breakdown in the feet and toes. Please refer to below for detail of this issue.

Issues: His wife reported that Veteran continues struggling with the hospital bed which were previously prescribed by the VA due to several significant issues that are impacting comfort, safety, and overall quality of care for Veteran as following:

(1) Bed Sleep Surface Inadequacy: The current hospital bed's sleep surface is too short to accommodate the tightness and stiffness in the patient's feet, which are constantly pointing downward due to his condition of plantar-flexion contractures. As a result, the patient is experiencing difficulty with positioning, particularly in relation to the bed footboard surface. Despite efforts with heel cushions, the patient continues to hit his feet on the bed footboard, exacerbating his discomfort and risking injury. Additionally, the patient requires his head to be elevated at all times due to his inability to manage his own secretions, putting him at risk for aspiration pneumonia. The inability to maintain proper positioning in the bed is affecting the patient's ability to receive necessary care and putting him at significant health risk.

(2) Requirement for Full Rails: The current bed's short railings are insufficient to prevent the patient from falling out of bed, particularly given his limited mobility and the need to keep his head elevated due to his stroke. The patient's paralysis on his left side further increases the risk of falling, necessitating the use of full rails for improved safety and security.

(3) Lack of Turning Feature: The patient's current bed lacks the essential features for regular turning, necessary to prevent pressure ulcers and maintain skin integrity. Due to his stroke and paralysis, the patient cannot reposition himself, requiring frequent turning by nursing staff or his caregiver every [2] two hours. This schedule disrupts the patient's sleep, impacts his mental health, and burdens his caregiver. Without adequate turning, there is a risk of pressure sores in vulnerable areas like the tailbone, heels, and buttocks, affecting the patient's overall well-being and quality of life. This situation places a significant burden on the patient's family and caregivers, leading to the hiring of a home nurse for the demanding task of turning the patient, adding emotional and financial strain to the situation.

Provide information if known:
Bed info:
Vendor:
Part number:
Quote #:

Why does a standard hospital bed not meet this patient s needs? See above medical justification."

On the morning of April 26, 2024, we contacted the Deputy COS (who was the acting COS that day) and intervened on behalf of the Veteran. At the direction of the COS, the MMSEC met on April 29, 2024 (the week of our site visit) and developed a plan to visit the Veteran's home on Friday May 3, 2024, per requirements defined in SOP 117-21-02 to determine the best options for the Veteran. During interviews, the physician who made the consult request along with an MMSEC member indicated they discussed this proximate to the time of our call. We reviewed the Veteran's medical record and determined that he was admitted to the intensive care unit through the Emergency Department on May 2, 2024, for pneumonia and a urinary tract infection. The Veteran was discharged home on May 7, 2024, and the MMSEC rescheduled the home visit for Tuesday May 14, 2024.

Clinicians and managers provided multiple anecdotes describing the difficulties they have working with PSAS to obtain DME complicated by pushback and rework. One clinician described continued questions by the Chief of PSAS regarding medical needs of the Veteran despite the determination by the prescribing VA health care provider of the necessity of the requested DME. We reviewed guidance from a PSAS NPO document titled *"Information from Office hours: PSAS Regulations - March 2021 - Rehab Admin Call"* which states: *"If the clinician provides justification describing how the item is a direct and active component of the Veteran's rehabilitation plan, PSAS should not review the quality of the justification from a clinical perspective."*

We heard from three PSAS and WMC staff members who stated that Veterans *"abuse the system"* related to request and use of WMD. Examples provided include Veterans using WMD as a primary means of transportation. We reviewed VHA Directive 1173.06 which may unintentionally set this as an expectation in that it states:

> *"The WMC Team Lead or Prescribing VA Health Care Provider is responsible for [among other things]….(18) Reevaluating Veteran circumstances if WMD misuse is suspected.* ***NOTE****: If the prescribing VA health care provider or WMC team agrees or independently suspects misuse, then the prescribing VA health care provider will reevaluate the Veteran's circumstances to determine whether that specific WMD continues to be the most appropriate device, or whether an alternative WMD may be more suitable."*[20]

We reviewed Temple's risk management logs and did not find any Issue Briefs, Peer Reviews, Institutional Disclosures, etc., related to either delay or failure to provide DME resulting in delay in care or harm to a Veteran. There was a total of 11 Joint Patient Safety Reports from FY 2023 to present related to delays in care secondary to failure to provide prescribed DME. These events were scored by Risk Management, and none of them had a significant safety assessment code score.

We determined that Temple PSAS published a SharePoint site in approximately April 2024, that had beneficial information for clinicians ordering DME. We reviewed the hospital bed ordering aid and determined that it was very clear, however it also included

20 VHA Directive 1173.06, Wheeled Mobility Devices (WMD), dated December 13, 2021.

a link to documents from CY 2009 that are out of date. We contacted the site's owner and ensured the link was removed as of May 2, 2024.

Conclusions for Allegation 3

- We **substantiate** patient care was delayed in the delivery of DME. In 7 of 10 examples provided to us, documentation was adequate to fulfill the request, yet the consults were cancelled.

- As noted previously, the Chief of PSAS failed to note the role of an interdisciplinary team, to include specialty care and PSAS staff, in the evaluation, education, and training of patients on DME in questioning the request for a new hospital bed for a veteran with a pontine stroke, causing a delay in providing necessary medical equipment.

- The Chief of PSAS failed to follow procedures defined in SOP 117-21-02 in the same case.

- The Chief of PSAS is outside their scope by offering medical treatment suggestions to VA health care providers and questioning the quality of the justification from a clinical perspective.

- VHA Directive 1173.06 provides guidance for the WMC Team lead or prescribing VA health care provider to assess for misuse of WMD by the Veteran, placing them in a potentially adversarial position of enforcement versus a therapeutic relationship.

- Temple PSAS SharePoint site included an out-of-date link from CY 2009 that needs to be updated.

Recommendations to Temple

3. See Allegation 1, Recommendation 1.

4. During the rescheduled PSAS and PMR NPO review, include a review of the appropriateness of consults closed by PSAS FY 2023 to present and provide related training to ordering providers and PSAS.

5. Enforce SOP 117-21-02 with a focus on MMSEC team responsibilities and add CITC representation to the MMSEC.

6. Ensure the Chief of PSAS is aware of and complies with their responsibilities under VHA Directive 1173, paragraph 2i through 2i(17), and that these responsibilities do not include offering medical treatment suggestions to VA health care providers or questioning the quality of the justification from a clinical perspective.

7. PSAS provide in-service training to providers on the new Temple PSAS SharePoint after removing out of date SharePoint website link.

Recommendation to VHA

2. Provide guidance on interpretation of VHA Directive 1173.06 regarding responsibilities of the WMC Team lead or prescribing VA health care provider, particularly paragraph 18 and its associated note.

Additional Findings

Any other, related allegations of wrongdoing discovered during the investigation of the foregoing allegations.

Findings

The PSAS Chief provided CTVHCS Medical Center Policy (MCP) 674-121-001, Procedures for Requesting Prosthetic & Sensory Aids Service (PSAS) Appliances, Medical Equipment, and Repairs, dated October 25, 2023, recertified October 30, 2023,[21] to us as evidence that it was allegedly signed by the Medical Center Director as a replacement MMSEC SOP. However, we were unable to find this MCP anywhere on Temple's policy website. We verified with the facility policy coordinator and determined that this MCP does not exist. It is unclear whether PSAS is using this unpublished and unsigned MCP in its operations.

In one interview, a clinician indicated that during an interdisciplinary team call on April 29, 2024, PSAS stated that all power wheelchairs must be purchased from VA Federal Supply Schedule. The clinician stated they had to radically modify a request for a power wheelchair that did not match the Veteran's unique needs to meet the request for FSS purchase only. However, VHA procurement hierarchy includes flexibility to accommodate the Veteran's medical needs. Under certain circumstances, open market purchases to support procurement in situations where the clinical needs are not fulfilled by devices on VA Federal Supply Schedule are permitted under the procurement hierarchy.

Conclusions for Additional Findings

- CTVHCS MCP 674-121-001 is not an actual policy that has been signed by the Medical Center Director.

- PSAS is providing incorrect interpretations of policy which impacts clinical decisions on DME.

Recommendations to Temple

8. Conduct a review of policies currently in use by PSAS to validate accuracy.

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21 CTVHCS Medical Center Policy (MCP) 674-121-001, Procedures for Requesting Prosthetic & Sensory Aids Service (PSAS) Appliances, Medical Equipment, and Repairs, dated October 25, 2023, recertified October 30, 2023. Available at: https://dvagov.sharepoint.com/:w:/r/sites/ctx/ELC/ClinicalExecutiveCouncil/_layouts/15/Doc.aspx, last accessed September 23, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public*.

9. Ensure all staff are aware of the correct guidance relating to use of VA Federal Supply Schedule for DME and exceptions to this policy.

VI. Summary Statement

We have developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel concerns that alleged conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; and a substantial or specific danger to public safety occurred. We reviewed the allegations and determined the merits of each. We discovered evidence of delays in supplying DME to Veterans. There are recommendations contained in this report for Temple to follow VHA Directives, facility policy, and for VHA to review business practice guidelines and wheeled mobility device policy.

Attachment A
References

Code of Federal Regulations, Title 42, Chapter IV, Subchapter B, Part 414, Subpart D, § 414.202, last amended September 17, 2024. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.202, last accessed September 23, 2024.

CTVHCS Medical Center Policy (MCP) 674-121-001, Procedures for Requesting Prosthetic & Sensory Aids Service (PSAS) Appliances, Medical Equipment, and Repairs, dated October 25, 2023, recertified October 30, 2023. Available at: https://dvagov.sharepoint.com/:w:/r/sites/ctx/ELC/ClinicalExecutiveCouncil/_layouts/15/Doc.aspx, last accessed September 23, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public*.

CTVHCS SOP 117-21-02, Major Medical and Special Equipment Committee (MMSEC), dated July 1, 2021. Available at: https://dvagov.sharepoint.com/sites/ctx/memorandum/SOP%20Repository/Forms/AllItems.aspx, last accessed September 23, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public*.

NIH, National Library of Medicine, National Center for Biotechnical Information, Pontine Infarction, dated May 29, 2023. Available at: https://www.ncbi.nlm.nih.gov/books/NBK554418/, last accessed June 24, 2024.

Prosthetic and Sensory Aids Service in collaboration with Office of Community Care Central Texas Healthcare System (V17) (674) Summary of Virtual Site Visit and Recommendations, dated December 6, 2021. Available at: https://dvagov.sharepoint.com/sites/ctx/ELC/CCSC/CommitteeDocuments/Forms/By%20Year.aspx, last accessed September 23, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public.*

Prosthetic and Sensory Aids, Service (PSAS) Business Practice Guidelines (BPG) for PSAS Consult Management, dated May 2017. Available at: https://dvagov.sharepoint.com/sites/VHAPREIntranet/Org/ProsDocs/Forms/AllItems.aspx, last accessed September 23, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public.*

Safe Patient Handling and Mobility Technology to support Veterans in Home Settings (SPHMT) SOP, dated July 18, 2019. Available at: https://dvagov.sharepoint.com/sites/VHAProsthetics/safe%20patient%20handling/forms/allitems.aspx, last accessed September 23, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public.*

VA Functional Organization Manual, version 8, Description of Organizations Structure, Mission, Function, Task and Authorities, Volume 1, Administrations, dated 2023. Available at: https://department.va.gov/wp-content/uploads/2024/06/va-functional-

organizational-manual-volume-1.pdf, last accessed June 24, 2024. ***Note**: This is an internal VA website that is not available to the public*.

VHA Directive 1173, Prosthetic and Sensory Aids Service, dated March 27, 2023.

VHA Directive 1173.06, Wheeled Mobility Devices (WMD), dated December 13, 2021.

VHA Facility Complexity Model Fact Sheet, undated. Available at: http://raft.vssc.med.va.gov/SelfPacedDocuments/FY23, last accessed June 24, 2024. ***Note**: This is an internal VA website that is not available to the public.*

VHA Support Service Center, Trip Pack-Operational Statistics Table, Temple, Texas. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx, last accessed June 20, 2024. ***Note**: This is an internal VA website that is not available to the public.*

Additional documents reviewed as part of this report.

***Note**: The standard work document, and email listed below are internal facility documents and are not available to the public.*

Email, From the Chief of PSAS, Subject "Hospital Bed Order from PMR Service Physiatry," dated April 25, 2024.

Standard Work Document for Care in the Community Request for Service, dated April 3, 2023.

Attachment B
List of Acronyms

AAE[2]	Automobile Adaptive Equipment
BPG[2]	Business Practice Guidelines
CARF[2]	Commission on Accreditation of Rehabilitation Facilities
CITC	Care in the Community
COR[2]	Contracting Officer Representative
CoS	Chief of Staff
CPRS	Computerized Patient Record System
CTVHCS	Central Texas Veterans Healthcare System
CTVAHCS[1]	Central Texas Veterans Administration Health Care System
CY	calendar year
DME[1]	durable medical equipment
DOA	delegation of authority
EHR	electronic health record
FY	fiscal year
HISA[2]	Home Improvements and Structural Alterations
ICD[2]	International Classification of Diseases
KT[2]	Kinesiotherapy
MCP	Medical Center Policy
MME[2]	major medical equipment
MMSEC	Major Medical and Special Equipment Committee
NPO	National Program Office
NPPD	National Prosthetic Patient Database
OT[2]	Occupational Therapy

PMR	Physical Medicine and Rehabilitation
PSAS[1]	Prosthetics and Sensory Aids Service
RFS	Request for Service
RN	registered nurse
SPHMT	Safe Patient Handling and Mobility Technology
SOP[1]	standard operating procedure
VA	Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VPR[2]	VISN Prosthetics Representative
WMC[2]	Wheeled Mobility Clinic
WMD[2]	wheeled mobility devices

[1]Note: Acronym first defined in allegation contained in this report.
[2]Note: Acronym first defined in direct quote contained in this report.

Table B-1 List of Acronyms