U.S. OFFICE OF SPECIAL COUNSEL
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Washington, D.C. 20036-4505

The Special Counsel

May 21, 2025

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-24-000447

Dear Mr. President:

I am forwarding to you a report transmitted to the Office of Special Counsel (OSC) by the Department of Veterans Affairs (VA) in response to the Special Counsel's referral of disclosures of wrongdoing at the VA Central Texas VA Healthcare System (Temple), Temple, Texas. [redacted] Chief, Prosthetic and Sensory Aid Service (Prosthetics), Temple, consented to the release of his name and commented on the report.[1] OSC has reviewed the disclosures, the agency report, and the whistleblower comments, and, in accordance with 5 U.S.C. § 1213(e), I have determined that the report contains the information required by statute and the findings appear reasonable. The following is a summary of the whistleblower's allegations, the VA's findings, and the whistleblower's comments in response.

[redacted] alleged that Temple's leadership refused to adhere to national directives, policies, and standard operating procedures for the processing of durable medical equipment (DME) prescriptions, including Veterans Health Administration (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 from 10-10172 Standard Operating Procedures; Safe Patient Handling and Mobility Technology to Support Veterans in Home Settings, facility standard operating procedures and Prosthetics Business Practice Guidelines for Consult Management.

[redacted] frequently encountered requests for service requiring him to obtain missing information and, in some cases, to deny the requests for DME and cancel prescriptions that did not comply with directives and standard operating procedures. Despite this noncompliance, Chief of Staff [redacted], Associate Chief of Staff [redacted], and Director of

[1] OSC referred this matter to former VA Secretary Denis McDonough, who reviewed and signed the report. Secretary McDonough tasked the VA Office of Medical Inspector with conducting the investigation.

Operations [redacted] refused to adhere to and enforce compliance for these prescriptions, instead, instructing [redacted] and his staff to "just process" prescriptions to avoid any delays. [redacted] alleged that over the past several years this lack of adherence to directives and standard operating procedures has led to Prosthetics consistently expending agency funds on improper equipment orders and caused delays in patient care.

The agency partially substantiated the allegations. The agency determined that in seven out of ten examples [redacted] provided, the documentation was adequate to fulfill the DME requests, yet the consults were cancelled for lack of compliance and the delivery of equipment lapsed. The agency determined these cancellations were largely based on a combination of outdated information on processes and miscommunication between Temple Prosthetics and VA prescribers. To address this issue, the agency recommended that officials educate Prosthetics staff that VHA Directive 1173 supports the use of an interdisciplinary team approach to evaluation that requires collaboration, education, and training of patients on DME. The agency confirmed that beginning in November 2024, following OSC's referral of this matter, it has implemented new training and guidance emphasizing a team approach to evaluating and educating patients on DME.

The agency did not substantiate that [redacted], [redacted] and [redacted] refused to adhere to and enforce national directives, policies, and SOPs for the processing of DME prescriptions. The agency determined that Temple Prosthetics, led by [redacted], closed consultants for DME based on [redacted] belief that the prescribers' assessments of the patients were inadequate, and the agency guidance required an unreasonable level of description.[2] Additionally, the agency did not substantiate a gross waste of funds through unnecessary or superfluous DME orders. While the agency determined Temple stored approximately $100,000 in excess or improperly ordered equipment because of rejection or non-delivery, these values represented .02% of the total Temple Prosthetics annual budget and, thus, did not constitute a gross waste of agency funds.

In his comments, [redacted] conveyed his belief that the OMI team conducting the investigation had a preexisting relationship with the CTVAHCS staff and therefore conducted a biased investigation. [redacted] also voiced concern that leadership consistently violated national directives and facility policies and ignored protocols and prioritized efficiency over convenience. [redacted] asserted that contrary to the agency's findings, CTVACHS leadership was not taking meaningful steps to "resolve concerns in compliance with national policies, reaching out to the Veterans Integrated Service Network (VISN) 17 and to the [PSAS] National Program Office." OSC contacted the agency to ensure that the service units are communicating adequately and complying with national program policies, and the agency confirmed compliance.

[2] For example, PSAS required that vendor, make and model be included in the clinicians' prescriptions, and cancelled prescriptions that did not provide this level of detail.

I thank the whistleblower for bringing these allegations to OSC's attention. As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency report, and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs. OSC has filed redacted copies of this letter, the agency reports, and the redacted referral letter in our public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

Charles N. Baldis
Senior Counsel and Designee
of Acting Special Counsel Jamieson Greer

Enclosures