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

The Special Counsel

March 5, 2024

The Honorable Denis R. McDonough
Secretary
U.S. Department of Veterans Affairs
6401 Security Boulevard, Suite 300
Baltimore, MD 21235

Re: OSC File No. DI-24-000447
Referral for Investigation-5 U.S.C. § 1213(c)

Dear Secretary McDonough:

I am referring to you for investigation a whistleblower disclosure that employees at the Department of Veterans Affairs (VA), Central Texas VA Healthcare System (CTVAHCS), Temple, Texas engaged in conduct that may constitute a violation of law, rule or regulation; gross mismanagement; a gross waste of funds; and a substantial and specific danger to public health and safety. A report of your investigation on this allegation and any related matters is due to the Office of Special Counsel (OSC) on May 6, 2024.

[redacted], Chief of the Prosthetic and Sensory Aid Service (PSAS) at CTVAHCS, who consented to the release of his name, disclosed that officials are refusing to adhere to national Veterans Health Administration (VHA) directives and policies related to durable medical equipment (DME) prescription process requirements.[1] The allegations to be investigated include:

- CTVAHCS Chief of Staff [redacted], Associate Chief of Staff [redacted], and Director of Operations [redacted] have refused to adhere to and enforce national directives, policies, and standard operating procedures (SOPs) 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; and
- Due to the noncompliance of these officials, PSAS consistently expends agency funds on improper equipment orders; and
- Patient care is delayed because patients are not receiving prescribed DME on a timely basis; and

[1] DME is ordered by health care providers for home use; examples include wheelchairs, crutches, blood testing strips, oxygen equipment, back braces, orthotics, artificial limbs and eyes, and orthotics.

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

[redacted] explained that approximately five years ago, he observed that prescriptions for DME from both community care providers and internal VA providers lacked the requisite medical studies, home visits, and, in the case of community care referrals, review by VA designated Subject Matter Experts (SMEs). [redacted] described daily encounters with requests for services that required him to obtain missing information, and, in some cases, to deny the requests pursuant to agency SOPs.[2] Despite this noncompliance, [redacted] and his staff routinely directed [redacted] staff to order and process DME prescriptions lacking the requisite justification in the interest of expediency.

[redacted] disclosed that when agency officials require him to order DME for patients despite a lack of information and studies supporting an item, he must "guess" which item to order, resulting in a high percentage of equipment that is ultimately unneeded or unusable. [redacted] estimates the cost of unused DME over the past three years is approximately $1 million. He explained that the unused DME was ultimately relegated as surplus.

Since 2020, [redacted] has met with agency officials to facilitate adherence to Directives and SOPs. These meetings culminated in a VHA program review of the facility's PSAS in 2021.[3] The review recommended, in relevant part, that the facility implement several business practice changes to adhere to national standards and "optimize" service to veterans. The recommendations included ensuring that [redacted] assigns Delegation of Authority [4] duties to review requests for DME services from community care providers to applicable SMEs, such as optometry, oncology, or podiatry, and not solely to primary care providers within the facility. Moreover, the recommendations noted that "adherence to national guidance and the use of standard operating procedures and tools should be required and not viewed as optional guidance."[5] [redacted] asserts that CTVAHCS has yet to implement these recommendations and that [redacted], [redacted], and [redacted] persist in directing him to process DME prescriptions without the requisite documentation and studies, with little or no oversight or accountability for employees who do not comply with national directives and SOPs.

Pursuant to my authority under 5 U.S.C. § 1213(c), I have concluded that there is a substantial likelihood that the information provided to OSC discloses a violation of law, rule, or regulation, a gross waste of funds, gross mismanagement, and a substantial and specific danger to public health and safety. Please note that specific allegations and references to specific violations of law, rule or regulation are not intended to be exclusive. If, in the course of your investigation, you discover

[2] *See, e.g.,* "Requests for Service (RFS) form 10-10172, Standard Operating Procedures (SOP)."
[3] This review originated with the Rehabilitation and Prosthetic Services at VA Headquarters in Washington, D.C. *See* "Prosthetic and Sensory Aid Service in Collaboration with Office of Community Care, Central Texas Healthcare System, Summary of Virtual Site Visit Recommendations."
[4] This refers to the delegation of specific specialists within the CTVAHCS who must review outside provider care to ensure it adheres to VHA standards.
[5] Prosthetic and Sensory Aids Service in collaboration with Office of Community Care, Summary of Virtual Site Visit Recommendations, December 2021.

additional violations, please include your findings on these additional matters in the report to OSC. As previously noted, your agency must conduct an investigation of these matters and produce a report, which must be reviewed and signed by you. Per statutory requirements, I will review the report for sufficiency and reasonableness before sending copies of the agency report along with the whistleblower's comments and any comments or recommendations I may have, to the President and congressional oversight committees and making these documents publicly available.

Additional important requirements and guidance on the agency report are included in the attached Appendix, which can also be accessed at https://osc.gov/Pages/DOW.aspx. If your investigators have questions regarding the statutory process or the report required under section 1213, please contact Catherine A. McMullen, Chief, Disclosure Unit, at (202) 804-7088 or cmcmullen@osc.gov for assistance. I am also available for any questions you may have.

Sincerely,

Karen Gorman

Karen Gorman
Acting Special Counsel

Enclosure

cc: Michael J. Missal, Inspector General

APPENDIX
AGENCY REPORTS UNDER 5 U.S.C. § 1213

GUIDANCE ON 1213 REPORT

- OSC requires that your investigators interview the whistleblower at the beginning of the agency investigation when the whistleblower consents to the disclosure of his or her name.
- Should the agency head delegate the authority to review and sign the report, the delegation must be specifically stated and include the authority to take the actions necessary under 5 U.S.C. § 1213(d)(5).
- OSC will consider extension requests in 60-day increments when an agency evidences that it is conducting a good faith investigation that will require more time to complete.
- Identify agency employees by position title in the report and attach a key identifying the employees by both name and position. The key identifying employees will be used by OSC in its review and evaluation of the report. OSC will place the report without the employee identification key in its public file.
- Do not include in the report personally identifiable information, such as social security numbers, home addresses and telephone numbers, personal e-mails, dates and places of birth, and personal financial information.
- Include information about actual or projected financial savings as a result of the investigation as well as any policy changes related to the financial savings.
- Reports previously provided to OSC may be reviewed through OSC's public file, which is available here: https://osc.gov/Pages/Resources-PublicFiles.aspx. Please refer to our file number in any correspondence on this matter.

RETALIATION AGAINST WHISTLEBLOWERS

In some cases, whistleblowers who have made disclosures to OSC that are referred for investigation pursuant to 5 U.S.C. § 1213 also allege retaliation for whistleblowing once the agency is on notice of their allegations. The Special Counsel strongly recommends the agency take all appropriate measures to protect individuals from retaliation and other prohibited personnel practices.

EXCEPTIONS TO PUBLIC FILE REQUIREMENT

OSC will place a copy of the agency report in its public file unless it is classified or prohibited from release by law or by Executive Order requiring that information be kept secret in the interest of national defense or the conduct of foreign affairs. 5 U.S.C. § 1219(a).

EVIDENCE OF CRIMINAL CONDUCT

If the agency discovers evidence of a criminal violation during the course of its investigation and refers the evidence to the Attorney General, the agency must notify the Office of Personnel Management and the Office of Management and Budget. 5 U.S.C. § 1213(f). In such cases, the agency must still submit its report to OSC, but OSC must not share the report with the whistleblower or make it publicly available. See 5 U.S.C. §§ 1213(f), 1219(a)(1).