THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

April 28, 2026

Ambassador Jamieson Greer
Acting Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Dear Ambassador Greer:

Thank you for your office's August 25, 2025, letter to the Department of Veterans Affairs (VA) regarding whistleblower allegations that employees at the VA Oklahoma City Healthcare System (hereinafter Oklahoma City), Oklahoma City, Oklahoma, engaged in conduct that may constitute violations of law, rule, or regulation, and a substantial and specific danger to public health and safety.

The investigation substantiates the whistleblower's allegations. VA makes seven recommendations to Oklahoma City. The report is enclosed for your information.

Thank you for the opportunity to respond.

Sincerely,

Douglas A. Collins

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-25-002034

VA Oklahoma City Healthcare System
Oklahoma City, Oklahoma

Report Date: February 3, 2026

Content Manager 2025-C-27

Executive Summary

The Office of the Secretary of Veterans Affairs received an email from the Office of Special Counsel on August 25, 2025, requesting formal resolution. Subsequently, the Acting Under Secretary for Health, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector assemble and lead a VA team to investigate allegations concerning the Department of Veterans Affairs (VA) Oklahoma City Healthcare System (hereinafter Oklahoma City) located in Oklahoma City, Oklahoma. The whistleblower alleged conduct that may constitute violations of law, rule, or regulation, and a substantial and specific danger to public health and safety. We conducted an onsite investigation on October 7, 2025, through October 9, 2025, to investigate these allegations.

Specific Allegations of the Whistleblower

1. *Oklahoma VHA providers' failure to review and document chronic opioid patients' course of treatment, etiology of pain, and progress toward treatment objectives at intervals prescribed by statute.*

2. *Oklahoma VHA providers' failure to make and document reasonable efforts for chronic opioid patients to stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities, or otherwise attempt to reduce the potential for abuse or development of an opioid use disorder.*

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:

Conclusions for Allegation 1

- We **substantiate** that Oklahoma City Primary Care Providers (PCP) episodically fail to complete opioid monitoring requirements, such as reviewing and documenting chronic opioid patients' course of treatment, etiology of pain, and progress toward treatment objectives at intervals required by Oklahoma statute and VA guidelines.

- There is a lack of knowledge regarding VHA opioid-related data tools available that could assist in PCP compliance with opioid monitoring requirements.

- The current ongoing professional practice evaluation (OPPE) process is an insufficient monitor of PCP compliance with opioid monitoring requirements due to the low number of patients reviewed and lack of consistency regarding the inclusion of patients prescribed opioids in the reviews.

- Oklahoma City Medical Center Policy (MCP) 11-48 and Oklahoma City MCP 11-148 are not compliant with current Oklahoma statutes regarding opioid prescribing. Specifically, they note a requirement for a 3-month reassessment, but the statute requires a 6-month reassessment.

- PCPs reported varying degrees of support by Patient Aligned Care Team (PACT) members to complete opioid monitoring requirements, which if increased could assist in compliance and decrease workload on the provider.

Recommendations to Oklahoma City

1. Request a consultation by the VHA Office of Primary Care for PACT Pain Care operations and management to review pain management services and compliance with opioid monitoring requirements.

2. Provide training for Ambulatory Care Service leadership and PACT staff regarding available VHA opioid-related data tools.

3. Develop a process to monitor PCP compliance with the opioid monitoring requirements beyond what is currently included in the PCPs' OPPEs, utilizing existing opioid related data.

4. Revise Oklahoma City MCP 1148 and Oklahoma City MCP 11148 to ensure compliance with current Oklahoma statutes and provide education to pertinent staff following revision.

5. Encourage non-PCP PACT member participation in the opioid monitoring requirement process

Conclusions for Allegation 2

- We **substantiate** that Oklahoma City PCPs episodically failed to make and document reasonable efforts for chronic opioid patients to stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities, or otherwise attempt to reduce the potential for abuse or development of an opioid use disorder, which is required by Oklahoma law and VA guidelines.

- The facility aggregate opioid-related data show the facility has had significant success in decreasing the number of Veterans on opioid medications as well as decreasing opioid dosages.

Recommendations to Oklahoma City

6. Provide education to all PCP staff regarding the need to document efforts to decrease or stop the use of opioids or try other drugs or treatment modalities, as required by Oklahoma law and VA guidelines.

7. Develop a tool to monitor that patients on chronic opioid prescriptions have documented efforts to decrease or stop the use of opioids or try other drugs or treatment modalities.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel's concerns that Oklahoma City engaged in alleged conduct that may constitute violations of law, rule, or regulation, and a substantial and specific danger to public health and safety. We reviewed the allegations and determined the merit of each. We determined that Oklahoma City PCPs episodically failed to complete opioid monitoring requirements and failed to make and document reasonable efforts regarding chronic opioid patients stopping the use of the controlled substances, decrease dosages, or trying other drugs or treatment modalities as required by Oklahoma statute and VA guidelines. We found insufficient monitoring at the PCP level to ensure compliance with opioid monitoring requirements as well as a lack of knowledge regarding VHA opioid-related data tools. We identified facility policies that are not compliant with Oklahoma opioid prescribing statutes; however, PCPs are aware of the timing required by statute for reassessing patients receiving chronic opioid therapy. On an aggregate level, we determined that Oklahoma City has had significant success with decreasing the number of Veterans on opioid medications as well as decreasing opioid dosages during a time period of increasing number of Veterans receiving care. We did not identify any patient harm related to PCPs' opioid prescribing practices.

Table of Contents

I. Introduction

The Office of the Secretary of Veterans Affairs received an email from the Office of Special Counsel on August 25, 2025, requesting formal resolution. Subsequently, the Acting Under Secretary for Health, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector assemble and lead a VA team to investigate allegations concerning the Department of Veterans Affairs (VA) Oklahoma City Healthcare System (hereinafter Oklahoma City) located in Oklahoma City, Oklahoma. The whistleblower alleged conduct that may constitute violations of law, rule, or regulation, and a substantial and specific danger to public health and safety. We conducted an onsite investigation on October 7, 2025, through October 9, 2025, to investigate these allegations.

II. Facility Profile

Oklahoma City, which is a part of Veterans Integrated Service Network (VISN) 19, is a complexity level 1b facility.[1] Oklahoma City provides care at the main facility, 15 outpatient clinics, 4 outpatient clinic partnerships with the Department of War, and a Friendship House-Compensated Work Therapy transitional residence.[2] Oklahoma City served 80,092 unique Veterans in fiscal year (FY) 2025.[3]

III. Specific Allegations of the Whistleblower

1. *Oklahoma VHA providers' failure to review and document chronic opioid patients' course of treatment, etiology of pain, and progress toward treatment objectives at intervals prescribed by statute.*

2. *Oklahoma VHA providers' failure to make and document reasonable efforts for chronic opioid patients to stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities, or otherwise attempt to reduce the potential for abuse or development of an opioid use disorder.*

IV. Conduct of Investigation

The VA team conducting the investigation consisted of the Chief Senior Medical Investigator and a Clinical Program Manager, both from the Office of the Medical Inspector; a Human Resources Consultant from the VHA Workforce Management and Consulting Office, Human Resources Center of Expertise; and the National Coordinator

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[1] Complexity level 1b facilities have medium-high-volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs. VHA Office of Productivity, Efficiency & Staffing, Complexity Fact Sheet, undated. Available at: http://raft.vssc.med.va.gov/SelfPacedDocuments/FY23, last accessed December 5, 2025. ***Note**: This is an internal VA website that is not available to the public*.

[2] Oklahoma Facility Trip Pack, dated March 3, 2025. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx, last accessed December 5, 2025. ***Note**: This is an internal VA website that is not available to the public*.

[3] VHA Support Service Center Trip Pack-Operational Statistics Table, Oklahoma City, undated. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fMgmtReports%2fPocketCard%2fTripPack_OperationalStatisticsTable&rs:Command=Render, last accessed December 5, 2025. ***Note**: This is an internal VA website that is not available to the public*.

for Post Deployment and PACT Pain Care from the VHA Office of Primary Care. We reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A.

We interviewed the whistleblower on September 11, 2025.

We conducted an entrance briefing on October 7, 2025, with the following VISN 19 and Oklahoma City leadership:

- Quality Management Officer, VISN 19
- Quality Consultant, VISN 19
- Health Care System Director
- Associate Director
- Chief of Staff (CoS)
- Associate Director for Patient Care Services
- Chief, Quality, Safety, and Value
- Chief Nurse, Medicine Service
- External Accreditation Coordinator

We interviewed the following staff:

- CoS
- Chief, Ambulatory Care Service
- Deputy Chief, Ambulatory Care Service
- Chief, Pharmacy Service
- Chief, Neurology and Rehabilitation Service
- Medical Director, PACT (4)
- Chief Nurse, Ambulatory Care Service
- Associate Chief, Clinical Pharmacy and Education
- Coordinator, Pain Management, Opioid Safety, and Prescription Drug Monitoring Program (PMOP)

- Pain Pharmacist
- Physician, Primary Care Section (2)
- Physician Assistant (PA), Neurology and Rehabilitation Service
- PA, Primary Care (2)
- Nurse Practitioner (NP), Primary Care Section (3)
- Peer Review Coordinator
- Registered Nurse (RN), Primary Care Section (2)
- Patient Safety Manager
- Business Manager, Ambulatory Care Service

We conducted an exit briefing on October 9, 2025, with the following VISN 19 and Oklahoma City leadership:

- Network Director, VISN 19
- Chief Medical Officer, VISN 19
- Quality Management Officer, VISN 19
- Deputy Chief Medical Officer, VISN 19
- Executive Assistant to the Chief Medical Officer, VISN 19
- Chief Planning Officer, VISN 19
- Chief Human Resources Officer, VISN 19
- External Accreditation Coordinator, VISN 19
- Chief Nursing Officer (acting), VISN 19
- Special Advisor to the Network Director, VISN 19
- Health Care System Director
- Associate Director
- CoS
- Deputy CoS

- Assistant Director
- Chief, Quality, Safety, and Value
- Chief Nurse, Medicine Service

V. Background, Findings, Conclusions, and Recommendations

Allegation 1

Oklahoma VHA providers' failure to review and document chronic opioid patients' course of treatment, etiology of pain, and progress toward treatment objectives at intervals prescribed by statute.

Background

VHA Directive 2009-053(1), Pain Management, dated October 28, 2009, provides policy and implementation procedures for the improvement of pain management consistent with VHA national pain management strategy, and compliance with generally accepted pain management standards of care. Regarding pain assessment and treatment, "the safe and effective use of opioid analgesics for the management of pain, particularly complex chronic pain conditions, requires special attention to personal and public health risks."[4] VHA Directive 2009-053(1) encourages the use of a written opioid pain care agreement to document the provider and patient discussion of the potential risks and benefits of opioids, provider and patient responsibilities related to opioid use, and the parameters for continued opioid use. In this context, other methods such as the use of random urine drug monitoring, frequent clinic visits, and opioid renewal clinics may be useful to ensure adherence and safety. VHA Directive 2009-053(1) describes an individualized goal-oriented, prioritized pain management plan of care, that may include, but is not limited to, prescribing opioids, which require the documentation of effectiveness (such as pain control) and safe storage and management in the home.[5]

The VA and Department of Defense (DoD) Clinical Practice Guideline (CPG) for the Use of Opioids in the Management of Chronic Pain, Version 4.0, dated May 2022, *"…provides an evidence-based framework for evaluating and managing patients with chronic pain who are on or being considered for prescribed opioids toward improving clinical outcomes."*[6] VHA's Opioid Safety Initiative (OSI), deployed in calendar year (CY) 2013, aims to ensure the safe, effective, and judicious use of opioids. The OSI uses VHA's electronic health record (EHR) to identify patients who may be at high-risk for

[4] VHA Directive 2009-053(1), Pain Management, dated October 28, 2009.
[5] Ibid.
[6] VA/DoD CPG for the Use of Opioids in the Management of Chronic Pain, Version 4.0, dated May 2022. Available at: https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPG.pdf, last accessed December 5, 2025. ***Note**: This is an internal VA website that is not available to the public*.

adverse outcomes related to the use of opioids and providers whose prescribing practices may not reflect the best evidence.[7]

From CY 2014 through CY 2016, VHA issued various opioid safety-related guidelines, such as patient education requirements, written informed consent for long-term opioid therapy (LTOT), excluding patients enrolled in hospice care and on opioids for cancer pain, and requiring providers to query the state prescription drug monitoring program (PDMP) for patients receiving a controlled substance prescription for longer than 5 days and for shorter courses of refills (except for hospice care). These PDMP queries provide clinicians with a complete and cohesive controlled substance prescription history, across all care locations, to drive informed decisions.[8]

In CY 2018, VA initiated an interdisciplinary team review and a care coordination process to further enhance the risk mitigation for Veterans receiving opioid medications and who are estimated to be at high-risk for overdose or suicide. The determination of risk is based on the Stratification Tool for Opioid Risk Mitigation (STORM). The STORM is updated daily and uses predictive analytics to estimate a risk score of adverse outcomes (such as suicide related events, overdose, or overdose death) from variables in the EHR for all patients with an opioid prescription.[9]

On November 1, 2018, Oklahoma Senate Bill 1446, which describes the process for opioid prescribing practices in the state, went into effect. The law differentiated between acute and chronic opioid prescribing requirements. For chronic pain prescriptions, if continuing treatment for 3 months or more, Senate Bill 1446 required practitioners to review the course of treatment every 3 months, as well as any new information regarding pain etiology and progress toward treatment objectives.[10] In CY 2019, Senate Bill 848 modified the provisions of Senate Bill 1446 related to opioid prescribing. Specific to chronic opioid therapy lasting 3 months or longer, the modifications included the provider's review of the treatment plan with the patient, and extending the review interval to every 6 months after the first year of compliance.[11]

Current Oklahoma opioid prescribing requirements are codified in title 63, Public Health and Safety, and continue the requirement for review of the treatment plan and patient assessment every 6 months after 1 year of compliance with the patient and provider agreement. The requirements of the Oklahoma statutes do not apply to a patient who has sickle cell disease, is in cancer treatment, or receiving aftercare cancer treatment, hospice, palliative care, or residents of a long-term care facility, or to medications for treatment of substance abuse or opioid dependence.[12]

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[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Oklahoma Senate Bill 1446, effective November 1, 2018. Available at: https://www.oklegislature.gov/cf_pdf/2017-18%20ENR/SB/SB1446%20ENR.PDF, last accessed December 5, 2025.
[11] Oklahoma Senate Bill 848, dated May 21, 2019. Available at: https://legiscan.com/OK/bill/SB848/2019, last accessed December 5, 2025.
[12] 63 O.S. § 2-309I (OSCN 2025). Available at: https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=482877, last accessed December 5, 2025.

Oklahoma City MCP 11-48, Pain Management, dated December 5, 2022, establishes policy on facility-wide compliance with VHA and Oklahoma state requirements regarding pain management and related matters. The MCP notes that chronic pain management will be provided by the PCP using the biopsychosocial model, therefore, the approach for each patient's treatment should involve functional lifestyle modifications, pharmacologic, behavioral, and social-support options to optimally manage pain. For patients not responding to initial biopsychosocial strategies, the PCP has access to the facility chronic pain program and if services are not available internally, the Veteran can be referred to community care.[13]

Oklahoma City MCP 11-48 describes the processes for the safe use of opioids, which include, but are not limited to:

- *"… All patients on opioids for pain for [greater than] 90 days (consecutive or not) within a 12-month rolling period must have a formal consent reviewed, discussed and signed in [the EHR] …"*

- *Urine drug screenings (UDS) will be done at least once per year, or more often if clinically indicated, or documented high risk…*

- *Per Oklahoma state policy, notes are completed at the initiation of opioids and on follow-up at a minimum of every three months and monthly efficacy and safety assessments are required. More frequent monitoring and documentation may be indicated."*[14]

- The PDMP check will be completed upon prescribing a controlled substance and at least every 6 months for as long as the prescription is continued.[15]

Oklahoma City MCP 11-148, Chronic Opioid Use in Non-Cancer Pain, dated December 5, 2022, defines chronic opioid use as the consistent use of an opioid *"…with an average daily use of one dose per day for three months out of any rolling 12-month period, or three months out of any four-month treatment period.(Use of opioids for chronic pain does not have a defined end.)"*[16] In addition, MCP 11-148 defines chronic non-cancer pain as *"…any continuous pain lasting longer than three months. It may or may not have an identifiable organic cause and typically includes exacerbations and remissions."*[17]

In VHA, the PACT is a team of health care professionals that provides comprehensive primary care in partnership with the patient and manages and coordinates comprehensive health care services consistent with agreed upon goals of care.[18]

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[13] Oklahoma City MCP 11-48, Pain Management, dated December 5, 2022. ***Note:*** *This is an internal VA document that is not available to the public.*
[14] Ibid.
[15] Ibid.
[16] Oklahoma City MCP 11-148, Chronic Opioid Use in Non-Cancer Pain, dated December 5, 2022. ***Note****: This is an internal VA document that is not available to the public*.
[17] Ibid.
[18] VHA Handbook 1101.10(2), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

Oklahoma City MCP 11-148 describes the responsibilities of the PACT, which include, but are not limited to the following:

- *"An opioid risk assessment which will include both medical and psychiatric substance use risk. This needs to occur at the time of first prescription, and per Oklahoma House Bill 1446, every three months. In addition, per Oklahoma law, assessment of outcomes and complications need to occur monthly."*[19]

- Patient follow up should be directed by the provider based on patient behavior, progress, medication use, and compliance with the pain management program, to include a UDS.

- Opioid overdose risk should be reviewed with the patient to plan alternate strategies on pain management to allow only the use of the lowest opioid dosage possible to control pain and improve function.

- Prescription of naloxone (the antidote to acute opioid toxicity) kits to all patients on opioids, prioritizing high-risk patients, with education provided to the patient and caregiver by pharmacy or nursing staff.

- A PDMP check must occur at the time of initial prescription, and at least every 6 months thereafter.

- An opioid consent is required for any patient receiving opioids for chronic pain for periods longer than 90 days within any 12-month rolling period and must be signed by the prescribing provider and the patient. *"For patients with an opioid consent for chronic pain, all opioids must be prescribed through Primary Care. In some exceptional cases, opioids may be prescribed by the Emergency Department."*[20]

Per Oklahoma City MCP 11-148, patients should be assessed for the efficacy of treatment, adverse drug effects, and the appearance of either misuse or abuse of the drugs, and the assessment results should be clearly documented in the EHR. The Narcotic Therapy Note or the STORM Point of Care Data-Based Opioid Risk Review Note should be used to document indications for use of opioids, risk factors for adverse effects, efficacy, and aberrant behaviors.[21]

Oklahoma City Standard Operating Procedure (SOP)-06, Ambulatory Care SOP for PACT, dated August 2, 2024, notes that compliance with the requirements of the OSI, VHA regulations, and Oklahoma laws are mandatory. The PCP must see the patient face-to-face every 3 months (which can be alternated with telehealth appointments) and *"evaluate the patient for chronic pain during the first year of chronic opioid management, then, after the first year, every 6 months."*[22] During the first year, the patient evaluation

[19] Oklahoma City MCP 11-148, Chronic Opioid Use in Non-Cancer Pain, dated December 5, 2022. ***Note**: This is an internal VA document that is not available to the public*.
[20] Ibid.
[21] Ibid.
[22] Oklahoma City SOP-06, Ambulatory Care Standard Operating Procedure (SOP) for Patient Aligned Care Team (PACT), dated August 2, 2024. ***Note**: This is an internal VA document that is not available to the public*.

must be completed monthly at every prescription renewal, and the evaluation must cover items such as presence of side effects, alleviation of pain, whether taking medication as prescribed, and asking if the medication can be gradually decreased. The SOP notes that patients on chronic pain medication for 60 days or longer must have a signed narcotic consent with a PCP in the EHR. Also, a STORM Point of Care Data-Based Opioid Risk Review note is required when a new opioid is started, then once yearly. The UDS must be obtained when a new controlled prescription is written and at least every 6 months. The PDMP check must be completed and documented by the PCP or pharmacist when a new controlled prescription is written and then at least every 6 months.[23]

Findings

Chronic pain treatment at Oklahoma City includes controlled substance management by the PCP and interdisciplinary services through the Pain Rehabilitation Clinic. The Primary Care Section is organizationally aligned under the Ambulatory Care Service and is led by a Chief and Deputy Chief who are PCPs. Primary Care PACTs are supervised by Medical Directors who are also PCPs. The PCP manages a patient's chronic pain condition and the opioid prescribing process with consultative assistance provided by PACT pharmacists.

The Neurology and Rehabilitation Service provides oversite of other pain management services such as the interdisciplinary Pain Rehabilitation Clinic, the outpatient pain rehabilitation program, the Veterans Integrated Pain team, interventional treatments, whole health modalities, and clinical pharmacists who specialize in pain management. The Pain Rehabilitation Clinic focuses on providing an individualized, whole-person treatment of chronic pain that includes non-pharmacologic therapies and use of non-opioid pharmacotherapies for pain therapy. A PCP can enter a consult for the Pain Rehabilitation Clinic or Pain Pharmacist to assist with a patient's pain management if needed.

The whistleblower clarified that the allegations were regarding PCPs' opioid prescribing practices. The whistleblower described a perception of feeling *"pressured"* by leadership to prescribe controlled substances when cross-covering other PCPs. The whistleblower explained that when an opioid refill has been requested and the patient's EHR was reviewed, at times the whistleblower found opioid monitoring elements required by Oklahoma statute not completed and as a result the whistleblower did not feel comfortable ordering the medications.

We asked PCPs if they had ever perceived that their leadership had pressured them to order opioids and all but one stated they had not. While covering for another provider a PCP stated feeling pressured once by leadership to prescribe an opioid; however, this feeling was attributed to being a new provider out of residency and not being comfortable with ordering opioids at the time. Another PCP explained that when cross-covering other PCPs, if there were missing elements of the opioid monitoring

[23] Ibid.

requirements, they would prescribe a short-term bridge prescription to provide time to complete the missing items. The PCP stated that if a patient who has been on long-term opioids does not have their medication there is a risk for withdrawal leading to medical complications.

A PACT Medical Director stated that they would never force or pressure a PCP to order a medication and explained that if a cross-covering PCP is hesitant to refill an opioid for another provider's patient, they would *"not recommend stopping them [the patient] cold turkey"* and would advise the PCP to order a bridge prescription for the amount of time that the other PCP is out of the office. Another PACT Medical Director explained that if a PCP who is cross-covering for a PCP finds that opioid monitoring requirements are not completed for a patient requesting an opioid refill, that a bridge prescription is recommended to prevent the patient from experiencing withdrawal. When notified by the cross-covering PCP of this type of situation, the PACT Medical Director explained that they will educate the assigned PCP regarding opioid monitoring requirements when they return. The Ambulatory Care Service Chief stated that if a cross-covering PCP is uncomfortable with prescribing an opioid that the expectation is to do what is *"best for the patient,"* to not stop the opioid and order a bridge prescription, and to place orders for what requirement is missing to ensure that the patient is taken care of properly.

Our review of Oklahoma City MCPs and SOPs related to opioid prescribing practices noted inconsistencies between them and that the MCPs were not in alignment with current Oklahoma statute. Specifically, Oklahoma City MCP 11-48 and Oklahoma City MCP 11-148 both state that documentation of a reassessment should be completed every 3 months after the first year of opioid therapy in accordance with Senate Bill 1446. As noted previously, this statute was modified in CY 2019 to extend the reassessment to every 6 months after the first year of opioid therapy. Oklahoma City SOP-06 states that after the first year of opioid therapy for chronic pain, that evaluation of the patient should occur every 6 months in accordance with current Oklahoma statute (Senate Bill 848). All PCPs we interviewed noted the requirement for a 6-month reassessment following the first year of opioid therapy. The Neurology and Rehabilitation Service Chief referenced Senate Bill 1446 (previous statute) stating the requirement of a reassessment is every 3 months following the first year of opioid therapy. The Neurology and Rehabilitation Service Chief was not aware of later modifications to Oklahoma law that had changed the reassessment timeframe.

The whistleblower provided four Veterans (hereinafter Veteran 1, Veteran 2, Veteran 3, and Veteran 4) as examples of the allegations. We performed a clinical review of the Veterans' EHRs and noted that three of the four examples lacked the required opioid monitoring requirements. Specifically, our clinical review noted that:

- Veteran 1's EHR lacked a follow up assessment by the prescribing PCP within 6 months and the LTOT consent was not present at the timeframe of the concern in June 2025 but was later completed by the PCP on July 15, 2025.

- Veteran 2's EHR accounted for several PCP visits and interactions, but most lacked discussion related to opioid use and lacked reassessment every 6 months. We

identified several missed opportunities to address pain and the patient's underlying health condition (chronic obstructive pulmonary disease) may be exacerbated by chronic opioid use.

- Veteran 3's EHR met all opioid monitoring requirements.

- Veteran 4's EHR included a chronic opioid prescription with VA and an acute opioid prescription from a non-VA provider following surgery in July 2025, which is concerning for the potential for overdose. A return to clinic order with a clinically indicated date of 6 months later was entered in December 2024 after a pain management evaluation. However, the return to clinic appointment was not scheduled or completed within the 6-month timeframe. In addition, an LTOT consent was not present.

We completed a clinical review of 29 patients with chronic opioids prescribed by multiple PCPs. Our review noted noncompliance that included evidence of inconsistencies regarding completion of required opioid monitoring requirements and a lack of documentation describing the course of pain treatment and progress towards treatment objectives. Of the 29 EHRs reviewed:

- 20 (69%) EHRs included a UDS completed every 6 months.

- 21 (72%) EHRs included LTOT consents.

- 21 (72%) EHRs included a pain-specific follow-up assessment completed every 6 months.

- 25 (86%) EHRs included a PDMP check completed every 6 months.

Our review did not find systemic concerns regarding a particular PCP or primary care location. We reviewed the Pain Committee agendas and minutes from FY 2024 and FY 2025 and noted that aggregate opioid-related data, monitored by the PMOP Coordinator, is consistently shared and discussed. The Pain Committee has action plans in place to address negative trends in the aggregated data. For example, current action plans address noncompliance with PDMP checks, primarily for new-start opioid therapy, and maintaining the improvements made in those patients who are prescribed both benzodiazepines and opioids. Per the PMOP Coordinator, individual providers are not monitored unless a trend or significant outlier is identified in OSI data.

Ambulatory Care Service leadership and PACT leadership explained that the only provider-specific opioid prescribing monitoring is the OPPE. The PCPs OPPE is comprised of multiple metrics that include four elements of the opioid monitoring requirements described below:

- Documentation of the LTOT consent for the current course of opioid therapy.

- Documentation of a current PDMP query, consistent with VHA and facility guidelines.

- An opioid risk assessment has been documented within the past year.

- Documentation of UDS results within the past year which have been acted upon appropriately.

The Ambulatory Care Service leaders and PACT leaders randomly select the patients reviewed for their direct reports' OPPEs. For their OPPE, each PCP has five patients' EHRs reviewed during a 6-month timeframe. Some Ambulatory Care Service leaders and PACT leaders stated that they ensure that the five patients selected for the OPPEs include those prescribed opioids, but others stated they do not specifically include those patients.

VHA has multiple data tools, such as STORM and OSI reports, to assist staff in monitoring various opioid-related metrics. These tools can be used to assist in gaining a more complete assessment regarding opioid prescribing practices, completion of opioid monitoring requirements, and if fully utilized improving compliance. However, many PACT leaders and staff were not familiar with these types of data assessment tools.

The PMOP Coordinator explained that the facility is currently considering the use of a standardized controlled substance ordering note. Members of the Pain Committee are reviewing note templates developed by VHA and VISN 19 to determine which note would be preferable for the facility. The template will address the required elements for chronic opioid prescription practices, such as UDS, PDMP, completion of an opioid risk review, naloxone prescription and education, and LTOT consent. However, the templated notes being considered do not have components regarding assessment, tapering efforts, or exploring other treatment options. The PMOP Coordinator explained that the standardized note template will improve facility compliance with opioid monitoring requirements and will improve the efficiency of the reviews completed by the Pain Board. The new note will also make it easier for providers to document the requirements in one note location as well as containing order sets and a link to complete the PDMP.

PCPs reported varying degrees of involvement by other PACT members assisting in the monitoring and completion of opioid monitoring requirements. PACT staff explained that they perform a daily morning huddle that includes the review of patients scheduled in clinic that day, but the review does not include opioid monitoring requirements for potential patients on long-term opioid therapy. Per the Ambulatory Care Service Chief Nurse, nurses may place a standing order for UDSs for patients who are prescribed opioids, which is supported in policy through the Oklahoma City SOP 118-AMB-029, Standing Orders Registered Nurses and Licensed Practical/Vocational Nurses in Ambulatory Care, dated September 15, 2023. The Ambulatory Care Service Chief acknowledged that nurses could assist the PCP by placing the UDS order when indicated but noted that it ultimately is the PCP's responsibility to ensure and check that all opioid monitoring requirements are completed.

We reviewed Joint Patient Safety Reporting system reports entered from FY 2024 through FY 2025 and found no concerns related to PCPs' opioid prescribing practices.

Conclusions for Allegation 1

- We **substantiate** that Oklahoma City PCPs episodically fail to complete opioid monitoring requirements, such as reviewing and documenting chronic opioid patients' course of treatment, etiology of pain, and progress toward treatment objectives at intervals required by Oklahoma statute and VA guidelines.

- There is a lack of knowledge regarding VHA opioid-related data tools available that could assist in PCP compliance with opioid monitoring requirements.

- The current OPPE process is an insufficient monitor of PCP compliance with opioid monitoring requirements due to the low number of patients reviewed and lack of consistency regarding the inclusion of patients prescribed opioids in the reviews.

- Oklahoma City MCP 11-48 and Oklahoma City MCP 11-148 are not compliant with current Oklahoma statutes regarding opioid prescribing. Specifically, they note a requirement for a 3-month reassessment, but the statute requires a 6-month reassessment.

- PCPs reported varying degrees of support by PACT members to complete opioid monitoring requirements, which if increased could assist in compliance and decrease workload on the provider.

Recommendations to Oklahoma City

1. Request a consultation by the VHA Office of Primary Care for PACT Pain Care operations and management to review pain management services and compliance with opioid monitoring requirements.

2. Provide training for Ambulatory Care Service leadership and PACT staff regarding available VHA opioid-related data tools.

3. Develop a process to monitor PCP compliance with the opioid monitoring requirements beyond what is currently included in the PCPs' OPPEs, utilizing existing opioid related data.

4. Revise Oklahoma City MCP 11-48 and Oklahoma City MCP 11-148 to ensure compliance with current Oklahoma statutes and provide education to pertinent staff following revision.

5. Encourage non-PCP PACT member participation in the opioid monitoring requirement process.

Allegation 2

Oklahoma VHA providers' failure to make and document reasonable efforts for chronic opioid patients to stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities, or otherwise attempt to reduce the potential for abuse or development of an opioid use disorder.

Background

In regard to opioid prescribing, Oklahoma Senate Bill 848 notes that for chronic pain prescriptions, the practitioner shall periodically make reasonable efforts, unless clinically contraindicated, to stop, decrease dosage, or try other treatment modalities.[24]

The VA and DoD CPG for the Use of Opioids in the Management of Chronic Pain describes the process of tapering, discontinuing, and switching opioids. If the decision is made to taper, the CPG suggests that providers take a collaborative and patient-centered approach. Collaborative tapering strategies may include dose reduction or opioid discontinuation. The CPG notes that the benefits of a collaborative, patient-centered approach to tapering outweigh the harm. A potential benefit is risk reduction for overdose, opioid use disorder, and other adverse events. There are potential harms of forced tapering, which can destabilize patients, precipitating opioid withdrawal that may be accompanied by worsening pain, loss of function, increased suffering, worsening depression, increased suicidal ideations and attempts, and use of other substances. These potential harms can be mitigated by using gradual patient-centered tapering strategies. Tapering may be best tolerated at a rate of decrease that is slow enough to avoid withdrawal symptoms.[25]

Per Oklahoma City MCP 11-148, if there is no documented support for continued use, the patient should be tapered off opioids, and other treatment options explored. If a patient's opioid medication is discontinued for any reason, a new note containing the reason for the discontinuance will be entered into the EHR. Diagnoses supporting the need for chronic opioid analgesia are to be documented in the EHR. In addition, *"All patients receiving opioids are to have a urine drug screen (UDS) annually or more often based on the risk assessment. All patients with a confirmed positive test for illegal drugs should be tapered off opioids by the provider."*[26]

Oklahoma City MCP 11-48 notes that the interdisciplinary Pain Board is a resource for PCPs to receive second-level reviews of problematic cases of pain management issues, such as intractable pain, nonadherence, behavioral problems related to opioid use, red flags, or adverse effects. The Pain Board is used for case review when high-risk opioids are being considered for use for chronic pain or when doses of opioids exceed

[24] Oklahoma Senate Bill 848, dated May 21, 2019. Available at: https://legiscan.com/OK/bill/SB848/2019, last accessed December 5, 2025.
[25] VA/DoD CPG for the Use of Opioids in the Management of Chronic Pain, Version 4.0, dated May 2022. Available at: https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPG.pdf, last accessed December 5, 2025. ***Note**: This is an internal VA website that is not available to the public*.
[26] Oklahoma City MCP 11-148, Chronic Opioid Use in Non-Cancer Pain, dated December 5, 2022. ***Note**: This is an internal VA document that is not available to the public*.

morphine equivalent doses of 90 milligrams (mg) per day. The Pain Board performs high-risk STORM reviews and documents the review in the EHR.[27] Oklahoma City MCP 11-148 notes that if a provider or clinic discontinued an opioid, it may not be reinstituted by another provider without discussion with the Pain Board and the original provider.[28]

Findings

We reviewed VA data sources for Oklahoma City's opioid prescription data and found positive progress regarding decreasing the number of Veterans dispensed long-term opioids. In the 2nd quarter (Q2) of FY 2016, 5,374 Veterans received long-term opioids; by Q3 FY 2025, 2,222 Veterans received opioids, a 59% reduction. The reduction in Veterans receiving opioids has occurred during a timeframe of increasing Veteran population growth at Oklahoma City. The total unique Veterans that Oklahoma City served has increased from 68,209 Veterans in FY 2021 to 80,092 Veterans in FY 2025. In addition, we reviewed the dose amounts of Oklahoma City Veterans prescribed opioids and noted positive progress regarding decreasing the number of Veterans with morphine equivalent daily doses greater than or equal to 90 mg. In Q2 FY 2016, 413 Veterans received morphine equivalent daily doses greater than or equal to 90 mg; by Q3 FY 2025, there were 122, a 70% reduction.

Our clinical review of patients receiving chronic opioids, described in Allegation 1, resulted in evidence of episodic care failures, such as missing documentation describing other modalities of pain treatment (other than opioids) being used by Veterans or previously attempted by the Veterans, and inconsistent or missing documentation of attempts to reduce medication doses or stop medications. Our review did not find a pattern or consistent concern for care by a specific provider or primary care location.

We also reviewed ten patient cases discussed at the facility's Pain Board meetings held on September 19, 2025, and October 3, 2025. Of the 10 cases, 2 were cancer cases and the board made no recommendations regarding reducing or tapering their opioid prescriptions. One case was a short-term opioid therapy patient who was reviewed by the board due to also being prescribed a benzodiazepine and the board made no recommendations regarding reducing or tapering the opioid prescription. One case was a requested new start opioid patient for whom the PCP had referred due to not agreeing with the patient's request and the board did not recommend starting the opioid. The remaining six cases were all prescribed long-term opioid therapy and the board recommended that two of the patients should have their opioids tapered, one should be referred to the Pain Pharmacist for further management of pain medications, and one should be switched from morphine to buprenorphine (on opioid partial agonist) for risk mitigation. The board made no recommendations regarding reducing or tapering the other two patients' prescriptions. The board also determined if any elements of the

[27] Oklahoma City MCP 11-48, Pain Management, dated December 5, 2022. ***Note:*** *This is an internal VA document that is not available to the public.*
[28] Ibid.

opioid monitoring requirements were missing and made those recommendations when indicated.

The Pain Pharmacist explained that the Pain Pharmacy Clinic was developed to assist providers in decreasing or stopping the use of the controlled substances. The clinic has received increasing numbers of referrals from providers for assistance with patients having chronic pain that led to the recent expansion of the clinic and the addition of two full-time pharmacists (for a total of three pharmacists) to address the increased workload. The Pain Pharmacist also shared that the facility's Pain Rehabilitation Program is available for patient referral and is an eight-week outpatient program unique to Oklahoma City. The program assists with medication management as well as non-pharmacologic modalities to support pain control. The Pain Pharmacist is also consulted to review new patients or patients transferred from other VA sites with existing opioid prescriptions to evaluate, assess, and determine if the medications are appropriately prescribed, if dosages are safe, and if non-opioid pain therapy modalities could be added.

Conclusions for Allegation 2

- We **substantiate** that Oklahoma City PCPs episodically failed to make and document reasonable efforts for chronic opioid patients to stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities, or otherwise attempt to reduce the potential for abuse or development of an opioid use disorder, which is required by Oklahoma law and VA guidelines.

- The facility aggregate opioid-related data show the facility has had significant success in decreasing the number of Veterans on opioid medications as well as decreasing opioid dosages.

Recommendations to Oklahoma City

6. Provide education to all PCP staff regarding the need to document efforts to decrease or stop the use of opioids or try other drugs or treatment modalities, as required by Oklahoma law and VA guidelines.

7. Develop a tool to monitor that patients on chronic opioid prescriptions have documented efforts to decrease or stop the use of opioids or try other drugs or treatment modalities.

VI. Summary Statement

We have developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel's concerns that Oklahoma City engaged in alleged conduct that may constitute violations of law, rule, or regulation, and a substantial and specific danger to public health and safety. We reviewed the allegations and determined the merit of each. We determined that Oklahoma City PCPs episodically failed to complete opioid monitoring requirements and failed to make and document reasonable efforts regarding chronic opioid patients stopping the use of the controlled substances,

decrease dosages, or trying other drugs or treatment modalities as required by Oklahoma statute and VA guidelines. We found insufficient monitoring at the PCP level to ensure compliance with opioid monitoring requirements as well as a lack of knowledge regarding VHA opioid-related data tools. We identified facility policies that are not compliant with Oklahoma opioid prescribing statutes; however, PCPs are aware of the timing required by statute for reassessing patients receiving chronic opioid therapy. On an aggregate level, we determined that Oklahoma City has had significant success with decreasing the number of Veterans on opioid medications as well as decreasing opioid dosages during a time period of increasing number of Veterans receiving care. We did not identify any patient harm related to PCPs' opioid prescribing practices.

Attachment A
References

63 O.S. § 2-309I (OSCN 2025). Available at: https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=482877, last accessed December 5, 2025.

Oklahoma Facility Trip Pack, dated March 3, 2025. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx, last accessed December 5, 2025. ***Note****: This is an internal VA website that is not available to the public*.

Oklahoma City MCP 11-148, Chronic Opioid Use in Non-Cancer Pain, dated December 5, 2022. ***Note****: This is an internal VA document that is not available to the public*.

Oklahoma City MCP 11-48, Pain Management, dated December 5, 2022. ***Note:*** *This is an internal VA document that is not available to the public.*

Oklahoma City SOP-06, Ambulatory Care Standard Operating Procedure (SOP) for Patient Aligned Care Team (PACT), dated August 2, 2024. ***Note****: This is an internal VA document that is not available to the public*.

Oklahoma Senate Bill 1446, effective November 1, 2018. Available at: https://www.oklegislature.gov/cf_pdf/2017-18%20ENR/SB/SB1446%20ENR.PDF, last accessed December 5, 2025.

Oklahoma Senate Bill 848, dated May 21, 2019. Accessible at: https://legiscan.com/OK/bill/SB848/2019, last accessed December 5, 2025.

VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain, Version 4.0, dated May 2022. Available at: https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOpioidsCPG.pdf, last accessed December 5, 2025. ***Note****: This is an internal VA website that is not available to the public*

VHA Directive 2009-053(1), Pain Management, dated October 28, 2009.

VHA Handbook 1101.10(2), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

VHA Office of Productivity, Efficiency & Staffing, Complexity Fact Sheet, undated. Available at: http://raft.vssc.med.va.gov/SelfPacedDocuments/FY23, last accessed December 5, 2025. ***Note****: This is an internal VA website that is not available to the public*.

VHA Support Service Center Trip Pack-Operational Statistics Table, Oklahoma City, undated. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fMgmtReports%2fPocketCard%2fTripPack_OperationalStatisticsTable&rs:Command=Render, last accessed December 5, 2025. ***Note**: This is an internal VA website that is not available to the public*.

Other documents reviewed as part of this report.

***Note:** The agendas, minutes, OPPE, SOPs, and dashboards, are internal VA documents that are not available to the public.*

Oklahoma City Pain Committee agendas and minutes, FY 2024 and FY 2025.

Oklahoma City PCP OPPE FY 2025.

Oklahoma City SOP 118-AMB-029, Standing Orders Registered Nurses and Licensed Practical/Vocational Nurses in Ambulatory Care, dated September 15, 2023.

Power BI-OSI Dashboard, Oklahoma City Veterans with Long Term Opioids, Q2 FY 2016 through Q3 FY 2025. Available at: https://app.powerbigov.us/groups/me/reports/5860a664-d9eb-4d73-9aaf-816f9ef8a425/ReportSection490b51581a23aca1c602, last accessed October 14, 2025.

Power BI-OSI Dashboard, Oklahoma City Veterans with Morphine Equivalent Daily Doses Greater Than or Equal to 90 mg, Q2 FY 2016 through Q3 FY 2025. Available at: https://app.powerbigov.us/groups/me/reports/5860a664-d9eb-4d73-9aaf-816f9ef8a425/ReportSection490b51581a23aca1c602, last accessed October 28, 2025.

Attachment B
List of Acronyms

CoS	Chief of Staff
CPG	clinical practice guideline
CY	calendar year
FY	fiscal year
EHR	electronic health record
LTOT	long-term opioid therapy
MCP	medical center policy
NP	nurse practitioner
OPPE	ongoing professional practice evaluation
OSI	Opioid Safety Initiative
PA	physician assistant
PACT	Patient Aligned Care Team
PCP	primary care provider
PMOP	Prescription Drug Monitoring Program
RN	registered nurse
SOP	standard operating procedure
STORM	Stratification Tool for Opioid Risk Mitigation
UDS	urine drug screen
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table B-1 List of Acronyms

Index of Names

Key to Investigative Team Members

- [redacted], Chief Senior Medical Investigator
- [redacted], Clinical Program Manager
- [redacted], VHA Workforce Management and Consulting Office, Human Resources Center of Expertise
- [redacted], National Coordinator for Post Deployment and PACT Pain Care, VHA Office of Primary Care

Key to Interviewees

- [redacted] CoS
- [redacted] Chief, Ambulatory Care Service
- [redacted] Deputy Chief, Ambulatory Care Service
- [redacted], Chief, Pharmacy Service
- [redacted]., Chief, Neurology and Rehabilitation Service
- [redacted]., PACT Medical Director
- [redacted], Associate Chief, Clinical Pharmacy and Education
- [redacted] Chief Nurse, Ambulatory Care Service
- [redacted], Coordinator, PMOP
- [redacted], Pain Pharmacist
- [redacted] PACT Medical Director
- [redacted] Physician, Primary Care Section
- [redacted] PACT Medical Director
- [redacted] Physician, Primary Care Section
- [redacted] PACT, Medical Director
- [redacted], Neurology and Rehabilitation Service

- [redacted], Primary Care Section
- [redacted], Primary Care Section
- [redacted], Primary Care Section
- [redacted] Primary Care Section
- [redacted] Primary Care Section
- [redacted]
- [redacted] Primary Care Section
- [redacted], Primary Care Section
- [redacted], Patient Safety Manager
- [redacted], Ambulatory Care Service