U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

July 8, 2026

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

Re: OSC File No. DI-25-002034

Dear Mr. President:

I am forwarding to you a report transmitted to the Office of Special Counsel (OSC) by the U.S. Department of Veteran Affairs (VA) in response to the Special Counsel's referral of a disclosure of wrongdoing at the Veterans Health Administration (VHA), Oklahoma City Health Care System (Oklahoma City), Oklahoma City, Oklahoma.[1] OSC has reviewed the disclosure, agency report, and 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 those findings and comments.

The whistleblower, [redacted], a former VHA Ambulatory Care Physician, who consented to the release of his name, disclosed that Oklahoma VHA providers are prescribing and refilling opioid medications for VA patients without following Oklahoma Public Health and Safety Statutes (OK State Statutes).[2] First, [redacted] disclosed that Oklahoma VHA providers consistently fail to review and document chronic opioid patients' course of treatment, etiology of pain, and progress toward treatment objectives at intervals prescribed by statute.[3] Second, [redacted] disclosed that Oklahoma VHA providers consistently fail to make and document reasonable efforts for chronic opioid patients to stop the use of the controlled substance, decrease the dosage, prescribe other drugs or treatment modalities, or otherwise attempt to reduce the potential for abuse or development of an opioid use disorder as required by statute.[4]

[redacted] explained that as a float physician with the Oklahoma VHA, he travels the state filling in for physicians across nine clinics within Veterans Integrated Service Network 19.

[1] The whistleblower's allegations were referred to the Secretary of Veterans Affairs Douglas A. Collins on August 25, 2025, for investigation pursuant to 5 U.S.C. §§ 1213(c) and (d). The VA Office of the Medical Inspector conducted the investigation. Secretary Collins reviewed and signed the agency report.
[2] Okla. Stat. tit. 63, § 2-309I(F) (2024).
[3] *Id*. at Section (F)(2).
[4] *Id*. at Section (F)(3).

The scope of his duties as a float physician includes ordering prescription refills for patients, including prescription opioids. Prior to filling an opioid prescription, [redacted] reviews the patient's chart to ensure compliance with OK State Statutes. With respect to Sections (F)(1) and (F)(2) of the OK State Statutes, [redacted] observed that providers were not assessing patients at the intervals required prior to prescription and, if they were, the patients' charts lacked proper documentation. [redacted] reported that he reviewed patient records that did not include any assessment documentation for up to two years, even though it is a requirement that patients be assessed on either a three- or six-month basis.[5] Some providers tried to use unrelated appointments, for instance when veterans sought treatment for a skin rash or digestive issue, as documentation of proper opioid assessment. However, [redacted] found that these interactions did not include discussions required by OK State Statutes regarding course of pain management treatment and/or etiology of pain.[6]

With respect to OK Statute Section (F)(3), [redacted] observed that providers were not engaging in proper risk assessment or attempting to taper the use of opioids in their patients. Instead, [redacted] saw regular increases in dosages, often without documentation for the increase. In [redacted] extensive prior experience with pain management in chronic opioid patients, the standard of care required practices such as random pill counts or urinalysis; however, he reported these practices were rarely employed by Oklahoma City. Notably, [redacted] rarely encountered documentation assessing whether a patient was experiencing dependency or potentially engaging in diversion. When [redacted] attempted to report his concerns internally, he was met with resistance and was often pressured to prescribe controlled substances without following OK State Statutory procedure.

The agency investigation substantiated both of [redacted] allegations. For the first allegation, the investigators found that Oklahoma City providers episodically failed to complete opioid monitoring requirements such as reviewing and documenting chronic opioid patients' course of treatment, etiology of pain, and treatment progress at intervals required by OK State Statutes and VA guidelines. For the second allegation, the investigation found that Oklahoma City providers episodically failed to document reasonable efforts to reduce the potential for abuse or the development of an opioid use disorder. In particular, providers did not attempt to cease the use of the controlled substance, decrease the prescribed dosage, or prescribe other drugs or treatment modalities as required by OK State Statutes.[7]

The investigation also uncovered that some Oklahoma City Medical Center policies are not compliant with current Oklahoma statutes regulating opioid prescriptions. The investigation further identified that the current ongoing professional practice evaluation process is insufficient to track providers' compliance with opioid monitoring requirements. Additionally,

[5] *Id*. at Section (F)(1) and (F)(2).
[6] *Id*.
[7] *Id*. at Section (F)(3).

the investigation found a lack of knowledge regarding available VHA opioid-related data tools that could aid in compliance with opioid monitoring requirements.

In response to [redacted] substantiated disclosures and the additional wrongdoing uncovered, the Office of the Medical Inspector made seven recommendations: (1) request a consultation by the VHA Office of Primary Care for the Pain Care and Patient Aligned Care Teams to review pain management services and compliance with opioid monitoring requirements; (2) provide staff training regarding available VHA opioid-related data tools; (3) develop a process to monitor compliance with the opioid monitoring requirements; (4) revise Oklahoma City medical center policies to ensure compliance with current Oklahoma State Statutes and provide education to pertinent staff following revision; (5) encourage non-primary care provider members of the Patient Aligned Care Team to participate in the opioid monitoring requirement process; (6) provide education to all primary care 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; and (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.

[redacted] agreed with several important report findings including the determination that Oklahoma City primary care providers failed to consistently comply with opioid-monitoring requirements required by Oklahoma law and VA guidance and failed to consistently document reasonable efforts to decrease opioid use or pursue alternative treatment modalities. [redacted] also identified key areas of the investigation that could have been more comprehensive. For instance, while the review substantiated that providers failed to attempt to reduce the potential for development of an opioid use disorder (OUD), it did not specifically evaluate whether patients were being screened for active or ongoing OUD. [redacted] further commented that the report understated the scope of the identified deficiencies and questioned whether such deficiencies should be characterized as "episodic." Finally, [redacted] emphasized that he reported these allegations to improve patient care and ensure compliance with Oklahoma law and evidence-based opioid prescribing practices.

I appreciate the seriousness with which the VA is taking this matter, and I encourage the agency to adopt the Office of Medical Inspector's recommendations and to review and ensure completion of those steps. The substantiated findings reflect more than isolated or technical deficiencies. The failure to meet statutory requirements for monitoring chronic opioid therapy and for documenting efforts to reduce the risk of opioid use disorder carries serious implications for patient health and safety. Without regular, documented assessments, providers may continue or increase opioid prescriptions without clear evidence that the therapy remains appropriate or effective. Likewise, the failure to document efforts to taper, reduce dosage, or try alternatives raises the risk that veterans will stay on long-term opioids without meaningful steps to address dependence or the development of opioid use disorder.

I thank the whistleblower for bringing these allegations to OSC. [redacted] disclosure led to the identification of additional wrongdoing, and the implementation of multiple corrective actions and process improvements designed to strengthen opioid prescribing oversight and regulatory compliance. Given [redacted] contribution and efforts to improve the management of opioids and care for veterans, OSC recommends that the VA consider issuing him a monetary award.

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 also filed redacted copies of these documents and a redacted copy of the letter referring this matter in our public file, which is available online at https://www.osc.gov/cases/. This matter is now closed.

Respectfully,

Charles N. Baldis
Chief Counsel

Enclosures