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The Special Counsel

December 13, 2023

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

Re: OSC File Nos. DI-21-000033, DI-21-000470, and DI-21-000503

Dear Mr. President:

I am forwarding to you reports 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 Central Texas VA Healthcare System (CTVAHCS, Temple), Temple, Texas. The whistleblowers, [redacted], a physician in the CTVAHCS Pain Management Clinic, and [redacted]i, former Chief, CTVAHCS Pain Management Clinic (the whistleblowers), consented to release of their names and commented on the reports. I have reviewed the disclosures, agency reports and whistleblower comments and, in accordance with 5 U.S.C. §1213(e), have determined that the reports contain the information required by statute and the findings appear reasonable.[1]

The Allegations

The whistleblowers' allegations relate to several policy changes instituted at Temple following a 2020 reorganization of the Pain Management Clinic in which agency officials re-aligned the Pain Management Clinic, placing it under the umbrella of Whole Health and Integrated Services (Whole Health). The whistleblowers disclosed that at the outset of the reorganization, Dr. Edward Lee, Chief, inappropriately sought to rescind the facility's Standard operating procedures (SOP) for prescribing Buprenorphine, an opioid used to treat opioid use disorder (OUD), acute pain, and chronic pain. The whistleblowers further alleged that Dr. Lee pressured providers to prescribe Buprenorphine regardless of patient diagnosis and promoted incorrect guidance regarding the drug's use and efficacy. The whistleblowers also alleged that Dr. Lee improperly documented "self-consults" with pain management patients prior to their initial appointments, leading to potential billing irregularities and inequitable care.

[1] The allegations were referred to former VA Secretary Robert L. Wilkie for investigation pursuant to 5 U.S.C. § 1213(c) and (d). Former Secretary Wilkie tasked the Under Secretary for Health with conducting the investigation and, in turn, the Under Secretary for Health directed the Veterans Integrated Service Network 17 to investigate. Secretary Denis McDonough reviewed and signed the agency report.

The whistleblowers further alleged that Dr. Lee, together with Dr. Olawale Fashina, Chief of Staff, violated the MISSION Act of 2018 (MISSION Act) and jeopardized patient health and safety by initiating changes to the pain management referral process that placed unnecessary barriers to veterans' access to care. Specifically, the whistleblowers alleged that the new policies for approval of community care emphasized that patients should not receive approval to see outside pain management providers if the sole basis for the referral was "best medical interests-improved continuity of care," thus disrupting the established courses of treatments used by many pain management patients. The whistleblowers also alleged that Dr. Lee implemented a new SOP wherein all providers seeking referrals for pain management for patients must complete an "Intro to Whole Health" course, which unduly inhibits referrals to the program. The whistleblowers acquiesced to these new processes initially, but placed disclaimers on electronic records memorializing these encounters, indicating that they disagreed with the new protocols and stating that they signed off on the direction of Dr. Fashina and Dr. Lee. The whistleblowers alleged that Dr. Lee and Dr. Fashina sought to redact the disclaimers from the electronic health records, in violation of VA Directive 6500 (VA Cybersecurity Program and 1907.01 (Health Information Management). Finally, the whistleblowers alleged that Dr. Lee abused his authority by manipulating his clinical schedule in the CPRS system to inappropriately limit his availability to see patients in clinic for his personal convenience.

The Reports' Findings

The agency substantiated the whistleblowers' allegation that Dr. Lee pressured providers to prescribe Buprenorphine, finding that he took measures to financially incentivize treating patients with Buprenorphine. Shortly after taking the position as Chief of Whole Health, Dr. Lee initiated a policy requiring all pain management providers to complete a "DEA-X waiver training," or a Drug Enforcement Administration (DEA)-issued training that allowed providers to legally prescribe Buprenorphine. Additionally, one of Dr. Lee's identified performance plan goals, or "pay for performance goals" for 2021 included the metric that providers "manage five patients with concurrent chronic pain and complex persistent opiate dependence using appropriate medications." The agency concluded that Dr. Lee's policy changes indicated an effort to incentivize Buprenorphine prescription and appeared to incentivize making specific accompanying diagnoses. The agency determined that this practice had the potential to jeopardize patient health and safety. Finally, the agency substantiated that Dr. Lee abused his authority by manipulating his clinical scheduling. The investigation determined that as Chief, Dr. Lee was required to maintain a clinical practice of a 0.7 full-time employee equivalent, and the scheduling records demonstrated that he consistently failed to comport with this standard.

Further, the agency determined at the outset of the investigation that Temple's Pain Oversight Committee was in the midst of revising the facility's existing policy and SOP regarding Buprenorphine prescription, and that on review, Dr. Lee's amendments to these policies were consistent with these revisions.[2] The agency did not substantiate that Dr. Lee violated agency directives related to patient

[2] In particular, the agency noted that VHA Notice 2019-18, which instructed the VHA to remove barriers to treating opioid use dependency with Buprenorphine, was consistent with Dr. Lee's proposed SOP revisions regarding Buprenorphine prescription.

consults by seeing pain management patients in advance of scheduled visits. The agency determined that while Dr. Lee may have insufficiently documented some patient encounters in the electronic system, as then-director of Whole Health, he was authorized to contact patients prior to their appointments and these initial contacts did not result in improper diagnoses, billing, or inequitable care.

The agency did not substantiate that Dr. Lee placed undue barriers on providers related to referrals for pain management consults. The agency found that the providers' "Intro to Whole Health" requirement only applied to referrals to Complimentary and Integrative Health Services and did not apply to interventional pain management. Likewise, the agency did not substantiate that Dr. Lee and Dr. Fashina improperly redacted portions of medical records in which the whistleblowers attempted to place disclaimers. Though the agency determined Dr. Lee and Dr. Fashina expressed an interest in making these redactions, there was no evidence indicating any redactions were ultimately made to the patient records.

The agency made several recommendations based on the findings. First, the agency recommended further investigation into Dr. Lee's improper manipulation of clinical scheduling and additional action, where appropriate. The agency made several additional recommendations, including that: CTVAHCS and Temple follow up to ensure current Buprenorphine prescription protocols conform to national standards; Temple's Whole Health Department review the high rate of community referrals and potential competency and training gaps that may explain this high rate of community referrals, with the goal of providing the highest quality of care to veterans; Temple review all service agreements to ensure adherence to all governing policies, authorities, and directives; and that Temple review and streamline the interpretation of the "best medical interests" criterion to ensure alignment with VA directives and the MISSION Act.

In a supplemental report, the agency confirmed that following the referral of this matter, CTVHCS rescinded its SOP related to Buprenorphine therapy for OUD and removed the requirement that physicians complete DEA Mental Health Services training and hold DEA waivers—each of which aligned with national standards for OUD and pain management. The agency also confirmed that all pain management physicians must complete training on "Pain Management and Opioid Safety." The agency stated that Temple now has an Integrated Pain Management Service Agreement in place that is aligned with the Mission Act and national standards of care. Finally, the agency confirmed that, to ensure consistent application of the referral process, all pain medicine service providers at CTVAHCS, including Temple, must complete a comprehensive training on ordering consults. Finally, the agency confirmed it investigated Dr. Lee's practices and took appropriate disciplinary action to address them.

The Whistleblower Comments

The whistleblowers noted that many of the findings appeared to support substantiation of most of their allegations, yet the agency only substantiated two of the allegations. The whistleblowers also expressed continuing concern that the agency's realignment of Pain Management into Whole Health without seeking input from the physicians trained specifically in pain management created an ongoing, inherent risk to patient health and safety, particularly because Dr. Lee, at least initially, had no

credentialing in pain management. Regarding the undue burden placed on patients seeking pain management care from outside providers, the whistleblowers pointed out that the agency found no wrongdoing based solely on the language of service agreements— but claimed Dr. Lee routinely failed to follow the direction of these service agreements—which rendered the agency findings confusing and misleading. Finally, the whistleblowers expressed concern that the agency findings minimized the gravity of the allegations and appeared inappropriately deferential to the agency.

The Special Counsel's Findings

While recognizing that agency managers have wide discretion to realign services within an agency to increase efficiency and better serve the agency's needs, management decisions that are self-serving or jeopardize patient care have the opposite effect—a negative impact on the agency's mission. I applaud [redacted] and [redacted] efforts to highlight the ongoing concerns within Temple's Whole Health Department realignment, and I am encouraged that the agency has taken steps to ensure the department is now on a better path to delivering the exemplary care our veterans deserve.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of this letter, the agency reports, and the whistleblower comments to the Chairs and Ranking Members of the Senate and House Committees on Veterans Affairs. I have also filed redacted copies of these documents and the redacted referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Karen P. Gorman
Acting Special Counsel

Enclosures