Congressional Testimony

Inspector General Testifies before the House Committee on Veterans’ Affairs on VA’s Staffing Challenges

Inspector General Michael Missal testified before the House Committee on Veterans’ Affairs on September 18, 2019, regarding the barriers to hiring at VA that impact patient care and access. Mr. Missal’s testimony was drawn largely from the Office of Inspector General’s (OIG’s) June 2019 report Staffing and Vacancy Reporting under the MISSION Act of 2018 and June 2018 report OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages FY 2018. He discussed the OIG’s findings in these reports, focusing on the Veterans Health Administration’s (VHA’s) failure to implement comprehensive staffing models and the need for stability in leadership across VHA and VA, more generally. Committee members highlighted OIG findings related to VHA staffs’ usage of human resources software that led to VA’s data not being transparent or reliable.

Assistant Inspector General for Audits and Evaluations Testifies on OIG’s Oversight of VA’s Medical Scheduling Enhancement Efforts

Mr. Larry Reinkemeyer, Assistant Inspector General for Audits and Evaluations, testified before the House Committee on Veterans’ Affairs Subcommittee on Technology Modernization on September 26, 2019. The hearing focused on assessing how VA plans to transition from the legacy scheduling modules to the Cerner Scheduling Software. Mr. Reinkemeyer’s testimony was drawn from the OIG report, VA’s Implementation of the Veterans Information System and Technology Architecture Scheduling Enhancement Project Near Completion. He discussed the OIG’s findings related to VA’s failure to adequately define requirements, conduct mandatory testing, and use staff with program knowledge. These issues are similar to those the OIG has reported on regarding many VA information technology systems.

Criminal Investigations Involving Health Care

Widow Indicted for Defrauding VA’s Civilian Health and Medical Program

The widow of a deceased veteran was indicted in the Southern District of Texas for mail fraud, healthcare fraud, and making false statements relating to healthcare matters. A VA OIG investigation resulted in charges alleging that over the course of approximately four years, the defendant submitted counterfeit prescription receipts to VA for reimbursement under VA’s Civilian Health and Medical Program (CHAMPVA). The loss to VA is approximately $650,000.

Sister of Spina Bifida Beneficiary Indicted for Healthcare Fraud

The sister of a now deceased VA spina bifida beneficiary was indicted in the Southern District of West Virginia for healthcare fraud. A VA OIG, Health and Human Services OIG (HHS OIG), and Federal
Bureau of Investigations (FBI) investigation resulted in charges alleging the defendant fraudulently billed VA’s Spinal Bifida Health Care Benefits Program by charging eight hours of home health care, seven days a week, at $736 per day. The defendant allegedly spent only a few hours per week with her sister and maintained full-time employment during a portion of the period in which she billed VA for her sister’s home health care. During the time frame in which she maintained full-time employment, VA paid $257,914 to the defendant for her sister’s care. The defendant also gave the VA spina bifida beneficiary over $30,000 from the money received for home healthcare services. The loss to VA is approximately $469,983.

Former Bedford, Massachusetts, VA Medical Center Hospice Nurse Charged with Drug Tampering and Diversion
A former VA Medical Center hospice unit nurse was arrested after being criminally charged in the District of Massachusetts with tampering with a consumer product and drug diversion. A VA OIG investigation resulted in charges alleging the defendant used tap water to dilute liquid morphine and subsequently administered the diluted substance to medical center hospice patients. The defendant then ingested the remaining drug to support her addiction. To conceal her drug diversion, the defendant also allegedly falsified medical records by reporting that the patients had received more pain medication than they did. After conducting a review of patient records, the medical center identified a patient whose end-of-life comfort appeared to have been negatively impacted by the defendant’s actions.

Criminal Investigations Involving Benefits

Former Contract Physician Pled Guilty to Sexual Assault
A VA OIG and Medical Board of California investigation revealed a former contract physician engaged in inappropriate acts while conducting Compensation and Pension (C&P) examinations. In support of this investigation, a VA C&P physician determined through an independent review that the defendant conducted examinations that were outside standard practices. Ultimately, the defendant pled guilty in the County of San Diego to the sexual assault of five female patients who were referred to him by VA. As part of the plea, the defendant agreed to a suspended prison sentence of 36 months and probation of 36 months. The defendant was also required to surrender his medical license and register as a sex offender.

Three Individuals Indicted for Compensation Benefits Fraud Scheme
Three defendants were indicted in the District of Maryland in connection with a compensation benefits fraud scheme which impacted VA and the Social Security Administration (SSA). One defendant was charged with conspiracy, theft of government property, aggravated identity theft, and SSA fraud. The other two defendants were charged with conspiracy and theft of government property. A VA OIG and SSA OIG investigation resulted in charges alleging the defendants submitted fraudulent documents and misrepresented the severity of their disabilities to obtain VA compensation benefits. It is alleged that one defendant fraudulently received approximately $35,000 in SSA Disability Insurance benefits for her claimed disabilities. The loss to VA is approximately $820,000.
Veteran Sentenced for Compensation Benefits Fraud Scheme
A veteran was sentenced in the Northern District of Florida to three years’ probation and ordered to pay over $243,000 in restitution to VA. A VA OIG investigation revealed the defendant maintained a full-time position as an auto service manager while receiving Individual Unemployability, a VA benefit reserved for veterans who demonstrate that they cannot work due to their service-connected disability.

Huntington, West Virginia, VA Regional Office Employee Pled Guilty to Fraud in Connection with Computers
A VA Regional Office employee pled guilty in the Southern District of West Virginia to an information (a formal charging document) charging him with fraud in connection with computers. A VA OIG and FBI investigation revealed that between March 2018 and May 2018, the defendant accessed service-connected medical diagnoses of six veterans without authorization or a legitimate business purpose. One of the victims was a former West Virginia State Senator. The defendant subsequently shared a computer screenshot of that victim’s health information via text message with an acquaintance.

Criminal Investigations Involving Other Matters

Eight Individuals Charged in Compound Pharmacy Scheme
A superseding indictment was filed in the Northern District of Texas against seven defendants for various charges including conspiracy to commit healthcare fraud, conspiracy to launder money and engage in monetary transactions in criminally derived property, and money laundering in connection with healthcare fraud. One additional subject was indicted for conspiracy to defraud the United States in connection with healthcare fraud. A VA OIG, U.S. Postal Service (USPS) OIG and Department of Labor (DOL) OIG investigation resulted in charges alleging that multiple doctors received kickbacks from a compounding pharmacy’s owner and associates. The loss to the government is approximately $70 million and, of this amount, the loss to VA is approximately $7.5 million.

Five Individuals Indicted in Healthcare Fraud Scheme
Five subjects were indicted in the Northern District of Texas for healthcare fraud and conspiracy to commit healthcare fraud. Three of the subjects subsequently self-surrendered and one was arrested. A VA OIG, Defense Criminal Investigative Service, Office of Personnel Management OIG, Health and Human Services (HHS) OIG, FBI, and DOL OIG investigation resulted in charges alleging that the defendants participated in multiple fraudulent practices to defraud CHAMPVA and the Department of Defense’s TRICARE healthcare program. The scheme included kickbacks, use of unapproved ingredients, and the filling of unauthorized prescriptions. The loss to the federal government is approximately $90 million. Of this amount, the loss to VA is approximately $3.3 million.

Two Subjects Indicted in Workers’ Compensation Fraud Scheme
Two subjects were arrested after being indicted in the Northern District of Texas for conspiracy to commit healthcare fraud, payment of illegal remuneration, and identity theft. The investigation resulted
in charges alleging that the subjects fraudulently billed DOL’s Office of Workers’ Compensation Program and purchased illegally obtained government employees’ personally identifiable information to further their fraudulent billing scheme. The loss to the federal government is approximately $6.5 million. Of this amount, the loss to VA is approximately $2.5 million. The VA OIG, Department of Homeland Security OIG, USPS OIG, and DOL OIG conducted the investigation.

**Two Defendants Pled Guilty in Durable Medical Equipment Fraud Scheme**

Two defendants pled guilty in the District of New Jersey to various fraud related charges for their part in a nationwide healthcare fraud scheme involving the use of durable medical equipment (DME), telemedicine doctors, and telemarketers. A VA OIG, Internal Revenue Service Criminal Investigation, HHS OIG, and FBI investigation revealed that the defendants were key participants in a scheme which solicited DME to patients and used telemedicine doctors to certify medical necessity. The telemedicine doctors did not have a relationship with the patients, and the telemarketers sold the completed orders to the DME companies. Many of the target companies identified in the scheme impacted VA through billing disbursements from the CHAMPVA program. The loss to VA is approximately $330,000.

**Audit(s) and Review(s)**

**Accuracy of Claims Decisions Involving Conditions of the Spine**

Spinal conditions account for two of VA’s top 10 service-connected disabilities, totaling some 1.5 million cases. The OIG conducted this review after determining those claims have a higher risk of errors that could keep veterans from receiving proper benefits. The OIG estimated the Veterans Benefits Administration (VBA) incorrectly processed more than half of the 62,500 claims decided in the first six months of 2018, accounting for at least $5.9 million in either over- or underpayments. The OIG found these incorrectly decided claims resulted from VBA’s inadequate process for ensuring accurate and complete evaluation. The Under Secretary for Benefits concurred with the OIG’s recommendations to update VBA’s disability rating process to establish objective criteria for spine-related conditions and improve internal controls to help ensure the accuracy and consistency of claims decisions.

**Security and Access Controls for the Beneficiary Fiduciary Field System Need Improvement**

The OIG conducted this audit to determine if the Beneficiary Fiduciary Field System (BFFS), the information technology system for VA’s Fiduciary Program, could maintain data integrity and safeguard protected information. The OIG found the BFFS lacked controls to ensure privacy of sensitive data and prevent fraud and misuse. VA inappropriately set the security risk level for the system at moderate instead of high because risk managers did not follow established standards or consider whether stored information was sufficiently protected. The OIG also found more than 1,600 BFFS users had access to records not needed for their duties. Finally, the OIG identified duties in the report submission process were not fully separated, potentially allowing sensitive information to be changed without approval or
documentation. The OIG recommended reevaluating the security risk level for the BFFS, improving controls over access, fully enabling audit logs, and improving separation of duties.

**Problems Were Identified on One Regional Procurement Office Central Ambulance Service Contract**

An OIG team reviewed 18 sole-source contracts awarded in FY 2017 by the VHA Regional Procurement Office (RPO) Central with a total value of about $77 million to determine whether the proper justification had been filed and the subsequent approval obtained. The OIG found that a contracting officer did not obtain the required approval for a service contract worth about $2.2 million because he did not understand the procedures. The same contracting officer also unnecessarily limited competition on the contract by failing to plan for the procurement in advance. The new sole-source contract was awarded based on compelling urgency, even though RPO Central officials knew for several years that the existing contract would expire, requiring new competition. The OIG recommended VHA ensure awareness of approval procedures for sole-source contracts and that adequate time is allotted for soliciting and awarding recurring services competitively.

**Sole-Source Service Contracting at Regional Procurement Office East Needs Improvement**

The OIG reviewed 20 sole-source contracts awarded by VHA’s RPO East totaling $41.4 million to determine if proper justification and approval were obtained. The audit team found contracting officers did not receive the required approval before awarding 10 contracts worth about $14.2 million. Officials did not follow the proper process, did not receive correct guidance, and misinterpreted regulations. Contracting officers also unnecessarily limited competition on four recurring contracts worth about $8.5 million. They knew that the existing contracts would expire but did not sufficiently plan for fair and open competition. The OIG recommended VHA ensure personnel’s awareness of approval procedures for sole-source contracts and make certain adequate time is allotted for soliciting and awarding recurring services competitively. The OIG also recommended the director review the actions of contracting personnel involved in the cited contracts to determine whether administrative actions are warranted.

**Sole-Source Service Contracting at Regional Procurement Office West Needs Improvement**

An OIG team review of 15 sole-source contracts awarded in FY 2017 by VHA Regional Procurement Office (RPO) West, valued at about $19 million, focused on whether they were properly justified and approved. The OIG found that five contracts worth about $6 million did not include the necessary justification and approval. This occurred because RPO West contracting officers did not follow the required approval process and misunderstood who was the proper approval authority. As a result, the costs of those contracts were not completely justified. The OIG recommended the executive director of VHA procurement ensures awareness of approval procedures and the requirement to prepare a written justification for sole-source contracts; establishes procedures to help make certain the appropriate
authority approves all sole-source contracts; and reviews the actions of contracting personnel involved in the cited contracts to determine whether administrative actions are warranted.

**Boston, Massachusetts, VA Regional Office Supervisor Incorrectly Processed Work Items**

This review determined whether a supervisor at the VA regional office in Boston, Massachusetts, incorrectly processed system-generated messages known as “work items” that may have affected recipients’ benefits. The OIG found the supervisor incorrectly cancelled 33 of 55 work items, and improperly cleared another nine work items from the electronic record. The incorrect and improper actions led to VA making about $117,300 in improper payments to veterans or other beneficiaries and delaying about $8,600 in payments. The supervisor said he did not intentionally process the work items incorrectly, but rather that the errors were the result of working too quickly and misunderstanding procedures. The OIG recommended the Boston regional office director immediately review and correct all cases the supervisor incorrectly processed that are likely to result in adjustments to recipients’ benefits and ensure quality controls for supervisors’ work. Administrative action was also taken by VA.

**A Synopsis of OIG Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2018**

The federal government spends more than $11 billion annually on pharmaceuticals through VA’s Federal Supply Schedule (FSS) contracting program. This report provides a synopsis of 22 FSS reviews conducted by the OIG during FY 2018 of pharmaceutical proposals prior to VA awarding the contracts (preaward reviews). This report summarizes the OIG’s findings for the FSS proposals, which included 2,040 offered drug items, and identifies the monetary benefit to VA without disclosing any sensitive commercial information. The OIG determined that commercial pricing disclosures were not reliable for negotiations for 16 of the 22 proposals and recommended VA obtain revised disclosures prior to contract awards. The OIG’s FSS lower pricing recommendations collectively reflected more than $515 million in estimated cost savings to VA, nearly 75 percent of which were sustained. The OIG’s preaward reviews demonstrate the importance of having reliable information for negotiations and determining fair and reasonable pricing.

**State Prescription Drug Monitoring Programs Need Increased Use and Oversight**

This audit examined whether VA clinicians used state-operated prescription drug monitoring program (PDMP) databases to manage care for patients who are prescribed opioids. These databases track prescriptions issued by both VA and non-VA prescribers to reduce the risk of overdose, misuse, and complications. The OIG estimated clinicians did not annually check PDMP databases for 73 percent of the 779,000 VA patients prescribed opioids, and an estimated 19 percent of VA patients were at risk because clinicians were unaware of other prescriptions. VHA’s controls and policy communications were ineffective, and VHA policy did not address significant developments or increased risks. The OIG found inadequate national VHA oversight led to insufficient local monitoring at medical facilities because VHA officials did not always prioritize database queries. The OIG made eight
recommendations to strengthen VA’s policies and ensure leaders and clinicians understand and comply with those policies. VHA has convened a work group to examine possible technological solutions.

**Los Angeles Vocational Rehabilitation and Employment Program Generally Met Requirements After Hiring Additional Staff**

Acting on a congressional request, the OIG reviewed the Vocational Rehabilitation and Employment program at the VA regional office in Los Angeles, California. The program helps veterans with service-connected disabilities prepare for, find, and maintain suitable employment. The OIG found that the program generally complied with VA requirements, criteria, or goals for staffing, making required veteran contacts, meeting rehabilitation outcomes, and reimbursing veterans for supplies. Additionally, the program approval percentage was comparable to the national program for the past four years. Despite staffing shortages, the program generally demonstrated progress toward placing veterans on track to gainful employment. The OIG team determined employees made the appropriate number of veteran contacts according to program requirements and that the program processed veterans’ reimbursement requests for academic supplies accurately. Therefore, the OIG made no recommendations for improvement.

**Workload Management Challenges Identified at the Salt Lake City, Utah, Fiduciary Hub**

The OIG determined that the Salt Lake City, Utah, Fiduciary Hub had hundreds of annual accounting reports that were overdue for review, along with a significant number of tasks associated with incoming mail that required action. There were more than 3,000 pending action mail tasks as of February 2019. The fiduciary hub’s workload management plan did not specify how to prioritize action mail tasks and did not require review and resolution of duplicate tasks. The OIG did not substantiate an allegation that fiduciary hub managers hid pending accounting reports to make it seem the work was completed more quickly. The OIG recommended that the fiduciary hub workload management plan include timeliness goals for action mail tasks and require a routine review of duplicate tasks, and that the director ensure managers measure performance and monitor adherence to those goals.

**Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia**

The OIG received allegations of mismanagement of equipment and supplies resulting in wasted funds and canceled operating room procedures at the Hampton VA Medical Center in Virginia. According to the complaint, these deficiencies were identified in quality control reviews but never addressed by facility leaders. Allegations included unused equipment not being inventoried, poor inventory practices, and operating room cancellations because supplies were unavailable. The OIG did not substantiate that operations were canceled or that excessive funds were spent on overnight deliveries. However, equipment valued at about $1.8 million was found not inventoried in an unmarked storage room and warehouse basement. The OIG also found that staff ordered too many supplies and partially substantiated that the facility did not have an effective inventory system. These deficiencies had not been addressed since their identification in 2017 and 2018 quality control reviews. The OIG made 12 recommendations for improving inventory management.
**Construction Project Management at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina**

The OIG audit team reviewed four allegations regarding potential mismanagement of construction projects at the Ralph H. Johnson VA Medical Center. The OIG substantiated two of the allegations—that construction for some nonrecurring maintenance projects took years to begin after contract awards, resulting in increased costs of at least $441,000, and that engineers had planned to spend about $74,000 to create separate drawings from a single rendering completed for a project. Regarding the first allegation, the OIG recommended establishing a reporting process if construction is not planned to start within 150 days after contract awards. The OIG made no recommendations for the improper spending of $74,000 because the separate drawings were never made. The OIG did not substantiate allegations that construction items were inappropriately removed from the solicitation on the intensive care unit project to reduce the contract price, or that a construction project was inappropriately classified.

**Oversight and Resolution of Home Loan Defaults**

This audit examined whether the Loan Guaranty Service provided required oversight of the default resolution process for VA-guaranteed home loans. The Loan Guaranty Service monitors loan servicers and intervenes as needed to ensure delinquent VA home loan borrowers have all available alternatives to foreclosure. The OIG found the Loan Guaranty Service did not always provide enough oversight to ensure borrowers received needed assistance. An estimated 14 percent of loans had at least one oversight deficiency. The audit team and the Loan Guaranty Service also identified potential loan servicing risks to borrowers in disaster areas. The OIG recommended VA implement controls to identify and address unreported monthly loan statuses, make certain loan servicers report when loss mitigation letters are sent and cite them for infractions, ensure key loan servicer performance statistics are generated, and develop a formal tier-ranking system for servicers.

**National Healthcare Review(s)**

**National Review of Hospice and Palliative Care at the Veterans Health Administration**

The OIG evaluated how Hospice and Palliative Care (HPC) services are used at VHA by examining the electronic health records of patients who were newly diagnosed with malignant cancer, and to determine whether there was a formal HPC consult or informal HPC-related discussion with a care provider. The OIG staff also assessed whether completed HPC consults were linked to required stop codes (standardized codes to identify the work group providing a clinical service) used to measure HPC workload. The OIG determined that just more than 10 percent of reviewed malignant cancer patients had a formal HPC consult or related interaction (such as a conversation) without designating there was an HPC consult or linking to a stop code. Subsequently, the OIG found that 78.5 percent of consults were appropriately linked to an HPC stop code and 21.5 percent were not. Overall, the OIG found that patients were receiving HPC consults or having related conversations but the HPC workload was not consistently tracked. The OIG made one recommendation to the Under Secretary for Health to ensure
the development and implementation of a consistent and standardized approach for HPC documentation, consult management, and coding.

Healthcare Inspection(s)

Quality of Care and Patient Safety Concerns on the Acute Behavioral Health Unit at the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania

The OIG identified quality of care deficiencies that may have contributed to a patient’s death during an acute behavioral health unit admission. These included involved staff and providers not intervening, not communicating with each other, or not adding team members as additional signers in the electronic health record when documenting signs consistent with oversedation. Also, some providers were not monitoring for electrocardiogram changes or drug-drug interactions. The facility did not comply with VHA requirements for issue briefs, root cause analyses, and peer reviews. The acute behavioral health unit staff also did not follow the facility’s observation policy. Leaders noted equipment deficiencies and staff training needs related to medical emergency responses. Facility care providers did not adhere to policies requiring discussion, documentation, and a patient-signed informed consent prior to initiating methadone treatment. The OIG made nine recommendations.

Alleged Care Delays and Inadequate Instrument Precleaning at the New Mexico VA Health Care System, Albuquerque

A healthcare inspection team assessed allegations regarding patient care concerns in the facility’s ophthalmology and gastroenterology (GI) departments. The OIG found the ophthalmology department failed to meet VHA consult (referral) management scheduling expectations. Authorizations of non-VA care consults for comprehensive eye appointments were delayed. Significant delays in access to outpatient GI care and a lack of monitoring for consult performance deficiencies were also identified. GI providers did not consistently communicate test results to patients per facility policy or arrange for other practitioners to take over their patients’ care when they were unavailable. The timeliness of GI providers’ test result notifications to patients was not monitored. The OIG did not substantiate that patients underwent procedures with improperly cleaned endoscopes. The OIG made 13 recommendations related to improving non-VA care appeals, consult management, eye appointments and surgery timeliness, test result issues, and precleaning of endoscopic instruments.

Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility

The OIG reviewed concerns provided by the U.S. Office of Special Counsel regarding an ophthalmologist at a Veterans Integrated Service Network (VISN) 10 medical facility. The OIG found credentialing and privileging activities were deficient, including primary source verification from foreign educational institutions and reference checks attesting to the surgeon’s suitability to perform procedures. The ophthalmologist was hired regardless. The ophthalmologist lacked VHA-required training for cataract surgery and laser procedures, did not meet surgical productivity requirements, and
did not consistently demonstrate surgical skills necessary to assure good patient outcomes. Once the surgeon’s deficits were identified, facility leaders were slow to respond. Despite ongoing concerns, the chief of staff endorsed the surgeon’s reappointment as the facility’s sole ophthalmologist. The surgeon’s employment was subsequently terminated. The OIG made five recommendations related to credentialing and privileging, professional practice evaluations, management of performance deficits, and the chief of staff’s actions.

**Alleged Poor Quality of Cancer Care at the VA Caribbean Healthcare System, San Juan, Puerto Rico**

This inspection was conducted in response to an allegation of poor quality of cancer care to a community living center patient, and to follow up on the adequacy and implementation status of an action plan at the VA Caribbean Healthcare System. The OIG substantiated staff inadequately monitored the patient. The action plan at issue did not address all prior findings of deficiencies. During the inspection, the OIG found instructions provided to interrater reviewers were not identical. The OIG made one recommendation to the VISN 8 director related to clear and consistent instructions for concurrent management reviews and six recommendations to the facility director related to chemotherapy patient monitoring, care coordination agreements, communication of patient status changes, patient care plan accuracy, primary care provider training on prostate cancer patient management, and addressing the findings of non-facility reviewers.

**Emergency Department Care of Intoxicated Patients and Those with Mental Health Conditions at the Louis Stokes Cleveland VA Medical Center, Ohio**

An inspection team evaluated whether some patients who presented with mental health-related issues to the facility’s Emergency Department were adequately assessed prior to transfer to the facility’s Psychiatric Assessment and Observation Center (PAOC), as failure to do so put patients at risk. The OIG substantiated the allegation; however, the conditions generally occurred prior to August 2018 and complied with then-facility policy. The facility changed its policy to require all patients presenting with intoxication or an acute mental health condition to be medically screened in the Emergency Department before transfer to the PAOC. A review of 205 relevant patient encounters in early 2019 found the facility was complying with the new policy related to medical screening examinations and notes. No evidence of adverse clinical outcomes related to patients receiving care in the PAOC was found. The OIG made one recommendation related to medical screening examinations prior to transfer to the PAOC.

**Facility Hiring Processes and Leaders’ Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina**

The OIG conducted a healthcare inspection to evaluate concerns regarding deficiencies identified in the practice of a fee-basis radiologist, and the facility’s oversight of the radiologist’s performance during the six-month tenure in 2014. Facility leaders did not complete the credentialing and privileging of the radiologist as required. Specifically, the references used to approve the radiologist’s request for privileges did not include a reference from peers and the most recent employer. Facility managers also
did not provide adequate oversight of the radiologist and did not complete a timely and focused professional performance evaluation. Prompt administrative action was not taken in response to inaccurate interpretations of radiology imaging and clinical documentation. Facility managers and leaders failed to complete the radiologist’s Exit Memorandum, required by VHA to comply with state licensing board reporting requirements, during the mandatory reporting period of seven days after the employee’s separation from the facility. They also failed to report the results of a 100-percent clinical review of the radiologist’s imaging reports to the facility professional standards board until August 2018—three years after the assigned target date.

The patient safety manager was not notified during the case reviews, nor after the results were issued. Facility leaders failed to submit an issue brief to the VISN, as is required for significant clinical incidents negatively affecting patients. On January 25, 2019, the facility director issued notices to eight state licensing boards citing that the radiologist failed to meet generally accepted standards of clinical practice and two disclosures were made to patients. The OIG made four recommendations related to credentialing and privileging requirements, state licensing board reporting, disclosures of adverse events, and potential administrative actions.

**OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages, Fiscal Year 2019**

Pursuant to the VA Choice and Quality Employment Act of 2017, the OIG conducted a review to identify clinical and non-clinical Veterans Health Administration occupations having the largest occupational staffing shortages at each VA medical facility. In this sixth staffing report, OHI evaluated facility leader-identified severe occupational staffing shortages and explored the impact of medical center director vacancies. Ninety-six percent of facilities identified at least one occupation as having a severe shortage. The most frequently cited shortages were in the Medical Officer and Nurse occupations. Human Resources Management was the most commonly cited non-clinical occupation with a severe staffing shortage. Since 2015, over 46 facilities annually saw at least one change in medical center directors. The OIG made two recommendations to the Under Secretary for Health related to previous recommendations and causes of severe occupational staffing shortages.

**Comprehensive Healthcare Inspection Program Reviews**

Comprehensive Healthcare Inspection Program (CHIP) reviews are one element of the OIG's overall efforts to ensure that the nation’s veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG’s current areas of focus:

1. Quality, Safety, and Value;
2. Credentialing and Privileging;
3. Environment of Care;
(4) Medication Management;
(5) Mental Health Care;
(6) Geriatric Care;
(7) Women’s Health; and
(8) High-Risk Processes

Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma
Sheridan VA Medical Center, Wyoming
North Florida/South Georgia Veterans Health System, Gainesville, Florida
Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
Tuscaloosa VA Medical Center, Alabama

To listen to the podcast on the OIG’s September 2019 activity highlights, go to
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