



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Facility
Leaders' Oversight and
Response to Allegations of a
Provider's Sexual Assaults
and Performance of
Acupuncture at the Beckley
VA Medical Center in West
Virginia



MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

FOR MORE
VA OIG REPORTS
CLICK HERE



**Report suspected wrongdoing in VA programs and operations
to the VA OIG Hotline:**

www.va.gov/oig/hotline

1-800-488-8244



Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to examine the oversight of a provider, Dr. Jonathan Yates (subject physician), at the Beckley VA Medical Center (facility) in West Virginia, who engaged in inappropriate sexual conduct toward patients and practiced acupuncture without being credentialed. The OIG also reviewed leaders' awareness and response to the allegations of sexual assault and the subject physician's practice of acupuncture.¹

The subject physician was employed as the facility's Whole Health Medical Director from April 29, 2018, through July 23, 2019. On June 12, 2019, the OIG Office of Investigations, in conjunction with the U.S. Attorney's Office for the Southern District of West Virginia and the Federal Bureau of Investigation, launched a criminal probe. On May 12, 2020, the subject physician was indicted and charged with five counts relative to sexual assaults committed while providing services at the facility, including an allegation of temporarily immobilizing a patient with acupuncture needles.² The subject physician pled guilty on September 17, 2020, to three felony counts related to sexual abuse and was sentenced to 300 months in prison.³

The subject physician was credentialed and privileged to practice within the primary care service line, which included the ability to perform osteopathic manipulation treatment.⁴ However, the subject physician was not credentialed and privileged to perform acupuncture.

The OIG identified deficient oversight of the subject physician's clinical practice. Current and former facility leaders provided conflicting information about responsibility for the subject physician's supervision. The OIG could not clearly identify a line of clinical supervision for the subject physician but noted the former Chief of Staff and the Chief of Primary Care functioned

¹ For the purposes of this report, the OIG considered facility leaders to include senior level executives and service chiefs. Mayo Clinic, "acupuncture," accessed August 25, 2021, <https://www.mayoclinic.org/tests-procedures/acupuncture/about/pac-20392763>. The technique of inserting thin needles through the skin at strategic points of the body to treat pain, stress and promote overall wellness.

² The Office of Investigations is one of six directorates within the OIG and "investigates potential crimes and civil violations of law involving VA programs and operations committed by VA employees, contractors, beneficiaries, and other individuals." VA OIG, *Semiannual Report to Congress*, Issue 84, April 1–September 30, 2020.

³ Department of Justice, "Former Veterans Affairs Doctor Indicted on Multiple Civil Rights Charges," news release no. 20-446, May 12, 2020, <https://www.justice.gov/opa/pr/former-veterans-affairs-doctor-indicted-multiple-civil-rights-charges>. Department of Justice, "Former Veterans Affairs Doctor Sentenced to Prison for Sexual Abuse of Veterans," news release no. 21-86, January 25, 2021, <https://www.justice.gov/opa/pr/former-veterans-affairs-doctor-sentenced-prison-sexual-abuse-veterans>.

⁴ Cleveland Clinic, "Osteopathic Manipulation Treatment (OMT)," accessed October 19, 2021, <https://my.clevelandclinic.org/health/treatments/9095-omt-osteopathic-manipulation-treatment>. Osteopathic manipulation treatment is a hands-on treatment method used to diagnose and prevent disease and improve body function.

as clinical supervisors and provided varying levels of oversight.⁵ The OIG found that none of the facility leaders responsible for oversight of the subject physician's clinical practice acknowledged their responsibility for clinical supervision of the new Whole Health program. Additionally, the Chief of Primary Care and the former Associate Director for Patient Care Services failed to properly complete the subject physician's professional practice evaluations as required to assess the clinical performance of a provider.⁶

In February 2019, the Virginia Department of Health Professions notified the subject physician of an investigation due to patient complaints at the subject physician's previous employer.⁷ The OIG learned through interviews with former facility leaders that the subject physician notified them upon awareness. On February 27, 2019, the facility's Associate Director issued a memorandum removing the subject physician from direct patient care, pending the result of the Virginia Department of Health Professions' investigation.⁸ The OIG learned there had been four patient complaints made to facility staff and the former Associate Director for Patient Care Services concerning the subject physician's inappropriate sexual conduct from October 2018 through May 2019, but that the former facility leaders had not taken required actions upon awareness of the complaints.

Specifically, former facility leaders failed to thoroughly investigate the complaints, nor did they identify and report patient safety concerns. Additionally, facility leaders did not summarily suspend the subject physician as recommended in Veterans Health Administration (VHA) guidance, as facility leaders were awaiting the results of the Virginia Department of Health

⁵ "Leadership Team," Beckley VA Medical Center, accessed October 4, 2021, <https://www.beckley.va.gov/about/leadership.asp>. The Chief of Staff is responsible for all clinical operations at the Beckley VAMC and two community clinics.

⁶ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. VHA requires Focused Professional Practice Evaluations (FPPEs) and Ongoing Professional Practice Evaluations (OPPEs) to evaluate the competency of practicing providers. The Joint Commission, "Focused Professional Practice Evaluation (FPPE) - Understanding the Requirements," accessed December 13, 2021, <https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/medical-staff-ms/000001485/?p=1>. The Joint Commission, "Ongoing Professional Practice Evaluation (OPPE) - Understanding the Requirements," accessed December 14, 2021, <https://www.jointcommission.org/standards/standard-faqs/critical-access-hospital/medical-staff-ms/000001500/>. According to The Joint Commission, FPPEs are performed to evaluate the performance of practitioners who are newly privileged or lack documented competencies. OPPEs are used to evaluate the performance of privileged providers.

⁷ This complaint described allegations of the subject physician sexually assaulting patients.

⁸ "Leadership Team," Beckley VA Medical Center. The Associate Director is responsible for all non-clinical operations at the facility. On the date of the memorandum, the Associate Director was serving in an Acting Facility Director role. The subject physician continued employment at the facility performing administrative duties such as completing student evaluations and working on a revised Whole Health template.

Professions' investigation.⁹ The OIG determined that former facility leaders' failure to share information amongst themselves partially contributed to these failures.

Upon receipt of the complaints, the facility Risk Manager recognized the complaints could pertain to criminal intent and notified VA Police. On June 3, 2019, VA Police contacted the OIG Office of Investigations to report the April and May 2019 complaints.¹⁰ On June 7, former facility leaders initiated an issue brief to Veterans Integrated Service Network (VISN) and VHA leaders that identified patient reports of "inappropriate contact" from the subject physician.

The OIG also learned the former Associate Director for Patient Care Services became aware, in November or December of 2018, of the subject physician performing acupuncture on patients without being credentialed and privileged as required.¹¹ The former Associate Director for Patient Care Services told the OIG of instructing the subject physician to stop and notifying the former Chief of Staff and former Facility Director, but took no further action. Additionally, in September 2019 the facility VA Police Chief notified former facility leaders, via email, that the subject physician was performing acupuncture without being credentialed.¹²

The OIG found that former facility leaders failed to ensure (i) disclosures were made to patients potentially impacted; (ii) clinical follow-up was initiated; and (iii) quality management actions, such as electronic health record (EHR) reviews and patient safety reporting, occurred. The former Associate Director for Patient Care Services reported placing priority on the criminal allegations related to sexual assaults as opposed to the subject physician's use of acupuncture. Neither the former Acting Facility Director nor the former Chief of Staff recalled being made aware of the unauthorized practice of acupuncture.

The VISN Director initiated an Administrative Investigation Board (AIB) in March 2021 to investigate if facility leaders "appropriately address[ed] any and all patient complaints and/or known concerns raised as to [the subject physician]." The OIG determined the AIB only reviewed facility leader actions following the first complaint in October 2018 but failed to examine specific former facility leaders' actions following the second, third, and fourth complaints received during April and May 2019, electing to generally address culture of safety issues in the resultant action plan that were not addressed by criminal investigation.

⁹ VHA Handbook 1100.19. Facility, *Bylaws and Rules of the Medical Staff*, 2017, rescinded and replaced with Facility, *Bylaws and Rules of the Medical Staff*, 2020.

¹⁰ This began the combined OIG and Federal Bureau of Investigation process that culminated in the subject physician pleading guilty to three felony counts in September 2020.

¹¹ VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017. The Associate Director for Patient Care Services is responsible for oversight of facility nursing personnel and is a member of the facility executive team.

¹² The facility VA Police Chief provided an email update to the issue brief to facility administrative staff who then forwarded it to facility leaders. The email noted the information was discovered on September 30, 2019, through patient interviews with VA Police, the Assistant United States Attorney, and the Federal Bureau of Investigation during their investigation of allegations that the subject physician sexually assaulted patients.

The OIG determined that following the subject physician's removal from direct patient care in February 2019, and subsequent termination in July 2019, facility leaders did not timely submit reports to state licensing boards. The OIG learned that although the Credentialing and Privileging Specialist attempted to facilitate state licensing board reporting as early as July 2019, the former Assistant Human Resources Officer provided inaccurate guidance to former facility leaders, which delayed the required reporting processes.

The OIG reviewed VHA and facility documents and identified 22 patients who reported receiving acupuncture treatment from the subject physician.¹³ Although not credentialed and privileged to perform acupuncture, the subject physician documented performing acupuncture on only 5 of the 22 patients, as evidenced by EHR documentation. The OIG conducted a comprehensive review of the five patients' EHRs and found no evidence of adverse medical outcomes.¹⁴

During an interview on September 28, 2021, the OIG expressed concerns to the VISN Chief Medical Officer that no EHR reviews had been conducted to identify if the subject physician performed acupuncture on facility patients. The VISN Chief Medical Officer then commenced a review that found 48 EHRs included documentation of acupuncture.¹⁵

The OIG reviewed all facility acupuncture needle orders. However, the OIG was unable to determine how the subject physician accessed the needles, raising concerns related to the quality and sterility of needles, and possible patient exposure to bloodborne pathogens as the needles were likely obtained outside of normal facility processes. As a result, the VISN also initiated testing of patients for bloodborne infectious diseases and facilitated the institutional disclosure process.

The OIG found that the subject physician performed sensitive osteopathic manipulation treatment exams without a chaperone present, even though there was a relevant patient complaint, and did not find evidence that former facility leaders followed up on the refusal to use chaperones when one was assigned. On April 13, 2022, facility leaders enacted a new policy regarding chaperones during sensitive exams and specifically recommended that during sensitive

¹³ The OIG reviewed VA Police reports, an AIB that included exhibits and patient interviews, reports of contact, and patient complaints. The OIG focused on the 22 patients who reported inappropriate contact as well as receiving acupuncture treatment, and did not include all the subject physician's patients who may have received acupuncture. The OIG also requested facility and VISN leaders ensure a comprehensive review.

¹⁴ Within the context of this report, the OIG considered an adverse medical outcome to be death, progression of disease, worsening prognosis, suboptimal treatment, or need for a higher level of care.

¹⁵ The VISN Chief Medical Officer acknowledged EHR reviews had not been done, nor had a list been created, and agreed to facilitate a review capturing the subject physician's patients. The OIG opined that a VISN led comprehensive review would support disclosures and patient safety improvements.

exams of male patients, a male chaperone should be offered, regardless of the provider's gender.¹⁶

The OIG made one recommendation to the VISN Director to ensure closure of the March 2021 AIB actions.

The OIG made four recommendations to the Facility Director to ensure a review of professional practice evaluation policies; review and evaluate policies related to disclosures and quality management actions; ensure staff education of policies related to employee misconduct; and evaluate processes for reporting providers to the state licensing boards.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes C and D). Based on information provided, the OIG considers recommendation 4 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

¹⁶ Facility Policy MCP 517-2021-PC-04, *Chaperones*, December 10, 2021. The policy was developed as a result of the AIB and signed by the Facility Director on April 13, 2022.

Contents

Executive Summary	i
Abbreviations	vii
Introduction.....	1
Scope and Methodology	3
Inspection Results	4
1. Oversight of the Subject Physician	4
2. Facility Leaders' Response to Allegations of Sexual Misconduct.....	14
3. Acupuncture: Former Facility Leaders' Awareness and Response	24
Conclusion	30
Recommendations 1–5.....	32
Appendix A: Facility Executive Leadership Timeline	33
Appendix B: Supervisory Documents and Signatures.....	34
Appendix C: VISN Director Memorandum.....	35
Appendix D: Facility Director Memorandum.....	37
OIG Contact and Staff Acknowledgments	42
Report Distribution	43

Abbreviations

AIB	administrative investigation board
ADPCS	associate director for patient care services
EHR	electronic health record
FPPE	focused professional practice evaluation
OIG	Office of Inspector General
OMT	osteopathic manipulation treatment
OPPE	ongoing professional practice evaluation
PSB	professional standards board
SLB	state licensing board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to examine the oversight of a Whole Health provider, Dr Jonathan Yates (subject physician), who engaged in inappropriate sexual conduct (misconduct) toward patients and practiced acupuncture without being credentialed to do so.¹ The OIG also reviewed leaders' awareness and response to the allegations of sexual assault and the subject physician's practice of acupuncture.²

The subject physician was employed at the Beckley VA Medical Center (facility) from April 29, 2018, through July 23, 2019, as a Doctor of Osteopathic Medicine and as the Whole Health Medical Director. In February 2019, the Virginia Department of Health Professions notified the subject physician of an investigation due to patient complaints at the subject physician's previous employer.³ Between April 1, 2019, and May 31, 2019, the former Associate Director for Patient Care Services (ADPCS) became aware of three sexual assault allegations against the subject physician at the facility.⁴ On June 12, 2019, the OIG Office of Investigations in conjunction with the U.S. Attorney's Office for the Southern District of West Virginia, and the Federal Bureau of Investigation launched a criminal probe into the allegations.⁵ On May 12, 2020, the subject physician was indicted and charged with five counts relative to sexual assaults committed while providing services at the facility, including an allegation that the subject physician temporarily immobilized a patient with acupuncture needles.⁶ The subject physician pled guilty on September 17, 2020, to three felony counts related to sexual abuse and was sentenced on January 25, 2021, to 300 months in prison.⁷

¹ Mayo Clinic, "acupuncture," accessed August 25, 2021, <https://www.mayoclinic.org/tests-procedures/acupuncture/about/pac-20392763>. The technique of inserting thin needles through the skin at strategic points of the body to treat pain, stress and promote overall wellness.

² Given that law enforcement entities have already reviewed the merits of the sexual assault allegations, the scope of this report includes facility leaders' awareness and response to the sexual assault allegations.

³ This complaint described allegations of the subject physician sexually assaulting patients.

⁴ VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017. The ADPCS is responsible for oversight of facility nursing personnel and is a member of the facility executive team.

⁵ The Office of Investigations is one of six directorates within the OIG and "investigates potential crimes and civil violations of law involving VA programs and operations committed by VA employees, contractors, beneficiaries, and other individuals." VA OIG, *Semiannual Report to Congress*, Issue 84, April 1–September 30, 2020.

⁶ Department of Justice, "Former Veterans Affairs Doctor Indicted on Multiple Civil Rights Charges," news release no. 20-446, May 12, 2020, <https://www.justice.gov/opa/pr/former-veterans-affairs-doctor-indicted-multiple-civil-rights-charges>.

⁷ Department of Justice, "Former Veterans Affairs Doctor Sentenced to Prison for Sexual Abuse of Veterans," news release no. 21-86, January 25, 2021, <https://www.justice.gov/opa/pr/former-veterans-affairs-doctor-sentenced-prison-sexual-abuse-veterans>.

Background

The facility is part of Veterans Integrated Service Network (VISN) 5 and provides services to 11 counties in southern West Virginia. The facility is designated as a level 2, medium complexity, and has 30 general medical and surgical beds with a 50-bed community living center. The facility provides comprehensive health care including acute and intensive care, primary care, and specialty care.

Whole Health

Veterans Health Administration (VHA) policy promotes “patient-centered care through the implementation of a Whole Health approach.”⁸ Within this approach, patients’ goals are incorporated into health care decisions and providers use complementary and integrative health modalities, such as acupuncture and yoga.⁹ On May 15, 2018, VHA selected the facility as a flagship Whole Health site.¹⁰

Prior OIG Reports

In August 2018, the OIG published a report, *Comprehensive Healthcare Inspection Program Review of the Beckley VA Medical Center, West Virginia*. For renewal of privileges, the OIG found that multiple providers had “no evidence of complete service-specific data collection, resulting in providers continuing to deliver care without a thorough evaluation of their practice.” The OIG recommended the Chief of Staff ensure that service line managers consistently collect and review professional practice evaluation data and monitor compliance.¹¹ The OIG made eight recommendations, all of which have been closed.¹²

⁸ VHA Directive 1137(2), *Provision of Complementary and Integrative Health*, May 18, 2017, amended July 2, 2021. Barbara G. Bokhour et al., “Transforming the Veterans Affairs to a Whole Health System of Care: Time for Action and Research,” *Official Journal of the Medical Care Section, American Public Health Association*, (April 2020): 295-300.

⁹ “Whole Health Basics,” VA Whole Health, accessed September 2, 2021, <https://www.va.gov/WHOLEHEALTH/veteran-resources/whole-health-basics.asp>. Within VHA’s Whole Health program, a patient’s health plan is centered around what matters to the patient, and is personalized to meet the patient’s values, needs, and goals.

¹⁰ VA, “VA Announces Whole Health Flagship Sites,” news release, May 15, 2018, <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=4059>. The facility was one of eighteen flagship sites.

¹¹ “Leadership Team,” Beckley VA Medical Center, accessed October 4, 2021, <https://www.beckley.va.gov/about/leadership.asp>. The Chief of Staff is responsible for all clinical operations at the Beckley VAMC and two community clinics.

¹² VA OIG, *Comprehensive Healthcare Inspection Program Review of the Beckley VA Medical Center, West Virginia*, Report No. 17-05401-240, August 13, 2018.

Concerns

On June 8, 2021, an OIG Office of Investigations Special Agent presented results of the criminal investigation of the subject physician to OIG Office of Healthcare Inspections medical consultants. As a result of this presentation, a medical consultant identified patient safety concerns related to acupuncture. Following the criminal conviction and sentencing of the subject physician, on August 16, 2021, the OIG initiated a healthcare inspection to review¹³

- oversight of the subject physician including credentialing, privileging, and professional practice evaluations,
- facility leaders' awareness and response to allegations of sexual assault,¹⁴
- facility leaders' awareness and response to the subject physician's practice of acupuncture without proper credentials and privileges, and
- the subject physician's access to needles.¹⁵

Scope and Methodology

The OIG initiated the inspection on August 16, 2021, and conducted a virtual site visit from September 21 through October 15, 2021.

The OIG interviewed VHA, VISN, and current and former facility senior level executives, the Risk Manager, the Patient Safety Manager, the Whole Health Program Manager, the Credentialing and Privileging Specialist, a patient advocate, an inventory management specialist, and staff physicians who assisted in the facility review of the subject physician's patient care. The OIG interviewed former employees including an Assistant Human Resources Officer, an Executive Assistant to the Facility Director, a Whole Health Program Manager, a Whole Health Nurse, an Infection Control Nurse, and a Whole Health Program Support Assistant.¹⁶ See [appendix A](#) for an employment timeline of facility executive leadership.

¹³ The OIG awaited the conclusion of the criminal investigation before initiating a healthcare inspection. The subject physician was sentenced on January 25, 2021. "Former Veterans Affairs Doctor Sentenced to Prison for Sexual Abuse of Veterans."

¹⁴ For the purposes of this report, the OIG considered facility leaders to include senior level executives and service chiefs.

¹⁵ For the purposes of this report, the OIG considered needles to be acupuncture and trigger point needles.

¹⁶ VHA leaders included the Executive and Deputy Directors from the Office of Patient Centered Care and Cultural Transformation and the National Lead for Acupuncture. VISN leaders included the Network Director, the Chief Medical Officer, and the Quality Management Officer. Facility senior level executives included a former Facility Director, a former Acting Facility Director, the current and former ADPCS, the current and former Chief of Staff, the Chief, Primary Care, and the current and former Quality Management Chiefs. The former Whole Health Program Manager served in that role as a collateral duty, but was generally recognized as the Program Manager, including by the former ADPCS.

The OIG reviewed VHA directives and handbooks, external standards, guidelines, and professional literature. The OIG reviewed facility policies and procedures, medical staff bylaws, internal VISN and facility reviews, facility reports of contact, meeting minutes, administrative investigations and action plans, credentialing and privileging documents, staff emails, issue briefs, the subject physician's onboarding documents, focused professional practice evaluations (FPPE) and ongoing professional practice evaluations (OPPE), VA Police reports, and needle purchase requests.¹⁷ The OIG reviewed the April 2018–April 2019 Professional Standards Board (PSB) and Clinical Executive Board committee meeting minutes. The OIG also conducted an independent electronic health record (EHR) review and analysis related to the subject physician's provision of care from April 29, 2018, through July 23, 2019.¹⁸

The OIG also used a software application to analyze relevant individual's emails related to leaders' awareness and response to patient safety concerns including performance of acupuncture and allegations of sexual assault.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Oversight of the Subject Physician

The OIG determined the subject physician, a Doctor of Osteopathic Medicine, was appropriately credentialed and privileged at the facility to practice within the primary care service line with a specialty in family practice. However, the subject physician was not credentialed and privileged to perform acupuncture and was not clinically supervised per VHA policy.

¹⁷ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. This handbook was in effect at the time of the events discussed in this report until it was partially rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. The two policies contain the same or similar language related to FPPEs and OPPEs. Medical staff leaders use an FPPE to evaluate the specific privileges and competency of providers. An OPPE is used to provide ongoing medical staff leaders' monitoring of provider privileges.

¹⁸ The subject physician was employed by the facility from April 29, 2018, through July 23, 2019.

Subject Physician's Credentials and Privileges

Credentialing is a systematic process of screening and evaluating a provider's qualifications and other credentials including licensure, required education, and relevant training and experience. Privileging refers to the process of approving a provider's procedures and services. VHA requires clinical privileges be facility, service, and provider specific and are based on "clinical competence as determined by peer references, professional experience, health status, education, training, and licensure."¹⁹

VHA and facility policies require physician applicants to undergo a credentialing process, which includes verification of experience, training, education, professional references, previous state licensing board (SLB) complaints, malpractice complaints, and licensure through an application called VetPro.²⁰ To complete the credentialing and privileging process facility policy requires certain actions:

- The "service line medical director reviews the credentialing folder and requested privileges and makes recommendations regarding appointment."²¹
- The PSB reviews the credentialing file and the service line medical director's recommendations.²²
- The Clinical Executive Board reviews and submits their final recommendation to the facility director.²³
- The facility director approves the physician's credentials and privileges.²⁴

The OIG examined the subject physician's credentialing and privileging documents and learned the Credentialing and Privileging Specialist followed VHA policy and reviewed the subject

¹⁹ VHA Handbook 1100.19.

²⁰ VHA Handbook 1100.19. VetPro is an internet enabled data bank used to credential VHA healthcare practitioners to ensure that credentialing is uniform, accurate and complete. Facility Memorandum 517-2016-11-18, *Credentialing and Privileging of Licensed Independent Practitioners (LIPs)*, March 2016.

²¹ Facility Memorandum 517-2016-11-18.

²² Facility Memorandum 517-2019-11-3, *Professional Standards Board for Licensed Independent Practitioners*, November 2019. The PSB reviews and evaluates the qualifications of providers for initial and continued appointment, reviews and recommends individual clinical privileges, and investigates issues related to a provider's clinical or ethical professional conduct.

²³ Facility Memorandum 517-2018-11-2, *Clinical Executive Board*, September 4, 2018. The Chief of Staff chairs the Clinical Executive Board, which acts upon major policy changes and recommendations from clinical service lines, medical center committees and the PSB to include initial appointments and continued privileging of all medical staff.

²⁴ Facility Memorandum 517-2016-11-18.

physician's education, previous employment, background investigation, and licensure.²⁵The OIG found that on April 23, 2018,

- the facility's PSB reviewed the subject physician's credentialing and privileging file and determined the appointment qualifications were met,
- the facility's Clinical Executive Board reviewed the file and recommended that the subject physician be appointed as a full-time physician, and
- the Associate Director, in the capacity of interim Acting Facility Director, approved the subject physician's appointment as a full-time physician as the "Approving Authority."²⁶

The subject physician began employment at the facility on April 29, 2018. The OIG learned that the subject physician was hired as the facility's Whole Health Medical Director but worked briefly in primary care at the beginning of employment.²⁷ The OIG reviewed facility documents and found the subject physician was credentialed and privileged in the primary care service line with a specialty in family practice and osteopathic medicine. In addition to family practice, the subject physician's privileges included the ability to perform osteopathic manipulation treatment (OMT), myofascial techniques, and trigger point therapy.²⁸

The OIG concluded that the subject physician was credentialed and privileged according to VHA and facility policies at the time of appointment.

Lack of Credentialing and Privileging to Perform Acupuncture

The OIG found the subject physician was not credentialed or privileged to perform battlefield or

²⁵ The subject physician held an active license as a Doctor of Osteopathic Medicine in Virginia and West Virginia.

²⁶ "Leadership Team," Beckley VA Medical Center. The Associate Director is responsible for all non-clinical operations at the facility. The Associate Director served as the Acting Facility Director from April 20, 2018, through April 27, 2018.

²⁷ The subject physician transitioned from Primary Care to Whole Health on September 28, 2018.

²⁸ Cleveland Clinic, "Osteopathic Manipulation Treatment (OMT)," accessed October 19, 2021, <https://my.clevelandclinic.org/health/treatments/9095-omt-osteopathic-manipulation-treatment>. Osteopathic manipulation treatment is a hands-on treatment method used to diagnose and prevent disease and improve body function. Cleveland Clinic, "Myofascial Pain Syndrome," accessed October 19, 2021, <https://my.clevelandclinic.org/health/diseases/12054-myofascial-pain-syndrome>. Myofascial treatment involves identifying and treating pain caused by trigger points, a small bump or knot in the muscle that causes pain, treatment can include the use of trigger point injections. University of Wisconsin-Madison School of Medicine and Public Health, "Trigger Point Dry Needling: On-Point Pain Relief," accessed November 29, 2021, <https://www.uwhealth.org/news/trigger-point-dry-needling-on-point-pain-relief>. Trigger point therapy is different from acupuncture and involves placing a needle into muscle tissue to reduce pain in muscles, tendons, and joints.

medical acupuncture on patients at the facility.²⁹

VHA policy and facility bylaws require providers to formally request a change in privileges including the addition of new privileges. Providers are responsible for initiating the change and must provide evidence of appropriate credentials and qualifications to support the request.³⁰

The OIG reviewed the subject physician's credentialing and privileging file and determined the subject physician's initial privileges did not include battlefield or medical acupuncture. Additionally, the subject physician signed an initial privileging memo on March 26, 2018, acknowledging receipt and understanding of the facility bylaws, including the process to request new privileges.

The OIG learned the subject physician completed training for battlefield acupuncture in July 2018 and medical acupuncture in December 2018.³¹ Following training, VHA policy and facility bylaws required the subject physician to request credentials and privileges to perform acupuncture on patients. The OIG reviewed correspondence between the subject physician and the Credentialing and Privileging Specialist and determined the subject physician failed to initiate the required credentialing and privileging process, despite reminders from the Credentialing and Privileging Specialist.

The OIG concluded that although the subject physician was trained in battlefield and medical acupuncture, the subject physician was never credentialed or privileged at the facility to perform either service.

Supervision and Evaluation of the Subject Physician

The OIG found that three facility leaders participated in various aspects of the subject physician's supervision, which led to confusion about who was ultimately responsible for the oversight of the subject physician's clinical practice. The OIG also identified deficient supervisory performance evaluations of the subject physician's professional practice.

Deficient Supervision of the Subject Physician

The OIG found that the former ADPCS, the former Chief of Staff, and the Chief of Primary Care, participated in aspects of the subject physician's supervision. The OIG interviewed current and former facility leaders who provided conflicting information about responsibility for the

²⁹ Department of Defense, *Battlefield Acupuncture (BFA) Handbook*, January 2021. Battlefield acupuncture is a technique used to relieve pain and involves inserting semi-permanent needles into the skin of the outer ear at five distinct points.

³⁰ VHA Handbook 1100.19. Facility, *Bylaws and Rules of the Medical Staff*, 2017, rescinded and replaced with Facility, *Bylaws and Rules of the Medical Staff*, 2020.

³¹ The OIG found that facility leaders approved the subject provider to attend battlefield and medical acupuncture training, including travel costs.

subject physician's administrative and clinical supervision.³²

Per the facility bylaws, the Chief of Staff is ultimately responsible for facility physicians. This includes oversight of their clinical services and credentialing and privileging.³³ To determine how current and former facility leaders viewed their role, and the role of other facility leaders in supervising the subject physician, the OIG interviewed the former ADPCS, former Chief of Staff, former Whole Health Program Manager, and Chief of Primary Care.

During an OIG interview, the former ADPCS denied clinically supervising the subject physician and reported

- administratively supervising the subject physician and Whole Health,
- not having direct knowledge of the subject physician's clinical privileges,
- the Chief of Primary Care was the supervising physician, and
- the Chief of Staff was responsible for overseeing physician practice and professional practice evaluations.

The former Chief of Staff denied directly supervising the subject physician and told the OIG

- the subject physician worked in primary care, and
- the Chief of Primary Care was responsible for clinical supervision.³⁴

The Chief of Primary Care denied any supervisory responsibility over the subject physician and reported

- not being seen as the subject physician's supervisor by others,
- signing documents including the subject physician's performance pay and professional practice evaluations, at the request of facility leaders, and
- the subject physician seeing a small panel of patients in a primary care clinic prior to transitioning full-time to Whole Health.

The OIG found the subject physician's privileges indicated assignment to primary care. The OIG questioned the Chief of Primary Care's view of not having clinical oversight over the subject physician despite signing multiple documents in a supervisory role. When asked whether others

³² The OIG considered administrative supervision to be oversight of organizational requirements, for example, time and leave requests, travel requests, and other clerical responsibilities. The OIG considered clinical supervision to be oversight of the subject's clinical practice, including FPPEs, OPPEs, performance pay, and approval for clinical privileges.

³³ Facility Bylaws.

³⁴ The former Chief of Staff told the OIG that the Chief of Primary Care supervised the subject physician because the Chief of Primary Care was also a Doctor of Osteopathy and because the subject physician worked in primary care.

saw the Chief of Primary Care in a supervisory role the Chief of Primary Care told the OIG,

I didn't feel like [the subject physician] was my responsibility. I felt like I was a team player and I helped them get the stuff off the ground for Whole Health, but I never felt like I was [the subject physician's] supervisor...I was completely out of [the subject physician's] care other than [...] chart review which isn't uncommon.

The Chief of Primary Care further stated, "So, I mean that's between [the former ADPCS] and [the former Chief of Staff]. And that was their job. I didn't mind to help, but I don't feel like I was [the subject physician's] supervisor."

The former Whole Health Program Manager denied any supervisory responsibility of the subject physician and told the OIG

- the former Chief of Staff and the Chief of Primary Care supervised the subject physician's clinical practice, and
- the former ADPCS was responsible for administrative supervision.

The OIG reviewed documents and found the former ADPCS, the former Chief of Staff, and the former Whole Health Program Manager signed documents in a supervisory capacity. See [appendix B](#).

The OIG determined that the former ADPCS provided administrative supervision for Whole Health. The OIG could not clearly identify a line of clinical supervision for the subject physician but noted the former Chief of Staff and the Chief of Primary Care functioned as clinical supervisors and provided varying levels of oversight. The OIG found that none of the facility leaders responsible for oversight of the subject physician's clinical practice acknowledged their responsibility for clinical supervision. Also uncertain about supervision, the subject physician, in a June 13, 2018, communication to the former Whole Health Program Manager, asked, "are you my supervisor[?]"

The OIG also learned that following the subject physician's criminal proceedings in January 2021, the VISN Network Director convened an Administrative Investigation Board (AIB) in March 2021 to examine the supervision of the subject physician.³⁵ The AIB found the subject physician was inadequately supervised and concluded that "if supervision of [the subject physician] was centralized to a physician, that supervisor would have potentially had the

³⁵ VA Directive 0700, *Administrative Investigations*, March 25, 2002. This directive was in effect at the time of the events discussed in this report until it was rescinded and replaced by VA Directive 0700, *Administrative Investigation Boards and Fact Findings*, August 10, 2021. The two policies contain the same or similar language related to administrative investigations. When significant incidents occur, VHA conducts administrative investigations to collect and analyze evidence. An AIB is a group of people with the knowledge and expertise to sufficiently review items of concern. The VISN Network Director also charged the AIB members with determining if facility leaders "appropriately" addressed patient complaints and whether facility leaders executed "due diligence" during the hiring process to gather adverse information about the subject physician's past employment.

opportunity to directly monitor the subject physician's clinical performance and completion of required documentation." The AIB also recommended that similarly trained or privileged physicians should clinically supervise other physicians.

In response to the AIB findings, facility leaders developed an action plan to review privileging documents and verify appropriate supervisory oversight of privileged providers. The action plan also included realigning Whole Health under the Chief of Staff and ensuring that clinical oversight was clarified with Whole Health staff.³⁶ During interviews, the OIG found that in late September 2021, oversight of Whole Health had transitioned from under the ADPCS to the Chief of Staff. The OIG also learned through document reviews that in September 2021, facility leaders had reviewed all licensed independent providers at the facility to verify a similarly trained or privileged provider was providing appropriate supervision.

The OIG concluded that the lack of a clear line of clinical supervision resulted in deficient oversight of the subject physician's clinical practice.

Deficient Professional Practice Evaluations

VHA requires FPPEs and OPPEs to evaluate the competency of practicing providers.³⁷ According to The Joint Commission, FPPEs are performed to evaluate the performance of practitioners who are newly privileged or lack documented competencies. OPPEs are used to evaluate the performance of privileged providers.³⁸ Facility policy states that "Professional Practice Evaluation is a process that requires monitoring and evaluation of a provider's professional performance to ensure that the provider is delivering safe and high-quality patient care."³⁹ Additionally, VHA requires the competency of licensed independent providers to be evaluated by another provider with similar training and privileges.⁴⁰

For new employees or for employees that request new clinical privileges, facility policy requires service line chiefs to conduct an FPPE each month with a minimum of two chart reviews per month. The FPPEs must be completed for three consecutive months. Upon completion of the third monthly FPPE, the PSB and the Clinical Executive Board review and recommend the provider convert to OPPE, however if "deemed necessary by the service line," the FPPE review

³⁶ The OIG found that both actions were closed on or before September 14, 2021.

³⁷ VHA Handbook 1100.19.

³⁸ The Joint Commission, "Focused Professional Practice Evaluation (FPPE) - Understanding the Requirements," accessed December 13, 2021, <https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/medical-staff-ms/000001485/?p=1>. The Joint Commission, "Ongoing Professional Practice Evaluation (OPPE) - Understanding the Requirements," accessed December 14, 2021, <https://www.jointcommission.org/standards/standard-faqs/critical-access-hospital/medical-staff-ms/000001500/>.

³⁹ Facility Memorandum 517-2018-11-1, *Professional Practice Evaluation*, February 2018.

⁴⁰ Acting Deputy Under Secretary for Health for Operations and Management VA Memorandum, "Requirements for Peer Review of Solo Practitioners," December 23, 2015.

period can be extended. The OPPE process includes reviews every six months and requires a minimum of 12 chart reviews for each OPPE.⁴¹

At the time of the subject physician's appointment, the facility's PSB recommended the completion of monthly FPPEs for three consecutive months to "establish competency based on chart review, direct observation or conversation with others."⁴² The OIG reviewed the subject physician's FPPEs and OPPE. See table 1.

Table 1. FPPEs and OPPE of the Subject Physician

Professional Practice Evaluation	Review Period	Number of EHRs Reviewed
April 29, 2018: the Subject Physician's Start Date		
First FPPE	April 15 – April 30, 2018	0
Second FPPE	May 1 – May 30, 2018	0
Third FPPE	June 1 – June 30, 2018	12
Fourth FPPE	July 1 – September 30, 2018	11
OPPE	October 1, 2018 – March 31, 2019	12

Source: OIG analysis of subject physician's FPPEs and OPPEs.

The OIG found that in November 2018, approximately six months after the subject physician's start date, the former Whole Health Program Manager sent an email to the Credentialing and Privileging Specialist to ask if the subject physician required an OPPE. The Credentialing and Privileging Specialist responded, "Yes, we need (3) FPPE's for three months (April, May, and June) then [the subject physician] would convert to OPPE for July to Sept. The next rating period would start Sept 2018 to March 2019." The email also stated, "[The subject physician] is Family practice, so will need someone in family practice to review. This is under PCSL [Primary Care Service Line] therefore [Chief of Primary Care] would complete."

The OIG also found the former ADPCS signed the five professional practice evaluations as the "Service Chief." The OIG also identified that the Chief of Primary Care signed all five of the professional practice evaluations for the subject physician as the "SL [service line] Medical Director/Chief of Staff."

The OIG determined the former ADPCS and the Chief of Primary Care did not follow VHA and facility policies when completing the subject physician's professional practice evaluations including the following deficiencies:⁴³

⁴¹ Facility Standard Operating Procedure, *Professional Practice Evaluation (PPE) Focused and Ongoing*, February 1, 2018. Facility Memorandum 517-2018-11-1.

⁴² Facility Memorandum 517-2018-11-2.

⁴³ VHA Handbook 1100.19. Facility Memorandum 517-2018-11-1.

- The former ADPCS, a registered nurse, signed as “Service Chief” although the former ADPCS was not similarly trained.
- The subject physicians did not begin employment at the facility until April 29, 2018, however the evaluation period for the first FPPE was April 15 through April 30, 2018.
- The first and second FPPEs included an assessment of “patient care and procedural skills” through EHR reviews even though the FPPEs stated the subject physician was not seeing patients during these time periods.
- The fourth FPPE included a review of 11 EHRs and spanned from July through September 2018, although facility policy requires a one-month evaluation period.⁴⁴
- The Chief of Primary Care did not comply with the PSB and Clinical Executive Board’s recommendation to establish the subject physician’s initial competency through “chart review, direct observation or conversation with others.”

When the OIG questioned the former ADPCS about having a role in the subject physician’s professional practice evaluations, the former ADPCS did not recall signing them. Specifically the former ADPCS told the OIG, “I definitely would never review charts for a physician” and “Nurses review nurses and doctors review doctors.” The OIG determined that the former ADPCS failed to follow VHA policy, which required a similar trained provider to complete the subject physician’s professional practice evaluations.

When the OIG questioned the Chief of Primary Care about the deficiencies, the Chief of Primary Care

- denied being aware of the subject physician’s start date,
- reported the former Whole Health Program Manager provided prefilled FPPEs,
- could not recall when the first and second FPPE were completed,
- acknowledged completing the third and fourth FPPEs on the same date, and
- told the OIG that professional practice evaluations were conducted based only on chart reviews.

The OIG was unable to determine when the first and second FPPEs were completed. The documents did not include dates of completion, nor did the Chief of Primary Care or former ADPCS date the document upon their signatures. The Chief of Primary Care signed and completed the third and fourth FPPEs on the same date in December 2018.

The OIG spoke with the former Whole Health Program Manager to determine who prefilled the

⁴⁴ Facility Standard Operating Procedure, *Professional Practice Evaluation (PPE) Focused and Ongoing*, February 1, 2018. Facility Memorandum 517-2018-11-1.

subject physician's FPPEs prior to providing them to the Chief of Primary Care. The former Whole Health Program Manager told the OIG "I'm not saying that I didn't. I'm just saying do I remember doing this? No."

The OIG was unable to determine who prefilled the subject physician's FPPE forms before the former Whole Health Program Manager provided them to the Chief of Primary Care. However, the OIG determined that the pre-completion of the professional practice evaluations by someone other than the clinical reviewer was not appropriate and compromised the integrity of the subject physician's practice evaluations.

Additionally, the Chief of Primary Care was present at the December 2018 PSB meeting that approved the subject physician's conversion from FPPE to OPPE. The Chief of Primary Care acknowledged to the OIG during interviews that the FPPE period should have been extended because FPPEs did not include at least three consecutive months of patient chart reviews, and that the subject physician's move to an OPPE was not correct.

The Chief of Primary Care told the OIG that the subject physician's FPPEs were conducted based only on chart reviews. The OIG, however, found that the subject physician saw no patients during the first and second FPPE review periods. When questioned, the Chief of Primary Care told the OIG of signing because a physician's signature was needed to maintain compliance and denied ever using direct observation during the professional practice evaluation process. The OIG found that the Chief of Primary Care did not comply with the recommendation of the Clinical Executive Board and PSB that required evaluation of the subject physician's competency through "chart review, direct observation or conversation with others."⁴⁵

Upon review of the May 2021 final AIB report, the OIG identified that, in response to the subject physician's inadequate supervision, the facility action plan identified a strategy to ensure direct supervisors or service chiefs sign FPPEs and OPPEs. Actions included

- increasing communication between the medical staffing office and the Chief of Staff, and
- ensuring providers of the same discipline review professional practice evaluations.

The OIG learned that the Chief of Staff was the executive sponsor for these actions and both actions were marked completed on June 14, 2021.

The OIG concluded that the Chief of Primary Care and the former ADPCS failed to provide adequate oversight of the subject physician's clinical practice through the professional practice evaluation process. The OIG found multiple deficiencies within the subject physician's FPPE process, including the former ADPCS participating in the clinical oversight of the subject physician despite not being similarly trained and the Chief of Primary Care's failure to conduct

⁴⁵ Facility Memorandum 517-2018-11-2.

the minimum number of required chart reviews, comply with the required monthly review periods, and follow the Clinical Executive Board recommendations to establish the subject physician's initial competency based on chart review, direct observation, or conversations with others.⁴⁶

2. Facility Leaders' Response to Allegations of Sexual Misconduct

VA requires employees to maintain high standards of conduct and facilitate prompt corrective actions when standards are not met.⁴⁷ The OIG learned, from October 2018 through May 2019, four patients alleged misconduct by the subject physician, related to inappropriate sexual contact. All of these complaints occurred before the initiation of the criminal investigation. See table 2.

Table 2. Patient Complaints Against the Subject Physician

Complaint	Date	Summary
First	10/16/18	An employee drafted a report of contact that described a patient's account of an "uncomfortable" experience. VA Police investigated and closed the case as the former Facility Director reviewed the report and it was referred to clinical staff for further disposition.
Second	4/1/19	The Patient Advocate received an electronic message from a patient describing inappropriate touching and feeling violated and depressed. The former ADPCS and the Patient Advocate unsuccessfully attempted to reach the patient. ⁴⁸
Third	4/19/19	A patient spoke with the former ADPCS, who then drafted a report of contact, detailing the touching of the patient's groin and buttocks in an uncomfortable manner.
Fourth	5/31/19	A patient met with the former ADPCS, who then drafted a report of contact which described the patient reporting feeling violated during appointments.

Source: OIG analysis of patient complaints.

The OIG found that former facility leaders did not follow required actions upon awareness of the complaints surrounding the subject physician's alleged misconduct per VHA and facility policies. Specifically, former facility leaders failed to thoroughly investigate complaints regarding clinical care or identify and report patient safety concerns. Additionally, facility

⁴⁶ VA OIG, [Comprehensive Healthcare Inspection Program Review of the Beckley VA Medical Center, West Virginia](#). The OIG report identified similar FPPE and OPPE inconsistencies and deviations from policies and recommended that similarly trained providers conduct professional practice evaluations. The recommendation was closed on April 23, 2019. This period overlaps with the subject physician's professional practice evaluation period and the OIG will not make a new recommendation regarding similarly trained providers signing professional practice evaluations.

⁴⁷ VA Handbook 5021/25, *Employee/Management Relations*, December 28, 2017.

⁴⁸ The OIG learned from the Patient Advocate that this patient never provided a formal statement to the former ADPCS.

leaders did not summarily suspend the subject physician as VHA guidance recommends. The OIG also determined that following the subject physician's removal from direct patient care in February 2019, and subsequent termination in July 2019, facility leaders did not follow VHA and facility policies to timely report the subject physician to the SLBs.

Internal Actions

VHA leaders who receive reports of VA employee misconduct are required to "inquire into the matter sufficiently to determine whether a full administrative investigation is needed."⁴⁹ The supervisor must begin an inquiry as soon as possible, including gathering information from the employee who was alleged to have engaged in misconduct as well as from other individuals with relevant information, and document the results.⁵⁰ All VA employees must immediately report all "knowledge of or information about actual or possible violations of criminal law related to VA programs," to "their supervisor, any management official, or directly to the Office of Inspector General." Management officials must report possible sexual assault to VA police.⁵¹

Facility policy states, "In any case of suspected or alleged mistreatment or abuse, a prompt inquiry will be made to determine the facts, and where indicated, appropriate corrective action will be taken immediately."⁵² Facility policy also requires employees to "promptly" report the incident verbally or in writing to the facility director through supervisory channels. Supervisors are then to document the incident through use of VA Form 10-2633, *Report of Special Incident Involving a Beneficiary*, even if a verbal report was made.⁵³ Further, per VHA policy and facility bylaws, a facility director can summarily suspend a provider's clinical privileges when it is in the best interest of patient care due to potential imminent harm.⁵⁴

The facility's patient safety improvement policy emphasizes the need for staff to comprehensively identify and review sentinel events.⁵⁵ The policy also states that staff must report intentional unsafe acts as well as sentinel events to the patient safety manager, the quality management coordinator, and the risk manager within 24 hours of the event following the first

⁴⁹ VA Handbook 0700, *Administrative Investigations*, July 31, 2002.

⁵⁰ VA Handbook 5021/25.

⁵¹ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

⁵² Facility Memorandum 517-2018-05-24, *Mistreatment or Abuse of Patients*, February 2018.

⁵³ Facility Memorandum 517-2018-05-24.

⁵⁴ VHA Handbook 1100.19. Facility Bylaws.

⁵⁵ Facility Memorandum 517-2018-11Q-9. As defined in the policy, a sexual abuse sentinel event is considered nonconsensual "sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal, or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ, or object" of which "sufficient clinical evidence obtained by the hospital to support allegations of unconsented sexual contact" must be present.

official business day after the event occurred. Intentional unsafe acts include events that result from “alleged or suspected patient abuse of any kind.”⁵⁶

The OIG learned of complaints concerning the subject physician's misconduct, specifically, inappropriate sexual conduct with four patients from October 2018 through May 2019. The OIG found that the former ADPCS and the former Whole Health Program Manager attributed the first complaint to the patient's lack of knowledge regarding OMT and what it entailed. As a result, the former ADPCS along with the former Whole Health Program Manager created a document, distributed to OMT patients, describing OMT treatment. Additionally, following the complaint, the OIG was told that the former ADPCS reassigned a nurse to Whole Health to assist the subject physician and act as a chaperone when needed.

In February 2019, the Virginia Department of Health Professions notified the subject physician of an investigation due to patient complaints at the subject physician's previous employer.⁵⁷ Former facility leaders told the OIG that the subject physician then notified facility leaders. On February 27, 2019, the facility's Associate Director issued a memorandum removing the subject physician from direct patient care, but did not implement a summary suspension, pending the result of the Virginia Department of Health Professions' investigation.⁵⁸

In April 2019, two additional facility patients placed complaints regarding the subject physician's misconduct during appointments. The former ADPCS was unsuccessful in reaching the first patient but was able to speak with the second patient and documented the complaint within a report of contact.

Upon the fourth complaint at the end of May 2019, the former ADPCS spoke with the VISN Chief Medical Officer. Together they decided to have the facility Risk Manager investigate the April and May 2019 complaints and prepare a formal report with any findings. The former ADPCS provided the April and May complaints to the facility Risk Manager and asked for a fact finding investigation to be initiated. However, upon receipt of the complaints, the facility Risk Manager recognized the complaints could pertain to criminal intent and notified VA Police. On June 3, 2019, VA Police contacted the OIG Office of Investigations to report the April and May 2019 complaints.⁵⁹

On June 7, former facility leaders initiated an issue brief to VISN and VHA leaders that identified patient reports of “inappropriate contact” from the subject physician. The former

⁵⁶ Facility Memorandum 517-2018-11Q-9.

⁵⁷ This complaint described allegations of the subject physician sexually assaulting patients.

⁵⁸ On the date of the memorandum, the Associate Director was serving in an Acting Facility Director role. The subject physician continued employment at the facility performing administrative duties such as completing student evaluations and working on a revised Whole Health template.

⁵⁹ This began the combined OIG and Federal Bureau of Investigation process that culminated in the subject physician pleading guilty to three felony counts in September 2020.

Acting Facility Director told the OIG of receiving direction from the VISN Chief Medical Officer to convene a summary review board.⁶⁰ The summary review board conducted the review on June 27, 2019, and examined the subject physician's alleged misconduct, specifically "multiple reports of inappropriate intimate contact with patients while under [the subject physician's] care."⁶¹

After reviewing the evidence file and meeting with the subject physician, the summary review board members recommended the subject physician remain a facility employee as there was "a legitimate clinical methodology to the procedures described in the patient complaints" and that "patient complaints are derived from a legitimate misunderstanding of the therapeutic purpose of hands-on manipulations associated with Osteopathic Manipulative Therapy." During interviews the OIG learned that the summary review board was allowed to interview patients, but according to the former Assistant Human Resources Officer, this was "generally discouraged simply because of the unanticipated impact of interviewing a patient about those specific types of interactions would have on the patient."

On July 2, 2019, the former Acting Facility Director "disapproved" the summary review board recommendation to retain the subject physician and initiated the process of terminating the subject physician.⁶² The Acting Facility Director reported disagreeing with the summary review board's recommendation and not wanting the subject physician to provide care to patients.

The OIG interviewed former facility leaders and found conflicting recollections of events following the patient complaints. The former Facility Director told the OIG of

- unawareness of the October and April complaints;
- not participating in the subject physician's removal from patient care upon knowledge of the Virginia Department of Health Professions investigation; and
- leaving facility employment prior to the May complaint.⁶³

The former Chief of Staff told the OIG of

- discussing the October complaint with the former Facility Director;

⁶⁰ VA Directive 5021/5, Summary review boards are comprised by members of the Professional Standard Board who conduct reviews regarding professional competence or conduct when a separation from federal service must be justified. The employee is given an opportunity to respond to issues under discussion. "The Board will issue findings and recommend the employee's retention or separation."

⁶¹ The former Assistant Human Resources Officer told the OIG that the summary review board examined an evidence file which included patient complaints and the Virginia Department of Health Professions' investigation letter. The summary review board also interviewed the subject physician.

⁶² The former Acting Facility Director told the OIG of not agreeing with the summary review board recommendation due to the nature of the patient complaints coupled with the Virginia Department of Health Professions investigation.

⁶³ The former Facility Director left the facility on April 27, 2019.

- awareness of the Virginia Department of Health Professions investigation and involvement in the removal of the subject physician from patient care;
- no knowledge of the second April complaint; and
- awareness of the May complaint.

The former ADPCS told the OIG of

- awareness of all four complaints;
- working with the former Facility Director to facilitate removal of the subject physician from patient care upon knowledge of the Virginia Department of Health Professions investigation;
- reporting the second April complaint to the former Facility Director who provided guidance to have the former Chief of Staff “take care of it;”
- placing documentation of the second April complaint in the former Chief of Staff’s box;⁶⁴ and
- meeting with the former Acting Facility Director upon the awareness of the May complaint.⁶⁵

The OIG reviewed emails and other documents and was unable to reconcile the inconsistencies that former facility leaders reported following their awareness of the patient complaints. The OIG determined, however, that the former facility leaders did not follow required and recommended actions upon awareness of the complaints surrounding the subject physician’s alleged misconduct and as outlined within VHA and facility policies to

- immediately report allegations of sexual assault to a supervisor, the VA Police, or directly to the OIG,
- report and document the incidents through use of VA Form 10-2633,
- summarily suspend the subject physician upon awareness of potential imminent harm, and
- review if a sentinel event or intentional unsafe act had occurred.

⁶⁴ The former ADPCS told the OIG that the former Chief of Staff was out of the office for a few weeks in April 2019 and that communication was placed in a box for the former Chief of Staff to review upon return. The former Chief of Staff also confirmed being out of the office during that time period.

⁶⁵ The Former ADPCS told the OIG that after receiving the third complaint they reported the second and third patient complaints to the former Facility Director who instructed them to provide the information to the former Chief of Staff for action, although the former Chief of Staff was out of the office during this time. On May 31, 2019, after receiving the fourth patient complaint the former ADPCS told the OIG of providing the patient complaints to the former acting Facility Director who immediately contacted VA police.

As the former ADPCS confirmed awareness of all four of the patient complaints and the Virginia Department of Health Professions investigation, the OIG asked why no required actions were taken until the fourth complaint. The former ADPCS reported

- the first patient complaint surrounded a lack of understanding regarding OMT and the complaint was addressed through creation of an OMT brochure;
- being unable to reach the second patient to verify information and there was no urgency to address as the subject physician was already removed from patient care;
- providing the third complaint to the former Chief of Staff, who confirmed receipt, and thinking the former Chief of Staff was addressing the complaint; and
- meeting with the fourth patient and feeling it was similar to the previous complaints so “nothing prompted me to think that, that [it] was anything real until I actually spoke with the [patient] in person.”

During an OIG interview, the former ADPCS reported having reviewed and being familiar with VHA and facility policies regarding allegations of sexual assaults. However, the OIG found no reports of the incidents through VA Form 10-2633, nor did the former ADPCS immediately report the incident to their direct supervisor, the VA Police, or the OIG.

The OIG determined that although former facility leaders were concerned enough to remove the subject physician from patient care upon awareness of the Virginia Department of Health Professions investigation, the former Facility Director did not follow VHA guidance to summarily suspend the subject physician's privileges. When questioned, the former Facility Director reported understanding that the subject physician's privileges were already taken away.

The OIG found that because former facility leaders did not collaborate with the Patient Safety Manager, there was no opportunity to review the complaints from a patient safety perspective and therefore determine if a sentinel event or intentional unsafe act had occurred. The Patient Safety Manager told the OIG of no conversations with former facility leaders regarding the patient complaints and would have expected to have been involved.

The OIG also reviewed the actions of the former Acting Facility Director who began that position at the facility on April 28, 2019. The former Acting Facility Director told the OIG of

- first learning of the misconduct complaints from the former ADPCS, approximately three weeks after arriving at the facility;⁶⁶
- connecting with VA Police and the OIG criminal investigator;
- initiating the issue brief process;

⁶⁶ The date of awareness coincides with the date of the fourth complaint.

- speaking with the VISN Chief Medical Officer, who suggested convening a review board to determine whether the subject physician would be retained as an employee;
- initiating the summary review board;
- indicating “disapproved” for the results of the summary review board; and
- terminating the subject physician as a probationary employee.⁶⁷

The VISN Network Director initiated an AIB in March 2021 to investigate if facility leaders “appropriately address[ed] any and all patient complaints and/or known concerns raised as to [the subject physician].” The OIG determined the AIB only reviewed actions following the first complaint in October 2018, but did not examine specific former facility leaders’ actions following the second, third, and fourth complaints received in April and May 2019, electing to address general culture of safety issues in the resultant action plan. The AIB did find however, that the subject physician’s privileges were not properly removed by a summary suspension and recommended

all adverse actions of credentialed and privileged providers that the Chief of Staff office, the Credentialing or Medical Staff Office, and Human Resources be involved in the preliminary discussions to ensure all requirements, obligations, and rights of the provider are met in accordance with all applicable VHA policies.

The subsequent AIB action plan identified a human resource owned record system that tracks adverse actions in addition to how the Medical Staff Office is informed of employee adverse actions. Although the AIB action item indicated “completed” on September 1, 2021, the OIG found that supporting documents did not provide information on the content and distribution of this information to applicable facility employees.

The OIG concluded that former facility leaders did not follow required actions upon awareness of the complaints surrounding the subject physician’s alleged misconduct per VHA and facility policies. The lack of communication between former facility leaders partially contributed to a failure to initiate required follow-up actions. Furthermore, the AIB action plan to educate facility staff regarding the process of adverse actions of credentialed and privileged providers lacked evidence of completion.

Chaperones

The former Whole Health Program Manager and the former Whole Health Program Support Assistant told the OIG that the subject physician declined to use the male nurse chaperone that the former ADPCS assigned to the subject physician after the October 2018 complaint. The OIG

⁶⁷ The subject physician’s probationary period ended on April 27, 2020. Therefore, the Former Acting Facility Director terminated the subject physician as a probationary employee who was “not a proper fit for the organization.”

found no evidence that former facility leaders followed up on the subject physician's refusal to use chaperones. Per the American Medical Association, the use of chaperones during sensitive exams prevents "misunderstandings between patient and physician" and respects the dignity of the patient.⁶⁸ The OIG found that the subject physician was performing sensitive OMT exams without a chaperone present, even though there was a relevant patient complaint.⁶⁹ On April 13, 2022, facility leaders enacted a new policy regarding chaperones during sensitive exams. While the policy primarily focuses on women veterans, the policy states, "It is highly recommended that [during] any sensitive exam of male genitalia, rectum, or breast that a male chaperone be offered for the duration of the exam regardless of the gender of the provider."⁷⁰

External Reporting

VHA requires a facility director or designee to report any licensed healthcare provider whose clinical practice or behavior "so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients" to their respective SLBs.⁷¹ There are two review phases for an SLB review: an initial review and a comprehensive review. An initial review is to occur within seven calendar days from when "information is received suggesting that a current employee's clinical practice has met the reporting standard," and "to determine if there may be substantial evidence that the individual so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients." A Provider Exit Review Form serves as the initial review of a provider's conduct within seven calendar days following separation from VA employment.⁷²

If an initial review of a provider's conduct determines there may be substantial evidence that the individual's practice meets the reporting criteria, the facility director initiates a comprehensive

⁶⁸ American Medical Association, "Use of Chaperones," accessed December 3, 2021, <https://www.ama-assn.org/delivering-care/ethics/use-chaperones>.

⁶⁹ American College Health Association Guidelines, "Best Practices for Sensitive Exams," October 2019, accessed December 8, 2021, https://www.acha.org/documents/resources/guidelines/ACHA_Best_Practices_for_Sensitive_Exams_October2019.pdf. A sensitive exam is the "evaluation, palpation, physical therapy for, placement of instruments in, or exposure of: genitalia, rectum, [or] breast."

⁷⁰ Facility Policy MCP 517-2021-PC-04, *Chaperones*, December 10, 2021. The policy was developed as a result of the AIB and signed by the Facility Director on April 13, 2022.

⁷¹ VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. VHA Notice 2018-05, Amendment to VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, February 5, 2018. This handbook was in effect at the time of the events discussed in this report until it was rescinded and replaced by VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. The two policies contain the same or similar language related to reasonable concern. Reasonable concern for the safety of patients is when, given all the circumstances, a reasonable person would be concerned for the safety of patients treated by the licensed health care professional.

⁷² VHA Handbook 1100.18. VHA Notice 2018-05.

review to assess whether substantial evidence exists.⁷³ Per facility bylaws, the Chief of Staff appoints a reviewer to complete the comprehensive review which is “typically completed within 30-calendar days but may be extended if circumstances warrant a longer review period.”⁷⁴

In February 2018, VHA released an amendment to the SLB reporting requirement stating that “VA medical facility Directors have ultimate authority in deciding whether to report a licensed health care professional [provider] to their respective SLB(s).”⁷⁵

The OIG found that two conditions existed that met SLB reporting requirements:

- The “reasonable concern” threshold was met where the subject physician’s inappropriate behavior included “[u]nethical behavior or moral turpitude (such as sexual misconduct toward any patient involved in VA health care)” and “[p]atient abuse, including mental, physical, sexual, and verbal abuse.”
- The subject physician was removed from patient care at the facility in response to similar concerns from the Virginia Department of Health Professions investigation.⁷⁶

The OIG reviewed facility documentation and conducted interviews to determine if former facility leaders followed the SLB reporting processes after the subject physician’s removal from patient care in February 2019, and subsequent termination from employment in July 2019. The OIG learned that the VISN Chief Medical Officer reported the subject physician to the Virginia SLB in April 2020 and West Virginia SLB in May 2020.⁷⁷

The OIG found that the Chief of Primary Care and former facility leaders failed to

- initiate a timely SLB review within seven calendar days upon receipt of information suggesting the subject physician’s clinical practice may have met the reporting standard,
- complete the required Provider Exit Review Form within seven calendar days of the subject provider’s termination, and
- initiate a timely comprehensive review of the subject physician’s patients.

The OIG determined that although the Credentialing and Privileging Specialist attempted to facilitate SLB reporting as early as July 2019, the former Assistant Human Resources Officer

⁷³ VHA Handbook 1100.18. VHA Notice 2018-05.

⁷⁴ Facility Bylaws.

⁷⁵ VHA Notice 2018-05.

⁷⁶ VHA Handbook 1100.18. VHA Notice 2018-05.

⁷⁷ The VISN Chief Medical Officer told the OIG of being the individual assigned to report the subject physician to the SLBs. The VA Office of General Counsel provided an opinion that the VISN Chief Medical Officer could be the deciding official as there was no Acting Facility Director available at the time.

provided inaccurate guidance to former facility leaders, which delayed the required reporting processes.

During an OIG interview, the Credentialing and Privileging Specialist described not knowing specifics but being aware of the subject physician's sexual improprieties and felt that something needed to be done. In July 2019, the Credentialing and Privileging Specialist emailed the former Assistant Human Resources Officer identifying VHA and facility policies requiring reporting to SLB.⁷⁸ In August 2019, the Credentialing and Privileging Specialist obtained guidance from the VHA Medical Staff Affairs Director, which stated "[Human Resources] appointment status has nothing to do with reporting to SLBs" and that "It is the Directors [*sic*] obligation to report when required and ensure that it is done timely." The Credentialing and Privileging Specialist forwarded the guidance to the former Acting Facility Director, the former Chief of Staff, and the former Assistant Human Resources Officer. The former Assistant Human Resources Officer replied that as the subject physician was removed due to the "determination that the employee was a bad fit for the organization" and there was "no documentation on which to base an SLB reporting." The OIG found the former Assistant Human Resources Officer did not follow VHA policy regarding SLB reporting by disregarding the conditions that met SLB reporting requirements, and focused only on the reasons the subject physician was removed.

The OIG also found that the Credentialing and Privileging Specialist attempted timely facilitation of the Provider Exit Review Form in July 2019 following the subject physician's termination. The OIG learned the Credentialing and Privileging Specialist emailed the Chief of Primary Care to complete the Provider Exit Review Form in July 2019 and again in August 2019. The Chief of Primary Care responded in August 2019, deferring the completion of the form to the former Chief of Staff. In September 2019, one and a half months after the subject physician's termination, the former Chief of Staff completed the Provider Exit Review Form and documented that the subject physician

- was terminated for "Conduct/Administrative/Professionalism Issues,"
- met "generally-accepted standard of clinical practice," and
- did not fail "to meet generally-accepted standards of practice as to raise reasonable concern for the safety of patients."

When asked why the form documented that the subject physician met generally-accepted standards of practice, the former Chief of Staff stated, "what I may have been thinking and I don't know, is a person is innocent until proven guilty, and we didn't have proof yet that all of this bad stuff had gone on." As the former Chief of Staff did not identify the subject physician "failed to meet generally-accepted standards of practice as to raise reasonable concern for the

⁷⁸ The Credentialing and Privileging Specialist told the OIG of emailing the policies to the former Assistant Human Resources Officer as human resources was facilitating SLB reporting at that time.

safety of patients,” the former Acting Facility Director was not required to sign the form and SLB reporting did not occur at that time.

During an OIG interview, the Credentialing and Privileging Specialist reported being asked by the former Acting Facility Director in September 2019, to take over the SLB reporting as the former Acting Facility Director “had faith that I was the expert on it and could do that.” Following assignment, the Credentialing and Privileging Specialist told the OIG of initiating the comprehensive review process in November 2019.

The OIG learned, in interviews with the Chief of Primary Care and the Credentialing and Privileging Specialist that, in December 2019, the former Acting Facility Director assigned the Chief of Primary Care to perform a comprehensive review of the subject physician’s patients. However, the OIG found that the comprehensive review only included the four patients who initially placed complaints. When asked, the Chief of Primary Care confirmed with the OIG of only reviewing the four patient complaints and not reviewing additional EHRs. The Credentialing and Privileging Specialist and the former Acting Facility Director confirmed with the OIG that the comprehensive review only addressed the four patient complaints and no additional records were reviewed. When asked why no additional patients were selected for the comprehensive review, the former Acting Facility Director stated: “I can’t explain. I don’t have an answer for that.”⁷⁹ As the subject physician’s SLB reporting was in April and May 2020, the OIG asked the former Acting Facility Director why there was such a long delay in reporting the subject physician. The former Acting Facility Director stated

Virginia was also already investigating [the subject physician] so I did know there was a lot of discussions and questions. I will say that nobody, including myself, nobody was intentionally refusing or suggesting that we not report. We were trying to determine as to whether or not it was appropriate to report.

Former facility leaders’ noncompliance with VHA policy, specifically timely reporting to the SLB, and a SLB related comprehensive review that only examined the four initial patient complaints, represented a failure to meet the “obligation to alert those entities charged with licensing health care professionals when there is serious concern with regard to a licensed health care professional’s [practitioner's] clinical practice.”⁸⁰

3. Acupuncture: Former Facility Leaders’ Awareness and Response

The OIG found that, although the subject physician was not credentialed and privileged to perform acupuncture, multiple patients reported receiving acupuncture from the subject

⁷⁹ In an email to the OIG, the facility Quality Management Chief stated the subject physician documented on 379 patients from May 2018 through February 2019.

⁸⁰ VHA Handbook 1100.18.

physician.⁸¹ The OIG determined former facility leaders became aware of the subject physician performing acupuncture on patients without required credentials and privileges and did not act per VHA and facility policies. Specifically, former facility leaders did not ensure disclosures were made to patients potentially impacted and completion of quality management actions such as EHR reviews and patient safety reporting.

OIG Independent Review

The OIG reviewed facility provided documents and identified 22 patients who reported receiving acupuncture treatment from the subject physician.⁸² The OIG reviewed the 22 EHRs and found the subject physician documented

- acupuncture on two patients,
- acupuncture and trigger point treatment on three patients,⁸³
- trigger point treatment with the use of needles on one patient,
- trigger point treatment without documented use of a needle on four patients, and
- no acupuncture or trigger point treatment on 12 patients.

Additionally, the OIG conducted a comprehensive review of the five EHRs that included documentation of acupuncture and found no evidence of adverse medical outcomes.⁸⁴

The OIG recognized that a patient's understanding of the term acupuncture may differ from the clinical definition, contributing to the discrepancy between some of the patients' reports and the OIG findings. The OIG concluded that, although not being credentialed and privileged to perform acupuncture, the subject physician performed and documented acupuncture on at least five patients who reported receiving acupuncture.⁸⁵

⁸¹ The OIG Office of Healthcare Inspections team did not independently speak with patients to verify care received during this review.

⁸² The OIG reviewed VA Police reports, an AIB which included exhibits and patient interviews, reports of contact, and patient complaints. The OIG focused on the 22 patients who reported inappropriate contact as well as receiving acupuncture treatment and did not include all of the subject physician's patients who may have received acupuncture.

⁸³ The OIG was concerned that the subject physician did not obtain needles through facility processes. Therefore, OIG's independent review included an examination of the subject physician's documentation of trigger point treatment to determine if needles were used on patients aside from acupuncture.

⁸⁴ Within the context of this report, the OIG considered an adverse medical outcome to be death, progression of disease, worsening prognosis, suboptimal treatment, or need for a higher level of care.

⁸⁵ At the request of the OIG, the VISN Chief Medical Officer acknowledged the concerns regarding acupuncture and agreed to facilitate a comprehensive review of all of the subject physician's patients. This review is discussed later in this report.

Facility Leaders' Awareness

During an interview with the OIG, the former ADPCS stated that in November or December of 2018, the subject physician informed the ADPCS of performing acupuncture on a patient. The former ADPCS further told the OIG of instructing the subject physician to stop, as he was not yet credentialed, and then informed the former Facility Director and former Chief of Staff, but no further action was taken. The OIG learned that on September 30, 2019, which was after the initiation of the criminal investigation against the subject physician for sexual assaults, the VA Police Chief at the facility wrote in an email, "it was discovered that the Physician was performing undocumented acupuncture procedures on patients without being Re-Credentialed."⁸⁶ Ensuing emails regarding the VA Police Chief notification, on October 2 and 3, 2019, documented the former Acting Facility Director, former ADPCS, and former Chief of Staff's awareness of this information.

Lack of Former Facility Leaders' Response

Per VHA and facility policies, a look-back, or EHR review is "an organized process for identifying patients or staff with exposure to potential risk incurred through past clinical activities, with the explicit intent to notify them and offer care and recourse, as appropriate."⁸⁷ The Joint Commission notes that a facility may consider the benefit achieved through a review of all relevant cases, not just a sample of records.⁸⁸ If an adverse event is discovered through a look-back, facility leaders and staff are required to report the event to the patient safety manager, disclose the event to patients potentially impacted, and offer care to those patients as needed.⁸⁹

⁸⁶ The VA Police Chief provided an email update to the issue brief to facility administrative staff who then forwarded it to facility leaders. The email noted the practice of acupuncture was discovered on September 30, 2019, through patient interviews with VA Police, the Assistant United States Attorney, and the Federal Bureau of Investigation during their investigation of allegations that the subject physician sexually assaulted patients.

⁸⁷ VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012. This policy was in place for a portion of the time frame of the events discussed in this report. It was rescinded and replaced by VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. The two policies contain the same or similar language related to adverse events and disclosures. Adverse events are "occurrences of harm or potential harm directly associated with care or services delivered by VA providers." Facility Memorandum 517-2015-11-35, *Disclosure of Adverse Events to Patients*, September 15, 2015.

⁸⁸ The Joint Commission, "About the Joint Commission," accessed June 24, 2021, <https://www.jointcommission.org/about-us/>. The Joint Commission is a healthcare accreditation organization whose focus is "safe and effective care of the highest quality and value." The Joint Commission, *Specifications Manual for Joint Commission National Quality Measures, Population and Sampling Specifications*, accessed November 30, 2021, <https://manual.jointcommission.org/releases/TJC2021A1/SamplingChapterTJC.html>.

⁸⁹ VHA Directive 1004.08, 2018. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

The patient safety manager is responsible for analyzing each event to determine the associated risk level and whether a further quality review, such as a root cause analysis is warranted.⁹⁰

Additionally, per VHA policy, adverse events related to a “patient’s care that resulted in, or is reasonably expected to result in, death or serious injury” must be disclosed to patients or their representatives through the institutional disclosure process.⁹¹ If it is determined that multiple patients were potentially impacted due to a systems issue, facility or VISN leaders must initiate the process to decide whether a large-scale disclosure is warranted.⁹² Clinical follow-up is required for potentially affected patients.⁹³

The former ADPCS informed the OIG of telling the former Chief of Staff and former Facility Director of the subject physician performing acupuncture on a patient; however, no further actions were taken. The former Facility Director was unable to recall being notified of this incident. The former Chief of Staff recalled becoming aware through a “rumor,” but was unable to recall any actions taken in response. Additionally, the OIG found that following the email communication from the VA Police Chief at the facility regarding the subject physician performing acupuncture on multiple patients, the former Acting Facility Director, former ADPCS, and former Chief of Staff did not

- initiate a look-back review to determine the occurrence of any adverse events, which the Risk Manager, the Quality Management Chief and the Patient Safety Manager confirmed to the OIG,⁹⁴
- report the incident to, or consult with, the Patient Safety Manager to review and analyze the risk level associated with the subject physician’s actions, and
- discuss the need for, or perform any, disclosures.

The OIG asked former leaders what actions were taken at the facility following the notification from the VA Police Chief. The former ADPCS reported placing priority on the criminal allegations related to sexual assaults as opposed to the subject physician’s use of acupuncture and therefore took no action. Neither the former Acting Facility Director nor the former Chief of

⁹⁰ VHA Handbook 1050.01. The patient safety manager analyzes each reported event using severity and probability categories to assign a risk level. A root cause analysis must be chartered for any event that is considered high-risk. A root cause analysis “is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls.” Facility Memorandum 517-2016-11Q-9, *Patient Safety Improvement*, January 19, 2016.

⁹¹ VHA Handbook 1004.08, 2012. VHA Directive 1004.08, 2018.

⁹² VHA Handbook 1004.08, 2012. VHA Directive 1004.08, 2018. Large-scale disclosure “is a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event.”

⁹³ VHA Handbook 1004.08, 2012. VHA Directive 1004.08, 2018. Facility Memorandum 517-2015-11-35.

⁹⁴ Although the VISN Network Director convened an AIB on March 23, 2021, to investigate processes related to the hiring, on-going supervision, and complaints made “prior to [the subject physician’s] removal from patient care,” the AIB did not include a charge to examine the performance of acupuncture.

Staff recalled being made aware. Specifically, the former Acting Facility Director stated, "I was not aware of it" and "I don't recall a discussion in which [the subject physician] was perhaps practicing outside of ... privileging."

As former facility leaders did not report their awareness of the subject physician's performing acupuncture to the Patient Safety Manager, further analysis of the event did not occur. When questioned why a patient safety report was not submitted retroactively, the Patient Safety Manager told the OIG "At the time I would have expected them to do it. Now that all this has been investigated, I would not expect them to put it in now for that event. But at that time they should have."

The OIG interviewed the VHA Executive Director for the Office of Patient Centered Care and Cultural Transformation, VISN Chief Medical Officer, and VISN Quality Management Officer and learned that if a provider were to perform acupuncture on patients without required credentials and privileges, a look-back review and disclosures would be recommended. The VISN Chief Medical Office told the OIG a disclosure should have occurred upon discovery of, and review of the provision of acupuncture without proper credentialing. The VISN Quality Management Officer further noted if there was a lack of documentation of acupuncture, all patients would need to be contacted and treated. Notably, the VISN Chief Medical Officer was not aware of the subject physician's use of acupuncture while not having the required credentials and privileges, while the VISN Quality Management Officer reported becoming aware during this OIG inspection.

The OIG concluded that upon former facility leaders' awareness of the subject physician performing acupuncture on patients without the required credentials and privileges, they did not act per VHA and facility requirements related to reporting adverse events, and ensuring the completion of a look-back, and identification of a need for disclosures of adverse events.

VISN Led EHR Review of the Subject Physician's Patients

During an interview with the VISN Chief Medical Officer on September 28, 2021, the OIG asked about the failure to conduct EHR reviews to identify if the subject physician had performed acupuncture treatment on patients. The OIG also asked about former facility leaders' awareness of the subject physician performing acupuncture and whether an independent list of patients was developed. The VISN Chief Medical Officer acknowledged EHR reviews had not been done, nor had a list been created, and agreed to facilitate a review capturing the subject physician's patients.

On November 18, 2021, the VISN Chief Medical Officer reported that a review had been initiated on all of the subject physician's patients. The review found that 48 EHRs included documentation of acupuncture and the VISN initiated testing of patients for bloodborne

infectious diseases.⁹⁵ Additionally, the VISN Chief Medical Officer reported working with VHA's Clinical Episode Review Team to facilitate the institutional disclosure process.⁹⁶ Although the OIG did not independently verify the VHA data for accuracy and completeness, the OIG found that the review exhibited a close examination of the subject physician's patients.

The OIG concluded that facility leaders did not act upon their awareness of the subject physician performing acupuncture on patients without the proper credentials and privileges. The OIG also noted the VISN Chief Medical Officer ultimately ensured a comprehensive review of the subject physician's patients was performed and the required VHA actions were initiated, including a comprehensive look-back review and patient disclosures in addition to VISN facilitated testing for bloodborne pathogens.

Subject Physician's Access to Needles

The OIG found through the independent review of care that the subject physician documented the performance of acupuncture and trigger point therapy with needles on six patients. However, the OIG was unable to determine how the subject physician accessed the needles outside of normal facility ordering processes.

Per the Council of Colleges of Acupuncture and Herbal Medicine, single-use needles kept in sterile packaging must be used to prevent treatment with broken needles and possible transmission of bloodborne pathogens.⁹⁷ The OIG learned that during the subject physician's employment, the former Whole Health Program Support Assistant managed provider requests for needles. These requests were sent electronically to the Logistics Department where logistics staff ordered, tracked, and delivered the needles to a locked Whole Health supply closet. The OIG also learned that providers did not submit their own needle requests.

⁹⁵ Centers for Disease Control and Prevention, "Bloodborne Infectious Diseases: HIV/AIDS, Hepatitis B, Hepatitis C," accessed December 6, 2021, <https://www.cdc.gov/niosh/topics/bbp/default.html>. Bloodborne infectious diseases are caused by pathogens spread through contact with blood or other bodily fluids. Examples of pathogens include, "the human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV)."

⁹⁶ VHA Directive 1004.08. "The Clinical Episode Review Team (CERT) is the name of the team that serves as the Deputy Under Secretary for Health for Operations and Management's coordinated triage process for review of each potential adverse event that may require large-scale disclosure."

⁹⁷ Council of Colleges of Acupuncture and Oriental Medicine, "Clean Needle Technique Manual," accessed November 29, 2021, https://www.ccaom.org/images/ccaom/Documents/7th_Edition_Manual_English_June_2017.pdf. Council of Colleges of Acupuncture and Herbal Medicine, "CCAAM," accessed February 22, 2022, <https://www.ccaom.org/ccaom/History.asp>. The OIG learned that the Council of Colleges of Acupuncture and Oriental Medicine changed their name to the Council of Colleges of Acupuncture and Herbal Medicine in early 2021.

The OIG reviewed all facility acupuncture needle orders from January 1, 2018, through February 28, 2019, and found an order placed on behalf of Whole Health on February 7, 2019.⁹⁸ Current and former Whole Health staff told the OIG that the February 2019 order was placed for a former Whole Health acupuncturist who began employment on February 3, 2019.⁹⁹

Additionally, the OIG examined needle orders and found the subject physician did not submit any requests for needles. The OIG then reviewed the six patients' EHRs in which the subject physician documented acupuncture and trigger point therapy with needles and determined five of the six patients received treatment with needles prior to the first Whole Health needle order.

Although the subject physician documented the performance of acupuncture and trigger point therapy with needles, the OIG was unable to determine how the subject physician accessed needles. The former ADPCS told the OIG of being unable to determine this as well. Therefore, the OIG is unable to determine if the subject physician practiced with single-use needles that were kept in sterile packaging. This raised concerns related to the quality and sterility of needles and possible patient exposure to bloodborne pathogens as the needles were likely obtained outside of normal facility processes.

Conclusion

The OIG determined the subject physician was hired as the facility's Whole Health Medical Director and credentialed and privileged to practice within the primary care service line. The subject physician's privileges also included the ability to perform OMT, myofascial techniques, and trigger point therapy. However, the subject physician did not have the credentials and privileges to perform acupuncture.

The OIG identified deficient oversight of the subject physician's clinical practice. The OIG interviewed current and former facility leaders who provided conflicting information about responsibility for the subject physician's administrative and clinical supervision. The OIG found that none of the facility leaders responsible for oversight of the subject physician's clinical practice acknowledged responsibility for clinical supervision. The subject physician was also uncertain about who had responsibility for clinical supervision.

The OIG concluded that current and former facility leaders failed to provide adequate oversight of the subject physician's clinical practice through the professional practice evaluation process. The facility leaders failed to complete the subject physician's FPPEs per VHA and facility policies.

⁹⁸ The period reviewed encompasses three months prior to the subject physician's start date through removal from patient care date. The OIG included the additional months prior to subject physician's start date to analyze whether needles were present in Whole Health prior to the subject physician's arrival.

⁹⁹ According to a human resources staff member from VISN 5, the former Whole Health Program acupuncturist was employed at the facility from February 3, 2019, through October 15, 2019.

The OIG found that former facility leaders did not follow recommended and required actions upon awareness of the complaints surrounding the subject physician's alleged misconduct per VHA and facility policies. Specifically, former facility leaders failed to thoroughly investigate complaints regarding clinical care, suspend the subject physician's privileges, nor identify and report patient safety concerns.

The OIG found that the subject physician performed sensitive exams without a chaperone present and declined to use a male nurse chaperone assigned after the October 2018 complaint. On April 13, 2022, facility leaders enacted a new policy that recommended a male chaperone be offered to male patients during sensitive exams regardless of the provider's gender.

The OIG also determined that following the subject physician's removal from direct patient care in February 2019, and subsequent termination in July 2019, facility leaders did not follow recommended and required VHA and facility policies to timely report to the SLB.

The OIG found that, although not credentialed and privileged to perform acupuncture, the subject physician documented performing acupuncture on five patients. The OIG conducted a review of the five EHRs that included documentation of acupuncture and found no evidence of adverse medical outcomes.

The OIG determined former facility leaders became aware of the subject physician performing acupuncture on patients without required credentials and privileges and did not act per VHA and facility policies. Specifically, former facility leaders did not ensure disclosures were made to patients potentially impacted, clinical follow-up was initiated, and quality management actions such as EHR reviews and patient safety reporting occurred.

The OIG discussed concerns with the VISN Chief Medical Officer who ultimately ensured a comprehensive look-back review of the subject physician's patients was performed, the required VHA actions were initiated, including patient disclosures, and VISN facilitated testing for bloodborne pathogens.

The OIG independently reviewed the subject physician's documented performance of acupuncture and trigger point therapy with needles on six patients. However, the OIG was unable to determine how the subject physician accessed the needles, raising concerns related to the quality and sterility of needles and possible patient exposure to bloodborne pathogens as the needles were likely obtained outside of normal facility processes.

Recommendations 1–5

1. The Capital Health Care Network Director reviews and evaluates the March 2021 Administrative Investigation Board action plan to identify open actions and ensures completion.
2. The Beckley VA Medical Center Director ensures a review of Veterans Health Administration and Beckley VA Medical Center policies related to professional practice evaluations, including supervisory roles, review periods, and service-specific data collection, and takes action as appropriate.
3. The Beckley VA Medical Center Director reviews and evaluates Veterans Health Administration and Beckley VA Medical Center policies related to disclosures and quality management actions such as look-back reviews and patient safety reporting to ensure such actions are timely, objective, and documentation is sufficient to address the issue under review.
4. The Beckley VA Medical Center Director ensures staff education of Veterans Health Administration and Beckley VA Medical Center policies related to employee misconduct and monitors compliance.
5. The Beckley VA Medical Center Director evaluates processes for reporting providers to the state licensing boards, including initial and comprehensive reviews, and monitors compliance.

Appendix A: Facility Executive Leadership Timeline

Table A.1. OIG's Review of the Employment Timeline of Facility Leaders Prior to and Following Subject Physician's Tenure

Title	April 2019	May 2019	June 2019	July 2019	August 2019	November 2019	December 2019	March 2020	April 2020	Current*
Whole Health Director	Subject Physician: 4/29/18-7/23/19									
Facility Director	Former: 9/18/16-4/27/19†	Former Acting: 4/28/19-8/25/19				A variety of facility leaders covered		Current Associate Director: 3/8/20-4/24/20		4/26/20-Current
ADPCS	Former: 7/3/11-3/29/20							3/29/20-Current		
Chief of Staff	Former: 11/26/17-11/22/19					A variety of facility leaders covered				4/26/20-Current
Associate Director	Current Associate Director: 11/26/17-3/7/20							A variety of facility leaders covered‡		4/25/20-Current

Source: OIG analysis of facility documents.

Note: Blocks of time in the timeline header are approximate. The timeline begins in April 2019, to reflect the change in facility leaders during the subject physician's tenure.

*Current in this table indicates as of September 2021.

†Indicates individual retired from VHA.

‡A variety of leaders covered for the Associate Director position while the Associate Director served as Acting Facility Director from March 8, 2020, through April 24, 2020.

Appendix B: Supervisory Documents and Signatures

Table B.1. OIG's Review of Facility Supervisory Documents

Document(s)	Designated Title of Signer	Signer's Actual Title
Approval for Clinical Privileges	Service Line Approving Authority	Facility Geriatric Physician on behalf of the Chief of Primary Care
FPPE 1-4/OPPE	Service Chief	Former ADPCS*
FPPE 1-4/OPPE	Service Line Medical Director/Chief of Staff	Chief of Primary Care
Performance Pay Recommendation & Approval	Supervisory Official	Chief of Primary Care
Performance Pay Recommendation & Approval	Recommending Official	Former Chief of Staff
Leave Request Approval	Supervisor	Former and Current Whole Health Program Managers Former ADPCS
Travel Approval	Supervisor	Former Chief of Staff Former ADPCS
Provider Exit Review	First or Second Line Supervisor	Former Chief of Staff

Source: OIG analysis of the subject physician's Office of Personnel Management file and other documents found in email searches.

**During one of the professional practice evaluations the former ADPCS, a registered nurse, documented the subject physician received written counseling due to untimely documentation.*

†According to the form, the supervisory official signed a performance pay recommendation and approval to verify performance pay goals and objectives were communicated and discussed with the employee.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 31, 2022

From: Director, Capital Health Care Network (10N5)

Subj: Healthcare Inspection—Deficiencies in Facility Leaders' Oversight and Response to Allegations of a Provider's Sexual Assaults and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia

To: Director, Office of Healthcare Inspections (54HL07)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG's) draft report entitled Deficiencies in Facility Leaders' Oversight and Response to a Provider's Allegations of Sexual Assault and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia.
2. I have reviewed and concur with the Medical Center Director's response and the completed corrective actions to the recommendations. Recommendations # 3, 4, and 5 are requested for closure. Recommendation # 2 will remain open in progress.
3. Furthermore, corrective actions for recommendation #1 assigned to the network office are outlined in the response. Recommendation #1 will also remain open and in progress.
4. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VISN 5 Quality Management Officer.

(Original signed by:)

Alissa K Stredney
Quality Management Officer
for
Robert M. Walton, FACHE
Network Director

VISN Director Response

Recommendation 1

The Capital Health Care Network Director reviews and evaluates the March 2021 Administrative Investigation Board action plan to identify open actions and ensures completion.

Concur.

Target date for completion: December 2022

Director Comments

The Veterans Integrated Service Network (VISN) 5 Network Director convened an Administrative Investigation Board (AIB) in March 2021, to examine the vetting and hiring process, supervision and appropriate investigation of patient complaints prior to removal from patient care of the subject physician. In response to the AIB findings, facility leaders developed an action plan that included systematic review of privileging documents, verification of appropriate supervisory oversight of facility providers, and verification of adequate oversight of facility provider's clinical practice through the professional practice evaluation process. In addition, the VISN assisted the facility with a comprehensive training related to psychological safety. The VISN 5 Network Director re-reviewed Beckley VA Medical Center's (VAMC) AIB action plan to ensure completion and ongoing compliance upon receipt of the health care inspection report. Each action item was re-reviewed with the facility and evidence of completion resubmitted ensuring compliance with VHA and facility policy. All required trainings were noted to be completed and attendance documented. Audits continue to be under review by the VISN.

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 31, 2022

From: Medical Center Director, Beckley VA Medical Center (517/00)

Subj: Healthcare Inspection—Deficiencies in Facility Leaders' Oversight and Response to Allegations of a Provider's Sexual Assaults and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia

To: Director, Capital Health Care Network, (10N5)

1. This memorandum is submitted in response to the Healthcare Inspection related to Deficiencies in Facility Leaders' Oversight and Response to a Provider's Allegations of Sexual Assault and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia.
2. I have reviewed the draft report for the VA Medical Center, Beckley, WV, and concur with the findings and recommendations.
3. The attached comments and supportive documentation are evidence that the recommendations made during the Healthcare Inspection-Deficiencies in Facility Leaders' Oversight and Response to a Provider's Allegations of Sexual Assault and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia were put forward into action and measures put in place to ensure sustained improvement.
4. Please express my thanks to the team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our veterans.

(Original signed by:)

Desmond McMullan
Medical Center Director
Beckley VAMC

Facility Director Response

Recommendation 2

The Beckley VA Medical Center Director ensures a review of Veterans Health Administration and Beckley VA Medical Center policies related to professional practice evaluations, including supervisory roles, review periods, and service-specific data collection, and takes action as appropriate.

Concur.

Target date for completion: August 2022

Director Comments

The Beckley VAMC Chief of Staff instructed the credentialing staff to ensure all provider Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) documents are signed by the direct licensed independent practitioner (LIP) Supervisor and/or LIP Clinical Service Chief. In addition, the reviewer must be the same discipline as the provider being reviewed. For new employees or for employees that request new clinical privileges, facility policy requires service line chiefs to conduct an FPPE each month with a minimum of two chart reviews per month. The FPPEs must be completed for 3 consecutive months. Upon completion of the third monthly FPPE, the Professional Standards Board (PSB) and the Healthcare Delivery Council reviewed and recommend the provider convert to OPPE; however, if “deemed necessary by the service line,” the FPPE review period can be extended. The OPPE process includes reviews every 6 months and requires a minimum of 12 chart reviews for each OPPE. Per the Chief of Staff’s direction, credentialing staff are currently reviewing FPPE/OPPE forms with Service Chiefs and service line staff to ensure accurate completion of the FPPE/OPPE forms. On April 26, 2022, the PSB voted to change the current rating cycle to 8 months for one cycle only. Therefore, the current cycle will run from October to May 2022. This will change the rating period and decrease demands/responsibilities at the end of the year, or during the October time period each year. The current period was extended by 2 months, through May 31, 2022, and will now have a due date of August 1, 2022. After the one-time 8-month cycle, the new rating period will run as follows: June to November (6 months) and December to May (6 months). There are 60 days to complete at the end of each rating cycle. Facility FPPE/OPPE summary forms include the review of service-specific data used to support the competency assessment of each provider according to their clinical practice. Current forms (October 2021 – May 2022) will reflect service-specific data previously approved by the medical staff. The June to November cycle will reflect the newly approved specialty-specific clinical indicators per the May 2021 implementation memorandum (Implementation of Enterprise-Wide Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation Specialty-Specific Clinical Indicators). The Chief of Staff will review 6 consecutive months of

FPPE/OPPE forms and ensure the VAMC to be 100% complaint with VHA Directive and Medical Center Bylaws.

Recommendation 3

The Beckley VA Medical Center Director reviews and evaluates Veterans Health Administration and Beckley VA Medical Center policies related to disclosures and quality management actions such as look-back reviews and patient safety reporting to ensure such actions are timely, objective, and documentation is sufficient to address the issue under review.

Concur.

Target date for completion: Completed. March 2022

Director Comments

The Beckley VA Medical Center Director ensured a thorough review and evaluation of current Medical Center processes compared with VHA Directive 1004.08, Disclosure of Adverse Events to Patients. When the facility became aware of the need for a disclosure, the Medical Center followed this VHA Directive to perform the large-scale disclosure and look-back reviews related to the provider in question reviewing a total of 379 patients, involving 16 facilities nationwide. A collaborative effort was put forth by the facility, the VISN 5 Network office, and the National Clinical Episode Review Team (CERT) to facilitate the large-scale disclosure and ensure testing for all patients involved. Each large-scale disclosure may include different actions as recommended by the VISN and CERT team, which is why the VHA Directive mandates this collaborative effort in order to determine large scale disclosure actions for each specific event.

Additionally, the Medical Center continues to use VHA Directives as facility policies to direct practice for any potential clinical or institutional disclosures, look-back reviews, and patient safety reporting to ensure such actions are timely, objective, and documentation is following the VHA Directive for each type of disclosure to address the issue under review. The Patient Safety Manager ensures each employee completes annual training in addition to new hire orientation regarding the VHA National Center for Patient Safety's Joint Patient Safety Reporting program and database.

We request closure of this recommendation based on evidence provided above.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 4

The Beckley VA Medical Center Director ensures staff education of Veterans Health Administration and Beckley VA Medical Center policies related to employee misconduct, and monitors compliance.

Concur.

Target date for completion: Completed. February 2022.

Director Comments

The Beckley VAMC collaborated with VISN 5 leadership to create a civil work environment through staff development to encourage a psychologically safe environment in which to report and escalate concerns, a Just Culture, and to provide training to 100% of employees.

Additionally, training was provided on how to appropriately respond to complaints, including but not limited to Employee Equal Opportunity policies and resources to follow up for resolution. The VISN 5 Human Resources Officer and VISN 5 Organization Development Psychologist conducted face-to-face trainings on December 2, 2021. The team was successful in training a total of 576 employees including supervisors during the initial onsite training sessions. A series of virtual dates were offered to reach the remaining 309 employees with the final nine employees receiving training on February 16, 2022, to reach 100% compliance. Two employees retired prior to the completion of the training, therefore, the total number of employees that received training is 885.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 5

The Beckley VA Medical Center Director evaluates processes for reporting providers to the state licensing boards, including initial and comprehensive reviews, and monitors compliance.

Concur.

Target date for completion: Completed. May 2022.

Director Comments

The VISN 5 Quality Management staff presented Management Review & State Licensing Board (SLB) training including exit reviews on March 16, 2021 and March 31, 2021, to the VISN 5 facility Chief of Staff, Associate Director for Patient Care Services, Credentialing & Privileging Managers and Specialists, Risk Managers, and Executive Assistants to the Chief of Staff. The Chief of Staff and Lead Credentialing & Privileging Specialist attended from Beckley VAMC.

On May 25, 2022, VISN 5 Quality Management staff provided refresher training to include a new process flow sheet reflective of the information to the Beckley Human Resources Strategic Business Partner, Chief of Staff, Risk Manager, Lead Credentialing & Privileging Specialist, and VISN 5 Credentialing & Privileging (C&P) Officer (Acting C&P Manager for Beckley). Audits related to SLB reporting were noted to be 100% compliant for 6 consecutive months through verification of exit evaluations completed of employees who have separated. It was confirmed with leadership and Human Resources that there are no employees under investigation in the last 6 months that could potentially require SLB reporting. All required trainings were found to be complaint and attendance documented.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

OIG Contact and Staff Acknowledgments

Contact For more information about this report, please contact the Office of Inspector General at (202) 461-4720.

Inspection Team Alison Loughran, JD, BSN, Director
Debbie Davis, JD, RN
Marlene DeMaio, MD
Sandra Dickinson, MSW, LCSW
Ariel Drobnes, LCSW, MBE
Kevin Hosey, LCSW, MBA
Patrice Marcarelli, MD

Other Contributors Reynelda Garoutte, MHA, BSN
Adam Hummel, MPPA
Barbara Mallory-Sampat, JD, MSN
Natalie Sadow, MBA
April Terenzi, BA, BS
Robert Wallace, MPG, ScD

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Capital Health Care Network (10N5)
Director, Beckley VA Medical Center (517/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Shelley Moore Capito, Joe Manchin III
U.S. House of Representatives: David McKinley, Carol Miller, Alex Mooney

OIG reports are available at www.va.gov/oig.