US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Allegations Related to Nurse Practitioner Supervision and Controlled Substance Prescribing in Pain Management at the VA Central Texas Healthcare System in Temple

Healthcare Inspection	25-02145-25	December 11, 2025

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection in March 2025 and conducted virtual interviews from April 22–May 15, 2025, to assess allegations that two pain management advanced practice registered nurses (pain management APRNs) were not appropriately supervised and were unqualified to prescribe controlled substances at the VA Central Texas Healthcare System (system) in Temple.[1] The complainant also reported concerns regarding the potential for patient harm; however, the complainant was not aware of any patient safety events.[2] The OIG did not substantiate the allegations and made no recommendations.

The Veterans Health Administration (VHA) requires supervisors to evaluate the competency of licensed independent practitioners (LIPs) such as APRNs, and to complete an annual proficiency report of the LIPs they supervise and monitor performance through practice evaluations.[3] The OIG reviewed the pain management APRNs' proficiency reports and practice evaluations from October 2022 through March 2025, did not identify any competency concerns, and found the supervisor completed the reports properly. The OIG also reviewed reports entered into VHA's patient safety event reporting system during the same time frame and did not find any patient safety events related to the pain management APRNs.[4]

When asked about supervisory oversight of the pain management APRNs, the service chief offered examples of three patient cases. Upon review of the patients' electronic health records, the OIG found evidence that the service chief reviewed the cases with the APRNs and provided appropriate supervisory guidance.

VHA requires healthcare providers with licenses, certifications, or registrations be credentialed prior to providing health care.[5] Further, the Drug Enforcement Administration requires APRNs

[1] A controlled substance is a drug that is "tightly controlled by the government because it may be abused or cause addiction." National Cancer Institute, "controlled substance," accessed July 2, 2025. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/controlled-substance.

[2] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. "A patient safety event is an event, incident, or condition, directly associated with care or services provided to a patient, that could have resulted or did result in unintentional harm."

[3] VA Directive 5013, *Performance Management Systems,* April 15, 2002, rescinded and replaced by VA Handbook 5013/18, *Title 38 Proficiency Rating System*, January 29, 2024. The directives contain the same or similar language unless otherwise noted; VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 13, 2017, rescinded and replaced by VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 3, 2025. The directives contain the same or similar language unless otherwise noted.

[4] VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

[5] VHA Directive 1100.20(2), *Credentialing of Health Care Providers,* September 15, 2021, amended September 11, 2024. Credentialing is the "process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system."

to obtain a registration prior to prescribing controlled substances.[6] The OIG learned from a system quality management staff member that, in August 2017, in accordance with VHA policy, the system APRNs were granted full practice authority, which allowed the pain management APRNs "to practice to the full extent of their education, training and certification, without the clinical supervision or mandatory collaboration of physicians."[7]

The OIG reviewed the pain management APRNs' credentialing and privileging documentation and found the APRNs had active Texas-issued registered nurse licenses and nurse practitioner certifications, Drug Enforcement Administration registrations, and system approved clinical privileges with authorization to prescribe controlled substances. Further, the OIG did not identify any reported patient complaints or patient safety events. Additionally, the deputy chief of staff reported reviewing the service chief's supervisory oversight of the APRN's care and prescribing practices and identified no patient safety concerns.

The OIG concluded that the pain management APRNs' service chief provided supervision as required by VHA and the APRNs were authorized and qualified to prescribe controlled substances.

VA Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report (see appendixes A and B). No further action is required.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

[6] Drug Enforcement Administration, "Registration," accessed June 3, 2025, https://www.deadiversion.usdoj.gov/drugreg/registration.html.

[7] VHA Directive 1350.

Contents

Abbreviations

APRN	advanced practice registered nurse
DEA	Drug Enforcement Administration
FPPE	focused professional practice evaluation
LIP	licensed independent practitioner
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
TMB	Texas Medical Board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on March 27, 2025, and conducted virtual interviews from April 22–May 15, 2025, at the VA Central Texas Healthcare System (system) to assess allegations that two advanced practice registered nurses (pain management APRNs) working in system pain management clinics were not appropriately supervised and were unqualified to prescribe controlled substances.[1]

Background

The system, part of Veterans Integrated Service Network (VISN) 17, provides primary and specialty care services, including pain management. The chief of anesthesia (service chief) reported that the system has pain management clinics located in Austin and Temple, Texas.[2] From October 1, 2023, through September 30, 2024, the system served 119,459 patients and is classified as level 1a complexity.[3]

Advanced Practice Registered Nurses Privileging

"[P]rivileges are based on the [APRNs] clinical competence as determined by peer references, professional experience … education, training, and licensure."[4] The service chief is responsible for reviewing APRNs requested privileges to ensure they reflect current clinical duties.[5] If the service chief concurs with the requested privileges, the privilege request is reviewed by the medical executive committee. The medical executive committee makes privileging recommendations to the facility director, who ultimately makes privileging decisions.[6]

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[1] A controlled substance is a drug that is "tightly controlled by the government because it may be abused or cause addiction." National Cancer Institute, "controlled substance," accessed July 2, 2025, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/controlled-substance.

[2] The service chief reported the system pain management department is under anesthesia and they supervise the pain management APRNs.

[3] VHA Office of Productivity, Efficiency and Staffing (OPES), "Data Definitions: VHA Facility Complexity Model," October 1, 2023. The Facility Complexity Model classifies VHA facilities as 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex.

[4] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, rescinded and replaced by VHA Directive 1100.21, *Privileging*, March 2. 2023; rescinded and replaced by VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. The policies contain the same or similar language unless otherwise noted. Competence is an individual's demonstration of knowledge or skill needed "to perform up to a defined standard and to be granted, and maintain, privileges."

[5] VHA Directive 1100.21(1).

[6] VHA Handbook 1100.19; VHA Directive 1100.21(1).

Prior OIG Reports

The OIG published a 2024 report that included one recommendation to the system related to privileging and professional practice evaluation processes for APRNs in specialty care clinics.[7] As of September 3, 2025, this recommendation is closed.

Allegations

In March 2025, a complainant alleged that two pain management APRNs were not appropriately supervised and were unqualified to prescribe controlled substances.[8] The complainant also reported concerns regarding the potential for patient harm; however, the complainant was not aware of any patient safety events.[9]

Scope and Methodology

The OIG interviewed the complainant, Chief of Staff, deputy chief of staff, service chief, pain management opioid safety and prescription drug monitoring program coordinator, and the pain management APRNs.[10]

The OIG reviewed Veterans Health Administration (VHA) directives, system policies, applicable Texas state law, as well as the electronic health records of three patients, emails, and other relevant documents.

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).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

[7] VA OIG, *Delay of a Patient's Prostate Cancer Diagnosis, Failure to Ensure Quality Urologic Care, and Concerns with Lung Cancer Screening at the Central Texas Veterans Health Care System in Temple*, Report No. 22-04131-49, January 18, 2024.

[8] Throughout this report, any reference to pain management APRNs refers to these two pain management APRNs. The pain management APRNs reported that one worked at the Austin pain management clinic and the other worked at the Temple pain management clinic.

[9] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. "A patient safety event is an event, incident, or condition, directly associated with care or services provided to a patient, that could have resulted or did result in unintentional harm."

[10] A pain management opioid safety and prescription drug monitoring program coordinator is responsible for "a broad range of responsibilities related to … administrative and programmatic support for [pain management] initiatives." VHA Clinical Services Specialty Care Program Office, *Veterans Integrated Services Network and Facility PMOP Triad Roles and Responsibilities Guidance*, February 20, 2024.

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. 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

APRNs are graduate-level nurses who have obtained a national nurse practitioner certification and have a license from a state licensing board.[11] APRNs may practice in a variety of clinical specialties, including pain management.

In VHA facilities, APRNs provide patient care services, including diagnosis, treatment, and management of patients with acute and chronic diseases.[12] APRNs can prescribe medications, including controlled substances.[13] APRNs are licensed independent practitioners (LIPs) who are "permitted by law and the VA medical facility … to provide patient care services independently, without supervision or direction."[14]

APRN Supervision

The OIG determined that the pain management APRNs were appropriately supervised and did not substantiate the allegation.

VHA and System Requirements

VHA requires supervisors evaluate LIP competency and complete an annual proficiency report of the LIPs they supervise as well as monitor performance through focused professional practice

[11] 38 C.F.R. § 17.415 (2025).

[12] 38 C.F.R. § 17.415.

[13] 38 C.F.R. § 17.415; VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 13, 2017, rescinded and replaced by VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 3, 2025. The directives contain the same or similar language unless otherwise noted.

[14] VHA Handbook 1100.19; VHA Directive 1100.21(1); VHA Directive 1350.

evaluations (FPPEs) and ongoing professional practice evaluations (OPPEs).[15] The proficiency rating system allows analysis and evaluation by supervisors to determine the effectiveness of an employee's performance, designating one of five achievement levels with *outstanding* as the highest level.[16] Service chiefs also evaluate APRN competencies including patient care, clinical knowledge, interpersonal and communication skills, and professionalism.[17] An FPPE is the process of service chief evaluation of LIP performance when a LIP "does not yet have documented evidence of competently performing the requested privileges at the [system]."[18] Service chiefs utilize an FPPE to monitor new APRNs during the initial 90 days in a position and, after evaluation elements are met, service chiefs must complete OPPEs an "average [of every] six months."[19] An OPPE "is the ongoing monitoring of privileged LIPs to identify clinical practice trends that may impact the quality and safety of care."[20]

The OIG reviewed the pain management APRNs' proficiency reports and practice evaluations from October 2022 through March 2025. The OIG found that the service chief completed the proficiency reports as required and assigned outstanding ratings in all categories, which included clinical, educational, and administrative competencies.[21] The OIG also found that the service chief reviewed and signed the APRNs' FPPEs and OPPEs and recommended continued performance monitoring.[22] Additionally, the FPPEs and OPPEs did not identify patient or peer complaints and some OPPEs included patient compliments.

During interviews, the service chief told the OIG that supervisory oversight of the pain management APRNs included regular meetings (scheduled and unscheduled) to discuss patient cases and consults. The deputy chief of staff reported the service chief met with the APRNs every other week to discuss patient cases and the pain management APRNs confirmed meeting and consulting with the service chief.

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[15] VA Directive 5013, *Performance Management Systems,* April 15, 2002, rescinded and replaced by VA Handbook 5013/18, *Title 38 Proficiency Rating System*, January 29, 2024. The directives contain the same or similar language unless otherwise noted; VHA Directive 1350.

[16] VA Directive 5013; VA Handbook 5013/18.

[17] System Medical Staff Office, "Standard Operating Procedures for FPPE/OPPE," December 28, 2023. The credentialing and privileging manager reported the system had no policy or procedure prior to December 28, 2023.

[18] VHA Handbook 1100.19; VHA Directive 1100.21(1).

[19] System Medical Staff Office, "Standard Operating Procedures for FPPE/OPPE." Practice evaluations include chart reviews, clinical assessments and knowledge, and patient and peer compliments and complaints.

[20] VHA Handbook 1100.19; VHA Directive 1100.21(1).

[21] VA Directive 5013; VA Handbook 5013/18. Prior to January 2024, rating categories included nursing practice and interpersonal relationships.

[22] System Medical Staff Office, "Standard Operating Procedures for FPPE/OPPE." Service chief FPPE recommendation options include continue an FPPE, convert to an OPPE, or initiate a privileging action. Service chief OPPE recommendation options include: continue, limit, or revoke privileges. The FPPEs and OPPEs assessed the pain management APRNs' clinical knowledge of pain assessment, pain management, and long-term opioid therapy.

When asked about supervisory oversight of the pain management APRNs, the service chief offered examples of three patient cases. Upon review of the three patients' electronic health records, the OIG found evidence that the service chief reviewed the cases with the APRNs and provided appropriate supervisory guidance.

The deputy chief of staff reported being unaware of any patient safety events related to the service chief's supervision of the pain management APRNs. The Chief of Staff reported no concerns about the quality of care provided by the pain management APRNs. The OIG independently reviewed reports entered into the Joint Patient Safety Reporting system from October 2022 to March 2025 and did not find any patient safety events related to the pain management APRNs.[23]

The OIG concluded that the service chief supervised the pain management APRNs according to VHA and system requirements. In addition, the OIG did not identify any patient safety concerns regarding supervision of the pain management APRNs.

Application of Texas State Law

In January 2017, VHA permitted system leaders to grant APRNs full practice authority allowing "APRNs to practice to the full extent of their education, training and certification, without the clinical supervision or mandatory collaboration of physicians."[24] According to VHA, the only exception to APRNs' full practice authority is any state licensure restrictions on an APRN's controlled substance prescribing.[25] The OIG learned from a system quality management staff member that, in August 2017, in accordance with VHA policy, the system APRNs were granted full practice authority.

Texas state law allows physicians to delegate controlled substance prescribing (delegation of prescriptive authority) to an APRN under physician supervision (delegating physician).[26] In addition, Texas state law allows APRNs to prescribe controlled substances as documented in a written authorization.[27] Effective January 2025, the delegating physician must register the delegation of prescriptive authority with the Texas Medical Board (TMB).[28]

[23] VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023. The Joint Patient Safety Reporting system is VHA's patient safety event reporting system.

[24] VHA Directive 1350.

[25] VHA Directive 1350.

[26] Texas Administrative Code §222.4 (2013), amended February 16, 2021, updated March 27, 2024; Texas Administrative Code § 222.6 (2013), updated March 27, 2024.

[27] Texas Administrative Code §222.8 (2019), updated March 27, 2024; Texas Administrative Code §222.4. For the purposes of this report, the OIG considered the pain management APRNs' privileges to prescribe controlled substances as written authorization.

[28] Texas Administrative Code §169.5 (2025).

The OIG reviewed documentation and found the service chief had a Texas medical license, which included delegation of prescriptive authority for the pain management APRNs. The OIG also found the pain management APRNs had Texas nursing licenses, were certified nurse practitioners, and were privileged to prescribe controlled substances.

When asked about the Texas requirements for prescriptive authority for the pain management APRNs, the deputy chief of staff explained that the medical staff executive committee had discussed state requirements for a delegation of prescriptive authority and told the OIG of challenges "to keep up with" varying state licensure requirements. In an interview, the Chief of Staff explained that a leader from another clinical service contacted the TMB for guidance about requirements for physician delegation of prescriptive authority for APRNs. Upon review of documentation, the OIG confirmed that a leader from another clinical service sent an email to the TMB asking whether physicians needed to register a delegation of prescriptive authority for APRNs at the system. The TMB registrations department responded that

> individuals who are employed at federal facilities are outside of the purview of the [TMB]. The delegated prescriptive authority must only be reported to the [TMB] if the [Texas] licensed [APRN] will be working and treating Texas patients under the supervision of a Texas licensed physician outside of [a] federal facility.

The OIG contacted the TMB general counsel to confirm the accuracy of the TMB registrations department staff member's guidance.[29] The TMB general counsel confirmed the guidance and explained that, since the pain management APRNs were practicing at a federal facility, there was no requirement for delegating physician registration of supervision or delegation of prescriptive authority with the TMB.

The OIG concluded that although VHA defers to Texas state law requirements for controlled substance prescribing, the TMB does not require a physician to register a delegated prescriptive authority for VHA APRNs. While not required, the service chief reported delegation of prescriptive authority to the TMB. Further, the pain management APRNs had system approved privileges to prescribe controlled substances.

APRN Qualifications for Controlled Substance Prescribing

The OIG did not substantiate that the pain management APRNs were unqualified to prescribe controlled substances.

VHA requires healthcare providers with licenses, certifications, or registrations be credentialed prior to providing health care; credentialing includes verification of licensure, education,

[29] The TMB general counsel provides legal counsel to the TMB.

training, and experience.[30] VHA also requires that the facility director and chief of staff ensure credentialed providers have privileges that are consistent with approved clinical duties in advance of providing patient care.[31] Further, the Drug Enforcement Administration (DEA) requires APRNs to obtain a DEA registration prior to prescribing controlled substances.[32]

The OIG reviewed October 2022 through March 2025 credentialing and privileging documentation and found the pain management APRNs had

- full, unrestricted, and active registered nurse licenses and nurse practitioner certifications issued by the Texas Board of Nursing;
- active DEA registrations authorizing controlled substance prescribing; and
- approved clinical privileges signed by the service chief that included authorization to prescribe certain controlled substances.

The DEA has classified controlled substances into five different schedules based on the potential for drug abuse or dependency; schedule I drugs have the highest potential and schedule V the lowest.[33] Upon review of the pain management APRNs' DEA registrations, the OIG found that the pain management APRNs had authorization to prescribe schedule III through V controlled substances.[34]

In interviews with the OIG, system leaders, the pain management opioid safety and prescription drug monitoring program coordinator, and the service chief did not report any concerns with the pain management APRNs' prescribing of controlled substances. The deputy chief of staff reported reviewing the pain management APRNs controlled substance prescribing from May 13, 2024, to May 12, 2025, and found no unauthorized prescribing.[35]

The OIG concluded that the pain management APRNs were credentialed, had approved clinical privileges, and were qualified to prescribe controlled substances.

[30] VHA Directive 1100.20(2). *Credentialing of Health Care Providers,* September 15, 2021, amended September 11, 2024. Credentialing is the "process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system."

[31] VHA Directive 1100.21(1).

[32] Drug Enforcement Administration, "Registration," accessed June 3, 2025, https://www.deadiversion.usdoj.gov/drugreg/registration.html.

[33] United States Drug Enforcement Administration, "Drug Scheduling," accessed July 29, 2025, https://www.dea.gov/drug-information/drug-scheduling.

[34] Schedule III drugs have a moderate to low potential for drug dependency.

[35] The deputy chief of staff reported the chief of pharmacy generated a controlled substance prescribing report for APRNs from May 13, 2024, to May 12, 2025; the deputy chief of staff supplied the OIG with a copy of the report and did not report any concerns with pain management APRNs prescribing of controlled substances. The OIG did not independently verify VHA data for accuracy or completeness.

Conclusion

The OIG did not substantiate the allegations.

The OIG reviewed the pain management APRNs' proficiency reports and practice evaluations and found that the service chief completed the reports properly. Upon review of three patients' electronic health records, the OIG found evidence that the service chief provided appropriate supervisory guidance.

Although VHA defers to Texas state law requirements for controlled substance prescribing, the TMB does not require a physician to register a delegated prescriptive authority for VHA APRNs.

The OIG concluded that the service chief supervised the pain management APRNs according to VHA and system requirements. The OIG determined that the pain management APRNs were credentialed, licensed, had approved clinical privileges, and were qualified to prescribe controlled substances.

The OIG made no recommendations.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 23, 2025

From: Network Director, VA Heart of Texas Healthcare Network (10N17)

Subj: Department of Veterans Affairs (VA) Office of Inspector General (OIG) report, Review of Allegations Related to Nurse Practitioner Supervision and Controlled Substance Prescribing in Pain Management at the VA Central Texas Healthcare System in Temple (VIEWS 13870567)

To: Director, Office of Healthcare Inspections (54HL09)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. We note that the OIG did not make any recommendations and appreciate the OIG's comprehensive review.

2. Should you need further information, please contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Wendell Jones, M.D., M.B.A.

[OIG comment: The OIG received the above memorandum from VHA on October 23, 2025.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 23, 2025

From: Facility Director, VA Central Texas Healthcare System (674)

Subj: Department of Veterans Affairs (VA) Office of Inspector General (OIG) Report, Review of Allegations Related to Nurse Practitioner Supervision and Controlled Substance Prescribing in Pain Management at the VA Central Texas Veterans Healthcare System in Temple (VIEWS 13870567)

To: Network Director, Heart of Texas Healthcare Network (10N17)

1. We appreciate the opportunity to review and comment on VA OIG report, Review of Allegations Related to Nurse Practitioner Supervision and Controlled Substance Prescribing in Pain Management at the VA Central Texas Healthcare System in Temple.

2. VA Central Texas Healthcare System notes that the OIG did not make any recommendations.

3. Should you need further information, please contact the Chief, Quality and Patient Safety.

(*Original signed by*:)

Chris Myhaver, MHA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on October 23, 2025.]

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