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VETERANS HEALTH ADMINISTRATION

Review of Responsiveness to Patient Care Concerns, and Credentialing and Supervision of a Nurse Practitioner and Physician Assistant at the VA Loma Linda Healthcare System in California

Healthcare Inspection	25-02464-105	April 24, 2026

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an inquiry from Congressman Pete Aguilar and an allegation regarding patient care involving a nurse practitioner (NP) and physician assistant (PA) in the hematology/oncology section at the VA Loma Linda Healthcare System (system) in California. The OIG initiated the inspection in May 2025, conducted a site visit June 10 through 12, 2025, and continued off-site inspection activities through late November 2025.

The objectives of the review were to determine whether

- the Chief of Staff reviewed the clinical care of four patients identified by the complainant and took appropriate action,
- the NP and PA were credentialed to practice in the hematology/oncology section, and
- service leaders supervised the NP and PA.

The OIG determined that the Chief of Staff assessed the clinical care provided to the four patients through appropriate reviews; however, the Chief of Staff delayed the initiation of two peer reviews by approximately five months. According to Veterans Health Administration (VHA) Directive 1190(1), *Peer Review for Quality Management,* peer reviews are “confidential and nonpunitive assessments of care at the individual clinician level” that can result in opportunities to improve clinical practice. Once a case has been identified for a peer review, a designation memorandum should be signed within three business days, which begins the peer review completion timeline.[1] The Chief of Staff identified that two cases warranted peer review in February 2025 but did not sign the designation memoranda until July 2025. The Chief of Staff acknowledged the delay and cited competing operational priorities.

Credentialing documentation confirmed that the NP and PA were credentialed and met VHA requirements to provide hematology/oncology care at the facility. According to VHA program officials, VHA does not require specialty certification or prior experience in hematology/oncology for credentialing NPs or PAs.

VHA Directive 1100.21(1), *Privileging,* mandates the completion of professional practice evaluations to assess the competencies of NPs and PAs, including patient care and clinical knowledge. Additionally, the system’s professional practice evaluations include review of interpersonal and communication skills, and professionalism.[2] A focused professional practice

[1] VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018.

[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, was rescinded and replaced by VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

evaluation is required at the time of a practitioner's initial appointment and any time a new privilege is granted.[3] The OIG determined that hematology/oncology leaders supervised the NP and PA through focused professional practice evaluations, ongoing professional practice evaluations, annual performance appraisals, and physician collaboration. However, the OIG found that leaders delayed completing the NP's initial focused professional practice evaluation and an additional privilege focused professional practice evaluation. When interviewed, the former service chief cited inadequate supervisory training and the lack of a reliable tracking system as reasons for not completing focused professional practice evaluations, while the acting service chief, who had served in the role multiple times since August 2024, was unaware of the focused professional practice evaluation requirement for additional privileges until receiving credentialing and privileging training in January 2025.

Through interviews, the OIG found that service line and section leaders had a history of not completing service-wide ongoing professional practice evaluations within a 12-month period, as VHA Standard Operating Procedure, *Ongoing Professional Practice Evaluation (FPPE)*, referred to in VHA Directive 1100.21, required.[4] However, the OIG learned that the acting service chief was aware of this prior to the OIG site visit and initiated corrective actions to ensure timely completion of ongoing professional practice evaluations.

Through document reviews, the OIG found that the Chief of Staff had not designated collaborating physicians for the PA. According to VHA Directive 1063(2), *Utilization of Physician Assistants (PA)*, the Chief of Staff is responsible for ensuring each PA has a primary and alternate collaborating physician to consult with and provide oversight of the PA's clinical activities. The PA's scope of practice, which defines the patient care activities the PA is privileged to perform and the extent of involvement required by the collaborating physicians, must identify the collaborating physicians.[5] The OIG found the PA's scope of practice listed a primary collaborating physician who was no longer in the role, and lacked an alternate designation. Leaders resolved the issue after OIG inspectors pointed out the deficiency.

The OIG made two recommendations to the System Director related to the timely signing of designation memoranda to initiate peer reviews and the completion of focused professional practice evaluations.

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[3] VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

[4] VHA Directive 1100.21(1); VHA Privileging, "Ongoing Professional Practice Evaluation (FPPE)" (standard operating procedure -P13) Version: 1, January 16, 2024, was replaced by VHA Privileging, "Ongoing Professional Practice Evaluation (FPPE)" (standard operating procedure -P13) Version: 2, January 8, 2025; Focused Professional Practice Evaluation (FPPE) Ongoing Professional Practice Evaluation (OPPE) Frequently Asked Questions (V1), February 26, 2024. According to VHA's Frequently Asked Questions, an ongoing professional practice evaluation is considered delinquent if not completed within 12 months of previous ongoing professional practice evaluation completion.

[5] VHA Directive 1063(2).

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments

The Veterans Integrated Service Network and System Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The System Director shared that staff had developed a tracker that records the date the episode of care is requested for peer review, Chief of Staff's approval date, and date of signed designation memorandum; and that the Chief of Staff will provide monthly updates on focused professional practice evaluation requirements to service chiefs during Medical Executive Committee meetings. The System Director will monitor compliance through the Quality and Patient Safety Council and Medical Executive Committee respectively. The OIG will follow up on the planned actions until they are completed.

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Abbreviations

NP	nurse practitioner
OIG	Office of Inspector General
PA	physician assistant
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an inquiry from Congressman Pete Aguilar and an allegation regarding patient care involving a nurse practitioner (NP) and physician assistant (PA) in the hematology/oncology section at the VA Loma Linda Healthcare System (system) in California.[1] The OIG initiated the inspection in May 2025, conducted a site visit June 10 through 12, 2025, and continued off-site inspection activities through late November 2025.

Background

The system, part of Veterans Integrated Service Network (VISN) 22, provides outpatient and inpatient care such as medical, surgical, and behavioral health care to nearly 78,000 patients. The system, a Level 1a, high complexity medical center, operates an ambulatory care center, eight community-based outpatient clinics throughout California, and a cancer center.[2]

The cancer center provides diagnostics, treatment, and clinical research services. The cancer center director (service chief) oversees hematology/oncology, radiation oncology, palliative care, and cancer registry/clinical research sections. The hematology/oncology section chief supervises hematology/oncology providers including attending physicians, NPs, and a PA. The service chief reports to the system's Chief of Staff. According to the chief of medicine, the cancer center was aligned under the medicine service before becoming an independent service line in January 2024. At the time of the inspection, one NP was employed in the hematology/oncology section.

NP and PA Clinical Practice Distinctions

An NP is an advanced practice registered nurse certified to provide medical care independently.[3] In 2017, the Veterans Health Administration (VHA) granted NPs full practice authority, allowing them to practice independently based on their education, training, and certification. VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, officially recognized NPs as licensed independent practitioners.[4] VHA Directive 1100.21(1), *Privileging,*

[1] The complaint was received April 3, 2025.

[2] VHA Office of Productivity, Efficiency, and Staffing, "VHA Facility Complexity Model," October 1, 2023. VHA facilities are classified at levels (from most complex to least complex) 1a, 1b, 1c, 2, or 3.

[3] ANA Nursing Resources Hub, "What is a Nurse Practitioner," accessed July 15, 2025, https://www.nursingworld.org/content-hub/resources/becoming-a-nurse/what-is-nurse-practitioner/. Nurse practitioners, also known as advanced practice registered nurses, are licensed independent practitioners. VHA Directive 1100.21(1), *Privileging,* March 2, 2023, amended April 26, 2023.

[4] 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.

defines licensed independent practitioners as "an individual permitted by law and the VA medical facility, through its Medical Staff Bylaws to provide patient care services independently, without supervision or direction, within the scope of the individual's license and in accordance with privileges granted by the facility."[5] Full practice authority enables NPs to provide care without physician supervision or mandatory collaboration.[6]

According to VHA Directive 1063(2), *Utilization of Physician Assistants (PA)*, a PA is a credentialed healthcare provider who delivers care and makes independent medical decisions within a pre-defined scope of practice.[7] A scope of practice defines "the patient care activities for which the individual PA is privileged" and includes the required degree of consultation and input from a "collaborating physician for specific patient care activities." The scope of practice is tailored to the PA's education, training, experience, skills, and competency within the assigned area.[8]

Prior OIG Report

In a May 2023 comprehensive healthcare inspection report, the OIG found that system clinical managers initiated the focused professional practice evaluation process without the licensed independent practitioners' awareness and acceptance of the evaluation criteria.[9] Additionally, clinical managers did not clearly identify time frames for focused professional practice evaluations.[10] The OIG made two recommendations related to these findings, which have been closed.

OIG Concerns

On April 3, 2025, the OIG received an allegation related to care provided to patients in the system's hematology/oncology section by an NP and a PA. The complainant identified three of the NP's patients and six of the PA's patients. Upon review of the care provided to the nine patients, the OIG determined that two of the NP's patients, and two of the PA's patients had hematology/oncology clinical care concerns such as lack of documentation and timely ordering of medication, imaging, and laboratory testing. The OIG determined that one of the three NP patient case examples and two of the six PA patient case examples were not clinical care concerns and were not included in this inspection. One NP patient case was reviewed by the

[5] VHA Directive 1100.21(1).

[6] VHA Directive 1350; VHA Directive 1100.21(1).

[7] VHA Directive 1063(2), *Utilization of Physician Assistants (PA),* December 24, 2013, amended June 24, 2024.

[8] VHA Directive 1063(2).

[9] VA OIG, *Comprehensive Healthcare Inspection of the VA Loma Linda Healthcare System in California*, Report No. 22-00048-120, May 24, 2023; VHA Directive 1100.21(1).

[10] VA OIG, *Comprehensive Healthcare Inspection of the VA Loma Linda Healthcare System in California*; VHA Directive 1100.21(1).

service chief who determined no further review was necessary, and one was peer reviewed by another medical specialty. In April 2025, after initial review of the allegations and prior to opening an inspection, the OIG notified the Chief of Staff about one of the four patients' care that possibly warranted timely action, the Chief of Staff reported awareness of all four patients, and that reviews of the patients' care were underway.

The OIG opened an inspection in May 2025 to determine whether

- the Chief of Staff reviewed the clinical care of four patients and took appropriate action;
- the NP and PA were credentialed to practice in the hematology/oncology section; and
- service leaders supervised the NP and PA through clinical supervision, performance (annual performance appraisals), and privileging, including focused professional practice evaluations and ongoing professional practice evaluations.

Scope and Methodology

The OIG announced the inspection on May 23, 2025, conducted a site visit June 10–12, 2025, and completed additional inspection activities November 26, 2025. The OIG interviewed the Chief of Staff, former and current cancer center and hematology/oncology leaders and providers, the chief of medicine, licensed independent practitioners, nursing staff, an acting credentialing and privileging manager and staff member, a risk manager, an administrative staff member, and a medical support supervisor.

The OIG reviewed applicable VHA and system policies, procedures, and bylaws related to the hematology/oncology section, credentialing and privileging, utilization of nurse practitioners (NPs) and physician assistants (PAs), and select electronic health records. Additionally, the team reviewed documentation related to supervision, credentialing and privileging, and administrative or clinical reviews of the NP and the PA from calendar years 2022 through 2025.

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, 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

Chief of Staff's Review of Clinical Care

The OIG determined that the Chief of Staff reviewed the four patient cases with clinical care concerns. Specifically, the OIG found that the Chief of Staff completed a peer review of two patient cases and initiated a peer review that transitioned to a management review of two patient cases. However, the OIG found that the Chief of Staff did not initiate two of the peer reviews for approximately five months after determining the need for such a review.

According to VHA Directive 1190(1), *Peer Review for Quality Management,* peer reviews are "confidential and nonpunitive assessments of care at the individual clinician level" that can result in opportunities to improve clinical practice.[11] The Chief of Staff, a member of system leadership, can make the determination if a peer review is warranted. Once a provider's care has been identified for a peer review, a designation memorandum should be signed within three business days, which begins the peer review completion timeline. After a healthcare professional with comparable education, training, experience, licensure, and clinical privileges has reviewed the episode of care and assigned a level of care, the Peer Review Committee discusses Level 2 or 3 assignments and provides a final level assignment. A Level 2 assignment implies that "most experienced and competent clinicians might have managed the case differently, but it remains within the standard of care." Level 3 indicates that "most experienced and competent clinicians would have managed the case differently."[12]

VHA Directive 1190(1) defines management reviews as nonprotected reviews that provide a basis for a potential personnel action or adverse privileging action.[13] According to VHA Standard Operating Procedure—P23, "Focused Clinical Care Reviews," referred to in VHA Directive 1100.21, a focused clinical care review is a type of management review that can be

[11] VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024. VHA Directive 1320, *Quality Management and Patient Safety Activities that can Generate Confidential Records and Documents*, July 10, 2020. "Records and documents created by the Department of Veterans Affairs (VA) as part of a medical quality-assurance program are confidential and privileged and must not be disclosed to any person or entity except under limited circumstances as authorized by 38 U.S.C. § 5705 and its implementing regulations."

[12] VHA Directive 1190(1).

[13] VHA Directive 1190(1).

done through retrospective, clinical chart reviews at the discretion of the Chief of Staff.[14] After the focused clinical care review is completed, the Medical Executive Committee considers the information and makes one of the following recommendations to the System Director: clinical care concerns were not substantiated and no further actions taken; perform a focused professional practice evaluation for cause; or move forward with a privileging adverse action.[15]

According to email correspondence, in February 2025, the Chief of Staff became aware of four patients and acknowledged the cases should be sent for peer review. However, the OIG found the Chief of Staff signed the designation memoranda for two of the cases in July 2025, approximately five months after identifying the cases for peer review. The risk manager informed the OIG that one of the peer reviews was completed in July 2025 and the other was completed in August 2025. The Peer Review Committee reviewed both peer reviews in November 2025. The Chief of Staff told the OIG the reason for sending the two cases to peer review in July was likely related "to an oversight that occurred during a period of competing operational priorities" and that having the cases peer reviewed was always the intent.

For two of the cases, the Chief of Staff told the OIG there was enough concern to stop the peer review process and decided to conduct a focused clinical care review in May. The focused clinical care review, completed in July 2025, did not identify clinical concerns. In July 2025, the Medical Executive Committee discussed the management review results and recommended no further action. The OIG determined the Chief of Staff's actions for the two patient cases were timely and in accordance with VHA policy.

The OIG concluded the Chief of Staff assessed the four patient cases through appropriate reviews; however, the Chief of Staff delayed the initiation of two peer reviews by approximately five months. A timely review would have allowed earlier identification of potential improvements to the provider's management of hematology/oncology patients.

Credentialing and Privileging of the NP and PA

The OIG determined the nurse practitioner (NP) was credentialed and privileged, the physician assistant (PA) was credentialed and placed on a scope of practice.

According to VHA 1100.20, *Credentialing of Health Care Providers*, "credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care provider to

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[14] VHA Privileging Directive 1100.21; "Focused Clinical Care Reviews" (standard operating procedure -P23), February 13, 2025; VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, was rescinded and replaced by VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA Handbook 1100.19 does not mention FCCRs; however, VHA Directive 1100.21(1) and Standard Operating Procedure -P23 covers the FCCR period in this report (May—July 2025).

[15] VHA Directive 1100.21(1). The system uses Medical Executive Committee in lieu of Executive Committee of the Medical Staff, which is used in the directive. VA Loma Linda, *Bylaws and Rules of the Medical Staff of VHA,* June 18, 2024.

provide care or services" within the VA healthcare system.[16] All VHA healthcare providers must be credentialed prior to providing care. The credentialing process begins with credentialing and privileging staff completing verification of licensure and other required documentation. Upon completion, the service chief reviews the verified documents and submits a recommendation for approval to the Medical Executive Committee. Following the Medical Executive Committee's review and endorsement, the System Director makes the final decision to appoint the provider.[17]

VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority,* requires NPs to complete a nationally accredited, graduate-level education program, pass a national basic board certification exam, and maintain state licensure.[18] VA Handbook 5005/134 Appendix G8, *Physician Assistant Qualification Standard,* requires PAs be graduates of an accredited training program, have passed the PA National Certifying Exam, and possess an active, current, and unrestricted license to practice.[19] According to VHA program officials, VHA does not require NPs or PAs to have specialty certification or previous experience in hematology/oncology care to be credentialed.

The OIG reviewed credentialing documentation and found the NP (1) completed a nationally accredited, graduate-level education program; (2) was certified in Adult Gerontology/Primary Care; and (3) was licensed in California. The PA (1) graduated from an accredited training program, (2) held certification from the National Commission on Certification of Physician Assistants, and (3) was licensed in California.

According to Medical Executive Committee meeting minutes, the Medical Executive Committee discussed the credentials of the NP and PA and submitted recommendations for medical staff appointment to the System Director, who later approved the appointments. Specifically, the NP's initial credentialing and privileging was reviewed and approved in October 2023. The PA's initial credentials and scope of practice were approved in 2014, and again when the PA transitioned to the hematology/oncology section in February 2018.

The OIG concluded that the NP was credentialed and privileged, and the PA was credentialed and placed on a scope of practice to work in the hematology/oncology section within the system.

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[16] VHA Directive 1100.20(2), *Credentialing of Health Care Providers*, September 15, 2021, amended September 11, 2024.

[17] VHA Directive 1100.20: Standard Operating Procedure- C1, *Initial Credentialing Process,* August 31, 2020.

[18] VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 3, 2025. The previous version of the VHA Directive 1350, September 13, 2017, stated "a determination must be made that the APRN has demonstrated the knowledge and skills necessary to provide the services described in 38 C.F.R. § 17.415(d), as relevant to their specific role, without the clinical oversight of a physician, and is thus qualified to be privileged for such scope of practice."

[19] VA *Appendix G8. Physician Assistant Qualification Standard [VN/AD] -0603 Veterans Health Administration,* September 27, 2020. This document is an appendix update to VA Handbook 5005, *Staffing*, April 15, 2002, and outlines qualifications for PAs.

Supervision of the NP and PA

The OIG determined that hematology/oncology leaders supervised the NP and the PA. However, leaders did not follow required procedures for conducting professional practice evaluations for the NP. In contrast, professional practice evaluations were completed for the PA. Both the NP and PA received additional formal and informal supervision, including annual proficiency assessments, and direct oversight. The OIG found that the Chief of Staff had not designated physicians to collaborate with the PA, as required; however, leaders resolved the issue shortly after OIG inspectors pointed out the deficiency.

Professional Practice Evaluations

According to VHA Directive 1100.21(1), *Privileging*, VHA mandates the completion of professional practice evaluations to assess the competencies of NPs and PAs, including patient care and clinical knowledge.[20] Additionally, the system's professional practice evaluations include a review of interpersonal and communication skills, and professionalism. A focused professional practice evaluation is required at the time of initial appointment and any time a provider is granted a new privilege.[21] The results of a focused professional practice evaluation must be presented to the Medical Executive Committee and, if warranted, the provider is transitioned to an ongoing professional practice evaluation.[22] Ongoing professional practice evaluations must be completed in 12-month cycles and used as the basis for privileging decisions.[23] Service chiefs are responsible for timely completion of professional practice evaluations. Credentialing and privileging staff are responsible for maintaining a tracking system and communicating when evaluations are due to service chiefs and the Chief of Staff.[24] The Chief of Staff, who chairs the Medical Executive Committee, oversees the credentialing and privileging process of NPs and PAs.

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

[21] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, was 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 related to professional practice evaluations.

[22] VHA Privileging, "Focused Professional Practice Evaluation (FPPE)" (standard operating procedure -P14) Version: 1, January 16, 2024, was rescinded and replaced by VHA Privileging, "Focused Professional Practice Evaluation (FPPE)" (standard operating procedure -P14) Version: 2, January 8, 2025. The language regarding transition from focused professional practice evaluation to ongoing professional practice evaluation is similar.

[23] VHA Directive 1100.21(1); VHA Privileging, "Ongoing Professional Practice Evaluation (FPPE)" (standard operating procedure -P13) Version: 1, January 16, 2024, was replaced by VHA Privileging, "Ongoing Professional Practice Evaluation (FPPE)" (standard operating procedure -P13) Version: 2, January 8, 2025. Focused Professional Practice Evaluation (FPPE) Ongoing Professional Practice Evaluation (OPPE) Frequently Asked Questions (V1), February 26, 2024.

[24] VHA Directive 1100.21(1).

Focused Professional Practice Evaluation Completion

The NP received new privileges when being appointed to the hematology/oncology section in October 2023 and additional privileges to perform bone marrow biopsies in August 2024.[25] Focused professional practice evaluations for both initial and additional privileges were not completed until July 2025, which is not consistent with VHA Standard Operating Procedure—P14, "Focused Professional Practice Evaluation (FPPE)," as referred to in VHA Directive 1100.21.[26] While the timeliness guidance was published in the focused professional practice evaluation standard operating procedure in January 2024, the OIG would have expected the focused professional practice evaluation for the NP's initial appointment to have been completed prior to July 2025 as it exceeded time limits established at the time of hire. The NP was prematurely placed on a cycle of ongoing professional practice evaluations in September 2023 and March 2024, prior to successfully completing a focused professional practice evaluation.

The former service chief acknowledged being responsible for the completion of the focused professional practice evaluations and that these evaluations were not initiated. During an interview, the former service chief explained not completing the evaluations due to insufficient supervisory training and lack of a reliable tracking system. The acting service chief told the OIG of having occupied the acting role multiple times since August 2024 and being unaware of the requirement for completing a focused professional practice evaluation when an additional privilege is requested until January 2025, when the system provided credentialing and privileging training. The acting credentialing and privileging manager acknowledged not tracking the required focused professional practice evaluations at the time and described staff turnover as a contributing factor.

In July 2025, after the OIG on-site inspection, the service chief completed the missing focused professional practice evaluations based on a review of patient records from 2024, which reflected no clinical care concerns. Although the evaluations were completed, the OIG is concerned that the delays could have impeded timely recognition of competency concerns. A credentialing and privileging analyst outlined improvements to address the challenges including tracking professional performance evaluations, notifying service chiefs of due dates, and having daily meetings with the Chief of Staff to review overdue evaluations.

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[25] Bone marrow biopsy is a procedure "to collect and examine bone marrow—the spongy tissue inside of some larger bones." The biopsy assists healthcare providers "to diagnose and monitor blood and marrow diseases, including some cancers […]." "Bone marrow biopsy and aspiration," Mayo Clinic, accessed August 21, 2025 from https://www.mayoclinic.org/tests-procedures/bone-marrow-biopsy/about/pac-20393117; *VHA Privileging Directive 1100.21*: Standard Operating Procedure—P13.

[26] *VHA Privileging Directive 1100.21*: Standard Operating Procedure—P14.

Ongoing Professional Practice Evaluation Timeliness

In addition to the NP's ongoing professional practice evaluation being started prematurely, the OIG learned that service line and section leaders had a history of not completing ongoing professional practice evaluations service-wide within the mandated 12-month period.[27] During interviews, the acting service chief reported discovering delinquent ongoing professional practice evaluations in August 2024, prior to the OIG site visit. The acting service chief initiated corrective actions to ensure timely completion of the evaluations. No clinical concerns were identified through the retrospective review. The OIG reviewed ongoing professional practice evaluations of section providers completed during fiscal year 2025 and found that four of five were completed timely.

Other Clinical Supervision

Another required supervision method is annual proficiency assessments, through which supervisors systematically review a provider's performance. As defined by VHA Handbook 5013/19, *Performance Management Systems*, the proficiency rating system allows supervisors to determine the effectiveness of an employee's performance, designating one of five achievement levels with *outstanding* as the highest level.[28] Additionally, service leaders may directly supervise providers as needed, through observations, scheduled meetings, and case consultations.[29]

Annual Proficiency Appraisals

Annual performance appraisals for the NP and PA reflected successful performance. The Chief of Staff attested that neither the NP nor PA had any performance counseling, improvement plans, or disciplinary actions.

Direct Supervision

The NP began employment in December 2023 and was privileged to provide hematology/oncology services. The NP described a brief orientation period under the former service chief and an initial assignment of shadowing the attending hematology/oncology physicians. According to interviews, the OIG learned the NP primarily managed a restricted

[27] VHA Directive 1100.21(1); *VHA Privileging Directive 1100.21*: Standard Operating Procedure—P13. Focused Professional Practice Evaluation (FPPE) Ongoing Professional Practice Evaluation (OPPE) Frequently Asked Questions (V1), February 26, 2024.

[28] VA Handbook 5013/19, *Performance Management Systems*, February 22, 2024; VA Directive 5013, *Performance Management Systems*, April 15, 2002, was rescinded and replaced by VA Handbook 5013/19, *Performance Management Systems,* February 22, 2024. The policies contain similar language related to employee performance.

[29] VA Handbook 5013/19; VA Directive 5013, *Performance Management Systems*, April 15, 2002, was rescinded and replaced by VA Directive 5013/19, *Performance Management Systems*, February 22, 2024; VHA Directive 1100.21(1); *VHA Privileging Directive 1100.21*: Standard Operating Procedure—P14.

caseload of hematology/oncology patients in remission. The NP reported having started regular meetings with the section chief in March 2025. The section chief confirmed meetings occurred "almost on a daily basis" with the NP to review patients and develop the NP's knowledge and skills. The acting service chief told the OIG the section chief worked closely with the NP.

During an interview, the PA reported being hired in 2018 in the hematology/oncology section. The PA described having primary responsibility for the bone marrow biopsy clinic, seeing a variety of hematology/oncology patients in clinic, reviewing incoming consults, and assisting the infusion clinic with emergent concerns. The PA reported transitioning from a previous non-specialty position to being trained by the section chief, and, after one year of training, going to the hematology/oncology section as a full-time provider. The PA told the OIG this period included attending meetings, journal reviews, conferences, and inpatient rounding. The PA described the transition to treating more complex hematology/oncology patients as highly structured with multiple layers of supervision. The section chief told the OIG that the PA has developed knowledge and skills and no longer requires much supervision. Additionally, the section chief reported that the PA discusses complex and challenging patients with leaders or attending physicians; however, supervision is not routinely scheduled.

Designation of Collaborating Physicians for the PA

According to VHA Directive 1063(2), *Utilization of Physician Assistants (PA)*, the Chief of Staff is responsible for ensuring each PA has a primary and alternate collaborating physician to consult with and provide oversight of the PA's clinical activities.[30] The collaborating physicians must be identified on the PA's scope of practice, which defines the patient care activities the PA is privileged to perform.[31]

In May 2025, the OIG reviewed the PA's scope of practice and found that the former service chief, who had not served in the role since March 2025, was listed as the primary collaborating physician, and there was no alternate collaborating physician listed. However, the OIG learned through interviews that the acting service chief and the section chief, both physicians, routinely collaborated with the PA after the former service chief left VA employment.

The OIG learned that after communicating these deficiencies to a facility manager, the primary collaborating physician listed on the PA's scope of practice had been updated in July 2025 and alternate collaborating physicians were added in October 2025.

The OIG concluded that despite the PA not having a collaborating physician documented, hematology/oncology leaders routinely collaborated with the NP and PA. Although the NP did

[30] VHA Directive 1063(2).

[31] VHA Directive 1063(2).

not receive a formal or structured orientation, the smaller caseload with lower risk acuity and routine meetings between the NP and section chief demonstrated supervision.

Conclusion

Upon learning of patient care concerns, the Chief of Staff reviewed the four patient cases with clinical care concerns. The Chief of Staff completed a peer review of two patient cases and initiated a peer review that transitioned to a management review of two patient cases. However, the Chief of Staff did not initiate two of the peer reviews for approximately five months after determining the need for such a review, which could have delayed opportunities for improved care.

The OIG determined the nurse practitioner (NP) was credentialed and privileged, the physician assistant (PA) was credentialed and placed on a scope of practice to provide care to patients in the hematology/oncology section according to VHA guidance, and hematology/oncology leaders provided adequate supervision of the NP and PA through regular meetings. However, leaders delayed completing an initial focused professional practice evaluation and a focused professional practice evaluation for an additional privilege for the NP. Additionally, service-wide ongoing professional practice evaluations were not completed timely as required by VHA; however, the OIG learned through interviews that the service chief was aware of this prior to the OIG site visit and initiated corrective actions to ensure timely completion of ongoing professional practice evaluations. The lack of timely professional practice evaluations of the NP and PA delayed comprehensive reviews to ensure quality care was provided.

The Chief of Staff did not appoint a primary and alternate collaborating physician to oversee the PA's practice. By October 2025, the PA's scope of practice was updated with the required collaborating physicians.

The OIG issued two recommendations to the System Director on the timely signing of peer review designation memoranda and completion of focused professional practice evaluations.

The Veterans Integrated Service Network and System Directors concurred with the recommendations and provided acceptable action plans (see appendixes A and B). The System Director shared that staff had developed a tracker that records the date the episode of care is requested for peer review, Chief of Staff's approval date, and date of signed designation memorandum; and that the Chief of Staff will provide monthly updates on focused professional practice evaluation requirements to service chiefs during Medical Executive Committee meetings. The System Director will monitor compliance through the Quality and Patient Safety Council and Medical Executive Committee, respectively.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–2

1. The VA Loma Linda Healthcare System Director ensures the Chief of Staff signs peer review designation memoranda within three days of determining a peer review is needed as outlined in Veterans Health Administration policy.
2. The VA Loma Linda Healthcare System Director ensures that focused professional practice evaluations for initial appointments and additional privileges are completed in accordance with Veterans Health Administration policy and monitors for compliance.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 6, 2026

From: Interim Network Director, Department of Veterans Affairs (VA) Desert Pacific Healthcare Network (10N22)

Subj: VA Office of Inspector General (OIG) Report, Review of Responsiveness to Patient Care Concerns, and Credentialing and Supervision of a Nurse Practitioner and Physician Assistant at the VA Loma Linda Healthcare System in California

To: Director, Office of Healthcare Inspections (54HL04)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the OIG Draft Report-Review of Responsiveness to Patient Care Concerns, and Credentialing and Supervision of a Nurse Practitioner and Physician Assistant at the VA Loma Linda Healthcare System in California. I reviewed the action plan provided by VA Loma Linda Healthcare System and concur with the response.

2. Should you need further information, please contact the Veterans Integrated Service Network 22 Quality Management Officer.

(*Original signed by:*)

Bryan E. Arnette, FACHE

[OIG comment: The OIG received the above memorandum from VHA on March 9, 2026.]

Appendix B: System Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 6, 2026

From: Interim Director, Department of Veterans Affairs (VA) Loma Linda Healthcare System (605)

Subj: VA OIG Draft Report—Review of Responsiveness to Patient Care Concerns, and Credentialing and Supervision of a Nurse Practitioner and Physician Assistant at the VA Loma Linda Healthcare System in California

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. We appreciate the opportunity to review and comment on the OIG draft report—Review of Responsiveness to Patient Care Concerns, and Credentialing and Supervision of a Nurse Practitioner and Physician Assistant at the VA Loma Linda Healthcare System in California. The VA Loma Linda Healthcare System concurs with the recommendations and will take corrective action.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Scott Kelter

[OIG comment: The OIG received the above memorandum from VHA on March 9, 2026.]

System Director Response

Recommendation 1

The VA Loma Linda Healthcare System Director ensures the Chief of Staff signs peer review designation memoranda within three days of determining a peer review is needed as outlined in Veterans Health Administration policy.

_X _Concur

____Nonconcur

Target date for completion: August 2026

Director Comments

On January 26, 2026, VA Loma Linda Healthcare System Peer Review Coordinator developed a tracker that records the timeframe from the date the episode of care is requested for peer review to the approval date received from the Chief of Staff (COS) to the date of the signed designation memorandum, in alignment with Veterans Health Administration (VHA) Directive 1190(1), Peer Review for Quality Management. The tracker will assist in ensuring the peer review designation memorandum is signed by the COS within 3 business days of request and prior to the start of the review. This tracker will be utilized by the COS and Risk Management team as part of their regular weekly meetings to ensure compliance with VHA policy.

Compliance will be reported monthly by the Peer Review Coordinator to the Medical Center Director (MCD) and COS through the Quality and Patient Safety Council (QPSC). Any non-compliance will be reported monthly to the MCD through the Executive Leadership Board. The numerator will be the number of peer review designation memorandums signed within 3 business days. The denominator will be the total number of peer review designation memorandums signed per month. Compliance will be monitored until 90% compliance is achieved and sustained for 6 consecutive months.

Recommendation 2

The VA Loma Linda Healthcare System Director ensures that focused professional practice evaluations for initial appointments and additional privileges are completed in accordance with Veterans Health Administration policy and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: August 2026

Director Comments

VA Loma Linda Healthcare System COS has established a clear expectation that all medical staff will comply with focused professional practice evaluations (FPPE) requirements for new providers and when granting new privileges. Service Chiefs are accountable for ensuring initial FPPEs are completed within the required 90-day proctoring period, or that a formal request for extension of proctoring is submitted when clinically or operationally necessary, in full compliance with VHA Directive 1100.21(1), Privileging, and the associated VHA Standard Operating Procedure.

VA Loma Linda Healthcare System COS through the Credentialing and Privileging Analyst (CPA) will provide monthly updates to Clinical Service Chiefs regarding their services' FPPE requirements. This information is provided during monthly Medical Executive Committee meetings. Updates to the VA Loma Linda Healthcare System's COS Daily Management System tiered morning huddle will be given to the COS and service chiefs on any overdue FPPEs, along with updates during the monthly Medical Executive Committee meeting. FPPEs at 30 days before their 90-day deadline will be presented to the COS through the Medical Executive Committee for action. The COS will be notified of services' delinquent status to ensure FPPE that are delinquent are prioritized to be completed or a formal request for extension is granted.

Compliance will be reported monthly to the COS through the QPSC by the Acting Credentialing & Privileging Manager or the CPA. Any potential non-compliance will be reported monthly to the Executive Leadership Board. The numerator will be the number of FPPEs for initial appointments in accordance with VHA Policy. The denominator will be all initial appointment FPPEs audited. The second metric to be monitored for compliance as follows: the numerator will be the number of compliant FPPE with additional privileges and the denominator will be all FPPE with additional privileges audited. Compliance will be monitored until 90% compliance is achieved and sustained for 6 consecutive months.

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