THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
March 30, 2011

Mr. William E. Reukauf
Acting Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036

RE: OSC File No. D1-10-1024

Dear Mr. Reukauf:

This is in response to your letter regarding allegations reported by a former employee of the Northport Department of Veterans Affairs Medical Center (VAMC), Nuclear Medicine Service. Based on VA's Office of Inspector General (OIG) hotline complaint, the OIG's Office of Healthcare Inspections (OHI), conducted an inspection to determine the validity of the allegations (OSC File No. D1-10-1024).

The former employee alleged that the medical center was operating an unauthorized nuclear medicine program and improperly submitting bills to third-party payers for services provided by Nuclear Medicine Service residents, which fell outside established VA residency training policies and VA personnel policies. The Assistant Inspector General for OHI thoroughly investigated the allegations regarding Northport, New York, VAMC's Nuclear Medicine Service focusing particularly on the allegations pertaining to licensure status, supervision, and performance of resident physicians in Northport VAMC's Nuclear Medicine Service residency training program, as well as the accreditation status of the program.

As a result of the investigation, the medical center director discontinued the nuclear medicine residency training program and removed the two unlicensed trainee physicians. In addition, the Veteran's Health Administration's, Office of Academic Affiliations discontinued funding nuclear medicine resident positions at the medical center. Findings of the review are included in the enclosed Report Summary and in the entitled "Healthcare Inspection: Alleged Residency Training Issues in Nuclear Medicine Service, Northport VA Medical Center, Northport, New York."

Thank you for the opportunity to respond to these issues.

Sincerely,

Eric K. Shinseki

Enclosure

OSC FILE D1-10-1024
REPORT SUMMARY

I. Summary of Information:

From 1976 through June 2007, the medical center operated an Accreditation Council for Graduate Medical Education (ACGME)-accredited nuclear medicine residency. The VA-sponsored program accepted two residents for a year-long training appointment, renewable on an annual basis. Effective July 1, 2007, the medical center voluntarily withdrew its ACGME accreditation, because the program lost training resources when the State University of New York (SUNY) Medical School at Stony Brook and a community hospital decided to no longer affiliate with the program. From June 2007 through June 2010, the medical center employed unlicensed physicians in an unaccredited nuclear medicine residency program that fell outside established VHA residency training policies and VA personnel policies.

Despite the unaccredited status of the program, the Chief, Nuclear Medicine Service/Program Director, continued to recruit and accept trainee physicians in nuclear medicine. The Chief believed that the unaccredited program was allowed by VA since the program continued to receive funding despite its unaccredited status. However, the investigation found that personnel at the medical center failed to properly notify the Veterans Health Administration's (VHA), Office of Academic Affiliations (OAA) regarding the unaccredited status of the program and failed to properly inform OAA of the termination of the affiliation with SUNY Stony Brook.

Each year, OAA requires medical centers to submit two reports through its Web site. Even though the medical center reported the voluntary withdrawal of accreditation on the mid-July 2008 report and despite possible discrepancies on the medical center's submission, OAA did not verify the information submitted by the medical center due to a lack of staffing. Such failure of communication led to the operation of an unauthorized nuclear medicine program.

II. Conduct of Investigation:

The Assistant Inspector General for Healthcare Inspections conducted an investigation from May 25 through July 9, 2010, regarding the allegations pertaining to licensure status, supervision, and performance of resident physicians in Northport VAMC's Nuclear Medicine Service residency training program, as well as the accreditation status of the program. The investigation consisted of interviews of multiple complainants; medical center leaders and performance improvement staff; staff physicians, trainee physicians, and technologists in the Nuclear Medicine Service; other clinical staff at the medical center; program officials in OAA, and National Program Office for Nuclear Medicine and Radiation Safety; the Chief, Nuclear Medicine Service, and an official from the New York State Office of the Professions. The Assistant Inspector General for Healthcare Inspections also reviewed the Official Personnel Folders and education records for Nuclear Medicine Service physicians-in-training, accreditation records at the Northport VA Medical Center, and the public access Web site for ACGME.

III. Summary of Evidence:

OIG interviewed the Chief, Nuclear Medicine Service and the medical center Chief of Staff (COS), both individuals acknowledged that they did not realize the impact that voluntarily withdrawing ACGME accreditation would have with regards to VA policy requirements, state medical licensing issues, and third-party billings. Based on the interviews conducted by OIG, it was found that the unaccredited status of the nuclear medicine program was made known at the medical center. While the unaccredited status of the program was known at the medical center, OIG found that the medical center officials did not proactively communicate the unaccredited status to OAA.

OIG determined in the course of the investigation that when asked by the OAA for significant data on the facility and affiliate(s) for FYs 2008-2010, the medical center presented misleading information, noting that SUNY Stony Brook was a sponsor for the medical center program in nuclear medicine, which after mid-year 2007, was incorrect. OIG also found that there was no correspondence between the medical center and OAA officials to notify them of the changed accreditation status. However, OIG found the medical center staff did contact OAA regarding the withdrawal of accreditation through OAA's online support center Web site. Additionally, OIG found evidence that two trainee physicians signed letters notarizing that they understood that the program was not accredited.

IV. Sustained or Unsustained Violations:

Issue 1: *Accreditation Status – sustained in part*
OIG sustained the allegation that the medical center was operating an unaccredited residency training program in its Nuclear Medicine Service, but OIG did not sustain that the medical center misrepresented the program's accreditation status to attending physicians since there was evidence that two trainee physicians signed acknowledgements stating they knew the program was unaccredited.

Issue 2: *Qualifications and Licensure – sustained in part*
OIG sustained the allegations that the Chief, Nuclear Medicine Service, allowed unqualified individuals to work in Nuclear Medicine. OIG did not sustain the allegations that the trainee physicians were permitted to function as attending physicians because the responsibilities varied and weren't sufficiently documented.

Issue 3: *Third-Party Billing - unsustained*
A review of a sample of billing during the period that the nuclear medicine residency was not accredited show that a staff physician verified all the episodes of care, thereby meeting the VA and Department of Health and Human Services requirements.

Issue 4: *Patient Death During Nuclear Medicine Test - unsustained*
The patient cited in this allegation died in 2005, almost two years prior to the loss of the nuclear medicine residency program's accreditation.

V. Action Taken:

As a result of the OIG investigation, the Medical Center Director discontinued the nuclear medicine residency training program and removed the two unlicensed trainee physicians. In addition, VHA's Office of Academic Affiliations discontinued funding nuclear medicine resident positions at the medical center.

VA also conducted a review of the overall local management of graduate education, and created a process to validate residency program data submitted by facilities. VA informed the New York State Licensing Board the facts of the incident.