US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Radiology Staffing and Services at the VA Washington DC Healthcare System

Healthcare Inspection | **25-03881-160** | **August 5, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection of the VA Washington DC Healthcare System (facility) on August 11, 2025, following allegations that a "mass exodus" of radiologists caused delays in radiologic studies, a backlog of imaging examinations, and an increase in community care referrals. The complainant reported that the departure of body magnetic resonance imaging (MRI) specialists resulted in a curtailment of body MRIs. The OIG conducted virtual interviews beginning September 12, 2025, a site visit December 1–3, and additional interviews through January 28, 2026.

The OIG substantiated that most of the facility's diagnostic radiologists resigned between July and December 2025, which contributed to delays in completion of radiologic studies.

Facility radiologist staffing shortages resulted in two service interruptions—the curtailment of body MRI services and a backlog of computed tomography (CT) scans. Facility leaders developed action plans to address staffing shortages and the backlog, which included recruitment of radiologists, referrals to community care and the National Teleradiology Program, and the utilization of other Veterans Health Administration (VHA) radiologists. Despite encountering barriers that initially limited resolution of the backlog, facility leaders reported the CT backlog as resolved on January 28, 2026.

VHA's "Standard Operating Procedure Incomplete Exam Management" states, "any incidents of harm or potential harm" that occur related to incomplete radiologic studies, "will be reported to the facility Quality Manager (or appropriate leadership representative) … These incidents should be locally tracked and reported through submission of an Issue Brief as determined by facility leadership."[1] The OIG found that although facility leaders took steps to mitigate delays, they did not notify quality management or locally track incomplete radiologic studies as required. The OIG reviewed the electronic health records of six patients and found concerns related to delayed radiologic studies and results. On December 8, 2025, the OIG communicated the concerns to facility and Veterans Integrated Service Network leaders, who were unaware of these specific cases and the potential clinical impacts. According to an action plan submitted by facility leaders to the OIG in early January 2026, quality management staff began tracking incomplete radiologic exams. Additionally, the facility executive leadership team and quality staff conducted a comprehensive review of the six patient cases and identified no patient harm.

VHA leaders acknowledged that delays in completion of radiologic studies creates potential patient safety risks but did not conduct a comprehensive, proactive assessment of the clinical impacts for patients awaiting studies. After the OIG's on-site visit, VHA leaders established a

[1] VHA, "Standard Operating Procedure Incomplete Exam Management," (SOP 1234-08), July 25, 2023.

national workgroup to develop enterprise-wide radiology solutions, including workforce strategies and improved image-sharing capabilities.

The OIG made two recommendations to the Under Secretary for Health to ensure (1) the continuation of plans toward a sustainable workforce model, enterprise-wide image-sharing capabilities, and standardization of clinical workflows and workload distribution; and (2) that facilities experiencing interruptions in radiology services assess for clinical impacts and alert quality management staff of harm or potential harm due to delays. Additionally, the OIG made one recommendation to the facility director to ensure incidents of actual or potential harm related to incomplete radiologic studies are reported to quality management staff.

The OIG is aware of VA's transformation in the Veterans Health Administration'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 and OIG Response

The Under Secretary for Health concurred with recommendations 1 and 2 and provided an action plan to implement enterprise-wide standardization of radiology processes, including a unified imaging system and reinforce the requirements of facilities to conduct proactive assessments of how delays in radiology studies affect patient care and report actual or potential harm to quality management staff (see appendix A). The Veterans Integrated Service Network and facility directors concurred in principle with recommendation 3, stating a multidisciplinary team reviews, tracks, and reports incidents involving harm or potential harm from incomplete or delayed radiologic studies, using local tracking and issue briefs. The action plan outlined completion of a comprehensive review of delayed radiologic study interpretation and patient safety event reporting training, as well as the plan to continue audits of delayed studies for six months (see appendixes B and C). The OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

DAVID C. KRULAK, MD, MPH, MBA
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

CT	computed tomography
MRI	magnetic resonance imaging
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on August 11, 2025, at the VA Washington DC Healthcare System (facility) to assess the merit of allegations concerning a "mass exodus" of radiologists from the facility and a growing backlog of radiologic studies and an increase in community care referrals for radiology care. The OIG began virtual interviews on September 12, conducted a site visit December 1–3, 2025, and continued additional virtual interviews through January 28, 2026.

Background

Part of Veterans Integrated Service Network (VISN) 5 at the time of this review, the facility, designated as level 1a, treated 118,072 unique patients from October 1, 2024, through September 30, 2025.[1] The facility offers radiology imaging services such as magnetic resonance imaging (MRI) and computed tomography (CT) scans.[2] From October 1, 2024, through September 30, 2025, facility radiology staff completed 17,746 MRIs and CT scans.

Overview of Radiology and Nationwide Workforce Shortage

Radiologists are physicians trained to interpret diagnostic images, such as x-rays, MRIs, and CT scans, to provide essential diagnostic and interventional services that guide clinical decision-making.[3] A radiologist's interpretation of diagnostic images can reveal findings that require immediate clinical intervention, making timely interpretation and reporting imperative.[4]

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[1] VHA Office of Productivity, Efficiency, & Staffing, "VHA Facility Complexity Model Fact Sheet." The Facility Complexity Model rates facilities as a level 1a, 1b, 1c, 2, or 3, with 1a being the most complex and 3 the least. A level 1a facility is considered the highest complexity "with high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs."; In December 2025, VA announced plans to reorganize and consolidate its Veterans Integrated Service Networks (VISNs) from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

[2] "VA Washington DC Healthcare System: Health services," VA, accessed February 10, 2026, https://www.va.gov/washington-dc-health-care/health-services/#specialty-care.

[3] "What is a Radiologist?," American College of Radiology, accessed February 9, 2026, https://www.acr.org/About/Radiology-Overview.

[4] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Management of Unread Radiology Examinations," memorandum to VISN Directors (10N1-23), August 14, 2024; Chief Executive Officer of the American College of Radiology, Dana H. Smetherman, MD, communication to The Honorable Doug Collins, Secretary US Department of Veterans Affairs, March 31, 2025.

When radiologic reports are delayed, the consequences of postponed diagnoses and treatments can increase the risk of patient harm.[5]

For decades, the radiology profession has faced a persistent shortage of radiologists across the United States.[6] In recent years, this shortage has become critical, putting increased pressure on healthcare delivery due to a combination of factors, such as an aging population and an increasing demand for imaging for patients with chronic diseases like cancer.[7] Inadequate staffing of radiologists can lead to extended wait times for appointments and delayed reporting of results, which can postpone medical interventions.[8] Additionally, the burden on remaining radiologists and other healthcare providers increases significantly, often leading to fatigue and burnout.[9]

The adoption of remote work, where radiologists can work from an alternative location, such as their home, began as a temporary measure during the COVID-19 pandemic and has since become standard practice in radiology. The availability of remote work options and the establishment of teleradiology—the provision of radiology interpretations from a remote site to a distant site—infrastructure have become factors in employment decisions for many radiologists, influencing recruitment and retention strategies across the industry.[10]

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[5] VHA, "Standard Operating Procedure Incomplete Exam Management," July 25, 2023; RSNA News, "Radiology Challenged to Demonstrate Value in the Era of Value-Based Health Care, July 12, 2021, https://www.rsna.org/news/2021/july/Radiology-And-Value-Based-Health-Care; Chief Executive Officer of the American College of Radiology, Dana H. Smetherman, MD, communication to The Honorable Doug Collins, Secretary US Department of Veterans Affairs, March 31, 2025.

[6] Gonzalez, N., "New Studies Shed Light on the Future Radiologist Workforce Shortage by Projecting Future Radiologist Supply and Demand for Imaging," Harvey L. Neiman Health Policy Institute news release, February 12, 2025, https://www.neimanhpi.org/press-releases/new-studies-shed-light-on-the-future-radiologist-workforce-shortage-by-projecting-future-radiologist-supply-and-demand-for-imaging/; Matsumoto, A.H., "The Radiologist Shortage Conundrum," *American College of Radiology*, July 2, 2024, https://www.acr.org/Clinical-Resources/Publications-and-Research/ACR-Bulletin/The-Radiologist-Shortage-Conundrum. (Web page no longer accessible.)

[7] Matsumoto, A.H., "The Radiologist Shortage Conundrum"; Gonzalez, N., "New Studies Shed Light on the Future Radiologist Workforce Shortage by Projecting Future Radiologist Supply and Demand for Imaging."

[8] Sohrab Afshari Mirak, MD, et al., "Burnout Fueling Workforce Woes," *American College of Radiology Bulletin*, July 3, 2024, https://www.acr.org/Clinical-Resources/Publications-and-Research/ACR-Bulletin/Burnout-Fueling-Workforce-Woes; "The Growing Nationwide Radiologist Shortage: Current Opportunities and Ongoing Challenges for International Medical Graduate Radiologists," *Radiology* 314, no. 3 (March 1, 2025), https://pubs.rsna.org/doi/epdf/10.1148/radiol.232625.

[9] Mirak, MD, et al., "Burnout Fueling Workforce Woes."

[10] Belfi, L.M., et al., "Current Trends in Remote and Flexible Work Options in Radiology and Perception of Impact on Radiologist Well-Being," *Academic Radiology* 32, no. 3, (March 1, 2025): 1661-1670, https://doi.org/10.1016/j.acra.2024.11.071; Recht, M.P., "Work From Home in Academic Radiology Departments: Advantages, Disadvantages and Strategies for the Future," *Academic Radiology* 30, no.4, (April 2023): 585-589, https://doi.org/10.1016/j.acra.2022.11.019; VHA Directive 1916(1), *VHA Teleradiology Programs*, June 10, 2021, amended November 26, 2025.

Prior OIG Report

In December 2025, the OIG published a report, *Review of Veterans Health Administration's National Teleradiology Program*.[11] The OIG found delayed completion of radiologic studies may be correlated with the impact of the national radiologist shortage. The OIG made three recommendations to the Under Secretary for Health and directors of the National Teleradiology Program and National Radiology Program to review barriers to and devise action plans for recruitment and retention of radiologists in the National Teleradiology Program and across the Veterans Health Administration (VHA).[12] The National Teleradiology Program provides final diagnostic interpretations of radiologic studies to VA medical facilities.[13] As of February 2026, these recommendations remained open.

Allegations and Related Concerns

On August 11, 2025, the OIG received a confidential complaint alleging that the facility is experiencing a "mass exodus" of radiologists, which has contributed to delays in patients receiving radiology studies, a growing backlog of radiologic studies, and an increase in referrals to the community. The same day, the OIG opened an inspection. The complainant clarified that the departure of the radiologists trained to interpret body MRIs left the facility's radiology service unable to offer this service, resulting in a curtailment of body MRIs.[14]

The OIG also included a review of facility leaders' response to delays in radiologic care.

[11] VA OIG, *Review of Veterans Health Administration's National Teleradiology Program*, Report No. 25-01255-242, December 4, 2025.

[12] VA OIG, *Review of Veterans Health Administration's National Teleradiology Program*.

[13] VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020.

[14] A radiologist subspecialized in body imaging interprets radiologic studies from the body ranging from the throat to the pelvis using many types of imaging, including MRIs and CT scans. "Why Is Subspecialty Radiology Important?," Strategic Radiology, accessed September 15, 2025, https://www.strategicradiology.org/why-subspecialty-radiology; A body MRI is an imaging technique that uses a magnetic field to create images of organs and tissues to check for tumors and other irregularities in many organs of the body. "MRI," Mayo Clinic, accessed February 6, 2026, https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768.

Scope and Methodology

The OIG opened the inspection on August 11, 2025, and conducted virtual interviews beginning September 12, a site visit December 1–3, and additional virtual interviews through January 28, 2026. The OIG interviewed the complainant, as well as VHA leaders from the Office of the Deputy Under Secretary for Health, National Radiology Program, and National Oncology and Hematology Program; the VISN chief medical officer; and pertinent facility leaders and staff.

The OIG reviewed relevant VHA and facility radiology policies and procedures; organizational charts and staffing data; relevant study timeliness reports; community care consults for MRIs; and action plans regarding delayed studies.

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 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.

Inspection Results

1. Facility Radiologists Staffing and Impact to Services

According to VHA Directive 1065(1), *Productivity and Staffing Guidance for Specialty Provider Group Practice*, each facility must have enough specialty providers, such as radiologists, to ensure providers can deliver high-quality, timely care to patients.[15] VHA's "Standard Operating Procedure Incomplete Exam Management," defines timely radiologist interpretation of studies as completion of 90 percent within two days and 100 percent within three days.[16]

On January 20, 2025, a Presidential Memorandum, *Return to In-Person Work*, was issued, stating

> Heads of all departments and agencies in the executive branch of Government shall, as soon as practicable, take all necessary steps to terminate remote work arrangements and require employees to return to work in-person at their respective duty stations on a full-time basis, provided that the department and agency heads shall make exemptions they deem necessary.[17]

In February 2025, the VA Chief Human Capital Officer issued a bulletin regarding the process for requesting exemptions from return to in-person work.[18] As of May 23, 2025, the VHA "Modification—Approval for Exemption to Return to Work Requirement for Radiologists," memorandum exempted radiologists providing telehealth or virtual care from in-person work, including National Teleradiology Program providers. As of October 28, 2025, the exemption was expanded to all radiologists.[19] This exemption requires annual review and renewal.

The OIG substantiated that most of the facility's diagnostic radiologists resigned, which contributed to delays in completion of radiologic studies.

Through review of facility staffing documents from October 2024 through December 2025, the OIG learned that four of five full-time facility radiologists, including the chief of radiology (former chief of radiology), who read body MRI and CT scans, resigned during a six-month time

[15] VHA Directive 1065(1), *Productivity and Staffing Guidance for Specialty Provider Group Practice*, December 22, 2020, amended May 19, 2023.

[16] VHA, "Standard Operating Procedure Incomplete Exam Management."

[17] Executive Office of the President, "Return to In-Person Work," memorandum to the heads of Executive Departments and Agencies, January 2, 2025.

[18] VA Office of the Chief Human Capital Officer (OCHCO) Bulletin, "Return to In-Person Work Implementation Guidance," February 20, 2025.

[19] Acting Under Secretary for Health, "Modification—Approval for Exemption to Return to Work Requirement for Radiologists," memorandum to the Secretary, October 21, 2025. The OIG has not evaluated the impact of these exemptions.

frame. Specifically, the facility lost all body MRI diagnostic radiologists in July 2025—which resulted in a curtailment of body MRIs—and an additional diagnostic radiologist in October 2025. An executive office staff member reported the former chief of radiology resigned from the chief position in December 2025 and became a part-time fee-basis provider. Fee basis is a VA employment method that pays qualified health care providers per service when a facility has a limited or specialized need.[20] Additionally, a diagnostic radiologist converted from full-time to part-time in November 2025.

The former chief of radiology reported that before January 2025, radiologists were authorized to work from home several days a week, and the radiologists' departures were related to the return to in-person work requirement. Additionally, the former chief of radiology shared that it was unclear if the exemption would extend beyond one year, creating uncertainty that drove radiologists to seek non-VA, telework-permitted positions, and hindered VHA's ability to recruit and hire radiologists. The former chief of radiology also stated that an additional factor that influenced the former chief of radiology's departure was the increased patient care workload resulting from the shortage of radiologists. From October to December 2025, the former chief of radiology reported a productivity level more than double the expected amount.

During an interview, the VISN chief medical officer expressed the belief, and facility leaders agreed, that the return to in-person work requirement was the "tipping point" and contributed to the loss of radiologists. Specifically, the initial message that mandated a return to in-person work, "spooked" the radiologists. Additionally, the VISN chief medical officer did not believe an earlier exemption would have helped.

The OIG reviewed VHA's gains and losses data for diagnostic radiologists from October 2024 through September 2025 and found that after January 2025, the loss of radiologists outnumbered the gains. (See figure 1.)

[20] VHA Handbook 5007/64 Transmittal Sheet, *Pay Administration*, May 12, 2024.

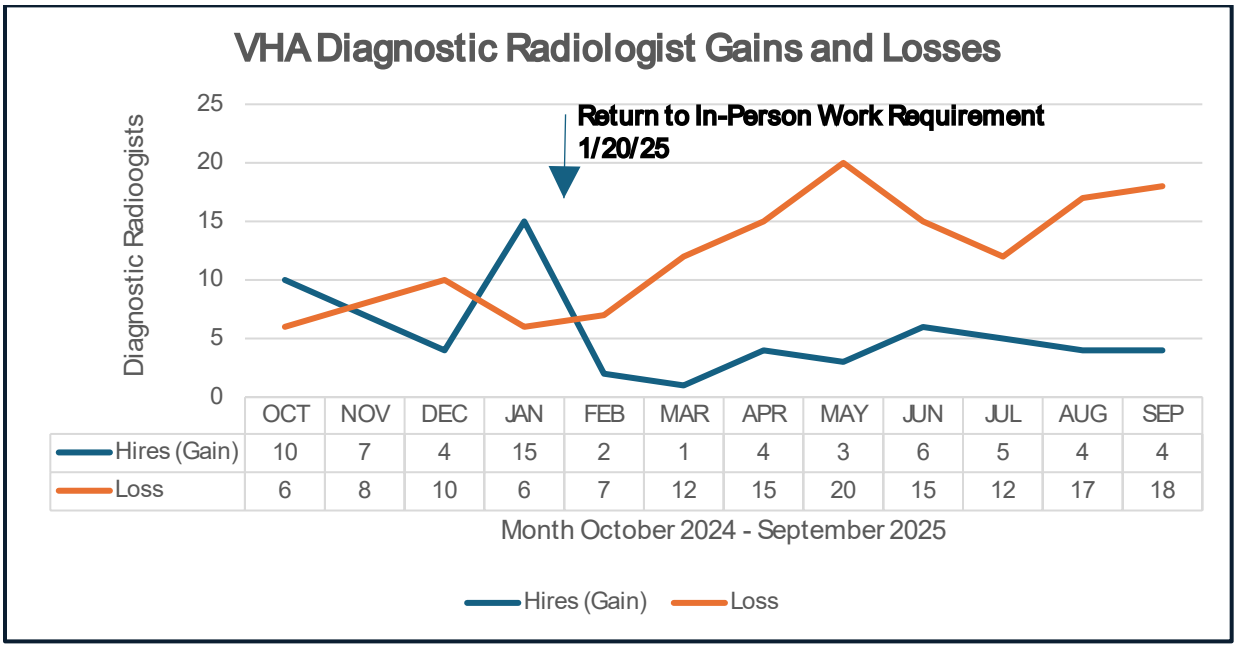

Figure 1. *VHA Diagnostic Radiologist Gains and Losses from October 2024 through September 2025.*
Source: *The OIG analysis of VHA HR Smart data of total loss and onboarding of radiologists by month.*

Review of Staffing Impact on Radiology Services

The shortage of radiologists also led to two interruptions of facility radiology services, which facility leaders outlined in issue briefs, as required—one on July 11, 2025, concerning the curtailment of body MRIs upon losing the two radiologists with the interpreting expertise, and another on September 25, 2025, regarding a backlog of CT studies. Issue briefs, as outlined in the VA Enterprise Issue Reporting System *Guide to VHA Issue Briefs*, are clear, factual, internally generated reports that document situations or events that could affect VHA's ability to deliver high-quality patient care and services, and to inform leaders' decision-making and operational management.[21]

When facility operations are curtailed, facility leaders must submit an issue brief to their VISN describing the specifics of the curtailment, alternatives considered, and the impact on patient care.[22] The VA memorandum, *Management of Unread Radiology Examinations*, outlines that facility leaders must also submit an issue brief to the VISN for backlogs of 20 or more

[21] VA Enterprise Issue Reporting System, *Guide to VHA Issue Briefs*, October 24, 2024.
[22] VA Enterprise Issue Reporting System, *Guide to VHA Issue Briefs*.

incomplete radiologic studies that are pending for seven days or more.[23] The issue briefs should include an action plan and an expected date for resolution.[24]

The OIG found facility leaders created and employed action plans to address the curtailment of body MRIs and the backlog of CT studies, which included efforts such as recruitment of radiologists, referrals to the National Teleradiology Program and community care, and utilization of other VHA radiologists. Through review of electronic communications, the OIG learned that leaders met weekly beginning mid-September 2025 through December 1, 2025, to review the status of and work to resolve the backlog.[25] Leaders reported encountering barriers that initially limited the success in resolving the backlog; however, on January 28, 2026, leaders reported the backlog of CT studies had been eliminated.

Facility leaders employed several strategies to mitigate staffing shortages and impact of the requirement to return to in-person work. Efforts included accelerating recruitment of fee-basis candidates and offering monetary incentives. However, radiologists who perform fee-basis work were limited to a salary cap. The OIG learned that the Elizabeth Dole Act, enacted in January 2025, would exempt fee-basis earnings from the salary cap, allowing increased utilization of fee-basis radiologists for coverage; however, a VHA Office of Human Capital Management staff reported the implementation of fee-basis pay limit changes are not expected until July 31, 2026.[26]

To efficiently share radiology resources across VA medical facilities, VHA Directive 1916(1), *VHA Teleradiology Programs*, states that a facility may use teleradiology.[27] The executive director of the National Radiology Program and the acting director of the National Teleradiology Program told the OIG that the National Teleradiology Program usually offered off-tour urgent exam and radiologist gap coverage. However, due to a staffing shortage, services were limited to urgent exams for hospitalized patients or those in the emergency department. A facility issue brief reflected that leaders' request for National Teleradiology Program coverage was denied.

Since the National Teleradiology Program was not able to provide radiologist support to the facility, starting July 11, 2025, all outpatient body MRI orders were sent to community care. VHA's Community Care Program provides care in the community for eligible veterans when

[23] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Management of Unread Radiology Examinations," memorandum to Veteran Integrated Services Network Directors (10N1-23), August 14, 2024.

[24] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Management of Unread Radiology Examinations," memorandum.

[25] Meetings were not held on October 13, 2025, and November 17, 2025.

[26] Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, Pub. L. No. 118-210, (2025). "The Secretary may waive any pay limitation described in this section … that the Secretary determines necessary for the recruitment or retention of critical health care personnel whom the Secretary determines would provide direct patient care."

[27] VHA Directive 1916(1).

VA is unable to provide the necessary service.[28] In an interview, the former chief of radiology described the challenge of determining when to refer patients, because canceling VHA appointments and referring to community care to catch up with incomplete radiologic studies may result in longer delays, with patients waiting weeks to months.

Additionally, the facility director explained cross-utilization of VHA radiologists is limited due to use of different radiology imaging software systems across the enterprise. The director reported identifying one radiologist in Hawaii who could provide coverage services; however, this solution was complicated and involved shipping computer workstations containing the facility's radiology imaging software to Hawaii and sending a radiology staff member for implementation.

2. Review of Response to Staffing Impact on Patient Safety

VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, affirms VHA's "unwavering commitment to quality health care and patient safety for Veterans" and outlines the expectation that leaders, throughout VHA, promote high-quality and safe patient care.[29] Additionally, VHA's "Standard Operating Procedure Incomplete Exam Management," states "any incidents of harm or potential harm" that occur related to incomplete radiologic studies, "will be reported to the facility Quality Manager (or appropriate leadership representative)…These incidents should be locally tracked and reported through submission of an Issue Brief as determined by facility leadership."[30]

The OIG found that while facility leaders took action to address the shortage of radiologists, facility, VISN, and VHA leaders had not assessed the clinical impact of the radiologist shortage to patients awaiting radiologic studies.

Facility and VISN Response

The OIG found facility leaders submitted issue briefs and implemented various operational measures to reduce delays in radiologic studies. However, the delays were not reported to quality management staff and locally tracked as required by VHA policy.[31]

During on-site interviews, the OIG learned that some patients awaiting completion of radiologic studies may have experienced delays in subsequent care, increasing the risk of patient harm. The OIG received six patient case examples from a healthcare provider and, after reviewing

[28] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 505; VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

[29] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[30] VHA, "Standard Operating Procedure Incomplete Exam Management."

[31] VHA, "Standard Operating Procedure Incomplete Exam Management."

electronic health records, found concerns related to delayed radiologic studies and interpretation of results. On December 8, 2025, the OIG communicated the concerns to facility and VISN leaders, who were unaware of these specific cases and the potential clinical impact on those patients who experienced delays in receiving care.

The chief of quality told the OIG of being detailed to the role in July 2025 and appointed permanently in mid-December 2025, and having no awareness of the radiology delays. The VISN chief medical officer and chief of quality told the OIG that the facility's actions to address the delays were taken with patients' safety in mind. However, both acknowledged quality management involvement should have started at the onset of the delays.

According to an action plan submitted by facility leaders to the OIG on January 2, 2026, quality management staff began tracking incomplete radiologic exams and employed strategies to enhance patients' safety and mitigate further impact to care. The acting deputy chief of quality told the OIG that quality staff and the acting facility chief of staff, with support from the VISN, began conducting ongoing retrospective reviews of delayed patient radiology studies in mid-December. Additionally, according to the acting facility chief of staff, an external provider conducted a focused clinical review of the six patient cases and noted varying levels of potential harm. However, the facility director, the acting facility chief of staff, and the acting deputy chief of quality told the OIG the executive leadership team and quality staff conducted a subsequent comprehensive review and identified no actual harm. The OIG agreed that the facility's review addressed the patient safety concerns.

VHA Response

VHA leaders were aware of potential patient safety risks related to the shortage of radiologists since May 2025; however, leaders did not conduct comprehensive, proactive assessments of the clinical impact on patients awaiting completion of necessary radiology studies.

During interviews, VHA's Deputy Under Secretary for Health and the acting VHA chief of staff acknowledged that delays in completion of radiologic studies creates the potential for patient harm. Further, the May 2025 memorandum requesting exemption of radiologists providing telehealth or virtual care from return to in-person work outlined justifications such as maintaining continuity of, and preventing delays in, patient care, as well as preserving access to clinical services.[32] However, the OIG learned through interviews that prior to the OIG visit, VHA leaders had not implemented systemic plans to assess impacts to patient care related to the loss of radiologists and resulting delays in radiology studies. The Deputy Under Secretary for Health told the OIG of the establishment of a national workgroup to identify radiology service challenges to develop and implement enterprise-wide solutions. As of February 10, 2026, VHA

[32] Acting Under Secretary for Health Department of Veterans Affairs, "Request for Approval for Exemption to Return to Work Requirement for Radiologists," memorandum to the Secretary, May 22, 2025.

leaders outlined a plan for future radiology service goals such as a sustainable workforce model (including recruitment and retention strategies), enterprise-wide image-sharing capabilities, and standardization of clinical workflows and workload distribution.

Conclusion

The OIG substantiated the allegation that most of the facility's diagnostic radiologists resigned, which contributed to delays in completion of radiologic studies and led to two interruptions of facility radiology services. The OIG found that although facility leaders implemented operational steps to manage disruptions to patient care and resolved the backlog of CT studies in approximately four months, leaders did not follow policy requirements for notifying quality management and locally tracking incomplete radiologic studies until the OIG raised concerns. Additionally, VHA leaders acknowledged that delays in radiologic studies create the potential for patient safety risks; however, leaders at multiple levels missed earlier opportunities to assess or mitigate these risks.

The Under Secretary for Health concurred with recommendations 1 and 2 and provided an action plan to implement enterprise-wide standardization of radiology processes, including a unified imaging system and reinforce the requirements of facilities to conduct proactive assessments of how delays in radiology studies affect patient care and report actual or potential harm to quality management staff (see appendix A). The VISN and facility directors concurred in principle with recommendation 3, stating a multidisciplinary team reviews, tracks, and reports incidents involving harm or potential harm from incomplete or delayed radiologic studies, using local tracking and issue briefs. The action plan outlined completion of a comprehensive review of delayed radiologic study interpretation and patient safety event reporting training, as well as the plan to continue audits of delayed studies for six months (see appendixes B and C). The OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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 1–3

1. The Under Secretary for Health ensures the Veterans Health Administration continues plans toward a sustainable workforce model, enterprise-wide image-sharing capabilities, and standardization of clinical workflows and workload distribution.

2. The Under Secretary for Health ensures that leaders at Veterans Health Administration facilities experiencing interruptions in radiology services (1) conduct comprehensive, proactive assessments of the clinical impact to patients awaiting completion of radiology studies; and

(2) report any incidents of harm or potential harm from incomplete radiologic studies to facility quality management leaders for local tracking to reduce patient safety risks.

3. The VA Washington DC Healthcare System Director ensures that any incidents of harm or potential harm from incomplete radiologic studies are reported to facility quality management leaders for local tracking to reduce patient safety risks.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: May 21, 2026

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Review of Radiology Staffing and Services at the VA Washington DC Healthcare System

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report, Review of Radiology Staffing and Services at the VA Washington DC Healthcare System. The Veterans Health Administration (VHA) concurs with the recommendations made to the Under Secretary for Health and provides an action plan in the attachment.

2. VHA remains committed to continually enhancing our processes and tools to deliver the highest-quality care to Veterans. We appreciate your attention to this important area of focus.

3. Comments regarding this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)
John J. Bartrum, JD. MBA

[OIG comment: The OIG received the above memorandum from VHA on May 22, 2026.]

Office of the Under Secretary for Health Response

Recommendation 1

The Under Secretary for Health ensures the Veterans Health Administration continues plans toward a sustainable workforce model, enterprise-wide image-sharing capabilities, and standardization of clinical workflows and workload distribution.

_X _Concur

____Nonconcur

Target date for completion: July 2026

Under Secretary for Health Comments

VHA has currently developed, through its Radiology Solutions Integrated Project Team (IPT) project, national templates and guidance to facilitate cross facility workload sharing at the VISN level and is implementing a long term strategy to unify its current 18 separate imaging information systems into a single enterprise imaging solution which will allow distribution of professional capacity across the enterprise and further standardization of clinical workflows and workflow distribution. In addition, VHA is developing comprehensive guidance for a sustainable workforce model for radiologists, including role-based Return to Office (RTO) exemptions and retention and recruitment strategies.

Recommendation 2

The Under Secretary for Health ensures that leaders at Veterans Health Administration facilities experiencing interruptions in radiology services (1) conduct comprehensive, proactive assessments of the clinical impact to patients awaiting completion of radiology studies; and (2) report any incidents of harm or potential harm from incomplete radiologic studies to facility quality management leaders for local tracking to reduce patient safety risks.

_X _Concur

____Nonconcur

Target date for completion: July 2026

Under Secretary for Health Comments

VHA will develop and issue guidance as part of its national radiology solutions IPT that requires submission of an issue brief and action plan whenever a facility exceeds a national designated threshold of unread exams. This will reinforce the requirements of facilities to (1) conduct comprehensive, proactive assessments of the clinical impact to patients awaiting completion of radiology studies, and (2) report any incidents of harm or potential harm from incomplete

radiologic studies to facility quality management leaders for local tracking to reduce patient safety risks. VHA has developed standard recommendations for action plans to address backlogs in unread exams as well as performance indicators which are communicated twice weekly to field leaders. VHA is developing guidance to facilities and VISNs for extended hours radiologist coverage during nights and weekends.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 21, 2026

From: Director, VA Capitol Health Care Network (10N5)

Subj: Office of Inspector General (OIG) Report, Review of Radiology Staffing and Services at the Veterans Affairs (VA) Washington DC Healthcare System

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54HL04)
Chief Integrity and Compliance Officer (10OIC)

1. I have reviewed and concur with the Office of Inspector General's (OIG's) draft report entitled - Review of Radiology Staffing and Services at the Veterans Affairs (VA) Washington DC Healthcare System and concur in principle with recommendation three.

2. Furthermore, I have reviewed and concur with the Medical Center Director's response and actions to recommendation three. Recommendations one and two were assigned to the Veterans Health Administration for response.

3. Should you need further information, please contact the Quality Management Officer, VA Capitol Health Care Network.

(*Original signed by:*)

Daniel L. Dücker

[OIG comment: The OIG received the above memorandum from VHA on May 22, 2026.]

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 21, 2026

From: Director, VA Washington DC Healthcare System (688)

Subj: Office of Inspector General (OIG) Report, Review of Radiology Staffing and Services at the Veterans Affairs (VA) Washington DC Healthcare System

To: Director, VA Capitol Health Care Network (10N5)

1. We appreciate the opportunity to review and comment on the OIG draft report. The Healthcare System concurs in principle with recommendation three 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 and Patient Safety.

(*Original signed by*:)

Vamsee Potluri, MHA/MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on May 22, 2026.]

Facility Director Response

Recommendation 3

The VA Washington DC Healthcare System Director ensures that any incidents of harm or potential harm from incomplete radiologic studies are reported to facility quality management leaders for local tracking to reduce patient safety risks.

_X _Concur in Principle

____ Nonconcur

Target date for completion: December 2026

Director Comments

The Washington DC VA Healthcare System Director affirms that a multi-disciplinary approach is in place involving the Patient Safety Manager, Risk Management and facility leadership, which involves review of each incident that involves harm or potential harm related to incomplete or delayed radiologic studies. These incidents are tracked locally and reported through submission of an Issue Brief as determined by facility leadership.

To determine current compliance, a comprehensive review of 2,734 radiology records identified a 13% rate (352 records) of delayed interpretations, defined as reads not completed within 7 days of study completion. Importantly, all identified cases had appropriate clinical follow-up when indicated, mitigating risk to patients. To further strengthen reporting and transparency, Joint Patient Safety Reporting (JPSR) training was delivered to Clinical Service Chiefs on December 12, 2025, with reinforcement communication on December 31, 2025.

To ensure ongoing sustainability, a 6-month audit with a goal of 90% compliance with radiology records noted to have delayed interpretations, defined as reads not completed within 7 days of study, will be completed and tracked through the Quality and Patient Safety Council. The numerator will be the number of radiology records compliant with delayed interpretations and the denominator will be the number of delayed interpretations reviewed.

OIG Comments

This recommendation is not intended to prescribe which facility staff must conduct local tracking of incidents of harm or potential harm. Rather, the VA Washington DC Healthcare System Director should ensure that local tracking includes a necessary, preliminary review of the patients awaiting completion of radiologic studies to determine whether harm or potential harm occurred. The OIG considers this recommendation open.

During VHA's review of an OIG draft report, it is usual practice, as outlined in VA OIG GM Directive 308, *Comments to Draft Reports*, for VHA to submit comments for consideration and

discussion. For this report, VHA provided further comments to the OIG after formally responding to the draft report. The OIG considered and reviewed the comments. Based on the review, some changes were made to the report for clarification, but no changes were made to OIG findings.

OIG Contact and Staff Acknowledgments

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