



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in a Patient's
Lung Cancer Screening,
Renal Nodule Follow-Up,
and Prostate Cancer
Surveillance at the VA
Southern Nevada
Healthcare System in Las
Vegas



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Southern Nevada Healthcare System (facility) in Las Vegas to assess an allegation that the facility failed to diagnose and treat a patient's [cancer](#).¹

During the inspection, the OIG identified concerns about potential deficiencies related to the patient's care: specifically lung cancer screening, [renal nodule](#) follow-up, and [prostate cancer surveillance](#); an [oncology](#) consult delay; the copying and pasting of electronic health record notes; and the facility's response to family complaints.

The OIG substantiated that providers failed to make a cancer diagnosis and treat the patient's cancer. The OIG found that providers did not take steps that would have allowed them to make a diagnosis. The OIG determined that after 2017, primary care providers 2 and 3 did not order screening tests, such as chest x-rays or [computerized tomography](#) (CT) scans or both, that may have given the providers the information to make a diagnosis for the patient who was at high risk for lung cancer.

The patient, who was in his seventies, had a history of more than 60 [pack-years](#) of smoking, exposure to [Agent Orange](#) in Vietnam 1966–1968, [chronic obstructive pulmonary disease](#), prostate cancer in 1996 treated with [prostatectomy](#) in 1998, [lung nodules](#), and [mediastinal lymphadenopathy](#).

In late summer 2020, the patient presented, via ambulance, to a community hospital (community hospital 1) emergency department with a complaint of right lower back pain for one week and history of a fall two weeks prior. The emergency department physician suspected [metastasis](#) of prostate cancer. Approximately three weeks later, the patient was admitted to another community hospital (community hospital 2) and found to have left lung primary lung cancer with metastasis to brain, liver, and other areas. A [magnetic resonance imaging](#) of the brain determined the metastasis to likely be from the lung. The patient chose [hospice care](#), was discharged home, and died three weeks later.

The OIG concluded that the patient had known lung cancer risk factors of extensive smoking history and Agent Orange exposure that warranted annual screening. The OIG did not find evidence beyond 2013 that [pulmonology](#) staff followed up with the patient or scheduled pulmonology appointments, or that after 2017, primary care providers 2 or 3 addressed the patient's high risk for lung cancer by ensuring completion of annual screening. During interviews, facility leaders told the OIG that some providers followed the U.S. Preventive

¹ The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

Services Task Force recommendations for lung cancer screening; however, the facility had no set requirements for lung cancer screening.²

The OIG determined that primary care providers 2 and 3 did not follow up on the patient's care as recommended by [Radiology](#) Service staff after finding on a fall 2017 chest CT scan that a renal nodule had increased in size. Primary Care Provider 2 failed to take action on the patient's abnormal imaging finding of a renal nodule by not referring the patient to [Urology](#) Service. Primary care providers 2 and 3 did not discuss the abnormal chest CT scan during subsequent appointments with the patient. Primary Care Provider 2 was no longer employed by VA and did not respond to requests for an interview with the OIG.³ Primary Care Provider 3 told the OIG that a provider has a responsibility to review information contained in a patient's electronic health record and acknowledged having reviewed Pulmonary Service notes but not the patient's fall 2017 CT scan or the diagnostic interpretation. Primary Care Provider 3 also told the OIG that another provider ordered the fall 2017 CT scan and the ordering provider would receive a notification with the results of the chest CT scan.

The OIG found that after summer 2016, the patient did not have annual [prostate-specific antigen](#) (PSA) testing completed at the facility to check for prostate cancer recurrence. The OIG determined that the yearly PSAs for 2017 and 2018 were ordered; however, the orders were marked as lapsed.⁴ Primary Care Provider 3 told OIG that sometimes patients do not complete ordered laboratory tests. The OIG concluded that due to the patient's history of prostate cancer with prostatectomy, annual PSAs were warranted but not completed. However, the patient's PSA result in early fall 2020 was within normal limits (less than 0.04 ng/mL), indicating no signs of prostate cancer recurrence.

The OIG determined that in late summer 2020, Primary Care Provider 3 delayed ordering an oncology consult for 25 days after the patient requested the consult despite being aware of the patient's request for an oncology appointment. Primary Care Provider 3 received the patient's non-VA hospital medical records eighteen days prior to ordering the oncology consult, which included information about a new diagnosis of suspected metastasis of the prostate cancer. Primary Care Provider 3 reported there was a delay in receiving the non-VA hospital medical records, and could not recall why the oncology consult was not placed sooner.

The OIG determined that Primary Care Provider 3 copied and pasted documentation from Primary Care Provider 2's electronic health record entry regarding the patient's lung nodules. Primary Care Provider 3 told the OIG of having not reviewed the patient's fall 2017 CT scan results and copied and pasted the lung nodule information because documentation would be

² U.S. Preventive Services Task Force. The patient began receiving care for lung abnormalities in 2011. The task force guidelines for annual low-dose CT scans were published in 2014.

³ The OIG does not have testimonial subpoena power to compel the testimony of those who are not VA employees.

⁴ The last PSA ordered for the patient was at the end of 2018.

difficult without the exact wording. The OIG did not find evidence of documentation in the electronic health record that Primary Care Provider 3 assessed the current status of the patient's lung nodules and updated the plan of care at each clinic visit, as required.

A family member contacted a facility [patient advocate](#) in early fall 2020 to request care for the patient and submitted a White House VA Hotline complaint one week later to report that the patient had been misdiagnosed. The Assistant Chief of Medicine documented in an email not having a phone number for the family member and having contacted the patient twice, discussed the patient's recent cancer diagnosis, and expressed empathy in response to the patient's frustration and anger with the government because of being exposed to Agent Orange while serving in Vietnam. Despite not contacting the family, facility staff documented resolution of the family member's contacts in the Patient Advocate Tracking System.⁵

After the OIG's notification of the hotline inspection, the facility initiated peer reviews of several providers to determine whether the care they provided to the patient was appropriate. The OIG found that the facility peer reviewers, Peer Review Committee, and supervisors of the primary care providers completed the peer review requirements in accordance with peer review findings and Veterans Health Administration (VHA) policy.

The OIG made five recommendations to the Facility Director related to evaluation of primary care and pulmonology processes for lung cancer screening and follow-up care; follow-up for abnormal radiology findings; surveillance for patients who have undergone prostatectomy; review of copy and paste practices and plan of care documentation in the electronic health record; and review of complaint reporting and responding.

Comments

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes B and C for the Directors' comments.) The OIG will follow up on the planned actions until they are completed.



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⁵ VHA Handbook 1003.04, *VHA Patient Advocacy*, February 7, 2018. The Patient Advocate Tracking System is a computerized program used to document complaints, facility responses, and resolutions to complaints.

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Abbreviations

CT	computerized tomography
EHR	electronic health record
ml	milliliter
MRI	magnetic resonance imaging
ng	nanogram
OIG	Office of Inspector General
PACT	patient aligned care team
PET	positron emission tomography
PSA	prostate-specific antigen
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations that providers failed to diagnose and treat a patient's [cancer](#) at the VA Southern Nevada Healthcare System (facility) in Las Vegas.¹

Facility Background

The facility, part of Veterans Integrated Service Network (VISN) 21, has a medical center with 110 operating hospital beds providing medical, surgical, and mental health services in North Las Vegas.² The facility has seven outpatient clinics (Southwest, Northeast, and Northwest located in Las Vegas; Southeast located in Henderson; and three others located in North Las Vegas, Pahrump, and Laughlin, Nevada). From October 1, 2019, through September 30, 2020, the facility served 64,736 unique patients.

Veterans Health Administration Primary Care

The Veterans Health Administration (VHA) describes Primary care as "...the provision of integrated, accessible health care services by health care professionals accountable for addressing a large majority of personal health care needs" and includes the "diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, post deployment care, and patient and caregiver education."³ Primary care providers are "physicians, advanced practice registered nurses, and physician assistants who provide primary care to an assigned panel of patients and in accordance with licensure, privileges, scope of practice or functional statement."⁴ Primary care providers are responsible for offering, providing, and arranging patient care for clinically indicated services.⁵ Primary care providers are members of the Patient Aligned Care Team (PACT), a team of healthcare

¹ The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

² VHA Office of Productivity, Efficiency and Staffing, "Facility Complexity Level Model Fact Sheet," accessed January 5, 2021. Medical Center Memorandum 11-18-14, *Provision of Care, Treatment, and Services*, December 2018.

³ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014. The handbook was in effect during the time of the events discussed in this report that occurred prior to May 26, 2017. The handbook was amended on May 26, 2017. Unless otherwise specified, the two policies contain same or similar language related to PACT services.

⁴ VHA Handbook 1101.10(1); VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 13, 2017.

⁵ VHA Handbook 1101.10(1).

professionals who collaborates with patients and their support person(s) and “coordinates comprehensive health care services consistent with agreed upon goals of care.”⁶

Allegations and Related Concerns

On October 1, 2020, the OIG received an allegation that the facility failed to diagnose and treat a patient's cancer. The OIG initiated a healthcare inspection to evaluate the allegation and identified concerns related to the patient's care: specifically, lung cancer screening, [renal nodule follow-up](#), [prostate cancer surveillance](#), and an [oncology](#) consult delay; the copying and pasting of electronic health record (EHR) notes; and the facility's response to family complaints.

Scope and Methodology

The OIG initiated a healthcare inspection on January 4, 2021, and conducted a virtual site visit March 1–4, 2021.

The OIG team interviewed the complainant; the facility's Chiefs of Staff, Health Information Management, [Radiology](#), Medicine, Oncology, [Urology](#), and Quality Management; the Assistant Chief of Medicine; the Acting Chief of Primary Care; PACT primary care providers and nurses; and a [pulmonologist](#), as well as other staff knowledgeable about the patient's care.

The OIG received and reviewed the patient's non-VA medical records and the patient's VHA EHR for the period 2011 through 2020. The OIG also reviewed relevant VHA and facility policies and procedures: committee minutes, the facility's [service line agreements](#) between Primary Care and [Pulmonology](#) Services, and between Primary Care and Urology Services; [patient advocate](#) complaints; peer reviews; selected medical literature on lung cancer, renal nodules, and [prostate-specific antigens](#) (PSA); email communication; and relevant quality and administrative reports.⁷

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.

⁶ VHA Handbook 1101.10(1).

⁷ The OIG subpoenaed the patient's non-VA medical records directly from the non-VA facilities after noting that not all of the non-VA records had been scanned into the patient's VA EHR.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence 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.

Patient Case Summary

The patient who was in his seventies had a history of more than 60 [pack-years](#) of smoking, exposure to [Agent Orange](#) in Vietnam 1966–1968, [chronic obstructive pulmonary disease](#), prostate cancer in 1996 treated with [prostatectomy](#) in 1998, [lung nodules](#), and [mediastinal lymphadenopathy](#).

The patient's health care was managed by three primary care providers from 2011 through 2020. In early 2011, after the initial patient visit at the Southwest Clinic, Primary Care Provider 1 ordered a baseline chest x-ray that showed a possible [malignancy](#). Radiology Service staff suggested further evaluation with a chest [computerized tomography](#) (CT) scan. The chest CT scan results indicated "Prominent diffuse [bilateral hilar](#) and mediastinal adenopathy" and lung nodules in both lungs, and Radiology Service staff recommended a [positron emission tomography](#) (PET) scan. The following month, the patient had the PET scan that showed mediastinal [lymph nodes](#) suspicious for a malignant process.

After Primary Care Provider 1 ordered a pulmonology consult in spring 2011, a pulmonologist evaluated the patient twice the following month 2011 and performed a [biopsy](#), and the results were nondiagnostic. The pulmonology note showed "the patient most likely has [carcinoma](#) of the lung or [lymphoma](#). For definite diagnosis, [mediastinoscopy](#) for lymph node biopsy is indicated." The pulmonologist referred the patient to a [thoracic](#) surgeon for consultation.⁸

In late spring 2011, a thoracic surgeon saw the patient and completed the biopsy of the lymph nodes. The results of the biopsy were negative for [infections](#) or cancer, and the pulmonologist advised the patient to continue follow-up visits with primary care and pulmonology.

During 2012 and 2013, Primary Care Provider 1 evaluated the patient for multiple medical conditions and monitored PSA for recurrence of prostate cancer. Primary Care Provider 1 also monitored the patient for lung cancer symptoms and advised smoking cessation. During several clinic visits, Primary Care Provider 1 encouraged the patient to see the pulmonologist for history

⁸ For this report, the terms "thorax" and "chest" are used interchangeably.

of lung nodules. In spring 2013, the pulmonologist evaluated the patient, and counseled him to stop smoking, and instructed him to follow up in one year.

One year later, the patient had a chest x-ray in spring 2014 that showed “Mild lobular increased soft tissue...likely associated with previously described mediastinal adenopathy.” A chest CT scan was performed two months later and did not show changes compared to a prior chest CT scan. Five months later, in late 2014, during a follow-up appointment, Primary Care Provider 1 reviewed the results of the chest CT scan, noted that follow-up with the pulmonologist was required, and encouraged the patient to quit smoking. Primary Care Provider 1 documented the last PSA test was normal and that a current PSA test was due.⁹

In summer 2015, Primary Care Provider 1 evaluated the patient for a skin problem. Primary Care Provider 1 checked the PSA test, which was interpreted as normal, and instructed the patient to follow up with the pulmonologist. The next return to primary care clinic was planned for 12 months.

In early fall 2016, the patient requested laboratory test results during a clinic visit. Primary Care Provider 1 reviewed the laboratory test results from summer 2016, including the last PSA test result; discussed cessation of smoking; ordered a chest CT scan; and encouraged follow-up with the pulmonologist. The patient declined the pulmonology follow-up.

In spring 2017, the patient had a chest CT scan that showed a decrease of left lung nodules and multiple small nodules in the right lung. Radiology Service staff recommended a follow-up visit in six months.

Four months later, in summer 2017, the patient was seen by Primary Care Provider 2 at the Southeast Clinic.¹⁰ During this visit, Primary Care Provider 2 evaluated the patient for chronic obstructive pulmonary disease and history of lung nodules. Primary Care Provider 2 added a medication for the chronic obstructive pulmonary disease and ordered a six-month chest CT scan for surveillance of the lung nodules. Primary Care Provider 2 did not order a PSA test to monitor for recurrence of prostate cancer. Primary Care Provider 2 offered the patient a tobacco cessation clinic and recommended a return-to-clinic appointment in six months.

In fall 2017, the surveillance chest CT scan was completed and showed the mediastinal lymph nodes and left upper lung nodules were stable compared to previous imaging.¹¹ Radiology Service staff noted a nodule within the right kidney had “slightly increased in size” since 2014, and recommended a CT scan of the abdomen. Four days later, Primary Care Provider 2 entered a

⁹ An elevated postprostatectomy PSA value of greater than 0.2 nanograms per milliliter (ng/ml) indicates recurrence of prostate cancer, *PSA Levels After Prostatectomy and Expected Results*, Robotic Oncology, accessed March 18, 2021, <https://www.roboticoncology.com/news/psa-after-prostatectomy/>. The patient's PSA was 0.02 ng/ml.

¹⁰ Due to closer proximity of the clinic, the patient began receiving care at the Southeast clinic.

¹¹ The chest CT also captured partial images of the kidney as the upper kidney and lower lungs shared similar planes on scanning.¹¹

note in the EHR and added Primary Care Provider 1 as an additional signer with the statement “CT thorax for your review.”

Primary Care Provider 1 ordered a CT scan of the abdomen and pelvis eight days after the surveillance chest CT scan to gather more information about the right renal (kidney) nodule. The same day, Primary Care Provider 1 sent a notification letter to the patient that contained a copy of the Radiology Service's findings and impressions from the fall 2017 chest CT scan. Primary Care Provider 1 recommended completion of the next chest CT scan in spring 2019 or sooner if new symptoms presented. The letter also stated that an abdominal CT scan was ordered “to check out the right kidney nodule.” The patient was instructed to contact Radiology Service to schedule the CT scan. Approximately two and one-half weeks later, an administrative staff member canceled the abdominal and pelvic CT scan order after being unable to contact the patient and schedule an appointment.¹²

In spring 2018, the patient had a follow-up appointment with Primary Care Provider 2. From end of 2018 through end of 2019, the patient had three clinic visits with Primary Care Provider 3 for reevaluation and follow-up of chronic medical conditions.¹³

Based on the patient's non-VA records, in late summer 2020, the patient presented via ambulance to a community hospital (community hospital 1) emergency department with a complaint of right lower back pain for one week and history of a fall two weeks prior. The physical exam described a three centimeter mass on the patient's back (thoracic area), freely movable without [erythema](#) or tenderness. An x-ray of the thoracic spine showed “probable [sclerotic](#) bone [lesion](#) at T8. This may correlate with the reported history of prostate cancer.” The emergency department physician suspected [metastasis](#) of the prostate and discussed the findings with the patient. The discharge paperwork included information about “Prostate cancer: Treating Cancer That Has Spread,” and instructions to follow up in one to two days with a urologist.

Two days later, a PACT nurse called the patient and discussed the patient's recent emergency department visit, which the patient reported making for complaints of back pain from a “new problem with a protruding disk” and was told of having possible metastasis of the previous prostate cancer.¹⁴ During the call, the patient requested an oncology consult. The PACT Nursing Telephone Note showed the patient had a scheduled primary care appointment in 18 days and the patient denied other medical problems or complaints.

¹² VHA Directive 1230(3), *Outpatient Scheduling Processes and Procedures*, July 15, 2016. Scheduling staff attempted to contact the patient by phone, sent a letter with no response from the patient, and after 14 days canceled the order according to policy.

¹³ The patient was assigned to a different PACT team at the Southeast Clinic from fall 2018 through fall 2020.

¹⁴ An emergency department physician at community hospital 1 informed the patient of suspected metastasis from the prostate. Subsequent imaging showed radiological changes that were more consistent with metastasis from a primary lung cancer rather than the prostate.

Later that month, during the scheduled appointment, Primary Care Provider 3 documented the patient's visit to community hospital 1's emergency department, the finding of a mass along the right lower spine, and the diagnosis of suspected metastasis of prostate cancer. The plan was to refer the patient to rehabilitation for back pain and order a urology consult.¹⁵

Two days later, the patient was taken to community hospital 1's emergency department via ambulance for bilateral lower leg swelling with weakness and history of falls (last fall one week prior). The emergency department medical record notes showed normal vital signs and described the thoracic nodules on the back and bilateral lower leg [edema](#). An emergency department physician documented a [neurological](#) exam with no concerns or findings.

The emergency department physician ordered laboratory tests, chest x-ray, [electrocardiogram](#), and CT scans of the spine, abdomen/pelvis, and brain. The medical record showed additional orders for [nuclear medicine bone scan](#), [magnetic resonance imaging](#) (MRI) of the brain, [interventional radiology](#) lung biopsy, and consults for [hematology](#)/oncology, pulmonology, and neurology. The CT scan results showed left lung primary lung cancer with metastasis to brain, liver, and other areas.

After evaluation, the patient was admitted to community hospital 1 and treatment was initiated for [intracranial hemorrhage](#), lung mass, [encephalopathy](#), metastatic disease, [pulmonary embolism](#), [deep vein thrombosis](#), lower legs edema, and chronic obstructive pulmonary disease.

Within 25 hours of admission, the patient was transferred emergently to another community hospital (community hospital 2) for a [neurosurgery](#) consultation of brain metastasis and confusion. The patient was admitted to community hospital 2's intensive care unit and evaluated by neurosurgery. An MRI was ordered to document the location of brain lesions.

The neurosurgery consultant at community hospital 2 found the patient was not a candidate for surgery and requested an oncology consult. The oncologist explained to the patient that a biopsy followed by [chemotherapy](#) or [radiation](#) would not extend quality of life. An [inferior vena cava filter](#) was placed to prevent deep vein thrombosis from traveling to the lungs. The patient chose [hospice care](#), was discharged home, and died three weeks later.

Appendix A contains a timeline of the events related to the patient's care from 2011 through 2020.

¹⁵ Three days after the patient's oncology consult request, primary care provider 3 requested the patient's community hospital 1 medical records, which were received four days later. A facility file clerk scanned the community hospital 1 medical records into the EHR five weeks later.

Inspection Results

1. Deficiencies in the Patient's Care and a Delay in Consult

The OIG substantiated that providers failed to make a cancer diagnosis and treat the patient's cancer. Specifically, the OIG found that providers did not take steps that would have allowed them to make a diagnosis. The OIG determined that primary care providers 2 and 3 did not order screening tests for the patient who was high risk for lung cancer, follow up on Radiology Service's recommendation for the patient to have a CT scan of the abdomen based on a finding of a renal nodule that had increased in size, or follow prostate cancer surveillance guidelines. In addition, Primary Care Provider 3 delayed ordering an oncology consult for 25 days after the patient requested the consult.

Deficiencies in Screening for Lung Cancer in the High-Risk Patient

The OIG determined that after 2017, primary care providers 2 and 3 did not order screening tests, such as chest x-rays or CT scans or both, that may have given the providers the information to make a diagnosis for the patient who was high risk for lung cancer.

The U.S. Preventive Services Task Force recommends that patients ages 55–80 years with a 30 pack-year or more smoking history need to undergo lung cancer screening annually with low-dose CT scan and stop screening once a person has not smoked for 15 years.¹⁶ During interviews, facility leaders told the OIG that some providers followed the U.S. Preventive Services Task Force recommendations for lung cancer screening; however, the facility had no set requirements for lung cancer screening.¹⁷

The facility's Primary Care and Pulmonology Service Line Agreement outlines that if a primary care provider determines a patient should be seen by a pulmonologist, the primary care provider requests a pulmonology consult. The pulmonologist determines whether the patient should receive pulmonary treatment until resolution or stabilization, or referral to other subspecialties for further treatment.

The OIG reviewed the patient's EHR and found that during the initial visit with the patient in 2011, Primary Care Provider 1 ordered a chest CT scan for an abnormality found on a chest x-ray. The patient had a mediastinoscopy that established the patient did not have malignant processes. In spring 2013, the patient was evaluated by a pulmonologist, counseled for smoking, and instructed to follow up with pulmonology in one year. After spring 2013, there was no EHR

¹⁶ U.S. Preventive Services Task Force, *Screening for Lung Cancer: Recommendation Statement*, July 2014.

¹⁷ U.S. Preventive Services Task Force. The patient began receiving care for lung abnormalities in 2011. The task force guidelines for annual low-dose CT scans were published in 2014.

documentation that pulmonology followed up with the patient or any pulmonology appointments were scheduled.

Follow-up chest CT scans in 2014 and 2017 ordered by the primary care providers noted the patient's right middle lobe lung nodules to be unchanged and the left lung nodule had no progression since 2017.¹⁸ Primary Care Provider 2 saw the patient in spring 2018, and Primary Care Provider 3 saw the patient for five consecutive appointments from end of 2018 through early fall 2020 and did not discuss the risk factors of, or a plan for, further lung cancer screening. After 2017, primary care providers 2 and 3 did not order chest CT scans or chest x-rays to screen for lung cancer.

During an interview with the OIG, a facility pulmonologist stated that low-dose CT scans are performed for early detection of lung cancer in patients who are smokers. The Chief of Staff told the OIG that the facility is just starting to perform low-dose CTs for lung cancer screening and relies on community care because the facility has a high volume of CT scans. The Acting Chief of Primary Care was aware of the U.S. Preventive Services Task Force guidelines that recommend low-dose CT scans for lung cancer screening in patients who are high risk; however, stated that the facility does not currently have a requirement for providers to order the low-dose CT scan. The Chief of Medicine told the OIG that given the patient's "extensive smoking history," annual CT screenings would be expected.

The OIG concluded that the patient had known lung cancer risk factors of extensive smoking history and Agent Orange exposure that warranted annual screening. The OIG did not find evidence beyond 2013 that pulmonology staff followed up with the patient or scheduled pulmonology appointments. The OIG did not find evidence that after 2017, primary care providers 2 or 3 addressed the patient's high risk for lung cancer by ensuring completion of annual screening. The OIG determined that without annual lung cancer screening in a high-risk patient, early signs and symptoms of lung cancer might go undetected and treatment would be delayed.

Failure to Follow Up on the Patient's Renal Nodule

The OIG determined that primary care providers 2 and 3 did not follow up on the patient's care as recommended by Radiology Service staff after finding on a fall 2017 chest CT scan that a renal nodule had increased in size. Primary Care Provider 2 failed to take action on the patient's abnormal imaging finding of a renal nodule by not referring the patient to Urology Service. Primary care providers 2 and 3 did not discuss the abnormal chest CT scan during subsequent appointments with the patient.

¹⁸ The right lower lobe lung nodules were 2 and 3 millimeters in size.

VHA policy requires the ordering provider to “initiat[e] appropriate clinical action and follow up for any orders that they have placed.”¹⁹ The facility’s Urology Service Agreement requires the primary care provider to consult general urology within 14 days of a renal mass found on imaging. The minimum primary care provider evaluation should include a CT scan with and without contrast if there is a suspected renal mass.²⁰

The OIG reviewed the patient’s EHR and found that Primary Care Provider 2 saw the patient at the Southeast Clinic in summer 2017 and ordered a chest CT scan that was completed in fall 2017 that showed a renal nodule had increased in size from 2014. Four days later, Primary Care Provider 2 entered a note in the EHR and added Primary Care Provider 1 as an additional signer with the statement “CT thorax for your review.”²¹ After four additional days Primary Care Provider 1 documented notifying the patient of the imaging finding of the increased renal nodule and ordered a follow-up abdominal CT scan in accordance with the Radiology Service’s recommendation. The abdominal CT scan order was canceled after the patient did not respond to staff’s attempts to contact the patient to schedule the patient’s abdominal CT scan.

The OIG found that the patient attended an appointment with Primary Care Provider 2 in spring 2018, and five primary care appointments with Primary Care Provider 3 between late 2018 and fall 2020. During those visits, there was no documented evidence of a discussion with the patient about the need for an abdominal CT scan due to an increased size of a renal nodule, and the abdominal CT scan was not reordered. No further imaging studies were ordered to follow up on the increased size of the renal nodule.

Primary Care Provider 1 told the OIG of no longer being the patient’s provider as of fall 2016, when the patient transferred to the Southeast Clinic and could not recall why Primary Care Provider 2 did not order the CT scan to evaluate the renal nodule. Effective summer 2018, Primary Care Provider 2 was no longer employed by VA and did not respond to requests for an interview with the OIG.²² Primary Care Provider 3 told the OIG that a provider has a responsibility to review information contained in a patient’s EHR and acknowledged having reviewed Pulmonary Service notes but not the patient’s fall 2017 CT scan or the diagnostic interpretation. Primary Care Provider 3 also told the OIG that another provider ordered the fall 2017 CT scan and the ordering provider would receive a notification with the results of the chest CT scan. The Chief of Medicine and the Acting Chief of Primary Care told the OIG that they

¹⁹ VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

²⁰ Facility Policy, *VA Southern Nevada Healthcare System (VASNHS) Service Line Agreement Primary Care & Urology*, January 3, 2005.

²¹ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. An additional signer is used to alert clinicians to patient information. The patient’s last appointment with primary care provider 1 was in fall 2016. In late 2017, primary care provider 1 requested PACT reassignment for the patient who had transferred to the Southeast clinic.

²² The OIG does not have testimonial subpoena power to compel the testimony of those who are not VA employees.

found no documentation in the patient's EHR that a primary care provider at the Southeast Clinic addressed the renal nodule in the abnormal CT scan.

During interviews, the OIG learned the Acting Chief of Primary Care would have probably documented the size of the renal nodule and that, after noticing the CT scan of the abdomen was canceled, might have reordered the CT scan. The Chief of Staff reviewed the patient's EHR and told the OIG that Primary Care Provider 2 should have been aware of the patient's history and discussed scheduling the Radiology Service appointment with the patient. Further, the Chief of Staff told the OIG this was a missed opportunity that Primary Care Provider 3 failed to address the increase in size of the renal nodule.

The OIG concluded that primary care providers 2 and 3 did not follow up on the Radiology Service's recommendation for the patient to have an abdominal CT scan and did not consult Urology Service in accordance with the Urology Service Agreement after the patient's fall 2017 chest CT scan showed an increase in the size of the right renal nodule.

Failure to Follow Prostate Cancer Surveillance Guidelines

The OIG found that after summer 2016 the patient did not have annual PSA testing completed at the facility to check for prostate cancer recurrence. The Prostate Cancer Foundation notes that a PSA should be undetectable in a patient who underwent a prostatectomy.²³ The Chief of Urology told OIG that in patients who have had a prostatectomy, PSAs should be monitored annually. The OIG determined that the yearly PSAs for 2017 and 2018 were ordered; however, the orders were marked as lapsed.²⁴ Primary Care Provider 3 told the OIG that sometimes patients do not complete ordered laboratory tests.

The patient's PSA result, less than 0.04 ng/mL, from community hospital 1 in fall 2020 was within normal limits, indicating no signs of prostate cancer recurrence. Initially, the patient was diagnosed with metastasis from the prostate, but subsequently, the patient had an MRI at community hospital 2 and the metastasis was determined to be from the lung. The OIG concluded that due to the patient's history of prostate cancer with prostatectomy, annual PSAs were warranted but not completed.

Delayed Oncology Consult

The OIG determined that in fall 2020, Primary Care Provider 3 ordered a routine oncology consult 25 days after the patient requested an oncology consult.

²³ "Is your PSA Rising?" Prostate Cancer Foundation, accessed March 25, 2021, <https://www.pcf.org/about-prostate-cancer/diagnosis-staging-prostate-cancer/psa-rising/>.

²⁴ Late 2018 was the last PSA ordered for the patient.

VHA policy requires consult processes to be “timely” including pre-work required by the Care Coordination Agreement.²⁵ The Primary Care-Hematology/Oncology Clinic Service Line Agreement warrants a high priority referral within one week to confirm a cancer diagnosis.²⁶

The OIG found that two days after the patient's visit to community hospital 1's emergency department a PACT nurse called the patient and documented in the EHR that the patient reported having a new problem with a protruding disk causing back pain and may now have metastasis of cancer. During the call, the patient requested a telephone appointment with Primary Care Provider 3 and an oncology consult. The PACT nurse documented in the EHR that the patient had an appointment with Primary Care Provider 3 in 18 days. Three days after the patient's request, Primary Care Provider 3 signed the PACT nurse's EHR note and requested the patient's community hospital 1 medical records, which were received four days later.

During the patient's early fall 2020 telephone appointment, Primary Care Provider 3 documented in the EHR that the patient presented to community hospital 1's emergency department earlier in the month, and that a mass along the right lower spine was found and the patient was diagnosed with “suspected isolated metastasis” of prostate cancer. Primary Care Provider 3 ordered a routine oncology consult 25 days after the patient's request.

The Chief of Hematology and Oncology Service told the OIG of having accepted the consult placed by Primary Care Provider 3 and recalled that the consult indicated that the patient had been to a community hospital and had prostate cancer. The Chief of Hematology and Oncology Service also reported that no one had called and requested that the patient be seen right away or evaluated within a week. During an interview, Primary Care Provider 3 reported there was a delay in receiving the community hospital 1 medical records, and could not recall why the oncology consult was not placed sooner.

The facility oncologist accepted the consult the day after it was ordered. Nineteen days later, the oncology consult was canceled due to the facility not being able to reach the patient. The patient died two days later.

The OIG found that Primary Care Provider 3 did not order the patient's oncology consult until approximately three weeks after being aware of the patient's request for an oncology appointment. Primary Care Provider 3 received the patient's community hospital 1 medical records in late summer 2020 that included information about a new diagnosis of suspected metastasis of the prostate cancer. The OIG determined that an earlier appointment with oncology would not have changed the patient's outcome but may have improved the patient's quality of life.

²⁵ VHA Directive 1243(2), *Consult Processes and Procedures*, August 24, 2016.

²⁶ Facility Policy, Primary Care-Hematology/Oncology Service Line Agreement Protocol, May 5, 2005.

2. Primary Care Provider's Misuse of Copy and Paste

The OIG determined that Primary Care Provider 3 copied and pasted documentation from Primary Care Provider 2's EHR entry regarding the patient's lung nodules.

VHA states that facility directors are responsible for “ensuring the elimination or [judicious](#) use of copy and paste.”²⁷ VHA cautions that “Clinical, ethical, financial, and legal problems may result when text is copied in a manner that implies the author or someone else...documented a plan of care when the author or someone else did not personally collect the information at the time the visit is documented.”²⁸

The OIG reviewed the patient's EHR and found that in spring 2018, Primary Care Provider 2 documented the exact wording from the fall 2017 imaging report regarding the “stable” lung nodule finding. Subsequently, Primary Care Provider 3 documented the exact wording used by Primary Care Provider 2 five times in the EHR assessment and plan after the patient's clinic visits in late 2018 to fall 2020. The OIG did not find evidence of documentation in the EHR that Primary Care Provider 3 assessed the current status of the patient's lung nodules and updated the plan of care at each clinic visit. Primary Care Provider 3 told the OIG of having not reviewed the patient's fall 2017 CT scan and having copied and pasted the lung nodule information because documentation would have been difficult without the exact wording.

Primary Care Provider 2 and 3's misuse of copy and paste coupled with Primary Care Provider 3's failure to update a current plan of care to address the patient's high risk for lung cancer resulted in a missed opportunity by the primary care providers to identify and address potential changes in the patient's health status.

²⁷ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. “Copy and paste means duplicating selected text or graphic(s) and inserting it in another location, leaving the original unchanged.”

²⁸ VHA Handbook 1907.01.

3. Facility Review of the Patient's Care

Family Member Complaints

A family member contacted a facility patient advocate in fall 2020 to request care for the patient and submitted a White House VA Hotline complaint the following month to report that the patient was misdiagnosed.²⁹

VHA patient advocacy policy requires that after receipt of a complaint, the facility will provide a response to the complainant, which addresses the complaint issues, within seven days of receipt.³⁰

The OIG found that in fall 2020, the facility patient advocate created an entry in the facility's Patient Advocate Tracking System that indicated the family member requested to speak with someone regarding the patient's condition and discharge from the community hospital.³¹ The following day a PACT registered nurse (RN) documented in the EHR having called the family member to follow up on a request to discuss the patient's care. The PACT RN was unable to reach the family member and left a voice mail requesting a return call. Two days later, a PACT RN made a post-hospital discharge call to the patient who told the RN of not wanting to have anything to do with the VA. Later that week, facility patient advocacy staff documented the PACT RN's contact and discussion with the patient in the Patient Advocate Tracking System and closed the complaint.

The family member submitted a White House Hotline complaint and indicated that the facility misdiagnosed the patient with "just swelling in the legs and arthritis of the hips" and that during the recent community hospitalization, the patient was diagnosed with cancer. The same day, the Assistant Chief of Medicine documented in an email not having a phone number for the family member and having contacted the patient twice, discussed the patient's recent cancer diagnosis, and expressed empathy in response to the patient's frustration and anger with the government because of being exposed to Agent Orange while serving in Vietnam. A Medicine Service Administrative staff member entered information from the Assistant Chief of Medicine's

²⁹ VHA Handbook 1003.04, *VHA Patient Advocacy*, February 7, 2018. A patient advocate provides facility level response to customer concerns and documents compliments and complaints in the Patient Advocate Tracking System, an electronic tracking system. VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. In 2007, VHA established the National Veterans Suicide Prevention Hotline, known as the Veterans Crisis Line, to assist patients or persons concerned about patients in crisis. White House VA Hotline, accessed March 2, 2021, <https://www.va.gov/ve/whvaHotline.asp>. After receipt of a complaint from the White House VA Hotline, the call taker inputs the complaint into the Patient Advocate Tracking System for the facility to review, address, and resolve.

³⁰ VHA Directive 1003.04. Facility Policy VE-19-01, *Patient Advocate and Patient Advocate Liaison Program*, February 2019.

³¹ VHA Handbook 1003.04. The Patient Advocate Tracking System is a computerized program used to document complaints, facility responses, and resolutions of complaints.

discussions with the patient in the Patient Advocate Tracking System. Four days after the receipt, a VISN staff member responsible for reviewing National White House Call Center Complaints closed the complaint in the Patient Advocate Tracking System information.

The family member told the OIG of having received a call from the facility shortly after the patient was discharged from community hospital 2 and twice after the patient was deceased to schedule appointments for the patient. However, the family member indicated that no one from the facility made contact to discuss the request to speak to someone regarding the patient's condition or the complaint about the patient's care.

Despite not contacting the family, facility staff documented resolution of the family member's contacts in the Patient Advocate Tracking System. A discussion with and response to the family member would have afforded an opportunity for the facility to address the family member's complaint of the patient being misdiagnosed and to review the patient's care.

Facility Protected Peer Reviews

After the OIG's notification of the hotline inspection, the facility initiated peer reviews of several providers to determine whether the care they provided to the patient was appropriate.³²

Peer review is a confidential process to evaluate the performance of healthcare professionals. It is intended to be non-punitive "and can result in both short-term and long-term improvements in patient care by revealing areas of improvement in the provision of health care of one or multiple clinicians."³³ VHA requires that when the Peer Review Committee assigns a Level 2 or Level 3 to peer review cases "the supervisor of the individual(s) that was assigned a Level 2 or a Level 3 will communicate with the individual(s)... and ensure that appropriate action is implemented."³⁴

The OIG found that the facility peer reviewers, Peer Review Committee, and supervisors of the primary care providers completed the peer review requirements in accordance with peer review findings and VHA policy.

Conclusion

The OIG substantiated that providers failed to make a cancer diagnosis and treat the patient's cancer. Specifically, the OIG found that providers did not take steps that would have allowed

³² VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. The peer review process is a focused review designated as a confidential and privileged quality management activity under 38 USC 5705 and therefore not discussed in this report.

³³ VHA Directive 1190.

³⁴ VHA Directive 1190. A level of care is assigned by the initial peer reviewer and by the Peer Review Committee after the committee's evaluation and discussion of the initial review and episode of care. "Level 2 is the level at which most experienced and competent clinicians might have managed the case differently but remains within the standard of care." "Level 3 is the level at which most experienced and competent clinicians would have managed the case differently."

them to make a diagnosis. The OIG concluded that the patient had known lung cancer risk factors of extensive smoking history and Agent Orange exposure that warranted annual screening. The OIG did not find evidence beyond 2013 that pulmonology staff followed up with the patient or scheduled any pulmonology appointments. The OIG did not find evidence that after 2017, primary care providers 2 or 3 addressed the patient's high risk for lung cancer by ensuring completion of annual screening. The OIG determined that without annual lung cancer screening in a high-risk patient, early signs and symptoms might go undetected and treatment would be delayed.

The OIG concluded that primary care providers 2 and 3 did not follow up on Radiology Service staff's recommendation for the patient to have an abdominal CT scan and did not consult with Urology Service staff after the patient's fall 2017 chest CT scan showed an increase in the size of the right renal nodule.

The OIG found that after summer 2016, the patient did not have annual PSA testing completed at the facility to check for prostate cancer recurrence. The OIG concluded that due to the patient's history of prostate cancer with prostatectomy, annual PSAs were warranted but not completed. However, the patient's PSA result in fall 2020 was within normal limits (less than 0.04 ng/mL), indicating no signs of prostate cancer recurrence.

The OIG determined that in late summer 2020, Primary Care Provider 3 ordered a routine oncology consult 25 days after the patient requested an oncology consult. The OIG found that Primary Care Provider 3 did not order the patient's oncology consult until three weeks later despite being aware of the patient's request for an oncology appointment. Primary Care Provider 3 received the patient's community hospital 1 medical records in late summer 2020, which included information about a new diagnosis of suspected metastasis of the prostate cancer. The OIG determined that an earlier appointment with oncology would not have changed the patient's outcome but may have improved the patient's quality of life.

The OIG determined that Primary Care Provider 3 copied and pasted documentation from Primary Care Provider 2's EHR entry regarding the patient's lung nodules. Primary Care Provider 2 and 3's misuse of copy and paste coupled with Primary Care Provider 3's failure to update a current plan of care to address the patient's high risk for lung cancer resulted in a missed opportunity by primary care providers 2 and 3 to identify and address potential changes in the patient's health status.

A family member contacted a facility patient advocate in early fall 2020 to request care for the patient and submitted a White House VA Hotline complaint one week later to report that the patient was misdiagnosed. Despite not contacting the family, facility staff documented resolution of the family member's contacts in the Patient Advocate Tracking System. A discussion with and response to the family member would have afforded an opportunity for the facility to address the family member's complaint of the patient being misdiagnosed and to review the patient's care.

After the OIG's notification of the hotline inspection, the facility initiated peer reviews of several providers to determine whether the care they provided to the patient was appropriate. The facility peer reviewers, Peer Review Committee, and supervisors of the primary care providers completed the peer review requirements in accordance with the peer review findings and VHA policy.

Recommendations 1–5

1. The VA Southern Nevada Healthcare System Medical Center Director reviews primary care and pulmonology processes to ensure patients with high-risk factors for lung cancer receive screening and follow-up care and monitors compliance.
2. The VA Southern Nevada Healthcare System Medical Center Director implements processes to ensure that patients with abnormal radiology findings have appropriate follow-up and monitors compliance.
3. The VA Southern Nevada Healthcare System Medical Center Director ensures that providers follow the guidelines for surveillance for patients who have undergone prostatectomy.
4. The VA Southern Nevada Healthcare System Medical Director reviews primary care providers' copy and paste practices, implements processes to ensure a current plan of care is documented in the electronic health record, and monitors compliance.
5. The VA Southern Nevada Healthcare System Medical Center Director reviews the complaint reporting and responding processes, ensures complaints are addressed in accordance with Veterans Health Administration policy, and monitors compliance.

Appendix A: Timeline of Care

Table A.1. Summary of Events Related to Care 2011 through 2020

Date	Event
Early 2011	Patient's first appointment with Primary Care Provider 1 at Southwest Clinic. ³⁵ Primary Care Provider 1 ordered a baseline chest x-ray due to patient's smoking history. Radiology Service completed chest x-ray and recommended chest CT scan for possible malignancy. Primary Care Provider 1 ordered chest CT scan.
Next day	Primary Care Provider 1 ordered chest CT scan.
Six days later	Radiology Service completed chest CT scan and found "bilateral hilar, mediastinal adenopathy," "left upper lobe (1.1 cm x 0.8 cm) and scattered right subcentimeter nodules," and recommended a PET scan.
Seventeen days later	Primary Care Provider 1 ordered PET scan.
Thirteen days later	A non-VA facility completed PET scan that showed lymph nodes suspicious for malignant process.
Six days later	Primary Care Provider 1 ordered Pulmonology Service consult.
Spring 2011	Pulmonology Service staff evaluated the patient and consulted thoracic surgeon for mediastinoscopy for lung lymph node biopsy. Pulmonology Service staff ordered thoracic surgery consult.
Following month	Thoracic surgeon completed biopsy that was negative for malignancy.
	Pulmonology Service appointment. Patient with mediastinal adenopathy. Pulmonology Service recommended follow-up with primary care physician and Pulmonology Service in one year. Primary Care Provider 1 acknowledged receipt of Pulmonology Service's EHR consult response.
Early 2012 through Spring 2013	Patient appointments with Primary Care Provider 1 for multiple medical problems. Primary Care Provider 1 noted Pulmonology Service follow-up appointment was due.
Spring 2013	Patient attended Pulmonology Service appointment. Pulmonology Service staff ordered chest x-ray. Radiology Service staff completed chest x-ray that was negative for malignancy and noted no change since early 2011. Pulmonology Service recommended follow-up in one year.

³⁵ VHA Directive 1406, *Patient Centered Management Module (PCMM) For Primary Care*, June 20, 2017. VHA requires a patient to have only one active PACT assignment at a time because multiple assignments can increase "risk for error." While the OIG found inaccuracies in the primary care provider assignments of the patient, there was no evidence that the inaccuracies contributed to the deficiencies in follow-up. The patient was assigned to the Geriatric Clinic from 2011 to summer 2016 and to the Southwest Clinic from summer 2016 to spring 2018.

Deficiencies in a Patient's Lung Cancer Screening, Renal Nodule Follow-Up, and Prostate Cancer Surveillance at the VA Southern Nevada Healthcare System in Las Vegas

Date	Event
Spring 2014	Primary Care Provider 1 ordered chest x-ray. Chest x-ray showed changes associated with mediastinal adenopathy. Radiology Service indicated follow-up CT scans would be helpful.
Summer 2014	Primary Care Provider 1 ordered chest CT scan for surveillance of lung nodules. A non-VA facility completed chest CT scan and noted stable upper nodularity and mild lobular tissue changes and follow-up CT studies would be helpful.
Late 2014	Patient attended Primary Care Provider 1 appointment. Primary Care Provider 1 noted follow-up with Pulmonology Service was due.
Summer 2015	Patient attended Primary Care Provider 1 appointment. Primary Care Provider 1 instructed patient to follow up with the pulmonologist.
Fall 2016	Patient's last appointment with Primary Care Provider 1. Primary Care Provider 1 instructed patient to follow up with the pulmonologist and ordered a chest CT scan.
Spring 2017	Radiology Service completed chest CT scan that showed a decrease of left lung nodules and multiple small nodules in the right lung. Radiology Service recommended six-month follow-up.
Summer 2017	First appointment with Primary Care Provider 2 at Southeast Clinic. Primary Care Provider 2 discussed previous CT scan and ordered a chest CT scan. ³⁶
Fall 2017	Radiology Service staff completed the chest CT scan that showed the mediastinal lymph nodes and lung nodules were stable and noted a renal nodule had "slightly increased in size" since 2014, and recommended a CT scan of the abdomen.
Four days later	Primary Care Provider 2 entered a note in the EHR and added Primary Care Provider 1 as an additional signer with the statement "CT thorax for your review."
Four days later	Primary Care Provider 1 documented having sent the patient a notification letter with the abnormal imaging results and ordered a CT scan of the abdomen and pelvis to gather more information about the renal nodule.
Seventeen days later	After the patient did not respond to staff's attempts to contact the patient to schedule the patient's abdominal CT scan, the order was canceled.
Spring 2018	Second and last appointment with Primary Care Provider 2.
Late 2018	First appointment with Primary Care Provider 3. ³⁷
Summer 2019 through Summer 2020	Patient attended three appointments with Primary Care Provider 3.
Late Summer 2020	Patient presented to community hospital 1 emergency department and emergency department physician noted suspected metastasis of the prostate cancer.
Two days later	Patient informed a PACT nurse of possible metastasis of cancer and requested a telephone appointment with primary care provider and an oncology consult.
Eighteen days later	Patient attended a telephone appointment with Primary Care Provider 3 who acknowledged the patient's community hospital emergency department visit.

³⁶ The patient was assigned to a PACT team at the Southeast Clinic from late 2017 through fall 2018.

³⁷ The patient was assigned to a different PACT team in the Southeast Clinic from fall 2018 through fall 2020.

Deficiencies in a Patient's Lung Cancer Screening, Renal Nodule Follow-Up, and Prostate Cancer Surveillance at the VA Southern Nevada Healthcare System in Las Vegas

Date	Event
	Primary Care Provider 3 ordered a rehabilitation consult for the patient's back pain and indicated a plan to order a urology consult.
Three days later	Patient admitted to community hospital 1 and diagnosed with cancer.
Two days later	Community hospital 2 determined the brain mass was likely from the metastatic lung cancer.
Twenty-four days later	Patient died.

Source: *OIG review of EHR and facility documents.*

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 29, 2021

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Deficiencies in a Patient's Lung Cancer Screening, Renal Nodule Follow-Up, and Prostate Cancer Surveillance at the VA Southern Nevada Healthcare System in Las Vegas

To: Director, Office of Healthcare Inspections (54HL09)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I have reviewed the draft report and responses provided by the VA Southern Nevada Healthcare System in Las Vegas. I concur with the recommendations and the Healthcare System Director's responses.
2. If you have additional questions or need further information, please contact the VISN 21 Quality Management Officer.

(Original signed by:)

Ada Clark, FACHE, MPH
Deputy Network Director, VISN 21
for John Brandecker, Network Director

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 28, 2021

From: Director, VA Southern Nevada Healthcare System (593)

Subj: Healthcare Inspection—Deficiencies in a Patient's Lung Cancer Screening, Renal Nodule Follow-Up, and Prostate Cancer Surveillance at the VA Southern Nevada Healthcare System in Las Vegas

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations from the OIG Health Care virtual inspection conducted at the VA Southern Nevada Healthcare System from March 1-4, 2021.
2. Please find the attached response to each recommendation included in the report. We have completed, or in the process of completing, actions to resolve these issues.

(Original signed by:)

William J. Caron, PT, MHA, FACHE
Medical Center Director/CEO
VA Southern Nevada Healthcare System

Facility Director Response

Recommendation 1

The VA Southern Nevada Healthcare System Medical Center Director reviews primary care and pulmonology processes to ensure patients with high-risk factors for lung cancer receive screening and follow-up care and monitors compliance.

Concur.

Target date for completion: April 29, 2022

Director Comments

The VA Southern Nevada Healthcare System Medical Center Director reviewed primary care and pulmonology processes to ensure patients with high risk factors for lung cancer receive screening and follow-up care and will monitor compliance.

Primary Care Providers received education on Lung Cancer Screening guidelines from The United States Preventive Services Taskforce at a staff meeting on March 16, 2021. They will also receive reeducation on the Fleischner Society pulmonary nodule recommendations. The focus will include appropriate consults to pulmonology and responsibilities of Primary Care follow-up.

VA Southern Nevada Healthcare System (VASNHS) is in the process of recruiting for a Registered Nurse (RN) coordinator for the pulmonary nodule monitoring program who will coordinate and ensure timely and appropriate follow-up care for those patients who require lung nodule screening and surveillance.

A facility System Redesign project was initiated to ensure streamlined implementation of a new Computerized Patient Record System (CPRS) lung cancer screening local clinical reminder, which alerts the Primary Care Team of the need for further lung cancer screening when appropriate and follow-up care can be ordered.

Monthly audits of Electronic Health Records (EHR) of Veterans who have high risk factors for lung cancer will be conducted to validate appropriate screening and follow-up care, until 90% compliance is achieved for 3 months. Compliance data will be monitored in governance oversight committee.

Recommendation 2

The VA Southern Nevada Healthcare System Medical Center Director implements processes to ensure that patients with abnormal radiology findings have appropriate follow-up and monitors compliance.

Concur.

Target date for completion: April 29, 2022

Director Comments

VASNHS will continue to follow Medical Center Policy (MCP #11-20), Communication of Test Result to Providers and Veterans, which includes an algorithm for communication of critical results and directs radiology on the notification process. Pursuant to the policy, the Primary Care Provider (PCP) communicates all required actions to the patient within 7 calendar days from the date the results are made available. On October 25, 2021 the Primary Care Service Chief reviewed the requirements of MCP #11-20 with all Primary Care Providers.

Monthly audit of EHRs of Veterans with abnormal radiology findings will be conducted to validate appropriate follow-up occurred until 90% compliance is achieved for 3 months. Compliance data will be monitored in governance oversight committee.

Recommendation 3

The VA Southern Nevada Healthcare System Medical Center Director ensures that providers follow the guidelines for surveillance for patients who have undergone prostatectomy.

Concur.

Target date for completion: April 29, 2022

Director Comments

On October 20, 2020, Primary Care Providers received education by Urology provider related to surveillance guidelines via clinical vignettes regarding outlining appropriate treatment options based upon test results and clinical presentation. Reeducation on Urology surveillance guidelines will be provided during the November provider staff meeting.

On August 25, 2021, new guidelines for entering Urology consults were communicated by the Acting Chief of Primary Care during the monthly "Virtual Chat with The Chief." The attendees included front-line Primary Care Providers, Supervisors and Pharmacists. Additionally, the Urology Referral Triage Tool was shared with Clinical Supervisors. Clinical Supervisors shared the triage tool and provided education to front-line Primary Care Providers.

Monthly audits of EHRs of Veterans who have abnormal prostate specific antigen (PSA) lab tests will be conducted to validate appropriate surveillance until 90% compliance is achieved for 3 months. Compliance data will be monitored in governance oversight committee.

Recommendation 4

The VA Southern Nevada Healthcare System Medical Director reviews primary care providers' copy and paste practices, implements processes to ensure a current plan of care is documented in the electronic health record, and monitors compliance.

Concur.

Target date for completion: April 29, 2022

Director Comments

The VA Southern Nevada Healthcare System Medical Director reviewed primary care providers' copy and paste practices and will implement processes to ensure a current plan of care is documented in the electronic health record.

Front-line Primary Care Providers received education regarding expectations on the use of copy/paste in the medical record, according to VHA Handbook 1907.01 Health Information Management and Health Records, during the Clinical Documentation Lunch and Learn on October 19, 2021. The PowerPoint presented during the Clinical Documentation Lunch and Learn was sent out to all front-line Primary Care Providers on October 19, 2021 and was also reviewed during staff meetings held on October 26, 2021.

Health Information Management Service (HIMS) will conduct monthly medical record audits for evidence of copy/paste for Primary Care. Thirty (30) Primary Care records will be audited monthly until 90% compliance is achieved for 3 months. Compliance data will be monitored in governance oversight committee.

Recommendation 5

The VA Southern Nevada Healthcare System Medical Center Director reviews the complaint reporting and responding processes, ensures complaints are addressed in accordance with Veterans Health Administration policy, and monitors compliance.

Concur.

Target date for completion: April 29, 2022

Director Comments

The VA Southern Nevada Healthcare System Medical Center Director reviewed the complaint reporting and responding processes and will ensure complaints are addressed in accordance with Veterans Health Administration policy, and monitors compliance.

Patient Advocate Tracking System-Replacement (PATS-R) Reporting system is in place at VASNHS for reporting and tracking patient complaints. This system tracks reported issues,

requires deadlines for response and resolution, and provides transparency to all levels of leadership.

Veterans Experience Service (VES) will conduct monthly random audits of PATS-R complaints for compliance of routing to correct service, evidence of patient contact, appropriate and timely complaint response, and complaint resolution until 90% compliance is achieved for 3 months. Compliance data will be monitored in governance oversight committee.

Glossary

To go back, press "alt" and "left arrow" keys.

Agent Orange. Chemical used during the Vietnam War to remove tree cover and "clear vegetation from the perimeters of US [United States] bases." Agent Orange has been linked to several cancers.³⁸

bilateral. Relates to both "the right and left sides of the body."³⁹

biopsy. "removal and examination of tissue, cells, or fluids from the living body."⁴⁰

cancer. Malignant tumor capable of local invasion and spreading.⁴¹

carcinoma. Most common type of cancer originating in the skin or internal organs.⁴²

chemotherapy. Drug treatment used to treat cancer.⁴³

chronic obstructive pulmonary disease. Lung disease that "makes it hard to breathe."⁴⁴

computerized tomography. Scan that creates a cross sectional or three-dimensional image of an internal body part by assembling multiple x-ray images and is used for diagnostic purposes.⁴⁵

deep vein thrombosis. "A condition in which one or more thrombi form in a deep vein, especially in the leg or pelvis" and increases the risk of a pulmonary embolus in the lung.⁴⁶

edema. Abnormal "excess accumulation of serous fluid in connective tissue or in a serous cavity."⁴⁷

³⁸ "Agent Orange and Cancer Risk, What is Agent Orange?" American Cancer Society, accessed March 29, 2021, <https://www.cancer.org/cancer/cancer-causes/agent-orange-and-cancer.html>.

³⁹ Merriam Webster, "Definition of Bilateral," accessed April 2, 2021, <https://www.merriam-webster.com/dictionary/bilateral#medicalDictionary>.

⁴⁰ Merriam Webster, "Definition of biopsy," accessed April 4, 2021, <https://www.merriam-webster.com/dictionary/biopsy>.

⁴¹ Merriam Webster, "Definition of cancer," accessed April 7, 2021, <https://www.merriam-webster.com/dictionary/cancer>.

⁴² "Carcinoma," Cancer Treatment Centers of America, accessed April 7, 2021, <https://www.cancercenter.com/carcinoma>.

⁴³ "Chemotherapy," Mayo Clinic, accessed April 8, 2021, <https://www.mayoclinic.org/tests-procedures/chemotherapy/about/pac-20385033>.

⁴⁴ "Chronic obstructive pulmonary disease (COPD)," MedlinePlus, accessed March 29, 2021, <https://medlineplus.gov/ency/article/000091.htm>.

⁴⁵ Merriam Webster, "Medical Definition of CT scan," accessed March 30, 2021, <https://www.merriam-webster.com/dictionary/CT%20scan#medicalDictionary>.

⁴⁶ American Heritage Dictionary, "Deep vein thrombosis (DVT)," accessed April 8, 2021, <https://ahdictionary.com/word/search.html?q=deep+vein+thrombosis>.

⁴⁷ Merriam Webster, "Definition of edema," accessed April 8, 2021, <https://www.merriam-webster.com/dictionary/edema>.

Electrocardiogram. Non-invasive diagnostic test which records the electrical signals in the heart and is used to detect problems or monitor the heart's status.⁴⁸

encephalopathy. Disease of the brain.⁴⁹

erythema. "abnormal redness of the skin or mucous membranes."⁵⁰

hematology. Study of blood.⁵¹

hemorrhage. "copious or heavy discharge of blood from the blood vessels."⁵²

hilar. Area on the middle aspect of the lung.⁵³

hospice care. "for patients who are in the late phase of an incurable illness and wish to receive end-of-life care at home or in a specialized care setting."⁵⁴

infection. A disease in the body caused by bacteria or a virus.⁵⁵

inferior vena cava filter. "a small device that can stop blood clots from going up into the lungs."⁵⁶

interventional radiology. Utilizes "image-guided procedures to diagnose and treat diseases."⁵⁷

⁴⁸ "Electrocardiogram (ECG or EKG)," Mayo Clinic, accessed April 8, 2021, <https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983>.

⁴⁹ Merriam Webster, "Medical definition of encephalopathy," accessed April 8, 2021, <https://www.merriam-webster.com/dictionary/encephalopathy>.

⁵⁰ Merriam Webster, "Definition of erythema," accessed July 21, 2021, <https://www.merriam-webster.com/dictionary/erythema>.

⁵¹ American Society of Hematology, "Hematology Glossary," accessed April 8, 2021, <https://www.hematology.org/education/patients/blood-basics/hematology-glossary>.

⁵² Merriam Webster, "Definition of hemorrhage," accessed April 8, 2021, <https://www.merriam-webster.com/dictionary/hemorrhage>.

⁵³ Merriam Webster, "Medical definition of hilum," accessed April 2, 2021, <https://www.merriam-webster.com/dictionary/hilum>.

⁵⁴ "A Definition of Hospice Care," Centers for Disease Control and Prevention, accessed April 8, 2021, <https://www.cdc.gov/training/ACP/page35093.html>.

⁵⁵ Cambridge Dictionary, "Infection," accessed April 7, 2021, <https://dictionary.cambridge.org/dictionary/english/infection>.

⁵⁶ "Inferior Vena Cava (IVC) Filter Placement," Johns Hopkins Medicine, accessed April 6, 2021 <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/inferior-vena-cava-ivc-filter-placement>.

⁵⁷ "What Is Vascular and Interventional Radiology," Johns Hopkins Medicine, accessed April 8, 2021, https://www.hopkinsmedicine.org/interventional-radiology/what_is_IR.html#:~:text=Interventional%20radiology%20is%20a%20medical%20sub-specialty%20of%20radiology,and%20treat%20diseases%20in%20nearly%20every%20organ%20system.

intracranial. Existing or occurring within the skull.⁵⁸ **judicious.** Having or exercising sound judgment.⁵⁹

lesion. “an abnormal change in structure of an organ or part due to injury or disease.”⁶⁰

lung nodules. Small masses that appear in the lungs “as round, white shadows on a chest x-ray or computerized tomography (CT) scan.”⁶¹

lymph nodes. “small structures that work as filters for foreign substances, such as cancer cells and infections.”⁶²

lymphoma. “cancer of the lymphatic system.”⁶³

magnetic resonance imaging. Use of magnets and radio wave to produce images.⁶⁴

malignant. Cancer cells “that have the ability to spread to other sites in the body.”⁶⁵

mediastinal lymphadenopathy. Lymphadenopathy is “abnormal enlargement of the lymph nodes.” The mediastinum is the space located between the lungs.⁶⁶

mediastinoscopy. Medical procedure used to look behind the breastbone between the lungs.⁶⁷

metastasis. Spread of cancer cells from the primary site to another area of the body.⁶⁸

⁵⁸ Merriam Webster, “Medical definition of intracranial,” accessed April 8, 2021, <https://www.merriam-webster.com/dictionary/intracranial>.

⁵⁹ Merriam Webster, “Definition of judicious,” accessed April 12, 2021, <https://www.merriam-webster.com/dictionary/judicious>.

⁶⁰ Merriam Webster, “Definition of lesion,” accessed September 20, 2021, <https://www.merriam-webster.com/dictionary/lesion>.

⁶¹ Mayo Clinic, “Lung nodules: Can they be cancerous?,” accessed March 29, 2021, <https://www.mayoclinic.org/diseases-conditions/lung-cancer/expert-answers/lung-nodules/FAQ-20058445?p=1>.

⁶² “Lymph Nodes and Cancer”, American Cancer Society, accessed September 15, 2021, [Lymph Nodes and Cancer](https://www.cancer.org/treatment/understanding-your-diagnosis/tests/endoscopy/mediastinoscopy.html).

⁶³ “Lymphoma,” Mayo Clinic, accessed April 7, 2021, <https://www.mayoclinic.org/diseases-conditions/lymphoma/symptoms-causes/syc-20352638>.

⁶⁴ “Magnetic Resonance imaging,” Mayo Clinic, accessed April 14, 2021, <https://www.mayoclinic.org/tests-procedures/mri/multimedia/mri/vid-20084743>.

⁶⁵ “Malignancy,” MedlinePlus, accessed April 2, 2021, https://medlineplus.gov/ency/article/002253.htm?utm_source=email&utm_medium=share&utm_campaign=mplus_share.

⁶⁶ Merriam Webster, “Medical definition of lymphadenopathy,” accessed September 21, 2021, <https://www.merriam-webster.com/dictionary/lymphadenopathy>. Merriam Webster, “Medical definition of mediastinum,” accessed April 6, 2021, <https://www.merriam-webster.com/dictionary/mediastinum#medicalDictionary>.

⁶⁷ “Mediastinoscopy,” American Cancer Society, April 7, 2021, <https://www.cancer.org/treatment/understanding-your-diagnosis/tests/endoscopy/mediastinoscopy.html>.

⁶⁸ Merriam Webster, “Medical definition of metastasis,” accessed April 7, <https://www.merriam-webster.com/dictionary/metastasis>.

neurological. Nervous system.⁶⁹

neurosurgery. Medical specialty concerned with the diagnosis and treatment spinal cord injuries.⁷⁰

nodule. Small mass.⁷¹

nuclear medicine bone scan. Shows the effects of injury, infection, or disease in bones.⁷²

oncology. “[S]cientific study of cancer.”⁷³

pack-years. Calculated by number of cigarettes smoked per day multiplied by the number of years smoked.⁷⁴

patient advocate. Provides facility level response to customer concerns and documents compliments and complaints in the Patient Advocate Tracking System.⁷⁵

positron emission tomography. Scan that uses a radioactive tracer to identify disease in the body.⁷⁶

prostate-specific antigen. Protein produced by the prostate gland measurable in a man’s blood. The results are reported as nanograms per milliliter (ng/mL).⁷⁷

prostate cancer. Common in older men affecting the prostate gland that produces fluid for semen.⁷⁸

⁶⁹ Merriam Webster, “Medical definition of neurological,” accessed April 8, 2021, <https://www.merriam-webster.com/medical/neurological>.

⁷⁰ “What is neurosurgery?” Oregon Health & Science University, accessed April 8, 2021, <https://www.ohsu.edu/school-of-medicine/neurosurgery/what-neurosurgery>.

⁷¹ Merriam Webster, “Definition of nodule,” accessed March 25, 2021, <https://www.merriam-webster.com/dictionary/nodule>.

⁷² “Nuclear Medicine Bone Scan,” Inside Radiology, accessed April 8, 2021, <https://www.insideradiology.com.au/nuclear-medicine-bone-scan/#:~:text=A%20nuclear%20medicine%20bone%20scan%20shows%20the%20effects,or%20deterioration%20in%20a%20bone%20abnormality%20after%20treatment>.

⁷³ “Hematology Glossary,” American Society of Hematology, accessed April 8, 2021, <https://www.hematology.org/education/patients/blood-basics/hematology-glossary>.

⁷⁴ Pack Years Calculator, Dudley Respiratory Group for GlaxoSmithKline, accessed June 25, 2021. https://www.dudleyrespiratorygroup.org/assets/downloads/Pack_Years_Smoked_Calculator.pdf.

⁷⁵ VHA Handbook 1003.04, *VHA Patient Advocacy*, February 7, 2018.

⁷⁶ “PET Scan,” Cleveland Clinic, accessed April 2, 2021, <https://my.clevelandclinic.org/health/diagnostics/10123-pet-scan>.

⁷⁷ “Prostate-Specific Antigen (PSA) Test,” National Cancer Institute, accessed April 7, 2021, <https://www.cancer.gov/types/prostate/psa-fact-sheet>.

⁷⁸ “Prostate Cancer,” MedlinePlus, accessed March 29, 2021, <https://medlineplus.gov/prostatecancer.html>.

prostatectomy. Surgical removal of the prostate gland.⁷⁹

pulmonary embolism. When a blood clot in a vein detaches and travels to the lungs.⁸⁰

pulmonologist. “[S]pecialist in the anatomy, physiology, and pathology of the lungs.”⁸¹

pulmonology. Affecting or occurring in the lungs.⁸²

radiation. “[H]igh doses of radiation to kill cancer cells.”⁸³

radiology. “[B]ranch of medicine concerned with the use of radiant energy (such as X-rays) or radioactive material in the diagnosis and treatment of disease.”⁸⁴

renal. “[R]elating to, involving, or located in the region of the kidneys.”⁸⁵

sclerotic. “[G]rown rigid or unresponsive especially with age.”⁸⁶

service line agreement. Service agreements (service line agreements) are formalized documents of agreement between services.⁸⁷

surveillance. Close observation or testing.⁸⁸

thoracic. The area of the middle back. (T1–T12).⁸⁹

urology. Branch of medicine “that deals with diseases of the male and female urinary tract (kidneys, ureters, bladder, and urethra)” and male organs (penis, testes, scrotum, and prostate).⁹⁰

⁷⁹ Merriam Webster, “Medical definition of prostatectomy,” accessed March 29, 2021, <https://www.merriam-webster.com/dictionary/prostatectomy#medicalDictionary>.

⁸⁰ “Hematology Glossary,” American Society of Hematology, accessed April 8, 2021, <https://www.hematology.org/education/patients/blood-basics/hematology-glossary>.

⁸¹ Merriam Webster, “Definition of pulmonologist,” accessed April 4, 2021, <https://www.merriam-webster.com/dictionary/pulmonologist#medicalDictionary>.

⁸² Merriam Webster, “Definition of pulmonary,” accessed April 8, 2021, <https://www.merriam-webster.com/dictionary/pulmonary>.

⁸³ “Radiation Therapy,” MedlinePlus, accessed April 14, 2021, <https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=radiation+therapy>.

⁸⁴ Merriam Webster, “Medical definition of radiology,” accessed April 8, 2021, <https://www.merriam-webster.com/dictionary/radiology#medicalDictionary>.

⁸⁵ Merriam Webster, “Definition of renal,” accessed May 12, 2021, <https://www.merriam-webster.com/dictionary/renal>.

⁸⁶ Merriam Webster, “Definition of sclerotic,” accessed September 20, 2021, <https://www.merriam-webster.com/dictionary/sclerotic>.

⁸⁷ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014. This handbook was in effect at the time of the events discussed in this report until it was amended on May 26, 2017.

⁸⁸ Merriam Webster, “Definition of surveillance,” accessed April 7, 2021, <https://www.merriam-webster.com/dictionary/surveillance>.

⁸⁹ “Thoracic,” MedlinePlus, accessed September 15, 2021, <https://medlineplus.gov/ency/imagepages/1774.htm>.

⁹⁰ “Urology,” Urology Care Foundation, accessed May 10, 2021, <https://www.urologyhealth.org/urology-a-z/what-is-urology>.

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