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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth

Healthcare Inspection | **24-00990-99** | **April 17, 2025**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations related to a delay in diagnosis and treatment for a patient's lung cancer and deficiencies in the lung cancer screening (LCS) program at the VA Eastern Kansas Healthcare System (system) in Topeka and Leavenworth.

The OIG substantiated the patient experienced a delay in the diagnosis of and treatment for lung cancer. The OIG also identified deficiencies in the system's community care staff's efforts to retrieve records that may have contributed to the delay in the patient's cancer diagnosis and care.

Case Summary

The patient, in their 60s, had a history of tobacco use, hypertension (high blood pressure), and hyperlipidemia (high cholesterol).[1] Following the completion of a computed tomography (CT) scan to screen for lung cancer in summer 2023, the patient met with a patient aligned care team (PACT) provider and was informed that the CT scan showed a left sided lung mass concerning for lung cancer. The PACT provider ordered a community care consult for a positron emission tomography (PET) scan and entered a system pulmonary consult.

The next day, a system pulmonologist converted the consult to an e-consult and documented the recommendation for the patient to also undergo an endobronchial ultrasound (EBUS) bronchoscopy, which was not available at the system. The pulmonologist recommended the PACT provider either place a consult to the Kansas City VA Medical Center (a separate VA facility within Veterans Integrated Service Network [VISN] 15) for the EBUS or, if the patient preferred to have the EBUS in the community, notify the pulmonologist, who would enter a community care consult. That day, the PACT nurse contacted the patient regarding the EBUS and documented the patient reported already having a "process for getting Bronchoscope set up"; however, neither a Kansas City VA Medical Center nor a community care consult for the EBUS bronchoscopy was found in the patient's electronic health record (EHR).[2]

The following month, the patient's PET scan was completed at a community hospital. The PET scan results were abnormal and consistent with lung cancer with metastatic spread to the lymph nodes of the chest. That same day, the community hospital faxed the PET scan results to the wrong VA facility. Specifically, results were faxed to the Kansas City VA Medical Center rather than to the system (VA Eastern Kansas Healthcare System).

[1] The OIG uses the singular form of they, "their" in this instance, for privacy purposes; The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] The PACT nurse reported typically verifying an EHR to ensure a consult was placed but could not recall the patient or the actions taken.

Four days after the PET scan was completed, a system community care advanced medical support assistant (AMSA) documented that the patient attended the appointment and a request for records was made. The AMSA then administratively closed the consult. A day later, the ordering PACT provider cosigned an EHR note indicating the PET scan was completed and a request for records was sent. There were no further EHR notes related to the PET or EBUS bronchoscopy from summer until late 2023.

In late 2023, the patient experienced vertigo and was admitted to a community hospital. Approximately five days later, the patient was transferred to the Kansas City VA Medical Center where the inpatient attending physician acknowledged the patient's previous abnormal CT and PET scan results. A Kansas City VA Medical Center pulmonologist conducted a face-to-face consult and recommended an EBUS bronchoscopy, which was completed six days later and revealed small cell lung cancer. While inpatient at the Kansas City VA Medical Center, the patient was treated for small cell lung cancer from late 2023 through early 2024, after which the patient was transferred to the system's community living center for continued cancer treatment.

Delayed Diagnosis and Treatment of a Patient's Lung Cancer

The OIG found the following failures contributed to the delay in the diagnosis of and treatment for lung cancer:

- The PACT provider and the pulmonologist failed to order the consult needed for the patient to obtain the recommended EBUS bronchoscopy and failed to follow up to ensure that the procedure was scheduled and completed.
- The PACT provider failed to track the patient's PET scan, communicate the abnormal results to the patient, and initiate timely, appropriate clinical actions.

EBUS Bronchoscopy

The PACT provider, who acknowledged a lack of experience coordinating the workup of a patient with possible lung cancer, reported to the OIG that a pulmonary consult was placed with the expectation the system's pulmonologist would see and evaluate the patient's condition, make related recommendations, and assist with facilitating the patient's recommended course of treatment. Rather than seeing the patient, the pulmonologist reported converting the consult to an e-consult to expedite the patient's care, and recommended the patient undergo an EBUS bronchoscopy either within the community or at the Kansas City VA Medical Center.

The PACT nurse contacted the patient and documented the patient reported having a "process for getting Bronchoscope set up." During interviews, the OIG learned that no related order was placed due to the PACT provider incorrectly assuming the pulmonologist placed the related consult. Based on that assumption, the PACT provider did not follow up with the patient or verify the order was placed by reviewing the patient's EHR. Similarly, the pulmonologist

believed the EBUS bronchoscopy had been scheduled based on the PACT nurse's EHR documentation. Despite recognizing the seriousness of the patient's lung mass and converting the face-to-face consult to an e-consult to expedite the patient's care, the pulmonologist did not follow up with the PACT provider or patient to ensure the recommendation was addressed or review the EHR to verify a related order was placed or completed. As a result, the EBUS bronchoscopy was not completed until more than four months later.

PET Scan Results

The Veterans Health Administration (VHA) requires that ordering providers maintain responsibility for the results of tests they order, including communicating test results to patients and initiating "timely and appropriate clinical actions and follow up for any test orders they have placed."[3]

Within VHA, when a patient undergoes diagnostic imaging or a diagnostic procedure, the system's diagnostic services provider must communicate test results to the system's "ordering provider or designee within a timeframe that allows for prompt attention and appropriate action to be taken." The diagnostic provider is responsible for "identifying and communicating all new emergent and imminently life-threatening test results and new urgent not immediately life-threatening abnormal test results to the … ordering provider or designee" and ensuring "test result reports are available in the patient's EHR as soon as the reports are verified." Once available, test results that require further action must be communicated to the patient within seven calendar days.[4]

In contrast, when a community provider completes the requested service, system community care staff wait to receive medical documentation, such as diagnostic test results, from the community provider.[5] If not received soon after the appointment is complete, community care staff request the medical records and close the consult in the patient's EHR either with or without the records. The closure triggers an electronic alert to the ordering provider to notify them of the consult status. When medical records are received, community care staff upload and attach the records to the original consult and an alert that records are available is sent to the ordering provider.

[3] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, July 11, 2023.

[4] VHA Directive 1088.

[5] *VHA Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, Office of Integrated Veteran Care (IVC) Community Care, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. (This website is not publicly accessible.) VHA medical facilities "may purchase care in the community for eligible Veterans, after VA options to render care have been considered." VHA's Office of Integrated Veteran Care is responsible for managing the community care program. VHA system providers place a consult for community care; once placed, system community care staff schedule consult appointments, follow up with community care providers to ensure the patient received the care and request patient records, and close the consult in the patient's EHR.

The PACT provider acknowledged having forgotten about the patient's PET scan and reported relying upon receiving an electronic alert when the patient's records were received and uploaded to the EHR. The PACT provider's failure to track the PET scan, notify the patient of abnormal results, and initiate timely clinical actions significantly contributed to the delay in diagnosis and treatment of the patient's lung cancer.

Additionally, the OIG is concerned with the absence of an established process for community care providers to communicate new urgent not immediately life-threatening abnormal test results, such as the patient's abnormal PET scan result, ,promptly and directly to the system's ordering providers.

Deficiencies in Community Care Records Retrieval

VHA established a process for community care staff to administratively close consults when community care providers have not sent a patient's medical documentation to the ordering facility following the completed appointment. VHA requires community care staff to make three attempts to retrieve a patient's records. Additionally, VHA guidelines emphasize that community care managers should convey to "staff that administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation is expected to ensure continuity of care."[6]

Inadequate Efforts to Obtain Patient's PET Scan Result

Community care staff did not follow VHA guidelines to make three attempts to retrieve the patient's PET scan results within 90 days of completion. Community care staff explained that resources are focused on scheduling community care appointments. Given the nature of the diagnostic consult, the OIG is concerned by the minimal efforts made by community care staff and the associate chief nurse to retrieve the patient's PET scan results, which may have contributed to the delay in diagnosing and treating the patient's lung cancer.

Community Care Records Sent to Wrong Facility

The patient's EHR revealed that on the same day the PET scan was completed, the community provider sent the patient's abnormal PET scan result to the Kansas City VA Medical Center instead of the VA Eastern Kansas Healthcare System.[7] The OIG learned that, because the records

[6] VHA IVC, "Consult Completion and Medical Records Management," chap. 4 in *Community Care Field Guidebook,* August 29, 2023*;* Assistant Under Secretary for Health for Community Care (13), "Revised Administrative Closure of Community Care Consult Process (VIEWS #06042227)," memorandum to VISN Directors, October 1, 2021; VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022; VHA SOP*, Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure,* July 28, 2022. Low-risk consults require community care staff to make one attempt, rather than three, to retrieve community records. A PET scan is not a low-risk consult.

[7] System staff reported that because the two VA facilities are near one another and use some of the same community care providers, records have been mistakenly sent to the wrong VA facility.

were not attached to the original VA Eastern Kansas Healthcare System's consult, the system's ordering PACT provider was not alerted to the patient's abnormal results; consequently, no timely clinical action was taken on the patient's abnormal test results. The System Director stated communication between the system and Kansas City VA Medical Center regarding the receipt of patients' community care records was an area in need of improvement. The OIG recognized this to be a system issue and vulnerability.

System Failures to Retrieve Community Care Records

The OIG determined that the system's community care staff routinely failed to make additional requests to obtain patients' community care medical records. The associate chief nurse reported the community care program had difficulty making the required attempts to retrieve records after consults are completed and explained that performance metrics focus on scheduling timeliness versus care coordination activities. The Associate Director of Patient Care Services confirmed that system community care staff prioritized consult scheduling to meet VISN and VHA expectations. VISN and system leaders conveyed scheduling metrics to be the priority.

The VISN community care program manager expressed the importance of obtaining patients' community care records and noted that other community care leaders in the VISN have reported struggling with the record retrieval requirements of the consult process. VHA monitors whether community care consults are closed within 90 days of an appointment; however, the metric is satisfied whether consults are closed with or without community care records. VHA does not monitor how many consults were closed without records or whether community care staff made three attempts to secure records.

Although VHA guidance emphasizes the importance of retrieving patients' community care records, the significance of such is not mirrored in VHA's community care metrics. An administrative closure without records places a vulnerability on patient care and safety by directly affecting the patient and ordering provider who are dependent on consult results and records for further care coordination. The OIG concluded there could be unintended delays and clinically related consequences when medical record retrieval is not closely monitored by VHA.

Institutional Disclosure

Upon recognizing the failures affecting the patient's care, system leaders completed an institutional disclosure; however, the OIG determined system leaders did not meet institutional disclosure requirements as crucial components of the disclosure were not documented.[8]

The institutional disclosure documentation did not include details of the disclosure required by VHA policy, including the discussion points of the adverse events, assistance offered, and questions addressed; as such, the OIG could not discern the nature of the adverse event disclosed

[8] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

or what was explained to the patient. The OIG is concerned the patient may not have been fully informed of the events that contributed to the delay in diagnosis and treatment for lung cancer or of the available options for recourse.

Deficiencies in the System's Lung Cancer Screening Program

The OIG substantiated that the system's lung cancer screening (LCS) program lacked the oversight and multidisciplinary engagement necessary to implement, evaluate, and manage an effective program. System and program leaders failed to develop the program's infrastructure prior to implementation, including the LCS Oversight Board, LCS program policy, and adequate primary care engagement and training.[9] These deficiencies created vulnerabilities that could negatively affect the care for patients requiring lung cancer screening.

The OIG found that the system's LCS Oversight Board failed to provide adequate oversight of the program. The LCS program did not have a charter that outlined the LCS Oversight Board's mission, members, or responsibilities for several months after implementation, and there were inconsistencies in the board's membership, poor attendance to board meetings, and a lack of formal meeting minutes. Similarly, at the time of implementation, system and program leaders had not created the LCS program's standard operating procedures that would have guided providers' management of a patient's progress through the LCS program. Further, PACT providers and nurses received minimal training on the system's LCS program prior to initiation and their knowledge deficit was unresolved at the time of the OIG site visit in February 2024.

The OIG made one recommendation to the Under Secretary for Health related to the communication of patients' community care test results.[10] The OIG made one recommendation to the VISN Director related to the system's LCS program. The OIG made four recommendations to the Facility Director related to patient test results, institutional disclosures, and community care records.

[9] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Revision Memorandum: Guidelines for Lung Cancer Screening in Veterans Health Administration," memorandum to VISN directors and VISN chief medical officers, July 15, 2022, rescinded and replaced by VHA Directive 1417, *Lung Cancer Screening*, May 29, 2024. The policies contain similar language related to LCS Oversight Board responsibilities. The LCS Oversight Board is "responsible for the oversight of the conduct and management of the LCS program" and includes representation from pulmonary, radiology, and primary care services, "with consideration to add other relevant stakeholders (e.g., medical, surgical, and radiation oncology providers, Veteran Engagement specialists, etc.)" and participation from the LCS coordinator.

[10] The recommendation addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position.

VA Comments

The Acting Under Secretary for Health concurred in principle with recommendation 5, and the Veterans Integrated Service Network and Facility Directors concurred with recommendations 1–4 and 6. Acceptable action plans were provided for each recommendation (see appendixes A, B, and C). The OIG will follow up on the planned actions until they are completed.

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

Contents

Abbreviations

AMSA	advanced medical support assistant
CT	computed tomography
EBUS	endobronchial ultrasound
EHR	electronic health record
IVC	Office of Integrated Veteran Care
LCS	lung cancer screening
NCLCS	National Center for Lung Cancer Screening
OIG	Office of Inspector General
PACT	patient aligned care team
PET	positron emission tomography
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations related to a delay in diagnosis and treatment for a patient's lung cancer and deficiencies in the lung cancer screening (LCS) program at the VA Eastern Kansas Healthcare System (system).

Background

The system, part of Veterans Integrated Service Network (VISN) 15, consists of two medical centers: the Colmery-O'Neil VA Medical Center in Topeka, Kansas; and the Dwight D. Eisenhower VA Medical Center located in Leavenworth, Kansas. The system, designated as a level 2 complexity healthcare system, provides services to patients throughout eastern Kansas and northwestern Missouri.[1] From October 1, 2022, through September 30, 2023, the system treated 37,953 patients.

Lung Cancer

Lung cancer "is the second most common cancer in both men and women in the United States (not counting skin cancer)" and is the leading cause of cancer death.[2] The American Cancer Society estimates there will be approximately 234,580 new lung cancer cases and 125,070 lung cancer deaths in 2024. Smoking continues to be responsible for most lung cancer deaths; individuals "who used to or continue to smoke tobacco for a long period of time are considered to be at "high risk" … Screening lowers the risk of death from lung cancer."[3] Per the Centers for Disease Control and Prevention, "The U.S. Preventive Services Task Force (Task Force) recommends yearly lung cancer screening with [low-dose computed tomography (low-dose CT) scans] for [high-risk individuals]."[4]

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[1] VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes medical facilities by complexity levels that include 1a, 1b, 1c, 2 or 3. Level 2 complexity generally refers to facilities with "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." The system has six rural health clinics throughout Eastern Kansas (Chanute, Fort Scott, Garnett, Lawrence, Junction City, and Kansas City) and two clinics in northwestern Missouri (Platte City and St. Joseph).

[2] "Key Statistics for Lung Cancer," American Cancer Society, accessed May 9, 2024, https://www.cancer.org/cancer/types/lung-cancer/about/key-statistics.html.

[3] "Key Statistics for Lung Cancer," American Cancer Society.

[4] "Screening for Lung Cancer," CDC Lung Cancer, accessed May 15, 2024, https://www.cdc.gov/lung-cancer/screening/?CDC_AAref_Val=https://www.cdc.gov/cancer/lung/basic_info/screening.htm. High-risk factors include having a 20 pack-year smoking history (a pack-year is equal to smoking an average of one pack of cigarettes per day for one year); currently smoking or have quit within the past 15 years; and are between 50 and 80 years old.

Communicating Test Results to Providers and Patients

Per policy, "VHA [the Veterans Health Administration] is committed to the timely communication of test results, which is essential to ensuring safe and effective health care … Delayed follow-up of abnormal test results has been identified as a contributor to poor outcomes and can be a source of considerable anxiety to patients and families … Patients have a right to be notified of test results within a timeframe that minimizes risk and allows them to be informed and engaged in their health care."[5]

VA Community Care

VHA facilities "may purchase care in the community for eligible Veterans, after VA options to render the care have been considered." VHA's Office of Integrated Veteran Care (IVC) is responsible for managing the community care program.[6] The process is initiated when a VHA provider at the system places a community care consult (order) for a patient to obtain healthcare services from a community provider.[7] Once placed, system community care staff are responsible for confirming eligibility, scheduling consult appointments, and following up with community care providers to ensure the patient received care, obtain patient records, and close the consult in the patient's electronic health record (EHR).[8]

Allegations and Related Concerns

In December 2023, the OIG received allegations that VHA standards for the Lung Cancer Screening (LCS) program at the system were not met. Specifically, the LCS program allegedly lacked oversight, did not have multidisciplinary physicians, and LCS program staff did not follow up with patients. Further, the OIG received the name of a patient who allegedly had a delay in the diagnosis and treatment of lung cancer. The OIG opened a healthcare inspection to evaluate the allegations.

During the inspection, the OIG identified related concerns regarding an institutional disclosure, and efforts to obtain community care records.

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[5] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, July 11, 2023.

[6] VHA IVC Community Care, "Introduction," chap. 1 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook,* accessed July 11, 2024, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. (This site is not publicly accessible.) The guidebook is a continually updated process and information guide outlining specific functions of community care operations. This specific chapter outlines the program's requirements, processes, and tools.

[7] VHA Directive 1232(5), *Consult Processes and Procedures,* August 24, 2016, amended December 5, 2022.

[8] VHA IVC, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022; VHA IVC Community Care, "Care Coordination Model," chap. 3:05.03.01 in *VHA IVC Community Care Field Guidebook*, accessed January 31, 2024.

Scope and Methodology

The OIG initiated the inspection on January 8, 2024, and conducted a site visit February 27–29. The team conducted interviews from February 21, through April 22, 2024. The OIG interviewed VISN and system leaders, and relevant providers and staff within the system. The OIG also interviewed selected providers and staff from the Kansas City VA Medical Center, located in Kansas City, Missouri; who were familiar with the patient reviewed in this report and with LCS program processes.[9] The OIG team interviewed subject matter experts from the National Center for Lung Cancer Screening (NCLCS).

The OIG reviewed VHA directives, memoranda, and guidelines relevant to the topics in this report, as well as external standards and professional literature. The OIG reviewed system policies and procedures, email correspondence, selected patients' EHRs, a committee board charter, committee meeting minutes February–April 2024, quality reviews, and system care coordination agreements. The OIG reviewed non-VHA patient records obtained by subpoena.

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.

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.

[9] Interviews included VISN and system leaders; service line managers; and staff knowledgeable about lung cancer screening, community care, quality management, primary care, and pulmonology.

Case Summary

The patient, in their 60s, had a history of tobacco use, hypertension (high blood pressure), and hyperlipidemia (high cholesterol).[10] The patient's Patient Aligned Care Team (PACT) provider ordered a computed tomography (CT) scan to screen for lung cancer, which was completed at the system in midsummer 2023.[11] The day of the CT scan, the PACT provider informed the patient the CT scan showed a left sided lung mass that was concerning for lung cancer. The PACT provider ordered a community care consult for a positron emission tomography (PET) scan and a system pulmonary consult to be completed at the system's campus in Leavenworth.

The next day, a system pulmonologist converted the face-to-face consult request to an e-consult. In the e-consult, the pulmonologist recommended an endobronchial ultrasound (EBUS) bronchoscopy.[12] The pulmonologist noted an EBUS was not available at the system and recommended the patient undergo an EBUS outside the system. The pulmonologist's note stated, "please consult KCVA [Kansas City VA Medical Center] multi-disciplinary clinic or pulmonary" if the patient "would like to go to KCVA;" however, if the patient prefers to have the EBUS bronchoscopy in the community, "message me [the pulmonologist] on TEAMS to refer [the patient] to them."[13]

The same day, through a cosigned note, the PACT provider tasked the PACT nurse to call the patient to "inform the veteran that the pulmonologist recommended [the patient] to have a bronchoscopy which is not available at [the system]." The nurse was told to ask the patient "which facility [the patient] would like to go for bronchoscopy," and to provide the patient the options of seeing Kansas City VA Medical Center or one of three community providers. One day later, the PACT nurse documented contacting the patient and noted the patient "has process for getting Bronchoscope set up." However, neither a Kansas City VA Medical Center nor a community care consult for the patient's EBUS bronchoscopy was found in the patient's record.

The following month, the patient's PET scan was completed at a community hospital. The PET scan results were abnormal and consistent with lung cancer with metastatic spread to the lymph nodes of the chest. That same day, the community hospital faxed the abnormal PET scan results to Kansas City VA Medical Center, rather than the system's community care department.

Four days after the PET scan was completed, a system community care advanced medical support assistant (AMSA) noted the patient attended the appointment and that no records had

[10] The OIG uses the singular form of they, "their" in this instance, for privacy purposes. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[11] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT)*, June 2, 2014, amended February 29, 2024. The PACT provider is the primary care provider for the patient.

[12] EBUS is a sophisticated lung biopsy procedure that requires a consult to be sent to a pulmonologist who has the specialized training required to perform the procedure.

[13] TEAMS is a Microsoft messaging and communications application.

been received from the community provider. The same day, the AMSA documented having faxed a request for records to the community provider noting, "one attempt to obtain medical records without timely response from the community provider," and administratively closed the PET consult.

One day later, a system radiology scheduler documented the community PET scan had been completed and that a "Request for records has been sent." The ordering PACT provider cosigned the note.

Approximately two weeks later, a Kansas City VA Medical Center staff member uploaded the PET scan results to the patient's EHR; however, the results were not attached to the original PET scan consult created at the system. There were no further EHR notes for care received from fall until the end of 2023.

In late 2023, the patient had an episode of vertigo and was admitted to a community hospital. Approximately five days later, the patient was transferred from the community hospital to the Kansas City VA Medical Center for continued care needs related to vertigo. The inpatient attending physician at the Kansas City VA Medical Center acknowledged the patient's previous abnormal CT and PET scan results and placed Kansas City VA Medical Center pulmonary and oncology consults. The Kansas City VA Medical Center pulmonologist completed a face-to-face consult and recommended an EBUS bronchoscopy that was completed six days later at Kansas City VA Medical Center. Lung biopsies obtained from the EBUS bronchoscopy revealed small cell lung cancer. The Kansas City VA Medical Center oncologist documented "Interval hx: After first PET CT, Veteran states he did not get recommendation to see oncology. He assumed there was no urgency ..." An oncologist recommended repeating the PET and CT scan given that the previous PET scan was now over three months old. The PET scan showed no new distant spread. Repeat CT scans showed findings consistent with lung cancer with localized spread to the mediastinal (chest) nodes with lymph nodes having enlarged since the scans in August 2023.

Following consultation by a radiation oncologist, the patient was started on a combination of chemotherapy and radiation treatment. The intent of the treatment was described by the oncologist as "palliative (possibly curative)." The patient was treated for small cell lung cancer at the Kansas City VA Medical Center from late 2023 through early 2024, when the patient was transferred to the system's community living center for continued cancer treatment.

Inspection Results

1. Delayed Diagnosis and Treatment of a Patient's Lung Cancer

The OIG substantiated that the patient experienced a delay in the diagnosis of and treatment for lung cancer. The OIG found the following failures contributed to this delay:

- The PACT provider and the pulmonologist failed to order the consult needed for the patient to obtain the recommended EBUS bronchoscopy and failed to follow up to ensure that the procedure was scheduled and completed.
- The PACT provider failed to track the patient's PET scan; communicate the abnormal results to the patient; and initiate timely, appropriate clinical actions.

Further, the OIG learned that, upon recognizing these failures, system leaders completed an institutional disclosure with the patient; however, the insufficient institutional disclosure documentation raised concerns regarding whether the patient received a full disclosure of the system failures that led to the delay in diagnosis and treatment for lung cancer.

The OIG also identified deficiencies in the system's community care staff's efforts to retrieve patient records that may have contributed to the delay in the patient's cancer diagnosis and care; these issues are addressed in section 2.

Failure to Coordinate Patient's EBUS Bronchoscopy

The OIG found that neither the PACT provider nor the pulmonologist ordered the consult needed for the patient to obtain the recommended EBUS bronchoscopy and neither provider followed up to ensure the procedure was scheduled and completed.

Per VHA policy, a "consult is a request for clinical services on behalf of a patient" and consists "of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider (receiver)."[14] The receiver may complete a request for face-to-face consult as an e-consult, in which the receiver utilizes the information provided in the consult request or from an EHR review to provide a response that addresses the request without having a face-to-face visit with the patient, or both.[15]

VHA defines a care coordination agreement as "an agreement or understanding between two or more services within or between facilities, one of which sends work to the other(s), defining the

[14] VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022.

[15] VHA Directive 1232(5); *Electronic Consultation (E-Consult) Implementation Guide*, May 2019. Although VHA policy allows the service receiving the consult to convert a face-to-face consult to an e-consult, VHA guidance states "the PCP [PACT provider] should retain the ability to decline the E consult … if either the PCP [PACT provider] or the Veteran feels strongly that a face-to-face consult is needed."

workflow rules."[16] A care coordination agreement must establish clear processes and include the "method for communicating recommendations and treatment plan back to the referring clinician … in order to simplify, standardize, and clarify communication."[17] The system's pulmonary service care coordination agreement in place at the time of the e-consult did not identify who was responsible for ordering, tracking, and following up on tests recommended by the pulmonologist. In April 2024, the OIG reviewed an updated care coordination agreement, which identified pulmonologists as "responsible for ordering and communicating … test results for the test they recommend after the initial patient consultation."

During an OIG interview, the PACT provider acknowledged a lack of experience coordinating the workup of a patient with possible lung cancer. Following the identification of the patient's suspicious lung mass, the PACT provider reported placing a pulmonary consult with the expectation the pulmonologist would see the patient, evaluate the condition, make related recommendations, and assist with facilitating the recommended course of treatment. However, the PACT provider explained the pulmonologist converted the consult to an e-consult and made recommendations for the PACT provider to follow up regarding further evaluation of the patient's lung mass. The pulmonologist tasked the PACT provider with contacting the patient to inquire where the patient would like to have the procedure, and if the patient chose to obtain the bronchoscopy in the community, the PACT provider was to contact the pulmonologist to place the community care consult.

The OIG interviewed the pulmonologist who reported converting the pulmonary consult to an e-consult in an effort to expedite the patient's care. The pulmonologist explained the patient's lung mass was highly suspicious for malignancy and the patient needed an EBUS bronchoscopy, which was unavailable at the system and required a referral to a pulmonologist who could conduct the procedure. The OIG learned in interviews that either the PACT provider would have had to enter a consult to the Kansas City VA Medical Center, or the pulmonologist would have had to enter a consult to the community for the EBUS bronchoscopy procedure to be completed.

After reviewing the e-consult recommendations, the PACT provider asked a PACT nurse to contact and obtain the patient's preference on where to have the procedure completed. The next day, the nurse called the patient and documented the patient reported already having a "process for getting Bronchoscope set up." The OIG found no documentation in the patient's EHR indicating either the PACT provider or the pulmonologist made follow-up contacts to verify that the EBUS bronchoscopy had been ordered and scheduled, and no related order was placed after the nurse called the patient.

[16] VHA Directive 1232(5).

[17] VHA Directive 1232(5).

When asked why the pulmonologist did not contact the patient directly to obtain the patient's preference rather than delegating the task to the PACT provider, who would then need to report back to the pulmonologist if the patient opted to have community care, the pulmonologist said PACT staff are best to communicate with the patient because they have an established relationship.[18] The pulmonologist reported having reviewed the patient's record and believed the bronchoscopy had been scheduled based on the PACT nurse's EHR documentation.

During an OIG interview, the PACT provider reported reviewing the nurse's documentation regarding the bronchoscopy and having the impression that the pulmonologist had ordered the patient's EBUS bronchoscopy but did not review the EHR to verify an order was placed. The PACT provider stated, after recently rereviewing the EHR, "I think the patient has confusion and [the patient] did not know what bronchoscopy is." The PACT provider added there was a "misunderstanding between nurse and the patient, because the nurse is not my nurse, [rather] a surrogate nurse."[19] The PACT provider opined that talking to the patient directly may have resulted in a different outcome, as the patient may not have understood the medical terms.

During an OIG interview, the nurse who had contacted the patient regarding the EBUS bronchoscopy described usually verifying patient-provided information about a consult order being scheduled with EHR documentation. However, the surrogate nurse had no recollection of the patient and could not remember what actions were taken to communicate information relayed by the patient to the PACT provider.

The OIG found that the PACT provider incorrectly assumed the pulmonologist had placed the related consult, and based on that assumption, the PACT provider did not follow up with the patient or verify the order was placed by reviewing the patient's EHR. Despite recognizing the seriousness of the patient's lung mass and converting the face-to-face consult to an e-consult to expedite the patient's care, the pulmonologist did not follow up with the PACT provider or patient to ensure the recommendation was addressed or review the EHR to verify a related order was placed or completed.

The OIG concluded that following the pulmonologist's recommendation that the patient have an EBUS bronchoscopy, neither the PACT provider nor the pulmonologist took the steps needed to ensure the necessary consult to either the Kansas City VA Medical Center or to a community provider was placed. As a result, the patient did not have an EBUS bronchoscopy until more than

[18] Per the system's subspecialty care service line manager, the pulmonologist is the delegated authority for approving and placing pulmonary-related community care consults. As such, the pulmonologist must place all community care consults for EBUS bronchoscopies. VHA IVC, "Defining Eligibility," chap. 2 in *VHA IVC Community Care Field Guidebook*, accessed February 28, 2024. Once community care eligibility has been confirmed, some consults require further review and approval by an individual who has the authority (delegated authority) to clinically review and determine if the service requested is appropriate.

[19] A surrogate PACT nurse is another PACT nurse covering the duties of the regularly assigned PACT nurse.

four months later when ordered by a Kansas City VA Medical Center pulmonologist while undergoing evaluation for lung cancer.

PACT Provider's Failure to Track and Communicate PET Scan Results

The OIG found that the patient's PACT provider, who ordered the PET scan and was alerted that the test was completed, failed to ensure the system received the results. Consequently, the PACT provider failed to communicate the PET scan results to the patient and to initiate timely, appropriate clinical actions.

VHA requires that ordering providers maintain responsibility for the results of the tests they order, including communicating test results to patients and initiating "timely and appropriate clinical action and follow-up for any test orders that they have placed."[20]

Within VHA, when a patient undergoes diagnostic imaging or a procedure, the system's diagnostic services provider must communicate test results to the system's "ordering provider or designee within a timeframe that allows for prompt attention and appropriate action to be taken."[21] The diagnostic provider is responsible for "identifying and communicating all new emergent and imminently life-threatening test results and new urgent not immediately life-threatening abnormal test results to the … ordering provider or designee" and ensuring "test result reports are available in the patient's EHR as soon as the reports are verified."[22] When test results require further action, such as the abnormal results discussed above, the ordering provider or designee must communicate the results to patients within seven calendar days from the date the results are available, and some test results may need to be reviewed and communicated earlier.[23]

In contrast, when a community provider completes the requested service, system community care staff wait to receive medical documentation, such as diagnostic test results, from the community

[20] VHA Directive 1088.

[21] VHA Directive 1088.

[22] VHA Directive 1088. The VHA directive uses the terms "not immediately" and "not imminently" interchangeably when speaking of a type of abnormal test result.

[23] VHA Directive 1088.

provider.[24] If not received soon after the appointment is complete, community care staff request the medical records and close the consult in the patient's EHR either with or without the records. The closure triggers an electronic alert to the ordering provider to notify them of the consult status. When medical records are received, community care staff upload and attach the records to the original consult and an alert that records are available is sent to the ordering providers.

Through an EHR review, the OIG learned the PACT provider placed a community care PET scan consult in late summer 2023. Approximately one month later, the PACT provider cosigned an EHR note that stated the patient's PET scan was completed and that a request for records had been sent to the community care provider. Despite having ordered the PET scan, the PACT provider did not document any attempt to obtain the PET scan results.

EHR documentation showed that in late 2023, a Kansas City VA Medical Center provider informed the patient of the abnormal results from the PET scan performed three months earlier. During an interview, the Kansas City VA Medical Center provider told the OIG that when informed of the abnormal results, the patient reported having no idea there was a problem and had thought that "no news is good news."

During an interview, the PACT provider acknowledged forgetting about the patient's PET scan order and rather than having an independent system to track orders placed, the PACT provider relied upon receiving an alert in the EHR when community care staff obtained consult results. After learning of the OIG inspection and reviewing the patient's EHR, the PACT provider, with the assistance of the chief of primary care, implemented an independent tickler system in the EHR to track orders and avoid further occurrences of missing test results.

The OIG found that the PACT provider's reliance on the system's community care staff to retrieve and notify the provider when the patient's PET scan results were available did not relieve the obligation of the ordering provider to track and follow up on orders placed. The OIG concluded that the PACT provider's failure to track the PET scan, notify the patient of abnormal results, and initiate timely clinical actions significantly contributed to the delay in diagnosis and treatment of the patient's lung cancer.

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[24] VHA IVC, "Consult Completion and Medical Records Management, How to Close Community Care Consults," chap. 4 in *VHA IVC Community Care Field Guidebook,* accessed February 27, 2024, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000226159/FGB-Chapter-4-050402-Update-to-Current-Procedure-Administratively-Closing-the-Community-Care-Consult. (This website is not publicly accessible.) The guidebook is a continually updated process and information guide outlining specific functions of community care operations; *VHA Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, Office of Integrated Veteran Care (IVC) Community Care, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. (This website is not publicly accessible.) VHA medical facilities "may purchase care in the community for eligible Veterans, after VA options to render care have been considered." VHA's Office of Integrated Veteran Care (IVC) is responsible for managing the community care program. VHA system providers place a consult for community care; once placed, system community care staff schedule consult appointments, follow up with community care providers to ensure the patient received the care and request patient records, and close the consult in the patient's EHR.

Further, the OIG is concerned with the absence of an established process for community care providers to communicate new urgent not imminently life-threatening abnormal test results promptly and directly, such as the patient's abnormal PET scan result, to the system's ordering provider. These vulnerabilities, as well as deficiencies found in community care staff's medical records retrieval process, are further discussed in issue 2.

Insufficient Institutional Disclosure

Although EHR documentation stated system leaders conducted an institutional disclosure with the patient, the OIG determined the documentation did not provide the details of the disclosure and discussion points of the adverse event as required. As a result, the OIG could not discern what information was disclosed to the patient, including what adverse event occurred.[25] The OIG found the PACT and pulmonary providers' failure to coordinate the patient's EBUS bronchoscopy, and the PACT provider's failure to track and notify the patient of the abnormal PET scan results, were adverse events that resulted in the delayed diagnosis and treatment of the patient's lung cancer.

An institutional disclosure is a formal process for system leaders to inform a patient or the patient's "representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury …"[26] "It is VHA policy to disclose harmful or potentially harmful adverse events to patients … in order to maintain trust between patients and VA health care professionals, and to ensure uniform practice across all VA medical facilities."[27]

The system director is responsible for ensuring disclosures "are performed openly and promptly" and "correctly documented" in a patient's EHR, utilizing a standardized note template that outlines the required disclosure components. System leaders are required to update the template with the details of the disclosure, including the discussion points of the adverse event, assistance offered, questions addressed, advisement of potential claims for compensation, and other specific disclosure details.[28]

The OIG learned that prior to the OIG alerting system leaders to the adverse events of the patient's abnormal PET scan results and subsequent delay in the diagnosis and treatment of lung cancer, the PACT and pulmonology providers were unaware of the patient's clinical situation. During an interview, the System Director discussed the patient's care and acknowledged that

[25] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[26] VHA Directive 1004.08. VHA policy provides examples of serious injury to include, but not limited to, an injury that results in significant or permanent disability, prolonged hospitalization, or requires life-sustaining intervention.

[27] VHA Directive 1004.08.

[28] VHA Directive 1004.08.

missing critical PET scan results may have caused a delay in treatment or an acceleration in the patient's condition.

System leaders conducted an institutional disclosure with the patient on March 14 and documented the meeting in the EHR on March 18, 2024. The institutional disclosure was documented on the required note template and included the date, location, and names of those present when the disclosure was conducted, and noted the patient was given information regarding potential claims for compensation. The documentation did not include details of the disclosure, including the discussion points of the adverse event, assistance offered, questions addressed, and other specific disclosure detail as required by VHA policy. Further, the required open text fields to document resources provided or questions addressed, stated, "none." As a result, the OIG could not discern the nature of the adverse event disclosed or what was explained or offered to the patient.

The OIG found the absence of documentation of an explanation of facts associated with the adverse event lacked transparency about the substantive issues related to the patient's care that an institutional disclosure is intended to convey. The OIG concluded that system leaders did not meet institutional disclosure requirements as crucial components of the disclosure were not documented. The OIG is concerned that the patient may not have been informed of the adverse events that led to the delay in the diagnosis and treatment for lung cancer or of the available options for recourse.

The OIG concluded that the system PACT provider and pulmonologist failed to order a consult to obtain a recommended EBUS, and that the PACT provider who had ordered a PET scan for the patient failed to track and communicate the abnormal test results to the patient. Furthermore, the OIG found that the system's institutional disclosure lacked required documentation to confirm if the patient received a full disclosure of the system failures that led to the delay in diagnosis and treatment for lung cancer.

2. Deficiencies in Community Care Records Retrieval

The OIG determined that the system's community care staff failed to make the required number of attempts to obtain the patient's PET scan results from the community provider within 90 days of the completed appointment, contributing to the delay in diagnosis of and treatment for lung cancer. The OIG learned that these deficiencies were not isolated to the patient but were indicative of a broader system issue of community care staff routinely failing to request community care records, in accordance with VHA requirements, after consults are completed and administratively closed.

VHA established a process for system community care staff to administratively close consults when community care providers have not sent patients' medical documentation to the system following completed appointments. VHA requires community care staff to make three attempts to retrieve patients' records. Community care staff must

- confirm the patient attended the appointment,
- make and document an initial attempt to obtain records,
- administratively close the consult with or without documentation within 90 days, and
- make two subsequent attempts to retrieve records within 90 days of the completed appointment.[29]

Additionally, VHA guidelines emphasize that community care managers should convey to "staff that administrative closure does not release the obligation of gathering clinical documentation. Continued attempts to obtain clinical documentation is expected to ensure continuity of care." Further, efforts to obtain records "should continue until all viable interventions for resolving documentation deficiencies with the community provider have been attempted."[30]

Inadequate Efforts to Obtain Patient's PET Scan Results

A review of the EHR revealed the patient's PET scan appointment occurred in summer 2023. Several days later, an AMSA documented having made the initial attempt to obtain the patient's records from the community care provider, and one minute later documented that the consult was administratively closed without records.[31] No additional attempts to retrieve the patient's PET scan records were documented within the required 90-day time frame. In early 2024, five months after the consult was administratively closed, the associate chief nurse of community care (associate chief nurse) documented making two additional attempts to retrieve the patient's community care records in the EHR.[32]

The OIG interviewed the AMSA who administratively closed the patient's consult. The AMSA explained that community care AMSAs are responsible for scheduling community care consults, ensuring patients attend scheduled appointments, and following up with community care providers to obtain patients' records. The AMSA stated that after making an initial attempt to obtain the patient's records and administratively closing the consult, making two additional

[29] VHA IVC, chap. 4 in *Community Care Field Guidebook,* August 29, 2023; Assistant Under Secretary for Health for Community Care (13), "Revised Administrative Closure of Community Care Consult Process (VIEWS #06042227)," memorandum to Veterans Integrated Service Network Directors, October 1, 2021; VHA Directive 1232(5), Consult Processes and Procedures, 08.24.2016, amended 12.05.2022; VHA SOP*, Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure,* July 28, 2022. Low-risk consults require community care staff to make one attempt, rather than three, to retrieve community records. A PET scan is not a low-risk consult.

[30] VHA IVC, chap. 4 in *Community Care Field Guidebook,* August 29, 2023.

[31] A review of the patient's community care records show the patient completed the appointment on September 1, 2023.

[32] The associate chief nurse made the two additional attempts to obtain the patient's records after system leaders were notified of the OIG review.

attempts to obtain records within the 90-day time frame was the expectation; however, the AMSA explained that because system community care staff were behind on scheduling community care appointments, "my focus is on getting my veterans scheduled."

The OIG concluded community care staff did not follow VHA guidelines to make three attempts to retrieve the patient's PET scan results within 90 days of completion. Given the nature of the diagnostic consult, the OIG is concerned about the minimal efforts made by community care staff and the associate chief nurse to retrieve the patient's PET scan results, which contributed to the delay in diagnosing and treating the patient's lung cancer.

Community Care Records Sent to Wrong Facility

An OIG review of the patient's EHR revealed that on the same day the PET scan was completed, the community provider sent the patient's abnormal PET scan result to the Kansas City VA Medical Center instead of sending the result to the system. Kansas City VA Medical Center staff uploaded the records to the patient's EHR 13 days later in late summer 2023. During interviews, the OIG learned that because the records were not attached to the system's consult, the system's ordering PACT provider was not alerted to the patient's abnormal results. Consequently, no timely clinical action was taken on the patient's abnormal test results.

System and Kansas City VA Medical Center staff interviewed explained that because the two VA facilities are close and use some of the same community providers, there have been times that community providers have sent records to the wrong facility and relayed that the individual who identifies the error is responsible for getting the records to the correct location. The System Director and Chief of Staff described the incident as a deficiency that affected the patient's care. The System Director stated communication between the system and Kansas City VA Medical Center staff regarding receipt of patients' community care records was an area that needed improvement. The OIG recognized this as a system issue and vulnerability, not isolated to the patient.

System Failures to Retrieve Community Care Records

During an interview, the associate chief nurse informed the OIG that the system's community care program has had challenges following up with community care providers to obtain medical records, sharing that the practice was not "incorporated into our processes as a regular occurrence." The associate chief nurse explained that performance metrics are focused on scheduling timeliness versus care coordination activities, and as such, when the system was not meeting scheduling standards, VISN and system leaders conveyed these to be the priority. The associate chief nurse reported having shared concerns with VISN and system leaders that the efforts required by community care staff to meet scheduling metrics would limit staffing resources available to coordinate care and retrieve medical records. Although system leaders

listened to the concerns, the associate chief nurse reported the guidance from the VISN remained the same.

During an interview, the Associate Director of Patient Care Services confirmed that in order to meet VISN and VHA expectations, system community care staff prioritized timely scheduling of community care appointments.[33] The Associate Director of Patient Care Services reported the associate chief nurse expressed concerns to VISN and system leaders about closing community care consults before completing the additional attempts to obtain records and the risk to patients if additional attempts were not made.

The OIG reviewed documentation showing the associate chief nurse reported concerns about community care priorities and limited resources to VISN and system leaders. In an email response to the System Director in October 2021, the associate chief nurse expressed concerns about proposed community care metrics stating,

> It is important that we do not lose focus on follow-up after care is received (i.e., requesting medical documentation and completing scheduled consults) … we will not be able to meet these metrics with the existing amount of [staff] and fulfill the remaining responsibilities related to coordination of care once the care has been scheduled. Without adjustment, we will continue to see improvement in the area of "current focus" while all other areas of care coordination falter. We cannot make meaningful progress when we are "robbing Peter to pay Paul."

To which the System Director responded, "As you know I don't like to chase metrics just to meet them. I want to see that our Veterans are being taken care of and that care coordination does occur."

The OIG learned that at the time of the above communication, VHA issued a memorandum revising the community care administrative closure criteria and procedure. Prior to October 2021, the criteria required more arduous efforts before community care staff could administratively close a consult. Specifically, after a consult appointment was completed, community care staff could administratively close the consult if records were not received within 30 days of the appointment and if staff had made three documented attempts on separate days to acquire the documentation.[34]

[33] A review of the system's organization chart reveals the system's Associate Director of Patient Care Services has direct oversight over the system's community care program.

[34] Deputy Under Secretary for Health for Operations and Management (10N), "Clarification of Administrative Closure of Community Care Consults (VAIQ# 7880748)," memorandum to Veterans Integrated Service Network Directors, March 6, 2018; this memorandum was superseded by Assistant Under Secretary for Health for Community Care (13), "Revised Administrative Closure of Community Care Consult Process (VIEWS #06042227)," memorandum to Veterans Integrated Service Network Directors, October 1, 2021.

On October 1, 2021, VHA's revised administrative community consult closure procedure eliminated some criteria previously required. The revised procedure did not require community care staff to wait 30 days to receive medical records and only required staff to make one attempt versus three to obtain records before administratively closing a consult.[35]

During an OIG interview, the VISN community care program manager (VISN program manager) expressed the importance of obtaining patients' community care records and noted that other community care leaders in the VISN have also reported struggling with the record retrieval requirements of the consult process. Although VHA monitors whether community care consults are closed within 90 days of scheduled appointments, the VISN program manager stated the closure of a consult, whether closed with or without community care records, satisfies the metric. Further, VHA does not monitor how many consults were closed without records or whether community care staff made three attempts to secure records. The VISN program manager shared that community care leaders nationwide have been challenged with reviewing the resources they have (staffing), assessing main priorities, and determining what can be reasonably accomplished.

The OIG learned the system's failure to make additional attempts to retrieve community care records was not unique to the system or VISN. A recent OIG report reviewed community care staff's compliance in making additional attempts to retrieve community care records after administratively closing consults at two VA medical centers in VISN 9.[36] The OIG found that one VHA facility did not make additional attempts to retrieve records for 73 percent of the cases reviewed; another VHA facility did not make additional attempts to retrieve records for 57 percent of the cases reviewed. A community care leader from one of the facilities cited prioritizing scheduling efforts over retrieving records as a reason for noncompliance, and community care leaders from both facilities cited staffing challenges.[37]

The OIG concluded that the system's community care staff routinely failed to make additional requests to obtain patients' medical records, which system leaders and the associate chief nurse attributed to focusing community care staffing resources and efforts on meeting consult scheduling metrics, leaving minimal resources available to follow up after consult appointments were complete.

[35] Assistant Under Secretary for Health for Community Care, "Revised Administrative Closure of Community Care Consults Process," memorandum; VHA IVC, chap. 4 in *Community Care Field Guidebook,* August 29, 2023. The Administrative Closure Report is a tool that shows consults that have been administratively closed without receiving patient records; the tool helps community care staff track consults that require staff to make additional attempts to retrieve community care patient records.

[36] VA OIG, *Care in the Community Inspection of VA MidSouth Healthcare Network (VISN 9) and Selected VA Medical Centers*, Report No. 23-01737-205, August 15, 2024.

[37] VA OIG, *Care in the Community Inspection of VA MidSouth Healthcare Network (VISN 9) and Selected VA Medical Centers*. The OIG made a recommendation to the VISN Director to ensure compliance with VHA requirements for retrieving records.

Although VHA guidance emphasizes the importance of retrieving patients' community care records, the OIG noted that the significance of such is not mirrored in VHA's community care metrics. The OIG is concerned that an administrative closure without records places a vulnerability on the care and safety of patients by directly affecting the patient and ordering provider, who are dependent on consult results and records being made available for further care coordination. The OIG concluded that there could be unintended delays and clinically related consequences when medical record retrieval is not closely monitored by VHA.

3. Deficiencies in the System's Lung Cancer Screening Program

The OIG substantiated that the system's LCS program lacked the oversight and multidisciplinary engagement necessary to implement, evaluate, and manage an effective program. Specifically, system and program leaders failed to develop the program's infrastructure prior to implementation, including the LCS Oversight Board, LCS program policy, and adequate primary care engagement and training. These deficiencies created vulnerabilities that could negatively affect the care for patients receiving lung cancer screening. Although on paper the LCS program meets NCLCS required minimum criteria, the OIG found that operationally, the system's LCS program was not in alignment with these standards.

VHA's Lung Cancer Screening Program

In November 2017, VHA issued a memorandum providing recommendations for LCS with a low-dose CT scan at VHA facilities.[38] This memorandum was updated in July 2022. The update detailed LCS program accountability and oversight requirements through specific members of an oversight board and access to a multidisciplinary Lung Nodule Management Board.[39] The memoranda stipulated that, "VA medical facilities may perform lung cancer screening only when all the [specified] criteria for components of a high-quality lung cancer screening program are met."[40]

In May 2024, VHA rescinded the LCS memorandum and published a "new directive that establishes instructions and procedures for the implementation, staffing, and performance of

[38] Deputy Under Secretary for Health for Operations and Management (10N), "Lung Cancer Screening with Low Dose Computed Tomography," memorandum to Network Director and VISN Chief Medical Officers, November 27, 2017.

[39] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memorandum, "Guidelines for Lung Cancer Screening in Veterans Health Administration," July 15, 2022. The memorandum served as a revision memorandum, replacing prior guidance from a March 24, 2022, memorandum.

[40] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Revision Memorandum: Guidelines for Lung Cancer Screening in Veterans Health Administration (VHA) (Views 6762531)," memorandum to Veterans Integrated Service Network (VISN) Directors and VISN Chief Medical Officers (CMOs), July 15, 2022, rescinded and replaced by VHA Directive 1417, *Lung Cancer Screening*, May 29, 2024. The policies contain similar language related to lung cancer screening guidelines, and the OIG notes there are no changes to the criteria outlined within this report.

Lung Cancer Screening (LCS) Programs in Department of Veterans Affairs (VA) medical facilities."[41] The directive outlines oversight duties and details the roles and responsibilities of staff who are involved with LCS at the national, VISN, and system levels. The criteria required to offer a high-quality LCS program remained the same, with one exception related to CT scan protocols that are no longer required.[42] As of August 2024, criteria discussed in this report remained active.

In 2021, VHA established the NCLCS, whose mission is to "[i]ncrease systematic, integrated, and equitable access to high-quality lung cancer screening processes for Veterans through a collaborative, interdisciplinary network."[43] The NCLCS describes lung cancer screening as a multidisciplinary process, aimed at obtaining "very high levels of adherence to follow-up recommendations."[44]

System's LCS Program

The OIG reviewed system documents and learned that in July 2021, system leaders submitted a clinical restructuring request to initiate an LCS program. The request was approved by the Acting Under Secretary for Health in January 2022.[45] Per the system LCS coordinator, the LCS program was launched on June 27, 2023, nearly two years after the initial clinical restructuring request was submitted.

The OIG reviewed documents that included the system's approved clinical restructuring request and noted that when the LCS program was originally approved, the plan designated a system oncologist to manage the LCS program, and two system oncology registered nurses to serve as LCS coordinators. Staffing resources originally designated to implement the program were no longer available. As such, at the time of implementation, several LCS program components were different from those outlined in the approved clinical restructuring request. Through document reviews and interviews, the OIG learned that due to the system oncologist's planned retirement, changes were made to the LCS program when implemented, including the designation of the

[41] VHA Directive 1417, *Lung Cancer Screening*, May 29, 2024.

[42] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Revision Memorandum: Guidelines for Lung Cancer Screening in Veterans Health Administration," memorandum; VHA Directive 1417, "Optimized radiology CT protocols and standardized procedures names, along with standardized reporting methodology/codes and lung nodule management guidelines" is no longer listed under eligibility criteria in the directive; all other criteria remained the same.

[43] "National Center for Lung Cancer Screening," accessed May 8, 2024, https://dvagov.sharepoint.com/sites/NCLCS/SitePages/Our-Story.aspx. (This site is not publicly accessible.)

[44] "National Center for Lung Cancer Screening," accessed May 8, 2024.

[45] VHA Directive 1043, *Restructuring of VHA Clinical Programs*, November 2, 2016. A clinical restructuring request is a proposal to restructure, reduce, or augment major clinical services that may change the care provided to veterans.

system's pulmonologist to manage the LCS program with an advanced practice registered nurse and a registered nurse to serve as the LCS coordinators.

The OIG found system staff communicated the changes made in the LCS program to an NCLCS program manager, who informed system staff that changes in oversight responsibilities could be reflected in the system's LCS program standard operating procedures. The OIG found that changes in oversight responsibilities were reflected in the system's LCS program standard operating procedures.

Inadequate LCS Program Infrastructure and Oversight

The OIG determined that system and program leaders failed to develop the infrastructure needed to effectively implement the system's LCS program. The NCLCS developed recommended guidance for VA facilities implementing an LCS program.[46] Through interviews and a review of documents, the OIG learned that the LCS program's infrastructure was neither fully developed nor functional when system leaders and LCS program staff launched the program.

Lack of LCS Board Oversight and Standard Operating Procedures

The OIG found that the system's LCS Oversight Board failed to provide adequate oversight of the program. LCS Oversight Board meetings were poorly attended, and meeting minutes documented limited oversight discussions. Similarly, at the time of implementation, system and program leaders had not created the LCS program's standard operating procedures that would have guided providers' management of a patient's progress through the LCS program.

VHA guidelines state the LCS Program Oversight Board is "responsible for the oversight of the conduct and management of the LCS program."[47] The board involves representation from pulmonary, radiology, and primary care services, "with consideration to add other relevant stakeholders (e.g., medical, surgical, and radiation oncology providers, Veteran Engagement specialists, etc.)" and participation from the LCS coordinator. The NCLCS recommends VA facilities establish standard operating procedures prior to LCS program implementation to assist in guiding "how patients will move through the program from enrollment to diagnosis."[48]

Prior to launching the LCS program, the system had not established a formal LCS Oversight Board, developed LCS program standard operating procedures, or provided sufficient training to

[46] The NCLCS implementation steps referenced in this report were dated April 10, 2023.

[47] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Revision Memorandum: Guidelines for Lung Cancer Screening in Veterans Health Administration," memorandum, July 15, 2022; VHA Directive 1417. The policies contain similar language related to LCS Oversight Board responsibilities.

[48] "LCS Advisory Boards, Program Models, and Standard Operating Procedures," accessed May 9, 2024, https://dvagov.sharepoint.com/sites/. (This site is not publicly accessible.); "LCSP Implementation Roadmap," accessed May 9, 2024, dvagov.sharepoint.com/sites/. (This site is not publicly accessible.)

ensure PACT providers and nursing staff were aware of the LCS program and understood their roles and responsibilities (see figure 1).[49]

Figure 1. LCS Program Implementation Process (Recommended versus Actual)

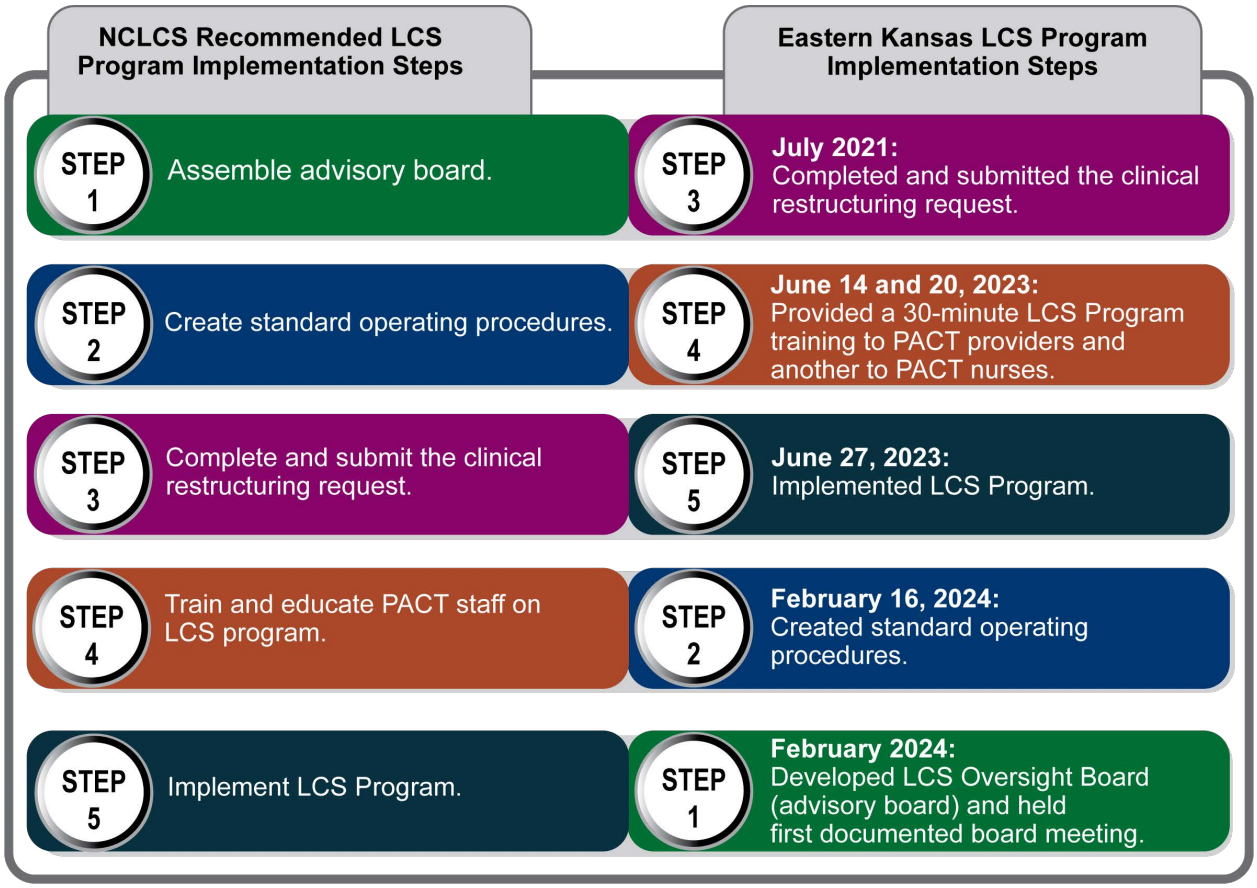


Figure 1. *VHA and System LCS program implementation comparison.*
Source: OIG's comparison of the NCLCS' recommended LCS program implementation process versus the system's implementation process, which includes information found in document reviews and provided in interviews.

The OIG reviewed the system's LCS Program Oversight Board's charter and found system and program leaders did not complete the charter outlining the board's mission, members, scope, or responsibilities until February 28, 2024, eight months after the LCS program became operational.[50] The LCS Oversight Board charter noted the pulmonologist as the board's chair and listed eight board voting members, by position, to include the pulmonologist, a radiologist, the service line manager for subspecialty care, a radiation oncologist, a medical oncologist, a respiratory therapist, a surgeon, and a primary care service representative, which the system and

[49] The system created a Radiology Lung Cancer Screening standard operating procedure on November 1, 2023. The standard operation procedure outlines guidance for staff who provide CT scans for LCS patients and details ordering procedures, imaging parameters and reporting, and quality control to obtain "optimal image quality."

[50] The LCS coordinator informed the OIG the system's LCS Program became operational on June 27, 2023.

program leaders designated to be fulfilled by the deputy chief of staff. The LCS Oversight Board charter noted that a quorum is met when 50 percent of the members are present.[51]

The LCS coordinator provided the OIG with the names of the radiation oncologist and the medical oncologist noted to be voting members of the LCS Program Oversight Board and clarified that these two members were oncologists from the Kansas City VA Medical Center. When queried by the OIG, neither Kansas City VA Medical Center oncologists reported being aware of their membership on the board and denied having participated in or being asked to attend the system's LCS Oversight Board meetings.

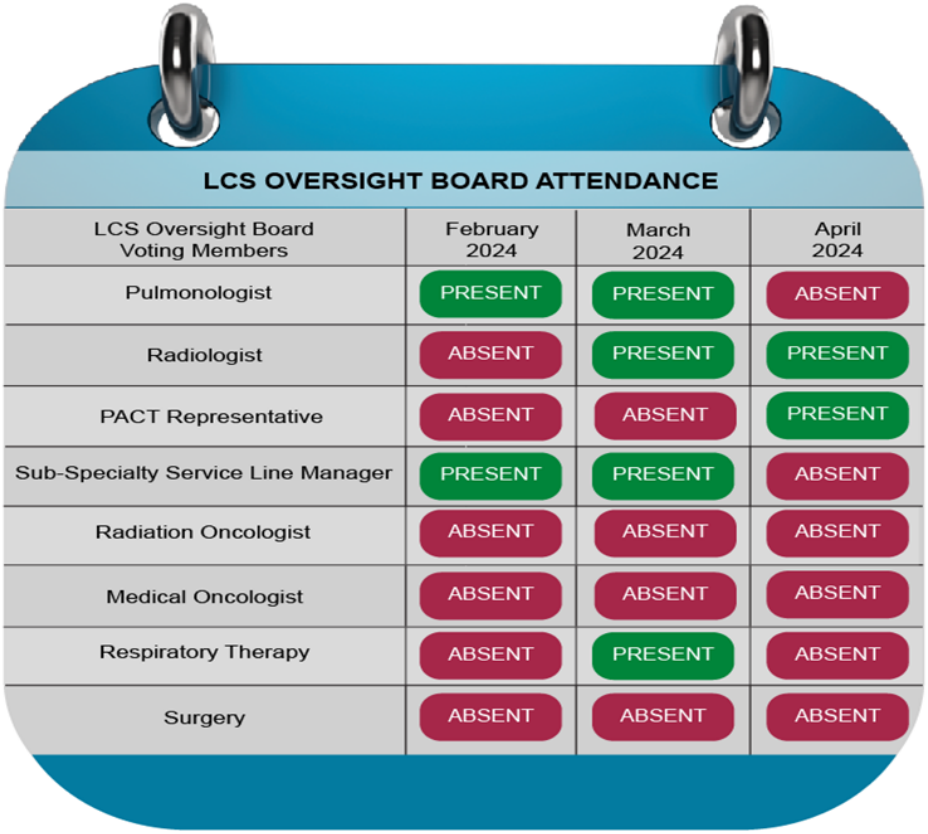
In interviews, members of the LCS Oversight Board informed the OIG that the LCS Oversight Board met monthly to discuss the infrastructure and oversight of the LCS program. The LCS coordinator provided the OIG with the LCS Oversight Board's meeting minutes for February, March, and April 2024, and explained that although regular board meetings began in March 2023, no formal meeting minutes were taken until February 2024.[52]

The OIG reviewed the LCS Program Oversight Board's monthly meeting minutes and found several concerning and conflicting items. The meeting minutes listed one of the LCS coordinators, rather than the pulmonologist, as the board's chair, and two of the three meeting minutes were unsigned. The February meeting minutes had no discussion points, and the only notation included two items under new business that stated the committee charter "was sent out for signature" and the LCS standard operating procedure draft "was sent out for voting." The LCS Oversight Board meetings did not have the attendance needed to have a quorum in either February or April. Additionally, the deputy chief of staff who served as the primary care representative as a required team member, attended only one of three meetings held (see figure 2).

[51] Quorum is defined as "the minimum number of officers or members of a body that is required to be present at a given meeting (as to transact business)." *Merriam-Webster.com Dictionary,* "quorum," accessed April 24, 2024, https://www.merriam-webster.com/dictionary/quorum.

[52] The OIG reviewed the meeting minutes and found the title on the minutes was Eastern Kansas Healthcare System Lung Cancer Screening Advisory Board but confirmed with the LCS Coordinator the LCS Oversight Board is the same as the Lung Cancer Advisory Board.

Figure 2. LCS Oversight Board Meeting Attendance



LCS OVERSIGHT BOARD ATTENDANCE

LCS Oversight Board Voting Members	February 2024	March 2024	April 2024
Pulmonologist	PRESENT	PRESENT	ABSENT
Radiologist	ABSENT	PRESENT	PRESENT
PACT Representative	ABSENT	ABSENT	PRESENT
Sub-Specialty Service Line Manager	PRESENT	PRESENT	ABSENT
Radiation Oncologist	ABSENT	ABSENT	ABSENT
Medical Oncologist	ABSENT	ABSENT	ABSENT
Respiratory Therapy	ABSENT	PRESENT	ABSENT
Surgery	ABSENT	ABSENT	ABSENT

Figure 2. *LCS Oversight Board meeting attendance.*
Source: OIG analysis of the system's LCS Oversight Board meeting minutes and attendance log.

The OIG asked the LCS coordinator what the LCS program staff utilized for procedural guidance due to the approximately eight-month delay in development of the LCS standard operating procedures. The LCS coordinator indicated the system's LCS program used the VHA memorandum dated July 2023 as guidance; however, the memorandum did not outline the detailed procedural steps that guide an LCS program.

The OIG concluded that for several months after implementation of the system's LCS program, the LCS Oversight Board did not have established procedures and member involvement to provide adequate oversight and management. The lack of adequate oversight and management may diminish the effectiveness of lung cancer screening for patients.

Lack of PACT Training and Engagement

The OIG found PACT providers and nursing staff received limited training, if any, about the LCS program, and the PACT staff interviewed by the OIG had minimal awareness of the program's operations.

A review of a system LCS process map, used to show the steps that guide a patient's progress through the LCS program, outlined the critical role of PACTs in the system's LCS program. PACTs are responsible for identifying patients at risk of lung cancer and placing a low-dose CT scan order to enroll an eligible patient in the LCS program. Additionally, when patients are found to have incidental findings, an LCS coordinator is responsible for alerting PACT providers to coordinate follow-up care with the patient.[53]

The LCS program's clinical restructuring request identified the importance of the PACT provider's role in creating a successful LCS program, and as such, the LCS coordinator was to provide monthly education to PACT providers during the early program stages to minimize LCS program implementation issues.

During an interview, the LCS coordinator informed the OIG of having conducted training to PACT providers and nurses about the LCS program before the program was implemented. When asked for specific information about the training provided, the LCS coordinator reported conducting a 30-minute LCS training to PACT providers and another to PACT nurses in June 2023 but shared that participant attendance was not recorded. As a result, the OIG was unable to verify that PACT staff received training.

The OIG interviewed the chief of primary care and a PACT nurse. The PACT nurse informed the OIG of having limited knowledge of the LCS program. Additionally, the PACT nurse indicated having not received LCS training and was not aware when the LCS program began. After the LCS program began, the chief of primary care reported receiving reports from PACT staff regarding their confusion about the program and the process of ordering a low-dose CT scan for lung cancer screening. In response, the chief of primary care provided individual guidance to PACT providers on how to complete the process. Additionally, the chief of primary care reported PACT staff communicate, and shared information related to training and issues experienced by PACT providers with each other via Microsoft TEAMS. However, at the time of the OIG interview, the chief of primary care stated PACT staff had not received any additional training regarding the LCS program but noted additional training would be helpful.

The OIG acknowledges the deputy chief of staff was aware that PACT providers would benefit from additional training on the LCS program. A review of the April 2024 LCS Program Oversight Board meeting minutes included one line item under new business that stated the deputy chief of staff "has requested the LCS [Program staff] present at the Primary Care monthly meeting to inform providers of the program being offered."

The OIG concluded that PACT providers and nurses received minimal training on the system's LCS program prior to initiation and their knowledge deficit was unresolved at the time of the

[53] Incidental findings are low-dose computed tomography results "not directly associated with lung cancer screening" that can require additional evaluation and treatment to address. Yenpo Lin et al., "Incidental Findings in Lung Cancer Screening," *Cancers (Basel),* 16, no. 14 (July 20, 2024), https://doi.org/10.3390/cancers16142600.

OIG site visit in February 2024. As PACT staff are responsible for identifying patients who meet criteria for lung cancer screening, enrolling eligible patients into the LCS program, and comanaging patients' care when high-risk lung nodules are identified. PACT staff's knowledge of and engagement with the LCS program and staff is critical.

VISN and NCLCS Program Office Oversight Response

In an interview, the OIG expressed concerns to the VISN Chief Medical Officer that the LCS program lacked oversight and did not have an established LCS Oversight Board charter or standard operating procedures until several months after the program was implemented and after the OIG announced the inspection. When apprised of LCS program concerns by the OIG, the VISN Chief Medical Officer acknowledged the seriousness of the information shared and planned to contact system leaders to discuss the LCS program and address deficiencies identified.

In an interview on April 11, 2024, NCLCS staff were also concerned about the system's LCS program not having developed standard operating procedures until several months after the LCS program implementation.[54] Further, NCLCS staff stated although not a requirement, the development of an oversight board and standard operating procedures are the first steps to complete when creating an LCS program "so that everyone agrees on how their program's going to run."

Additionally, the OIG was told that due to NCLCS having limited staffing and resources, NCLCS staff had not conducted oversight but were in the beginning stage of ensuring facilities with operating LCS Programs and approved clinical restructuring requests are offering services consistent with the approved request.

Subsequent to the interview with NCLCS staff, VHA published the LCS directive, which outlined responsibilities of the LCS chief consultant, that included "providing oversight and facilitating corrective actions to VISNs and VA medical facilities regarding LCS program compliance."[55] Requirements outlined in the LCS directive became effective in May 2024 and were to be implemented within one year.[56] The OIG identified concerns with the system's LCS program, including the lack of defined oversight roles and responsibilities; however, the OIG did not make related oversight recommendations because the LCS directive delineates oversight roles and responsibilities for staff involved in LCS at the VHA national, VISN, and system levels.

[54] NCLCS staff interviewed included the Chief Consultant, NCLCS; Program Manager, NCLCS; Associate Director NCLCS; and Lung Cancer Screening Program Manager—VHA National Radiology Program.

[55] VHA Directive 1417.

[56] VHA Directive 1417.

Conclusion

The OIG substantiated that the patient experienced a delay in the diagnosis of and treatment for lung cancer. The PACT provider and the pulmonologist failed to order the consult needed for the patient to obtain the recommended EBUS bronchoscopy and failed to follow up to ensure that the procedure was scheduled and completed. As a result, the patient did not have an EBUS bronchoscopy until more than four months after it was recommended, and it was ordered by a Kansas City VA Medical Center pulmonologist while the patient was undergoing evaluation for lung cancer.

The PACT provider failed to track the patient's PET scan, communicate the abnormal results to the patient, and initiate timely, appropriate clinical actions, which contributed to the delay in diagnosis and treatment for lung cancer. The PACT provider's reliance on the system's community care staff to retrieve and notify the provider when the patient's PET scan results were available did not relieve the obligation of the PACT provider to track and follow up on orders placed.

Further, the OIG is concerned about the absence of an established process for community care providers to communicate new urgent not imminently life-threatening abnormal test results promptly and directly to the system's ordering providers.

System leaders completed an institutional disclosure with the patient; however, the OIG concluded that system leaders did not meet institutional disclosure requirements as crucial components of the disclosure were not documented. The OIG is concerned that the patient was not fully informed of the adverse events or of the available options for recourse.

The system's community care staff failed to make the required number (three) of attempts to obtain the patient's PET scan results from the community provider within 90 days of the completed appointment, contributing to the delay in diagnosis of and treatment for lung cancer. Further, the OIG found the system's community care staff routinely failed to request community care records after completed consults were administratively closed. System leaders and the associate chief nurse attributed the failure to focusing community care staffing resources and efforts on meeting consult scheduling metrics, leaving minimal resources available to follow up after consult appointments were complete.

The OIG learned the system's failure to make additional attempts to retrieve community care records was not unique to the system or VISN. The OIG concluded that there could be unintended delays and clinically related consequences when medical records retrieval is not closely monitored by VHA.

The system's LCS program lacked the oversight and multidisciplinary engagement necessary to implement, evaluate, and manage an effective program. System and program leaders failed to

develop the program's infrastructure prior to implementation. These deficiencies created vulnerabilities that could negatively affect the care for patients requiring lung cancer screening.

The LCS program did not have a charter that outlined the LCS Oversight Board's mission, members, or responsibilities for several months after implementation, and there were inconsistencies in the board's membership, poor attendance at board meetings, and a lack of formal meeting minutes. Further, PACT providers and nurses received minimal training on the system's LCS program prior to initiation and their knowledge deficit was unresolved eight months after implementation.

Recommendations 1–6

1. The VA Eastern Kansas Healthcare System Director ensures the chief of primary care reviews, strengthens, and implements system Patient Aligned Care Team processes for tracking and following up on community care consults ordered, particularly diagnostic consults, to verify patients receive care and to review and act upon consult results, as clinically indicated.

2. The VA Eastern Kansas Healthcare System Director reviews institutional disclosures conducted by the system over the past 12 months, including the patient's institutional disclosure, and ensures these disclosures fully adhere to Veterans Health Administration Directive 1004.08, *Disclosure of Adverse Events to Patients,* October 31, 2018, including documenting the details of the adverse event and discussion points of the disclosure, and takes action needed to remediate disclosures that do not meet these standards.

3. The VA Eastern Kansas Healthcare System Director ensures community care staff make the required three attempts to obtain patients' community care records within 90 days of completed appointments, and monitors for compliance.

4. The VA Eastern Kansas Healthcare System Director collaborates with the Kansas City VA Medical Center Director to review the frequency and circumstances of community care records being sent to the incorrect VA facility, develops, and implements a process for ensuring community care records are delivered to the correct ordering VA facility, educates staff on the process, and monitors for compliance.

5. The Under Secretary for Health establishes and monitors compliance with a process that ensures the Veterans Health Administration ordering provider receives urgent non-life-threatening abnormal test results from care obtained in the community, such as the diagnostic positron emission tomography scan results described in this report, within a time frame that allows timely attention and appropriate action to be taken.[57]

[57] The recommendation addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position

6. The Veterans Integrated Service Network Director, in conjunction with the Veterans Health Administration National Center for Lung Cancer Screening Program Office, evaluates the VA Eastern Kansas Healthcare System's Lung Cancer Screening Program to ensure operational adherence to the Lung Cancer Screening Program requirements, and takes action as needed.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: March 25, 2025

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth (VIEWS 12566151)

To: Director, Office of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth. The Veterans Health Administration (VHA) concurs with recommendation 5 made to the Under Secretary for Health and provides an action plan in the attachment.

2. VHA values OIG's assistance in recognizing an opportunity to enhance our procedures through the creation, documentation, and execution of standard operating procedures.

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

(Original signed by:)

Steven L. Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on March 26, 2025.]

Office of the Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report - Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth (2024-00990-HI-1429)

Recommendation 5: The Under Secretary for Health establishes and monitors compliance with a process that ensures the Veterans Health Administration ordering provider receives urgent non-life-threatening abnormal test results from care obtained in the community, such as the diagnostic positron emission tomography scan results described in this report, within a time frame that allows timely attention and appropriate action to be taken.

VHA Comments: Concur in Principle. VHA will review and refine existing processes to ensure the Veterans Health Administration ordering provider receives all urgent non-life-threatening abnormal radiologic test results from care obtained in the community within a time frame that allows timely attention and appropriate action to be taken. This updated process will also guide the framework for establishing a monitoring system to ensure compliance with the return of radiologic test results, ultimately enhancing the coordination of care and ensuring Veterans receive timely and effective medical attention.

Target Completion Date: December 2025

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 10. 2025

From: Network Director, Department of Veterans Affairs (VA) Heartland Network (10N15)

Subj: Office of Inspector General (OIG) Draft Report, Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth

To: Director, Office of Healthcare Inspections (54HL03)
Executive Director, Office of Integrity and Compliance (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I have reviewed and concur with the facility's response to the findings and recommendations in the attached action plan.

2. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.1.

(*Original signed by:*)

Patricia L. Hall, PhD, FACHE

[OIG comment: The OIG received the above memorandum from VHA on February 26, 2025.]

VISN Director Response

Recommendation 6

The Veterans Integrated Service Network Director, in conjunction with the Veterans Health Administration National Center for Lung Cancer Screening Program Office, evaluates the VA Eastern Kansas Healthcare System's Lung Cancer Screening Program to ensure operational adherence to the Lung Cancer Screening Program requirements, and takes action as needed.

_X _Concur

____Nonconcur

Target date for completion: January 2026

Director Comments

In collaboration with the VHA National Center for Lung Cancer Screening Program Office and the National Radiology Program Office, the Veterans Integrated Service Network (VISN) 15 Chief Medical Officer and VISN 15 Quality Management Officer will develop an audit tool to evaluate the operational adherence to the Lung Cancer Screening Program requirements. Elements of the audit will be based on the standard operating procedures specified in VHA Directive 1417, Lung Cancer Screening (May 29, 2024). The audit will address imaging technical standards, examination coding and syntax, reporting requirements, image report tracking, care coordination for community care, the required oversight board, and access to the tumor board. Any deficiencies identified will result in an action plan that will be tracked to closure by the VISN 15 Quality Management Officer. The program evaluation will be reported to the VISN 15 Specialty Care Integrated Care Community, with updates provided until the action plan is closed.

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 10, 2025

From: Executive Director, Department of Veterans Affairs (VA) Eastern Kansas Healthcare System (589A5/00)

Subj: Office of Inspector General (OIG) Draft Report, Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth

To: Director, VA Heartland Network (10N15)

1. We appreciate the opportunity to review and comment on OIG's draft report on Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Kansas Healthcare System in Topeka and Leavenworth.

2. VA Eastern Kansas Healthcare System concurs with the findings and submits the attached action plan.

3. Should you need further information, contact the Chief of Quality Management.

Original signed by:

A. Rudy Klopfer, FACHE

[OIG comment: The OIG received the above memorandum from VHA on February 26, 2025.]

Facility Director Response

Recommendation 1

The VA Eastern Kansas Healthcare System Director ensures the chief of primary care reviews, strengthens, and implements system Patient Aligned Care Team processes for tracking and following up on community care consults ordered, particularly diagnostic consults, to verify patients receive care and to review and act upon consult results, as clinically indicated.

_X _Concur

____Nonconcur

Target date for completion: January 2026

Director Comments

The Eastern Kansas Healthcare System (EKHCS) Director will ensure that the primary care chief educates providers regarding reviewing, following up, and acting upon results for all consults, including Care in the Community consults. Providers will be reminded of the tools within the electronic health record to help track consults and pending results. This includes using the "ticker" alert, which allows providers to place reminders to follow up on concerns. The goal is to have 90% of the providers educated by the end of March 2025. The Primary Care Chief or designee will review community care medical records requiring action by the ordering provider or designee. Monitoring will be completed with a target compliance rate of 90% or above for two consecutive quarters. If this benchmark is not met, action will be taken as warranted. The results of this review will be reported to the Medical Executive Board quarterly until closed.

Recommendation 2

The VA Eastern Kansas Healthcare System Director reviews institutional disclosures conducted by the system over the past 12 months, including the patient's institutional disclosure, and ensures these disclosures fully adhere to Veterans Health Administration Directive 1004.08, *Disclosure of Adverse Events to Patients,* October 31, 2018, including documenting the details of the adverse event and discussion points of the disclosure, and takes action needed to remediate disclosures that do not meet these standards.

_X _Concur

____Nonconcur

Target date for completion: January 2026

Director Comments

The EKHCS Director or designee completed their review of the institutional disclosures over the past 12 months, including the patient involved in this report, and identified reasons for noncompliance. A Standard of Work document has been developed to assist staff in the necessary steps in the institutional disclosure process. EKHCS will review compliance with the implementation of the standard of work document and report results to the Quality and Patient Safety Board quarterly. Monitoring will be completed with a target compliance rate of 90% or above for two consecutive quarters. If this benchmark is not met, action will be taken as warranted.

Recommendation 3

The VA Eastern Kansas Healthcare System Director ensures community care staff make the required three attempts to obtain patients' community care records within 90 days of completed appointments, and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: January 2026

Director Comments

The EKHCS Director evaluated the recommendation, and reasons for non-compliance were considered. The Community Care Service Line Manager ensures the "Community Care Closed without Records" report is run monthly to identify which consults need subsequent attempts to obtain medical records and review a random sample of consults from that report. Follow-up with staff to request medical records for all outliers identified in the review will be provided. The review results and issues determined will be reported to the Quality and Patient Safety Board quarterly. Monitoring will be completed with a target compliance rate of 90% or above for two consecutive quarters. If this benchmark is not met, action will be taken as warranted.

Recommendation 4

The VA Eastern Kansas Healthcare System Director collaborates with the Kansas City VA Medical Center Director to review the frequency and circumstances of community care records being sent to the incorrect VA facility, develops and implements a process for ensuring community care records are delivered to the correct ordering VA facility, educates staff on the process, and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: January 2026

Director Comments

The EKHCS Director collaborated with the Kansas City VA Medical Center Director to review the frequency and circumstances of sending community care records to the incorrect VA facility. A standard operating procedure will be developed to ensure the community care records are delivered to the correct ordering VA facility, and the appropriate staff will be educated on the process. Monitoring the process will include the Health Information Management Service Director or designee reviewing a random sample of community care medical records a month. Any identified incorrect locations will be sent to the correct location. This will be reported to the Quality and Patient Safety Board quarterly. Monitoring will be completed with a target compliance rate of 90% or above for two consecutive quarters. If this benchmark is not met, action will be taken as warranted.

Glossary

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

administrative closure. Administrative closure is the action of documenting, electronically, the action of closing a community care consult. Consult closure does not release the requirement to obtain clinical records.[1]

adverse event. An adverse event as an occurrence that causes harm or potential harm to a patient directly associated with care or services delivered by VA providers.[2]

bronchoscopy. A procedure that looks "directly at the airways in the lungs using a thin, lighted tube" that is put in the nose or mouth and moved down the throat and into the airways.[3]

clinical consult. A clinical consult is used when a referring provider at a VHA facility seeks an "opinion, advice, or expertise" from another provider "regarding evaluation or management" of a patient's specific need.[4]

computed tomography scan. "an imaging test that helps healthcare providers detect diseases and injuries. It uses a series of X-rays and a computer to create detailed images of [a person's] bones and soft tissues. A CT scan is painless and noninvasive."[5]

e-consult. "… referrals designed for Veteran/provider questions about advice for diagnostic and therapeutic issues. They can also be used to better prepare a Veteran for a face-to-face visit by arranging for the completion of necessary tests in advance of the visit with a specialist." An e-consult is also known as a "chart only consult."[6]

emergent and imminently life-threatening. "An emergent and imminently life-threatening abnormal test result is any new test result which must be acted upon by the VA medical facility ordering provider or their designee immediately or within a short window of time and could result in severe morbidity or mortality if left unaddressed. Example: An imaging test suggestive of acute ruptured abdominal aortic aneurysm."[7]

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[1] VHA IVC, "Consult Completion and Medical Records Management," chap. 4 in *Community Care Field Guidebook,* August 29, 2023.

[2] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[3] John Hopkins Medicine, "Bronchoscopy," accessed May 16, 2024, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/bronchoscopy.

[4] VHA Directive 1232(5).

[5] Cleveland Clinic, "CT scan," accessed January 22, 2025, https://my.clevelandclinic.org/health/diagnostics/4808-ct-computed-tomography-scan.

[6] *Electronic Consultation (E-Consult) Implementation Guide v 3.0*, May 2019.

[7] VHA Directive 1088.

endobronchial ultrasound. "In people with lung cancer, a bronchoscope with a built-in ultrasound probe may be used to check the lymph nodes in the chest." The EBUS "helps doctors determine the appropriate treatment."[8]

low-dose computed tomography scan. A screening test for lung cancer in which "an x-ray machine uses a low dose (amount) of radiation to make detailed images of your lungs."[9]

hyperlipidemia. Also known as high cholesterol. An excess of fats in blood that can increase the risk of heart attack and stroke because blood cannot flow through arteries easily.[10]

institutional disclosure. A formal process for system leaders to inform the patient or the patient's "representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury."[11]

palliative. "specialized medical care for people living with a serious illness, such as cancer or heart failure. Patients in palliative care may receive medical care for their symptoms, or palliative care, along with treatment intended to cure their serious illness. Palliative care is meant to enhance a person's current care by focusing on quality of life for them and their family."[12]

patient aligned care team. "a team of health care professionals that provides comprehensive primary care in partnership with the patient." Within PACTs are teamlets assigned to groups of patients and generally consist of a primary care provider (physician, advanced practice registered nurse, or physician assistant), a registered nurse care manager, a clinical associate, and an administrative associate.[13]

positron emission tomography scan. "an imaging test that can help reveal the metabolic or biochemical function of your tissues and organs. The PET scan uses a radioactive drug called a tracer to show both typical and … atypical metabolism of the tracer in diseases before the disease shows up on other imaging tests …"[14]

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[8] Mayo Clinic, "Bronchoscopy," accessed January 31, 2024, https://www.mayoclinic.org/tests-procedures/bronchoscopy/about/pac-20384746.

[9] Centers for Disease Control and Prevention, *Who Should be Screened for Lung Cancer*, accessed January 31, 2024, https://www.cdc.gov/lung-cancer/screening/?CDC_AAref_Val=https://www.cdc.gov/cancer/lung/basic_info/screening.htm.

[10] Cleveland Clinic, "Hyperlipidemia," accessed May 28, 2024, https://my.clevelandclinic.org/health/diseases/21656-hyperlipidemia.

[11] VHA Directive 1004.08.

[12] National Institutes of Health, What are Palliative Care and Hospice Care, accessed May 28, 2024, https://www.nia.nih.gov/health/hospice-and-palliative-care/what-are-palliative-care-and-hospice-care.

[13] VHA Handbook 1101.10(2).

[14] Mayo Clinic, "Positron emission tomography scan," accessed January 31, 2024, https://www.mayoclinic.org/tests-procedures/pet-scan/about/pac-20385078.

pulmonologist. A "healthcare provider that specializes in diagnosing and treating conditions that affect your respiratory system, including your airways and lungs."[15]

urgent not imminently life-threatening. "An urgent not imminently life-threatening abnormal test result is any new test result which must be acted upon by the VA medical facility ordering provider or designee within a relatively urgent timeframe as clinically indicated to ensure timely, appropriate and effective therapeutic action (e.g., A test suggestive of a diagnosis of a new or unexpected malignancy.)"[16]

vertigo. A feeling of "motion in which the individual or the individual's surroundings seem to whirl dizzily."[17]

[15] Cleveland Clinic, "Pulmonologist," accessed November 5, 2024, https://my.clevelandclinic.org/health/articles/22210-pulmonologist.

[16] VHA Directive 1088.

[17] *Merriam-Webster.com Dictionary*, "vertigo," accessed May 28, 2024, https://www.merriam-webster.com/dictionary/vertigo.

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