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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Community Care Consult Management at the VA Fayetteville Coastal Healthcare System in North Carolina

Healthcare Inspection	24-03186-99	April 8, 2026

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the coordination of care and scheduling of a community care appointment for a patient with a lung mass suspicious for cancer and system leaders' review of the quality of care provided to the patient at the VA Fayetteville Coastal Healthcare System (system) in North Carolina.

A complainant contacted the OIG alleging system staff did not provide a patient with timely diagnosis of and care for lung cancer between December 2023 and May 2024. In August 2024, the OIG asked system leaders to respond to the allegation by providing a review of the patient's clinical care.

The System Director's response substantiated the delay in scheduling the patient's community care pulmonary appointment but did not address the other aspects of the patient's care. Therefore, the OIG opened a hotline inspection. Additionally, the OIG evaluated system leaders' review of the quality of care provided to the patient from the onset of symptoms in March 2022 through final diagnosis in June 2024, the system's timeliness in scheduling care-in-the-community consults, and programmatic oversight.[1]

In the healthcare setting, "leadership's first priority is to be accountable for effective care while protecting the safety of patients."[2] The Veterans Health Administration's (VHA's) Veterans Community Care Program provides care in the community for eligible veterans when VA is unable to provide the necessary services.[3] In addition, if a VA medical facility is unable to provide care within established wait time standards, system staff may refer the patient to receive

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

[2] The Joint Commission, "The Essential Role of Leadership in Developing a Safety Culture," Sentinel Event Alert 57, March 1, 2017, revised June 18, 2021, accessed April 8, 2025, https://www.jointcommission.org/resources/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-57-the-essential-role-of-leadership-in-developing-a-safety-culture/.

[3] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018), § 101.

community care.[4] To ensure timely care, community care staff are responsible for scheduling appointments in the community within seven days of receiving a consult.[5]

Diagnosis and Scheduling of Treatment for a Patient's Lung Cancer

The OIG found deficiencies that contributed to the delay in diagnosis and treatment of the patient. Specifically, the patient's primary care provider did not order a radiologist-recommended chest computed tomography (CT) scan to further evaluate the patient's abnormal chest x-ray results for over 15 months after becoming aware of the abnormal result in March 2022. Additionally, community care staff delayed scheduling the patient's community care pulmonary care appointment for over five months, significantly exceeding VHA's seven-day guideline. As a result, the 15-month delay in ordering the recommended CT scan and additional 5-month delay in scheduling care in the community may have decreased the opportunity for an earlier diagnosis and treatment of the patient's lung cancer. The patient was subsequently diagnosed with a Stage III right upper lung adenocarcinoma, and has received care including chemotherapy and radiation for the lung cancer with a community pulmonologist and oncologist.

Factors Contributing to Scheduling Delays

The OIG determined several factors may have contributed to the patient's scheduling delays including a four-year period of leadership turnover from 2020 to 2024 in the system's community care service, lack of an operational oversight council for the system's community care service, system leaders not providing written processes for staff to follow to avoid community care scheduling delays for patients with serious health conditions, and a sudden increase in the number of consults for community care primary care services that community care staff had to process.

Veterans Integrated Service Network (VISN) and system leaders also identified the multi-year vacancy of the chief of community care—the leader of the community care service—as a

[4] VHA Office of Community Care, "Eligibility," chap. 2 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, accessed April 1, 2025. The guidebook is a continually updated process and information guide outlining specific functions of community care operations. Patients may be eligible for community care primary care services if VA appointment wait time exceeds 20 days.

[5] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure," January 12, 2022. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," July 8, 2024. Unless otherwise specified, the 2024 standard operating procedure contains the same or similar language as the rescinded 2022 standard operating procedure; VHA Office of Community Care, "Care Coordination Model," chap. 3, in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, August 6, 2024.

primary factor in the lack of consistent oversight of processes, which may have contributed to deficiencies in the system's community care service.

VHA requires VA medical facilities to have a local community care oversight council made up of both clinical and administrative staff responsible for the oversight of care in the community.[6] These councils provide an opportunity for leaders to review key community care metrics, discuss opportunities for improvement, or track action items intended to correct deficiencies. The OIG found that the system did not have an oversight council for calendar year 2023 and that system leaders had not developed a procedure or policy to ensure community care consults were prioritized for patients with serious health conditions (high-priority consults), such as cancer.

The Patient's Delayed Diagnosis and Treatment

The OIG determined system leaders missed several opportunities to review the delay in the patient's diagnosis and treatment and resolve programmatic deficiencies in the community care service.

Patient safety reports in the Joint Patient Safety Reporting (JPSR) system provide an opportunity for investigating and analyzing root causes to prevent future events.[7] System patient safety managers (PSMs) are responsible for ensuring the accuracy of JPSR investigations and validating that actions are taken to prevent further harm.[8] The patient's delay in care was reported via the JPSR system on May 18, 2024. The OIG confirmed a clinical review of the patient's JPSR event was completed; however, system leaders did not ensure the JPSR investigation included a review of the community care process, identification of opportunities for improvement, and implementation of recommendations.

VA policy requires allegations from VA OIG case referrals to be independently reviewed by an individual not involved in the alleged incident.[9] System leaders did not follow VA policy when responding to the VA OIG case referral specific to the care of the patient by not providing the full complaint to the assigned investigator and not assigning the review to an individual independent from the service associated with the complaint.

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[6] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #7843114)," memorandum to Network Directors (10N1-23), October 17, 2017; VHA Office of Community Care, "VHA Office of Community Care Operating Model- Master Deck Library," updated November 1, 2017.

[7] VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

[8] VHA National Center for Patient Safety, *JPSR Guidebook*.

[9] VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*, December 16, 2020.

VHA requires screening of information that may necessitate a peer review to occur within three business days of identification to determine if a peer review is appropriate.[10] Despite the PSM sending an email on May 18, 2024, alerting the chief of quality management, the peer review coordinator (PRC), and the risk manager of the patient's delay in diagnosis and treatment of lung cancer, the OIG found that system leaders did not initiate peer reviews for six months. Additionally, process or system issues not appropriate for peer review should be referred by the PRC and addressed using other types of quality management activities.[11] The OIG did not find evidence indicating system leaders initiated a review to identify and address system issues that led to consult processing delays, despite their awareness of a six-month delay in processing the community care pulmonary consult.

An institutional disclosure is a formal process in which system leaders and clinicians inform a patient or their family that an adverse event has occurred during the course of the patient's care.[12] The chief of staff acknowledged that staff did not complete one, citing ongoing attempts to contact the patient.

Additionally, the OIG found deficiencies in the review of the backlog of unscheduled consults. Despite awareness of a large number of unscheduled community care consults, VISN and system leaders did not develop a comprehensive plan to complete the electronic health record reviews. Rather, the OIG found a well-intended but poorly coordinated effort with varied lists of patient names, starts and stops, a lack of follow-through, and the lack of an individual assigned to manage the process.

The OIG concluded that there were several missed opportunities to identify ways of improving system processes. Leaders did not focus on the patient and get to the root cause of system issues, contributing to the delay in scheduling the patient's community care consult.

The OIG is aware that at the time of the publication of this report, VHA announced significant changes in the VISN process. The OIG will continue to monitor this process and follow-up on the changes that impact this report.

The OIG made two recommendations to the Under Secretary for Health related to the review of practices and procedures for managing consults for patients with serious health conditions and a review of the system's response to the community care consult backlog; and six recommendations to the Facility Director related to the establishment of community care policies

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[10] VHA Directive 1190 (1), *Peer Review for Quality Management,* November 21, 2018, amended July 19, 2024. A peer review is a confidential and non-punitive assessment of a clinician's care, decisions, and actions to identify learning opportunities to improve veteran care.

[11] VHA Directive 1190 (1).

[12] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VHA requires an institutional disclosure to be documented in the patient's EHR.

in alignment with VHA community care standards, adherence to VA policy on OIG case referrals, review of quality management processes, and the disclosure of the adverse event to the patient.

The OIG is aware of VA's transformation in VHA's management structure. As we monitor the implementation, our oversight remains focused on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families

VA Comments and OIG Response

The Under Secretary for Health, the Interim Veterans Integrated Service Network, and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A, B, and C). Based on information provided, the OIG considers recommendation 7 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

The Under Secretary for Health reported that VHA will review the practices and procedures for appropriate prioritization of appointments for community care consults and ensure the system's electronic health records related to the backlog are formally reviewed. The Facility Director confirmed implementation of a community care oversight council, plans to develop and train staff on a procedure for managing high-priority consults, and attempts to disclose the adverse event to the patient and next of kin. Additionally, the Facility Director agreed to improve quality management tracking processes and provide training for staff processing OIG case referrals.

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Abbreviations

AMSA	advanced medical support assistant
APP	advanced practice provider
CT	computed tomography
EHR	electronic health record
IVC	Office of Integrated Veteran Care
JPSR	joint patient safety reporting
OIG	Office of Inspector General
PCP	primary care provider
PRC	peer review coordinator
PSM	patient safety manager
QMO	quality management officer
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the coordination of care and scheduling of a community care appointment for a patient with a lung mass suspicious for cancer and system leaders' review of the quality of care provided to the patient from early 2022 through mid-2025 at the VA Fayetteville Coastal Healthcare System (system) in North Carolina.[1] Additionally, the OIG evaluated the system's timeliness in scheduling community care consults and programmatic oversight by the system and Veterans Integrated Service Network (VISN) 6.[2]

Background

The system, part of VISN 6, operates one medical center in Fayetteville, seven community-based outpatient clinics located across southeastern North Carolina, two healthcare centers (located in Fayetteville and Wilmington), and two jointly-funded VA/Department of Defense centers (Fayetteville and Womack Army Medical Center).[3] The Veterans Health Administration (VHA) classifies the system as a level 1c complexity.[4] From October 1, 2023, through September 30, 2024, the system served 83,284 patients and completed 826,919 outpatient visits. As of July 2024, the system reported having 100 total operating beds, including 59 inpatient and 41 community living center beds. The system provides primary care, surgery, mental health, and specialty care services, including pulmonology. The system is designated as one of the five most medically underserved facilities for primary care in VHA.[5]

Community Care

Established in 2018 by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act, VHA's Veterans Community Care Program provides care in the

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[1] The OIG initiated the healthcare inspection on October 10, 2024, and conducted an on-site visit December 10 through 12, 2024.

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

[3] The system's community-based outpatient clinics are located in Hamlet, Lee County, Brunswick County, Robeson County, Goldsboro, Jacksonville, and Wilmington.

[4] VHA Office of Productivity, Efficiency, & Staffing (OPES), "Data Definitions VHA Facility Complexity Model," October 1, 2023. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

[5] GAO, *VA Health Care: The Medically Underserved Facilities Initiative*, GAO-24-106306, December 2023. "VA underserved facilities for primary care are generally in geographic areas in which veterans and nonveterans alike may face a shortage of health professionals."

community for eligible veterans when VA is unable to provide the necessary services.[6] VHA's Office of Integrated Veteran Care (IVC) aims to provide veterans referred to community care timely access to high-quality care through the Veterans Community Care Program in a way "that is easy to understand [and] simple to administer." [7] The IVC field guidebook "defines systematic business and clinical processes for VA staff as they coordinate Veteran care across the continuum."[8]

When a veteran is referred for care in the community, there are a series of processes that must occur within a required time frame to ensure the patient receives timely and appropriate access to care. In general, to refer a patient to a community provider for care, a VHA provider orders a consult in the patient's electronic health record (EHR). System community care staff receive the consult and schedule the appointment. Community care staff are responsible for scheduling appointments within seven days of receiving the consult (see figure 1).[9]

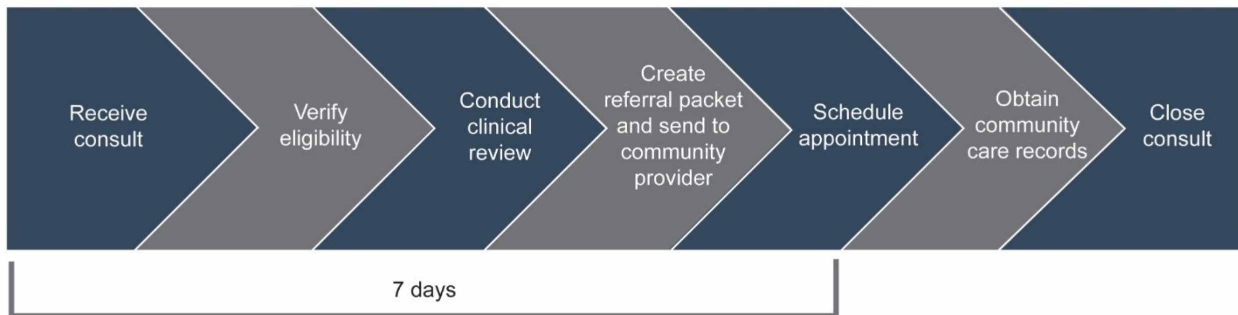

Figure 1. *Community care consult scheduling processes.*
Source: OIG analysis of Consult Timeliness Standard Operating Procedure (SOP); "Care Coordination Model," chap. 3, August 6, 2024, and "Consult Completion and Medical Records Management How to Close Community Care Consults," chap. 4 in Office of Integrated Veteran Care (IVC) Community Care Field Guidebook, January 7, 2025.

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[6] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393, (2018), § 101.

[7] VHA Office of Community Care, *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, accessed April 10, 2025. The guidebook is a continually updated process and information guide outlining specific functions of community care operations.

[8] VHA Office of Community Care, "Introduction," chap. 1 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, July 11, 2024.

[9] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure," January 12, 2022. This standard operating procedure was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," July 8, 2024. Unless otherwise specified, the 2024 standard operating procedure contains the same or similar language as the rescinded 2022 standard operating procedure; VHA Office of Community Care, "Care Coordination Model," chap. 3 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook* August 6, 2024; VHA Office of Community Care, "Consult Completion and Medical Records Management How to Close Community Care Consults," chap. 4, in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, January 7, 2025.

After the appointment, staff request the community provider's medical documentation if not already received. Community care staff also coordinate care for the patient, which may include "post appointment follow-up to identify future needs," and the review of community care provider records pertaining to the care provided.[10]

Allegations and Related Concerns

On May 24, 2024, the OIG received a complaint alleging that system staff did not timely diagnose and treat a patient's lung cancer. On August 6, 2024, the OIG sent a case referral tasking system leaders to respond to the allegation by providing a review of:

- the patient's clinical care once imaging showed a right upper lung nodule in early 2022, to include comment on delays in follow-up of the abnormal imaging result;
- the delay in action on the community care pulmonology consult placed in late 2023 but not acted on until over three months later, and two additional months of delays in scheduling the community care appointment;
- whether system leaders completed an institutional disclosure for the patient, who experienced significant delays in diagnosis, care, and treatment for the lung abnormality, now known to be cancerous.

Additionally, the OIG asked system leaders to identify corrective actions taken to address each substantiated allegation and provide dates actions were taken or completed.

The OIG received the System Director's response on September 4, 2024, which substantiated the delay in diagnosis and treatment of the patient's lung cancer but limited its review of the patient's care to the period after the community care pulmonology consult was ordered in late 2023 through the time the appointment was scheduled in late spring 2024. The System Director's response did not include a review of the patient's care from the initial abnormal imaging result in early 2022 as requested in the instructions provided in the original OIG case referral. In response to the OIG's query regarding the delay in action on the community care pulmonology consult, the System Director reported:

> It was discovered that the [late 2023] Community Care Pulmonary consult was submitted with a "routine" urgency by the requesting provider. Consults submitted as routine are 30-45 days at minimum due to backlog, which resulted in the delay. Consults to be expedited should be submitted as "urgent" or "STAT" to be reviewed with an expected turnaround of 72 hours.

[10] VHA Office of Community Care, "Care Coordination Model," chap. 3 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook.*

The System Director's response did not answer the OIG's question regarding the completion of an institutional disclosure but reported that the patient was contacted, provided "service recovery," and given "sincere apologies." The response stated "[community care] will prioritize consult action" and start a "comprehensive review" of community care processes and training to "streamline and expedite services for all veterans." However, the response did not provide any additional details on when the actions would be initiated or specifically how the corrective actions would address the substantiated allegation.

As a result of the incomplete response, the OIG opened a hotline inspection to review the patient's delay in cancer diagnosis and care and system leaders' inadequate response when the OIG requested a case referral. Additionally, the OIG evaluated system leaders' review of the quality of care provided to the patient, the system's timeliness in scheduling care-in-the-community consults, and deficiencies in programmatic oversight.

Scope and Methodology

The OIG initiated the healthcare inspection on October 10, 2024, and conducted an on-site visit December 10 through 12, 2024. The OIG also conducted virtual interviews through April 3, 2025.

The OIG interviewed IVC staff; and VISN 6 leaders, including the VISN business implementation manager, VISN quality management officer (VISN QMO), VISN risk manager, and a VISN 6 nurse. The OIG interviewed system leaders, including the System Director, chief of staff, an acting deputy chief of staff, associate director of access and clinical business operations, associate director for patient care services, chief of medicine, chief of pulmonary, and the chief of quality management. Other interviews conducted included system quality management staff; a system primary care provider (PCP); a system pulmonologist; a former and a current system community care manager; community care advanced medical support assistant (AMSA) staff; and community care clinical staff.[11]

The OIG reviewed the patient's EHR from early 2022 through mid-2025 and email correspondence from staff related to the issues under review. The OIG also reviewed relevant VHA and system policies and procedures along with system council charters and minutes, action plans, quality reviews, patient safety reports, peer reviews, and organizational charts. The OIG reviewed community care consult data from June 2023 through March 2025.[12]

[11] The acting deputy chief of staff reported also serving as the acting system community care medical director.

[12] "Corporate Data Warehouse," VA, accessed on May 1, 2025, https://www.hsrd.research.va.gov/for_researchers/cdw.cfm. The OIG reviewed community care data retrieved from VHA's Corporate Data Warehouse, a large-scale data warehouse that collects near real-time healthcare data from VHA's electronic health record system. Data from this site is not publicly accessible.

Within the context of this report, the OIG defines harm to be an adverse clinical outcome that results in death, continued disease activity, disease progression, a change or delay in diagnosis, or a change in the course of treatment. The risk of an adverse clinical outcome associated with a delay in a patient's care varies depending on the severity of the underlying medical condition and the magnitude of the delay in medical treatment.[13]

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.

[13] As an example, a delay in the provision of radiation therapy for a cancer patient may increase the risk of cancer progression or may cause the patient to experience severe pain symptoms or suffer from the anxiety of knowing a prescribed treatment is delayed. For some cases, a delay may even decrease a patient's chances for survival.

Patient Case Summary

The patient, who was in their seventies, had a medical history that included hypertension, diabetes, and a smoking history of one and a half packs per day for 30 years (quit smoking in 2000). In early 2022, the patient presented to a community hospital emergency department with complaints of elevated blood sugar, chest pain, and weakness. An emergency department physician diagnosed the patient with a urinary tract infection, and the patient was discharged on a course of antibiotics. Imaging studies included a chest x-ray that showed abnormalities in the left lung but no abnormal findings in the right lung.

Several weeks later, the patient presented to the system's emergency department complaining of back pain for several weeks duration. A computed tomography (CT) scan of the abdomen and pelvis revealed an intra-abdominal abscess, and a chest x-ray showed an asymmetric nodular opacity in the right upper lung. A radiologist recommended a CT scan of the chest for further evaluation. The patient was transferred to a community hospital for admission and further treatment, including abscess drainage and antibiotic therapy. After a seven-day hospital stay, the patient was discharged to a skilled nursing facility. Two days after the patient's visit to the system's emergency department, the primary care clinic nurse documented that the patient had been transferred to a community hospital and the PCP cosigned the note.

After a prolonged stay at the skilled nursing facility, the patient was discharged home and seen by their PCP later that summer. During this visit, the PCP documented the abnormal chest x-ray findings identified during the patient's early 2022 system emergency department visit as well as the radiologist's recommendation for a follow-up CT scan. However, the PCP did not place an order for a follow-up CT scan of the lung. The patient saw the PCP in late 2022 and early 2023. On both occasions, the PCP documented the asymmetric nodular opacity in the right upper lung but did not order the recommended follow-up chest CT scan.

In spring 2023, the patient presented to a community hospital emergency department complaining of chest pain and was subsequently admitted. The results of a chest x-ray performed at the community hospital during the patient's stay showed a patchy infiltrate or pulmonary nodule in the right upper lobe of the lung. Documentation in the radiology report recommended a "short-term follow-up chest x-ray to ensure resolution."

Approximately six weeks later, the patient presented to the system emergency department complaining of chest pain and shortness of breath. Chest x-ray results showed "findings suspicious of a nodular opacity 2.6 cm right upper lobe. Possibility of a malignancy must be considered." A radiologist documented in the chest x-ray report that a follow-up chest CT scan "may be of value in further evaluation."

Later that month, the PCP met with the patient and documented discussing the chest x-ray finding of a pulmonary nodule concerning for a malignancy and ordered a chest CT scan. System staff documented that the patient was unable to be reached to schedule the test, and the order was

discontinued approximately two months later.[14] The PCP saw the patient again in early fall 2023, documented reviewing the chest x-ray findings that were concerning for malignancy with the patient, and reordered the chest CT scan. Two days later, the PCP changed the chest CT scan order to a community care consult to accommodate the patient's preference for a shorter drive time to the appointment.[15] The CT scan was scheduled with a community provider for the next month; however, the patient did not keep the appointment and system staff canceled the community care consult.

The patient underwent a chest CT scan at a community provider in late 2023, which revealed a 5.2 x 2.7 cm mass in the right upper lung lobe concerning for a malignancy.[16] The day after the CT scan was completed, the PCP ordered a pulmonary e-consult for further evaluation of the mass. A system pulmonologist did a review of the patient's EHR, documented concern for the rapid growth of the lung mass, and recommended an "expedited diagnostic and staging evaluation" at a community hospital. The system pulmonologist placed a community care pulmonary consult containing this recommendation for expedited evaluation, and the consult was documented as "received" by a community care advanced practice provider (APP) on the same day.

Several months later, a community care AMSA documented that the patient's records had been faxed to the community care pulmonary provider. Ten days later, the PCP added a comment to the consult note inquiring about the status of the consult. The AMSA added a comment that same day that the "provider [in the community] needs more time to schedule [the appointment]. Follow up in 3 days." The PCP inquired again the next month about the status of the referral, and the AMSA added a comment to the consult that the community care provider requested updated imaging of the chest prior to scheduling the appointment. The patient underwent a repeat CT scan of the chest, which showed an enlarging 4.3 x 6.5 x 4.7 cm right upper lobe lung mass concerning for malignancy. The patient was subsequently scheduled for an appointment with a community care pulmonologist in late spring 2024; diagnosed with a Stage III right upper lung adenocarcinoma; and has received care, including chemotherapy and radiation, for lung cancer with a community pulmonologist and oncologist.

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[14] VHA Office of Integrated Veteran Care, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," July 28, 2022. VHA requires minimum scheduling efforts to ensure that patient appointments are managed safety and timely. VHA staff may cancel VA system appointments or community care consults if they are unable to reach the patient after multiple attempts.

[15] VHA Office of Community Care, "Eligibility," chap. 2 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*. Patients may be eligible for community care when the drive time to a VHA provider is more than 60 minutes.

[16] The OIG was unable to determine from the EHR review how the patient received a CT scan after the community care consult was canceled.

Inspection Results

The OIG determined that insufficient leadership and structure within the system's community care service at that time contributed to a delay in diagnosis and treatment of the patient's lung cancer. Particularly concerning was the lack of a process for prioritizing incoming consults, especially for patients with serious health conditions. The effects of this absence became heightened as the volume of consults for community care primary care increased, possibly subjecting other system patients with serious health conditions to significant community care scheduling delays.

Pursuant to VHA Directive 1050.01(1), VHA's quality and patient safety policy defines quality as, "the provision of highly reliable health care services that are safe, timely, effective, efficient, equitable and patient-centered."[17]

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

The OIG determined the following deficiencies contributed to the delay in diagnosis and treatment of the patient's lung cancer:

- The PCP did not order a chest CT scan, which was recommended by the interpreting radiologist and needed to further evaluate the patient's abnormal chest x-ray, for over 15 months.
- Community care staff delayed scheduling the patient's pulmonary care appointment.

The OIG learned that multiple factors may have contributed to community care staff not identifying the patient's serious health condition and prioritizing scheduling the community care appointment. These factors resulted in an over five-month delay in a community care provider's evaluation of the patient's suspected lung cancer.

Delay in Ordering Patient's Chest CT Scan

The OIG found the PCP did not order a radiologist-recommended chest CT scan to follow up on the patient's abnormal chest x-ray results from early 2022 for over 15 months after becoming aware of the abnormal result. This additional diagnostic testing was needed to further characterize the abnormal finding. The PCP not pursuing further testing potentially impacted the patient's clinical management. Further, when first aware of the early 2022 abnormal chest x-ray finding, the PCP did not document a discussion with the patient regarding the significance of the right upper lobe finding, or the rationale for not ordering the follow-up chest CT scan, as required.

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

VHA Directive 1088(1), *Communicating Test Results to Providers and Patients,* requires an ordering provider or designee to have a discussion with the patient and initiate “potential actions or therapeutic intervention options” when test results indicate the need.[18] VHA also requires providers to document “patient notifications and subsequent clinical actions” in response to “clinically significant test results that require therapeutic intervention or action.”[19] While there are no strict guidelines regarding timeliness in managing pulmonary nodules found on chest imaging, delay in making a diagnosis of a nodule that is concerning for a lung cancer can have significant clinical and prognostic effects. With time, lung cancers can progress from an earlier stage to a more advanced stage, potentially impacting survival rates, treatment options, effectiveness of treatments, and mortality. It is therefore recommended that evaluation of patients with pulmonary nodules be performed in a timely and efficient manner.

During multiple office visits beginning in July 2022, the PCP documented awareness of the patient’s early 2022 abnormal chest x-ray and the radiologist’s recommendation for a follow-up CT scan. However, the OIG found no documentation in the patient’s EHR indicating that the PCP discussed the abnormal results with the patient or initiated further workup until an appointment in June 2023. Additionally, the OIG found no documentation by the PCP in the patient’s EHR that explained the provider’s decision to not order the radiologist-recommended follow-up CT scan.

When asked, the PCP could not recall documenting decision-making or rationale regarding further management of the abnormal chest x-ray results in the patient’s EHR. The PCP indicated that the patient had a clear chest x-ray two and a half weeks prior to the early 2022 abnormal finding and that it would be “exceedingly unusual” for a patient to “suddenly” develop a nodule. The PCP told the OIG that after the initial abnormal chest x-ray was done at the system, the patient had additional imaging performed during a procedure a few days later at a community hospital and “there was no mention at all of anything suspicious … in the lungs at that time.” The PCP reported not being concerned with the chest x-ray results because there was “probably something infectious or inflammatory” occurring, noting the patient had been treated with antibiotics.

Over one year later, the PCP first entered documentation of a discussion with the patient regarding an abnormal result when the PCP wrote of informing the patient of the abnormal nodule seen on the summer 2023 chest x-ray and concern that it was malignant. That same visit, the PCP ordered a chest CT scan. In an interview, the PCP noted the radiologist’s recommendation for a follow-up chest CT scan and reported explaining the abnormal findings to the patient along with the importance of obtaining a chest CT scan to evaluate for possible

[18] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[19] VHA Directive 1088(1).

cancer.

Due to multiple unsuccessful scheduling attempts, the patient did not complete the chest CT scan until late 2023, which confirmed a right upper lung mass consistent with cancer. The PCP described placing an e-consult to the system pulmonologist (pulmonologist) the day after receiving the chest CT scan result and reported discussing the patient's case via an electronic message with the pulmonologist, who then recommended a referral to a community pulmonologist for further care.

The OIG concluded that the PCP was aware of the patient's initial abnormal chest x-ray. However, the PCP did not discuss the result or potential actions with the patient and did not order a recommended chest CT scan until a subsequent chest x-ray reconfirmed abnormal results of a lung nodule over one year later. The OIG would have expected the PCP to document both a discussion with the patient regarding the initial abnormal finding and the rationale for not pursuing additional testing given the radiologist's recommendation for a chest CT scan.

Delayed Scheduling of Patient's Consult

The OIG found that community care staff delayed scheduling the patient's community care pulmonology consult for over five months, which resulted in a delay in diagnosis and treatment of the patient's cancer.

To ensure timely, efficient scheduling of community care appointments, IVC developed standard operating procedures that require staff to schedule community care consults within seven calendar days of the file entry date.[20]

The OIG learned that the pulmonologist entered a community care pulmonary consult for the patient the day the e-consult was received from the PCP. In an interview, the pulmonologist explained that the patient's late 2023 chest CT scan revealed a pulmonary nodule significantly larger than when the nodule was identified in summer 2023. The pulmonologist reported ordering the consult because the patient needed care that was unavailable at the system and required referral to a community provider who could provide the services. The consult included instructions from the pulmonologist to community care staff to "please expedite" scheduling the patient's appointment. The pulmonologist recalled also sending a community care APP a warm handoff via electronic message with information that the consult should be expedited.

That same day, a community care APP received the consult, triaged the consult as "complex/chronic," flagged the consult as "high risk," and documented that community care

[20] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)."

staff should "continue trying to schedule after mandated effort."[21] During an interview, the APP explained that the consult was identified as high risk due to the patient's diagnosis and the instructions included from the pulmonologist. The APP then contacted community care AMSAs and nursing staff via email with instructions to "please expedite" scheduling of the patient's pulmonary appointment in the community.

Seven days after the APP received the consult, a community care registered nurse completed a Community Care-Care Coordination Plan note. The note stated the consult was considered "complex/chronic" and required "moderate care coordination services indicating that the community care registered nurse should have followed up with the patient at least monthly."[22] The community care registered nurse did not document making any contact with the patient or other activity on the note until four months later.

Although the APP received and handed off the consult for scheduling on the same day the consult was submitted, the patient did not receive an initial evaluation by a community care provider for almost six months (see figure 2).

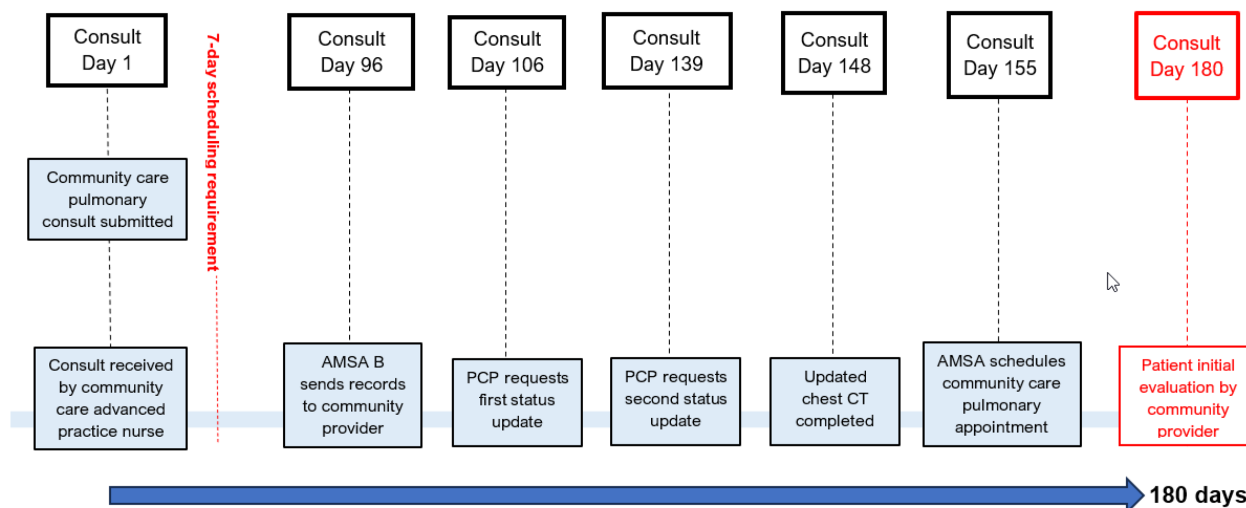

Figure 2. *Timeline of consult scheduling delays for patient's community care pulmonary appointment.*
Source: OIG analysis of patient's EHR documentation.

In email correspondence reviewed by the OIG, community care AMSA A responded to the APP's email requesting expedited scheduling the same day it was received and informed the

[21] VHA Office of Community Care, "Department of Veterans Affairs Screening Triage Tool Standard Operating Procedure," July 2, 2019, revised January 2025. Community care staff are required to screen patient consults using an algorithm-based tool used to determine the appropriate care coordination level for each patient. Levels of care are assigned based on the intensity, frequency, duration, and type of care coordination each patient needs. Based on a patient's level of care, IVC recommends how frequently community care staff must contact the patient and document in the EHR.

[22] VHA Office of Community Care, "Department of Veterans Affairs Screening Triage Tool Standard Operating Procedure."

APP that the consult was *complete*. In an interview, the APP reported the assumption that complete indicated that AMSA A had scheduled the patient's community care appointment. When AMSA A was asked during an interview to explain what was meant when writing *complete* in response to the message, AMSA A could not recall responding to the email but indicated that "complete" would mean that whatever was requested was completed. After reviewing the email with the OIG, AMSA A reported being unsure if the request was directed at an individual or the group on the message and acknowledged responding but could not recall specifics.

Despite the documented handoff from the APP to AMSA A, community care staff took no further action on the consult until three months later when AMSA B documented on the consult "records faxed/sent" to the community provider. In an interview, the PCP reported reviewing the patient's EHR the next month, noting the patient's appointment still had not been scheduled, and reaching out to community care staff via the patient's EHR to request an update on the status of the consult, noting in the EHR "this patient likely has lung cancer. Please expedite." A month later, the PCP again contacted community care staff via the EHR to check on the status of the consult and documented

> What is the status of this referral? [The patient] has a large lung mass concerning for lung cancer, and it's been almost 5 months since [the system] pulmonologist placed this referral.

That next day, AMSA B documented one unsuccessful attempt at contacting the community provider to check the consult status and noted "left message requesting return phone call. Follow up in [three] days." The patient's EHR showed that one day later, the community care registered nurse provided the community provider with the patient's late 2023 chest CT scan. However, AMSA B documented speaking with a community provider staff member, who informed the AMSA that the patient's CT scan needed to be less than three months old. Nine days later, the PCP documented on the consult that an updated CT scan was done that showed a mass suspicious for lung cancer and urgently requested the patient be scheduled

> [community care staff], please get [the patient] scheduled with [the community provider] ASAP. This is [five] months out from the original request.

Another five days after the updated CT scan, AMSA B documented sending records to the community provider. Two days later, AMSA B scheduled the patient's appointment, over five months after the original consult was entered.

Although both confirmed being assigned to manage pulmonary consults at that time, during interviews neither AMSA A nor B were able to explain why the delay occurred. When asked what actions should have been taken on the consult, AMSA A acknowledged the delay in scheduling the consult and noted the consult should have been scheduled when received in late 2023. AMSA B was unable to recall being alerted of the need to process the patient's consult,

also acknowledged the delay, and reported that in hindsight the consult should have been followed closer.

To gain an understanding of the potential impact of the delay, the OIG interviewed a system pulmonologist, who reported that although there is no guideline available on timelines for evaluating a lung nodule, in general "the clock is ticking for upstaging (of the cancer)" and that a higher stage increases risk of mortality. The system chief of pulmonary told the OIG that a delay could have a "huge" clinical impact on the patient because cancer can quickly advance and progress. The system chief of pulmonary also described that earlier detection and treatment for cancer helps provide better patient outcomes. The chief of medicine informed the OIG that it would be "hard to say that it [the delay] wouldn't impact" the patient's course of care.

The OIG concluded that community care staff significantly exceeded VHA's seven-day scheduling guideline, which resulted in the patient being required to undergo an additional CT scan before being seen by a community provider. Although the pulmonologist submitted the community care consult the same day, and the APP reviewed and identified the patient's consult as needing immediate attention, community care staff did not take timely action on the consult despite status queries by the PCP. As a result, the delay in ordering the recommended CT scan and scheduling care in the community may have decreased the opportunity for an earlier diagnosis and treatment of the patient's lung cancer.

2. Factors Contributing to Scheduling Delays

The OIG determined there was a four-year period of leadership turnover in the system's community care service. In addition, the system did not have an operational and effective oversight council. Particularly concerning was the lack of written processes for staff to follow to avoid significant community care scheduling delays for patients with serious health conditions.

Further complicating the scheduling of the patient's care in the community in late 2023 into 2024 was a significant increase in consults for care in the community that challenged available resources to act timely.

Turnover in Key Leadership Positions

During interviews, the OIG learned of turnover from 2020 through 2024 among staff in leadership positions key to the management of the system's community care service.

Hospital leaders play a central role in establishing organizational culture through their words, expectations, and behavior.[23] Previous OIG reports have identified frequent turnover and

[23] The Governance Institute, "Leadership in Healthcare Organizations. A Guide to Joint Commission Leadership Standards," Winter 2009, accessed April 17, 2025, https://neltoolkit.rnao.ca/sites/default/files/Leadership%20in%20Healthcare%20Organizations_%20A%20Guide%20to%20Joint%20Commission%20Leadership%20Standards%202009.pdf.

vacancies in leadership positions as well as the long-term use of leaders in interim positions as a barrier to leaders' effectiveness at achieving organizational goals.[24]

The system chief of staff reported that the community care service had multiple different leaders over the past few years. The OIG learned from system leaders and staff that from mid-2020 through July 2024, the position of chief of community care was primarily held by acting staff until a permanent selection was made in August 2024. Additionally, the OIG learned from the System Director that the assistant chief of community care position was vacant.

In interviews with the OIG, VISN and system leaders identified the multi-year vacancy of the chief of community care as a primary factor in the lack of oversight and processes, which may have contributed to deficiencies in the system's community care service.

The System Director shared, "if you don't have the appropriate service chief, then you don't understand the policies and the procedures, consult oversight management, and it just is a trickle-down effect" noting that "multiple things that we probably should have had in place … were not in place like referral coordination." The System Director explained that the system now has a permanent chief of community care with extensive community care experience.

VISN and system leaders interviewed by the OIG acknowledged the changes in leadership as a challenge and noted the need to ensure the stability of leadership within community care to implement and sustain processes.

Required Community Care Oversight Council

During interviews, the OIG learned that system leaders did not ensure compliance with VHA requirements for a community care oversight council.

As a part of VHA's national community care operating model implementation, VA medical facilities were required to establish a local community care oversight council no later than November 9, 2017.[25] These councils, made up of both clinical and administrative staff, "ensure appropriate resources are allocated to deliver a quality experience" and are "foundational to the success of [the community care service's] clinical care and administrative functions."[26] VA

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[24] VA OIG, *Comprehensive Healthcare Inspection of Veterans Integrated Service Network 5: VA Capitol Health Care Network in Linthicum, Maryland*, Report No. 21-00239-180, July 14, 2022; VA OIG, *Descriptive Analysis of Select Performance Indicators at Two Healthcare Facilities in the Same Veterans Integrated Service Network*, Report No. 20-02899-22, November 16, 2021; VA OIG, *Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan*, Report No. 22-04099-153, July 18, 2023; VA OIG, *Increased Utilization of Primary Care in the Community by the VA Loma Linda Healthcare System in California*, Report No. 23-01602-147, April 23, 2024.

[25] Deputy Under Secretary for Health for Operations and Management (10N), "National Implementation of the Community Care Operating Model (VAIQ #7843114)," memorandum to Network Directors (10N1-23), October 17, 2017.

[26] VHA Office of Community Care, "VHA Office of Community Care Operating Model- Master Deck Library," updated November 1, 2017.

facilities implement oversight councils by establishing a charter, approved and signed by system leaders, that provides the strategy and purpose of the council, identifies the required council members, and determines the frequency of meetings.[27] Additionally, each facility must establish a mechanism used by the council to track action items and ensure they are followed until resolution.[28]

To gain understanding of the status of the community care oversight council during calendar years 2023 and 2024, prior to the current chief's arrival, the OIG reached out to the previous acting chief of community care. In a written response, the OIG learned the system had a combined community care oversight and consult management council during that time. However, when requested, the system was unable to provide a council charter, signed copies of council minutes, or documentation showing the review of community care metrics or action tracking in the committee during this period.

A review of system provided agendas for the combined community care oversight and consult management council for the 16 months from October 2022 through January 2024 indicated the council met 11 times, was canceled four times, and one month lacked documentation to determine if the meeting was held. While the agendas showed members expected to be in attendance and members present for the meetings, the System Director was listed as "excused/substitute" for every meeting date but no substitute was identified.[29] The OIG reviewed available agendas from January 2023 through January 2024 and found a listing of topics to be covered but no documentation of meeting minutes showing review of key community care metrics, discussion of opportunities for improvement, or tracking of action items intended to correct deficiencies.

During an interview, the newly hired current chief of community care reported an expectation that the system has a community care oversight council and informed the OIG of plans to resume the council, later providing the OIG with a copy of a charter for a combined community care oversight and consult management council dated December 2024. A review of the charter found it specified membership, purpose, scope, reporting structure, roles and responsibilities, administrative expectations, and meeting frequency. To assess the implementation of the newly chartered council, the OIG requested minutes for January–March 2025 and received a written response indicating the first meeting of the new council was held on April 4, 2025.

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[27] VHA Office of Community Care, "Community Care Oversight Council Overview," October 11, 2017.

[28] VHA Office of Community Care, "Community Care Oversight Council Overview."

[29] Following the issuance of this report to VHA, the system provided the OIG with an unsigned charter dated 2022 that was reported to be in effect during the time frame of the minutes reviewed. This document does not include the System Director as a member of the committee.

Process to Prioritize Patients with Serious Health Conditions

The OIG found that community care leaders did not establish processes that ensured community care consults were reviewed to identify and prioritize appointment scheduling for patients with serious health conditions (high-priority consults) such as cancer.[30] The need for this process became particularly important as the volume of consults for community care increased.

VHA Office of Integrated Veteran Care, “Consult Business Rules and Uses of the Consult Package Standard Operating Procedure,” states that VHA providers have an option to enter a consult’s urgency classification as routine or stat to communicate and indicate a time frame for when the consult should be addressed. Providers should enter consults as stat for patients with an immediate need, and appointments must then be scheduled and completed within 48 hours of entry.[31] All other consults should be entered as routine.[32] VHA community care staff are expected to schedule all patient appointments within seven days of receiving a consult, regardless of clinical need.[33] However, VHA’s IVC policies and field guidebook do not specify expectations for how or when community care staff should prioritize and schedule consults for patients with serious health conditions that may be considered high priority (high risk) in nature.

At the time of the patient’s consult, system leaders and providers had varying understanding of the option to use stat to prioritize community care appointment scheduling for patients. In the September 2024 response to the OIG, the System Director reported that the pulmonologist submitted the patient’s community care pulmonary consult with a “routine” urgency and noted that due to a “backlog,” as set forth in VHA Directive 1232, *Consult Management*, consults that needed expedited scheduling should be submitted as “urgent” or “STAT.”[34] The OIG found that the pulmonologist entered the patient’s consult as routine with a text comment in the body of the consult regarding the need to expedite. When speaking with the OIG, the pulmonologist explained that including written instructions to expedite a consult was the process used at the time to get a patient seen by a provider within the community sooner rather than later. When

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[30] For the purpose of this report, the OIG considers a high priority (also known as high risk) consult to be a routine consult that does not require immediate attention but involves an active disease process or medical concern that is time sensitive and where, if managed with the pool of lesser-priority routine consults, could introduce a risk for delay. An example of a lesser-priority routine consult would be a screening mammogram for an individual with no symptoms or family history of breast cancer, whereas a high-priority consult would be a mammogram for an individual with symptoms suggestive of breast cancer and a family history of the cancer.

[31] VHA Office of Integrated Veteran Care, “Consult Business Rules and Uses of the Consult Package Standard Operating Procedure”; VHA Office of Integrated Veteran Care, “Consult Timeliness Standard Operating Procedure (SOP).”

[32] VHA Office of Integrated Veteran Care, “Consult Business Rules and Uses of the Consult Package Standard Operating Procedure.”

[33] VHA Office of Integrated Veteran Care, “Consult Timeliness Standard Operating Procedure (SOP).”

[34] VHA Directive 1232, *Consult Management*, November 22, 2024. VA policy allows VA providers the use of two urgency classifications when entering a consult, routine and stat. The policy does not include the option for a VA provider to order a consult as “urgent” to communicate the need to expedite a consult.

asked if stat was an option for the patient's consult, both the chief of pulmonary and the pulmonologist described being instructed not to use stat. The chief of medicine told the OIG that the former acting chief of community care discouraged the use of stat consults, stating community care is not "built" to take stat consults. The former acting chief of community care reported that ideally a provider would enter a consult as stat if a patient needed to be seen more quickly than routine but that consults that were not true medical emergencies should not be entered as stat.

The OIG questioned system community care staff and leaders about the service's process to identify and expedite scheduling consults considered high priority, but not stat. Community care staff reported the system lacked a written process to identify high-priority consults at the time the patient's consult was received. Community care staff involved with consult processing told the OIG that clinical community care staff review and determine which consults need to be expedited.[35] While VHA Directive 1232, *Consult Management*, allows the use of routine and stat as urgency classifications on consults, community care staff reported that once a consult is designated as needing to be expedited, clinical community care staff send a message via electronic group chat to inform the AMSAs that the consult needs expedited scheduling. A system APP reported being unsure who the consult is assigned to next but recalled seeing evidence in an electronic group chat of a lead AMSA assigning consults to a specific AMSA at times.

When asked how community care consults were assigned for scheduling, AMSAs confirmed the expectation that clinical community care staff or AMSA supervisors immediately alert the AMSAs of consults that need expedited scheduling. Community care AMSA staff told the OIG that consults are assigned to AMSAs for scheduling using a break down by medical specialty and then by an alphabetical split. One community care AMSA reported that all consults would go "into one big queue and would be separated" by the alphabetical split but the AMSAs' assignments would get "flopped around so much" that, at the time of the patient's consult, there were "a lot of breaks in the care." A second community care AMSA shared the consult is managed by identifying the community provider the patient will see, mailing a letter to the patient with the provider's information, and faxing the patient's records to the provider in the community for review and appointment scheduling. The community care AMSA noted that high-priority consults are processed the same way as regular consults. While able to describe a process for managing high-priority consults, community care AMSA staff reported not having specific training on doing so.

The OIG interviewed the former acting chief of community care to gain further understanding of consult management at the time of the patient's consult in late 2023, who reported that "there's

[35] System community care clinical staff includes registered nurses and APPs, such as nurse practitioners or physician assistants.

not great guidance" available for managing high-priority consults. The former acting chief further described "deprioritizing certain types of consults" that were not "critical medical specialties" and having "a wall of sticky notes" of the community care staff assigned to manage specialties with high-priority consults. The former acting chief added that providers were encouraged to reach out to points of contact within community care to expedite consult scheduling.

When asked about the process at the time of the OIG site visit, the current chief of community care confirmed that the system lacked a procedure or policy for managing high-priority consults. The current chief added that although a written policy or procedure is not available, the expectation is that an APP receives the consult and if no issues are present, the APP hands the consult off to an AMSA to confirm eligibility for care in the community and to send to a community provider for consideration of acceptance and scheduling. The APP assigned to the patient's community care consult informed the OIG that initial training did not include written guidance on how to perform consult management. The current chief acknowledged finding inconsistencies and inefficiencies in service processes but confirmed that absent a policy, community care staff are referred to the IVC field guidebook for direction on community care processes.

The OIG also interviewed staff from VHA's IVC for insight into national-level guidance and expectations related to the management of high-priority consults. IVC staff reported that current IVC guidelines do not define which consults are considered high priority. VHA's Director of Integrated Access Operations told the OIG that the IVC guidebook does not serve as a policy but instead serves as guidance. Additionally, the Director, Field Operations reported that if there are challenges with specific consults, VA facilities can expand on the IVC guidebook and create stricter guidance if needed. The Director of Integrated Access Operations and an IVC supervisory health systems specialist explained that while there is no specific high priority flagging system in the EHR used to alert staff, there is functionality within the EHR that can be used as a tool to identify consults for prioritized scheduling. The supervisory health systems specialist explained that individual VA facilities must make the decision locally to enable the tool in the system.

In addition, the OIG learned that the number of consults for community care rose from 12,067 in December 2023, to 19,072 in January 2024. Some of those interviewed reported that they believed that pre-existing challenges with the system's community care staffing levels, combined with the increased workload, made it difficult for system community care staff to timely process consults and caused a strain on the service. As such, this may have contributed to the delayed scheduling of the patient's community care pulmonology consult for over five months, which resulted in a delay in diagnosis and treatment of the patient's cancer.

The OIG concluded that the increase in demand for community care likely contributed to the timely processing of incoming consults. System leaders did not follow VHA guidance and

establish a consistent, fully functioning community care oversight council, representing a missed opportunity to track community care performance. While the system has moved toward compliance through the recent chartering of a new council to address community care oversight, ongoing monitoring of the process is warranted. The lack of oversight, turnover in key leadership, and lack of processes for managing incoming consults, particularly those that are high priority, resulted in a lack of internal controls to ensure patients with the greatest need are cared for first.

3. System Leaders' Response to the Patient's Delayed Diagnosis and Treatment and Backlog of Unscheduled Consults

The OIG determined that, despite first becoming aware of the patient's delay in diagnosis and treatment in May 2024, system leaders missed several opportunities to proactively review the event to identify further actions needed and resolve programmatic deficiencies in community care that contributed to the event. Additionally, the OIG determined that leaders did not perform a coordinated and comprehensive review of the backlog of unscheduled consults to identify patients with urgent needs and any additional actions staff needed to take.

Leaders Missed Opportunities to Identify System Issues

The OIG found system leaders were informed of the patient's delayed diagnosis and treatment in May 2024 but did not ensure a thorough investigation of the event and case referral response, and the initiation of peer reviews until six months later.

First Missed Opportunity

The OIG determined an investigation was conducted in response to a patient safety report of the patient's event but the results were incomplete, inaccurate, and lacked corrective actions to prevent a recurrence.

Patient safety reports in the Joint Patient Safety Reporting (JPSR) system, "provide the foundation for investigating and analyzing root causes with contributing factors to take action to prevent future events."[36] System patient safety managers (PSMs) are responsible for ensuring that events entered into the JPSR system are assigned to investigators who are subject matter experts for the issue of concern.[37] The investigation phase is a key part of the JPSR process used to understand circumstances specific to an event and gives system staff opportunities to learn about process gaps that, if addressed, may prevent a recurrence of the event. Once an investigator's review is complete, VHA instructs PSMs to conduct a final review of the report to

[36] VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

[37] VHA National Center for Patient Safety, *JPSR Guidebook*.

ensure the accuracy of the investigation and validate that actions are taken to prevent further harm.[38]

The patient's delay in care was reported via the JPSR system on May 18, 2024, after it was noticed that community care staff did not schedule the patient's community care pulmonary consult that was submitted in late 2023. That same day, a system PSM reviewed the patient safety report, assigned staff from the community care service to investigate the event, and sent an email to the system's chief of quality management, a second system PSM, the system peer review coordinator (PRC), and system risk manager, notifying them of the need to consider the patient's case for risk management or peer reviews. In an interview, the PSM told the OIG that the patient safety event was presented to system leaders at morning report on May 20, 2024, and explained that, according to the PSM's personal tracking tool, the System Director had not requested any follow-up on the report.

Twenty days after JPSR entry, an assigned investigator entered the results of the review in the JPSR system. A back-up PSM closed the report three days later and sent an electronic response to the acting deputy chief of medicine and acting chief of primary care, alerting them to a recommendation made by the investigator relevant to the medicine service. However, during interviews with staff involved in the patient's care, the OIG learned the recommendation was not implemented. In an interview, the chief of medicine recalled being aware of the patient's delayed appointment but could not recall the specific JPSR or being asked to review the patient's care. The back-up PSM was unaware whether patient safety staff monitored JPSR recommendations when asked if recommendations are monitored to ensure completion. When asked if PSMs follow up to ensure recommendations are completed, the PSM told the OIG "[follow-up] is not received well." The PSM explained that some system leaders are receptive to working with patient safety while others are not as receptive to input from patient safety program staff.

The OIG found that the results of the JPSR investigator's review lacked the specificity required to identify issues contributing to the scheduling delay, contained inaccurate information, and did not provide recommendations that would have prevented a similar patient event in the future. While the JPSR investigator acknowledged the patient's scheduling delay, the investigator's response did not provide a detailed look at why the delay occurred. Through an analysis of the patient's EHR, document reviews, and interviews with staff involved, the OIG learned that the investigator provided inaccurate information in the response. Additionally, the investigator did not make any recommendations specific to the community care service to address factors that may have contributed to the delay.

In discussions with system quality management staff and the VISN 6 patient safety officer to understand how, and if, consideration was given to conducting quality management reviews related to system issues in the community care service, the OIG learned the PSM's review of the

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[38] VHA Directive 1050.01(1); VHA National Center for Patient Safety, *JPSR Guidebook*.

event did not trigger a root cause analysis. In an interview, the PSM explained the rationale was based on an estimation of the low frequency of similar patient safety events occurring in the future.

The VISN 6 patient safety officer told the OIG that in September 2024, the VISN QMO requested a review of the JPSR. After reviewing the JPSR and discussing the event with the VISN 6 risk management officer, the VISN 6 patient safety officer reached out to the system PSMs and reported being told the system PSMs were aware of ongoing issues with community care consult delays and system leaders were working with the VISN on multiple action plans. As a result, the VISN 6 patient safety officer reported not recommending any further actions to the system patient safety program for this event.

The OIG confirmed a clinical review of the patient's JPSR event was completed; however, system leaders did not ensure a review of the community care process, identification of opportunities for improvement, and implementation of recommendations. In addition, the OIG determined the PSM's low estimation of the risk of future similar occurrences, coupled with JPSR investigators not identifying system issues, contributed to the lack of additional quality management reviews. Together, these represented the first missed opportunity to address system issues impacting the care of this patient.

Second Missed Opportunity

The OIG determined system leaders did not follow VA policy when responding to the VA OIG case referral specific to the care of the patient by not providing the full scope of the OIG's inquiry to the assigned investigator and not assigning the review to an individual independent from the service associated with the complaint. As a result, system leaders did not ensure completion of a thorough, unbiased review of the allegations to accurately identify corrective actions to address deficiencies in the community care appointment scheduling process.

Pursuant to VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*, complaints referred by the OIG to VA facilities for action are classified as case referrals.[39] VA policy requires allegations from case referrals to be independently reviewed by an individual not involved in the alleged incident.[40] VA staff assigned to review case referrals are responsible for conducting a review of each allegation.[41] The written response must include the findings, whether each allegation is substantiated or unsubstantiated, a description of corrective actions taken, and the dates the actions were initiated or completed.[42]

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[39] VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*, December 16, 2020.

[40] VA Directive 0701.

[41] VA Directive 0701.

[42] VA Directive 0701.

The OIG found that although the original case referral identified the "community care office" and several community care staff involved in the alleged incident, a system administrative staff member assigned the newly hired chief of community care rather than an independent reviewer to review the allegations and provide a written response. Additionally, the OIG learned through document reviews and interviews with the VISN 6 QMO and the chief of quality management that the system did not provide all allegations from the original OIG case referral to the chief of community care as required by the VA Directive 0701. Therefore, the chief of community care's response was limited to a review of the delay in action for the community care pulmonary consult ordered in late December 2023, resulting in a partial response to the case referral.

The OIG determined that the written response submitted by the system did not address the full OIG inquiry included in the case referral. Specifically, the response did not address the patient's clinical care and follow-up delays that occurred after the initial chest x-ray identifying the right lung nodule taken in early 2022, and completion of an institutional disclosure for the patient. The OIG reviewed requested documents and the patient's EHR and found that after becoming aware of the consult delay, system staff obtained updated images and an oncology appointment for the patient. However, the OIG did not find documentation that an institutional disclosure was provided to the patient or evidence of an apology as indicated in the case referral response. In addition, the response reported that the system had initiated a "comprehensive review" of community care service processes but did not provide information on the date this review was initiated, current status, or timeline for completion. In an interview with the OIG, the newly hired chief of community care described being in the process of understanding the operations of the service and identifying many recommendations at the time of the case referral.

The OIG concluded that although the system's written response substantiated a delay for one of the three allegations in the original case referral, system leaders did not address all three allegations and assign an independent reviewer, as required. The lack of a comprehensive review of the patient's care after the initial imaging in early 2022, and implementation of corrective actions, was the second missed opportunity to identify and address all relevant factors, including system issues, regarding the care of this patient.

Third Missed Opportunity

Despite the PSM sending an email on May 18, 2024, alerting the chief of quality management, the PRC, and the risk manager of the patient's delay in diagnosis and treatment of lung cancer, the OIG found that system leaders did not initiate peer reviews for another six months.

A peer review is a confidential and non-punitive assessment of a clinician's care, decisions, and actions within a specific period to identify learning opportunities to improve veteran care.[43] VHA

[43] VHA Directive 1190(1), *Peer Review for Quality Management,* November 21, 2018, amended July 19, 2024.

requires screening of information that may necessitate a peer review to occur within three business days of identification to determine if a peer review is appropriate.[44]

During an interview, the PRC reported initially becoming aware of the delays in the patient's care through a notification from patient safety staff in May 2024 but deferred completing an initial screening for a peer review at that time due to a four-month backlog of cases to go to the peer review committee. The OIG learned the PRC was alerted a second time over three months later, when the chief of quality management, after receiving the OIG case referral, sent an email advising the PRC and risk manager to again review the patient's care for a potential peer review and disclosure.

On November 12, 2024, the OIG sent the system notification of a healthcare inspection related to deficiencies in the patient's care. Through document reviews, the OIG learned two peer reviews were initiated in November 2024, six months after the PRC first became aware of the patient's delay in diagnosis and care coordination.

Although both peer reviews were initiated and completed, the OIG found the system exceeded the three-day screening time frame. To understand the delay in screening the patient's care, the OIG asked about reasons for the backlog of peer reviews with the peer review committee. The PRC reported the peer review committee meets monthly but oftentimes scheduled cases are not presented due to initial reviewers not submitting documents timely or the absence of service chiefs or representatives to present the cases, leading to the cases being scheduled later and adding up. Although peer reviews may be scheduled for review by the peer review committee at a later date, the OIG would have expected the initial screening to occur within the recommended time frame to determine if the case met peer review requirements.

In reviewing documents, the OIG determined the peer reviews that were initiated were focused on the clinical aspects of the patient's care. When asked about the need for, and disposition of, a review of the patient's community care pulmonary consult processing delays, the PRC reported not identifying any standard of care issues within the actions of system community care staff that may have warranted a peer review. However, later, during the interview with the OIG, the PRC substantiated the consult delays and acknowledged overlooking consult details that may have involved action by clinical staff and reported, "this was an error on my part." On February 10, 2025, the OIG contacted the PRC to inquire about a reconsideration for additional peer reviews related to community care consult processing delays after the consult was entered and learned that, after a secondary review of the EHR documentation by the PRC, no additional licensed clinicians involved with the processing of the consult were identified for peer review. However, the OIG's review of the patient's EHR identified licensed clinical community care

[44] VHA Directive 1190(1).

staff responsible for care coordination efforts and documentation in the patient's EHR for whom consideration for peer review could have been given.

According to VHA Directive 1190(1), *Peer Review for Quality Management*, process or system issues not appropriate for peer review should be referred by the PRC and addressed using other types of quality management activities.[45] The OIG did not find evidence indicating system leaders initiated a review to identify and address system issues that led to consult processing delays, despite their awareness of a six-month delay in processing the community care pulmonary consult. The OIG would have expected the PRC to identify and refer any issues outside the scope of peer review such as process or system issues for additional quality management reviews. Not conducting a timely comprehensive review of system issues may delay identification of the root cause and contributing factors, and prevent additional opportunities to reduce the risk of harm.

Although select peer reviews were completed, the OIG recognizes that system leaders did not initiate additional quality reviews such as peer reviews for clinicians involved with consult processing or refer processing deficiencies for additional quality reviews to identify and address system issues. These constitute a third missed opportunity to study the care of the patient to identify system-related areas for improvement.

Identification and Disclosure of Event

The OIG found that despite awareness of the patient's delayed diagnosis and treatment, system leaders did not complete a timely institutional disclosure to the patient.

An institutional disclosure is a formal process in which system leaders and clinicians inform a patient or their family that an adverse event has occurred during the course of the patient's care.[46] This discussion may include an explanation of the event, outline of treatment options, and offer of information related to the "patients' rights and recourse."[47] Facility leaders are responsible for initiating an institutional disclosure as soon as possible, regardless of when the event was discovered, if an event has had or is expected to have an effect on the patient or requires a change in the patient's care.[48] VHA requires an institutional disclosure to be documented in the patient's EHR.[49]

The OIG found that an institutional disclosure was not completed at the time system leaders first became aware of the patient's delay in care. As noted previously, the risk manager was alerted of the patient's delay in May 2024 and again about three months later in September 2024. In the

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[45] VHA Directive 1190(1).

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

[47] VHA Directive 1004.08.

[48] VHA Directive 1004.08.

[49] VHA Directive 1004.08.

September 2024 email, the chief of quality management told the risk manager, “This will likely need to be a disclosure;” however, a disclosure was not completed.

During an interview with the OIG, the chief of staff reported that the patient most likely would have had better results if a chest CT scan was completed as recommended by the interpreting radiologist following the initial abnormal chest x-ray results in early 2022. When asked about the clinical impact of this delay on the patient, the chief of staff stated, “[the patient] had advanced disease” but noted the patient’s quality of life may have been better. In response to the need for a disclosure, the chief of staff reported not feeling the need to complete a disclosure initially. However, after completion of a peer review related to the patient, the chief of staff reconsidered, stating “I think I made a mistake, I should have done an institutional disclosure.” During the interview, the chief of staff noted system staff subsequently attempted to contact the patient but attempts were unsuccessful.

In speaking with the OIG, the VISN risk manager reported reviewing the patient’s EHR, confirming the delay in care coordination, and recommending an institutional disclosure. Through document review, the OIG learned the VISN risk manager shared the recommendations for the patient’s institutional disclosure with the system risk manager. The OIG reviewed a system report of contact documenting multiple unsuccessful attempts to contact the patient between December 27, 2024, to January 3, 2025. However, as of June 2, 2025, the OIG found no additional documentation of unsuccessful contact attempts or documentation in the patient’s EHR of a completed institutional disclosure. When asked how the VISN ensures recommendations made to a system are implemented, the VISN QMO reported, “we can’t force them” noting “there is a level of understanding that if the VISN submits an action that you need to implement it” but ultimately things such as peer review or institutional disclosures are just suggestions.

The OIG concluded that system leaders did not complete an institutional disclosure within VHA’s recommended time frame. The commitment to disclose harmful events to patients or patient representatives fosters ethical principles consistent with VA core values. Not disclosing the circumstances of the delay experienced by this patient has the potential to erode trust and effective communication and represents a missed opportunity to inform a patient and family about all clinically significant facts regarding the event.

Completion of Comprehensive Clinical Reviews

The OIG determined that VISN and system leaders were aware of the large number of community care consults that remained unscheduled for an extended period and recognized the need to complete EHR reviews to determine the circumstances and pending care needs for each patient. However, system leaders did not develop a comprehensive plan to complete the EHR reviews. Rather, the OIG found a well-intended but poorly coordinated effort with varied lists of

patient names, starts and stops, a lack of follow-through, and the lack of an individual assigned to manage the process.

In the healthcare setting, "leadership's first priority is to be accountable for effective care while protecting the safety of patients." As those most responsible for the care and services provided, leaders must ensure issues impacting patient safety "are promptly identified, fully evaluated, and promptly addressed and corrected commensurate with their significance."[50]

The OIG learned that in June 2024, VISN 6 Office of Community Care staff were on-site to help manage the system's backlog of unscheduled community care consults during the transition period prior to the arrival of the new chief of community care. During this time, a VISN 6 nurse (VISN nurse) reported working collaboratively with the system's community care nurses to review consult metrics and identifying a "high" amount of community consults that had been unscheduled for more than 270 days. To address concerns related to the unscheduled consults, the VISN nurse recommended community care staff review the EHRs and call patients to determine the status of each consult. Specifically, the VISN nurse suggested a systematic approach to determine if the consult was still needed, care had already been rendered, or the consult delay resulted in potential harm. The VISN nurse reported that the selection of unscheduled consults pending for greater than 270 days was chosen as a "workable" starting point to "chip away" at the backlog "because the next bracket down, the greater than 180" days, was believed to have "several thousand" unscheduled consults.

During interviews, the OIG learned VISN 6 staff and system leaders met and developed a process to address the unscheduled consults pending for greater than 270 days. When asked about methodology used to review the consults, the chief of quality management was unable to provide specific details related to the review process or related reviewer training. Through document review, the OIG learned community care staff nurses were trained to review the unscheduled consults, assign a safety assessment code score, and refer patients with potential harm related to the delay for a secondary review. During interviews, the OIG was told that consults with a safety assessment code score of 2 (intermediate risk) or 3 (high risk) were flagged for a secondary review and assigned to APPs or subject matter experts for further evaluation of safety concerns and documentation of a disposition. The chief of quality management explained that community care nurses initiated EHR reviews beginning August 2024 and identified 51 patients requiring a secondary review. Although the initial reviews identifying potential patient harm due to the delays were completed and sent to the

[50] The Joint Commission, "The Essential Role of Leadership in Developing a Safety Culture," Sentinel Event Alert 57, March 1, 2017, revised June 18, 2021, accessed April 8, 2025, https://www.jointcommission.org/resources/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-57-the-essential-role-of-leadership-in-developing-a-safety-culture/.

VISN nurse for review in late August 2024, the chief of quality management reported secondary reviews were not completed until December 2024.

In late August 2024, the chief of quality management reported meeting with the acting chief of staff, acting deputy chief of staff, acting chief of surgery, and chief of medicine to discuss the consults flagged for a secondary review and determine which specialist would complete the reviews. During the team meeting, attendees discussed risk stratification, developed a list of questions to be answered during the secondary review, and were tasked to refine the list of questions prior to the next scheduled meeting on August 23, 2024. The chief of quality management told the OIG the meetings scheduled for August 23, 2024, and August 30, 2024, were canceled, causing the review to be "lost to follow up" until the OIG's site visit in December 2024. In September 2024, the VISN risk manager reviewed 15 cases from the list that system staff identified to be of concern. From those 15, 4 were identified as possibly needing an institutional disclosure. The system's chief of quality management reported to the OIG that one institutional disclosure was completed; however, the OIG did not find evidence of that disclosure in the patient's chart. The OIG learned the secondary reviews and final analysis of the consults unscheduled for greater than 270 days were completed in December 2024.

The OIG reviewed documents used to conduct the EHR reviews that were provided by the VISN staff, chief of quality management, and the acting deputy chief of staff and found the documents did not provide a comprehensive summary of actions taken for patients with identified harm or a significant clinical impact as a result of the delay. When asked about the methodology used to conduct the review, the chief of quality management was unable to provide specific details. When asked who was responsible for oversight of the review process, the VISN nurse and acting deputy chief of staff reported an understanding that the chief of quality management was responsible, while the chief of quality management told the OIG that the acting deputy chief of staff was the responsible individual.

In addition to the list generated in August 2024 showing the unscheduled consults pending more than 270 days, the acting deputy chief of staff described working with the system's chief health informatics officer in October 2024 to filter a list of all unscheduled community care consults by specialty provider or APP. Once sorted, providers were given a list of unscheduled community care consults to review. To understand the scope of the EHR reviews, the OIG reviewed the list provided by the acting deputy chief of staff and the list from the chief of quality management. In doing so, the OIG determined the lists were not identical.

In reviewing the actions taken by the VISN and system to identify patients with unscheduled consults with urgent needs following the influx of community care consults, the OIG determined the system did not manage the process in a manner that allowed tracking of the disposition of each consult with all actions taken clearly documented. In addition, the initial completed review did not include a large volume of patients with consults waiting more than the seven days allowed by VHA for scheduling a patient and less than 270 days. While later addressed in the

review of all backlogged unscheduled community care consults initiated by the acting deputy chief of staff, not initially including this population of patients with unscheduled consults was an oversight that may have resulted in further delays for individuals with unmet urgent care needs. Additionally, the OIG is concerned that, given the large number of patients who had unscheduled community care consults for extended periods of time, only one was identified as meeting criteria for institutional disclosure.

Therefore, the OIG lacks confidence that the reviews of the unscheduled community care consults were comprehensive, well managed, well documented, and effective in identifying all patients at risk for or harmed by the delayed scheduling of their consult, and that institutional disclosures were conducted as warranted. The OIG is concerned that the limited action taken may represent another missed opportunity to identify ways of improving system processes through the analysis of findings following a large review of patient records.

Conclusion

The OIG concluded that the PCP was aware of the patient's initial abnormal chest x-ray but delayed ordering a recommended chest CT scan over for 15 months until a subsequent chest x-ray reconfirmed the abnormal results of a lung nodule. In addition, community care staff exceeded VHA's seven-day scheduling guidelines and delayed scheduling the patient's consult for over five months, despite status inquiries by the PCP. As a result, the delay in ordering the recommended chest CT scan and scheduling care in the community may have decreased the opportunity for an earlier diagnosis and treatment of the patient's lung cancer.

Four factors contributed to the system community care staff's delay in scheduling the patient's community care pulmonary appointment. VISN and system leaders identified leadership turnover in key positions within the system's community care service as a factor that may have resulted in system leaders' inability to implement and sustain processes to effectively manage large consult volumes. The system was unable to provide documentation showing compliance with VHA requirements for a community care oversight council, an important forum to review community care metrics and identify areas for improvement. In addition, community care leaders did not establish a process to ensure consults were reviewed to identify and prioritize appointment scheduling for patients with serious health conditions such as cancer. Further challenges occurred in late 2023 and early 2024 when there was a sudden increase in the overall volume of community care consults. While the system has taken steps to address some of these concerns, opportunities to strengthen community care service processes remain.

Despite becoming aware of the patient's delay in diagnosis and treatment in May 2024, system leaders missed several opportunities to review and resolve community care service deficiencies that may have contributed to the event. Although system leaders' response to an OIG case referral substantiated the delay in the patient's community care appointment, system leaders did not assign an independent reviewer to conduct a comprehensive assessment of the patient's care

after the initial imaging in early 2022 and implement corrective actions to address system issues related to the care of this patient.

Select peer reviews were initiated six months after becoming aware of the patient's delay in care and diagnosis of lung cancer. However, system leaders did not initiate additional quality reviews to identify system-related issues for improvement. Further, system leaders not completing an institutional disclosure within the recommended time frame was a missed opportunity to inform the patient and family about all clinically significant facts regarding the event.

Once aware that a large number of community care consults remained unscheduled for an extended period, VISN and system leaders recognized the need to complete EHR reviews to address pending care needs. However, the OIG found system leaders did not assign an individual to manage the process and develop a comprehensive plan to conduct EHR reviews, track follow-up, and document actions taken.

The OIG is aware that at the time of the publication of this report, VHA has announced significant changes in the VISN process. The OIG will continue to monitor this process and follow up on the changes that impact this report.

The OIG made eight recommendations. In response, the Under Secretary for Health reported plans to review practices and procedures related to prioritization of appointments for consults and the system's electronic health records related to the backlog. The Facility Director provided action plans for a community care oversight council, a procedure for managing high-priority consults, quality management tracking processes, staff training, and disclosure of the adverse event to the patient or next of kin.

The OIG is aware of VA's transformation in VHA's management structure. As we monitor the implementation, our oversight remains focused on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–8

1. The VA Fayetteville Coastal Healthcare System Director confirms full implementation of the VA Community Care Oversight and Consult Management Council.

2. The Under Secretary for Health reviews practices and procedures for managing consults to identify and prioritize appointment scheduling for patients with serious health conditions (high-priority consults), such as cancer, and provide direction to the field on the process to use to make this determination.

3. The VA Fayetteville Coastal Healthcare System Director directs the development and implementation of community care service standard operating procedures to address identification and management of high-priority consults, timeliness of consult processing, and

care coordination that aligns with direction provided by Veterans Health Administration's Integrated Veterans Care program.

4. The VA Fayetteville Coastal Healthcare System Director ensures staff are trained in all newly developed community care standard operating procedures and that adherence to policy and practice is monitored.

5. The VA Fayetteville Coastal Healthcare System Director confirms completion of a review of quality management processes to ensure quality management staff, when reviewing patient safety events, consider potential system issues and, if present, recommend they be addressed using other quality management reviews.

6. The VA Fayetteville Coastal Healthcare System Director ensures local processes are in place, including assigned roles and responsibilities, to manage Office of Inspector General case referrals in compliance with VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*.

7. The VA Fayetteville Coastal Healthcare System Director confirms reasonable efforts to conduct an institutional disclosure with the patient regarding circumstances that led to the delay in the diagnosis of and treatment for lung cancer are made and, if a disclosure is completed, that it is documented in the electronic health record.

8. The Under Secretary for Health assesses the electronic health record reviews completed by the system in response to the community care backlog to determine if a more comprehensive review is warranted with appropriate disclosure to patients placed at risk or harmed as a result of a delay in action on their community care consult, and takes action accordingly.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: February 27, 2025

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Review of Community Care Consult Management at the VA Fayetteville Coastal Healthcare System in North Carolina

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on the Review of Community Care Consult Management at the VA Fayetteville Coastal Healthcare System in North Carolina.

2. The Veterans Health Administration (VHA) greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

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:)*

John J. Bartrum, JD, MBA

[OIG comment: The OIG received the above revised memorandum from VHA on March 2, 2026, and the original memo was received on October 31, 2025.]

Office of the Under Secretary for Health Response

Recommendation 2

The Under Secretary for Health reviews practices and procedures for managing consults to identify and prioritize appointment scheduling for patients with serious health conditions (high-priority consults), such as cancer, and provide direction to the field on the process to use to make this determination.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Under Secretary for Health Comments

Concur. In fall 2025, VHA began reviewing practices and procedures for managing consults to ensure timely scheduling for Veterans with serious health conditions. VHA's scheduling policy applies to all community care consults and does not establish different timelines based on category of care; however, VHA has focused on strengthening care coordination processes to guide decision-making and scheduling.

To address the recommendations in the report, VHA has:

- Collaborated with the Office of Integrated Veteran Care (IVC) and the Clinical Episode Review Team (CERT)—beginning in December 2024 following the Buffalo OIG report findings—to identify categories of care that indicate higher complexity or higher-risk services.
- Initiated review and reporting of data on open and unscheduled consults for these categories to VHA leadership as part of ongoing efforts that started prior to the Fayetteville report.
- Continued evaluation of care coordination processes for community care consults throughout 2025 to ensure consults are assessed for the level of coordination required and that care plans are developed for Veterans with greater-than-basic needs. This included revisions to existing standardized tools, expansive training across multiple field facing calls, and targeted engagement with Veterans Integrated Service Networks (VISN) and VA medical center leadership.
- Since the release of this report, in fall 2025 IVC Integrated Optimization, Senior Nurse Advisor, and Integrated Informatics & Analytics teams have been working to finalize a revised Care Coordination Dashboard in to provide better visibility into community care coordination practices at the facility level and ensure appropriate support for Veterans with complex needs.

VHA is actively evaluating current processes and procedures to determine if updates are needed to ensure Veterans with high-priority consults are scheduled timely. This review is anticipated to be completed by March 2026, and any updates to guidance and subsequent process assessments will be communicated to the field.

Recommendation 8

The Under Secretary for Health assesses the electronic health record reviews completed by the system in response to the community care backlog to determine if a more comprehensive review is warranted with appropriate disclosure to patients placed at risk or harmed as a result of a delay in action on their community care consult, and takes action accordingly.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Under Secretary for Health Comments

Concur. CERT has discussed the issue with the VISN. CERT will formally review the electronic health record reviews completed to date and provide recommendations on whether additional actions are needed. Depending on the findings, this action will be updated with additional review requirements and/or disclosure timeline.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 17, 2026

From: Interim VA Mid-Atlantic Health Care Network Director, VISN 6 (10N6)

Subj: VA Office of Inspector General (OIG) Report, Review of Community Care Consult Management at the VA Fayetteville Coastal Healthcare System in North Carolina

To: Director, Office of Healthcare Inspections (54HL05)
Chief Integrity and Compliance Officer (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 concur with the report findings and recommendations of the OIG report, Review of Community Care Consult Management at the VA Fayetteville Coastal Healthcare System in North Carolina.

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

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

(*Original signed by:*)

Joanna Weber
for
Kevin P. Amick, MBA, MHRM

[OIG comment: The OIG received the above revised memorandum from VHA on March 2, 2026, and the original memo was received on October 31, 2025.]

Appendix C: System Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 13, 2026

From: Director, Department of Veterans Affairs (VA) Fayetteville Coastal Healthcare System (565)

Subj: VA Office of Inspector General (OIG) Report, Review of Community Care Consult Management at the VA Fayetteville Coastal Healthcare System in North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N06)

1. We appreciate the opportunity to review and comment on the OIG report, Review of Community Care Consult Management at the VA Fayetteville Coastal Healthcare System in North Carolina. VA Fayetteville Coastal Healthcare System concurs with the recommendations and will take corrective action.

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

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

(*Original signed by:*)

John Stout
for Marri "Nicki" Fryar, MBA, MHA, BSN, NE-BC, VHA-CM

[OIG comment: The OIG received the above revised memorandum from VHA on March 2, 2026, and the original memo was received on October 31, 2025.]

System Director Response

Recommendation 1

The VA Fayetteville Coastal Healthcare System Director confirms full implementation of the VA Community Care Oversight and Consult Management Council.

_X_ Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

Concur. The Department of Veterans Affairs (VA) Fayetteville Coastal Healthcare System Community Care Oversight and Consult Management Council began meeting and was fully implemented in April 2025. The council charter was signed on January 13, 2025, and outlines the purpose, scope, responsibilities, and meeting structure. Council meetings continue monthly. Compliance has been reported monthly for six consecutive months with reports occurring monthly to the Clinical Business Operations Executive Council. With submission of supporting evidence, we request closure of this recommendation.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The VA Fayetteville Coastal Healthcare System Director directs the development and implementation of community care service standard operating procedures to address identification and management of high-priority consults, timeliness of consult processing, and care coordination that aligns with direction provided by Veterans Health Administration's Integrated Veterans Care program.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Director Comments

Concur. In spring 2025, VHA established Community Care Consult Oversight Committee and has been meeting monthly. VHA developed an audit tool with the Corporate Compliance office

aligned with field guidebook standards. VHA conducted quarterly audits and identified training opportunities based on results. Oversight involves weekly VISN Engagement meetings and bimonthly reviews with facility Executive Leadership Team for planning and best practice implementation. Patient Safety Manager completed Joint Patient Safety Patient Reporting (JPSR) training for Care in the Community staff on January 30, 2025. The standard operating procedure (SOP) titled Community Care – High Priority is currently undergoing significant revisions under the guidance of VISN Leadership. The updated SOP, which outlines the management of High Priority consults, is expected to be finalized by March 2026, for implementation. In addition, the facility will follow the Veterans Integrated Service Network (VISN) 6 SOP 483-035 "Standardized Care Coordination Processes for Community Care Consults" and the IVC SOP "Consult Timeliness Standard Operating Procedure."

Recommendation 4

The VA Fayetteville Coastal Healthcare System Director ensures staff are trained in all newly developed community care standard operating procedures and that adherence to policy and practice is monitored.

_X_ Concur

____Nonconcur

Target date for completion: July 2026

Director Comments

Concur. Community Care staff will receive training on all newly developed Community Care SOPs, with a goal of achieving a completion rate of 90% or higher. An audit tool will be developed to monitor adherence to requirements for high priority consult management, timelines of consult processing, and care coordination per the newly developed SOP. A sample of 30 high priority consults per month will be audited for adherence to newly developed SOP with a goal of 90% compliance for six consecutive months. Compliance will be reported monthly to the Community Care Oversight and Consult Management Council.

Recommendation 5

The VA Fayetteville Coastal Healthcare System Director confirms completion of a review of quality management processes to ensure quality management staff, when reviewing patient safety events, consider potential system issues and, if present, recommend they be addressed using other quality management reviews.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Director Comments

Concur. The Chief, Quality & Patient Safety is responsible for ensuring weekly meetings are held in which the Patient Safety Managers, Risk Manager, and Peer Review Coordinator review JPSRs, Institutional Disclosures, and Peer Reviews to ensure all are consistent with a thorough quality management review process. During the weekly meetings, this interdisciplinary team reviews the event (type and date), Severity Assessment Code score, sentinel event criteria, and the status of any Root Cause Analysis, need for and/or status of peer review, and disclosure until completion. Weekly meetings began in January 2025, and are sustained; however, improvements will be made to the tracking process for the weekly meetings to better capture a comprehensive discussion. The Chief, Quality & Patient Safety, Patient Safety Manager, Risk Manager/Peer Review Coordinator reviewed the current tracking process and identified additional information is needed to track review dates, expected due dates and completion dates of quality management reviews to ensure compliance with VHA Directives.

Recommendation 6

The VA Fayetteville Coastal Healthcare System Director ensures local processes are in place, including assigned roles and responsibilities, to manage Office of Inspector General case referrals in compliance with VA Directive 0701, *Office of Inspector General Hotline Complaint Referrals*.

_X_ Concur

____Nonconcur

Target date for completion: May 2026

Director Comments

Concur. The VA Fayetteville Coastal Healthcare System staff who process Office of Inspector General (OIG) case referrals will receive training on the guidelines for processing these requests per VA Directive 0701. Staff who process OIG case referrals will be trained on the guidelines outlined in VHA Directive 0701, with a goal of 90% of staff trained. Routing investigative responses to case referrals will include the original, complete case referral request for investigation. The Chief, Quality & Patient Safety will review all OIG case referrals responses prior to submission to the facility Director for approval. All OIG case referrals will be audited for compliance with VA Directive 0701 for six consecutive months with a goal of 90% compliance.

Recommendation 7

The VA Fayetteville Coastal Healthcare System Director confirms reasonable efforts to conduct an institutional disclosure with the patient regarding circumstances that led to the delay in the diagnosis of and treatment for lung cancer are made and, if a disclosure is completed, that it is documented in the electronic health record.

_X_ Concur

____Nonconcur

Target date for completion: January 2025

Director Comments

Concur. The System Director has confirmed that reasonable efforts were conducted to request a meeting with the Veteran and/or representative for disclosure. The Risk Manager documented on a Report of Contact form the eight attempts that were made to contact the Veteran between December 27, 2024, and January 3, 2025. This included six attempts to reach the Veteran by telephone; The Risk Manager was unable to leave voicemails due to the Veteran's voicemail box being full. Two certified letters were mailed to the Veteran, one to the residential address and one to the Post Office Box address. Additional attempts to contact the Veteran for institutional disclosure have been made. The VA Fayetteville Coastal Healthcare System Director requests closure based on evidence provided.

OIG Comments

The OIG considers this recommendation closed.

Glossary

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

adenocarcinoma. A type of cancer that starts in the gland cells and can affect several areas of the body including the lungs, stomach, pancreas, and colon. Treatment options may include surgery, chemotherapy, or radiation therapy.[51]

case referral. A complaint received by the OIG and referred to a VA entity for further review and formal response. [52]

complex/chronic. A complex/chronic care coordination level requires community care staff to contact the assigned veteran weekly to monthly for care coordination services.[53]

computed tomography. A painless, noninvasive imaging test that helps healthcare providers detect disease and injuries that regular x-rays cannot show such as certain types of cancer, broken bones, blood clots, and bowel disorders.[54]

consult. A request or referral for service on behalf of a veteran.[55]

e-consult. "A clinical consultation involving chart review which does not entail a face-to-face examination of the Veteran. The VA medical facility consult receiving clinician provides diagnostic and/or medical management recommendations of a specific Veteran in response to a request seeking opinion, advice, or expertise."[56]

file entry date. The last date a file was put in a status of pending.[57]

full-time equivalent. "The hours worked by one employee on a full-time basis in a normal 80 hour pay period. The value usually ranges from 0.0 to 1.0. For example, a 1.0 FTE [full-time equivalent] would work 80 hours in a pay period, while a 0.5 FTE would work 40 hours per pay period."[58]

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[51] Cleveland Clinic, "Adenocarcinoma Cancers," accessed April 15, 2025, https://my.clevelandclinic.org/health/diseases/21652-adenocarcinoma-cancers.

[52] VA Directive 0701.

[53] VHA Office of Community Care, "Department of Veterans Affairs Screening Triage Tool Standard Operating Procedure."

[54] Cleveland Clinic, "CT (Computed Tomography) Scan," accessed April 15, 2025, https://my.clevelandclinic.org/health/diagnostics/4808-ct-computed-tomography-scan.

[55] VHA Directive 1232.

[56] VHA Directive 1232.

[57] Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)."

[58] VHA Directive 1406(1).

institutional disclosure. "A formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal 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, and provide specific information about the patient's rights and recourse."[59]

joint patient safety reporting (JPSR) system. A system for reporting patient safety events that is accessible to VHA employees through a web-based system.[60]

lung nodule. A small mass of dense tissue, also called a pulmonary nodule, on the lung that may be an indicator of lung disease.[61]

opacity. An opaque spot in a normally transparent structure.[62]

panel size. The total number of patients assigned to a provider.[63]

patchy infiltrate. A substance in the bodily tissue that is irregular in appearance and forms an abnormal accumulation.[64]

pulmonologist. A healthcare provider that specializes in diagnosing and treating conditions and illnesses that affect the respiratory system, including the airway and lungs.[65]

root cause analysis. A comprehensive study of systems-level concerns that is conducted by a team with the goal of reviewing close calls and adverse health events.[66]

routine. A consult that does not require immediate attention.[67]

safety assessment code. A score given to a patient safety event that, using a matrix of low to high, takes the severity and probability of harm into account.[68]

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[59] VHA Directive 1004.08.

[60] VHA Directive 1050.01(1).

[61] American Lung Association, "Lung Nodules (Pulmonary Nodules)," accessed April 23, 2025, https://www.lung.org/lung-health-diseases/warning-signs-of-lung-disease/nodules.

[62] *Merriam-Webster.com Dictionary*, "opacity," accessed April 15, 2025, https://www.merriam-webster.com/dictionary/opacity.

[63] VHA Directive 1406(1).

[64] *Merriam-Webster.com Dictionary*, "patchy", accessed April 16, 2025, https://www.merriam-webster.com/dictionary/patchy; *Merriam-Webster.com Dictionary*, "infiltrate," accessed April 16, 2025, https://www.merriam-webster.com/dictionary/infiltrate.

[65] Cleveland Clinic, "Pulmonologist," accessed April 15, 2025, https://my.clevelandclinic.org/health/articles/22210-pulmonologist.

[66] VHA Directive 1050.01(1).

[67] VHA Directive 1232.

[68] VHA Directive 1050.01(1).

service recovery. An element "that empowers all staff to quickly acknowledge concerns, clearly communicate the plan for resolution, and make needed amends to fulfill VA's duty to veterans and their families, beneficiaries, caregivers and survivors."[69]

stage III. Lung cancer where there is cancer in lymph nodes of the chest. Treatment for stage III cancer includes a combination of chemotherapy, surgery, radiation, targeted therapies, and immune therapies.[70]

stat. A consult that has an immediate need and is to be completed within 48 hours.[71]

urgent. A term to describe action needing to be taken immediately, with a sense of urgency.[72]

warm handoff. A transfer of information or care that occurs between two members of a team caring for a patient, often done in front of the patient. Also used to describe direct communication from one member of the healthcare team to another.[73]

[69] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.

[70] Memorial Sloan Kettering Cancer Center, "Stages of Non-Small Cell and Small Cell Lung Cancer," accessed April 16, 2025, https://www.mskcc.org/cancer-care/types/lung/diagnosis/stages-lung?msclkid=417673dbdbd61f65e76c142434a89633&pn_mapping=pn_13.

[71] VHA Directive 1232.

[72] *Merriam-Webster.com Dictionary*, "urgent," accessed April 30, 2025, https://www.merriam-webster.com/dictionary/urgent.

[73] Agency for Healthcare Research and Quality, "Warm Handoffs, A Guide for Clinicians," accessed April 29, 2025, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warm-handoff-guide-for-clinicians.pdf.

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