



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Care Coordination for a Patient with Breast Disease at the VA Eastern Colorado Health Care System in Aurora



OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

CONNECT WITH US



Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.



Executive Summary

On December 4, 2025, the VA Office of Inspector General (OIG) initiated an inspection to evaluate a concern inspectors identified during a hotline healthcare inspection in September 2025 regarding the coordination of care for a patient with breast disease at the VA Eastern Colorado Health Care System (facility) in Aurora. After an abnormal mammogram, the patient's primary care provider placed a breast biopsy consult in late 2023; however, the procedure was not completed until late spring 2024, approximately five months later, prompting concerns about the delay. The OIG determined that the care coordination level assigned for the breast biopsy consult, which permitted the patient to self-schedule, aligned with Veterans Health Administration (VHA) policy. The primary care provider assessed the patient for a pre-op visit for hip surgery but did not document or coordinate follow-up care for the incomplete breast biopsy. Additionally, the OIG found that the facility's breast imaging tracking spreadsheet omitted the patient's breast imaging studies.

Scope and Objective

The OIG's inspection evaluated care coordination for the patient with breast disease from mid-fall 2023 through fall 2024. A virtual site visit was conducted from December 17, 2025, through February 23, 2026. The review included virtual interviews, analysis of relevant VHA and facility policies, and examination of both VA and non-VA health records.

Major Findings

Care Coordination Level and Patient's Autonomy to Self-Schedule

Facility community care staff assigned the biopsy consult a basic designation, aligning with VHA guidance. Despite multiple outreach attempts by facility community care staff, the patient did not schedule the breast biopsy appointment, which led to cancellation of the consult in late winter 2024. When the patient later presented to a community emergency department, imaging suggested metastatic disease, prompting a new biopsy consult and additional diagnostic imaging.

Staff followed VHA guidance in assigning care coordination levels and supported the patient's self-scheduling preference. However, had the administrative consult tool's list of complex/chronic conditions included high-risk conditions, like suspected cancer, it would have required community care staff to conduct a clinical assessment to ensure patient care coordination needs are met and minimize risk of harm.

Primary Care Provider's Management of Abnormal Findings

The OIG determined that, during a mid-winter 2024 visit, the patient's primary care provider did not coordinate follow-up care for the breast biopsy ordered approximately two months earlier

and did not document a treatment plan or discussions concerning the abnormal mammogram results, including associated risks or treatment options. Insufficient documentation and inadequate care coordination may increase the likelihood of disruptions in continuity of care, which could compromise patient outcomes. Furthermore, not clarifying the significance of timely diagnostic procedures or communicating the risks associated with delayed treatment could further impact patient care. The OIG noted that facility leaders and quality staff completed a review of the patient's care coordination and, therefore, made no recommendations regarding the care coordination concerns.

Tracking Process for Breast Cancer Screening and Follow-Up

The OIG reviewed the facility's breast imaging study tracking spreadsheet and found that the patient's imaging test results from the late 2023 mammogram were not properly recorded. The facility hired a breast cancer screening coordinator in June 2025, who implemented a new breast cancer tracking tool. Given the corrective actions, and a parallel recommendation issued in a May 2026 VA OIG report, no additional recommendations were made.¹

Impact on Veterans

The care coordination and documentation issues identified by the OIG reflect operational vulnerabilities that may affect the timeliness and continuity of care for veterans. Assigning the consult a basic level without clinical triage, combined with missed scheduling opportunities and limited provider documentation, reduced the ability to ensure appropriate follow-up for abnormal findings. Inaccurate tracking of breast imaging further underscored gaps in processes essential to monitoring veteran care. These conditions highlight the need for clear guidance to support consistent, coordinated care for high-risk conditions.

Key Recommendation

The OIG made one recommendation to the Under Secretary for Health to consider including high-risk conditions, such as suspected cancer, to the listing of complex/chronic conditions in the consult tool.²

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

¹ VA OIG, [*Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora*](#), Report No. 25-02420-118, May 21, 2026.

² The recommendation addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position.

VA Comments and OIG Response

The Under Secretary for Health concurred with the recommendation and shared plans to review the current list of complex and chronic conditions and assess the feasibility of expanding the list to include additional conditions, such as suspected cancer (see appendix A). The OIG will follow up on the planned actions until they are completed.



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

Contents

Executive Summary	i
Abbreviations	v
Introduction.....	1
Scope and Methodology	2
Patient Case Summary	4
Inspection Results	5
1. Care Coordination Level and Self-Scheduling	5
2. Primary Care Provider’s Management of Abnormal Findings	7
3. Tracking Process for Breast Cancer Screening and Follow-Up.....	9
Conclusion	9
Recommendation	10
Appendix A: Office of the Under Secretary for Health Memorandum	11
OIG Contact and Staff Acknowledgments	13
Report Distribution	14

Abbreviations

CT	computed tomography
OIG	Office of Inspector General
PET CT	positron emission tomography-computed tomography
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on December 4, 2025, to review care coordination for a patient with breast disease at the VA Eastern Colorado Health Care System (facility) in Aurora. A virtual site visit was conducted from December 17, 2025, through February 23, 2026.

Background

The facility, part of Veterans Integrated Service Network (VISN) 19 at the time of the inspection (later VISN 4), consists of the Rocky Mountain Regional VA Medical Center located in Aurora, Colorado, and community-based outpatient clinics throughout Colorado.³ The facility offers a wide range of healthcare services, including primary and mental health care, specialty care, and inpatient medical and surgical care. From October 1, 2024, through September 30, 2025, the facility served 115,384 unique patients. The Veterans Health Administration (VHA) classifies the facility as a level 1a, the highest complexity designation for a VA facility.⁴

Breast Cancer and Screening Guidelines

Breast cancer is the most common cancer, and the second most common cause of cancer death, among women in the United States.⁵ VHA and the US Preventive Services Task Force recommend biennial mammography screening for women aged 40–74 years at average risk for breast cancer.⁶ According to VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, breast cancer screening may be provided at VA facilities or through contracted care in the community.⁷

³ In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit <https://digital.va.gov/rise/>.

⁴ VHA Office of Productivity, Efficiency, & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." The Facility Complexity Model categorizes "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 "Cancer Facts for Women," American Cancer Society, accessed April 1, 2026, <https://www.cancer.org/cancer/risk-prevention/understanding-cancer-risk/cancer-facts/cancer-facts-for-women.html>.

⁶ US Preventive Services Task Force, "Screening for Breast Cancer: US Preventive Services Task Force Recommendation Statement," *JAMA* 331, no. 22 (September 30, 2024): 1918–1930, [doi:10.1001/jama.2024.5534](https://doi.org/10.1001/jama.2024.5534).

⁷ VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017, amended May 14, 2023.

VHA Community Care Referral

According to VHA Directive 1232, *Consult Management*, when VA medical facilities are unable to provide necessary services, VA can authorize eligible veterans to receive care in the community (community care).⁸ Facility providers initiate a referral for community care by entering a community care consult in the patient's electronic health record.⁹

Prior OIG Report

During a hotline healthcare inspection, initiated on May 8, 2025, with inspection activities continuing through September 11, 2025, the OIG found deficiencies in the availability of community care breast images, processes for tracking breast cancer screening and follow-up, and processes for credentialing and privileging a new mammographer. The OIG issued six recommendations aimed at strengthening breast cancer screening processes, including timely receipt and uploading of imaging, tracking of breast cancer screening and follow-up, and patient notification and follow-up for abnormal imaging. As of September 28, 2026, five of the six recommendations remained open.¹⁰

OIG Concern

In September 2025, during the inspection mentioned in the preceding paragraph, OIG inspectors identified concerns related to a delayed breast biopsy for a patient with breast disease. These concerns included permitting the patient to self-schedule appointments, discontinuation of a consult, and multiple consults for the same episode of care. On December 4, 2025, the OIG opened a healthcare inspection to evaluate these concerns.

Scope and Methodology

The OIG initiated the inspection on December 4, 2025, and conducted virtual interviews through February 23, 2026.

The OIG team interviewed the facility associate chief of staff for primary care, chief of community care, and women veterans program manager; as well as providers, nurses, and medical support assistants.

The OIG reviewed relevant VHA and facility policies related to consult complexity designation, self-scheduling practices, and breast cancer screening imaging studies. The OIG also reviewed facility email communications, issue briefs, and quality management documents. The OIG

⁸ VHA Directive 1232, *Consult Management*, November 22, 2024.

⁹ VHA Directive 1232.

¹⁰ VA OIG, [*Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora*](#), Report No. 25-02420-118, May 21, 2026.

reviewed the electronic health record of the patient identified for this review as well as non-VHA health records obtained by subpoena.¹¹

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of the Inspectors General on Integrity and Efficiency's standards.¹² During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. Office of Healthcare Inspections teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget Memorandum M-25-21, "*Accelerating Federal Use of AI through Innovation, Governance, and Public Trust*."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).

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.

¹¹ The team requested and reviewed non-VHA patient records obtained by subpoena.

¹² Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

¹³ Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

Patient Case Summary

A female patient, in her forties, presented to the facility's Alamosa VA clinic in mid-fall 2023 to establish primary care with a nurse practitioner (primary care provider). On the same day, the primary care provider placed an order for a community care mammography screening. Two days later, the patient called the clinic and stated that she had a lump of her right breast and underarm, which had been present for approximately two months. She also reported never having had a mammogram.

Five days later, the primary care provider entered an order for a community care breast ultrasound and a bilateral diagnostic mammogram. These two tests were completed at a community facility in late 2023. The results showed right breast calcifications and enlarged right axillary (armpit) lymph node abnormalities that required further studies. Follow-up biopsies were recommended and the primary care provider placed a community care general surgery consult for breast biopsy on the same day for a right axilla ultrasound-guided biopsy and a right breast stereotactic breast biopsy.

Two days later, the patient was informed of her community care eligibility. The patient was offered and chose the self-scheduling preference for the community care consult and chose a local provider. In early 2024, the patient reported to the facility's community care staff that the community care provider had not received the authorization. The authorization was refaxed on the same day. Twelve days later, the patient was sent a VA text reminder to schedule the appointment, followed by a mailed reminder one month later.

One week later, the patient presented to the facility's Alamosa VA clinic for a pre-op visit for right total hip surgery. During this visit, the primary care provider documented the abnormal mammogram as one of the patient's problems in the electronic health record but made no mention of the abnormal mammogram in the assessment and plan. About three weeks later, facility staff canceled the general surgery consult for breast biopsy after making unsuccessful attempts to contact the patient to schedule an appointment. Two months later, in mid-spring, the patient presented to a community emergency department with complaints of shortness of breath. A chest computed tomography (CT) scan performed during this visit revealed multiple enlarged right axillary and subpectoral lymph nodes, along with multiple bony lesions in the skeleton, findings concerning for metastatic disease. Two days later, the patient called to inform the clinic of her emergency department visit and stated being instructed to follow up immediately for an oncology consultation.

The next day, the primary care provider ordered a general surgery consult for biopsy of a right axillary lymph node and right breast. Additionally, the general surgery physician assistant ordered a diagnostic mammogram and an oncology appointment.

Two weeks later, the patient underwent a diagnostic mammogram and an ultrasound-guided axillary biopsy at a community hospital. Five days later, the facility general surgery physician

assistant spoke to the community care pathologist, who reported that it was a poorly differentiated cancer. As a result, the biopsy had to be sent out to an additional pathologist for further reading, diagnosis, and finalization of the report. Four days later, the primary care provider evaluated the patient and recorded a plan to await further pathology results, consult with oncology, and proceed with a positron emission tomography-computed tomography (PET CT) scan.

The patient's subsequent oncology care was managed by a community care oncologist. The patient's PET CT scan in early summer 2024 was consistent with stage 4 cancer with bony metastases. The patient began chemotherapy in fall 2024 and continues to be followed by a community oncologist.

Inspection Results

1. Care Coordination Level and Self-Scheduling

According to the patient's electronic health record, the breast biopsy that was originally ordered in late 2023 was not completed until late spring 2024, approximately five months later. To understand the delay, the OIG reviewed the patient's electronic health record for care received from mid-fall 2023 through fall 2024.

The VHA Office of Integrated Veteran Care (IVC) Community Care Field Guidebook requires facility community care staff to use a consult tool to assign a care coordination level (basic, moderate, complex/chronic, or urgent) to determine patients' care coordination needs based on clinical, psychosocial, and timing factors. This process helps community care staff assess patient needs to determine the best resources to support optimal care transitions and communication between VA and community providers. An administrative screening is initiated to assess care coordination needs, with consideration of urgency, complex conditions, and service requirements. If a consult is designated a care coordination level beyond basic, a clinical assessment is required and a clinical staff member reviews the patient's medical record, applies clinical judgment, and decides whether a greater level of coordination is needed.¹⁴ Patients may schedule their own appointments with community care providers unless facility community care staff determine that scheduling assistance is needed or the consult is designated as an urgent level of care coordination. If a patient does not respond to either of two scheduling efforts, community care staff can cancel the community care consult 14 calendar days after the second

¹⁴ VHA Directive 1232; VHA Office of Integrated Veteran Care (IVC) Community Care, "Care Coordination Tools and Systems," chap. 3 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, accessed January 7, 2026, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000278573/FGB-Chapter-3-050311-Screening-and-Triage-Tool. (This website is not publicly accessible.) A July 14, 2026, update indicated this guidebook was renamed *VHA Office of Veterans Community Care (VCC) Field Guidebook*.

contact attempt. These attempts include the initial contact attempt made by phone, secure message, text message, or email; and the follow-up contact attempt made by any of these modalities or by sending a letter, which must differ from the initial contact method.¹⁵ According to the patient's electronic health record, the primary care provider placed a consult for a mammogram in mid-fall 2023 and a general surgery consult for breast biopsy in late 2023. Through document review, the OIG found that the mammogram and general surgery consults were designated as a basic level of care coordination. The OIG confirmed through email correspondence with the interim deputy chief of clinical access that the consults were appropriately assigned a basic level of care coordination. The interim deputy chief of clinical access told the OIG that if a higher care coordination level was warranted, care coordination responsibility would shift to clinical staff, who would ensure appointment completion and actively engage with the patient or provider to ensure timely care by removing barriers and monitoring progress.

The patient was seen by the community provider in late 2023 for a mammogram. Results showed right breast calcifications and enlarged right axillary lymph node and were categorized by the radiologist as BI-RADS 4, which is suspicious abnormality suggestive of possible cancer.¹⁶ The same day, the primary care provider requested a general surgery consult for a breast biopsy, referencing the mammogram results "birads [BI-RADs] 4 suspicious." A facility staff member documented in the consult that the patient preferred to self-schedule the appointment and declined offered scheduling support. Despite multiple outreach attempts, including self-scheduling letters, faxed authorizations to the community provider, and a text reminder to the patient, the patient did not schedule the biopsy appointment, and facility community care staff subsequently canceled the general surgery consult for breast biopsy in late winter 2024 in alignment with VHA guidance.¹⁷

Two months later, the patient presented to a community emergency department with complaints of shortness of breath and underwent a CT scan, which revealed findings concerning for metastatic disease. Subsequently, the primary care provider placed a general surgery consult for right breast biopsies. Following a review of the general surgery breast consult, a general surgery physician assistant in the facility's department of surgery forwarded this request to facility

¹⁵ VHA Office of Integrated Veteran Care (IVC) Community Care, "Community Care Veteran Self-Scheduling Process," chap. 2 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, accessed September, 18, 2025, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000225425/FGB-Chapter-2-050227-Community-Care-Veteran-Self-Scheduling-Process (This website is not publicly accessible.); VHA Office of Integrated Care (IVC), "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," last updated July 28, 2022.

¹⁶ Breast Imaging Reporting and Data System (BI-RADS) is a standardized system developed by the American College of Radiology to categorize findings from breast imaging studies. BI-RADS 4 is defined as *suspicious abnormality*.

¹⁷ VHA Office of Integrated Veteran Care (IVC) Community Care, "Community Care Veteran Self-Scheduling Process," chap. 2 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

community care staff six days later for scheduling. A community care staff member designated the general surgery consult as a basic level of care coordination, a designation the interim deputy chief of clinical access confirmed was appropriate, and the patient elected to self-schedule the biopsies. Following the review of the general surgery breast consult, the general surgery physician assistant also generated a request for a diagnostic mammogram, and a facility community care staff nurse determined the request to be of a “Complex/Chronic” level of care coordination and designated “New cancer diagnosis” in the consult. The patient was seen at a community hospital and completed an axillary lymph node biopsy and diagnostic mammogram two weeks later. Five days later, in late spring 2024, a community care provider reported poorly differentiated cancer and a need for further pathology review. The patient’s PET CT scan performed in early summer 2024 showed findings consistent with stage 4 cancer that had spread to the bones.

The OIG concluded that facility staff designated care coordination levels for the patient’s consults in accordance with VHA requirements and supported the patient’s preference to self-schedule community care appointments.¹⁸ However, the basic care coordination designation level for the late 2023 abnormal mammogram report did not require a clinical triage assessment according to VHA policy.¹⁹ Adding high-risk conditions, like suspected cancer, to the listing of complex/chronic conditions within the administrative consult tool, may increase the care coordination level beyond basic and require community care staff to conduct a clinical assessment to ensure patient care coordination needs are met and minimize risk of harm.²⁰

2. Primary Care Provider’s Management of Abnormal Findings

The OIG determined that the patient’s primary care provider did not document or coordinate follow-up care for the breast biopsy ordered approximately two months earlier in response to abnormal mammogram results, despite having an opportunity to do so during the patient’s pre-op visit for hip surgery.

According to VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, primary care providers are responsible for providing comprehensive care for women veterans, including screening for breast cancer.²¹ Additionally, VHA Directive 1330.01(7) and VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, require ordering providers to

¹⁸ VHA Office of Integrated Veteran Care (IVC) Community Care, “Care Coordination Tools and Systems,” chap. 3 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*; VHA Office of Integrated Veteran Care (IVC) Community Care, “Community Care Veteran Self-Scheduling Process,” chap. 2 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

¹⁹ VHA Office of Integrated Veteran Care (IVC) Community Care, “Care Coordination Tools and Systems,” chap. 3 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

²⁰ VHA Office of Integrated Veteran Care (IVC) Community Care, “Care Coordination Tools and Systems,” chap. 3 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

²¹ VHA Directive 1330.01(7).

communicate all mammogram results requiring actions to patients and document follow-up diagnostic or treatment plans in the electronic health record.²²

The OIG found that the primary care provider, who began overseeing the patient's care in mid-fall 2023, ordered the initial mammogram.²³ Following the imaging study in late 2023, the primary care provider was notified of abnormal findings and placed an order for a biopsy the same day.

In mid-winter 2024, the patient was seen by the provider for a pre-op visit for right total hip surgery. The OIG found that the primary care provider added "abnormal findings on diagnostic imaging of breast" to the patient's problem list in the electronic health record in late 2023. During an OIG interview, the primary care provider recalled discussing the abnormal mammogram with the patient but acknowledged not recording the discussion in the electronic health record. Additionally, the primary care provider reported the patient wished to prioritize addressing ongoing hip pain. However, the provider did not document a discussion regarding the risks associated with delaying the recommended breast biopsy. This documentation, by policy, should have included details about the breast care treatment plan and pending breast biopsy, ordered approximately seven weeks earlier.²⁴ The OIG is concerned that the primary care provider did not document discussions about the importance of early diagnostic procedures, the risks associated with delaying diagnosis, or available treatment options. Furthermore, the OIG found no documented evidence in the electronic health record that the primary care provider tried to assist with scheduling, outreach, or care coordination after the breast biopsy was canceled in late winter 2024. During the inspection, the OIG learned that the primary care provider retired in late 2025.

Without documentation of discussion of abnormal mammogram results and recommended diagnostic follow-up or treatment plans, the risk of lapses in continuity of care may increase, which could compromise patient outcomes. Furthermore, not clarifying the significance of timely diagnostic procedures or communicating the risks associated with delayed treatment could further impact patient care. Facility leaders and quality staff completed a quality review of the patient's care coordination for breast disease from mid-fall 2023 through late fall 2025; therefore, the OIG made no recommendation related to the concerns with the provider's care coordination.

²² VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024; VHA Directive 1330.01(7).

²³ A breast exam was not completed at the initial primary care appointment in mid-fall 2023. However, the US Preventive Services Task Force concluded that evidence is insufficient to recommend for or against performing clinical breast exams. US Preventive Services Task Force, "Breast Cancer: Final Recommendation Statement," December 15, 2009. The US Preventive Services Task Force updated recommendations in 2016 and 2024; however, there are no new statements regarding clinical breast exams in the updated recommendations.

²⁴ VHA Directive 1330.01(7).

3. Tracking Process for Breast Cancer Screening and Follow-Up

The OIG reviewed the facility's breast imaging study tracking spreadsheet from fall 2023 through fall 2024 and found that the patient's imaging tests and results were not accurately documented. Specifically, the spreadsheet did not capture the community care mammogram consults placed in mid-fall and late 2023.

VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, requires facilities to have a process to track and follow up on breast cancer screening results.²⁵ Based on the inaccurate documentation, which included missing imaging tests and results in the spreadsheet, the OIG alerted facility leaders during the inspection of potential care coordination delays for the patient.

During the inspection, the OIG learned that a breast cancer screening coordinator (coordinator) was hired in June 2025 and assumed responsibility for tracking breast imaging studies. During an OIG interview, the coordinator reported being aware of inaccurate documentation in the spreadsheet and stated that facility leaders discontinued use of the spreadsheet in June 2025. The coordinator reported creating a new breast cancer tracking tool in June 2025, which compiles data from the consult tracking management system to track imaging orders, follow-up tests, and results. Additionally, due to concerns with the spreadsheet, the coordinator reported tracking breast imaging studies requiring any follow-up testing discovered during review of breast imaging consults prior to June 2025.

The OIG concluded that although the facility's breast cancer screening and follow-up tracking process was deficient before June 2025, the subsequent addition of the coordinator and the comprehensive tracking tool is expected to resolve those deficiencies. The OIG team did not make a recommendation regarding this issue as the concerns identified with the tracking spreadsheet had been addressed with a corresponding recommendation in the May 2026 VA OIG report, *Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora*.²⁶

Conclusion

Facility staff met the patient's care coordination needs related to consult management and scheduling, assigned basic care coordination levels to consults in accordance with VHA policy, and supported the patient's choice to self-schedule community care appointments. However, the OIG identified concerns regarding the administrative screening section of the consult tool described in VHA's community care field guidebook. Specifically, this section does not evaluate high-risk conditions, like suspected cancer, which may prompt a clinical triage assessment to

²⁵ VHA Directive 1330.01(7).

²⁶ VA OIG, *Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora*.

improve care coordination for patients potentially diagnosed with cancer. The primary care provider initiated appropriate breast imaging and diagnostic consults; however, follow-up for abnormal imaging results and the pending breast biopsy was not completed.

Prior to June 2025, the facility's breast cancer screening and follow-up tracking process exhibited deficiencies, including errors and omissions in the breast imaging tracking spreadsheet. Subsequently, facility leaders implemented a comprehensive tracking tool and appointed a dedicated coordinator to address previously identified challenges. The OIG did not make a recommendation regarding the tracking process, as this matter had been addressed in the May 2026 VA OIG report.

The OIG made one recommendation to the Under Secretary for Health.²⁷ The Under Secretary for Health concurred with the recommendation and shared plans to review the current list of complex and chronic conditions and assess the feasibility of expanding the list to include additional conditions, such as suspected cancer.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendation

The Under Secretary for Health considers including high-risk conditions, such as suspected cancer, to the listing of complex/chronic conditions within the administrative portion of the consult tool outlined in the Veterans Health Administration *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

²⁷ The recommendation addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: September 1, 2026

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Review of Care Coordination for a Patient with Breast Disease at the Department of Veterans Affairs (VA) Eastern Colorado Health Care System (HCS) in Aurora (VIEWS 15176348)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Review of Care Coordination for a Patient with Breast Disease at the VA Eastern Colorado HCS in Aurora. The Veterans Health Administration (VHA) concurs with the recommendation made to the Under Secretary for Health and provides an action plan in the attachment.
2. VHA is committed to continually improving our processes and tools to support optimal care coordination, ensuring that we provide the best possible care to our Veterans. Thank you for highlighting this important area of focus.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office.

(Original signed by:)

John Figueroa
Acting Under Secretary for Health

[OIG comment: The OIG received the above memorandum from VHA on September 1, 2026.]

Office of the Under Secretary for Health Response

Recommendation

The Under Secretary for Health considers including high-risk conditions, such as suspected cancer, to the listing of complex/chronic conditions within the administrative portion of the consult tool outlined in the Veterans Health Administration *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

☒ Concur

☐ Nonconcur

Target date for completion: December 2026

Under Secretary for Health Comments

VHA Office of Veterans Community Care (VCC) will review the current list of complex and chronic conditions incorporated within the administrative section of the tool and assess the feasibility of expanding the list to include additional conditions, such as suspected cancer. Based on the findings, VCC will implement any necessary adjustments to existing systems and guidance to ensure alignment with clinical and operational needs.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Clarissa Reynolds, MBA, NHA, Director Kristen Blaisdell, DNP, RN Debbie Davis, JD Tammy Linton, DNP, RN James McMahon, MPT, AT
Other Contributors	Shelby Assad, LCSW Karen Berthiaume, RPh, BS Natalie Sadow, MBA Thomas Wong, DO

Report Distribution

VA Distribution

Office of the Secretary
Office of Accountability and Whistleblower Protection
Office of Congressional and Legislative Affairs
Office of General Counsel
Office of Public and Intergovernmental Affairs
Veterans Health Administration
Director, VA Heart of America Health Network (10N04)
Director, Health Service Area 4.2
Director, VA Eastern Colorado Health Care System (554)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Michael Bennet, John Hickenlooper
US House of Representatives: Lauren Boebert, Jeff Crank, Jason Crow, Diana DeGette, Gabe Evans, Jeff Hurd, Joe Neguse, Brittany Pettersen

OIG reports are available at va.aoig.gov.