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VETERANS HEALTH ADMINISTRATION

Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding community care consult appointment scheduling practices and delays for patients with serious health conditions who received community care at the VA Western New York Healthcare System (system) in Buffalo.

The OIG substantiated that community care staff's delays in scheduling patients' radiation therapy and neurosurgery appointments resulted in delays in care, and in some cases, either caused or increased the risk of patient harm.[1] The OIG determined system and community care leaders failed to resolve significant community care scheduling delays for patients with serious health conditions, despite providers' and community care staff's efforts to advocate on the behalf of patients.

The OIG team reviewed 42 patients' electronic health records (EHRs) to evaluate how community care scheduling delays affected patients and may have resulted in patient harm. All 42 patient consults significantly exceeded the seven-day Veterans Health Administration (VHA) scheduling requirement.[2] Further, for 3 of the 42 patients, the scheduling delay affected the provider's management of the patient's condition, and for 9 of the 42, the delay affected the patient's clinical status or condition.[3]

A review and analysis of 4 of the 9 patients is detailed in the body of this report, including: a patient with a new cancer malignancy who waited nine weeks to obtain radiation therapy; a patient who experienced ongoing seizures while waiting 10 months for a neurosurgery consult; a patient who, while at increased risk of developing ischemic stroke, waited 9 months to obtain a computed tomography angiography; and a patient, discussed below, who died while waiting over 2 months to receive radiation therapy to treat cancer pain.

Failure to Provide Radiation Therapy and Disclose an Adverse Event

The OIG found that a delay in scheduling, and eventual cancellation of, community care radiation therapy to treat a patient's (Patient A) cancer-related pain resulted in progressive pain

[1] 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.

[2] For purposes of this report, the OIG team uses the term "significantly exceeded" the 7-day scheduling requirement to mean the delay was equal to or greater than 21 days.

[3] The OIG team used the descriptor "affected the patient's clinical status or condition" to convey that the patient experienced continued disease activity (such as pain or seizures), disease progression, or delayed diagnosis. "Affecting the provider's management" of the condition refers to the provider changing the treatment modality, course, or sequence of care, as well as increasing the risk of harm or delaying intervention.

that became debilitative in the last two months of the patient's life.[4] Despite multiple pleas to system community care leaders and staff by the chief of oncology, a staff oncologist, and Patient A's spouse, community care leaders did not take action. The radiation therapy consult remained unscheduled and was subsequently discontinued following Patient A's death, nearly two and a half months from the date the consult was placed.

The OIG concluded that although Patient A had advanced esophageal cancer with metastasis to the bone, was late in the course of disease, and had a poor prognosis, timely action by community care staff to oncology providers' repeated requests to schedule radiation therapy would likely have decreased the level of pain and improved the quality of life in the patient's final months.

The OIG found that despite system leaders' awareness that delayed radiation therapy had negatively affected Patient A's final months of life, leaders had not conducted an institutional disclosure to Patient A's family.[5] Leaders acknowledged that an institutional disclosure should have taken place but did not complete one, citing the need for further OIG clarification and ongoing efforts to schedule with the patient's family. As of late spring 2024, the institutional disclosure was still not documented in the patient's EHR.

The OIG concluded leaders missed a critical opportunity to model their commitment to quality care and patient safety by failing to have a timely, forthright, and empathetic discussion (institutional disclosure) with the patient's family acknowledging how the lack of radiation therapy affected the patient's quality of life.

Leaders' Delayed Actions to Resolve Community Care Deficiencies

The OIG found leaders were apprised of patients at risk of harm due to delayed community care scheduling; however, system leaders relied on inaccurate assurances from system community care leaders that urgent, high-risk patient care consults were reviewed and prioritized, even when alerted to continued patient concerns.

In September and November 2022, the Veterans Integrated Service Network (VISN) 2 community care manager notified system community care leaders that radiation therapy, neurosurgery spine, and neurosurgery consults were among a number of unscheduled consults

[4] Stephen Lutz et al., "Palliative radiotherapy for bone metastases: an ASTRO evidence-based guideline," *International Journal of Radiation Oncology, Biology, Physics*, 79, no. 4 (March 15, 2011): 965–76, https://doi.org/10.1016/j.ijrobp.2010.11.026. "Radiation therapy is a successful and time efficient method by which to palliate pain and/or prevent the morbidity of bone metastases."

[5] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is a formal process where system leaders and clinicians have a "forthright and empathetic" discussion with a patient or their family to communicate an adverse event occurred during the patient's care. The disclosure must be initiated as soon as realistically possible, regardless of when the event was discovered, and documented in the patient's EHR.

with no recent activity. In communications, the VISN 2 community care manager urged system community care leaders to prioritize consults identified as high risk for scheduling.

The System Director reported that system community care leaders had established a process in December 2022 to conduct a daily review of high-risk consults and to prioritize and schedule consults to ensure patients received care for time-sensitive medical needs; however, the OIG learned community care leaders reviewed consults but did not consistently ensure high-risk consults were prioritized or scheduled. Providers and staff continued to raise patient concerns to leaders, and high-risk consults remained unscheduled for extended periods.

The system community care manager acknowledged receiving alerts from community care nurses regarding consults that had not been reviewed and reported typically addressing concerns the same day but admitted that some concerns may not have been addressed. Similarly, the community care manager acknowledged delays in responding to patient advocate complaints and explained, "I was juggling multiple things. The notifications amongst the emails, amongst this and that, were getting lost. So it's not that I didn't handle them, I just didn't do them timely."

The Chief of Staff (COS) reported receiving emails regarding concerns with scheduling delays but noted system community care leaders never reported patients were waiting months for cancer treatment to be scheduled. The System Director recalled being made aware of staff concerns about patient delays via email and through discussions with the COS and responded to concerns by speaking with the COS or the community care medical director, who followed up on the issue and reported resolution.

The OIG concluded system and community care leaders' lack of action to be contrary to high reliability organization principles and values. Leaders failed to consistently focus on patients, respond to staff concerns, get to the root cause of concerns regarding delayed scheduling of urgent consults, and predict and eliminate risks before causing patient harm.

System leaders did not request or conduct a thorough review of the concerns related to community care practices until August 2023, when the System Director issued a memorandum authorizing a "third-party" factfinding to investigate allegations of mismanaged community care consults.[6] The September 2023 factfinding report found the community care team lacked a process to address time-sensitive, high-risk consults and had no standard operating procedures. The report also found that community care staff were unfamiliar with community care basic processes and were not following all national standards, and there was no management oversight of community care practices.

During the November 2023 site visit, the OIG's concerns regarding the system's community care fundamental deficiencies mirrored those summarized in the September factfinding report. During

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

interviews, system and community care leaders and staff discussed challenges that contributed to the deficiencies, including difficulties maintaining staff, and frequent turnover, interpersonal challenges, and a lack of formal training and oversight. The OIG noted that some of the factfinding recommendations were implemented, and there was an overall decrease in the average number of days to process time-sensitive oncology and radiation therapy consults. Although system community care leaders initiated a new process to address time-sensitive consults, as of March 2024, the process had not been written in a standardized operating procedure.

The OIG is concerned that despite the VISN, clinical providers, patients, and community care staff repeatedly sounding the alarm regarding significant deficiencies within community care, system leaders waited approximately eight months to request an in-depth evaluation of the program. The findings not only confirmed the concerns brought forward but revealed fundamental gaps in knowledge, competencies, management, and oversight that require significant attention, intervention, and accountability by system leaders and focused oversight by VISN leaders.

The OIG made two recommendations to the VISN Director related to system leaders' response to patient safety concerns, and oversight of the system's community care practices; and two recommendations to the System Director related to the establishment of community care policies in alignment with VHA community care standards, and the disclosure of an adverse event.

VA Comments and OIG Response

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes B and C). Based on the information provided, the OIG considers recommendation 4 closed. For the remaining recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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Contents

Abbreviations

AMSA	advanced medical support assistant
COS	Chief of Staff
CTA	computed tomography angiography
EHR	electronic health record
HRO	high reliability organization
LTM	long-term electroencephalogram monitoring
OIG	Office of Inspector General
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding community care consult appointment scheduling practices and delays for patients who received community care at the VA Western New York Healthcare System (system) in Buffalo.[1]

Background

The system, designated as a level 1b high complexity facility, is part of Veterans Integrated Service Network (VISN) 2. The system includes the Buffalo and Batavia VA Medical Centers and seven outpatient clinics throughout New York and provides comprehensive care including primary and specialty services.[2] From October 1, 2022, through September 30, 2023, the system served 54,761 patients.

VA's Commitment to Quality Health Care

Veterans Health Administration (VHA) policy emphasizes an "unwavering commitment to quality health care and patient safety," and notes VHA's active engagement in quality improvement activities since 1990.[3] Further, "VHA's Journey to High Reliability is a long-term commitment to our Veterans and our workforce to continuously improve and advance toward Zero Harm across VHA, drawing on lessons learned from other industries, other health systems and all areas of VHA."[4] Leadership commitment, a high reliability organization (HRO) pillar, occurs when leaders reflect a commitment to safety and reliability in their decisions and actions. Continuous process improvement, another HRO pillar, occurs when all staff members engage in improvement activities. Culture of safety, the third HRO pillar, refers to the importance of staff feeling comfortable to report safety concerns because they trust leaders will communicate openly about meaningful improvements to prevent harm and learn from mistakes.[5]

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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] VHA Office of Productivity, Efficiency, & Staffing, Fact Sheet Facility Complexity Model. 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. A level 1b facility has "high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs."

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

[4] VA/VHA, *VHA High Reliability Organization (HRO) Reference Guide*, April 2023, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/Edit_View.aspx?id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Reference%20Guide%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This site is not publicly accessible.)

[5] VA/VHA, *VHA High Reliability Organization (HRO) Reference Guide*, April 2023.

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."[6] This definition mirrors the "six fundamental aims for health care—that it be safe, effective, patient-centered, efficient, equitable, and timely," identified by the Institute of Medicine (US) Committee on Quality Health Care in 2001.[7] For purposes of this report, the OIG adopts this definition of quality health care.

Timeliness: A Tenet of Quality Care

Following an OIG report that found "inappropriate scheduling practices" at a VHA facility in 2014, VA commissioned the Institute of Medicine to conduct a study on "the experiences and opportunities throughout the nation related to the scheduling of and access to health care.[8] The study discussed the various ways access, scheduling, and wait-time delays affect patients.

> A patient's inability to obtain a timely health care appointment may result in various outcomes: the patient eventually seeing the desired health care providers, the patient obtaining health care elsewhere, the patient seeking an alternative form of care, or the patient not obtaining health care at all for the condition that led to the request for an appointment. In any of these cases, the condition may worsen, improve (with or without treatment elsewhere), or continue until treated. Thus, long wait times may be associated with poorer health outcomes . . . . Long wait times may also cause frustration, inconvenience, suffering and dissatisfaction with the health care system . . . . Extended wait times and delays for care have been shown to negatively affect morbidity, mortality, and the quality of life via a variety of health issues, including cancer.[9]

VA Community Care

In support of VA's commitment "to providing Veterans access to timely, high-quality health care . . . . VA Medical Centers (VAMCs) may purchase care in the community for eligible Veterans, after VA options to render care have been considered." Eligibility for community care is based on specific criteria, including but not limited to

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[6] VHA Directive 1050.01(1).

[7] Institute of Medicine (US) Committee on Quality of Health Care in America, "Improving the 21st-Century Health Care System," chap. 2 in *Crossing the Quality Chasm: A New Health System for the 21st Century*, (Washington DC: National Academies Press 2001), 39.

[8] Committee on Optimizing Scheduling in Health Care; Institute of Medicine, "Improving Health Care Scheduling," chap. 1 in Transforming Health Care Scheduling and Access: Getting to Now, eds. Kaplan G, Lopez MH, McGinnis JM: (Washington DC: National Academies Press 2015), 1; VA OIG, *Interim Report: Review of VHA's Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System*, Report No. 14-02603-178, May 28, 2014; VA OIG, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, Report No. 14-02603-267, August 26, 2014.

[9] Committee on Optimizing Scheduling in Health Care; Institute of Medicine, "Improving Health Care Scheduling," 22.

- when a VA facility cannot provide an appointment within a specific amount of time,
- when services are not available at a VA medical facility, or
- when the drive time to a VHA provider is more than 30 minutes for primary care or 60 minutes for specialty care.[10]

Community care may also be an option if the referring VHA physician and the patient agree that seeking care from a community provider is in the patient's best medical interest.[11]

VA Community Care Consult Process

A VHA provider initiates the process by placing a community care consult for a patient to obtain healthcare services from a community provider (see figure 1).[12] Once placed, VHA community care staff receive the consult, determine whether the patient meets eligibility requirements, and track and record the consult progress in the patient's electronic health record (EHR).[13]

Once community care eligibility has been confirmed, some consults require further review and approval by an individual who has the authority (delegated authority) to clinically review and determine whether the service requested is appropriate.[14] Following the delegated authority's clinical review and approval, community care staff begin the appointment scheduling process by preparing a referral packet, obtaining relevant medical records needed by the community provider, and scheduling the patient's appointments.[15] Community care staff are responsible for scheduling appointments within seven days of receiving a consult and following up with

[10] VHA Office of Community Care, "Veteran Community Care General Information Fact Sheet," September 9,2019.

[11] VHA Office of Community Care, "Best Medical Interest vs. Delegation of Authority," chap. 2: 05.02.05 in *VHA Office of Integrated Veteran Care (IVC) Community Care Field Guidebook (FGB)*, accessed June 20, 2023, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/content/554400000225944/FGB-Chapter-2-050205-Best-Medical-Interest-vs-Delegation-of-Authority?query=Best%20Medical%20Interest%20vs%20delegation%20of%20Authority. (This website is not publicly accessible.) The Office of Community Care Field Guidebook contains "live" documents that are continually revised with new and updated information.

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

[13] VHA Directive 1232(5); VHA Office of Community Care, "Care Coordination Model," chap. 3: 05.03.01 in *VHA IVC Community Care FGB,* accessed January, 31, 2024, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/search?q=05.03.01. (This website is not publicly accessible.)

[14] VHA Office of Community Care, "Best Medical Interest vs. Delegation of Authority," chap. 2: 05.02.05 in *VHA IVC Community Care FGB*. The VHA medical center chief of staff has the responsibility for identifying designated authorities at the VHA medical center.

[15] VHA Office of Community Care, "Care Coordination Model," chap. 3:05.03.01 in *VHA IVC Community Care FGB.*

community care providers to assure the patient received the care, obtain patient records, and close the consult in the patient's EHR.[16]

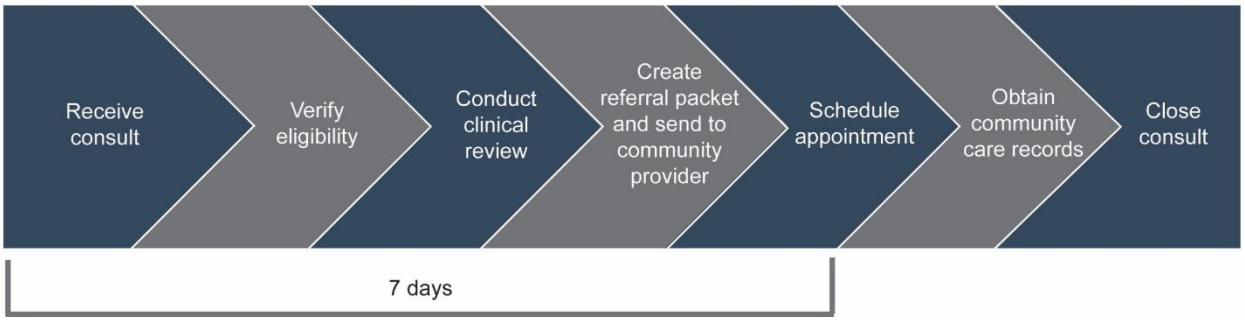

Figure 1. *Community care consult scheduling processes.*
Sources: OIG analysis of Consult Timeliness Standard Operating Procedure, December 1, 2022; VHA Office of Community Care Field Guidebook, Chapter 3, Care Coordination Model, August 25, 2024.

Allegations and Related Concerns

On March 16, 2023, the OIG received a complaint alleging the system had a backlog of nearly 3,000 consults for oncology, radiation oncology, and neurosurgery services. Consequently, patients with serious health conditions were forced to wait for long periods to receive care. On April 4, 2023, the OIG tasked system leaders to respond to the allegation and to provide corrective actions taken, including quality reviews, to address the issue.

On May 9, 2023, the OIG received the System Director's response. The System Director "partially substantiated" the allegation reporting that as of May 1, 2023, 492 oncology, radiation oncology, neurosurgery, and neurosurgery spine consults were in an unscheduled status beyond the "VHA targeted standard of thirty (30) days for clinical services" and noted "utilizing overtime and scheduling stand downs" to reduce the backlog.[17] In response to the OIG's query of conducting quality reviews of patient care delays, the System Director reported

> Beginning in Dec[ember] 2022, the facility Community Care Physician Medical Director began a daily review of all urgent/high-risk consults referrals thru community care. As of May 1, 2023, there were no urgent/high-risk consults beyond VHA scheduling standards for the respective consult category.

[16] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022; VHA Office of Community Care, "Care Coordination Model," chap. 3:05.03.01 in *VHA IVC Community Care FGB*.

[17] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022. At the time of the System Director's response to the OIG and the 2022 SOP, VHA required community care staff to schedule consults within seven days of receiving the consult.

From May 25 through July 27, 2023, the OIG received three additional complaints regarding community care consult practices and continued delays for patients receiving care. Following the review of the fourth complaint, the OIG opened a hotline inspection to evaluate whether

- delays in scheduling radiation therapy and neurosurgery consults led to delays in care that resulted in patient harm, and
- system community care leaders directed staff to inappropriately manage radiation therapy and neurosurgery consults through canceling, rescheduling, veteran self-scheduling, and provider scheduling.

During the inspection, the OIG identified additional concerns regarding system and community care leaders' failures

- to resolve concerns about high-risk consults,
- to respond timely once appointment scheduling delays were identified, and
- to disclose adverse events.

Scope and Methodology

The OIG conducted an on-site visit November 28 through 30, 2023. The OIG also conducted virtual interviews between October 2023 and March 2024.

The OIG interviewed VISN and system leaders, including a VISN 2 community care manager and a VISN 2 business implementation manager; the System Director, Chief of Staff (COS), chief of medicine, chief of hematology and oncology (oncology), system community care medical director; and the chief of quality, safety, and value. Other interviews conducted included providers from hematology and oncology (oncology) and neurology; a health systems specialist to the COS; the system community care manager; current and former community care advanced medical support assistant (AMSA) staff; community care nursing staff; a patient advocate; and a senior nurse consultant.[18]

Relevant VHA and system policies and procedures in place during the time frame of events were reviewed along with system committee charters, minutes, compliance audits, action plans, quality reviews, patient safety reports, patient advocate reports, and organizational charts. The OIG reviewed email correspondence from staff related to the issues under review and the EHRs of select patients with delayed community care consults to evaluate the impact, if any, the delay

[18] The chief and providers of hematology and oncology will be referred to as chief of oncology and oncology providers for the remainder of the report.

had on the patient's clinical status, condition, or course of treatment. Additionally, the OIG reviewed community care consult data from October 1, 2023, through January 31, 2024.[19]

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.[20]

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.

Inspection Results

Despite the System Director's report that in December of 2022, the community care medical director had begun "a daily review of all urgent/high-risk community care consults," the OIG found patients with serious health conditions continued to experience excessive consult scheduling delays. An OIG review of selected patients revealed that at least one patient experienced debilitating cancer-related pain while other patients experienced ongoing disease

[19] "Corporate Data Warehouse," VA, accessed on July 10, 2024, 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.

[20] 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.

activity, disease progression, or delays in diagnosis and treatment; this care did not meet the tenets of quality care.

Particularly concerning was system and community care leaders' failure to meaningfully respond to multiple providers and community care staff's pleas, on behalf of patients, to schedule consults considered urgent, such as radiation oncology. Although leaders primarily attributed the consult scheduling backlog to the loss of community care staff in late 2022, neither system nor community care leaders could clearly articulate why they failed to address recurring urgent patient scheduling concerns brought to leaders' attention. The OIG found system and community care leaders actions were inconsistent with HRO principles and values, specifically getting to the root cause of the problem, focusing on the veteran, listening and responding to staff concerns, and predicting and eliminating risks before they cause harm.[21]

1. Community Care Delays Caused Patient Harm and Increased Risk of Harm

The OIG substantiated that community care staff's delays in scheduling patients' radiation therapy and neurosurgery appointments resulted in delays in care and, in some cases, either caused or increased the risk of patient harm. This finding was not isolated to radiation therapy and neurosurgery consults.

Community Care Scheduling Delays Impact on Selected Patients

The OIG team reviewed 42 patients' EHRs to evaluate how community care scheduling delays, primarily for radiation oncology and neurosurgery consults, affected patients and resulted in patient harm.[22]

The OIG developed criteria to categorize the impact, if any, the community care consult scheduling delays had on the 42 patients reviewed. The criteria and categories were primarily based on a review of patients' EHRs; as such, the emotional impact associated with long wait times (frustration, inconvenience, suffering, and dissatisfaction) could not be fully assessed.

[21] VA, "HRO Value, Duty to Speak Up," (fact sheet), January 2024; VA/VHA, *VHA High Reliability Organization (HRO) Reference Guide*, April 2023. In High Reliability Organizations, "everyone has a Duty to Speak Up when they see a safety issue, and leaders have a duty to listen and respond to the concerns that staff members raise." An HRO principle, preoccupation with failure, means having "a laser-sharp focus on catching errors before they happen and predicting and eliminating risks before they cause harm."

[22] The OIG reviewed system staff email correspondence, patient advocate reports, and patient safety reports to identify patients potentially affected by delayed community care appointment scheduling. The OIG reviewed information in a total of 48 patients' EHRs, including the clinically indicated date, appointment dates, pertinent medical notes, and laboratory and diagnostic test results when evaluating the impact of scheduling delays. Delayed scheduling for 6 of the 48 patients reviewed were not attributed to community care staff and were excluded from OIG categorization to evaluate for patient impact.

Level 1: no clear indication the delay affected the patient's clinical status or the provider's management of the condition

Level 2: affected the provider's management of the patient's condition (such as changing the treatment modality, course or sequence of care, increased the risk of harm, or delayed intervention)

Level 3: affected the patient's clinical status or condition (continued disease activity [pain and seizure activity], disease progression, or delayed diagnosis)

The OIG found that all 42 patient consults significantly exceeded the seven-day VHA scheduling requirement.[23] Table 1 shows the breakdown of the 42 patients reviewed according to the type of consult placed and the levels of negative impacts from appointment scheduling delays.

Table 1. Number of Patients and Corresponding Level of Impact

Service Requested	Level 1	Level 2	Level 3
Gastroenterology	2	0	0
Interventional Radiology	1	0	2
Neurosurgery/Neurosurgery Spine/Neurology	14	0	1
Oncology	4	0	0
Prosthetics	1	0	0
Diagnostic Imaging	6	2	1
Radiation Therapy	1	1	5
Surgery	1	0	0

Source: OIG analysis of patients' EHRs and determination of how patients were affected by community care delays.

Nine of the 42 (21 percent) patients reviewed experienced level 3 impact (affecting the patient's clinical status and/or condition). Patients A, B, and C presented below are examples of level 3 impact. Three of the patients (7 percent) reviewed had a level 2 impact (affecting the provider's management of or treatment used for the patients' conditions). Patient D presented below is an example of a level 2 impact.

Failure to Provide Patient A Radiation Therapy to Treat Cancer Pain

Medical research discusses the benefit of radiation therapy to reduce pain in patients with bone metastases. "Radiation therapy is a successful and time efficient method by which to palliate

[23] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)." The OIG found during analysis of the 42 patient EHRs that the number of days for community care staff to schedule these consult appointments ranged from a minimum of 21 to a maximum of 285 days, with an average of 128 days to schedule. For the purposes of this report the phrase "significantly exceeded" refers to equal to or greater than 21 days.

pain and/or prevent the morbidity of bone metastases."[24] Radiation therapy can reduce analgesic requirements, prevent pathologic fractures, maintain skeletal function, and improve quality of life. Patients responding to radiation therapy for metastatic bone pain typically do so within 4 weeks of treatment and have a mean duration of remission of approximately 19 weeks. Rates of pain relief in this setting range from 50 to 85 percent with up to one-third of patients reporting a complete resolution of pain.[25]

Patient A Case Review and Analysis

A delay in scheduling, and eventual cancellation of, community care radiation therapy to treat Patient A's cancer-related pain resulted in progressive pain that became debilitative in the last two months of the patient's life. The radiation therapy consult remained unscheduled and was subsequently discontinued following Patient A's death, nearly two and a half months from the date the consult was placed.

Patient A, who was in in their mid-seventies, was diagnosed in spring 2022 with cancer of the esophagus. Two weeks later, Patient A was evaluated with positron emission tomography/computed tomography (PET/CT) imaging, which revealed the patient's cancer had spread to the liver and bones, including the patient's low back and right hip region. That same month, Patient A started a palliative care regimen of chemo-immunotherapy. During a fall 2022 appointment with a system oncology attending provider (attending provider), the patient complained of right leg weakness and repeat PET/CT imaging reviewed by the attending provider showed Patient A's cancer was advancing to the right pelvis and thigh region.

Patient A continued chemo-immunotherapy, and in late 2022, the patient underwent repeat imaging that demonstrated further bony destruction at the right hip region and severe progression of disease. The following day, the attending provider entered a community care consult for radiation therapy. That same day, a community care AMSA received the consult and documented that the "consult has been flagged with urgency for expedited processing" and alerted the chief of oncology to review and approve the consult.[26] When the consult remained unapproved, a community care registered nurse sent additional electronic messages via Patient A's EHR to the chief of oncology. Fifteen days after the consult was placed, the chief of oncology approved Patient A's consult. The community care registered nurse again documented the same day that the consult was "flagged with urgency for expedited processing" by community care staff.

[24] Stephen Lutz et al., "Palliative radiotherapy for bone metastases: an ASTRO evidence-based guideline."

[25] Francesca De Felice, Andrea Piccioli, Daniela Musio, and Vincenzo Tombolini, "The role of radiation therapy in bone metastases management," *Oncotarget* 8, no. 15 (January 26, 2017): 25691–9, https://doi.org/10.18632/oncotarget.14823.

[26] The chief of oncology is assigned as the delegated authority for community care consults requesting oncology and radiation oncology services.

Providers' Unsuccessful Advocacy to Schedule Patient A's Care

Despite multiple pleas to system community care leaders and staff by the chief of oncology, a staff oncologist, and Patient A's spouse, the radiation therapy appointment was never scheduled (see figure 2).

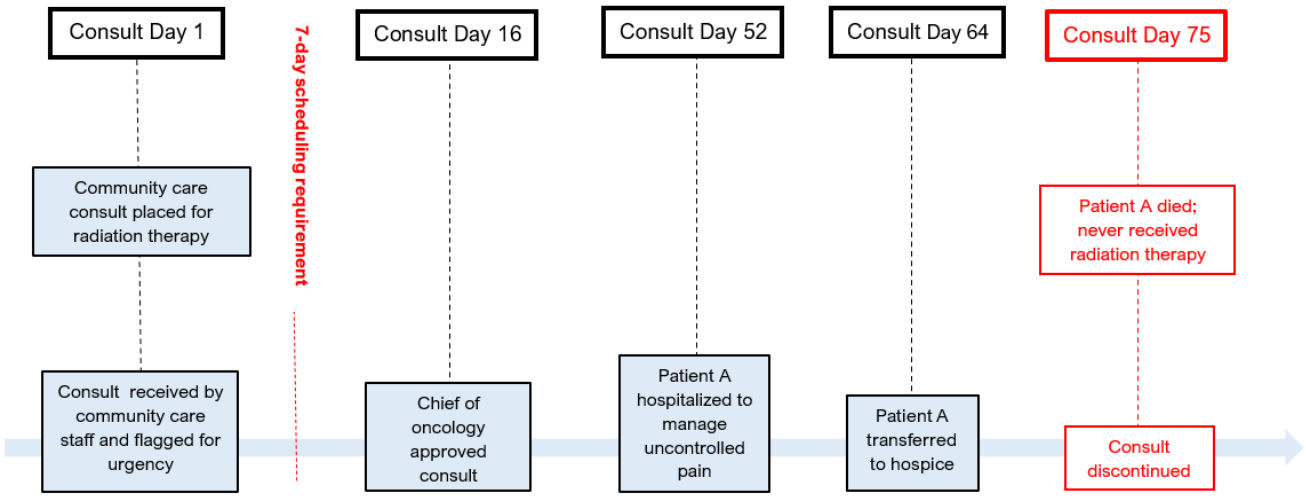

Figure 2. *Timeline of consult scheduling delay and impact on Patient A.*
Source: OIG analysis of Patient A's EHR.

Although alerted on the same day the consult was submitted by an oncology provider, the chief of oncology did not approve the consult until almost two weeks after the consult was submitted. During an OIG interview, the chief of oncology, who had the delegation of authority to approve the consult, acknowledged the two-week delay and cited "human error." The chief of oncology explained being alerted to the consult but stated "somehow, I didn't do it."[27]

Following Patient A's early 2023 visit, another oncology provider documented the patient's pain was affecting mobility and requiring the use of a walker. In an email sent to system community care leaders and staff the same day, the oncology provider wrote the following:

> Pain is now affecting [Patient A's] mobility. [Patient A] has not been contacted yet regarding scheduling . . . . I am hoping the priority of this radiation oncology referral can be escalated to help with this veteran's pain management.

The community care manager responded to the oncology provider's email, "We will review as soon as possible for prioritization."

[27] In some specialty consults, a provider is assigned as the delegated authority tasked with reviewing consults and assuring that the services requested are appropriate for the patient and to be rendered in the community. The consult cannot be scheduled until approval is provided. According to system staff interviews, the chief of oncology is assigned as the delegated authority for community care consults requesting oncology and radiation therapy services.

Seventeen days later, the oncology provider documented having had a telephone call with Patient A, noted that the patient's right hip and right lower extremity pain and weakness was now severely affecting the patient's ability to stand and walk and that symptoms had steadily worsened over the seven weeks since requesting radiation therapy. The oncology provider documented in the EHR that the patient's "Spouse was very upset about the prolonged delay in the patient receiving necessary cancer treatments," and noted "[oncology staff] will again request community care to assist in prioritizing" the scheduling of the consult.

That same day, after alerted to concerns regarding Patient A's care delays from the oncology provider, the chief of oncology placed a note in the patient's EHR and contacted the chief of medicine and system community care leaders via email, requesting "please expedite approval" of Patient A's radiation therapy consult. The chief of oncology's email noted that Patient A was reporting severe pain:

> Please expedite approval of this radiation oncology consult which was approved [30 days ago] . . . [The patient and the patient's] wife are now reporting severe pain at the site of metastasis. We will do the best we can to palliate pain as an outpatient but if needed patient will need to be admitted for pain control if we are unsuccessful.

The community care manager responded the same day to the email indicating that the consult would be prioritized and scheduled. Additionally, the oncology provider noted having encouraged Patient A's spouse to follow up with the patient advocate about concerns with the scheduling delay.

The OIG reviewed patient advocate reports and found that Patient A's spouse contacted the patient advocate six days after speaking to the oncology provider and reported that the scheduling delay for Patient A's radiation treatment resulted in an Emergency Department visit and subsequent hospitalization. The patient advocate documented having sent an email to the COS, chief of medicine, the patient's oncology providers and primary care provider, and the patient advocate's supervisor requesting a review of Patient A's care. The OIG did not find any evidence at the time of the complaint that the system completed a clinical review as requested by the patient advocate.

That same day, the EHR revealed that system internal medicine providers admitted Patient A to the hospital and documented a note in the patient's EHR describing the patient had "uncontrolled pain" at the right thigh, low back, and right chest wall, debilitating to the point of not being able to function at home. The next day, an orthopedic consultant noted that Patient A did not apply any weight to the right lower extremity due to pain and weakness and that there was "pain with any attempts to move" the extremity. A palliative care provider noted that Patient A's intended radiation therapy had already "been delayed almost 2 months since initial referral" and "would not necessarily add any significant benefit." Attempts to manage the patient's pain during hospitalization required concurrent doses of several opioids (hydromorphone, oxycodone, and

methadone).[28] The following month, an internal medicine provider documented the patient's status was designated to be that of "comfort care" and transfer was made to hospice. Patient A died 11 days later.

The OIG found that although Patient A had stage IV esophageal cancer with metastasis to the bone, was late in the course of disease, and had a poor prognosis, timely action by community care staff to oncology providers' repeated requests for radiation therapy would likely have decreased the level of pain and improved the quality of life in the patient's final months.

Delay in Patient B's Radiation Therapy

Squamous cell lung cancer is a type of non-small cell lung cancer.[29] In stage I, the tumor is confined to the lung and has not spread to lymph nodes or to sites outside the chest.[30] Surgical resection is the first line of therapy for patients with stage I disease but, if the patient is a poor surgical candidate, radiation therapy is considered. The type of radiation therapy that has become the preferred choice for medically inoperable patients with early stage non-small cell lung cancer is stereotactic body radiation therapy, "defined as very high dose, precisely focused radiation given over a limited number of treatments . . . having been shown to be safe, effective, and favorable for a vulnerable patient population, "such as patients assessed to be inoperable."[31]

Patient B Case Review and Analysis

The case of Patient B illustrates delays in scheduling radiation therapy for a new malignancy despite multiple requests by oncology providers for treatment. Community care staff failed to schedule Patient B's community care consult for radiation therapy, resulting in a nine-week delay in the requested services.

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[28] GW Hanks et al., "Morphine and alternative opioids in cancer pain: the EAPC recommendations," *British Journal of Cancer*, 84, no. 5 (March 2, 2001): 587–93; https://doi.org/10.1054/bjoc.2001.1680; Andrea M. Trescot, et al., "Opioids in the Management of Chronic Non-Cancer Pain: An Update of American Society of the Interventional Pain Physicians' (ASIPP) Guidelines," Pain Physician, 11 (2008): S5–S62; "Hydromorphone," Drug Enforcement Agency, accessed February 27, 2024, https://www.dea.gov/factsheets/hydromorphone. Prior to admission the patient was taking oxycodone, an opioid one and a half to two times as potent as oral morphine, without adequate pain control. Upon admission, two additional opioids were prescribed, methadone and intravenous hydromorphone. Methadone is an opioid medication potentially useful in treating severe pain that has been resistant to other opioids. Hydromorphone injection is a high potency analgesic formulation, two to eight times greater than morphine, and is only prescribed when pain relief has been inadequate with other treatment options.

[29] "Non-Small Cell Lung Cancer Treatment (PDQ)-Health Professional Version," National Cancer Institute, accessed June 4, 2024, https://www.cancer.gov/types/lung/hp/non-small-cell-lung-treatment-pdq.

[30] "Stages of Non-Small Cell and Small Cell Lung Cancer," Memorial Sloan Kettering Cancer Center, accessed May 29, 2024, https://www.mskcc.org/cancer-care/types/lung/diagnosis/stages-lung.

[31] David S. Buchberger and Gregory M.M Videtic, "Stereotactic Body Radiotherapy for the Management of Early-Stage Non0Small_Cell Lung Cancer: A Clinical Overview," *JCO Oncology Practice* (February 17, 2023): 239, http://ascopubs.org/doi/full/10.1200/OP.22.00475.

Patient B in their mid-seventies had been diagnosed with a large cell neuroendocrine tumor (a type of lung cancer) in 2019 and was treated with chemoradiation in 2019 and immunotherapy in 2020. No evidence of recurrence or metastasis from that malignancy was noted.

In late 2022, Patient B was diagnosed with primary stage I lesion squamous cell lung cancer. At an oncology appointment one week later, the chief of oncology informed the patient and family that the lung cancer diagnosis was different than the patient's original lung cancer event of 2019, was discovered at an early stage, and was considered to be potentially curable at the time of diagnosis. Due to Patient B having active chronic obstructive pulmonary disease, surgery was not considered. Rather, the chief of oncology (treating oncologist) recommended stereotactic body radiation therapy and placed a community care radiation therapy consult. The following day, the chief of oncology approved, and community care staff received, the consult. Community care staff documented a care coordination plan note, "Plan: pending scheduling." During that month and the following month, community care staff took no additional action on the consult (see figure 3).

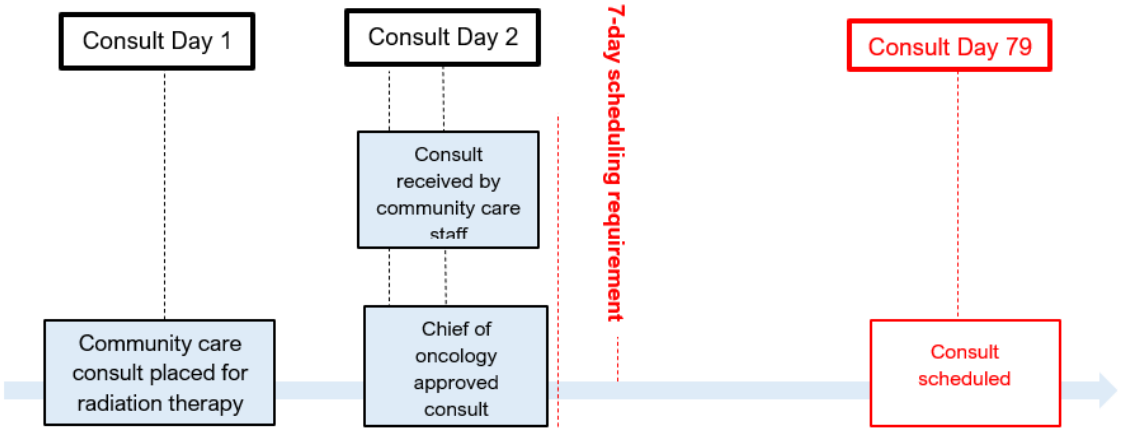

Figure 3: Timeline of consult scheduling delay for Patient B's radiation therapy.
Source: OIG analysis of Patient B's EHR documentation.

Provider's Unsuccessful Advocacy to Schedule Patient B's Care

According to the patient's EHR, the chief of oncology contacted community care staff multiple times after placing the community care consult for radiation therapy to facilitate scheduling. Seven weeks after placing the consult, Patient B informed the chief of oncology that there had been no contact with community care staff to schedule the radiation therapy. The chief of oncology documented having contacted community care regarding scheduling the consult and expressed, "It is hoped [Patient B] can be seen within the next seven business days." Further documentation states that community care replied they would make "all efforts . . . to be scheduled as soon as possible." The chief of oncology documented, "I will be in contact directly with [the community based] radiation oncology as needed."

On a telephone call eight days later, Patient B informed the chief of oncology of having still not been contacted by community care. The chief of oncology documented, "I again emailed the committee in charge of scheduling triage and asked that this be scheduled as soon as possible."

Two weeks later, Patient B attended an oncology appointment. The chief of oncology noted they would "once again contact the [community care] team for scheduling." The patient's EHR reflected the community care appointment occurred the same day. Patient B underwent a series of weekly stereotactic body radiation therapy treatments during spring 2023.

The OIG concluded that although the delay in receiving radiation therapy affected the patient's clinical status and exceeded the chief of oncology's clinically indicated date by 10 weeks, the impact on the patient's ultimate clinical outcome could not be determined.[32]

Delay in Patient C's Neurology Treatment for Seizures

Medical research explains that epilepsy is termed drug-resistant when two antiepileptic drugs fail to achieve sustained seizure freedom.[33] "About one-third of epilepsy patients have seizures that cannot be controlled with medication." For some patients with drug-resistant seizures, resection of epileptogenic brain may improve control of these seizures better than continued drug trials.[34] Long-term electroencephalogram monitoring (LTM) is a preliminary test necessary when referring a drug-resistant seizure patient for neurosurgical evaluation and is done to "confirm and localize focal epilepsy."[35]

Patient C Case Review and Analysis

Community care staff delayed scheduling of Patient C's LTM consult for nearly 10 months during which time, the patient continued to experience ongoing seizures despite the use of multiple antiepileptic drugs. This failure delayed the patient's neurosurgery evaluation needed to consider possible surgical options for drug-resistant epilepsy.

In early 2021, Patient C, in their mid-twenties, was evaluated for a seizure disorder by a neurology provider, after a recent electroencephalogram confirmed the patient was experiencing seizure activity. Despite attempts to control the seizures with several different medications, by

[32] VHA Directive 1232(5). The clinically indicated date refers to the date provided by the referring provider establishing the date that the services requested should be provided, determined by patient necessity.

[33] Patrick Kwan et al., "Definition of drug resistant epilepsy: consensus proposal by the ad hoc Task Force of the ILAE Commission on Therapeutic Strategies," *Epilepsia*, 51, no. 6 (June 2010): 1069–77, https://doi.org/10.1111/j.1528-1167.2009.02397.x.

[34] John W. Miller and Shahin Hakimian. "Surgical treatment of epilepsy." American Academy of Neurology Continuum *(Minneap Minn)*, 19, no. 3, (June 2013) :730–42, https://doi.org/10.1212/01.CON.0000431398.69594.97; William O. Tatum, "4th. Long-term EEG monitoring: a clinical approach to electrophysiology," *Journal of Clinical Neurophysiology*, 18, no. 5 (September 2001):44255, https://doi.org/10.1097/00004691-200109000-00009.

[35] Miller and Hakimian, "Surgical treatment of epilepsy."

fall 2021, Patient C was experiencing generalized convulsions two to six times per month. Additional seizure medications were utilized with some improvement, but the patient continued to have breakthrough seizures one to two times per month with impairment of consciousness, lip-smacking, involuntary hand movements, and generalized convulsing.

In late 2022, due to persistent seizures, a neurologist discussed the possibility of epilepsy surgery with Patient C and family, and Patient C expressed interest in this treatment option. That same day, the neurologist placed a community care consult for long-term LTM, a prerequisite for seeing neurosurgery and being considered for possible epilepsy surgery. Although the community care consult was received by a community care registered nurse three days later and approved by the chief of surgery the next day, no further action was taken until 4 months later, when the community care manager canceled the consult in spring 2023 (see figure 4).[36]

Three months after the consult was approved, in early 2023, the neurologist again evaluated Patient C and documented the patient continued to experience breakthrough seizures with associated symptoms to include trouble speaking, lip-smacking, and body pain following seizures. The neurologist's EHR documentation stated that surgical options would offer a "high chance of seizure freedom," and Patient C again expressed willingness to complete the preliminary work-up required for neurosurgical assessment prior to surgery.

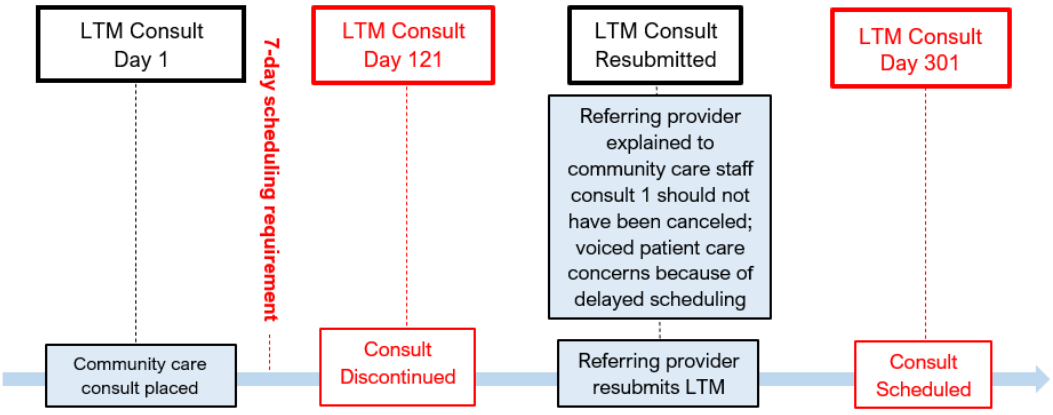

Figure 4. Timeline of consult scheduling delay for Patient C's neurosurgery evaluation. Source: OIG analysis of Patient C's EHR documentation.

Provider's Unsuccessful Advocacy to Schedule Patient C's Care

In early 2023 when the neurologist evaluated Patient C, the neurologist placed a separate community care consult to neurology for neuropsychologic testing, another assessment for "pre-surgical planning." At that time, the neurologist also noted that the consult request for LTM,

[36] At the time the consult was originally placed in late 2022, the chief of surgery was assigned as the delegated authority for community care consults requesting neurosurgery services.

submitted three months earlier (end of 2022), had been approved but had not been scheduled. The neurologist advised Patient C to contact community care.

Approximately five weeks after the neuropsychological testing consult was placed, the community care medical director canceled the LTM consult stating, "duplicate consult placed with additional details." The OIG learned through a review of email correspondence that the neurologist sent an email to community care staff explaining that the two consults, though both for neurology, were for two different services. The neurologist noted patient care concerns due to scheduling delays:

> [The consults] are two different referrals. I have ordered them separately . . . to avoid confusion. I will order LTM referral again. Please do not cancel again. Also for a [community care] referral from [end of 2022] which was not yet scheduled by [spring 2023], it is not acceptable. This is affecting [patient] care.

Following the realization that the community care medical director was conflating the LTM and neuropsychologic testing request, the neurologist resubmitted the consult for LTM six days after it was canceled. A community care AMSA received the second consult two days later.

In late summer 2023, Patient C again saw the neurologist who documented the patient's breakthrough seizure activity continued, though less often, but included a seizure episode resulting in an ambulance transport to a local hospital. The possibility of epilepsy surgery was again discussed with Patient C, but the neurologist documented that the requested LTM still had not been scheduled. The neurologist documented advising Patient C once more to contact community care "to schedule the tests."

In early fall 2023, the neurologist documented contacting the community provider via phone to discuss the results of the LTM, which demonstrated numerous seizures and associated abnormalities.[37] The neurologist entered a community care consult for neurosurgery for continued evaluation and treatment of Patient C's seizure disorder. The patient's appointment for LTM was scheduled nearly 10 months after the neurologist placed the original community care consult for LTM.

The OIG concluded that the community care medical director canceled Patient C's LTM consult nearly four months after submission, after mistakenly determining the consult was a duplicate. When noted and resubmitted by the referring neurologist, community care staff did not schedule the appointment for another five months. During the nine months, the patient continued to experience seizure activity despite the use of multiple antiepileptic drugs. The delay in obtaining the LTM while the patient experienced ongoing seizure activity delayed the provider's ability to initiate further treatment interventions.

[37] According to EHR documentation by the neurologist, Patient C completed LTM by a community provider in fall 2023. The OIG was unable to determine the exact date the community provider completed Patient C's LTM.

Delay in Patient D's Radiology Imaging

Amaurosis fugax is a temporary vision loss for seconds or minutes in one or both eyes due to an interruption in blood flow to the eye. Following an episode of amaurosis fugax, patients "are at high risk of developing IS [ischemic stroke] both in the short and long term."[38] The American Heart Association/American Stroke Association recommends that patients experiencing amaurosis fugax undergo prompt imaging of the carotid arteries as extracranial carotid artery disease is an important and treatable cause of stroke. Amaurosis fugax patients with high-grade carotid artery stenosis may be candidates for surgical intervention to prevent stroke.[39]

Patient D Case Review and Analysis

Patient D experienced a delay in obtaining a computed tomography angiography (CTA), which increased the patient's risk of developing ischemic stroke and negatively affected the referring provider's ability to determine and implement the best course of action to manage the patient's medical condition. Community care staff failed to schedule Patient D's CTA appointment for more than nine months.

In early fall 2022, Patient D, in their early seventies, was seen in the optometry clinic at another VHA facility and reported experiencing complete loss of vision in the left eye for less than a minute followed by complete recovery of vision (amaurosis fugax). Patient D had no other neurological symptoms. Two days later, a system vascular surgery attending provider (vascular surgery provider) evaluated the patient and documented that a previous carotid artery doppler study completed over two months earlier had identified the presence of vascular disease obstructing the internal carotid arteries but to a degree below the threshold level for surgical intervention. Given that Patient D had not had imaging performed since the amaurosis fugax event, the vascular surgery provider documented advising that a CTA be done to assess whether the carotid artery obstruction had progressed. In addition, the vascular surgery provider requested that Patient D again be referred to Vascular Surgery Service if CTA imaging demonstrated "50 [percent] or greater stenosis of the left [internal carotid arteries] or greater than 80 [percent] stenosis of either [internal carotid arteries]."

Six days later, a primary care provider placed an order with community care to schedule the CTA. Seven weeks later, at the next primary care visit, the provider observed that CTA imaging

[38] Amir A. Mbonde MBChB, Cumara B. O'Carroll MD, MPH, Octaviana A. Dulamea MD, PhD, Daniela Anghel MD, PhD, Brian W. Chong MD, Oana M. Dumitrascu MD, MSc. "Current Guidelines on Management of Amaurosis Fugax and Transient Ischemic Attacks," *Asia-Pacific Journal of Opthalmology* Volume 11, Issue 2, (2022), p. 168–76, https://www.sciencedirect.com/science/article/pii/S2162098923006953).

[39] Dawn Kleindorfer et al., "2021 Guideline for the Prevention of Stroke in Patients With Stroke and Transient Ischemic Attack: A Guideline From the American Heart Association/American Stroke Association," *Stroke. 2021* Jul;52(7):e364-e467. http://doi.org/10.1161/STR.0000000000000375. Epub 2021 May 24. Erratum in: Stroke. 2021 Jul;52(7):e483-e484. PMID: 34024117.

had not yet been scheduled and documented "reached out to Community Care" regarding scheduling the appointment.

The OIG learned through review of emails that when the primary care provider placed the consult in Patient D's EHR, a community care AMSA received the consult and alerted community care registered nurses to initiate a clinical review. That same day, a community care registered nurse verified Patient D's eligibility for community care and documented in the EHR alerting the chief of radiology to approve the consult.[40] Fifteen days after the consult was placed, a second community care registered nurse documented sending a second alert to the chief of radiology to review the consult. The chief of radiology approved the consult 18 days after the primary care provider placed the initial consult. A community care registered nurse flagged the consult for urgent scheduling that same day (see figure 5).

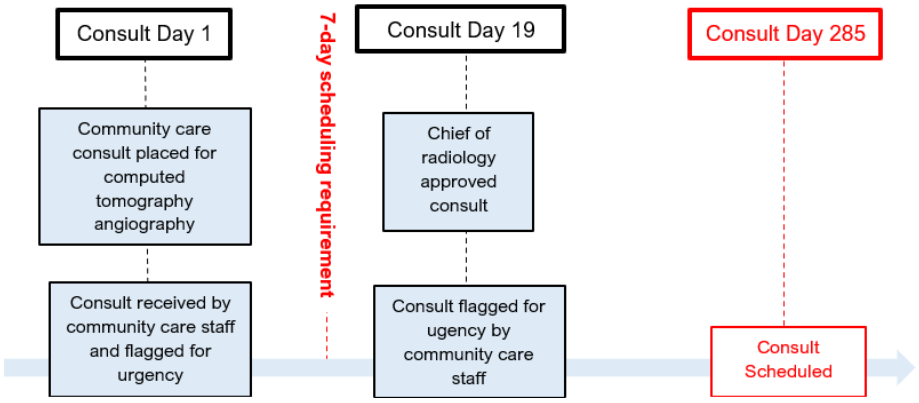

Figure 5. *Timeline of consult scheduling delay for Patient D's radiology imaging.*
Source: OIG Analysis of Patient D's EHR documentation.

Staff's Unsuccessful Advocacy to Schedule Patient D's Care

Between early and mid-2023, a community care registered nurse documented twice in Patient D's EHR requesting system community care leaders' assistance scheduling the "urgent" consult. In mid-2023, when Patient D was next seen by primary care, the same provider documented again that community care staff had not scheduled the patient's CTA imaging. The provider indicated again contacting community care. In an email, the primary care provider voiced concern that, almost seven months later, the consult remained unscheduled:

> I just saw [Patient D] . . . Patient still has not been scheduled. I understand and appreciate the enormous workload that your department has but I am dismayed that the CTA . . . has been sitting there this long despite the request to expedite.

Although the consult was indicated as "flagged for urgency" multiple times and the referring provider requested that scheduling be expedited, community care staff did not schedule the CTA

[40] The chief of radiology was the delegated authority for community care radiology services consults.

appointment for over nine months. The consult, placed in early fall 2022, was scheduled for summer 2023.

In fall 2023, the primary care provider observed that the CTA requested in fall 2022 "was finally performed in [summer 2023]." The imaging revealed progression of blockage in the right internal carotid artery to "greater than 80%" and the patient was determined to have met vascular surgery's criteria for reassessment. At Patient D's request, the provider entered a community care vascular surgery consult and documented in the EHR, "I have also emailed Community Care asking them to expedite [the consult]."

The OIG concluded that the nine-month delay in obtaining the CTA of the head and neck delayed further vascular surgery evaluation and increased Patient D's risk of developing ischemic stroke.

2. System and Community Care Leaders' Failures and Deficiencies

The OIG determined system and community care leaders failed to resolve significant community care scheduling delays for patients with serious health conditions, despite providers' and community care staff's efforts to advocate on the behalf of patients. The OIG found leaders were apprised of patients at risk of harm due to delayed community care scheduling; however, system leaders relied on system community care leaders' inaccurate assurances that urgent, high-risk patient care consults were reviewed and prioritized, even when alerted to continued patient concerns. Additionally, leaders failed to judiciously identify and resolve underlying programmatic issues contributing to delays and to evaluate the clinical impact of the consult delays on patients.

Failure to Address High-Risk Consult Concerns and Delays in Care

The OIG determined system and community care leaders failed to address significant community care scheduling delays for patients with serious health conditions, regardless of staff's repeated efforts to notify leaders of these patient concerns.

Healthcare systems should have established processes to prioritize care in a manner that ensures patients with urgent or high-risk health concerns receive care ahead of those with less immediate needs.[41] VHA does not specify expectations for how or when community care staff should prioritize and schedule consults that may be considered time-sensitive or high risk in nature; however, within seven days of receiving a consult, VHA community care staff are expected to have scheduled patients' appointments.[42]

[41] Julien Dery et al., "Patient prioritization tools and their effectiveness in non-emergency healthcare services: a systematic review protocol," *Systematic Reviews*, 8, (March 30, 2019):78, https://doi.org/10.1186/s13643-019-0992-x.

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

VISN Urges System to Address High-Risk Consult Concerns

The OIG learned that the VISN 2 community care manager identified and communicated concerns regarding unscheduled community care consults to system community care leaders in September and November 2022, explicitly emphasizing the need to address high-risk consults.

In an email sent on September 16, 2022, the VISN 2 community care manager notified the system community care manager that "greater than 50 [percent]" of unscheduled community care consults had no activity within the last 14 days. The email included radiation therapy, neurosurgery spine, and neurosurgery consults on a list of consults "with the highest numbers" of unscheduled consults with no recent activity. In response to the email, the system community care manager reported being aware of the issue and noted ongoing challenges with community care AMSA staffing stating, "as expected things will be worse before they get better." In a second email sent that same day, the VISN 2 community care manager acknowledged the reported staffing challenges but urged the system community care manager to ensure that community care staff prioritized consults based on the risk of not scheduling the consults.

On November 3, 2022, the VISN 2 community care manager alerted the system community care manager that 703 unscheduled consults had no activity in the past 14 days and again asked the system community care manager to confirm that community care staff were using a process that ensured the prioritization of consults identified as high-risk for scheduling so that "we don't let those high priority service/Veterans fall through the cracks."

Through correspondence, the OIG asked the VISN which consults would be considered high-risk or high-priority services as referenced in the email exchange noted above. The VISN 2 community care manager explained that while all consults are important and need to be reviewed on a regular basis, the VISN considered oncology, radiation therapy, and neurosurgery consults to be high-risk or high-priority.

During interviews with the OIG, the VISN 2 community care manager acknowledged that the system had "scheduling timeliness challenges for quite some time," and reported working closely with system community care leaders to address issues. The VISN 2 business implementation manager told OIG of reporting community care metrics, including outliers, to system and community care leaders adding they initially engaged system community care leaders to address needed improvement but follow-up with system leaders when further assistance to correct deficiencies is needed.

Additionally, the VISN 2 community care manager reported conducting a site visit and briefing system and community leaders in late 2022; however, when the OIG requested the site visit findings, VISN leaders explained that the visit was informal and there was no formal documentation of findings. The VISN 2 community care manager reported conducting a subsequent follow-up visit based on continued scheduling and timeliness challenges.

Numerous Providers and Staff Raised Delay in Care Concerns to Leaders

In addition to VISN leaders raising concerns about scheduling delays, the OIG found numerous providers and staff repeatedly raised concerns regarding patient-specific appointment scheduling delays to system and community care leaders. Providers and staff apprised leaders of these concerns by alerting them to a patient's EHR, through email correspondence, through patient safety reports, and by sending a letter of concern.

Through a review of email correspondence, the OIG learned that when referring providers contacted system community care leaders about an urgent consult, system community care leaders responded to the provider with this standard email response:

> Thank you for your request. Please note, your email has been received in Community Care and will be reviewed and prioritized based on the type of request, and forwarded for clinical and/or administrative review. All requests will be monitored by department leadership to ensure consults are addressed accordingly and timely. Updates will not be provided unless, we require additional information needed for processing.

After receiving the above response to a patient's oncology consult in late 2022, the chief of oncology replied to the community care manager's message seeking clarification on community care's triage process and questioning what "higher level of triage" is completed after system oncology providers have indicated a consult to be urgent. In response, the community care medical director informed the chief of oncology that all consults were reviewed and prioritized daily by system community care leaders, and explained that the previous reply sent by the community care manager was a "standard message [that] goes out to anyone saying their consult is urgent . . . . This allows focus on patients with cancer and a few other things that need scheduled as soon as possible."

On March 2, 2023, community care staff sent a letter to the chief of quality, safety, and value (chief of quality) via email expressing patient care concerns related to delays in processing consults. The letter, dated February 28 and signed by multiple community care AMSAs and nursing staff, noted that patients seeking cancer care, along with other patients with urgent requests, were left "waiting for an unacceptable period of time." In an interview with OIG, the chief of quality recalled staff reporting concerns regarding scheduling delays and acknowledged receiving the letter from community care staff. The chief of quality reported discussing the letter with the COS and reviewing "some of the cases" related to the letter. The chief of quality reported making the determination that, while some consults were delayed, none of the delays affected patient care and could not recall if the COS took other actions in response to the letter.

A provider notified system and community care leaders in another email sent in April 2023, of "serious delays" regarding another patient's community care consult for chemotherapy:

> We asked about the status of the [community care] consult on March 30, but we did not get a reply. We asked again about it on April 6, and still we did not get a reply. The patient called and asked if "we even know what we are doing." [The patient] will be going through the patient advocate due to community care processing delays.[43]

The provider stated in the email, "I want the [system] administration aware before this becomes a bigger issue." That same month, another staff member sent an email to the System Director regarding scheduling delays:

> I have been alerted to some issues from members of community care as well as clinical staff . . . due to repeated requests to schedule a veteran who has been waiting over 5 months for a surgical consultation for a chest mass . . . a veteran with breast cancer approved for a community surgical consultation that has been waiting 2 months to be scheduled . . . [and] . . . a veteran with a life threatening neurological issue who has been waiting over 6 months for a neurosurgical consultation.[44]

Also, in April 2023, a community care registered nurse forwarded the chief of quality an email sent by a neurologist expressing concerns with delays in scheduling Patient C's LTM ordered in late 2022. The neurologist noted in the email that the delay in scheduling the appointment was "not acceptable. This is affecting [Patient C's] care."

The chief of quality, the COS, and the System Director received another email in June 2023 from a community care registered nurse who requested leaders review delays in a patient's evaluation for abdominal cancer. In the email, the community care registered nurse included details about the patient's consult, approved by the chief of radiology in early 2023, which identified that system community care leaders were alerted regarding the consult via secure email four times between March and May 2023 (see figure 6). [45]

[43] The OIG reviewed this patient's care as part of the 42 identified patients and determined that while the delay significantly exceeded VHA scheduling guidelines, there was no indication the delay clearly affected the patient's management or clinical status.

[44] No patient names were identified in the email sent to the System Director.

[45] The OIG reviewed this patient's care as part of the 42 identified patients and determined that while the delay significantly exceeded VHA scheduling guidelines there was no indication the delay clearly affected the patient's management or clinical status.

Figure 6. CPRS consult comments demonstrating contacts to system community care leaders.
Source: OIG analysis of patient EHR and staff email.

In the email, the community care registered nurse wrote to leaders:

> Please review this chain of events on this consult. This is one of many. There is no oversight or prioritization of urgent consults and there is a lack of response to alerts by [system community care leaders]. The [system community care registered nurses] are spending many hours checking on consults for follow up.

The community care registered nurse sent two more emails, one in July and one in August 2023 , to the chief of quality, the COS, and the System Director communicating ongoing concerns with processing consults designated as "urgent" and noted the following:

> Again there isn't any attention to "urgents" unless the MD or Veteran complains. There is not a plan for addressing these urgent consults. The MSAs have all been hired, trained, and able to process consults for a long time now. No management or oversight of these consults.

Leaders Minimize Concerns with Ineffective High-Risk Consult Process

The OIG was informed that system community care leaders had established a process, including a daily review of consults considered high-risk, to prioritize and schedule consults to ensure patients received care for time-sensitive medical needs, such as cancer and neurosurgery services. However, the OIG found that despite implementing the daily review in December 2022, the process was ineffective, providers and staff continued to raise patient concerns to system and community care leaders, and high-risk consults remained unscheduled for extended periods.

The OIG questioned system community care leaders about the department's process for identifying and scheduling high-risk, urgent consults. The community care manager reported working with the community care medical director to review consults, and explained that at that time, community care registered nurses reviewed and assigned a high-risk alert to a consult they "felt [was] high risk" or was considered high-risk based on information given by the ordering VHA provider via email. The community care medical director reported that after being alerted to a consult an ordering provider identified as urgent, the community care medical director reviewed the consult to determine the actual urgency. The community care manager reported the community care medical director used a spreadsheet to track and review unscheduled high-risk consults. Once the community care medical director reviewed the consult, AMSAs would schedule the appointment. The community care manager was unable to provide a standard operating procedure or policy that outlined the department's process or a list of consults or services community care staff were to manage as high-risk during this period.

When asked by the OIG if staff had communicated concerns regarding oncology or neurosurgery consult scheduling delays adversely affecting patients, the community care manager acknowledged receiving alerts from community care nurses regarding consults that had not been reviewed. The community care manager noted the majority of concerns were raised in late 2022 and early 2023 during the consult backlog "chaos." When learning of a concern, the community care manager reported typically asking community care staff to address the concern that day but acknowledged that some concerns may not have been addressed stating, "It probably did happen, but based on the load that we were dealing with, it was probably imminent." Similarly, the community care manager acknowledged delays in responding to patient advocate complaints and explained "I was juggling multiple things. The notifications amongst the emails, amongst this and that, were getting lost. So it's not that I didn't handle them, I just didn't do them timely."

System leaders interviewed by the OIG reported having some awareness of the multiple attempts made by staff and patients to elevate concerns related to community care appointment scheduling delays. During an interview, the chief of medicine acknowledged an awareness of scheduling delays but did not recall providers reporting patient care concerns directly or through email. However, the OIG identified multiple cases where the chief of medicine was included on emails sent by providers to community care staff about concerns with delays in scheduling patients. The COS reported receiving emails regarding concerns with scheduling delays but noted that system

community care leaders never reported patients were waiting months for cancer treatment to be scheduled. The COS described having meetings with system community care leaders and reinforcing the importance of ensuring community care staff used a process to prioritize patients with time-sensitive conditions for scheduling. The COS reported that feedback received from the community care medical director indicated that the method used by community care staff to manage consults was effective. The System Director recalled being made aware of staff concerns about patient delays via email and through discussions with the COS. The System Director recalled responding to the concerns by speaking with the COS or the community care medical director, who would follow up on the issue and report the patient scheduling issue was resolved.

The OIG found system and community care leaders failed to address and resolve delays in care concerns repeatedly brought to their attention by multiple providers and staff. System leaders relied upon the community care medical director's and manager's inaccurate assurances that high-risk, time-sensitive consults were effectively addressed. The OIG concluded system and community care leaders' lack of action to be contrary to HRO principles and values. Leaders failed to consistently focus on the patient, respond to staff concerns, get to the root cause of concerns regarding delayed scheduling of urgent consults, and predict and eliminate risks before causing patient harm.

System Leaders Deficient Response to Resolve Delays

The OIG determined that, despite numerous system staff's reports of concerns and the OIG case referral in April 2023, system leaders failed to judiciously identify and resolve underlying core leadership and programmatic deficiencies within community care. Further, leaders failed to take action to evaluate the clinical impact of the consult delays on patients until after receiving notification of the OIG inspection in October 2023.

VHA requires leaders to adhere to any consult program guidance and ensure regular review and improvement of department performance gaps.[46] As those most responsible for the care and services provided, system leaders must effectively manage factors affecting safety and quality of care.[47] As an HRO, VHA is a "learning organization," where leaders and staff should be committed to learning from mistakes when they happen and working together to create safer, more efficient processes to prevent patients from experiencing the same mistakes.[48]

Delayed Actions to Identify and Resolve Community Care Deficiencies

Although efforts to reduce the number of unscheduled community care consults began as early as December 2022, system leaders did not request or conduct a thorough review of the concerns

[46] VHA Directive 1232(5).

[47] The Joint Commission, *Standards Manual,* LD.03.03.01, January 2023. "Leaders use hospital wide planning to establish structures and processes that focus on safety and quality."

[48] VA, "Learn, Inquire, and Improve HRO Value" (fact sheet), January 2024.

related to community care practices, including processing time-sensitive consults, until August 2023.

In August 2023, the System Director issued a memorandum authorizing a "third-party" factfinding to investigate "Allegations of Mismanagement of Community Care Consults."[49] The investigative team conducted an on-site review from August 16 through 28, and completed a summary report with findings and recommendations on September 18, 2023. Per the report, the substantiated allegations with findings included, but were not limited to

- "Lack of process to address time sensitive consults in Oncology, GI [gastroenterology], Imaging and MH [mental health], with potential delays in scheduling." There was "no special consideration or practice for high risk and complex consults."
- "Lengthy delays in scheduling CITC [care in the community] consults." "The majority of [community care] staff were unfamiliar with the CC [community care] Field Guide's most basic processes on the way to manage consults and every single employee interviewed . . . [told the factfinding team] that the field guide was just a recommendation and was not specific enough for actual use."
- Community care staff were "following some but not all standardized national practices," had no local standard operating procedures or standards of work, and there was "no management oversight of practice to prevent the individualized practices that are occurring."
- "Scheduling is not following best practices with multiple hand-offs and call backs." The findings noted, "Important emails get lost in the barrage of unnecessary email "handoffs." This use of email handoffs is inefficient at best and potentially dangerous."

At the time of the site visit in late November 2023, the OIG's concerns regarding the system's community care fundamental deficiencies mirrored those summarized in the September 2023 factfinding report. During interviews with system leaders and staff, the OIG learned of continuing challenges that interviewees felt contributed to the system's community care deficiencies. The community care manager described being new to the VA and reported not receiving formal community care-related training when hired into the position in May 2020. Staff reported difficulties maintaining a sufficient number of community care AMSA staff to adequately manage consults due to frequent turnover. Leaders and staff also identified interpersonal challenges within the department that created a negative workplace environment and hampered the community care team's functionality. The System Director reported that community care had experienced "personnel issues" for the past two to three years and noted the department had multiple managers during that same time period.

[49] Per the System Director's Factfinding memorandum, the "third-party" investigative team included three employees with subject matter expertise from another VA facility.

The System Director told the OIG that the initial increase in delayed consults raised questions whether the delays were related to the system's community care processes or deficiencies in department staffing and reported requesting a site visit from another facility in VISN 2. After more extensive issues within the system's community care department became clear, the System Director initiated a factfinding in August 2023 to review "concerns of consult mismanagement" by community care staff. The System Director reported being very involved in trying to understand and resolve the challenges within community care.

At the time of the OIG site visit, the System Director and system community care leaders and staff had already begun incorporating many of the factfinding team's recommendations. The OIG noted an overall decrease from January 2023 through January 2024 in the average number of days to process time-sensitive oncology and radiation therapy consults (see appendix A). Leaders reported implementing a new process to address high-risk consults including the establishment of a community care team to be responsible for scheduling high-risk consults. Leaders and staff explained that the new process included having a list that identified the types of consults considered to be high-risk, which included oncology and radiation therapy, for scheduling priority. However, the community care manager reported that, as of March 2024, system community care leaders had not formalized this process in a written standardized operating procedure or policy for community care staff, as had been recommended by the factfinding team. During an interview, the community care manager described making changes to "some" department standardized operating procedures but explained that updates to procedures were ongoing.

The OIG is concerned that despite the VISN, clinical providers, patients, and community care staff repeatedly raising the alarm regarding significant deficiencies within the department, system leaders waited approximately eight months to request an in-depth evaluation of the program. The findings not only confirmed the concerns brought forward but revealed fundamental gaps in knowledge, competencies, management, and oversight that require significant attention, intervention, and accountability by system leaders and focused oversight by VISN leaders.

Delay in Clinical Review

The OIG found that leaders did not take steps to review whether scheduling delays contributed to any negative patient clinical outcomes until October 2023, despite an ongoing awareness of delays in patient appointment scheduling and reported concerns regarding patient care.

On October 26, 2023, the OIG requested system leaders provide documentation of any reviews or investigations completed by system staff to evaluate timeliness, delays, or patient harm related

to appointment scheduling for radiation therapy and neurosurgery consults.[50] The health systems specialist to the COS contacted the chief of medicine and the associate chief of staff for research (chief of research) via email on November 7, 2023, 12 days after the OIG inspection notification, with a list of eight patient names, and requested both providers review the patients' care to determine whether "delays in scheduling community care likely have had a negative clinical impact."[51] Of note, the health systems specialist to the COS included Patient A's name in the list provided to the chief of medicine and the chief of research.

The chief of medicine determined one patient may have experienced "physical discomfort" due to scheduling delays. However, the chief of medicine responded that none of the other seven patients, including Patient A, likely had negative clinical impact from scheduling delays.[52] The chief of research determined that while the delay in Patient A's radiation therapy would not have altered the outcome, the treatment would have reduced Patient A's pain. The chief of research also identified in the review that another patient's outcome may have been altered by an over three-month delay in scheduling diagnostic imaging. When asked about the timing of the review, the chief of quality told the OIG the review was completed "in the past month." The chief of quality reported "talking about doing [the review]" and that after receiving the OIG inspection notification in October 2023 deciding "we better hurry up and do it sooner."

When asked why system leaders did not complete a review to determine the impacts of delays on patients until after receiving the OIG case referral, the COS described waiting for the results of the August 2023 factfinding before deciding to move forward with a clinically-focused review. During an interview with the OIG, a factfinding team member reported that the scope of the factfinding did not include identifying whether scheduling delays negatively affected patients. However, the OIG learned that a provider interviewed during the factfinding provided the factfinding team with the names of patients with delays in community care consults. The email from the provider to the factfinding team included Patient A's name.

The OIG would expect that once aware of repeated unresolved patient care concerns by staff and providers, system leaders would have conducted a review of patient care to determine the clinical consequences from delayed appointment scheduling. Furthermore, the timing of the review completed by the chief of medicine and the chief of research indicates the review was likely prompted by the OIG's notification of this inspection sent to system leaders. This failure to address repeated patient care concerns and conduct a review of patient care represents a critical

[50] As a part of the OIG inspection notification, the OIG requested documents including, but not limited to, administrative investigations, fact-findings, clinical reviews of care, and other quality management documents from October 1, 2022, through September 30, 2023.

[51] The email included the names of two patients identified during the system's record review along with the names of six other patients from sources including JPSRs and patient advocate reports.

[52] The OIG reviewed all eight patients included on the list of names sent by the health systems specialist to the chief of medicine and the chief of research as part of the review of the 42 patients affected by community care delays discussed previously in this report.

missed opportunity to promote a culture of patient safety and foster an environment of high reliability.

Failure to Identify and Disclose an Adverse Event

The OIG found that despite system leaders' awareness that delayed radiation therapy had negatively affected the quality of life in Patient A's final months, they failed to complete an institutional disclosure to the patient's family.

According to VHA, an institutional disclosure is a formal process where system leaders and clinicians have a "forthright and empathetic" discussion with a patient or their family to communicate that an adverse event occurred during the patient's care and provide specific information on the patient's rights and recourse.[53] An institutional disclosure must be initiated as soon as realistically possible, regardless of when the event was discovered, if an event has had or is expected to have an effect on the patient or otherwise requires a change in the patient's care.[54] VHA requires an institutional disclosure to be documented in the patient's EHR.[55]

When the OIG provided a synopsis of Patient A's condition and lack of radiation therapy for cancer-related pain, the chief of quality and the COS acknowledged that an institutional disclosure should have taken place. The System Director responded that, "it definitely affected [Patient A's] quality of life for the last few months." The System Director later reported that steps were being taken to complete an institutional disclosure.

Upon becoming aware of the clinical impact to Patient A resulting from the delay in care from the failure to schedule the patient's radiation therapy, system leaders were required to review the patient's care, determine if an institutional disclosure was warranted, and conduct and document the institutional disclosure in the patient's EHR. However, when the OIG reviewed Patient A's EHR over three months later, an institutional disclosure with the patient's family had not been completed and documented in the EHR. In a March 2024 interview, when asked why an institutional disclosure had not been completed, the COS reported waiting for further OIG guidance before conducting the disclosure but stated they would proceed with the disclosure at that time. In follow-up correspondence with the OIG in March 2024, the COS reported that quality management staff had reached out to the patient's family and that efforts to schedule and conduct the disclosure were ongoing. As of late spring 2024, an institutional disclosure with the patient's family had not been completed and documented in the EHR.

The OIG concluded leaders missed a critical opportunity to model their commitment to quality care and patient safety by failing to have a timely, forthright, and empathetic discussion

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

(institutional disclosure) with the patient's family acknowledging how the lack of radiation therapy affected the patient's quality of life. Further, the failure to recognize and disclose adverse events is inconsistent with VHA's commitment to quality care and patient safety.

3. Alleged Mismanagement of Consults to Manipulate Wait Times

The OIG did not substantiate system community care leaders directed staff to inappropriately manage radiation oncology and neurosurgery consults in an effort to manipulate scheduling timeliness metrics. Staff were not instructed to place consults in patient self-scheduling or provider scheduling status or to cancel consults.

Patient Self-Scheduling and Provider Scheduling

Community care appointment scheduling can be performed by VHA community care staff, the community provider, or the patient.[56] Patients can use self-scheduling to schedule appointments directly with community care providers after VHA community care staff determine eligibility and authorize care.[57] Provider scheduling occurs when the community provider prefers to schedule appointments for authorized care directly with the patient.[58]

During OIG interviews, none of the community care staff (nine AMSAs and six registered nurses) reported being directed by system community care leaders to use patient self-scheduling or provider scheduling inappropriately to manipulate consult timeliness metrics. However, community care staff explained that system community care leaders had recently encouraged staff to offer patient self-scheduling, as a result of the updated VHA guidance. [59]

Additionally, the OIG reviewed a random sample of 50 patients' EHRs who had an oncology, radiation therapy, or neurosurgery community care consult placed and had been designated with the "veteran self-scheduling" preference from October 1, 2022, through December 31, 2022. The OIG did not identify instances where community care staff appeared to have inappropriately used patient self-scheduling.

Conclusion

[56] VHA Office of Community Care, "How to Schedule Care Under Community Care Network," chap. 3 in Office of IVC Community Care FGB.

[57] VHA Office of Community Care, "Coordinating Care Delivery (Pre/Post CCN)" and "How to Schedule Care Under Community Care Network," chap. 3 in Office of IVC Community Care FGB.

[58] VHA Office of Community Care, "How to Schedule Care Under Community Care Network."

[59] Acting Assistant Under Secretary (AUSH) for Health for Integrated Veteran Care (IVC), "Community Care Veteran Self Scheduling Enhancements," memorandum to VISN Directors, September 6, 2023. VHA issued updated guidance in September 2023 requiring facilities to use veteran self-scheduling through a phased process for consults, such as physical therapy, primary care, massage therapy, and podiatry; this does not include radiation treatment or neurosurgery services.

The OIG concluded that community care staff's delays in scheduling patients' radiation therapy and neurosurgery appointments resulted in delays in care and, in some cases, either caused or increased the risk of patient harm. This finding was not isolated to radiation therapy and neurosurgery consults. An OIG review of 42 patients' EHRs found that the delay in community care consult scheduling affected nine patients' clinical status or condition or both, and for three of the patients reviewed, the delay affected the provider's management of or treatment used for the patients' conditions.

System and community care leaders failed to resolve significant community care scheduling delays for patients with serious health conditions, despite providers' and community care staff's efforts to advocate on the behalf of patients. The OIG found system leaders relied upon the community care medical director's and manager's inaccurate assurances that high-risk, time-sensitive consults were effectively addressed.

System leaders failed to judiciously identify and resolve underlying core leadership and programmatic deficiencies within community care. Although efforts to reduce the number of unscheduled community care consults began as early as December 2022, system leaders did not request or conduct a thorough review (factfinding investigation) of the concerns related to community care practices, including processing time-sensitive consults, until August 2023. The investigation's findings not only confirmed the concerns brought forward but revealed fundamental gaps in knowledge, competencies, management, and oversight.

The OIG found that despite leaders' ongoing awareness of delays in patient appointment scheduling and reported concerns regarding patient care that required significant attention, intervention, and accountability by system leaders and focused oversight by VISN leaders, system leaders did not take steps to review whether scheduling delays contributed to any negative patient clinical outcomes until October 2023. Additionally, system leaders failed to complete an institutional disclosure to Patient A's family despite being made aware of the negative impact that delayed radiation therapy had on the quality of life in the patient's final months.

The OIG concluded system and community care leaders' lack of action was contrary to HRO principles and values and represented multiple, critical missed opportunities to promote a culture of patient safety and foster an environment of high reliability. Specifically, leaders failed to focus on the patient, respond to staff concerns, get to the root cause of concerns regarding delayed scheduling of urgent consults and underlying programmatic and management deficiencies, and predict and eliminate risks before causing patient harm.

The OIG did not substantiate system community care leaders directed staff to inappropriately manage radiation oncology and neurosurgery consults in an effort to manipulate scheduling timeliness metrics.

Recommendations 1–4

1. The New York/New Jersey VA Health Care Network Director conducts a review of system leaders' responses to repeated concerns regarding delayed community care consult scheduling for patients with serious health conditions to determine whether leaders' actions were in alignment with patient safety and high reliability organizational principles, and take action as warranted.

2. The New York/New Jersey VA Health Care Network Director ensures VA Western New York Health Care System Director develops community care consult practices and procedures for managing consults deemed high-risk or complex, implements an effective process to ensure consistency with processing consults within Veterans Health Administration timeliness requirements, and audits for compliance.

3. The VA Western New York Health Care System Director ensures system community care leaders develop and implement standardized operating procedures for consult management consistent with Veterans Health Administration standards, provide training to community care staff, monitor compliance, and evaluate effectiveness.

4. The VA Western New York Health Care System Director ensures all efforts to conduct an institutional disclosure to Patient A's family are made and that the disclosure is documented in the patient's electronic health record, as required.

Appendix A: Timeliness of Community Care Oncology and Radiation Therapy Appointment Scheduling January 2023 Through January 2024

To ensure patients who were referred to the community for oncology and radiation therapy evaluation or treatment were receiving services within the required time frame, the OIG reviewed the system's community care scheduling timeliness for these consult types from January 2023 through January 2024.

The OIG found community care appointment scheduling timeliness for oncology and radiation therapy consults had significantly improved during this timeframe. The average number of days to schedule appointments for oncology consults had decreased from 42 days in January 2023 to 10 days in January 2024. Radiation therapy scheduling had reduced from 36 days in January 2023 to 5 days in January 2024 (see figures A.1 and A.2 below).

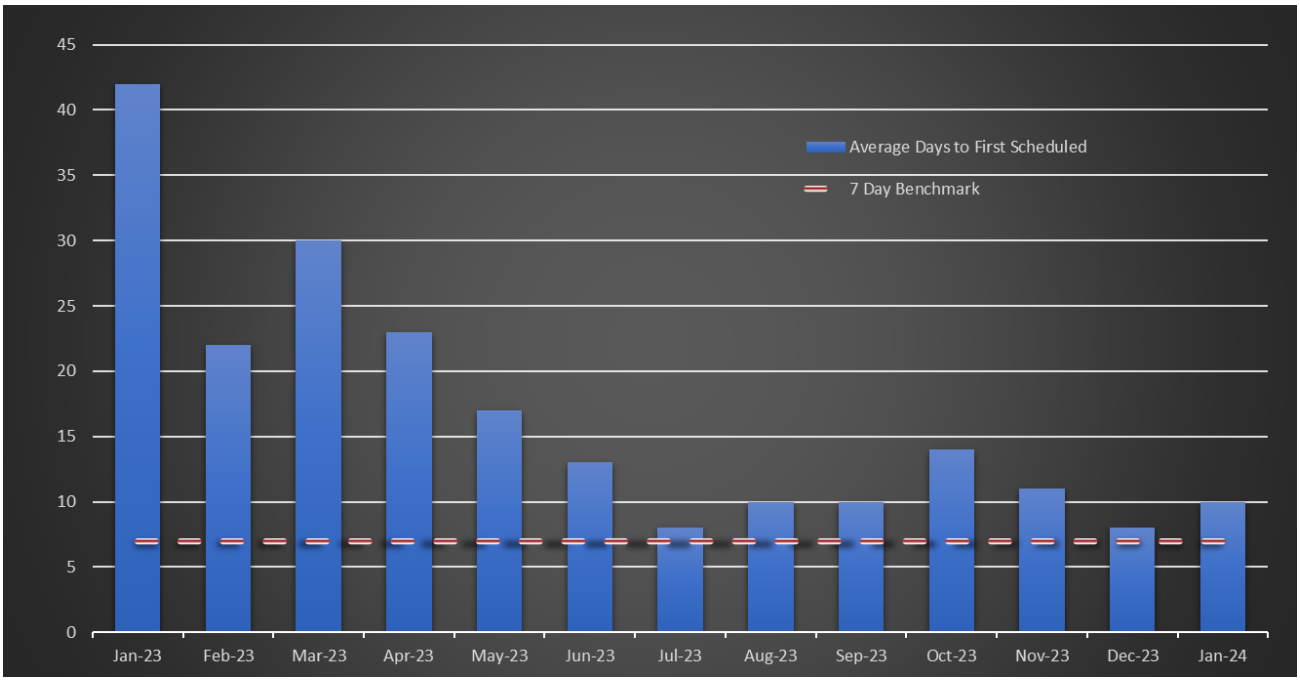

Figure A.1. *Average days from consult entry date to first scheduled appointment made by VA staff for community care consults for oncology.*
Source: OIG analysis of VHA Corporate Data Warehouse community care oncology consult data from January 2023 through January 2024.

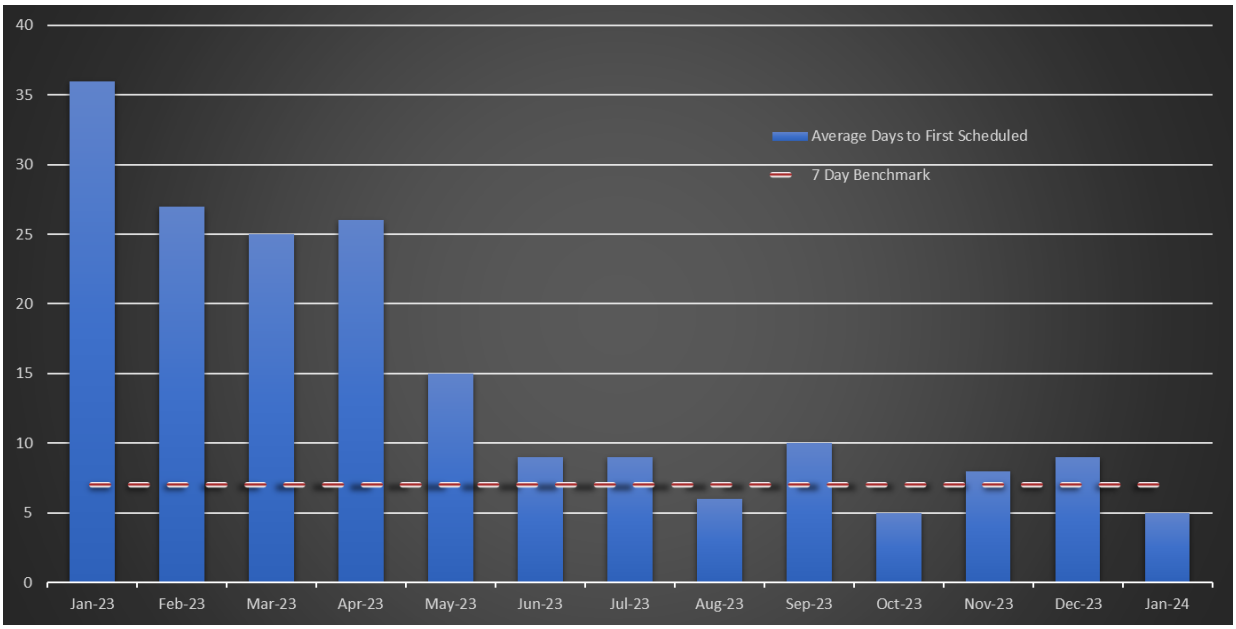

Figure A.2. *Average days from consult entry date to first scheduled appointment made by VA staff for community care consults for radiation therapy.*
Source: OIG analysis of VHA Corporate Data Warehouse community care radiation therapy consult data from January 2023 through January 2024.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 12, 2024

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subj: Healthcare Inspection—Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo (VIEWS 12003577)

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

1. We deeply regret the circumstances identified in the Office of Inspector General (OIG) report that impacted the care of Veterans and thank the OIG for their comprehensive assessment. We will do everything we can to utilize these findings to improve care for Veterans and support the Veterans and family members whose lives were impacted.

2. 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.

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

(*Original signed by:*)

Joan E. McInerney, MD, MBA, MA, FACEP

[**OIG comment:** The OIG received the above memorandum from VHA on September 13, 2024.]

VISN Director Response

Recommendation 1

The New York/New Jersey VA Health Care Network Director conducts a review of system leaders' responses to repeated concerns regarding delayed community care consult scheduling for patients with serious health conditions to determine whether leaders' actions were in alignment with patient safety and high reliability organizational principles, and take action as warranted.

_X_Concur

____Nonconcur

Target date for completion: February 2025

Director Comments

The New York/New Jersey VA Health Care Network Director will conduct a review of system leaders' responses to repeated concerns regarding delayed community care consult scheduling for patients with serious health conditions. The review will be completed using VHA guidelines and Directives and in accordance with Just Culture and high reliability organization principles. Warranted actions will be taken in accordance with these same principles.

Recommendation 2

The New York/New Jersey VA Health Care Network Director ensures VA Western New York Health Care System Director develops community care consult practices and procedures for managing consults deemed high-risk or complex, implements an effective process to ensure consistency with processing consults within Veterans Health Administration timeliness requirements, and audits for compliance.

__X_Concur

____Nonconcur

Target date for completion: February 2025

Director Comments

The VISN Community Care Oversight Council will ensure the facility establishes a standard process for high-risk consult management and prioritization which follows guidance outlined in the VHA Directive 1232(5) Consult Processes and Procedures. Effective implementation of the new Standard Operating Procedures (SOP) will be monitored monthly at the VISN Community Care Council meetings. Effectiveness will be tracked for no less than six months and reported

quarterly by the Business Implementation Manager at the Community Care Oversight Council, chaired by the VISN Chief Medical Officer and Deputy Network Director.

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 12, 2024

From: Director, VA Western New York Healthcare System, Buffalo, NY (528)

Subj: Healthcare Inspection—Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo (VIEWS 12003577)

To: Director, New York/New Jersey VA Health Care Network (10N2)

1. We deeply regret the circumstances identified in the Office of Inspector General (OIG) report that impacted the care of Veterans and thank the OIG for its comprehensive assessment. We will do everything we can to utilize these findings to improve care for Veterans and to support the Veterans and family members whose lives were impacted.

2. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Inspection—Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo. VA Western New York concurs with the findings and will take appropriate actions as recommended.

3. If you have additional questions or need further information, please contact the Chief of Quality, Safety and Value.

(*Original signed by*:)

Shawn De Fries, MS, MBA, RHIA, FACHE
Interim Executive Director

[**OIG comment:** The OIG received the above memorandum from VHA on September 13, 2024.]

Facility Director Response

Recommendation 3

The VA Western New York Health Care System Director ensures system community care leaders develop and implement standardized operating procedures for consult management consistent with Veterans Health Administration standards, provide training to community care staff, monitor compliance, and evaluate effectiveness.

__X_Concur

____Nonconcur

Target date for completion: February 2025

Director Comments

Workflows for consult management that had previously been in use by the community care staff have been converted to align with the VHA Directive 1232(5) Consult Processes and Procedures in the form of a local SOP to identify and effectively manage High Risk/High Priority consults. Implementation and staff education to be completed by the end of October 2024. Compliance monitoring will be conducted monthly, and effectiveness will be tracked for no less than six months and reported quarterly by the Community Care Medical Director at the facility's Executive Committee of the Medical Staff (ECMS).

Recommendation 4

The VA Western New York Health Care System Director ensures all efforts to conduct an institutional disclosure to Patient A's family are made and that the disclosure is documented in the patient's electronic health record, as required.

__X_Concur

____Nonconcur

Target date for completion: June 2024

Director Comments

Patient A's family was contacted by phone to request a meeting with the facility leadership to conduct the institutional disclosure. Subsequently, a certified letter expressing condolences was sent, which included the Office of General Counsel Frequently Asked Questions Brochure titled "Claim Options after Injury." The institutional disclosure note was documented in the Veteran's electronic medical record on June 18, 2024, by the Chief of Staff, outlining the above information.

OIG Comments

The OIG considers this recommendation closed.

Glossary

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

adverse event. "Untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."[1]

amaurosis fugax. Temporary vision loss for seconds or minutes in one or both eyes due to an interruption in blood flow to the eye.[2]

carotid artery. Blood vessel(s) on the left and right side of the neck coming from the upper chest to the head that carry blood to the brain, face, and neck. Plaque buildup in the arteries can reduce or block the flow of blood to the brain causing serious complications or stroke.[3]

carotid artery doppler study. A doppler ultrasound is completed by using sound waves to obtain images of the carotid artery to check for narrowing or blockage.[4]

chemoradiation. The combination of chemotherapy and radiation therapy to increase effectiveness of cancer treatment.[5]

chemotherapy. Refers to drugs that are given that inhibit the division of or kills cancer cells, which stops the growth of cancer. It can be given in conjunction with surgery, radiation therapy, or alone.[6]

chemo/immunotherapy. A relatively new treatment option that provides chemotherapy alongside immunotherapy to increase the effectiveness of cancer treatment by use of immunotherapy to improve the immune system's capacity to fight the cancer while combating the cancer through chemotherapy.[7]

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[1] VHA Directive 1004.08.

[2] "Amaurosis fugax," Cleveland Clinic, accessed February 26, 2024. https://my.clevelandclinic.org/health/diseases/amaurosis-fugax.

[3] "Carotid Artery," Cleveland Clinic, accessed February 26, 2024. https://my.clevelandclinic.org/health/body/21492-carotid-artery.

[4] "Carotid ultrasound," Cleveland Clinic, accessed February 26, 2024. https://my.clevelandclinic.org/health/diagnostics/22916-carotid-ultrasound.

[5] "Chemoradiation," Yale Medicine, accessed March 7, 2024. https://www.yalemedicine.org/clinical-keywords/chemoradiation.

[6] "Chemotherapy," National Cancer Institute, accessed February 26. 2024. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/chemotherapy.

[7] "Chemo-immunotherapy," National Library of Medicine, National Center for Biotechnology Information, accessed March 28, 2024, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10252089/.

chronic obstructive pulmonary disease. Refers to a category of diseases such as emphysema and chronic bronchitis that contribute to problems with breathing and blocking airflow.[8]

computed tomography angiography. A test that involves injecting a dye into the hand or arm and using computed tomography, x-rays and computer technology, to obtain detailed internal images of heart arteries to determine if irregularities exist, how the heart is functioning and detect cardiovascular disease.[9]

consult. A request for services on behalf of a patient through the electronic health record (EHR) and further used to document consult information in the patient EHR.[10]

electroencephalogram. A test that measures electrical activity in the brain to detect irregularities. When diagnosed with epilepsy an EEG may be used to evaluate seizure activity.[11]

epilepsy. A brain disorder causing a "sudden alteration of behavior due to a temporary change" in electrical activity in the brain characterized as a seizure.[12]

epilepsy surgery. "A procedure that removes an area of the brain where seizures occur."[13]

extracranial. "Outside of the cranium (bones that surround the brain)."[14]

factfinding. One of the tools VHA uses to complete a "systematic, thorough and objective analysis of evidence, documented in a manner that clearly conveys the facts, the evidence from which those facts are ascertained and the investigator's conclusions about disputed matters."[15]

immunotherapy. Therapy that consists of using specific elements such as vaccines and some antibodies to specifically stimulate or suppress the immune system to help fight cancer, disease, and infection.[16]

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[8] "Chronic obstructive pulmonary disease," Centers for Disease Control and Prevention, accessed March 7, 2024. https://www.cdc.gov/copd/about/?CDC_AAref_Val=https://www.cdc.gov/copd/basics-about.html.

[9] "Coronary computed tomography angiography," John Hopkins Medicine, accessed February 26, 2024. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/computed-tomography-angiography-cta#:~:text=What%20is%20computed%20tomography%20angiography,a%20part%20of%20your%20body.

[10] VHA Directive 1232(5).

[11] "Electroencephalogram (EEG)," Johns Hopkins Medicine, accessed February 28, 2024. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/electroencephalogram-eeg.

[12] "Epilepsy," American Association of Neurological Surgeons, accessed February 28, 2024. https://www.aans.org/en/Patients/Neurosurgical-Conditions-and-Treatments/Epilepsy.

[13] "Epilepsy surgery, "Mayo Clinic, accessed March 12, 2024. https://www.mayoclinic.org/tests-procedures/epilepsy-surgery/about/pac-20393981.

[14] "Extracranial," National Cancer Institute, accessed March 28, 2024. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/extracranial.

[15] VA Directive 0700, *Administrative Investigation Boards and Factfindings*, August 10, 2021.

[16] "Immunotherapy," National Cancer Institute, accessed February 26, 2024. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/immunotherapy.

internal carotid artery. The carotid arteries on the left and right side of the neck split and make up the internal and external carotid arteries that continue to branch off into smaller arteries providing blood to the head, neck and sustaining organs and tissues.[17]

ischemic stroke. A type of stoke that occurs due to a blockage of blood supply to the brain, usually caused by a blood clot or stenosis due to plaque buildup.[18]

joint patient safety report. Refers to patient safety events entered into the Joint Patient Safety Reporting (JPSR) system by VHA employees.[19]

malignancy. Refers to cancers that spread uncontrollably into nearby tissue and other areas of the body.[20]

metastatic. In reference to cancer, the spread of cancer from the point of origin to other parts of the body. [21]

neuropsychologic testing. Tests conducted by psychologists specifically trained in neuropsychology (neuropsychologists). "It tests for a range of mental functions, like reading, language use, attention, learning, processing speed, reasoning, remembering and problem solving," to determine how well the brain is functioning and can help clinicians diagnose and treat disorders such as epilepsy.[22]

palliative care. Specialty care with an emphasis on improving comfort and quality of life while treating pain and symptoms from serious illness; as well as the side effects due to medical care.[23]

positron emission tomography/computed tomography. A type of imaging using small quantities of radioactive material ingested or injected to diagnose and evaluate numerous diseases. While CT imaging is the use of x-ray equipment used to develop images of internal anatomy. Combined PET/CT scans "may provide more accurate diagnoses than the two scans performed separately, " as well as "more precise information."[24]

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[17] "Carotid Artery," Cleveland Clinic, accessed February 26, 2024. https://my.clevelandclinic.org/health/body/21492-carotid-artery.

[18] "Ischemic stroke," Medline Plus, accessed March 18, 2024. https://medlineplus.gov/ischemicstroke.html.

[19] VHA Directive 1050.01.

[20] "Malignancy," National Cancer Institute, accessed February 26, 2024. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/malignancy.

[21] "Metastatic," National Cancer Institute, accessed February 26, 2024. https://www.cancer.gov/publications/dictionaries/cancer-terms/def/metastatic.

[22] "Neuropsychological testing," Cleveland Clinic, accessed March 18, 2024. https://my.clevelandclinic.org/health/diagnostics/4893-neuropsychological-testing-and-assessment.

[23] "Palliative care," Mayo Clinic, accessed February 27, 2024. https://www.mayoclinic.org/tests-procedures/palliative-care/about/pac-20384637#:~:text=Overview,your%20condition%20can%20be%20cured.

[24] "PET/CT," RadiologyInfo.org, accessed March 19, 2024. https://www.radiologyinfo.org/en/info/pet.

radiation therapy. Uses carefully targeted doses of high-energy radiation to kill cancer cells.[25]

routine consult. Refers to the scheduling urgency of the consult. A routine consult is to be scheduled according to the clinically indicated date provided by the referring clinician.[26]

squamous cell carcinoma, non-keratinizing. Squamous cell carcinoma has three sub-categories consisting of keratinizing, non-keratinizing and basaloid variant. Diagnosis is provided based upon microscopic differences. Non-keratinizing cells can resemble small cell carcinoma and are considered, "poorly differentiated," making this type of lung cancer difficult to distinguish from other types of carcinoma.[27]

squamous cell lung cancer. Refers to one of three main categories of non-small cell lung cancer. This type of cancer originates in the cells that cover the airway and often grows close to the center of the lung.[28]

stenosis. "A narrowing or constriction of the diameter of a bodily passage or orifice."[29]

stereotactic body radiation therapy. A type of cancer treatment using advanced imaging to determine the precise location of a cancerous tumor to deliver intense doses of radiation with minimal damage to healthy tissue.[30]

vascular disease. Refers to any disease affecting the body's system of blood vessel such as carotid artery disease which can lead to a stroke.[31]

[25] "Radiation therapy," Mayo Clinic, accessed February 29, 2024, https://www.mayoclinic.org/departments-centers/radiation-oncology/sections/overview/ovc-20188591.

[26] VHA Directive 1232 (5).

[27] Michael Kmeid, et al., "Squamous cell carcinoma mimics small cell carcinoma of the lung: a case report," *Journal of Surgical Case Reports,* 12 (December 2020): 1-3, https://doi.org/10.1093/jscr/rjaa531.

[28] "Types of lung cancer," Cancer Research UK, accessed March 7, 2024. https://www.cancerresearchuk.org/about-cancer/lung-cancer/stages-types-grades/types.

[29] *Merrriam-Webster.com Dictionary*, "Stenosis," accessed March 19, 2024, https://www.merriam-webster.com/dictionary/stenosis.

[30] "What is Stereotactic Body Radiation Therapy (SBRT)," accessed March 8, 2024, https://www.mskcc.org/cancer-care/diagnosis-treatment/cancer-treatments/radiation-therapy/what-sbrt.

[31] "Vascular Disease," Cleveland Clinic, accessed February 28, 2024, https://my.clevelandclinic.org/health/diseases/17604-vascular-disease.

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