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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia

Healthcare Inspection | **22-02800-225** | **September 29, 2023**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Hampton VA Medical Center (facility) in Virginia to assess allegations received May 10, 2022, related to a delay in diagnosis and treatment of a patient's lung mass.

The OIG identified additional concerns related to coordination of care for the identified patient, including deficiencies in the facility oncology program and inadequate facility review and response to the patient's cancer care.[1]

Patient Case Summary

The patient, in their 60s, presented to the facility's Emergency Department in late September 2021 (day 0) complaining of new chest pain.[2] During the visit, a chest x-ray and a computerized tomography (CT) scan of the chest showed a mass in the right upper lobe. The radiologist noted the mass as "worrisome for malignancy" and adenopathy. The Emergency Department physician discharged the patient home with instructions to follow up with the patient's primary care provider (PCP) by phone as soon as possible regarding an outpatient positron emission tomography (PET) scan referral and pulmonology consult for a possible lung biopsy.[3]

Five days after the Emergency Department visit, the patient called the PCP to discuss the Emergency Department visit and possible lung cancer. Five days later, in early October 2021, a PET scan request was referred to community care due to the facility being unable to schedule the patient.[4] The PET scan was completed seven weeks later in late November 2021 (day 59). The results demonstrated a right upper lobe lung mass concerning for malignancy and possible spread of cancer. In early December 2021 (day 75), sixteen days after the PET scan was completed, the PCP documented a follow-up phone appointment with the patient.

Additionally, in mid-October 2021, the PCP ordered a pulmonary consultation. The consultation was scheduled for day 49, mid-November 2021; however, the patient missed the appointment

[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] Upon review of the EHR, the OIG found that from September 2021 to March 2022, the patient had a total of five Emergency Department visits with a chief complaint of pain, and was admitted to the hospital following the last Emergency Department visit in March.

[3] The patient's PCP began caring for the patient in 2016. There was no documentation of discussion regarding, nor orders for, low-dose lung CT screening for lung cancer. When asked in an interview by the OIG, the PCP could not recall ordering a low-dose lung CT.

[4] The patient agreed to having the PET scan completed in the community as the facility was "unable to schedule within VA guidelines."

and was rescheduled for 21 days later in early December 2021. This appointment was canceled by the clinic and the patient was rescheduled for another appointment seven days later (day 77).

The patient ultimately saw the pulmonologist in mid-December, 72 days after the patient had contacted the PCP. The pulmonologist ordered a CT scan of the abdomen and pelvis for suspected lung cancer with metastasis and the CT scan was completed one week later. In addition to enlarging pulmonary nodules, the CT scan revealed multiple bone lesions worrisome for metastatic disease and a large destructive bone lesion in the sacrum. After consulting with a radiologist, the pulmonologist ordered a deep bone biopsy of the sacral lesion.

In mid-January 2022, twenty-five days after the bone biopsy was ordered, a pulmonary clinic nurse contacted and informed the patient that the Radiology Department had been trying to reach the patient to schedule the bone biopsy. The next day, the radiology nurse contacted the patient by phone to provide education for the bone biopsy procedure. One week later, the CT technologist sent the patient a letter with the appointment information including date, time, and instructions for the biopsy. The bone biopsy procedure was initially scheduled for early February (day 131), 47 days after the order was written but was twice rescheduled by the facility to mid-February 2022, 60 days after the initial biopsy order (day 144).

The biopsy result was finalized seven days after the biopsy and the results were consistent with metastatic disease from a primary adenocarcinoma lung cancer. The PCP requested an oncology consult for metastatic lung cancer the following day (day 152).

During this period of diagnostic evaluations, the patient presented to the Emergency Department on three occasions in early January 2022, mid-January 2022, and late February 2022 complaining of pain. During each encounter, Emergency Department providers treated the patient's pain and recommended follow-up with the PCP for pain management. Additionally, on the day of the bone biopsy in mid-February 2022, the radiology procedure nurse documented the patient complained of pain not relieved by the prescribed medications. The nurse alerted the Patient Aligned Care Team (PACT) through the electronic health record (EHR) to contact the patient to assist with pain management.

The patient saw the hematology oncologist (oncologist) for the first time in early March (day 160) and the oncologist requested a community care radiation therapy consult for the treatment of lung cancer and pain control. Three days later (day 163), the patient presented to the Emergency Department complaining of shortness of breath, chest pain, and total body pain not controlled by previously prescribed medications and was admitted to the hospital.

On the third hospital day, a CT scan of the brain was completed and demonstrated multiple brain masses consistent with metastatic disease. On the fourth hospital day (day 166), the patient was transferred to a community hospital for whole brain radiation therapy to treat the brain metastases. The patient was discharged home from the community care hospital with hospice care and died at home in late March 2022 (day 185).

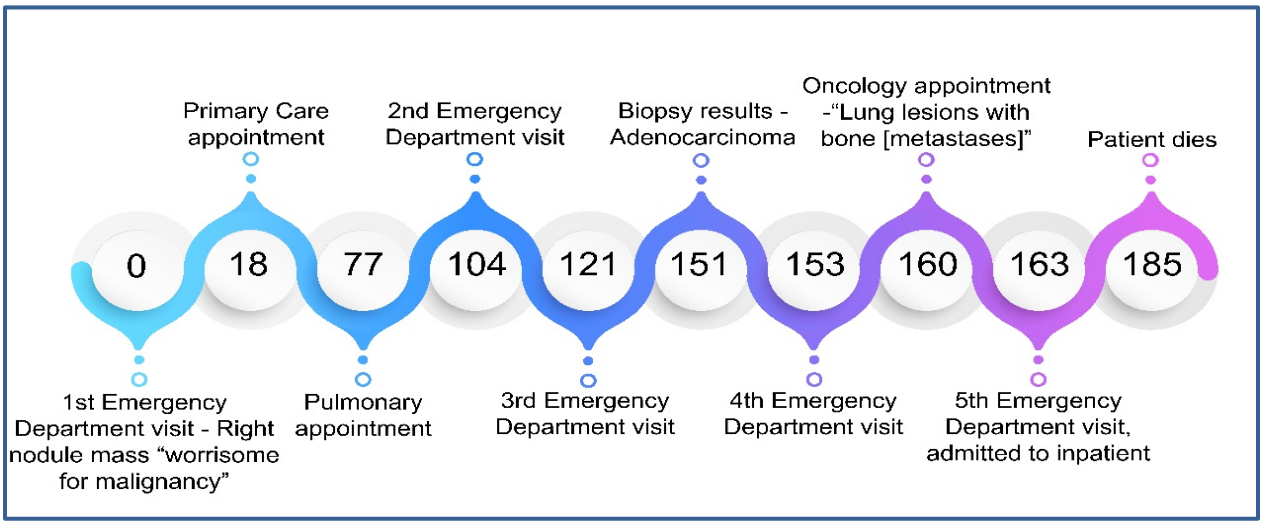


Figure 1. *Timeline of days elapsed from the first Emergency Department visit to the patient's death. Source: The OIG's review of the patient's EHR.*

Inspection Results

The OIG substantiated that the patient experienced a delay in diagnosis and treatment for the new lung mass that was highly suspicious for cancer. The OIG found facility leaders were unaware of the patient's case until notification of the OIG inspection in late June 2022.

While there is no prescribed timeline for the investigation and treatment of a highly suspicious mass, the OIG would have expected that, given the age of the patient who also had a history of smoking, the development of a lung mass would warrant prompt and thorough evaluation.

Scheduling Delays

The OIG determined delays in scheduling contributed to the delay in diagnosis of the patient's lung cancer. The OIG identified deficiencies in primary and specialty care services to provide prompt scheduling and access to care that might have resulted in an earlier diagnosis and treatment.

Primary Care and Pulmonology

Veterans Health Administration (VHA) policy states that when a consult is placed, it is the responsibility of the requesting provider to determine the soonest appropriate date the patient should be seen based upon the clinical needs of the patient, called the clinically indicated date

(CID).[5] Patient appointments are to be scheduled timely, accurately, and no more than 30 days from the CID.[6]

In total, 72 days elapsed between the patient contacting the PCP after the first Emergency Department visit and the completion of the pulmonology appointment. The PCP told the OIG, that after submitting the pulmonary consult, the next steps, such as determining the urgency of the case and other tests to be completed, would be decided by the pulmonologist as the specialist. Although the appointment scheduling in this case met basic requirements, there was an expectation from facility leaders that this case would have been handled more quickly. During interviews, the Chief of Staff described the delay as "highly unacceptable."

Further, based on the high-risk nature of the patient's case, the OIG would have expected the Primary Care and Pulmonary Services to ensure the patient was scheduled for the requested pulmonary appointment in an efficient and timely manner.

Radiology

The OIG determined that the patient was not scheduled nor seen for a diagnostic imaging procedure timely, which also contributed to the delay in diagnosis and treatment of the patient's cancer. Although the pulmonologist considered the patient a "high-risk" case, the pulmonologist failed to translate that urgency into the order for the CT guided deep bone biopsy, and submitted a routine order.[7]

The OIG found that the first action taken to schedule the bone biopsy by the Radiology Department occurred 19 days after the order was placed by the pulmonologist. The facility rescheduled the appointment twice and the bone biopsy was performed in mid-February, 60 days after the initial biopsy order. The OIG would have expected a shorter time frame due to the high suspicion for cancer. The chief of Radiology told the OIG that the multiple rescheduled appointments were due to scheduling errors because the radiologist capable of performing the biopsy was not available.

Patient Aligned Care Team Deficiencies

The OIG identified deficiencies within four PACT processes, which likely impacted the quality of care provided, and contributed to the delay in cancer treatment of the patient. The PACT

[5] VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021.

[6] VHA Directive 1230(3), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 7, 2021.

[7] Hampton VA Medical Center Diagnostic Imaging Service Standard Operating Procedure, *Department Scheduling*, February 2, 2021. Policy allows the choice of one of two order urgencies, routine and stat. A routine order is to be used by the referring provider when the patient should be seen as indicated in the CID. A stat order is to be used by the referring provider when the patient has an immediate need to be seen.

processes included improper determination of CID, insufficient pain management, failure to conduct post-Emergency Department discharge follow-up, and lack of daily huddles.

Improper Determination of the Clinically Indicated Date

The OIG reviewed consults placed by the PCP for the patient from September 2021 to March 2022, and found a range of CID's between 27 and 33 days documented for diagnostic consults. The PCP stated that entering a CID of 30 days was a standard process, that the specialty provider who received the consult request would determine the urgency in which the patient should be seen, "because I don't know what their [specialty care clinic] schedule is."

Consistent with VHA policy, the OIG was told by multiple facility service chiefs that the CID was not based on the specialty clinic availability but rather the need of the patient as determined by the requesting provider.[8] The OIG would have expected that the requesting provider recognize when a patient's condition warrants a more immediate response and translates that into an earlier CID.

Insufficient Pain Management

The OIG also found that the PCP failed to provide effective pain management for the patient as a result of not conducting routine pain assessments or evaluations even when alerted by other providers, and did not document plans of care for pain management.

VHA established a model to provide a systematic approach to pain management in the setting of primary care that requires documentation of all pain management elements, including routine pain screenings, pain assessments, and plans of care for pain management.[9] The facility reinforced these requirements in a local policy, which states all patients must have a pain screening documented in the EHR at every PACT visit.[10]

In an interview with the OIG, the PCP stated that the patient's pain was addressed during PACT follow-ups, contrary to findings of the OIG's review of the EHR from September 2021 to March 2022. Despite multiple Emergency Department visits for complaints of pain, and alerts to the PACT, as well as two in-person PACT appointments with the PCP, the OIG found no documented evidence of pain assessment or evaluation by the PCP for any of the visits.

The OIG would have expected that the PCP routinely assess and address the patient's pain to determine if a referral to pain management was appropriate. The OIG concluded that had the patient been offered effective pain management, it may have prevented multiple Emergency Department visits and the patient's quality of life may have been improved.

[8] VHA Directive 1232(4).

[9] VHA Directive 2009-053, *Pain Management*, October 28, 2009.

[10] Hampton VA Medical Center Memorandum no. 11-18, *Pain Management,* October 2, 2020.

Failure to Conduct Post-Emergency Department Discharge Follow-up

The OIG determined that PACT members failed to conduct post-discharge follow-up after the patient left the Emergency Department, in accordance with VHA and facility policy.

Per VHA policy, when a patient transitions from one healthcare setting to another, including being discharged from an emergency department, the PACT is responsible for ensuring the transfer of care is safe and effective.[11] Further, facility policy states that patients recently discharged from the Emergency Department should be contacted by a PACT member who is then required to document the contact with the patient in the EHR.[12]

The OIG found that the patient was seen five times in the Emergency Department between September 2021 to March 2022, but found no documentation indicating that the patient was contacted by the PACT for a post-Emergency Department discharge follow-up after any of the five visits. A PACT nurse acknowledged that the patient's Emergency Department visit notifications may have been missed, but was not able to recall the circumstances as to why the patient was not contacted by the PACT.

Lack of Daily Huddles

The OIG found that daily huddles did not occur within the patient's PACT as required, which may have negatively impacted communication of important patient issues within the PACT.

VHA policy requires a daily PACT huddle to enhance communication and ensure each member of the PACT is informed of patient issues.[13] The chief of Primary Care told the OIG that the core members of the team are responsible for coordinating care for patients, and are expected to huddle daily. A PCP reported that formal daily huddles did not occur due to patient appointments and staggered work schedules. Instead, the PACT utilized dedicated administrative time for an extended huddle once a week, and issues needing immediate attention were communicated to the providers electronically.

The OIG team determined that in the absence of daily huddles, patient safety and care may be negatively impacted due to possible delays in addressing patient care needs.

Deficiencies in the Facility Oncology Program

The OIG found that, at the time of the inspection, the facility did not have an operational cancer committee, tumor board, or a cancer registrar as required. Since the inspection, however, the

[11] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook,* February 5, 2014, amended May 26, 2017.

[12] Hampton VA Medical Center, *Emergency Department Notifications for Nurse Follow-up, Standard of Work, Primary Care*, October 2020.

[13] VHA Handbook 1101.10(1).

facility has taken action to establish the cancer committee and tumor board, as well as taken steps to fill the facility cancer registrar position.[14]

VHA's Oncology Program policy "seeks to ensure that the delivery of VA cancer care is provided following a national standard of practice," which includes the requirement that each facility have a facility-level cancer committee, tumor board, and cancer registry.[15]

The OIG learned that the facility's cancer committee and tumor board were chartered on July 13, 2022. The Chief of Staff told the OIG that the lack of a cancer committee was due to an "oversight." However, the Facility Director stated that a cancer committee had not been chartered earlier due to a lack of continuity of relevant staff.

The OIG concluded that without an active facility cancer committee and tumor board, the facility was unable to conduct the additional review necessary to assist with the assessment and identification of cancer patients' needs; as a result, there may have been negative impacts on patients' quality of oncological care.

VHA policy requires the use of the VA Cancer Registry System to monitor all cancer diagnosed or treated in VHA. As such, each VA medical facility must identify and report data on patients with a cancer diagnosis.[16] Each Facility Director is responsible for appointing a facility cancer registrar responsible for ensuring the provision of complete, timely, and accurate data of at least 90 percent of cases within six months of first contact with the facility.[17]

In March 2022, the National Program Office for Oncology Director emailed the Facility Director, voicing concern regarding the low number of patients entered into the facility's cancer registry from 2020 to February 13, 2022, and the need to hire a qualified employee in the position of cancer registrar.

The Chief of Staff told the OIG during interviews that the facility was behind in submitting data to the cancer registry due to a vacancy in the cancer registrar position and that a cancer registrar had been hired; at the time of the review, the newly hired registrar had not yet started at the facility.

[14] A cancer committee is a formal, multidisciplinary meeting that occurs to monitor, assess, and identify needs of the facility's oncology program.

[15] VHA Directive 1415, *VHA Oncology Program*, April 9, 2020.

[16] VHA Directive 1412(1), *Department of Veterans Affairs Cancer Registry System*, May 29, 2019, amended April 7, 2020; VHA Directive 1415.

[17] VHA Directive 1412(1).

Delayed Facility Identification of and Response to the Patient's Cancer Care

The OIG found that the facility was unaware of the patient's case until notification of the OIG inspection in late June 2022. However, once notified, facility leaders initiated a review of the staff's delivery of care, including adverse event reporting, root cause analysis (RCA), and completion of a comprehensive institutional disclosure.[18]

The OIG discovered an event in the Joint Patient Safety Reporting system was submitted after the OIG inspection notification and, in response, facility leaders initiated an RCA in early July 2022, to determine the root causes and contributing factors.[19]

The OIG team reviewed the facility's completed RCA and found that, although some of the root causes were consistent with the OIG's findings, the facility failed to identify processes that led to the adverse event. Given the nearly five-month delay in diagnosing the patient's malignancy, the OIG would have expected the RCA team to identify care coordination deficiencies, such as ineffective communication and scheduling delays, as contributing factors to the patient's delay in diagnosis and treatment. A more comprehensive review would have allowed for the identification of knowledge gaps and timely interventions, as well as opportunities for training and education.

VHA policy describes an institutional disclosure as a formal process in which facility leaders and clinical staff inform a patient, or the patient's personal representative, that an adverse event has occurred and "resulted in, or is reasonably expected to result in, death or serious injury." During an institutional disclosure, information about the patient's rights and possible recourse is also shared, including information about potential compensation from the Veterans Benefits Administration and under the Federal Tort Claims Act.[20]

The OIG team found that in July 2022, after notification of the OIG's inspection, facility leaders provided an institutional disclosure to a member of the patient's family. Through review of the facility's institutional disclosure, the OIG discovered that while facility leaders had issued a disclosure, the disclosure did not include documentation of all required elements. Specifically, the OIG found no documented evidence that facility leaders provided the patient's family member the required information about potential compensation.

The OIG concluded that facility leaders failed to communicate a comprehensive institutional disclosure with all required elements. When comprehensive institutional disclosures are not

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

[19] An RCA is a confidential quality assurance process used to identify factors that contributed to an adverse event to improve patient safety.

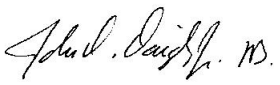
[20] VHA Directive 1004.08.

completed as required, patients and their personal representatives may inadvertently be denied their rights.[21]

The OIG made seven recommendations to the Facility Director related to care coordination within the Patient Aligned Care Team and between the Patient Aligned Care Team and specialty care services, scheduling processes, the facility oncology program, and completeness of the root cause analysis and institutional disclosure.

VA Comments and OIG Response

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



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[21] VHA Directive 1004.08.

Contents

Abbreviations

CT	computed tomography
EHR	electronic health record
OIG	Office of Inspector General
PACT	patient aligned care team
PET	positron emission tomography
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Hampton VA Medical Center (facility) in Virginia to assess allegations related to a delay in diagnosis and treatment of a patient with a newly found lung mass.

Background

The facility, part of Veterans Integrated Service Network (VISN) 6, consists of the main campus located in Hampton, Virginia, and four community-based outpatient clinics. The facility is a 432-bed teaching site that serves six counties in eastern Virginia and nine counties in northeastern North Carolina, with a growing veteran population of 300,000. The care provided by the facility includes primary care, pulmonology, oncology, diagnostic imaging, acute inpatient medicine, a 169-bed domiciliary, and a 112-bed long-term Community Living Center and hospice care unit. As of March 2022, the facility served 62,000 unique patients and is classified as a level 1c, mid-high complexity, facility.[1]

Prior OIG Reports

An OIG report regarding the same facility that published on June 28, 2022, included recommendations related to communication and documentation of abnormal test results, ensuring the review of the appropriateness of required imaging tests on the urology consult template, placement of process and procedures related to nuclear medicine orders, submission of patient safety reports, and the initiation of timely quality management reviews. As of May 24, 2023, seven recommendations remain open.[2]

Allegations and Related Concerns

On May 10, 2022, the OIG received an allegation regarding a delay in diagnosis and treatment of a patient's lung cancer. After review of the patient's electronic health record (EHR), the OIG identified additional concerns related to coordination of care for the identified patient, including insufficient pain management by the Patient Aligned Care Team (PACT); deficiencies in the facility oncology program; and inadequate facility review and response to patient's cancer care. The OIG initiated a healthcare inspection to evaluate the allegation and additional concerns.

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[1] VHA Office of Productivity, Efficiency, and Staffing. 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 1c facility has "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs."; The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] VA OIG, *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia*, Report No. 21-03349-186, June 28, 2022.

Scope and Methodology

The OIG initiated the inspection on June 10, 2022, and conducted a virtual site visit July 25–28, 2022.[3]

The OIG team interviewed the complainant, and facility leaders, managers, and staff familiar with the patient's care.[4] Further, the OIG team interviewed the VISN 6 Chief Medical Officer and a National Oncology Program staff member.

The OIG reviewed the identified patient's EHR entries dated from August 2000 through July 2022, as well as pertinent Veterans Health Administration (VHA) and facility policies and procedures related to care coordination, service agreements, and other related documents.

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. §§ 401–24. 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.

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[3] OIG interviews were conducted virtually using online meetings due to the COVID-19 pandemic. World Health Organization, *WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020,* accessed June 6, 2023, https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020; *Merriam-Webster.com Dictionary,* "pandemic," accessed June 14, 2023, https://www.merriam-webster.com/dictionary/pandemic. A pandemic is a disease outbreak over a wide geographic area that affects most of the population.

[4] Facility leaders interviewed included the Facility Director; Chief of Staff; Deputy Chief of Staff; and department chiefs for the Emergency Department, Medicine, Primary Care, Radiology, Quality, and Health Administration Services. Facility staff interviewed included a pulmonologist, a hematologist oncologist, and the group practice manager.

Patient Case Summary

The patient, in their 60s, received care at the facility for more than 15 years. The patient's primary care provider (PCP) began caring for the patient in 2016. The patient's medical history includes hypertension, joint pain, hyperlipidemia, hepatitis C, diabetes, and tobacco use. The patient received smoking cessation counseling from the PCP.[5]

In the fall of 2021, the patient presented to the facility's Emergency Department (day 0) complaining of new chest wall pain that increased with movement and palpation, but did not have associated shortness of breath.[6] During the visit, a chest x-ray demonstrated a new right upper lobe mass. A computerized tomography (CT) scan of the chest, which was also completed during that visit, demonstrated a mass in the right upper lobe "worrisome for malignancy" and adenopathy. An Emergency Department physician spoke to an on-call pulmonologist; the pulmonologist advised the patient to follow up with their PCP for an outpatient positron emission tomography (PET) scan, as well as a referral to the pulmonology service. The Emergency Department physician discharged the patient home with instructions for the patient to follow up with their PCP by phone as soon as possible regarding the PET scan referral and pulmonology consult for a possible lung biopsy.

Five days after the Emergency Department visit (day 5), the patient called their PCP to discuss the Emergency Department visit and possible lung cancer. That same day, the PCP placed a routine order for outpatient pulmonary function tests with a clinically indicated date (CID) of 30 days from the request. The patient completed the pulmonary function tests two weeks later, which demonstrated results similar to previous pulmonary function tests.

Five days after the patient contacted their PCP (day 10), a PET scan request was referred to community care due to the facility being unable to schedule the patient.[7] The PET scan was completed 54 days after the patient contacted the PCP (day 59), and demonstrated a right upper lobe lung mass concerning for malignancy. In addition, the PET scan indicated a possible spread of cancer to the chest lymph nodes and the sacrum, as well as other bone lesions. Sixteen days after the PET scan was completed (day 75), the PCP documented a follow-up phone appointment with the patient and ordered a magnetic resonance image to evaluate the abnormal findings noted on the PET scan.

[5] There was no documentation of discussion regarding, nor orders for, low-dose lung CT screening for lung cancer. When asked in an interview by the OIG, the PCP could not recall ordering a low-dose lung CT.

[6] Upon review of the EHR, the OIG found that from September 2021 to March 2022, the patient had a total of five Emergency Department visits with a chief complaint of pain, and was admitted to the hospital following the last Emergency Department visit in March.

[7] The patient agreed to having the PET scan completed in the community as the facility was "unable to schedule within VA guidelines."

In addition, the PCP had ordered a pulmonary consultation 14 days after being contacted by the patient (day 19). That appointment was scheduled for 44 days after the patient contacted the PCP (day 49); however, the patient missed the appointment due to being at the wrong clinic. The pulmonary appointment was rescheduled for 21 days later. This appointment was canceled by the clinic and the patient was rescheduled for another appointment seven days later (day 77).

The patient ultimately saw the pulmonologist 72 days after the patient had contacted the PCP in September (day 77). The pulmonologist suspected lung cancer with metastasis and discussed obtaining a biopsy with a facility radiologist. A CT scan of the abdomen and pelvis was ordered by the pulmonologist to evaluate possible biopsy sites; the CT scan was completed one week later (day 84). In addition to enlarging pulmonary nodules, the CT scan revealed multiple bone lesions worrisome for metastasis in the vertebral bodies and the pubic bone, as well as a large destructive bone lesion in the sacrum and surrounding soft tissue masses. After consulting with a radiologist, the pulmonologist ordered a deep bone biopsy of the sacral lesion.

Twenty-five days after the bone biopsy was ordered, a pulmonary clinic nurse contacted the patient to inform the patient that the Radiology Department had been trying to reach them to schedule the bone biopsy. The next day, the radiology nurse contacted the patient by phone to provide education for the bone biopsy procedure. One week later, the CT technologist sent the patient a letter with the appointment information including date, time for the biopsy, and instructions for the biopsy. The bone biopsy procedure was initially scheduled for early February (day 131), 47 days after the order was written but was twice rescheduled by the facility to mid-February, 60 days after the initial biopsy order (day 144).

A sacral biopsy was performed 60 days after the initial order was placed by the pulmonologist (day 144). Three days after the procedure, a member of the patient's family called the nurse triage line regarding the patient's complaint of pain at the biopsy site.[1] The PACT nurse and the PCP acknowledged receipt of the note five days later.[1] The biopsy result, finalized seven days after the biopsy (day 151), was consistent with metastatic disease from a primary adenocarcinoma lung cancer. The PCP requested an oncology consult for metastatic lung cancer the following day.

During this period of diagnostic evaluations, the patient presented to the Emergency Department on three occasions in January and February 2022 complaining of pain. During each encounter, Emergency Department providers treated the patient's pain and recommended follow-up with the PCP for pain management. Eight days after the third Emergency Department visit for pain, the PCP evaluated the patient for the complaint of lung cancer with metastasis to the bone. The PCP documented "patient is doing well and does not report any new health issues." The PCP renewed pain medications that had been ordered by an Emergency Department provider. Additionally, the PCP counseled the patient to exercise in moderation as tolerated and ordered a kinesiotherapy consult for low back pain.

On the day of the bone biopsy, the radiology procedure nurse documented the patient complained of pain not relieved by the prescribed medications. The nurse alerted the PACT through the EHR to contact the patient to assist with pain management. The PACT nurse acknowledged the note three days later and the PCP acknowledged the note nineteen days later.[1]

The patient saw the hematology oncologist (oncologist) for the first time in early March (day 160). The oncologist requested a community care radiation therapy consult for the treatment of lung cancer and for pain control related to the erosive sacral bone metastasis. A PET scan and CT scan of the chest and brain were also requested. In addition, chemotherapy was to be initiated after the PET scan. The oncologist explained the treatment plan to the patient and the patient's spouse. Three days later (day 163), the patient presented to the Emergency Department complaining of shortness of breath, chest pain, and total body pain not controlled by previously prescribed medications. The patient was admitted to the hospital for pain control and treatment of a pulmonary embolus.

The second day in the hospital (day 164), the hospitalist requested a pharmacy consult for assistance with medication for severe metastatic cancer pain. A clinical pharmacy specialist provided consultation on the third day of the hospital stay (day165) and recommended a fentanyl patch for the severe bone pain and need for continuous pain control. Additional medication for breakthrough pain not controlled by the patch was also ordered. On the same day, a CT scan of the brain was completed and demonstrated multiple brain masses consistent with metastatic disease. By the fourth hospital day (day 166), the hospitalist spoke to the patient and spouse regarding goals of care and the patient requested a do not resuscitate, do not intubate (DNR/DNI) status. On the same day, the patient was transferred to a community hospital for whole brain radiation therapy to treat the brain metastases. The patient was discharged home from the community care hospital with hospice care and died at home in late March 2022 (day 185).

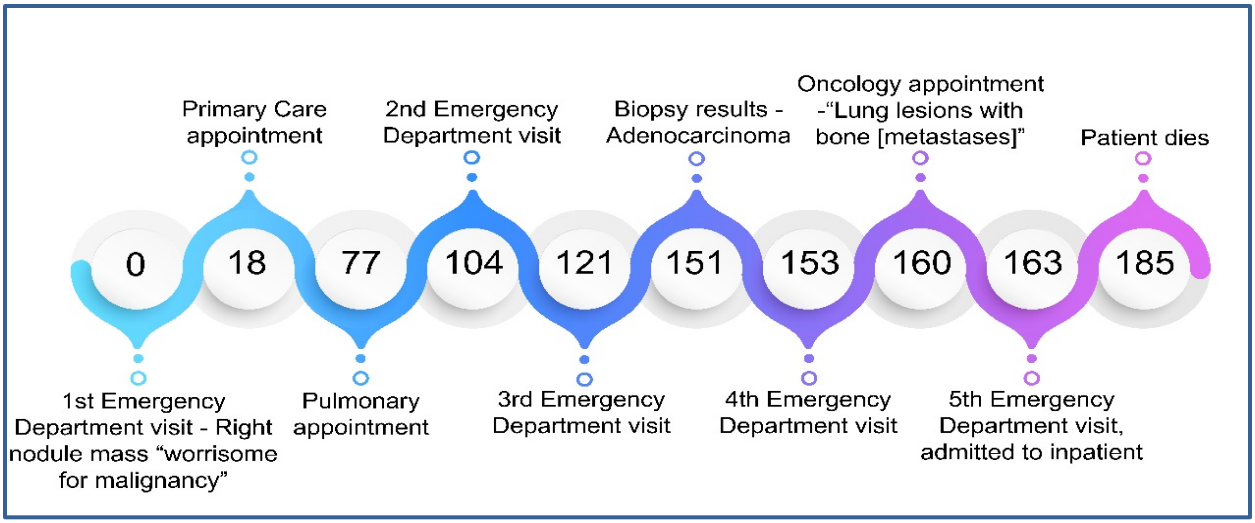

***Figure 1**. Timeline of days elapsed from the first Emergency Department visit to the patient's death.*
Source: The OIG's review of the patient's EHR.

Inspection Results

1. Delay in Diagnosis and Treatment

The OIG substantiated that the patient experienced a delay in diagnosis and treatment for the new lung mass that was highly suspicious for cancer. The OIG identified deficiencies in effective and timely coordination of care by the facility specialty care services and PACT that contributed to the delay in diagnosis and treatment. Specific coordination of care issues included communication and scheduling deficiencies amongst services, as well as deficiencies in PACT processes.

Communication and Scheduling Deficiencies

The OIG identified deficiencies in primary and specialty care services to provide prompt scheduling and access to care that might have resulted in an earlier diagnosis. VHA recognizes that access and timeliness are critical components in providing high quality customer service.[8] In this effort, it is essential that care coordination includes open and effective communication with all involved health care providers to ensure there is no lapse in patient care.[9]

VHA established a standardized consult management process to ensure timely completion of clinical consults.[10] A clinical consult is used as a "two-way communication" tool between providers, via the EHR, for patient evaluations and management of issues.[11] Providers of primary care and specialty care are expected to use "bidirectional communications" in the coordination of care for patients to ensure continuity of care.[12] VHA policy states that when a consult is placed, it is the responsibility of the requesting provider to determine the soonest appropriate date the patient should be seen based upon the clinical needs of the patient (also called the CID).[13] In addition, patient appointments are to be scheduled timely, accurately, and no more than 30 days from the CID.[14]

While there is no prescribed timeline for the investigation and treatment of a highly suspicious mass, the OIG would have expected that, given the age of the patient, who also had a history of smoking, the development of a lung mass would warrant prompt and thorough evaluation.

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[8] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook,* February 5, 2014, amended May 26, 2017.

[9] VHA Handbook 1101.10(1).

[10] VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021.

[11] VHA Directive 1232(4).

[12] VHA Handbook 1101.10(1).

[13] VHA Directive 1232(4).

[14] VHA Directive 1230(3), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 7, 2021.

Primary Care and Pulmonary Care

In the course of the patient's care, the PCP ordered a pulmonary consultation 14 days after being contacted by the patient (day 19). The consult was reviewed by the pulmonologist six days after submission by the PCP. The patient was scheduled for an appointment 30 days after the consult request (day 49); however, the patient missed this appointment due to presenting to the wrong clinic.[15] The pulmonary appointment was rescheduled for 21 days later. This appointment was canceled by the clinic and the patient was rescheduled for another appointment seven days later (day 77).[16] In total, 72 days elapsed between the patient contacting the PCP after the first Emergency Department visit and completing the pulmonology appointment.

The OIG learned during an interview with the PCP, that other than submitting the pulmonary consult, the PCP had no contact or communication with the pulmonologist or anyone in the Pulmonary Service regarding the patient's case. In addition, the PCP stated that after submitting the pulmonary consult, the next steps, such as determining the urgency of case and other tests to be completed, would be decided by the pulmonologist as the specialist.

The pulmonologist told the OIG that contacting primary care was usually not part of the pulmonary practice, and communication with primary care would generally occur if there was a specific question from primary care for the pulmonologist. The pulmonologist also reported considering the consult a "high-risk" case as it relates to the urgency of when the patient should be seen; however, the patient's appointment with the pulmonologist was 58 days after the PCP requested the consult (day 77). During interviews, the Chief of Staff described the delay as "highly unacceptable."

Although the appointment scheduling in this case met basic requirements, there was an expectation from facility leaders that this case would have been handled more quickly. Based on the high-risk nature of the patient's case, the OIG would have expected the Primary Care and Pulmonary Services to ensure the patient was scheduled for the requested pulmonary appointment in an efficient and timely manner. The OIG determined the delays in scheduling may have contributed to the delay in diagnosis of the patient's lung cancer.

Of note, VHA policy encourages the development of care coordination agreements between Primary Care and Specialty Care Services to ensure clinical care and treatment plans are consistent, warranted, and promote effective patient care.[17] The service chiefs from all involved services sign the care coordination agreement.[18] The facility did not have an active and signed care coordination agreement between the Primary Care and the Pulmonary Services during the

[15] Facility documentation did not provide a clear reason for the patient's presentation to the wrong clinic location.
[16] The pulmonologist was unable to provide a reason to the OIG for the final rescheduling of the appointment.
[17] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook,* February 5, 2014, amended May 26, 2017.
[18] VHA Directive 1232(4).

time of the patient's care. The OIG concluded that the establishment and use of a care coordination agreement may have been of benefit in the patient's care.

Radiology Care

The OIG substantiated that the patient was not scheduled or seen for a diagnostic imaging procedure timely, which contributed to the delay in diagnosis and treatment of the patient's cancer. Facility guidance states the first attempt to schedule a patient for a diagnostic imaging appointment should be made within three calendar days of receiving the order, and routine radiology exams should be completed within 30 days of the CID.[19] The facility defers to the ordering provider to define CID for diagnostic imaging based on the healthcare needs of the patient as determined by the ordering provider. This approach is consistent with VHA policy.[20]

Although the pulmonologist considered this a "high-risk" case, the pulmonologist failed to translate that urgency into the order for the CT guided deep bone biopsy, and submitted a routine order.[21] Nineteen days after the pulmonologist entered the order (day 103), a radiology technologist called the patient to schedule the procedure.[22] The radiology technologist documented that the patient was called, and a letter was mailed with instructions to contact the Radiology Department within the next three weeks, to schedule the biopsy. The radiology technologist's actions of calling the patient for an appointment and mailing a letter to the patient with instructions met the minimum VHA requirement for attempts at scheduling. However, the scheduling attempts failed to meet facility expectations requiring that the first attempt to schedule the patient should be made within three calendar days of receiving the order, and routine radiology exams should be completed within 30 days of the CID.[23]

The OIG also found that a pulmonary nurse notified the patient on day 109 that radiology staff had attempted to contact the patient to schedule the biopsy. The pulmonary nurse documented that the patient reported not receiving notification from radiology, but that the patient would contact radiology to schedule the procedure. According to the EHR, another radiology technologist contacted the patient and informed the patient that the biopsy was scheduled for day 131, and a reminder letter was documented in the EHR as mailed to the patient. Later that afternoon, the patient was contacted again by the radiology technologist, and the procedure was

[19] Hampton VA Medical Center Diagnostic Imaging Service Standard Operating Procedure, *Department Scheduling*, February 2, 2021.

[20] VHA Directive 1232(4).

[21] Hampton VA Medical Center Diagnostic Imaging Service Standard Operating Procedure, *Department Scheduling*, February 2, 2021. Policy allows the choice of one of two order urgencies, routine and stat. A routine order is to be used by the referring provider when the patient should be seen as indicated in the CID. A stat order is to be used by the referring provider when the patient has an immediate need to be seen.

[22] This radiology technologist retired from the facility. As a result, the OIG did not interview this technologist.

[23] Hampton VA Medical Center Diagnostic Imaging Service Standard Operating Procedure, *Department Scheduling*, February 2, 2021; VHA Directive 1230(3).

rescheduled for two weeks later. One day before the scheduled procedure, the radiology technologist contacted the patient and rescheduled the procedure for seven days later (day 144). The chief of Radiology told the OIG during an interview that the multiple rescheduled appointments were due to scheduling errors because the radiologist capable of performing the biopsy was not available.

In the end, the OIG found that the CT guided deep bone biopsy was completed 60 days after the pulmonologist ordered the procedure (day 144). The specimens were sent to a non-VA laboratory and, seven days later, the non-VA laboratory reported the result of metastatic disease from a primary adenocarcinoma lung cancer to the facility (day 151). In total, 67 days elapsed between the time the CT guided deep bone biopsy order was placed, and the diagnosis was determined. The OIG would have expected a shorter time frame due to the high suspicion for cancer. In an interview with the OIG, when asked about the delay in scheduling the patient, the chief of Radiology stated, "no clear rationale as to why that happened."

The OIG determined that the combination of multiple scheduling delays contributed to the facility's failure to diagnose the patient's lung cancer timely. Additionally, the OIG determined that the decisions made regarding the patient's care, including the timing of the appointments and the initial biopsy, suggested a lack of urgency, despite the patient's multiple symptoms and worrisome imaging results.

Patient Aligned Care Team Deficiencies

Two of VHA's essential components in providing high quality customer service are access and timeliness. VHA established the PACT team-based model to deliver primary care based on principles that include coordination of care, access to care, and patient-centered care. PACT members are expected to apply these principles to ensure patients receive care that is prompt and appropriate.[24]

In the course of the inspection, the OIG identified deficiencies within four PACT processes, which likely impacted the quality of care provided and contributed to the delay in cancer treatment of the patient. The deficient processes included

- failure to conduct post-Emergency Department discharge follow-up,
- lack of daily huddles,
- improper determination of CID, and
- insufficient pain management.

[24] VHA Handbook 1101.10(1).

Failure to Conduct Post-Emergency Department Discharge Follow-up

The OIG determined that PACT members failed to conduct post-discharge follow-up after the patient left the Emergency Department. Specifically, the OIG determined that the patient was seen five times in the Emergency Department but was not contacted by the PACT in accordance with VHA policy.

Per VHA, when a patient transitions from one healthcare setting to another, the PACT is responsible for ensuring the transfer of care is safe and effective. VHA considers a patient being discharged from an emergency department a transition of care.[25] Furthermore, facility policy states that recently discharged patients from the Emergency Department should be contacted by a PACT member to ensure timely follow-up. The PACT member is then required to document the contact with the patient in the EHR using a standard note template titled "Outpatient Nurse Emergency Care Follow Up Note."[26]

The chief of Primary Care told the OIG during an interview that the PACT is expected to make contact with the patient within two business days of the Emergency Department discharge. A PACT nurse also reported in an interview with the OIG that the post-Emergency Department discharge process requires the PACT to run the emergency department discharge report to identify patients who have recently been discharged. The PACT nurse further stated that the discharge report is to be reviewed on Tuesdays and Thursdays of every week.[27]

Upon review of the EHR, the OIG found that the patient had a total of five Emergency Department visits with a chief complaint of pain from September 2021 to March 2022, and was admitted to the hospital following the last Emergency Department visit in March. The patient called the PACT following the September 2021 Emergency Department visit (September 29, 2021) to notify the PCP that during the Emergency Department visit, staff found a lung nodule "that appears to be cancerous." However, the OIG did not find documented evidence in the patient's EHR that the PACT contacted the patient for a post-Emergency Department discharge follow-up after any of the Emergency Department visits between September 2021 to March 2022. A PACT nurse acknowledged that the patient may have been missed, but was not able to recall the circumstances as to why the patient was not contacted by the PACT.

Lack of Daily Huddles

To enhance communication among members of a PACT, a daily huddle is required to ensure each member of the PACT is informed of patient issues. Additionally, a team huddle allows for

[25] VHA Handbook 1101.10(1).

[26] Hampton VA Medical Center, *Emergency Department Notifications for Nurse Follow-up, Standard of Work, Primary Care*, October 2020.

[27] Hampton VA Medical Center, *Emergency Department Notifications for Nurse Follow-up, Standard of Work, Primary Care*, October 2020.

proactive case management of patient care.[28] During the course of the review, the OIG found that daily huddles did not occur within the patient's PACT team as required, which may have negatively impacted communication of important patient issues within the PACT.

Through interviews with facility PACT staff, the OIG learned that a PACT consists of four core members: a primary care provider, registered nurse care manager, licensed practical nurse, and medical support assistant. The chief of Primary Care told the OIG that the core members of the team are responsible for coordinating care for patients, and are expected to huddle daily. A PCP also acknowledged that the PACT should huddle for at least 15 minutes daily; however, the PCP reported that formal daily huddles do not occur due to patient appointments and staggered work schedules. Instead, the PACT utilizes dedicated administrative time for an extended huddle, which occurs once a week. Additionally, the PCP and a PACT nurse told the OIG that issues needing immediate attention were communicated to the providers electronically.

Daily huddles, when conducted in accordance with VHA policy, provide consistent and timely communication. The OIG team determined that in the absence of daily huddles, patient safety and care may be negatively impacted due to possible delays in addressing patient care needs.

Improper Determination of Clinically Indicated Dates

VHA policy states that the CID must be included in consult requests and the requesting provider determines the CID, the date deemed clinically appropriate to render care.[29]

The OIG reviewed consults placed by the PCP for the patient from September 2021 to March 2022, and found a range of CIDs of between 27 and 33 days documented for diagnostic consults, including the referral to the Pulmonary Service. In an interview with the OIG, the PCP stated that entering a CID of 30 days was a standard process; the PCP relayed that this had been presented through training, and reinforced by "admin." Additionally, the PCP reported that the specialty provider who received the consult request would determine the urgency in which the patient should be seen in the specialty care clinic, and stated that is "because I don't know what their [specialty care clinic] schedule is." However, the OIG did not find support for standardly entering 30 days, but instead was told by multiple facility service chiefs that the CID was not based on the specialty clinic availability but rather the need of the patient as determined by the requesting provider. Although 30 days may be the standard for a routine consult order, the OIG would have expected that the requesting provider have awareness of when a patient's condition warrants a more immediate response and request an earlier CID.[30]

[28] VHA Handbook 1101.10(1).
[29] VHA Directive 1232(4).
[30] VHA Directive 1230(3).

Insufficient Pain Management

The OIG determined that the patient was not assessed for pain nor provided effective pain management when seen by the PACT. Specifically, the OIG identified deficiencies in pain screening and evaluations for the patient upon the finding of a new lung mass.

In 1998, effective pain management became a VHA national priority with an overall objective to improve patients' quality of life. VHA established a model to provide a systematic approach to pain management in a primary care setting.[31] VHA policy states, "The overall objective of the national strategy is to develop a comprehensive, multicultural, integrated, system-wide approach to pain management that reduces pain and suffering and improves quality of life for Veterans experiencing acute and chronic pain associated with a wide range of injuries and illnesses, including terminal illness."[32] Further, VHA requires documentation of all pain management elements, including routine pain screenings, pain assessments, and plans of care for pain management.[33] The facility reinforced these requirements in a local policy, which states all patients must have a pain screening documented in the EHR at every PACT visit.[34]

The OIG found that the patient presented to the Emergency Department on three occasions in January and February 2022 complaining of pain. Emergency Department providers provided treatment for pain and recommended the patient follow up with the PCP for pain management. Additionally, on the day of the bone biopsy (mid-February 2022), the radiology procedure nurse documented the patient complained of pain not relieved by the prescribed medications and alerted the PACT to contact the patient to assist with pain management. Further, a member of the patient's family called the nurse triage line for the patient's complaint of pain at the biopsy site three days after the procedure.[35]

In an interview with the OIG, the PCP stated that the patient's pain was addressed during PACT follow-ups, contrary to documentation found in the EHR during the OIG's review. Despite multiple Emergency Department visits and alerts to the PACT, as well as two in-person PACT appointments with the PCP, the OIG found no documented evidence of pain assessment or evaluation by the PCP for any of the visits. Furthermore, the PCP acknowledged in an interview with the OIG that consulting specialty care services for pain management is an option; however, pain treatment is still ultimately the responsibility of the PACT.

The OIG found that the PCP failed to provide effective pain management as a result of not responding timely to alerts of the patient's pain from other providers or conducting routine pain

[31] VHA Directive 2009-053, *Pain Management*, October 28, 2009.

[32] VHA Directive 2009-053.

[33] VHA Directive 2009-053.

[34] Hampton VA Medical Center Memorandum no. 11-18, *Pain Management,* October 2, 2020.

[35] The PACT team nurse and the PCP acknowledged the receipt of the note five days later.

assessments, pain evaluations, or plans of care for pain management. The OIG would have expected that the PCP would have routinely assessed and addressed the patient's pain to determine if a referral to pain management was appropriate. The OIG concluded that had the patient been offered effective pain management, it may have prevented multiple Emergency Department visits and the patient's quality of life may have been improved.

2. Deficiencies in the Facility Oncology Program

During the inspection, the OIG identified additional concerns regarding the facility's oncology program compliance with VHA policy requirements. VHA's Oncology Program policy "seeks to ensure that the delivery of VA cancer care is provided following a national standard of practice," which includes the requirement that each facility has a facility-level cancer committee, tumor board, and cancer registry.[36]

As of early April 2020, cancer was the second leading cause of death among veterans and was projected to become the leading overall cause of death in this decade.[37] A diagnosis of cancer imposes a significant emotional burden on both patients and families.[38] Having a coordinated, comprehensive program ensures specialists from different medical disciplines collaborate to plan, evaluate, and deliver cancer treatment for the patients.[39]

Lack of a Cancer Committee and Tumor Board

The OIG determined that the facility did not have a cancer committee or tumor board during the period of the OIG review. VHA policy requires each facility have a cancer committee, which is a formal, multidisciplinary meeting that occurs to monitor, assess, and identify needs of the facility's oncology program.[40] Additionally, VHA policy requires tumor board conferences to take place at each facility.[41] Tumor board conferences are a forum to discuss "diagnosis, staging, and management" for patients with cancer; although, ultimately, the oncologist determines the individual treatment plan with the patient.[42]

The OIG learned through document review that the facility's cancer committee and tumor board were chartered on July 13, 2022. The Chief of Staff told the OIG that the lack of a cancer committee was due to an "oversight." However, the Facility Director stated that a cancer committee had not been chartered earlier due to a lack of continuity of relevant staff.

[36] VHA Directive 1415, *VHA Oncology Program*, April 9, 2020.
[37] VHA Directive 1415.
[38] VHA Directive 1415.
[39] VHA Directive 1415.
[40] VHA Directive 1415.
[41] VHA Directive 1415.
[42] VHA Directive 1415.

The OIG concluded that without an active facility cancer committee and tumor board, the facility was unable to conduct the additional review necessary to assist with the assessment and identification of cancer patients' needs; as a result, there may have been negative impacts on patients' quality of oncological care.

Lack of a Facility Cancer Registrar

VHA policy requires the use of the VA Cancer Registry System to monitor all cancer diagnosed or treated in VHA. As such, each VA medical facility must identify and report data on patients with a cancer diagnosis.[43] This data includes patient demographics, cancer identification, staging, treatment, recurrence, and subsequent treatments, which are used by the Office of the National Program Director for Oncology to assess the VA's oncology program and strengthen oncology care. [44] This data and its reporting to the State Cancer Registries assists to facilitate a complete understanding of the national cancer burden and associated mortality.[45] Each facility director is responsible for appointing a facility cancer registrar responsible for ensuring the provision of complete, timely, and accurate data of at least 90 percent of cases within six months of a patient's first contact with a facility.[46]

On March 1, 2022, the Director of the National Program Office for Oncology emailed the Facility Director voicing concern regarding the low number of patients entered into the facility's cancer registry from 2020 to February 2022, and the need to hire a qualified employee in the position of cancer registrar. The Director of the National Program Office for Oncology estimated, "Hampton likely has 250 – 300 patients to report annually." Through the course of the review, the OIG became aware of these communications and reviewed the data included in the email, which showed only 52 patients had been registered from 2020 to February 2022.

The Chief of Staff told the OIG during interviews that the facility was behind in submitting data to the cancer registry due to a vacancy in the cancer registrar position. The Chief of Staff told the OIG that a cancer registrar had been hired, but at the time of the review, they had not yet started at the facility.

The OIG found that, at the time of the inspection, the facility did not have an operational cancer committee or tumor board, or a cancer registrar as required; however, since the inspection, the facility has taken action to establish the cancer committee and tumor board, as well as taken steps to fill the facility cancer registrar position.

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[43] VHA Directive 1412(1), *Department of Veterans Affairs Cancer Registry System*, May 29, 2019, amended April 7, 2020; VHA Directive 1415.

[44] VHA Directive 1415; VHA Directive 1412(1).

[49] VHA Directive 1412(1).

[46] VHA Directive 1412(1).

3. Delayed Facility Identification of and Response to the Patient's Cancer Care

The OIG found that the facility was unaware of the patient's case until notification of the OIG inspection in late June 2022. However, once notified, the facility leaders initiated a review of the staff's delivery of care, including adverse event reporting, RCA, and completion of an institutional disclosure. [47]

Adverse Event Reporting and Root Cause Analysis

VHA policy requires staff to identify and report adverse events, such as a diagnosis not made timely, to the patient safety manager through an electronic reporting system.[48] Any staff member can enter an event in the Joint Patient Safety Reporting system. The patient safety manager facilitates a review of the adverse event and determines appropriate next steps, such as conducting a root cause analysis (RCA).[49] An RCA is a confidential quality assurance process used to identify factors that contributed to an adverse event to improve patient safety.[50]

During the course of the inspection, the OIG discovered a Joint Patient Safety Report was submitted after the OIG notified the facility of the OIG's inspection. In response, facility leaders initiated an RCA in early July 2022, which was signed by the Facility Director four days later, to determine the root causes and contributing factors. The RCA process typically includes interviewing facility staff, evaluating the patient's care, and reviewing relevant documents. The RCA team then normally develops a Final Understanding of Events and identified action plans to address the identified system and process issues. The Deputy Chief of Staff, who was the acting Facility Director, signed the RCA in August 2022.

The OIG team reviewed the facility's completed RCA and found that, although some of the identified root causes were consistent with the OIG's findings, the facility review failed to identify processes that led to the adverse event. Given the nearly five-month delay in diagnosing the patient's malignancy, the OIG would have expected the RCA team to identify care coordination deficiencies, such as ineffective communication and scheduling delays, as

[47] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. "Institutional disclosure of adverse events, sometimes referred to as administrative disclosure, is a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

[48] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. Adverse events may occur due to acts of commission or omission (such as provision of the wrong medication, failure to complete a timely diagnosis or begin the appropriate therapeutic intervention, and negative outcomes of treatment).

[49] Hampton VA Medical Center Memorandum no. 11-28, *Patient Safety Improvement Program,* April 30, 2020.

[50] VHA Handbook 1050.01. An RCA is protected as a quality management and safety activity under Title 38 U.S.C. § 5705 per VHA Directive 1320, *Quality Management and Patient Safety Activities That Can Generate Confidential Records and Documents* (July 10, 2020).

contributing factors to the patient's delay in diagnosis and treatment, pain control, and ultimately, quality of life. A more comprehensive review would have allowed for the identification of knowledge gaps and timely interventions, as well as opportunities for training and education.

Institutional Disclosure

VHA policy describes an institutional disclosure as a formal process in which facility leaders and clinical staff inform a patient, or the patient's personal representative, that an adverse event has occurred and "resulted in, or is reasonably expected to result in, death or serious injury." Information about the patient's rights and possible recourse is also shared. Further, VHA policy states an institutional disclosure is required regardless of when the event was discovered. In addition, VHA policy requires an institutional disclosure include information about potential compensation from the Veterans Benefits Administration and under the Federal Tort Claims Act.[51]

The OIG team found that in July 2022, after notification of the OIG's inspection, facility leaders provided an institutional disclosure to a member of the patient's family. Through review of the facility institutional disclosure, the OIG discovered that while facility leaders had issued a disclosure, the disclosure did not include documentation of all required elements. Specifically, the OIG found no documented evidence that facility leaders provided the patient's family member the required information about potential compensation. When asked by the OIG, facility leaders reported that the information about potential compensation was not provided because the family member did not ask about it.

The OIG concluded that facility leaders failed to communicate a comprehensive institutional disclosure with all required elements. When comprehensive institutional disclosures are not completed, as required, patients and their personal representatives may inadvertently be denied their rights.[52]

Conclusion

The OIG substantiated that the patient experienced a delay in diagnosis and treatment for a new lung mass that was highly suspicious for cancer. The OIG determined that multiple care coordination deficiencies, including scheduling delays, ineffective communication, and insufficient pain management, led to a delay in diagnosis and treatment.

The OIG determined the facility did not have an operational cancer committee, tumor board, or a cancer registrar, as required, at the time of the inspection. The lack of administrative oversight,

[51] VHA Directive 1004.08.
[52] VHA Directive 1004.08.

programmatic development, and review of cancer care and related services directly impacts the quality of cancer care delivered to patients. The registry data plays a critical role in cancer surveillance. This information is vital to VHA's abilities to plan and evaluate cancer prevention and control interventions. The lack of these processes did not necessarily contribute to the patient's death, but may impact the quality of oncology services provided to patients at the facility.

The OIG determined that the facility was unaware of the patient's case until notification of the OIG inspection in late June 2022; at that time, a Joint Patient Safety Report was submitted. Although an RCA was conducted, the facility failed to identify care coordination deficiencies, such as ineffective communication and scheduling delays, as contributing factors to the patient's death. An institutional disclosure was also conducted, but lacked documented evidence that facility leaders provided the patient's family member the required information about potential compensation.

Recommendations 1–7

1. The Hampton VA Medical Center Director assesses the current use of care coordination agreements between the Patient Aligned Care Team and specialty care services, and determines if there would be benefit in developing agreements where they do not currently exist.

2. The Hampton VA Medical Center Director, in conjunction with the Radiology Department chief, reviews the Radiology Department standard operating procedures and scheduling processes, identifies deficiencies, and ensures compliance with Veterans Health Administration policies.

3. The Hampton VA Medical Center Director, in conjunction with the Primary Care Service chief, reviews the Patient Aligned Care Team processes, identifies deficiencies, and ensures compliance with Veterans Health Administration Patient Aligned Care Team requirements, including scheduling huddles, follow-up of Emergency Department patient discharges, and communication with and coordination of specialty care.

4. The Hampton VA Medical Center Director, in conjunction with the Primary Care Service chief, reviews the Patient Aligned Care Team pain management and referral processes, identifies deficiencies, and takes action as warranted.

5. The Hampton VA Medical Center Director, in consultation with a subject matter expert from the National Program Office for Oncology, reviews the facility cancer registry program, identifies deficiencies, and ensures compliance with Veterans Health Administration requirements, including the need for a qualified cancer registrar and entry of all cancer cases in the registry.

6. The Hampton VA Medical Center Director reviews the completed root cause analysis in order to ensure its completeness, and take action if warranted.

7. The Hampton VA Medical Center Director reviews the institutional disclosure made to the patient's family and completes any required items not addressed, including providing the patient's family with information about potential compensation from the Veterans Benefits Administration and under the Federal Tort Claims Act.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 5, 2023

From: VA Mid-Atlantic Health Care Network Director, VISN 6 (15N6)

Subj: Healthcare Inspection—Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia

To: Director, Office of Healthcare Inspections (54HL02)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I appreciate the opportunity to review the draft report: Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia.
2. I would like to thank the OIG Inspection team for a thorough review that identified improvement opportunities.
3. I have reviewed the OIG recommendations, facility response and action plans and am committed to supporting process improvement and sustainment at the Hampton VA Medical Center and throughout VISN 6.

(*Original signed by*:)

Jonathan S. Benoit
Deputy Network Director
for
Paul S. Crews, MPH, FACHE
Director, Mid-Atlantic Health Care Network

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 5, 2023

From: Director, Hampton VA Medical Center

Subj: Healthcare Inspection—Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia

To: Network Director, Veterans Integrated Service Network 6 (VISN 6)

1. We are deeply saddened by the loss of this patient at the Hampton VA Health Care System, and we empathize regarding the impact this has had on the Veteran's family and the staff within the health care system who are very passionate about the care they provide Veterans.

2. Thank you for the opportunity to review and respond to draft report, Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia. I have reviewed the draft report and concur with the recommendations. The findings outlined in the Office of Inspector General report reflect a thorough evaluation.

3. If you have any questions regarding the information provided, please contact the Chief, Quality & Patient Safety.

(*Original signed by*:)

Taquisa K Simmons, Ph.D., LCSW
Director, Hampton VA Medical Center

Facility Director Response

Recommendation 1

The Hampton VA Medical Center Director assesses the current use of care coordination agreements between the Patient Aligned Care Team and specialty care services, and determines if there would be benefit in developing agreements where they do not currently exist.

_X _Concur

____Nonconcur

Target date for completion: September 2023

Director Comments

The Interim Chief, Primary Care Services and the Chief, Medicine reviewed the service agreements between Primary Care/Community Based Outpatient Clinics (PC/CBOC) and subspecialty services. From that review, service agreements were developed for the following specialties (Pulmonology, Cardiology, Hematology/Oncology, Nephrology, Emergency Department, Infectious Disease, Endocrinology, and Neurology). As of July 19, 2023, service agreements are also being reviewed for Gastroenterology. To ensure providers are knowledgeable and able to access these service agreements, all providers will sign an Attestation Memo indicating they have reviewed all the above service agreements and are able to access the service agreements located on the department's SharePoint by August 31, 2023. Attestation compliance will be monitored by the Interim Chief, Primary Care and the Chief, Medicine Services and reported to the Chief of Staff as an agenda item at the Medical Executive Council.

OIG Comments

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

Recommendation 2

The Hampton VA Medical Center Director, in conjunction with the Radiology Department chief, reviews the Radiology Department standard operating procedures and scheduling processes, identifies deficiencies, and ensures compliance with Veterans Health Administration policies.

_X _Concur

____Nonconcur

Target date for completion: April 2024

Director Comments

The Diagnostic Imaging Service has reviewed the Radiology Department standard operating procedures and scheduling processes and noted a lack of specific instructions for scheduling Interventional Procedures as a deficiency. To address this deficiency a new consult/order set is being created by the Clinical Applications Coordinators (CACs). On July 17, 2023, the new Diagnostic Imaging standard operating procedure was initiated to supplement the current scheduling standard operating procedure on scheduling limited Interventional Procedures using consults. This standard operating procedure is in accordance with VHA Directive 1230(5), Outpatient Scheduling Process and Procedures and with the VHA Outpatient Radiology Scheduling Policy and Interim Guidance, dated August 12, 2016, and the operational memorandum: Radiology and Nuclear Medicine Orders Management, dated May 1, 2019. Training for all Radiology staff with Consult Management on the proper disposition of consults, has been scheduled for July 24 - July 27, 2023. This training has also been incorporated into the Diagnostic Imaging New Employee Orientation. Compliance with scheduling as demonstrated by imaging order scheduling and cancelation audits will be tracked and reported to the Chief of Staff as a standing agenda item at the Medical Executive Council until 90% compliance is met for six (6) consecutive months.

Recommendation 3

The Hampton VA Medical Center Director, in conjunction with the Primary Care Service chief, reviews the Patient Aligned Care Team processes, identifies deficiencies, and ensures compliance with Veterans Health Administration Patient Aligned Care Team requirements, including scheduling huddles, follow-up of Emergency Department patient discharges, and communication with and coordination of specialty care.

_X _Concur

____Nonconcur

Target date for completion: April 2024

Director Comments

To address PACT deficiencies, the Assistant Chief, Primary Care, PACT Coordinator and the Advanced Medical Support Assistant attended the VISN 6 PACT Training (Train the Trainer) from June 12- June 16, 2023. All staff will be re-trained on PACT Operations, which will include huddles, roles and responsibilities, team dynamics, care and data management on September 6, 2023, September 14, 2023, September 20, 2023, September 28, 2023, October 3, 2023, October 12, 2023, October 18, 2023, and October 26, 2023. To address the lack of huddles, the Interim Chief of Primary Care re-enforced the mandated requirements for daily and weekly huddles during the PACT staff meeting on July 19, 2023. Primary Care Leaders will

monitor to ensure huddles are being conducted daily and weekly. Daily and weekly huddle compliance will be reported to the Chief of Staff as a standing agenda item at the Medical Executive Council. Refresher training will be provided to all PACT Nurses on the Post Emergency Department Discharge follow up in accordance with VHA Handbook 1101.10 by Oct 1, 2023. Compliance on the Post Emergency Department Discharge will be monitored and reported monthly to the Associate Director for Patient Care Services (ADPCS) as a standing agenda item at the Patient Care Services Council. Both monitors will continue until 90% compliance is met for six (6) consecutive months.

Recommendation 4

The Hampton VA Medical Center Director, in conjunction with the Primary Care Service chief, reviews the Patient Aligned Care Team pain management and referral processes, identifies deficiencies, and take action as warranted.

_X _Concur

____Nonconcur

Target date for completion: April 2024

Director Comments

The Interim Chief, Primary Care Services reviewed the pain management and referral process and noted there was a lack of a service agreement between Primary Care and Pain Management. The Interim Chief, Primary Care Services and the Pain Management, Opioid Safety, and Prescription Drug Monitoring Program (PMOP) Coordinator initiated the Service Line Agreement for Integrative Pain Recovery Service and the Patient Aligned Care Team. This agreement was approved by the Chief of Staff on May 30, 2023. Training on the service agreement was provided at the PACT staff meeting on July 19, 2023, by the PMOP Coordinator. Compliance to pain management and the referral process will be monitored and reported to the Chief of Staff as a standing agenda item at the Medical Executive Council.

Recommendation 5

The Hampton VA Medical Center Director, in consultation with a subject matter expert from the National Program Office for Oncology, reviews the facility cancer registry program, identifies deficiencies, and ensures compliance with Veterans Health Administration requirements, including the need for a qualified cancer registrar and entry of all cancer cases in the registry.

_X _Concur

____Nonconcur

Target date for completion: April 2024

Director Comments

On July 31, 2022, the Hampton VAMC hired a full time Certified Cancer Tumor Registrar. The Certified Cancer Tumor Registrar works with the oncology team and enters all cancer cases in the registry. The Hampton VA Medical Center Director in consultation with the VISN 6 CMO/DCMO is scheduled to meet with the National Program Office for Oncology on August 4, 2023, to review the cancer registry program, identify any deficiencies in the oncology program and assist in ensuring compliance with VHA Directive requirements. The Cancer Tumor Registrar will ensure all cancer cases are entered into the registry. Compliance will be monitored until 90% compliance has been met for six (6) consecutive months. Compliance data will be reported to the Medical Executive Council.

Recommendation 6

The Hampton VA Medical Center Director reviews the completed root cause analysis in order to ensure its completeness, and take action if warranted.

_X _Concur

____Nonconcur

Target date for completion: April 2024

Director Comments

The Medical Center Director reviewed the completed Root Cause Analysis (RCA) for completeness, and it represents a comprehensive review. The status of the RCA actions and outcomes have been included on the RCA Dashboard and provided for memorialization in the Quality, Safety and Value Council (QSVC) minutes every month. The status of the lung mass RCA actions and outcomes will continue to be updated in the WebSPOT database with completion of the final actions/outcomes on August 31, 2023. A Proactive Risk Assessment Healthcare Failure Mode and Effect Analysis (HFMEA) will be conducted to assess the risks and potential failure modes for care coordination deficiencies to include communication and scheduling. The completed HFMEA will be reviewed by the Hampton VA Medical Center Director. Compliance for the HFMEA actions will be monitored and reported to the Quality Patient Safety Council.

Recommendation 7

The Hampton VA Medical Center Director reviews the institutional disclosure made to the patient's family and completes any required items not addressed, including providing the patient's family with information about potential compensation from the Veterans Benefits Administration and under the Federal Tort Claims Act.

_X _Concur

____Nonconcur

Target date for completion: July 2023

Director Comments

The Chief, Quality Safety and Value reviewed the institutional disclosure made to the Veteran's family. All required items were addressed, except for the advisement about potential compensation through the Veterans Benefits Administration and the Federal Tort Claims Act. A certified letter to include the potential compensation under the Federal Tort Claims Act and the contact information for the Risk Manager was mailed to the Veteran's family on July 20, 2023. As this work is complete, we request OIG consider this recommendation for closure.

OIG Comments

The Facility Director provided sufficient supporting documentation, and the OIG considers this recommendation closed.

Glossary

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

adenocarcinoma. Presence of cancer within glands that line different organs in the body, such as the lung[1]

adenopathy. A disease that involves glandular tissues such as lymph nodes.[2]

adverse event. Unexpected or untoward incidents directly associated with the medical care or services provided at VHA facilities. Examples include patient falls, administration of the wrong medication, or procedural errors.[3]

biopsy. Diagnostic process of removing and examining cells, fluids, or tissues from a living organism.[4]

care coordination agreement. A written document, based on discussion and consensus, defining the workflow rules between two or more services, one of which refers work to the other.[5]

clinically indicated date. The earliest date that the requesting provider determines care is clinically appropriate.[6]

computerized tomography (CT) scan. A scan that uses a series of x-rays to create cross-sectional images of bones, blood vessels, and soft tissues to diagnose disease or injury.[7]

fentanyl patch. A medication, the form of a patch, that is applied to the skin used to treat pain.[8]

hepatitis C. One of the main types of hepatitis viruses that can lead to chronic liver disease or liver cancer.[9]

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[1] NIH National Cancer Institute, "NCI Dictionary of Cancer Terms – Adenocarcinoma," accessed June 5, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/adenocarcinoma.

[2] *Merriam-Webster.com Dictionary*, "adenopathy," accessed October 19, 2022, Adenopathy Definition & Meaning | Merriam-Webster Medical.

[3] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[4] Mayo Clinic, "Biopsy: Types of biopsy procedures used to diagnose cancer," accessed June 5, 2023, https://www.mayoclinic.org/diseases-conditions/cancer/in-depth/biopsy/art-20043922.

[5] VHA Directive 1232(4).

[6] VHA Directive 1232(4).

[7] Mayo Clinic, "CT scan," accessed June 5, 2023, https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.

[8] Cleveland Clinic, "Fentanyl Skin Patch," accessed June 5, 2023, https://my.clevelandclinic.org/health/drugs/18137-fentanyl-skin-patch.

[9] Johns Hopkins All Children's Hospital, "Hepatitis C," accessed, June 5, 2023. https://www.hopkinsallchildrens.org/Patients-Families/Health-Library/HealthDocNew/Hepatitis-C-(7).

hospice care. A set of services provided to patients "who are near the end of life" to help control pain and address physical, social, spiritual, and emotional needs of the patient and family member.[10]

huddles. A type of brief meeting with patient align care team members to discuss patient care workload and concerns.[11]

hyperlipidemia. A condition in which cholesterol and triglycerides (or a combination of both) are abnormally elevated in the blood.[12]

hypertension. A medical term for high blood pressure. A condition that occurs when there is a sustained increase of blood pushing against the artery walls.[13]

Institutional disclosure. A formal process used by facilities to inform the patient or the patient's representatives that an adverse event has occurred related to the care rendered at the facility that is expected to have resulted in, death, or serious injury. Specific information about the patient's rights and recourse options is also provided.[14]

lesions. An abnormal change of an organ or part due to disease.[15]

magnetic resonance imaging. A noninvasive tool used to look at organs, tissue, and skeletal systems and to produce detailed computer-generated images of the body using magnetic fields.[16]

malignancy. "A term for diseases in which abnormal cells divide without control and can invade nearby tissues."[17]

metastasis. "The spread of cancer cells from the place where they first formed to another part of the body."[18]

metastatic. "Cancer that spreads from where it started to a distant part of the body."[19]

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[10] NIH National Cancer Institute, "NCI's Dictionary of Cancer Terms – Hospice," accessed February 7, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/hospice.

[11] VHA Handbook 1101.10(1)

[12] Cleveland Clinic, "Hyperlipidemia," accessed June 5, 2023, https://my.clevelandclinic.org/health/diseases/21656-hyperlipidemia.

[13] Mayo Clinic, "High Blood Pressure (hypertension)," accessed June 6, 2023, https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410.

[14] VHA Directive 1004.08.

[15] *Merriam-Webster.com Dictionary*, "lesion," accessed June 6, 2023, https://www.merriam-webster.com/dictionary/lesion.

[16] Mayo Clinic, "MRI," accessed June 6, 2023, https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768.

[17] National Cancer Institute, "Malignancy," accessed June 6, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/malignancy.

[18] National Cancer Institute, "Metastasis," accessed November 30, 2022, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/metastasis.

[19] National Cancer Institute, "*Metastatic Cancer: When Cancer Spreads*," accessed June 6, 2023, https://www.cancer.gov/types/metastatic-cancer.

oncologist. A doctor who specializes in diagnosing and treating cancer.[20]

oncology. A branch of medicine focused on the prevention, diagnosis, treatment, and study of cancer.[21]

Patient Aligned Care Team. A team of health care professionals including a physician, nurse, and administrative support staff who work together to manage and coordinate the primary care needs of patients.[22]

positron emission tomography. An imaging procedure that uses a small amount of radioactive sugar injected into a vein to identify cancer cells within the body. After the injection, a scanner is used to make detailed, computerized pictures of the body.[23]

pulmonary embolus. "A blood clot that blocks and stops blood flow to an artery in the lung."[24]

pulmonary function testing. Noninvasive tests used by physicians to determine how well the lungs are working. Pulmonary function tests measure lung volume, capacity, rates of flow, and gas exchange.[25]

Pulmonologist. A doctor who "diagnoses and treats diseases" of the lungs.[26]

pulmonology. "A branch of medicine concerned with the anatomy, physiology, and pathology of the lungs."[27]

radiation therapy. Treatment which targets and damages cancer cells by applying x-ray beams or other types of energy.[28]

radiologist. A physician who specializes in medical radiology.[29]

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[20] National Cancer Institute, "Oncologist," accessed June 6, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/oncologist.

[21] *Merriam-Webster.com Dictionary*, "oncology," accessed June 6, 2023, https://www.merriam-webster.com/dictionary/oncology.

[22] VHA Handbook 1101.10(1).

[23] National Cancer Institute, "PET scan," accessed June 6, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/pet-scan.

[24] Mayo Clinic, "Pulmonary Embolism," accessed June 6, 2023, https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/symptoms-causes/syc-20354647.

[25] Johns Hopkins Medicine, "Pulmonary function tests," accessed June 6, 2023, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/pulmonary-function-tests.

[26] Cleveland Clinic, "Pulmonologist," accessed June 6, 2023, https://my.clevelandclinic.org/health/articles/22210-pulmonologist.

[27] *Merriam-Webster.com Dictionary*, "pulmonology," accessed October 19, 2022, https://www.merriam-webster.com/medical/pulmonology.

[28] Mayo Clinic, "Radiation therapy," accessed June 6, 2023, https://www.mayoclinic.org/tests-procedures/radiation-therapy/about/pac-20385162.

[29] *Merriam-Webster.com Dictionary*, "radiologist," accessed June 6, 2023, https://www.merriam-webster.com/dictionary/radiologist.

radiology. A division of medicine that uses radiant energy (such as x-rays or ultrasound) in diagnosing and treating diseases.[30]

sacrum. A triangle-shaped bone that is part of the pelvis in the lower spine.[31]

specialty care. Examples of specialty care include cardiology and oncology.[32]

Tumor Board. A group of doctors and other health care providers with different specialties that meets regularly to discuss cancer cases and share knowledge. The board's goal is to determine the best possible cancer treatment and care plan for an individual patient.[33]

[30] *Merriam-Webster.com Dictionary*, "radiology," accessed June 6, 2023, https://www.merriam-webster.com/dictionary/radiology.

[31] National Cancer Institute, "sacrum," accessed April 14, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/sacrum.

[32] NLM MedlinePlus, "Types of health care providers," accessed June 14, 2023, https://medlineplus.gov/ency/article/001933.htm.

[33] National Cancer Institute, "Tumor board review," accessed June 6, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/tumor-board-review.

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