US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Delay of a Patient's Prostate Cancer Diagnosis, Failure to Ensure Quality Urologic Care, and Concerns with Lung Cancer Screening at the Central Texas Veterans Health Care System in Temple

Healthcare Inspection | 22-04131-49 | January 18, 2024

BE A

VOICE FOR VETERANS

REPORT WRONGDOING

va.gov/oig/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

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

PRIVACY NOTICE

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

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations of a delay in diagnosis of a patient's prostate cancer and lung cancer at the Central Texas VA Health Care System (facility) in Temple.[1] During the review, the OIG identified concerns with the quality of care provided by two nurse practitioners in the urology clinic and leaders' failure to ensure the competency of nurse practitioners to practice independently. The OIG also identified a related concern regarding leaders' failure to communicate expectations that providers offer patients low-dose computed tomography (CT) scans in the community for lung cancer screening.

Patient Case Summary

The patient, in their seventies, was diagnosed with two primary cancers in 2021: prostate cancer and lung cancer.[2] The patient's medical history was notable for atrial fibrillation requiring treatment with a blood thinner, peripheral vascular disease, a 40+ year history of smoking tobacco, back pain, and cervical myelopathy that required the patient to use a cane or wheelchair for mobility. The patient had elevated prostate-specific antigen (PSA) levels and an abnormal prostate exam more than two years prior to the diagnosis of prostate cancer.[3]

Between 2016 and 2018, the patient was seen in the urology clinic for difficulty with bladder emptying. The patient was diagnosed with benign prostatic hyperplasia (BPH or prostate enlargement), was prescribed finasteride, and discharged back to primary care. In early 2019, Primary Care Provider 1 referred the patient back to the urology clinic due to an elevated PSA level.

In early 2019, Nurse Practitioner 1 met with the patient in the urology clinic, performed a prostate exam and found a "probable [nodule] at right upper base area." Nurse Practitioner 1 documented that the three elevated PSA values were "likely related to high PVR [post-void residual]," restarted the finasteride, and planned to repeat the PSA and prostate exam in six months.[4]

---

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

[2] The OIG uses the singular form of they, (their) in this instance, for privacy purposes.

[3] The term "prostate exam" used in this report refers to digital rectal examination. "Digital rectal exam," Mayo Clinic, accessed October 6, 2022, https://www.mayoclinic.org/diseases-conditions/prostate-cancer/multimedia/digital-rectal-exam/img-20006434. Digital rectal examination involves a provider "inserting a gloved, lubricated finger into the rectum and feeling the back wall of the prostate gland for enlargement, tenderness, lumps, or hard spots."

[4] A normal PSA is 4 ng/mL and lower. The patient's PSA values were 4.6 ng/mL (early fall 2018), 5.6. ng/mL (fall 2018), and 5.8 ng/mL (early 2019).

Six months later, in summer 2019, the patient returned to the urology clinic and was seen by another nurse practitioner (Nurse Practitioner 2). Nurse Practitioner 2 documented reviewing the patient's PSA level that had been drawn earlier that month but did not document a prostate exam. Nurse Practitioner 2 documented a lengthy discussion with the patient about the risks of undergoing a prostate biopsy, including infection and death, and that the patient may not tolerate the prostate biopsy due to spinal and vascular problems. In summer 2019, Nurse Practitioner 2 documented that the patient wanted to speak to Primary Care Provider 1 before deciding on the prostate biopsy, and also undergo a scheduled spine surgery in early 2020.[5] Nurse Practitioner 2 documented a plan to have the patient return in four months, after recovery from spine surgery.

In spring 2020, after completing spine surgery, the patient contacted Nurse Practitioner 2 and requested to reschedule the urology clinic follow-up appointment and agreed to an appointment four months later.

In late summer 2020, the patient returned to the urology clinic. During this appointment, Nurse Practitioner 2 informed the patient of being "very high risk" for a prostate biopsy, despite the previous plan of care. Nurse Practitioner 2 further documented in the patient's electronic health record that the American Urological Association did not recommend a prostate biopsy for patients with several co-morbid health issues due to the "risk for infection and death from the procedure." Nurse Practitioner 2 instructed the patient to continue current medications and return to the urology clinic in nine months.

In spring 2021, as part of a separate evaluation of the patient's peripheral vascular disease, a CT angiogram revealed a pelvic mass. Subsequent biopsy of the mass confirmed the diagnosis of prostate cancer and the patient was treated with hormone therapy. The following month, a follow-up positron emission tomography (PET) scan revealed a left lung mass. In fall 2021, a community provider performed a bronchoscopy and biopsy of the lung mass, revealing lung cancer. The patient was admitted to a community hospital and underwent removal of the left lung in early 2022. The patient was discharged to a skilled nursing facility and five days later, the patient was found deceased by nursing home staff.[6]

Deficiencies in Quality of Urologic Care

The OIG substantiated a delay in diagnosis of the patient's prostate cancer related to deficiencies in the urologic care provided by the patient's urology nurse practitioners.

[5] The OIG did not find documentation of a discussion with Primary Care Provider 1 as the patient had requested, and Primary Care Provider 1 did not recall discussing the biopsy with the patient.

[6] The death certificate listed "Vietnam-Era Herbicide-Exposed Veteran" as the immediate cause of death and carcinoma of the lung as a condition leading to the cause of death.

Nurse Practitioner 1's Failure to Offer Prostate Biopsy

The OIG found that Nurse Practitioner 1 failed to offer the patient a prostate biopsy in early 2019, despite persistent elevated PSA levels and an abnormal prostate exam, therefore delaying the patient's diagnosis of prostate cancer.

During an interview, Nurse Practitioner 1 reported that the patient's elevated PSA levels were likely related to the patient's high post-void residual (PVR) and stated that the abnormal prostate exam findings could have been caused by inflammation or a prostatic stone, but acknowledged that a biopsy would be necessary to determine the cause of the abnormal prostate exam.[7] The OIG found no evidence that Nurse Practitioner 1 discussed a prostate biopsy with the patient.

Nurse Practitioner 2's Failures to Provide Accurate Information and a Biopsy

The OIG found that Nurse Practitioner 2 provided inaccurate information about prostate biopsy risks and failed to provide the patient with significant information about the risks of delaying or not performing a prostate biopsy. These failures denied the patient a balanced presentation of the risks and benefits of prostate biopsy and contributed to a delay in diagnosis of prostate cancer.

In summer 2019, Nurse Practitioner 2 documented that the patient's PSA levels remained elevated and documented discussing the risks of a prostate biopsy with the patient.[8] The OIG did not find documentation that Nurse Practitioner 2 discussed the risk of forgoing a prostate biopsy.[9]

Approximately four months later, Nurse Practitioner 2 documented that the patient "want[s] to find out if [the patient] has prostate cancer" and agreed to return after a scheduled spine surgery. The OIG did not find that Nurse Practitioner 2 documented a discussion about the risks of delaying a prostate biopsy.

During the next urology appointment, in summer 2020, Nurse Practitioner 2 documented discussing the patient's elevated PSA levels and informed the patient of the "very high risk" of a prostate biopsy but did not document discussing the risks of not having a biopsy. Nurse Practitioner 2 documented, "AUA [American Urological Association] does not recommend

[7] The OIG utilized a VHA board-certified urologist with several years of experience in the VA system (VHA urology consultant) to review the urologic care provided to the patient based upon the standard of quality medical care consistent with evidence-based medicine. The VHA urology consultant did not consider the patient to have a substantially elevated PVR.

[8] Aside from the patient's early 2019 appointment with Nurse Practitioner 1, Nurse Practitioner 2 provided the patient's urologic care.

[9] In an email to the OIG, when asked what was meant by the "pros and cons" of prostate cancer, Nurse Practitioner 2 stated, "the probability for prostate cancer is 50/50. I have had patients with as many as 7 prostate biopsies and no cancer. . . I always inform patients of the potential adverse effects from a prostate biopsy," and specifically referenced infection and bleeding, as well as further adverse effects from prostate cancer treatment.

prostate bx [biopsy] procedures for pt [patient] with several co-morbid health issues [due] to risk for infection and death from procedure." During an interview, Nurse Practitioner 2 was asked to describe the patient's specific risk for prostate biopsy and listed the patient's use of an anticoagulant and "body issues."[10] However, the OIG determined that prostate biopsy accommodations can be made for cervical and lumbar issues as well as long-term anticoagulation and that there was no evidence Nurse Practitioner 2 discussed the risks of delaying or forgoing a biopsy. Further, the OIG determined that it was medically inconsistent to plan for a prostate biopsy and then advise against it six months later due to the patient's age.

Facility Leaders' Failure to Ensure Quality Urologic Care

The OIG determined that facility leaders failed to ensure quality urologic care and identified concerns related to specialty specific training and competency of nurse practitioners privileged to practice independently. Due to both nurse practitioners' fundamental errors managing this patient's urological care, the OIG is concerned that other patients' care may have been negatively affected.

In 2017, Veterans Health Administration (VHA) allowed facility leaders to decide whether to implement full practice authority for nurse practitioners. Nurse practitioners 1 and 2 discussed in this report were granted independent privileges later that same year, and were therefore expected to have the competence to provide independent care to patients.

VHA requires that facility directors grant clinical privileges "based on evidence of an individual's current competence," which is established through review of peer references, professional experience, education, training, and licensure.[11] While VHA does not mandate specialty specific training for nurse practitioners in areas such as urology, the OIG is concerned that the urology nurse practitioners' training did not adequately prepare them to practice independently.

The OIG found that Nurse Practitioner 1 had experience working as a nurse practitioner in other clinics at the facility, but not as a nurse practitioner within the urology clinic.[12] Nurse

[10] Nurse Practitioner 2 documented in summer 2019 that the patient may not tolerate a biopsy due to cervical and lumbar spine issues. Nurse Practitioner 2 stated the patient's "other frailties and body issues" could limit the patient's ability "to lay on the table to have the procedure" and could have caused discomfort.

[11] VHA acknowledged an error in the rescinded date of VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. In VHA Directive 1100.21 (1), *Privileging*, March 2, 2023, amended April 26, 2023, the rescinded date of VHA Handbook 1100.19 should have been October 15, 2012, and not December 15, 2012. VHA Handbook 1100.19, October 15, 2012, VHA Directive 1100.21 (1), March 2, 2023. The two policies contain similar language regarding how competence is determined for privileging of providers. VHA Directive 1100.21 (1) states, "Clinical privileges are based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure."

[12] Nurse Practitioner 1 reported experience working as a registered nurse in specialty care clinics, including urology, though not as a nurse practitioner.

Practitioner 1 stated that initial urology training consisted of two to four weeks of shadowing Nurse Practitioner 2 and doing some "self-reading."[13] Nurse Practitioner 2 had been a nurse practitioner in urology for approximately 10 years at the time of the inspection, but both Nurse Practitioner 1 and Nurse Practitioner 2 denied having any urology-specific certification.

In an interview with the OIG, the Chief of Staff confirmed that the lack of a standardized training or orientation program for nurse practitioners in specialty care was an area for improvement and that the facility had not implemented a standardized process. Service chiefs must monitor competency through initial (focused) and ongoing professional practice evaluations to identify competency issues in a provider's practice.[14]

The OIG found that facility leaders did not complete the required focused professional practice evaluations when the nurse practitioners were granted independent privileges. The credentialing and privileging supervisor told the OIG that new focused professional practice evaluations were not completed since the "core privileges" did not change. The OIG concluded, however, that because the nurse practitioners were granted independent privileges, rather than remaining under a scope of practice, new focused professional practice evaluations should have been completed. Additionally, while leaders completed ongoing professional practice evaluations, the professional practice evaluations did not include any urology-specific indicators.[15]

Lung Cancer Screening and Diagnosis

The OIG was unable to substantiate a delay in the patient's lung cancer diagnosis. However, the OIG identified a related concern regarding leaders' failure to communicate expectations that providers were to offer lung cancer screening with low-dose CT scans in the community to patients who met United States Preventive Services Task Force (USPSTF) criteria.[16]

In November 2017, VHA issued a memorandum that recommended, but did not require, providers offer LCS with low-dose CT scans to eligible patients. The Chief of Staff told the OIG

[13] The former chief of urology stated that Nurse Practitioner 1 was provided a textbook and advised to bring any questions to one of the urologists. The former chief of urology left the service in early 2021.

[14] Focused professional practice evaluations are used to monitor a provider's practice and are required when new privileges are granted. VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. This handbook was in effect at the time of the events discussed in this report until the credentialing portion of this handbook was superseded by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. The privileging portion of this handbook was in effect at the time of the events discussed in this report until superseded by VHA Directive 1100.21, *Privileging*, on March 2, 2023.

[15] VHA Handbook 1100.19, October 15, 2012, VHA Directive 1100.21 (1), March 2, 2023. VHA Directive 1100.21 (1) now requires that service chiefs develop specialty-specific criteria for focused professional practice evaluations and ongoing professional practice evaluations to monitor the clinical performance of licensed independent health care practitioners granted privileges within their service.

[16] The USPSTF makes evidence-based recommendations about preventive services such as screenings, behavioral counseling, and preventive medications. "Task Force at a Glance," USPSTF, accessed June 7, 2023, https://uspreventiveservicestaskforce.org/uspstf/about-uspstf/task-force-at-a-glance.

that the expectation was that providers were to offer low-dose CT scans to patients who met USPSTF criteria.

The patient discussed in this report met USPSTF criteria for lung cancer screening using low-dose CT scan, though neither Primary Care Provider 1 or Primary Care Provider 2 offered the patient a low-dose CT scan. Both of the patient's primary care providers noted lack of information as a reason for not offering the screening.

The OIG was unable to determine if or when the lung mass would have been detected by low-dose CT scan, or if earlier detection would have changed the patient's prognosis or treatment plan. The OIG found that upon identification of the lung mass, facility and community providers worked to diagnose the patient's lung cancer and provide treatment.

The OIG found that the associate chief of staff of ambulatory care's email to ambulatory care providers lacked clear direction to offer screening to patients meeting USPSTF criteria. The OIG also found that the Chief of Staff failed to effectively communicate to providers the expectation that low-dose CT scans be offered to patients who met USPSTF criteria. The OIG is concerned that the failure to clearly communicate expectations may limit eligible patients' access to low-dose CT in the community. The OIG made four recommendations to the Facility Director to review the care Nurse Practitioner 1 and Nurse Practitioner 2 provided the patient as well as other urology patients, to review the privileging and professional practice evaluation processes and performance indicators for nurse practitioners granted full practice authority in specialty care clinics, and to ensure that facility leaders communicate expectations related to low-dose CT to facility primary care providers.

VA Comments and OIG Response

The Veterans Integrated Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes B and C). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

ACOS	associate chief of staff ambulatory care
BPH	benign prostatic hyperplasia
CT	computed tomography
FPPE	focused professional practice evaluations
OIG	Office of Inspector General
PET	positron emission tomography
PSA	prostate-specific antigen
PVR	post-void residual
USPSTF	United States Preventive Services Task Force
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations of a delay in diagnosis of a patient's prostate cancer and lung cancer at the Central Texas VA Health Care System (facility) in Temple.[1]

Background

The facility, part of Veterans Integrated Services Network (VISN) 17, is a complexity level 1a facility serving central Texas.[2] The facility provides primary and specialty care services. From October 1, 2021, through September 30, 2022, the facility served 116,359 patients and had 141 operating hospital beds, 179 domiciliary beds, and 194 community living center beds.

Prostate Cancer

Prostate cancer is one of the most common types of cancer in male patients and is the Veterans Health Administration's (VHA's) most diagnosed cancer.[3] Risk factors for prostate cancer include age, race, and family history.[4] In early stages, prostate cancer may not cause symptoms. In more advanced stages, prostate cancer may cause urological symptoms, such as trouble urinating and decreased flow of urine, and can metastasize to other parts of the body, most commonly to lymph nodes and bones.[5] While prostate cancer confined to the prostate generally has a high survival rate, survival decreases when prostate cancer becomes widely metastatic.[6]

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

[2] VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes medical facility by complexity level based on factors including patient population, clinical services, and teaching and research programs. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex.

[3] Leah L. Zullig et al, "Cancer Incidence among Patients of the United States Veterans Affairs (VA) Healthcare System: 2010 Update," Military Medicine 182, no. 7 (July 2017): e1883–e1891, https://pubmed.ncbi.nlm.nih.gov/28810986/. This data is from 2010.

[4] "Prostate Cancer," Mayo Clinic, accessed October 6, 2022, https://www.mayoclinic.org/diseases-conditions/prostate-cancer/symptoms-causes/syc-20353087.

[5] "Prostate Cancer," Mayo Clinic; "Prostate cancer metastasis: Where does prostate cancer spread," Mayo Clinic, accessed February 1, 2023, https://www.mayoclinic.org/diseases-conditions/prostate-cancer/expert-answers/prostate-cancer-metastasis/faq-20058270#:~:text=In%20theory%2C%20prostate%20cancer%20cells,lymph%20nodes%20and%20the%20bones.

[6] "Survival Rates for Prostate Cancer," American Cancer Society, accessed May 17, 2023, https://www.cancer.org/cancer/types/prostate-cancer/detection-diagnosis-staging/survival-rates.html.

Prostate-specific antigen (PSA) testing is a method of prostate cancer screening. PSA normally enters the blood stream in small amounts.[7] Usually, prostate cancer cells make more PSA than noncancerous cells.[8] Elevated PSA levels can have other causes, such as benign prostatic hyperplasia (BPH or prostate enlargement), prostate infection, or prostate inflammation.[9] Therefore, other factors are considered when evaluating PSA results, such as a patient's age, the size of the prostate, how quickly the PSA levels change, and the patient's medications.[10] Prostate screening may include a digital rectal exam (prostate exam) to check the prostate for abnormalities. A prostate biopsy is performed to diagnose the presence of prostate cancer.[11]

Lung Cancer

Lung cancer is the third most diagnosed type of cancer in the United States and is the leading cause of cancer deaths.[12] Approximately 5,000 veterans die each year because of lung cancer, and it is the leading cause of cancer-related deaths among veterans.[13] Smoking and increasing age are risk factors in the development of lung cancer. Symptoms can include persistent or worsening cough, coughing up blood, and unexplained weight loss.[14] The diagnosis of lung cancer at an early stage is more treatable than lung cancer found at a later stage.

Prior OIG Reports

The OIG published a report on August 16, 2023, and made three recommendations to VHA addressing the mandated elements for lung cancer screening implementation in VHA operational memoranda and the lack of a requirement to offer eligible patients lung cancer screening.[15] The recommendations remained open as of December 19, 2023.

---

[7] "Prostate cancer screening: Should you get a PSA test?" Mayo Clinic, accessed January 25, 2023, https://www.mayoclinic.org/tests-procedures/psa-test/in-depth/prostate-cancer/art-20048087.

[8] "Prostate Cancer", Mayo Clinic.

[9] "Prostate cancer diagnosis and treatment," Mayo Clinic, accessed January 25, 2023, https://www.mayoclinic.org/diseases-conditions/prostate-cancer/diagnosis-treatment/drc-20353093.

[10] "Prostate cancer screening: Should you get a PSA test?" Mayo Clinic.

[11] "Prostate cancer diagnosis and treatment," Mayo Clinic.

[12] "Cancer Stat Facts: Lung and Bronchus Cancer," National Institutes of Health (NIH), National Cancer Institute, Surveillance, Epidemiology, and End Results Program (SEER)," accessed April 24, 2023, https://seer.cancer.gov/statfacts/html/lungb.html.

[13] "VHA National Oncology Program (NOP)," Veterans Health Administration (VHA), accessed December 2, 2022, https://dvagov.sharepoint.com/sites/vhanop. (This website is not publicly accessible); Moghanaki, D. and Hagan, M., "Strategic Initiatives for Veterans with Lung Cancer," *Federal Practitioner*, 37(Suppl 4) (August 2020): S76–S80, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7473723/.

[14] "Signs and Symptoms of Lung Cancer," American Cancer Society, accessed April 21, 2023, https://www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/signs-symptoms.html.

[15] VA OIG, *Concern with Veterans Health Administration's Lung Cancer Screening Program Requirements*, Report No. 22-01511-174, August 16, 2023.

Allegations and Additional Concerns

On September 12, 2022, the OIG received allegations of delays in diagnosing the patient's cancers. The OIG reviewed the allegations and initiated an inspection on October 5, 2022, to review the patient's care and the timeliness of the patient's cancer diagnoses. During the review, the OIG identified concerns with the quality of care provided by nurse practitioners in the urology clinic and leaders' failure to ensure the competency of nurse practitioners to practice independently. The OIG also identified a related concern regarding leaders' failure to communicate expectations that providers were to offer low-dose computed tomography (CT) scans in the community to patients who met the United States Preventive Services Task Force (USPSTF) criteria.[16]

Scope and Methodology

The OIG conducted a site visit November 15–16, 2022, to interview facility leaders and staff relevant to the inspection.[17] The OIG reviewed VHA and facility policies and other written guidance related to prostate and lung cancer, nurse practitioner credentialing and privileging records, and pertinent email communication. The OIG reviewed documentation in the patient's electronic health record between 2015 and 2022 related to the patient's prostate and lung cancers.[18] The OIG also utilized a VHA board-certified urologist with several years of experience in the VA system (VHA urology consultant) to review the urologic care provided to the patient.

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.

[16] The US Preventive Services Task Force makes evidence-based recommendations about preventive services such as screenings, behavioral counseling, and preventive medications. "Task Force at a Glance," USPSTF, accessed June 7, 2023, https://uspreventiveservicestaskforce.org/uspstf/about-uspstf/task-force-at-a-glance.

[17] The OIG interviewed the Chief of Staff, chief of surgery, the former chief of urology, the current and former associate chief of staff for primary care, and the credentialing and privileging manager. The OIG also interviewed urology and primary care providers, a surgical oncologist, a pulmonologist, a vascular surgery provider, and a consult referral coordinator.

[18] The team requested and reviewed relevant community care patient records obtained by subpoena.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General (IG) 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.

Patient Case Summary

The patient, in their seventies, was diagnosed with two primary cancers in 2021, prostate cancer and lung cancer.[19] The patient's medical history was notable for diabetes, atrial fibrillation requiring treatment with a blood thinner, peripheral vascular disease, a 40+ year history of smoking tobacco, back pain, and cervical myelopathy that required the patient to use a cane or wheelchair for mobility.

Between 2016 and 2018, the patient was seen in the urology clinic for difficulty with bladder emptying, was diagnosed with BPH, and prescribed finasteride. The patient's PSA level at the time of discharge from the urology clinic back to primary care in early 2018, was 2.2 nanograms per milliliter (ng/mL).[20] In early 2019, the patient's primary care provider (Primary Care Provider 1) referred the patient to the urology clinic for an elevated PSA level of 5.8 ng/mL.

The same month, a nurse practitioner (Nurse Practitioner 1) met with the patient in the urology clinic, performed a prostate exam and found a "probable [nodule] at right upper base area." Nurse Practitioner 1 documented three elevated PSA values, from late summer 2018 to early 2019, "likely related to high PVR [post-void residual]," and noted that the patient had stopped taking finasteride. In response, Nurse Practitioner 1 restarted the finasteride to "help to both empty bladder and lower PSA," and planned to repeat the PSA and prostate exam in six months. Later that same day, the patient spoke with Nurse Practitioner 1 to ask if the patient had prostate cancer. Nurse Practitioner 1 informed the patient that there were many causes for an elevated PSA level and planned to repeat the patient's PSA and prostate exam in six months.

In summer 2019, the patient returned to the urology clinic and was seen by another nurse practitioner (Nurse Practitioner 2). The patient informed Nurse Practitioner 2 of undergoing back surgery in spring 2020, with a plan for further spine surgery. Nurse Practitioner 2 documented reviewing the patient's PSA level, drawn earlier that month, as 4.3 ng/mL, but did not document

[19] The OIG uses the singular form of they, (their) in this instance, for privacy purposes.

[20] A normal PSA is 4 ng/mL and lower. Finasteride decreases PSA levels by approximately 50 percent when taken for six months or longer. The PSA is "adjusted" in patients taking finasteride by doubling the measured value.

a prostate exam. Nurse Practitioner 2 documented a lengthy discussion with the patient about the risks of undergoing a prostate biopsy, including infection and death, and that the patient may not tolerate the prostate biopsy due to spinal and vascular problems. The patient indicated wanting to speak with Primary Care Provider 1 before deciding about the prostate biopsy.[21]

In late 2019, Nurse Practitioner 2 documented a PSA level of 4.7 ng/mL and found that the right lobe of the prostate gland was slightly higher than the left lobe during prostate examination. Nurse Practitioner 2 informed the patient that finasteride decreases the PSA level, and discussed the possibility of a prostate biopsy. The patient decided to undergo a prostate biopsy after completing back surgery scheduled for the next month. Nurse Practitioner 2 planned to have the patient return in four months for repeat labs, after recovery from spine surgery, but did not schedule a biopsy. In spring 2020, after completing spine surgery, the patient contacted Nurse Practitioner 2 and requested to reschedule the urology clinic follow-up appointment and agreed to an appointment four months later, in summer 2020.

In summer 2020, the patient returned to the urology clinic for a follow-up appointment with Nurse Practitioner 2. Despite the previous plan of care, during the summer 2020 appointment, Nurse Practitioner 2 informed the patient of being "very high risk" for prostate biopsy due to co-morbid health issues. Nurse Practitioner 2 further documented in the patient's electronic health record that the American Urological Association did not recommend prostate biopsy for patients with several co-morbid health issues due to the "risk for infection and death from the procedure." Nurse Practitioner 2 instructed the patient to continue current medications and return to the urology clinic in nine months. Nurse Practitioner 2 documented that the patient understood the plan and "seems to agree with advice given and plan for further evaluation and treatment."

The patient had been followed by the vascular clinic since spring 2018 for peripheral vascular disease. During a follow-up appointment in spring 2021, a vascular surgery provider ordered a CT angiogram to assess symptoms in the patient's right leg. The next month, the completed CT angiogram showed a right-sided pelvic mass.[22] The vascular surgery provider discussed the case with a surgeon who recommended expedited evaluation by urology and gastroenterology, and the vascular surgery provider entered both of the recommended consults that day. On that same day, the patient's primary care provider (Primary Care Provider 2) added a comment to the urology consult requesting that the urology appointment be expedited "due to possibility of malignancy." The consult referral coordinator added a "sig[nificant] finding" update to the consult that included the CT angiogram results and alerted the clinic urologist and a urology physician assistant. The consult referral coordinator noted the previously scheduled appointment

[21] The OIG did not find documentation of a discussion with Primary Care Provider 1 as the patient had requested, and Primary Care Provider 1 did not recall discussing the biopsy with the patient.

[22] The CT angiogram showed an "irregular 8.0 x 6.4 x 5.8 cm soft tissue mass at the deep right pelvis adjacent to the distal sigmoid colon/rectum and posterior wall of the bladder. Prostate gland not seen separately from this mass."

for the following month and asked if the patient should be seen sooner or sent into the community. Primary Care Provider 2 responded to the consult referral coordinator comment with the information that the patient was complaining of severe pain shooting to the patient's back and difficulty with urination. Three days later, the consult referral coordinator alerted Nurse Practitioner 2 that the "patient now presents with possible prostate mass" and requested that Nurse Practitioner 2 review for scheduling and urgency recommendations. Two days later, the consult referral coordinator discontinued the consult and documented that a follow-up urology appointment had been previously scheduled.[23]

Nine days later, the patient met with a provider in the gastroenterology clinic. Four days later, the patient underwent a colonoscopy and the results showed no findings in the colon to explain the presence of the pelvic mass. Approximately two weeks later, the patient saw Nurse Practitioner 2, who reported the patient, "continues to state [the patient] has a mass in [the patient's] stomach." Nurse Practitioner 2 documented that the patient's PSA level was elevated at 6.9 ng/mL and recommended that the patient continue finasteride. Nurse Practitioner 2 entered a general surgery consult for evaluation of the pelvic mass seen on the CT angiogram. On the same day, a general surgeon reviewed the consult, added a comment that the patient's PSA level was elevated, and inquired if the patient had a prior prostate biopsy. The general surgeon also requested that the patient be seen in the surgical oncology clinic and that Nurse Practitioner 2 order a positron emission tomography (PET) scan to evaluate the mass.

The PET scan was performed six days later, and the results revealed that the pelvic mass had increased in size and was blocking urine outflow from the patient's right kidney. The PET scan also showed a left lung mass, and possible cancer in a lymph node above the patient's left clavicle (collar bone). The same day, the radiologist discussed the findings with Nurse Practitioner 2, and suggested the patient may need a ureteral stent to treat the blockage. Nurse Practitioner 2 documented discussing the PET scan results with the urologist and noted that the patient was going to be seen by the oncology surgeon.

Two days later, in summer 2021, the patient saw the oncology surgeon who documented that the PET scan findings were suspicious for metastatic cancer and that the patient needed a biopsy of the pelvic mass "ASAP [as soon as possible]." The same day, the oncology surgeon entered a community care interventional radiology consult for biopsy of the pelvic mass. That month, the patient underwent biopsy of the right pelvic mass, which showed metastatic prostate cancer. The oncology surgeon alerted the urologist and Nurse Practitioner 2 to the biopsy result. Eight days later, the patient was seen in the urology clinic by Nurse Practitioner 2 and started on hormone therapy.

[23] During an interview with the OIG, the consult referral coordinator could not recall receiving a reply from any member of the urology staff regarding the inquiries related to expediting the appointment.

Two weeks later, the patient was seen in the facility pulmonary clinic for evaluation of the left lung mass.[24] The pulmonologist felt that it would be difficult to reach the mass with bronchoscopy and referred the patient to community care interventional radiology for a CT-guided needle biopsy. Approximately three weeks later, the community care interventional radiologist met with the patient and aspirated a lymph node above the patient's left collar bone, that showed adenocarcinoma believed to be secondary to prostate cancer. In addition, the community care interventional radiologist determined that the location of the lung mass was too high risk for a CT-guided needle biopsy and recommended that the patient be seen by a community pulmonologist. The following month, in fall 2021, a community provider performed a bronchoscopy and biopsy of the lung mass, revealing squamous cell carcinoma.

Between the patient's diagnosis of lung cancer in fall 2021, and the patient's lung cancer surgery four month later, in early 2022, the patient underwent a series of tests in the community to determine if the patient was a candidate for lung cancer surgery. In early 2022, the patient was admitted to a community hospital and underwent removal of the left lung. Six days later, the patient was discharged to a skilled nursing facility and five days after, the patient was found deceased by nursing home staff.[25]

Inspection Results

The OIG substantiated a delay in the diagnosis of the patient's prostate cancer. The OIG determined that facility leaders failed to ensure this patient received quality urologic care. The OIG was unable to substantiate that there was a delay in the diagnosis of the patient's lung cancer. The OIG also identified a related concern regarding leaders' failure to communicate expectations that providers were to offer low-dose (CT) scans in the community to patients who met USPSTF criteria for lung cancer screening.

Deficiencies in Quality of Urologic Care

The OIG substantiated a delay in diagnosis of the patient's prostate cancer related to deficiencies in the urologic care provided by the patient's urology nurse practitioners. Specifically, the two nurse practitioners failed to act on the patient's abnormal prostate findings. The patient had elevated PSA levels and an abnormal digital rectal exam more than two years prior to the finding of metastatic prostate cancer, which was found during an evaluation for vascular disease.

[24] Primary Care Provider 2 submitted a pulmonary consult during summer 2021 for evaluation of the lung mass. The patient was offered a community care referral though declined and accepted the next available appointment in the facility pulmonary clinic.

[25] The death certificate listed "Vietnam-Era Herbicide-Exposed Veteran" as the immediate cause of death and carcinoma of the lung as a condition leading to the cause of death.

Prostate biopsy is the standard method used to diagnose prostate cancer. However, the patient did not receive a prostate biopsy, which delayed the patient's prostate cancer diagnosis.

Nurse Practitioner 1's Failure to Offer Prostate Biopsy

The OIG found that Nurse Practitioner 1 failed to offer the patient a prostate biopsy despite persistent elevated PSA levels and an abnormal prostate exam, therefore delaying the patient's diagnosis of prostate cancer.

In an interview with the OIG, Nurse Practitioner 1 stated that if a patient had elevated PSA levels and an abnormal prostate exam, "then that raises the concern that it could be a cancer and then I would recommend to schedule the biopsy." However, despite the patient having persistently elevated PSA levels and an abnormal prostate exam, the OIG found no evidence that Nurse Practitioner 1 discussed or scheduled a prostate biopsy with the patient.

Instead, Nurse Practitioner 1 reported that the patient's elevated PSA levels in early 2019 were "likely related to [the patient's] high PVR." Nurse Practitioner 1 documented that the plan was for the patient to take finasteride, to "help to both empty the bladder and lower PSA," and to repeat PSA testing and a prostate exam in six months.

When asked about the plan of care, Nurse Practitioner 1 told the OIG that the plan was to repeat the PSA, prostate exam, and check the "efficacy" of finasteride after six months. When asked why the patient was not referred for a biopsy, Nurse Practitioner 1 again attributed the patient's early 2019 PSA level to the patient's high PVR.[26] Although Nurse Practitioner 1 told the OIG that a nodule found during a patient's prostate exam could be prostate cancer, Nurse Practitioner 1 also stated that a nodule could be caused by inflammation or a prostatic stone. Nurse Practitioner 1 acknowledged that the cause of a nodularity would not be known unless a prostate biopsy was performed.

The VHA urology consultant opined that Nurse Practitioner 1 should have offered the patient a prostate biopsy in early 2019. The VHA urology consultant also opined that the patient did not have a "substantially elevated PVR" and that Nurse Practitioner 1's primary concern should have been prostate cancer given the patient's elevated PSA levels and abnormal prostate exam.

The OIG concluded that Nurse Practitioner 1 failed to offer the patient a prostate biopsy and failed to recognize that the patient's elevated PSA levels and abnormal prostate exam may have been indicators of prostate cancer. While the plan of care to prescribe finasteride was not inappropriate, Nurse Practitioner 1 should have offered a biopsy given the patient's history of elevated PSA levels and abnormal prostate exam. This failure contributed to a delay in the patient's prostate cancer diagnosis.

[26] The VHA urology consultant did not consider the patient to have a substantially elevated PVR.

Nurse Practitioner 2's Failures to Provide Accurate Information and a Biopsy

The OIG found that Nurse Practitioner 2 provided inaccurate information about prostate biopsy risks and failed to provide the patient with significant information about the risks of delaying or not performing a prostate biopsy. These failures denied the patient a balanced presentation of all significant information regarding the risks and benefits of prostate biopsy and contributed to a delay in diagnosis of prostate cancer.

The facility's Medical Staff Bylaws & Rules state that patients have "the right to talk with their physician and other health professionals and be informed of the diagnosis, proposed treatment, prognosis, possible alternative treatments, and all significant information regarding their condition."[27]

During a follow-up appointment in summer 2019, approximately six months after the patient was seen by Nurse Practitioner 1, Nurse Practitioner 2 documented that the patient's PSA levels remained elevated.[28] Nurse Practitioner 2 documented discussing the risks of a prostate biopsy with the patient, including the potential for infection, death, and an inability to tolerate the procedure due to the patient's cervical and lumbar spine, and vascular problems. The OIG did not find that Nurse Practitioner 2 documented a discussion about the risks of forgoing a prostate biopsy, such as delaying diagnosis and treatment of prostate cancer.

Approximately four months later, during an appointment, Nurse Practitioner 2 documented that the patient "want[s] to find out if [the patient] has prostate cancer" and agreed upon a plan to return in spring 2020 after a spine surgery.[29] The OIG did not find that Nurse Practitioner 2 documented a discussion about the risks of delaying a prostate biopsy.

During the next urology appointment in late summer 2020, Nurse Practitioner 2 documented discussing the risk of a prostate biopsy, and noted, "AUA [American Urological Association] does not recommend prostate bx [biopsy] procedures for pt [patient] with several co-morbid health issues [due] to risk for infection and death from the procedure." Nurse Practitioner 2 documented informing the patient of the "very high risk" for infection and death from prostate biopsy due to several co-morbid health issues, and instructed the patient to continue with

[27] Facility Medical Staff Bylaws and Rules, adopted 2017, amended 2020. The patient's care timeline spans two versions of the facility's Medical Staff Bylaws and Rules. The verbiage quoted above is the same in both the 2017 and 2020 versions.

[28] Aside from the patient's early 2019 appointment with Nurse Practitioner 1, Nurse Practitioner 2 provided the patient's urologic care.

[29] Nurse Practitioner 2 documented that the patient's spine surgery was scheduled for early 2020. The patient's spine surgery did not occur until spring 2020.

medications and to follow-up in nine months. The OIG found that Nurse Practitioner 2 failed to document a discussion about the risks of not having a prostate biopsy.

In an interview, the OIG asked Nurse Practitioner 2 to describe the patient's specific risks for prostate biopsy. Nurse Practitioner 2 stated the patient's "other frailties and body issues" could limit the patient's ability "to lay on the table in order to have the procedure" and could have caused discomfort.[30] Nurse Practitioner 2 stated that the patient's use of an anticoagulant may increase the risk for bleeding. Later in the interview, Nurse Practitioner 2 stated that stopping the anticoagulant would put the patient at risk for a clot. Although Nurse Practitioner 2 told the OIG that it would be necessary to contact the ordering provider to determine whether "they can stop the medication [anticoagulant] without having any problems," the OIG found that there was no evidence to support that Nurse Practitioner 2 consulted with the patient's cardiologist to discuss this concern. Further, the OIG found that the patient's cardiologist approved discontinuing the anticoagulant prior to the patient's other procedures, including back surgery and a colonoscopy.

The VHA urology consultant opined:

- cervical and lumbar issues can be accommodated and are "not a reason to not biopsy," nor was the patient's use of an anticoagulant;
- providers need to discuss the risks of biopsy, as well as the risks of delaying diagnosis, so that a patient may make a reasonable decision concerning the procedure;
- there was no evidence to support that Nurse Practitioner 2 had a "reasonable conversation" with the patient about the benefits of prostate biopsy as well as the risks of delaying a prostate cancer diagnosis; and
- the patient needed a prostate biopsy, and it was medically inconsistent for Nurse Practitioner 2 to plan for a prostate biopsy and then advise against it six months later due to the patient's age.

The OIG concluded that Nurse Practitioner 2 provided the patient with inaccurate information about the risks of prostate biopsy. Further, Nurse Practitioner 2 failed to provide significant information about the risks of forgoing or delaying a prostate biopsy as required by the facility's Medical Staff Bylaws & Rules. Despite the patient's expressed desire for prostate biopsy, an abnormal prostate exam, and continued elevated PSA values, a prostate biopsy was never performed.

[30] Nurse Practitioner 2 documented in summer 2019 that the patient may not tolerate a biopsy due to cervical and lumbar spine issues.

Facility Leaders' Failure to Ensure Quality Urologic Care

The OIG determined that facility leaders failed to ensure quality urologic care and identified concerns related to specialty specific training and competency of nurse practitioners privileged to practice independently.

In 2017, VHA allowed facility leaders to decide whether to implement full practice authority for nurse practitioners.[31] Upon review of privileging documents, the OIG found that the facility had implemented full practice authority for the urology nurse practitioners discussed in this report in 2017. The urology nurse practitioners were therefore expected to have the competence to provide care to patients independently within the assigned area of practice.

VHA requires facility directors grant clinical privileges to health care professionals licensed for independent practice "based on evidence of an individual's current competence," which is established through review of peer references, professional experience, education, training, and licensure. [32] Service chiefs must monitor competency through initial and ongoing professional practice evaluations to identify competency issues in a provider's practice.[33]

Training

During the inspection, the OIG identified a concern with the urology-specific training of the two nurse practitioners discussed in this report. The OIG found that Nurse Practitioner 1 had experience working as a nurse practitioner in other clinics at the facility, but not as a urology nurse practitioner.[34] Nurse Practitioner 1 denied having obtained any urology specialty certifications. Nurse Practitioner 1 stated that the initial urology section training consisted of two

[31] VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 13, 2017. "[Full practice authority] permits APRNs [advanced practice registered nurses] to practice to the full extent of their education, training and certification, without the clinical supervision or mandatory collaboration of physicians." 38 C.F.R § 17.415 (2022). Advanced practice registered nurses (APRNs) include individuals who have completed a nationally accredited, graduate-level nurse practitioner educational program, passed a national certification exam, obtained a license from a state licensing board, and maintained certification and licensure in the role of nurse practitioner.

[32] VHA acknowledged an error in the rescinded date of VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. In VHA Directive 1100.21 (1), *Privileging*, March 2, 2023, amended April 26, 2023, the rescinded date of VHA Handbook 1100.19 should have been October 15, 2012 and not December 15, 2012. VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. This handbook was in effect at the time of the events discussed in this report and was rescinded and replaced by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021, and VHA Directive 1100.21 (1), *Privileging*, on March 2, 2023. These two policies contain similar language regarding privileging of licensed independent practitioners prior to the provision of patient care and how competence is determined for privileging of providers.

[33] VHA Handbook 1100.19, October 15, 2012, VHA Directive 1100.21 (1), March 2, 2023. The two policies contain similar language regarding responsibility for professional practice evaluations.

[34] Nurse Practitioner 1 reported experience working as a registered nurse in specialty care clinics, including urology, though not as a nurse practitioner.

to four weeks of shadowing Nurse Practitioner 2 and doing some "self-reading." Nurse Practitioner 1 denied any formal training or shadowing with the former chief of urology, and acknowledged that urologists were available for consultation as needed.[35] During an OIG interview, the former chief of urology stated that Nurse Practitioner 1 was provided a textbook and advised to bring any questions to one of the urologists.[36] In an interview, the Chief of Staff confirmed that the lack of a standardized training or orientation program for nurse practitioners in specialty care was an area for improvement, and told the OIG that the facility had not implemented a standardized process across all specialties.

During an OIG interview, Nurse Practitioner 2 relayed being a nurse practitioner in urology for approximately 10 years. Nurse Practitioner 2 had not obtained any urology-specific certification, but reported attending urology training conferences.

While VHA does not mandate specific specialty training for nurse practitioners in specialty areas such as urology, the OIG is concerned that the training provided to the urology nurse practitioners did not prepare them to practice independently in specialty care.

Assessment of Competency

As noted, the OIG identified concerns with the nurse practitioners' quality of care, specifically lack of clinical knowledge of elevated PSA levels and abnormal prostate exam results. The OIG identified an additional concern regarding Nurse Practitioner 2's failure to offer accurate information regarding the risks of prostate biopsy and failure to provide the patient with significant information about the risks of delaying or not performing a prostate biopsy.

VHA requires service chiefs to monitor the professional competency of providers with clinical privileges, including professional practice evaluations.[37] Focused professional practice evaluations (FPPEs) are used to assess the privilege-specific competence of practitioners when they are granted new privileges.[38] The Joint Commission requirements, VHA guidance, and

[35] The OIG did not find evidence that Nurse Practitioner 1 consulted a urologist on this patient's care.

[36] The former chief of urology confirmed leaving the department in early 2021 during an OIG interview.

[37] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21(1), March 2, 2023. The two policies contain the same or similar language related to service chief responsibility for monitoring professional competency. VHA Directive 1100.21 (1) states that service chiefs are responsible for implementing FPPE and OPPE requirements within their clinical service.

[38] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023. The two policies contain the same or similar language related to Focused Professional Practice Evaluations.

facility bylaws state that a period of FPPE is required for all new privileges, including all newly-requested privileges for existing practitioners.[39]

The OIG found that the facility completed periodic ongoing professional practice evaluations, which included medical record reviews. No significant practice concerns were noted on the nurse practitioners' ongoing professional practice evaluations. However, the professional practice evaluation and medical record review forms did not include urology-specific indicators, which, while not mandated, may have identified urology competency concerns.[40]

The OIG also found the facility leaders did not complete a required FPPE when the nurse practitioners were granted independent privileges in 2017. The credentialing and privileging supervisor stated that since FPPEs were completed when the nurse practitioners started, a new FPPE was not completed when the nurse practitioners were granted independent privileges or changed specialties, since the "core privileges" did not change. The privileging documents for both nurse practitioners did not have urology-specific privileges listed. However, the OIG concluded that because the nurse practitioners were granted new privileges, rather than remaining under a scope of practice, FPPEs should have been completed.

The OIG concluded that facility leaders failed to ensure that the nurse practitioners were competent to practice independently in urology and did not adequately assess the nurse practitioners' urology-specific competency. Due to both nurse practitioners' fundamental errors managing this patient's urological care, the OIG is concerned that the quality of other patients' care may have been negatively affected.

Lung Cancer Screening and Diagnosis

The OIG was unable to substantiate a delay in the patient's lung cancer diagnosis. However, the OIG identified a related concern regarding leaders' failure to communicate expectations that providers offer lung cancer screening (LCS) with low-dose CT scans in the community to patients who met USPSTF criteria.

[39] "Focused Professional Practice Evaluation (FPPE) – Understanding the Requirements," The Joint Commission, accessed November 6, 2022, https://www.jointcommission.org/standards/standard-faqs/critical-access-hospital/medical-staff-ms/000001485/; Facility Medical Staff Bylaws and Rules, adopted 2017, amended 2020; VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023. VHA Directive 1100.21 (1) states, "A Focused Professional Practice Evaluation (FPPE) is an oversight process within a defined period of evaluation whereby the respective clinical service chief and the ECMS (Executive Committee of the Medical Staff) evaluates the privilege-specific competence of a LIP [licensed independent health care practitioner] who does not yet have documented evidence of competently performing the requested privileges at the VA medical facility."

[40] VHA Handbook 1100.19, October 15, 2012; VHA Directive 1100.21 (1), March 2, 2023. VHA Directive 1100.21 (1) now requires that Service Chiefs develop specialty specific criteria for FPPE and OPPE to monitor the clinical performance of LIP's granted privileges within their service.

In November 2017, VHA issued a memorandum that recommended, but did not require, providers to offer LCS with low-dose CT scans to eligible patients. The memorandum stated, "Lung cancer screening with [low-dose] CT will be made available to [patients] on a voluntary basis. If the patient and provider. . . desire screening, VHA should provide access to screening using VA or Care in the Community resources."[41] The memorandum directed facilities to a VHA Lung Cancer Screening toolkit, which referenced the USPSTF guidelines to determine if patients were eligible for lung cancer screening. The Chief of Staff told the OIG that the expectation was that providers were to offer LCS with low-dose CT scans to patients who met USPSTF criteria.

On March 3, 2019, the associate chief of staff ambulatory care (ACOS) sent an email to notify ambulatory care providers of the chief of Radiology's request to stop ordering chest CTs for lung cancer screening at the facility, as the facility did not have the resources to support a lung cancer screening program (see appendix A). One provider responded to the email asking if patients should be referred to the community for lung cancer screening, and the ACOS replied, "if clinically indicated."

In an email to the OIG, the Chief of Staff stated that a Community Care LCS with low-dose CT scan consult was activated on July 9, 2019, and the facility chief health informatics officer reported that the first consult was placed on July 31, 2019. The Chief of Staff told the OIG that the expectation for providers to order LCS with low-dose CT scan had been shared "more than once;" however, the Chief of Staff could not provide the OIG with documented evidence of how this expectation was disseminated between the activation of the consult in July 2019 and the end of this inspection.

The patient discussed in this report met USPSTF criteria for lung cancer screening using low-dose CT scan, though neither of the patient's primary care providers offered the patient LCS with low-dose CT scan. Primary care providers had the opportunity to enter a LCS with low-dose CT scan Community Care consult during the patient's in-person visit with Primary Care Provider 1 in fall 2019, and telephone visit in spring 2020, and during a virtual visit with Primary Care Provider 2 in early 2021. Both of the patient's primary care providers noted lack of information as a reason for not offering the screening. Primary Care Provider 1 told the OIG it "would have been good to know" that LCS with low-dose CT scan was available in the community. Primary

[41] Deputy Under Secretary for Health for Operations and Management, "Lung Cancer Screening with Low Dose Computed Tomography," memorandum to Network Director and Veteran Integrated Service Network (VISN) Chief Medical Officers, November 27, 2017. This memorandum was in effect at the time of the inspection and was rescinded and replaced by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Guidelines for Lung Cancer Screening in Veterans Health Administration (VHA)," memorandum to Veterans Integrated Service Network (VISN) Directors and VISN Chief Medical Officers (CMOs), July 8, 2022. The two memorandums contain similar language, which recommends, but does not mandate, offering lung cancer screening using low-dose CT scan to eligible veterans at high risk of developing lung cancer. "Guidelines for Lung Cancer Screening in Veterans Health Administration (VHA)," accessed April 14, 2023, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=9862.

Care Provider 2, who reported being relatively new to the position at the time of first seeing the patient, stated being in the process of learning about Community Care consults at that time.

The OIG was unable to determine if or when the lung mass would have been detected by LCS with a low-dose CT scan, or if early detection would have changed the patient's prognosis or treatment plan. The mass was incidentally observed on imaging during summer 2021, and was identified while still confined to the lung and amenable to treatment with surgery. The OIG found that upon identification of the lung mass, facility and community providers worked to diagnose the patient's lung cancer and provide treatment.

The OIG found that the ACOS email lacked clear direction to offer screening to patients meeting USPSTF criteria. The OIG also found that the Chief of Staff failed to effectively communicate to providers the expectation that LCS with low-dose CT scan be offered to patients who met USPSTF criteria. Moreover, the Chief of Staff was unable to provide the OIG with documented evidence regarding how information about the availability of the Community Care consult for LCS with low-dose CT scan was disseminated to providers before the end of the period of review. The OIG is concerned that the failure to clearly communicate expectations may have limited eligible patients' access to LCS with low-dose CT scan in the community.

Conclusion

The OIG substantiated a delay in the diagnosis of the patient's prostate cancer due to the patient not receiving a prostate biopsy, despite persistently elevated PSA levels, an abnormal prostate exam, and an expressed desire for prostate biopsy.

Nurse Practitioner 1 failed to recognize that the patient's elevated PSA levels and abnormal prostate exam may have been indicators of prostate cancer, and failed to offer the patient a prostate biopsy. Nurse Practitioner 2 failed to provide accurate information to the patient about the risks of having a biopsy and further failed to provide the patient with significant information about the risks of delaying or not performing a prostate biopsy. Facility leaders failed to ensure that the nurse practitioners had the training and competency necessary to independently practice within the urology clinic as required by VHA policy.

The OIG was unable to substantiate a delay in the patient's lung cancer diagnosis. However, a related concern was identified of leaders' failure to communicate the expectation that providers offer LCS with low-dose CT scan in the community to patients who met USPSTF criteria. While the patient did not receive LCS with low-dose CT scan, such screening was recommended, but not required, by VHA at the time of the patient's care, and it is unclear if the lung cancer would have been identified earlier with screening. The OIG is also unable to determine whether earlier detection of the lung mass would have led to a different prognosis or treatment plan. However, the OIG is concerned that the failure to clearly communicate expectations to providers may have limited eligible patients' access to LCS with low-dose CT scan in the community.

Recommendations 1–4

1. The Central Texas VA Health Care System Director reviews the care provided to the patient by Nurse Practitioner 1 and Nurse Practitioner 2 and takes action as warranted.
2. The Central Texas VA Health Care System Director reviews the care provided by Nurse Practitioner 1 and Nurse Practitioner 2 as licensed independent practitioners to other urology patients, and takes action as warranted.
3. The Central Texas VA Health Care System Director reviews the privileging and professional practice evaluation processes and performance indicators for nurse practitioners granted full practice authority in specialty care clinics to ensure compliance with current Veterans Health Administration policy and quality of care.
4. The Central Texas VA Health Care System Director ensures that facility leaders communicate expectations related to low-dose computed tomography scans for lung cancer screening to facility primary care providers.

Appendix A: ACOS's Email

From: Bandela, Srikanth
Sent: Sunday, March 3, 2019 8:52 AM
To: CTXAMBCAREMD; CTXAMBCARE PA/NP
Cc: Hussain, Nasir
Subject: RE: Low dose CT Chest scanning for Lung CA

Dear Providers,

Please see the excerpt of an email I received from Dr. Vincent, Chief of Radiology.

"Unfortunately, CTVHCS [Central Texas VA Health Care System] simply does not currently have a low dose chest CT scanning program; such a program that requires a significant number of both trained personnel and equipment resources. While Imaging can technically perform a Chest CT scan that is lower dose than our standard Chest CT protocol, it does not come close to satisfying the numerous requirements for a low dose screening program.

Please inform your providers to cease ordering chest CTs to screen for lung cancer. Screening exams will not be offered until CTVHCS makes the decision to fund and subsequently implement the full program."

S. Bandela MD

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 3, 2023

From: Director, VA Heart of Texas Health Care Network (10N17)

Subj: Delay of a Patient's Prostate Cancer Diagnosis, Failure to Ensure Quality Urologic Care, and Concerns with Lung Cancer Screening at the Central Texas Veterans Health Care System in Temple

To: Director, Office of Healthcare Inspections (54HL10)

Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. We deeply regret the circumstances that impacted the care delivered to one of our Veterans. I have reviewed the draft report and the Facility Response for Delay of a Patient's Prostate Cancer Diagnosis, Failure to Ensure Quality Urologic Care, and Concerns with Lung Cancer Screening at the Central Texas Veterans Health Care System in Temple.

2. The VA Heart of Texas Health Care System is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. I support the Director's response and the action plan of the VA Central Texas Veterans Health Care System.

3. I would like to thank the Office of Inspector General for their thorough review of this case and if you have any additional questions, please contact the VISN 17 Quality Management Officer (QMO).

(*Original signed by:*)

Jamie D. Park
Deputy Network Director, VISN 17

For

Wendell Jones, MD, MHA
Network Director
VA Heart of Texas Network (VISN 17)

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 3, 2023

From: Director, Central Texas Veterans Health Care System (674/00)

Subj: Healthcare Inspection—Delay of a Patient's Prostate Cancer Diagnosis, Failure to Ensure Quality Urologic Care, and Concerns with Lung Cancer Screening at the Central Texas Veterans Health Care System in Temple

To: Director, VA Heart of Texas Health Care Network (10N17)

1. We deeply regret the circumstances that impacted the care delivered to one of our Veterans. I have reviewed the draft report and the Facility Response for Delay of a Patient's Prostate Cancer Diagnosis, Failure to Ensure Quality Urologic Care, and Concerns with Lung Cancer Screening at the VA Central Texas Veterans Health Care System (CTVHCS).

2. The VA Central Texas Veterans Health Care System (CTVHCS) is committed to honoring our Veterans by ensuring they receive high-quality healthcare services. The Chief of Staff and the CTVHCS Risk Manager team have developed and are in the process of implementing the action items presented in the Office of Inspector General's report.

These items include:

- A focused clinical review evaluating the care provided to this Veteran as pertains to his urologic care.
- Submitting a sample of charts of urology patients seen by the two identified Nurse Practitioners to external reviews tasked with evaluating their clinical expertise.
- Developing and presenting education by the Chief of Staff for providers on the US Preventive Services Task Force recommendations for Low-dose computer tomography lung cancer screening.

3. I would like to thank the Office of Inspector General for their thorough review of this case. Should there be any additional questions, please contact the VISN 17 Quality Management Officer (QMO).

(*Original signed by*:)

Kalpana Mehta, MBA, FACHE
Acting Executive Director

Facility Director Response

Recommendation 1

The Central Texas VA Health Care System Director reviews the care provided to the patient by Nurse Practitioner 1 and Nurse Practitioner 2 and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: April 30, 2024

Director Comments

The identified patient's record will be sent to the VHA Office of Quality and Patient Safety Medical-Legal Risk Management by November 30, 2023, for an external administrative review of the care rendered by Nurse Practitioner 1 and Nurse Practitioner 2 during the specified time period.

The Chief of Staff, in consultation with Human Resources, will determine the appropriateness of further action, if any, based on the reviewer's opinion(s) of the care rendered.

Recommendation 2

The Central Texas VA Health Care System Director reviews the care provided by Nurse Practitioner 1 and Nurse Practitioner 2 as licensed independent practitioners to other urology patients, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: February 29, 2024

Director Comments

The Central Texas Chief Health Informatics Officer (CHIO) will be tasked with generating a list of patients with a urological diagnosis, e.g., Benign Prostate Hypertrophy, Prostatitis, Prostate Cancer, etc., treated by Nurse Practitioner 1 and a separate list utilizing the same criteria of Nurse Practitioner 2's patients. 15 randomly selected patients for each Nurse Practitioner will be selected and sent to the VHA Office of Quality and Patient Safety Medical-Legal Risk Management by November 30, 2023 for an external administrative review.

The Chief of Staff, in consultation with Human Resources, will determine the appropriateness of further action, if any, based on the reviewer's opinion(s) of the care rendered.

Recommendation 3

The Central Texas VA Health Care System Director reviews the privileging and professional practice evaluation processes and performance indicators for nurse practitioners granted full practice authority in specialty care clinics to ensure compliance with current VHA policy and quality of care.

_X _Concur

____Nonconcur

Target date for completion: February 29, 2024

Director Comments

The Chair of the Medical Executive Committee and the Chair of the Professional Standards Board will be tasked with reviewing the privileging and professional practice evaluation processes and performance indicators for nurse practitioners granted full practice authority in specialty care clinics to ensure compliance with current Veterans Health Administration policy and quality of care as well as compliance with the Central Texas VA Health Care System on-boarding Standard Operating Procedure. They will present their findings to the Chief of Staff by November 30, 2023, along with recommendations as warranted.

Recommendation 4

The Central Texas VA Health Care System Director ensures that facility leaders communicate expectations related to low-dose computed tomography scans for lung cancer screening to facility primary care providers.

_X _Concur

____Nonconcur

Target date for completion: March 30, 2024

Director Comments

On March 30, 2023, the Central Texas Veterans Health Care System Chief of Staff, emailed all Central Texas Veterans Health Care System physicians a reminder regarding lung cancer screening for smokers. He provided a link to the United States Preventive Services Taskforce Final Recommendation Statement titled: "Lung Cancer: Screening" dated March 9, 2021.

A PowerPoint presentation on the US Preventive Services Task Force's recommendations regarding Low Dose Computerized Tomography for lung cancer screening has been developed, see attached. The Chief of Staff presented this information at the Medical Staff Meeting, on November 9, 2023. This information will be submitted to the Clinical Education Service for inclusion in their new provider orientation training. The presentation will also be repeated on an annual basis during a Medical Staff meeting.

Using the task force's definition of "high-risk" patients who should be referred for low-dose computerized tomography for lung cancer screening, compliance with referral for screening by primary care providers will be assessed monthly beginning with November primary care appointments. Results will be reported to the Chief of Staff and to the monthly Accreditation Readiness Committee. In addition to general compliance, data elements will include demographic data, compliance by provider, and clinic location. Patients with a pre-existing cancer diagnosis will be excluded from the sample. The goal of 95% compliance will be set.

Glossary

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

aspirate. "Refers to the act of withdrawing the fluid, tissue, or other substance through a needle."[1]

atrial fibrillation. An irregular heartbeat in which the heart's upper two chambers (the atria) beat irregularly and out of coordination with the heart's lower two chambers (the ventricles). It increases the risk of stroke and other heart-related complications.[2]

benign prostatic hyperplasia. "Enlargement of the prostate gland caused by a benign overgrowth of chiefly glandular tissue that occurs especially in men over 50 years old and that tends to obstruct urination by constricting the urethra."[3]

bronchoscopy. "A procedure that lets doctors look at [a patient's] lungs and air passages… During bronchoscopy, a thin tube (bronchoscope) is passed through [a patient's] nose or mouth, down [a patient's] throat and into [a patient's] lungs."[4]

adenocarcinoma. "… a type of cancer. It develops in the glands that line your organs." "[It] is the most common type of cancer affecting your organs…" and "is responsible for almost all prostate cancers."[5]

cervical myelopathy. A condition resulting "from compression of the spinal cord in the neck." "Symptoms of cervical myelopathy may include problems with fine motor skills, pain or stiffness in the neck, loss of balance, and trouble walking."[6]

colonoscopy. An exam using "a long, flexible tube (colonoscope) [inserted] into the rectum" with a camera to view possible changes in the large intestine and rectum.[7]

---

[1] National Cancer Institute, *Dictionary of Cancer Terms*, "aspirate," accessed January 20, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/aspirate.

[2] "Atrial fibrillation," Mayo Clinic, accessed January 26, 2023, https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624.

[3] *Merriam-Webster.com Dictionary*, "benign prostatic hyperplasia," accessed October 6, 2022, https://www.merriam-webster.com/dictionary/benign%20prostatic%20hyperplasia.

[4] "Bronchoscopy," Mayo Clinic, accessed January 20, 2023, https://www.mayoclinic.org/tests-procedures/bronchoscopy/about/pac-20384746.

[5] "Adenocarcinoma," Cleveland Clinic, accessed June 21, 2023, Adenocarcinoma Cancers: Symptoms, Causes, Diagnosis & Treatment (clevelandclinic.org).

[6] "Cervical Myelopathy," Johns Hopkins Medicine, accessed January 20, 2023, https://www.hopkinsmedicine.org/health/conditions-and-diseases/cervical-myelopathy.

[7] "Colonoscopy," Mayo Clinic, accessed August 18, 2020, https://www.mayoclinic.org/tests-procedures/colonoscopy/about/pac-20393569.

computed tomography angiogram. "an imaging test to view your blood vessels and tissues. It uses an injection of contrast dye and specialized X-rays."[8]

computed tomography scan. A scan that uses a series of x-rays to "create cross-sectional images (slices) of the bones, blood vessels and soft tissues" to diagnose disease or injury.[9]

computed tomography-guided needle biopsy. "A biopsy procedure that uses a CT scan (a special type of x-ray linked to a computer) to find an abnormal area in the body and help guide the removal of a sample of tissue from that area. A needle is usually used to remove the sample, which is then checked under a microscope for signs of disease."[10]

diabetes. A disease that occurs when the body cannot make or use insulin well and blood glucose (blood sugar) levels are too high.[11]

finasteride. A medication that "treats the symptoms of an enlarged prostate. It works by decreasing the size of the prostate."[12]

focused professional practice evaluation. "…an oversight process within a defined period of evaluation whereby the respective clinical service chief and the ECMS [Executive Committee of the Medical Staff] evaluates the privilege-specific competence of a LIP [licensed independent health care practitioner] who does not yet have documented evidence of competently performing the requested privileges at the VA medical facility. This is a routine process with standardized criteria approved by the VA medical facility's ECMS and Director and applied to LIPs within the same specialty who hold the same privileges."[13]

gastroenterology. "The study of the normal function and diseases of the esophagus, stomach, small intestine, colon and rectum, pancreas, gallbladder, bile ducts, and liver."[14]

hormone therapy. When used for prostate cancer treatment, hormone therapy reduces male hormones to stop them from fueling prostate cancer cell growth.[15]

---

[8] "Computed Tomography Angiogram," Cleveland Clinic, accessed July 12, 2023, CT Coronary Angiogram (clevelandclinic.org).

[9] "CT Scan," Mayo Clinic, accessed June 18, 2018, https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675.

[10] National Cancer Institute, *Dictionary of Cancer Terms*, "CT-guided biopsy," accessed January 20, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/ct-guided-biopsy.

[11] "What is Diabetes?" National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), accessed January 24, 2023, https://www.niddk.nih.gov/health-information/diabetes/overview/what-is-diabetes.

[12] "Finasteride Tablets (BPH)," Cleveland Clinic, accessed October 22, 2022, https://my.clevelandclinic.org/health/drugs/20804-finasteride-tablets-bph.

[13] VA Directive 1100.21 (1), *Privileging*, March 2, 2023, amended April 26, 2023.

[14] "What is a Gastroenterologist," American College of Gastroenterology, accessed November 25, 2019, https://gi.org/patients/gi-health-and-disease/what-is-a-gastroenterologist/.

[15] "Hormone Therapy for Prostate Cancer," American Cancer Society (ACS), accessed February 22, 2023, https://www.cancer.org/cancer/prostate-cancer/treating/hormone-therapy.html.

interventional radiology. "A medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases in nearly every organ system." Patients are diagnosed and treated using the least invasive techniques currently available to minimize the risk to patients and improve health outcomes.[16]

lung cancer. "Cancer that forms in tissues of the lung, usually in the cells lining air passages. The two main types are small cell lung cancer and non-small cell lung cancer."[17]

lymph node. "Small bean-shaped structure[s] that [are] part of the body's immune system. Lymph nodes filter substances that travel through the lymphatic fluid, and they contain lymphocytes (white blood cells) that help the body fight infection and disease."[18]

metastatic. "The spread of cancer from the primary site (place where it started) to other places in the body" to form new tumors. The new tumor is the same type as the primary tumor.[19]

metastasize. To spread or grow by metastasis. Metastasis is the spread of cancer cells "from the initial or primary site of disease to another part of the body."[20]

nodule. "a growth or lump that may be malignant (cancer) or benign (not cancer)."[21]

oncology. "A branch of medicine concerned with the prevention, diagnosis, treatment, and study of cancer."[22]

ongoing professional practice evaluation. "The on-going monitoring of privileged practitioners… to confirm the quality of care delivered…Data must be practitioner specific, reliable, easily retrievable, timely, justifiable, comparable, and risk adjusted where appropriate."[23]

peripheral vascular disease. "A slow and progressive circulation disorder. Narrowing, blockage, or spasms in a blood vessel can cause PVD. PVD may affect any blood vessel outside

---

[16] "What is Vascular and Interventional Radiology," Johns Hopkins Medicine, accessed April 23, 2023, https://www.hopkinsmedicine.org/interventional-radiology/what_is_IR.html.

[17] National Cancer Institute, "lung cancer," accessed January 20, 2023, accessed January 20, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/lung-cancer.

[18] National Cancer Institute, "lymph node," accessed November 26, 2019, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/lymph-node.

[19] National Cancer Institute, "metastatic," accessed January 23, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/metastatic.

[20] *Merriam-Webster.com Dictionary*, "metastasis," accessed April 26, 2023, https://www.merriam-webster.com/dictionary/metastasis; *Merriam-Webster. com Dictionary*, "metastasize," accessed April 26, 2023, https://www.merriam-webster.com/dictionary/metastasize.

[21] National Cancer Institute, *Dictionary of Cancer Terms*, "nodule," accessed January 20, 2023, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/nodule.

[22] *Merriam-Webster.com Dictionary*, "oncology," accessed June 4, 2020, https://www.merriam-webster.com/dictionary/oncology.

[23] VA Handbook 1100.19.

the heart including the arteries, veins, or lymphatic vessels… However, the legs and feet are most commonly affected"[24]

positron emission tomography scan. 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.[25]

post-void residual. The amount of urine that remains in the bladder after urination. Ideally, when a patient goes to the bathroom, the bladder should be emptied. A PVR test measures the amount of urine left in the bladder.[26]

prostate cancer. A cancer that occurs in the prostate, a small gland in men that produces the fluid that supports and transports sperm.[27]

prostate biopsy. "a procedure to remove samples of suspicious tissue from the prostate." During the biopsy, "a needle is used to collect a number of tissue samples from [a patient's] prostate gland." This procedure may be recommended if results from other tests, like a digital rectal exam or prostate-specific antigen, indicate a concern for prostate cancer.[28]

prostate-specific antigen. A protein which is made by the prostate gland and is often elevated in prostate cancer but can also be elevated in several benign conditions. The results are reported as nanograms per milliliter (ng/mL). [29]

pulmonary. "of, relating to, affecting, or occurring in the lungs."[30]

squamous cell carcinoma. A specific type of lung cancer "that forms in the thin, flat cells lining the inside of the lungs."[31]

---

[24] "Peripheral Vascular Disease," Johns Hopkins Medicine, accessed January 23, 2023, https://www.hopkinsmedicine.org/health/conditions-and-diseases/peripheral-vascular-disease.

[25] National Cancer Institute, *Dictionary of Cancer Terms*, "PET scan," accessed June 17, 2019, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/pet-scan.

[26] "Post-Void Residual Urine Test," Cleveland Clinic, accessed October 6, 2022, https://my.clevelandclinic.org/health/diseases/16423-postvoid-residual.

[27] "Prostate cancer," Mayo Clinic, accessed October 6, 2022, https://www.mayoclinic.org/diseases-conditions/prostate-cancer/symptoms-causes/syc-20353087.

[28] "Prostate biopsy," Mayo Clinic, accessed January 20, 2023, https://www.mayoclinic.org/tests-procedures/prostate-biopsy/about/pac-20384734.

[29] "Prostate-Specific Antigen (PSA) Test," National Cancer Institute, accessed January 24, 2023, https://www.cancer.gov/types/prostate/psa-fact-sheet#what-is-the-psa-test.

[30] *Merriam-Webster. com Dictionary*, "pulmonary," accessed January 20, 2023, https://www.merriam-webster.com/dictionary/pulmonary.

[31] "Non-Small Cell Lung Cancer Treatment (PDQ®) – Patient Version," National Cancer Institute, accessed January 20, 2023, https://www.cancer.gov/types/lung/patient/non-small-cell-lung-treatment-pdq.

ureteral stent. Thin, flexible tubes that allow urine to flow from the kidneys to the bladder.[32]

urology. A medical specialty that deals with diseases of the urinary tract (kidneys, ureters, bladder, and urethra).[33]

vascular. "of, relating to, or affecting a channel for the conveyance of a body fluid (such as blood. . .) or a system of such channels."[34]

[32] "Ureteral Stents," Cleveland Clinic, accessed February 1, 2023, https://my.clevelandclinic.org/health/treatments/21795-ureteral-stents.

[33] "What is Urology?" Urology Care Foundation, accessed March 22, 2021, https://www.urologyhealth.org/urologic-conditions/what-is-urology.

[34] *Merriam-Webster.com Dictionary*, "vascular," accessed January 25, 2023, https://www.merriam-webster.com/dictionary/vascular.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Valerie Lumm, MHL, BSN, Director Mark Bartuska, MHA, RN Margaret Fox, MS, RDN Stephanie Long, MSW, LCSW Meredith Magner-Perlin, MPH Larry Melia, MD Robin Moyer, MD Jennifer Nalley, AuD Dawn Rubin, JD
Other Contributors	Josephine Biley Andrion, MHA, BSN Shelby Assad, LCSW Sherry Becker, MSN, RN-BC Limin Clegg, PhD Christopher D. Hoffman, LCSW, MBA Kevin Hosey, LCSW Hanna Lin, LCSW Sheena Mesa, MSN, RN Natalie Sadow, MBA Zaire Smith, LCSW Erica Taylor, MSW, LICSW Robert Wallace, ScD Joanne Wasko, LCSW, MSW

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Heart of Texas Health Care Network (10N17)
Director, Central Texas Veterans Health Care System (674)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: John Cornyn, Ted Cruz
US House of Representatives: John Carter, Greg Casar, Michael Cloud, Lloyd Doggett, Jake Ellzey, Michael McCaul, August Pfluger, Chip Roy, Pete Sessions, Roger Williams

OIG reports are available at www.vaoig.gov.