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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

Healthcare Inspection | **25-02420-118** | **May 21, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection on May 8, 2025, to evaluate allegations related to the availability of breast images from community providers and potential impact on patient care at the VA Eastern Colorado Health Care System (facility) in Aurora, Colorado. A site visit was conducted from June 10 through 12, 2025, followed by virtual interviews from June 17 through September 11, 2025.

The OIG found deficiencies in the availability of breast images needed by facility providers for coordination of patient care, processes for tracking breast cancer screening and follow-up, and processes for credentialing and privileging a new mammographer.[1]

Availability of Breast Images for Coordination of Patient Care

In February 2024, the facility's sole radiologist with specialization in mammography (mammographer) left the facility, resulting in the loss of American College of Radiology mammography accreditation and closure of the facility's in-house mammography program.[2] The closure of the facility's in-house mammography program resulted in all patients requiring breast imaging being referred to community care.[3]

The OIG substantiated that delayed receipt of images from community care providers, and delayed uploading of images by facility staff once the images were received, did not ensure timely availability of breast images for facility providers to coordinate patient care. The OIG determined that several factors contributed to the delayed availability of breast images, including community providers not routinely sending breast images with reports, facility community care staff not following medical record request processes, facility backlogs of images to be uploaded, and limitations of VA technology systems.

Tracking of Breast Cancer Screening and Follow-Up

The OIG found that the facility lacked detailed guidance regarding required women's health tracking processes, and that facility primary care staff had not fully implemented processes to identify and notify patients due for breast cancer screening.

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

[2] All VA facility mammography programs are required to be accredited by the American College of Radiology. "Frequently Asked Questions about MQSA," US Food and Drug Administration, accessed August 8, 2025, https://www.fda.gov/radiation-emitting-products/mammography-information-patients/frequently-asked-questions-about-mqsa.

[3] The Veterans Health Administration's Veterans Community Care Program provides care in the community for eligible veterans when VA is unable to provide the necessary service.

The Veterans Health Administration (VHA) Directive 1330.01(7), *Health Care Services for Women Veterans,* requires that all facilities have a process to track breast cancer screening and follow-up, including notification of patients who are due for screening, completion of screening, reporting of results, and follow-up care.[4]

While patients' care is managed through their primary care team, facility policy 11B-1, *Breast Cancer Screening*, requires that women's health program staff maintain a system for tracking abnormal mammography results. However, the OIG determined that the facility's existing policy and standard operating procedures (SOPs) lacked sufficient guidance on women's health tracking responsibilities.[5] Additionally, the facility did not establish a mammography coordinator position until 2025, despite allocating responsibilities to that role in policy in 2019.[6]

The OIG learned the facility's primary care service established an SOP in February 2025, outlining a process for primary care registered nurse case managers to track and coordinate care for patients due for breast cancer screening.[7] However, reported barriers to full implementation included inaccurate and incomplete reports used to identify patients, as well as understaffing.

Credentialing and Privileging of a New Mammographer

The OIG found that the facility credentialing and privileging staff and interim chief of radiology did not sufficiently verify the new mammographer's specialty training credentials, did not complete a review of supporting documentation during the new mammographer's credentialing and privileging process, and did not initiate the required focused professional practice evaluation timely, potentially delaying the processes required to reopen the facility's in-house mammography program and posing risk for patient harm.

As of January 2026, the facility had not reestablished mammography program accreditation in accordance with VHA Directive 1043, *Restructuring of VHA Clinical Programs*, or resumed provision of breast imaging services.[8]

The OIG made two recommendations to the Under Secretary for Health related to ensuring community providers' understanding of expectations and processes for provision of breast images and reviewing limitations of current VA image sharing technologies and considering implementation of technologies to support timely availability of images with community providers.

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

[5] VA Eastern Colorado Health Care System 11B-1, *Breast Cancer Screening*, May 31, 2019.

[6] VA Eastern Colorado Health Care System 11B-1.

[7] VA Eastern Colorado Health Care System SOP PACT-5, "Patient Aligned Care Team Registries," February 18, 2025.

[8] VHA Directive 1043, *Restructuring of VHA Clinical Programs*, November 2, 2016.

The OIG made seven recommendations to the Facility Director related to community care medical record request processes, processes for timely receipt and uploading of community care images, facility guidance and resources for tracking breast cancer screening and follow-up, ensuring patients with abnormal breast imaging findings receive appropriate notification and timely follow-up, and ensuring compliance with required credentialing and privileging processes.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with recommendations 2–9 and concurred in principle with recommendation 1. Acceptable action plans were provided (see appendixes A, B, and C). Based on information provided, the OIG considers recommendation 4 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

The Under Secretary for Health reported plans to communicate expectations for community care providers sending breast images and actions taken to develop an enterprise strategy to standardize and modernize image sharing. The Facility Director outlined plans to address timely requests, receipt, and uploading of imaging; breast cancer screening and care coordination processes; and credentialing and privileging processes.

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Contents

Abbreviations

BIRADS	breast imaging reporting and data system
EHR	electronic health record
FPPE	focused professional practice evaluation
MQSA	Mammography Quality Standards Act
OIG	Office of Inspector General
PACS	Picture Archiving and Communication System
SEOC	standardized episode of care
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	women veterans program manager

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on May 8, 2025, to assess the availability of breast images from community care providers and potential impact on patient care at the VA Eastern Colorado Health Care System (facility) in Aurora, Colorado. A site visit was conducted June 10 through 12, 2025, followed by virtual interviews from June 17 through September 11, 2025. The OIG also identified concerns related to the credentialing and privileging of a new mammographer.[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 19, consists of the Rocky Mountain Regional VA Medical Center in Aurora, and community-based outpatient clinics throughout Colorado. The facility is level 1a, highest complexity, and offers a wide range of healthcare services, including primary and mental health care, specialty care, and acute inpatient medical and surgical care. From October 1, 2023, through September 30, 2024, the facility served 114,225 patients and had 238 operating beds, including 148 hospital beds, 60 domiciliary beds, and 30 community living center beds. During this time frame, more than 15,600 women veterans received care through the facility, including primary care, gender-specific care, and mental health services.

Breast Cancer Screening

Breast cancer is the most diagnosed cancer and the second leading cause of cancer deaths among women in the United States.[2] A screening mammogram is the most reliable way to detect breast cancer early, often before physical symptoms develop. Regular screening mammograms can lower the risk of death, as breast cancer is treated more successfully when found early, before it spreads. Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.[3]

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

[2] "Breast Cancer Facts & Figures," American Cancer Society, accessed August 13, 2025, https://www.cancer.org/research/cancer-facts-statistics/breast-cancer-facts-figures.html; "United States Cancer Statistics: Data Visualizations," US Cancer Statistics Working Group, US Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute, accessed August 13, 2025, https://www.cdc.gov/cancer/dataviz.

[3] "Screening for Breast Cancer," Centers for Disease Control and Prevention and National Cancer Institute, accessed August 13, 2025, https://www.cdc.gov/breast-cancer/screening/index.html; "American Cancer Society Recommendations for the Early Detection of Breast Cancer," American Cancer Society, accessed August 13, 2025, https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html.

Breast Imaging

Breast imaging refers to "a sub-specialty of diagnostic radiology that involves imaging of the breast for cancer screening or diagnostic purposes."[4] Breast imaging studies use various techniques to create images of internal breast tissue, which radiologists use to detect abnormalities that may signal disease. Breast imaging studies are commonly used to screen, diagnose, and guide treatment of breast cancer, including mammograms, breast ultrasound, and breast magnetic resonance imaging (MRI).[5]

VA Community Care

The Veterans Health Administration's (VHA's) Veterans Community Care Program authorizes care in the community for eligible veterans when VA is unable to provide the necessary service. In general, to refer a patient to a community provider, a VHA provider enters a consult (an order) in the patient's electronic health record (EHR).[6] Facility community care staff receive the consult and send the referral to a community care provider, authorizing the requested healthcare services for the patient. Depending on the type of care and the patient's preference, an appointment may be scheduled by facility community care staff or scheduled directly by the patient with the community provider. After the appointment, community providers should return clinical documentation to the referring facility, generally within 30 days of the patient's care. If the community care provider does not send documentation promptly, facility community care staff request medical documentation from the provider.[7]

Prior OIG Reports

An OIG Office of Audits and Evaluations report, published on August 7, 2025, included recommendations related to medical record sharing processes between VA and community care providers, including identifying opportunities for standardization and the use of technology to

[4] Fabio Garcea, Alessio Serra, Fabrizio Lamberti, and Lia Mor, "Data augmentation for medical imaging: A systematic literature review," *Computers in Biology and Medicine* 152, (2023): 1-20, https://doi.org/10.1016/j.compbiomed.2022.106391.

[5] Dedy Hermansyah and Naufal Nandita Firsty, "The Role of Breast Imaging in Pre- and Post-Definitive Treatment of Breast Cancer," chap. 6 in *Breast Cancer,* ed. Harvey N. Mayrovitz (Brisbane: Exon Publications, 2022), 83-99, https://doi.org/10.36255/exon-publications-breast-cancer.

[6] VHA Directive 1232, *Consult Management*, November 22, 2024.

[7] VHA Office of Integrated Veteran Care, "How to Close Community Care Consults/Manage Clinical Documentation from Community Providers/How to Verify the Veteran Attended Appointment," chap. 4 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, accessed April 17, 2025, https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/554400000001031/topic/554400000023651/0504-Chapter-4-Consult-Completion-and-Medical-Records-Management. (This site is not publicly accessible.)

improve efficiency and availability of records in the EHR. As of April 20, 2026, two recommendations remained open.[8]

An OIG Care in the Community report for VISN 16, published March 20, 2025, included recommendations related to community care staffing and practices for timely retrieval, upload, and VA provider notification of diagnostic imaging results. As of January 22, 2026, all recommendations were closed.[9]

An OIG Healthcare Inspection report for the facility, published June 24, 2024, included recommendations related to oversight of staffing, hiring, and retention practices, and evaluation of clinical service leader vacancies. As of January 22, 2026, all recommendations were closed.[10]

Allegations and Related Concern

While conducting a routine Healthcare Facility Inspection, an OIG inspection team learned of deficiencies in the facility's management of radiology imaging for screening and diagnosis of breast disease.

The OIG opened an inspection to evaluate allegations that a lack of access to community care breast images for VHA providers caused delays in care. Specifically, there was a delay in the

- receipt of images from community care providers,
- uploading of community care breast images by facility staff, and
- treatment of breast disease related to the unavailability of community care breast images for VHA providers.

Additionally, there was an allegation that the spreadsheet used by women's health to track breast imaging was incomplete and inaccurate.

During the inspection, the OIG team identified additional concerns in the facility's credentialing and privileging processes.

[8] VA OIG, *Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records*, Report No. 24-02154-154, August 7, 2025.

[9] VA OIG, *Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers*, Report No. 24-00823-68, March 20, 2025.

[10] VA OIG, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety*, Report 23-02179-188, June 24, 2024.

Scope and Methodology

The OIG initiated the inspection on April 17, 2025, and conducted a site visit June 10–12, 2025. Virtual interviews were conducted following the site visit from June 17 through September 11, 2025.

The OIG team interviewed VHA leaders (director of the digital transformation center in the office of information and technology, director of National Radiology Program); VISN 19 leaders [Health Information Management, credentialing and privileging, women veterans program manager (WVPM)]; facility leaders [interim chiefs of staff, deputy chief of staff, associate chief of staff for primary care, acting chief of radiology, acting chief of surgery, chief of community care, deputy chief of surgery, chief nurse for community care and referral coordination initiative, women's health medical director, former WVPM, acting WVPM, chief nurse outpatient services, chief of health administration service, assistant chief of health administration service (health information management)]; imaging program administrator; credentialing and privileging supervisor; and facility staff (radiology, surgery, women's health, community care, and informatics).

The OIG reviewed relevant facility policies and procedures, organizational charts, human resource personnel documents, committee meeting minutes, email communications, issue briefs, compliance reports, and facility mammography program accreditation documentation. The OIG also reviewed women's health mammography tracking spreadsheets and EHR entries from October 2023–March 2025.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

In February 2024, the facility's sole radiologist with specialization in mammography (mammographer) left the facility, resulting in the loss of American College of Radiology mammography accreditation and closure of the facility's in-house mammography program.[11] The closure resulted in all breast imaging being referred to community care.

The OIG found deficiencies in the availability of breast images needed by facility providers for coordination of patient care, processes for tracking breast cancer screening and follow-up, and processes for credentialing and privileging a new mammographer.

1. Availability of Breast Images and Coordination of Patient Care

The OIG substantiated that delayed receipt of images from community care providers, and delayed uploading of images by facility staff once the images were received, resulted in a lack of timely availability of breast images for facility providers and the potential to affect patient care.

Medical providers need timely access to breast imaging results, including images, for timely diagnosis, staging, and treatment of breast cancer.[12] Radiology images play a vital role in treatment planning by allowing providers to visualize where cancer is located and how far it has spread, which informs treatment recommendations, and may also be used to guide delivery of surgical and other cancer treatments.[13] When a patient is referred to community care for breast imaging, timely receipt of medical reports and images from the community provider is necessary for continuity of care.[14]

The process of community care providers sending images to facilities and facility staff uploading the images to the EHR and ensuring the images are viewable to providers is a complex, multi-step, multi-person process, resulting in multiple opportunities for process failure. The OIG determined that several factors contributed to delayed availability of breast images, including community providers not routinely sending breast images with reports, facility community care staff not following medical record request processes, facility backlogs of images to be uploaded,

[11] All VA facility mammography programs are required to be accredited by the American College of Radiology. "Frequently Asked Questions about MQSA," US Food and Drug Administration, accessed August, 8, 2025, https://www.fda.gov/radiation-emitting-products/mammography-information-patients/frequently-asked-questions-about-mqsa.

[12] CA Donovan et al., "Timeliness of Breast Diagnostic Imaging and Biopsy in Practice: 15 Years of Collecting, Comparing, and Defining Quality Breast Cancer Care," Annals of Surgical Oncology 30, (August 1, 2023): 6070-6078, https://doi.org/10.1245/s10434-023-13905-6.

[13] "Cancer Imaging Basics for Diagnosis and Treatment," National Cancer Institute, accessed September 15, 2025, https://dctd.cancer.gov/research/research-areas/imaging/basics.

[14] VHA Office of Integrated Veteran Care (IVC) Community Care, "How to Close Community Care Consults/Manage Clinical Documentation from Community Providers/How to Verify the Veteran Attended Appointment," chap. 4 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

and limitations of VA technology systems.

Community Care Providers Sending Images

When community care providers complete an episode of care, VHA guidance (chapter 4 of the Office of Integrated Veteran Care Field Guidebook, "Consult Completion and Medical Records Management") and contracts with third-party administrators—entities that provide and manage VHA's network of community care providers—require community providers to send medical documentation to the referring VA facility within 30 days.[15] Language in the community care contract regarding the provision of any medical documentation, including results for testing or imaging, specifies that it must be provided to VA when requested.

When requesting mammography services from a community provider, facility community care staff send an authorization with a standardized episode of care (SEOC) that covers services associated with the episode of care. The SEOC for mammography includes the following instructions:

> Please provide a DVD disc of the study to the Veteran and mail a separate DVD disc copy of the study to the VHA local site that authorized the study. Please include a .pdf of the final report in the image series on the DVD. Please also send a copy of the final report by mail, fax, or secure email to the local VA facility. If the facility can share images through a bi-directional image-sharing platform (e.g., Medicom) with the local VA site, then a disc doesn't need to be mailed.[16]

The OIG learned through interviews that, despite the instructions on the SEOC including a request for images, community provider representatives typically provided breast imaging reports, but did not routinely send breast images unless the images were requested by the facility after the imaging study was completed. Community provider representatives interviewed by the OIG consistently expressed an understanding that providing images was not required unless a separate request was received from the facility. When asked about the instructions to provide images within the referral document, one community provider representative acknowledged being unaware of this language within the SEOC and described only sending images upon receipt of a faxed request. In addition, the OIG was told by a facility community care leader (community care leader 1) that community providers often asked for a release of information prior to sending the images, which could cause delays. The OIG found that despite the instructions in the SEOC to provide images, and 45 CFR 164.506, the Health Information

[15] VHA Office of Integrated Veteran Care (IVC) Community Care, "How to Close Community Care Consults/Manage Clinical Documentation from Community Providers/How to Verify the Veteran Attended Appointment," chap. 4 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

[16] Medicom is the interface between the VA PACS and VistA importer. "VA Technical Reference Model v 25.7," U.S. Department of Veterans Affairs, April 30, 2025, accessed August 6, 2025, https://www.oit.va.gov/services/trm/ToolPage.aspx?tid=11612#. (This website is not publicly accessible.)

Portability and Accountability Act (HIPAA) Privacy Rule allowing for the sharing of health information without obtaining authorization, community providers requested authorization prior to releasing images to the facility.[17]

The OIG found that facility leaders were aware of the challenges related to obtaining images from community care providers. Facility community care leader 1 reported that challenges with receipt of community care images is a wide-spread issue, affecting other facilities across VISNs, noting that there is no mechanism to enforce the return of records from community providers.[18] While VA guidance states clinical documentation from community care providers "is critical to care coordination," there is no requirement for the receipt of records prior to payment for the services.[19] Facility community care leader 1 also reported that the challenges with timely receipt of images have been elevated to facility leaders, discussed during visits from VHA's Office of Integrated Veteran Care, and addressed in repeated discussions with the facility's third-party administrators. Through review of documentation, the OIG learned that the third-party administrator is responsible for educating community care providers on submitting final medical documentation, including documentation covering the entire SEOC, within 30 days of the appointment.

The OIG determined that the lack of knowledge or understanding by community providers of the expectation to provide all images with imaging reports contributed to the delayed receipt of images from community care providers.

Facility Community Care Medical Record Requests and Documentation

When community providers do not send clinical documentation after a patient receives approved care, facility community care staff must make three attempts to contact the community provider to request the records, which include imaging reports and images.[20] VHA Memorandum Guidance on administrative closure of community care consults, in effect at the time of the review, required staff to make the first request to retrieve records, administratively close the

[17] Covered entities (such as VA and community care network healthcare facilities) may use or disclose protected health information for treatment, payment, or healthcare operations, except with respect to uses or disclosures that are prohibited or require specific authorization. 45 C.F.R. §164.506 (2025).

[18] A prior OIG report also detailed challenges for VHA facilities related to receipt and uploading of medical records from community care providers. VA OIG, *Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records*, Report No. 24-02154-154, August 7, 2025.

[19] VHA Health Information Management, "Medical Document Submission Requirements for Care Coordination," (fact sheet), June 9, 2025.

[20] VHA Office of Integrated Veteran Care (IVC) Community Care, "How to Close Community Care Consults/Manage Clinical Documentation from Community Providers/How to Verify the Veteran Attended Appointment," chap. 4 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

consult, and then make two more requests within 90 days if no records are received.[21] Facility community care staff must document attempts to obtain the records from the community provider in the patient's community care consult.[22] Facility standard operating procedure (SOP) "Community Care Breast Cancer Screening Local Handoff Process," also requires that the facility community care nurses use the patient's community care consult to notify the ordering provider of mammogram records that have been received using a significant finding alert.[23]

In interviews, facility community care leaders explained challenges with medical records requests when all breast imaging was referred to community care following the departure of the mammographer in February 2024. The leaders reported that consults were administratively closed after the initial attempt to obtain breast images and that the required two additional attempts were not consistently made due to facility community care staffing shortages. The community care leaders reported a substantial increase of more than 400 additional mammogram consults each month without any increase in resources. The leaders also explained that in fall 2024, 10 additional community care nurse positions were approved, but no medical support assistant (MSA) positions were approved, leaving them short staffed. The OIG reviewed staffing documentation of approved positions and vacancies provided by the facility and found that as of May 2025, facility community care still had multiple vacancies in approved positions, including 22 of the 85 approved MSA positions and 14 of 60 approved registered nurse case manager positions.

The OIG learned that the facility chartered a monthly Community Care Oversight Committee in February 2025.[24] Community Care Oversight Committee meeting minutes from March 2025 documented that the VISN approved an additional 19 MSAs and 10 registered nurses for hire at the facility to address identified staffing shortages in facility community care. A facility community care leader reported that the facility was in the process of hiring the approved positions, but reported that, even with the new positions filled, facility community care staffing needs would still not be met. The Interim Deputy Chief of Staff also told the OIG of using a

[21] Assistant Under Secretary for Health for Community Care (13), "Revised Administrative Closure of Community Care Consults Process (VIEWS# 06042227)," memorandum to Veterans Integrated Service Network Directors (VISN 1-23), October 1, 2021; Acting Assistant Under Secretary for Health for Integrated Veteran Care, "For Action: Updated Guidance for Retrieval of Medical Documentation for Community Care Consults (VIEWS #13434288)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), July 30, 2025. Revised consult closure policy per the July 30, 2025, memorandum requires staff make three documented requests to retrieve medical documentation from community providers within 90 days of the appointment completion, for all community care consults, prior to administrative completion.

[22] VHA Office of Integrated Veteran Care (IVC) Community Care, "How to Close Community Care Consults/Manage Clinical Documentation from Community Providers/How to Verify the Veteran Attended Appointment," chap. 4 in *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*.

[23] Eastern Colorado Health Care System SOP OCC-4, "Community Care Breast Cancer Screening Local Handoff Process," January 11, 2022.

[24] Eastern Colorado Health Care System Charter CCOC, "Community Care Oversight Committee," February 7, 2025.

contract service to fill some of the 100 positions authorized for facility community care.

The facility's Community Care Oversight Committee meeting minutes also documented the number of mammography consults, the number of attempts by community care staff to obtain records, and the total number of referrals without records.[25] The OIG's review of meeting minutes for March and April 2025 indicated that there were 247 and 277 total breast imaging records requests with no records received for each month, respectively. Of the breast imaging records requests, only 22 of the 247 and 23 of the 277 documented three or more attempts to request records as required.

The OIG also found deficiencies in the facility's community care staff's documentation of the receipt of reports or images in patients' community care consult as required.[26] The OIG learned, from community care leaders, that nurses did not consistently document receipt of records within the community care consult, and there was only one code for staff to document receipt of reports or images in the consult, making it difficult for clinical staff to discern if images were received versus only the report.

The OIG concluded that facility community care understaffing, combined with the increased workload from the higher volume of referrals, may have contributed to delays requesting and receiving community care breast images. The OIG also noted that facility community care staff did not always make the required number of record requests to obtain images and did not consistently document receipt of images in patients' community care consult. These deficiencies likely contributed to challenges for clinical staff to discern if images were received and resulted in additional time and effort to locate the images.[27]

Facility Uploading of Images to the EHR

According to VHA Directive 1104, *Radiology Picture Archiving and Communication Systems (PACS)*, diagnostic radiology images must be stored in both the facility's radiology PACS and EHR imaging systems.[28] Additionally, if documentation has been received but not imported into the EHR within five days of receipt, VHA Directive 1907.01(1), *VHA Health Information*

[25] At the time of the review, the minutes for the May 2025 meeting had not been finalized and did not contain tracking data.

[26] Assistant Under Secretary for Health for Community Care (13), "Revised Administrative Closure of Community Care Consults Process (VIEWS# 06042227)," memorandum.

[27] Assistant Under Secretary for Health for Community Care (13), "Revised Administrative Closure of Community Care Consults Process (VIEWS# 06042227)," memorandum.

[28] The Picture Archiving and Communication System supports storage for the display and interpretation of radiologic images and "expedite[s] health care decisions by making images available anywhere in the medical facility as soon as they are acquired." Patient information stored in the Picture Archiving and Communication System is archived in VistA Imaging, a component of the EHR system. VHA Directive 1104, *Radiology Picture Archiving and Communication Systems (PACS),* September 1, 2017.

Management and Health Records, requires an action plan to decrease the backlog be submitted to facility leaders.[29]

Through review of documents and email communication, the OIG learned that in spring 2025, the VISN health information manager notified facility leaders via an issue brief of three discrete backlogs of radiology images (see table 1).[30] Two of the backlogs (backlog 1 and backlog 2) were related to imaging from completed community care consults that needed to be uploaded into the EHR by facility staff. Backlog 3 was related to facility imaging needed for comparison by community care radiologists to interpret results for community care consults.

Table 1. Backlogs of Images Requiring Action

Backlog	Date	Source	Type	Action Required to Resolve
1	Late 2024	Community care providers	1,000 radiology images on disc	Facility radiology technicians upload into the EHR*
2	Mid-2024	Community care providers	4,815 unique sets of electronic images	Facility community care staff retrieve from Medicom and facility radiology staff upload into the EHR
3	Early 2025	VHA	849 requests for images related to consults	Facility staff "push" images into Medicom for community provider retrieval

Source: OIG review of spring 2025 issue brief.
**An unspecified number also required provider review or a new order entered prior to upload.*

Complex Upload Process

The OIG found that once images were received by the facility, there were several complex steps to upload the images to make them viewable for providers.

Facility community care and radiology staff described the imaging upload process, in which facility community care nurses monitor for the receipt of records and communicate with radiology technologists, who upload community care breast images into the PACS. Community care nurses were given access to Medicom to check for images and established an application in Microsoft Teams for community care staff to alert radiology staff when they identified that images were available and needed to be uploaded. While the communication process reportedly worked, a facility community care leader noted that reports were typically received prior to

[29] VHA Directive 1907.01(1), *VHA Health Information Management and Health Records*, April 5, 2021, amended December 11, 2023.

[30] The backlogs quantities discussed were for all of radiology imaging, included breast imaging; Issue briefs provide facility, VISN, and VHA leaders clear, concise, information about a situation or event. Assistant Undersecretary for Health for Operations (15), *Guide to VHA Issue Briefs*, April 6, 2022; The VISN health information manager reported that of the backlog of radiology examinations on disc (backlog 1), 58 sets of images were mammograms.

images, and staff must continue to check in Medicom when related images are not initially found.

The OIG learned from facility staff that, prior to uploading a mammography image from a community care consult, the associated report must already be uploaded and there must be an active order from the referring provider in the EHR for the image. A member of the facility's Imaging Task Force reported that, in mid-2024, a new mammography order set, containing both community care and in-house imaging orders, was created to reduce delays resulting from this issue.[31] The in-house imaging orders are placed on hold with radiology until the community care referral is completed and the images returned from the community provider. This process eliminates the need to contact the provider for a new order and ensures that images can be uploaded once received.

Increased Image Upload Demands and Radiology Staffing Shortages

An imaging service leader told the OIG that the increase in mammography referrals to community care caused a significant increase in the number of images requiring upload by radiology staff, noting an increase of 5,000 breast images per year needing to be uploaded without dedicated staff. Imaging staff explained that the radiology technologists worked on uploading images in between providing patient care and were further challenged by staffing shortages and leave. A member of the facility's Imaging Task Force also reported that a need for additional radiology staff to process the influx of mammograms was identified after mapping facility processes for community care mammography referrals, but the recommendation for additional radiology staff was not approved by facility leaders.

The OIG found the increased volume of community care breast imaging referrals following the loss of the facility's mammographer, complex upload processes, and understaffing contributed to a backlog of images requiring upload and delayed image availability.

VA Image Sharing Technology

As detailed in the mammography SEOC, community care providers may send images to the facility on a physical disc or provide the images electronically via an image sharing platform. The OIG's review of literature found that the practice of using physical discs to share digital

[31] The Imaging Task Force manager explained that an informal work group with representatives from the facility's office of community care, primary care, and radiology services was convened in approximately mid-2024 to address problems related to orders for community care mammography referrals, which were recognized after the closure of the facility's in-house mammography program. Following a visit from VHA's Office of Integrated Veteran Care in October 2024, the workgroup was formalized and tasked with improving processes for community care mammography referrals.

images was obsolete and could lead to delays in care, errors, omissions, and repeated imaging.[32]

Facility community care leader 1 noted that some community providers are not on the network to transmit images via Medicom, the image sharing platform used by the facility, and those providers must send images via disc. The leader explained that when community providers send images via discs, it takes a very long time to receive and upload the images. An imaging service leader told the OIG that when breast images were received via disc, the discs had to be manually uploaded using an external drive that was available in radiology service.

In interviews with the OIG, community care provider representatives confirmed sending images via discs due to not using the facility's electronic image sharing platform. A community care provider representative added that sending images via disc would eventually not be an option, because when the current disc burner is no longer operational, it will not be replaced.

A facility imaging service leader and community care provider representatives both reported electronic transmission as the preferred method for image sharing. An imaging service leader told the OIG that the facility uses Medicom as the image sharing program to send and receive images with other facilities. Although Medicom allows the facility to share images with community care providers, an imaging service leader described the lack of real-time access to radiology images (on demand) as a limitation and inefficiency of Medicom. The leader explained that the system requires community providers to take active steps to upload images from their own systems into Medicom before facility staff can view and retrieve them. The leader contrasted this with the functionality of sharing a cloud-based system used by community providers, which would allow facility staff to go in to the system, view, and retrieve desired images directly.

An imaging service staff member described additional challenges, indicating that staff were not alerted when requested records were uploaded to Medicom. As a result, staff had to repeatedly check the system to determine whether a community provider had uploaded images, making them available for download by facility community care staff. Further, the staff member described Medicom as a repository, explaining that the request of two images for a patient can lead to 30 to 35 unrelated images being pushed into Medicom from the community provider's system, requiring staff to sort through a sometimes "overwhelming" volume to find the necessary images and determine which images needed to be retrieved. An imaging service leader told the OIG, "[Medicom] is better than discs, but now instead of having discs lying around, we have them [images] sitting in Medicom."

[32] Laura Sirtonski, "Interinstitutional Electronic Image Exchange: A 'Last Mile Problem,'" *Radiological Society of North America*, May 5, 2022, https://www.rsna.org/news/2022/may/electronic-image-exchange; R Legha et al., "Interinstitutional outside imaging transfer: Benefits Challenges, and Evolving Technology," *Current Problems in Diagnostic Radiology* 53, issue 6, (November–December 2024): 753-757, https://doi.org/10.1067/j.cpradiol.2024.07.009; G McGinty, "#Ditchthedisk," *Journal of Digital Imaging* 35, (June 9, 2022): 737-738, https://doi.org/10.1007/s10278-022-00664-1.

When speaking with representatives from a sample of four community care providers that provided breast imaging services for the facility, the OIG learned that all four used a cloud-based bi-directional image sharing platform to send and receive images with other community facilities. Through review of the Imaging Task Force minutes, the OIG learned that the facility is unable to use the imaging sharing platform used by many community providers because it is not approved for use within VA.

The OIG learned through review of documentation that VHA staff have placed several requests for a cloud-based image sharing platform since 2018.[33] When speaking with the OIG, a VHA information technology leader confirmed that three requests submitted by VHA facilities to use the platform had been closed due to the vendor declining to go through the Federal Risk and Authorization Management Program process, which was required for approval.[34] Federal Risk and Authorization Management Program designation indicates that the security capabilities of a cloud service offering have been reviewed and deemed acceptable for use within VHA. The information technology leader was unable to specify the reason the platform vendor declined but acknowledged that some vendors chose not to pursue approval due to the process being cumbersome and cost prohibitive for the vendors.

The Executive Director of the National Radiology Program told the OIG of challenges with using VA's contract image sharing system, Medicom, and noted that during site visits with facilities, the national program office has observed confusion about how Medicom connects with systems used by community providers. The Executive Director explained that the process of sending, receiving, and uploading images with community providers via Medicom involves complex workflows, which span across services. The Executive Director recognized challenges for facilities to effectively use the existing image sharing capabilities, explaining the need for a workflow to connect facilities with community providers so that images could be sent to the facility portal, verified, connected to the imaging report, and uploaded into the patient's EHR, and the provider alerted that the results were available. The Executive Director described "we want to make it mandatory for community partners to interact with the VA, but to do that, we really have to create a consistent platform for them to do it and a consistent workflow."

The Executive Director of the National Radiology Program described recent efforts to revise VHA policy to require each facility to have an SOP for exchanging records with community care providers, noting that the revised policy is in the process of approval and not yet published.[35] The Executive Director noted that the National Radiology Program has provided an SOP template,

[33] VA Technical Reference Model, "Request and Inquiries Lists," https://trm.oit.va.gov/TRMRequestListSummaryPage.aspx. (This site is not publicly accessible.)

[34] The Federal Risk and Authorization Management Program provides a standardized approach to security risk assessment and authorization for cloud service offerings. "FedRAMP," accessed September 18, 2025, https://www.fedramp.gov/.

[35] VHA Directive 1104.

which facilities are encouraged to use to create a standard policy. The Executive Director also shared that the National Radiology Program office put forth a proposal for development of an enterprise contract for a cloud-based community information exchange system, explaining that the benefit would be to minimize the variability between systems and create a more uniform platform and uniform standards for community providers interacting with the VA. The Executive Director reported that the proposal had been approved by the Chief Operating Officer in July 2025, and National Radiology Program staff are working with VHA's Digital Health Office, with a goal of completing the contracting process in fiscal year 2026.

The OIG found that technological challenges and complex workflows hampered the image sharing process, resulting in the unavailability of or delayed access to images.

Impact on Treatment of Patients

The OIG substantiated that the treatment of breast disease may be delayed due to unavailability of community care breast images for facility surgical providers who provide consultation and treatment for breast cancer. The OIG learned that surgical staff had to employ extensive efforts and workarounds to obtain the necessary images and minimize impact on patients.

A facility surgeon explained the challenges and impact of imaging delays on patient care, indicating that images are critical for making real-time care decisions with patients. The surgeon explained that most breast surgeries are image-guided, and if the images are not available, the surgeon could not safely conduct the surgery. The surgeon stressed that cancer is a time-sensitive diagnosis, thus availability of images to inform care decisions is essential for care.

During interviews, surgical staff described instances of images being unavailable prior to patients' appointments, as well as "close calls" where images were not available for the surgeon's review until the day of the patients' scheduled surgeries. As a result, surgical staff went to great lengths to obtain images and rescheduled patient appointments when images were not available. Surgical staff also described that the administrative workload associated with efforts to obtain the necessary images from community care providers detracted from time for direct clinical care. A facility provider described the extensive process to obtain community care images prior to a patient's appointment, including calling the community provider to request that the images be sent or pushed to Medicom, emailing the facility radiology technologist, requesting the image be uploaded into the system, and following up as necessary to try and ensure the image would be available when needed.

A surgeon told the OIG that "it is hard to know when images from the community come in," and the timeline for images being accessible in a patient's record was "extremely variable." Due to the identified problems with timely image accessibility, surgical staff reported instituting a process for reviewing the clinic schedule, checking records, and requesting missing images in advance of patient appointments. A surgical physician assistant described that in the process of preparing for a patient's appointment, locating breast images may require looking in multiple

systems, including PACS and different components of the patient's EHR, and often resulted in duplicative efforts. The surgical physician assistant also reported that images were generally not available and described contacting staff in community care, radiology, and the nurse manager of surgery to ascertain if the imaging was completed and ask for assistance with obtaining images. The surgeon acknowledged using "workarounds" in some instances, relying on community facility privileges and imaging systems to access the necessary images. However, the surgeon stressed that reliance on workarounds was concerning and the facility process needed to be fixed to ensure timely access to necessary images to support patient care.

2. Tracking of Breast Cancer Screening and Follow-Up

The OIG found that the facility lacked required processes for women's health tracking of breast cancer screening and follow-up, and substantiated the spreadsheet used by women's health staff for tracking abnormal mammography results was incomplete and inaccurate. The OIG also learned that facility primary care staff did not fully implement processes to identify and notify patients due for breast cancer screening.

VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, requires that all facilities have a process to track breast cancer screening and follow-up including

- notification of patients who are due for screening,
- tracking of the completion of screening,
- reporting of results, and
- follow-up care.[36]

According to facility policy 11B-1, *Breast Cancer Screening*, tracking breast cancer screening and follow-up care is managed by primary care, community care, and women's health. Facility policies assign responsibility for ordering breast cancer screening at appropriate intervals to patients' primary care providers, who are also responsible for notifying patients of test results and monitoring follow-up care after ordered screening is completed.[37] While patients' care is managed through their primary care team, the policy specifies that women's health program staff are responsible for maintaining a system for tracking "abnormal mammography," and a

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

[37] VA Eastern Colorado Health Care System 11B-1, *Breast Cancer Screening*, May 31, 2019; When breast cancer screening is referred to community providers, facility community care staff are responsible for tracking the status of the referral and ensuring ordering providers are notified when reports are received from community providers. VA Eastern Colorado Health Care System SOP OCC-4, "Community Care Breast Cancer Screening Local Handoff Process."

mammography coordinator is responsible for conducting regular quality assurance reviews to ensure timeliness of follow-up care.[38]

The facility was unable to provide an SOP or other guidance document that detailed the required tracking processes for women's health staff. While the facility's community care SOP OCC-4, *Community Care Breast Cancer Screening Local Handoff Process*, specified that "Women Veterans Health Program (WVHP) staff … are responsible for tracking breast imaging reporting and data system (BIRADS) 0, 2, 3, 4, 5, 6 to ensure that the ordering [primary care provider] (PCP) provides patient(s) with timely notification and follow-up care," no further guidance was provided.[39] Additionally, facility leaders reported that the facility did not have a mammography coordinator, and did not approve hiring for that position for more than five years after the 2019 facility policy 11B-1, *Breast Cancer Screening*, allocated responsibilities to that role.[40] During interviews, the OIG learned that a women's health staff member was assigned to track completed breast imaging orders for patient and provider notification of imaging results and follow-up procedures, starting in 2014.[41] The former facility WVPM provided a tracking spreadsheet to the women's health staff member each month, with a list of breast imaging orders completed for the prior month. The former facility WVPM told the OIG that the list of completed orders was obtained from a database report created by a facility informaticist. When following up with facility informatics, the OIG was told that the report had not been maintained or updated since it was built in 2014 and the parameters used to build the report were unknown.

To evaluate the accuracy and completeness of the data and functionality of the tracking spreadsheet, the OIG reviewed the available tracking spreadsheets from October 2023 through March 2025 and found that 18 of 18 monthly tracking sheets (100 percent) had inaccurate or missing data.[42] The OIG identified 14 patients with breast imaging results that confirmed cancer (BIRAD 6) or were highly suggestive of the presence of cancerous cells (BIRAD 5), and 34 associated breast imaging orders for those patients within the tracking sheets. The OIG reviewed the EHRs for the 14 patients and found that all imaging orders had missing or inaccurate data in the tracker. For example, most of the monthly tracking sheets reviewed contained broken formulas, resulting in inaccurate calculations of the number of days to provider

[38] VA Eastern Colorado Health Care System 11B-1.

[39] VA Eastern Colorado Health Care System SOP OCC-4, "Community Care Breast Cancer Screening Local Handoff Process."

[40] VA Eastern Colorado Health Care System 11B-1.

[41] During an interview, the OIG learned the women's health staff member was a licensed practical nurse, serving in a position of nurse navigator for women's health.

[42] The OIG reviewed women's health tracking of breast cancer screening and follow-up from October 2023 through June 2025 and found tracking spreadsheets were not completed after March 2025. When asked, the women's health staff member responsible for completing the tracking sheets reported not receiving tracking sheets beginning in April. The OIG noted this timing coincided with the departure of the former facility WVPM. In July 2025, the newly hired facility mammography coordinator told the OIG that the previous process for monthly tracking had been discontinued.

and patient notifications of results, and some orders on the tracker had missing information for follow-up procedures.[43]

The OIG also noted that the tracking spreadsheets presented challenges for the women's health staff member in tracking patients across their full episode of care. The spreadsheet only tracked orders completed in a given month. By presenting a new spreadsheet each month, the spreadsheet hindered the reviewer in determining delays or gaps in care.

A women's health staff member confirmed challenges with locating data in the EHR and with tracking patient mammography orders across multiple monthly spreadsheets. Further, the women's health staff member reported that the tracker did not include patients in all the facility's community-based outpatient clinic locations. Through interviews, the OIG also found that women's health staff did not have a process in place to communicate relevant information from their tracking to other staff involved in the patient's care.

The Women's Health Medical Director reported that the women's health mammography tracking process would be revamped under the newly hired mammography coordinator. Facility leaders reported receiving approval for a mammography coordinator position in late 2024 and onboarding the new coordinator in June 2025. The Women's Health Medical Director reported that arrangements were made for the newly hired mammography coordinator to receive training from another VA facility's mammography coordinator using that facility's tracking process.

In addition to the deficiencies in women's health tracking, the OIG learned of challenges for the facility's primary care service in tracking patients due for breast cancer screening. During an interview with the OIG in July 2025, the chief nurse for outpatient services explained that prior to February 2025, facility primary care teams did not have a process in place to identify and notify patients due for breast cancer screening. In February 2025, facility primary care established an SOP, outlining a process for primary care registered nurse case managers to track and coordinate care for patients due for breast cancer screening.[44] However, the chief nurse for outpatient services reported that the processes detailed in the SOP were not yet fully implemented. The chief nurse reported barriers to full implementation including

[43] A formula performs calculations or other actions on data in a spreadsheet. For example, a formula may be used to calculate the number of days between two dates in a spreadsheet. The OIG found that, for the 14 patients (34 orders) reviewed, providers and patients received timely notification of results for 29 of 34 orders (85 percent) and that follow-up care was scheduled for 34 of 34 orders (100 percent).

[44] VA Eastern Colorado Health Care System SOP PACT-5, "Patient Aligned Care Team Registries," February 18, 2025.

- inaccuracies in the reports used by primary care teams to identify patients due for breast cancer screening;[45]
- delays in including breast cancer screening on the report used by managers to monitor performance, pending resolutions of the inaccuracies; and[46]
- understaffing affecting the ability to dedicate time for primary care nurses to track patients due for breast cancer screening.

Ensuring routine screenings, timely notification of results, and follow-up treatment are important to reduce harm and optimize patient outcomes. The OIG determined that insufficient guidance, absence of a mammography coordinator, lack of staffing resources, and a gap in quality assurance mechanisms contributed to the tracking and coordination deficiencies.

3. Credentialing and Privileging of a New Mammographer

During the inspection, the OIG identified deficiencies in the facility's credentialing and privileging processes for a new mammographer, who was appointed in September 2024, and came on board at the facility in January 2025. The OIG determined that the interim chief of radiology did not complete a sufficient review of supporting documentation during the new mammographer's credentialing and privileging process and did not initiate the required focused professional practice evaluation (FPPE) timely.

When onboarding healthcare providers, VHA Directive 1100.20(2), *Credentialing of Health Care Providers*, requires primary source verification of the educational credentials used to qualify for a position, including all graduate and postgraduate training.[47] During the privileging process, the service chief is responsible for reviewing all primary source verified credentials, reviewing the privileges requested by the provider, and using that information as a basis for decisions when recommending privileges.[48] VHA Directive 1100.21(1), *Privileging*, also requires that all providers who are granted new or additional privileges are placed on an FPPE.[49]

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[45] VA Office of Information and Technology, *Clinical Reminders, Manager's Manual*, March 2005, revised September 2022. The facility used clinical reminders to track patients due for breast cancer screening. A clinical reminder is a software decision support tool used to assist healthcare staff by identifying patients who need a clinical action. The chief nurse explained that, when breast cancer screenings are referred to community care providers and results return, the completion of the screening must be manually documented in the clinical reminder in the patient's EHR. If this additional step is not completed, the software does not reset the associated clinical reminder. Inaccuracies in the status of breast screening clinical reminders became a prevalent issue when all breast cancer screenings were referred to community care.

[46] The chief nurse for outpatient services reported that the new mammography coordinator is working with primary care to assess the clinical reminders for breast cancer screenings and resolve the inaccuracies.

[47] VHA Directive 1100.20(2), *Credentialing of Health Care Providers*, September 15, 2021, amended September 11, 2024.

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

[49] VHA Directive 1100.21(1).

The FPPE provides specialty-specific criteria used to monitor the clinical performance of providers who have been granted new privileges at a facility and to identify concerns regarding clinical performance. For providers new to a facility, the respective service chief is responsible for implementing the FPPE "at the time of the initial appointment to the medical staff."[50] According to facility *Bylaws and Rules of the Medical Staff*, providers are transitioned to ongoing professional practice evaluation (OPPE) upon successful completion of the FPPE.[51]

The OIG found that the facility did not sufficiently verify the new mammographer's specialty training credentials during the credentialing process. During an interview, the OIG learned that facility credentialing staff relied on prior documentation from another VA facility where the new mammographer provided radiology services as a locum tenens (temporary provider). The documentation only described the new mammographer's fellowship specialty as "other," and therefore lacked adequate information to confirm the specialty training to provide mammography services at the facility. Failure to sufficiently verify healthcare providers' training credentials during the hiring process places patients at risk for harm if care is rendered by unqualified providers.

Privileging documentation showed that the interim chief of radiology recommended all requested privileges for the new mammographer, including core radiology privileges and delineated diagnostic radiology privileges for breast imaging and procedures. However, the interim service chief did not verify breast imaging experience or completion of the volume of breast imaging procedures consistent with the "suggested minimums" listed on the privileging request form, intended to demonstrate the applicant's proficiency with the privileges requested. When asked about the process for reviewing and recommending approval of the privileges, the interim chief of radiology described having relied solely on the new mammographer's interview and resume. Completion of the initial FPPE process documents the privilege-specific competence of a provider and serves as a baseline for ongoing quality assurance monitoring.[52] The interim chief of radiology emailed the initial FPPE to the new mammographer on May 15, 2025, with a request for signature to document the new mammographers acceptance of initiation of the FPPE. During the inspection, the OIG learned the new mammographer signed and returned the initial FPPE in July 2025, approximately six months after onboarding at the facility and starting to provide radiology readings.[53]

[50] VHA Directive 1100.21(1).

[51] VA Eastern Colorado Healthcare System, *Bylaws and Rules of the Medical Staff*, February 2024. The FPPE was never completed, and the OIG learned that the new mammographer left the facility mid-August 2025.

[52] VHA Directive 1100.21(1).

[53] The OIG was told the facility does not have accreditation for mammography from the American College of Radiology at this time; therefore, the new mammographer told the OIG of providing general radiology readings only.

As of January 2026, the facility had not reestablished mammography program accreditation or resumed provision of breast imaging services. Facility leaders reported delays with reopening the facility's in-house mammography program pending a clinical restructuring approval process, in accordance with VHA Directive 1043, *Restructuring of VHA Clinical Programs*, which was initiated in early 2025.[54] In June 2025, the clinical restructuring request was placed on hold, with facility leaders reporting that the new mammographer did not provide the required Mammography Quality Standards Act (MQSA) documentation for American College of Radiology mammography accreditation, despite multiple requests for the documents.[55]

The OIG noted that, had the new mammographer's MQSA documentation been requested for verification of completed procedures during the credentialing and privileging process, the delays encountered to obtain the required documentation to support the facility's clinical restructuring request and reaccreditation may have been avoided or recognized earlier, allowing the issue to be addressed more expediently.[56]

The OIG determined that deficiencies in the facility's credentialing and privileging process, and lack of MQSA documentation, contributed to delays in reattaining American College of Radiology accreditation and reopening the facility's in-house mammography program. Additionally, the OIG noted that credentialing and privileging process deficiencies pose risks for patient harm.

Conclusion

The OIG found deficiencies in the availability of breast images, processes for tracking breast cancer screening and follow-up, and processes for credentialing and privileging a new mammographer.

The OIG substantiated that facility processes did not ensure timely availability of breast images for providers to coordinate patient care. The OIG found there were delays in both the receipt of images from community care providers and the uploading of community care images by facility

[54] When a facility plans major additions to services or programs, such as re-establishing the mammography program, VHA policy requires that a "clinical evaluation must be conducted to ensure competencies and skills of all clinical staff as well as necessary ancillary services needed." Facility leaders must submit a clinical restructuring request, which is overseen by the facility's respective VISN and approved through VHA central office. VHA Directive 1043, *Restructuring of VHA Clinical Programs*, November 2, 2016.

[55] During an interview with the OIG on June 16, 2025, the new mammographer reported having the required MQSA documents, and sent several documents to the OIG via email on July 7, 2025. The OIG did not verify the documents nor assess whether they met the American College of Radiology requirements for MQSA. As of September 9, 2025, the deputy chief of staff reported the new mammographer had not provided the required MQSA documentation to the facility as requested by leaders.

[56] "All interpreting physicians … must meet MQSA requirements and must have initial and continuing qualification documentation available at the facility." "Interpreting Physician: Mammography (Revised 05-22-2024)," American College of Radiology, accessed August 4, 2025, https://accreditationsupport.acr.org/support/solutions/articles/11000049778-mammography-interpreting-physician.

staff once the images were received. Contributing factors to the delayed receipt of images included community providers' lack of understanding of the expectation to provide radiology images with reports, increased volume of community care referrals, and understaffing in the facility's office of community care, which affected consistency of facility requests for and documentation of images. Contributing factors to the delayed uploading of images once received included the increased volume of community care breast imaging referrals, radiology staffing, complex uploading processes, and technology limitations, which resulted in a backlog of images requiring upload.

The OIG found that the facility lacked detailed guidance regarding required women's health tracking processes, and found the spreadsheet used by women's health staff for tracking abnormal mammography results was incomplete, inaccurate, and used an outdated data source that did not identify all patients to be tracked. Additionally, women's health tracking did not include a process to communicate relevant clinical information between services and, therefore, did not effectively support care coordination as intended.

The OIG also learned that facility primary care staff did not fully implement processes to identify patients due for breast cancer screening. Barriers to full implementation included inaccurate and incomplete reports used to identify patients, as well as understaffing.

During the inspection, the OIG identified deficiencies in the facility's credentialing and privileging processes for a new mammographer. The facility did not sufficiently verify the new mammographer's specialty training credentials during the credentialing process, complete sufficient review of supporting documentation, or initiate the required FPPE timely.

The OIG made two recommendations to the Under Secretary for Health and seven recommendations to the Facility Director. The Under Secretary for Health reported plans to communicate expectations for community care providers sending breast images and actions taken to develop an enterprise strategy to standardize and modernize image sharing. The Facility Director outlined plans to address timely requests, receipt, and uploading of imaging; breast cancer screening and care coordination processes; and credentialing and privileging processes.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–9

1. The Under Secretary for Health ensures the third-party administrator and community care breast imaging providers are informed of the expectations and processes for provision of breast images to the referring VA facility, addresses any barriers identified, and follows up to ensure compliance.

2. The VA Eastern Colorado Health Care System Director ensures that facility community care staff comply with Veterans Health Administration requirements for requesting medical records, including images, from community providers and documentation of the receipt of medical records, including images, and follows up to ensure compliance.

3. The VA Eastern Colorado Health Care System Director reviews processes, to ensure community care images are uploaded timely; assesses identified barriers, including staffing; and follows up to ensure compliance.

4. The Under Secretary for Health reviews limitations of current VA image sharing technologies, considers implementation of technologies to support timely sharing of images with community providers, and takes action as warranted.

5. The VA Eastern Colorado Health Care System Director reviews facility policy and standard operating procedures to ensure sufficient guidance and resources for compliance with Veterans Health Administration requirements for breast cancer screening, follow-up, and care coordination, and takes action as warranted.

6. The VA Eastern Colorado Health Care System Director assesses the scope of the lack of tracking of breast cancer screening and follow-up for patients with a BIRADS 0, 3, 4, 5, or 6 from at least February 2024 forward to ensure all patients receive appropriate notification and timely follow-up of findings, and takes action as indicated.

7. The VA Eastern Colorado Health Care System Director ensures credentialing and privileging staff complete primary source verification of credentials, and monitors for compliance.

8. The VA Eastern Colorado Health Care System Director makes certain that clinical service chiefs follow processes for review of supporting documentation during the credentialing and privileging process, and follows up to ensure compliance.

9. The VA Eastern Colorado Health Care System Director ensures that the radiology service chief initiates focused professional practice evaluations timely, as required, and monitors for compliance.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: April 15, 2026

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora

To: Acting Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora. The Veterans Health Administration (VHA) concurs with the action plan provided by the Eastern Colorado Health Care System Director. Additionally, VHA concurs in principle with recommendation 1, and concurs with recommendation 4 made to the Under Secretary for Health. The associated action plans are attached.
2. I would like to take this opportunity to clarify that VHA revised the consult closure policy via a memorandum which was released July 31, 2025. This document updated the administrative closure process, requiring staff to make three requests for medical documentation from community providers within 90 days on all community care consults before the consult is administratively closed. I believe this update is important to highlight since the report indicates that the OIG evaluated the VA Eastern Colorado Health Care System using guidance provided in an October 1, 2021, memorandum on administrative closures.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)

John J. Bartrum, JD, MBA

[OIG comment: The OIG received the above memorandum from VHA on April 20, 2026.]

Office of the Under Secretary for Health Response

Recommendation 1

The Under Secretary for Health ensures the third-party administrator and community care breast imaging providers are informed of the expectations and processes for provision of breast images to the referring VA facility, addresses any barriers identified, and follows up to ensure compliance.

_X _Concur in Principle

____Nonconcur

Target date for completion: October 2026

Under Secretary for Health Comments

The Third-Party Administrator (TPA) holds direct contracts with individual providers, which limits VHA's authority to mandate education and compliance with the providers. VHA will work closely with TPAs to address the limitations identified in this recommendation.

VHA will immediately obtain all current relevant guidance and collaborate with internal stakeholders, including the communications department, to ensure clear, consistent messaging is developed and disseminated to providers. Updated informational materials will outline expectations and processes for the timely provision of breast images to referring VA facilities. TPAs will use these materials to inform imaging providers, and VHA will request documentation confirming dissemination of informational materials to providers to promote accountability.

TPAs will communicate any barriers to VHA, and VHA will work collaboratively with TPAs to resolve those barriers. Both VHA personnel and TPAs can formally escalate barriers during the monthly Network Adequacy Meeting (NAM) and VHA personnel can enter a ticket into the Network Adequacy (NA) Issue tracker for return of medical documentation issues to facilitate resolution.

Recommendation 4

The Under Secretary for Health reviews limitations of current VA image sharing technologies, considers implementation of technologies to support timely sharing of images with community providers, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: February 2026

Under Secretary for Health Comments

Through the Community Care Network Next Generation Bi-Directional Image Exchange workgroup, Integrated Veteran Care (IVC) in partnership with National Radiology Program has reviewed the limitations of current image-sharing technologies and identified significant gaps impacting timely care coordination. These limitations include delays in accessing community imaging, variability in existing contracts, and increased burden on Veterans due to repeat imaging. In response, the National Radiology Program developed an enterprise strategy to standardize and modernize image exchange across all Veterans Integrated Service Networks (VISN). This strategy ensures timely, secure image sharing, reduce delays, and strengthen continuity of care for Veterans receiving services both within VA and through community providers. With this work, VHA has reviewed limitations, considered implementation, and acted as warranted. VHA requests closure of this recommendation.

OIG Comments

The OIG considers this recommendation closed.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 17, 2026

From: Director, Department of Veterans Affairs (VA) Rocky Mountain Network (10N19)

Subj: VA Office of Inspector General (OIG) Report, Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora

To: Director, Office of Healthcare Inspections (54WH00)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report. I reviewed the action plan provided by the facility and concur with the response.
2. Should you need further information, please contact the Veterans Integrated Service Network Quality Management Officer.

(*Original signed by:*)

Chelsea Childress, MBA
Deputy Network Director, VA Rocky Mountain Network (10N19)
for
Sunaina Kumar-Giebel, MHA
Director, VA Rocky Mountain Network (10N19)

[OIG comment: The OIG received the above memorandum from VHA on April 20, 2026.]

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 16, 2026

From: Director, Department of Veterans Affairs (VA) Eastern Colorado Healthcare System (554)

Subj: VA Office of Inspector General (OIG) Report, Review of the Availability of Community Care Breast Images and Impact to Surgical Care at the VA Eastern Colorado Health Care System in Aurora

To: Director, Office of Healthcare Inspections (54WH00)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to review and comment on the OIG draft report. The Eastern Colorado Healthcare System concurs with the recommendations and will take corrective action.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Duane B. Gill, FACHE
Executive Director, Eastern Colorado Health Care System

[OIG comment: The OIG received the above memorandum from VHA on April 20, 2026.]

Facility Director Response

Recommendation 2

The VA Eastern Colorado Health Care System Director ensures that facility community care staff comply with Veterans Health Administration requirements for requesting medical records, including images, from community providers and documentation of the receipt of medical records, including images, and follows up to ensure compliance.

_X _Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

VA Eastern Colorado Health Care System (ECHCS) will continue to focus on timely receipt and upload of imaging reports and addressing barriers to the process to obtain appropriate medical documentation.

The VA ECHCS Office of Community Care (OCC) revised SOP-4 to clarify roles, designated a Mammography Coordinator for continued outreach, and prioritized mammography records in the workflow. Health Information Management has routed external records to OCC for community care consults. Expanded MSA staffing has supported timely record requests, and all MSAs have received biannual refresher training. A pilot program with another facility will automate record requests. A Provider Liaison RN conducts targeted outreach to community providers.

VA ECHCS will monitor receipt of medical records or the three attempts to obtain medical records within 90 days of scheduled mammography or breast imaging appointment; provide additional training and monitor compliance through Community Care Oversight Committee reporting; and monitor until two consecutive quarters of data is 90% or greater.

Recommendation 3

The VA Eastern Colorado Health Care System Director reviews processes, to ensure community care images are uploaded timely; assesses identified barriers, including staffing; and follows up to ensure compliance.

_X _Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

VA ECHCS will continue to focus on timely receipt and upload of imaging reports and address barriers to the process to obtain appropriate medical documentation. To date, several actions have been taken to improve the situation. Support was deployed to address the existing backlog, and a breast imaging Community Care Tracker was implemented. Additionally, a workflow was established for uploading reports via Imaging, OCC, or the Health Information Management Section (HIMS). National leadership was engaged to discuss staffing and interoperability options.VA ECHCS will: 1) Prioritize imaging report upload compliance to avoid backlog and monitoring "records received" that are greater than five business days from receipt; 2) Collaborate with OCC and HIMS to ensure timely receipt and upload of mammogram and breast imaging reports; 3) Review staffing needs to support upload workflows. Revise staffing models and/or request staffing based on needed resources to sustain compliance; and 4) Monitor monthly and report to VA ECHCS Community Care Oversight Committee, until two consecutive quarters of data are 90% or greater.

Recommendation 5

The VA Eastern Colorado Health Care System Director reviews facility policy and standard operating procedures to ensure sufficient guidance and resources for compliance with Veterans Health Administration requirements for breast cancer screening, follow-up, and care coordination, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

Several actions have been taken to date by the VA ECHCS Women's Health Program to ensure compliance and improve processes for breast cancer screening and care coordination. The program reviewed the Veterans Health Administration Directive 1330.01(7), Healthcare Services for Women Veterans, originally issued on February 15, 2017, and amended on May 14, 2023, to determine compliance with breast cancer screening, follow-up, and care coordination. Consequently, the VA ECHCS 11B-1 directive regarding breast cancer screening, dated May 31, 2019, was rescinded and replaced by the Women's Health Program Breast Cancer Screening and Tracking Process Standard Operating Procedure (SOP WHP-01). SOP WHP-01 was developed to incorporate all relevant requirements and guidelines from VHA Directive 1330.01(7). The new SOP was reviewed and approved by the Clinical Review of Publications Committee, Nurse Executive Council, and Healthcare Delivery Council, passing all levels of concurrence, and was finalized on February 5, 2026.

The VA ECHCS Women's Veterans Health (WVH) Program Manager will ensure compliance with VHA requirements through review of: VHA Directive 1330.01(7); VA ECHCS 11B-1, Breast Cancer Screening, May 31, 2019, was rescinded and replaced by Women's Health Program Breast Cancer Screening and Tracking Process Standard Operating Procedure. This will be monitored by the Women's Health Advisory Committee and the Healthcare Delivery Council. Compliance will be monitored until two consecutive quarters of data is 90% or greater.

Recommendation 6

The VA Eastern Colorado Health Care System Director assesses the scope of the lack of tracking of breast cancer screening and follow-up for patients with a BIRADS 0, 3, 4, 5, or 6 from at least February 2024 forward to ensure all patients receive appropriate notification and timely follow-up of findings, and takes action as indicated.

_X _Concur

____Nonconcur

Target date for completion: October 2026

Director Comments

On June 24, 2025, the Breast Cancer Screening Coordinator implemented a tool to ensure comprehensive monitoring of all breast imaging consults including screening and diagnostic mammograms, breast MRIs, breast ultrasound, and biopsies. The Breast Cancer Screening Coordinator ensures tracking and timely follow-up of abnormal breast imaging findings through comprehensive care coordination. Additionally, daily tracking ensures timely notification between community imaging providers, the VA ordering provider, and the patient. This is tracked through governance in the Women's Health Advisory Committee and the Healthcare Delivery Council.

The VA ECHCS Women Veteran Program Manager will oversee ongoing compliance with appropriate notifications and follow-up for patients with BI-RADS 0, 3, 4, 5, 6 results through quarterly audits. The total number of BI-RADS 0, 3,4,5,6 results with the percentage of patient notification and follow-ups will be reported to Women's Health Advisory Committee quarterly. The audit will include patient harm or no patient harm status. If patient harm is identified, evidence of clinical or institutional disclosure documented will be provided. This will be reported and monitored by the Women's Health Advisory Committee and the Healthcare Delivery Council. Compliance will be monitored until two consecutive quarters of data is 90% or greater.

Recommendation 7

The VA Eastern Colorado Health Care System Director ensures credentialing and privileging staff complete primary source verification of credentials, and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: September 2026

Director Comments

To date, refresher training has been provided to Credentialing and Privileging (C&P) staff on the process of primary source verification in accordance with Veterans Health Administration Credentialing Directive 1100.20 Standard Operating Procedures C01 through C08. Prior to onboarding all new practitioners, the C&P staff complete audits of VetPro files to ensure all appropriate primary source verifications are complete. C&P audit results will be used for compliance assessment through continuous monitoring and sustainment efforts. Data will be reported to the C&P Committee until a compliance rate of 90% or higher is achieved for two consecutive quarters.

Recommendation 8

The VA Eastern Colorado Health Care System Director makes certain that clinical service chiefs follow processes for review of supporting documentation during the credentialing and privileging process, and follows up to ensure compliance.

_X _Concur

____Nonconcur

Target date for completion: September 2026

Director Comments

Resources detailing the processes for service chiefs, as required by directives, are available on the C&P SharePoint.

The Chief of Staff through the C&P Supervisor will continue to support clinical service chiefs with the current process by reviewing supporting documentation within VetPro prior to the service chief approving file. Additional training will be provided to all service chiefs on VHA Credentialing Directive 1100.20 Standard Operating Procedure C9.

As the Chair of the C&P Committee, the Deputy Chief of Staff will monitor compliance using audits. Compliance will be assessed through continuous monitoring and sustainment efforts, with data being reported to the C&P Committee until two consecutive quarters achieve a compliance

rate of 90% or higher. The C&P Committee reports through the governance structure to the Medical Executive Board, chaired by the Chief of Staff.

Recommendation 9

The VA Eastern Colorado Health Care System Director ensures that the radiology service chief initiates focused professional practice evaluations timely, as required, and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

The Service Chiefs will continue to implement monthly tracking of professional practice evaluations for new providers to ensure compliance with start date, end date, required data points and timely completion in accordance with directive requirements. A new focused professional practice evaluation (FPPE) tracking mechanism was implemented in August 2025 within C&P Committee after having been approved in Medical Executive Council. The new provider's FPPEs dates are monitored until completion and conversion to an ongoing professional practice evaluation (OPPE). All service chiefs have been educated on this new tracking mechanism to ensure compliance and completion of FPPEs. All of VA Eastern Colorado Health Care System FPPEs are tracked by the C&P staff.

Compliance will be assessed through continuous monitoring and sustainment efforts, with data being reported to the C&P Committee until two consecutive quarters achieve a compliance rate of 90% or higher.

Glossary

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

breast imaging reporting and data system (BIRADS). A "scoring system classification for breast cancer risk." [1]

breast magnetic resonance imaging. An imaging test that "uses a large magnet, radio waves, and a computer to produce detailed" images of breast tissue.[2]

breast ultrasound. An imaging test that "uses high-frequency sound waves to take pictures of the tissues and structures inside" the breast.[3]

consult. "A request for service on behalf of a veteran."[4]

credentialing. "The systematic process of screening and evaluating qualifications and other credentials, including, but not limited to, licensure, education, training, experience, current competence, and health status."[5]

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 practitioner] who does not yet have documented evidence of competently performing the requested privileges at the VA medical facility."[6]

locum tenens. A medical practitioner who temporarily takes the place of another.[7]

mammogram. An x-ray of breast tissue, used to look for early signs of breast cancer (screening mammogram) or investigate suspicious changes in breast tissue (diagnostic mammogram).[8]

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[1] VA Eastern Colorado Health Care System, Community Care Breast Cancer Screening Local Handoff Process, January 11, 2022.

[2] "Breast MRI," Cleveland Clinic, accessed April 29, 2025, https://my.clevelandclinic.org/health/diagnostics/8332-breast-mri.

[3] "Breast Ultrasound," Cleveland Clinic, accessed April 29, 2025, https://my.clevelandclinic.org/health/diagnostics/21496-breast-ultrasound.

[4] VHA Directive 1232, *Consult Management*, November 22, 2024.

[5] VA Eastern Colorado Healthcare System, *Bylaws and Rules of the Medical Staff*, February 2024.

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

[7] "Locum Tenens," Merriam-Webster Medical Dictionary, accessed August 11, 2025, https://www.merriam-webster.com/dictionary/locum%20tenens#medicalDictionary.

[8] "Mammogram," Mayo Clinic, accessed April 29, 2025. https://www.mayoclinic.org/tests-procedures/mammogram/about/pac-20384806.

Mammography Quality Standards Act. A federal law that sets standards intended to ensure high-quality mammography services and patient safety.[9]

ongoing professional practice evaluation. An oversight process for the ongoing monitoring of privileged licensed independent practitioners used "to identify clinical practice trends that may impact the quality and safety of care."[10]

primary source verification. Verification via "the original source or an approved agent of that source of a specific credential that can verify the accuracy of a qualification reported by an individual practitioner."[11]

privileging. The granting of authority to a licensed independent practitioner by a facility's "governing body to independently render specific diagnostic, therapeutic, medical, or surgical services, without supervision or direction."[12]

radiology. A branch of medicine concerned with the use of radiant energy (such as x-rays) or radioactive material in the diagnosis and treatment of disease.[13]

[9] "Mammography Quality Standards Act (MQSA) and MQSA Program," US Food and Drug Administration, accessed July 28, 2025, https://www.fda.gov/radiation-emitting-products/mammography-quality-standards-act-mqsa-and-mqsa-program.

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

[11] VHA Directive 1100.20(2), *Credentialing of Health Care Providers*, September 15, 2021, amended September 11, 2024.

[12] VA Eastern Colorado Healthcare System, *Bylaws and Rules of the Medical Staff*, February 2024.

[13] *Merriam-Webster.com Dictionary*, "radiology," accessed August 13,2025, https://www.merriam-webster.com/dictionary/radiology.

OIG Contact and Staff Acknowledgments

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