DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Deficiencies in the Care of a Patient with Gastrointestinal Symptoms at the Eastern Oklahoma VA Health Care System in Muskogee

HEALTHCARE INSPECTION | REPORT #21-01801-45 | DECEMBER 15, 2021

## MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

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

**Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:**

**www.va.gov/oig/hotline**

**1-800-488-8244**

# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection for an allegation related to a patient who sought help with gastrointestinal symptoms at the Eastern Oklahoma VA Health Care System in Muskogee (facility) three times in 2020 and was allegedly sent away.[1] The patient went to a non-VA hospital and was diagnosed with colorectal cancer (CRC) in early 2021.

During the review of the allegation, the OIG identified concerns about potential deficiencies related to

- Primary Care staff's follow-up of the patient's fecal immunochemical test (FIT),
- an Emergency Department physician's assessment of the patient,
- the facility's response to the patient's complaints, and
- leaders' response to multiple complaints about the Emergency Department physician.[2]

The OIG did not substantiate that the patient who sought help with gastrointestinal symptoms from the facility three times was sent away. The OIG found that the patient, who was in their late 40s with diagnoses of irritable bowel syndrome, posttraumatic stress disorder, tobacco use, and low back pain, was seen by Primary Care providers in spring and fall 2020, and by an Emergency Department physician in late 2020.[3]

Primary care staff did not follow up with the patient's FIT in fall 2020. The OIG determined that the facility had established procedures in accordance with Veterans Health Administration's (VHA) March 2020 guidance to use FIT for CRC screening instead of colonoscopies during the COVID-19 pandemic.[4] The Primary Care nurse reported mailing the FIT to the patient the day after the patient's fall 2020 Primary Care visit but not sending a follow-up letter or contacting the patient after 14 days. However, the OIG found no documented evidence in the electronic health record that the FIT was mailed to or discussed with the patient and there were no FIT results available for the patient or evidence that the patient was contacted when the FIT was not returned.

---

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

[2] The facility had a contract with the Oklahoma State University to provide Emergency Department physician services during the time frame of the events discussed in this report.

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

[4] On March 15, 2020, during the COVID-19 pandemic, the VHA Deputy Under Secretary for Health and Operations Management required all non-urgent elective procedures to cease no later than March 18, 2020, and eight days later provided guidance that emphasized the use of FIT for screening patients at average risk for colorectal cancer, VA Memorandum, *Primary Care Guidance for COVID-19 Pandemic Response,* March 23, 2020.

The OIG found that the Emergency Department physician did not adequately assess the patient in late 2020 by failing to perform a digital rectal examination when the patient's clinical presentation included having blood in the stool. The Emergency Department physician, when asked whether a digital rectal examination was needed, stated "I did not at the time feel it was necessary." The OIG concluded that by omitting a digital rectal examination during the patient's late 2020 visit, the Emergency Department physician did not adequately evaluate the patient based on the presentation with blood in the stool. Had a digital rectal examination been performed, a rectal mass or other sources of bleeding may have been identified.

Facility staff did not adequately review and respond to the patient's complaints. The Chief of Medicine reported having an understanding that a chief or supervisor was to contact patients to better understand patients' frustrations. The Assistant Chief of Primary Care described receiving patient advocacy on-the-job training, which included contacting patients to try to resolve complaints. The Assistant Chief of Primary Care did not address the patient's concerns related to Primary Care providers' response to reported bowel changes. The Assistant Chief of Primary Care stated having reviewed the patient's Primary and Emergency Department care, determined that the patient did not qualify for a colonoscopy, and reported to the Patient Advocate that the patient was given a FIT, which was not completed. The Assistant Chief of Primary Care reported not contacting the patient, but would have contacted the patient "if there was a care aspect which I felt was continuing to be missed." The Patient Advocate failed to address the patient's complaint of not receiving an exam in the Emergency Department, document the involved providers, or contact the patient.[5] The Patient Advocate told the OIG of not having addressed the Emergency Department complaint, and thought that "once I took it to the service chief, they [service chief] would kind of double check" and provide "the answer for the one thing that was pertinent about [the patient's] complaint." Fully addressing the patient's complaint would have afforded facility staff the opportunity to verify the issues, make amends, and assess for indicated process improvements.

In summer 2021, the Chief of Staff completed a review of the patient's care and an institutional disclosure to the patient for "our lapse in timely diagnosis, treatment, and care of [the patient's] colon cancer."

The OIG identified inadequate leaders' response to multiple complaints about the Emergency Department physician. The OIG reviewed 10 patient or caregiver complaints about Emergency Department care from early 2020 through early 2021 and found that six complaints (60 percent), including the patient's complaint, involved the Emergency Department physician. Three complainants described the Emergency Department physician as rude, disrespectful, or

[5] VHA Directive 1003.04, *VHA Patient Advocacy*, February 7, 2018. Patient advocates are employees "designated at each VHA facility to manage the complaint and compliment process, including complaint resolution, data capture and analysis of issues/complaints and communicate this information to facility leadership to help drive system improvements."

unprofessional, and three complainants reported not being taken care of or not receiving an examination by the physician. The Chief of Medicine told the OIG of speaking to the Emergency Department physician about the complaints "intermittently" and discussing the provider's complaints with the lead Emergency Department physician, Chief of Staff, and Contracting Officer Representative. Beyond reporting and intermittent discussions with the provider, the Chief of Medicine and the Chief of Staff did not take further actions to address the Emergency Department physician's performance concerns. Further actions by these leaders may have provided an opportunity to review and address the patient's care needs, including but not limited to the care issues noted in this report.

The OIG made four recommendations to the Facility Director to review processes to ensure patients with ordered FITs are tracked; evaluate processes for Emergency Department providers' physical examinations when a patient presents with gastrointestinal symptoms that include associated bleeding, and determine if modifications, including provider education, are needed; ensure that patient advocates and Primary Care leaders perform thorough reviews of all components of complaints for resolution and patient advocates document according to policy; and ensure facility leaders monitor complaints and take action on issues that are identified related to the Emergency Department physician's performance.

## Comments

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

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

# Contents

# Abbreviations

| | |
|---|---|
| CRC | colorectal cancer |
| EHR | electronic health record |
| FIT | fecal immunochemical test |
| IBS | irritable bowel syndrome |
| OIG | Office of Inspector General |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation related to a patient who sought help with gastrointestinal symptoms from the Eastern Oklahoma VA Health Care System in Muskogee (facility) three times in 2020 and was allegedly sent away.[1] The patient went to a non-VA hospital and was diagnosed with colorectal cancer (CRC) in early 2021.

## Background

The facility, part of Veterans Integrated Service Network (VISN) 19, consists of a main hospital, the Jack C. Montgomery VA Medical Center, which offers inpatient, primary, surgical, and specialty care, and four outpatient clinics.[2] The facility has teaching affiliations with the University of Oklahoma College of Medicine, Oklahoma State University, and Griffin Memorial Hospital.

From October 1, 2019, through September 30, 2020, the facility served 40,406 unique patients and had 63 operating beds. The Veterans Health Administration (VHA) classifies the facility as Level 2, medium complexity.[3]

### CRC Screening

According to the American Cancer Society, "colorectal cancer is the third most common cancer diagnosed in both men and women in the United States," and the third leading cause of cancer death. The rate of CRC diagnosis has dropped since the 1980s due to increased CRC screening.[4] Most CRCs begin as growths, called polyps, and change into cancer over a period of years.[5] The presence of blood in the stool can be indicative of an abnormal colon growth (such as cancer and polyps).[6] A fecal immunochemical test (FIT) and colonoscopy are two screening tests for

[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] Specialty care includes gastroenterology, mental health, and orthopedics. Community-based outpatient clinics are located in Tulsa, Idabel, McAlester, and Vinita.

[3] VHA Office of Productivity, Efficiency and Staffing Fact Sheet, Facility Complexity Model. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and complexity. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and Level 3 facilities are the least complex.

[4] "Key Statistics for Colorectal Cancer," American Cancer Society, accessed May 11, 2021, https://www.cancer.org/cancer/colon-rectal-cancer/about/key-statistics.html.

[5] "What Is Colorectal Cancer?" American Cancer Society, accessed May 11, 2021, https://www.cancer.org/cancer/colon-rectal-cancer/about/what-is-colorectal-cancer.html.

[6] "Colon Polyps," Mayo Clinic, accessed May 11, 2021, https://www.mayoclinic.org/diseases-conditions/colon-polyps/symptoms-causes/syc-20352875?p=1.

patients who are at average risk, such as no family or personal history of colon cancer.[7] To conduct a FIT, a patient is provided a stool collection kit and patient information to complete the FIT.[8]

### Primary Care

VHA defines primary care as "the provision of integrated, accessible health care services," and includes "diagnosis and management of acute and chronic…conditions, health promotion, disease prevention, overall care management, post deployment care, and patient and caregiver education."[9] Primary care providers are "physicians, advanced practice registered nurses, and physician assistants who provide primary care to an assigned panel of patients and in accordance with licensure, privileges, scope of practice or functional statement."[10] VHA leaders expect Primary Care providers to ensure "the patient's care plan contains medical recommendations for clinically indicated care."[11] VHA requires that providers record facts in the electronic health record (EHR) about the patient's health history, examinations, and treatments that facilitate communication and continuity of care among health professionals.[12]

## Allegation and Related Concerns

In February 2021, the OIG received an allegation that a patient sought help with gastrointestinal symptoms from the facility three times in 2020 and was allegedly sent away. The patient went to a non-VA hospital and was diagnosed with CRC in early 2021.

During the review of the allegation, the OIG identified concerns about potential deficiencies related to

- Primary Care staff's follow-up of the patient's FIT,
- an Emergency Department physician's assessment of the patient,
- the facility's response to the patient's complaints, and
- leaders' response to multiple complaints about the Emergency Department physician.

[7] American Cancer Society, "When Should You Start Getting Screened for Colorectal Cancer?," accessed March 31, 2021, https://www.cancer.org/latest-news/american-cancer-society-updates-colorectal-cancer-screening-guideline.html.

[8] Facility Standard Operating Procedure, *SOP #11,* recertified March 9, 2020. The SOP did not have a title.

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

[10] VHA Handbook 1101.10(1).

[11] VHA Handbook 1101.10(1).

[12] VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.

# Scope and Methodology

The OIG initiated the inspection on March 18, 2021, and conducted a virtual site visit from April 26–29, 2021.

The OIG interviewed the complainant; the Facility Director; Chief of Staff; Chief of Medicine and Emergency Medicine (Chief of Medicine), Chief of Primary Care, and Chief of Gastroenterology; Primary Care leaders; Emergency Department and Primary Care staff; Veterans Experience staff; and other staff with knowledge about the processes and events.

The OIG reviewed relevant documents dated April 1, 2019, to May 3, 2021, including facility policies and procedures, the patient's EHR, emails, patient complaints, and quality improvement document reviews. Emergency Department physician services contracts and related documents in effect during the time frame of this hotline between the facility and Oklahoma State University were reviewed.

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, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

# Patient Case Summary

The patient was in their late 40s with diagnoses of posttraumatic stress disorder, tobacco use, and low back pain.[13] In early 2018, the patient began to experience bowel irregularities with episodes of constipation followed by several days of loose stools. In spring 2018, Primary Care provider 1 diagnosed the patient with irritable bowel syndrome (IBS) and added the medication dicyclomine, as needed, to the fiber supplement and probiotics the patient was already taking. In spring 2019, Primary Care provider 2 described the patient's IBS as stable and continued the dicyclomine and fiber supplement.

In late spring 2020, the patient attended a scheduled telephone visit with Primary Care provider 3. The patient's concerns on this visit were allergies and neck and back pain.

In fall 2020, the patient presented for an annual follow-up visit with Primary Care provider 4. During the visit, the Primary Care nurse documented the patient's "[r]equest [for a] colonoscopy due to continued issues with IBS." The same day, Primary Care provider 4 saw the patient and did not document active gastrointestinal issues or the patient's request for a colonoscopy, recorded a negative review of systems in the EHR, and did not include documentation of an abdominal examination. The following day, Primary Care provider 4 ordered a FIT.

In late 2020, the patient presented to the facility's Emergency Department with a three-day history of constipation, and described having "a scant amount of blood and mucous on [the patient's] last bowel movement." The patient denied prior occurrences of gastrointestinal bleeding. The Emergency Department physician documented that the patient had a poor diet, a history of IBS, and ate one meal per day. The patient reported a poor appetite but described it to be a chronic issue. The patient denied abdominal pain. An abdominal examination was recorded without abnormalities, and a digital rectal examination was not documented.[14]

The Emergency Department physician attributed the patient's presentation to "IBS" and "constipation due to low caloric intake" with treatment recommendations for increased fluid intake, regular meals, fiber, and a three-day course of antibiotics. However, before receiving prescriptions and instructions, the patient requested the desk personnel "open the doors and let [the patient] leave" and the patient departed the Emergency Department.

The next day, the Primary Care nurse telephoned the patient to follow up on the Emergency Department visit. The patient reported "not feeling good," and described having abdominal pain and bloating. The patient did not wish to fill the prescriptions provided by the Emergency Department physician, indicating the patient would not be taking them, and also declined the

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

[14] No laboratory tests, stool analysis, or imaging tests were performed at the late 2020 Emergency Department visit.

nurse's offer to reach out to Primary Care provider 4. The patient stated a plan to pursue care from a non-VA provider for further work-up.

In early 2021, the patient underwent a colonoscopy performed by a non-VA provider. The colonoscopy revealed a rectal mass 4 centimeters (cm) from the anal verge, which was interpreted to be an adenocarcinoma. A non-VA general surgeon evaluated the patient approximately two weeks later, and performed a digital rectal examination, which revealed a palpable mass in the rectum. Approximately two weeks later, a non-VA oncologist described the cancer staging as stage IIIB. The patient's management included initial chemoradiation therapy with plans for future surgery and additional chemotherapy.

# Inspection Results

## 1. Allegation: Patient Sought Help for Gastrointestinal Symptoms and Was Sent Away

The OIG did not substantiate that the patient who sought help with gastrointestinal symptoms from the facility three times was sent away. The OIG found that the patient was seen by Primary Care providers in spring and fall 2020 and by an Emergency Department physician in late 2020. The OIG identified concerns that Primary Care staff did not follow up with the patient's FIT in fall 2020 and the Emergency Department physician did not adequately assess the patient in late 2020.

### *Lack of Primary Care Follow-up on the Patient's FIT*

The OIG found that Primary Care staff did not follow up with the patient's FIT in fall 2020.

VHA policy states that providers are to ensure shared decision-making and inform patients of options for CRC screening and the risk, benefits, and option of no screening. The facility CRC screening policy requires a diagnostic colonoscopy for a positive FIT result.[15]

Guidance from VHA National Center for Health Promotion and Disease Prevention indicates that colon cancer screening, for men and women with no personal or family history or symptoms, begins at age 50. If symptoms are present, patients are advised to speak with their provider.[16] VHA policy states that "there are multiple acceptable methods of colorectal cancer

[15] Facility Standard Operating Procedure, *SOP #11*.

[16] National Center for Health Promotion and Disease Prevention, "Get Recommended Screening Tests and Immunizations for Women," accessed May 19, 2021, https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Women.asp. "Get Recommended Screening Tests and Immunizations for Men," accessed May 19, 2021, https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Men.asp.

(CRC) screening that have similar efficacies" and that a FIT is an alternative to a screening colonoscopy.[17]

On March 15, 2020, during the COVID-19 pandemic, the VHA Deputy Under Secretary for Health and Operations Management required all non-urgent elective procedures to cease no later than March 18, 2020, and eight days later provided guidance that emphasized the use of FIT for screening patients at average risk for CRC. On April 1, 2021, VHA Assistant Under Secretary for Health for Operations provided guidance to VISNs for the resumption of non-urgent and elective screening and surveillance colonoscopies.[18]

In spring 2020, the patient attended a scheduled telephone visit with Primary Care provider 3. The patient's concerns on this visit were allergies and neck and back pain. Post-visit, the Primary Care provider entered orders for imaging and allergy medication.[19]

The patient attended a Primary Care visit in fall 2020, and the Primary Care nurse documented that the patient requested a colonoscopy "due to continued issues with IBS." The Primary Care nurse told the OIG of having provided a verbal report of the patient's colonoscopy request to Primary Care provider 4. Primary care provider 4 evaluated the patient and documented issues of low back pain, request for an orthopedist, and interest in smoking cessation. Primary care provider 4 documented that the patient had no gastrointestinal complaints. Primary care provider 4 ordered a FIT the following day; however, at the time of the OIG's inspection, the order was in pending status.[20]

According to the facility standard operating procedure for CRC screening,

- the patient is to receive education and the procedure for stool collection for the FIT,
- the patient is to be encouraged to complete the testing within a week and mail the test to the facility when completed,
- a nurse is to mail out a reminder letter the same day the FIT is provided, and
- if a result has not been received within 14 days of receiving the FIT, a nurse will call the patient as a reminder to return the FIT as soon as possible.[21]

During interviews, the OIG learned of differing accounts from the patient, Primary Care provider 4, and the Primary Care nurse about the discussion and receipt of the FIT. Primary care

[17] VHA Directive 1015, *Colorectal Cancer Screening*, April 3, 2020.

[18] Assistant Under Secretary for Health for Operations, *Memorandum: Screening Colonoscopy and other Elective Gastroenterology Procedures During COVID-19*, April 1, 2021.

[19] The imaging ordered were magnetic resonance imaging and x-rays of the spine.

[20] Staff reported that an order in pending status was not completed. Orders in pending status have been placed but the Laboratory has not yet accepted the order, such as when awaiting a completed FIT.

[21] Facility Standard Operating Procedure, *SOP #11*.

provider 4 told the OIG that the patient requested a colonoscopy due to IBS and that a FIT was offered, but that no explanation regarding the FIT was provided. Primary care provider 4 indicated that the FIT was an alternative for a colonoscopy and "would have picked up occult blood, which if present would have alerted us to possibility of other conditions." Primary care provider 4 reported not asking the patient about gastrointestinal symptoms and incorrectly documenting the patient having no gastrointestinal symptoms in the EHR prior to signing the note. The Primary Care nurse reported mailing the FIT to the patient the day after the patient's fall 2020 Primary Care visit but not sending a follow-up letter, or contacting the patient after 14 days. The patient reported not receiving the FIT or information about FIT from VA. The OIG did not find documented evidence in the EHR that the FIT was mailed to or discussed with the patient, or that the patient was contacted when the FIT was not returned.

The OIG determined that the facility had established procedures in accordance with VHA guidance to use FIT for CRC screening instead of colonoscopies during the COVID-19 pandemic.[22] However, the OIG found no documentation that the patient received the FIT and there were no FIT results or follow-up for the patient to complete the FIT.[23] The OIG was unable to determine if a completed FIT would have prompted colonoscopy testing.

### *Inadequate Emergency Department Physician Assessment*

The OIG found that the Emergency Department physician did not adequately assess the patient by failing to perform a digital rectal examination when the patient's clinical presentation included having blood in the stool. VHA policy states that "[a]ll physicians who practice in a VA ED/UCC [Emergency Department/Urgent Care Center] must possess training, experience, and competence in emergency medicine sufficient to evaluate and initially manage and treat all patients who seek emergency care."[24]

In late 2020, the patient went to the facility's Emergency Department with complaints of constipation, and blood and mucous in the stool. The Emergency Department physician documented the patient's history of IBS and that the patient reported a "scant" amount of blood and mucous in the last bowel movement.

The Emergency Department physician told the OIG that the patient had a history of multiple episodes of bleeding over many months, and after evaluating the patient, "my interpretation…was an irritable bowel flare…could have anything from Crohn's disease to

[22] VA Memorandum, *Primary Care Guidance for COVID-19 Pandemic Response,* March 23, 2020.

[23] The OIG queried the VA Corporate Data Warehouse and did not find evidence of a FIT for the patient in the database as of May 10, 2021. The VA Corporate Data Warehouse "is a repository comprising data from multiple VHA clinical and administrative systems," accessed July 1, 2021, https://www.vacsp.research.va.gov/CSPEC/Studies/CSPEAR/Objectives-Products-Data-Source.asp.

[24] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017.

ulcerative colitis…any number of things." The Emergency Department physician, when asked whether a digital rectal examination was needed, stated "I did not at the time feel it was necessary." The OIG did not find evidence of prior episodes of rectal bleeding recorded in the EHR or reported by the patient.[25]

During an interview, the Chief of Medicine stated that a digital rectal examination would have been appropriate when the patient was seen in the Emergency Department. The Section Chief of Gastroenterology told the OIG that with the patient's change of bowel habits and relatively new onset of constipation, a digital rectal examination should have been done.

The OIG concluded that by omitting a digital rectal examination during the patient's late 2020 visit, the Emergency Department physician did not adequately evaluate the patient based on the presentation with blood in the stool. Had a digital rectal examination been performed, a rectal mass or other sources of bleeding may have been identified.

## 2. Inadequate Facility Response to the Patient's Complaints

The OIG determined that facility staff did not adequately review and respond to the patient's complaints. The Assistant Chief of Primary Care did not fully resolve complaints related to Primary Care providers' patient interactions and care. The Patient Advocate failed to address the patient's Emergency Department complaint, document the involved providers, or contact the patient.

A patient experience "encompasses the range of interactions that patients have with the health care system, including their care from health plans, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities."[26] A "positive patient experience leads to improved care quality and patient safety."[27]

Patient advocates are employees "designated at each VHA facility to manage the complaint and compliment process, including complaint resolution, data capture and analysis of issues/complaints and communicate this information to facility leadership to help drive system improvements."[28] Patient advocates are required to document final resolution for all issues in the complaint tracking system. Facility guidance for a good resolution includes documenting all employees involved in the complaint or compliment. VHA advises that for a complaint, "full resolution is complete when the resolution outcome is communicated to the complainant."[29]

[25] The time frame for the OIG's EHR review was from April 6, 2018, to May 3, 2021.
[26] VHA Directive 1003.
[27] VHA Directive 1003.
[28] VHA Directive 1003.04, *VHA Patient Advocacy*, February 7, 2018.
[29] VHA Directive 1003.04.

In early 2021, the Patient Advocate received a complaint from the patient that "three different professionals at your facility 'blew me off.'" The patient reported being seen at Primary Care appointments in spring and fall 2020 and being informed that colonoscopies were not being provided by the facility. Additionally, the patient reported having presented to the Emergency Department in late 2020 for "blood, mucus and tissue" and not receiving an examination. Due to "lack of care from your facility [the patient] sought treatment elsewhere" and received a diagnosis of colon cancer.

The Patient Advocate responded to the patient indicating that the "patient interactions concern" would be forwarded to the Primary Care leadership team. The Patient Advocate documented in the complaint tracking system that the patient complained of "a change in my [the patient's] bowels" at one appointment and "my [the patient's] bowels were increasing in symptoms and needed to be investigated" at following 2020 Primary Care appointment.

Two days after receipt of the complaint, the Patient Advocate resolved the complaint and documented a response from the Assistant Chief of Primary Care in the facility's complaint tracking system, which indicated that a FIT was ordered, and "if this was completed and returns a positive result would have led to a colonoscopy." The Chief of Medicine reported having an understanding that a chief or supervisor was to contact patients to better understand patients' frustrations. The Assistant Chief of Primary Care stated having received patient advocacy on-the-job training, which included contacting patients to try to resolve complaints.

The OIG found that the Assistant Chief of Primary Care did not follow up with the patient to fully evaluate the patient's Primary Care concerns and ensure the complaint was resolved. During interviews, the Patient Advocate told the OIG that after reviewing the EHR and being unable to address the clinical nature of the patient's concerns, requested the Assistant Chief of Primary Care to review the complaint. The Assistant Chief of Primary Care stated having reviewed the patient's primary and Emergency Department care, determined that the patient did not qualify for a colonoscopy, and reported to the Patient Advocate that the patient was given a FIT, which was not completed. The Assistant Chief of Primary Care reported not contacting the patient, but would have contacted the patient "if there was a care aspect which I felt was continuing to be missed."

The OIG found that the patient's complaint of not receiving an exam in the Emergency Department was not addressed. The Patient Advocate told the OIG of not having addressed the Emergency Department complaint, and thought that "once I took it to the service chief, they [service chief] would kind of double check" "and then give me [the Patient Advocate] the answer for the one thing that was pertinent about [the patient's] complaint."

The OIG also found the Patient Advocate did not identify the providers who were involved in the patient's complaint and instead, documented that no employees were associated with the complaint. In addition, the Patient Advocate told the OIG of speaking to the patient; however,

the OIG did not find documentation or evidence that the Patient Advocate informed the patient of the complaint resolution, as required.

The OIG concluded that the Assistant Chief of Primary Care and the Patient Advocate did not adequately resolve the patient's complaint. The Assistant Chief of Primary Care did not address the patient's concerns related to Primary Care providers' response to reported bowel changes. The Patient Advocate resolved the complaint without addressing the patient's complaint of not receiving an exam in the Emergency Department and not documenting the involved providers or patient contact in the complaint tracking system. Fully addressing the patient's complaint would have afforded facility staff the opportunity to verify the issues, make amends, and assess for indicated process improvements.

## 3. Leadership Oversight

The OIG acknowledged that the facility-initiated peer reviews and provided an institutional disclosure to the patient but identified leaders' inadequate response to multiple complaints about the Emergency Department physician.

### Protected Peer Reviews and Institutional Disclosure

Peer review is a confidential process to evaluate the performance of health care professionals. It is intended to be non-punitive and "can result in both short-term and long-term improvements in patient care by revealing areas for improvement in the provision of health care of one or multiple clinicians."[30]

VHA policy is "to disclose harmful or potentially harmful adverse events to patients or their personal representatives in order to maintain trust between patients and VA health care professionals."[31]

In April 2021, after the OIG's notification of the hotline inspection, facility leaders initiated peer reviews of providers who cared for the patient. The Assistant Inspector General for Healthcare Inspections and OIG team met with the Facility Director in August 2021 to discuss the peer review results. During the meeting, the Facility Director informed the OIG that a separate review of the patient's care was conducted and a decision was made to complete an institutional disclosure to the patient. In summer 2021, the Chief of Staff completed an institutional disclosure to the patient for "our lapse in timely diagnosis, treatment and care of [the patient's] colon cancer."

[30] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.
[31] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

## Inadequate Leader Response to Emergency Department Physician

VHA states that service chiefs are responsible for "[m]onitoring and surveillance of the professional competency and performance of those who provide patient care services with delineated clinical privileges." VHA allows for a focused professional practice evaluation when a provider lacks evidence of competent performance.[32] Facility policy states that contract providers are subject to the compliance of the facility's Bylaws and that service chiefs are responsible for monitoring the professional performance of all individuals in the service, including contract providers who have clinical privileges through focused professional practice evaluation and ongoing professional practice evaluation."[33] The Joint Commission requires leaders to "monitor contracted services by evaluating these services in relation to the hospital's expectations" and "take steps to improve contracted services that do not meet expectations."[34]

The facility had a contract with the Oklahoma State University to provide Emergency Department physician services during the time frame of the events discussed in this report. As identified in the contract, the facility's Chiefs of Staff and Medicine were responsible for monitoring the performance of contract personnel. Surveillance methods of contract Emergency Department provider performance included direct observation, random sampling of selected patient files, focused and ongoing professional practice evaluations, and validated user or customer complaints.

The OIG reviewed 10 patient or caregiver complaints about Emergency Department care from early 2020 through early 2021, and found that six complaints (60 percent), including the patient's complaint, involved the Emergency Department physician. Three complainants described the Emergency Department physician as rude, disrespectful, or unprofessional, and three complainants reported not being taken care of or not receiving an examination by the physician.

The OIG also reviewed eight contract Emergency Department ongoing professional practice evaluations from October 1, 2019, through September 30, 2020, and found that the number of complaints a provider received was included as part of each provider's evaluation. The OIG found that the Emergency Department physician received more complaints than all other Emergency Department providers. There were no focused professional practice evaluations initiated from October 1, 2019, through September 30, 2020.

---

[32] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[33] Bylaws and Rules of the Medical Staff of VHA Eastern Oklahoma VA Healthcare System, May 2018, were in effect during the time of the events discussed in this report. The Bylaws and Rules of the Medical Staff were amended on May 2020. Unless otherwise specified, the two policies contain same or similar language related to contract providers and service chiefs' responsibilities for monitoring provider performance.

[34] The Joint Commission, *Facts About The Joint Commission*. "The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care."

The Chief of Staff told the OIG that the Chief of Medicine had responsibility for the Emergency Department contract providers and for reporting problems to the Chief of Staff. The Chief of Staff reported being made aware by the Chief of Medicine of "one or two incidents" "a couple of months ago" related to insensitive or inappropriate remarks made by the Emergency Department physician. No actions were taken by the Chief of Medicine and the Chief of Staff to address the Emergency Department physician's performance concerns. The Chief of Staff indicated there would be reason to review individual conduct if there were more complaints. The Chief of Staff stated that the Director of the Oklahoma State University Medical Department was aware of the concerns.

During an interview with the OIG, the Chief of Medicine reported that the Emergency Department physician received "an unequal number" of complaints than other Emergency Department providers. The Chief of Medicine reported not seeing complaints related to a quality of care issue, and that patients indicated they "didn't feel like the provider listened, took the time, heard what their concerns were." The Chief of Medicine told the OIG of speaking to the Emergency Department physician about the complaints "intermittently" and discussing the provider's complaints with the lead Emergency Department physician and the Chief of Staff. The Chief of Medicine also notified the Director of the Oklahoma State University Medical Department but was unsure whether there was follow-up. The Chief of Medicine also told the OIG of reporting concerns to the Contracting Officer Representative.

Beyond reporting and intermittent discussions with the provider, the Chief of Medicine and the Chief of Staff did not take further actions to address the Emergency Department physician's performance concerns. Further actions by these leaders may have provided an opportunity to review and address the patient's care needs, including but not limited to the care issues noted in this report.

# Conclusion

The OIG did not substantiate that the patient who sought help from the facility three times in 2020 was sent away. The patient attended Primary Care appointments in spring and fall 2020 and was seen by an Emergency Department physician in late 2020. The OIG identified related concerns with the patient's Primary Care FIT follow-up in fall 2020 and the Emergency Department physician's assessment in late 2020.

The facility had established procedures in accordance with VHA guidance to use FIT instead of colonoscopies during the COVID-19 pandemic. However, the OIG found no documentation that the patient received the FIT or related instructions for completion of the FIT and there were no FIT results available for the patient or evidence of follow-up for the patient to complete the FIT. The OIG was unable to determine if a completed FIT would have prompted colonoscopy testing.

The OIG found that the Emergency Department physician did not adequately assess the patient by failing to perform a digital rectal examination when the clinical presentation included having blood in the stool. Had a digital rectal examination been performed, a rectal mass or other sources of bleeding may have been identified.

Facility staff did not adequately review and respond to the patient's complaint by not taking action related to (1) the patient's Primary Care concerns, (2) the Emergency Department exam, and (3) identification of involved providers. The Chief of Medicine reported having an understanding that a chief or supervisor was to contact patients to better understand patients' frustrations. The Assistant Chief of Primary Care stated having received patient advocacy on-the-job training, which included contacting patients to try to resolve complaints. The Assistant Chief of Primary Care did not follow up with the patient to fully evaluate the Primary Care concerns and ensure the complaint was resolved. The OIG found that the patient's complaint of not receiving an exam in the Emergency Department was not addressed. The Patient Advocate did not identify the providers who were involved in the patient's complaint and instead, documented that no employees were associated with the complaint. In addition, the Patient Advocate told the OIG of speaking to the patient; however, the OIG did not find documentation or evidence that the Patient Advocate informed the patient of the complaint resolution, as required. Fully addressing the patient's complaint would have afforded facility staff the opportunity to verify the issues, make amends, and assess for indicated process improvements.

In summer 2021, the Chief of Staff completed a review of the patient's care and an institutional disclosure to the patient for "our lapse in timely diagnosis, treatment, and care of [the patient's] colon cancer."

The OIG identified inadequate leadership response to multiple complaints about the Emergency Department physician. Beyond reporting and intermittent discussions with the provider, the Chief of Medicine and the Chief of Staff did not take further actions to address the Emergency Department physician's performance concerns. Further actions by these leaders may have provided an opportunity to review and address the patient's care needs, including but not limited to the care issues noted in this report.

# Recommendations 1–4

1. The Eastern Oklahoma VA Health Care System Facility Director reviews processes to ensure patients with ordered Fecal Immunochemical Test (FIT) are tracked according to Veterans Health Administration policy, documentation is complete, and takes action if necessary.

2. The Eastern Oklahoma VA Health Care System Facility Director evaluates processes for Emergency Department providers' physical examinations when a patient presents with gastrointestinal symptoms that include associated bleeding and determines if modifications, including provider education, are needed.

3. The Eastern Oklahoma VA Health Care System Facility Director ensures that patient advocates and Primary Care leaders perform thorough reviews of all components of complaints for resolution and patient advocates document according to policy.

4. The Eastern Oklahoma VA Health Care System Facility Director ensures facility leaders monitor complaints and take action on issues that are identified related to the Emergency Department physician's performance.

# Appendix A: VISN Director Memorandum

## Department of Veterans Affairs Memorandum

Date: November 4, 2021

From: Director, Rocky Mountain Network (VISN 19)

Subj: Healthcare Inspection—Deficiencies in the Care of a Patient with Gastrointestinal Symptoms at the Eastern Oklahoma VA Health Care System in Muskogee

To: Director, Office of Healthcare Inspections (54HL09)
Director, GAO/OIG Accountability Liaison office (VHA 10BGOAL Action)

1. I have reviewed the findings, recommendations, and action plan of the Eastern Oklahoma VA Health Care System in Muskogee. I am in agreeance with the above.

(*Original signed by*:)

Ralph Gigliotti
Network Director, VISN 19

# Appendix B: Facility Director Memorandum

## Department of Veterans Affairs Memorandum

Date: November 4, 2021

From: Director, Rocky Mountain Network (VISN 19)

Subj: Healthcare Inspection—Deficiencies in the Care of a Patient with Gastrointestinal Symptoms at the Eastern Oklahoma VA Health Care System in Muskogee

To: Director, Rocky Mountain Network (10N19)

1. I have read and concur with the findings and recommendations in the OIG Report entitled, *Healthcare Inspection—Deficiencies in the Care of a Patient with Gastrointestinal Symptoms at Eastern Oklahoma VA Health Care System in Muskogee*.
2. Please find attached our response to each recommendation provided in this report.
3. If there are any questions regarding the response to the recommendations or any additional information is required, please contact the Chief of Quality, Safety, and Value.

(*Original signed by*:)

Mark E. Morgan, MHA, FACHE
Medical Center Director

# Facility Director Response

## Recommendation 1

The Eastern Oklahoma VA Health Care System Facility Director reviews processes to ensure patients with ordered Fecal Immunochemical Test (FIT) are tracked according to Veterans Health Administration policy, documentation is complete, and takes action if necessary.

Concur.

Target date for completion: 4/30/2022

### Director Comments

The Primary Aligned Care Team (PACT) Nurse will pull the list of patients who have not returned FIT test kits daily and the team will discuss calls needing to be placed during huddle. The Medical Support Assistant (MSA), supported by other PACT members, will take primary responsibility for the clerical work and phone calls to the patient. Up to three attempts to contact the patient by phone, with results recorded in Computerized Patient Reporting System (CPRS), will be made. After three attempts, the MSA will advise the provider of inability to contact the Veteran and the provider will determine the next course of action and document in CPRS.

Steps to accomplish this work:

- Colorectal Cancer Screening standard operating procedure (SOP) will be updated.
- All members of the PACT will receive a copy of the revised policy.
- Training and education will be provided to support the revised SOP as evidenced by signature of those attending.
- Twice a month, beginning December 1, 2021, reports will be created to show the number of patients by locality who have not returned Colorectal Cancer Screening Kits.
- MSAs will attempt to contact Veteran and verify receipt of test and willingness to comply.
- Monthly Reports on the number of veteran patients failing to return completed Colorectal Cancer Screening Kits will be presented to the Medical Executive Committee (MEC) by the Chief Nurse of Primary Care until six consecutive months of a minimum of 90% compliance is achieved.

## Recommendation 2

The Eastern Oklahoma VA Health Care System Facility Director evaluates processes for Emergency Department providers' physical examinations when a patient presents with gastrointestinal symptoms that include associated bleeding and determines if modifications, including provider education, are needed.

Concur.

Target date for completion: 4/30/2022

### Director Comments

Eastern Oklahoma Veterans Administration Health Care System is actively working with leadership at the Oklahoma State University to provide education on general evaluation of a patient presenting with gastrointestinal (GI) symptoms. All Provider's working at the Jack C. Montgomery Emergency Department (ED) will receive this education. Chief of Medicine or designee will complete 30 chart audits on patients treated in the ED with GI symptoms to review appropriateness of care and will be reported to Quality, Safety, and Value (QSV). Review will continue until six consecutive months of a minimum of 90% compliance is achieved.

## Recommendation 3

The Eastern Oklahoma VA Health Care System Facility Director ensures that patient advocates and Primary Care leaders perform thorough reviews of all components of complaints for resolution and patient advocates document according to policy.

Concur.

Target date for completion: 4/30/2022

### Director Comments

The Patient Advocates have been re-educated and re-trained to report all components of complaints to each service line. The Program Manager will audit at least (10) closed Patient Advocate Tracking System (PATS) for each Advocate per month for a total of 50 audits per month. The PATS are audited for appropriate reporting on Patient Safety, Malpractice, Negligence, Abuse and Harassment, and Privacy concerns. Program Manager audits customer service recovery, appropriate documentation of PATS, days to closure, and PATS Coding accuracy. Monthly audit reports will be completed and will be reported to QSV. Review will continue until six consecutive months of a minimum of 90% compliance is achieved.

## Recommendation 4

The Eastern Oklahoma VA Health Care System Facility Director ensures facility leaders monitor complaints and take action on issues that are identified related to the Emergency Department physician's performance.

Concur.

Target date for completion: 4/30/2022

### Director Comments

Patient Advocate Tracking System (PATS) Emergency Department Service Line was updated on 10/18/2021 to include Chief of Staff, Deputy Chief of Staff and Oklahoma State University (OSU) Physician Supervisor for increased reporting and accountability of ED physicians. 100% of all Emergency Department complaints will be reviewed by the Patient Advocate Program Manager and compliance of resolution documentation confirmed and will be reported to QSV. Review will continue until six consecutive months of a minimum of 90% compliance is achieved.

Any actions required on issues that are identified with Emergency Department Provider's performance will be discussed with the provider and the provider's direct Supervisor for further intervention. If issues continue with the provider's care, OSU will be requested to remove the provider and replace with a different physician. This action will be effective immediately.

# Glossary

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

**adenocarcinoma.** A "cancer that starts in the cells that form glands making mucus to lubricate the inside of the colon and rectum. This is the most common type of colon and rectum cancer."[35]

**adverse events. "**[U]ntoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."[36]

**anal. "**[R]elating to, situated near or involving the anus."[37]

**centimeter.** "[A] unit of length equal to 1/100 meter." One centimeter is equal to 0.39 inch.[38]

**chemoradiation.** "Treatment that combines chemotherapy with radiation therapy."[39]

**chemotherapy.** A drug treatment that uses chemicals to kill fast-growing cells in the body and is most often used to treat cancer.[40]

**colon.** "[P]art of the large intestine (a tube-like organ)" at the end of the digestive system that ends at the anus.[41]

**colonoscopy**. "[A]n exam used to detect changes or abnormalities in the large intestine (colon) and rectum."[42]

---

[35] "Understanding Your Pathology Report: Invasive Adenocarcinoma of the Colon," American Cancer Society, accessed May 25, 2021, https://www.cancer.org/treatment/understanding-your-diagnosis/tests/understanding-your-pathology-report/colon-pathology/invasive-adenocarcinoma-of-the-colon.html#:~:text=Adenocarcinoma%20is%20a%20type%20of%20cancer%20that%20starts,most%20common%20type%20of%20colon%20and%20rectum%20cancer.

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

[37] *Merriam-Webster.com Dictionary*, "anal," accessed May 25, 2021, https://www.merriam-webster.com/dictionary/anal.

[38] *Merriam-Webster.com Dictionary*, "centimeter," accessed May 25, 2021, https://www.merriam-webster.com/dictionary/centimeter. *Merriam-Webster.com Dictionary*, "metric system," accessed May 25, 2021, https://www.merriam-webster.com/dictionary/metric%20system.

[39] National Cancer Institute at National Institutes of Health, "chemoradiation," accessed September 18, 2021, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/chemoradiation.

[40] Mayo Clinic, "chemotherapy," accessed April 1, 2021, https://www.mayoclinic.org/tests-procedures/chemotherapy/about/pac-20385033.

[41] National Cancer Institute at National Institutes of Health, "Colon," accessed May 25, 2021, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/colon.

[42] Mayo Clinic, "colonoscopy," accessed May 18, 2021, https://www.mayoclinic.org/tests-procedures/colonoscopy/about/pac-20393569.

**colorectal cancer.** Cancer that begins in the colon or rectum.[43]

**constipation.** "[A]bnormally delayed or infrequent passage of usually dry hardened feces."[44]

**COVID-19.** (Coronavirus Disease 2019). "[A] disease caused by a virus called SARS-CoV-2."[45]

**dicyclomine**. An oral antispasmodic medication used for IBS.[46]

**digital rectal examination.** A physical examination of the lower rectum in which a provider uses a gloved and lubricated finger to check for abnormalities of the rectum.[47]

**fecal immunochemical test (FIT).** A test for colorectal cancer that "uses antibodies to detect blood in the stool."[48]

**focused professional practice evaluation.** "[A] time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance."[49]

**gastroenterology.** "[A] branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines."[50]

**gastrointestinal.** "[R]elating to, affecting, or including both stomach and intestine."[51]

**institutional disclosure.** "[A] formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[52]

---

[43] "What is Colorectal Cancer?" American Cancer Society, accessed April 5, 2021, https://www.cancer.org/cancer/colon-rectal-cancer/about/what-is-colorectal-cancer.html.

[44] *Merriam-Webster.com Dictionary*, "constipation," accessed May 25, 2021, https://www.merriam-webster.com/dictionary/constipation.

[45] Centers for Disease Control and Prevention, "What Is COVID-19?" accessed September 14, 2021, https://www.cdc.gov/coronavirus/2019-ncov/faq.html.

[46] Prescribers' Digital Reference, "Dicyclomine," accessed April 1, 2021, https://www.pdr.net/drug-summary/Bentyl-dicyclomine-hydrochloride-1358.24.

[47] National Cancer Institute, "Digital Rectal Examination," accessed September 14, 2021, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/digital-rectal-examination.

[48] Centers for Disease Control and Prevention, "fecal immunochemical test (FIT)," accessed May 18, 2021, https://www.cdc.gov/cancer/colorectal/basic_info/screening/tests.htm.

[49] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[50] *Merriam-Webster.com Dictionary*, "gastroenterology," accessed May 18, 2021, https://www.merriam-webster.com/dictionary/gastroenterology.

[51] *Merriam-Webster.com Dictionary*, "gastrointestinal," accessed May 18, 2021, https://www.merriam-webster.com/dictionary/gastrointestinal.

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

**irritable bowel syndrome.** "a chronic functional disorder of the colon that is of unknown etiology but is often associated with abnormal intestinal motility and increased sensitivity to visceral pain and that is characterized by diarrhea or constipation or diarrhea alternating with constipation, abdominal pain or discomfort, abdominal bloating, and passage of mucus in the stool."[53]

**mass.** "[A] quantity or aggregate of matter usually of considerable size."[54]

**occult.** "[N]ot manifest or detectable by clinical methods alone."[55]

**oncologist.** A doctor who has special training in diagnosing and treating cancer.[56]

**ongoing professional practice evaluation.** "[T]he ongoing monitoring of privileged clinicians to confirm the quality of care delivered and ensure patient safety."[57]

**orthopedist.** "[A] doctor who specializes in the branch of medicine concerned with the correction or prevention of deformities, disorders, or injuries of the skeleton."[58]

**polyp.** "[A] growth projecting from a mucous membrane (as of the colon)."[59]

**posttraumatic stress disorder.** "[A] mental health condition that's triggered by a terrifying event-either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event."[60]

**rectal.** "relating to, affecting, or being near the rectum."[61]

**rectum.** The last part of the intestine, or colon, that ends at the anus.[62]

---

[53] *Merriam-Webster.com Dictionary*, "irritable bowel syndrome," accessed June 29, 2021, https://www.merriam-webster.com/dictionary/irritable%20bowel%20syndrome.

[54] *Merriam-Webster.com Dictionary*, "mass," accessed May 25, 2021, https://www.merriam-webster.com/dictionary/mass.

[55] *Merriam-Webster.com Dictionary*, "occult," accessed August 12, 2021, https://www.merriam-webster.com/dictionary/occult.

[56] National Cancer Institute, "oncologist," accessed September 14, 2021, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/oncologist.

[57] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[58] *Merriam-Webster.com Dictionary*, "orthopedist," accessed May 25, 2021, https://www.merriam-webster.com/dictionary/orthopedist.

[59] Mayo Clinic, "polyp," accessed May 18, 2021, https://www.merriam-webster.com/dictionary/polyps.

[60] Mayo Clinic, "post traumatic stress disorder," accessed April 1, 2021, https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967.

[61] *Merriam-Webster.com Dictionary*, "rectal," accessed May 25, 2021, https://www.merriam-webster.com/dictionary/rectal.

[62] *Merriam-Webster.com Dictionary*, "rectum," accessed May 25, 2021, https://www.merriam-webster.com/dictionary/rectum.

**review of systems.** "[A]n inventory of the body systems that is obtained through a series of questions in order to identify signs and/or symptoms which the patient may be experiencing."[63]

**screening.** A test performed to detect potential health problems in persons who are not showing signs of a disease and may need additional testing.[64]

**stage IIIB**. A system for doctors to quantify the spread of cancer. Stage IIIB means the cancer has grown through the wall of the colon or rectum and spread to lymph nodes.[65]

**verge**. "[A]n outer margin of an object or structural part."[66]

[63] American College of Cardiology, "Review of Systems," accessed August 12, 2021, https://www.acc.org/tools-and-practice-support/practice-solutions/coding-and-reimbursement/documentation/evaluation-and-management/review-of-systems.

[64] "Screening Tests for Common Diseases" Johns Hopkins Medicine, accessed May 25, 2021, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/screening-tests-for-common-diseases.

[65] "Colorectal Cancer Stages" American Cancer Society, accessed May 25, 2021, https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/staged.html.

[66] *Merriam-Webster.com Dictionary*, "verge," accessed May 25, 2021, https://www.merriam-webster.com/dictionary/verge.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| **Inspection Team** | Chris Iacovetti, BA, RD, Director<br>Erin Butler, LCSW<br>Thomas W. Jamieson, MD<br>Eileen Keenan, MSN, RN<br>Seema Maroo, MD<br>Teresa Pruente, MHA, RN |
| **Other Contributors** | Jennifer Christensen, DPM<br>Limin Clegg, PhD<br>Reynelda Garoutte, MHA, BSN<br>Natalie Sadow, MBA<br>Andrew Waghorn, JD<br>Dawn Woltemath, MSN, RN<br>Jarvis Yu, MS |

# Report Distribution

## VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Director, Rocky Mountain Network (10N19)
Director, Eastern Oklahoma VA HCS Jack C. Montgomery VAMC (623)

## Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: James M. Inhofe, James Lankford
U.S. House of Representatives: Stephanie Bice, Tom Cole, Kevin Hern, Frank D. Lucas, Markwayne Mullin

**OIG reports are available at www.va.gov/oig.**