



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Community Care
Coordination Delays for a
Patient with Oral Cancer at
the Veterans Health Care
System of the Ozarks in
Fayetteville, Arkansas



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation regarding community care coordination delays that may have contributed to the death of a patient with oral cancer at the Veterans Health Care System of the Ozarks (facility) in Fayetteville, Arkansas. Specifically, the OIG evaluated the facility's coordination of [radiation therapy](#) and [chemotherapy](#) for the patient.¹ The OIG also evaluated a related concern regarding scheduling community care appointments for the patient's [radical resection](#) surgery.²

The patient was in their seventies and had a history of head and neck cancers, including [laryngeal cancer](#) and oral [verrucous carcinoma](#).³ A facility ear, nose, and throat (ENT) provider recommended a radical resection surgery to treat the patient's oral verrucous carcinoma pain and referred the patient to a community hospital because the surgery was not offered at the facility. The patient agreed to the surgery, and the initial [community care consult](#) was entered into the patient's electronic health record (EHR) on March 8, 2020. Due to a series of delays and lack of follow-up by the facility's Office of Community Care (OCC) staff, the patient was not evaluated by a head and neck surgeon at a community hospital for six months and did not undergo the necessary surgery at a community hospital until September 29, 2020.

The OIG determined that facility OCC staff failed to schedule community care appointments for the patient within 30 days of the clinically indicated date determined by the provider, per Veterans Health Administration (VHA) policy. The OIG found that facility OCC staff did not thoroughly review the patient's EHR when coordinating community care services for the patient, which ultimately delayed access to care and the patient's surgery. Facility OCC staff did not take action for over three months on the first consult for community care, entered March 8, 2020. The OCC staff told the OIG the delays were due to not having "the time to put in enough effort" to follow up on scheduling an appointment, and "missing information" needed to schedule the patient with a [community provider](#). The OCC staff also stated there was a period when patients were not being scheduled for community care appointments due to the COVID-19 pandemic; however, facility leaders confirmed there was never a stoppage in scheduling appointments for patients in the community. From March 25 to August 3, 2020, facility providers entered four subsequent consults for the patient to receive the community care that was requested in the first consult. The four consults were delayed as a result of facility OCC staff sending duplicate referrals to community ENT providers, who had previously declined to provide services due to

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 In a radical resection surgery, a tumor is removed in its entirety as well as the surrounding tissue to ensure all cancerous cells near the tumor are removed.

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

the complexity of the surgery, and facility OCC staff not taking action for over two weeks when facility providers entered the subsequent consults. Facility OCC staff could not provide an explanation for their delay in taking action on the subsequent consults. In total, a delay of 140 days occurred before the evaluation appointment was scheduled with a community head and neck surgeon. The patient waited 205 days between the initial consult and the surgery.

The OIG substantiated that facility OCC staff failed to coordinate the patient's post-surgical radiation therapy. The community hospital's plan of care for the patient included an evaluation with the community hospital [oncologists](#) for radiation therapy and chemotherapy to begin within six weeks after surgery. Community hospital staff scheduled the evaluation for November 10, 2020. Community hospital staff told the OIG that they faxed a referral for radiation therapy to the facility on October 22, and also contacted facility OCC staff on November 2 to request authorization for radiation therapy and chemotherapy at the community hospital. Facility OCC staff requested that the community hospital staff submit a [request-for-services](#) form. On November 9, facility OCC staff documented receiving a fax from the community hospital with a cover sheet titled "VA referral to [Medical Oncology](#) at [community hospital]" and noted that a request-for-services form was not included in the fax. That same day, a facility OCC staff member documented in the EHR an attempt to contact a nurse at the community hospital regarding the missing request-for-services form but was unable to speak to the community hospital staff by phone. The OIG did not find documented evidence that facility OCC staff made other attempts to reach the nurse at the community hospital.

Facility OCC staff told the OIG they did not authorize the evaluation appointment for radiation therapy on November 10, 2020, because they did not receive the request-for-services form from the community hospital. The facility OCC leaders and staff stated that in the absence of a local policy, they referred to the VHA OCC Field Guidebook (Field Guidebook) for guidance and recommendations related to community care coordination.⁴ The Field Guidebook suggests, but does not require, that community care providers should submit a request-for-services form. Subsequently, the patient's evaluation appointment for both radiation therapy and chemotherapy at the community hospital was canceled. The OIG would have expected facility OCC staff to continue their efforts to contact the community hospital for the request-for-services form to proceed with authorization.

The OIG substantiated that facility OCC staff also delayed coordinating chemotherapy within the community provider's requested six-week timeline. Over nine weeks elapsed between the day of the surgery and the follow-up [oncology](#) appointment at the facility. Consistent with eligibility criteria, facility OCC staff did not authorize chemotherapy at the community hospital since the service was available at the facility. Facility OCC staff did not alert the primary care provider, facility ENT provider, or facility oncologist of the urgency of the consult or how much time had

⁴ VHA Office of Community Care Field Guidebook.

passed since the surgery. Instead, facility OCC staff documented that the patient was willing to complete oncology services at the facility. Finally, on November 13, 2020, facility OCC staff scheduled the patient for an initial appointment with the facility Oncology Service on December 4. The facility oncologist reported to the OIG that poor communication with facility OCC staff was a constant issue, and that oncology service does not get alerted by OCC of urgent cases.

At the December 4 appointment, a facility oncology resident documented that there were changes to the patient's condition concerning residual or returning cancer. The facility oncology resident also noted that since the patient was "already almost 3 months out" from surgery, the benefits of radiation therapy were "diminished at this point." A review of EHR documentation during follow-up appointments with the facility oncologist identified that the patient's cancer had an extensive reoccurrence. By early 2021, the patient's primary care provider coordinated [palliative care](#) before the patient died the following month.

Due to the aggressive nature of the patient's head and neck cancer and the complexity of cancer treatments, the OIG was unable to determine if the failure and delay in community care coordination contributed to the patient's death. However, the OIG concluded that the facility's failure to schedule community care appointments timely, failure to coordinate radiation therapy, and delay in coordinating chemotherapy within the requested time limited the patient's opportunity to receive optimal treatment and potentially a more favorable outcome.

The OIG made one recommendation to the Under Secretary for Health related to standardized processes for community care coordination specific to follow-up requests for services from community providers and two recommendations to the Facility Director related to ensuring OCC staff complete consults within the 30-day requirement and evaluating the process for coordinating oncology care in the community.

Comments

The Under Secretary for Health concurred in principle with one recommendation and the Veterans Integrated Service Network and Facility Directors concurred with two recommendations and provided an acceptable action plan (see appendixes B, C, and D). The OIG will follow up on the planned actions until they are completed.



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Contents

Executive Summary	i
Abbreviations	v
Introduction.....	1
Scope and Methodology	4
Patient Case Summary	5
Inspection Results	7
1. Delays in Scheduling Community Care Appointments for the Patient’s Radical Resection Surgery	7
2. Failure to Coordinate Radiation Therapy and Delay in Coordinating Chemotherapy for a Patient with Head and Neck Cancer.....	10
Conclusion	13
Recommendations 1–3.....	14
Appendix A: Patient’s Appointments and Consults Timeline.....	15
Appendix B: Office of the Under Secretary for Health Memorandum	18
Appendix C: VISN Director Memorandum.....	21
Appendix D: Facility Director Memorandum.....	22
Glossary	25
OIG Contact and Staff Acknowledgments	29
Report Distribution	30

Abbreviations

ENT	ear, nose, and throat
EHR	electronic health record
OCC	Office of Community Care
OIG	Office of Inspector General
PET	positron emission tomography
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess an allegation regarding community care coordination delays that may have contributed to the death of a patient with oral cancer at the Veterans Health Care System of the Ozarks (facility) in Fayetteville, Arkansas. Specifically, the OIG evaluated the facility's coordination of [radiation therapy](#) and [chemotherapy](#) for the patient.¹ The OIG also evaluated a related concern regarding scheduling community care appointments for the patient's [radical resection](#) surgery.

Background

The facility, part of Veterans Integrated Service Network (VISN) 16, is classified as a level 2 complexity.² In addition to operating 78 beds at the main campus, the facility consists of seven community-based outpatient clinics providing acute medical, surgical, and psychiatric services to veterans in Arkansas, Missouri, and Oklahoma. The facility has academic affiliations with four universities, including the University of Arkansas for Medical Sciences. From October 2020 through September 2021, the facility served a total of 55,981 patients.

Community Care Consults

In 2018, as part of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (VA MISSION) Act of 2018, a process was established for eligible veterans to access health care with [community providers](#).³ To receive healthcare services in the community, a Veterans Health Administration (VHA) provider enters a [community care consult](#) on behalf of a patient. The facility's Office of Community Care (OCC) clinical staff review the consult to determine if the patient is eligible to receive care in the community.⁴ The eligibility criteria 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 VHA Office of Productivity, Efficiency, and Staffing, *FY20 Facility Complexity Levels List*, April 20, 2021. "The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex." A level 2 facility has low risk patients, few complex clinical programs, medium volume, and small or no research and training programs.

³ The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (VA MISSION) Act of 2018, Pub. L. No. 115-182 (2018), site accessed March 16, 2022, <https://www.congress.gov/bill/115th-congress/senate-bill/2372>. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

⁴ VHA Office of Community Care Field Guidebook, *Chapter 2: Eligibility, Referral and Scheduling*, March 17, 2020. The Office of Community Care Field Guidebook "contains 'live' documents that are consistently updated with new and updated information."

community care are based on guidance from legislation in the VA MISSION Act of 2018.⁵ Once the OCC establishes eligibility, the level of care coordination required is determined. OCC clinical staff review the electronic health record (EHR) and other available documents to evaluate the patient's condition and need for treatment.⁶ OCC clinical staff then assign the patient's level of care coordination and complexity for requested services.⁷ The level of care coordination can range from basic, moderate, complex/chronic, to urgent. Once the level of care coordination is established by the OCC clinical staff, a [care coordination plan](#) is developed and implemented to initiate treatment referrals by OCC administrative staff. The care coordination plan involves preparing a referral packet, which includes any necessary medical records to release to community providers, and scheduling appointments for care.⁸ OCC administrative staff also follow up with the community care provider to ensure the services and care have been provided to the patient.⁹

When a consult is submitted by a VHA provider through the EHR, the consult is entered in a pending status. VHA requires consults to be received by OCC staff within two business days. Once the consult is received by OCC staff, the consult status changes from *pending* to *active*. OCC staff are then required to schedule an appointment within 30 days of the clinically indicated date as determined by the provider. Once scheduled, the consult status changes from *active* to *scheduled*. After the patient's appointment with the community provider, the community care records are obtained by OCC staff, which closes out the consult, and the consult status in the EHR is changed to *complete* (see figure 1).¹⁰

⁵ The three criteria most relevant to this report include: best medical interest of the patient, lack of a full-service medical facility, and required care or services not offered.

⁶ For this report, OCC administrative staff can include an OCC lead advanced medical support assistant and an assigned advanced medical support assistant. OCC clinical staff can include OCC nurses and other specialty providers in the facility.

⁷ VHA Office of Community Care Field Guidebook, *Chapter 2: Eligibility, Referral and Scheduling*, March 17, 2020.

⁸ The referral packet is a collection of documents compiled from the EHR about the patient's case that is sent to community providers electronically or via fax for consideration for treatment.

⁹ Field Guidebook, *Chapter 3: How to Perform Care Coordination*, June 29, 2020.

¹⁰ VHA Directive 1232(3), *Consult Processes and Procedures*, August 24, 2016, amended April 5, 2021. The 2016 directive and the 2021 amended directive contain the same or similar language related to community care.

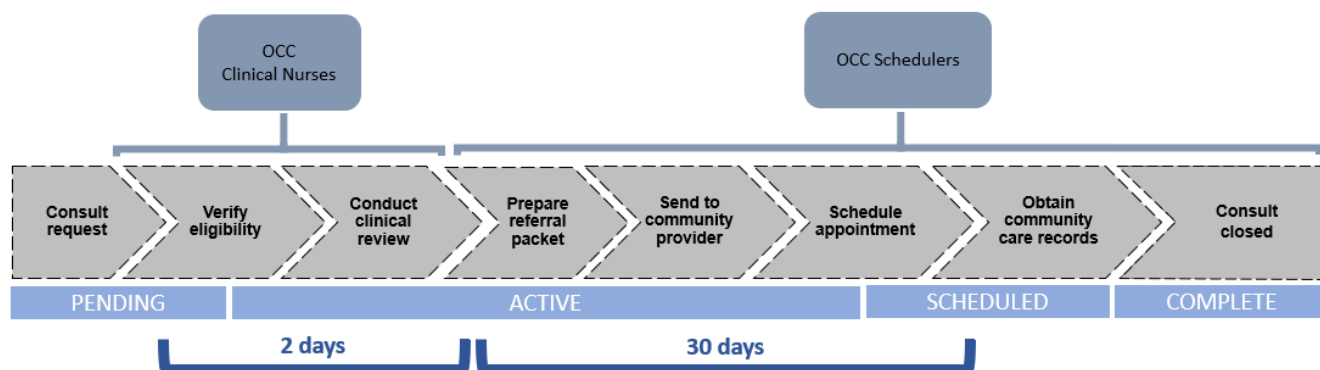


Figure 1. Care Coordination Process for Routine Consults.

Source: VA OIG analysis of Office of Community Care Field Guidebook Chapter 3: Care Coordination; VHA Directive 1232(3).

Head and Neck Cancer

Head and neck cancers account for approximately 4 percent of new cancer cases in the United States and include [tumors](#) of the mouth and throat.¹¹ Signs and symptoms include painful sores in the mouth or throat that do not heal, lumps in the neck, sore throat, and difficulty swallowing. A patient’s chance of recovery from head and neck cancer is dependent on several factors, including the [stage](#) of the cancer, the location, and if the cancer has spread to other areas of the body.¹² Types of head and neck cancer treatment include surgery, radiation therapy, and chemotherapy. The type or combination of treatments used may differ depending on the severity and location of the cancer and the patient’s overall health.¹³

Allegation and Related Concern

In April 2021, the OIG received an allegation from a complainant regarding care coordination delays for a patient with recurrent head and neck cancer, which may have contributed to the patient’s death. The OIG evaluated the following:

- Scheduling community care appointments for the patient’s radical resection surgery
- Coordination of radiation treatment and chemotherapy for the patient

¹¹ National Comprehensive Cancer Network, *Guidelines for Head and Neck Cancers*, Version 3, 2021

¹² National Cancer Institute, “Head and Neck Cancers,” accessed August 13, 2021, <https://www.cancer.gov/types/head-and-neck/head-neck-fact-sheet>.

¹³ National Cancer Institute, “Lip and Oral Cavity Cancer Treatment (Adult) (PDQ)– Patient Version,” accessed August 13, 2021, <https://www.cancer.gov/types/head-and-neck/patient/adult/lip-mouth-treatment-pdq>.

Scope and Methodology

The OIG initiated the inspection on May 6, 2021, and conducted a virtual site visit June 14–24, 2021.¹⁴

The OIG interviewed the complainant; patient’s spouse; the facility’s former Chief of Staff; Chief of Primary Care; Acting Chief of Medical Service; Associate Chief of Staff for the OCC; OCC clinical and administrative staff; an ear, nose, and throat (ENT) provider; [oncologists](#); and community providers.

The OIG reviewed relevant VHA and facility policies and procedures; facility committee meeting minutes; facility functional statements, competencies, and service agreements; and the patient’s EHR from February 2020 through February 2021.¹⁵

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.

¹⁴ The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. World Health Organization (WHO), “WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020,” March 11, 2020, accessed February 22, 2022, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. Merriam-Webster.com Dictionary, “pandemic,” accessed February 22, 2022, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*, accessed February 22, 2022, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

¹⁵ The OIG reviewed non-VHA medical records that were scanned and available in the patient’s EHR.

Patient Case Summary

The patient, who was in their seventies, had a history of [laryngeal cancer](#), that was treated with radiation therapy at a non-VA hospital in 2016.¹⁶ The patient also had a separate oral [verrucous carcinoma](#) on the right side of the mouth with various treatments and recurrences from 2016 through 2020. On February 21, 2020, the patient saw an ENT provider at the Central Arkansas Veterans Healthcare System (Little Rock VA) for complaints of continued pain around the oral verrucous carcinoma.¹⁷ The Little Rock VA ENT provider obtained a [biopsy](#) of the patient's mouth. At the same visit, the Little Rock VA ENT provider recommended a radical resection surgery, and the patient agreed. On the same day, the Little Rock VA ENT provider submitted a consult for the patient to be seen at a non-VA hospital for the radical resection surgery. The [pathology report](#) of the mouth biopsy revealed no evidence of the recurrence of cancer.

A Little Rock VA OCC staff member canceled the consult on February 21, 2020, and documented that the patient was not enrolled at the Little Rock VA, and “outsourced care should be coordinated with the patient’s care team at the facility.” On February 26, 2020, the Little Rock VA ENT provider subsequently submitted an [interfacility consult](#) to the facility requesting the patient’s primary care provider submit a new consult for community ENT care for surgery. On March 8, 2020, the primary care provider submitted a consult for community ENT care.

On March 25, 2020, the patient saw a facility ENT provider for routine follow-up care. The facility ENT provider documented in the EHR that the patient had recently been seen by a Little Rock VA head and neck surgeon and noted that there had been a discussion about radical resection surgery. After the visit, the facility ENT provider also submitted a consult for community ENT care for surgery for the area of the verrucous carcinoma that was causing pain.

On July 2, 2020, the patient went to the facility’s Emergency Department with complaints of a rapid increase in pain and a change in the shape of the [lesions](#) in the mouth. The Emergency Department provider examined the patient and documented that the patient had an [erosive](#) lesion in the right [oral mucosa](#) and the right hard palate. The Emergency Department provider noted that the patient did not have “evidence of obvious infection” but would start the patient on an [antibiotic](#).

On July 29, 2020, the patient had another follow-up appointment with the facility ENT provider. The patient complained of increasing pain and a new mass near the oral verrucous carcinoma. The facility ENT provider noted that the patient was scheduled to see a head and neck surgeon at a community hospital in October 2020 for consideration of surgery. The facility ENT provider documented that the patient had a large mass in the area previously treated for verrucous carcinoma. The facility ENT provider recommended and performed another biopsy of the mass

¹⁶ The OIG uses the singular form of they (their) in this instance for privacy purposes.

¹⁷ The patient was enrolled at the facility, but received certain specialty care at the Little Rock VA.

in the mouth. On July 31, 2020, the facility's Chief of Surgical Service called to inform the patient of the biopsy results that revealed a new diagnosis of [squamous cell carcinoma](#).

On August 3, 2020, the facility ENT provider discussed the patient's case and the new diagnosis of squamous cell carcinoma with the Little Rock VA ENT provider. The Little Rock VA ENT provider recommended that the patient be seen by a head and neck surgeon at the community hospital for the radical resection surgery.

Two weeks later, the facility ENT provider alerted both social work service staff and the patient's primary care provider that the patient would be scheduled to see the community hospital head and neck surgeon pending a review of the patient's records.

The community hospital head and neck surgeon examined the patient on September 3, 2020, and performed the radical resection surgery on September 29. The surgeon and the [tumor board](#) from the community hospital recommended that the patient undergo both radiation and chemotherapy. Approximately one month later, the patient was seen for a post-surgical visit at the community hospital and subsequently scheduled to see both radiation and [medical oncology](#) at the community hospital on November 10. The day before these appointments occurred, facility OCC clinical staff notified the patient's spouse that the community hospital appointments had not been approved as the facility had not received the [request-for-services](#) form for radiation and chemotherapy. Documentation by facility OCC clinical staff indicated that the patient's spouse reported that the patient did not want radiation.

On December 4, 2020, the patient was seen by a facility oncologist who documented in the EHR that the patient had undergone surgery. A facility medicine resident (a physician in training), with concurrence from the facility oncologist, noted that since the surgery had been in September, radiation therapy would not be as effective. The facility medicine resident ordered a [positron emission tomography scan](#) (PET scan) to determine the extent of the cancer. The PET scan results demonstrated a recurrence of the patient's tumor with multiple [metastases](#).

Before being seen for follow-up by the facility oncologist, the patient was admitted to the community hospital for evaluation of the metastases. In late December, the community hospital staff convened a tumor board and mentioned that [adjuvant](#) radiation therapy was not done due to "issues with VA clearance."

The patient was seen in the facility's [oncology](#) clinic for follow-up in early 2021 and started on [palliative](#) therapy. With rapid progression of the cancer, the patient did not respond to chemotherapy and died the following month.

Inspection Results

1. Delays in Scheduling Community Care Appointments for the Patient's Radical Resection Surgery

The OIG determined that OCC administrative staff failed to schedule a community care appointment within the 30-day time frame required by VHA policy, and subsequently delayed the patient's radical resection surgery.¹⁸

VHA policy states that when a referring provider submits a consult a clinically indicated date, which identifies when the service is needed, must be included. VHA requires that consults be completed and that actions taken are documented in the EHR within 30 days of the clinically indicated date.¹⁹ Within this time frame, OCC administrative staff are expected to prepare and upload the referral packet, as well as schedule the community care appointments.²⁰

On March 8, 2020, the patient's primary care provider submitted a community care ENT consult (first consult) with a clinically indicated date of the same day, indicating that action needed to be taken within 30 days. The primary care provider entered a community care consult for the patient because the type of surgery needed was not offered at the facility. The next day, OCC clinical staff received the first consult changing the status from pending to active; however, no other action was taken until March 24 when OCC administrative staff uploaded the referral packet to a shared records system (see [appendix A](#) for timeline of appointments and consults).²¹

OCC administrative staff documented more than 30 days later that the patient's appointment remained unscheduled. During interviews with the OIG, OCC administrative staff acknowledged a delay in care occurred when OCC staff failed to follow up on the patient's unscheduled consult. OCC administrative staff reported not having "the time to put in enough effort" to follow up on scheduling an appointment. The first consult was discontinued in August 2020 with a comment stating that this was a duplicate consult, and the surgery was not scheduled.

OCC administrative staff told the OIG that when attempting to schedule the patient's radical resection surgery, the first consult had "missing information" needed to schedule the patient with a community provider. However, OCC administrative staff were not able to give a definitive reason for the absence of follow-up actions. OCC administrative staff added that there was a period when patients were not being scheduled for community care appointments due to the

¹⁸ VHA Directive 1232(3).

¹⁹ VHA Directive 1232(3).

²⁰ Field Guidebook, *Chapter 3: How to Perform Care Coordination*, June 29, 2020.

²¹ The shared records system used was the Health Share Referral Manager, which is a records system that VA providers and community providers can access to update and share documents for care coordination.

COVID-19 pandemic; however, facility leaders confirmed there was never a stoppage in scheduling appointments for patients in the community.

On March 25, 2020, while no appointment had been scheduled for the first consult, the facility ENT provider entered another community care ENT consult (second consult) for the radical resection surgery because the type of surgery needed was not offered at the facility.²² That same day, the second consult was reviewed by OCC clinical and administrative staff and sent to a community ENT provider (community ENT provider 1) who returned it back to facility OCC staff stating the surgery was too complicated to complete at the community ENT provider's clinic. The referral packet was subsequently sent to a second community ENT provider (community ENT provider 2) on the same day.

From March 26, 2020, through June 30, 2020, OCC administrative staff failed to follow up with community ENT provider 2 and ensure the patient was scheduled for an appointment. OCC administrative staff did not take further actions to schedule the surgery until July 1, 2020, when they re-sent the referral packet to community ENT provider 2, who declined to accept the referral due to the type of care not being offered at the non-VA hospital. During interviews, OCC administrative staff told the OIG that actions should have been taken to address the second consult and agreed that there were delays. However, OCC staff were not able to provide an explanation for the delay in taking action. The lack of action resulted in a 140-day delay to schedule the patient's surgery at a non-VA hospital (see figure 2).²³

On July 1, 2020, the facility ENT provider entered another community care ENT consult (third consult). Facility OCC administrative staff re-sent the consult to, community ENT provider 1 and community ENT provider 2, who had previously declined the referral. The OIG determined that OCC administrative staff did not review the EHR to avoid this duplication. When asked in OIG interviews, OCC administrative staff were unable to provide an explanation and admitted that they "didn't read enough" through the third consult and were unable to explain why the consult was re-sent to the same two community ENT providers.

Though the third consult was declined, community ENT provider 1 made a recommendation to have the patient seen by a Little Rock VA head and neck surgeon. On July 10, 2020, OCC clinical staff contacted a Little Rock VA head and neck surgeon, who requested an interfacility consult for the patient to be evaluated at the Little Rock VA by the head and neck surgeon. That same day, the patient's primary care provider entered the requested interfacility consult (fourth consult) and an appointment was scheduled for October 9, 2020.

²² At the time of the second consult, the request was not considered an emergency and therefore was not designated as a STAT consult. STAT consults have priority over routine consults and should be scheduled within 24 hours once entered.

²³ VHA Directive 1232(3). The facility has 30 days from the clinically indicated date, so the delay time frame was from April 8 through August 24, 2020.

On July 29, 2020, before the appointment with a Little Rock VA head and neck surgeon, the facility ENT provider evaluated the patient who reported increased pain and changes to the lesions in the mouth (the same complaints made to a facility Emergency Department physician on July 2). That same day, the facility ENT provider performed a biopsy of the area. On July 31, the results revealed an invasive squamous cell carcinoma.

On August 3, 2020, the facility ENT provider entered a community care ENT consult (fifth consult) for the patient to receive radical resection surgery at the community hospital.

The Associate Chief of Staff for OCC told the OIG that a new process to review every active and unscheduled consult every seven days had been implemented in August 2020.²⁴ OCC administrative staff told the OIG that the new process included contacting a community provider twice a week to follow up on referrals to ensure each consult was scheduled. Despite this change in process, the OIG found no documented evidence of any action taken between August 4 and August 23 to address the fifth consult for the patient. The referral packet for the fifth consult was sent on August 24.

The patient was scheduled for an evaluation with a community hospital head and neck surgeon on September 3, 2020, which was 32 days from the initiation of the fifth consult on August 3. On September 29, the patient underwent radical resection surgery at the community hospital.

²⁴ A consult is considered *active* during the time between when the receiving service accepts the consult and when an appointment is scheduled.

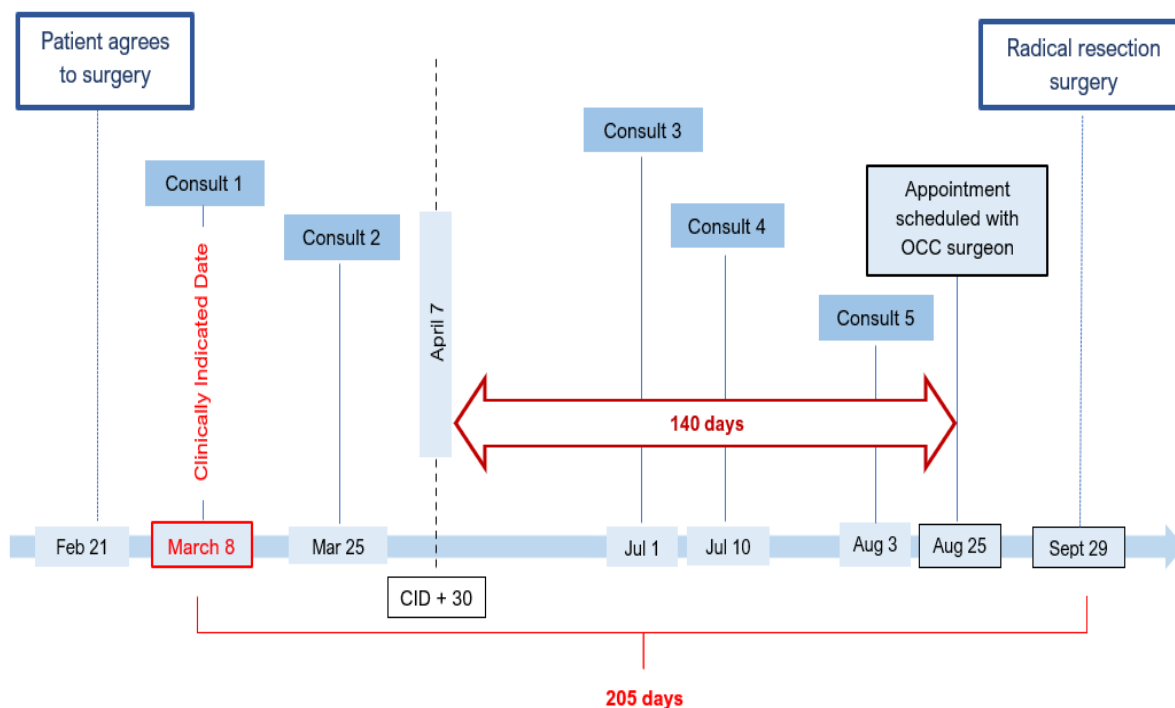


Figure 2. Timeline of days elapsed from clinically indicated date (CID) to date of radical resection surgery.

Source: VA OIG analysis of the patient’s EHR.

The OIG found that the patient experienced significant delays before the surgery was scheduled. As a result of the duplicate referrals sent to providers who had previously declined services for the patient and repeated consults submitted for the same OCC service (radical resection surgery), there was a 140-day delay from April 7 to August 24. Though the patient consented to having the radical resection surgery in February, close to seven months passed (205 days) after the first consult was entered on March 8 (see figure 2).

During discussions with the OIG, the facility and the community hospital providers recognized the importance of earlier surgical intervention in cases of head and neck cancer. The community hospital head and neck surgeon stated that the seven-month surgical delay placed the patient at greater risk for disease progression. The facility ENT provider reported “not [being] aware at the time [the patient] was being delayed.” The facility ENT provider acknowledged “unnecessary delays” in scheduling the patient’s surgery, but noted it was impossible to know the exact effect of the delay.

2. Failure to Coordinate Radiation Therapy and Delay in Coordinating Chemotherapy for a Patient with Head and Neck Cancer

The OIG substantiated that facility OCC staff failed to coordinate radiation and delayed coordinating chemotherapy for a patient with head and neck cancer. The OIG determined that

facility OCC staff's lack of care coordination with community providers for the patient's post-surgical follow-up appointments for radiation and chemotherapy was a result of the absence of specific VHA or facility policies related to community care coordination specific to follow-up requests for services from community providers.

The OIG found that the lack of care coordination for post-surgical radiation and chemotherapy treatment changed the original plan of care developed by the community hospital surgical team, which would have given the patient an opportunity to receive optimal treatment and potentially a more favorable outcome.

VHA policy requires that OCC staff coordinate care with community providers and ensure a patient's care is rendered timely through completion of consults within 30 days.²⁵ Once care has been rendered and additional clinical needs are requested by the community provider, the VHA OCC Field Guidebook (Field Guidebook), which provides guidance and recommendations to facilities, states community care providers should submit a request-for-services form. However, there is no guidance for staff on the process of follow-up if the request-for-services form is not used by the community care provider.²⁶ The National Comprehensive Cancer Network Guidelines for Head and Neck Cancer recommend that post-surgical radiation therapy begin within six weeks of a patient's surgery.²⁷

The community hospital surgical team's plan of care included an initial evaluation with the community hospital medical and radiation oncologists six weeks after the patient's surgery. In discussions with the OIG, the community hospital head and neck surgeon described the patient's cancer as aggressive and reported that the patient understood and expressed a desire to receive post-surgical radiation and chemotherapy, contrary to what the patient's spouse stated regarding not wanting to proceed with radiation.

The community hospital staff scheduled an initial evaluation for oncology and radiation therapy on November 10, 2020, six weeks after the patient's surgery (see figure 3). A community hospital staff member told the OIG that a referral for oncology and radiation therapy was sent by fax to the facility on October 22. On November 2, a community hospital staff member also contacted facility OCC staff to request authorization for radiation therapy and chemotherapy services at the community hospital. Facility OCC administrative staff requested that the community hospital staff member submit a request-for-services form via fax. On November 9, OCC clinical staff documented receiving a fax from the community hospital with a cover sheet titled "VA referral to Medical Oncology at [community hospital]" and noted that a request-for-services form was not included in the fax. That same day, facility OCC clinical staff documented

²⁵ VHA Directive 1232(3); VHA Office of Community Care Field Guidebook, Chapter 3.

²⁶ VHA Office of Community Care Field Guidebook; Deputy Under Secretary for Health for Operations and Management Memorandum, *Community Provider Orders and Requests for Services Processes*, September 16, 2019.

²⁷ National Comprehensive Cancer Network, *Guidelines for Very Advanced Head and Neck Cancer*, Version 3.2021

in the EHR an attempt to contact a community hospital nurse regarding the missing request-for-services form but were unable to speak to the community hospital staff by phone. The OIG did not find documented evidence that facility OCC staff made other attempts to reach the nurse at the community hospital. When reviewing the patient’s EHR, the OIG found that facility OCC staff did not receive the required request-for-services form from the community hospital staff for radiation evaluation, and subsequently did not authorize the patient’s community care appointment scheduled for November 10.

The OIG did not find a VHA or facility policy or standardized process in the Field Guidebook related to community care coordination specific to follow-up requests for additional services from the community provider. The OIG would have expected facility OCC staff to continue their efforts to contact to the community care provider for the request-for-services form to proceed with authorization.

VHA Office of Community Care staff informed the OIG that the recommendations in the Field Guidebook are not requirements that VHA facilities must follow. During interviews with the OIG, facility OCC leaders and staff stated there were no local policies for community care practices; therefore, the OCC staff referred to the Field Guidebook often. Because the Field Guidebook does not include guidance on how OCC staff should address referrals that are submitted without a request-for-services form, and the facility did not have policies and procedures in place, OCC staff did not have a process to follow when the community hospital sent the fax referral without a request-for-services form.

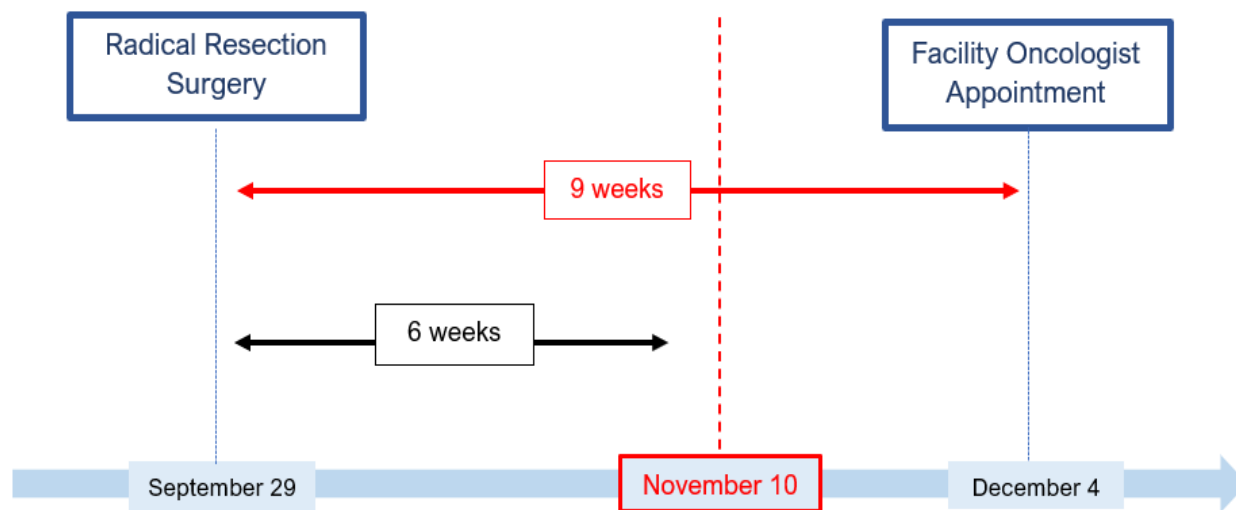


Figure 3. Timeline of Weeks Elapsed from Date of Radical Resection Surgery to First Appointment with Facility Oncologist.

Source: VA OIG analysis of the patient’s EHR.

On November 10, 2020, consistent with eligibility criteria, facility OCC staff also did not authorize chemotherapy at the community hospital as this service was available at the facility.

On the same day, the OCC staff alerted the primary care provider and a primary care nurse about the denial for chemotherapy in the community but did not include any information about the urgency of the request or how much time had already passed since the patient's surgery. Instead, facility OCC staff documented that the patient was willing to participate in oncology appointments at the facility, and failed to include in the documentation that the original evaluation date on November 10 was already six weeks after the surgery date. The facility ENT provider was also alerted the same day and entered a routine outpatient oncology consult for the patient to be evaluated at the facility. Finally, on November 13, facility OCC staff scheduled the patient for an appointment with Oncology Service on December 4. In an interview with the OIG, the facility ENT provider did not recall being involved with the chemotherapy consult after surgery and was not able to provide any additional information on the delay. The consult was accepted on the same day by a facility oncologist who ordered imaging scans for "clinical appropriateness and scheduling capacity" and recommended that the patient be scheduled within two to three weeks with a facility oncologist. In an interview with the OIG, the facility oncologist reported that poor communication with facility OCC staff was a constant issue and that oncology service does not get alerted by the OCC of urgent cases.

On December 4, 2020, during the patient's initial visit with facility oncology services, nine weeks after surgery, a facility oncology resident documented that there were changes to the patient's condition concerning for residual or returning cancer. The facility oncology resident also noted that since the patient was "already almost 3 months out" from surgery, the benefits of radiation therapy were "diminished at this point." A review of EHR documentation during follow-up appointments with the facility oncologist identified that the patient's cancer had an extensive reoccurrence. By early 2021, the patient's primary care provider coordinated [palliative care](#) before the patient died the following month.

The OIG determined that the lack of a standardized process from the VHA Office of Community Care and absence of a facility policy may have resulted in facility OCC staff failing to complete care coordination for the patient when a referral for additional services was received via fax but the request-for-services form was not included.

Conclusion

The OIG determined that the facility's OCC staff failed to schedule community care appointments for the patient within 30 days as per VHA policy. The OIG determined that the patient experienced significant delays before the surgery was scheduled. In total, there was a delay of 140 days before the evaluation appointment was scheduled with a community head and neck surgeon.

Additionally, the OIG substantiated that facility OCC staff failed to coordinate the patient's post-surgical radiation and chemotherapy within the six-week timeline recommended by the community hospital's plan of care for the patient. The facility did not have a policy in place for

care coordination specifically related to the follow-up of requests for services from the community provider and referred to the Field Guidebook for guidance and recommendations relating to community care coordination. The Field Guidebook suggests, but does not require, community care providers should submit a request-for-services form; however, it does not provide guidance for OCC staff on how to follow up on a referral if the request-for-services form is not received. Over nine weeks elapsed between the day of surgery and the follow-up oncology appointment at the facility. The OIG was unable to determine if the failure and delay in community care coordination contributed to the patient's death because of the aggressive nature of the patient's head and neck cancer and the complexity of cancer treatments. However, the OIG concluded that the facility's failure to schedule community care appointments timely, and failure to coordinate radiation therapy and delay in coordinating chemotherapy within the requested time frame, limited the patient's opportunity to receive optimal treatment and potentially a more favorable outcome.

Recommendations 1–3

1. The Veterans Health Care System of the Ozarks Facility Director ensures that Office of Community Care staff take action on active consults within seven days and schedule community care appointments within the 30-day clinically indicated date requirement and monitors compliance.
2. The Veterans Health Care System of the Ozarks Facility Director evaluates the process for authorization of requests for community care and for coordinating care for patients receiving oncology treatment in the community, and takes corrective action to address any deficiencies identified.
3. The Under Secretary of Health ensures the Veterans Health Administration Office of Community Care defines a standardized process for community care coordination related to follow-up requests for additional services from community providers.

Appendix A: Patient’s Appointments and Consults Timeline

Date	Action
February 21, 2020	<ul style="list-style-type: none"> • Patient had a follow-up appointment with a Little Rock VA ENT provider and expressed interest in a radical resection of the lesion within the oral cavity. • After facility ENT staff spoke with an OCC nurse, a facility primary care provider was notified by the OCC nurse to place a community care ENT consult (first consult) for “radical resection buccal mucosa with free flap.”
March 8	<ul style="list-style-type: none"> • Facility primary care provider entered ENT community care consult (first consult).
March 25	<ul style="list-style-type: none"> • Community Care ENT consult (second consult) entered as routine with a clinically indicated date of March 25, 2020. • Facility OCC staff accepted consult. • Triage completed and identified as moderate, which required follow-up in 30 days. • Packet referral sent to community ENT provider 1. • Community ENT provider 1 returned the referral, noting the care was too complicated and recommended patient be seen at Little Rock VA. • Packet referral sent to community ENT provider 2.
May 13	<ul style="list-style-type: none"> • Facility OCC scheduler added comment to the second consult stating spoke with patient who had not been contacted for an appointment.
May 20	<ul style="list-style-type: none"> • Facility primary care provider added comment to ask facility OCC staff to follow up because patient was asking about appointment.
June 24	<ul style="list-style-type: none"> • Facility ENT clinic staff added comment to ask facility OCC staff to follow up with community ENT provider 2 for an appointment.
July 1	<ul style="list-style-type: none"> • Facility ENT clinic staff contacted community ENT provider 2, who stated fax request was not received. • Facility ENT staff alerted OCC staff to re-fax request. • Facility OCC staff faxed request and spoke with community ENT provider 2 who did not offer service for chief complaint and recommended neurosurgical consult. • OCC scheduler forwarded the second consult to facility neurosurgery. • Facility ENT staff added comment that this was not for neurosurgery and entered a new consult (third consult) for community care ENT.
July 2	<ul style="list-style-type: none"> • Consult returned from facility neurosurgery. • Consult discontinued, documented as over 30 days old and needed another type of care.
July 10	<ul style="list-style-type: none"> • Interfacility consult (fourth consult) entered by facility primary care provider to Little Rock VA head and neck surgeon. • Patient was scheduled to see the Little Rock VA surgeon on October 9.

Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

Date	Action
July 29	<ul style="list-style-type: none"> • Patient had a follow-up appointment and biopsy with the facility ENT.
July 31	<ul style="list-style-type: none"> • Biopsy results showed invasive squamous cell carcinoma and patient was informed of the results the same day by the Chief of Surgical Service.
August 3	<ul style="list-style-type: none"> • Facility ENT consulted with the Little Rock VA ENT, who recommended the patient be seen at the community hospital for head and neck cancers for surgery. • Facility ENT entered a new consult (fifth consult) for Community Care ENT for the patient to be evaluated at the community hospital. • Patient was scheduled for an appointment at the community hospital on September 3.
September 29	<ul style="list-style-type: none"> • Patient underwent radical resection surgery.
October 22	<ul style="list-style-type: none"> • Three-week post-operative follow-up and wound check at the community hospital. • Community hospital staff entered internal referrals for both medical oncology (chemotherapy) and radiation therapy.
November 2	<ul style="list-style-type: none"> • Community hospital staff contacted facility OCC staff to request authorization for oncology care. • Facility OCC clinical staff requested the community hospital submit a request-for-services form.
November 9	<ul style="list-style-type: none"> • Facility OCC staff received a fax from the community hospital; however, no request-for-services form was included. • OCC staff alerted the patient's primary care provider of the unauthorized appointment scheduled the next day with the community hospital radiation and chemotherapy specialists. • OCC staff asked the primary care provider to consider requesting a consult for oncology care at the facility. • OCC staff contacted the patient's spouse and informed the spouse that facility OCC staff did not authorize the community hospital radiation and chemotherapy appointment scheduled the next day at the community hospital. OCC staff noted the spouse stated the patient did not want radiation therapy.
November 10	<ul style="list-style-type: none"> • Six-week post-operative follow-up and wound check at the community hospital. • Initial appointment with the community hospital for chemotherapy and radiation evaluation canceled due to a lack of authorization from facility OCC staff. • Community hospital staff contacted facility OCC staff to request authorization for medical oncology and radiation therapy referral approvals "as soon as possible." • Facility ENT provider entered a new consult requesting community care oncology services. • Facility oncologist accepted the new consult and ordered additional labs and radiology testing; documented to schedule the patient with facility oncology services in two to three weeks.

Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

Date	Action
November 13	<ul style="list-style-type: none"> • First appointment with facility oncology services scheduled for December 4.
November 19	<ul style="list-style-type: none"> • Facility primary care provider entered a second consult for community care oncology due to scheduled “appointment greater than wait time standards.” • Facility primary care provider entered a consult for community care radiation therapy. • Consult was approved by the facility’s Chief of OCC.
November 20	<ul style="list-style-type: none"> • Consult for community care oncology canceled by a facility oncologist due to “not eligible under MISSION act” and noted that the patient can be referred to the facility for radiation.
November 24	<ul style="list-style-type: none"> • OCC staff sent a referral packet for radiation treatment to the patient.
December 2	<ul style="list-style-type: none"> • OCC staff sent a referral packet for radiation treatment to the community hospital.
December 4	<ul style="list-style-type: none"> • Facility oncologist saw the patient. • PET scan was ordered due to a suspicion of metastatic disease. • During discussions between a facility oncologist, the patient, and spouse, it was determined that radiation therapy benefits were diminished at this time due to previous history of radiation to the same field and “already almost 3 months out” from surgery.
Late 2020	<ul style="list-style-type: none"> • PET scan results “showed extensive, recurrent disease.” • Facility oncologist reported results to the patient and spouse; and altogether “elected that [patient] was not a candidate for chemo.” • Decision made to start palliative therapy.
Early 2021	<ul style="list-style-type: none"> • First dose of palliative therapy administered in facility oncology clinic.
Three weeks later	<ul style="list-style-type: none"> • Second dose of palliative therapy administered in oncology clinic.
Following month	<ul style="list-style-type: none"> • Patient died.

Source: VA OIG analysis of the patient’s EHR and statements from a facility staff member.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: July 13, 2022

From: Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health (10)

Subj: OIG Draft Report, Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas (2021-02326-HI-1175) (VIEWS 07961693)

To: Associate Director, Office of Healthcare Inspections (54HL05)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report regarding the Community Care Coordination Delays and Facility Response at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas. We appreciate OIG's recommendations and acknowledge there are improvements to be made. We are committed to ensuring a safe environment for all Veterans.
2. I concur in principle with the OIG's recommendation to the Office of the Under Secretary for Health and request OIG to consider closure as fully implemented. Comments and action plans for recommendation 1 and 2 are provided by the Medical Center Director at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas.
3. Comments regarding the content of this memorandum can be directed to the GAO-OIG Accountability Liaison at VHA10BGOALAction@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D.
Acting Under Secretary for Health

Office of the Under Secretary for Health Response

Recommendation 3

The Under Secretary of Health ensures the Veterans Health Administration Office of Community Care defines a standardized process for community care coordination related to follow up requests for additional services from the community provider.

Concur in principle.

Target date for completion: August 2022

Under Secretary for Health Comments

Concur in principle. In June 2022, VHA's Office of Community Care and Office of Veterans Access to Care merged to become the VHA Office of Integrated Veteran Care (IVC). This office is working to develop, and will implement and oversee, an integrated access and care coordination model. VHA IVC concurs in principle with this recommendation for the following reasons: 1) we currently have a standardized process for community care coordination related to follow up requests for additional services from the community provider, supported by the artifacts noted below; 2) as above, we are working to streamline and standardize access processes holistically – including but not limited to community care.

In September 2019 we defined a standardized process for community care coordination in VHA Memorandum – National Deployment of the Community Care Coordination Model (VIEWS #01360306). This memo provided instructions for implementing a Care Coordination Model (CCM) for a community care consult or episode of care. Additional information is also provided in the OCC Field Guidebook Chapter 3. The guidebook describes a care coordination model, use of a Standardized Triage Tool (STT) as a standardized method to determine the level of care coordination support a Veteran would need, and creation of a Care Coordination Plan (CCP) note for each episode of care. Additionally, the STT Standardized Operational Procedure (SOP) and STT Reference Sheet are provided as attachments for further clarification.

VHA IVC has the following activities related to community care coordination in progress:

1. VHA IVC has updated guidance and the SOP for the RFS (Request for Service) process. RFS is part of our care coordination process and includes processes sites should follow when urgent requests are received by a community care office from community care providers. This updated RFS guidance will be reviewed during an upcoming training, tentatively scheduled for mid-August 2022.
2. VHA IVC has revised the standardized Community Care Coordination Plan (CC-CCP) and Community Care Emergency Self-Presenting Care Coordination Plan (CC-EMER) notes in CPRS [computerized patient record system]. Training for use of these notes is tentatively

scheduled for August 2nd and August 4th, 2022. Training will cover when to utilize the CC-CCP note and CC-EMER note, how to incorporate the notes into the care coordination workflow, and how to appropriately develop and document a care coordination plan for the Veteran. VHA requests OIG consider closure of this recommendation.

OIG Comments

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

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 5, 2022

From: Director, South Central VA Health Care Network (10N16)

Subj: Health Inspection—Community Care Coordination Delays for a Patient with Oral Cancer at the
Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

To: Director, Office of the Under Secretary for Health (10)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)
Director, Office of Healthcare Inspections (54HL06)

The South Central VA Health Care Network has reviewed and concurs with the actions submitted by the Veterans Health Care System of the Ozarks, Fayetteville, AR, in response to the Community Care Coordination Delays for a Patient with Oral Cancer Draft Report.

(Original signed by:)

Skye McDougall
VISN 16 Network Director

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 30, 2022

From: Acting Medical Center Director, Veterans Health Care System of the Ozarks Fayetteville,
Arkansas (564/00)

Subj: VAOIG DRAFT REPORT—Community Care Coordination Delays for a Patient with Oral Cancer
at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

To: Director, South Central VA Health Care Network (10N16)

1. I have reviewed the draft report for the Veterans Health Care System of the Ozarks and concur with the report, conclusions rendered, and the recommendations.
2. If there are any further questions regarding this response, please contact the Veterans Health Care System of the Ozarks.

(Original signed by:)

Chris Myhaver, MHA, FACHE
Acting Medical Center Director

Facility Director Response

Recommendation 1

The Veterans Health Care System of the Ozarks Facility Director ensures that the Office of Community Care staff take action on active consults within seven days and schedule community care appointments within the 30-day clinically indicated date requirement and monitors compliance.

Concur.

Target date for completion: September 30, 2022

Director Comments

The Veterans Health Care System of the Ozarks (VHSO) Facility Director recognizes the importance of the scheduling of community care appointments within the indicated date requirements. We are actively monitoring compliance. Facility Community Care staff report daily to the Facility Executive Leadership every morning to ensure consults are worked within the time guidelines. We consistently use Consult Tool Manager (CTM) program to manage our consults. VHSO runs reports every morning to know the status of every consult in our consult inventory. The Facility Community Care OCC clinical staff are following the current OCC Field Guidebook regarding care coordination, staff received training from OCC Clinical Integration in November 2021 and receive ongoing internal training.

Recommendation 2

The Veterans Health Care System of the Ozarks Facility Director evaluates the process for authorization of requests for community care and for coordinating care for patients receiving oncology treatment in the community and takes corrective action to address any deficiencies identified.

Concur.

Target date for completion: September 30, 2022

Director Comments

The Veterans Health Care System of the Ozarks (VHSO) Facility Director and Chief of Staff evaluate the process for community care clinical oversight, clarify who has responsibility for coordinating care for patients receiving oncology treatment in the community, and verify that patients receive authorized community care. The Facility Community Care staff Office of Community Care currently follows the National Field Guidebook and policies for Care

Coordination and provides ongoing training and education for the staff. If deficiencies in meeting the standards are discovered, they are investigated, and corrective action is taken.

Glossary

To go back, press “alt” and “left arrow” keys.

adjuvant. A type of treatment used after primary cancer treatments are completed to decrease the chance of cancer recurring.¹

antibiotic. Medicine used to prevent infections by stopping the growth of bacteria that can be used on the skin, injected, or taken by mouth.²

biopsy. A process in which cells are taken from an area of the body and examined.³

care coordination plan. A templated note in the electronic health record to describe the required actions to address the care needed and may include patient information, clinical history, and appointment management.⁴

chemotherapy. The use of chemicals to kill fast-growing cancer cells and prevent them from multiplying in the body.⁵

community care consult. Submitted by a provider on behalf of a patient to request a specific service. In VHA, consult requests are made through the electronic health record to the service being requested.⁶

community providers. Refers to non-VA medical providers in the community.

erosive. “to diminish or destroy by degrees: to eat into or away by slow destruction of substance (as by acid, infection, or cancer).”⁷

interfacility consult. A “request for services between different parent facilities.”⁸

¹ National Cancer Institute, “adjuvant therapy,” accessed August 20, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/adjuvant-therapy>.

² Merriam Webster.com Dictionary, “antibiotic,” accessed August 20, 2021, <https://www.merriam-webster.com/dictionary/antibiotic>.

³ Merriam Webster.com Dictionary, “biopsy,” accessed August 6, 2021, <https://www.merriam-webster.com/dictionary/biopsy>.

⁴ VHA Office of Community Care Field Guidebook, Chapter 3.

⁵ Mayo Clinic, “chemotherapy,” accessed May 18, 2021, <https://www.mayoclinic.org/tests-procedures/chemotherapy/about/pac-20385033>.

⁶ VHA Directive 1232(3), Consult Processes and Procedures.

⁷ Merriam Webster.com Dictionary, “erode,” accessed August 20, 2021, <https://www.merriam-webster.com/dictionary/erode>.

⁸ VHA Directive 1232(3).

laryngeal cancer. Cancer of the larynx, or voice box, that usually begins on the surface of the inner lining with small growths. Additional symptoms may include pain in and around the affected area, problems with swallowing, difficulty breathing, and coughing up blood.⁹

lesion. Abnormal tissue that can have cancer.¹⁰

medical oncology. A type of cancer treatment using chemotherapy and other drugs.¹¹

metastases. The spread of cancer cells from the original tumor to other areas of the body through the blood or lymph nodes.¹²

oncologist. A doctor who diagnoses and treats cancer.¹³

oncology. “A branch of medicine that specializes in the diagnosis and treatment of cancer.”¹⁴

oral mucosa. The membrane lining the inside of the mouth, cheeks, and lips.¹⁵

palliative. “reducing the severity of a disease or condition without curing it.”¹⁶

palliative care. A type of specialized medical care provided by a team of medical professionals focused on relieving pain and other symptoms of serious illness while improving a patient’s quality of life.¹⁷

⁹ John Hopkins Medicine, “Laryngeal Cancer,” accessed May 18, 2021, <https://www.hopkinsmedicine.org/health/conditions-and-diseases/laryngeal-cancer>.

¹⁰ National Cancer Institute, “lesion,” accessed August 6, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/lesion>.

¹¹ National Cancer Institute, “oncology,” accessed August 6, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/oncology>.

¹² National Cancer Institute, “metastases,” accessed August 6, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/metastasis>.

¹³ Merriam Webster.com Dictionary, “oncologist,” accessed August 23, 2021, <https://www.merriam-webster.com/dictionary/oncologist#other-words>.

¹⁴ National Cancer Institute, “oncology,” accessed August 6, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/oncology>.

¹⁵ University of California-Davis Health, “oral mucosa,” accessed August 20, 2021, <https://health.ucdavis.edu/dermatology/specialties/medical/oral.html>.

¹⁶ Merriam Webster.com Dictionary, “palliative,” accessed May 3, 2021, <https://www.merriam-webster.com/dictionary/palliative>.

¹⁷ Mayo Clinic, “palliative care,” accessed October 19, 2021, <https://www.mayoclinic.org/tests-procedures/palliative-care/about/pac-20384637>.

pathology report. “A medical report about a piece of tissue, blood, or body organ that has been removed from” the body.¹⁸

positron emission tomography scan. An imaging test that can “help identify a variety of conditions, including cancer, heart disease and brain disorders.” The information can be used to help with monitoring and treatment of these conditions.¹⁹

radiation therapy. A type of cancer treatment using radiation from x-rays and other sources to destroy cancerous cells and minimize the size of a tumor.²⁰

radical resection. A procedure that removes the entire tumor, along with some healthy tissue surrounding the tumor, to ensure that no cancerous cells remain near the tumor.²¹

request-for-services. A form to be used by community providers when requesting additional or continued care in the community for a patient.²²

squamous cell carcinoma. A type of cancer that develops from the squamous cells “found in the tissue that forms the surface of the skin, the lining of the hollow organs of the body, and respiratory and digestive tracts.”²³

stage. “The extent of cancer in the body.”²⁴

tumor. An abnormal mass of tissues in any part of the body that can be cancerous or noncancerous and can also spread to other parts of the body.²⁵

¹⁸ John Hopkins Medicine, “pathology report,” October 19, 2021, <https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/the-pathology-report>.

¹⁹ Mayo Clinic, “PET scan, accessed August 23, 2021, <https://www.mayoclinic.org/tests-procedures/pet-scan/about/pac-20385078>.

²⁰ National Cancer Institute, “radiation therapy,” accessed July 22, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/radiation-therapy>.

²¹ Penn Medicine, “radical resection,” accessed August 20, 2021, <https://www.pennmedicine.org/cancer/types-of-cancer/sarcoma/soft-tissue-sarcoma/soft-skin-tissue-sarcoma-treatment/radical-resection>.

²² VHA Office of Community Care Field Guidebook, Chapter 3.

²³ National Cancer Institute, “squamous cell carcinoma,” accessed August 13, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/squamous-cell-carcinoma>.

²⁴ National Cancer Institute, “stage,” accessed September 7, 2021, <https://www.cancer.gov/search/results?swKeyword=stage>.

²⁵ National Cancer Institute, “tumor,” accessed September 7, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/tumor>.

tumor board. A group of physician experts from different medical specialties that meet to discuss and review the medical condition and treatment options of a cancer patient.²⁶

verrucous carcinoma. A rare type of slow growing squamous cell carcinoma that commonly occurs in the insides of the mouth as a painless area resembling a cauliflower. This type of cancer occurs most frequently in older males and is generally considered to have a good prognosis if treated appropriately.²⁷

²⁶ National Cancer Institute, “tumor board review,” accessed August 20, 2021, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/tumor-board-review>.

²⁷ NIH National Center for Biotechnology Information, “verrucous carcinoma,” accessed August 13, 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4570003/?report=classic>.

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