



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Coordination of
Care for a Patient at the
West Palm Beach
VA Healthcare System in
Florida



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the West Palm Beach VA Healthcare System (facility) in Florida to assess allegations related to the [cancer](#) care a patient received.¹

In July 2021, the OIG received allegations that a primary care provider failed to coordinate the patient's cancer care and a [pulmonologist](#) failed to surveil the patient's cancer following [CyberKnife](#) treatment.² The complainant also alleged that these failures led to progression of the cancer and contributed to the patient's death in spring 2020. During the healthcare inspection, the OIG identified a related concern with community care coordination by the facility's community care staff.

Patient Case Summary

The patient, in their sixties, had a past medical history that included smoking and [chronic obstructive pulmonary disease](#). In early 2016, the patient completed a chest [computerized tomography](#) (CT) scan for lung cancer screening.³ The CT scan noted a small (10 millimeter) left upper lobe nodule that required monitoring and a follow-up CT scan in three months. During a follow-up chest CT scan in spring 2017, the [radiologist](#) noted that the nodule increased in size. The patient was referred to a pulmonologist, who after [consultation](#) with the facility Chest Conference, developed a plan for further evaluation of the nodule.⁴ In late 2017, a [biopsy](#) of the nodule was completed and a diagnosis of confirmed [well-differentiated neuroendocrine carcinoid tumor](#) in the left upper lobe was made. Because of the patient's clinical status and results of pulmonary function tests, the patient was considered high risk for surgical removal of the tumor and therefore underwent treatment with CyberKnife in early 2018. In early summer 2018, the

¹ The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together. Neuroendocrine tumors are rare cancers that begin in specialized cells called neuroendocrine cells. The exact cause of neuroendocrine tumors is unknown. Carcinoid tumors are a subset of neuroendocrine tumors. Carcinoid tumors commonly occur in the lungs, are typically slow growing, and often do not cause symptoms until late in the disease. Mayo Clinic, "[neuroendocrine tumor](#)," accessed March 3, 2022, <https://www.mayoclinic.org/diseases-conditions/neuroendocrine-tumors/symptoms-causes/syc-20354132>. Mayo Clinic, "[Carcinoid tumors](#)," accessed March 4, 2022, <https://www.mayoclinic.org/diseases-conditions/carcinoid-tumors/symptoms-causes/syc-20351039>.

² CyberKnife treatment delivers radiation by using x-rays to treat cancerous abnormalities typically in one to five sessions.

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

⁴ According to VHA, the Tumor Board is a multidisciplinary case conference that occurs at individual VHA facilities and nationally. The facility's Tumor Board for lung cancer is also known as the Chest Conference. During Chest Conferences, clinical subject matter experts discuss the diagnosing, staging, and treatment options, and provide recommendations to teams treating patients with lung cancers. VHA Directive 1415, *VHA Oncology Program*, April 9, 2020.

patient was referred back to the pulmonologist for [surveillance](#). That same day, a repeat chest CT scan showed that the left upper lobe nodule decreased in size from 15 millimeters to 12 millimeters and confirmed development of a new five-millimeter [ground glass](#) nodule in the right upper lobe. The next day, the pulmonologist documented a plan to share the results with the patient at the scheduled appointment later that same day, but the patient subsequently canceled that appointment. Also that month, the patient complained about back pain to the primary care provider. An [x-ray](#) showed mild arthritis. The patient's primary care provider referred the patient to a [chiropractor](#). The next month, the patient requested a follow-up appointment with the pulmonologist. The follow-up appointment was scheduled for late fall but was again canceled by the patient. The patient called about rescheduling the missed pulmonary appointment and was instructed by the patient's pulmonologist to reschedule after the chest CT scan that was ordered for early summer 2019.

The following month, the patient presented to the facility's Emergency Department with neck and lower back pain and a chest CT scan and additional imaging were completed. The results of the imaging showed that the patient had a large (7.5 centimeter x 5.5 centimeter) left sided lung mass. The patient was admitted to the facility. A [magnetic resonance imaging](#) (MRI) showed that the patient had a spine compression fracture that was likely related to an underlying [metastatic](#) disease. A lung biopsy was non-diagnostic, but a bone biopsy demonstrated a [poorly-differentiated neuroendocrine tumor](#) consistent with [small cell carcinoma](#). While hospitalized, the patient received [radiation treatment](#) and [chemotherapy](#). Upon discharge from the hospital, the patient relocated closer to family and transferred care to another VA medical center to continue treatment.

In early 2020, the patient was informed that despite treatment, the cancer continued to spread further. The patient received [palliative care](#) and hospice services until the patient's death in spring 2020.

Inspection Results

The OIG did not substantiate that the primary care provider failed to coordinate the patient's care. The OIG did not substantiate that the pulmonologist failed to surveil the patient's cancer. However, the OIG found that the pulmonologist failed to notify the patient of the early summer 2018 repeat chest CT scan results and failed to use required processes to ensure appropriate follow-up appointment scheduling. These failures may have contributed to a delay in the patient's follow-up care.

While not an allegation, the OIG identified related concerns involving community care coordination. The OIG found no documented evidence that a facility chiropractor reviewed the records and recommendation for an MRI submitted by a community care chiropractor.

Primary Care Provider

To prevent lapses in care, the Veterans Health Administration (VHA) requires that patients receive coordinated care, and that relevant information be communicated between providers and patients.⁵ The OIG found that the patient's primary care provider and team managed the patient's care and repeatedly addressed the patient's pain complaints through consistent communication within the primary care team and with the patient.

Pulmonologist

Although VHA does not have a policy that addresses cancer surveillance or assign responsibility for cancer care coordination, VHA does state that the patient's electronic health record (EHR) must be timely, relevant, and complete. Documentation facilitates the provider's ability to evaluate and plan the patient's treatment and to monitor the patient's health care over time and allows for communication and continuity of care among the patient's providers.⁶ VHA also requires timely communication of test results to patients and notes that the lack of timely communication of test results contributes to poor outcomes.⁷ To ensure appropriate scheduling, VHA requires that providers enter a [return-to-clinic order](#) and include the date the appointment is deemed clinically appropriate.⁸

The OIG found that the patient's pulmonologist utilized the Chest Conference for discussion and recommendations about the patient's treatment options and the cancer navigator for assisting with scheduling and coordinating appointments. The OIG found that the patient's pulmonologist made multiple attempts to meet with the patient to discuss the results of the early summer 2018 chest CT scan and the surveillance plan; however, the patient repeatedly canceled the scheduled appointments. Once the patient had completed cancer treatment and was discharged from [Radiation Oncology](#) Service to Pulmonary Service for cancer surveillance, the patient's pulmonologist attempted to coordinate the patient's cancer surveillance.

In early summer 2018, the patient had a chest CT scan done that showed the treated left lung nodule decreased in size from 15 millimeters to 12 millimeters and the development of a new ground glass right lung nodule. The next day following the chest CT scan, the patient was

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

⁶ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015, rescinded and replaced with VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. Handbook 1907.01 was in effect at the time of the patient's care at the facility. The handbook and the directive contain similar language related to documentation within the patient's EHR.

⁷ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, October 7, 2015, amended January 24, 2022. The directives contain similar language related to communicating test results.

⁸ VHA Directive 1230(5), *Outpatient Scheduling Process and Procedures*, July 15, 2016, amended September 24, 2021. The directives contain similar language related to the use of return-to-clinic orders.

scheduled to meet with the pulmonologist, but the patient canceled this appointment. The OIG found that the patient's pulmonologist documented a plan to discuss the results of the chest CT scan and the cancer surveillance plan. After the patient canceled the appointment, the pulmonologist documented two unsuccessful attempts to reach the patient via telephone to discuss the results of the chest CT scan. In summer 2018, the patient requested a follow-up appointment with the pulmonologist, and an appointment was scheduled for three months later. The patient again canceled the appointment. When the patient called to reschedule the appointment, the pulmonologist advised that the patient should be seen after the chest CT scan ordered for early summer 2019. The patient had the chest CT scan in summer 2019, and was admitted to the facility on the same day for further testing and treatment. Although the patient's pulmonologist repeatedly rescheduled canceled appointments, the OIG found no documentation that the patient's pulmonologist communicated the results of the summer 2018 chest CT scan results to the patient.

The OIG also found that the patient's pulmonologist entered return-to-clinic orders during the diagnostic phase of the patient's cancer care. However, the patient's pulmonologist did not enter return-to-clinic orders during the surveillance phase of the patient's cancer care. In an interview, the patient's pulmonologist acknowledged that return-to-clinic orders should be used when a patient needs to return for an appointment, but did not elaborate to the OIG team why return-to-clinic orders were not used during the patient's surveillance phase. By not entering return-to-clinic orders during the surveillance phase, the scheduling of the patient's follow-up appointments may have been delayed.

Chiropractic Care

According to VHA, when a community care provider completes a consult, an electronic notification is generated in the EHR to the ordering provider.⁹ The intent of the notification is to prompt the ordering provider to review the clinical documentation from the community care provider and take follow-up action as needed.¹⁰

The OIG found no documented evidence that the facility chiropractor (ordering provider) followed up on the recommended MRI by the community care chiropractor. In summer 2018, the patient's primary care provider referred the patient to a facility chiropractor for back pain. After the initial appointment, the facility chiropractor referred the patient to a community care chiropractor due to limited appointment availability at the facility. After meeting with the

⁹ VHA previously used the term non-VA care to describe care provided outside of VA. The term has been replaced with community care.

¹⁰ VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016; VHA Directive 1232(4), *Consult Processes and Procedures*, amended December 14, 2021. Directive 1232(1) was in effect at the time of the patient event. Directive 1232(1) and directive 1232(4) contain similar language related to notifying the ordering provider. VHA Office of Community Care, *Community Care Consult/Referral Management*, June 30, 2017.

patient, the community care chiropractor recommended that the patient have an MRI of the spine. In fall 2018, community care staff scanned the community care chiropractor's notes into the patient's EHR and included the clinical care coordinator and the facility chiropractor as additional signers. Through an interview, the clinical care coordinator confirmed reviewing the note based on the signature. The clinical care coordinator stated that the practice is for the ordering provider, in this case the facility chiropractor, to review the notes from the community care provider and determine what, if any, action should be taken. Aside from the facility chiropractor's signature, the OIG found no documented evidence that the facility chiropractor reviewed the records provided by the community care chiropractor to determine if an MRI was needed. Through an interview, the facility chiropractor could not recall this patient or comment on any care provided to the patient. The patient had an MRI done in summer 2019 that showed a fracture likely related to underlying metastatic disease. The OIG could not determine if an earlier MRI would have affected the patient's outcome.

The OIG made three recommendations addressed to the Facility Director to improve cancer care coordination. The recommendations included ensuring that pulmonology providers communicate test results to patients, ensuring pulmonology providers and staff are trained on the use of return-to-clinic orders and that compliance is monitored, and ensuring that chiropractor providers review community care notes and take action as needed.

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.



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Abbreviations

CT	computerized tomography
EHR	electronic health record
MRI	magnetic resonance imaging
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 at the West Palm Beach VA Healthcare System (facility) in Florida to assess allegations related to the [cancer](#) care a patient received.

Background

The facility is designated as a Level 1c, mid-high complexity facility, and is part of Veterans Integrated Service Network (VISN) 8.¹ The facility operates seven community-based outpatient clinics.² From October 1, 2020, through September 30, 2021, the facility served 61,770 patients and reported having a total of 333 operating beds, including 153 hospital beds, 60 domiciliary beds, and 120 community living center beds. The facility provides primary and specialty care, including pulmonology, [hematology](#), and [oncology](#) services.

Neuroendocrine Tumors, Carcinoid Type

[Neuroendocrine tumors](#) are rare cancers that begin in specialized cells called neuroendocrine cells. The exact cause of neuroendocrine tumors is unknown.³ [Carcinoid tumors](#) are a subset of neuroendocrine tumors that commonly occur in the lungs but can occur in other parts of the body. Carcinoid tumors typically grow slowly and often do not cause symptoms until late in the disease.⁴

Diagnosis and treatment of neuroendocrine tumors depend on the type of tumor, location, production of excess hormones, and if the tumor has spread to other parts of the body.⁵ Imaging tests to diagnose neuroendocrine tumors include [ultrasound](#), [computerized tomography](#) (CT), and

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

² The facility has seven contractor-operated community-based outpatient clinics in Boca Raton, Delray Beach, Fort Pierce, Okeechobee, Port Saint Lucie, Stuart, and Vero Beach, Florida.

³ Mayo Clinic, "Neuroendocrine tumors," accessed March 3, 2022, <https://www.mayoclinic.org/diseases-conditions/neuroendocrine-tumors/symptoms-causes/syc-20354132>.

⁴ Mayo Clinic, "Carcinoid tumors," accessed March 4, 2022, <https://www.mayoclinic.org/diseases-conditions/carcinoid-tumors/symptoms-causes/syc-20351039>.

⁵ Mayo Clinic, "Neuroendocrine tumors," accessed June 15, 2022, <https://www.mayoclinic.org/diseases-conditions/neuroendocrine-tumors/diagnosis-treatment/drc-20465865?p=1>.

[magnetic resonance imaging](#) (MRI).⁶ Treatment for neuroendocrine tumors may include surgery, [chemotherapy](#), medications, and [radiation therapy](#) (radiation).⁷

Stereotactic body radiotherapy is a type of radiation that uses many focused radiation beams to treat tumors in the body, including the lungs, neck, and spine.⁸ When using stereotactic body radiotherapy, linear accelerator machines, such as [CyberKnife](#), deliver radiation by using [x-rays](#) to treat cancerous abnormalities typically in one to five sessions.⁹ After radiation, follow-up evaluation and [surveillance](#) are necessary to monitor for [acute](#) and [chronic](#) complications as well as tumor recurrence.¹⁰

Prior OIG Reports

An OIG report published on December 9, 2021, included recommendations related to disclosures, peer review, reporting patient safety events, privileging, and oversight documentation for a facility committee.¹¹ All recommendations have been closed.

Allegations and Related Concerns

On July 20, 2021, the OIG received allegations that a primary care provider failed to coordinate the patient's cancer care and a [pulmonologist](#) failed to surveil the patient's cancer following CyberKnife treatment. The complainant also alleged that these failures led to progression of the cancer and contributed to the patient's death in spring 2020. Through the course of the healthcare inspection, the OIG identified a related concern with community care coordination by a facility chiropractor.

Scope and Methodology

The OIG initiated the inspection on March 7, 2022, and conducted a site visit from April 4–7, 2022.

⁶ Mayo Clinic, "Neuroendocrine tumors," accessed June 15, 2022, <https://www.mayoclinic.org/diseases-conditions/neuroendocrine-tumors/diagnosis-treatment/drc-20465865?p=1>.

⁷ Mayo Clinic, "Neuroendocrine tumors," accessed June 15, 2022, <https://www.mayoclinic.org/diseases-conditions/neuroendocrine-tumors/diagnosis-treatment/drc-20465865?p=1>.

⁸ Mayo Clinic, "stereotactic body radiotherapy," accessed March 3, 2022, <https://www.mayoclinic.org/tests-procedures/sbrt/pyc-20446794>.

⁹ Mayo Clinic, "stereotactic body radiotherapy" accessed March 2, 2022, <https://www.mayoclinic.org/tests-procedures/sbrt/pyc-20446794>.

¹⁰ "Safety is no Accident: A Framework for Quality Radiation and Oncology Care," American Society for Radiation Oncology, accessed March 4, 2022, https://www.astro.org/uploadedFiles/Main_Site/Clinical_Practice/Patient_Safety/Blue_Book/SafetyisnoAccident.pdf.

¹¹ VA OIG, *Deficiencies in Disclosures and Quality Processes for Perforations Resulting from Urological Surgeries at West Palm Beach VA Medical Center in Florida*, Report No. 21-01049-39, December 9, 2021.

The OIG interviewed the complainant, facility leaders, and relevant providers and staff.¹² The OIG reviewed the identified patient’s electronic health record (EHR) as well as pertinent Veterans Health Administration (VHA) and facility policies and procedures related to cancer care coordination, treatment and surveillance, oversight of the cancer care program, peer reviews, and institutional disclosures; relevant emails; facility committee meeting minutes; and other related documents.

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

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, Pub. L. No. 117-286, § 3(b), 136 Stat. 4196, 4206 (2022) (to be codified at 5 U.S.C. §§ 401–24). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summary

The patient, who was in their sixties, had a past medical history that included smoking, [chronic obstructive pulmonary disease](#), [type 2 diabetes](#), and [bipolar disorder](#).¹³

Cancer Detection and Treatment: Early 2016–Summer 2018

With the patient’s smoking history, the primary care provider ordered a chest CT scan for lung cancer screening. The lung cancer screening completed in early 2016 found a small

¹² Facility leaders interviewed included the Facility Director and Chiefs of Staff, Pulmonology, Oncology, Pathology, Medicine, Primary Care, Quality Management, and Health Administration Services. Facility staff interviewed included pulmonary staff, oncology staff, a pathologist, risk manager, patient safety manager, and primary care nurse.

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

(10 millimeter) left upper lobe nodule that required monitoring and a follow-up CT scan in three months.

On a follow-up chest CT scan in spring 2017, the [radiologist](#) noted that the nodule increased in size. On the same day, the primary care provider referred the patient to the pulmonary clinic for evaluation. The pulmonologist saw the patient the following month and the patient had a subsequent [biopsy](#) of the nodule five months later that had non-diagnostic results. A repeat biopsy was done the following month. In early 2018, the pathologist received the results indicating a diagnosis of [well-differentiated](#) neuroendocrine carcinoid tumor in the left upper lobe of the lung. The pulmonologist notified the patient the next day along with follow-up instructions to see thoracic surgery. The pulmonologist documented that “surgical resection is the treatment of choice and radiation is not typically curative.” Five days later, the facility’s Chest Conference members discussed the patient’s case and also recommended follow-up with a thoracic surgeon.¹⁴

Three days later, during an appointment, the thoracic surgeon documented a detailed discussion of the cancer and the patient’s clinical situation. The thoracic surgeon determined the patient would be considered high risk for a [lobectomy](#), and the patient agreed to forgo surgical resection of the cancer. The thoracic surgeon recommended the patient undergo evaluation for radiation treatment or CyberKnife and made a referral to [Radiation Oncology](#) Service for evaluation. The radiation oncologist examined the patient four days later and discussed both external beam radiation treatment and CyberKnife treatment with the patient, and the patient chose to pursue external beam radiation treatment. After three treatments and at the patient’s request, the radiation oncologist switched the patient from external beam radiation treatment to CyberKnife. The patient completed CyberKnife in spring 2018. In summer 2018, the patient met with a radiation oncologist and was advised to follow up with Pulmonary Service. Later that day, the patient had a follow-up chest CT scan.

Cancer Surveillance: Summer 2018–Summer 2019

Following discharge from the Radiation Oncology Service, the patient had a scheduled appointment with a different pulmonologist (patient’s pulmonologist) the next day. The patient’s pulmonologist documented that the chest CT scan results showed that the left upper lobe nodule decreased in size from 15 millimeters to 12 millimeters and development of a new five-millimeter [ground glass](#) nodule in the right upper lobe. The patient’s pulmonologist wrote a plan to share the results with the patient at the scheduled appointment, but the patient canceled the appointment. In summer 2018, a medical support assistant noted calling the patient and leaving a message to schedule a follow-up pulmonary appointment. Nineteen days later, the cancer

¹⁴ VHA Directive 1415, *VHA Oncology Program*, April 9, 2020. Chest Conference is a multidisciplinary case conference that occurs at VHA facilities.

navigator reviewed the summer 2018 chest CT scan with the patient's pulmonologist and indicated that the patient's pulmonologist decided to repeat the chest CT scan in one year.¹⁵

The following month, the patient came to the pulmonary clinic requesting a follow-up appointment. A medical support assistant included the patient's pulmonologist to the note as an additional signer. The patient's pulmonologist attached an addendum to the note stating that the patient should have a follow-up appointment within the month and every six months thereafter for the next two years. A follow-up pulmonology appointment was scheduled for fall 2018, but the patient subsequently canceled the appointment. One day after the appointment was canceled, a telephone triage note showed the patient contacted both the pulmonary and primary care clinics inquiring about a follow-up chest CT scan for the lung cancer nodule. The note also reflected that the patient voiced concerns about the lung cancer follow-up timeline. On the same day, the patient's pulmonologist documented that the patient was due for a chest CT scan in summer 2019, and the patient would be rescheduled with the pulmonologist after that scan. The pulmonary clinic medical support assistant communicated the follow-up plan to the patient. Two days later, the primary care provider entered an addendum note asking the cancer navigator to comment on the recommended chest CT scan follow-up interval.

In early 2019, the patient spoke with a primary care nurse on the telephone. The primary care nurse documented that the patient restarted smoking and requested an earlier appointment for the follow-up chest CT scan. After consulting with the primary care provider, the primary care nurse notified the patient that the chest CT scan was ordered for summer and that an earlier CT scan was not necessary.

The patient was scheduled for a chest CT scan in summer 2019, but the patient canceled that appointment. The chest CT scan was rescheduled for later that month, and the patient was scheduled to see the pulmonologist the next day. Instead, on the day the chest CT scan was rescheduled to take place, the patient was hospitalized and was seen by the inpatient pulmonologist.

Pain Evaluation and Management: Spring 2018–Summer 2019

During a primary care appointment in spring 2018, the patient complained of buttocks pain when sitting for long periods of time. Late spring, the patient called requesting treatment for back pain. The primary care provider ordered an x-ray to facilitate a referral to the [orthopedic](#) clinic. The patient called the primary care clinic twice the following month asking for a plan of action for pain management for back and buttocks pain. The primary care nurse reminded the patient by telephone and by mail to obtain the ordered spine x-rays because, per the primary care provider, orthopedic consults required completed x-rays.

¹⁵ A cancer navigator is a clinical position at the facility, and the incumbent is responsible for providing diagnostic and clinical care consultation for patients followed by the oncology clinic.

Later that month, the patient presented to the facility's Emergency Department with low back pain radiating bilaterally to the buttocks and upper thighs. The Emergency Department physician examined and diagnosed the patient with [sacroiliac joint dysfunction](#), gave the patient an injection along with an outpatient non-steroidal anti-inflammatory medication prescription, and discharged the patient.

The following month, the patient completed the ordered spine x-rays. Two days later, a primary care nurse called the patient with the spine x-ray results showing mild arthritis and to discuss the treatment plan. The patient started physical therapy late summer 2018, and a facility [chiropractor](#) referred the patient to a community care chiropractor later that month for the back pain. That same month, the non-VA chiropractor documented the patient needed an MRI. In the fall, the patient's non-VA chiropractic records were scanned into the EHR.

That same month, the patient's primary care provider referred the patient for [acupuncture](#). In early 2019, the acupuncturist noted the patient's pain mainly originated from the [sacral](#) region, which was not visible on the initial x-ray, and suggested ordering a sacral x-ray. When requested by the patient a day later, the primary care provider ordered a sacral x-ray that was completed two weeks later showing a tailbone fracture. The primary care provider referred the patient to pain management. In early 2019, the patient was seen in urgent care for continuing severe tailbone pain. The urgent care provider examined the patient and recommended ice packs and a change of non-steroidal anti-inflammatory medication.

The following month, the pain management provider evaluated the patient and offered several treatment options. The patient chose to continue with acupuncture and the current non-steroidal anti-inflammatory medication.

Two months later, in spring 2019, the patient called telephone triage with complaints of shoulder pain. The telephone triage nurse provided the patient with shoulder care education, and advised the patient to follow up with primary care if the pain did not improve. Six days later, the patient presented to the facility's Emergency Department with left neck and shoulder pain of several months' duration. During the evaluation, the Emergency Department provider noted an increased density in the left lung on the chest x-ray and offered the patient a chest CT scan. The patient declined the chest CT scan since one was scheduled for approximately eight weeks later. The Emergency Department provider documented that the patient understood the risk of delaying the chest CT scan. The shoulder x-ray showed arthritis.

In mid-summer 2019, the patient presented to the facility's Emergency Department with complaints of pain and shortness of breath. The patient was treated with muscle injections, steroids, and an inhaler, and advised to follow up with physical therapy.

Cancer Recurrence: Summer 2019–Spring 2020

In mid-summer 2019, the patient had a follow-up chest CT scan scheduled, but before the scan was completed, the patient presented to the facility's Emergency Department with complaints of pain. The Emergency Department provider ordered additional imaging that the patient completed. A second Emergency Department provider informed the patient there was a large (7.5 centimeter x 5.5 centimeter) left sided lung mass and admitted the patient to the hospital to expedite the medical evaluation.

The patient was hospitalized at the facility for approximately one month during summer 2019. During hospitalization, the patient underwent additional testing, including a lung biopsy. The results of the lung biopsy showed no malignancy, and an inpatient physician documented a plan to contact the pulmonologist for a new biopsy and outpatient plan. Six days later, the patient had a spine MRI that showed a fracture likely related to underlying [metastatic](#) disease. The next day, [interventional radiology](#) completed a bone biopsy that reflected a [poorly-differentiated](#) neuroendocrine tumor consistent with [small cell carcinoma](#). While hospitalized, the patient received radiation and chemotherapy treatment. Upon discharge, the patient relocated closer to family and transferred care to another VHA facility.

In early 2020, while receiving care at another VHA facility, the Hematology Oncology provider informed the patient, that despite treatment, the cancer continued to spread further. The patient received [palliative care](#) and hospice services until the patient's death in spring 2020.

Inspection Results

Care Coordination and Cancer Surveillance

The OIG did not substantiate that the primary care provider failed to coordinate the patient's cancer care. The OIG did not substantiate that the patient's pulmonologist failed to surveil the patient's cancer. However, the OIG found that the patient's pulmonologist failed to notify the patient of the summer 2018 repeat chest CT scan results and enter [return-to-clinic orders](#) when requesting the patient's follow-up appointments be rescheduled. The patient's pulmonologist's failure to communicate the patient's chest CT scan results and use return-to-clinic orders may have contributed to a delay in the patient's follow-up care.

While not an allegation, the OIG identified related concerns involving community care coordination. The OIG found no documented evidence a facility chiropractor, who referred the patient to a community care chiropractor, reviewed the community care chiropractor's notes or recommendation that the patient have an MRI.

Alleged Failure of the Patient’s Primary Care Provider to Coordinate Cancer Care

To prevent lapses in care, VHA requires that patients receive care that is coordinated, and relevant information is communicated between providers and patients.¹⁶ The role of the primary care team is to provide this care coordination.¹⁷

The OIG found consistent communication within the primary care team and with the patient. Between 2018 and 2019, the OIG found that primary care nursing staff documented communication with the patient including follow-up calls after Emergency Department visits and calls placed to telephone triage. In addition, the OIG found documented evidence that primary care nursing staff relayed patient concerns to the primary care provider.

In early summer 2018, the patient first reported back pain, which the patient’s primary care provider assessed. In response to the patient’s request for a treatment plan to address the pain, the primary care provider ordered an x-ray with the plan to refer the patient to orthopedics. The x-ray, completed in mid-summer, showed mild degenerative changes and mild arthritis. The OIG found that over the course of the next year, the primary care provider responded to the patient’s ongoing complaints of pain by referring the patient to orthopedics, physical therapy, pain management, chiropractic care, and acupuncture.

Alleged Failure of the Patient’s Pulmonologist to Coordinate Cancer Care

According to VHA, the Tumor Board occurs at VHA facilities, and is a multidisciplinary meeting to discuss managing patients with cancer.¹⁸ The facility’s Tumor Board for lung cancers is also known as the Chest Conference. During Chest Conferences, participants discuss the diagnosing, staging, and treatment options for patients with lung cancer. Chest Conference participants make recommendations; the cancer navigator assists with scheduling and coordinating appointments; and the referring provider determines the treatment plan with the patient.

The OIG found that after the patient’s abnormal chest CT scan in spring 2017, the patient’s pulmonologist referred the patient’s case to the Chest Conference for recommendations and care coordination. The Chest Conference members recommended that the patient be evaluated by a thoracic surgeon to determine whether the patient was a surgical candidate. After the thoracic surgeon and patient determined that a lobectomy was too high risk, the thoracic surgeon referred

¹⁶ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

¹⁷ VHA Handbook 1101.10(1). Primary care team members collectively take responsibility for care of the patients assigned to a primary care provider’s panel.

¹⁸ VHA Directive 1415, *VHA Oncology Program*, April 9, 2020.

the patient to Radiation Oncology Service for radiation therapy or CyberKnife evaluations. The thoracic surgeon communicated the recommendations to the patient's pulmonologist, primary care provider, cancer navigator, and the radiation oncologist by adding each as additional signers to the progress note. The OIG determined that the patient's pulmonologist utilized the Chest Conference for recommendations about the patient's treatment options and the cancer navigator for assisting with scheduling and coordinating appointments.

Failure to Communicate Test Results and Use Return-To-Clinic Orders by the Patient's Pulmonologist

VHA outlines expectations for cancer prevention, detection, and treatment, but does not address cancer surveillance or assign responsibility for cancer care coordination.¹⁹ However, VHA states that the patient's EHR must be timely, relevant, and complete. Documentation facilitates a providers ability to evaluate and plan a patient's treatment, monitor the patient's health care over time, and allows for communication and continuity of care among the patient's providers.²⁰ VHA also requires timely communication of test results to patients and connects the lack of timely communication of test results to poor outcomes.²¹ VHA requires that providers enter a return-to-clinic order and include the date the appointment is deemed clinically appropriate, also known as the *clinically indicated date*. Appointments are to be scheduled timely, accurately, and no more than 30 days from the clinically indicated date. Schedulers must use the clinically indicated date to schedule appointments. If a patient requests to cancel a scheduled appointment, the scheduler will document "cancelled by patient" and the patient may choose to reschedule the appointment.²²

In summer 2018, a radiation oncologist saw the patient and advised to follow up with pulmonology the next day. Later that month, the patient completed a subsequent chest CT scan that showed the existing left lung nodule, decreasing in size, and a new right lung nodule. The patient canceled the follow-up appointment with the patient's pulmonologist. The patient's pulmonologist documented two attempts to reach the patient via telephone to discuss the chest CT scan results. The OIG found no documented evidence that the patient's pulmonologist communicated the results of the chest CT scan or the follow-up plan of care. The OIG found

¹⁹ VHA Directive 2003-034, *National Cancer Strategy*, June 20, 2003, rescinded and replaced with VHA Directive 1415, *VHA Oncology Program*, April 9, 2020. Directive 2003-034 was in effect at the time of patient's care at the facility. The directives contain different language related to cancer prevention, detection, and treatment with Directive 1415 containing more detailed information. Neither directive addresses who is responsible for coordination of cancer surveillance.

²⁰ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

²¹ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, October 7, 2015, amended January 24, 2022. The directives contain similar language related to communicating test results.

²² VHA Directive 1230(5), *Outpatient Scheduling Process and Procedures*, July 15, 2016, amended September 24, 2021. The directives contain similar language related to the use of return-to-clinic orders.

through a review of the patient's EHR that the patient appeared aware of the summer 2018 chest CT scan results; however, the OIG found no documentation that the patient's pulmonologist communicated the test results to the patient.

In mid-summer 2018, the patient presented to the clinic to ask about making another pulmonology appointment. The medical support assistant notified the patient's pulmonologist in an EHR note about the patient's request for an appointment. The patient's pulmonologist documented an addendum to the medical support assistant's EHR note that the patient was due for a follow-up visit within the month and should be seen every six months for the next two years. However, the patient's pulmonologist did not enter a return-to-clinic order for this appointment to be scheduled. The OIG found that although the patient's pulmonologist added an addendum to the medical support assistant's EHR note, the OIG found no documented evidence that the patient's pulmonologist communicated the plan to the medical support assistant to ensure the patient was scheduled for an appointment. Instead, the patient's pulmonology appointment was scheduled for fall 2018, but the patient canceled the appointment. The same month as the canceled pulmonary appointment, the patient's pulmonologist documented in an administrative note in the patient's EHR that the patient would be seen for a follow-up appointment after a scheduled chest CT scan in summer 2019. Again, the patient's pulmonologist did not enter a return-to-clinic order for a follow-up appointment following the scheduled chest CT scan in summer 2019.

Following the summer 2018 chest CT scan, the patient's pulmonologist attempted to communicate the test results to the patient. The OIG found that the patient's pulmonologist used return-to-clinic orders during the diagnostic phase of the patient's care but failed to use return-to-clinic orders during the patient's surveillance phase. In an interview with the OIG, the patient's pulmonologist could not recall any details about the patient's case. The pulmonologist's failure to communicate the patient's chest CT scan and the failure to use return-to-clinic orders may have contributed to a delay in the patient's follow-up care.

Additional Finding: Lack of Community Care Coordination

According to VHA, when a community care provider completes a consult, an electronic notification is generated in the EHR to the ordering provider.²³ The intent of the notification is to

²³ VHA previously used the term non-VA care to describe care that was provided outside of VA. The term has been replaced with community care.

prompt the ordering provider to review the clinical documentation from the community care provider and take follow-up action as needed.²⁴

In mid-summer 2018, the patient's primary care provider referred the patient to a facility chiropractor for evaluation of low back pain. The facility chiropractor saw the patient once in the fall before referring the patient to community care for ongoing chiropractic services due to limited appointment availability at the facility. The facility chiropractor (ordering provider) entered the consult for community care. After seeing the patient, the community care chiropractor documented a recommendation for the patient to have an MRI of the back. Following the appointment with the community care chiropractor, the patient called the primary care provider and requested an MRI. The primary care provider requested clinical information from the patient regarding the need for an MRI.

In late 2018, community care staff scanned the community care chiropractor's notes into the patient's EHR and included the clinical care coordinator and the facility chiropractor as additional signers. The clinical care coordinator and the facility chiropractor acknowledged the notification through signature. In an interview, the clinical care coordinator stated that the signature was evidence that the clinical care coordinator reviewed the community chiropractor's notes. The clinical care coordinator stated that it was and is the practice that the ordering provider is responsible for reviewing the community provider's notes and to respond to any requested action. The OIG found no documented evidence that the facility chiropractor followed up on the recommended MRI. In an interview with the OIG, the facility chiropractor could not recall any details about the patient's case, but stated that in general, if a community chiropractor requested an MRI, the patient would be referred to a medical provider at the facility to evaluate the request. The EHR reflected that the patient had an MRI during the summer 2019 hospitalization that showed a fracture likely related to underlying metastatic disease. The OIG could not determine if an earlier MRI would have affected the patient's outcome.

The OIG concluded that the primary care provider addressed the patient's pain complaints. The patient's pulmonologist utilized the Chest Conference members to review the patient's case and make recommendations for treatment options including a referral to the thoracic surgeon. The patient's pulmonologist attempted to communicate the patient's summer 2018 chest CT scan results and surveillance plan and instruction to schedule follow-up appointments according to the surveillance plan. The OIG found no documented evidence that the patient was informed of the summer 2018 chest CT scan results. The patient canceled several appointments and then requested that the appointments be rescheduled. Although the patient's pulmonologist responded

²⁴ VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016. Directive 1232(1) was in place during the time of the events discussed in this report. It was rescinded and replaced by Directive 1232(4), *Consult Processes and Procedures*, amended December 14, 2021. Both directives contain the same language regarding the definition of a completed consult. VHA Office of Community Care, *Community Care Consult/Referral Management*, June 30, 2017.

to the patient's requests to reschedule, the patient's pulmonologist failed to enter return-to-clinic orders for rescheduling appointments. These failures may have contributed to a delay in the patient's follow-up care. Additionally, the facility chiropractor failed to document a review of the community care chiropractor's recommendation that the patient should have an MRI.

Conclusion

The OIG did not substantiate that the primary care provider failed to coordinate the patient's cancer care. The OIG found that the patient's primary care provider and team managed the patient's care and repeatedly addressed the patient's pain complaints through consistent communication within the primary care team and with the patient.

The OIG found that the patient's pulmonologist utilized the Chest Conference for recommendations about the patient's treatment options and the cancer navigator for assisting with scheduling and coordinating appointments. Upon completing CyberKnife treatment, the patient was to follow up with the patient's pulmonologist for cancer surveillance.

The OIG did not substantiate that the patient's pulmonologist failed to surveil the patient's cancer. A repeat chest CT scan in summer 2018 showed that the left lung nodule decreased in size, but a new ground glass right lung nodule had appeared. The pulmonologist documented planning to discuss the chest CT scan results with the patient at the next scheduled follow-up appointment; however, the patient canceled the appointment. The patient's pulmonologist attempted but was unsuccessful in reaching the patient twice. The OIG found no documented evidence that the patient was told of the imaging results or of the cancer surveillance plan. In addition, the OIG found no evidence that the patient's pulmonologist entered return-to-clinic orders when rescheduling the patient's follow-up appointments. The patient's pulmonologist's failure to communicate the imaging results and enter return-to-clinic orders may have contributed to a delay in the patient's follow-up care.

In addition, the OIG found no documented evidence that the facility chiropractor reviewed the records provided by the community care chiropractor or determined if an MRI was needed. The patient had an MRI done in summer 2019, which showed a fracture likely related to underlying metastatic disease. The OIG could not determine if an earlier MRI would have affected the patient's outcome.

Recommendations 1–3

1. The West Palm Beach VA Healthcare System Director ensures that pulmonary providers communicate and document test results and surveillance care plans to patients.
2. The West Palm Beach VA Healthcare System Director ensures that pulmonary providers and staff are trained on the use of return-to-clinic orders and monitors for compliance.
3. The West Palm Beach VA Healthcare System Director ensures that chiropractor providers review community care notes and takes action as needed.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 21, 2023

From: Executive Director, VA Sunshine Healthcare Network (10N8)

Subj: Healthcare Inspection—Inadequate Coordination of Care for a Patient at the West Palm Beach VA Healthcare System in Florida

To: Director, Office of Healthcare Inspections (54HL08)

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

1. Thank you for the opportunity to review the report. The actions put into place by the facility are directly related to the OIG's recommendations. VA Sunshine Healthcare Network is committed to continuous process improvement and ensuring that the West Palm Beach VA Healthcare System continues to be a healthcare system Veterans trust and choose.
2. For additional information or questions, contact the VISN 8 Quality Management Officer.

(Original signed by:)

David B. Isaacks, FACHE
Network Director, VISN 8

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 17, 2023

From: Director, West Palm Beach VA Healthcare System (548)

Subj: Healthcare Inspection—Inadequate Coordination of Care for a Patient at the West Palm Beach VA Healthcare System in Florida

To: Director, VA Sunshine Healthcare Network (10N8)

1. I have reviewed the VAOIG's draft report and concur with the findings and recommendations. This includes changes to recommendation # 3 which was discussed, agreed upon, and modified by the OIG team. The West Palm Beach VA Healthcare System has implemented actions in response to the findings.
2. The West Palm Beach VA Healthcare System's Chief of Office of High Reliability (OHR) will act as the facility's point of contact for this report.
3. For questions regarding this response, please contact the Office of High Reliability of West Palm Beach VA Healthcare System.

(Original signed by:)

Cynthia O'Connell

Associate Director

for

Cory P. Price, FACHE

Executive Director

West Palm Beach, Florida

Facility Director Response

Recommendation 1

The West Palm Beach VA Healthcare System Director ensures that pulmonary providers communicate and document test results and surveillance care plans to patients.

Concur.

Target date for completion: Training to all pulmonary providers will be completed by March 1, 2023. Chart audits will continue until compliance benchmark of 90% or above is met for six (6) consecutive months.

Director Comments

The Executive Director identified opportunities for additional education for the practice of Pulmonary providers' communication and documentation of test results and surveillance plans to patients.

Chief of Pulmonary Service will educate all pulmonary providers on communicating and documenting test results and surveillance care plans to patients. 100% of pulmonary providers will be trained on communicating and documenting test results and surveillance care plans to patients utilizing sign in sheets as recorded proof of training.

A random chart audit of thirty (30) charts per month will demonstrate that pulmonary providers are communicating and documenting test results and surveillance care plans to patients. The audit will demonstrate a compliance rate of 90% or above for six (6) consecutive months.

Recommendation 2

The West Palm Beach VA Healthcare System Director ensures that pulmonary providers and staff are trained on the use of return-to-clinic orders and monitors for compliance.

Concur.

Target date for completion: Training to all pulmonary providers will be completed by March 1, 2023. Chart audits will continue till compliance benchmark of 90% or above is met for six (6) consecutive months.

Director Comments

The Executive Director identified opportunities requiring education to all Pulmonary providers on return to clinic orders.

Chief of Pulmonary Service will educate all pulmonary providers on return to clinic orders and monitor for compliance. 100% of pulmonary providers will be trained on the use of return-to-clinic orders utilizing sign in sheets as recorded proof of training.

A random chart audit of thirty (30) charts per month with compliance rate of 90% or above will demonstrate that pulmonary providers are using return-to-clinic orders. Chart audits will continue to meet compliance of 90% or above for six (6) consecutive months.

Recommendation 3

The West Palm Beach VA Healthcare System Director ensures that chiropractor providers review community care notes and takes action as needed.

Concur.

Target date for completion: Training to all Chiropractor providers will be completed by March 1, 2023. Chart audits will continue till compliance benchmark of 90% or above is met for six (6) consecutive months.

Director Comments

The West Palm Beach VA Healthcare System Director confirms that an opportunity exists to strengthen Chiropractor providers' practice for review of community care notes and recommended action are taken as needed.

100% of Chiropractor Providers will be educated on the requirement of review of Care in the Community care notes and take actions as appropriate, utilizing sign in sheets as recorded proof of training.

A 100% of chart audit per month with compliance rate of 90% or above will demonstrate that chiropractor providers are reviewing community care notes and taking actions as appropriate. The audit will demonstrate a compliance rate of 90% or above for six (6) consecutive months.

Glossary

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

acupuncture. “An originally Chinese practice of inserting fine needles through the skin at specific points especially to cure disease or relieve pain (as in surgery).”²⁵

acute. “Having a sudden onset, sharp rise, and short course.”²⁶

biopsy. “The removal and examination of tissue, cells, or fluids from the living body.”²⁷

bipolar disorder. “Any of several psychological disorders of mood characterized usually by alternating episodes of depression and mania.”²⁸

cancer. “A malignant tumor of potentially unlimited growth that expands locally by invasion and systemically by metastasis.”²⁹

carcinoid tumor. “A type of slow-growing cancer that can arise in several places throughout your body. Carcinoid tumors often don’t cause signs and symptoms until late in the disease.”³⁰

chemotherapy. “Chemotherapy is a drug treatment that uses powerful chemicals to kill fast-growing cells in your body. Chemotherapy is most often used to treat cancer, since cancer cells grow and multiply much more quickly than most cells in the body.”³¹

chiropractor. “A licensed health-care professional who treats disorders (such as back and neck pain) chiefly of the musculoskeletal system especially through the manual adjustment or manipulation of the spinal vertebrae to correct nervous system dysfunction.”³²

chronic. “Continuing or occurring again and again for a long time.”³³

²⁵ Merriam-Webster.com Dictionary, “acupuncture,” accessed March 3, 2022, <https://www.merriam-webster.com/dictionary/acupuncture>.

²⁶ Merriam-Webster.com Dictionary, “acute,” accessed March 2, 2022, <https://www.merriam-webster.com/dictionary/acute>.

²⁷ Merriam-Webster.com Dictionary, “biopsy,” accessed March 3, 2022, <https://www.merriam-webster.com/dictionary/biopsy>.

²⁸ Merriam-Webster.com Dictionary, “bipolar disorder,” accessed March 3, 2022, <https://www.merriam-webster.com/dictionary/bipolar%20disorder>.

²⁹ Merriam-Webster.com Dictionary, “cancer,” accessed March 3, 2022, <https://www.merriam-webster.com/dictionary/cancer>.

³⁰ Mayo Clinic, “Carcinoid tumors,” accessed March 4, 2022, <https://www.mayoclinic.org/diseases-conditions/carcinoid-tumors/symptoms-causes/syc-20351039>.

³¹ Mayo Clinic, “chemotherapy,” accessed March 3, 2022, <https://www.mayoclinic.org/tests-procedures/chemotherapy/about/pac-20385033>.

³² Merriam-Webster.com Dictionary, “chiropractor,” accessed November 1, 2022, <https://www.merriam-webster.com/dictionary/chiropractor>.

³³ Merriam-Webster.com Dictionary, “chronic,” accessed November 1, 2022, <https://www.merriam-webster.com/dictionary/chronic>.

chronic obstructive pulmonary disease. “A chronic inflammatory lung disease that causes obstructed airflow from the lungs.”³⁴

computerized tomography (CT) scan. “Radiography in which a three-dimensional image of a body structure is constructed by computer from a series of plane cross-sectional images made along an axis.”³⁵

consultation. “A deliberation between physicians on a case or its treatment.”³⁶

CyberKnife. “Linear accelerator (LINAC) machines use X-rays (photons) to treat cancerous and noncancerous abnormalities in the brain and other parts of the body. LINAC machines are also known by the brand name of the manufacturer, such as CyberKnife and TrueBeam. These machines can perform SRS [stereotactic radiosurgery] in a single session or over two to five sessions for larger tumors (fractionated stereotactic radiotherapy).”³⁷

ground glass opacification (or nodule). Refers to hazy gray or cloudy areas, similar to frosted glass, seen on x-rays and CT scans of the lungs through which the underlying lung bronchi and blood vessels are still visible. There are many causes from benign to cancer including infection and chronic lung disease.³⁸

hematology. “A medical science that deals with the blood and blood-forming organs.”³⁹

interventional radiology. “A medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases in nearly every organ system. The concept behind interventional radiology is to diagnose and treat patients using the least invasive techniques currently available in order to minimize risk to the patient and improve health outcomes.”⁴⁰

³⁴ Mayo Clinic, "Chronic Obstructive Pulmonary Disease," accessed June 10, 2020, <https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679>.

³⁵ Merriam-Webster.com Dictionary, “computerized tomography,” accessed March 3, 2022, <https://www.merriam-webster.com/dictionary/computerized%20tomography>.

³⁶ Merriam-Webster.com Dictionary, “consultation,” accessed March 2, 2022, <https://www.merriam-webster.com/dictionary/consultation>.

³⁷ MayoClinic.org, “Stereotactic body radiotherapy,” accessed March 2, 2022, <https://www.mayoclinic.org/tests-procedures/sbrt/pyc-20446794>.

³⁸ Definition provided by OHI physician.

³⁹ Merriam-Webster.com Dictionary, “hematology,” accessed March 3, 2022, <https://www.merriam-webster.com/dictionary/hematology>.

⁴⁰ Hopkinsmedicine.org, “interventional radiology,” accessed March 3, 2022, https://www.hopkinsmedicine.org/interventional-radiology/what_is_IR.html.

lobectomy. A surgical procedure performed to remove a diseased lobe of the lung. The lungs have sections called lobes. The right lung has three lobes while the left lung has two lobes. After removal of the diseased portion, the remaining healthy lung tissue can function as normal.⁴¹

magnetic resonance imaging (MRI). “A noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves.”⁴²

metastasis. “The spread of a disease-producing agency (such as cancer cells) from the initial or primary site of disease to another part of the body.”⁴³

neuroendocrine tumor. “Cancers that begin in specialized cells called neuroendocrine cells. Neuroendocrine cells have traits similar to those of nerve cells and hormone-producing cells. Neuroendocrine tumors are rare and can occur anywhere in the body. Most neuroendocrine tumors occur in the lungs, appendix, small intestine, rectum and pancreas. There are many types of neuroendocrine tumors. Some grow slowly and some grow very quickly.”⁴⁴

oncology. “A branch of medicine concerned with the prevention, diagnosis, treatment, and study of cancer.”⁴⁵

orthopedics. “A branch of medicine concerned with the correction or prevention of deformities, disorders, or injuries of the skeleton and associated structures (such as tendons and ligaments).”⁴⁶

palliative care. “Specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious illness, no matter the diagnosis or stage of disease. Palliative care teams aim to improve the quality of life for both patients and their families. This form of care is offered alongside curative or other treatments.”⁴⁷

⁴¹ Johns Hopkins, “Lobectomy,” accessed June 17, 2019, https://www.hopkinsmedicine.org/healthlibrary/test_procedures/pulmonary/lobectomy_92,p07749.

⁴² Mayo Clinic, “MRI,” accessed November 6, 2019, <https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768>.

⁴³ Merriam-Webster.com Dictionary, “metastasis,” accessed March 3, 2022, <https://www.merriam-webster.com/dictionary/metastasis>.

⁴⁴ Mayo Clinic, “neuroendocrine tumor,” accessed March 3, 2022, <https://www.mayoclinic.org/diseases-conditions/neuroendocrine-tumors/symptoms-causes/syc-20354132>.

⁴⁵ Merriam-Webster.com Dictionary, “oncology,” accessed March 2, 2022, <https://www.merriam-webster.com/dictionary/oncology>.

⁴⁶ Merriam-Webster.com Dictionary, “orthopedics” accessed November 1, 2022, <https://www.merriam-webster.com/dictionary/orthopedics>.

⁴⁷ Mayo Clinic, “palliative care,” accessed March 3, 2022, <https://www.mayoclinic.org/tests-procedures/palliative-care/about/pac-20384637>.

poorly differentiated. “Very irregular. Unlike typical cells. In general, these cancers may be aggressive.”⁴⁸

pulmonologist. “A specialist in the anatomy, physiology, and pathology of the lungs.”⁴⁹

radiation oncology. “The use of radiation therapy to treat cancer.”⁵⁰

radiation therapy. “The use of high-energy radiation from x-rays, gamma rays, neutrons, protons, and other sources to kill cancer cells and shrink tumors.”⁵¹

radiologist. A physician who specializes in medical radiology.⁵²

return-to-clinic order. An order entered into the electronic health record “by the health care provider to communicate the need for an episode of care to be scheduled/appointed in one of their clinics.”⁵³

sacral. “Of, relating to, or lying near the sacrum//the *sacral* region of the spinal cord.” The sacrum is “the part of the spinal column that is directly connected with or forms a part of the pelvis and in humans consists of five fused vertebrae.”⁵⁴

sacroiliac joint dysfunction/sacroiliitis. “An inflammation of one or both of your sacroiliac joints – situated where your lower spine and pelvis connect. Sacroiliitis can cause pain in your buttocks or lower back and can extend down one or both legs.”⁵⁵

small cell carcinoma. “An aggressive (fast-growing) cancer that forms in tissues of the lung and can spread to other parts of the body. The cancer cells look small and oval-shaped when looked at under a microscope.”⁵⁶

⁴⁸ Mayo Clinic, “Small cell, large cell cancer: What this means,” accessed October 6, 2022, <https://www.mayoclinic.org/diseases-conditions/cancer/expert-answers/cancer/faq-20058509>.

⁴⁹ Merriam-Webster.com Dictionary, “pulmonologist,” accessed March 3, 2022, <https://www.merriam-webster.com/dictionary/pulmonologist>.

⁵⁰ NIH National Cancer Institute, “oncology,” accessed March 3, 2022, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/oncology>.

⁵¹ NIH National Cancer Institute, “radiation therapy,” accessed November 1, 2022, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/radiation-therapy>.

⁵² Merriam-Webster, “radiologist,” accessed August 19, 2020, <https://www.merriam-webster.com/dictionary/radiologist>.

⁵³ VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022.

⁵⁴ Merriam-Webster.com Dictionary, “sacral,” accessed December 16, 2022, <https://www.merriam-webster.com/dictionary/sacral>; Merriam-Webster.com Dictionary, “sacrum,” accessed December 16, 2022, <https://www.merriam-webster.com/dictionary/sacrum>.

⁵⁵ Mayo Clinic, “sacroiliitis,” accessed June 21, 2022, from <https://www.mayoclinic.org/diseases-conditions/sacroiliitis/symptoms-causes/syc-20350747?p=1>.

⁵⁶ NIH National Cancer Institute, “small cell lung cancer,” accessed June 23, 2022, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/small-cell-lung-cancer>.

surveillance. “In medicine, closely watching a patient’s condition but not treating it unless there are changes in test results. Surveillance is also used to find early signs that a disease has come back. It may also be used for a person who has an increased risk of disease, such as cancer. During surveillance, certain exams and tests are done on a regular schedule.”⁵⁷

type 2 diabetes mellitus. “A common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production.”⁵⁸

ultrasound. “An imaging method that uses sound waves to produce images of structures within your body. The images can provide valuable information for diagnosing and directing treatment for a variety of diseases and conditions.”⁵⁹

well-differentiated. “In cancer, well differentiated cancer cells look more like normal cells under a microscope and tend to grow and spread more slowly than poorly differentiated or undifferentiated cancer cells.”⁶⁰

x-ray. “A quick, painless test that produces images of the structures inside your body—particularly your bones. X-ray beams pass through your body, and they are absorbed in different amounts depending on the density of the material they pass through. Dense materials, such as bone and metal, show up as white on X-rays. The air in your lungs shows up as black. Fat and muscle appear as shades of gray.”⁶¹

⁵⁷ NIH National Cancer Institute, “surveillance,” accessed May 9, 2022, <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/surveillance>.

⁵⁸ Merriam-Webster.com Dictionary, “type 2 diabetes mellitus,” accessed March 3, 2022, <https://www.merriam-webster.com/dictionary/type%20%20diabetes>.

⁵⁹ Mayo Clinic, “ultrasound,” accessed June 21, 2022, from <https://www.mayoclinic.org/tests-procedures/ultrasound/about/pac-20395177?p=1>.

⁶⁰ NIH National Cancer Institute, “well-differentiated,” accessed October 6, 2022, from <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/well-differentiated>.

⁶¹ Mayo Clinic, “x-ray,” accessed June 21, 2022, from <https://www.mayoclinic.org/tests-procedures/x-ray/about/pac-20395303>.

OIG Contact and Staff Acknowledgments

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