DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina

HEALTHCARE INSPECTION | REPORT #21-01304-275 | SEPTEMBER 27, 2021


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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Fayetteville VA Coastal Health Care System (facility) in North Carolina to assess concerns related to quality, coordination, and timeliness of a patient's care in 2020.[1] The impact of the coronavirus (COVID-19) on the care of the patient was also evaluated.[2] The patient later died at another Veterans Health Administration (VHA) facility.

## Synopsis of Events

The salient aspects of this case occurred during 2020. The patient was in their 70s with multiple medical problems and resided in a non-VA assisted living facility.[3] Due to COVID-19, all of the patient's Primary Care Clinic, social work, and dietitian appointments were converted to telephone appointments beginning in spring 2020, except for one face-to-face appointment with a primary care provider.[4] During this mid-summer face-to-face appointment, the primary care provider documented a 1 centimeter right submandibular lymph node on examination.[5] Over an eight-month period, the patient had four appointments with three different dietitians to discuss progressively worsening unintentional weight loss and to monitor the use of oral nutrition supplements (supplements).[6]

In addition, the patient was seen at the facility's Urgent Care Center on three occasions during 2020. In late spring and late summer 2020, the patient visited the Urgent Care Center with complaints of coughing up blood. The urgent care providers assessed the patient's condition and determined on both occasions that the patient had bronchitis. The patient was prescribed medications and discharged home. On the third urgent care visit in late 2020, the patient complained of troubles with speaking and secretions, unintentional weight loss, and right-sided

[1] The facility underwent a name change from the Fayetteville VA Medical Center to the Fayetteville VA Coastal Health Care System.

[2] World Health Organization, *Naming the coronavirus disease (COVID-19) and the virus that causes it,* accessed June 22, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(COVID-19-2019)-and-the-virus-that-causes-it.

[3] The patient's non-VA assisted living facility provided 24-hour care and meals and assisted the patient with medication management and activities of daily living, such as bathing and getting dressed. The OIG uses the singular form of they (their) in this circumstance for the purpose of patient privacy.

[4] VA Memorandum, *COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home*, March 11, 2020. VA Memorandum, *Primary Care Guidance for COVID-19 Pandemic Response*, March 23, 2020.

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

[6] The patient met with a geriatric clinic dietitian twice, a PACT dietitian once, and another PACT dietitian once. The patient was seen by three different dietitians rather than one, because the first PACT dietitian transferred to another VA medical center and the geriatric clinic dietitian was on extended leave.

jaw pain. On exam, the urgent care provider documented "oropharynx: tongue with diffuse thick dark colored plaque on it, visual mass in right posterior pharynx, MMM [moist mucus membranes], no erythema, no exudate. Patient has mild pooling of…secretions and…is very hard to understand. Neck: supple, no lymphadenopathy." Computerized tomography exam of the neck showed what appeared to be a malignant tongue/neck mass that encased the carotid artery. The urgent care provider decided to transfer the patient to another VA medical center for evaluation by an ear, nose, and throat (ENT) specialist. Over the course of the next 10 days, the patient had a tracheostomy done because of ongoing bleeding and an airway that was blocked or reduced, a biopsy of the tumor, and a nasogastric tube placed. The decision was made to forgo further interventions for the patient's inoperable, aggressive tumor. The patient was transferred to hospice and died on the same day.

## Healthcare Inspection Results

The OIG determined that the primary care provider and dietitians did not provide quality care to the patient. Also, a lack of coordination of care occurred between the Patient Aligned Care Team (PACT) registered nurse and the primary care provider, and between dietitians and the primary care provider.[7]

Although the primary care provider documented wanting a computerized tomography of the patient's chest during a mid-summer face-to-face appointment, the primary care provider failed to enter this order. The primary care provider told the OIG team that this was an error. The OIG found that the patient's family member requested, through the PACT registered nurse, that the patient's next appointment be face-to-face. The PACT registered nurse advised the patient's family member that a face-to-face appointment would need to be approved by the primary care provider. The OIG found no documented evidence that the PACT registered nurse communicated the family member's request to the primary care provider. The primary care provider recalled not being told of the family member's request. The late summer appointment was conducted over the telephone. By the PACT registered nurse failing to communicate the family member's request to the primary care provider, the primary care provider failed to follow up on the previously found soft right submandibular lymph node. The OIG concluded that the lack of further diagnostic evaluation of the submandibular lymph node most likely resulted in a delay in the diagnosis and treatment of the patient's oral cancer. The facility conducted a peer

[7] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. A PACT team consists of the patient, the patient's personal supports (such as a family member), a primary care provider, a registered nurse, a licensed vocational nurse/a licensed practical nurse/health technician, and a clerk. Discipline-specific team members provide continuity of direct discipline-specific care and may include a registered dietitian and a social worker. VA, *Health Care*, *Quality of Care*, accessed May 18, 2021, https://www.va.gov/QUALITYOFCARE/.

review of the provider and offered to conduct an institutional disclosure, but the patient's family member declined.[8]

Using selected items from the facility's internal peer review form, the OIG reviewed dietitians' documentation and found that for three telephone appointments, dietitians did not update the patient's nutrition diagnosis to reflect weight loss and did not estimate the patient's energy and protein requirements. In addition, the last dietitian's note did not include an updated weight or an assessment of the patient's chewing and swallowing abilities. In early 2020, the patient weighed 170.4 pounds and nearly 12 months later, a day after being transferred to another VA medical center, the patient weighed 134.1 pounds, a loss of approximately 36 pounds. Although the patient was started on supplements in early summer and the amount was increased three months later, the patient had continual, unintentional weight loss. According to a Nutrition and Food Services leader, the ordering and monitoring of supplements is considered routine and thus, the OIG team was told that dietitians were not required to add the primary care provider as an additional signer to their notes. Although the patient had a significant weight loss, the same Nutrition and Food Services leader acknowledged that a higher level of intervention was not offered to the patient, and the patient was not referred to the primary care provider for further evaluation. The OIG identified two possible reasons why a higher level of intervention was not offered. First, the three appointments that addressed weight loss were conducted over the telephone. Telephone appointments did not allow dietitians to visually assess or weigh the patient. Second, there was a lack of consistency in dietitians who were assigned to this patient. The patient met with three dietitians over four appointments. This lack of consistency was compounded by the fact that three of the four appointments were telephone appointments.

The OIG found that urgent care providers and the non-VA dentist provided quality care and social workers coordinated care with the PACT team. For the three urgent care visits, the OIG found that providers assessed the patient's presenting complaints, conducted radiologic studies and laboratory tests, and documented the patient's condition and plan of care. During the patient's non-VA dental appointment, the dentist documented performing an oral exam and noted "pain during palpation in submandibular." As this was outside the expertise of general dentistry, the non-VA dentist referred the patient to oral surgery for further evaluation. Facility social workers assessed the patient's needs timely, worked with both inpatient and primary care

[8] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018. Following an adverse event (an act of commission or omission), VHA states that a peer review, when conducted as part of a facility's quality management program, is a confidential, non-punitive review process. Peer review focuses on improving the quality of health care or utilization of resources. Specifically, a peer review focuses on whether an individual provider's clinical decisions and actions during an episode of care met the standard of care. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients,* October 31, 2018. An institutional disclosure of an adverse event "is a formal process by which VA medical facility leader(s), together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provides specific information about the patient's rights and recourse."

providers to coordinate care, and maintained frequent and open communication with the patient and the patient's family member.

The OIG found a lack of timeliness of care due to a scheduling error for a dietitian follow-up appointment and a delay in scheduling a non-VA dental appointment. In fall 2020, the dietitian requested a return-to-clinic appointment for one month; however, a scheduling error occurred, and the patient was not scheduled until three months later. The scheduling error created a missed opportunity for the dietitian to further address the patient's unintentional weight loss. In summer 2020, a non-VA dental consult was entered and received by Community Care staff the next day. The OIG found that 67 days elapsed between receipt of the consult and processing of the consult. The patient's initial appointment was scheduled for early fall; however, due to a lack of communication by staff at the patient's assisted living facility, the patient missed this appointment. The patient was rescheduled and seen by a non-VA dentist 36 days later.

The OIG determined that the facility's response to COVID-19 affected the care provided to the patient by dietitians, because dietitians were unable to conduct face-to-face appointments. Telephone appointments did not allow for dietitians to visually assess the patient, complete a nutrition-focused physical examination, and weigh patients. This limited dietitians' ability to assess if the patient needed a higher level of nutrition intervention. In late 2020, the patient required a higher level of care and was transferred to another VA medical center. The next day, a dietitian conducted a face-to-face assessment of the patient and documented severe malnutrition, severe muscle wasting, and weight loss of approximately 36 pounds within one year, and recommended the patient receive enteral nutrition support.

The OIG determined that the facility's response to COVID-19 did not affect the care provided to the patient by the primary care provider, social workers, urgent care providers, and the non-VA dentist. The facility's response to COVID-19 allowed for primary care providers to schedule face-to-face appointments with patients when clinically necessary. As previously mentioned, the patient's family member requested a face-to-face appointment, but because of a lack of communication, the appointment was conducted over the telephone. The OIG attributed this missed opportunity to a lack of communication and coordination of care rather than COVID-19. Facility social workers coordinated care between the patient and the inpatient and primary care providers. The social workers ensured a safe and appropriate discharge home following the patient's hospitalization in early 2020. When the patient or the patient's family member called the social worker with a concern, the social worker consistently either notified the PACT registered nurse or added the primary care provider on documentation as an additional signer. When notified, the primary care provider responded timely to the concerns. The Urgent Care Center remained open and did not adjust services available to VA patients. Urgent care providers addressed and treated the patient's presenting complaints. The non-VA dental clinic was closed for 2–3 weeks because of COVID-19 but reported reopening and bringing back patients by early June 2020. When facility Community Care staff faxed the patient's non-VA dental consult in early fall 2020 to the non-VA dental clinic, the dental clinic scheduled the patient's initial

appointment for 24 days later. The OIG concluded that COVID-19 did not negatively impact the timeliness of care provided by the non-VA dental clinic.

The OIG made six recommendations to the Facility Director related to dietitians complying with conducting and documenting comprehensive nutrition assessments, consistently coordinating care between the PACT registered nurses and the primary care providers, providing guidance on care coordination between outpatient dietitians and primary care providers when a higher level of nutrition intervention is required, scheduling dietitian follow-up appointments as ordered, scheduling of non-VA dental appointments by Community Care staff within recommended time frames, and evaluating the COVID-19 scheduling practices and the impact of telephone appointments on the patient's care.

## Comments

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

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Assistant Inspector General
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# Contents

# Abbreviations

| | |
|---|---|
| CLC | community living center |
| COVID-19 | coronavirus disease |
| EHR | electronic health record |
| ENT | ear, nose, and throat |
| OIG | Office of Inspector General |
| PACT | Patient Aligned Care Team |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Fayetteville VA Coastal Health Care System (facility) in North Carolina to assess concerns related to quality, coordination, and timeliness of a patient's care in 2020.[1] The impact of the coronavirus (COVID-19) on the care of the patient was also evaluated.[2] The patient later died at another Veterans Health Administration (VHA) facility.

## Background

The facility is part of Veterans Integrated Service Network (VISN) 6, and has six community-based outpatient clinics and two health care centers.[3] The facility provides general medicine, surgery, and mental health services. From October 1, 2019, through September 30, 2020, the facility served 80,021 patients and had a total of 129 operating beds including 60 inpatient beds and 69 community living center beds. VHA classifies the facility as Level 1c-mid complexity.[4]

### Coronavirus Disease

The World Health Organization reported first learning of a new coronavirus (SARS-CoV-2) that causes severe respiratory infectious diseases at the end of December 2019. The disease was later named COVID-19.[5] On March 11, 2020, due to its "alarming levels of spread and severity," the

[1] The facility underwent a name change from the Fayetteville VA Medical Center to the Fayetteville VA Coastal Health Care System.

[2] World Health Organization, *Naming the coronavirus disease (COVID-19) and the virus that causes it,* accessed June 22, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(COVID-19-2019)-and-the-virus-that-causes-it.

[3] VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019. A community-based outpatient clinic provides primary and mental health services and may include specialty or subspecialty services. A health care center provides "primary care, mental health care, on site specialty services, and performs ambulatory surgery and/or invasive procedures, which may require moderate sedation or general anesthesia." The facility's community-based outpatient clinics are located in Brunswick County, Goldsboro, Hamlet, Jacksonville, Robeson County, and Sanford. The health care centers are located in Fayetteville and Wilmington.

[4] 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, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex. Level 3 facilities are the least complex.

[5] World Health Organization, *About WHO*, accessed May 6, 2021, https://www.who.int/about. The World Health Organization (WHO) is a global organization "working with 194 Member States…in a shared commitment to achieve better health for everyone, everywhere."

World Health Organization declared COVID-19 a pandemic.[6] Since its appearance in 2019, knowledge about the mode of transmission and the severity of associated illnesses has been evolving. On June 16, 2020, the Centers for Disease Control and Prevention reported that COVID-19 is "thought to spread mainly through close contact from person-to-person" and that "some people without symptoms may be able to spread the virus."[7] The need to prepare for an influx of patients challenged VHA and the overall delivery of healthcare.[8]

### Managing Virtual Care

On March 11, 2020, to reduce exposure risk to veterans and to the VA workforce, VHA issued guidance to all VA medical centers that, "facilities should consider assessing upcoming Veteran appointments for conversion to in-home virtual care visits (e.g. Telephone or VA Video Connect)."[9] On March 23, VHA provided guidance on how to support patients in primary care clinics.[10] Primary care appointments were to be reviewed and if clinically appropriate, converted to virtual modalities that had the lowest technology requirement, such as secure messaging, telephone, or if a patient preferred, a video appointment. If a patient required a face-to-face appointment based on clinical need, the patient was to be scheduled accordingly.[11]

## Concerns

The OIG received concerns regarding the care and care coordination of a patient at the facility. Specifically, the OIG reviewed concerns regarding the diagnosis and treatment of a patient with unintentional weight loss and a malignant tongue and neck mass. The OIG team reviewed the quality, coordination, and timeliness of the patient's care in 2020. The OIG team also reviewed the possible impact of COVID-19 on the care provided to the patient.

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[6] World Health Organization, *WHO Director-General's opening remarks at the media briefing on COVID-19 – 11 March 2020,* March 11, 2020, accessed June 22, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-COVID-19---11-march-2020. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the *alt* and *left arrow* keys together.

[7] Centers for Disease Control and Prevention, *How COVID-19 Spreads*, accessed June 22, 2020, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-COVID-19-spreads.html.

[8] VA OIG, *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*, Report No. 20-03076-217, July 16, 2020, accessed February 23, 2021.

[9] VA Memorandum, *COVID-19: Protecting Veterans and the Department of Veterans Affairs (VA) Workforce by Leveraging Video Telehealth from VA Clinics and Home*, March 11, 2020. VA Mobile, VA Video Connect, accessed November 24, 2020, https://mobile.va.gov/app/va-video-connect. VA Video Connect "allows Veterans and their caregivers to quickly and easily meet with VA health care providers through live video on any computer, tablet, or mobile device with an internet connection."

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

[11] For the purpose of this report, the OIG defines face-to-face as in-person clinic appointments.

# Scope and Methodology

The OIG initiated the inspection on February 16, 2021, and conducted a virtual site visit from March 22 through April 29, 2021. The OIG team reviewed the quality, coordination, and timeliness of care provided to the patient in 2020 by a primary care provider, registered dietitians, social workers, Urgent Care Center providers, and a non-VA dentist. In addition, the OIG team also reviewed the possible impact of COVID-19 on the patient's care.

The OIG interviewed facility leaders, providers, and staff who were knowledgeable about the patient and concerns under discussion.[12]

The OIG team reviewed the patient's electronic health record (EHR) as well as relevant VHA and facility policies and procedures related to Primary Care clinics, Community Care, Urgent Care Center, COVID-19, peer review, consult management, social work, nutrition, and long-term care. The OIG team also reviewed relevant committee meeting minutes, Patient Advocate Reports, Peer Review and other Quality Management reports, and the organizational chart.

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).

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 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.

[12] The OIG interviewed the Facility Director; Chiefs of Staff, Quality Management, Primary Care, Dental Service, Community Care, Veterans Experience, and Urgent Care Center/Emergency Department; the former Chief of Telehealth/Video Connect, the Assistant Chief of Dental Service, the non-VA dentist, relevant primary care providers and staff, scheduling staff, urgent care providers, a geriatric social worker, risk manager, and peer review coordinator.

# Patient Case Summary

The salient aspects of this case occurred in 2020.

The patient was in their 70s with a history of benign prostate hyperplasia with urinary obstruction requiring a Foley catheter, a significant smoking history, chronic obstructive pulmonary disease, noninsulin dependent diabetes mellitus and diabetic neuropathy, mild essential hypertension, post-traumatic stress disorder, anxiety, depression, and renal cell carcinoma.[13] The patient resided in a non-VA assisted living facility.[14]

In early 2020, due to recurrent urinary tract infections, the patient was admitted to the facility for intravenous antibiotics and to exchange the urinary catheter. Six days later, the patient was discharged to an assisted living facility.

The day after the patient's discharge, the patient's family member called a Patient Aligned Care Team (PACT) social worker with concerns about the patient's recurring urinary tract infections and the level of care provided at the assisted living facility.[15] Four days later, the patient's family member contacted the PACT social worker again to express concerns with the patient's physical and mental health. The family member reported that the patient was experiencing forgetfulness and had numerous falls and hospital admissions. The family member requested an appointment for the patient to be seen by the primary care provider and for placement in the facility's community living center (CLC).[16] The PACT social worker referred the patient to a PACT registered nurse for the requested appointment and explained the CLC application process including the required documentation.

Two weeks later, the patient had a follow-up appointment with a primary care provider. The patient complained about skin lesions and admitted to decreased exercise tolerance. Bruises from a recent fall were noted and dizziness was still present. The patient's family member was concerned about the patient's increased confusion. On examination, the patient's vital signs were normal, weight was 172.4 pounds, and no neck masses were felt on exam. No documented evidence of an oral exam was done. Because of the patient's general deteriorated health, falls, confusion and weakness; the primary care provider entered a geriatric consult.

[13] The OIG uses the singular form of they (their) in this circumstance for the purpose of patient privacy.

[14] The patient's assisted living facility provided 24-hour care and meals and assisted the patient with medication management and activities of daily living, such as bathing, getting dressed, and mobility.

[15] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. A PACT team consists of the patient, the patient's personal supports (such as a family member), a primary care provider, a registered nurse, a licensed vocational or practical nurse, a healthcare technician, and a clerk. Discipline-specific team members provide continuity of direct discipline-specific care and may include a registered dietitian and a social worker.

[16] Facility Memorandum No. 00-134, *Community Living Center/Community Nursing Home Screening Committee*, August 14, 2017. A CLC provides short- and long-term care based on the patient's clinical needs.

After collecting the required application documentation, another social worker submitted the CLC consult (application) a day later. The CLC steering committee reviewed the consult and denied placement, because the patient did not meet the long-term care criteria.

Approximately two weeks later, a detailed geriatric consult was completed. The geriatric provider started the patient on Finasteride to address the refractory benign prostate hyperplasia. No adenopathy was felt on neck exam. In addition, a geriatric clinic dietitian met with the patient face-to-face. The dietitian documented that the patient weighed 174 pounds and denied problems with chewing or swallowing. The patient reported not liking the food at the assisted living facility.

Approximately three months later, the patient was seen in the Urgent Care Center with a chief complaint of cough with blood tinged sputum. On exam, there was no cervical adenopathy, no respiratory distress, and few coarse crackles heard in the lungs. The patient experienced no distress or coughing while at the Urgent Care Center. The patient was diagnosed and treated for bronchitis with mucosal bleeding and discharged to the assisted living facility.

The next week, the patient called a PACT nurse requesting to start oral nutrition supplements (supplements). On the same day, the primary care provider entered an order for supplements twice daily. Six days later, a PACT dietitian called the patient to discuss the request for supplements and approved the order. During the call, the patient reported having a poor appetite because of not liking the food served at the assisted living facility. Due to the patient's possible 15-pound weight loss over 3–4 months, the dietitian authorized the patient to receive supplements twice a day with the goal to prevent further weight loss. The dietitian scheduled a return-to-clinic appointment in three months.

Approximately two weeks later, the patient's family member spoke with the PACT social worker and expressed concern about the prolonged time of the urinary catheter placement and the patient's recurrent urinary tract infections. The PACT social worker forwarded the family member's concern to the primary care provider. A face-to-face appointment was scheduled for the next week.

Four days after the family member's call, a non-VA dental care consult was entered for routine care.

During the face-to-face appointment, the primary care provider reviewed documentation from the patient's earlier Urgent Care Center visit for blood in the sputum. In addition, the primary care provider documented finding a 1 centimeter right submandibular lymph node on examination of the patient's neck. No oral exam was documented. The primary care provider's plan was to request a computerized tomography of the chest and to treat the patient for acute bronchitis with antibiotics.

The next month, the geriatric clinic dietitian received a call from the assisted living facility staff stating that the patient was out of supplements.

Two days later, the PACT registered nurse received a call from an employee at the assisted living facility advising that the patient was coughing up blood and refusing to go to an emergency department. The patient and family member expressed concern about the cost of an ambulance transport. The family member also requested that a previously scheduled late summer appointment be face-to-face with the family member included in the appointment.

The next day, the patient was seen at the facility's Urgent Care Center because of recurrent coughing up blood. On exam, no cervical adenopathy, erythema or exudate in the oropharynx was noted, but there was bilateral wheezing heard in the patient's lungs. The provider's impression was chronic obstructive pulmonary disease and hemoptysis and the patient was treated for bronchitis.

Approximately two weeks later, the primary care provider called the patient and noted that the patient's speech was slurred and difficult to understand. The patient reported that the bloody sputum had resolved.

Ten days later, the geriatric clinic dietitian documented that the patient reported a weight of 149.2 pounds that was a loss of approximately 31 pounds since early 2020. The patient reported chewing problems because of ill-fitting dentures. The patient's supplements were increased to three times a day.

The next month, another PACT dietitian had a telephone appointment with the patient. The patient reported having a poor appetite and consuming supplements three times a day. The dietitian did not document a new weight.

A week later, the patient's family member called the PACT social worker to discuss the patient's weight loss, and the family member attributed the weight loss to the patient feeling nauseous when eating and that the patient's top dentures were causing pain. The PACT social worker notified the primary care provider of the concerns.

The next day, the primary care provider spoke with the patient on the telephone and noted that the patient's speech was difficult to understand. The patient complained that the dentures were causing jaw pain. The patient denied any nausea or vomiting and reported taking supplements three times a day. The primary care provider instructed the patient to seek medical attention from the Emergency Department as needed.

Approximately three weeks later, the patient was seen by a non-VA dentist. The dentist documented an oral exam and noted pain in the submandibular area. An x-ray of the upper and lower jaw noted that the patient was edentulous, but no further interpretation of the study was given. The dentist referred the patient to a non-VA oral surgeon for evaluation of the pain and noted, if necessary, a follow-up appointment for dentures would be scheduled. An appointment with the oral surgeon was scheduled, but the patient did not attend the appointment.

Five weeks later, the patient's family member called a PACT social worker with concerns about the dental care the patient received in the community. The family member stated that the patient

continued to report weight loss, pain, and inability to eat. The PACT social worker notified Community Care staff of the family member's concerns.

The next week, the patient was seen at the facility's Urgent Care Center complaining of trouble speaking, trouble with secretions, unintentional weight loss, and right-sided jaw pain. On exam, the urgent care provider documented "oropharynx: tongue with diffuse thick dark colored plaque on it, visual mass in right posterior pharynx, MMM [moist mucus membranes], no erythema, no exudate. Patient has mild pooling of…secretions and…is very hard to understand. Neck: supple, no lymphadenopathy." Computerized tomography exam of the neck showed what appeared to be a malignant tongue and neck mass that encased the carotid artery. A decision was made to transfer the patient to another VA medical center for evaluation by an ear, nose, and throat (ENT) specialist.

Two days later, the other VA medical center attempted placement of a nasogastric tube, but because of the potential for ongoing bleeding and an airway that was blocked or reduced, a decision was made to perform a tracheostomy and to biopsy the tumor urgently. The patient was transferred to a non-VA hospital for a tracheostomy, nasogastric tube placement, and tumor biopsy. The biopsy revealed the patient was positive for the human papillomavirus and invasive squamous cell carcinoma. The patient returned to the other VA medical center three days later. The decision was made to forgo any interventions for the patient's inoperable, aggressive tumor. The patient transitioned to hospice five days later and died the same day.

# Inspection Results

## 1. Quality of Care

The OIG identified deficiencies in the quality of care provided by the patient's primary care provider and the clinical dietitians. The OIG determined that urgent care providers and the non-VA dentist provided quality care to the patient.

VA defines quality care as providing the right type of care for a patient's health condition that results in the best possible outcome.[17]

### Primary Care Provider

During a face-to-face appointment in mid-summer 2020, the primary care provider documented palpating a soft right submandibular lymph node and planned to follow up with the patient the next month. A review of the EHR found that the primary care provider planned to order a computerized tomography scan of the patient's chest. The OIG found no documented evidence that the primary care provider ordered the scan, and during interviews, the primary care provider admitted to not ordering the scan.

During the telephone appointment in late summer 2020, the primary care provider acknowledged that the patient had a recent urgent care appointment for coughing up blood, had a chest x-ray, and was treated for bronchitis. The patient reported "doing fair" and was no longer coughing up blood. The primary care provider documented that the patient's speech was slurred and difficult to understand, and that the patient had no unexplained weight loss. For this appointment, the primary care provider documented the patient's weight from a previous appointment, which was 159 pounds.

The OIG team found no documented evidence that the primary care provider asked about the previously palpated submandibular lymph node and no evaluation was done to assess the patient's slurred speech. The patient had a more recent documented weight of 150.2 pounds from an urgent care visit in late summer 2020. The OIG team determined that the patient lost 23.8 pounds between the patient's early 2020 face-to-face appointment with the dietitian and the patient's late summer 2020 Urgent Care Center visit.

In mid-fall 2020, the patient's family member contacted the PACT social worker and reported that the patient had weight loss and experienced nausea when eating. The family member also reported that the patient's dentures were causing pain. During a telephone appointment the next day, the patient reported "pain in jaws from denture," taking supplements three times a day, and denied nausea or vomiting. The patient was unsure if weight loss had occurred. The primary care provider documented advising the patient "to seek medical attention in ER [emergency room] if

[17] VA, *Health Care*, *Quality of Care*, accessed May 18, 2021, https://www.va.gov/QUALITYOFCARE/.

any symptoms of concern and inform [the] caregiver." The patient was scheduled for a non-VA dental appointment approximately one month later to assess dental needs and denture pain.

The OIG concluded that the primary care provider failed to enter an order for a computerized tomography scan of the patient's chest, follow up on the documented soft submandibular lymph node, or address the patient's continued unintentional weight loss even after taking supplements. The OIG determined that the lack of further diagnostic evaluation and follow-up of the submandibular lymph node and the patient's unintentional weight loss may have led to a delay in the diagnosis and treatment of the patient's oral cancer and the patient's death.

### *Facility Response*

In January 2021, the facility identified issues with the care provided to the patient by the primary care provider and conducted a peer review.[18] The facility also offered an institutional disclosure, but the family declined.[19] The facility's Risk Manager sent a follow-up letter to the patient's family member stating that the offer for the institutional disclosure remained available.

Because the facility conducted a peer review for quality management and offered to conduct an institutional disclosure, the OIG made no recommendations related to facility responses to the provider's deficiencies.

## Dietitians

The OIG team was told that in 2020, the Assistant Chief of Nutrition and Food Services used an internal peer review form to monitor the quality of nutrition care provided by dietitians. Based on the internal peer review form, the OIG team chose four documentation requirements as pertinent to the patient's care and used those requirements in reviewing dietitians' nutrition assessments.[20] The four requirements included assessing and documenting a patient's weight, chewing and swallowing problems, nutrition diagnosis, and energy (calories) and protein requirements at each appointment.

[18] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018. Following an adverse event (an act of commission or omission), VHA states that a peer review, when conducted as part of a facility's quality management program, is a confidential, non-punitive review process. Peer review focuses on improving the quality of health care or utilization of resources. Specifically, a peer review focuses on whether an individual provider's clinical decisions and actions during an episode of care met the standard of care.

[19] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients,* October 31, 2018. An institutional disclosure of an adverse event "is a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

[20] This internal review was not a peer review conducted by the facility as part of a medical quality assurance program protected under 38 U.S.C. § 5705.

The OIG team found that the early 2020 nutrition assessment contained the four identified requirements. However, the three subsequent nutrition assessments did not include an update to the nutrition diagnosis to reflect weight loss and did not estimate the patient's energy and protein requirements. In addition, the last nutrition assessment did not include an updated weight or an assessment of chewing and swallowing.

In early 2020, the patient's documented weight was 170.4 pounds and by the end of the year, after being transferred to another VA medical center for a higher level of care, the patient weighed 134.1 pounds. The OIG calculated that the patient lost a total of approximately 36 pounds. The OIG concluded that the incomplete nutrition assessments did not reflect the patient's declining nutrition status and may have contributed to the delay in diagnosis.

## Urgent Care Providers

The patient was seen in the Urgent Care Center in spring and summer 2020 for coughing up blood. The OIG team found that the urgent care providers assessed the patient's presenting complaints, documented the patient's condition as stable, conducted radiologic studies and laboratory tests, and discharged the patient with medications to the assisted living facility. During interviews, an urgent care provider stated that as the patient had a history of chronic obstructive pulmonary disease, and continued to smoke, it was possible to have blood in the sputum. During the late summer 2020 visit, an urgent care provider reported completing an oral examination and palpating the patient's neck but did not find anything unusual.

In late 2020, the patient presented to the Urgent Care Center with trouble speaking, secretions, unintentional weight loss, and jaw pain. The urgent care provider identified a visual mass at the back of the pharynx and tongue discoloration and ordered a computerized tomography of the patient's head. The urgent care provider documented that "The patient seems to have tongue/neck mass which is likely malignant given [the] extensive smoking history." Because the facility did not have an ENT specialist or an oncology service, the patient was transferred to another VA medical center for care and treatment.

The OIG concluded that urgent care staff provided the patient with quality care by assessing the patient's presenting complaint, conducting necessary studies and tests, and implementing appropriate care plans.

## Non-VA Dentist

During the patient's late fall 2020 dental appointment, the non-VA dentist documented performing an oral exam and noted "pain during palpation in submandibular" and referred the patient to a non-VA oral surgeon for the pain. The non-VA dentist told the OIG team that evaluation for pain was outside the expertise of general dentistry and a specialty consult was considered appropriate. An oral surgery consult was placed the next day through the facility's Community Care program with an urgency rating of within one week, and an appointment was

scheduled for four days later. The OIG was told that the non-VA oral surgery clinic called the patient's assisted living facility and left a message. The patient did not attend the oral surgery appointment and the consult was discontinued after the patient's death.

The OIG concluded that the non-VA dentist provided quality care to the patient by performing an oral exam and when the dentist discovered jaw pain that was outside the expertise of general dentistry, referred the patient to an oral surgeon for further evaluation.

## 2. Lack of Care Coordination

The OIG determined that a lack of care coordination occurred between the PACT registered nurse and the primary care provider, and between dietitians and the primary care provider. However, the OIG identified that the social workers exhibited coordination of care with the primary care team.

VHA states that it is essential to have effective informal, structured, and respectful communication among PACT staff to ensure that the right person has the right information at the right time and that every PACT team member is included in making decisions that affect patient care and team function.[21] In addition, VHA "embraces the strong practice of teamwork among members dedicated to achieving the common goal of excellent comprehensive primary care for Veterans."[22] The Joint Commission requires that facilities have a process for the sharing of patient information between providers of care, which offers an opportunity for discussion between the "giver and receiver of patient information."[23]

### PACT Registered Nurse and the Primary Care Provider

The OIG team was told by facility leaders and staff that, because of COVID-19, appointments were often transferred from face-to-face examinations to telephone calls. A medical support assistant told the OIG that during COVID-19, the PACT registered nurse provided a list of appointments that should be transferred from a face-to-face appointment to a telephone appointment.

The OIG team was told that in mid-summer 2020, a medical support assistant transferred the patient's late summer face-to-face appointment to a telephone appointment because of COVID-19. The OIG team found documented evidence that the patient's family member spoke with the PACT registered nurse two weeks before the appointment requesting that the scheduled appointment be conducted face-to-face. The PACT registered nurse told the patient's family member that a face-to-face appointment would have to be cleared through the primary care

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

[22] VHA Handbook 1101.10(1).

[23] The Joint Commission E-dition, accessed April 5, 2021, The Joint Commission E-dition September 2020.

provider. The OIG team found no documented evidence that the PACT registered nurse alerted the primary care provider to the request. The primary care provider reported that due to COVID-19, patients were rarely seen face-to-face from March through September 2020 and recalled not being told that the patient's family member had requested a face-to-face appointment. The primary care provider acknowledged not being able to conduct a physical examination because it was not a face-to-face appointment.

The OIG concluded that the PACT registered nurse's failure to communicate the family member's request for a face-to face appointment instead of a telephone appointment may have contributed to the delay in the patient's cancer diagnosis. By having a telephone appointment, the primary care provider failed to follow up on the previously found soft right submandibular lymph node and to physically examine the patient.

## Dietitians and Primary Care Provider

The patient met four times with three dietitians in 2020 during which time the patient lost approximately 31.2 pounds.[24] The dietitians documented poor intake due to loss of appetite, because the patient reported not liking the food provided at the assisted living facility.

In early 2020, during a face-to-face appointment with the geriatric clinic dietitian, the patient weighed 174 pounds and denied problems with chewing or swallowing. The patient reported not liking the food at the assisted living facility. The dietitian documented a visual assessment noting the patient appeared healthy with no signs of nutritional deficiencies. The nutrition diagnosis included the patient's dislike of assisted living facility food contributing to poor food consumption possibly causing inadequate caloric intake.

In early summer 2020, the patient called the PACT registered nurse requesting supplements. The PACT registered nurse added the primary care provider as a co-signer to the EHR note to alert the primary care provider of the patient's request. The primary care provider entered an order for the supplements on the same day. The dietitian had a telephone appointment with the patient six days later to assess the patient's need for supplements. Due to the patient's "possible 15.4 lb [pound weight] loss since last RD [dietitian] visit…3-4 months ago," the dietitian authorized the patient to receive supplements twice a day with the goal to prevent further weight loss. The dietitian scheduled a return-to-clinic appointment in three months.

[24] The patient met with the geriatric clinic dietitian twice, a PACT dietitian once, and another PACT dietitian once. The patient was seen by three different dietitians because the first PACT dietitian transferred to another VA medical center and the geriatric clinic dietitian was on extended leave. Mayo Clinic, *Mouth Cancer*, accessed June 21, 2021, https://www.mayoclinic.org/diseases-conditions/mouth-cancer/symptoms-causes/syc-20350997, The signs and symptoms of oral cancer include mouth pain, difficult or painful swallowing, and weight loss. Mayo Clinic, *Unexplained weight loss*, accessed June 21, 2021, https://www.mayoclinic.org/symptoms/unexplained-weight-loss/basics/causes/sym-20050700.

In late summer 2020, the geriatric clinic dietitian called the patient's assisted living facility to schedule a follow-up appointment. During that call, a representative from the assisted living facility stated the patient was out of supplements. During the early fall 2020 telephone appointment, the patient reported continued unintentional weight loss and chewing problems that were attributed to poorly fitting dentures. The dietitian calculated that the patient had lost 31.2 pounds since the beginning of the year. The dietitian increased the patient's supplements to three times a day with the goal to maintain the patient's current weight. The dietitian scheduled a return-to-clinic appointment in one month or as needed.

In fall 2020, the patient had a telephone appointment with another PACT dietitian and reported having a poor appetite and consuming the supplements three times a day. The dietitian documented "no new weight" and to continue the previously established nutrition goals. The dietitian scheduled a return-to-clinic appointment in one month; however, the appointment was not scheduled until early 2021.

According to VHA, dietitians can prescribe and monitor supplements in accordance with facility policy.[25] The OIG was told that Nutrition and Food Services was in the process of updating the facility's policies. The OIG team was also told that evaluation and re-evaluation for supplements was considered routine care and would not require an alert to the primary care provider. The OIG appreciates that the summer 2020 dietitian appointment with the patient was to confirm the patient's need for supplements and was in response to the primary care provider's order for supplements. However, as the patient continued to lose weight, the dietitian only increased the patient's daily supplements and did not consider that a medical problem may have been contributing to the patient's weight loss. The Assistant Chief of Nutrition and Food Services acknowledged that a higher level of intervention was not offered to the patient, nor was the patient referred to the primary care provider for further evaluation.

The OIG concluded that the lack of care coordination between dietitians and the primary care provider related to the patient's continual unintentional weight loss contributed to the delay in diagnosis. Because dietitians did not consider that the patient may need a higher level of intervention and did not communicate with the primary care provider about the patient's continual unintentional weight loss, a medical problem was unaddressed that may have led to a delay in diagnosing the patient's oral cancer.

## Social Workers and PACT Team

VHA requires that social workers participate in the planning, implementation, and evaluation of patients receiving medical interventions in inpatient, CLC, and Primary Care Clinic services. In addition, social workers serve as a liaison between the treatment team and family members.[26]

[25] VHA Directive 1438, *Clinical Nutrition Management and Therapy*, September 19, 2019.
[26] VHA Directive 1110.02, *Social Work Professional Practice,* July 26, 2019.

Facility policy requires that requests for admission to the CLC be communicated by placing a consult in the patient's EHR. The screening process is conducted by the CLC Screening Committee.[27]

The patient was admitted to the facility for a urinary tract infection in early 2020, and discharged six days later. The OIG team found that a social worker initially worked on CLC placement when the patient was to be discharged on intravenous antibiotics. When the plan changed to oral antibiotics, the social worker confirmed with the patient and the patient's assisted living facility that discharge back to the assisted living facility was appropriate.

The OIG team found that the social workers involved in the patient's care were responsive to the patient's and the family member's requests for assistance. During a telephone call with the PACT social worker in early 2020, the patient's family member expressed concern about the level of care provided at the patient's assisted living facility and requested that the patient be placed at a long-term care facility. The social worker spoke with the patient and confirmed that the patient was agreeable to the family member's request. The social worker initiated the consult process. Later that month, another social worker submitted the long-term care consult, and the next day, the facility's CLC Screening Committee determined that the patient did "not meet [long-term] criteria at this time."

The patient's family member also called the PACT social worker on three other occasions to voice concerns about the patient and the patient's care. The PACT social worker either documented contacting the PACT registered nurse about the concerns or added the primary care provider as an additional signer to the notes. The primary care provider responded by seeing the patient face-to-face on two occasions and calling the patient on one occasion.

The OIG concluded that the facility social workers assessed the patient's needs timely, worked with both inpatient and primary care providers to coordinate care, and maintained frequent and open communication with the patient and the patient's family member.

## 3. Timeliness of Care

The OIG determined that due to incorrect scheduling, the patient was not seen for a follow-up appointment by a dietitian, and a delay in scheduling a non-VA dental appointment occurred.

VHA requires that "Veterans' appointments are scheduled timely, accurately, and consistently with the goal of scheduling appointments no more than 30 calendar days from the date an appointment is deemed clinically appropriate by a VA health care provider…."[28] VHA requires that facility and non-VA dental care be provided to eligible patients and that patients have a

[27] Facility Memorandum No. 00-134.

[28] VHA Directive 1230(4), *Outpatient Scheduling Processes and Procedures,* July 15, 2016, amended June 17, 2021.

choice to opt-in for non-VA dental care.[29] "It is VHA policy to ensure timely and clinically appropriate care to all Veterans by standardizing and managing consultation processes."[30] Additionally, consults are required to "remain in [pending] status no more than 2 [two] business days from the consult creation date."[31]

## Dietitians

The OIG found that following the patient's last dietitian telephone appointment, the dietitian requested a return-to-clinic appointment for the patient in one month. However, the OIG found that, due to a scheduling error, the patient was scheduled for an early 2021 appointment instead of the requested appointment. The patient died before this scheduled follow-up appointment. The OIG concluded that if the patient had been seen as requested, the dietitian may have been able to address the patient's unintentional weight loss.

## Non-VA Dentist

The OIG team was told that the patient was eligible for dental care and applied for routine care. Because of limited access at the facility's dental clinic, routine dental care was often referred to non-VA dentists. In summer 2020, a Community Care dental consult was entered. The next day a Community Care staff member documented accepting the consult and noted that the consult was "received during COVID-19 Pandemic" and that "Scheduling prioritized during COVID-19 Pandemic." The patient was listed as COVID-19 Priority 2. The OIG was told that, regardless of COVID-19, a Priority 2 patient should be scheduled as community access and scheduling efforts are available.[32] The OIG team calculated that 67 days elapsed between when the consult was received by Community Care staff and when the consult was processed. The OIG team was told that the demand for dental care in the community by VA and non-VA patients exceeded the available access and that a new patient in the community could wait 60 days for a routine non-VA dental appointment.

In early fall 2020, the consult was faxed to the non-VA dental office for scheduling. The OIG team found that the non-VA dental clinic scheduled the initial appointment for 24 days later, and attempted to confirm the appointment with staff from the patient's assisted living facility;

[29] VHA Office of Community Care, *Field Guidebook Specialty Programs*, updated April 8, 2021. VHA Member Services, *Dental Benefits for Veterans*, IB 10-442, February 2019.

[30] VHA Directive 1232(3), *Consult Processes and Procedures*, August 24, 2016, amended April 5, 2021.

[31] VHA Directive 1232(3). Pending status "designates [consult] requests…have been sent, but not yet acted on by the receiving service."

[32] The Chief of Dental Service, who was detailed as the Chief of Community Care when interviewed by the OIG team, stated that "Priority 1 consults are generally expected to be scheduled within 30 days when possible and require efforts more frequently. STAT consults require warm handoff and goal is 24 hours."

however, the assisted living facility staff did not return the telephone call until nearly a month later. The patient's appointment was rescheduled for late fall 2020, which the patient attended.

The OIG concluded that although the facility reported limited dental access and referred patients to Community Care for more timely routine dental care, the patient waited 67 days from when the consult was approved until when the consult was processed. The patient waited a total of 130 days for the initial appointment.

## 4. Impact of COVID-19

The OIG determined that the facility's response to COVID-19 affected the care provided to the patient by dietitians, because dietitians were unable to conduct face-to-face appointments. However, COVID-19 did not impact the care provided to the patient by the primary care providers, the social workers, urgent care providers, or a non-VA dentist.

During COVID-19, VHA provided guidance that "Primary Care appointments should be reviewed and if clinically appropriate, converted to virtual modalities."[33] The guidance was to "use the modality that has the lowest technology requirement, such as secure messaging or telephone…." The Chief of Staff told the OIG that during COVID-19, the facility transitioned to primarily virtual care (telephone call or VA Video Connect).

### Dietitians

According to the Assistant Chief of Nutrition and Food Services, all face-to-face outpatient nutrition clinic appointments were canceled starting in March 2020. The OIG found that the dietitian met with the patient face-to-face in early 2020. Over the next eight months, the patient had three telephone appointments with dietitians. Because telephone calls were the only mode of meeting with the patient, dietitians were unable to visually assess, complete nutrition-focused physical examinations of the patient, and weigh the patient. This limited dietitians' ability to assess if the patient needed an increased nutrition intervention. Due to requiring a higher level of care, the patient was transferred from the facility to another VA medical center in late 2020. A dietitian at another VA medical center assessed the patient; documented severe malnutrition, severe muscle wasting, and weight loss of approximately 36 pounds within one year, and recommended the patient receive enteral nutrition support.

The OIG concluded that the lack of face-to-face appointments with this patient because of COVID-19 affected dietitians' ability to complete nutrition-focused physical examinations and weigh the patient. The lack of physical assessment and accurate weights likely affected dietitians' ability to determine the true extent of the patient's progressively worsening and unintentional weight loss.

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

## Primary Care Provider

Although face-to-face appointments could have been scheduled when clinically appropriate, for approximately nine months in 2020, the patient had only one face-to-face appointment with the primary care provider.[34] As previously discussed, the patient's family member requested that the late summer 2020 appointment be face-to-face, but that request was not communicated to the provider. Although the Chief of Primary Care told the OIG team that patient care was affected by a large number of PACT teams working from home, the OIG concluded that this patient's primary care was affected more by a lack of communication between the PACT registered nurse and the primary care provider than by issues related to COVID-19.

## Social Workers

The OIG team was told that the patient's PACT social worker split time between working in the Primary Care Clinic and working from home during COVID-19. The OIG found that the PACT social worker responded to telephone calls from the patient and the patient's family member and ensured that the primary care provider and the PACT registered nurse were aware of any medical concerns. The OIG concluded that COVID-19 did not negatively impact the care provided to this patient by the PACT social worker.

## Urgent Care Providers

The Urgent Care Center remained open during COVID-19. The Chief of Urgent Care Center/Emergency Department reported a decrease in patient volume and in some cases the Urgent Care Center was down to 30–50 patients a day. The OIG concluded that COVID-19 did not negatively impact the care provided to the patient through the Urgent Care Center.

## Non-VA Dentist

The OIG team was told that the non-VA dental clinic was closed because of COVID-19 for two to three weeks initially, but by early June 2020, the dental clinic was bringing patients back in for care. The OIG found that the facility's Community Care staff processed the Community Care dental consult in early fall 2020 and faxed it to the non-VA dental clinic two days later for scheduling. The patient was scheduled for an initial appointment 24 days later. The OIG concluded that COVID-19 did not negatively impact the timeliness of care provided by the non-VA dental clinic.

[34] VA Memorandum, *Primary Care Guidance*.

# Conclusion

The OIG identified that the primary care provider and dietitians did not provide consistent quality care to the patient. The provider failed to follow-up on the identified submandibular lymph node, and although the primary care provider documented a plan to order a computerized tomography of the chest, the primary care provider did not place the order. This may have led to a delay in the patient's diagnosis of cancer. Dietitians did not conduct comprehensive nutritional assessments leading to a delay in the workup of the cause of the patient's progressively worsening unintentional weight loss. The OIG found that urgent care providers and the non-VA dentist provided quality care to the patient.

The OIG determined that the PACT registered nurse and dietitians did not coordinate care with the primary care provider. The PACT registered nurse did not ensure that the request for a face-to-face appointment was scheduled or discussed with the primary care provider. Dietitians did not communicate the decline in the patient's nutritional status with the primary care provider. The lack of coordination in care may have caused a delay in examination and diagnosis. However, the OIG found that social workers exhibited coordination of care with the primary care provider and the PACT registered nurse.

Additionally, the OIG determined that due to incorrect scheduling, the patient was not seen for a follow-up appointment by a dietitian and that a delay in scheduling a non-VA dental appointment occurred. The dietitian planned to follow-up with the patient in one month, but the appointment was scheduled for more than three months later by the scheduling staff. The scheduling error prevented the dietitian from following up with the patient, monitoring the declining nutritional status, and considering a higher level of nutritional intervention by the provider. The facility's Community Care program did not schedule a timely appointment with a non-VA dentist. The patient waited 67 days from receipt of a Community Care dental consult through processing by Community Care staff.

The OIG also concluded that COVID-19 impacted the care provided to the patient by dietitians, because dietitians only conducted telephone appointments with the patient. By not using face-to-face appointments, dietitians were unable to visually assess, complete nutrition-focused physical examinations, and weigh the patient. The lack of physical assessment likely affected dietitians' ability to determine the true extent of the patient's progressively worsening unintentional weight loss.

# Recommendations 1–6

1. The Fayetteville VA Coastal Health Care System Director ensures that dietitians comply with conducting and documenting comprehensive nutrition assessments, including patients' weight measurements, changes to nutrition diagnosis, chewing and swallowing abilities, and calorie and protein requirements.

2. The Fayetteville VA Coastal Health Care System Director ensures there is consistent communication and coordination of care between the Patient Aligned Care Team registered nurses and the primary care providers.

3. The Fayetteville VA Coastal Health Care System Director provides guidance on care coordination between outpatient dietitians and primary care providers when a higher level of nutrition intervention is required.

4. The Fayetteville VA Coastal Health Care System Director monitors that follow-up appointments for dietitians are scheduled as ordered.

5. The Fayetteville VA Coastal Health Care System Director ensures that non-VA dental appointments are scheduled within recommended time frames by the Community Care program scheduling staff and monitors compliance.

6. The Fayetteville VA Coastal Health Care System Director evaluates the COVID-19 scheduling practices and the impact of telephone appointments on the patient's care.

# Appendix A: VISN Director Memorandum

## Department of Veterans Affairs Memorandum

Date: August 30, 2021

From: Acting VA Mid-Atlantic Health Care Network Director, VISN 6 (10N6)

Subj: VAOIG DRAFT REPORT - Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina

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

1. The attached subject report is forwarded for your review and further action. I reviewed the response from the Fayetteville VA Medical Center, Fayetteville, North Carolina and concur.

2. If you have further questions, please contact the Quality Management Officer, VISN 6.

(*Original signed by*:)

Stephanie A. Young

# Appendix B: Facility Director Memorandum

## Department of Veterans Affairs Memorandum

Date: August 30, 2021

From: Director, Fayetteville VA Coastal Health Care System (565/00)

Subj: Healthcare Inspection—Care Concerns and the Impact of COVID-19 on a Patient at the Fayetteville VA Coastal Health Care System in North Carolina

To: Acting Director, Mid-Atlantic Healthcare Network (10N06)

1. The Executive Director of the Fayetteville VA Coastal Health Care System has reviewed the draft report and concurs with the findings.
2. A plan for corrective actions to include timeline for completion and sustainment of improvements has been completed.

(*Original signed by*:)

Daniel L. Ducker, MSS, M ED
Executive Director
Fayetteville NC VA Coastal Health Care System

# Facility Director Response

## Recommendation 1

The Fayetteville VA Coastal Health Care System Director ensures that dietitians comply with conducting and documenting comprehensive nutrition assessments, including patients' weight measurements, changes to nutrition diagnosis, chewing and swallowing abilities, and calorie and protein requirements.

Concur.

Target date for completion: March 31, 2022

### Director Comments

All Clinical Dietitians will be educated on required documentation from Department Memorandum DS120-36. This education will be included in competencies and service orientation. The documentation template for required items on comprehensive nutritional assessments will be updated to include the following: patients' weight measurements, identification of or changes to nutrition diagnosis, chewing and swallowing difficulties, and calorie and protein requirements. A minimum of five comprehensive nutritional assessments conducted by each Registered Dietitian shall be reviewed monthly, in accordance with the Nutrition Care Process- Quality Evaluation and Standardization Tool (NCP-QUEST) created by 2021 Veterans Affairs (VA) Registered Dietitians and Academy staff. Validation of adherence to the required documentation will be completed monthly. Data will be reported to Medical Executive Board (MEB) until 90% compliance with a level "A" rating for at least three consecutive months.

## Recommendation 2

The Fayetteville VA Coastal Health Care System Director ensures there is consistent communication and coordination of care between the Patient Aligned Care Team registered nurses and the primary care providers.

Concur.

Target date for completion: March 31, 2022

### Director Comments

The Primary Care Team Leaders will be clinically responsible for all decisions on the mode of interaction with scheduled practices. They can override a scheduled mode of interaction and change to an alternate modality as clinically indicated under the direction of the provider. Patient Aligned Care Team (PACT) Registered Nurses [RN] will be re-educated on their role and responsibilities. This education will be added to current competencies regarding consistent

communication and coordination of care between the PACT RN and Provider. Completion of this re-training will be reported to the Medical Executive Board.

## Recommendation 3

The Fayetteville VA Coastal Health Care System Director provides guidance on care coordination between outpatient dietitians and primary care providers when a higher level of nutrition intervention is required.

Concur.

Target date for completion: March 31, 2022

### Director Comments

Appropriate care coordination between outpatient dietitians and primary care providers will be accomplished by notifying the primary care provider via the use of the additional signer feature in the Outpatient Nutrition electronic medical record note. This note will alert the provider of any decline in the patient's nutritional status and alert them when a higher level of nutritional intervention is required. Validation of adherence to this process will be established through monthly reviews of five records per clinician and reported to MEB until 90% compliance has been achieved for at least three consecutive months.

## Recommendation 4

The Fayetteville VA Coastal Health Care System Director monitors that follow-up appointments for dietitians are scheduled as ordered.

Concur.

Target date for completion: March 31, 2022

### Director Comments

Health Administrative Services (HAS) will track Dietician Return to Clinic (RTC) Orders. A weekly review will be completed by HAS Management, and timeliness of scheduling per VHA Directive 1230, Outpatient Scheduling Processes and Procedures, will be tracked. HAS will monitor the timeliness of scheduling and will report compliance to MEB until 90% compliance is achieved for at least three consecutive months.

## Recommendation 5

The Fayetteville VA Coastal Health Care System Director ensures that non-VA dental appointments are scheduled within recommended time frames by the Community Care program scheduling staff and monitors compliance.

Concur.

Target date for completion: March 31, 2022

### Director Comments

Fayetteville NC Care in the Community (CIC) is collaborating with the Office of Community Care to optimize scheduling in all services, including Dental. All non-VA dental consults will be monitored by the Community Care program scheduling staff to ensure scheduling within recommended time frames. The average days from consult File Entry Date to scheduled status will be reported to MEB until the recommended time frame of thirty days or less is achieved for three consecutive months.

## Recommendation 6

The Fayetteville VA Coastal Health Care System Director evaluates the COVID-19 scheduling practices and the impact of telephone appointments on the patient's care.

Concur.

Target date for completion: March 31, 2022

### Director Comments

A review of Primary Care telephone appointments' documentation during the COVID-19 pandemic will be completed to evaluate the care received. This evaluation will assess if the patients' care was believed to have been negatively impacted by non-face-to-face care. A sample of medical records will be reviewed, based on the number of monthly telephone appointments. If a patient's care is determined to have been negatively impacted, a video voice connect (VVC) call or a face-to-face appointment will be offered. The results of these evaluations will be reported to MEB for at least three consecutive months.

# Glossary

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

**adenopathy.** Any disease or enlargement involving glandular tissue.[35]

**anxiety.** An abnormal and overwhelming sense of apprehension and fear often marked by physical signs (such as tension, sweating, and increased pulse rate), by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it.[36]

**benign prostate hyperplasia.** An enlarged prostate gland that can block the flow of urine out of the bladder and can cause urinary symptoms.[37]

**biopsy.** The removal and examination of tissue, cells, or fluids from the living body.[38]

**bronchitis.** Acute or chronic inflammation of the bronchial tubes.[39]

**carotid artery.** Either of the two main arteries that supply blood to the head.[40]

**catheter.** A tubular medical device for insertion into canals, vessels, passageways, or body cavities for diagnostic or therapeutic purposes.[41]

**cervical.** Of or relating to the neck.[42]

**chronic obstructive pulmonary disease.** "A chronic inflammatory lung disease that causes obstructed airflow from the lungs."[43]

**computerized tomography.** A method of producing a three-dimensional image of an internal body structure by computerized combination of two-dimensional cross-sectional X-ray images.[44]

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[35] Merriam-Webster, "Adenopathy," accessed April 12, 2021, https://www.merriam-webster.com/medical/adenopathy.

[36] Merriam-Webster, "Anxiety," accessed April 12, 2021, https://www.merriam-webster.com/dictionary/anxiety.

[37] Mayo Clinic, "Benign prostatic hyperplasia (BPH)," accessed April 12, 2021, https://www.mayoclinic.org/diseases-conditions/benign-prostatic-hyperplasia/symptoms-causes/syc-20370087.

[38] Merriam-Webster, "Biopsy," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/biopsy.

[39] Merriam-Webster, "Bronchitis," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/bronchitis.

[40] Merriam-Webster, "Carotid artery," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/carotid%20arteries.

[41] Merriam-Webster, "Catheter," accessed February 17, 2021, https://www.merriam-webster.com/dictionary/catheter.

[42] Merriam-Webster, "Cervical," accessed April 12, 2021, https://www.merriam-webster.com/dictionary/cervical.

[43] Mayo Clinic, "COPD," accessed April 12, 2021, https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679.

[44] Merriam-Webster, "Computed tomography," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/computerized%20tomography.

**depression.** A mood disorder marked especially by sadness, inactivity, difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness, and sometimes suicidal thoughts or an attempt to commit suicide.[45]

**diabetes mellitus.** An inadequate secretion or use of insulin.[46]

**diabetic neuropathy.** A type of nerve damage that can occur with diabetes and often affects legs and feet.[47]

**edentulous.** Without teeth.[48]

**ear, nose, and throat.** Conditions involving the ear, nose, throat, head, and neck.[49]

**enteral nutrition. "**A way of delivering nutrition directly to [the] stomach or small intestine."[50]

**erythema.** Abnormal redness of the skin or mucous membranes due to capillary congestion (as in inflammation).[51]

**exudate.** The material composed of serum, fibrin, and white blood cells that escapes from blood vessels into a superficial lesion or area of inflammation.[52]

**Finasteride.** A medication used to treat men with benign prostatic hyperplasia.[53]

**Foley catheter.** A thin, flexible catheter (tube) used to drain urine from the bladder. The Foley catheter is often referred to as an indwelling catheter because it can be left in place for extended periods of time.[54]

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[45] Merriam-Webster, "Depression," accessed April 12, 2021, https://www.merriam-webster.com/dictionary/depression.

[46] Merriam-Webster, "Diabetes mellitus," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/diabetes%20mellitus.

[47] Mayo Clinic, "Diabetic neuropathy," accessed April 12, 2021, https://www.mayoclinic.org/diseases-conditions/diabetic-neuropathy/symptoms-causes/syc-20371580.

[48] Merriam-Webster, "Edentulous," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/edentulous.

[49] Mayo Clinic, "Otolaryngology (ENT)/Head and Neck Surgery," accessed April 13, 2021, https://www.mayoclinic.org/departments-centers/ent-head-neck-surgery/sections/overview/ovc-20424084.

[50] Mayo Clinic, "Home enteral nutrition," accessed May 26, 2021, https://www.mayoclinic.org/tests-procedures/home-enteral-nutrition/about/pac-20384955.

[51] Merriam-Webster, "Erythema," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/erythema.

[52] Merriam-Webster, "Exudate," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/exudate.

[53] Mayo Clinic, "Finasteride (Oral Route)," accessed April 12, 2021, https://www.mayoclinic.org/drugs-supplements/finasteride-oral-route/description/drg-20063819.

[54] Merriam-Webster, "Foley catheter," accessed April 12, 2021, https://www.merriam-webster.com/dictionary/Foley%20catheter.

**hemoptysis.** An expectoration of blood from some part of the respiratory tract.[55]

**hospice.** A facility or program designed to provide palliative care and emotional support to the terminally ill in a home or homelike setting so that quality of life is maintained, and family members may be active participants in care.[56]

**Human Papillomavirus.** "A viral infection that commonly causes skin or mucous membrane growths (warts)…and some can cause different types of cancer."[57]

**hypertension.** "A common condition in which the long-term force of the blood against [the] artery walls is high enough that it may eventually cause health problems, such as heart disease."[58]

**intravenous.** Situated within, performed within, occurring within, or administered by entering a vein.[59]

**lymphadenopathy.** An abnormal enlargement of the lymph nodes.[60]

**lymph node.** Any of the rounded masses of lymphoid tissue that are surrounded by a capsule of connective tissue.[61]

**malignant.** A tendency to produce death or deterioration.[62]

**mucosal.** A membrane rich in mucous glands that line body passages and cavities which connect directly or indirectly with the exterior.[63]

**nasogastric tube.** A feeding tube inserted through the nose and to the stomach.[64]

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[55] Merriam-Webster, "Hemoptysis," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/hemoptysis.

[56] Merriam-Webster, "Hospice," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/hospice.

[57] Mayo Clinic, "HPV infection," accessed April 13, 2021, https://www.mayoclinic.org/diseases-conditions/hpv-infection/symptoms-causes/syc-20351596.

[58] Mayo Clinic, "High blood pressure (hypertension)," accessed April 12, 2021, https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410.

[59] Merriam-Webster, "Intravenous," accessed April 12, 2021, https://www.merriam-webster.com/dictionary/intravenous.

[60] Merriam-Webster, "Lymphadenopathy," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/lymphadenopathy.

[61] Merriam-Webster, "Lymph node," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/lymph%20node.

[62] Merriam-Webster, "Malignant," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/malignant.

[63] Merriam-Webster, "Mucosa," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/mucosal.

[64] Mayo Clinic, "Home enteral nutrition," accessed April 13, 2021, https://www.mayoclinic.org/tests-procedures/home-enteral-nutrition/about/pac-20384955.

**oropharynx.** The part of the pharynx that is below the soft palate and above the epiglottis and is continuous with the mouth.[65]

**palpation.** To examine by medical touch.[66]

**pandemic.** An outbreak of a disease that occurs over a wide geographic area (such as multiple countries or continents) and typically affects a significant proportion of the population.[67]

**pharynx.** The part of the digestive and respiratory tracts situated between the cavity of the mouth and the esophagus.[68]

**post-traumatic stress disorder.** "A mental health condition that's triggered by a terrifying event – either experiencing it or witnessing it."[69]

**refractory.** Resistant to treatment or cure. Unresponsive to stimulus.[70]

**renal cell carcinoma.** "The most common type of kidney cancer."[71]

**sputum.** Matter expectorated from the respiratory system and especially the lungs.[72]

**squamous cell carcinoma.** A carcinoma that is made up of or arises from squamous cells and usually occurs in areas of the body exposed to strong sunlight over many years.[73]

**submandibular.** Of, relating to, situated, or performed in the region below the lower jaw.[74]

**tracheostomy.** The surgical formation of an opening into the trachea through the neck to allow the passage of air.[75]

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[65] Merriam-Webster, "Oropharynx," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/oropharynx.

[66] Merriam-Webster, "Palpation," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/palpation.

[67] Merriam-Webster, "Pandemic," accessed May 6, 2021, https://www.merriam-webster.com/dictionary/pandemic.

[68] Merriam-Webster, "Pharynx," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/pharynx.

[69] Mayo Clinic, "Post-traumatic stress disorder (PTSD)," accessed April 12, 2021, https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967.

[70] Merriam-Webster, "Refractory," accessed April 12, 2021, https://www.merriam-webster.com/dictionary/refractory.

[71] Mayo Clinic, "Kidney cancer," accessed April 12, 2021, https://www.mayoclinic.org/diseases-conditions/kidney-cancer/symptoms-causes/syc-20352664.

[72] Merriam-Webster, "Sputum," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/sputum.

[73] Merriam-Webster, "Squamous cell carcinoma," assessed April 14, 2021, https://www.merriam-webster.com/dictionary/squamous%20cell%20carcinoma.

[74] Merriam-Webster, "Submandibular," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/submandibular.

[75] Merriam-Webster, "Tracheostomy," accessed April 13, 2021, https://www.merriam-webster.com/dictionary/tracheostomy.

**urinary obstruction.** "A blockage in one or both of the tubes (ureters) that carry urine from [the] kidneys to [the] bladder."[76]

**urinary tract infection.** "An infection in any part of [the] urinary system – [the] kidneys, ureters, bladder and urethra."[77]

[76] Mayo Clinic, "Ureteral obstruction," accessed April 12, 2021, https://www.mayoclinic.org/diseases-conditions/ureteral-obstruction/symptoms-causes/syc-20354676.

[77] Mayo Clinic, "Urinary tract infection (UTI)," accessed April 12, 2021, https://www.mayoclinic.org/diseases-conditions/urinary-tract-infection/symptoms-causes/syc-20353447.

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