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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inconsistent Implementation of VHA Oncology Program Requirements Due to Insufficient Oversight

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Executive Summary

The VA Office of Inspector General (OIG) conducted a national review to examine the infrastructure and oversight of Veterans Health Administration (VHA) oncology programs.[1] Recent findings from the OIG's Office of Healthcare Inspections reports identified concerns regarding cancer care that negatively affected patient outcomes, including the lack of oncology program infrastructure and oversight, which VHA deems fundamental to high quality care (see appendix A).[2]

In the United States it was estimated that over two million people would be newly diagnosed with cancer in 2025.[3] Due to the aging population, cancer incidence is expected to increase to 2.29 million annual cases by 2050 and is the second leading cause of death for veterans and non-veterans alike.[4] Among veterans, about 50,000 new cases of invasive cancer occur each year.[5]

High quality cancer care is complex and requires a multidisciplinary approach. VHA policy defines the infrastructure and oversight needed at the national, Veterans Integrated Service Network (VISN), and facility levels to accomplish quality care.

Review Results

The OIG found inconsistent implementation of VHA requirements for oncology programs. Not all VISNs had an established multidisciplinary cancer committee, and VISN staff had not submitted an inventory of oncology services or facility points of contact within the last year to the National Oncology Program Office.

Additionally, not all facilities had an established cancer committee or partnered with another facility or VISN to provide the required committee functions. About 66 percent of facilities had either established their own facility cancer committee or fulfilled the function of a facility cancer

[1] Oncology is a branch of medicine concerned with the prevention, diagnosis, treatment, and study of cancer. M*erriam-Webster.com Dictionary*, "oncology," accessed February 26, 2025, https://www.merriam-webster.com/dictionary/oncology.

[2] VHA Directive 1415, *VHA Oncology Program,* April 9, 2020; VHA Directive 1217(1), *VHA Operating Units*, August 14, 2024, amended January 19, 2025; Underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[3] Rebecca L. Siegel, et al., "Cancer Statistics, 2025*," CA: A Cancer Journal for Clinicians,* 75, no. 1 (January 2025): 10-45, https://doi.org/10.3322/caac.21871.

[4] Armaan Ahmed, Jennifer Whittington, and Zahra Shafaee, "Impact of Commission on Cancer accreditation on cancer survival: A surveillance, epidemiology, and end results (SEER) database analysis," *Annals of Surgical Oncology* 31: (2024) 2286–2294, https://doi.org/10.1245/s10434-023-14709-4; VHA Directive 1415; "Leading Causes of Death," Centers for Disease Control and Prevention (CDC), accessed March 5, 2025, https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm.

[5] VHA Directive 1415; "About the National Oncology Program (NOP)," VHA National Oncology Program, accessed January 14, 2025, https://dvagov.sharepoint.com/sites/vhanop. (This website is not publicly accessible.)

committee through another facility or the VISN. Most level 1 complexity facilities had established a facility cancer committee.[6]

Further, the OIG learned that a majority of VISNs did not fully comply with the requirement for complexity level 1 and 2 facilities to pursue membership in the National Cancer Institute (NCI) National Clinical Trials Network (NCTN) or National Cancer Institute Community Oncology Research Program (NCORP).[7] VISN directors and staff reported barriers to participating in NCI-supported trials including a lack of resources such as staffing, leadership support, pharmacy services, and infrastructure.

The VA Cancer Registry System allows for monitoring trends and populations and evaluating the strength and quality of cancer programs. A 2024 OIG report found that cancer registries were not being maintained as required, and the recommendation to address the failure remains open.[8]

The OIG found a lack of oversight contributed to inconsistent implementation of oncology program requirements. The National Specialty Care Program Office's oversight of National Oncology Program implementation was insufficient to coordinate consistent implementation of program requirements. National Specialty Care Program Office leaders reported most programs under their purview do not conduct compliance audits and cited the burden of collecting necessary data as a barrier.

Further, National Oncology Program Office oversight of VISN and facility oncology program implementation was limited, and the National Oncology Program Office lacked the data to provide effective oversight. The OIG learned that a lack of resources is a barrier to oversight. The National Program Director for Oncology described not having permission to hire into vacant critical positions and a lack of sufficient resources and support, particularly human resources support. In addition, the National Program Director for Oncology stated that funding limitations contribute to difficulty completing work and that VISNs were struggling as a result.

[6] VHA Directive 1415; VHA Office of Productivity, Efficiency, and Staffing (OPES), "Data Definitions: VHA Facility Complexity Model," October 1, 2023. VHA facilities are classified at levels 1a, 1b, 1c, 2, or 3. Level "1a facilities are the most complex and level 3 facilities are the least complex."

[7] National Cancer Institute (NCI), "The National Institutes of Health," accessed March 18, 2024, https://www.cancer.gov/research/infrastructure/clinical-trials/nctn#:~:text=NCI%27s%20National%20Clinical%20Trials%20Network%20(NCTN)%20is%20a%20collection%20of,States%2C%20Canada%2C%20and%20internationally; The NCI is an agency in the National Institutes of Health and the federal government's primary agency for cancer research and training. The NCTN is a group of organizations and clinicians that coordinates and supports clinical trials and "provides the infrastructure for NCI-funded treatments … to improve the lives of people with cancer." The NCORP is a national network that works closely with NCTN and conducts clinical trials in patients' own communities for increased access. About 30–35 percent of patients enrolled in NCTN clinical trials are from NCORP sites.

[8] VA OIG, *Comprehensive Healthcare Inspection Program and Care in the Community Report: Mammography Services and Breast Cancer Care*, Report 23-00540-146, April 24, 2024.

Similar to the oversight responsibilities of program offices, VISNs are responsible for overseeing consistent and coordinated implementation of programs such as cancer care at VA medical facilities. VISN leaders and staff had inconsistent awareness of oncology program requirements, and not all VISN leaders were aware if facilities had established a facility multidisciplinary cancer committee as required. When discussing barriers to VISN oversight, some VISN and National Program Office leaders reported the VISNs lacked sufficient resources to fully ensure compliance with program requirements.

The OIG made five recommendations to the Under Secretary for Health related to VISN- and facility-level multidisciplinary cancer committees, annual VISN submissions of an inventory of oncology services and facility points of contact to the National Oncology Program Office, facility pursuit of membership in the NCI NCTN or NCORP, and a review of oncology-related program offices to ensure the required oversight of VISN and facility oncology programs.

VA Comments and OIG Response

The Under Secretary for Health concurred with the recommendations and provided acceptable action plans (see appendix B). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

GAO	Government Accountability Office
OIG	Office of Inspector General
NCI	National Cancer Institute
NCORP	National Cancer Institute Community Oncology Research Program
NCTN	National Clinical Trials Network
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a national review to examine the infrastructure and oversight of Veterans Health Administration (VHA) oncology programs.[1] Recent report findings from OIG's Office of Healthcare Inspections identified concerns regarding cancer care that negatively affected patient outcomes, including the lack of oncology program infrastructure and oversight, which VHA deems fundamental to high quality care (see appendix A).[2]

This OIG report focuses on infrastructure requirements and oversight responsibilities for implementing VHA's oncology programs. The report provides timely oversight, and shares identified concerns to facilitate VHA action.

Background

High quality cancer care is complex and requires a multidisciplinary approach. The care of patients with cancer begins with diagnosis and staging, followed by the appropriate treatment such as surgery, radiation, chemotherapy, and supportive care.[3]

In the United States it was estimated that over two million people would be newly diagnosed with cancer in 2025.[4] Cancer is the second leading cause of death for veterans and non-veterans alike. Among veterans, about 50,000 new cases of invasive cancer occur each year, and due to the aging population, cancer incidence is expected to increase in the US to 2.29 million annual

[1] Oncology is a branch of medicine concerned with the prevention, diagnosis, treatment, and study of cancer. *Merriam-Webster.com Dictionary*, "oncology," accessed February 26, 2025, https://www.merriam-webster.com/dictionary/oncology.

[2] VHA Directive 1415, *VHA Oncology Program,* April 9, 2020; VHA Directive 1217, *VHA Operating Units*, August 14, 2024; VHA Directive 1217(1), *VHA Operating Units*, August 14, 2024, amended January 18, 2025. Underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[3] The stage of a cancer refers to the extent of the cancer, including where the tumor is located in the body, the size of the tumor, and whether the cancer has spread to nearby lymph nodes or a different part of the body. "Cancer Staging," National Cancer Institute, accessed April 21, 2025, https://www.cancer.gov/about-cancer/diagnosis-staging/staging.

[4] Rebecca L. Siegel, et al., "Cancer Statistics, 2025," *CA: A Cancer Journal for Clinicians,* 75, no. 1 (January 2025): 10-45, https://doi.org/10.3322/caac.21871.

cases by 2050.[5] Prostate cancer is the most commonly diagnosed cancer within VA, with about 15,000 veterans diagnosed annually; lung cancer is the deadliest, claiming the lives of about 5,000 veterans each year.[6]

Oversight

In 2015, VA was added to the Government Accountability Office's (GAO's) High-Risk list with one area of concern being that VA's oversight activities were not always sufficient to ensure facilities' compliance with applicable requirements and, thus, not able to ensure timely, safe, cost-effective, quality care.[7] The GAO recently determined that VA lacks a clear plan with performance measures to assess progress in the areas of oversight and accountability.[8]

VHA policies are issued by the Under Secretary for Health.[9] VHA's Deputy Under Secretary for Health, Chief of Staff, and Chief Operating Officer are responsible for providing oversight and guidance for subordinate operating units including VHA programs and Veterans Integrated Service Networks (VISNs).[10] VHA principal offices, such as the Assistant Under Secretary for Health for Clinical Services, oversee and manage multiple subordinate program offices, such as the National Specialty Care Program Office and National Oncology Program Office.[11] Principal offices have a responsibility for "ensuring oversight of national programs and operations … within their span of control."[12] VHA program offices are responsible for developing related national policies, providing systematic oversight of the programs within their span of control, coordinating with VISNs in overseeing consistent implementation of those programs, and

[5] "Leading causes of death among veterans in the United States from 2020 to 2022," Statista, accessed May 21, 2025, https://www.statista.com/statistics/1367468/us-leading-causes-of-death-among-veterans/. Invasive cancer is cancer that has spread beyond its source and into surrounding, healthy tissues. National Cancer Institute, "invasive cancer," accessed April 2, 2025, https://www.cancer.gov/publications/dictionaries/cancer-terms/def/invasive-cancer; VHA Directive 1415; "About the National Oncology Program (NOP)," VHA National Oncology Program, accessed January 14, 2025, https://dvagov.sharepoint.com/sites/vhanop.(This website is not publicly accessible); Armaan Ahmed, Jennifer Whittington, and Zahra Shafaee, "Impact of Commission on Cancer accreditation on cancer survival: A surveillance, epidemiology, and end results (SEER) database analysis," *Annals of Surgical Oncology* 31: (2024) 2286–2294, https://doi.org/10.1245/s10434-023-14709-4; "Leading Causes of Death," Centers for Disease Control and Prevention (CDC), accessed March 5, 2025, https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm.

[6] "Prostate Cancer Care at VA," VHA National Oncology Program, accessed April 2, 2025, https://www.cancer.va.gov/prostate.html#:~:text=Every%20year%2C%20approximately%2015%2C000%20Veterans,effective%20prostate%20cancer%20care%20possible; "About the National Oncology Program (NOP)", VHA National Oncology Program.

[7] GAO, *High-Risk Series, An Update*, GAO-15-290, February 2015.

[8] GAO, *High Risk Series, Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness,* GAO-25-1-7743, February 2025.

[9] VHA Directive 1217.

[10] VHA Directive 1217.

[11] VHA Directive 1217.

[12] VHA Directive 1217.

documenting and reporting deficiencies in implementation. VISN directors are responsible for overseeing consistent and coordinated implementation of programs, such as cancer care, at VA medical facilities, while also "systematically identifying risks and unintended variances." VISN directors should document and report identified risks and variances to program offices and establish corrective action plans when appropriate.[13]

VHA Cancer Care Infrastructure and Oversight

Although VHA is the largest integrated healthcare system in the United States, that does not guarantee that the same level of care is available at each facility due to the varying availability of cancer specialists.[14] Some patients are diagnosed, staged, and treated for cancer by providers at one VA medical facility, while others may be treated at multiple VA medical facilities or in the community and require comprehensive coordination.[15] VHA policy defines the infrastructure and oversight needed at the national, VISN, and facility levels to accomplish quality care in areas such as screening, diagnosis, treatment, coordination, clinical research, and palliative and end-of-life care.[16]

National Oncology Program Office

A goal of the VHA National Oncology Program is to provide comparable care to all veterans no matter where they live. VHA requires its National Oncology Program to ensure high quality cancer care that aligns with the national standard of practice.[17] According to the GAO, health care must be timely, cost-effective, safe, and of high quality.[18]

The National Oncology Program Office provides multiple resources to support cancer care at VHA facilities nationwide, including subject matter expertise. Responsibilities of this office include the development of clinical pathways for cancer care, assistance with cancer registries,

[13] VHA Directive 1217.

[14] "About VHA," Veterans Health Administration, accessed February 20, 2025, https://www.va.gov/health/aboutVHA.asp; "Patient Care Elements of the National Oncology Program," VHA National Oncology Program, accessed June 4, 2024, https://dvagov.sharepoint.com/:w:/r/sites/vhanop/_layouts/15/Doc.aspx?sourcedoc=%7B9E5AAB1F-A8E0-430D-9C4C-A8C2965DEF88%7D&file=PatientCareElements_20190731.docx&action=default&mobileredirect=true&DefaultItemOpen=1. (This website is not publicly accessible.)

[15] "Patient Care Elements of the National Oncology Program," VHA National Oncology Program; Kristina M. Cordasco, et al., "Improving Care Coordination for Veterans Within VA and Across Healthcare Systems," *Journal of General Internal Medicine,* 34 (May 16, 2019): 1-3, https://doi.org/10.1007/s11606-019-04999-4.

[16] VHA Directive 1415; VHA, "Veterans Integrated Services Networks (VISNs)," accessed February 25, 2025, https://www.va.gov/health/visns.asp. VHA groups all its facilities into one of 18 VISNs.

[17] VHA Directive 1415.

[18] GAO, *High-Risk Series, An Update*.

teleoncology, and development of programs such as "Close to Me" to bring chemotherapy treatment to rural veterans.[19]

Staff from the National Oncology Program Office work with VISN directors who oversee the performance of facilities within each VISN.[20] Each VISN is led by a VISN Director who provides operational oversight of the facilities within the VISN.[21]

Prior OIG Reports

During the review period of June 1, 2022, through December 31, 2024, the OIG published 11 reports concerning cancer care; 3 of these reports highlighted deficiencies in cancer care oversight (see appendix A). The OIG made 14 recommendations in the 3 reports, 11 of which have been closed as of May 21, 2025.

[19] Teleoncology is using information and communication technology to deliver "clinical oncology services from a distance for diagnosis, treatment, and patient follow-up." Grosbeck Parham et al., "Teleoncology," chap. 23 in *Breast Cancer: Global Quality Care*, eds. Didier Verhoeven, Cary Kaufman, Robert Mansel, and Sabine Siesling (Oxford: Oxford Academic, 2019), 259-266, https://doi.org/10.1093/med/9780198839248.003.0023.

[20] VHA Directive 1217.

[21] VHA Directive 1217.

Scope and Methodology

The OIG initiated this review on June 13, 2024, to evaluate select components of VHA's oncology program, focusing on infrastructure and oversight at the national, VISN, and facility levels.

The OIG reviewed documentation relevant to VHA oncology programs and oversight including policies and guidance, waivers of policy requirements, and committee minutes.

Questionnaire Development and Distribution

The OIG developed VISN and facility questionnaires to gather information about select required oncology program components. The VISN questionnaire consisted of five questions addressing multidisciplinary cancer committees, clinical cancer trials, oncology service inventories, and available points of contact. The OIG distributed the VISN questionnaire to VISN chief medical officers beginning August 8, 2024, collected supporting documentation, and confirmed receipt of responses from all 18 VISNs by August 26, 2024.[22]

The facility questionnaire focused on topics related to oncology program requirements including clinical cancer trials, accreditation, cancer committees, the cancer registry, and tumor boards.[23] The OIG distributed the facility questionnaire to 139 VHA-identified facility points of contact beginning on August 5, 2024, and confirmed receipt of responses from all 139 facilities on September 4, 2024.[24] To verify committee activity of facilities that reported having a cancer committee, the OIG requested minutes from the prior year and received committee minutes from most facilities.

Questionnaire Analysis

The OIG analyzed questionnaire responses by calculating the frequency of multiple-choice responses to questions to determine respondents' perspectives on select aspects of VISN and facility cancer program components. The OIG also reviewed free-text responses associated with select questions to further understand respondents' perspectives and responses to multiple choice

[22] One VISN did not submit a completed questionnaire but provided documentation responsive to the request and clarification to the OIG during an interview.

[23] Tumor boards are forums where providers within the VA can present patient cases for discussion to a multidisciplinary team to develop a comprehensive treatment plan. "Introduction to VA National Teleoncology Virtual Tumor Boards," VHA National Oncology Program, https://dvagov.sharepoint.com/sites/vhanto/vtb/SitePages/Home.aspx. (This website is not publicly accessible.)

[24] The VA Manila Outpatient Clinic in Pasay City, Philippines, was excluded due to its unique status as the only VA healthcare facility located in a foreign country. Services available to service-connected veterans are limited. Services and costs related to the treatment of non-service-connected disabilities are the veteran's responsibility.

answers. The OIG validated the responses to the questions related to cancer committees but did not independently verify VHA data for accuracy or completeness.

Interviews

The OIG conducted virtual interviews with staff from all 18 VISNs, including chief medical officers, cancer committee chairpersons, and relevant support staff from all 18 VISNs to clarify questionnaire responses and to better understand VISN and facility oncology program components. The OIG also conducted virtual interviews with leaders from the Specialty Care Program Office (Chief Officer of Specialty Care Services, Acting Deputy Chief Officer, and Director of Specialty Care Program Operations) and National Oncology Program Office (National Executive Director for Oncology, National Data Program Manager, and National Oncology Program Oncology Data Program Specialist), and the Chief Medical Officer of National Teleoncology to better understand national oncology program components.

Authorities

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

Review Results

Inconsistent Implementation of VHA Requirements for Oncology Programs

Caring for patients with cancer is complex and requires a multidisciplinary approach.[25] To ensure the delivery of quality cancer care to patients across the country, regardless of where they live, VHA has delineated a variety of requirements.[26] The OIG found inconsistent implementation of VHA requirements for the oncology program. Specifically, VISNs did not consistently maintain VISN-level cancer committees or communicate their inventories of oncology services and points of contact to the National Program Office. Additionally, facilities did not all stand-up cancer committees, ensure access to clinical trials, or consistently update the VA cancer registry.

Veterans Integrated Service Network Cancer Committee

VHA requires VISN directors to establish a VISN-level multidisciplinary cancer committee to coordinate and regionalize the provision of cancer services throughout their respective networks.[27]

Through the review of VISN questionnaire responses, the OIG determined 6 of 18 VISNs (33 percent) did not have an active multidisciplinary cancer committee as required. Based on questionnaire responses and interviews with VISN leaders and staff, the OIG learned that those 6 VISNs had either initiated (but were not yet active) or planned to initiate (still in the planning stages), a VISN cancer committee. One of the reasons shared for not having an established VISN-level cancer committee was unawareness of the requirement. Some VISN staff stated that the directive was issued during the COVID-19 pandemic and subsequently overlooked due to competing priorities. Additionally, some VISN staff reported having a VISN-level oncology community of practice committee; however, the OIG found these committees were composed solely of medical oncologists and were not multidisciplinary as required.

VHA does not specify how a VISN cancer committee should function to meet its purpose; consistent with this flexibility, the OIG learned through interviews with VISN leaders that the methods used by the VISN cancer committees to coordinate and regionalize cancer care varied. Another factor, likely affecting coordination of care, is the fact that the complexity level of facilities within and across VISNs varies. Through interviews, the OIG found one example involving a VISN that consisted of all level 1 complexity facilities that can provide a wide range

[25] American College of Surgeons, *Optimal Resources for Cancer Care e-edition*, 2020 Standards, January 2020, Updated December 2024, accessed May 28, 2025, https://www.facs.org/quality-programs/cancer-programs/commission-on-cancer/standards-and-resources/2020/access/.

[26] VHA Directive 1415.

[27] VHA Directive 1415.

of in-house cancer care services. The OIG surmised that this VISN, as compared to other VISNs consisting of complexity level 1–3 facilities, may not have to focus as much on the coordination of service between its facilities.[28]

Inventory of Oncology Services and Facility Point of Contact Lists

VHA requires that VISN directors review each of their facilities' lists of available oncological services and names of points of contact for cancer care and communicate the lists annually with the National Program Director for Oncology.[29] The OIG surmises that this information assists VISN staff with coordination of services.

The OIG found through review of electronic communication that none of the VISNs provided an inventory of oncology services or facility points of contact to the National Oncology Program Office within the year prior to the OIG review, as required. While staff at 15 of the 18 VISNs reported maintaining these lists, when asked why they did not supply required information the past year, VISN staff told the OIG that the National Oncology Program Office did not request the lists. However, the OIG learned through review of electronic communication that the National Oncology Program Office solicited information directly from the facilities between January and May 2023, and that facility staff directly provided information regarding available oncology services to the National Oncology Program Office.

Facility Cancer Committees

VHA requires that facility directors establish a facility-level multidisciplinary cancer committee to manage, assess, and plan the actions of the facility's cancer program.[30] Facilities that only diagnose or treat a small number of patients with cancer may partner with another facility or the VISN to fulfill the functions of the facility-level cancer committee, as required.[31]

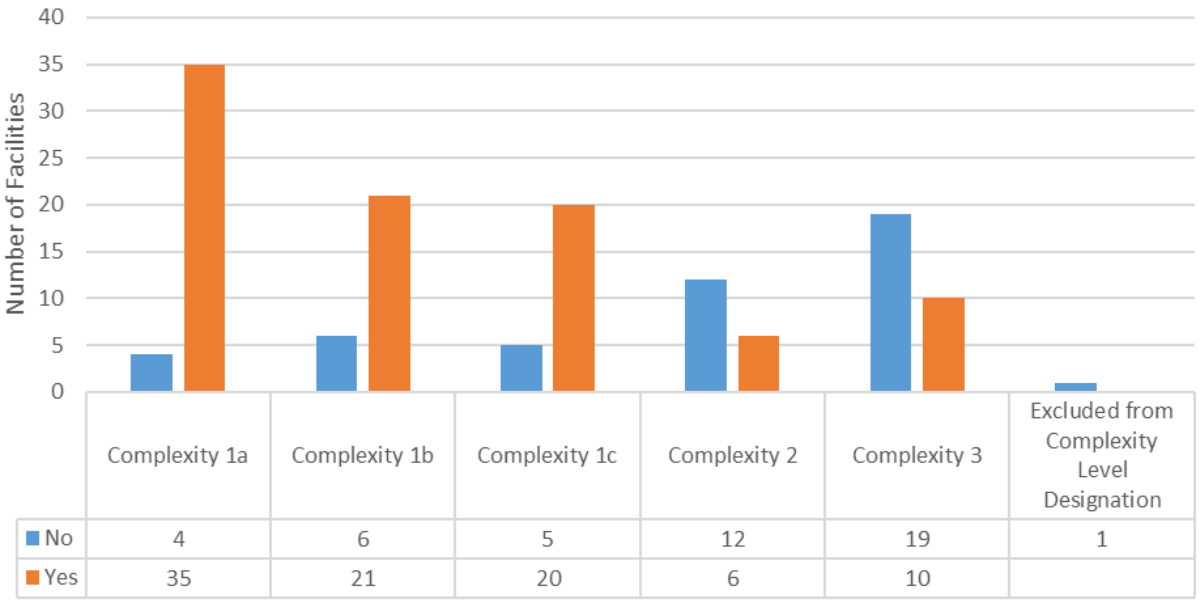
The OIG found that not all facilities established a cancer committee as required or partnered with another facility or VISN to provide the required committee functions. At the time of facility questionnaire submission to the OIG, 92 of the 139 facilities (66 percent) had either established their own facility cancer committee or fulfilled the function of a facility cancer committee through another facility or the VISN. The majority of level 1 complexity facilities had established a facility cancer committee (see figure 1).

[28] VHA Office of Productivity, Efficiency, and Staffing (OPES), "Data Definitions: VHA Facility Complexity Model," October 1, 2023. VHA facilities are classified at levels 1a, 1b, 1c, 2, or 3. Level "1a facilities are the most complex and the level 3 facilities are the least complex."

[29] VHA Directive 1415.

[30] VHA Directive 1415.

[31] VHA Directive 1415. VHA medical facility directors must request a time-limited exemption from establishing a formal process for cancer program activities.



	Complexity 1a	Complexity 1b	Complexity 1c	Complexity 2	Complexity 3	Excluded from Complexity Level Designation
No	4	6	5	12	19	1
Yes	35	21	20	6	10	

Figure 1: *Facilities, by complexity level, that established their own facility cancer committee or fulfilled the function of a facility cancer committee through another facility or the VISN, as of June 30, 2024.*
Source: OIG analysis of VHA's facilities' responses to the OIG's facility oncology program questionnaire.
Note: The Captain James A. Lovell Federal Health Care Center is excluded from VHA's facility complexity model because it is an integrated VA/Department of Defense health care center.

During interviews, several VISN staff reported their respective facilities had not established a cancer committee, as required, and were in the process of assisting these facilities to become compliant. VISN staff stated some of the reasons for noncompliance with the requirement were a lack of oncologists at a facility, or facilities not providing cancer care for patients. In addition, some VISN staff were unaware of the noncompliance but said they would investigate further.

Clinical Trials

Cancer clinical trials are research studies examining new modalities to treat cancer and improve quality of life for patients.[32] These clinical trials may focus on areas such as cancer prevention, screening, and treatment. Cancer clinical trials are essential for advancing treatment and provide innovative care to certain patients.[33]

Several organizations support patients and clinical trials. The National Cancer Institute (NCI) is part of the National Institutes of Health, and the federal government's primary agency for cancer

[32] VA National Oncology Program, "Clinical Trials Factsheet."

[33] Iranzu Monreal et al., "Understanding the Barriers to Clinical Trial Referral and Enrollment Among Oncology Providers Within the Veterans Health Administration," *Military Medicine,* 190, no. 3-4, (March/April 2025): 891-898, https://doi.org/10.1093/milmed/usae441; "Overcoming Barriers to Veteran Participation in Outside-VA Cancer Clinical Trials," US Medicine, accessed March 24, 2025, https://www.usmedicine.com/clinical-topics/oncology/overcoming-barriers-to-veteran-participation-in-outside-va-cancer-clinical-trials/.

research and training. The NCI National Clinical Trials Network (NCTN) is a group of organizations and clinicians that coordinates and supports clinical trials and "provides the infrastructure for NCI-funded treatment … to improve the lives of people with cancer."[34] The National Cancer Institute Community Oncology Research Program (NCORP) is a national network that conducts clinical trials in patients' own communities for increased access. The NCORP network works closely with NCTN. About 30–35 percent of patients enrolled in NCTN clinical trials are from NCORP sites.[35]

For complexity level 1 and 2 facilities, VISN directors must ensure membership in either the NCI NCTN or NCORP is pursued.[36] In addition, VISN directors are responsible for ensuring patients have access to NCI's sponsored clinical trials.[37] The VA medical facility director is responsible for maintaining an inventory of available oncology services and ensuring patients have access to clinical research trials.[38]

VHA and NCI developed a partnership program, the NCI and VA Interagency Group to Accelerate Trials Enrollment or NAVIGATE, to facilitate veterans with cancer enrolling in NCI-supported clinical trials. The goal of this partnership is to increase the number of facilities participating in NCI-supported cancer clinical trials and improve veteran access to NCI-supported cancer clinical trials.[39]

When appropriate, a VHA oncology provider should discuss the availability of clinical trials with each patient. If the patient is interested and eligible, the oncology provider should refer the patient to a clinical trial at the VHA facility or in the community. For patients receiving oncology care through community care, referral for clinical trials should be coordinated if the oncology provider determines clinical trial participation is the best option for the patient.

The OIG found that not all complexity level 1 and 2 facilities were compliant with membership or pursuit of membership in the NCI NCTN or NCORP. Additionally, through VISN interviews, the OIG learned that a majority of VISNs lacked full compliance with the requirement and less

[34] "NCTN: NCI's Clinical Trials Network," National Cancer Institute, accessed April 21, 2025 https://www.cancer.gov/research/infrastructure/clinical-trials/nctn#:~:text=NCI%27s%20National%20Clinical%20Trials%20Network%20(NCTN)%20is%20a%20collection%20of,States%2C%20Canada%2C%20and%20.

[35] "About NCORP," National Cancer Institute Community Oncology Research Program (NCORP), accessed January 7, 2025, https://ncorp.cancer.gov/about/.

[36] VHA Directive 1415; VHA Office of Productivity, Efficiency, and Staffing (OPES), "Data Definitions: VHA Facility Complexity Model." VHA facilities are classified at levels 1a, 1b, 1c, 2, or 3. Level "1a facilities are the most complex and the level 3 facilities are the least complex."

[37] VHA Directive 1415.

[38] VHA Directive 1415.

[39] "NAVIGATE: NCI and VA Interagency Group to Accelerate Trials Enrollment National Cancer Institute," National Cancer Institute, accessed March 18, 2025, https://www.cancer.gov/about-nci/organization/ccct/funding/navigate.

than half are monitoring facility participation in the NCI NCTN or NCORP, or have developed plans to initiate monitoring. One VISN leader reported planning to do an analysis of the requirements and the ability to achieve membership.

VISN directors and staff reported barriers to participating in NCI-supported trials including a lack of resources such as staffing, leadership support, pharmacy services, and infrastructure. Reported barriers also included patient distance to clinical trial sites, small patient populations, and noncompliance with completing cancer registries. The National Program Director for Oncology told the OIG that staff from the National Oncology Program Office reported working with the NCI to overcome barriers.

VA Cancer Registry System

VHA requires facility cancer registry staff to maintain a cancer registry that reports accurate cancer registry data electronically to the VA Cancer Registry System.[40] A cancer registrar is responsible for entering the data into the registry and ensuring the data entry is complete, timely, and accurate.[41]

The VA Cancer Registry System "is a data system used to monitor all types of cancer diagnosed or treated in VHA." The Registry contains information on each patient with cancer, including

- demographics,
- cancer identification,
- extent of disease and staging,
- first course of treatment,
- recurrence,
- subsequent treatments, and
- vital status.[42]

The registry allows for monitoring trends and populations and evaluating the strength and quality of cancer programs.[43] When staff enter data timely, leaders can generate local and national

[40] VHA Directive 1412 (1), *Department of Veterans Affairs Cancer Registry System,* May 29, 2019, amended April 7, 2020. This directive was in place during the review period for this report. It was rescinded and replaced by VHA Directive 1412, *Veterans Affairs Cancer Registry System*, November 15, 2024. Facilities that diagnose or treat a small number of patients with cancer may partner with another facility to provide cancer care services.

[41] VHA Directive 1412(1). Facilities that have a small number of patients receiving cancer treatment may partner with another facility to provide cancer registry services.

[42] VHA Directive 1415.

[43] VHA Directive 1412(1); VHA Directive 1415.

reports of cancer diagnoses and treatments and base patient care decisions on quality information.[44]

A 2024 OIG report found that cancer registries were not being maintained as required, and the recommendation to address this failure remains open.[45] Therefore, the OIG did not review data related to VA cancer registries as part of this report.

Lack of Oversight Contributed to Inconsistent Implementation of Oncology Program Requirements

National Specialty and Oncology Program Offices Oversight

VHA assigns oversight responsibilities to the various VHA operating units from the Deputy Under Secretary for Health down to facility directors.[46] The OIG focused this review on oversight responsibilities for national program offices and VISNs. The organizational and oversight structure as it applies to the national oncology program is illustrated in figure 2.

[44] VHA Directive 1412(1).

[45] VA OIG, *Comprehensive Healthcare Inspection Program and Care in the Community Report: Mammography Services and Breast Cancer Care*, Report 23-00540-146, April 24, 2024.

[46] VHA Directive 1217; VHA Directive 1217(1).

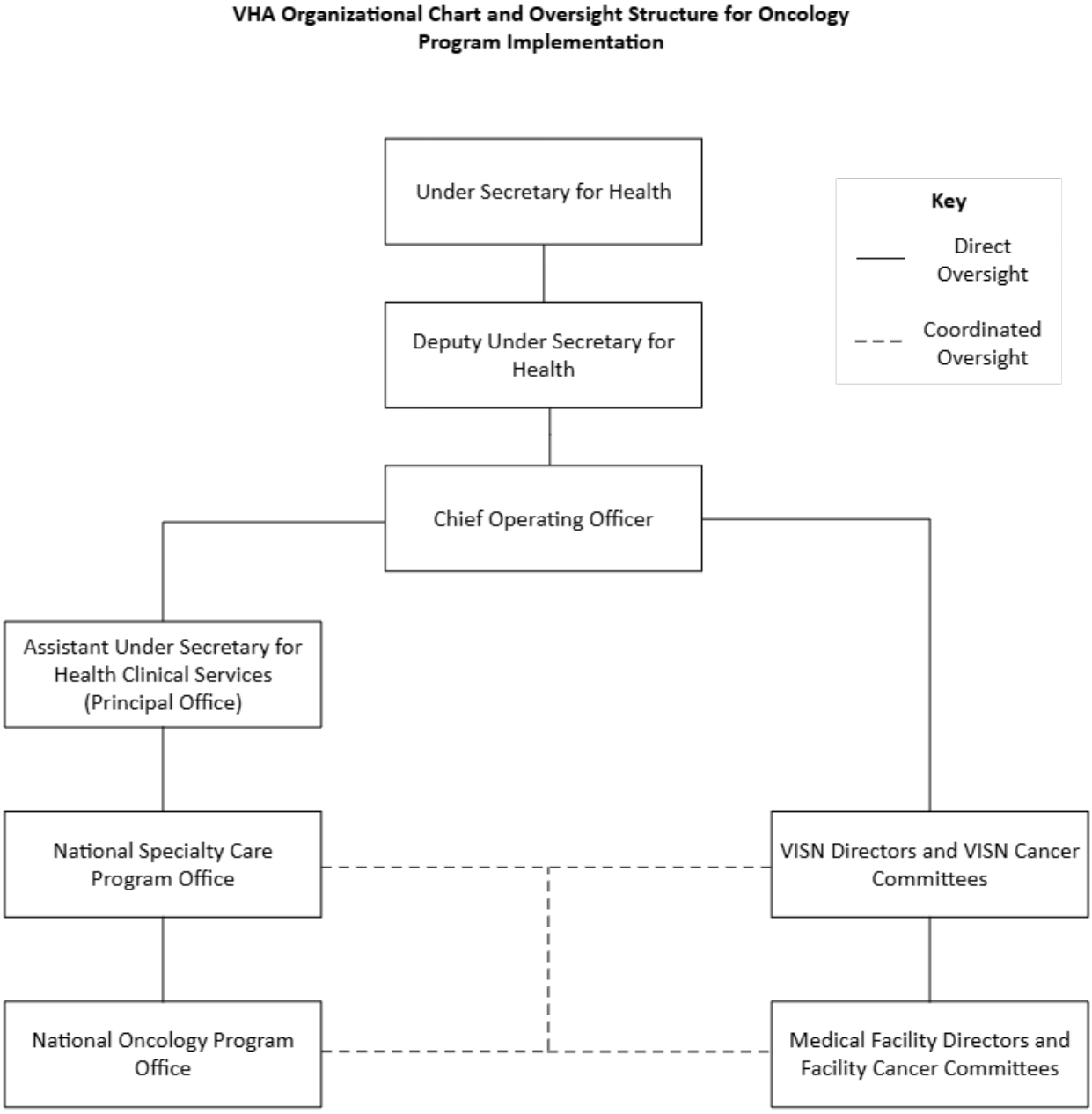


Figure 2. *VHA organizational chart and oversight structure for oncology program implementation.*
Source: OIG analysis of VHA documents and electronic communications.

VHA program offices, such as the National Specialty Care Program Office and National Oncology Program Office, are responsible for systematic oversight and resource allocation. In addition, the offices are responsible for managing quality, compliance, risk, and performance

within their span of control.[47] This includes reporting significant issues to the VHA principal offices, documenting identified deficiencies, and ensuring corrective actions are taken. Consistent implementation of national programs must be coordinated with VISNs.[48]

The National Oncology Program Office is a subordinate program office of the National Specialty Care Program Office. The National Program Director for Oncology is responsible for collaborating with other offices to establish goals for the oncology program, assessing progress toward the goals, and overseeing the management of the VA Cancer Registry System.[49]

The OIG found through an interview that National Specialty Care Program Office oversight of National Oncology Program implementation was insufficient to coordinate consistent implementation of program requirements. National Specialty Care Program Office leaders reported compliance audits are not conducted for most programs under their purview and cited the burden of collecting necessary data as a barrier. National Specialty Care Program Office leaders reported relying upon subordinate offices, such as the National Oncology Program Office, to elevate concerns related to program implementation, then evaluating the extent of the impact of noncompliance to plan remedial action. National Specialty Care Program Office leaders reported ongoing development of dashboards to support operational work and implementation of programs and policies by other stakeholders. They explained, however, that the dashboards only include a subset of requirements as identified by program and subordinate offices and were not intended to be comprehensive.

The OIG also found that National Oncology Program Office oversight of VISN and facility oncology program implementation was limited and that the National Oncology Program Office lacked the data to provide required oversight.[50] The OIG learned through review of documents and from an interview with the National Oncology Program Office leaders that the National Oncology Program Office has surveyed VHA facilities about cancer care services and oncology program infrastructure every seven years since 2009. When speaking with the leaders from the National Oncology Program Office, the OIG learned that the most recent survey, conducted in 2023, failed to provide the data for an evaluation of the current state of VHA oncology programs. The National Oncology Program leaders told the OIG of deciding not to use the data for a report because they found the survey was "flawed" and the data "problematic" and incomplete because not all facilities responded.

[47] VHA Directive 1217. Program offices are the main operating units at VHA Central Office and coordinate with VISN directors to oversee the performance of facilities within each VISN.

[48] VHA Directive 1217. VHA Principal Offices are led by a single Senior Executive and oversee, resource, and manage multiple program offices. These offices have broad spans of control to ensure program outcomes are organized and aligned within a comprehensive strategy.

[49] VHA Directive 1415; VA Functional Organizational Manual, Version 8, Volume: 1 of 2: Administrations, 2023.

[50] VHA Directive 1217.

The OIG found that the National Oncology Program Office did not provide proactive oversight to ensure the establishment of VISN cancer committees. The National Program Director for Oncology told the OIG, "I think there's been various levels of awareness." The OIG also found that the National Oncology Program Office's actions related to clinical research trial access and participation were supportive but did not monitor facilities' compliance.

The OIG learned during an interview that the National Oncology Program Office provided oversight of the cancer registry as required.[51] Leaders from one VISN told the OIG of National Oncology Program Office oversight activities, including hosting quarterly meetings attended by facilities where the facilities report on their cancer registry status and obtain support. The National Program Director for Oncology reported to the OIG of identifying barriers to maintaining up-to-date registries and collaborating with facilities to improve compliance as required.

The OIG learned that a lack of resources is a barrier to oversight. The National Program Director for Oncology described not having permission to hire into vacant critical positions and a lack of sufficient resources and support, particularly human resources support. In addition, the National Program Director for Oncology also stated that funding limitations contribute to difficulty completing work and that VISNs were struggling as a result.

The OIG concluded that proactive oversight may increase the National Oncology Program Office's awareness of VISNs' compliance with requirements for cancer committees and access to clinical trials, and barriers that prevent the VISNs from meeting requirements and enable the National Oncology Program Office to intervene more effectively to address the challenges faced when providing care.

VISN Oversight

Similar to the oversight responsibilities of program offices, VISNs are responsible for overseeing consistent and coordinated implementation of programs, such as cancer care, at VA medical facilities.[52] VISNs must identify, document, and report risks and unintended variances to program offices and establish corrective action plans when appropriate.[53] VISNs and facilities may submit a waiver request to the relevant program office to request an exemption from policy requirements, and program offices grant or deny these requests as warranted.[54]

VISNs are responsible for oversight and management of the facilities within their network.[55] Oversight includes evaluating the performance of facilities and programs within their span of

[51] VHA Directive 1415.
[52] VHA Directive 1217.
[53] VHA Directive 1217.
[54] VHA Directive 1217.
[55] VHA Directive 1217.

control and assessing the effectiveness of outcomes.[56] Despite VHA having an oncology program directive in place since 2020, the OIG found that VISN leaders and staff had inconsistent awareness of oncology program requirements.

Further, the OIG found that not all VISN leaders were aware whether facilities had established facility-level multidisciplinary cancer committees as required.[57] The OIG found that leaders and staff at some VISNs with newly established VISN cancer committees were not aware of the status of facilities' cancer committees. One VISN CMO stated, "I think several of our facilities do not have committees that I need to address." Another shared, "I wasn't aware of that. So, we'll have to look at that."

The OIG also found that VISN oversight of facilities' membership in the NCI NCTN or NCORP was insufficient in that only less than half were fully compliant with having the required membership. Additionally, staff across all VISNs were aware of registry issues, including the currency of data and availability of cancer registrars, and had varying degrees of involvement in resolving the issues.

When discussing barriers to VISN oversight, some VISN and National Program Office leaders reported that VISNs lacked sufficient resources to fully ensure compliance with program requirements. The OIG opines that VISN and National Oncology Program Office leaders' further oversight and assistance with mitigating barriers to facilities participating in clinical trials would afford patients' access to innovative treatments when indicated.

Conclusion

The OIG conducted a national review to examine the infrastructure and oversight of VHA oncology programs.

High quality cancer care is complex and requires a multidisciplinary approach. VHA policy defines the infrastructure and oversight needed at the national, VISN, and facility levels to accomplish quality care.

The OIG found inconsistent implementation of VHA requirements for oncology programs. Not all VISNs had an established multidisciplinary cancer committee, and VISN staff had not submitted an inventory of oncology services or facility points of contact within the last year to the National Oncology Program Office. Further, the OIG learned that a majority of VISNs lacked full compliance with the requirement for complexity level 1 and 2 facilities to pursue or have membership in the NCI NCTN or NCORP.

[56] VHA Directive 1217.

[57] VHA Directive 1415.

Not all facilities had an established cancer committee or partnered with another facility or VISN to provide the required committee functions. About 66 percent of facilities had either established their facility cancer committee or were having the function of a facility cancer committee fulfilled through another facility or the VISN. However, most level 1 complexity facilities had established a facility cancer committee.

The VA Cancer Registry System allows for monitoring trends and populations and evaluating the strength and quality of cancer programs. A 2024 OIG report found that cancer registries were not being maintained as required, and the recommendation to address the failure remains open.

The OIG also found a lack of oversight contributed to inconsistent implementation of oncology program requirements. The National Specialty Care Program Office's oversight of National Oncology Program implementation was insufficient to coordinate consistent implementation of program requirements. Further, National Oncology Program Office oversight of VISN and facility oncology program implementation was limited, and the National Oncology Program Office lacked the data to provide effective oversight.

Similar to the oversight responsibilities of program offices, VISNs are responsible for overseeing consistent and coordinated implementation of programs such as cancer care at VA medical facilities. VISN leaders and staff had inconsistent awareness of oncology program requirements, and not all VISN leaders were aware if facilities had established required facility multidisciplinary cancer committees.

The OIG made five recommendations to the Under Secretary for Health.

Recommendations 1–5

1. The Under Secretary for Health ensures the establishment of Veterans Integrated Service Network-level multidisciplinary cancer committees.

2. The Under Secretary for Health ensures Veterans Integrated Service Network staff submit an inventory of available oncology services and facility points of contact to the National Oncology Program Office annually.

3. The Under Secretary for Health ensures complexity level 1 and 2 facilities pursue membership in the National Cancer Institute's National Clinical Trial Network or the National Cancer Institute Community Oncology Research Program.

4. The Under Secretary for Health ensures the establishment of facility-level multidisciplinary cancer committees, or partnering with another facility or Veterans Integrated Service Network to provide the required committee functions.

5. The Under Secretary for Health reviews the operations of oncology-related program offices to ensure the required oversight of Veterans Integrated Service Network and facility oncology program implementation.

Appendix A: Prior OIG Reports

Healthcare Inspections Report	Publication Date
Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia, Report 21-03349-186	June 28, 2022
Community Care Coordination Delays for a Patient with Oral Cancer at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, Report 21-02326-233	September 12, 2022
Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center in Shreveport, Louisiana, Report 21-02612-53	February 1, 2023
Inadequate Coordination of Care for a Patient at the West Palm Beach VA Healthcare System in Florida, Report 22-01594-86	March 30, 2023
Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia, Report 22-02800-225	September 29, 2023
Improvements Needed in Lung Cancer Screening Through Use of Community Care, Report 22-00416-10	October 31, 2023
Deficiencies in Quality Management Processes and Delays in the Communication of Test Results and Follow-Up Care at the Phoenix VA Health Care System in Arizona, Report 22-03599-07	October 31, 2023
Delayed Receipt of Patients' Colorectal Cancer Screening Tests at the Phoenix VA Health Care System in Arizona, Report 23-00383-21	November 14, 2023
Delay of a Patient's Prostate Cancer Diagnosis, Failure to Ensure Quality Urologic Care, and Concerns with Lung Cancer Screening at the Central Texas Veterans Health Care System in Temple, Report 22-04131-49	January 18, 2024
Comprehensive Healthcare Inspection Program and Care in the Community Report: Mammography Services and Breast Cancer Care, Report 23-00540-146	April 24, 2024
Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo, Report 23-03679-262	September 27, 2024

Source: OIG analysis of prior OIG publications to identify concerns regarding cancer care.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: July 11, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Inconsistent Implementation of VHA Oncology Program Requirements Due to Insufficient Oversight (VIEWS 13327710)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the OIG's draft report. The Veterans Health Administration (VHA) concurs with the recommendations made to the Under Secretary for Health and provides an action plan in the attachment.

2. VHA appreciates the work performed by the OIG. VHA's National Oncology Program provides robust support to cancer care and collaborates closely with Veterans Integrated Service Networks (VISNs) to oversee facilities. While we have successfully established multidisciplinary cancer committees at most level 1 complexity facilities, work continues to bring level 2 and 3 complexity facilities into compliance and to ensure that multidisciplinary cancer committees are established at the VISN level.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vha10oicgoalaction@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on July 11, 2025.]

Office of the Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report - Inconsistent Implementation of the Veterans Health Administration Oncology Program Requirements due to Insufficient Oversight (2024-01618-HI-1436)

Recommendation 1: The Under Secretary for Health ensures the establishment of Veterans Integrated Service Network-level multidisciplinary cancer committees.

VHA Comments: Concur. The Veterans Health Administration (VHA) requested a report from the Veterans Integrated Service Networks (VISN) on aspects of oncology care including VISN cancer committees via the Chief Operating Officer's office. VHA will finalize a monitoring plan based on this report to ensure the establishment of VISN-level multidisciplinary cancer committees. Documentation supporting this response will be reviewed and validated by the National Oncology Program.

Status: In-Progress **Target Completion Date:** February 2026

Recommendation 2: The Under Secretary for Health ensures Veterans Integrated Service Network staff submit an inventory of available oncology services and facility points of contact to the National Oncology Program Office annually.

VHA Comments: Concur. VHA requested a report from the VISNs on aspects of oncology care via the Chief Operating Officer's office. VHA will finalize a monitoring plan based on this report to ensure an inventory of oncology services and facility points of contact are submitted consistent with VHA policy. Documentation supporting this response will be reviewed and validated by the National Oncology Program.

Status: In-Progress **Target Completion Date:** February 2026

Recommendation 3: The Under Secretary for Health ensures complexity level 1 and 2 facilities pursue membership in the National Cancer Institute's National Clinical Trial Network or the National Cancer Institute Community Oncology Research Program.

VHA Comments: Concur. VHA requested a report from the VISNs on aspects of oncology care via the Chief Operating Officer's office. VHA will finalize a monitoring plan based on this report to ensure complexity level 1 and 2 facilities pursue membership in the National Cancer Institute's National Clinical Trial Network or the National Cancer Institute Community Oncology Research Program, consistent with VHA policy. Documentation supporting this response will be reviewed and validated by the National Oncology Program.

Status: In-Progress **Target Completion Date:** February 2026

Recommendation 4: The Under Secretary for Health ensures the establishment of facility-level multidisciplinary cancer committees, or partnering with another

facility or Veterans Integrated Service Network to provide the required committee functions.

VHA Comments: Concur. VHA requested a report from the VISNs on aspects of oncology care via the Chief Operating Officer's office. VHA will finalize a monitoring plan based on this report to ensure facility level multidisciplinary cancer committee requirements are met. Documentation supporting this response will be reviewed and validated by the National Oncology Program.

Status: In-progress **Target Completion Date:** February 2026

Recommendation 5: The Under Secretary for Health reviews the operations of oncology-related program offices to ensure the required oversight of Veterans Integrated Service Network and facility oncology program implementation.

VHA Comments: Concur. VHA completed an operational review of its oncology programs and is implementing measures to ensure ongoing appropriate oversight and engagement of stakeholders at all levels of the organization. A representative of the National Oncology Program will attend at least one VISN Cancer Committee meeting for each VISN over the next year to ensure that VISN Cancer Committees have a clear understanding of requirements, including the roles of VISN and Facility level Cancer Committees. Additionally, the National Oncology Program will report the status of VISN and Facility compliance with Directive requirements quarterly to Specialty Care Services and identify any barriers to oversight, including access to data and resources.

Status: In-progress **Target Completion Date**: September 2026

OIG Contact and Staff Acknowledgments

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