Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02890-286

Healthcare Inspection

Alleged Improper Management of Dermatology Requests Fayetteville VA Medical Center Fayetteville, North Carolina

May 3, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
Web site: www.va.gov/oig

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

Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed allegations that dermatology appointments and consults were improperly cancelled or discontinued in 2011–2012 at the direction of the Director and Chief of Staff at the Fayetteville VA Medical Center (facility), Fayetteville, NC.

We substantiated that 1,993 dermatology clinic appointments were cancelled by the clinic between January 2011 and December 2012. We reviewed 344 randomly selected patient electronic health records and found that about 86 percent of the 316 patients who still required appointments were rescheduled and seen by dermatology providers. However, more than 30 percent of the rescheduled patients waited more than 3 months to be seen by dermatology providers, and some waited more than 1 year. We found no evidence that 45 patients received dermatologic care after their appointments were cancelled.

We could not substantiate that facility leadership improperly instructed employees to cancel dermatology appointments. Staff we interviewed did not report instances when they were instructed to cancel dermatology appointments without consideration for patients' needs.

We substantiated that 3,272 dermatology consults were cancelled or discontinued between January 2011 and December 2012. We reviewed 299 randomly selected patient electronic health records and found that, while about 65 percent of the 253 patients who still required appointments received dermatologic care subsequent to the consult cancellation, the average wait time for care provision was about 13 months. We found no evidence that 89 patients received dermatologic evaluation or care after the consults were cancelled or discontinued.

Further, our look-back of patients with diagnosed skin malignancies did not disclose cases where cancelled or discontinued dermatology consults in 2011–2012 negatively impacted these patients' subsequent diagnoses or treatment plans.

While some patients were not seen by dermatology providers in a timely manner due to cancelled appointments and/or consults, we did not identify instances where patients experienced clinically significant delays in diagnosis or treatment for the cases we reviewed. A shortage of dermatologists at the facility in 2011–2012 contributed to the appointment scheduling and consult completion delays. The facility has since hired additional dermatology providers in its Wilmington location and continues to use tele-dermatology and Non-VA Care Coordination to meet demand.

We recommended that the facility Director follow up on the specific cases referenced in this report and all other patients with cancelled dermatology appointments and consults in 2011–2012 who were *not* subsequently seen by a dermatology provider.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and initiated a corrective action plan. (See Appendixes A and B, pages 8–11 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections evaluated allegations of improper management of dermatology requests at the Fayetteville VA Medical Center (facility), Fayetteville, NC. The purpose of the review was to determine whether the allegations had merit.

Background

The facility provides general medical, surgical, and mental health services to more than 204,000 veterans living in a 21-county area of southeastern North Carolina and northeastern South Carolina. It operates 58 hospital beds and a 60-bed community living center and provides care at five community based outpatient clinics (CBOCs) located in Brunswick, Goldsboro, Hamlet, Jacksonville, and Robeson, and at two Health Care Centers (HCCs) located in Fayetteville and Wilmington, NC. The facility is part of Veterans Integrated Service Network (VISN) 6.

Dermatology focuses on the diagnosis and treatment of conditions related to the skin, hair, nails, and mucous membranes (lining inside the mouth, nose, and eyelids).[1] Typically, in Veterans Health Administration (VHA) facilities, a dermatology consult is submitted electronically for initial evaluation of a patient's new skin-related problem. In response to the consult, a new patient appointment is to be scheduled based on the requesting provider's specified timeframe but usually no later than 90 days of the consult request date. For established patients, appointments are to be scheduled for follow-up based on the dermatologist's request date and the patient's desired date.[2]

According to VHA policy, when a clinic cancels a patient appointment, the patient should be notified and the appointment promptly rescheduled.[3] When a clinic cancels a consult, the ordering provider receives a "View Alert" notifying him/her of the cancellation. The ordering provider then has responsibility for determining whether the consult is still needed and taking action accordingly.

From 2010 through 2013, the facility was not able to consistently provide in-house dermatology care due to inadequate or non-existent dermatologist staffing. During this time, dermatology care was primarily provided through a contractual arrangement with the University of North Carolina and a tele-dermatology agreement with the Durham, NC, VA Medical Center.

[1] American Academy of Dermatology, https://www.aad.org/public/diseases/why-see-a-dermatologist, accessed on March 24, 2016.
[2] Established patients could also be re-consulted to Dermatology Clinic for a new skin-related problem.
[3] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010. Although a revision changing the 14 day time frame to 30 days for a new mental health patient requiring follow-up was made on December 8, 2015 (p. 9, Section 4c(19)(c)), the expiration date of the Directive, June 30, 2015 was not modified at the time the revision was made.

Allegations

The OIG received an anonymous complaint alleging that 1,400 dermatology appointments were destroyed[4] and cancelled in 2011–2012, and the facility Director and former Chief of Staff (COS) improperly instructed staff to delete these appointments without regard for whether the patients still required the tests or services.

During preliminary interviews, we were also told that dermatology consults were cancelled or discontinued due to inadequate staffing.

Scope and Methodology

We reviewed pertinent documents and conducted interviews between December 18, 2014, and June 26, 2015. We reviewed relevant VHA and facility policies related to appointment scheduling and consult management and patient advocate reports related to dermatology care. We interviewed the facility Director, former COS, the former Associate Director for Operations, the Medical Service administrative officer, the current full-time Wilmington HCC dermatologist, the nurse manager for specialty care, the former nurse manager for Non-VA Care Coordination (NVCC), dermatology staff, and others with knowledge about the issues.

We conducted reviews of randomly selected electronic health records (EHRs) to determine whether appropriate actions and follow-up occurred after dermatology appointments and consults were cancelled or discontinued. We also conducted look-back reviews of patients with skin malignancies diagnosed in 2011–2014 or whose EHRs contained references to skin malignancies during this time. These reviews were to determine whether patients experienced appointment and consult cancellations during the specified timeframe, and if so, whether care delays may have impacted their subsequent diagnoses or treatment plans.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

[4] The complainant used the term "destroy" in describing the alleged action; however, it is unlikely that this is the correct descriptor. Because the complainant was anonymous, we were unable to clarify the issue. We believe the complainant meant that appointments were cancelled, and by doing so, were removed from the schedule. The EHR is a legal document and any alteration must meet strict VHA guidelines. VHA EHRs cannot be deleted or destroyed.

Inspection Results

Issue 1: Dermatology Appointment Cancellations 2011–2012

We substantiated that dermatology clinic staff cancelled 1,993 dermatology appointments between January 2011 and December 2012. According to VHA guidelines,[5] when an appointment is cancelled or a patient fails to appear for a scheduled appointment, the EHR should be reviewed by the responsible provider, surrogate, or designated team representative to ensure that urgent medical problems are addressed, medications are renewed, and the patient is rescheduled as soon as possible, if clinically appropriate.

We reviewed a random selection of 344 patients' cancelled dermatology appointments. We excluded 28 cases from further review, as the appointments were no longer needed.[6] Of the remaining 316 cases, our EHR review found that 271 cancelled appointments were rescheduled and patients were seen, as follows:

- 68 percent within 90 days of their cancelled appointment dates
- 24.4 percent between 91 and 365 days of their cancelled appointment dates
- 7.4 percent more than 1 year after their cancelled appointment dates

Despite the lack of timeliness in rescheduling some appointments, we found no evidence of clinically significant delays in diagnosis or treatment in these cases due to cancelled appointments.

However, we found no documented evidence that the remaining 45 patients received dermatologic care after their appointments were cancelled. We provided a list of these patients to the facility Director for further review and follow-up, if indicated.

Issue 2: Facility Leadership's Instructions Regarding Dermatology Appointment Cancellations

We could not substantiate that the facility Director or former COS improperly instructed employees to cancel appointments without regard for whether the patients still required the requested services**.** Staff we interviewed did not report instances when they were instructed by facility leaders to cancel dermatology appointments without consideration for patients' needs.

[5] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
[6] We defined appointments as no longer being needed if: the patient died prior to the scheduled appointment, no further treatment was required, there was a scheduling error, the patient declined care, the patient transferred care, or care was provided by another provider.

Issue 3: Dermatology Consult Cancellations 2011–2012

We substantiated that 3,272 dermatology consults had either been cancelled or discontinued between January 2011 and December 2012.

We reviewed a random selection of 299 dermatology consults. We excluded 46 consults from further review, as the patients either no-showed, cancelled scheduled appointments, or declined care, or the dermatology consult was otherwise no longer needed.[7]

Of the remaining 253 cases, our EHR review found that 164 patients (65 percent) received dermatologic care. However, the average wait time between when the identified consult was entered and when the patient was actually seen was 399 days. We did not identify clinically significant delays in diagnosis or treatment in these cases due to cancelled or discontinued consults that were not reinitiated and addressed timely.

We found no evidence that the remaining 89 patients received dermatologic evaluations or care after the consults were cancelled or discontinued. Often, we could find no further reference to the dermatologic condition that prompted the original consult even though most of these patients were being followed by primary care or other providers. According to guidance,[8] the requesting provider would receive a View Alert about cancelled or discontinued consults, prompting him or her to consider the continued need for the service. While this may have occurred, we found no documentation reflecting that the consult was no longer needed.[9] We noted that a majority of the consults were for minor conditions including eczema and dermatitis. We provided the list of 89 cases to the facility Director for further review and action, if indicated.[10]

Newly Diagnosed Skin Malignancies or Other References to Skin Malignancies 2011–2014[11]

We conducted look-back reviews of the EHRs of patients with newly diagnosed malignant skin cancer or whose EHRs contained other documented references to skin malignancies to determine whether these patients experienced dermatology consult cancellations during 2011–2012 and, if so, whether care delays impacted their subsequent diagnoses or clinical scenarios.

[7] Twenty-three patients either no-showed (did not come for the appointment and did not call to cancel), cancelled, declined care, or relocated; 14 patients opted to use a private dermatologist; 5 patients died; and 4 patients had pending appointments.
[8] *Computerized Patient Record System Technical Manual,* July 2014. The technical manual is periodically updated as patches are released; however, the section on View Alerts has not substantially changed since 2008.
[9] We could not determine whether these providers actually received View Alerts for the cancelled and/or discontinued dermatology consults as View Alert data is only available for the previous 365 days.
[10] Four of the 89 cases were more clinically complex; those cases were highlighted for priority evaluation by the facility.
[11] We selected a 2014 end date to account for the possible time lapse between delayed or cancelled dermatology care and new diagnosis of a skin malignancy.

Newly Diagnosed Skin Malignancies (2011–2014). We reviewed the EHRs of the 18 patients (as reported by the facility) with newly diagnosed skin malignancies documented from 2011 through 2014. We found no evidence of clinically significant delays in diagnosis or treatment in these cases due to cancelled or discontinued consults.

Other References to Skin Malignancies. We extracted data using key words "skin malignancy" or "malignancy NEO [neoplasm] skin" or "malignancy NEO of tissue" in the International Classification of Diseases (ICD) description, diagnosis text, or provider narrative as documented from 2011 through 2014.[12] We compared the list of all 3,272 consults with a list of patients with the key words (described above) documented in their EHRs. We determined that the EHRs of 72 patients with cancelled or discontinued dermatology consults contained the key words. We randomly selected and reviewed 60 EHRs of the 72 patients and found that 51 patients (85 percent) had subsequently received care either through the facility's Dermatology Clinic, Wilmington HCC Dermatology Clinic, tele-dermatology, interfacility dermatology clinics, or through NVCC, or the patients no longer needed dermatologic care.

We found no evidence that the remaining 9 patients (15 percent) received dermatologic care or were otherwise followed-up for the presenting condition after the initial consult was cancelled or discontinued. However, based on available documentation, we also found no evidence of clinically significant delays in diagnosis or treatment in these cases due to cancelled or discontinued dermatology consults. We provided the list of these nine patients to the facility to determine whether further review and/or follow-up care was needed.

A shortage of dermatologists at the facility during the time in question contributed to the delays.[13] Facility leaders confirmed that dermatologist staffing has been inadequate for several years, including during the timeframe in question.

Dermatology Staffing and Coverage 2013–2015

The facility leaders hired a full-time dermatologist for the Wilmington HCC in mid-2013; this dermatologist currently provides direct patient care and reviews dermatology consults for patients in the Wilmington, Jacksonville, and Brunswick areas. A part-time dermatologist was hired in early June 2015, and a second part-time dermatologist began in September 2015; both provide direct patient care only. In addition to the full-time dermatologist, both part-time dermatologists and two nurses are assigned to the Wilmington HCC Dermatology Clinic. Dermatology consults for facility-based patients and the other CBOCs are sent through NVCC and tele-dermatology. Due to

[12] Some data represented screening for or history of malignant neoplasm or represented the date the condition was added to the problem list—most conditions were not newly diagnosed skin malignancies.
[13] Prior to April 2012, the University of North Carolina provided dermatology care at the facility. From April 2012 to January 2014, the facility was without onsite dermatology care. A dermatologist started in January 2014 and began seeing patients in March 2014, but left the facility in May 2014, reportedly due to health reasons.

challenges in attracting dermatologists to the Fayetteville area, the facility leaders rely heavily on tele-dermatology through VA medical centers located in Richmond, VA, and the Bronx, NY.

Cancelled Dermatology Consults July–September 2014

To determine whether conditions had improved after staffing and process adjustments starting in mid-2013, we reviewed the 54 NVCC dermatology consults that were cancelled or discontinued in the 4th quarter fiscal year 2014. A majority of facility-based dermatology consults were sent to NVCC during this time due to in-house staffing shortages. We found that processes had improved and that, in general, entries in the EHRs we reviewed were appropriately documented and follow-up care was provided, when indicated.

Conclusions

We substantiated that 1,993 dermatology clinic appointments were cancelled by the clinic between January 2011 and December 2012. We reviewed 344 randomly selected EHRs and found that about 86 percent of the 316 patients who still required appointments were rescheduled and seen by a dermatology provider. However, more than 30 percent of the rescheduled patients waited more than 3 months to be seen by dermatology providers and some waited more than 1 year. We found that 45 patients did not receive dermatologic care after their appointments were cancelled, nor did their EHRs contain documentation that the appointments were no longer needed. We provided these cases to the facility Director for review and disposition.

We could not substantiate that facility leadership improperly instructed employees to cancel dermatology appointments. Staff we interviewed did not report that they were given improper instructions to cancel appointments. While we found lapses in documentation and follow-up in some cases, it did not appear to us that facility leadership played a substantive role in the events discussed in this report.

We substantiated that 3,272 dermatology consults were cancelled or discontinued between January 2011 and December 2012. We reviewed 299 randomly selected EHRs and found that about 65 percent of the 253 patients, who still required appointments, received dermatologic care subsequent to the consult cancellation; the average wait time for care provision was about 13 months. We found no evidence that 89 patients received dermatologic evaluation or care after the consults were cancelled or discontinued. We provided these cases to the facility Director for review and disposition.

Our look-back of patients with diagnosed skin malignancies did not disclose cases where cancelled or discontinued dermatology consults in 2011–2012 may have negatively impacted these patients' subsequent diagnoses or treatment plans. We found nine cases, however, where the EHRs did not contain evidence of follow-up after the cancelled or discontinued consults. We provided these cases to the facility Director for review and disposition.

In total, we provided the facility Director with the names of 143 patients for whom we found no evidence of care (45 patients whose appointments were cancelled, 89 patients who consults were cancelled or discontinued, and 9 patients with diagnosed skin malignancies).

While some patients were not seen by dermatology providers in a timely manner due to cancelled appointments and/or consults, we did not identify instances where patients experienced clinically significant delays in diagnosis or treatment for the cases we reviewed. A shortage of dermatologists at the facility in 2011–2012 contributed to the appointment scheduling and consult completion delays. The facility hired additional dermatology providers in its Wilmington location and continues to use teledermatology and NVCC. We noted improved access to care and consult timeliness as of late 2014.

Recommendations

1. We recommended that the facility Director follow up on the 143 patients referenced in this report who did not receive dermatology care after their appointments or consults were cancelled, and take appropriate action.

2. We recommended that the facility Director follow up on all the patients with cancelled dermatology appointments and consultations in 2011–2012 who were not subsequently seen by a dermatology provider to determine whether the requested evaluation and/or care is still needed.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: February 23, 2016

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

Subj: Healthcare Inspection—Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina

To: Director, Atlanta Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10E1D MRS Action)

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the Fayetteville VA Medical Center (VAMC), Fayetteville, NC and concur with the facility's responses.

2. If you have further questions, please contact Elizabeth Goolsby, Director, Fayetteville VAMC at (910) 822-7059.

(original signed by:)

DANIEL F. HOFFMANN, FACHE

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: March 6, 2016

From: Director, Fayetteville VA Medical Center (565/00)

Subj: Healthcare Inspection—Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. Fayetteville VA Medical Center concurs with the findings brought forth in this report. Specific corrective actions have been provided for the recommendations.

2. Should you have any questions, please contact Elizabeth Goolsby, Medical Center Director, at 910-822-7059.

(original signed by:)

ELIZABETH B. GOOLSBY

Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the facility Director follow up on the 143 patients referenced in this report who did not receive dermatology care after their appointments or consults were cancelled, and take appropriate action.

Concur

Target date for completion: July 15, 2016

Facility response:

Prior to cancelling any of the appointments or consults for this timeframe, a clinical review was completed by nurses on all of these cases. If there was a question about a patient situation, a physician was available for consultation. The clinical review included a review of each consult and appointment to determine if the patient had been seen by his or her primary care provider after the consult had been entered and whether there was an indication of a continuing need for the consult. The provider was alerted to the cancellation. If the patient had not been seen by the provider, the provider was alerted to the need to reenter a consult as the current consult was being cancelled.

A documented re-review of each case by a registered nurse using the medical record will occur with referral to a physician for any case review questions. The clinical review will include a review of each consult and appointment to determine if the patient had been seen by his or her primary care provider after the consult had been entered and whether there was an indication of a continuing need for the consult. If dermatology care is needed, the provider of record will be alerted to the clinical situation. If the patient has not been seen by the provider, the provider of record will be alerted to the need to reenter a consult, if clinical care is indicted. The results of the reviews will be reported to the Medical Executive Committee.

Recommendation 2. We recommended that the facility Director follow up on all patients with cancelled dermatology appointments and consultations in 2011–2012 who were *not* subsequently seen by a dermatology provider to determine whether the requested evaluation and/or care is still needed.

Concur

Target date for completion: November 15, 2016

Facility response:

Prior to cancelling any of the appointments or consults for this timeframe, a clinical review was completed by nurses on all of these cases. If there was a question about a patient situation, a physician was available for consultation. The clinical review included a review of each consult and appointment to determine if the patient had been seen by his or her primary care provider after the consult had been entered and whether there was an indication of a continuing need for the consult. The provider was alerted to the cancellation. If the patient had not been seen by the provider, the provider was alerted to the need to reenter a consult as the current consult was being cancelled.

A documented re-review of each case by a registered nurse using the medical record will occur with referral to a physician for any case review questions. The clinical review will include a review of each consult and appointment to determine if the patient had been seen by his or her primary care provider after the consult had been entered and whether there was an indication of a continuing need for the consult. If dermatology care is needed, the provider of record will be alerted to the clinical situation. If the patient has not been seen by the provider, the provider of record will be alerted to the need to reenter a consult, if clinical care is indicted. The results of the reviews will be reported to the Medical Executive Committee.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Toni Woodard, BS, Team Leader Daisy Arugay, MT Paula Chapman, CTRS Victoria Coates, LICSW, MBA LaFonda Henry, MSN, RN-BC Yoonhee Kim, PharmD Kevin Veatch, RN, MSN Joanne Wasko, LCSW Thomas Wong, DO Anita Pendleton, AAS George Boyles, Office of Investigations Robert LaChapelle, Office of Investigations

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Mid-Atlantic Health Care Network (10N6)
Director, Fayetteville VA Medical Center (565/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Richard Burr, Thom Tillis
U.S. House of Representatives: G.K. Butterfield, Renee Ellmers, George Holding, Richard Hudson, Walter B. Jones, Jr., David Price, David Rouzer

This report is available on our web site at **www.va.gov/oig**.