Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-01855-288

Healthcare Inspection

Dermatology Clinic Staffing and Other Concerns (2012–2014) Dayton VA Medical Center Dayton, Ohio

June 29, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review at the Dayton VA Medical Center (facility), Dayton, OH, during the week of February 2, 2015. A component of the CAP review was the administration by the OIG of an electronic employee survey known as the Employee Assessment Review (EAR) prior to the site visit regarding patient safety and quality of care at the facility. An EAR respondent raised concerns about staffing inadequacies, scheduling practices, and appointment timeliness in the Dermatology Clinic in quarters (Qs) 3 and 4, fiscal year (FY) 2012, and during FYs 2013–2014. The purpose of this review was to evaluate whether the conditions alleged by the EAR respondent existed at that time, and if so, whether facility managers mitigated those conditions.

In December 2014, an EAR respondent reported that during Qs 3 and 4, FY 2012, and FYs 2013 and 2014, the Dermatology Clinic lacked a sufficient number of permanent administrative staff to schedule patient appointments properly and timely. The following issues were raised by the respondent:

a) Patient Business Service (PBS) schedulers who were assigned on a temporary basis to cover the Dermatology Clinic were not adequately trained in the clinic's specific scheduling practices; therefore, appointments were not consistently scheduled [or rescheduled] in accordance with the provider's and/or patient's preferred date.

b) PBS schedulers did not return calls to patients in a timely manner.

c) As a result, Dermatology appointments were not scheduled timely.

d) One of 20 patients with scheduling delays had a clinically significant adverse outcome as a result.

OIG's goal is to conduct inspections, report on conditions, and provide information that is timely and useful for agency managers and other stakeholders. In this case, the deficient conditions alleged by the EAR respondent dated back several years and had since been corrected by facility managers. This report summarizes the allegations, conditions that existed, and sequence of events in FYs 2012–2014, with a focus on corrective actions taken, a look-back of patients diagnosed with new melanomas or other skin cancers from FY 2013 through Q3 FY 2016, and the status of Dermatology Clinic-related operations as of Q4 FY 2016.

We substantiated that in 2012, the Dermatology Clinic lost its permanently assigned PBS scheduler. Other PBS schedulers covered the Dermatology Clinic, along with other specialty care clinics, during FYs 2012–2014 (and in Qs 1 and 2 FY 2015). Dermatology managers and staff provided us with extensive documentation reflecting their concerns that PBS schedulers could not keep up with the volume of work, and PBS schedulers were not scheduling appointments timely. The documentation also showed clinical and administrative managers' attempts to work together to improve clinic access and timeliness, and the Chief of Dermatology Service regularly reported the staffing challenges and scheduling deficiencies to leadership.

While we substantiated specific instances of inadequate scheduling practices, poor follow-up to patient telephone calls, and delayed appointments during the time that PBS schedulers covered the Dermatology Clinic, we did not substantiate systemic deficiencies in those areas. Further, while we substantiated scheduling delays, we did not substantiate that patients experienced clinically significant adverse outcomes in the cases provided by the EAR respondent or in our look-back of patients diagnosed with new melanomas or other skin cancers from FY 2013 through Q3 FY 2016.

We made no recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our findings. (See Appendixes B and C, pages 11–12). No follow-up actions are required.

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

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations regarding staffing inadequacies, scheduling practices, and appointment timeliness in the Dermatology Clinic at the Dayton VA Medical Center (facility), Dayton, OH.

Background

The 356-bed facility provides a broad range of health care, including medical, surgical, and mental health services. The facility has contracts with Wright Patterson Air Force Base and 11 area hospitals, and active affiliations with the Wright State University Boonshoft School of Medicine, the School of Professional Psychology, and the Ohio State University College of Optometry. The facility provides outpatient care at four community based outpatient clinics located in Lima, Middletown, and Springfield, OH, and Richmond, IN. The facility is a part of Veterans Integrated Service Network (VISN) 10 and serves more than 170,000 veterans throughout 18 counties.

Dermatology is a medical specialty that focuses on the diagnosis and treatment of conditions related to the skin, hair, nails, and mucous membranes (lining inside the mouth, nose, and eyelids). In general, providers request a dermatology evaluation by entering an electronic consult noting the condition or concern to be assessed. A dermatology provider reviews the consult to determine the urgency and adds a comment to the consult notifying the scheduler of the recommended timeframe for scheduling the appointment. Schedulers are to contact the patient and coordinate the appointment date.

While Veterans Health Administration (VHA) guidance and nomenclature has evolved over the past several years, VHA has generally required that routine (non-urgent) care appointments be scheduled on or as close to the provider's clinically indicated date (CID) and the patient's preferred date (PD) as possible.[1] For in-house (VA) care and non-VA care, appointments should be completed no later than 30 days from the CID or PD.[2] For non-VA care, results of completed appointments should be linked and uploaded to the VA electronic health record (EHR) within 90 days of the consult request.

Allegations

The VA Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review at the Dayton VA Medical Center (facility), Dayton, OH, during the week of

[1] VHA Directive 2010-027, *Outpatient Scheduling Processes and Procedures,* June 9, 2010. This VHA directive was in effect during the time of the events discussed in this report. It was rescinded and replaced in July 2016 by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* July 15, 2016. The 2016 Directive established use of the terms clinically indicated date and preferred date versus desired date.
[2] Prior to VHA Directive 1230, VHA Directive 2006-041, Veterans Health Care Service Standards, June 27, 2006 stated that patient appointments needed to be scheduled within 30 days.

February 2, 2015.[3] A component of the CAP review was the administration of an electronic employee survey, prior to the site visit, regarding patient safety and quality of care at the facility known as the Employee Assessment Review (EAR). An EAR respondent raised concerns about staffing inadequacies, scheduling practices, and appointment timeliness in the Dermatology Clinic in quarters (Qs) 3 and 4, fiscal year (FY) 2012, and during FYs 2013–2014. The purpose of this review was to evaluate whether the conditions alleged by the EAR respondent existed at that time, and if so, whether facility managers mitigated those conditions or if they persisted.

In December 2014, an EAR respondent reported that during Qs 3 and 4, FY 2012, and FYs 2013 and 2014, the Dermatology Clinic lacked a sufficient number of permanent administrative staff to schedule patient appointments properly and timely. Per the EAR respondent:

a) Patient Business Service (PBS) schedulers who were assigned on a temporary basis to cover Dermatology Clinic were not adequately trained in the clinic's specific scheduling practices; therefore, appointments were not consistently scheduled [or rescheduled] in accordance with a provider's CID and/or patient's PD.

b) PBS schedulers did not return calls to patients in a timely manner.

c) As a result, dermatology appointments were not scheduled timely.

d) One of 20 patients with scheduling delays had a clinically significant adverse outcome as a result.

Scope and Methodology

We initiated our review on February 16, 2016, and completed our work on October 12, 2016. We conducted telephone interviews with the EAR respondent, Facility Director, assistant to the Chief of Staff, Chief of Dermatology Service, dermatology clinical and administrative staff, PBS schedulers, and other knowledgeable staff. We determined that a site visit was not required.

We reviewed VHA directives, facility policies, outpatient appointment scheduling practices, and relevant medical literature. We also reviewed patient advocate reports from FY 2014 through FY 2016, dermatology service agreements, Tumor Board cases from FY 2013 through Q3 FY 2016, Consult Management Committee meeting minutes from May 2014 through September 2015,[4] and aspects of Dermatology Clinic staffing, workload, and access data for FY 2012 through FY 2016. To evaluate dermatology appointment wait times and whether patients experienced delays in care, we reviewed appointment and consult completion timeliness for FY 2013 through FY 2016.

[3] *Combined Assessment Program Review of the Dayton VA Medical Center, Dayton, Ohio.* (Report No. 15-00073-200, April 9, 2015).

[4] The facility did not provide Consult Management Committee meeting minutes for July 2014 and June 2015.

We reviewed EHRs of the 20 patients whose names were provided by the EAR respondent. To determine whether other dermatology patients experienced delays in care that may have resulted in clinically significant adverse outcomes, we also reviewed 34 EHRs of patients with new melanoma diagnoses, and 5 EHRs of patients with skin cancers presented to the Tumor Board during FY 2013 through Q3 FY 2016.

OIG's goal is to conduct inspections, report on conditions, and provide information that is timely and useful for agency managers and other stakeholders. In this case, the deficient conditions alleged by the EAR respondent dated back several years and had since been corrected by facility managers. The Inspection Results section of this report summarizes the allegations, conditions present, and sequence of events in FYs 2012–2014, with a focus on corrective actions taken and the status of Dermatology Clinic-related operations as of Q4 FY 2016. Appendix A includes the details of our inspection findings.

VHA Directive 2007-033, *Telephone Service for Clinical Care,* October 11, 2007, cited in this report, expired on October 31, 2012. We considered the policy to be in effect because it has not been superseded by a more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[5] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[6] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[7]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is 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.

[5] VHA Directive 6330(1), *Controlled National Policy/Directives Management System,* June 24, 2016, amended January 11, 2017.
[6] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document,* June 29, 2016.
[7] Ibid.

Inspection Results

2012-2014 Dermatology Clinic Staffing and Other Concerns

The EAR respondent reported that in Qs 3 and 4 FY 2012, and in FYs 2013–2014, the Dermatology Clinic did not have permanently assigned administrative staff and had to rely on PBS schedulers.[8] The EAR respondent alleged that the use of PBS schedulers resulted in inconsistent scheduling practices and inadequate telephone responsiveness, which delayed appointments and caused a clinically significant adverse outcome in one patient.

We substantiated that in 2012, the Dermatology Clinic lost its permanently assigned PBS scheduler.[9] Other PBS schedulers covered the Dermatology Clinic, along with other specialty care clinics, during FYs 2012–2014.[10] Dermatology Service managers and staff provided us with extensive documentation including emails and workload reports reflecting their concerns that PBS schedulers could not keep up with the volume of work, and PBS schedulers were not scheduling appointments timely. The documentation also showed clinical and administrative managers' attempts to work together to improve clinic access and timeliness, although these improvement actions were slow to take shape. The Chief of Dermatology Service regularly reported the staffing challenges and scheduling deficiencies to leadership, and routinely requested administrative support staff to be specifically selected by and assigned to the Dermatology Clinic to manage scheduling needs.

While we substantiated specific instances of inadequate scheduling practices, poor follow-up to patient telephone calls, and delayed appointments during the time that PBS schedulers covered the Dermatology Clinic, we did not substantiate systemic deficiencies in those areas. Further, while we substantiated scheduling delays, we did not substantiate that patients experienced clinically significant adverse outcomes because of scheduling delays. Our inspection findings related to conditions present during FYs 2012–2014 are available in a table format in Appendix A.

OIG FY 2016 Review

In March and April 2015 respectively, clinical managers hired two medical support assistants (MSA) assigned specifically to the Dermatology Clinic. Conditions were improved at the time of our review in FY 2016, as follows:

[8] PBS schedulers are part of a general administrative employee "pool" who have been trained in VHA appointment scheduling practices and requirements and can be assigned to most clinic locations to provide, or assist with, patient scheduling.

[9] The permanently assigned PBS scheduler was always assigned to work the Dermatology Clinic when that clinic was in session, which promoted the scheduler's familiarity with providers' and clinic practices and promoted scheduling consistency.

[10] Other PBS schedulers covered the Dermatology Clinic until permanent staff were hired in Qs 1 and 2 FY 2015.

Scheduling Practices

The MSAs hired in 2015 completed online training courses and hands-on scheduling practice with the Dermatology Clinic program manager or a dermatology provider, and participated in monthly refresher training sessions for continuing education. Dermatology Clinic leaders we interviewed uniformly reported that the addition of permanent MSAs to manage dermatology appointments and other workload issues had enhanced the efficiency of the clinic. However, the Chief of Dermatology Service and the Dermatology Clinic program manager reported that another part-time MSA is needed to assist with scheduling.

Telephone Responsiveness

During regular business hours, patients calling the clinic telephone number must be connected to staff who can address management of appointments, medication issues, and clinical concerns.[11] VHA does not require specialty clinics to collect data related to telephone responsiveness.[12] We therefore reviewed patient advocate complaints regarding telephone responsiveness in the Dermatology Clinic. In FY 2016, 6 of 17 (35 percent) dermatology complaints to the patient advocate related to no or delayed return telephone calls from Dermatology Clinic staff.[13] While this number represented a decrease in like complaints since 2014, its comparative value is limited. (See Appendix A for details.) Employees we interviewed, however, consistently reported that with the addition of the permanent MSAs, appointment scheduling practices were substantially better than in years past.

We confirmed that patient advocates referred the referenced complaints to Dermatology Service managers for follow-up and resolution.

Outpatient Consult Completion Timeliness

To evaluate appointment wait times and whether patients experienced delays in care, we reviewed consult completion times as follows:

Outpatient Consults

a) In-house (VA) dermatology consults – In FY 2016, the Dermatology Clinic completed 2,668 consults in an average of 31 days. We identified 21 consults open greater than 90 days as of September 30, 2016.

b) Veterans Choice dermatology consults – In FY 2016, providers completed 8 Veterans Choice dermatology consults in an average of 117 days, and

[11] VHA Directive 2007-033, *Telephone Service for Clinical Care,* October 11, 2007. This VHA Directive expired on October 31, 2012, and has not yet been updated.
[12] VHA does require monitoring of call center responsiveness for large primary care clinics.
[13] The remaining complaints were miscellaneous, relating to receiving calls or appointments through Non VA Care Coordination or Veterans Choice, small waiting area in the clinic, or the wait time from check-in to see the provider.

18 consults remained open greater than 90 days as of September 30, 2016. Veterans Choice is an alternate form of non-VA care using a third-party administrator.

c) Non-VA care (non-Choice) dermatology consults – In FY 2016, providers completed 15 non-VA care dermatology consults in an average of 74 days. We did not identify any dermatology consults open greater than 90 days as of September 30, 2016.[14]

While not consistently meeting wait time goals in FY 2016, consult completion has, in general, progressively improved over the past 3 years. Further, Non VA Care Coordination (NVCC) and Veterans Choice consults are processed outside of the dermatology clinic and are not a direct reflection of in-house dermatology clinic processes.

Established Patient Appointments

Typically, dermatology providers would not use consults for established patients. Therefore, we evaluated appointment completion data to determine whether established patients were being seen within 30 days of the CID and/or patient's PD. In FY 2016, the Dermatology Clinic completed 6,562 established patient visits in an average of 11 days from the PD.

Patient Outcomes

We did not substantiate that scheduling delays caused clinically significant adverse outcomes in the cases provided by the EAR respondent or in our look-back of patients diagnosed with new melanomas or other skin cancers. (See Appendix A for our case review populations and findings.) We evaluated the one new skin cancer case documented in the Qs 1–3 FY 2016 Tumor Board minutes but did not identify dermatology-related delays.

Conclusions

We substantiated that in 2012, the Dermatology Clinic lost its permanently assigned PBS scheduler. Other PBS schedulers covered the Dermatology Clinic, along with other specialty care clinics, during FYs 2012–2014 and in Qs 1 and 2, FY 2015.

While we substantiated specific instances of inadequate scheduling practices, poor follow-up to patient telephone calls, and delayed appointments during the time that PBS schedulers covered the Dermatology Clinic, we did not substantiate systemic deficiencies in those areas. Further, while we substantiated dermatology scheduling delays, we did not find evidence that patients experienced clinically significant adverse

[14] We noted that in many of the NVCC cases we sampled, patients had received the care but the consult remained "open" for administrative reasons.

outcomes in the cases provided by the EAR respondent or in our look-back of patients diagnosed with new melanomas or other skin cancers.

The facility has since hired dedicated MSA staff and provided appropriate scheduling training. We found improvements in dermatology scheduling timeliness started in FY 2015 that continued through Q4 FY 2016. We made no recommendations.

Appendix A

SUMMARY of FINDINGS: We substantiated the EAR respondent's central issue—that the Dermatology Clinic did not have permanently assigned administrative staff and had to rely on PBS schedulers from Q3 FY 2012 through FY 2014. Because facility mangers did not assign permanent PBS schedulers until about Q3 FY 2015, our findings include conditions present in FY 2015 as well. While we substantiated specific instances or examples supporting allegations (a)–(c) below, we did not substantiate systemic deficiencies in those areas. We did not substantiate allegation (d).

Allegations Regarding Conditions During FYs 2012–2014	Criteria	Findings
(a) PBS schedulers were not trained in Dermatology Clinic-specific scheduling practices. As a result, appointments were not consistently scheduled [or rescheduled] in accordance with patients' or providers' requested timeframes or preferences.	VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedure*s, June 9, 2010, and revised on December 8, 2015. VHA policy required that: [15][16] • Patients be scheduled on or close to their desired date, or according to a timeframe communicated by the provider. • When an appointment is cancelled and rescheduled by the clinic, the scheduler enters as the desired date for the new appointment the desired date for the original appointment. Dermatology Clinic managers and a PBS supervisor told us that Dermatology Clinic[17] uses View Alerts to notify schedulers of scheduling instructions and patient preferences.	PBS schedulers had general training and knowledge of scheduling requirements; however, they did not consistently follow VHA policy and/or facility Dermatology Clinic practices when scheduling [or rescheduling] appointments, as follows: • View Alerts used by providers to notify PBS schedulers of scheduling instructions or of cancellations and rescheduling instructions were not reviewed, addressed, and cleared, resulting in a backlog as of May 2015. • Of the 20 patient examples provided by the EAR respondent, 15 patients (75 percent) had delays related to PBS schedulers not responding to View Alerts or scheduling appointments in accordance with providers' instructions. • A PBS scheduler confirmed that she did not always review the original consult or the medical record and reschedule the appointment according to the patient's initial PD, special preferences, or provider instruction. Rather, she scheduled the patient into the next available appointment slot.

[15]VHA Directive 2010-027, *Outpatient Scheduling Processes and Procedures,* June 9, 2010. This VHA directive was in effect during the time of the events discussed in this report. It was rescinded and replaced in July 2016 by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* July 15, 2016. The 2016 Directive established use of the terms clinically indicated date and preferred date versus desired date.
[16] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* July 15, 2016.
[17] Several, but not all, specialty care clinics communicate scheduling instructions and preferences via View Alerts.

<table>
<tr>
<td>(b) PBS schedulers did not consistently answer or return patients' phone calls in a timely manner.</td>
<td>VHA Directive 2007-033, Telephone Service For Clinical Care, October 11, 2007. This VHA Directive expired October 31, 2012, and has not yet been updated.[18]

During regular working hours, veterans calling the telephone number must be connected to staff who can address management of appointments, medication issues, and clinical concerns.</td>
<td>Of the 20 patient examples provided by the EAR respondent, 3 (15 percent) were related to phone calls not being answered or returned in a timely manner. Dermatology Clinic staff told us that during the period under review, administrative personnel may not have answered incoming phone calls or reviewed messages and returned calls timely if the clinic was busy. We also found:

• During FY 2014, 10 of 21 (48 percent) Dermatology Clinic-related complaints to the patient advocate were for delayed or no return calls.
• During FY 2015, 7 of 18 (39 percent) Dermatology Clinic-related complaints to the patient advocate were for delayed or no return calls.</td>
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<tr>
<td>(c) Dermatology appointments were not scheduled timely.</td>
<td>VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, June 9, 2010, and revised on December 8, 2015[19][20]

VHA policy requires that new patients be scheduled on or close to their desired date, or according to a timeframe communicated by the provider.</td>
<td>The EAR respondent provided, and we confirmed, several cases where appointments were not scheduled or rescheduled timely. Of the 20 case examples, 15 (75 percent) were related to delays in scheduling appointments; those 15 appointments were completed in an average of 149 days.

• In April 2014, a PBS supervisor acknowledged in an email that prior to [employee X] volunteering to help, "it usually took up to 6 weeks to make a first attempt" to contact [new] patients to offer appointments. (Employee X subsequently improved the timeliness of first contact to within 7-10 days of consult receipt.)

Figure 1. In-house (VA) Dermatology Consults FYs 2013-2015
<table>
<tr><th></th><th>Total consults completed</th><th>Average days to completion</th></tr>
<tr><td>FY 2013</td><td>2,333</td><td>44</td></tr>
<tr><td>FY 2014</td><td>2,807</td><td>31</td></tr>
<tr><td>FY 2015</td><td>2,799</td><td>31</td></tr>
</table>
Source: CDW VSSC Consult Cube</td>
</tr>
</table>

[18] VHA Directive 2007-033, *Telephone Service for Clinical Care*, October 11, 2007. This VHA Directive expired October 31, 2012, and has not yet been updated.

[19] VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, June 9, 2010. VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010. This VHA was in effect during the time of the events discussed in this report. It was rescinded and replaced in July 2016 by VHA Directive 1230, *VHA Outpatient Scheduling Processes and Procedures*, July 15, 2016. The 2016 Directive established use of the terms clinically indicated date and preferred date versus desired date.

[20] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures,* July 15, 2016.

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Figure 2. NVCC Dermatology Consults FYs 2013-2015

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<tr><th></th><th>Total consults completed</th><th>Average days to completion</th></tr>
<tr><td>FY 2013</td><td>70</td><td>149</td></tr>
<tr><td>FY 2014</td><td>269</td><td>119</td></tr>
<tr><td>FY 2015</td><td>284*</td><td>129</td></tr>
</table>

Source: CDW VSSC Consult Cube

**There were an additional 8 Veterans Choice dermatology consults completed in an average of 245 days.*
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</tr>
<tr>
<td>(d) Scheduling delays caused a clinically significant adverse outcome in one patient.</td>
<td>J Gen Intern Med. 2011 Nov; 26 Suppl 2:676-82. doi: 10.1007/s11606-011-1819-1. What are the consequences of waiting for health care in the veteran population? Pizer SD, Prentice JC.</td>
<td>

While we substantiated instances of delayed appointments, we did not find evidence of clinically significant adverse outcomes *as a result of the delays* in the EHRs we reviewed. Our reviews included:

- One case provided by the EAR respondent. The patient was in his 80s with a primary medical history that included Myocardial Infarction, Coronary Artery Bypass Graft, Congestive Heart Failure, Diabetes Mellitus, and Chronic Kidney Disease. The significant timeline for the dermatology concerns is as follows:
  - Dermatology consult entered in July 2012 for a concerning lesion/rule-out melanoma; the clinically indicated/preferred appointment date was within 3 weeks.
  - Appointment scheduled for August 2012 (about 3 weeks later), but the patient could not attend that day.
  - Appointment rescheduled for mid-October 2012.
  - Biopsy completed during mid-October appointment and results available 3 days later showing malignant melanoma.
  - Wide local excision of two sites completed in mid-November and patient discharged with home care support.
  - Apparent recurrent melanoma and several subsequent dermatology-related surgeries April to September 2013.
  - Patient declined palliative radiation in March 2014.
  - Home hospice consult entered late May 2014 with a provisional diagnosis of congestive heart failure.
  - Patient died 10 days after hospice referral.

We determined that while the patient was initially evaluated approximately 8 weeks later than the timeframe communicated by the provider, this delay did not impact his treatment plan or the ultimate outcome.

We also reviewed:

- The 34 cases of a primary melanoma diagnosed in FYs 2013–2014.
- The 4 non-melanoma skin cancer cases presented to the Tumor Board in FYs 2013–2015.

We did not identify clinically significant adverse outcomes as a result of scheduling delays
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Appendix B

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 3, 2017

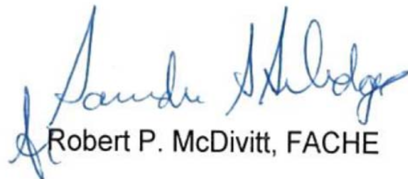
From: Director, VA Healthcare System (10N10)

Subj: Healthcare Inspection— Dermatology Clinic Staffing and Other Concerns (2012–2014), Dayton VA Medical Center, Dayton, Ohio

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

1. I have reviewed the draft report of the Dermatology Clinic Staffing and Other Concerns (2012-2014) regarding the Dayton VA Medical Center. I concur with the Medical Center director's response.

2. If you have any question, please contact Jane Johnson, VISN 10 Quality Management Officer, at (513) 247-2838.



Robert P. McDivitt, FACHE

Appendix C

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 1, 2017

From: Director, Dayton VA Medical Center (552/00)

Subj: Healthcare Inspection— Dermatology Clinic Staffing and Other Concerns (2012–2014), Dayton VA Medical Center, Dayton, Ohio

To: Director, VA Healthcare System (10N10)

1. Thank you for the opportunity to review the draft report of the Dermatology Clinic Staffing and Other Concerns (2012-2014) of the Dayton VA Medical Center, Dayton, Ohio.

2. I have reviewed the document and concur with no recommendations. While we did lose a permanently assigned PBS scheduler for the Dermatology clinic in 2012, our leadership team took actions to address Veteran and staff concerns, and there were no clinically significant adverse patient outcomes.

3. If you have any questions, please contact William Germann, Chief, Medical Service at 937-268-6511, extension 2705.

Glenn A. Costie 108284

Digitally signed by Glenn A. Costie 108284
DN: dc=gov, dc=va, o=internal, ou=people, 0.9.2342.19200300.100.1.1=glenn.costie@va.gov, cn=Glenn A. Costie 108284
Date: 2017.05.01 15:01:27 -04'00'

Glenn A. Costie, FACHE
Medical Center Director

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	LaFonda Henry, MSN, RN-BC, Team Leader Victoria Coates, LICSW, MBA Julie Kroviak, MD Toni Woodard, BS

Appendix E

Report Distribution

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Director, Dayton VA Medical Center (552/00)

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