



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Provider Assignment and
Dermatology Consult
Scheduling Delays at the
Joint Ambulatory Care
Center

Pensacola, Florida



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of a complainant's allegations that, when a patient's primary care provider (PCP) left, the patient (Patient A) did not have an assigned PCP for over a year, and that this patient also experienced delays in scheduling dermatology care at the Joint Ambulatory Care Center (JACC), Pensacola, Florida, a community based outpatient clinic of the Gulf Coast Veterans Health Care System (System) in Biloxi, Mississippi.

The OIG determined that the patient was not assigned to another PCP for approximately nine months, from the time Patient A's first PCP resigned until the patient was assigned to a second PCP. The Veterans Health Administration (VHA) requires every patient to be assigned to a PCP (a VHA provider who delivers ongoing and comprehensive primary care within VHA systems and facilities). PCP patient panels are tracked in an electronic web-based management program called the Primary Care Management Module (PCMM).¹ Upon review of Patient A's PCP assignments in PCMM, the OIG found that Patient A remained assigned to the panel of a provider who was no longer employed by the System until Patient A was assigned to a second PCP.

The OIG substantiated that Patient A experienced a scheduling delay of approximately three months for a dermatology consult because the receiving provider, the dermatologist, changed the sending provider's desired date for an appointment. VHA policy at the time of the consult request for Patient A required appointments to be scheduled on the desired date or as near to the desired date as possible, and the date not be changed due to a lack of availability of appointments. If the appointment needed to be changed, the scheduler would contact the sending provider to discuss the change.² The OIG determined that the desired date was changed by the receiving provider without discussion with the sending provider or patient. The receiving provider mistakenly believed that the patient had to be seen on the desired date (which had been identified as the same day as the consult request). The receiving provider reviewed the patient's electronic health record (EHR), decided the sending provider had not assessed the consult urgency correctly, and changed the consult date. Although the patient did not experience an

¹ A panel is the group of patients assigned to a specific PCP. VHA Handbook 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009. This handbook was rescinded by VHA Directive *Patient-Centered Management Module (PCMM) for Primary Care*, June 20, 2017, which provided updated guidance on the use of the PCMM database; PCMM is a web-based program used by all VHA facilities to manage patient panels in primary care. Management of patient panels through mandatory and consistent use of the PCMM allows facilities to track and assign their primary care providers throughout the VHA system; VHA Handbook 1101.02.

² VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedure*, June 9, 2010.

adverse clinical outcome, the risk of an adverse outcome was increased as a result of the scheduling delay.³

The OIG also reviewed JACC dermatology consults to determine whether scheduling delays occurred because staff did not follow VHA processes, and, if delays occurred, whether those delays resulted in an adverse clinical outcome(s) or an increased risk for an adverse clinical outcome.⁴

The OIG determined that scheduling delays occurred in 46 percent of the JACC dermatology consults initiated during fiscal year 2017, which did not meet the intent of the VHA goal for patients to have an appointment within 30 days of the sending or ordering provider's clinically indicated date.⁵ The OIG found that none of the patients affected by the scheduling delays experienced an adverse clinical outcome. Staff reported the reasons for these delays included misunderstanding by sending providers on how to assess consult urgency, disagreements between the sending and receiving providers, lack of sufficient dermatology and non-VA care scheduling staff, lack of available appointments, and a high demand for dermatology consults. However, JACC and System dermatologists had employed two alternative consult methods to address patient needs, and the Chief of Non-VA Care developed a staffing model to assist with resolving scheduling issues.

One patient (Patient B) experienced an increased risk of an adverse clinical outcome due to dermatology consult appointment scheduling delays, which was caused by differing case management opinions. However, the patient did not experience an adverse outcome.

OIG also determined that documented EHR communication between two physicians caring for Patient B was improper in that it contained derogatory and critical comments.

The OIG made four recommendations to the System Director:

- Patients are assigned PCPs, as required by VHA policy, and assignments are monitored for compliance.

³ For the purposes of this report, the OIG considers the risk of an adverse clinical outcome associated with scheduling delays in care to be a function both of the potential severity of the referring complaint and of the magnitude of the delay. The risk increases if the delay is prolonged and the patient's disease process is one that could progress to severe disability or death.

⁴ For purposes of this report, the OIG considers an adverse clinical outcome to be death, a change in diagnosis, a change in the course of treatment, or a significant change in the patient's level of care.

⁵ VHA Directive 1230. *Outpatient Scheduling Processes and Procedures*, July 15, 2016. The clinically indicated date is the date a VA health care provider (the sending provider) deems clinically appropriate for the patient's appointment.

- Patients with JACC dermatology consults are scheduled for care as required by VHA policy and within the VHA consults timeframe, and the scheduling process is monitored for compliance.
- Staffing levels for dermatology and non-VA care scheduling are reviewed, and an action plan is developed to address recommendations, if any, from the staffing level reviews.
- Appropriate action is taken as related to improper EHR documentation.

Comments

The Veterans Integrated Service Network and System Director concurred with the recommendations and provided acceptable action plans. (See Appendixes A and B, pages 19–22 for the Directors’ comments.) The OIG considers all recommendations open and will follow up on the planned actions until they are completed.



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Abbreviations

BCC	basal cell carcinoma
Choice	Veterans Choice Program
CID	clinically indicated date
EHR	electronic health record
FY	fiscal year
JACC	Joint Ambulatory Care Center
OIG	Office of Inspector General
PCMM	Primary Care Management Module
PCP	primary care provider
SCC	squamous cell carcinoma
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of a complainant's allegations regarding provider assignment and dermatology consult scheduling delays at the Joint Ambulatory Care Center (JACC), Pensacola, Florida, a community based outpatient clinic of the Gulf Coast Veterans Health Care System (System) in Biloxi, Mississippi.

Background

The JACC primarily provides outpatient primary and mental health services.⁶ In addition to the JACC, the System has three other community based outpatient clinics in Eglin Air Force Base and Panama City, Florida, and Mobile, Alabama. The System is part of Veterans Integrated Service Network (VISN) 16.

Skin Cancer

Skin cancer is an abnormal growth of skin cells and is the most common cancer in the United States.⁷ People with lighter skin color, a family history of skin cancer, and skin that burns, freckles, or reddens easily when exposed to the sun are at risk for developing skin cancer.⁸ Overexposure to the sun increases the risk for skin cancer.⁹ There are three main types of skin cancers.¹⁰

⁶ Gulf Coast Veterans Health Care System-Joint Ambulatory Care Center. <https://www.biloxi.va.gov/locations/JACC.asp>. (The website was accessed on August 28, 2017.)

⁷ American Academy of Dermatology. *Types of Skin Cancer*. <https://www.aad.org/public/spot-skin-cancer/learn-about-skin-cancer/types-of-skin-cancer>. (The website was accessed on February 9, 2018.); Centers for Disease Control and Prevention. *Skin Cancer*. Updated March 22, 2018. <https://www.cdc.gov/cancer/skin/index.htm>. (The website was accessed on April 19, 2018.)

⁸ Centers for Disease Control and Prevention. *Skin Cancer*. Updated June 26, 2018. https://www.cdc.gov/cancer/skin/basic_info/risk_factors.htm. (The website was accessed on August 1, 2018.)

⁹ Centers for Disease Control and Prevention. *Skin Cancer*. Updated April 19, 2018. <https://wwwnc.cdc.gov/travel/yellowbook/2018/the-pre-travel-consultation/sun-exposure>. (The website was accessed on May 19, 2018.)

¹⁰ American Academy of Dermatology. *Types of Skin Cancer*. Updated February 9, 2018. <https://www.aad.org/public/spot-skin-cancer/learn-about-skin-cancer/types-of-skin-cancer>. (The website was accessed on February 9, 2018.)

Basal Cell Carcinoma

Basal cell carcinoma (BCC) is the most common type of skin cancer, affecting more than 1 million people in the United States each year.¹¹ BCC develops in the top layer of the skin¹² and is diagnosed with a biopsy.¹³ BCC is generally curative with early diagnosis and treatment, which may include surgical excision;¹⁴ however, if left untreated, BCC can invade surrounding tissue and grow into the nerves and bones, causing damage and disfigurement.¹⁵

Squamous Cell Carcinoma

Squamous cell carcinoma (SCC) is the second most common type of skin cancer in the United States. SCC requires a biopsy for diagnosis and early treatment to prevent it from spreading to other parts of the body or deep in the skin, causing damage to surrounding body features.¹⁶ Treatment includes surgical excision, topical chemotherapy and, occasionally, radiation therapy. According to a description written by dermatologist Dr. Gregory Wells in the Merck Manual (widely used medical information resources for consumers and providers), “If the cancer is treated before metastasis, the patient is usually cured. However, if the cancer metastasizes, the chance of surviving the next 5 years, even with treatment is only 34 percent.”¹⁷

Melanoma

Melanoma is the deadliest type of skin cancer.¹⁸ It often develops in a mole or suddenly appears as a dark spot.¹⁹ Early diagnosis and treatment are critical.²⁰ A biopsy is necessary

¹¹ American Academy of Dermatology/Association. Updated April 19, 2018. *Basal Cell Carcinoma: Overview*. <https://www.aad.org/public/diseases/skin-cancer/basal-cell-carcinoma>. (The website was accessed on August 21, 2018.)

¹² American Academy of Dermatology/Association. *Basal Cell Carcinoma: Overview*.

¹³ Biopsy is the removal and examination of tissue from the living body. Mosby's Medical Dictionary, 9th edition. ©2009, Elsevier; American Academy of Dermatology/Association. *Skin Cancer*. Updated April 19, 2018.

¹⁴ Surgical excision refers to removal of the lesion. Skin Cancer Foundation. *Basal Cell Carcinoma Treatment Options*. <https://www.skincancer.org/skin-cancer-information/basal-cell-carcinoma/bcc-treatment>. (The website was accessed on April 26, 2018.)

¹⁵ American Academy of Dermatology/Association. *Types of Skin Cancer*.

¹⁶ American Academy of Dermatology/Association. *Types of Skin Cancer*.

¹⁷ Merck Manual. *Squamous Cell Carcinoma*. <https://www.merckmanuals.com/home/skin-disorders/skin-cancers/squamous-cell-carcinoma>. (The website was accessed on February 9, 2018.)

¹⁸ Centers for Disease Control. *Skin Cancer*. Updated March 22, 2018. <https://www.cdc.gov/cancer/skin/index.htm>. (The website was accessed April 19, 2018.)

¹⁹ American Academy of Dermatology. *Types of Skin Cancer*.

²⁰ American Academy of Dermatology. *Types of Skin Cancer*.

to make a diagnosis of melanoma.²¹ If diagnosed early, most melanoma patients have a five-year survival rate of 98 percent.²² If melanoma cells metastasize, prognosis is poor with a five-year survival of 15 percent.²³ In the state of Florida, the rate of developing melanoma is 23.2 (range 9.5 to 42.3) and the rate of dying from melanoma is 2.7 (range 1.6 to 4.0).²⁴

Treatment often involves surgically removing layers of skin and examining the tissue under a microscope to ensure that the melanoma has been eradicated. If melanoma cells remain, the surgical procedure is repeated until all the skin cancer has been completely excised.²⁵

Patient Primary Care Management

The Veterans Health Administration (VHA) has developed a primary care model that balances provider productivity with patient services, quality of care, and access to services. This model provides team based primary care that focuses on accessible and timely medical care customized by a team of health care providers and the patient to ensure that care is patient centered and comprehensive. The goal of this model is to provide primary care, defined as proactive/preventive health care that also addresses medical issues before they become serious, causing hospitalization.²⁶

The patient primary care model consists of a team which includes the primary care provider (PCP) who provides and manages ongoing and comprehensive primary care within VHA systems and facilities, and other support staff such as nurses, pharmacists, clerks, and

²¹ Merck Manual. Melanoma. <https://www.merckmanuals.com/home/skin-disorders/skin-cancers/squamous-cell-carcinoma>. (The website was accessed on February 9, 2018.)

²² Dermatology Reports. 2012. Defining an acceptable period of time from melanoma biopsy to excision. https://www.researchgate.net/publication/228085352_Defining_an_acceptable_period_of_time_from_melanoma_biopsy_to_excision. (The website was accessed on February 9, 2018.)

²³ Dermatology Reports. 2012. *Defining an Acceptable Period of Time from Melanoma Biopsy to Excision*.

²⁴ Rates are per 100,000 people and are age-adjusted to the 2000 U.S. standard population. Centers for Disease Control. *Skin Cancer Rates by State. Updated June 5, 2017*. <https://www.cdc.gov/cancer/skin/statistics/state.htm>. (The website was accessed on April 19, 2018.)

²⁵ Skin Cancer Foundation. *Melanoma Treatments*. <https://www.skincancer.org/skin-cancer-information/melanoma/melanoma-treatments>. (The website was accessed on February 9, 2018.)

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

medical/technical assistants.²⁷ A panel or group of patients is assigned to the PCP who delivers primary care to those patients.²⁸

To better achieve the model goals, VHA manages PCP patient panels through the mandatory and consistent use of the Primary Care Management Module (PCMM) software program. This software system allows VHA to track patients and their assigned PCPs.²⁹

Consults

A consult is a request by a provider (sending provider) for an opinion, advice, or expertise regarding evaluation or management of a specific patient problem.³⁰ The consult process allows a two-way communication between the sending provider and the provider receiving the consult (receiving provider), on behalf of the patient, and includes an automatic notification feature to notify the sending provider of actions or changes made regarding the consult by the receiving provider.³¹

As a consult is processed, the receiving or sending provider updates the status. There are multiple status levels:

- Pending—the consult request has been made by a sending provider, but the receiving provider has not acted on the request or has not yet updated the status.
- Active—the consult has been received by the receiving provider and efforts are being made to fulfill the consult.
- Scheduled—an appointment has been made with the receiving provider.
- Complete—the consult is complete, and the receiving provider has completed the actions requested by the sending provider on the consult.

²⁷ VHA Handbook, 1101.02, *Primary Care Management Module (PCMM)*, April 21, 2009. As of June 2017, VHA changed the name from Primary Care Management Module to Patient Centered Management Module and continued to use the acronym “PCMM.” For consistency purposes in this report, the OIG refers to PCMM as Primary Care Management Module. VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017.

²⁸ VHA Handbook 1101.02.

²⁹ VHA Handbook, 1101.02.

³⁰ VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This directive was in effect during the timeframe of the initial consult discussed in this report. This VHA Directive was rescinded and replaced by VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016. The 2008 and the 2016 directives contain the same or similar language to define a consult.

³¹ VHA Directive 1232(1).

- Discontinue—used by both the sending and receiving providers, this status designates that the consult is no longer wanted or needed, and the request is not acted upon; the consult no longer exists.
- Cancel—the receiving provider returns the consult request back to the sending provider because the sending provider either did not ask an appropriate consult question or provide sufficient information for the receiving provider to act upon.³²

VHA schedulers are charged with correctly acting on consult request information, scheduling consult appointments, and following through with appointment reminders for patients.³³

When a VA facility is unable to provide care, the patient may be eligible for non-VA care.³⁴

Non-VA Care

Non-VA care, such as the Veterans Choice Program (Choice), refers to community-based care purchased by, and coordinated through, VHA to eligible veterans when VA facilities cannot provide care and services to a patient.³⁵

Prior OIG Reports

In the VA OIG report, *Administrative Summary of Investigation by the VA Office of Inspector General in Response to Allegations Regarding Patient Wait Times—VA Medical Center in Biloxi, Mississippi/Joint Ambulatory Care Center in Pensacola, Florida*, (Report No. 14-02890-268, May 9, 2016), OIG determined consults were not scheduled timely. However, since patients did receive the services requested via the consults, no recommendations were made.

Allegations

In September 2016, the OIG received allegations from a complainant that a JACC patient waited over a year to be assigned a PCP and the patient experienced a scheduling delay for dermatology care in May 2016. The OIG Office of Healthcare Inspection Hotline Division requested that the

³² VHA Directive 1232(1).

³³ VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

³⁴ VHA Directive 1230.

³⁵ The Veterans Access, Choice Accountability Act (VACAA) of 2014 is a law that expands the number of options patients have for receiving care to ensure timely access to high-quality care. The Choice program provides patients the ability to receive medical care in the community if VA cannot schedule an appointment within 30 days of the date designated by the sending provider, if the patient resides more than 40 miles from a VA facility, or the patient faces one of several excessive travel burdens; Eligible veterans, in this context, means veterans that have been approved by VHA (using military and other records) and are enrolled in care at the VHA (generally have a PCP that is able to order a consult or other services); VHA Directive 1601A.02, *Eligibility Determination*, June 7, 2017, (amended July 27, 2017) rescinded VHA Handbook 1601A.02, *Eligibility Determination*, April 3, 2015.

System conduct a review of the complainant's allegations and submit a response. After reviewing the System response, OIG staff determined it to be insufficient, and subsequently initiated this inspection.

Specifically, the purpose of the inspection was to determine the validity of two allegations:

- After a patient's (Patient A) PCP resigned in June 2015, the patient was not assigned a PCP for over a year.
- The patient experienced a delay in scheduling a dermatology appointment/consult.

Additionally, based on the System's response prior to the OIG initiating this inspection, OIG staff reviewed JACC dermatology consults to determine whether scheduling delays occurred because staff did not follow VHA processes, and, if delays occurred, whether those delays resulted in adverse clinical outcomes or increased risk for adverse clinical outcomes.³⁶

Scope and Methodology

The OIG initiated this inspection on October 17, 2017, and conducted a site visit at the JACC on February 27, 2018.

The OIG interviewed the complainant to clarify the allegations. Additionally, OIG staff interviewed the Chief Medical Officer, Associate Chief of Staff, Medicine Service Chief, Non-VA Care Coordination Chief and Program Manager, Group Practice Manager, PCMM Coordinator and the JACC/System dermatologists.³⁷ The OIG also interviewed the VHA Program Manager for Consults with the VHA Program Office of Veterans Access to Care.

OIG staff reviewed relevant VHA and System directives, handbooks, and memorandums, and documents. The OIG reviewed the identified patient's electronic health record (EHR).

OIG staff reviewed 1,170 JACC dermatology consults initiated during fiscal year (FY) 2017 to determine whether scheduling delays occurred, based upon current VHA policy and timeframe, and why those delays, if any, occurred. OIG staff further reviewed the EHRs of patients for whom scheduling delays occurred to determine whether patients were at increased risk for, or experienced, adverse clinical outcomes as a result of scheduling delays.

³⁶ Within the context of this report, the OIG considered an adverse clinical outcome to be death, a change in diagnosis, a change in the course of treatment, or a significant change in the patient's level of care.

³⁷ VHA Handbook 1101.02; VHA Directive 1406.

For purposes of this report, during its review of the 1,170 JACC dermatology consults, the OIG considered a VA patient appointment that occurred or was scheduled beyond 30 days of the original consult's clinically indicated date (CID) as a scheduling delay.³⁸ The risk of an adverse clinical outcome associated with scheduling delays in care is a function both of the potential severity of the referring complaint and of the magnitude of the delay. The risk increases if the delay is prolonged and the patient's disease process is one that could progress to severe disability or death.

The OIG recognizes that in addition to the potential for adverse clinical outcomes, avoidable delays and cancellations associated with deficiencies identified and discussed in this report may impact the convenience and quality of care received by veterans, some of whom travel long distances to seek care from a VA healthcare facility. The OIG was unable to quantify the frustration, confusion, or disturbances in a patient's activities of daily living that may have resulted from these deficiencies and focused its evaluation of patient harm in terms of adverse clinical outcomes.

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 issues.

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

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

³⁸ The OIG defined "original consult" as the initial consult order for a dermatology appointment, including any discontinued consult for which a new dermatology consult was made with a new CID after the initial one was discontinued. VHA Directive 1232(1); The CID is the date a VA health care provider (the sending provider) deems clinically appropriate for the patient's appointment. VHA Directive 1230; For this inspection, the OIG omitted patient-driven scheduling delays (for example, the patient did not show, cancelled, or rescheduled).

Patient A Case Summary

At the time of the OIG’s review, Patient A was in his/her 70s with a history of BCC.³⁹

In mid-2014, Patient A initiated primary care services at the JACC and received treatment for right hand pain. Approximately one month later, Patient A’s assigned PCP (PCP 1) conducted an initial annual JACC physical exam. Patient A received medication for gout and shingles over the next several months. JACC staff canceled Patient A’s annual physical exam scheduled for mid-2015 as PCP 1’s “last day” was a few days before the appointment. In mid-2016, Patient A’s newly assigned PCP (PCP 2) performed the annual physical exam.

From mid-2015–mid-2016, Patient A contacted JACC four times with medical complaints, completed two audiology visits, and attended one nurse visit for immunizations. Patient A presented for three walk-in visits and was seen by a nurse who discussed a plan of care with a physician.

In mid-2016, Patient A called the primary care nurse and complained of a “spot” on the right cheek for the last four weeks that had gone from “pale whitish” to “black”, and inquired about “the status of [his/her] derm [dermatology] consult.”⁴⁰ The same day, PCP 2 ordered a JACC dermatology consult based on the patient-initiated phone call. According to EHR documentation, PCP 2 entered a day in mid-2016, as the CID. A JACC dermatologist reviewed the consult request the same day and changed the CID to a date two months later.

Approximately three months later, a JACC dermatologist evaluated the patient, described the spot on the cheek as a “pink keratotic⁴¹ lesion about 4 mm [millimeters] in size,” and noted a second lesion on the right chest. The dermatologist diagnosed Patient A with BCC and recommended biopsies of the lesions.

The dermatologist’s treatment note indicated Patient A was instructed to return to the clinic in two months for a biopsy. However, due to non-availability of appointments at JACC, schedulers placed the patient on the Veterans Choice List and Patient A was approved for a Choice dermatology consult approximately two weeks later.⁴² Although the CID was listed as three months later in late 2016, and VA’s EHR did not indicate a dermatology appointment was set up, a Choice dermatologist biopsied the lesions within two months. A few weeks later, the Choice dermatologist informed Patient A that the biopsies showed BCC and instructed Patient A to

³⁹ The OIG uses gender-neutral language to maintain patients’ privacy.

⁴⁰ This is the first documentation in the EHR relating to the patient’s dermatologic issue; however, the EHR notes that the patient presented with the complaint at an earlier date.

⁴¹ Keratosis is a localized horny overgrowth of skin, such as a wart or callus. Updated August 23, 2018 <https://www.medicinenet.com/script/main/art.asp?articlekey=4098>. (The website was accessed on August 23, 2018.)

⁴² VHA Directive 1230. This list is an electronic list used by the VHA for the defined purpose of the Veterans Choice Program.

return for removal of the lesions. Four weeks later, as scheduled, the Choice dermatologist removed Patient A's cheek lesion. Approximately two months later in early 2017, the Choice dermatologist removed Patient A's chest lesion.

Inspection Results

Issue 1: Patient A's PCP Assignment

Although the OIG did not substantiate that the patient was without an assigned PCP for over a year, the OIG determined that the patient was not assigned to a PCP for approximately nine months, from the time PCP 1 resigned until the patient was assigned to PCP 2. The OIG also identified that while waiting to be assigned to PCP 2, Patient A remained assigned to a provider who had resigned and no longer practiced at the System.

A PCP is a provider, such as a physician, nurse practitioner, or physician assistant, who provides ongoing and comprehensive care to VHA patients. VHA requires every patient to be assigned to a VHA PCP, and be enrolled in the PCP's patient panel to ensure that the patient receives primary care and, if specialty care (such as, in this case, dermatology), is needed, the assigned PCP may request appropriate consults.⁴³ VHA also requires VHA facilities to consistently use an electronic web-based management program, the PCMM, to track primary care patient/provider panel assignments.⁴⁴

In PCMM, PCP 1 was Patient A's assigned PCP when an annual physical examination was conducted in mid-2014. Patient A was scheduled to return to the JACC in one year. However, JACC staff canceled Patient A's 2015 annual physical exam because PCP 1 resigned a few days before the scheduled appointment. OIG staff found that, though not available to care for patients, PCP 1 remained in the PCMM between for nine months from mid-2015 to early 2016. Patient A remained assigned to this provider until reassigned in the PCMM to PCP 2. During the time not assigned to a PCP, Patient A sought and received treatment, as needed, by other JACC and community providers.

According to the PCMM Coordinator, prior to July 2016, the PCP assignment process was tasked to various medical support assistants whose practice was to keep patients assigned to a provider, even if the provider was no longer employed at the System, until the patient could be assigned to a new PCP. Otherwise, the patient would "disappear" in PCMM because no provider was assigned. As of July 2016, the PCMM Coordinator took over the PCP assignment process and now, according to the Coordinator, a patient losing a provider is reassigned to another PCP at the time the provider leaves the System.

⁴³ VHA Handbook 1101.02.

⁴⁴ VHA Handbook 1101.02.

Issue 2: Scheduling Delay for Patient A's Dermatology Care

The OIG substantiated that Patient A experienced a scheduling delay of approximately three months for a 2016 dermatology consult after the sending provider entered the consult with a requested date of service (CID). The OIG determined that, although Patient A did not experience an adverse clinical outcome attributable to this scheduling delay, the risk of an adverse outcome increased as a result.

At the time of Patient A's dermatology consult, VHA based appointment scheduling on a desired date or the date the patient or provider requested an appointment to ensure timely patient care. The date was defined by the patient without regard to the schedule's capacity and it was impermissible to alter this date on grounds of a lack of appointment availability. If an appointment was not available on the requested date, the patient would be offered an appointment as close to the desired data as possible. If there was a discrepancy between what the patient and provider wanted for the appointment date, the scheduler was to contact the provider for a decision.⁴⁵

In 2016, VHA policy reflected that the timeframe expected for response was often found in a service agreement between the sending and receiving provider services.⁴⁶ However, the OIG found that the System dermatology and primary care service agreement, and the System Medical Bylaws referred to in the System service agreement did not include timeframes for dermatology consults to be scheduled and completed.

A JACC dermatologist, who was the receiving provider in this instance, reviewed the consult request from the patient's PCP, the same day as the consult request, and without consulting the patient or PCP, changed the PCP's desired appointment date to two months later. Subsequently, the patient was not seen until a scheduled appointment three months after the PCP's desired appointment date, when the consult was completed.

The JACC dermatologist was not prohibited from changing the desired date and was concerned that the sending provider had not assessed the patient's urgency correctly (the dermatologist mistakenly believed that the patient had to be seen on the desired date); however, when the dermatologist changed the sending provider's CID, neither the sending provider or patient were notified of the change. The provider and patient were not notified until the scheduler contacted them two months later, via the provider receiving a clinical alert and the patient receiving a telephone call, arranging for an appointment with the dermatologist the following month.

⁴⁵ VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedure*, June 9, 2010. This directive was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

⁴⁶ VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008; VHA Directive 1232(1).

Issue 3: Scheduling Delays in Dermatology Consults

The OIG determined that scheduling delays occurred for 540 of 1170 (46 percent) JACC dermatology consults initiated during FY 2017. The OIG also determined that none of the patients affected by the scheduling delays experienced an adverse clinical outcome; although, for one patient (Patient B—see discussion below), the delay increased the risk of an adverse clinical outcome.

VHA schedulers have the responsibility to correctly apply consult request information and make patient appointments that are scheduled accurately, consistently, and timely, with the goal of scheduling the appointment no more than 30 calendar days from the CID (the policy timeframe for scheduling an appointment for a consult). According to the policy in effect for FY 2017, schedulers are directed not to change the CID unless the patient cancels and reschedules the appointment. The CID also cannot be changed by the scheduler or receiving provider due to a lack of available appointments. The CID date may only be changed if entered in error, and the error is corrected by either the sending or receiving provider canceling and resubmitting the consult.⁴⁷

According to the VHA National Program Manager for Consults, while a receiving provider should not change the CID, the receiving provider may cancel (return) the consult to the sending provider suggesting a new CID with an accompanying reason.

Of the 1,170 dermatology consults reviewed, the OIG found 540 consults (46 percent) in which the patient was not seen within 30 days of the original consult CID (scheduling delay), thus not meeting VHA's goal of 30 days. The OIG team identified that 50 of these 540 consult delays (9 percent) were attributable to the fact that the original consults had been discontinued by the receiving provider and new consults made, thereby changing the original consult's CID.⁴⁸ The process of discontinuing consults and submitting a new consult for the same reason is not prohibited by VHA policy but it may delay definitive patient care.

Another 35 of the 540 consult delays (6 percent) reflected a change in the original CID by the schedulers with no evidence the patient canceled the consult. The remainder and majority of delays, 455 of the 540 consults (85 percent), were due to appointments being scheduled beyond 30 days of the CID with no evidence these were errors.

⁴⁷ VHA Directive 1230.

⁴⁸ Of the 50 discontinued consults, 33 new consults were made to tele-dermatology, 13 to non-VHA providers, and 4 had no additional dermatology consults. This process follows VHA policy but delays the patient's appointment with a specialty provider, such as dermatology, because a new CID may be made with the new consult. OIG considered this a delay if the consult went 30 days past the discontinued consult CID or original CID.

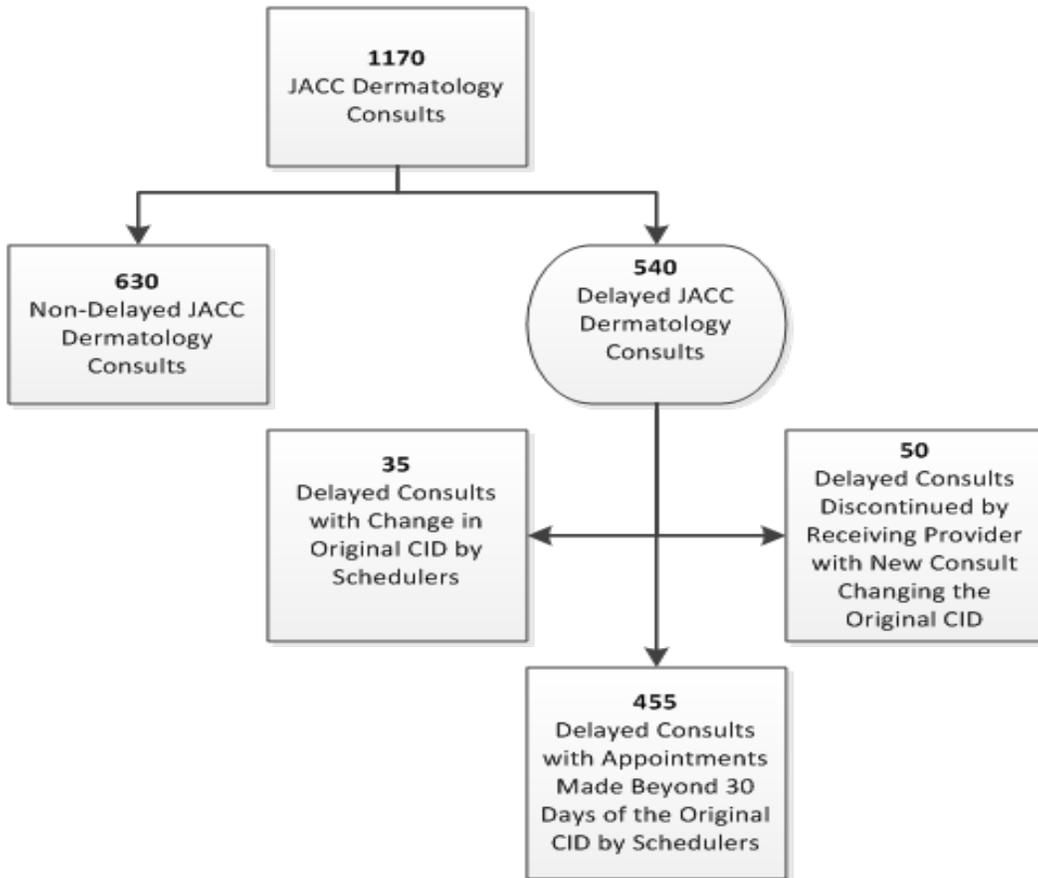


Figure 1. FY 2017 JACC dermatology consults delays
 Source: VA OIG analysis of VHA data

OIG determined that 114 of the 540 delayed dermatology consults had not yet been scheduled, and requested a response from the System for an action plan to address these unscheduled consults. According to the System Quality & Performance Management Chief, all 114 consults were reviewed and addressed as of May 17, 2018.⁴⁹

Of the 426 remaining delayed consults, OIG staff determined that scheduling delays ranged from 1–373 days, with an average delay of 38 days beyond 30 days after the CID.

Several reasons for these delays were identified by the JACC and System dermatologists as well as the System Chief of Non-VA Care:

⁴⁹ Of the 114 consults, 65 were seen by a dermatologist, and 49 consults were discontinued for various reasons including no shows for appointments, refusals for follow-up care in the community, and inappropriate for dermatology care, such as joint pain.

- Misunderstanding by sending providers on how to assess urgency of the consult
- Disagreements between the sending and receiving providers
- Lack of sufficient dermatology and non-VA care scheduling staff
- Lack of available appointments
- High demand for dermatology consults

JACC and System dermatologists described two alternative methods used to address patient care needs: referrals for a non-VA care consult or tele-dermatology consult.⁵⁰ In addition, the Chief of Non-VA Care stated that with support from the VISN Network Director, a staffing model was promoted that should assist in resolving scheduling issues.

Review of Delayed Consults for Adverse Clinical Outcome

OIG staff reviewed the EHRs of the 426 remaining delayed consults to determine whether the patient experienced, or was at increased risk for, an adverse clinical outcome as a result of the scheduling delay. OIG staff were unable to make a determination for 86 of the consults because the patient's final diagnosis or pathology report from the consult visit had not yet been uploaded to the patient's EHR. The OIG referred these consults to the System for review and response. According to the System Quality & Performance Management Chief, as of July 13, 2018, all 86 consults were reviewed and addressed.⁵¹

The OIG determined that, of the 340 remaining consults, none of the patients experienced an adverse clinical outcome as a result of the scheduling delay; however, one of the patients, Patient B, was put at increased risk of an adverse clinical outcome.⁵²

⁵⁰ In context of this report, a tele-dermatology consult is a process whereby a picture or image of the patient's lesion (that the sending provider wishes to be assessed) is uploaded to the dermatology consult, and the dermatologist assesses the lesion picture to triage whether the patient requires a face to face appointment.

⁵¹ Of the 86 consults, 73 received documented care based on pathology; nine consults had been canceled so no pathology was available (these were either because the veteran refused care or did not reschedule to get biopsy performed); two patients were re-scheduled for tele-dermatology; and one was a no-show for a community appointment. The Facility has followed up on one additional patient who was not scheduled in the community.

⁵² The OIG did not identify an increased risk related to consult delays for other dermatology patients who were reviewed; however, the OIG observed that patients with complex cases underwent a multi-step process before a cancer diagnosis was confirmed by biopsy. While care was timely within the context of VHA guidelines at each step, the OIG noted that the number of steps could interfere with overall timeliness of care.

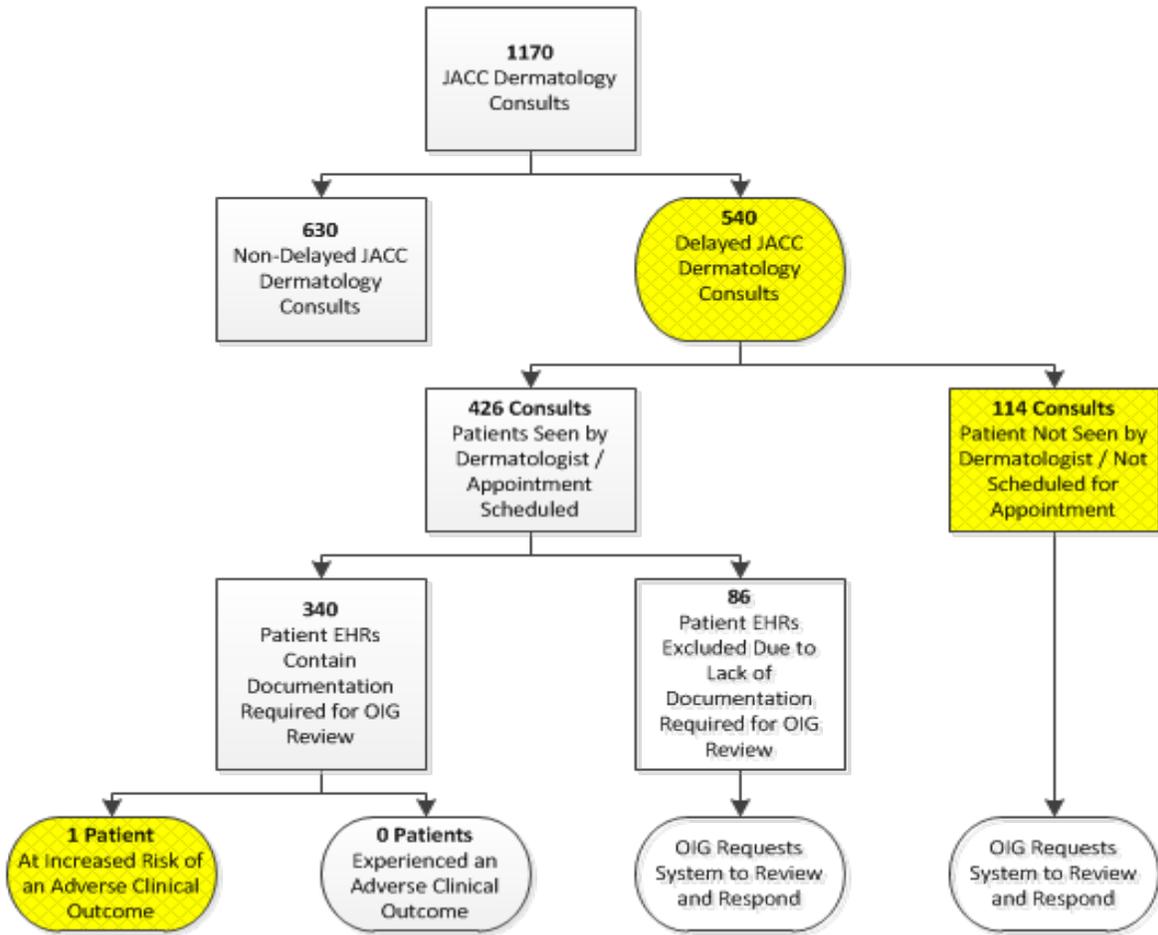


Figure 2. VA OIG evaluation of FY 2017 JACC dermatology consult delays for adverse clinical outcomes

Source: VA OIG analysis of VHA data

Patient B

Consult cancellation and/or discontinuation may be acceptable for receiving consultants if there is adequate two-way communication between the sending and receiving providers and the patient. The OIG found that consult cancellation/discontinuation was the case with 50 consults, as noted earlier.⁵³ However, the OIG determined that the repeated use of this process contributed to one of the 50 consult patients, Patient B, not being seen or scheduled within 30 days of the original CID. The 205-day delay in Patient B’s care resulted in frustration amongst PCPs and dermatologists as well as the patient and increased the patient’s risk of an adverse outcome.

⁵³ VHA Directive 1232(1).

Patient B Case Summary

Patient B was in his/her 50s when care was initiated at the JACC in mid-2012. Patient B's medical problems were managed by a PCP (PCP 3) and medical specialists at the JACC.

In early 2017, Patient B had an annual exam by another PCP (PCP 4) who was covering for PCP 3. During the exam, PCP 4 noted "multiple nevi, one irregular in the posterior chest measuring 5 mm diameter" and ordered a dermatology consult. That same day, a receiving provider (Dermatologist 1) discontinued the consult and recommended a tele-dermatology consult. The recommended tele-dermatology consult was not ordered, and no reason was given.

Seven months later, PCP 3 ordered a JACC dermatology consult because of "changing junctional nevus." Four days later, the consult was discontinued by another dermatologist (Dermatologist 2) who requested submission of a tele-dermatology consult and questioned why the PCP was not following the early 2017 dermatology recommendation. Approximately a week later, PCP 3 recommended Patient B for a biopsy and a dermatology clinic visit. That same day, Dermatologist 2 noted disagreement with biopsy and that a tele-dermatology appointment would better triage the patient for dermatology treatment. Dermatologist 2 again questioned why the PCP was not following the early 2017 dermatology recommendation. Later that day, PCP 3 added a comment to the EHR consult request that a referral to dermatology for a biopsy was within the practice of the PCP and documented "writer does not appreciate the delay in pt [patient] care." Two days later, Dermatologist 2 responded "stop delaying and place a tele-dermatology consult...or talk to the COS [Chief of Staff] and explain your stonewalling." About two hours later, PCP 3 noted placing a tele-dermatology consult approximately a week before, and that the dermatologist's comment about "stonewalling" was inappropriate. The tele-dermatology request was dated two days prior.

Patient B was seen by a tele-dermatologist the same day that PCP 3 submitted the tele-dermatology consult; the tele-dermatologist recommended a biopsy within 30 days for possible melanoma. Three weeks later, Dermatologist 1 recommended scheduling the patient in "60 days. Please do not overbook." PCP 3 pointed out that this was the third consult ordered regarding a lesion on the patient's back. PCP 3 questioned the recommendation from dermatology to schedule the patient in 60 days given a possible melanoma diagnosis.

Approximately six weeks later, Dermatologist 2 evaluated Patient B for the lesion on the back and obtained a biopsy for possible melanoma. The pathology report showed "malignant melanoma in situ at a nevus, extending to the peripheral margin." The deep margin was negative for cancer. Two weeks later, Dermatologist 2 ordered a surgery consult and Patient B was scheduled for surgery three days later. Patient B was seen by surgery and an excision procedure was performed to render the skin and tissue clear of cancer. The surgical procedure and consult report noted the biopsy pathology results indicating melanoma of the upper back. The patient had a skin excision procedure about a week later. A letter was sent to the patient approximately two weeks later, informing the patient that skin area did not show cancer.

Issue 4: Other Finding—Inappropriate EHR Documentation

The OIG determined that the documented exchange between providers caring for Patient B did not meet VHA requirements to exclude derogatory and critical comments from the patient's EHR.

VHA Handbook 1907.01, *Health Information Management and Health Records*, states “[t]he health record needs to reflect accurate and clinically-relevant statements; derogatory or critical comments are prohibited.”⁵⁴

As evidenced in Patient B's EHR and case summary above, providers made entries in the patient's record that used derogatory terms and included comments that were critical of each other.

Conclusion

The OIG did not substantiate that Patient A was without an assigned PCP for over a year. However, the OIG determined that the patient was not assigned to another PCP for approximately nine months, from the time PCP 1 resigned until the patient was assigned to PCP 2. Upon review of the patient's PCP assignments in PCMM, the OIG found that until Patient A was assigned to PCP 2, the System recorded the patient as on the panel of a provider who had left VA employment but was still listed in the PCMM.

The OIG substantiated that Patient A experienced a scheduling delay of approximately three months for a dermatology consult, because the receiving provider, a dermatologist, changed the sending provider's (PCP 2) desired date for an appointment. Although Patient A did not experience an adverse clinical outcome, the risk of an adverse outcome increased as a result of the scheduling delay.

Additionally, based on the System's responses prior to the OIG opening this review, OIG staff reviewed JACC dermatology consults to determine whether scheduling delays occurred because staff did not follow VHA processes, and, if delays occurred, whether those delays resulted in an adverse clinical outcome or an increased risk for an adverse clinical outcome.⁵⁵

The OIG determined that scheduling delays occurred in 46 percent of the JACC dermatology consults initiated during FY 2017, which did not meet the intent of the VHA goal for patients to have an appointment within 30 days of the sending provider's CID. The OIG found that none of the patients affected by the scheduling delays experienced an adverse clinical outcome. Staff reported reasons for these delays included misunderstanding by sending providers on how to

⁵⁴ VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

⁵⁵ For purposes of this report, the OIG considers an adverse clinical outcome to be death, a change in diagnosis, a change in the course of treatment, or a significant change in the patient's level of care.

assess consult urgency, disagreements between sending and receiving providers, lack of sufficient dermatology and non-VA care scheduling staff, lack of available appointments, and a high demand for dermatology consults. However, JACC and System dermatologists had employed two alternative consult methods to address patient needs, and the Chief of Non-VA Care developed a staffing model to assist with resolving scheduling issues.

Another patient, (Patient B) experienced an increased risk of an adverse clinical outcome due to delays in scheduling a dermatology consult appointment and differing diagnostic opinions.

OIG also determined that documented EHR communication between the two providers caring for Patient B was improper and contained derogatory and critical comments.

The OIG made four recommendations to the System Director.

Recommendations 1–4

1. The Gulf Coast Veterans Health Care System Director ensures that patients are assigned primary care providers, as required by Veterans Health Administration policy, and that the assignments are monitored for compliance.
2. The Gulf Coast Veterans Health System Director ensures that patients with Joint Ambulatory Care Center dermatology consults are scheduled as required by Veterans Health Administration policy and within the Veterans Health Administration consult timeframe, and that the scheduling process is monitored for compliance.
3. The Gulf Coast Veterans Health Care System Director ensures that system managers review dermatology and non-VA care scheduling staffing levels, and develop an action plan to address recommendations, if any, from the staffing level reviews.
4. The Gulf Coast Veterans Health System Director takes appropriate action as related to Patient B's physicians' improper electronic health record documentation as discussed in this report.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 10, 2018

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Provider Assignment and Dermatology Consult Scheduling Delays at the Joint Ambulatory Care Center, Pensacola, Florida

To: Director, Bedford Office of Healthcare Inspections, (54BN)

Director, Management Review Service (VHA 10E1D MRS Action)

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the response submitted by the Gulf Coast Veterans Health Care System, Biloxi, MS, regarding the Provider Assignment and Dermatology Consult Scheduling Delays Draft Report.

(Original signed by:)

Skye McDougall, PhD

Director, South Central VA Health Care Network (10N16)

Appendix B: System Director Comments

Department of Veterans Affairs Memorandum

Date: October 10, 2018

From: Director, Gulf Coast Veterans Health Care System (520/00)

Subj: Healthcare Inspection—Provider Assignment and Dermatology Consult Scheduling Delays at the Joint Ambulatory Care Center, Pensacola, Florida

To: Director, South Central VA Health Care Network (10N16)

Thank you for the opportunity to review this report. The collaborative, consultative and professional approach of the review team is worth noting as this contributed greatly to a thorough and beneficial inspection.

I concur with the recommendations outlined in this report. All findings have been reviewed and facility level action plans initiated as required.

Sincerely,

(Original signed by:)

Bryan C. Matthews, MBA

Comments to OIG's Report

Recommendation 1

The Gulf Coast Veterans Health Care System Director ensures that patients are assigned primary care providers, as required by Veterans Health Administration policy, and that the assignments are monitored for compliance.

Concur.

Target date for completion: January 31, 2019

Director Comments

Gulf Coast Veterans Health Care System will take steps to ensure patients are assigned primary care providers in accordance with VHA Directive 1406. Assignment results will be reported to Leadership via the Quality, Safety and Value Committee until compliance is achieved.

Compliance will be considered when assignments exceed 90% or greater for three consecutive months. Ongoing monitoring and reporting will occur in regularly scheduled Primary Care Leadership meetings thereafter.

Recommendation 2

The Gulf Coast Veterans Health System Director ensures that patients with Joint Ambulatory Care Center dermatology consults are scheduled as required by Veterans Health Administration policy and within the Veterans Health Administration consult timeframe, and that the scheduling process is monitored for compliance.

Concur.

Target date for completion: January 31, 2019

Director Comments

Medical Administration Service will work collaboratively with Medicine Service to ensure all Joint Ambulatory Care Center dermatology consults are scheduled as required by Veterans Health Administration guidelines. Weekly monitoring of consult activity is a part of the Group Practice Manager's reporting practices, and reporting will be enhanced for increased monitoring of JACC dermatology. Scheduling results will be reported to Leadership via the Quality, Safety and Value Committee until compliance is achieved. Compliance will be considered when scheduling practices exceed 90% or greater for three consecutive months. Ongoing monitoring and reporting will occur in regularly scheduled Consult Oversight Committee meetings as part of consult scheduling reporting thereafter.

Recommendation 3

The Gulf Coast Veterans Health Care System Director ensures that system managers review dermatology and non-VA care scheduling staffing levels, and develop an action plan to address recommendations, if any, from the staffing level reviews.

Concur.

Target date for completion: January 31, 2019

Director Comments

Staffing levels have been reviewed. In response, the Office of Community Care (Non-VA Care) has developed a work unit consisting of one Registered Nurse, one Licensed Practical Nurse and two Program Support Assistants dedicated to the improved management of dermatology consults for Gulf Coast VA Veterans. In addition, Gulf Coast VA will continue to recruit to fill vacant positions within the Dermatology section of Medicine Service and utilize Tele-Derm services as needed.

Recommendation 4

The Gulf Coast Veterans Health System Director takes appropriate action as related to Patient B's physicians' improper electronic health record documentation as discussed in this report.

Concur.

Target date for completion: November 30, 2018

Director Comments

A review has been initiated of the improper medical record documentation identified in the report. Service Leadership will consult with Human Resources and Clinical Applications to determine what, if any, actions are to be taken in correcting the electronic medical record.

OIG Contact and Staff Acknowledgments

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