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VETERANS HEALTH ADMINISTRATION

Leaders Failed to Ensure a Dermatologist Provided Quality Care at the Carl T. Hayden VA Medical Center in Phoenix, Arizona

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Carl T. Hayden VA Medical Center (facility) in Phoenix, Arizona, to assess concerns regarding facility leaders' responses to allegations of a dermatologist's deficiencies in quality of care and documentation.[1] The OIG determined that facility leaders (supervisory staff and senior leaders) failed to adequately review and address all of the concerns outlined in 48 patient safety reports and two consecutive unsatisfactory proficiency reports (proficiencies) related to the dermatologist's quality of care and documentation.[2] The OIG concluded that the dermatologist was allowed to continue practices that may have placed patients at risk from 2021 to late 2023.[3]

Interviews with clinical staff and a review of facility documents and patient electronic health records (EHRs), showed that the dermatologist

- delayed performing biopsies, allowing cancers the opportunity to grow;
- delayed communicating test results, potentially resulting in delayed treatment for skin cancers;
- misused copy and paste, increasing the potential for missed diagnoses;
- failed to address all lesions identified in consults, delaying assessments and biopsies;
- delayed entering specialty consults, thus delaying referral to specialists' care; and

[1] VHA defines quality as the delivery of "highly reliable health care services that are safe, timely, effective, efficient, equitable and patient centered." VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. For the purposes of this report, the term "facility leaders" includes both supervisory staff (chief of dermatology and chiefs of medicine) and senior leaders (Facility Director, Chief of Staff, and Associate Director of Patient Care Services). The dermatologist's direct supervisor was the chief of dermatology, and the second line supervisor was the chief of medicine. The credentialing and privileging manager told the OIG that the dermatologist was removed from patient care in late 2023; after the Medical Executive Board recommended that the dermatologist's privileges not be renewed based on clinical care concerns. The dermatologist "resigned/retired" mid-summer 2024.

[2] Supervisory staff rated the dermatologist's performance annually as required using a proficiency rating system documented on an annual proficiency report. VA Directive 5013, *Performance Management Systems*, April 15, 2002.

[3] Patient safety reports began in 2022, however, the chief of dermatology stated first becoming aware of an issue with the dermatologist in 2021.

- prescribed treatments that may have been "inadequate" (according to facility review) for treating certain cancers, placing patients at risk for recurrence or progression of the underlying skin cancers.[4]

Facility supervisory staff conducted a management review and focused professional practice evaluation (FPPE) for cause to address the delays in communicating test results and entering specialty consults.[5] However, supervisory staff failed to take adequate action to review and resolve the other clinical deficiencies.

Supervisory Staff's Failures

According to VA policy, "supervisors are responsible for evaluating the proficiency of employees they supervise, for counseling employees to improve the quality of service and to correct deficiencies, [and] for taking action if performance does not improve: . . ."[6]

The chief of dermatology rated the dermatologist's proficiencies as unsatisfactory for fiscal years 2022 and 2023; both proficiencies included documentation of deficiencies related to delays in performing biopsies and conduct concerns such as tardiness (arriving late for work) and lack of professionalism.[7] The chief of dermatology reported verbally discussing and counseling the dermatologist during the rating period and stated the belief that once the proficiency was rated and submitted, the chiefs of medicine were responsible for implementing corrective actions.[8]

To address the fiscal year 2022 unsatisfactory proficiency rating, the former chief of medicine, who was in an acting role, focused on conduct issues such as tardiness and lack of

[4] Misuse of copy and paste in patient electronic health records occurs when information is redundant, outdated, inconsistent, or includes another provider's signature. Facility Policy, *Rules and Regulations of the Medical Staff Phoenix VA Health Care System Phoenix, Arizona,* July 31, 2023; Amy Y. Tsou, et al., "Safe Practices for Copy and Paste in the EHR," *Applied Clinical Informatics 8* (2017): 12-34, https://doi.org/10.4338/aci-2016-09-r-0150.

[5] An FPPE for cause "is a time-limited period during which the clinical service chief assesses the health care LIP's [licensed independent practitioner's] performance to determine if any action should be taken on the LIP's privileges after a clinical concern has been triggered." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. The April 2023 directive has the same or similar language as the March 2023 directive related to FPPE for cause. The management review also included a retrospective review of delays in performing biopsies, but supervisory staff took ineffective actions to correct the deficiency.

[6] VA Handbook 5013/1, *Performance Management Systems*, November 18, 2003.

[7] "The federal government's fiscal year runs from October 1 of one calendar year through September 30 of the next." USA.gov, "The Federal Budget Process," accessed March 14, 2024, https://www.usa.gov/federal-budget-process#:%60:text=The%20federal%20government%27s%20fiscal%20year,September%2030%20of%the%20next. The 2022 proficiency covered a rating period from October 1, 2021, through September 30, 2022, and the 2023 proficiency covered a rating period from October 1, 2022, through September 30, 2023.

[8] The Chief of Staff is a senior leader responsible for oversight of clinical care provided at the facility. The chief of medicine, who reports to the Chief of Staff, is responsible for oversight of the Medicine Service at the facility.

professionalism but did not address the delays in performing biopsies.[9] During the 2023 rating period, the chief of medicine reprimanded the dermatologist for tardiness, mandated the dermatologist complete biopsies during the initial patient visit (unless contraindicated), and tracked the number of days from initial visit to biopsy. However, the chief of medicine reported not addressing the fiscal year 2023 proficiency rating due to recommending nonrenewal of clinical privileges after the dermatologist failed the FPPE for cause. Actions to correct the delays in performing biopsies were ineffective as the delays continued until the dermatologist was removed from patient care in late 2023.

Supervisory staff also failed to correct the dermatologist's misuse of copy and paste.[10] During an interview with the OIG, the chief of dermatology recalled that the dermatologist was not receptive to feedback regarding misuse of copy and paste and failures in updating clinical information in the EHR, and that the misuse continued. Additionally, the chief of dermatology and patient safety manager failed to report the misuse of copy and paste to Health Information Management Service (HIMS) staff, as required. The chief of HIMS told the OIG that the facility's randomized audit process did not detect concerns related to the dermatologist's misuse of copy and paste. The chief of dermatology described being unaware of reporting requirements, and the patient safety manager could not explain why HIMS staff were not notified of the concern.

After receiving allegations that the dermatologist documented electrodesiccation and curettage (ED&C) procedures that had not been performed, the chief of dermatology did not complete a comprehensive review as warranted.[11] Supervisors in the Veterans Health Administration (VHA) may utilize a tool known as a *factfinding* to prove or disprove an allegation by gathering and analyzing evidence and documenting conclusions in an investigative report.[12] The chief of dermatology reported conducting "essentially" a factfinding, including discussing the concern with the dermatologist and reviewing some of the dermatologist's notes in patients' EHRs. The

[9] According to the former chief of medicine, human resources' staff provided advisement to pursue conduct concerns but did not provide advisement to address performance concerns. The former chief of medicine presumed that human resources later advised the incoming chief of medicine to pursue performance because the "lack of professionalism" would not be a sufficient basis for termination. Human resources staff provide advisement to supervisors; however, supervisors have the duty to take action when performance does not improve. VA Handbook 5021, *Employee/Management Relations*, April 15, 2002.

[10] The OIG found instances when the dermatologist copied and pasted EHR notes from one visit to the next with minimal or no changes, and copied and pasted other provider's signatures as prohibited by facility policy. Facility Policy HIMS-01*, Completion of Medical Records*, March 25, 2021.

[11] American Cancer Society, "curettage and electrodesiccation," accessed March 14, 2024, https://www.cancer.org/cancer/types/skin-cancer/skin-biopsy-treatment-procedures/curettage-electrodesiccation.html. Electrodesiccation and curettage (ED&C) is a treatment a doctor uses to scrape and destroy skin cancer cells.

[12] VHA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021. A factfinding is a type of administrative investigation used to collect and analyze evidence, obtain facts, and document accurate and complete information.

chief of dermatology reviewed patient EHR follow-up notes for evidence of signs of tumor recurrence indicating that ". . . the tumors resolved with [the dermatologist's] treatments most of the time[;] that would not likely have occurred if they were not treated." However, the chief of dermatology did not seek additional information from other sources, and the EHR review was inadequate due to the dermatologist's misuse of copy and paste outlined in this report.[13] The OIG concluded that the review was not adequate due to the seriousness of the allegation and potential impact to patients.

Senior Leaders' Failures

The facility's Chief of Staff (COS) has a core responsibility to oversee the quality and safety of clinical and medical services provided to patients at the facility, and to review and address pervasive concerns related to perceived or actual compromises to patient safety and quality of care.[14]

Facility staff submitted 48 patient safety reports from September 2022 to December 2023 related to the dermatologist's care. The COS reported not learning until early 2023, through the chief of medicine, that the dermatologist delayed communicating test results. The COS also recalled learning about the delays in performing biopsies and entering specialty consults during the FPPE for cause.[15] When asked about documentation concerns, the COS did not recall awareness of these issues. However, according to the chief of quality, safety, and improvement (chief of quality management), the COS attended meetings that would have contained information about each patient safety report that was submitted.

The chief of quality management told the OIG that information about the patient safety reports that had been submitted the previous day were reported in daily meetings that included service chiefs and senior leaders. The chief of quality management explained that the specific dermatologist's name would not have been shared out of concern for implicating the dermatologist when the report had not been investigated and confirmed; however, the reporter would have identified dermatology and a summary of each concern. Despite staff continuing to report concerns that were shared at the meetings and two unsatisfactory proficiency ratings that included documentation of clinical care deficiencies, the COS reported not being aware of the full extent of the dermatologist's deficiencies in care and documentation. The OIG determined that the COS should have been aware of the extent of the care concerns regarding the

[13] VHA Handbook 0700. Other sources could have included interviewing resident physicians or nursing staff. The chief of dermatology told the OIG that information was not obtained from other sources due to a lack of awareness of who was in the room with the dermatologist. However, the OIG found instances where residents and nurses documented being present during biopsy procedures in which the dermatologist later documented that ED&C procedures were performed.

[14] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[15] The FPPE for cause was initiated in March 2023.

dermatologist when multiple concerns were reported, unsatisfactory proficiencies were issued, and supervisory staff were ineffective in addressing the deficient care.

The Facility Director decided to not renew the dermatologist's privileges due to recommendations from the facility's Medical Executive Board but failed to ensure timely initiation of state licensing board reporting processes, as required. The Facility Director, COS, and chief of medicine told the OIG that initiating the state licensing board reporting process would occur either after the exit review form or a fair hearing was completed. However, according to VHA policy, the state licensing board reporting process should not be delayed by the personnel or fair hearing process and must be initiated once there is "substantial evidence of the provider significantly failing to meet the generally accepted standards of clinical practice to raise reasonable concern for the safety of patients."[16] Multiple facility leaders had evidence that the dermatologist did not provide quality care, demonstrated by two consecutive unsatisfactory proficiency ratings and a failed FPPE for cause.[17]

Care Review and Disclosure

According to VHA policy, the disclosure of "harmful or potentially harmful adverse events to patients or their personal representatives" should be initiated "as soon as reasonably possible."[18] The COS told the OIG that patient disclosures regarding care by the dermatologist were not warranted because no patient harm was found during the management review, FPPE for cause, or continued review of patient care upon completion of the FPPE for cause. However, the chief of medicine, who conducted the reviews, told the OIG that the assessment for harm focused specifically on the dermatologist's delays in communicating test results and entering specialty consults, with an emphasis on patients diagnosed with melanoma. The OIG determined that the review for patient harm did not encompass all concerns laid out in this report, was not a comprehensive review of the care provided to patients, and was not conducted by a dermatologist. Additionally, disclosures should be considered not only when there is actual harm, but also when there is a potential for harm.[19]

After the OIG site visit, the chief of dermatology reviewed EHRs of 14 of the dermatologist's patients who were identified by a concerned nursing staff member and found that two patients should have received alternative treatments, one patient did not have all identified lesions

[16] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. An exit review "must be conducted to confirm that the licensed provider's clinical practice met the standard of care during the provider's professional relationship with the facility."

[17] The chief of dermatology also told the OIG that the dermatologist failed to meet generally accepted standards of clinical practice in the fall of 2022.

[18] "Adverse events are untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[19] VHA Directive 1004.08.

addressed, and four patients experienced biopsy delays.[20] Based on the chief of dermatology's identified care concerns from the review of 14 patients, patients may still be in need of follow-up care and disclosure.

The OIG made one recommendation to the Veterans Integrated Service Network Director related to noncompliance with state licensing board reporting processes. The OIG made seven recommendations to the Facility Director related to leaders addressing clinical deficiencies, the misuse of copy and paste, documentation of procedures not performed, and the need for follow-up care and disclosure.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred in principle with recommendation 1 and concurred with recommendations 2–8. Acceptable action plans were provided for each recommendation (see appendixes C and D). The OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.

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[20] The chief of dermatology noted a plan to order follow-up appointment for patients needing additional assessment.

Contents

Abbreviations

COS	Chief of Staff
ED&C	electrodesiccation and curettage
EHR	electronic health record
FPPE	focused professional practice evaluation
SLB	state licensing board
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Carl T. Hayden VA Medical Center (facility) in Phoenix, Arizona, to assess concerns regarding facility leaders' responses to allegations of a dermatologist's deficiencies in quality of care and documentation.[1]

Background

The facility is part of Veterans Integrated Service Network 22 and includes 12 community-based outpatient clinics. The Veterans Health Administration (VHA) classifies the facility as a level 1a complexity.[2] The facility offers a variety of clinical services such as primary care, mental health, and specialty care that includes dermatology. From October 1, 2022, through September 30, 2023, the facility served 115,127 patients. During this period, the facility had six dermatologists who provided care to 4,196 patients during 7,230 visits.

Dermatologists and Skin Cancer

"A dermatologist is a medical doctor who specializes in conditions that affect the skin, hair, and nails."[3] Dermatologists are responsible for the diagnosis and treatment of skin cancer. Diagnosing skin cancer requires a biopsy, which is a procedure to remove questionable lesions for laboratory testing.[4] Skin cancer is the most common type of cancer found in the United States and most can be cured if treated in early stages. Basal cell carcinoma is the most common skin cancer and can penetrate deep into tissue causing damage and disfigurement. Squamous cell carcinoma is the second most common type of skin cancer and can grow deep into tissue and

[1] VHA defines quality as the delivery of "highly reliable health care services that are safe, timely, effective, efficient, equitable and patient centered." VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. For the purposes of this report, the term "facility leaders" includes both supervisory staff (chief of dermatology and chiefs of medicine) and senior leaders (Facility Director, Chief of Staff, and Associate Director of Patient Care Services). The dermatologist's direct supervisor was the chief of dermatology, and the second line supervisor was the chief of medicine. According to the credentialing and privileging manager, the dermatologist stopped providing patient care at the facility in late 2023. The dermatologist "resigned/retired" mid-summer 2024.

[2] VHA Office of Productivity, Efficiency and Staffing (OPES), "Data Definitions VHA Facility Complexity Model," October 1, 2023. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

[3] "What is a Dermatologist," American Academy of Dermatology Association, accessed October 31, 2023, https://www.aad.org/public/fad/what-is-a-derm.

[4] *Merriam-Webster.com Dictionary*, "lesion," accessed March 14, 2024, https://www.merriam-webster.com/dictionary/lesion. A lesion is "an injured or diseased spot or area clearly marked off from healthy tissue around it."

spread to other parts of the body. Melanoma, the most serious skin cancer, also has a tendency to spread to other parts of the body; therefore, early diagnosis and treatment is critical.[5]

A dermatologist's responsibilities include timely assessment and biopsy, follow-up of test results including patient notification, and appropriate treatment or referral to a specialist if unable to provide appropriate treatment. Timely assessment is critical to allow for detection and treatment in early stages, before the cancer causes disfigurement and spreads to other areas of the body.

Prior OIG Reports

In 2023, the OIG published a report that identified concerns related to healthcare providers failing to properly communicate abnormal test results to patients. The OIG made five recommendations including a recommendation for the Facility Director to ensure that ordering providers deliver timely notification of abnormal test results to patients in accordance with VHA policy and monitors compliance. All five recommendations have been closed.[6]

In 2024, the OIG published a report that identified deficiencies in facility leaders' response to a medical emergency and an inadequate safety review. The OIG made 10 recommendations, including recommendations related to patient safety reporting and organizational communication. At the time of this inspection, all 10 recommendations remain open.[7]

Allegations and Concerns

In August 2023, the OIG received allegations that a dermatologist delayed performing biopsies and communicating abnormal test results; misused the copy and paste function (copy and paste) when documenting in patients' electronic health records (EHRs); and documented procedures that were not performed.

The OIG contacted the facility's Chief of Staff (COS) who reported that the dermatologist had been placed on a focused professional practice evaluation (FPPE) for cause, related to delays in communicating test results.[8] Because the FPPE for cause did not evaluate all of the allegations,

[5] "Types of Skin Cancer," American Academy of Dermatology Association, accessed April 1, 2024, https://www.aad.org/public/diseases/skin-cancer/types/common.

[6] VA OIG, *Deficiencies in Quality Management Processes and Delays in the Communication of Test Results and Follow-Up Care at the Phoenix VA Health Care System in Arizona*, Report No. 22-03599-07, October 31, 2023.

[7] VA OIG, *Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona,* Report No. 23-02958-203, July 24, 2024.

[8] An FPPE for cause "is a time-limited period during which the clinical service chief assesses the health care LIP's [licensed independent practitioners] performance to determine if any action should be taken on the LIP's privileges after a clinical concern has been triggered." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. The April 2023 directive has the same or similar language as the March 2023 directive related to FPPE for cause; In addition to the dermatologist's delays in communicating test results, the FPPE for cause also included a review of delays entering specialty consults.

the OIG opened an inspection to assess facility leaders' awareness and responses to the allegations that the dermatologist

- delayed performing biopsies,
- delayed communicating test results,
- misused copy and paste, and
- documented procedures not performed.[9]

The OIG also identified a concern related to the dermatologist's failure to perform all necessary biopsies for patients' lesions identified in consultations (consults).

Scope and Methodology

The OIG completed a site visit at the facility from December 5 through 7, 2023. Additional virtual interviews were conducted prior to and after the site visit.

The OIG interviewed 20 individuals including facility senior leaders, service chiefs, supervisory staff, quality management staff, and frontline clinical staff.[10]

The OIG reviewed VHA and facility policies; facility standard operating procedures; external standards and literature reviews; email correspondence; patients' EHRs; patient advocate tracking system reports; personnel and credentialing and privileging records; as well as administrative and quality management reviews.[11] The OIG also reviewed 48 patient safety reports that outlined clinical care concerns for 46 patients. During the inspection, the OIG reviewed documented clinical care concerns for an additional 13 patients identified by a nursing staff member.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG 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

[9] The OIG focused the inspection related to this allegation on the quality of care and patient safety concerns that could result from inaccurate documentation in a patient's EHR.

[10] The dermatologist's direct supervisor is the chief of dermatology, and the second line supervisor is the chief of medicine. For purposes of this report, the term supervisory staff is inclusive of both the chief of dermatology and the chief of medicine.

[11] Administrative reviews include a management review and the focused professional practice evaluation for cause referenced in this report. Quality management reviews include peer reviews referenced in Appendix A and reviews related to patient safety reports.

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Inspection Results

Facility leaders (supervisory staff and senior leaders) failed to adequately review and address all of the concerns outlined in 48 patient safety reports and two consecutive unsatisfactory proficiency reports (proficiencies) related to the dermatologist's quality of care and documentation.[12] The chief of dermatology noticed a quality of care deficiency starting in 2021. Staff reported concerns related to the dermatologist's care starting in September 2022. Additionally, the chief of dermatology rated the dermatologist's proficiencies as unsatisfactory in October 2022 and October 2023. However, the dermatologist was allowed to continue practices that may have placed patients at risk from 2021 to late 2023.[13] See table 1 in Appendix A for a timeline of the concerns and facility leaders' response.

Due to conflicting information from nursing staff and the dermatologist and a lack of a comprehensive review conducted by the chief of dermatology, the OIG was unable to verify whether the dermatologist documented procedures that had not been performed. However, based on interviews with clinical staff and a review of facility documents and patients' EHRs, the OIG confirmed that the dermatologist

- delayed performing biopsies, allowing potential cancers the opportunity to grow;
- delayed communicating test results, potentially resulting in delayed treatment for skin cancers;
- misused copy and paste, increasing the potential for missed diagnoses;

[12] Supervisory staff rated the dermatologist's performance annually as required using a proficiency rating system documented on an annual proficiency report. VA Directive 5013, *Performance Management Systems*, April 15, 2002.

[13] The credentialing and privileging manager told the OIG that the dermatologist was removed from patient care in late 2023, after a recommendation from the Medical Executive Board that the dermatologist's privileges should not be renewed based on clinical care concerns.

- failed to address all lesions identified in consults, delaying assessments and biopsies;
- delayed entering specialty consults, thus delaying referral to specialists' care; and
- prescribed treatments that may have been "inadequate" (according to facility review) for treating certain cancers, placing patients at risk for recurrence or progression of the underlying skin cancers.[14]

Facility supervisory staff were aware of the care and documentation deficiencies, and conducted a management review and FPPE for cause to address the delays in communicating test results and delays in entering specialty consults. However, supervisory staff failed to take adequate action to review and address the other concerns. See Appendix B, Patient A for an example of delays in communicating test results.

The COS is responsible for oversight of clinical operations and ensuring the delivery of high-quality and safe patient care but was unaware of and thus did not ensure evaluation and follow-up of the entirety of the care concerns. In March 2024, the Facility Director agreed with a recommendation to deny the dermatologist's re-privileging request after a failed FPPE for cause but did not initiate state licensing board (SLB) reporting as required.[15] The dermatologist continued to provide care to patients at the facility until privileges lapsed in late 2023.

Supervisory Staff's Failures

The OIG determined that supervisory staff failed to effectively address the dermatologist's unsatisfactory proficiencies and deficient documentation of information in patients' EHRs. Specifically, supervisory staff did not take effective actions to mitigate clinical concerns identified in the unsatisfactory proficiency ratings, correct the dermatologist's misuse of copy and paste, nor conduct a comprehensive review to assess the allegation of documenting procedures not performed.

Failure to Effectively Address Delays in Performing Biopsies Noted in Consecutive Unsatisfactory Proficiency Ratings

According to VA policy, "supervisors are responsible for evaluating the proficiency of employees they supervise, for counseling employees to improve the quality of service and to correct deficiencies, for taking action if performance does not improve. . . ."[16]

[14] Amy Y. Tsou, et al., "Safe Practices for Copy and Paste in the EHR," *Applied Clinical Informatics* 8, no.1 (January 11, 2017): 12-34, https://doi.org/10.4338/ACI-2016-09-R-0150.

[15] VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021; The Facility Director told the OIG that the SLB reporting process would be initiated after the dermatologist's employment ended.

[16] VA Handbook 5013/1, *Performance Management Systems*, November 18, 2003.

The chief of dermatology rated the dermatologist's proficiencies as unsatisfactory in fiscal years 2022 and 2023.[17] The former chief of medicine, who was in an acting role, approved the fiscal year 2022 rating and the chief of medicine approved the fiscal year 2023 rating.[18] Both proficiencies included documentation of deficiencies related to the dermatologist's delays in performing biopsies and conduct issues, such as tardiness (arriving late for work) and a lack of professionalism. Specifically, the fiscal year 2022 proficiency included documentation that the delays in performing biopsies "caus[ed] the cancer to grow."[19] To address the delays in performing biopsies during the rating periods, the chief of dermatology reported discussing concerns and verbally counseling the dermatologist, but the delays in performing biopsies continued.[20]

In May 2023, the chief of medicine reported verbally mandating the dermatologist to complete biopsies during the initial patient visit unless contraindicated, which was consistent with other facility dermatologists' practices and tracked the number of days from initial visit to biopsy. However, after the chief of medicine's mandate, the dermatologist continued to delay performing biopsies.

The following example describes the impact to a patient due to the dermatologist's delay in performing a biopsy.

A patient was referred to the facility dermatology clinic in early 2022 for treatment of facial skin cancer and for evaluation of a leg growth that had been increasing in size "over the past 1 year." The dermatologist saw the patient the following month. The dermatologist did not document acknowledgment of the growth on the patient's leg, but treated the facial lesions and instructed the patient to return in three months. The patient returned to see the dermatologist who then documented a three-month history of a purple nodule on the patient's leg. The dermatologist noted that the nodule could be cancer but did not perform a biopsy. The patient then saw the dermatologist at two more appointments in mid-summer 2022. Documentation from the appointments reflected that the dermatologist acknowledged the need for and scheduled a biopsy of the leg nodule. However, the dermatologist did not complete the biopsy at the scheduled appointment, and the patient was referred for a vascular surgery consult. A vascular

[17] "The federal government's fiscal year runs from October 1 of one calendar year through September 30 of the next." USA.gov, "The Federal Budget Process," accessed March 14, 2024, https://www.usa.gov/federal-budget-process#:%60:text=The%20federal%20government%27s%20fiscal%20year,September%2030%20of%the%20next; The 2022 proficiency covered a rating period from October 1, 2021, through September 30, 2022, and the 2023 proficiency covered a rating period from October 1, 2022, through September 30, 2023.

[18] The Chief of Staff is a senior leader responsible for oversight of clinical care provided at the facility. The chief of medicine, who reports to the Chief of Staff, is responsible for oversight of the medicine service at the facility.

[19] The proficiency did not include documentation of patient examples demonstrating cancers growing.

[20] Verbal counseling is not a form of disciplinary action. VA Handbook 5021, *Employee/Management Relations*, April 15, 2002. According to a facility document, the dermatologist was asked not to work with dermatology residents for education; however, the action did not address the delays in performing biopsies.

surgeon biopsied the nodule in late 2022, almost one year from the initial dermatology referral.[21] A pathologist determined the nodule to be an invasive malignant melanoma.[22] See Appendix B, Patient B for a detailed summary.

During an interview with the OIG, the chief of dermatology stated the belief that once the proficiency was rated and submitted, the chiefs of medicine were responsible for implementing corrective actions. The former chief of medicine reported focusing on conduct issues such as "tardiness" and "lack of professionalism" after the dermatologist's first unsatisfactory rating and noted that the incoming chief of medicine focused on clinical issues.[23] In early spring the chief of medicine reprimanded the dermatologist for tardiness. The chief of medicine reported not addressing the fiscal year 2023 proficiency rating due to recommending nonrenewal of clinical privileges after the dermatologist failed the FPPE for cause. After failing the FPPE for cause in the fall of 2023, the dermatologist continued clinical duties until late 2023.

The OIG concluded that the chief of dermatology, chief of medicine, and former chief of medicine failed to take effective action to address delays in performing biopsies documented in the unsatisfactory proficiencies. Supervisory staff failures to take effective action to address the dermatologist's delays in performing biopsies placed additional patients at risk.

Failure to Effectively Address Documentation Deficiencies

According to VHA guidance, health record documentation is an important element of high-quality care that facilitates "communication and continuity of care among VA medical staff members."[24] Complete health record documentation is imperative "as it impacts quality of patient care, patient safety, and the number of medical errors."[25]

[21] The delay between the mid-summer 2022 consult and the late 2022 biopsy occurred so the patient could undergo vascular testing required by the vascular surgeon prior to the consultation.

[22] After experiencing a series of falls in late summer, the patient was admitted to a community hospital and died two days later. The OIG did not have access to information regarding the patient's cause of death. The chief of dermatology stated that the melanoma was atypical in appearance because it did not contain pigment, though a biopsy should have been completed early in the patient's course if a vascular tumor was suspected.

[23] According to the former chief of medicine, human resources staff provided advisement to pursue conduct concerns and did not provide advisement to address performance concerns. The former acting chief of medicine presumed that human resources later advised the incoming chief of medicine to pursue performance because the "lack of professionalism" would not be a sufficient basis for termination. Human resources staff provide advisement to supervisors; however, the supervisors have the duty to take action when performance does not improve. VA Handbook 5021.

[24] VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023.

[25] Tom Ebbers, et al., "The Impact of Structured and Standardized Documentation on Documentation Quality; A Multicenter, Retrospective Study," *Journal of Medical Systems 46*, no.46 (May 27, 2022), https://doi.org/10.1007/s10916-022-01837-9.

Misuse of Copy and Paste

Although facility policy allows for the use of copy and paste, misuse of copy and paste occurs when information is redundant, outdated, inconsistent, or includes another provider's signature.[26] Facility policy requires authors who enter erroneous information into the EHR to add an addendum to the note indicating the error. Further, facility policy requires incorrect documentation to be reported to Health Information Management System (HIMS) staff for correction.[27] HIMS staff monitor the use of copy and paste; findings must be reported to the Medical Records Committee and violations must be reported to the Executive Committee of the Medical Staff (Medical Executive Board) for disciplinary or other adverse action.[28]

The chief of dermatology was alerted to the dermatologist's misuse of copy and paste in September 2022. The OIG reviewed patients' EHRs and found instances when the dermatologist copied and pasted notes from one visit to the next with minimal or no changes, and copied and pasted other provider's signatures as prohibited by facility policy.[29] The OIG also identified that, in some instances, the misuse of copy and paste perpetuated the documentation of erroneous information in the EHR.

In an OIG interview, the dermatologist acknowledged copying notes from one visit to the next without updating some of the information and identified the issue as a mistake. The dermatologist also reported not adding addenda to indicate the error, contrary to policy.[30] The dermatologist acknowledged that the practice resulted in erroneous information in the patient's EHR; however, stated the belief that the issue would be resolved with entries of newer documentation.

The chief of dermatology informed the OIG that misuse of copy and paste and the need to update clinical information was discussed with the dermatologist in general, but the dermatologist was not receptive to the feedback and tried to justify the practice.

One example of the dermatologist's misuse of copy and paste involved not documenting a newly identified nasal lesion.

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[26] Facility Policy, *Rules and Regulations of the Medical Staff Phoenix VA Health Care System Phoenix, Arizona,* July 31, 2023; Amy Y. Tsou, et al., "Safe Practices for Copy and Paste in the EHR," *Applied Clinical Informatics 8* (2017): 12-34, https://doi.org/10.4338/aci-2016-09-r-0150.

[27] *Rules and Regulations of the Medical Staff Phoenix VA Health Care System Phoenix, Arizona*; Facility Policy; HIMS-01*, Completion of Medical Records*, March 25, 2021.

[28] Facility Policy HIMS-19, *Utilization of Copy and Paste Functionality for Documentation Within the Computerized Medical Record*, April 1, 2021; *Rules and Regulations of the Medical* Staff *Phoenix VA Health Care System Phoenix, Arizona*; According to the facility's Medical Staff's Bylaws, the Medical Executive Board serves as their Executive Committee of the Medical Staff.

[29] Facility Policy HIMS-01.

[30] Facility Policy HIMS-01.

During a visit with a patient previously seen by the dermatologist, the chief of dermatology learned that the dermatologist did not document a suspicious lesion on the patient's nose that was later determined to be basal cell cancer. The chief of dermatology informed the OIG that the dermatologist's note from spring 2023 was identical to the spring 2022 note, except for a change in the patient's age. In this case, the dermatologist copied and pasted the prior note, which stated, "no suspicious lesion or rash," resulting in inaccurate information in the patient's EHR.[31] *See Appendix B, Patient C for extended case summary.*

The chief of HIMS explained that HIMS staff regularly audit a random selection of EHRs for misuse of copy and paste, and that service chiefs report documentation concerns to the Medical Records Committee. However, the chief of HIMS reported that random audits did not detect concerns with the dermatologist's use of copy and paste, and no reports had been submitted to the Medical Records Committee. The chief of dermatology stated being unaware of reporting requirements. The patient safety manager could not explain why HIMS staff were not notified of the reported concern. The chief of medicine reported being unaware of the dermatologist's instances of misuse of copy and paste.

The OIG concluded that the chief of dermatology's effort to correct the dermatologist's misuse of copy and paste through verbal discussion was not effective, as the practice continued. HIMS staff were not notified by the chief of dermatology nor patient safety staff and the errors were not corrected. The OIG is concerned that the dermatologist's deficient documentation practices were not effectively addressed and may have placed patients at risk due to documenting erroneous information or failing to document critical information, such as the nasal lesion in the example provided.

[31] The chief of dermatology biopsied the lesion revealing basal cell cancer. The patient received the needed treatment through removal of the cancer.

Inadequate Response to Allegation of Documenting Procedures That Had Not Been Performed

In 2020, VHA began to implement High Reliability Organization (HRO) concepts to promote a culture of safety.[32] Within HROs, leaders should actively seek knowledge about patient care concerns.[33] Supervisors in VHA may utilize a tool known as a factfinding to prove or disprove an allegation. A factfinding includes identifying and interviewing witnesses.[34]

Nursing staff told the OIG that the dermatologist documented electrodesiccation and curettage (ED&C) procedures that had not been performed.[35] Specifically, nursing staff told the OIG that during follow-up patient visits, the dermatologist documented that a patient had undergone an ED&C at a prior visit; however, the dermatologist had not documented the procedure in the EHR on the purported date of the visit, and equipment necessary to complete an ED&C procedure had not been present in the room.[36] The dermatologist informed the OIG that an ED&C procedure would have been documented if the procedure had been performed. See Appendix B, Patient D in for an example of a patient who staff told the OIG did not have an ED&C completed but documentation reflected completion.

In an OIG interview, the chief of dermatology recalled staff voicing concerns that the dermatologist documented ED&C procedures that had not been performed and had "essentially" completed a factfinding. The OIG reviewed email correspondence and found that the chief of

[32] VA, *VHA High Reliability Organization (HRO) Reference Guide,* March 2020, revised April 2023. "High reliability means evidence-based, exceptional care is consistently delivered for every patient, every time, at any facility across VHA." There are three HRO pillars: leadership commitment, culture of safety, and continuous process improvement.

[33] "FAQ's for HRO," High Reliability Organizing, accessed September 12, 2024, https://www.high-reliability.org/faqs.

[34] VHA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021. A factfinding is a type of administrative investigation used to collect and analyze evidence, obtain facts, and document accurate and complete information.

[35] American Cancer Society, "Curettage and Electrodesiccation," accessed March 14, 2024, https://www.cancer.org/cancer/types/skin-cancer/skin-biopsy-treatment-procedures/curettage-electrodesiccation.html. Electrodesiccation and curettage (ED&C) is a treatment a doctor uses to scrape and destroy skin cancer cells. During ED&C, a dermatologist scrapes out cancer cells with a sharp instrument (curette), and then applies an electric needle to further destroy cancer cells. ED&C can be performed immediately after biopsy for non-melanoma skin cancers. If an ED&C is not performed and the biopsy shows residual cancer, an additional visit is required to remove the remaining cancer through excisional surgery (cutting out cancer and surrounding healthy tissue) or Mohs surgery (removing cancer cells layer by layer utilizing a microscope to prevent the removal of excess healthy skin).

[36] VHA policy requires that documentation in patients' EHRs be accurate and timely. VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. Facility policy requires providers to write and sign progress notes "at the time of observation" when procedures are completed during outpatient visits and only additional information can be added later as an addendum; Facility policy HIMS-01, *Completion of Medical Records*, March 25, 2021. If an ED&C is not performed and the biopsy shows residual cancer, an additional visit is required for a procedure to remove the remaining cancer.

dermatology discussed the concern with the dermatologist and reviewed patient EHR follow-up notes for evidence of signs of tumor recurrence, as ". . . the tumors resolved with [the dermatologist's] treatments most of the time; that would not likely have occurred if they were not treated." However, the chief of dermatology did not interview other potential witnesses such as dermatology staff.[37] An OIG EHR review identified two separate instances when either a nurse or resident physician was in the room during the alleged procedure. The nurse staff member and resident documented the completion of the biopsies, but not the ED&C procedures. The OIG also determined that the chief of dermatology's EHR review was inadequate due to the dermatologist's misuse of copy and paste outlined in this report, which may have failed to accurately indicate the current assessment or treatments rendered.[38]

The OIG concluded that the chief of dermatology's reliance on a discussion with the dermatologist and review of patients' EHRs was insufficient in light of the seriousness of the allegations and potential impact to patients. The OIG would have expected the chief of dermatology to have conducted a comprehensive review to establish whether the dermatologist had falsely documented procedures that had not been performed. Documenting a procedure in a patient's EHR that was not performed may lead other providers to believe that the health issue was adequately addressed, thus delaying the needed treatment.[39]

Senior Leaders' Failures

In the health care setting, "leadership's first priority is to be accountable for effective care while protecting the safety of patients."[40]

Lack of Awareness of the Extent of the Concerns

The OIG determined that the COS should have been aware of the extent of the care concerns regarding the dermatologist when multiple concerns were reported, unsatisfactory proficiencies were issued, and supervisory staff were ineffective in addressing the deficient care.

[37] The chief of dermatology told the OIG that information was not obtained from other sources due to a lack of an awareness of who was in the room with the dermatologist. However, the OIG found instances where residents and nurses documented being present during biopsy procedures in which the dermatologist later documented that ED&C procedures were performed.

[38] The chief of dermatology reviewed for recurring tumors, however if the dermatologist had misused copy and paste, the assessment would have matched the previous assessment potentially portraying nonrecurrence inaccurately.

[39] Based on the factfinding conducted by the facility, there was inadequate evidence to support that the dermatologist had documented procedure(s) not performed. If on further investigation by the facility there is evidence to support the allegations, referral to the OIG's Office of Investigations may be warranted.

[40] The Joint Commission, "The Essential Role of Leadership in Developing a Safety Culture," *Sentinel Event Alert* 57, March 1, 2017, revised June 18, 2021, accessed March 26, 2024, https://www.jointcommission.org/-/media/tjc/newsletters/sea-57-safety-culture-and-leadership-final3.pdf.

High reliability organizations rely on staff at all levels to report issues before they cause harm to patients.[41] To ensure safe and effective care is provided to patients, senior leaders should foster a sense of collective responsibility and strategically create channels that facilitate communication of critical or pervasive deficiencies in care.[42]

The COS has a core responsibility to oversee the quality and safety of clinical and medical services provided to patients at the facility and to review and address pervasive concerns related to perceived or actual compromises to patient safety and quality of care.[43] Therefore, it is incumbent on the COS to have awareness of clinicians who are not providing quality care.

Facility staff submitted 48 patient safety reports from early fall 2022 to late fall 2023 relevant to the dermatologist's care. The COS reported learning in early 2023, through the chief of medicine, that the dermatologist delayed communicating test results. The COS also recalled learning about the delays in performing biopsies and entering specialty consults during the FPPE for cause.[44] When asked about documentation concerns, the COS did not recall awareness of these issues. However, according to the chief of quality, safety, and improvement (chief of quality management), the COS attended meetings that would have contained information about each patient safety report that had been submitted. The chief of quality management told the OIG that information about patient safety reports that had been submitted the previous day were reported in the meetings that included service chiefs and senior leaders and would have contained the specialty and a summary of the content. The chief of quality management explained that the dermatologist's name would not have been shared out of concern for implicating the dermatologist when the report had not been investigated and confirmed; however, the reporter would have identified dermatology and a summary of each concern. Despite staff reporting multiple concerns and risks to patient safety, the COS was not aware of the full extent of the dermatologist's ongoing deficiencies. During an interview with the OIG, the COS stated that the concerns related to the dermatologist may or may not have met the threshold to necessitate awareness at the COS level. The OIG would have expected the COS to be aware of, comprehensively review, and take action as warranted.

[41] Stephanie Veazie et al., *Evidence Brief: Implementation of High Reliability Organization Principles*, (Washington DC, VA, 2019), https://www.ncbi.nlm.nih.gov/books/NBK542883/.

[42] The Joint Commission, "The Essential Role of Leadership in Developing a Safety Culture."

[43] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[44] The FPPE for cause was initiated in March 2023.

Delay Initiating the State Licensing Board Reporting Process

The OIG determined that the Facility Director failed to ensure the SLB reporting process was initiated timely in accordance with VHA policy.

VHA policy assigns responsibility to the Facility Director for ensuring that the SLB reporting process is initiated timely after learning of a provider who potentially failed to meet generally accepted standards of clinical care.[45] Additionally, SLB reporting must be initiated within seven business days from when the Medical Executive Board proposes a privileging action to the Facility Director that is based on evidence of a provider's substandard care. "SLB reporting must not wait until a personnel action has been completed or until a related hearing process has concluded."[46]

During mid-summer 2024, the facility credentialing and privileging manager initiated the SLB reporting process. The chief of dermatology told the OIG of recognizing a deficiency in the dermatologist's care of patients in 2021. Additionally, the chief of dermatology stated that the dermatologist substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients in the fall of 2022, when staff started submitting patient safety reports. Additionally, the two consecutive unsatisfactory proficiency ratings included documentation of clinical practice concerns. Further, in mid-fall 2023, the dermatologist failed the FPPE for cause related to delays in communicating test results and entering specialty consults.

In late 2023, the COS notified the dermatologist that the Medical Executive Board recommended nonrenewal of clinical privileges, based on a failed FPPE for cause. The Facility Director, COS, and chief of medicine told the OIG that initiating the SLB reporting process would occur either after the completion of an exit review form or a fair hearing.[47]

The OIG concluded that the Facility Director failed to ensure SLB reporting was initiated timely when multiple facility leaders had substantial evidence to support that the dermatologist significantly failed to meet the generally accepted standards of clinical practice and the Medical Executive Board recommended nonrenewal of clinical privileges.

[45] VHA Directive 1100.18. The directive states, a "VA-initiated report to a[n] SLB is only notice to the SLB that there is a question of a professional's clinical practice or behavior. . . .VA has no authority to require a[n] SLB to take any action against a reported professional's license."

[46] VHA Directive 1100.18.

[47] VHA Directive 1100.18. An exit review "must be conducted to confirm that the licensed provider's clinical practice met the standard of care during the provider's professional relationship with the facility;" The dermatologist "resigned/retired" mid-summer 2024.

Care Review and Consideration for Disclosure and Follow-Up Care

After the OIG site visit, the chief of dermatology reviewed EHRs of 14 of the dermatologist's patients and found additional patient care concerns. Therefore, the OIG determined that because of the concerns outlined in this report and the results of the chief of dermatology's review of the patients' EHRs, additional reviews, consideration for disclosures, and follow-up care are warranted.

According to VHA policy, the disclosure of "harmful or potentially harmful adverse events to patients or their personal representatives" should be initiated "as soon as reasonably possible." Disclosures can be clinical or institutional. Clinical disclosures involve a clinician informing a patient or patient's representative that a harmful or potentially harmful adverse event occurred. Institutional disclosures require VA medical facility leaders and clinicians to inform a patient or patient's representative of an adverse event that resulted in, or is expected to result in, death or serious injury, and "provide specific information about the patient's rights and recourse."[48] Leaders are responsible for ensuring patients receive safe and effective care at the facility and when quality care is not provided, that patients receive follow-up care if needed.[49]

In February 2024, the chief of dermatology reviewed 14 patients' EHRs and identified that the dermatologist should have provided an alternative treatment for two of the patients. The chief of dermatology told the OIG that instead of an ED&C, one patient's (Patient D) lesion should have been treated through Moh's surgery, and a second patient's lesion should have been excised.[50] Additionally, the chief of dermatology identified that a third patient's consult had six lesions identified for assessment; however, the dermatologist's documentation mentioned only three lesions.[51] Furthermore, the chief of dermatology found that the dermatologist delayed performing biopsies on 4 of the 14 patients reviewed.[52] The chief of dermatology noted a plan to order follow-up appointments for patients needing additional assessment.

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[48] "Adverse events are untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[49] The Joint Commission, Sentinel Event Alert, "The Essential Role of Leadership in Developing a Safety Culture"; VHA Directive 1004.08.

[50] During the inspection, the OIG reviewed documented clinical care concerns for patients identified by a concerned nursing staff member. The chief of dermatology then reviewed the patients to assess the quality of care provided; Mohs surgery is a procedure that involves cutting away thin layers of skin to treat skin cancer and is most useful for skin cancers that are in areas such as around the eyes, ears, nose, mouth, hands, feet, and genitals. Mayo Clinic, "Mohs surgery," accessed March 25, 2024, https://www.mayoclinic.org/tests-procedures/mohs-surgery/about/pac-20385222; Patient D was also referenced in the report under "Inadequate Response to Allegation of Documenting Procedures that had Not been Performed." The chief of dermatology concluded that ED&C was performed but that a different treatment should have been chosen.

[51] The second and third patients' care is not presented in Appendix B.

[52] The four patients were not included in the facility's management review or identified in patient safety reports.

The COS told the OIG that patient disclosures were not warranted because no patient harm was found during the management review, FPPE for cause, and continued review of patient care upon the completion of the FPPE for cause. However, the chief of medicine, who conducted the reviews, told the OIG that the assessment for harm focused specifically on the dermatologist's delays in communicating test results and entering specialty consults with an emphasis on patients diagnosed with melanoma. The OIG determined that the review for patient harm did not encompass all concerns laid out in this report, was not a comprehensive review of the care provided to patients and was not conducted by a dermatologist. Additionally, disclosures should be considered not only when there is harm, but also when there is a potential for harm.[53]

The OIG concluded that based on the concerns noted in this report and the chief of dermatology's review of the 14 EHRs, further review of the patient care provided by the dermatologist and reconsideration for disclosures is warranted.

Conclusion

The OIG confirmed that the dermatologist delayed performing biopsies and communicating test results, misused copy and paste, and failed to address all lesions noted in consults. The OIG was unable to verify whether the dermatologist documented procedures that were not performed.

Supervisory staff failed to adequately review and address all care and documentation concerns related to the dermatologist, allowing the potential for patient harm.

Supervisory staff rated the dermatologist's proficiencies as unsatisfactory for fiscal years 2022 and 2023; both proficiencies included documentation of deficiencies related to delays in performing biopsies and conduct concerns such as tardiness (arriving late for work) and lack of professionalism. Supervisory staff's efforts to correct the delays in performing biopsies through verbal discussion, counseling, a mandate, and tracking were ineffective.

The chief of dermatology's effort to correct the dermatologist's misuse of copy and paste through verbal discussion was ineffective, as the practice continued. HIMS staff were not notified, and the errors were not corrected as required.

The OIG was unable to determine whether the dermatologist documented procedures not performed due to conflicting information from nursing staff and the dermatologist; and the supervisor failed to conduct a comprehensive review. The OIG would have expected the chief of dermatology to conduct a comprehensive review to determine whether the dermatologist had falsely documented procedures that had not been performed.

Leaders are responsible for ensuring patients receive safe and effective care at the facility. The COS was not aware of the full extent of the concerns regarding the dermatologist's care and

[53] VHA Directive 1004.08.

documentation deficiencies. Therefore, the COS was unable to ensure safe and effective care was provided to patients at the facility. The Facility Director failed to ensure timely initiation of the SLB reporting process after multiple facility leaders had substantial evidence to support that the dermatologist significantly failed to meet the generally accepted standards of clinical practice and the Medical Executive Board recommended nonrenewal of clinical privileges.

In February 2024, the chief of dermatology reviewed 14 patients' EHRs and found that the dermatologist should have provided different treatment to two patients and did not address all lesions identified in consults for a third patient. The OIG concluded that patients may still be in need of follow-up care and disclosure.

Recommendations 1–8

1. The Carl T. Hayden Medical Center Director ensures that supervisory staff take effective actions to correct clinical deficiencies.

2. The Carl T. Hayden Medical Center Director identifies electronic health records containing the dermatologist's misuse of copy and paste and takes action as warranted to ensure the safety of patients.

3. The Carl T. Hayden Medical Center Director ensures that service chiefs and patient safety staff report instances of misuse of copy and paste to Health Information Management System staff.

4. The Carl T. Hayden Medical Center Director ensures a comprehensive review is conducted to determine if the dermatologist documented electrodesiccation and curettage procedures that were not performed and takes action as warranted, including providing patients with clinical care and disclosures if needed, and notifying the Office of Inspector General.

5. The Carl T. Hayden Medical Center Director ensures that the Chief of Staff is aware of and addresses pervasive deficiencies, when they exist, in clinical care provided at the facility.

6. The Desert Pacific Healthcare System Network Director evaluates reasons for noncompliance with the state licensing board reporting policy with regard to the dermatologist, and takes action as needed.

7. The Carl T. Hayden Medical Center Director ensures that a dermatologist conducts a review of the dermatologist's patients with consideration of the concerns laid out in this report, to identify patients who may need follow-up care and disclosures, and takes action as warranted.

8. The Carl T. Hayden Medical Center Director reviews with facility leaders, disclosure requirements outlined in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*.

Appendix A

Table A.1. Timeline of the Concerns and Facility Leaders' Response

Time Frame	Event	Action
~2021	Chief of dermatology became aware of the dermatologist's delays in performing biopsies.	Chief of dermatology informally verbally counseled the dermatologist.
September 2022–April 2023	Eighteen patient safety reports identified deficiencies in the dermatologist's care.	Chief of dermatology reviewed the clinical care identified in the reports and documented a plan in multiple cases to discuss the concerns with the dermatologist.
December 2022–January 2023	Staff reported a delay in communicating test results to patient.	Peer review completed.
January 2023	Quality management staff alerted chief of medicine of continued concerns related to the dermatologist.	Chief of medicine conducted a management review of the dermatologist's delays in communicating test results and delays in entering specialty consults.
March 2023	Results of the management review identified clinical care concerns.	Chief of medicine issued a written counseling and initiated an FPPE for cause for delays in communicating test results and entering specialty consults. Chief of medicine later revised the FPPE for cause to reflect VHA policy time frames for communicating test results.
May 2023–September 2023	Twenty-seven more reports identified deficiencies in the dermatologist's care.	Chief of dermatology reviewed the clinical care identified in the reports and documented a plan in multiple cases to discuss the concerns with the dermatologist. One peer review was completed.
September – October 2023	Staff submitted one report that identified deficiencies in the dermatologist's care.	Peer review completed.
Fall 2023	The dermatologist does not meet FPPE for cause expectations.	Chief of medicine recommended not to renew privileges. Monitoring continued.
Late 2023	Staff submitted three reports about patient care issues including concerns related to the misuse of copy and paste.	Chief of dermatology reviewed each patients' clinical care and documented a plan to discuss documentation concerns with the dermatologist.
Late 2023	Privileges are not renewed and expired.	The dermatologist was removed from patient care.

Source: Facility documents and OIG interviews.

Appendix B: Case Summaries

Patient A

Patient A, who was in their 50 s, underwent a biopsy of a jaw lesion by the dermatologist in fall 2022.[54] The dermatologist documented that the lesion could be an atypical mole or melanoma. Approximately two weeks later, the pathologist reported not being able to exclude the possibility of an evolving melanoma. The pathologist recommended a complete excision of the lesion and surrounding margins to allow for a "thorough evaluation."

Approximately one month later, a nurse alerted the dermatologist via the EHR that the biopsy was "still pending your review." A week later, the dermatologist had not reviewed the biopsy and another nurse printed the results, marked them as high priority, and placed them in the dermatologist's message folder. Two weeks later, the results remained unaddressed by the dermatologist and the chief of dermatology notified the patient of the biopsy findings and referred the patient to head and neck clinic for excision of the lesion. The lesion was removed, three months and five days after the pathologist's recommendation; there were no findings concerning for melanoma.

Patient B

Patient B, who was in their 80 s, was referred to the facility dermatology clinic by the patient's primary care provider in early 2022, for treatment of facial skin cancer and for evaluation of a leg growth that had been increasing in size for more than one year. The dermatologist saw the patient the following month. The dermatologist did not document acknowledgment of the growth on the patient's leg, noting that the patient was there for consultation for three facial lesions. The dermatologist treated the facial lesions and instructed the patient to return in three months.

The patient returned to see the dermatologist three months later. At that time, the dermatologist documented a three-month history of a purple nodule on the patient's leg. The dermatologist opined that the nodule could be a type of blood vessel cancer, a collection of blood vessels, or a lesion that is caused by trauma. The dermatologist noted that the patient had leg swelling and wanted to assess whether a diuretic would help to clear the nodule.

The patient returned to see the dermatologist approximately two months later, "due to the urging of [the patient's] caretakers to r/o [rule out] malignancy." The dermatologist instructed the patient to return in two weeks for biopsy of the nodule. The patient returned for a biopsy. However, the dermatologist opined that the nodule was vascular in nature and possibly cancerous and referred the patient to a vascular surgeon for biopsy.

[54] The OIG uses the singular form of they for privacy purposes.

A vascular surgeon biopsied the nodule in late 2022, almost one year from the initial consult.[55] The pathologist determined the nodule to be an invasive malignant melanoma. After experiencing a series of falls in late summer 2023, the patient was admitted to a community hospital and died two days later. The OIG did not have access to information regarding the patient's cause of death.

Patient C

Patient C, in their 70 s, had a history of basal cell and melanoma skin cancers. The patient underwent initial consultation with the dermatologist in spring 2022. The dermatologist documented "no suspicious lesions or rash," and noted that there had been no recurrence of the melanoma in nine years. The dermatologist advised the patient to return for a full body skin exam in one year. The patient returned in spring 2023. The dermatologist again documented "no suspicious lesions or rash." The dermatologist noted that there had been no recurrence of the melanoma in 10 years and again advised the patient to return in another year for a full body skin exam.[56]

The patient sent a secure message to the patient's primary care team one week after the spring 2023 visit with the dermatologist to report that the dermatologist identified a "spot" on the patient's nose that needed to be removed. The patient stated that the dermatologist would not remove the lesion because the patient was on blood thinners and emergency services were not available at the dermatology clinic. The patient requested a referral to a community dermatologist. A nurse responded stating that the nasal lesion was not documented in the dermatologist's note and that the referral to a community dermatologist would need to come from the dermatologist. The patient replied not feeling comfortable with the dermatologist "doing anything on my face" and was advised by the nurse to schedule an appointment with a different VA dermatologist.

The patient spoke with a dermatology nurse approximately one month after the 2023 appointment and requested a new dermatology provider. The chief of dermatology saw the patient the following month. The chief of dermatology noted a dark spot on the patient's nose, near the location where a previous basal cell cancer was removed. The chief of dermatology biopsied the lesion revealing basal cell cancer. The patient underwent removal of the cancer approximately two months later.

[55] The delay between the August consult and December biopsy occurred so the patient could undergo vascular testing required by the vascular surgeon prior to the consultation.

[56] Notes written one year apart, during the spring of 2022 and 2023, respectively, were identical, including typographical errors, with the exceptions of updated patient age and number of years since the diagnosis of melanoma.

Patient D

Patient D, in their 60 s, underwent a shave biopsy of an ear lesion by the dermatologist in mid-spring 2022. A pathologist determined that the ear lesion was a basal cell carcinoma with infiltrative features that extended to the edge of the biopsy. The patient returned to see the dermatologist approximately two months later in late-spring 2022. At that appointment, the dermatologist documented that the basal cell carcinoma was "Cleared with Shave Excision and ED+C." The OIG did not find documentation of the ED&C in either the dermatologist's note or the note from the nurse who assisted the dermatologist with the biopsy in mid-spring 2022. Patient D relocated and was seen by a dermatologist at a different VA in summer 2023, for "scabbing" and "oozing blood" on his ear where the previous biopsy had been performed. The new dermatologist noted "could not identify a procedure note for any definitive treatment, and there is a Dermatology note . . . that states 'cleared with shave excision and ED+C.'" The new dermatologist performed Mohs surgery for "residual/recurrent BCC [basal cell carcinoma]."

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 21, 2024

From: Acting Director, Desert Pacific Health Care System (10N22)
Subj: Healthcare Inspection—Leaders Failed to Ensure a Dermatologist Provided Quality Care at the Carl T. Hayden VA Medical Center in Phoenix, Arizona

To: Director, Office of Healthcare Inspections (54HL10)
Executive Director, Office of Integrity and Compliance (10OIC)

1. Veterans Integrated Services Network (VISN) 22 appreciates the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur in principle with recommendation 1 and concur with recommendations 2-8 of OIG draft report, Healthcare Inspection – Leaders Failed to Ensure a Dermatologist Provided Quality Care at the Carl T. Hayden VA Medical Center in Phoenix, Arizona (2024-00194-HI-0002).

2. Should you need further information, please contact the VISN 22 Quality Management Officer.

(*Original signed by:*)

Bryan E. Arnette, FACHE
VISN 22 Acting Network Director

[OIG comment: The OIG received the above memorandum from VHA on November 27, 2024.]

VISN Director Response

Recommendation 6

The Desert Pacific Healthcare System Network Director evaluates reasons for noncompliance with the state licensing board reporting policy with regard to the dermatologist and takes action as needed.

_X _Concur

____Nonconcur

Target date for completion: June 2025

Director Comments

The Desert Pacific Healthcare System Network Director reviewed the actions taken by PVAHCS to report the dermatologist to the State Licensing Board. During the timeframe of October 4, 2022, through October 6, 2023, PVAHCS conducted three (3) reviews of over 1,233 electronic health records documented by the dermatologist. The reviews did not identify patient harm in these reviews but did identify that the dermatologist's failure to consistently meet timeliness expectations to communicate results and consultations. In late fall, 2023, PVAHCS Medical Executive Board voted to not renew the dermatologist's privileges due to the results of the reviews conducted. Applicable personnel processes were then followed as outlined in VHA policy. In mid-summer 2024the dermatologist was reported to National Practitioner Data Bank. In late summer, 2024, the State Licensing Board Intent to Report letter was signed by the PVAHCS Director. The next day, the State Licensing Board Intent to Report letter was sent via certified mail to the dermatologist with the right to respond. Approximately 6 weeks later, the evidence file was completed, reviewed by the VISN 22 Privacy Officer and the case was reported to the State Licensing Board.

VISN 22 acknowledges that there are opportunities to improve the State Licensing Board reporting process. PVAHCS will implement the State Licensing Board Tracker and the VHA State Licensing Board Tracker Standard Operating Procedure (SOP-C62), published by the VHA National Credentialing and Privileging Office. The State Licensing Board tracker will be actively managed and monitored by the PVAHCS Credentialing Manager. The State Licensing Board Tracker data and timeliness will be reported monthly to the Medical Executive Board.

VISN 22 will work with key stakeholders and program offices to develop and contribute feedback on the medical center's experience with the transition to the tracker and procedure to contribute to lessons learned taken into consideration during this effort.

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 21, 2024

From: Director, Phoenix Department of Veterans Affairs (VA) Health Care System (644/00)

Subj: Healthcare Inspection—Leaders Failed to Ensure a Dermatologist Provided Quality Care at the Carl T. Hayden VA Medical Center in Phoenix, Arizona

To: Director, Desert Pacific Health Care System (10N22)

1. Phoenix VA Health Care System appreciates the opportunity to review and comment on the OIG draft report, Healthcare Inspection – Leaders Failed to Ensure a Dermatologist Provided Quality Care at the Carl T. Hayden VA Medical Center in Phoenix, Arizona (2024-00194-HI-0002). Phoenix VA Health Care System concurs in principle with recommendation 1 and concurs with recommendations 2-8.
2. Should you need further information, please contact the Chief of Quality Management.

(*Original signed by*:)

Bryan C. Matthews, MBA
Medical Center Director

[OIG comment: The OIG received the above memorandum from VHA on November 27, 2024.]

Facility Director Response

Recommendation 1

The Carl T. Hayden Medical Center Director ensures that supervisory staff take effective actions to correct clinical deficiencies.

_X _Concur in Principle

____Nonconcur

Target date for completion: June 2025

Director Comments

Phoenix VA Healthcare System (PVAHCS) supervisory staff took actions to address the dermatologist's clinical deficiencies upon communication of the patient safety concerns.

PVAHCS acknowledges the ongoing efforts to ensure supervisory staff take effective actions. In response to the reported patient safety concerns, PVAHCS supervisory staff implemented multiple follow-up actions to correct the dermatologist's clinical deficiencies including performing protected peer reviews which triggered management reviews, Focused Professional Practice Evaluations (FPPE) for Cause, weekly and/or biweekly monitoring of FPPE for Cause, counseling of the dermatologist, progressive disciplinary action, and non-renewal of clinical privileges.

PVAHCS implemented processes for supervisory staff to be informed of patient safety reports to ensure actions are taken and clinical deficiencies are actively addressed. In September 2023, the PVAHCS Director implemented daily email communication of the patient safety reports by the Patient Safety Managers to the Executive Leadership Team (ELT), which supplemented the daily communication of patient safety reports during Leadership Huddle, attended by the ELT and Service Chiefs. On September 3, 2024, PVAHCS augmented the daily communication of patient safety reports with weekly meetings between the Patient Safety Managers, Quality Chief, Service Chiefs, and the ELT to promote enhanced leadership awareness of patient safety concerns that warrant additional discussion and appropriate corrective action.

Ensuring supervisory staff take effective actions will be an ongoing effort and rely on the support of the VISN and related program offices to address any systemic barriers that may be identified. All Clinical Service and Section Chiefs will continue to receive training on conducting management reviews and implementing effective actions to address clinical deficiencies, as part of training plans. Monitoring of training completion and actions taken as warranted, will be reported monthly, or as applicable, to the Medical Executive Board (MEB) by the Chief of Staff.

Recommendation 2

The Carl T. Hayden Medical Center Director identifies electronic health records containing the dermatologist's misuse of copy and paste and takes action as warranted to ensure the safety of patients.

_X _Concur

____Nonconcur

Target date for completion: January 2025

Director Comments

PVAHCS Director and Interim Chief of Staff Leadership will develop and implement a plan to review the electronic health records associated with the dermatologist's misuse of copy and paste to identify potential patient safety concerns and follow-up with the appropriate clinical care after the review. The Interim Chief of Staff consulted with the VHA Clinical Episode Review Team (CERT) on November 4, 2024, on the development of the review. The results of the review, and any follow-up actions warranted, will be reported, and tracked at the Medical Executive Board.

Recommendation 3

The Carl T. Hayden Medical Center Director ensures that service chiefs and patient safety staff report instances of misuse of copy and paste to Health Information Management System staff.

_X _Concur

____Nonconcur

Target date for completion: January 2025

Director Comments

The PVAHCS Medical Records Committee currently reviews monthly audits conducted by the Health Information Management Services regarding instances of copy and paste misuse, and subsequently the Medical Records Committee reports the data quarterly to the Medical Executive Board through governance structure. The Health Information Management Services also completes monthly service-level audits of instances of copy and paste misuse and disseminates the results to the Service Chiefs to address any concerns. Moving forward, PVAHCS will ensure that there is a patient safety review of any noted findings from either service level or HIMS audits and include the outcomes and actions of those reviews in the oversight reporting.

Acknowledging that the copy and paste concerns of the dermatologist noted in this inspection were not identified by the audits, PVAHCS will take additional actions to improve identification of copy and paste misuse and ensure Service Chiefs address any clinical care needs, as

warranted. The Interim Chief of Staff will incorporate reporting of the service-level audits and resolution of findings to the Medical Records Committee. The Service Chiefs will also receive additional training on the copy and paste policy, as outlined in PVAHCS Policy, HIMS-19, including the process to request additional audits, and reporting of copy and paste concerns to the Health Information Management Services. Compliance of the copy and paste audits, including any additional clinical care needs that were addressed, and the completed training will be reported monthly to the Medical Executive.

Recommendation 4

The Carl T. Hayden Medical Center Director ensures a comprehensive review is conducted to determine if the dermatologist documented electrodesiccation and curettage procedures that were not performed and takes action as warranted, including providing patients with clinical care and disclosures if needed, and notifying the Office of Inspector General.

_X _Concur

____Nonconcur

Target date for completion: June 2025

Director Comments

The PVAHCS Interim Chief of Staff consulted with the VHA Clinical Episode Review Team (CERT) on November 4, 2024, to discuss the development of a comprehensive review of the dermatologist's procedures and associated documentation to determine if electrodesiccation and curettage procedures were not performed. PVAHCS Interim Chief of Staff will implement the initial review and follow-up on necessary actions. The PVAHCS Interim Chief of Staff will report to the Medical Executive Board the results of the review and indicated follow-up actions taken, including any additional clinical care needs that were addressed or disclosures. PVAHCS will notify the Office of Inspector General of any additional findings.

Recommendation 5

The Carl T. Hayden Medical Center Director ensures that the Chief of Staff is aware of and addresses pervasive deficiencies, when they exist, in clinical care provided at the facility.

_X _Concur

____Nonconcur

Target date for completion: June 2025

Director Comments

PVAHCS will implement a multi-pronged approach to ensure that all supervisors effectively address deficiencies in clinical care. The PVAHCS Director will implement process changes, provide training on oversight responsibilities and defining accountability measures related to the management of patient safety reports, professional practice evaluations and unsatisfactory proficiencies. The approaches developed will include identification of appropriate effectiveness monitors to be reported to the Quality Board which ultimately reports to Governing Council through governance structure.

The PVAHCS Director will ensure continued daily email communication by the Patient Safety Managers of the patient safety reports to the Executive Leadership Team (ELT), daily communication of the patient safety reports during Leadership Huddle and the weekly meetings between the Patient Safety Managers, Quality Chief, Service Chiefs, and the ELT to promote enhanced leadership awareness of patient safety concerns that warrant additional discussion and appropriate corrective action.

Collaboration between medical centers, VISNs and key program stakeholders will be critical to ongoing improvement efforts in this area. PVAHCS is committed to supporting ongoing improvements through working with the VISN and VHA teams to review and enhance patient safety trend reports that will assist medical centers and VISNs in effectively identifying pervasive patient safety risk.

Recommendation 7

The Carl T. Hayden Medical Center Director ensures that a dermatologist conducts a review of the dermatologist's patients with consideration of the concerns laid out in this report, to identify patients who may need follow-up care and disclosures, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: March 2025

Director Comments

The PVAHCS Interim Chief of Staff consulted with the VHA Clinical Episode Review Team (CERT) on November 4, 2024, regarding the development of an objective clinical review to be conducted by dermatologists outside of PVAHCS. Results of the clinical review will be reported to the Medical Executive Board and follow-up actions will be taken as warranted.

Recommendation 8

The Carl T. Hayden Medical Center Director reviews with facility leaders disclosure requirements outlined in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*.

_X _Concur

____Nonconcur

Target date for completion: March 2025

Director Comments

PVAHCS will continue to review with facility leaders the disclosure requirements outlined in VHA Directive 1004.08, Disclosure of Adverse Events to Patients.

From December 2023 through August 2024, PVAHCS educated providers on conducting clinical disclosures as outlined in VHA Directive 1004.08. During this timeframe of December 2023 through August 2024, PVAHCS achieved greater than 90% compliance for providers who received education on conducting clinical disclosures as outlined in VHA Directive 1004.08. This compliance was reported to the Clinical Executive Board and the Governing Council.

On January 16, 2024, the Chief of Staff created the Service Line Mandatory Orientation Checklist for newly hired providers, which outlines the requirements for disclosure in VHA Directive 1004.08. The Service Chiefs are responsible for disseminating the Service Line Mandatory Orientation Checklist during orientation for newly hired providers.

PVAHCS will continue to monitor training for providers and facility leaders on conducting disclosures as outlined in VHA Directive 1004.08. Completion of training will be reported to the Clinical Executive Board.

OIG Contact and Staff Acknowledgments

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