



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Issues at a VA Mid South Healthcare Network Dental Clinic

To Report Suspected Wrongdoing in VA Programs and Operations:

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations regarding dental care provided at a Veterans Integrated Service Network (VISN) 9 dental clinic. OIG conducted an Employee Assessment Review survey, a short confidential survey that invites all system employees to share general observations about the quality of care and safety provided within the system. The Employee Assessment Review survey results included 15 allegations regarding dental patient care provided at a VISN 9 dental clinic. We divided the allegations into four categories: dental vacuum system; dentists practice issues; eligibility, scheduling, and productivity; and work environment and leadership.

Based on our interviews with leadership and staff, VISN Dental Consultant interviews and reports, electronic health record reviews, patient schedules, dental productivity reports, and onsite physical inspections, we substantiated three of the allegations.

We recommended that leadership:

- Ensure that dental clinic staff have adequate knowledge regarding periodontal disease.
- Ensure treatment plans are developed, revised, followed, and documented.
- Develop and implement a plan to improve communication and professional interaction among dental clinic staff.

The VISN and Facility Directors concurred with our recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Mid South Healthcare Network (10N9)

SUBJECT: Healthcare Inspection –Issues at a VA Mid South Healthcare Network Dental Clinic

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations regarding dental care provided at a Veterans Integrated Service Network (VISN) 9 dental clinic.

Background

The VA Mid South Healthcare Network provides primary care, mental health, pharmacy, dental, and audiology services.

Services provided at the dental clinic include general and restorative dentistry, prosthodontics, periodontics, endodontics, and oral maxillofacial surgery.

The OIG conducted a scheduled Combined Assessment Program Review of the system. One element of the review was an Employee Assessment Review survey, a short confidential survey that invites all system employees to share general observations about the quality of care and safety provided within the system. The Employee Assessment Review survey results included 15 allegations regarding dental patient care. We divided the allegations into four categories:

Dental Vacuum System

- Dental vacuum system incorrectly installed
- Dental suction insufficient in new exam rooms
- Patient exposure to fluid backwash

Dentists Practice Issues

- Failure to diagnose periodontal disease and tooth decay
- Failure to develop and follow a treatment plan
- Deletion of treatment plans
- Improper peer reviews
- Delay in treatment of emergency patients
- Poor customer service
- Practitioner impairment

Eligibility, Scheduling, and Productivity Issues

- Denial of dental care for eligible patients
- Manipulation of patients' dental schedule to reflect higher productivity
- Lack of dentist productivity

Other Issues

- Stressful work environment
- Lack of leadership

Scope and Methodology

On August 20-23, 2012, we visited the system and the dental clinic. We interviewed system executive leadership; the current and previous Chiefs of Dental Services; the Assistant Director of Quality Management; the Patient Safety Officer, the Infection Control Nurse, and the Chiefs of Sterile processing, Engineering and Environmental Services. We interviewed the dentists, dental assistants, dental hygienist, dental laboratory technician, manager, patient advocate, nursing manager, and chief medical officer.

We toured the dental clinic and inspected the vacuum system with an engineer. We reviewed the schematics for the vacuum system and traced the associated plumbing from the vacuum to the suction handpiece at the chair. We reviewed manufacturer's maintenance instructions. We reviewed vacuum system work orders and internal investigation documents related to the vacuum system. We met with a vendor who

provides sales and contracted maintenance services for the dental equipment. We reviewed the dentists' credentialing and privileging files, patient advocate reports, policies and procedures, dental eligibility guidelines, dental schedules and dental productivity reports. We reviewed 63 dental cases cited by a complainant to support the allegations and referred 16 of them to a VISN Dental Consultant (VDC) for specialized clinical review.

We did not address other allegations made that fell out of the scope of our review.

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

Inspection Results

Issue 1: Dental Vacuum System

Incorrect Dental Vacuum Installation

We did not substantiate that the dental vacuum system was incorrectly installed by locating the pipes in the ceiling instead of in the floor.

The dental clinic installed a new dental vacuum system in November 2010, which became operational in July 2011. The system's two air-based suction pumps are located in a pump room and connected to piping that runs from the pump room to ceiling main lines. The ceiling main lines connect to piping that runs down dental exam room walls and connects to floor piping.

The dentists, dental assistants, and system engineer informed us that although floor installation is common in dental clinics, the system manufacturer's instructions (MI) allow for ceiling routing as an acceptable alternative if the installation meets certain requirements. Specifically, there can be no 90-degree joints in the ceiling main lines, there must be a slight downward slope from the piping in the dental room to the pump room, and piping must meet minimum internal diameters.

We inspected the vacuum system and corresponding plumbing with the system engineer and the supervisory dentist. We found the configuration of the pumps and their connection to the piping met MI, the ceiling main lines had no joints greater than 45 degrees, the slope of the piping from the dental room to the pump room met MI, and the internal diameter of the pipes met or exceeded minimum specifications.

Insufficient Suction

We did not substantiate that suction was insufficient at the dental chairs in the new exam rooms.

The floor piping connects to suction tubing on the dental chair. The suction tubing goes through a debris collection filter (trap) and then connects to a suction handpiece, which dental staff use to remove fluids and small particles of debris out of patients' mouths. Along with the chair trap, the system has passive traps in the floor and ceiling to prevent material from back washing to the patient. The system engineer and the supervisory dentist were able to demonstrate that the suction at the chair in the new dental exam rooms was sufficient and comparable to suction in their other dental exam rooms.

During our onsite interviews, we found that dental staff did not receive initial training on either the new system or the MI for routine cleaning and maintenance. Maintenance and cleaning requires daily chair trap cleaning and flushing of the system with 1 liter of cleaning fluid. However, we found that dental staff flushed the system daily with approximately 4 liters of fluid, which was the amount required for a previous system. The system engineer and the system vendor both agreed that using a larger than recommended amount of fluid for daily flushing could overwhelm the air-based vacuum system, which could slow down or stop suctioning. In addition, staff did not regularly clean the chair trap, which could also affect the system's suction. There were two occasions when the maintenance technician was called to investigate suction problems. On one occasion, the technician found a sani-wipe wedged in the trap. On the second occasion, the technician found dental prophylaxis paste¹ clogging the trap. After the items were removed and the trap cleaned, suction was restored.

While we were onsite, dental staff received vacuum system cleaning and maintenance training.

Backwash of Fluids

We did not substantiate that patients were exposed to a backwash flow of fluids because of malfunctioning suction.

The pumps are designed to ensure no backwash flow occurs in the system when the system is turned off or shuts down during a power outage. No instances of backwash flow to a patient were reported. During demonstrations given by the system engineer and dentist, we did not observe backwash flow in the dental suction handpieces. On August 2, 2012, a system team including the Patient Safety Manager, Infection Control Nurse Manager, Chair of Infection Control Committee, Associate Chief of Staff–Ambulatory Care (previous system Chief of Dental Services), and the Assistant Chief of Engineering conducted an infection control risk assessment and determined that backwash flow was not a patient safety risk.

¹ Dentists and hygienists use prophylaxis paste to polish the enamel surfaces after removal of calculus or staining from teeth.

We found that the ceiling installation of the vacuum system plumbing met manufacturer's specifications, suction at the dental chairs was sufficient, and backwash flow did not pose a patient safety risk.

Issue 2: Dentists' Practice Issues

Failure to diagnose periodontal disease and tooth decay

We substantiated that two dentists failed to diagnose periodontal disease and tooth decay.

The VDC found that the dentists and the hygienist were underestimating pocket depths and believed that periodontal disease was being under diagnosed. The VDC also found the dentists did not detect decay that was evident by x-ray in 1 of 16 cases reviewed. Based on the electronic health record alone, and without actually examining the patients, the VDC could not definitively validate the presence or absence of tooth decay. In several cases, the records seemed to indicate that decay in a particular tooth was forgotten or overlooked, and the dentists did not acknowledge documentation by the hygienist or another provider regarding decay. The VDC suggested that the dental clinic could benefit from the expertise of a periodontist on staff.

Failure to develop and follow a treatment plan

We substantiated that two dentists failed to develop and follow treatment plans.

VHA Handbook 1130.01 outlines the requirement of treatment plans for each episode of care. The Handbook also requires dental staff to properly document dental care plans.² The VDC determined that 4 of 16 treatment plans were not well organized and actual treatments did not match the plans.

Deletion of treatment plans

We did not substantiate that treatment plans were deleted.

We reviewed 63 dental records and could not identify treatment plans that had been deleted or inappropriately changed. However, during interviews, one dentist acknowledged that he may have accidentally deleted treatment plans through computer errors or because the computer timed him out of the electronic health record.

Peer reviews

We did not substantiate that peer reviews were improperly conducted.

² VHA Handbook 1130.01, *Criteria and Standards for Dental Program*, December 25, 2008.

We found that the dentists followed the peer review process and took appropriate action with recommendations.³ All system dentists review 10 cases per quarter. To ensure an impartial and fair review, assignments are rotated between all dentists in the system.

Delay in treatment of emergency patients

We did not substantiate that emergency treatment was delayed to patients.

We did not find evidence that dental patients with emergent dental needs such as obvious swelling and pain were turned away without receiving a future appointment. We interviewed dentists and dental assistants who stated they always work emergency patients into the dental schedule. We also interviewed the patient advocate who did not have any documented patient complaints related to denials of emergency dental treatment.

Poor customer service

We did not substantiate that patients received poor customer service from the dentists.

We did not find that patients were rescheduled for 10-minute appointments because dentists would not see them. We interviewed the patient advocate and the CBOC Manager, reviewed patient advocate complaints and found no documented complaints regarding patients being asked to return for 10-minute follow up appointments.

Impairment due to visual problems

We did not substantiate that a dentist was impaired due to visual problems. We discussed this with the Chief of Dental Services and all dentists in the clinic.

Issue 3: Eligibility, Scheduling, and Productivity Issues

Denied Care for Eligible Patients

We did not substantiate that dentists denied dental care for eligible patients.

VHA assigns specific dental classifications ranging from I to VI⁴ to patients in order to define patient groups and the appropriate scope of care allowable.⁵ We reviewed nine patients' electronic health records with alleged denial of services. We found that those who were eligible for dental care received services that matched the scope of care allowable for their dental classification.

³ VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

⁴ VHA Handbook 1601A.02, *Eligibility Determination*, November 5, 2009.

⁵ VHA Handbook 1130.01, *Criteria and Standards for Dental Program*, December 25, 2008.

Manipulation of Patient Schedules

We did not substantiate that dentists manipulated patients' schedules to represent a higher workload.

VHA does not specify a required methodology for dental scheduling nor does it use scheduling information to measure dental productivity. Nonetheless, we interviewed the dentists and staff, and reviewed dental schedules. We found differences in scheduling methodology were related to dentist preference rather than attempts to manipulate productivity data. For example, one dentist preferred block scheduling that sets aside specific time slots for dental services such as restorative, prosthodontics, periodontics, and oral surgery. Another dentist preferred to set aside specific time for prosthodontics, which may require dental laboratory support and then leaves the rest of the schedule open for other dental services.

Dentist Productivity

We did not substantiate that a dentist was unproductive.

We reviewed monthly productivity tracking documents provided by the Chief of Dental Services. Current procedure terminology (CPT) codes⁶ are assigned a relative value unit (RVU)⁷, which measures the intensity and skill level required to provide a service. Dentists are required to select a CPT code for every procedure/visit performed and annual VHA Central Office dental coding audits support the accuracy of selected codes. The Chief of Dental Services monitors productivity by tracking RVU's monthly for each dental provider throughout the VA Tennessee Valley Healthcare System. All dentists met departmental productivity targets for FY 2011 and to date for FY 2012.

Issue 4: Other Issues

Stressful work environment

We substantiated that the dental clinic has a stressful working environment.

During interviews with dental clinic staff, we found there was a lack of mutual respect and cooperation among some of the staff. Staff provided us with descriptions of inappropriate comments made by various staff members regarding professionalism, competence, education, and personal issues. Offending staff confirmed some of the offhand remarks they made.

⁶ Current Procedural Terminology (CPT) is a system developed by the American Medical Association for standardizing the terminology and coding used to describe medical services and procedures.

⁷ Relative Value Units (RVU) are assigned to provide a method for quantifying and measuring physician productivity.

Lack of leadership

We did not substantiate the dental clinic lacked leadership.

During a three-month period when an onsite dentist was not available, the hygienist was appointed as the Acting Supervisor. A hygienist may function in a general supervisor capacity for dental assistants assigned to the work unit in the absence of a staff dentist.⁸ Additionally, the Chief Medical Officer, and Patient Advocate were onsite and available for consultation during this period. The system Chief of Dental Services was also available by telephone or email during this period. We found that there was adequate leadership available to dental staff during the period that the dental clinic did not have an onsite dentist.

Conclusions

Based on our interviews with system leadership and dental clinic staff, VDC interviews and reports, review of electronic health records, patient schedules, dental productivity reports, and onsite physical inspections, we substantiated three of the allegations. We did not substantiate 12 allegations. We made three recommendations.

Recommendation(s)

Recommendation 1. We recommend that the System Director ensure that dental clinic staff have adequate knowledge regarding periodontal disease.

Recommendation 2. We recommend that the System Director ensure treatment plans are developed, revised, followed, and documented.

Recommendation 3. We recommend that the System Director develop and implement a plan to improve communication and professional interaction among dental clinic staff.

Comments

The VISN and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 9–12 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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

⁸ Healthcare System Dental Service Dental Hygienist Functional Statement

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 27, 2012

From: Director (10N9), VA Mid South Healthcare Network

Subject: **Healthcare Inspection** – Issues at a VA Mid South Healthcare Network Dental Clinic

To: Director, Denver Office of Healthcare Inspections (54DV)

1. I have reviewed and concur with the recommendations in the report regarding the above referenced Healthcare Inspection of the Dental Clinic.
2. Appropriate action is taking place as detailed in the attached report.

(original signed by Vincent Alvarez, M.D., for:)
John Dandridge, Jr.

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 17, 2012

From: Director

Subject: **Healthcare Inspection** – Issues at a VA Mid South Healthcare Network Dental Clinic

To: Director, VA Mid South Healthcare Network (10N9)

1. Thank you for your consultation and review conducted at the Dental Clinic.
2. We concur with all the recommendations and appreciate the time and expertise of the OIG team. This review provides us with the opportunity to continue improving care to our Veterans.

(original signed by:)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommend that the System Director ensure that dental clinic staff has additional training or support regarding periodontal disease.

Concur

Target Completion Date: March 2013

Facility Response: Conduct in-service training in the dental clinic to provide ongoing education in periodontal disease and charting periodontal disease (Target: 100%). Add periodontal charting to Ongoing Professional Peer Review document: Dec 31, 2012. Conduct In-Service: Feb 28, 2013.

Recommendation 2. We recommended that the System Director implement additional supervision and training for dentists to ensure treatment plans are developed, revised, followed, and documented.

Concur

Target Completion Date: March 2013

Facility Response: Dental record manager charting within CPRS allows full treatment planning capability with sequencing of care. Plan to conduct training in-service for support staff and dentists to ensure treatment plan is entered and sequenced. Plan to add the element specifically to Ongoing Professional Peer Review (OPPE) quarterly review document for all providers adding a trigger for non-compliance (Target: 90%). Update OPPE form: Dec 31, 2012. Conduct In-Service: Feb 28, 2013.

Recommendation 3. We recommend the System Director develop and implement a plan to improve communication and professional interaction among dental clinic staff.

Concur

Target Completion Date: June 2013

Facility Response: Requested evaluation from the National Center for Organization and Development (NCOD) to assess and conduct focused training for staff. NCOD was on-site November 27 & 28, 2012, and

interviewed all staff. A feedback session has been completed with the Service Chief. Plan feedback with staff in January and development of a plan for improvement with specific training to follow. Initial assessment complete; Staff feedback by January 31, 2013; Training/group session by May 31, 2013.

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Virginia Solana, RN, MA, Project Leader Ann Ver Linden, RN, MBA, Team Leader Laura Dulcie, BSEE Alan Mallinger, MD, Physician Consultant

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