



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-04755-428

Healthcare Inspection

Alleged Dental Service Scheduling and Other Administrative Issues VA Palo Alto Health Care System Palo Alto, California

July 9, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to a request from Congresswoman Jackie Speier to evaluate the merit of allegations regarding Dental Service scheduling as well as administrative issues at the VA Palo Alto Health Care System, Palo Alto, CA.

A complainant alleged that appointments for four of five patients scheduled to be seen by a dentist were canceled 1 day prior to the appointment dates and rescheduled to later dates, the dental clinic was insufficiently staffed, dentists had to assume dental assistant duties due to insufficient staffing, the dental clinic had a long backlog of undelivered dental prosthetics, the dental clinic had insufficient and/or broken equipment, and the Dental Service Chief conducted inappropriate personnel practices.

We substantiated that two of the five patients' appointments were canceled and rescheduled to later dates. We did not find evidence of long-term impacts on their clinical outcomes. However, we noted a 5-month delay in scheduling appointment dates for the two patients.

We substantiated the allegation that the staffing ratio for dental assistants to dentists was slightly below Veterans Health Administration recommendations. However, we determined that the system has actively been recruiting for additional staff, including dental assistants, a dental hygienist, and a dental laboratory technician. We substantiated the allegation that dentists and residents assumed dental assistant duties after dental assistants ended their tours of duty, including the cleaning of instruments and disinfection of environmental surfaces. We were informed that in order to assist patients still being seen after dental assistants ended their tours of duty, all dentists and residents were given access to the Omnicells to obtain any necessary supplies. The Dental Service Chief informed us they were advertising to hire additional dental assistants.

We substantiated the allegation that the dental clinic had a long backlog of undelivered prosthetic devices. The system instituted corrective actions, but due to incomplete documentation, we were not able to fully assess progress in reducing "backlogs" of undelivered prostheses.

We substantiated the allegation that Dental Service had broken and/or insufficient equipment. However, we determined that additional equipment and a radiograph software program have been purchased.

We concluded that the Dental Service presented numerous concerns and challenges and that it would be beneficial for the Veterans Integrated Service Network to review the Service after all corrective actions have been implemented.

We recommended that the Veterans Integrated Service Network Director review the dental program after corrective actions have been implemented to ensure that dental care at the system is timely and of high quality. We recommended that the System Director monitor the dental clinic to ensure that patients are receiving appropriate

access to care, implement Veterans Health Administration's recommendations regarding staffing in the dental clinic, ensure timely delivery of prosthetic devices, and ensure the process of sending prosthetics from the contract laboratories to delivery of the prosthetics to patients is documented and reviewed routinely.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 9–13 for the Directors' comments.) We will follow up on the planned actions until they are completed.

A handwritten signature in black ink that reads "John D. Daigh, Jr., M.D." The signature is written in a cursive style.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to a request from Congresswoman Jackie Speier to evaluate the validity of allegations related to Dental Service scheduling and administrative issues at the VA Palo Alto Health Care System (system), Palo Alto, CA.

Background

The System

The system is a tertiary care system that provides a full range of patient care services, including medicine, surgery, psychiatry, rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. It is composed of three inpatient facilities in Palo Alto, Menlo Park, and Livermore. The system has seven Community Based Outpatient Clinics (CBOC) located in San Jose, Fremont, Capitola, Monterey, Stockton, Modesto, and Sonora. Geographically, the catchment area spans 131 miles east from the Palo Alto hospital to the Sonora CBOC and 83 miles south to Monterey CBOC. It operates nearly 900 beds, including three nursing homes and a 100-bed domiciliary, and is part of Veterans Integrated Service Network (VISN) 21.

Dental Service

The Dental Service performs a full spectrum of dental and oral surgical procedures including general dentistry, minor oral surgery, endodontics,¹ periodontics,² and prosthodontics.³ Dental care is provided at three clinics in the health care system located at Palo Alto, Livermore, and Menlo Park. The main clinic is located at the Palo Alto division. Palo Alto has 16 operatories (procedure rooms), Livermore has 5, and Menlo Park has 7, although only 4 are functional. Each site offers full services, with the exception of implant procedures and complex surgical procedures, which are performed only at Palo Alto. In fiscal year (FY) 2014, the service treated 4,078 unique patients. The dentists, dental assistants, dental laboratory technicians, and other dental employees report to the Dental Service Chief (Chief). The Chief reports to the system Deputy Chief of Staff. The Dental Service has a general practice residency program for hospital-based dentistry.

In 2011, the Veterans Health Administration (VHA) Office of Dentistry published a study that discussed variables affecting dentist productivity and identified the dental assistant to dentist ratio to be the most important driver for dentist productivity. The findings support the concept that sufficient assistant support in teaching and specialized clinics can mitigate anticipated productivity decreases.

¹ Endodontics is the diagnosis and treatment of dental pulp and root disease.

² Periodontics is the diagnosis and treatment of gum disease.

³ Prosthodontics is the area of dentistry that focuses on the replacement of teeth and related mouth and jaw structures with artificial devices, including dentures and implants.

VHA Requirements Related to Wait Times for Appointments – Access to Care

VHA Directive 2010-027, “*VHA Outpatient Scheduling Processes and Procedures*,” provides policy to implement processes and procedures for the scheduling of outpatient appointments. Facilities should have the ability to create appointments that meet the patient’s needs with no undue waits or delays.⁴ Beginning in May 2014, VA has made wait times for care its top priority. On May 21, 2014, former Secretary Shinseki directed VHA leadership to review processes to ensure everything possible was being done to schedule veterans timely for appointments. This initiative required:

- Facilities to make at least 3 attempts to contact any veteran new to VA care, or new to a particular clinic, who was scheduled for any appointment more than 30 days out, or was currently on the electronic wait list.
- Facilities to also assess whether the veteran wished to be seen sooner than currently scheduled.
 - If yes, and the capacity and resources existed, the veteran would be scheduled into a new appointment opening.
 - If yes, but the capacity and resources did not exist, non-VA medical care referral would begin.
- Facilities to review cancelations and available appointments on a daily and ongoing basis and contact veterans on the electronic waiting list to offer other available appointments.⁵

Allegations

On June 20, 2014, OIG received allegations from Congresswoman Speier related to the Dental Service at the system. The complainant alleged that:

- The appointments for four of the five patients scheduled to be seen by a dentist were canceled 1 day prior to the appointment date and rescheduled to later dates, and the dentist assigned to provide treatment was not notified of the change by the Chief of Dental Service nor provided with a reason for the change.
- The dental clinic was insufficiently staffed due to:
 - Failure to replace a dental hygienist and two dental technicians who left the system
 - Staffing ratio for dental assistant to dentist being inconsistent with VHA recommendations

⁴ VHA Directive 2010-027 *VHA Outpatient Scheduling Processes and Procedures*. June 9, 2010.

⁵ US Department of Veterans Affairs Fact Sheet “Accelerating Access to Care Initiative,” 5/27/14.

- As a result of this insufficient staffing, dentists had to assume duties ordinarily assigned to dental assistants to include obtaining supplies from the Omnicell units when they had no access to those units.
- The dental clinic had a long backlog of undelivered dental prosthetics. This was allegedly due to slow turnaround times in Dental Service delivering prosthetics to patients.
- The dental clinic had insufficient and/or broken equipment, including x-ray machines, a panorex machine,⁶ and the radiograph software program; x-ray machines and the radiograph software did not work properly.
- The Dental Service Chief conducted inappropriate personnel practices, including misuse of official time, abuse of authority, and disruptive behavior.

Scope and Methodology

This review covers the period from August 28, 2014, to February 11, 2015. We conducted a site visit from September 23–24, 2014, and interviewed the complainant, Chief of Staff, Deputy Chief of Staff, and the Dental Service Chief. We also communicated with the Assistant Under Secretary for Health for Dentistry. We conducted a physical inspection of the main dental clinic at Palo Alto.

We reviewed the VHA dental handbook and other directives, system policies, contract dental laboratory logs, dental quality improvement information from the system's dental retreat 2014, patient advocate reports of complaints related to dental prosthetics, equipment purchase requests, and other relevant documents. We reviewed the electronic health records (EHRs) of the patients whose appointments were allegedly canceled and for those who had made complaints regarding dental prosthetics.

We did not address the allegations of personnel issues, which included misuse of official time, disruptive behavior, and abuse of authority by the Chief, as these were outside 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.

⁶ A panorex is a machine that provides an x-ray view of the upper and lower jaws, teeth, temporomandibular joints (TMJs), and sinuses.

Inspection Results

Issue 1: Rescheduling of Four Dental Patients

We substantiated the allegation that two of five patients' appointments were canceled and rescheduled by the clinic (Patients 1 and 2). We determined that the clinic canceled the appointment for Patient 3 because the appointment was made in error, and Patient 4 canceled the appointment, as the necessary procedure was already performed. Patient 5 was treated on the scheduled date, by a dentist at the dental clinic. We could not substantiate the allegation that the dentist was not informed of the rescheduled appointments.

Patient 1

At the time of our review, the patient was in his 50s and had been referred to Endodontics for generalized cold sensitivity. His spring 2013 appointment that was made in fall 2013 was canceled the day before the appointment and rescheduled for approximately 7 weeks later. At the time of the rescheduled appointment, the endodontist determined the dental sensitivity was due to exposed dentin⁷ and instructed the patient to use prescription-strength fluoride toothpaste. The patient was referred back to his primary dentist, and no additional endodontics follow-up was recommended. Although he had a prolonged wait for an endodontic appointment, the patient did not complain about any dental issues to his health care providers between fall 2013, and spring 2014. We found no impact on clinical outcome due to the rescheduling.

Patient 2

At the time of our review the patient was in her 40s and had been referred by her primary dentist for root canal retreatment of two teeth. A spring 2014 appointment, made in fall 2013, was canceled on the day before the appointment. She was rescheduled to be seen by an endodontist in approximately 5 weeks and found to have pain with cold sensitivity on a third tooth. She was diagnosed with symptomatic irreversible pulpitis⁸ and root canal treatment was started the same day. She was re-evaluated by the endodontist a week later for an infection following pulpectomy and treated with antibiotics and pain medication, with additional follow-up appointments in one and two months. During the second follow-up examination, she did not have any further complaints. This treatment was completed and she had a crown placed about 4 months later. She was also seen by the endodontist in summer 2014, for re-evaluation of the two teeth that had previously had root canal treatments and crown placements. The patient was diagnosed with asymptomatic apical periodontitis,⁹ but as she had no symptoms for 15 years, and the crowns were in satisfactory condition, the

⁷ Dentin is the hard bony tissue forming the majority of the tooth under the enamel layer.

⁸ Pulpitis is the inflammation of the pulp of the tooth, which houses the nerve and blood vessels that supply nutrients to the tooth.

⁹ Apical periodontitis is the inflammation of the tissue at the apex of the tooth root, often causing gum shrinkage and loosening of the tooth.

endodontist did not plan for additional treatment of these teeth. Although there was a delay for an endodontics evaluation causing the patient to have pain for another month, she did not complain to any health care providers at the VA during the interim about this issue. We found that the delay in evaluation did not appear to cause any lasting adverse outcomes.

Patient 3

At the time of our review, the patient was in her 90s. The patient's EHR did not include progress notes or other documentation regarding a dental appointment. It was unclear why an appointment was scheduled for this patient. The only notation was "wrong patient" when the appointment in spring 2014 was canceled by the clinic.

Patient 4

At the time of our review, the patient was in his 50s. He was initially seen in the dental clinic in fall 2013 for pain in the upper and lower right teeth, and he was diagnosed with pulpitis¹⁰ secondary to dental caries. He was seen again 2 weeks later but wanted the pulpectomy procedure performed on another day as his symptoms had improved. An appointment was scheduled on that day for spring 2014. The patient was seen in mid-winter 2014, by another dentist for treatment of the same tooth which had an abscess. Because of the abscess, it was not possible to perform the procedure, and he was prescribed antibiotics and pain medications. Treatment was started and completed one month later. Since he already received treatment, the patient elected to cancel the spring 2014 appointment. We found that this canceled appointment was based on the patient's decision and not the clinic's.

In the course of our inspection, we determined that two patients (1 and 2) were not scheduled for evaluation for 5 months. Although we did not find evidence of long term impact on their clinical outcomes, 5 months was an excessively long wait to be evaluated.

Issue 2: Insufficient Staffing in the Dental Service

We substantiated the allegation that the dental assistant to dentist staffing ratio was lower than recommended by VHA. In 2011, VHA Office of Dentistry Workforce Study "Variables Affecting Dentist Productivity" recommended a ratio of 1.75 assistants to 1 dentist to significantly increase dentist productivity. As Table 2 on the next page describes, the system's dental assistant to dentist staffing ratio was often less than 1.75:1.

¹⁰ Inflammation or infection of the nerve in the tooth.

Table 2: Dental Assistant to Dentist Ratios

Date	Dental Assistants	Dentists - FTE ¹¹	Ratio
Oct. 2013	15	8.3	1.81:1
Jan. 2014	12	8.9	1.35:1
Apr. 2014	13	10	1.3:1
Jul. 2014	13	10	1.3:1
Oct. 2014	11	10.5	1.05:1
Jan. 2015	15	10.6	1.42:1

Source: System

We determined that a number of actions have been taken to improve staffing at the system. The Chief informed us that since January 2014, efforts have been made to recruit additional assistants, laboratory technicians, and hygienists. However, as of February 2015, the Chief told us that the system has 16 dentists, 15 dental assistants, 3 hygienists, and 2 laboratory technicians, which would still place dental assistant staffing below the level recommended by VHA. The Chief informed us that previously, four laboratory technicians staffed the Dental Service and recruitment was ongoing for one additional laboratory technician. However, a fourth laboratory technician was no longer deemed necessary due to a current contract with outside dental laboratories.

We substantiated that staff dentists and dental residents had to assume non-dentist duties and did not have access to Omnicell cabinets¹² once dental assistants ended their tours of duty. During normal business hours, the dental assistants were responsible for equipment pre-cleaning and disinfection of environmental surfaces after each patient, and retrieval of needed supplies. After the dental assistants ended their tours of duty, the dentists and dental residents were then responsible for the after-care dental assistant duties and were unable to obtain necessary medical supplies with which to complete dental procedures on patients. The Chief stated that all dentists and residents have since been provided with codes to access the Omnicell cabinets.

Issue 3: Undelivered Dental Prosthetics

We substantiated the allegation that the dental clinic had a long backlog of undelivered dental prosthetics through November 2014.

The Chief acknowledged that there had been long waits, in some instances, up to 2 years, for prosthetic devices. The Chief informed us that standard turnaround times¹³ for prosthetics vary according to the type of work being performed by the laboratory—approximately 4–6 weeks for crowns and bridges and 2–4 weeks for full dentures. The

¹¹ Full time employee equivalent.

¹² Omnicell cabinets are locked cabinets in which medical supplies are stored. Staff must utilize a code to gain entry into the cabinets.

¹³ Turnaround time is the time period from when the dental clinic sends the prosthesis to the lab to when it receives the prosthesis from the laboratory.

Chief attributed the long waits to staffing shortages but also stated that corrective actions had already been instituted, including:

- Contracting with non-VA dental laboratories for prosthetic services.
- Scheduling patients prior to the receipt of dental prosthetics. In the past, patients were scheduled after receipt of prosthetics from contract laboratories.
- Documenting information for each prosthetic device, including the turnaround times and patient delivery times.

We were able to independently verify that one of these three corrective actions had been implemented prior to our visit—the system had contracted with non-VA dental laboratories for prosthetic services.

The system provided us with contract dental laboratory prostheses tracking sheets for each dental clinic, so we were able to verify that prosthetics were being sent to the non-VA dental laboratories. However, documentation related to the receipt of the prosthetics from the laboratories and the deliveries to the patients was incomplete, so it was not possible to fully assess improvements in turnaround and patient delivery times. The Chief informed us that the scheduling of patients for return visits prior to the receipt of the prosthetics was implemented as of November 25, 2014. By doing this, patients had to wait less time to receive their prosthetic devices. We could not fully verify this due to the incomplete documentation on the tracking sheets.

Issue 4: Broken/Insufficient Equipment

We substantiated the allegation that the dental clinic had insufficient and/or broken equipment. At the time of our visit, the main dental clinic had two x-ray machines and a panorex machine, and the radiograph software program was not functioning properly. While the x-ray machines were operational, the clinic had too few. The Chief acknowledged that having one x-ray for every two operatories is ideal. Given that the main dental clinic has 16 operatories, the clinic should have 8 x-ray machines. We confirmed that the system had already addressed the equipment issues by purchasing eight x-ray machines (six for the main clinic at Palo Alto and one each for Livermore and Menlo Park dental clinics), two panorex machines, a new radiograph software program, and other dental equipment.

Conclusions

We substantiated that two of the five identified dental patients' appointments were canceled and rescheduled to later dates. We did not find evidence that the rescheduling impacted clinical outcomes. However, we noted a 5-month delay in scheduling appointments for these two patients. Two other patients were scheduled for appointments that did not need them. The fifth patient was not canceled and rescheduled but seen on the appointed day.

We substantiated the allegation that the staffing ratio for dental assistants to dentist was slightly below VHA's recommendation. However, we determined that the system has

actively been recruiting for additional staffing, including dental assistants, a dental hygienist, and a dental laboratory technician. We were also informed that if patients were still being seen after dental assistants ended their tours of duty, all dentists and residents had been provided with access to the Omnicells to obtain necessary supplies.

We substantiated the allegation that the dental clinic had a long backlog of undelivered prosthetic devices. The system had instituted improvements in its processes, but due to incomplete documentation, we could not fully assess progress in reducing “backlogs” of undelivered prostheses. We concluded that program managers needed to ensure timely delivery of prosthetic devices and that the process from sending prosthetics to the contract laboratories to delivery of prosthetics to patients be documented and reviewed routinely.

We substantiated the allegation that the dental clinic had broken and/or insufficient equipment. However, we determined that additional equipment and the radiograph software program were purchased.

We concluded that the dental program and clinic at the system continued to face significant challenges in the recruitment of sufficient staffing, documentation concerning prosthetic devices, and in ensuring that corrective actions to improve delivery of prosthetic devices described by system leaders are fully implemented.

Recommendations

1. We recommended that the Veterans Integrated Service Network Director review the dental program after corrective actions have been implemented to ensure that dental care at the system is timely and of high quality.
2. We recommended that the System Director monitor the dental clinic to ensure that patients receive appropriate access to care, as required by Veterans Health Administration policy.
3. We recommended that the System Director implement recommendations as described in the 2011 Veterans Health Administration Office of Dentistry Workforce Study regarding staffing in dental clinics.
4. We recommended that the System Director ensure timely delivery of prosthetic devices and documentation of each step in the process and monitor compliance.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 19, 2015

From: Director, VA Sierra Pacific Network (10N21)

Subject: Healthcare Inspection—Alleged Dental Service Scheduling and Other Administrative Issues, VA Palo Alto HCS, Palo Alto, California

To: Director, Los Angeles Regional Office of Healthcare Inspections (54LA)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Thank you for providing VA Palo Alto Health Care System the opportunity to review the report and provide you with their action plan in response to the site visit that was conducted back in September 2014.
2. I agree with Ms. Freeman's response and the VISN will ensure a review of the dental program is conducted as stated in the action plan.
3. If you have any questions please contact Terry Sanders, Associate Quality /Manager for V21 at (707) 562-8370.



Sheila M. Cullen
Network Director

Attachments

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Veterans Integrated Service Network Director review the dental program after corrective actions have been implemented to ensure that dental care at the system is timely and of high quality.

Concur

Target date for completion: December 31, 2015

VISN response: The VISN Chief Medical Officer will ensure that the VISN Dental Lead conducts a review of the Palo Alto Dental Service to ensure ongoing compliance with corrective actions and provision of timely, high quality care.

System Director Comments

**Department of
Veterans Affairs**

Memorandum

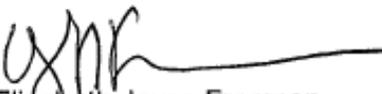
Date: June 18, 2015

From: Director, VA Palo Alto HCS (640/00)

Subject: Healthcare Inspection—Alleged Dental Service Scheduling and Other Administrative Issues, VA Palo Alto HCS, Palo Alto, California

To: Director, VA Sierra Pacific Network (10N21)

1. On behalf of the VA Palo Alto Health Care System (VAPAHCS), I would like to express my appreciation to the Office of the Inspector General (OIG) review of the Dental Service conducted September 24-26, 2014.
2. I have reviewed the findings from the report, and concur with recommendations two (2), three (3) and four (4). We have completed, or are in the process of completing, actions to resolve these issues.
3. Allegations were made that the Dental Service Chief conducted inappropriate personnel practices, including misuse of official time, abuse of authority, and disruptive behavior. These allegations were not investigated as part of this review of the Dental Service. It is our contention that these allegations are unfounded and, if investigated, would not be substantiated.
4. I appreciate the opportunity to this review as a continuing process to improve the care to our Veterans.


Elizabeth Joyce Freeman
Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 2. We recommended that the System Director monitor the dental clinic to ensure that patients receive appropriate access to care, as required by Veterans Health Administration policy.

Concur

Target date for completion: Completed

System response: The wait time for the specialty clinic reviewed have been reduced to no more than one week. Wait times are monitored on a weekly basis by the Chief, Dental Services and wait times in excess of 30 days will be reported to Chief of Staff Office.

Recommendation 3. We recommended that the System Director implement recommendations as described in the 2011 Veterans Health Administration Office of Dentistry Workforce Study regarding staffing in dental clinics.

Concur

Target date for completion: March 1, 2016

System response: The dental assistant to dentist ratio as of June 11, 2015 is 1.43:1. The Service will continue the active recruitment of dental assistants until the dental assistant to dentist ratio is at least 1.75:1, the standard established by the Veterans Health Administration Office of Dentistry. Until such time that staffing ratio is met, we will continue to use over time budget to ensure availability of dental assistants, thus reducing the necessity of dental residents to perform dental assistant duties. The Chief, Dental Services will provide monthly updates to Chief of Staff Office regarding recruitment activities and progress towards achieving the goal of 1.75:1 dental assistant to dentist ratio.

Recommendation 4. We recommended that the System Director ensure timely delivery of prosthetic devices and documentation of each step in the process and monitor compliance.

Concur

Target date for completion: Completed

A review of data for the period June 1, 2014 to May 31, 2015 indicates that across all Palo Alto VA Health Care System dental service locations the average time from

sending the request for a prosthesis to the lab to receipt of the prosthesis is 19 days and the average time from receipt to delivery to the patient is also 19 days. We consider a total time of 38 days from initiating the request for the prosthesis to delivery to the patient is a timely response.

During the data review it was determined that the Livermore Division did not document delivery time in the same manner as the other two divisions. The data is available in the medical record, but has not routinely been transferred into the tracking grid. The Livermore Division has been instructed to include this data into their tracking grid. The Chief, Dental Services will monitor the prosthetic request and delivery data on a monthly basis to ensure compliance with data entry requirements for tracking prosthetic orders.

RESPONSE TIMES FOR DELIVERY OF PROSTHETICS	
	AVERAGE NUMBER OF DAYS BETWEEN ORDERING AND RECEIVING PROSTHETICS
CUSTOM PROSTHETICS LAB - LIVERMORE	11
CUSTOM PROSTHETICS LAB – MENLO PARK	14
CUSTOM PROSTHETICS LAB - PALO ALTO	40
MASTERS DENTAL LAB - LIVERMORE	22
MASTERS DENTAL LAB - MENLO PARK	13
MASTERS DENTAL LAB - PALO ALTO	18
ALL LOCATIONS COMBINED	19
	AVERAGE NUMBER OF DAYS BETWEEN RECEIVING AND DELIVERING PROSTHETICS TO VETERAN
CUSTOM PROSTHETICS LAB - LIVERMORE	No Data
CUSTOM PROSTHETICS LAB – MENLO PARK	18
CUSTOM PROSTHETICS LAB - PALO ALTO	14
MASTERS DENTAL LAB - LIVERMORE	No Data
MASTERS DENTAL LAB - MENLO PARK	31
MASTERS DENTAL LAB - PALO ALTO	6
ALL LOCATIONS COMBINED	19

Allegations made against the Dental Service Chief, but not investigated as part of this review of the Dental Service, included inappropriate personnel practices, including misuse of official time, abuse of authority, and disruptive behavior. It is our contention that these allegations are unfounded and would not have been substantiated if they had been investigated.

Office of Inspector General Contact and Staff Acknowledgments

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