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STATEMENT OF
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VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
FIELD HEARING IN DAYTON, OH

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Senator Brown, thank you for the opportunity to discuss the way forward for Veterans and the Department of Veterans Affairs Medical Center (VAMC) in Dayton, Ohio. I am accompanied today by Mr. William D. Montague, Acting Director, Dayton VAMC; and Lisa Durham, Chief, Quality Management at the Dayton VAMC. We are here today to address the lapse in proper infection control practices of one dentist at the Dayton VAMC's Dental Clinic. More importantly, we are here to inform our stakeholders, including our Veterans, their families, the public and Congress, what we have done and will continue to do to ensure that the care Veterans receive meets the highest standards of quality and safety. We also want to reassure stakeholders that we are taking action to ensure that an event like this does not occur again. Part of the process of restoring confidence requires an honest and transparent account of what occurred. My testimony will begin with an overview of how we discovered the improper practices of the single dentist. From there, I will discuss the actions VA has already taken in response to this incident. I will conclude by describing our future plans.

Infection Control Deficiency at the Dayton VAMC Dental Clinic
During a scheduled internal review process by one of VA's System-wide Ongoing Assessment and Review Strategy (SOARS) teams in July 2010, concerns were raised about adherence to infection control procedures in the Dayton VAMC Dental Clinic. The leadership of the facility, in consultation with me, immediately initiated a fact finding review to assess the concerns. Once the concerns were confirmed, I immediately expanded the investigation. Rapid response teams from VA Central Office helped us analyze the problem and determine corrective actions, and we decided to suspend dental services. The dental service closed for approximately three weeks beginning August 19, 2010, while all employees in the clinic received extensive refresher training and competency certification on proper infection control techniques.

Investigation and outside review confirmed that a single dentist was not following proper infection control practices. VA initiated a Clinical Review Board (CRB) process to determine the level of risk to Veterans receiving care from this provider. This included an intensive review of our records dating back to January 1992. Though the risk for infection was considered very low,

the CRB recommended VA notify Veterans who received specific procedures involving invasive dental treatment performed by this dentist.

When the extensive review of records was completed and validated, it was determined that 535 Veterans should be notified about the possible exposure. The Dayton VAMC provided Veterans information regarding their potential exposure, and extended an opportunity for testing. As of April 15, 2011, all 535 Veterans have been contacted. 506 have been tested. Two new cases of hepatitis B have been identified. While it is impossible at this time to determine if the source of the infection arose from the dentist's failure to comply with infection control practices, the investigation through VA's Office of Public Health is continuing, and these patients are being actively evaluated and followed.

There have been no new cases of HIV identified, and only one patient has tested positive for hepatitis C. This patient does not exhibit evidence of illness and, again, we cannot determine the source of infection at this time. Testing to confirm hepatitis C, and research to determine a possible relationship to the dental clinic, is ongoing. If additional cases are confirmed, and even if we cannot determine if the source of the infection arose from treatment in the dental clinic, VA will offer treatment to any newly diagnosed Veteran.

Actions Taken to Ensure High Quality Care at the Dayton VAMC Dental Clinic
VA has taken a series of actions to assure high quality care is provided and maintained in the dental clinic at the Dayton VAMC. We have provided additional education and training for dental staff and completed a review of staff competencies related to the education and training they received. During the dental clinic closure, we updated and standardized operating procedures in the dental clinic. We also evaluated dental equipment and instruments and made changes where indicated. In addition, we completed repairs to improve the physical environment of the dental clinic. These measures are in addition to those taken to improve conditions for employees, which we expect will improve morale and performance. Improvements to increase communication among all dental employees, including leadership, have been implemented. Regular meetings and morning huddles provide the opportunity for increased communication and openness. The Acting Chief of the Dental Service held regular conference calls with other Dental Chiefs within the VISN to make certain they benefitted from the lessons learned at Dayton. This information was also shared nationally among dental professionals.

Beginning last July, a number of initiatives were instituted at the Network level. I convened an Administrative Investigation Board (AIB) to determine if there was a deviation in any dental standards of practice or improper handling, cleaning, or disinfection of dental equipment. This Board was composed of experienced external clinical members and an internal infection control professional. I directed the Dayton VAMC leadership and VISN 10 staff to review results of previous investigations, workplace evaluations, performance improvement plans, credentialing and privileging, VISN Readiness Reviews, and environment of care rounds. Patient safety and risk management reports were carefully reviewed to determine if there were any trends. Based upon the events at Dayton, I directed VISN professional staff members to conduct unannounced inspections of all VISN 10 dental services to ensure all expected dental policies and procedures were in place, all dental equipment and instruments were properly maintained, and all practices were in compliance with standards. I required VISN 10 facility directors to visit and conduct

similar reviews of their internal dental operations. I received the final AIB report in October and accepted the findings and conclusions. After reviewing the AIB report, Dayton VAMC Leadership proposed administrative actions. The dentist in question chose to retire before that process was complete. In December, I attended a meeting in Washington, D.C. to discuss the lessons we learned at Dayton with other Network Directors from across the country. VISN 10 staff has continued to conduct follow-up, unannounced, inspections of the Dayton Dental Service and other areas of the facility related to infection control.

In the area of infection control, the Dayton VAMC now includes a dentist as the Dental Representative on the Infection Control Committee. A dashboard was developed to summarize infection control practices and compliance. The Dayton VAMC infection control staff conducts quarterly observations of dental staff proficiency. Infection Control Practitioners maintain a daily log of their activities to document compliance with standard practices. Dayton developed a checklist for conducting clinical inspections and chart reviews to meet the requirements of focused and ongoing peer review programs. New standard operating procedures were implemented prior to the reopening of the clinic in September.

VA's National Center for Organizational Development staff visited Dayton and offered a number of recommendations that have subsequently been enacted. In the area of leadership, the Dayton dental organizational chart was revised to ensure oversight and sufficient staffing support. Position descriptions have been reviewed and revised. Dayton has updated performance appraisal plans to emphasize accountability for safe and quality care, and these updates have been communicated and issued to employees. Efforts are underway throughout the Dayton VAMC to improve communication by offering additional opportunities for providing information to leadership through regular meetings, committee assignments, and participation in the relationship-based care initiative.

We are evaluating staffing levels in the Dental Clinic. A new position of Assistant Chief for Dental Service was established. Recruitment has been completed for a new Lead Dental Assistant and Dental Lab Technician. Recruitment is being finalized for a general dentist and administrative support staff. Dental hygienists have been relocated into larger space to accommodate clinical need, and administrative support was added to improve customer service and scheduling. The Dayton VAMC set up a dedicated Dental Communication Center Hotline (1-877-424-8214) that is available 7 days a week, 24 hours a day. If Veterans or family members have any questions about the care provided at the Dayton VAMC Dental Clinic, we strongly encourage them to call. A special clinic was established for Veterans to come in for testing. Since we have been successful in contacting all of the Veterans, in the identified cohort, we are asking remaining Veterans that are interested in being tested to report to Primary Care, Monday through Friday from 8:00 am to 4:30 pm and follow-up with their Primary Care provider. Veterans may walk-in during clinic hours or call the hotline number for an appointment.

Since we began this series of improvements last summer, the Dayton VAMC has been inspected multiple times by various VA teams and the Office of the Inspector General (OIG). We appreciate the OIG's independence and counsel and have collaborated with them to ensure they have access to any information they need. In November, The Joint Commission conducted an unannounced review of the Dayton VAMC, with an additional surveyor focused specifically on

the Dental Clinic. There were no dental service infection control issues identified.. The hospital has received full 3-year accreditation.

The Way Ahead: Continuing to Deliver High Quality Care at Dayton
We have made significant progress and major changes to ensure that health care is delivered timely, safely and appropriately at the Dayton VAMC. While these accomplishments are notable, we still have more to do. We will continually strive to be the Veteran-centered, results-oriented and forward-looking organization the Secretary has called us to be, and that our Veterans deserve. Our immediate focus is on implementing the recommendations our colleagues at the OIG offered following their review of infection control practices at the Dayton VAMC in December 2010. The OIG issued a draft report to the VISN in March. We provided our comments on this report back to them in early April.

The OIG made two specific recommendations: first, I am to review the findings related to the Dayton VAMC Dental Clinic, including staffing issues, and take appropriate action; and second, I am to ensure the Dayton VAMC Director requires the Dental Service to comply with relevant infection control policies. I concurred with their recommendations. By the end of June, we will be in full compliance with the first recommendation as all necessary actions will have been taken. Administrative actions have been initiated against the parties responsible for allowing these lapses of infection control practices and inadequate oversight to occur. We will be finished modifying our Dental Service organizational structure consistent with findings in the OIG report. Regarding the second recommendation, by the end of May, systems will be in place to track all Dental Service mandatory infection control training. We will institute periodic random audits of infection control training compliance and observations, and will document staff knowledge of the infection control on the checklist in the Dental Dashboard. We will continue to work closely with infection control experts available in VA's system to ensure infection control practices are current with health care standards and expectations.

We are also taking other actions to improve the care we deliver beyond the OIG's recommendations. First and of greatest importance, we will continue to reach out to Veterans who had contact with this dentist to provide them whatever support they may need. VA Central Office has convened a Management Program Review Team to conduct an organizational assessment of the Dayton VAMC. The primary purpose of this assessment is to identify any organizational or leadership factors that may have allowed this particular practice to continue undetected or unreported. The Team's report will be used to evaluate operations and to assess whether similar conditions may be potentially present in other parts of the Dayton facility and potentially at other VA facilities. The Team will ensure that current key leaders have implemented systems to properly identify and effectively address clinical or administrative issues that require immediate response. The Team is being asked to do a retrospective review of the organizational and management structure and governance, operational dynamics and culture, key reporting structures, leadership, attitudinal factors, and other pertinent areas. Information gathered from this review will help VA look at system-wide opportunities for management improvement. The Team consists of experts with years of experience across the VA system, and will also include a representative from the National Center for Organizational Development, who will serve as a consultant and advisor. A member of my staff will accompany and support the team as needed.

Conclusion

Our primary mission is to serve the Nation's Veterans. We sincerely apologize to the Veterans who received notices regarding infection risks related to dental procedures while under our care. We also apologize to the public, whose trust may have been questioned. It is unacceptable that this situation went on for so long. The Dayton VAMC leadership took action when employees raised concerns in an internal review process, and the facility has been inspected multiple times by VA and non-VA experts. We have taken administrative actions to ensure that those responsible for this serious error are held accountable. In the days and weeks ahead, we will be working closely with our colleagues at the OIG to ensure we have addressed the concerns identified and to institute changes in the organizational and management structure and governance, operational dynamics and culture, and the overall environment of care. We will work closely with national VA program offices to make certain our practices and policies are current and responsive to changes in health care standards.

Thank you for inviting me here to testify today to discuss these plans and to listen to your recommendations. My colleagues and I are prepared to answer your questions.