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FIELD HEARING ON IMPROVING PATIENT SAFETY AND QUALITY CARE AT THE DAYTON VA MEDICAL CENTER

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

APRIL 26, 2011

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APRIL 26, 2011

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WITNESSES

FIELD HEARING ON IMPROVING PATIENT SAFETY AND QUALITY CARE AT THE DAYTON VA MEDICAL CENTER

TUESDAY, APRIL 26, 2011

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2 p.m., at the Dayton VA Medical Center, Dayton, OH, Hon. Sherrod Brown of Ohio, presiding.

Present: Senator Brown of Ohio, presiding.

OPENING STATEMENT OF HON. SHERROD BROWN, ACTING CHAIRMAN, U.S. SENATOR FROM OHIO

Senator BROWN OF OHIO. Thank you for joining us. I am Senator Sherrod Brown. This is an official hearing of the U.S. Senate Veterans' Affairs Committee, an official hearing even though it is not in Washington. Senator Patty Murray, who is a Democrat from the State of Washington, has empowered me as a Member of the Veterans' Affairs Committee to hold this hearing in Dayton at the VA Medical Center.

I thank you all for joining us. I thank Senator Murray, Ryan Pettit of her staff, and the Veterans' Affairs Committee staff. Also, John McDonald, to my right behind me, is with the Minority Staff of the Committee's Ranking Member, Senator Burr, a Republican from North Carolina. Also behind me is Doug Babcock of my office staff who advises us on veterans issues.

The investigation of the VA Dental Clinic has affected so many local veterans and their families that it makes sense to hold the hearing here. I will recognize Congressman Turner in a moment, who has been very, very involved in this. They will hold a hearing about Dayton and St. Louis in Washington with the Veterans' Committee there soon.

As I said, Chairman Murray and Secretary Shinseki and I have had many discussions about what happened, as has Congressman Turner with the Secretary. This hearing is a result of this work. It will operate with the same authority of any other hearing in the U.S. Senate that is held in Washington, DC.

We will be hearing from the Office of the Inspector General of VA and members of the VA leadership on what happened at the Dayton VA Dental Clinic. We need to know how we got here. We need to know how we move forward.

To any audience members who would like to submit testimony for the official record, please contact Mr. Babcock from my office and Rachel, if she would put her hand up, Rachel Miller of my staff in our Cincinnati office.

Before we start, I would like to ask anyone who is a veteran to please stand or put your hand up. Thank you. [Applause.]

All of us thank you, and I think I can speak for the Senate here, thank you for your service and we commit to doing better with this Vet Center, as the VA does in a great majority of places around the country.

A special thank you to the leaders of Ohio's Veterans Service Organizations. Tom Burke of the Buckeye State Council, President for Vietnam Veterans—is Tom here? If Tom would put his hand up. He was going to join us. Dave Kenyon, who is a State Service Officer for the AMVETS, thank you for joining us. And Susan Getz, who is National Vice Chair of the Women Veterans of America—where is she? Thank you for joining us, too.

For 150 years, Ohio has been a leader in providing veterans' services. Ohio founded one of the Nation's first chapters of the Veterans of Foreign Wars. Ohio has the Nation's best county Veterans Service Officers and Organization. The Dayton VA Medical Center was one of the Nation's first VA hospitals, providing continuous care and service to veterans for some 14 decades, 140 years.

As a Member of the Senate Veterans Committee, it is not only an honor for me to serve our Nation's veterans, it is a sacred responsibility that we all take when we take our oaths of office. We should not have to be here. This hearing should not have to take place. I would much rather have a hearing on the future of the VA in Dayton, how we can help the community leverage Federal resources to ensure that the hospital and the campus meet the needs of our veterans. I would rather be talking about our strong bid for the VA Archives, a distinction clearly earned by Ohio veterans and deserved by Ohio veterans.

One of the most important duties of representing Ohio's veterans on this Committee is to provide oversight of the Veterans Administration. That means undertaking what works at VA, this Vet Center, and other centers around the country. It also means making it better when it does not, finding out what is not working, and fixing it. In the process, it means recognizing that serving our veterans is a nonpartisan responsibility of our government. Our veterans deserve nothing less. That is why we are here today.

Most of us are aware of the inexcusable facts and unconscionable consequences behind what happened at the Dayton VA Dental Clinic. Over the course of 18 years, the clinic failed in its duty, in far too many cases, to serve our veterans. A dentist disregarded basic sterilization practices. Nurses and assistants were ignored when they reported substandard care. We heard reports of employees punished for reporting unsafe practices. Petty, mean-spirited interpersonal dysfunction led to physical and verbal confrontations. Dental students allegedly provided care beyond that for which they were qualified based on VA standards and regulations. Management at the dental clinic and medical center studiously ignored problem after problem after problem, a symptom of general management chaos. These are the irrefutable, inexcusable facts.

More than 500 patients, as we know too well, at the Dayton VA Dental Clinic have been told that they have to be tested for bloodborne pathogens as a result of the care they received at this facility. Some experts are saying that thousands should be tested. As many as nine patients have tested positive for hepatitis; perhaps there are more. Veterans received life-threatening bloodborne pathogens instead of high-quality health care.

The patients at the clinic are our Nation's veterans and their families. They served our Nation when called upon. High-quality health care is a benefit they have earned, they deserved, and we have pledged to them, and in most cases, that is what the VA system does—ensure a high standard of care to veterans who have earned it. I often tell people that nowhere in the world will you find better care than when you step into a VA facility. During the debate on health insurance reform, the VA health system was an example to emulate.

So this hearing is not a trial. It is not a witch hunt on the entire VA medical system. Far from it. We want to restore the public's confidence in the system. We want to ensure accountability for those responsible for these horrific wrongs. We want to instill transparency as we move forward to ensure no veteran is ever treated with such blatant disregard. We want transparency. We want accountability. We want to hear about the clinic's mistakes and learn from the clinic's mistakes so those mistakes are not repeated. This hearing is grounded in those goals.

We will explore specific questions about what happened over the last 18 years. Why was the clinic allowed to operate in this fashion for more than a decade? Why did it take so long to close the clinic? Has every person exposed to contagions from unsafe medical practices been notified and treated and tested? What is being done to hold those accountable, including those who knew and sat idly by and those who should have known?

We will explore where we are today. Is the Dayton Dental Clinic now safe for patients who rightfully expect the world-class care that VA rightfully, most of the time, prides itself on? Are systems in place for this to never happen again? What is VA doing to make those exposed whole? What is VA doing to reassure every veteran that VA care is, in fact, the best care anywhere? We will explore how to restore the public's confidence in this hospital.

I have heard from hundreds of veterans about the Dayton VA. Most are angry. Many are just disappointed. I want to share two of them. One veteran from just north of here, from Huber Heights, told me, "I desperately need dental care, but not at the expense of my health." A veteran in Minster in Auglaize County wrote, "I am one of the veterans who was potentially exposed by the dentist in question. I have been tested. Now I have to wait in limbo, being treated as if I am positive until said test results come back. No offense, Senator, but the testing is being done by the same agency that ignored the problem for 18 years. It put me in jeopardy to begin with. Am I to trust that the VA this time will get it right?"

I am not happy with the pace of the administrative process regarding the disciplining of those involved. I understand there are legal and procedural hurdles, and for that matter, criminal processes that need to be followed. But people must be held account-

able. Transparency, accountability, making sure this crisis in care and confidence must never, ever happen again, that is what this hearing is about today.

That is why I have asked Congressman Turner to offer his testimony. Congressman Turner and I have worked together to push for answers and accountability. While we represent two different parties in two different chambers, we represent the same Ohio veterans. He represents Ohio's Third Congressional District, and home to his district is home to this VA medical center. I have asked him to make a brief statement before we hear testimony. Congressman Turner, thank you for joining us.

STATEMENT OF HON. MICHAEL TURNER, U.S. REPRESENTATIVE FROM OHIO

Mr. TURNER. Thank you, Senator Brown. I want to thank you for holding this important hearing.

The importance of what you are doing here today is that you are not just sitting here as the Senator from Ohio, concerned about these veterans and this issue that is occurring in your State. I understand that this is a hearing that is occurring under the auspices of the Senate Veterans' Affairs Committee. A transcript is being taken, and I know this becomes a part of the official record of the work of the Senate in evaluating the VA, both this instance and nationally, so I appreciate that this is a special visit as we look to investigate this issue and broaden the scope, really, of what needs to be reviewed here at this site.

I appreciate your statement on what occurred here. This is abhorrent, that any patient who would enter the VA would be placed at risk. The fact that these practices were ongoing and none of us knew, you acknowledged, is equally abhorrent, and I think that is part of what brings everyone here with such anger.

We know that the dentist in question violated standards for practice for at least 18 years. The support staff was aware of the infractions, but apparently their reports were not followed through or they did not report it, because when he was found reported, the leadership, I believe, moved forward trying to cover up what had happened here and continues to not be forthcoming about the actions that had occurred here.

I believe that the VA is acting more as an obstacle than they are of help to resolve this, and I think this hearing that you have brought forth, Senator Brown, will help us in trying to dislodge some of the information that has occurred, and I would like to highlight some of that difficulty.

First, the VA notified my office that they wished to meet with our staff to provide what they called an update concerning the dental clinic at the Dayton VA Medical Center. The notice was provided at 9:30 p.m. the night before the briefing, which was scheduled at 10 a.m. the next morning. At this briefing, the VA informed us that standards of practice concerning infection control had been violated, and that 535 veterans in the Dayton community were going to be notified that they should come in and be tested for bloodborne pathogens, including HIV, along with hepatitis A, B, and C.

Following that notification, Senator Brown, yourself, Senator Portman, and I requested copies of the report and that they be provided to the Greater Dayton Area Hospital Association for their review and determination as to how the community should proceed. Instead of embracing this relationship and working together to solve an obvious problem, the VA has very lethargically and reluctantly responded to our request. I will give you a few examples, which I know you are aware.

First, my office requested a copy of the investigative report on February 17. Following that request, we were informed that the VA would have to redact information in the report and that would cause some delay. We were told that patient information was going to be protected. The documents really contained no patient information, but as you are aware, Senator Brown, the report that was released had many redactions of information which were important for us to be able to review as a community to determine what happened here and how we need to proceed.

Despite numerous requests, we did not receive the reports until 9:30 p.m. Friday, March 11, 2 days before Chairman Miller of the House Veterans' Affairs Committee and I were scheduled to meet with the leadership in Dayton. The delay inhibited our ability to both inform the Greater Dayton Area Hospital Association and the community. We later learned that the regional facility had released the report to the Dayton Daily News on February 9, a full month before they released it as a result of Congressional request.

Second, Chairman Miller and I visited the hospital to speak with the leadership to learn about what had happened. However, just prior to our visit, we learned that the VA had removed the director, Guy Richardson, from his position and moved him into a higher-level supervisory role. We were unable to meet with Mr. Richardson and still have been unable to meet with him to date.

Finally, during our visit, I raised concerns about the redactions made in the report. When I later met with the VA FOIA (Freedom of Information Advisory Council) office in April, they informed me that it took their office only 4 hours to redact the report, and it still took a month for the report to be released, for us to be able to provide it to the Greater Dayton Area Hospital Association.

Senator, as you are aware, the Greater Dayton Area Hospital Association has reviewed the information to date that has been released by Veterans Affairs, and the Dayton VA Task Force has released this report which they say concludes that additional veterans need to be tested and additional veterans need to be provided care. They believe that the practices that occurred here exposed many more veterans than VA is currently acknowledging were at risk. We are calling on Secretary Shinseki to provide testing and notice to those additional patients so that they can be properly cared for and VA can properly acknowledge the risk that these veterans were placed in.

With regard to the Office of Inspector General investigation that is the subject of discussion today, I would like to thank that panel for investigating this issue, but I would be remiss if I did not point out that the scope of the OIG investigation was limited by internal constraints. As the report itself states, the OIG investigative body was unable to interview several key witnesses simply due to their

retirement. These witnesses include the original source complainants, a fellow dentist, and the facility's chief of staff. Their absence raises serious concern over the comprehensive scope of the investigation and brings their conclusions into question.

What the investigation does do, however, is highlight a systematic flaw that allowed employees to evade the investigative process by retiring. This escape-hatch option neither serves our Nation's veterans nor the taxpayer and merits further investigation. After all, our country has thousands of young men and women that are making a great sacrifice, just as the generations before them. We need to make sure that they have the peace of mind to know that if they need help, there will be a fully functioning and competent VA here to give them that help when they need it, just as was promised.

Senator, thank you for reviewing this matter. Thank you for bringing this hearing. I believe that the VA has additional information that they need to provide to this community for us to be able to evaluate what happened here and what actions need to be taken to address the concerns of the veterans who received care, and for us to be able to have confidence that the other types of care beyond dental that are provided at this facility meet the highest standards for our veterans. Thank you, Senator.

Senator BROWN OF OHIO. Thank you, Congressman Turner. Thank you for being here. We will address, I hope, all of those concerns that you brought up today. Thank you very much, and thanks for your work on this since the story broke. You got so involved. Thank you. Thanks very much, Congressman Turner.

The first panel will consist of Dr. John Daigh, Assistant Inspector General for Health Care Inspections, Office of Inspector General. Dr. Daigh joined the VA as Associate Director of Medical Consultation in the Office of the Inspector General in January 2002 and was appointed as the Assistant Inspector General for Health Care Inspections in January 2004. He is responsible for the Office of Inspector General initiatives that review the quality of health care provided to veterans in Veterans Affairs hospitals, clinics, in nursing homes, in addition to the care provided to veterans through various health care contracts. Prior to joining the Office of Inspector General, he was active duty with the U.S. Army for 27 years, retiring as a Colonel 10 years ago.

Dr. Daigh is joined by Dr. George Wesley, Director of Medical Consultation and Review Division, Office of Health Care Inspections; and Kathleen Shimoda, Health Care Inspector, Office of Health Care Inspections, and you are a registered nurse, I believe?

Ms. SHIMODA. Yes.

Senator BROWN OF OHIO. Yes. Dr. Daigh, please begin with your testimony. I may end up asking questions of the other two with you, and they can certainly consult with you on the answers. So proceed, Dr. Daigh.

STATEMENT OF JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTH CARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GEORGE WESLEY, M.D., DIRECTOR, MEDICAL CONSULTATIONS AND REVIEW DIVISION, OFFICE OF HEALTH CARE INSPECTIONS; AND KATHLEEN SHIMODA, HEALTH CARE INSPECTOR, OFFICE OF HEALTH CARE INSPECTIONS

Dr. DAIGH. Yes, sir. Senator Brown, it is a pleasure to be here in Dayton, a community that is recognized worldwide for its innovation, hard work, and success. It is especially a privilege to be here at a hospital that has been one of the oldest in the VA. As you identified, Dr. Wesley and Kathleen Shimoda are here with me. These are the two individuals that led the team that resulted in the report that was published Wednesday, or yesterday, on our Web site, of which you speak.

We were both horrified and surprised when we were asked by the Senate and House Veterans' Affairs Committee to come to the Dayton Dental Clinic and review the allegations that infection control practices were not being adequately followed. As a result of those efforts, we published the report that I mentioned.

I believe that at the current time that these breaks in infection control policy that we saw in the dental clinic are not typical of what is seen in this hospital at all, nor do I believe that the issues that we discovered and have reported on in our report are typical of VA as a whole. I believe that this is an outlier from how VA normally operates.

I have a couple of suggestions that I think should be considered moving forward that I hope will prevent these issues from occurring again.

One, I think that there are a group of individuals in the hospital whose input may not be—and I do not speak specifically about this hospital but VA hospitals in general—whose input may not flow unfiltered to the leadership, and I would speak of the group of individuals who I would call hospital technicians. They would be the individuals who run the ultrasound machines, who are cath lab techs, who work in the ophthalmology clinic, and who would be the technicians in the dental clinic. I think that the physicians and providers, in fact, have a direct line of communication to the hospital leadership through the standard chain of command. I think that the nurses and the nursing staff have a direct line of communication to hospital leadership through the head nurse. I think this other group of people might, if talked to on a regular basis, might, in fact, allow some of these issues to come to light sooner and be dealt with more quickly.

The second recommendation that I would have would be that among the senior leadership group in the hospitals, that VA consider rotating or having terms of office for those leaders, that they ought to plan to move from hospital to hospital or that their positions be changed up on some program basis. There is a cost to that, and I am not sure, we have not studied it as to whether that should be done in all cases. But I think it provides for a relook at the relationships that exist in a hospital. It requires leaders at lower levels to prove to their new boss that, in fact, the standards

that they have in place and the criteria that they are managing their organization by are effective.

The third recommendation I would make is that the VA uses a policy which I think is quite excellent which deals with adverse event disclosure. That policy was written in 2008, and it essentially is the playbook that is used to try to determine who should be notified when more than one individual needs to be notified as a result of an outbreak or the risk of an outbreak. There have been many more notifications around this issue and reusable medical equipment than I think anyone expected.

I would refer you all to the *New England Journal* editorial of September 2, 2010, which discusses the notification issue broadly in the United States and which lays out 30 or 40 notifications countrywide. VA has a few of those on the list, but there are many other institutions that have covered that problem. I think that it is reasonable to consider empaneling someone like the Institute of Medicine or some other group to sit down and think about the risk that—the risk issues, where the limit of science comes up with policy in terms of whom and how we should notify individuals.

I think that the basic scientific fact that HIV has never been transmitted, that is found in published literature, through saliva from one patient to the next, I think is understood. The risk of whether hepatitis B could be transferred from one patient to another has limits in what people know and understand and what people think good government or good policy ought to be. So I think that there is a wider expanse with these issues beyond VA, and I think a discussion would be of some value.

I also think that included in that discussion at the Federal level is the relationship between the administration and the legislature. I think that the policy currently lays out that the administration, the Principal Deputy Under Secretary for Health, the PDUSH, will advise the Under Secretary for Health on an action to take. These actions involve many individuals at great expense, and I think that one should consider how, in fact, those discussions occur.

The last piece of advice or issue that I think should be considered is one that is difficult to articulate exactly except to say that it is not uncommon in medical institutions for physicians who are prominent in their society at that hospital, who have worked there for decades or many years, have established a wonderful working relationship in that hospital, to over time decide that their capabilities are less. What they typically then do is request a set of privileges in the hospital. It is not the full set of privileges that they might have had 10 years ago.

So an example might be a surgeon who fully engaged in the operating room and in clinic might at some point in time request privileges not to operate but simply to work in the clinic for a variety of reasons. Maybe their hand was injured. Maybe there is some other issue. But I think it is incumbent upon the leadership of the VA to take careful thought and look and be especially careful in the granting of privileges when there is a change over time. One wants to limit the privileges of a practitioner based on data. Certainly, one does not want to have to have adverse events occur or patients be harmed before a credentialing and privileging committee makes

the decision to limit the privileges of an individual or deny privileges to an individual.

I talked about this issue with the leadership of VHA. I think it is one that, through discussion and consideration, that credentialing and privileging committees can focus on and do a better job at that issue. I know that my office will assign more time to looking at that issue as we look at the performance of credentialing and privileging committees throughout VHA. I think that is the fourth suggestion I would have, is to have—these issues might, in fact, be improved and be made less likely to occur in the future.

My staff will be privileged to take questions from you as you see fit. Thank you, sir.

[The prepared statement of Dr. Daigh follows:]

PREPARED STATEMENT OF JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Senator Brown and other Members of the Committee, thank you for the opportunity to testify on the results of our review involving the Dental Clinic at the VA Medical Center (VAMC), in Dayton, Ohio. At the request of the Chairmen and Ranking Members of the Senate Committee on Veterans' Affairs and the House Committee on Veterans' Affairs, the Office of Inspector General (OIG) reviewed infection control issues at the Dental Clinic at the Dayton VAMC and on April 25, 2011, we issued our report, *Healthcare Inspection—Oversight Review of Dental Clinic Issues, Dayton VA Medical Center, Dayton, Ohio*. We concluded that the subject dentist did not adhere to established infection control guidelines and policies, and multiple dental clinic staff had direct knowledge of these repeated infractions. These violations of infection control policies placed patients at risk of acquiring infections including those that are bloodborne.

BACKGROUND

Dental Clinic—The Dayton Dental Clinic performs a full spectrum of dental and oral surgical procedures. The dental specialties recognized by the American Dental Association (ADA) practiced at the medical center include general dentistry, oral and maxillofacial surgery, oral and maxillofacial radiology, periodontics, and prosthodontics. In July 2010, the dental clinic had seven dentists and an oral surgeon, two dental hygienists, seven dental assistants (two expanded function, five non-expanded function), and three dental laboratory technicians. In fiscal year (FY) 2009, the dental clinic treated 3,164 unique patients, and in FY 2010 the clinic treated 3,005 unique patients.

The dentists, oral surgeon, administrative officer, expanded function dental assistants, registered dental hygienists, and dental laboratory technicians report to the service chief, while the non-expanded function dental assistants and administrative program staff report to the Dental Service's administrative officer. The Chief of Dental Service reports to the VAMC Chief of Staff. The dental clinic has a General Practice Residency, which is an independent medical center residency (as opposed to being the recipient of university residents rotating through the dental clinic). At the time of the review, there were three residents, although it is authorized four. The last accreditation review occurred in September 2006, and the Commission on Dental Accreditation adopted a resolution to grant the program the accreditation status of "approval without reporting requirements" at its January 25, 2007 meeting. The next scheduled accreditation site inspection is scheduled for September 2013.

VA Oversight—The Veterans Health Administration (VHA) operates a program of proactive inspections through its System-Wide Ongoing Assessment and Review Strategy (SOARS) program. Its mission is "to provide assessment and educational consultation to volunteer facilities using a systematic method for on-going self-improvement." SOARS inspection teams are composed of program staff and field (Veterans Integrated Service Network (VISN) and medical center level) health care experts.

During the week of July 20–23, 2010, a SOARS team inspected the Dayton VAMC. On the morning of July 21, 2010, during the course of this inspection, two dental clinic employees approached a team member. The employees articulated allegations about aspects of a staff dentist's practice that pertained to this dentist's

handling of dental burs and noncompliance with dental infection control guidelines. These improprieties allegedly were ongoing.

The allegations, if true, would have represented significant breaches of both medical center and VHA national standards regarding the handling of reusable medical equipment (RME), adherence to standards of infection control, and professional comportment expected of VHA dentists. At that time, it was also alleged that these concerns had been previously brought to Dental Service management's attention.

From August 19, 2010, through September 9, 2010, the dental clinic temporarily suspended operations. The VISN and medical center supervised an extensive re-organization of the dental clinic. This included employee training, employee counseling, environment of care improvements, and updates in operating procedures. Dayton's Quality Manager notified The Joint Commission (the JC) and the Commission on Accreditation of Rehabilitation Facilities that as of August 19, 2010, as a precautionary measure in order to evaluate infection control practices, dental services at the Dayton VAMC were temporarily suspended.

The allegations set in motion no less than five VHA investigations culminating in the notification, on February 8, 2011, to 535 patients of the medical center, that infection control practices in the Dayton Dental Clinic were not always followed.

OIG REVIEW

As a result of the requests from Congress, the OIG began a review of infection control issues at the Dayton Dental Clinic. Our review encompassed a review of VHA actions in response to the allegations as well as an evaluation of selected aspects of the daily functioning of the dental clinic and its management oversight.

Dental infection control practices are governed by a multitude of regulations, standards, and recommendations related to the appropriate use of personal protective equipment (PPE), hand hygiene, reprocessing of RME, and other measures to safeguard the health of patients and staff. VHA, Centers for Disease Control and Prevention (CDC), The JC, and the Occupational Safety and Health Administration (OSHA) have published documents to facilitate compliance with recommendations and requirements. The medical center has also developed local policies related to hand hygiene, RME, bloodborne pathogens, and disinfectants. The medical center requires its employees to comply with these established infection control policies.

We visited the VAMC from December 14–16, 2010. We interviewed relevant clinical and administrative staff at all levels of VHA, extending to the Under Secretary for Health, as well as medical consultants from the Prevention and Response Branch of the CDC, VA's Office of Public Health and Environmental Hazards (OPHEH), and attorneys from VA's Office of General Counsel.

We reviewed already completed VHA investigations as well as Issue Briefs; VHA Clinical Review Board (CRB) charters, memoranda, and reports; relevant medical and dental literature; facility-level Standard Operating Procedures (SOPs) and policies; relevant committee minutes; credentialing and privileging documents; dental clinic infection control training records; and e-mail communications. We also reviewed VHA directives, CDC guidelines, OSHA's Bloodborne Pathogens Rule, and ADA guidelines.

VHA RESPONSES TO THE DENTAL SERVICE ALLEGATIONS

Immediately after the allegations concerning the Dental Service were made to the SOARS team, VHA launched a series of reviews and investigations at the local VAMC, VISN, and VA Central Office (VACO) levels. Additionally, VHA convened an Administrative Investigative Board (AIB) and Clinical Review Board (CRB).

Administrative Investigative Board

On July 29, 2010, the VISN 10 Director charged the medical center to convene an AIB. The AIB was composed of five members: the Chair (an Associate Chief of Staff/Podiatrist), a dentist; an infection control nurse; a Supply, Processing and Distribution technical advisor; and a human resources/labor relations technical advisor (regional counsel). The AIB's expressed purpose was to investigate the facts and circumstances regarding allegations outlined in the July 2010, SOARS Report of Contact (ROC) documents received by the VISN 10 Director from the VAMC Director. Initially, the AIB was tasked to determine:

- Whether there was a deviation in any dental standard of practice and/or improper handling, cleaning and/or disinfection of dental burs during fitting procedures by the dentist as alleged in the ROC and occurring in the dental clinic and/or dental laboratory at the medical center.
- Whether there was evidence to support that the dental technicians referenced in the ROC (or others) communicated their concerns to their supervisor or other

management official(s) as indicated/implied in the ROC. If so, identify who knew what, and when, or if action was taken.

The AIB concluded its testimony on September 14, 2010, and its findings and conclusions were accepted by the VISN 10 Network Director on October 5. During the course of the AIB, a total of 31 witnesses were interviewed. They offered testimony sworn under oath and in the presence of a court reporter. Select witnesses were called back two or even three times in an effort to allow AIB members to ask follow-up or additional questions and to provide an opportunity to obtain fully comprehensive testimony. All witnesses were afforded the option of having personal counsel accompany them to their depositions.

After considering the totality of the record and the depositions, the AIB concluded that the subject dentist did, in fact, repeatedly violate infection control standards over a multiyear period. The AIB also concluded that testimony supported the subject dentist's violations as beginning in 1992, and without curtailment of this dentist's privileges by knowing superiors, there was potential exposure of patients to bloodborne pathogens.

Clinical Review Board

VHA Directive 2008–002, Disclosure of Adverse Events to Patients (January 18, 2008), provides guidance for disclosure of adverse events related to clinical care to patients or to their personal representatives. This directive recognizes that although it is difficult to weigh all benefits and harms, situations prompting a decision whether to conduct large-scale disclosure of adverse events likely involve the following considerations:

- Are there medical, social, psychological, or economic benefits or burdens to the veterans resulting from the disclosure itself?
- What is the burden of disclosure to the institution, focusing principally on the institution's capacity to provide health care to other veterans?
- What is the potential harm to the institution of both disclosure and non-disclosure in the level of trust that veterans and Congress would have in VHA?

The CRB may choose to recommend notification if "one patient or more in 10,000 patients subject to the event or exposure is expected to have a short-term or long-term health effect that would require treatment or cause serious illness if untreated."

We found that the need to convene a CRB was anticipated early on during VHA's initial investigations into the allegations. On August 30, 2010, VACO senior leadership held a meeting with subject-matter experts in which the decision was made to convene the full CRB. The initial scope of the CRB as outlined in the charge letter was to:

- Conduct a clinical risk assessment.
- Identify the types of dental procedures at risk for disease transmission.
- Make a recommendation as to whether a large-scale disclosure was indicated.

If the CRB recommended a large-scale disclosure, it was to identify which patients should be notified, determine whether the disclosure should include deceased veterans' next of kin, and define the look back timeframe. The CRB was also tasked to provide justification for its recommendations.

The CRB met on September 2, 2010, and issued its first report to the Principal Deputy Under Secretary for Health (PDUSH) on September 3, 2010. It conducted its review with VAMC members, the VISN 10 leadership team, members of the site visit team, the VHA dental program office, and the VHA National Director for Infectious Diseases. Multiple documents for fact finding included the charge letter, the issue brief and update, AIB testimony of one dental clinic staff member, the AIB summary, a VACO August fact finding team report, a dental office review by the Office of Dentistry Consultant for Infection Control, OPHEH reviews, VACO's summary of the site visit to the medical center, a timeline of events, and a universal precautions history and synopsis.

The CRB report identified three practices by the subject dentist that posed a potential risk for infection transmission. First, the subject dentist did not properly disinfect dentures when taking them to and from the dental laboratory. This practice breach potentially contaminated laboratory equipment and surfaces. Second, the subject dentist wore soiled gloves and gowns outside the dental operatory and the dental clinic and did not change gloves between patients, potentially contaminating common use areas. Third, the subject dentist used the same dental equipment on patients without cleaning or sterilizing the equipment between patients.

In forming its recommendations, the CRB considered only the risk of transmission of bloodborne viral infections (HIV, hepatitis B, and hepatitis C). To assess the risk to patients posed by these practices, the CRB also considered reviews of the medical

and dental literature on the transmission of bloodborne viral infections in dental clinics. It was able to risk stratify the patients based on the invasiveness of the procedure a patient received in the clinic, including removable and fixed prosthodontics (crowns and bridges), restorative fillings, and invasive procedures such as extractions and periodontal scaling.

Initial CRB Recommendations

The initial September 3, 2010, CRB report recommended disclosure to all patients who had received invasive dental procedures and restorative care from the subject dentist since 1975. It recommended that testing for the bloodborne pathogens (HIV, hepatitis B, and hepatitis C) should be offered to these patients. The CRB also recommended that the AIB obtain further testimony from the dental staff to determine whether the subject dentist was reusing needles and/or drug vials and to clarify the subject dentist's infection control practices prior to 1990. The CRB advised that, with evidence that the subject dentist did not reuse needles or vials and practiced with a dental assistant who monitored the dentist's infection control practices prior to 1990, it could narrow its disclosure recommendations to include fewer patients and shorten the look back timeframe.

Second CRB Review

After multiple senior level discussions, the CRB was re-convened to further clarify risk assessment and disclosure issues. The CRB was to review additional AIB testimony indicating that the subject dentist did not reuse needles or vials and that he/she had a dental assistant prior to 1992. The CRB was also directed to review the AIB's supplemental testimony and reports. Using this additional information, it was to again outline a recommendation on disclosure, identify the specific patient population and dental procedures, and define the look back timeframe.

The CRB met again on November 23, 2010, and December 2, 2010, to consider the new information provided by the subsequent AIB testimony, the analysis of the testimony by the Office of General Counsel, and additional VACO and VISN 10 summary reports and findings. The meetings were conducted with members of the VISN 10 leadership team, members of the site visit team, the VHA dental program office, the AIB Chair, the VHA National Director for Infectious Diseases, the Director of Public Health Surveillance and Research, and the Senior Medical Advisor of OPHEH.

A key factor in determining the CRB's final recommendations was its conclusions regarding the extent and duration of the subject dentist's infection control infractions. In its review of the testimony, the CRB felt there was sufficient evidence to support a conclusion that major infection control breaches did not likely occur prior to 1992, when the subject dentist was practicing with a dental assistant. It was also able to limit the size of the patient population placed at risk to those undergoing only more invasive procedures that might provide a portal of entry into the bloodstream. Such exposure could thus result in disease transmission from one patient to another.

The CRB submitted its revised set of recommendations to the PDUSH on December 3, 2010. By a six to one vote, it recommended that the original disclosure recommendations be narrowed to include only more invasive dental procedures and that the look back be limited to patients treated from January 1, 1992, onward. It identified specific invasive dental procedures to include: extractions and periodontal scaling, some restorative fillings, and fixed prosthodontics (crowns and bridges). The dissenting voter felt there was insufficient clinical or scientific proof that hepatitis C or HIV has been transmitted in dental settings. The dissenter also noted that "the risk of patient-to-patient transmission of bloodborne pathogens from occult blood in saliva cannot be determined and is biologically plausible."

The CRB further recommended that the disclosure "should emphasize that the risk of a bloodborne infection to patients is low." It also recommended that each patient be offered serologic testing for hepatitis B, hepatitis C, and HIV. This testing would be part of an investigation for the purpose of identifying whether exposure in a dental clinic is associated with transmission of bloodborne pathogens, as there is little scientific evidence of known transmission. OPHEH would conduct the investigation in collaboration with the VAMC.

CRB Recommendations and Final CRB Review

On reviewing the final CRB recommendations, VACO senior leadership required further clarification regarding the specifics of its decisionmaking process and justification of its conclusions. In a letter dated December 14, 2010, the PDUSH requested that the CRB address issues including the following:

• How it chose the 1992 date, whether other dates were considered, and whether it considered the availability of electronic versus paper records?
• What was its estimate of risk to patients and was it quantified?
• What information should be disclosed and to provide evidence supporting disclosed information?
• Did it consider input from the OGC's evaluation of the credibility of the witness' testimony?
• Did it consider the testimony of the dental residents?
• Why did it defer the issue of employee risk assessment and disclosure to the local medical center and local public health officials rather than VISN leadership and OPHEH?

The CRB met for a fourth and final time on December 17, 2010, to address the PDUSH's questions regarding its decisionmaking process and risk assessments. It submitted a written response to the PDUSH on December 17, 2010. The Chair of the CRB then met with senior VACO staff to review and discuss its written response.

On January 4, 2011, VACO senior management made the decision to proceed with a disclosure as recommended by the CRB's final report. The patient selection for notification was based on those patients who received invasive procedures performed by the subject dentist from January 1, 1992, to July 28, 2010. An algorithm and process were developed that identified 535 patients who met the CRB criteria for disclosure.

OIG Conclusions

We concluded that the subject dentist did not adhere to established infection control guidelines and policies, and multiple dental clinic staff had direct knowledge of these repeated infractions. These violations of infection control policies placed patients at risk of acquiring infections including those that are bloodborne.

This was based on many facts including:

• A June 29, 2010, e-mail, from a clinic dentist to the Chief of Dental Services reporting violations of basic infection control protocols by one specific dentist.
• An August 16, 2010, memorandum for the record in which the Dental Service Chief indicated that he witnessed violations of basic infection control protocols by the same dentist on several occasions.
• Multiple dental clinic employees telling us they had personally observed various infection control policy violations by the same dentist. Violations included failure to disinfect, or incorrectly disinfect, denture prostheses prior to transferring them to the dental laboratory and wearing gloves outside the operatory. They told us that the subject dentist went directly from one patient to another without changing exam gloves and did not properly clean and disinfect the operatory. Individuals told us that unsterilized instruments were reused on more than one patient.

We concluded that the AIB was thorough in its fact finding process. It deposed 31 witnesses, some witnesses were called back for a second and even third appearance before the AIB. Witnesses included current and former leadership in the Dental Service as well as current and former staff, support staff, and trainees. Testimony was gathered by various methods including such instruments as written affidavits, verbatim transcripts, or recordings of live testimony. Conducting the AIB was a time-consuming assignment and was carried out seriously and conscientiously by the AIB.

We also concluded that the CRB acted in good faith to address the potential risks to VA patients. The CRB incorporated an extensive amount of data from which to base its decisions. All recommendations were carefully considered, with input from a solid counsel of national subject area experts. Its recommendations appropriately followed VHA's notification for disclosure policy.

With regards to staffing and workplace environment issues, we found that the staffing levels at the dental clinic were persistently below their organizational approved FTE levels and the level recommended by VHA for optimal performance. Optimal staffing may have decreased the likelihood that deviations from approved infection control practices would occur. Senior leadership and committees at the VAMC did not fully support efforts to staff the dental clinic at these optimal ratios.

During our dental clinic staff interviews, employees discussed concerns as to work climate and morale. We heard multiple concerns regarding ongoing staff shortages, favoritism, and demeaning comments to staff, and we were told of staff altercations that resulted in formal police investigations. We found indications that interpersonal staff relations were strained, which negatively impacted the dental clinic.

OIG Recommendations

The OIG made two recommendations:

• The VISN Director review the findings related to the Dayton Dental Clinic, to include staffing issues, and take whatever action deemed appropriate.

• The VISN Director ensure that the Dayton VAMC Director requires the Dental Service to comply with the relevant infection control policies.

The VISN Director and Medical Center Director agreed with the findings and recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.

CONCLUSION

Established infection control practices and policies were not properly or consistently adhered to at the Dayton VAMC Dental Clinic. There was evidence that staff assigned to the Dental Clinic observed these poor infection control practices over an extended time period. While Dental Clinic management was notified of these unacceptable practices, it was not until a VACO review body was at the Dayton VAMC conducting a routine inspection that definitive actions began. These practices constitute unacceptable breaches of patient safety precautions and a violation of the OSHA Bloodborne Pathogens Standard—standards that veterans have a right to expect are followed with care and diligence.

Senator Brown and other Members, this concludes our statement and we would happy to answer any questions that you may.

Senator BROWN OF OHIO. Thank you, Dr. Daigh.

I will start with you. I have some general questions and some very specific questions. I want to talk first about a couple of your recommendations. You said at the outset, the number 1 recommendation, the inputs of individuals do not flow to leadership—some individuals do not flow to leadership. How do you encourage structurally the VA, not just in Dayton but in Chillicothe and everywhere, so that the lab techs and the rad techs and others can feel that they will not be punished as whistleblowers or simply that they can share information up the chain, that they have confidence and patients can have confidence that that information is heard? They know things that no doctor and nurse perhaps know, as the doctors and nurses know things they do not know. How do we build that structure so they can do that, let us just say in Dayton for now?

Dr. DAIGH. I would say that I think that there are many different leadership styles, and I think individuals have different ways of being effective. But one way would be to have a regular meeting between the director or the chief of staff, to sit down and talk to the health techs or the senior techs in each of the different areas of the hospital, either as a group or individually in some, and in a group forum on a regular basis, where real issues are discussed, where real issues that are important to the hospital are discussed, and through the administration then or the leadership responding back with sound data and change, how things can be built and the flow of information that is helpful to preventing these sorts of things, I think, would occur. So it is a communication problem and that level of communication, I think, needs to be set up, that is separate from being filtered through the chief of the dental clinic or the chief of whatever service you are talking about.

Senator BROWN OF OHIO. How do you then—understanding that can be the structure with the right kind of administration—how do you protect that worker who wants to talk about a medical person not changing her gloves, not doing the right kinds of sterilization procedures? How do you protect that x-ray technician or that—maybe they saw something on the elevator or whatever. How do

you protect them from any repercussions from management for that sort of whistleblower action that way?

Dr. DAIGH. I think that you have to first trust that the leadership of the hospital will do the right thing and not take repercussions. If the leadership does take action which is viewed as negative toward the person who made the allegation, then they can certainly—a variety of offices—the Office of the Inspector General will certainly point them in the right direction of where they can get help. I think that we——

Senator BROWN OF OHIO. If I can interrupt——

Dr. DAIGH. Yes.

Senator BROWN OF OHIO. Would every employee of this hospital right now at this center know that if they came directly, no matter how low paid or whatever their position here, no matter how newly hired, that they could go directly to the VA Inspector General anonymously and protect themselves from any repercussions from management?

[Murmuring from audience.]

Dr. DAIGH. So the crowd says no, but I will say that we do have—hopefully that our telephone number is in each of these facilities. In every report we write, we put out our identifying and contact information. We get over 30,000 allegations a year that come into our hotline, which we sit down and look at. We work very hard to protect the identify of those sources that choose to remain confidential. One of the issues is that people who complain to us often, or complain to whoever, so it is not sometimes probable that the name of the person who made the allegation could be discerned. But we do everything we can to protect the name of the person who made that allegation. So we work very hard not to have adverse events occur to someone who makes an allegation. We work very hard to ferret out what the truth of the allegation is.

Senator BROWN OF OHIO. I would assure—and while this is a hearing, I will for a moment speak to the audience—I would assure anyone in this center or any other, whether it is an employee or a family of a veteran or a patient, that is in touch with my office, with Doug Babcock or Rachel Miller, the two people I mentioned earlier, that their names will be confidential and protected. I mean, I will assure anybody that makes complaints to us.

Let me go in a different direction for a moment. Well, let me take your second recommendation, that terms rotate—that top management rotate between and among hospitals. Give me a suggestion there specifically. How much of top management? How long are they at a hospital? Where would they—would it matter, geographic or size of hospital movement in moving them around? Give me thoughts on that, if you would, more specifically.

Dr. DAIGH. I would say that between the director, the chief of staff, and probably the head nurse, depending on what the organization of the hospital is, that—and again, there are a variety of scenarios that one could put forth that would be least disruptive to all concerned and yet would achieve the goal of changing the leadership structure and causing them to re-equilibrate and to, in fact, rejustify that what they are doing is the right thing. So I would think on a period of, I do not know, 3 or 4 years, that you would rotate in some pattern at least one of the members of that

group. I do not have the study to back that up. I do not have data to cost account this out for you, but it seems to me that that would be a very reasonable thing to do.

Senator BROWN OF OHIO. OK. Every VA hospital must pass inspection by two organizations, the Joint Commission on Accreditation of Health Care Organizations, as you know, and the VA Systemwide Ongoing Assessment Review Strategy. How could what happened in Dayton over the last 18 years not have been ferreted out? How could it have slipped past both of these review panels?

Dr. DAIGH. Well, I cannot speak for JCAHCO, but I can speak for—we do a—every 3 years we go to VA hospitals and do what is called a CAP inspection, and that CAP inspection is an inspection where we come in and we look at the systems within the hospital, like the quality assurance committees and how they function, the peer review process, and other committees that are set up to try to ensure that when bad things happen in the hospital, that the hospital takes that data seriously, that it reacts to that data seriously, and that change is made. So whether it is an internal review group from VA or the group that I operate that goes through this hospital and has been here three times in the last 10 or 12 years, that we missed it is really dreadful. I am horrified that we missed that.

We look at the hospital at committees that look across all the organizational elements of the hospital. We typically do not look from leadership down to the dental clinic, or from surgery down to the plastic surgery clinic, or from medicine down to cardiology. We try to look at those committees that look across all elements of the organization and we did not find that.

It also means that nobody came up and talked to us and said, we are here when the visit is announced, when I have five or six people in the hospital going through the books and records. Nobody came up and said, we have a problem in the dental clinic. Nobody called us.

So I do not have a good explanation for how this remained encapsulated for so long other than poor leadership, at least at the level of the head of the dental clinic, who did not over several leaders of the clinic enforce the standards of infection control that everyone knows should be enforced, both for the protection of the providers and, more importantly, or equally importantly, for the protection of the veterans. So I have no——

Senator BROWN OF OHIO. Dr. Daigh, if you are not sure how this happened as you came in from this direction in your analysis or as the Systemwide Ongoing Assessment Review Strategy came in, the VA, or JCAHCO, and I understand you cannot speak for them, what assures us that this will not happen other places, again in Dayton or in Chillicothe or in Omaha? How do we know this, that these panels, these review panels will not see something this serious?

Dr. DAIGH. Well, I——

Senator BROWN OF OHIO. A better question: What have we learned? What does this—sorry to interrupt you. What does this review panel—what do these review panels, what did they learn from not being able—from the failure to find this, ferret this out on more

than one occasion over 18 years? It was not just one time that JCAHCO came or one time that SOARS came in, correct?

Dr. DAIGH. That is correct. The SOARS is an internal VA group, but I understand your point. The group I have is a CAP, which is a different—but point well taken.

I think that I have seen this actually twice, and what I have seen is a provider who is well-supported and respected in the community who, over time, the procedures are stepped down, if you will, and might go from being a full-speed dentist to someone who just does dentures. They might go from a practicing surgeon who spends time in the operating room to a surgeon who just sees patients outside the operating room. The community supports that individual; they like that individual. And that individual, over time, might, in fact, deviate in some way from the standard of care, and somehow people call it an eccentricity or they call it something else. There is agitation, then, when younger people come into that clinic and say, no, the standard of care is being broken. In this case, it is infection-control policies.

Finally, when you look at it, everyone goes, oh, my gosh, what has happened here really is a catastrophe, and what were seemed to be minor deviations from the standard of care or eccentricities really were quite major breaks. The leadership who knows they should have enforced the rule, but they are friends who worked with that individual for a long time and did not enforce the rule are then wholly embarrassed at this outcome. That is the best explanation I can give you for how something like this could occur over a period of time.

Senator BROWN OF OHIO. Let me ask you this, or suggest this. You came up with four or five, depending on how you divided them, very specific points about what you suggest we do differently, "we" meaning the Dayton VA. Can you come up with similar specific prescriptive recommendations on what SOARS should do differently, learning from their failures at the Dayton VA and apparently in St. Louis? Can you, as Inspector General, give them—is that in your power, and would you do that for them so they do not make these mistakes elsewhere or ever again here?

Dr. DAIGH. I certainly can. We would—so the answer is yes. I must say that when I do an inspection proactively and I do not know anything is wrong. We look hard, but I simply cannot guarantee that I will uncover all problems every time I do an inspection. So I do the best I can. We lay out what we think are the most critical things to look at. If we find a problem, we write the pattern down. We bring it to the leadership's direction and ask them to fix it. When I say that a hospital has passed the CAP inspection or has identified defects, you know, I simply cannot uncover every rock.

With respect to the issues here, we will work hard to make sure that this does not occur again.

Senator BROWN OF OHIO. Thank you. Walk me through the timeline regarding when the VA knew there was a problem and when patients were contacted. If I have this right, the VA closed the clinic in August 2010. They did not contact patients for testing until February 2011. That is September, October, November, December, January—6 months, more or less. Is that standard prac-

tice? Should patients have been notified? Are you agreeing with the process VA followed in determining who and when to notify all possible exposures? I mean, I assume that the 535 number is far, far, far fewer than the number of patients that said dentist had over the last 18 years. Why 535? Why 6 months? What did the VA not do that they should have? Run through those answers for us.

Dr. DAIGH. I am going to ask Dr. Wesley.

Dr. WESLEY. Sure. Yes, sir. I would like to speak to that a bit. I do agree with what I think you are implying, is that notification process and the Clinical Review Board process was protracted. The CRB, or the Clinical Review Board, which deals with large-scale notifications, first reported up the line to the Principal Deputy Under Secretary on September 3, and again, as you note, the notification letters did not go out until February 8. I think part of that——

Senator BROWN OF OHIO. Put the microphone a little closer to you, please.

Dr. WESLEY. Oh, I am sorry. So the first recommendation of the notification went out September 3, but letters did not go out until February 8. Part of that was——

Senator BROWN OF OHIO. Was September 3 the first notification——

Dr. WESLEY. No. The Advisory Board that dealt with the issue of who, if anyone, we should notify, in essence, reports or makes a recommendation to the Principal Deputy Under Secretary of the VA for Health. They convened very early in September, I believe it was September 2 of 2010——

Senator BROWN OF OHIO. After the clinic had been closed, knowing there was a problem——

Dr. WESLEY. Correct. Correct. I think the clinic closed for about 3 weeks between August and reopened about that time. So they convened about September 2, reported on September 3 up their chain, if you will, basically to the Principal Deputy Under Secretary, and, in fact, in their report recommended a fairly large-scale notification, in fact, actually more than 500 patients. They actually recommended notifying virtually everyone going back to 1975, when the dentist in question was first employed.

Senator BROWN OF OHIO. A lot longer than the 18 years that——

Dr. WESLEY. Correct. Even longer than the 18 years. It was not—it should be appreciated that it was not a simple issue, though, because we have talked to CDC about this, and it is easy when you have harm, it is easy to notify when there is harm. But here, there was theoretical harm. It was possible harm. So, in essence, over the ensuing 3 months they kept revisiting the issue and attempting to figure out from the universe of patients who should be notified. Quite frankly, again, that was about a 3-month process. It was not until December that they came up with more definitive recommendations.

Senator BROWN OF OHIO. Tell me who "they" is.

Dr. WESLEY. Oh, I am sorry. I apologize. When you live this, it——

Senator BROWN OF OHIO. OK——

Dr. WESLEY. It is the so-called Clinical Review Board. It is an ad hoc advisory board which recommends to the Principal Deputy

Under Secretary if and how there should be large-scale notification of adverse events in a VA facility.

Senator BROWN OF OHIO. These were all VA employees in Washington?

Dr. WESLEY. They were VA employees, although they—experts throughout the system—did consult with external bodies, most specifically the CDC.

Senator BROWN OF OHIO. So none of these were Dayton——

Dr. WESLEY. Dayton management certainly had input. Certainly at the VISN level, Dayton was involved. The Chairman of the AIB was involved. VA's National Infection Control Director was involved. It was a very—again, it was a very excruciating, carefully thought-out process as to who to—as to what universe of people to notify. Again, I think the core issue is it was theoretical harm and, in a way, theoretical exposure rather than known exposure.

Senator BROWN OF OHIO. It was theoretical because—was there no real sense of urgency among this board? Understanding——

Dr. WESLEY. Right.

Senator BROWN OF OHIO. I do not want to belittle your comments about how complicated it is, that there were thousands of patients and you do not want to scare everybody and you do not want to test everybody.

Dr. WESLEY. Right.

Senator BROWN OF OHIO. I understand that. But if they settle on the number 535 and it takes them 6 months to do it and the word begins to leak out that there is a problem and nobody really quite knows what is next, the affected population, most of whom were not damaged—I understand that—but was there not some sense of urgency by the VA around the country or in Washington to move on this a little quicker to reassure these potentially thousands of families?

Dr. WESLEY. I think that point is well taken. I think they worked very hard over 2 or 3 months, but I think by the time they decided in late December, and I distinctly remember meeting with the Under Secretary for Health on January 4, and by that time, a decision had been made to notify at 535, and again, why it takes another month, I do not know.

Senator BROWN OF OHIO. Well, how about as you were analyzing this, and again, I do not belittle at all or dispute the complexity of it, but as you are looking at this, I would assume almost immediately, you knew that Patient X, Y, and Z, with names attached, some number of them were at risk, and if that is the case, why would you not notify them in October instead of waiting until you could decide on some macro system of doing this?

Dr. WESLEY. Right. Again, I think the point is well taken. Actually, when I looked at the witness list, I regretted that the chairman of the CRB was not here. I think that is the best person to answer about, you know, the time course. An equally complex question is, again, what number. Do you notify, again, basically, the patients that had invasive procedures going back to 1992 or do you notify every patient that this dentist saw going back to 1992, which is what the Greater Dayton Hospital Association says? So not simple at all.

Senator BROWN OF OHIO. Do you in your mind now, or did any of the three of you settle on a number, what the number should have been? Should it be much higher than 535? Is 535 about the right number?

Dr. DAIGH. Let me comment. I actually think there are—I guess what I was speaking to when I said there was a limit to our science and then after that you had to apply policy or what you thought were good ethics. Science would say that people who did not have invasive procedures or had procedures in which there was little chance that there was significant contact with saliva would be unlikely to get any of these bloodborne pathogens. So there is no clear answer. I think that what the VA authored is one of many reasonable possibilities, and I think that the Dayton—that the local view that much wider testing should occur is also a reasonable possibility.

But I will say, if you go to the Ohio State Health site and you plot the incidence of acute hepatitis by county, by year, and you look at that, it is not clear to me that there has been an epidemic of acute hepatitis here. So I think there are data sets out there that one could look at, veterans versus, you know, compared to the excellent work done by the Ohio medical group collecting the incidences of these infectious diseases, to see if, in fact, there has been an outbreak of hepatitis in this community that could be traced back to this event.

Senator BROWN OF OHIO. I appreciate that answer. I still am not clear. Should I walk out of here today, when I meet with a VFW group or a Legion group or a Vietnam Veterans group and they ask me, is 535 the right number? Should I be tested? Should my friends at this post be tested? I went to that doctor and had some minor surgery in 2007 or 2001 or whatever. What do I tell them?

Dr. DAIGH. I think that the decision to test those individuals who had procedures by the dentist in question which were invasive and more likely to cause blood from the mouth to be mixed with sputum is a very reasonable set of people to test. I do not——

Senator BROWN OF OHIO. That number is significantly greater than 535.

Dr. DAIGH. No, that would be the 535 number.

Senator BROWN OF OHIO. That is the 535.

Dr. DAIGH. If you only talk about people who had a denture pulled out, adjusted, put back in, no blood transfer, then the risk would be much less. The problem, sir, is that if you took a denture out of a person's mouth and you did not properly sterilize it, you bring it to the lab where the dentures are worked on and you worked on that denture not being sterilized, you have contaminated the burrs in the lab. So if the next person has their dentures——

Senator BROWN OF OHIO. I have read in these reports the word "burr." What is that referring to?

Dr. DAIGH. It would be a device that spins rapidly that cuts a tooth, drills a hole in——

Senator BROWN OF OHIO. I really hate when I go——

Dr. DAIGH. Yes. So I think there are some just absolutely practical limits from science, and I think it is a difficult answer. I think VA authored a reasonable solution. We knew with the hearing in

St. Louis recently, and a similar problem occurred, and I had a staff member sit in the audience and listen to that hearing. She sat next to a lady who had gotten a letter saying that her husband might be at risk of HIV and she was mortified. As I sit there and think about the letter that said, you might be at risk of HIV for, again, a removable—for a piece of dental equipment that was not properly sterilized. I mean, I personally think the risk that they had HIV is remote, maybe even close to zero with no reportable cases of transmission through saliva of HIV. I sit there and want to make sure that we are not creating harm when we send these letters that scare people absolutely to death.

So it is a very difficult question in terms of how to decide and our science here. So I think there are several reasonable solutions to it.

Senator BROWN OF OHIO. Would you personally go to the dental clinic here right now?

Dr. DAIGH. Yes.

Senator BROWN OF OHIO. OK. Ms. Shimoda?

Ms. SHIMODA. Yes, I would.

Senator BROWN OF OHIO. Dr. Wesley?

Dr. WESLEY. Yes.

Senator BROWN OF OHIO. My last request is to walk me through the allegations that whistleblowers have been punished. Can you tell me what has happened to people that have tried to speak up, because we know of reports that people, in fact, saw some less than proper practices in the dental clinic. What happened to them? What were their lives—tell me what happened.

Dr. DAIGH. I do not have information on that.

Dr. WESLEY. Yes. I——

Dr. DAIGH. I would have to have—well, I would not address that issue.

Senator BROWN OF OHIO. Should you not?

Dr. DAIGH. If I have to have an answer, I have to have the name of an individual who makes a complaint to me that that happened to them, and if they would like us to look at that or if you would like us to look at that, we would be more than happy to take a look at that. But whistleblower issues are generally reviewed not so much by our office but by the Office of Special Counsel. So if they would apply through the Office of Special Counsel, they are the office that looks at whistleblower retaliation issues. It has been the case where we have done work, but they would provide it through the Office of Special Counsel, who makes determinations on whistleblower actions.

Senator BROWN OF OHIO. It seems to me from your—one more second, Dr. Wesley—it seems to me that from the inputs of individuals who do not flow—that the information does not flow to leadership. It seems to me that we need to know more. If you are making that recommendation, I appreciate that you did and I think the employees of the VA medical center in Dayton appreciate it. But we have to know more about what happened to whistleblowers here and what could happen and we need to establish protections.

I will call on you after the hearing, OK, sir?

We need this throughout the VA to be something that whistleblowers feel some confidence in doing. I know it is an age-old prob-

lem in government, an age-old problem in government management, but we need to do that.

Dr. Wesley, you wanted to say something?

Dr. WESLEY. All I was going to say, briefly, to expand on your question and Dr. Daigh's reply, was in this particular review, and we probably interviewed about 40 people and virtually everyone that was currently employed in the dental clinic, it was not so much whistleblower fear that came up. It was more of a sense of general frustration that if you articulated your concerns, nothing was done about them. So this was more frustration, I would have to say, than fear.

Dr. DAIGH. The other issue, sir, is not everyone will talk with us. If they are an employee, we can sit down and have a conversation. But if they have retired, then we cannot have a conversation, so——

Senator BROWN OF OHIO. Could you address that? I said it was the last question before, but I was looking at my notes from Congressman Turner's statement, his testimony, and that was a major concern of his. People who have retired can avoid any kinds of accountability or any kinds of reprimand or any kinds of punishment, apparently, unless it is criminal, correct? So what do we do about that?

Dr. DAIGH. Sir, I am not a lawyer, so I am going to talk about what I believe the answer is. If a crime has been committed or alleged to be committed, then our Investigations Unit, which is separate from our Office of Health Care Inspections, I believe, does have the authority to go look at that and bring it to the AUSA as a potential crime, retired or not. But if a crime has not been alleged, or there is no crime that has been alleged, then our ability—my office's ability to compel the discussion ends if they are not a VA employee.

Senator BROWN OF OHIO. So sloppy or worse safety practices, procedures, surely are not a criminal offense, I would not think. I assume they are not.

Dr. DAIGH. I am not a lawyer and I would assume they are not, too, sir.

Senator BROWN OF OHIO. So retirement basically protects that employee from—shields that employee from being accountable.

Dr. DAIGH. There is not a clawback provision.

Senator BROWN OF OHIO. Thank you for your testimony. Thank you all. Thank you for being here.

I would like to call up the second and concluding panel. Jack Hetrick is Network Director for the Veterans Integrated Service Network. Mr. Hetrick was appointed as a Network Director of VA Health Care System of Ohio, known as VISN 10, in November 2006. VISN 10 is comprised of four fully functional medical centers that, I guess, is Cleveland, Columbus, Chillicothe—or Cleveland, Chillicothe, Dayton, and Cincinnati, and one independent outpatient clinic and a network of 30 Community-Based Outpatient Clinics, including the Dayton Veterans Area Medical Center. Dayton is the satellite and four CBOCs around you, correct?

Mr. Hetrick is joined by Lisa Durham, who is the Chief of Quality Management at the Dayton VA Medical Center. Ms. Durham, thank you for joining us and for your public service. Bill Montague,

who I have known for years, is the Acting Director of the Dayton VA Medical Center. I thank Bill for coming out of retirement. I have worked with Bill in the VA, his work with the VA in the Cleveland Stokes VAMC, the former Director. I am pleased Secretary Shinseki convinced him to return to service, help restore a culture of care here. Next month, the Stokes VAMC is going to have the grand opening of a new state-of-the-art domiciliary, is that right?

Mr. MONTAGUE. It is the domiciliary, the bed tower, and it is big, and thank you for your help.

Senator BROWN OF OHIO. It is certainly large. Thank you for your work in that new facility.

Mr. Hetrick, if you would proceed, and perhaps Mr. Montague or Ms. Durham can answer questions, too.

STATEMENT OF JACK G. HETRICK, NETWORK DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 10, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WILLIAM D. MONTAGUE, ACTING DIRECTOR, DAYTON VA MEDICAL CENTER; AND LISA DURHAM, CHIEF, QUALITY MANAGEMENT, DAYTON VA MEDICAL CENTER

Mr. HETRICK. First of all, thank you, Senator Brown, for the opportunity to discuss the way forward for the veterans in the Dayton VA Medical Center. I am accompanied today by Mr. William D. Montague, as you introduced, Acting Director of Dayton, and Lisa Durham, Chief of the Quality Management at Dayton. I would like to request for my written statement to be submitted for the record.

We are here today to discuss the lapse in proper infection control practices of one dentist at the Dayton Dental Clinic. More importantly, we are here to inform everyone about what we have done and will continue to do to ensure that care veterans receive meets the highest standards of quality and safety. We appreciate the OIG's support in reviewing our program and developing recommendations, as well as our participation in today's hearing.

My written statement provides an overview of how we discovered the lapse in infection control. In the time I have now, I will discuss the efforts currently underway as well as those that will soon be implemented in response to this incident.

Our quality management enhancement efforts have taken many forms. First, we provided additional education and training and updated standard operating procedures in the dental clinic. We have evaluated dental equipment and instruments, making changes where indicated, and repaired the physical infrastructure in the dental clinic. Monitoring and compliance are two critical aspects of our quality and safety programs. I directed that there be unannounced inspections of all network dental services to ensure proper dental policies and procedures are in place and that instruments are properly maintained. We have made several changes to infection control procedures, and through regular and even daily assessments we are documenting our compliance with standard practices.

Turning to personnel matters, I convened an Administrative Investigation Board to determine if there was any deviation in dental standards of practice or improper handling, cleaning, or disinfec-

tion of dental equipment. I directed facility leadership and network staff to identify any possible trends based on available records.

Looking ahead, our immediate focus is on implementing the recommendations our colleagues at the OIG have offered. The OIG made two specific recommendations, to review the findings related to the dental clinic, including staffing issues, to take appropriate action, and to ensure the Dayton Director requires the dental service to comply with infection control policies. I concur with their recommendations.

By the end of June, we will be in full compliance with the first recommendation. We are taking administrative actions against the parties responsible for allowing this lapse to occur and we are modifying the organization of the dental service for better oversight. By the end of May, we will have systems in place to track dental service mandatory infection control training and will be randomly auditing compliance through documentation and observations to ensure quality care.

VA's central office has convened a Management Program Review Team to assess the Dayton VAMC to identify factors that may have allowed this particular practice to continue undetected or unreported. The team will ensure that we have implemented systems to properly identify and effectively address issues that require immediate response. Information from this review will help VA look at systemwide opportunities for management improvement.

In closing, I would like to emphasize that this is unacceptable that the situation went on so long. We have taken administrative actions to ensure 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 as we continue to enhance the care we provide. I have discussed the lessons we have learned here at Dayton with other VA leaders so they can benefit from our experience.

For those veterans who were affected by this incident, there is a dedicated hotline, and I will read the number, 1–877–424–8214, that is available 24 hours a day, 7 days a week. If veterans or family members have questions about the Dayton Dental Clinic, we strongly encourage them to call. We are asking veterans that want to be tested to report to the primary care clinic for an appointment. Veterans may walk in during clinic hours or call the hotline number for an appointment.

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

[The prepared statement of Mr. Hetrick follows:]

PREPARED STATEMENT OF JACK G. HETRICK, FACHE, NETWORK DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK (VISN) 10, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

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 benefited 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, DC, 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 a.m. to 4:30 p.m. 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.

Senator BROWN OF OHIO. Thank you, Mr. Hetrick.

You heard the Inspector General, Dr. Daigh's, recommendations. Give me general thoughts on implementing his ideas.

Mr. HETRICK. Well, I think, first of all, the recommendation about making sure that the management team, regardless of where the hospital is located at, listening to employees within the various levels of their organization is clearly a sound recommendation. I would not argue with that. I think that, as our testimony goes on, Mr. Montague will show you some of the things that he has already

done to try to make that happen here at Dayton by getting the message out to employees in the hospital and making sure they understand that they have the option to talk or to write anonymously, as the case may be, with their name, whatever way they want to do it. We certainly will listen.

I have the advantage in my office, which is located, as you know, in Cincinnati, but we receive messages, letters, e-mails from a variety of employees from around the network with concerns. I have said publicly when I visit a hospital, have a town hall meeting, or whatever forum that I am asked to speak in that we will address every issue that comes to our attention, whether we know who it was that brought that issue to our attention, even—I cannot obviously respond to somebody who sent me something anonymously, but we will document it for our records in the case we hear about it again or see something that happens similar in the future that we looked into it. If an employee has an issue and they bring it to my attention personally or through some other of the many message chains we have available to us, we will get back to them and give them an explanation of what happened.

We, just as in this case, when the situation was uncovered in the dental clinic, one of the first things we did was inform the employees who were working there they had two options. They could let the Joint Commission, as Dr. Daigh referenced in his testimony, they can call them and they would, in turn, come and perhaps do an on-site review of that issue. They would notify us of that complaint and we could look into it and get back to them, or they could call the OIG hotline number, which was provided to the employees at the time the incident was uncovered.

We certainly work very closely—Dr. Daigh mentioned, I think, 30,000 complaints his office gets. I am pleased to report we do not get that many in Ohio, but we do get referrals from the OIG hotline, and we provide a very comprehensive review and response back to them. So I am all for that. I think we will do everything within our power to make certain that we try to expand those levels of communication so we get to as many people as possible within the organization.

I am not sure—I only heard Dr. Daigh's recommendation about management movements in a period of time. I really have no comment on that at this point. I would need some time to think about that. But I am really rather focused on how we can continue to make things better with the people we have to work with.

Senator BROWN OF OHIO. Mr. Montague, tell us, if you would, from listening to Dr. Daigh's recommendations and thinking about what you have implemented since you have been here, give me the two or three most important things, most important changes you have recommended based on, or not based on, the IG report.

Mr. MONTAGUE. Well, I think the most important change we made is we made the lines of communication and the lines of authority and responsibility the same. Authority and responsibility are now at the same level, and there is no ambiguity as to whose task or whose responsibility something is, and they have the necessary authority to implement it. That helps with communications. It helps with figuring out what goes on.

For example, I think—well, number 2 would be patient satisfaction. We have truly emphasized patient satisfaction when we made a distinct change. In the past, the complaint department, namely the patient representatives, who are excellent, were given the responsibility for patient satisfaction. That is too late in the game. We made a formal move to give nursing responsibility for patient satisfaction, obviously in collaboration with the physicians and the support staff. But the nurses now own the wards. They know they own the wards. They have a number of relationship-based care initiatives which should cement better relationships between an individual patient and the staff.

Then, finally, on the cultural affairs question that you have been asking, we are sending cards to everyone that say, do not be afraid. We have to know. It is part of our quality management program.

Senator BROWN OF OHIO. Do you know, Mr. Hetrick, the total number of patients seen by the dentist in question?

Mr. HETRICK. I do not, sir, have the exact number at my disposal. The numbers range, because of the long period of time and the reliance on paper records versus computerized records, so we are more certain about the time period about the—when records are electronic versus the——

Senator BROWN OF OHIO. What year was that?

Mr. HETRICK. I believe that goes back for dental in the early 2000s, if my memory serves me correct.

Senator BROWN OF OHIO. Can you give me a rough estimate, within a few hundred, of how many he saw over 18 years?

Mr. HETRICK. Over 18 years? I do not know. I would have to—I was not totally involved in that. Let me——

Mr. MONTAGUE. Twenty-three hundred.

Mr. HETRICK. Twenty-three hundred, OK.

Senator BROWN OF OHIO. Twenty-three hundred? OK.

Mr. HETRICK. Yes. Thank you.

Senator BROWN OF OHIO. If someone wants to be tested and was not in, what do you call it——

Mr. HETRICK. The cohort.

Senator BROWN OF OHIO [continuing]. The cohort——

Mr. HETRICK. Yes.

Senator BROWN OF OHIO [continuing]. The identified cohort, what do they do?

Mr. HETRICK. I would point out that the defined cohort of 535 number, we have tested close to 100 the last time I checked outside of the cohort because they showed up and wanted to be tested.

Senator BROWN OF OHIO. So some were of the difference between 2,300 and 500, 100 of those 1,800, roughly.

Mr. HETRICK. Mm-hmm.

Senator BROWN OF OHIO. When they are tested, they get—if they are tested positively, they, I assume, get total VA benefits and compensation and care?

Mr. HETRICK. All patients that have—a special clinic was set up for the testing and counseling and explanation of what the next steps would be, should there be a positive finding. So the answer would be yes. That will be part of what will play out.

Senator BROWN OF OHIO. You have been in this position since November 2006, in the position of being the head, if you will, of

these four medical centers, a very responsible position. How do you think this could have happened in one of your four medical centers without your knowing it?

Mr. HETRICK. Well, I have asked myself that question a number of times——

Senator BROWN OF OHIO. I am sure you have.

Mr. HETRICK. It is very troubling. I do not want to be using the same words as others, but I cannot find any other word to fully describe——

Senator BROWN OF OHIO. Is there some culture——

Mr. HETRICK [continuing]. How troubled——

Senator BROWN OF OHIO. Our office—we have been working with this—I have only been in office since the same time you took office, around 2006, 2007, and we had been working to try to improve—there were significant management problems here. We knew that. We did not know anything about the dental issue. Maybe not a culture of recklessness, but morale was an issue. There were all kinds of patients—I mean, all kinds of employee-employer/management-labor issues going on. Did that not alert somebody like you, or else somebody else, to a carelessness, a recklessness, or a dysfunction that should have meant a deeper look at what was happening here?

Mr. HETRICK. Yes. If I remember correctly, I think this goes back to about April 2007, and you and some folks from here and myself had a conversation on the telephone about the issues you just raised. I think we had a very strong response to that at the time.

Addressing patient satisfaction was an issue with me across the network, not just here in Dayton. Despite the fact we have very good numbers with many performance measures and many with access numbers among the best anywhere in the VA system, we still had ongoing issues with our patient satisfaction results, primarily inpatient. So that was clearly something that I was very concerned about, and it resonated with me that you brought it up, and I certainly appreciated your support at the time, because I think that helped us to move into a number of new territories. Although it has not been as fast as I would like, we continuously see improvement in those numbers.

Now, with regards to the culture of the facility and the management, that part of your question, we worked very closely with the National Center for Organizational Development, affectionately known in our group as NCOD, which is sort of bipartisan in a way. They come in and do organizational assessments. They help figure out what is going on, what works right and what does not work right and how we can set a course to try to make improvements.

We took all of that—that followed your initial call with us and they came in, and they did a very top all the way down assessment and met with hundreds of employees, did all kinds of individual assessments, and really put together a good plan. Mr. Richardson at the time brought somebody in from their organization to be onsite to help carry that out. While Dayton was not the leader in moving up in employee satisfaction or results, they had made steady improvements in that area and were actually above the VA average, as I recall, the last time on the all employee satisfaction.

So when looking at those kinds of things, I saw things moving in the right direction. Was it perfect? No. We always have a lot of work to do. But I was satisfied that we were moving—that still does not answer the 18-year gap. I think that what I am trying to do now is to make sure that that never happens again and pooling all the resources I have available to me to figure out the way that we can possibly change that, that no one ever thinks it is OK to observe something that is wrong and not report it. So that is what I am trying to focus on now, because I just realize I am not going to be able to explain to you 18 years.

I sat down after this incident came to my attention. We went through every record that we had in our office and every review, every organization, and it has been the OIG, it has been SOARS, it has been you name it, they have been here. We looked to see, did we miss a trend? Did we miss something that should have alerted us? And, quite frankly, there were no—we did not have any record of patient complaints that came to us, any letters from an individual saying they had a concern about the dental practices. If any of those things had been there and I had missed that, I would be the first person to acknowledge that. But I did not see that, and so what I am trying to do now is just do the best we can to make sure we never have that situation happen again.

Senator BROWN OF OHIO. Was there an issue with—did you, or have you heard from others within the Dayton Medical Center that there was perhaps a problem with staffing shortages, that there was too much work being done by too few people here?

Mr. HETRICK. Well, staffing is always an interesting subject to take up. I would say most departments, if we went around and asked, might say they did not have enough staff. I think that the board, during their investigation, addressed that in terms of staffing—particularly in relationship to the residency program that they were operating—and I believe, and have discussed this with Mr. Montague, that he feels that the recommendations that they made in terms of what should have been in place, we do not disagree with.

Whether or not there are—I think that over the years, and again, this covers a long period of time and what rationale related to what decisions at that point in time is hard to speculate on, but I do think that as practice patterns change over time and more dentists now have assistants in use, I think we need to move along with that. I think they were partway there and not the entire way there. We have since done a top-down review. We are making, of course, changes once again to make sure that that staffing mix is right for the amount of work they have to do.

Senator BROWN OF OHIO. Does the VA put more emphasis on not rocking the boat than it does on patient care?

Mr. HETRICK. Well, that is a tough question. Not in my network. I personally do not think that we emphasize that in the field level. I really feel that since Secretary Shinseki has been in place—this is not about him, of course, but he has been very engaged in talking with leadership at the VISN level. As a matter of fact, tomorrow morning, I have a briefing with him on another subject. This is unprecedented in my time in the VA.

So I think that we are moving beyond rocking the boat. No one in the chain of command above me has attempted to make light of this or to slow things down. I think that folks were appalled at all levels and tried very hard to work their way through. You know, rocking the boat is something, I think, all of us should do all the time whenever patient care is involved.

Senator BROWN OF OHIO. Does the VA owe veterans in the Miami Valley an apology?

Mr. HETRICK. Well, I think we have done that. I know I personally wish I could meet every single one of them and apologize for what happened over the course of these years without—I mean, the only reason why we exist is to take care of veterans, so there is no question whatsoever about our mission, and what we should be doing. I believe that if anyone has been shaken in our confidence, we have a big job ahead of us to try to gain that confidence back, and I think that that has been the focus, once we got past the issues involving investigation and all the things that come with that. Now the work here at this hospital under the leadership of Mr. Montague and his staff is to try to restore that confidence, and whatever I can do as a Network Director, we will be certainly participating in.

Senator BROWN OF OHIO. Thank you for that. What kind of notification or outreach are you doing to those people outside the identified cohort of 535 patients?

Mr. HETRICK. There has been no direct communication via calls or letters to those outside the cohort.

Senator BROWN OF OHIO. Should there be?

Mr. HETRICK. Well, that is a policy question that I believe that many very highly qualified experts looked at, and I go back to Dr. Daigh's statement about notifying someone about something that is a very, very low risk can sometimes cause more harm than what it solves.

If the decision is made to do that, we would certainly do everything in our power to get to those folks and bring them back. But again, I think the focus is on doing sort of grassroots efforts now, that Mr. Montague and his staff are meeting with various groups, service organizations, and others to try to restore the confidence. Again, if someone wants to be tested, they are welcome to come forward.

Senator BROWN OF OHIO. For my last question, Mr. Montague, tell us what you are doing to restore trust to a public that includes veterans and non-veterans alike in the Miami Valley and the area beyond the Miami Valley that this clinic serves, that this hospital serves, what specifically are you doing to give people more trust and more faith and more certainty that this is not going to happen again here?

Mr. MONTAGUE. Well, our goal, day one, when Congressman Turner had the last presentation, we brought the media into the dental clinic, and we would invite anybody else to come into the dental clinic and actually see it. We will go to any organization that invites us, any service organization, any community, town, whatever, explain what happened, why. We stand ready to test anybody that wishes to be tested, and if the CRB changes its guidelines, we

stand ready, willing, and able to test whomever it is clinically determined is appropriate.

Senator BROWN OF OHIO. How many Veterans Service Organizations and others have you gone out to speak to so far, roughly?

Mr. MONTAGUE. Thus far, I have visited the Chief Service Officer of each of the six major service organizations. I have not been to a post or an American Legion hall yet, but I did offer the invitation to the leadership. I am involved in the Memorial Day parade, and I am sure—you know how many times I came to Lorain.

Senator BROWN OF OHIO. I do know that. [Pause.]

Thank you for your testimony and for your service.

I will adjourn the Committee meeting in a moment. For people who want to talk to me specifically, I will stay around for 30–40 minutes or so. My staff will stay around a little longer than that, I assume. I will stay around pretty much as long as I need to and people can individually bring up things to me. Understand, be assured that anyone that wants to speak to me or to my staff or to the Inspector General or to the VA, I will protect their confidentiality. That is a commitment from me to any of you or to your family members or to your coworkers.

The Committee will prepare a print of this hearing. The Committee staff and I may have other questions of the witnesses, which we will submit in writing to them, which they will, I would assume, answer promptly and that will be in the Committee print, also.

I thank the six witnesses. I thank you for your service. I thank particularly the people that work here and the patients who have served here. The apology from the VA was, I think, heartfelt, but the actions were not excusable and we need to assure people and we need to make sure that this does not happen again at this fine institution or any other, the Vet Centers, and the Community-Based Outpatient Clinics that serves veterans in this State. Your service is too important to deserve anything less. I thank you for your service.

The Senate Committee on Veterans' Affairs is adjourned.

[Whereupon, at 3:20 p.m., the Committee was adjourned.]

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