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BY THE COMPTROLLER GENERAL
**Report To The Honorable Alan Cranston,
United States Senate**

OF THE UNITED STATES

(1) LEVEL II

6 **Providing Veterans With Service-Connected
Dental Problems Higher Priority At VA
Clinics Could Reduce Fee-Program Costs .**

At the same time Veterans Administration (VA) dental clinics were giving routine care to veterans with no service-connected dental problems, most veterans with service-connected problems were being referred to dentists in private practice. In fiscal year 1979 VA paid to send 90,000 of the 146,000 veterans seeking outpatient care for service-connected dental problems to dentists in private practice. The referrals cost the Government over \$52 million.

(12) 59

The Veterans Health Care Amendments of 1979 directed VA to place greater emphasis on treating service-connected dental problems in VA clinics. Because VA has not effectively carried out the law, the number of referrals to dentists in the private sector has grown.

GAO offers a number of recommendations to increase the amount of dental care provided to veterans with service-connected problems and to improve the operations and productivity of VA dental clinics.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-203441

The Honorable Alan Cranston
United States Senate

Dear Senator Cranston:

This report is in response to your request as Chairman of the Senate Committee on Veterans' Affairs that we review selected aspects of the Veterans Administration's (VA's) dental program.

Our review showed that fewer veterans with service-connected dental conditions would be referred to private dentists on a fee-for-service basis and, as a result, substantial savings would be achieved if VA (1) established priorities for providing dental care in accordance with Public Law 96-22, (2) insured that care was provided only to veterans eligible to receive care, and (3) fully used its dental personnel.

We asked VA to submit written comments on the matters discussed in this report. However, VA had not done so when the 30-day statutory comment period expired, and advised us that it would withhold comment until issuance of the final report.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of issue. At that time we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Melton J. Aroslan

Acting Comptroller General
of the United States

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REPORT TO THE HONORABLE
ALAN CRANSTON
UNITED STATES SENATE

PROVIDING VETERANS WITH SERVICE-
CONNECTED DENTAL PROBLEMS
HIGHER PRIORITY AT VA CLINICS
COULD REDUCE FEE-PROGRAM COSTS

D I G E S T

Although the primary mission of the Veterans Administration's (VA's) health care system is to provide care to veterans whose disabilities are related to their military service, most veterans with service-connected dental conditions are unable to obtain care from a VA dental clinic. Instead, they are referred to private dentists on a VA-reimbursable fee-for-service basis. In fiscal year 1979 such referrals cost the Government over \$52 million.

Fewer veterans with service-connected dental conditions would be referred to private dentists and, as a result, substantial savings would be achieved if VA

--established priorities for providing dental care in accordance with the Veterans Health Care Amendments of 1979,

--insured that care was provided only to veterans eligible for care, and

--made better use of its dental personnel.

In 1979 VA dental clinics provided dental services to about 840,000 veterans, most of whom were hospital patients with no service-connected dental condition and, in many cases, no immediate need for treatment. At the same time, VA dental clinics referred about 90,000 of the 146,000 veterans seeking outpatient care for service-connected dental conditions to private dentists. (See p. 7.)

Most veterans referred to the fee program lived close to a VA clinic offering the type of dental care needed. They could have received the needed care at the VA facility if that facility had placed a higher priority on providing dental care to outpatients with service-connected dental conditions than on providing routine care to inpatients with nonservice-connected conditions. (See pp. 9 to 17.)

Because of the large amount spent on fee-for-service dental care, the Congress enacted the Veterans Health Care Amendments of 1979, which directed VA to place greater emphasis on providing outpatient dental care to veterans with service-connected dental conditions. Routine dental care was to be provided to inpatients with nonservice-connected dental conditions only to the extent that staff and facilities were available after care had been provided to veterans with service-connected conditions. (See pp. 8 and 9.)

However, over a year after enactment of the amendments, VA had not provided formal guidance to its clinics for carrying out the law. Furthermore, VA's informal guidance continued to place the highest priority on the provision of dental care to inpatients.

As a result, the amendments have had little effect. Fee program authorizations during fiscal year 1980 increased by about 20,000 over fiscal year 1979 authorizations. (See pp. 17 to 21.)

Many veterans have received fee-basis or outpatient dental care when they were not eligible. By limiting fee-basis authorizations to those cases in which the veteran is unable to obtain care from a VA facility because of geographical inaccessibility or the clinic's inability to provide the type of service needed, referrals to the fee program could be reduced. (See pp. 22 to 27.)

Similarly, by reducing the number of ineligible veterans provided dental services, VA clinics could increase their capacity to treat outpatients with service-connected dental conditions and further reduce fee-basis referrals. (See pp. 27 to 29.)

In a 1973 report GAO identified several factors that were limiting the productivity of VA dental clinics, including the

- large number of broken appointments,
- extensive use of VA dentists to perform clerical duties,

--limited use of hygienists and other dental auxiliaries, and

--limited use of two-chair dentistry.

Because VA has not effectively resolved these problems, the same factors continue to limit dental clinic productivity.

GAO could not make a detailed comparison of the productivity of VA and private-practice dentists because adequate standards and reliable management information to measure the productivity of VA dentists were lacking. However, a 1977 report by the National Academy of Sciences found that the VA dental service was not as efficient as dental care in the community. On the average, dentists at the VA clinics GAO visited were seeing only about half as many patients per day as were dentists in private practice. (See ch. 4.)

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

The Administrator of Veterans Affairs should, through the Chief Medical Director:

- Direct the Medical Administrative Service at each VA medical center to determine whether a veteran has a service-connected dental condition at the time of admission.
- Direct VA dental clinics to place a higher priority on providing care to outpatients with service-connected dental conditions than on providing routine dental care to inpatients with no service-connected dental condition.
- Direct VA clinics to provide dental examinations to inpatients with nonservice-connected dental conditions only if the clinic's staff and facilities are not needed to provide care to veterans with service-connected dental conditions unless (1) the admitting or attending physician determines that there are compelling medical reasons for giving the veteran an examination or (2) the veteran has a dental emergency.

To further reduce referrals to the fee-for-service program, the Administrator of Veterans Affairs should, through the Chief Medical Director:

- Strengthen procedures for authorizing fee-for-service dental care.
- Strengthen procedures for authorizing outpatient dental care for nonservice-connected dental conditions.
- Implement prior GAO recommendations concerning dental clinic productivity.

To improve VA's ability to identify needed improvements in dental clinic operations, the Administrator of Veterans Affairs should direct the Chief Medical Director to hasten the development of a more definitive and accurate management information system. (See pp. 50 and 51.)

- - - -

VA was given the opportunity to provide comments on a draft of this report. It had not done so when the 30-day statutory comment period expired, and advised GAO that it would withhold comment until issuance of the final report.

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ABBREVIATIONS

ADA	American Dental Association
AMIS	automated management information system
DOD	Department of Defense
EFDA	expanded function dental auxiliary
GAO	General Accounting Office
MAS	Medical Administrative Service
NAS	National Academy of Sciences
OPT/NSC	outpatient/non-service-connected
UCLA	University of California at Los Angeles
VA	Veterans Administration
VACO	VA Central Office
VAMC	VA Medical Center

CHAPTER 1

INTRODUCTION

Senator Alan Cranston as Chairman, Senate Committee on Veterans' Affairs, requested that we review selected aspects of the Veterans Administration's (VA's) dental program. Specifically, we were asked to

- determine the extent to which the provision of dental services to veterans with nonservice-connected dental conditions reduces VA's ability to provide dental care to veterans with service-connected conditions,
- determine the extent to which care was provided to ineligible veterans,
- review the administration of VA's fee-basis dental program, and
- review VA's use of expanded function dental auxiliaries (EFDAs).

HOW ARE DENTAL SERVICES PROVIDED?

VA operates dental clinics in most major cities. Each of the 172 VA Medical Centers (VAMCs) and 18 satellite outpatient medical clinics provides dental services. In addition, there are eight dental clinics which operate independently.

Eligible veterans can obtain dental services as (1) an inpatient at a VA hospital, nursing home, or domiciliary, (2) an outpatient at a VA dental clinic, or (3) a patient of a private dentist on a fee-for-service basis. However, eligibility requirements for the three types of patients differ.

WHO IS ELIGIBLE FOR DENTAL SERVICES?

Any veteran is eligible for dental care while an inpatient at a VA hospital, domiciliary, or nursing home. Title 38 U.S.C. 610(a) authorizes VA to furnish hospital, domiciliary, or nursing home care, including dental services, to any veteran for (1) a service-connected disability or (2) a nonservice-connected disability if the veteran is unable to pay for the care. Under section 610(c), VA is authorized, within the limits of VA facilities, to

"* * * furnish medical services [including dental] to correct or treat any non-service-connected disability of such veteran, in addition to treatment incident to the disability for which such veteran is hospitalized, if * * * the Administrator finds

such services to be reasonably necessary to protect the health of such veteran. * * *

Outpatient dental services are available to (1) veterans with service-connected dental conditions, (2) veterans with nonservice-connected dental conditions if treatment was begun while the veteran was an inpatient at a VA facility and it is reasonably necessary to complete the treatment, and (3) both veterans and non-veterans in cases of dental emergencies. The six classes of veterans considered to be service connected for dental conditions are:

- Class I. Veterans having service-connected dental disabilities or conditions for which they receive compensation.
- Class II. Veterans who apply for treatment of service-connected noncompensable dental conditions within 1 year after discharge from the military service.
- Class IIa. Veterans having service-connected noncompensable dental disabilities or conditions resulting from combat wounds or trauma while in service.
- Class IIb. Prisoners of war for less than 6 months with service-connected compensable dental disabilities or conditions.
- Class IIc. Veterans who were held as prisoners of war for at least 6 months.
- Class III. Veterans having dental conditions professionally determined to be aggravating service-connected medical conditions.
- Class IV. Veterans whose service-connected disabilities are rated at 100 percent or who are receiving a 100-percent disability rate by reason of unemployability.
- Class V. Veterans with service-connected disabilities who have been approved for vocational rehabilitation training.
- Class VI. Veterans of the Spanish-American War, Indian Wars, Philippine Insurrection, or Boxer Rebellion.

A veteran eligible for outpatient dental services may obtain these services from a private dentist on a VA-reimbursable fee basis, if the veteran does not live near a VA dental clinic or is unable to obtain such services from the clinic.

HOW BIG IS VA'S DENTAL PROGRAM?

In fiscal year 1979, VA reported that about 840,000 veterans were provided dental examinations and/or treatments at VA clinics at a cost of approximately \$77 million. According to VA, an additional 90,000 veterans were authorized care from private dentists on a fee-for-service basis. Fee program costs in fiscal year 1979 were over \$52 million.

HOW IS THE DENTAL PROGRAM ADMINISTERED?

The assistant chief medical director for dentistry, Department of Medicine and Surgery, has direct management responsibility for the dental program at the VA Central Office (VACO).

At each VAMC or outpatient clinic, a chief, dental services, is responsible for operation of the dental clinic. However, dental services eligibility determinations are the responsibility of the VAMC's Medical Administrative Service (MAS).

Within the VA health care system, 78 medical centers have been designated "clinics of jurisdiction" for administering the fee-basis program. These clinics are responsible for authorizing, processing, and paying for fee services within specified geographic areas. VAMCs that are not clinics of jurisdiction refer potential fee-basis cases to the nearest clinic of jurisdiction for processing.

WHICH VETERANS HAVE PRIORITY FOR DENTAL SERVICES?

Since its establishment more than 50 years ago, the VA health care system's primary mission has been to provide care to veterans with service-connected disabilities. Its secondary mission has been to provide care to veterans with nonservice-connected disabilities who are unable to pay for care from private providers, but only to the extent that facilities and staff are available.

VA attempts to meet the total health care needs of the hospitalized veteran, regardless of service connection, and considers the provision of dental services to hospitalized veterans to be the primary mission of its dental clinics.

According to a January 1974 speech by the assistant chief medical director for dentistry

"* * * Dentistry cannot be considered separately from other health services insofar as diagnosis and treatment of the patient are concerned. * * * In fact, the dissemination of organisms from a dental focus can be a life endangering matter for patients with certain disease

conditions and for those who are to undergo treatment for such special procedures or medical care programs as open heart surgery, hemodialysis, and organ transplant. * * *

"* * * Although the hospital dentist has an important role in the control and elimination of infection in a broader sense, it is the continuing interrelationship between medicine and dentistry that is our major concern. * * * Today's physician insists that dental infection, just as any other infection, must be eliminated in the treatment of a multitude of disease entities. Of those hospital admissions seen in the dental clinic, four out of five have need for some form of dental care * * *.

"We have continually stressed an oral examination by a dentist as part of the patient's total evaluation upon admission to the hospital. This serves to apprise both the patient and his physician of oral disease or conditions which need treatment * * *."

VA's Dentistry Manual states that an oral examination should be given as part of the physical examination required for all patients admitted to the hospital. Recognizing that some inpatients cannot be given dental examinations because of their medical conditions, the short durations of their hospital stays, or their unwillingness to be examined, VA has set an informal goal to provide dental examinations to at least 75 percent of the patients admitted to its hospitals.

HOW DOES PUBLIC LAW 96-22 AFFECT THE DENTAL PROGRAM?

Public Law 96-22, the Veterans Health Care Amendments of 1979, (1) limits the provision of dental services to veterans with non-service-connected dental conditions, (2) extends eligibility for outpatient dental services to two additional classes of veterans with service-connected conditions, and (3) establishes a ceiling for fee-basis dental expenditures. The dental provisions of the law, enacted on June 13, 1979, became effective on October 1, 1979.

Public Law 96-22 amended 38 U.S.C. 610(c) to provide that:

"The Administrator may furnish dental services and treatment, and related dental appliances, under this subsection for a nonservice-connected dental condition or disability of a veteran only (1) to the extent that the Administrator determines that

the dental facilities of the Veterans' Administration to be used to furnish such services, treatment, or appliances are not needed to furnish services, treatment, or appliances for dental conditions or disabilities described in section 612(b) of this title, or (C) if (A) such nonservice-connected dental condition or disability is associated with or aggravating a disability for which such veteran is receiving hospital care, or (B) a compelling medical reason or dental emergency requires furnishing dental services, treatment, or appliances (excluding the furnishing of such services, treatment, or appliances of routine nature) to such veteran during the period of hospitalization * * *."

Section 612(b) was amended to extend eligibility for outpatient dental services to veterans with service-connected medical disabilities rated as 100 percent and those who were prisoners of war for over 6 months. About 35,000 veterans were provided outpatient dental care under the two new classes in fiscal year 1980.

Public Law 96-22 also amended 38 U.S.C. 612(b) to require that VA provide written notification and justification to the appropriate congressional committees whenever its fee-basis dental expenditures in any year will exceed the amount of such expenditures made in fiscal year 1978.

OBJECTIVES, SCOPE, AND METHODOLOGY

The overall objectives of this review were to determine the potential effect of Public Law 96-22 on fee-basis referrals, evaluate VA's implementation of the law, and identify and evaluate other factors that contribute to the high number of fee-basis referrals. Specifically, we sought to determine

- to what extent routine dental care was provided to veterans with nonservice-connected dental conditions;
- whether veterans were referred to the fee program for reasons other than geographical inaccessibility or inability of the VA clinic to provide the type of care needed (i.e., whether the veteran could have been provided care at a VA dental clinic if the clinic's workload of nonservice-connected veterans were reduced);
- how effective were VA actions to implement Public Law 96-22;
- to what extent outpatient dental care was provided to veterans not eligible for such care;

--whether VA was effectively administering the fee program;
and

--whether VA dentists were as productive as non-VA dentists.

We interviewed VA officials and staff members, reviewed policies and guidelines, examined pertinent legislation, and reviewed pertinent documents and reports on VA's dental program. Our review was performed at VA's Office of Dentistry in Washington, D.C., and at dental clinics in (1) VAMCs at Bay Pines and Tampa, Florida; Chicago (Westside), Illinois; Martinez and San Francisco, California; and Seattle and Spokane, Washington, and (2) the outpatient medical clinic in St. Petersburg, Florida. Limited work was also performed at dental clinics in the Wadsworth VAMC, Los Angeles, and in the outpatient medical clinics in Orlando, Florida, and Sacramento and Los Angeles, California. Four of the VAMCs included in our detailed review--St. Petersburg, Chicago, Seattle, and San Francisco--are clinics of jurisdiction for the fee program. The clinics of jurisdiction were chosen because of their high number of fee program authorizations. The other clinics were selected from within the jurisdictional boundaries of the four clinics of jurisdiction.

Our review at the individual dental clinics was performed between August and December 1979, covering the months immediately preceding and following implementation of Public Law 96-22. We interviewed clinic officials concerning implementation of the law, policies and procedures with respect to fee-basis referrals, priorities for care, factors affecting the productivity of clinic personnel and related matters. We reviewed VAMC admissions records and the clinic's dental records to obtain data on the characteristics of patients receiving care at the VA clinics. Additional details on the methods used to perform our review are found throughout this report.

We were unable to determine how many hospitalized veterans were service-connected for dental conditions because such data were not readily available at the VAMCs or dental clinics. As a result, when this report provides statistics on service-connected inpatients, the data are based on combined medical and dental service-connected conditions. VA officials agreed that most inpatients would be service-connected for medical rather than dental conditions.

Our review efforts were hindered by the unreliability of information contained in reports from VA's automated management information system (AMIS). Much of the data were inaccurate, misleading, or inconsistently accumulated. The adequacy of AMIS data was determined through review of (1) supporting documentation at the clinics and (2) computer printouts to detect errors and inconsistencies.

CHAPTER 2

PUBLIC LAW 96-22 SHOULD BE MORE EFFECTIVELY IMPLEMENTED

In 1976, VA's Office of Dentistry urged VA dental clinics to reduce the number of veterans with service-connected dental conditions referred to private dentists by treating more such veterans in VA facilities. However, there was little increase in the services provided by VA clinics to outpatients with service-connected dental conditions between fiscal years 1977 and 1979. As a result, in fiscal year 1979, VA dental clinics referred about 90,000 veterans with service-connected dental conditions to private dentists at a cost to VA of about \$52 million. At the same time, VA dental clinics were used primarily to provide dental examinations and treatments to veterans who had no service-connected dental conditions and, in many cases, had no immediate need for the services. In fiscal year 1979, VA dental clinics provided dental services to about 840,000 veterans, only about 64,000 of whom had been identified by the clinics as having service-connected dental conditions.

Because of the large amount VA spends for fee-basis dental services, the Congress, through Public Law 96-22, directed VA to reduce the number of fee-basis referrals by placing greater emphasis on providing outpatient care to veterans with service-connected dental conditions and less emphasis on providing routine dental services to inpatients without such conditions. However, VA has not effectively implemented the law. As a result, VA dental clinics were unable to meet the increased demand for outpatient dental care during the first year after implementation of the act, and fee-basis authorizations increased by about 20,000 over fiscal year 1979 authorizations.

Although effective implementation of Public Law 96-22 could significantly reduce fee-basis referrals, VA could further reduce such referrals by

- strengthening procedures for authorizing fee-basis care to insure that such care is approved only when the VA clinic is unable to provide the type of care needed or unable to provide economical care due to geographical inaccessibility,
- improving enforcement of eligibility requirements for treating outpatients with nonservice-connected dental conditions, and
- increasing the productivity of VA dental clinics.

These additional opportunities to reduce fee-basis referrals are discussed in chapters 3 and 4.

PREVIOUS VA EFFORT TO
REDUCE FEE-PROGRAM REFERRALS
NOT EFFECTIVE

In a March 1, 1976, letter, VA's assistant chief medical director for dentistry urged VA clinics to increase the number of outpatients with service-connected dental conditions treated by VA dentists in order to decrease referrals to the fee program. Although referrals to the fee program decreased by over 36,000 between fiscal years 1977 and 1979, the decrease resulted primarily from a reduction in the number of veterans seeking outpatient care for service-connected dental conditions rather than from increases in dental care provided to such veterans by VA clinics. Only about 7,600 of the 36,000 reduction in fee-program referrals resulted from increases in services provided by VA clinics to outpatients with service-connected dental conditions.

During the same period, VA clinics increased the number of hospital inpatients examined by about 91,000, the number of hospital inpatients treated by about 49,000, and the number of outpatients treated for nonservice-connected dental conditions by about 23,000.

THE CONGRESS DIRECTS VA TO
REFOCUS DENTAL PROGRAM

The Veterans Health Care Amendments of 1979 (Public Law 96-22) directed VA to provide inpatient dental services for nonservice-connected dental conditions only to the extent that VA dental facilities are not needed to provide treatment to veterans authorized outpatient care unless (1) the nonservice-connected dental condition is associated with or aggravating a disability for which the veteran is receiving hospital care or (2) a compelling medical reason or a dental emergency requires dental services to be given to a hospitalized veteran. Routine dental work was expressly excluded from the compelling medical reason or dental emergency criteria. As discussed on page 4, the dental provisions of the amendments became effective October 1, 1979.

In its April 1979 Committee Report on the Veterans Health Care Amendments of 1979, the Senate Committee on Veterans' Affairs stated that:

"The Committee fully expects the VA in implementing the provisions of the Committee bill, to refocus its utilization of dental-care resources to ensure that care for service-connected conditions is emphasized rather than care for non-service-connected conditions, especially such care for veterans hospitalized for nondental conditions."

The Committee concluded that an overwhelming majority of care for service-connected dental conditions can and should be given by VA personnel rather than by private dentists and questioned whether VA personnel were being fully and effectively used. The report stated that much of the care provided to the two additional classes of veterans to be authorized care by the amendments (see p. 5) should be provided through the reallocation of existing in-house VA dental care resources rather than through an increase in VA's health care budget.

EFFECTIVE IMPLEMENTATION OF
PUBLIC LAW 96-22 COULD REDUCE
FEE-BASIS REFERRALS

Fee-basis referrals could be significantly reduced through effective implementation of Public Law 96-22. Many veterans referred to this program during 1979 could have received care at a dental clinic, if VA clinics had given higher priority to the provision of dental care to outpatients with service-connected dental conditions than to the provision of routine dental care to inpatients with nonservice-connected dental conditions.

The potential effect of the law on the number of fee-basis referrals depends on the extent to which VA dental clinics (1) provide routine dental care for nonservice-connected dental conditions and (2) refer veterans with service-connected dental conditions to the fee program for reasons other than geographical inaccessibility or inability of VA dental clinics to provide the type of care needed. To assess the potential effect of the law, we reviewed the operations of seven VA dental clinics during the 2 months immediately preceding, and 3 months immediately following, the effective date of the amendments.

The seven clinics were used primarily to provide dental examinations and treatments to veterans with nonservice-connected dental conditions, many of whom had no immediate need for the services provided. Also, the clinics referred most veterans seeking outpatient care for service-connected dental conditions to the fee program. Most of the referrals were made for reasons other than geographical inaccessibility or inability of VA dental clinics to provide the type of care required. The failure of the clinics to establish and follow appropriate priorities in providing dental care also resulted in many veterans having an immediate need for dental care not receiving it.

Most resources used to
provide care for nonservice-
connected conditions

The dental clinics at the seven VAMCs were using most of their resources for the care of veterans (1) hospitalized for treatment

of nonservice-connected conditions or (2) seeking outpatient treatment for nonservice-connected dental conditions.

Six of the seven VAMCs believed that their clinics' primary mission was to examine and treat hospitalized veterans. They devoted from 55 to 93 percent of their fiscal year 1979 patient sittings to hospital inpatients or outpatients whose treatment began as an inpatient. Although the seventh medical center--San Francisco--said that outpatients with service-connected dental conditions had the highest priority for care at the dental clinic, only 36 percent of its fiscal year 1979 sittings were devoted to such outpatients.

The table below shows the percent of VA direct patient care, in terms of patient sittings, devoted to inpatients and outpatients during fiscal year 1979, at each of the seven dental clinics.

Percent of Fiscal Year 1979 Dental Sittings

<u>Dental clinics</u>	<u>Hospital inpatients</u>	<u>Outpatients</u>	
		<u>Nonservice-connected conditions</u>	<u>Service-connected conditions</u>
Bay Pines (note a)	47	8	29
Chicago (Westside)	26	43	31
Martinez	84	9	7
San Francisco	31	33	36
Seattle	23	48	29
Spokane	66	16	18
Tampa	64	21	15
All VA clinics (note b)	51	21	23

a/16 percent of patient sittings provided to domiciliary and nursing home patients.

b/4 percent of patient sittings provided to domiciliary and nursing home patients. Figures do not total 100 percent because of rounding.

To determine the extent to which dental services were provided to hospital inpatients for nonservice-connected conditions, we reviewed the dental records of veterans admitted to seven VAMCs during a 1-month period in August, September, or October 1979. We found that

- from 55 to 83 percent of the inpatients examined had no service-connected medical or dental condition,
- from 47 to 79 percent of the inpatients receiving treatment at the five clinics for which data were available had no service-connected condition, and
- only 3.3 to 23.6 percent of the veterans admitted to the VAMCs were hospitalized for treatment of a service-connected condition. 1/

Although we could not readily determine how many veterans with service-connected conditions had dental conditions, the VAMCs were admitting few veterans for treatment of dental conditions and only the San Francisco VAMC could recall admitting any veterans for such treatment. The estimated number of veterans admitted by the seven VAMCs for treatment, during fiscal years 1978-79, ranged from 3 to 131. Of the 131 veterans admitted to the San Francisco VAMC for treatment of dental conditions during these fiscal years, only 54 were admitted for service-connected dental conditions. None of the other six VAMCs could identify any patients admitted for service-connected dental conditions during the 2-year period.

The director of VA's Dental Field Coordination program agreed that few veterans provided care as hospital inpatients were eligible to receive care as service-connected outpatients.

Much routine care provided
for nonservice-connected conditions

Each clinic we visited examined veterans with nonservice-connected medical or dental conditions without determining whether the veteran had an immediate need for the examination. The lack of a priority system for scheduling dental examinations may result in some veterans having compelling need for dental services not receiving an examination, while other veterans having no immediate need for such services were examined. Although each clinic gave priority to veterans identified as having immediate needs for treatment, many veterans with nonservice-connected conditions were provided treatment without immediate need. In at least one case--Spokane--most veterans identified by the clinic as having immediate needs for treatment did not receive any.

Because we could not readily determine whether a veteran with a service-connected condition (1) was service connected because of a medical condition or because of a dental condition and (2) received treatment for his or her service-connected condition, this section discusses only the care provided to veterans identified by VA as having neither a service-connected medical nor dental

1/Data were not available at the Chicago VAMC.

condition. The amount of routine dental care actually provided to veterans for nonservice-connected dental conditions was probably much higher.

According to VA, some patients require dental care as an integral part of their medical treatment. Such patients include those (1) with diabetes or cardiac disease, (2) requiring renal dialysis and/or transplants, (3) undergoing radiotherapy for head or neck malignancies, and (4) on immuno-suppressants. VA maintains that such patients require the elimination of actual or potential oral infection for successful medical care or to avoid life-threatening complications. Other patients may have immediate needs for dental care because they have dental conditions which are aggravating their medical conditions or because they have dental emergencies.

Examinations

None of the VA dental clinics we visited scheduled dental examinations based on the veteran's medical condition. Rather, the clinics generally scheduled examinations of available patients without regard to their service connections or medical conditions. The admitting and attending physicians--the individuals best qualified to identify patients with compelling medical reasons for receiving dental services--were generally not involved in scheduling dental appointments. Although such procedures will, by chance, result in examination and treatment of some patients having a medical need for dental services, they do not insure that all patients with compelling dental needs are provided services.

For example, the dental clerk at the Chicago (Westside) clinic scheduled inpatient dental examinations based on a computer printout identifying new admissions. No effort was made to identify the medical diagnosis of the patients admitted to insure that patients having compelling medical reasons for obtaining dental examinations were examined. Neither the admitting or attending physicians nor the clinic's dentists were involved in scheduling patients for dental examinations.

According to dental clinic records, about 40 percent of the veterans admitted to the Chicago (Westside) VAMC during October 1979 received dental examinations. 1/ Of the examined inpatients for whom a treatment priority was indicated, 50 percent were identified by the clinic as having no immediate need for treatment.

1/Dental clinic records indicate that 121 of the 304 first time direct admissions to the Chicago (Westside) VAMC during October 1979 had received dental examinations by November 14, 1979. According to the chief, dental services, patients are normally examined within 72 hours after admission.

Because the patients examined were, in effect, randomly selected, it appears likely that many of the veterans who did not receive examinations may have had immediate needs for dental treatment that was not provided.

Because dental examinations are one of the most time-consuming tasks performed by VA dentists, the provision of routine dental examinations to veterans with nonservice-connected dental conditions significantly reduces VA's ability to provide dental services to veterans with service-connected dental conditions. In a 1976 study ^{1/} by researchers from the University of California at Los Angeles (UCLA), VA dentists working without an assistant were found to spend more time performing new patient examinations than any other task. When a VA dentist worked with an assistant, new patient examinations were the fifth most time-consuming task.

VACO Office of Dentistry officials said that many of the dental examinations given to hospital patients may have been oral screening rather than comprehensive examinations and questioned the accuracy of the UCLA researchers' finding that examinations were one of the most time-consuming tasks performed by VA dentists. However, VA did not maintain data on the number of oral screening examinations.

The VACO officials believe it is essential that VA dental clinics continue to examine as many inpatients as possible because

- physicians generally examine the patient "from the neck down" and do not consider the patient's dental needs,
- the examinations identify many oral malignancies that might otherwise go undetected (834 previously unrecognized oral cancers were diagnosed in 1979), and
- the average inpatient does not look for dental care in the private sector.

Because VA has limited resources available for providing dental services, not all veterans in need of dental care can be treated at VA facilities. However, scheduling examinations without regard to the veterans' conditions and service connections does not insure that the patients VA considers to have the highest priority for care--those who have service-connected dental conditions and those who have compelling medical or dental needs for obtaining such care--obtain the care they need. We believe physicians should identify

^{1/}Marcus, Marvin, and Drabek, Leonard, "Study: VA Dental Manpower Requirements," School of Dentistry, University of California Los Angeles, 1976, National Academy of Sciences Contract # ALS34-75-125.

patients who have compelling needs for dental care and refer those patients to the dental clinics for examinations.

Treatment

Although each dental clinic visited established a priority system for scheduling dental treatment for inpatients, the clinics provided routine treatment to many inpatients with nonservice-connected dental conditions. For example, our review of samples of veterans who received treatment showed that:

- 32 percent 1/ of the veterans who received treatment at the Chicago (Westside) dental clinic had nonservice-connected dental conditions considered by the clinic to be completely unrelated to their medical conditions.
- 29 percent 2/ of the veterans who received treatment at the Seattle dental clinic had nonservice-connected dental conditions which, according to the clinic, could have gone untreated for 6 months without detrimental effect on the patients' health.
- 23 percent 3/ of the inpatient treatment at the Spokane clinic was provided to veterans who had not been identified by the dental clinic as having either (1) service-connected medical or dental conditions or (2) nonservice-connected dental conditions that were adjunct to their medical diagnoses or were dental emergencies.

1/Based on review of dental records of veterans admitted to the Chicago VAMC in October 1979. As of November 14, 1979, 56 patients admitted in October, identified as a treatment priority, had received dental treatment. Of those, 18 (32 percent) were veterans with nonservice-connected conditions considered by the clinic to be completely unrelated to their medical conditions.

2/Based on review of dental records of veterans who were inpatients at the Seattle VAMC on September 30, 1979. As of October 13, 1979, 35 of the 194 inpatients had received dental treatment. Of those inpatients receiving treatment, 10 (29 percent) were veterans with nonservice-connected conditions which the dental clinic determined could have gone untreated for 6 months without detrimental effect on the patients' health.

3/Based on review of dental records of inpatients admitted to the Spokane VAMC during September 1979. As of October 21, 1979, 47 September admittees had been given dental treatment, of whom 11 (23 percent) were veterans whose dental records did not indicate either (1) a service-connected medical or dental condition or (2) a nonservice-connected dental condition that was adjunct to a medical diagnosis or a dental emergency.

--38 percent 1/ of the inpatients treated at the Bay Pines dental clinic had nonservice-connected dental conditions which the clinic determined had no immediate need for treatment.

Many of the nonservice-connected veterans treated in dental clinics as inpatients, although they had no compelling need for treatment, continued their treatment on an outpatient basis. For example, of 22 nonservice-connected outpatients treated at the San Francisco dental clinic between September 17 and 30, 1979 (for whom we were able to determine the treatment priority established by the clinic), 19 (86 percent) were patients with no compelling need for treatment. The 19 veterans were given a total of 189 treatments between March 1977 and December 1979. Clinic officials told us that treatment was given to some nonservice-connected inpatients specifically to establish eligibility for outpatient treatment.

Similarly, of a sample of 81 nonservice-connected veterans authorized outpatient care at the Tampa dental clinic for whom inpatient treatment priorities could be identified, 29 (36 percent) had dental conditions unrelated to their medical conditions, and 8 (10 percent) were identified as not needing or not desiring dental treatment.

To determine whether veterans identified by a dental clinic as having immediate needs for dental treatment received treatment, we reviewed the records of 233 veterans admitted to the Spokane VAMC during September 1979 who were examined at the dental clinic and whose dental cases had been closed by October 21, 1979. The clinic had identified 52 of the veterans as having immediate needs for dental treatment, but only 18 were treated. The remainder had their treatment cases closed and were discharged without treatment. We discussed four of the cases closed without treatment with the Spokane VAMC's chief of dental services. He was unable to explain why treatment was not provided in three of the cases. In the fourth case, he said that the veteran did not have a dental emergency requiring treatment during hospitalization and that the veteran was eligible for outpatient dental care.

1/Based on review of dental records of inpatients at the Bay Pines VAMC who were provided dental treatment during fiscal year 1979. Of the 617 inpatients who received treatment, 235 (38 percent) were veterans with nonservice-connected dental conditions who had no compelling medical reasons for obtaining dental treatment, according to the clinic. While 182 of the 235 veterans had service-connected medical conditions, they were not service connected for their dental conditions because their dental conditions were not considered by the clinic to be adjunct to their medical conditions.

The chief of dental services said that he would not get concerned about the clinic's not treating some high-priority patients unless they were treating many patients having lower treatment priorities. However, the Spokane clinic was providing routine treatment for many nonservice-connected dental conditions.

According to VACO's assistant chief medical director for dentistry, VA dental clinics provide treatment to only about 15 percent of the hospital inpatients. He further stated that private-practice dentists would not provide care to many of the inpatients provided care at VA dental clinics because of the severity of the patients' physical or neuropsychiatric problems.

Patients unable to obtain care from a private dentist because of their medical condition would generally meet the definition of a patient having compelling medical need for dental treatment. We agree that, on a priority basis, such patients should be provided care at VA clinics. However, as shown on pages 14 to 16, VA clinics also provide care to many veterans who have no compelling medical need for dental care and should have had no problem in obtaining care from private-practice dentists. On a priority basis, such patients should be given treatment only if staff and facilities are available after veterans with compelling needs for treatment and veterans with service-connected dental conditions have been provided care.

Most service-connected outpatients referred to fee program

About 90,000 (62 percent) of the approximately 146,000 veterans authorized outpatient dental treatment for service-connected dental conditions during fiscal year 1979 were referred to private dentists on a fee-for-service basis according to data compiled under VA's AMIS program. At the clinics we visited, referrals to the fee program were most frequently made for reasons other than geographical inaccessibility or inability to provide the type of care required. For example:

- The Seattle VAMC referred most veterans seeking outpatient dental care for service-connected dental conditions to the fee program because of the dental clinic's inability to provide services within a reasonable period of time.
- The Spokane VAMC referred veterans to the Seattle clinic of jurisdiction for fee-program referral whenever the outpatient workload exceeded 30 to 40 percent of the overall clinic workload.
- The Martinez VAMC referred all veterans to the San Francisco clinic of jurisdiction for fee-program referral unless the veteran insisted on treatment at the VAMC.

--The Tampa VAMC referred patients to the St. Petersburg clinic of jurisdiction for fee-program referral whenever the outpatient workload exceeded 20 to 25 percent of the total clinic workload.

Additionally, although the San Francisco VAMC cited geographical inaccessibility as the justification for most fee-basis referrals, it defined this as residing more than 10 miles from the VAMC and adjusted its definition to control outpatient workload.

At the St. Petersburg clinic of jurisdiction, we were told that most veterans were referred to the fee program because of geographical inaccessibility. An official from the St. Petersburg clinic estimated that 60 percent of the fee-basis referrals, from the seven clinics under its jurisdiction, were made because the veteran lived more than 40 miles from a VA clinic. He said that the high number of referrals occurred because of the absence of VA facilities in the Florida panhandle area. Excessive workload was the reason most frequently cited for the remaining 40 percent.

Because most fee-basis referrals nationwide were made for reasons other than geographical inaccessibility or inability to provide the type of care needed, the potential exists to significantly reduce fee-basis referrals by refocusing dental program priorities and tightening referral procedures.

PUBLIC LAW 96-22 NOT
EFFECTIVELY IMPLEMENTED

As of October 1, 1980, over a year after enactment of Public Law 96-22, VA had provided no formal guidance to its dental clinics on implementation of the act. Furthermore, the informal guidance that was provided continued to place a higher priority on the provision of dental services to inpatients than on the provision of care to outpatients with service-connected dental conditions. As a result, AMIS reports show that the law has had little effect on many VA dental clinics' provision of dental services to inpatients and outpatients with nonservice-connected conditions. During the first year after implementation of the act, fee-basis authorizations increased over fiscal year 1979 authorizations by about 20,000.

Although the law clearly directed VA to give veterans seeking outpatient care for service-connected dental conditions priority over most inpatients with nonservice-connected dental conditions, VA has not directed its clinics to refocus their dental programs to give priority to outpatients with service-connected dental conditions. The law requires that patients with service-connected conditions be provided dental services before inpatients with nonservice-connected dental conditions unless they have (1) dental emergencies, (2) dental conditions that are adjunct to the medical

conditions for which the patients were hospitalized, or (3) compelling medical reasons for obtaining dental services. VA has directed its clinics to establish treatment priorities for inpatients based on such factors as the veteran's medical condition and service connection, but it has not told the clinics when to give outpatients with service-connected dental conditions priority over inpatients.

In an October 17, 1979, conference call to all VA dental clinics, the assistant chief medical director for dentistry advised clinic personnel that:

"We have a certain responsibility to the hospitalized veteran and on a priority basis they should be given care. * * * Again it is your prerogative [sic] and if you feel that you can increase your percentage [of outpatient care] and still get the needed dental care to the inpatient veteran, then fine."

The law also states that routine dental services are not included in the definition of compelling medical reasons or dental emergencies used to justify priority care for inpatients with nonservice-connected dental conditions. However, VA continues to pursue the goal of giving routine dental examinations to 75 percent of hospital inpatients. In the conference call, the assistant chief medical director for dentistry advised clinic personnel that:

"We are still a part of a team that is rendering comprehensive medical care to the hospitalized veteran and based on the oral examination and the needs and what the examination presents, I think you have to make a professional determination and a priority listing of who does and who doesn't get dental care as an inpatient and then go from there." (Emphasis added.)

Therefore, any determination on the medical necessity of the dental services provided is to be made only after the patient has been given an examination.

As shown on page 12, examinations were generally given without regard to the veterans' medical conditions or service connections and most were provided to veterans with nonservice-connected conditions. During the first year after implementation of the law, routine examinations of hospital inpatients and outpatients with nonservice-connected conditions accounted for more than one out of every three reported sittings at VA dental clinics.

Clinics continue to
emphasize inpatient care

Despite a significant increase in the dental services reportedly provided to service-connected outpatients during the first year after implementation of the law, VA dental clinics continue to provide most of their services to inpatients or outpatients with nonservice-connected conditions. In fact, many VA clinics reported increases in inpatient sittings.

During the first year after implementation of the law, reported sittings for outpatients with service-connected dental conditions increased by about 134,000 over those in fiscal year 1979. However, about 93,000 of the increase resulted from an increase in the total number of VA dental clinic sittings, not from decreases in care to inpatients and outpatients with nonservice-connected conditions. Sittings devoted to hospital inpatients decreased only about 16,000 (3 percent), and sittings devoted to outpatients with nonservice-connected conditions decreased by about 25,000 (10 percent) as compared to such sittings in fiscal year 1979.

Although there were net decreases in the reported sittings provided to inpatients and outpatients with nonservice-connected conditions compared to those in fiscal year 1979, many clinics reported increases in the services provided to such patients. Of the 172 dental clinics located at VA hospitals,

--80 (47 percent) reported an increase in the number of inpatients examined,

--72 (42 percent) reported an increase in the number of sittings provided to inpatients and outpatients with nonservice-connected conditions,

--57 (33 percent) reported an increase in the number of outpatients treated for nonservice-connected conditions, and

--62 (36 percent) reported an increase in the number of hospital inpatients treated.

Also, 62 of the 78 clinics of jurisdiction for the fee program reported increases in fee-basis authorizations. Of the 16 clinics reporting a decrease in fee-basis authorizations, 8 also reported a decrease in the total number of service-connected veterans authorized outpatient dental care.

At the time we completed our review, none of the clinics we visited had taken specific actions to redirect its dental program to emphasize care to outpatients with service-connected dental conditions. However, one of the clinics--Seattle--took several actions later to redirect its dental program. During fiscal year

1980, the Seattle clinic of jurisdiction was 1 of only 16 such clinics to report a decrease in fee-basis authorizations.

Two clinics reported increases in the dental services provided to inpatients and outpatients with nonservice-connected conditions after implementation of the law. During fiscal year 1980, the San Francisco clinic reported a 10.7 percent increase in inpatient sittings and a 1.3 percent increase in outpatient nonservice-connected sittings over fiscal year 1979. At the same time, sittings devoted to outpatients with service-connected dental conditions reportedly decreased 10.8 percent.

Similarly, reported inpatient sittings at the Chicago (West-side) dental clinic increased 30 percent during fiscal year 1980. Complete fiscal year data were not reported for outpatient nonservice-connected sittings, but such sittings increased 12 percent during the first 9 months of fiscal year 1980. Although sittings reported for outpatients with service-connected dental conditions also increased, the increase was only 1 percent.

When we visited the Seattle VAMC in September 1979, we found that it had stopped sending veterans with service-connected dental conditions to the dental clinic except for a few oral surgery cases. As a result of our review, the Seattle VAMC and its dental clinic took several actions to refocus the dental program. Specifically, the assistant chief of staff at the VAMC directed the acting chief, dental services, in a January 21, 1980, memorandum, to:

- Develop a procedure that will increase the number of dental examinations performed on inpatients with service-connected medical or dental conditions.
- Establish a schedule that will accommodate an average of eight treatment visits per dentist daily.
- Increase the number of service-connected outpatient treatment visits to 67 percent of all such visits.

In addition, on January 25, 1980, the acting chief, dental clinic of jurisdiction, notified the chief, dental services, at each VAMC within the Seattle clinic of jurisdiction, that the fiscal year 1980 objectives would be to

- review and modify referral procedures so that each medical center receives enough referrals to maintain a scheduling backlog of service-connected outpatients of at least 1 month and
- increase the percentage of service-connected outpatient dental visits to 25 percent of all dental visits.

As a result of these actions and others taken to eliminate the provision of care to ineligible veterans (see p. 28.), the Seattle dental clinic reported that sittings devoted to inpatients or nonservice-connected outpatients decreased from about 5,300 during fiscal year 1979 to about 3,100 during fiscal year 1980, while sittings devoted to outpatients with service-connected dental conditions increased from about 2,200 to about 3,600. Significantly, the Seattle clinic reported a decrease in fee-basis authorizations from about 3,900 to about 3,300 despite the extension of dental services to the two new classes of service-connected outpatients. This decrease in fee-basis authorizations was accomplished although the actions to decrease fee-basis referrals were not taken until 4 months after implementation of the law.

We believe the actions taken by the Seattle clinic clearly indicate the potential for other VA dental clinics to increase the service provided to outpatients with service-connected dental conditions, and thus reduce fee-program referrals.

CHAPTER 3

NEED TO STRENGTHEN PROCEDURES

FOR AUTHORIZING OUTPATIENT AND

FEE-BASIS DENTAL SERVICES

VA dental clinics have not complied with legislative restrictions on the authorization of outpatient and fee-basis dental care. As a result, many veterans not eligible to receive care on an outpatient or fee basis have been provided such care. Compliance with the limitations on approval of fee-basis care should result in a reduction of referrals to the fee program. Similarly, by reducing the number of ineligible veterans provided outpatient dental care at VA clinics, VA could increase its capacity to treat outpatients with service-connected dental conditions and further reduce fee-basis referrals.

IMPROPER AUTHORIZATION OF FEE-BASIS DENTAL SERVICES

Under 38 U.S.C. 601(4)(c), fee-basis dental care is to be authorized only when VA facilities are unable to provide care economically because of geographical inaccessibility or are unable to provide the services required. In a March 9, 1979, meeting with the Senate Committee on Veterans' Affairs, VA's Deputy General Counsel assured the Committee that VA intended to rigorously apply these limitations before authorizing any fee-basis care. However, the clinics we visited were not properly applying the limitations. Some VA clinics

- cited excessive workload as the reason for authorizing fee-program referrals, although few appointments were scheduled;
- gave veterans the option of private dental care without regard to the availability of VA care;
- authorized fee-program referrals when other nearby VA facilities could have provided the needed services;
- adjusted their definition of geographical inaccessibility to control the number of service-connected outpatients treated; or
- authorized fee-program referrals whenever the service-connected outpatient workload exceeded a specific percentage of overall clinic workload.

As a result, many veterans were authorized care from private dentists on a fee-for-service basis although the services could

have been provided in a VA dental clinic. By strengthening its procedures for authorizing referrals to the fee program, VA could further reduce the number of, and the amount spent on, such referrals.

Clinics citing excessive workload
have few scheduled appointments

The clinics we visited generally cited excessive workload rather than geographical inaccessibility or inability to provide the type of care needed to justify fee-basis referrals. According to VA's Dentistry Manual, the inability to initiate treatment within 60 days will be used to justify fee-basis referrals. To evaluate the clinics' ability to initiate treatment within 60 days, we reviewed scheduled appointments for a 4-week period at two of the clinics that cited excessive workload to justify fee-basis referrals.

At the Spokane dental clinic, the two full-time dentists had only 31 patients scheduled to receive examinations or treatments during the 5 workdays immediately following our visit, an average of about 3 patients per dentist per day. These dentists had scheduled only 22 appointments for the the following 15 workdays, less than 1 patient per dentist per day.

Similarly, the five full-time dentists at the Seattle clinic had only 54 appointments scheduled for the 5 days immediately following our visit, an average of about 2 patients per dentist per day. During the following 15 workdays, the five dentists had 28 scheduled appointments, about 2 patients per dentist per week.

Veterans given option
of using private dentist

Although VA's Dentistry Manual states that "* * * the decision for fee dental care is not the prerogative of the veteran beneficiary * * *," five clinics we visited gave at least some veterans a choice of receiving care from a VA clinic or a private dentist, without regard to the availability of VA care. Specifically:

- The Chicago (Westside) dental clinic allowed the veteran to decide whether he or she would obtain dental services from this clinic, from another VA clinic, or from a private dentist on a fee-for-service basis. Veterans were allowed to choose a private dentist after treatment had started at a VA facility, if they so desired.
- The Sacramento outpatient dental clinic gave Class II outpatients (veterans seeking dental treatment within 1 year after discharge) a choice of obtaining care (1) at the VA clinic or (2) from their own dentist.

- The Los Angeles outpatient dental clinic allowed veterans to obtain care from a private dentist if they had a "good" reason, such as having to work during VA clinic hours.
- The Wadsworth dental clinic allowed veterans wanting to be treated by a private dentist to apply to the clinic of jurisdiction for fee-basis authorization. The requests for fee-program authorization were forwarded to the clinic of jurisdiction even if the Wadsworth clinic was not operating at full capacity.
- The Spokane dental clinic allowed veterans to obtain dental care under the fee program if the veteran expressed a desire to see a private dentist. The clinic specifically suggested the option of fee-basis care if the clinic's outpatient workload exceeded 30 percent of the total clinic workload.

Availability of services at VA facilities not always determined

Although VA's Dentistry Manual requires that a determination be made with regard to the availability of care at VA facilities near the veteran's residence before fee-basis care is authorized, such determinations were not always made. Three of the four clinics of jurisdiction we visited were authorizing fee-basis care without determining the availability of care at other VA facilities. Also, because a veteran could apply directly to the clinic for fee-basis authorization without first attempting to obtain care from a VA clinic close to his or her residence, fee-basis authorizations may have been given without any determination made regarding the availability of care at VA facilities.

Many veterans authorized care by two clinics of jurisdiction--Seattle and Chicago (Westside)--could have obtained care at a facility close to their residence. We did not determine whether the veterans authorized fee-basis care by the third clinic of jurisdiction--San Francisco--could have obtained such care from VA.

The Seattle clinic of jurisdiction authorized fee-basis dental care for many veterans living near the Spokane dental clinic without determining whether the Spokane clinic could have provided the needed services. Neither the Seattle clinic nor the Spokane dental clinic were able to identify how many veterans living near the Spokane clinic were authorized fee-basis care. However, our review of 138 fee-basis cases closed by the Seattle clinic during a 2-week period in September 1979 identified 17 cases from the Spokane area. Twelve of the 17 veterans lived within 30 miles of the Spokane clinic. All of the veterans had applied directly to the Seattle clinic for fee-basis authorization without attempting to obtain care at the Spokane clinic.

We discussed four fee-basis treatment plans authorized by the Seattle clinic during October 1979 for veterans living in the Spokane area with the chief, dental services, at the Spokane clinic. In each case, the chief said that the Spokane clinic could have provided the needed services and started treatment within 2 weeks. He believed that Spokane should be given the opportunity to review fee-basis applications before treatment by a private dentist is authorized and said that, at times during fiscal year 1979, the Spokane dental clinic had to "look for" patients.

As discussed on page 23, the Chicago (Westside) clinic gave each veteran applying for dental services a choice of obtaining care from a VA facility or from a private dentist. Therefore, no attempt was generally made to determine whether veterans could have obtained dental services from a VA facility near their home. The dental service chiefs from two other Chicago area VA hospitals--Hines and Lakeside--told us that they had sufficient capacity to handle some of the veterans referred to private dentists by the Westside clinic.

Limits placed on
outpatient workload

38 U.S.C. 601(4)(c) authorized the use of fee-basis dental care if the VA clinic is unable to provide the services needed. Although the Tampa and Spokane dental clinics cited excessive workload as the justification for most fee-program referrals, they did not consider the total workload in making the determinations. Rather, they established limits on the amount of total dental clinic resources that could be devoted to care for outpatients with service-connected conditions. When that limit was exceeded, service-connected veterans were referred to the fee program. Specifically:

- The Tampa dental clinic limited the resources used to treat outpatients to between 20 and 25 percent of total clinic resources. Whenever the limit was exceeded, Class II and Class IV service-connected outpatients were referred to the fee program, regardless of the workload demands on the remaining 75 to 80 percent of the clinic's resources.
- The Spokane dental clinic attempted to limit the resources for service-connected outpatient care to 30 percent of its total resources, and referred patients to the fee program when workload exceeded that limit. As shown on page 23, the scheduled workload at the Spokane clinic would have permitted the treatment of more service-connected outpatients.

We believe that 38 U.S.C. 601(4)(c) requires that the determination of availability of services be made on the basis of total clinic resources, not on the basis of an arbitrary portion reserved for service-connected outpatients. Furthermore, such limits on the amount of care provided to service-connected outpatients are not consistent with the intent of Public Law 96-22 because they preclude the use of most dental clinic resources for the care of such outpatients.

Need for uniform definition
of geographical inaccessibility

A VA clinic is considered geographically inaccessible to a veteran residing more than an established distance from the clinic, and the veteran is authorized to obtain care from a private physician or dentist on a fee-for-service basis. Because VA has not established a uniform definition of geographical inaccessibility, each VA clinic develops its own definition. At the clinics we visited, the distances used to define geographical inaccessibility ranged from less than 10 miles to 40 miles. By contrast, the Department of Defense (DOD) is prohibited from paying Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds for nonemergency inpatient care available at a "uniformed services" ^{1/} hospital within 40 miles of the beneficiary's residence. (Public Law 94-212, section 750.)

Three dental clinics we visited--San Francisco, Orlando, and Los Angeles--were using definitions of geographical inaccessibility that differed from the definition used by their corresponding VA outpatient medical clinics located in the same building. In each case, the clinics were adjusting their definition to control the number of patients treated, and referring veterans to the fee program who would have been required to obtain outpatient medical care from VA.

At the time of our 1979 visit, the San Francisco VAMC referred veterans seeking outpatient medical care to the fee program if they lived more than 40 miles from the VAMC. However, veterans seeking outpatient dental care were referred to the fee program if they lived more than 10 miles from the VAMC. Most people in the San Francisco/Oakland metropolitan area live more than 10 miles but less than 40 miles from the San Francisco VAMC. The dental clinic expands the radius of patients it treats when it adds additional staff and needs extra workload. As of January 1981, the clinic was referring veterans to the fee program if they lived outside the San Francisco city limits.

^{1/}The uniformed services are the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the commissioned corps of the Public Health Service, and the commissioned corps of the National Oceanic and Atmospheric Administration.

In November 1979, the Orlando outpatient dental clinic began referring veterans to the fee program if they lived outside the Orlando city limits, in order to limit the clinic's workload. By contrast, veterans seeking outpatient medical care were treated at the outpatient clinic if they lived within 40 miles of the clinic. Most people in the Orlando metropolitan area live outside the city limits.

At the Los Angeles outpatient clinic, the definition of geographical inaccessibility for veterans seeking dental care fluctuated between 20 and 30 miles depending on the patient load. By contrast, the clinic was considered geographically inaccessible to veterans seeking outpatient medical care only if the veteran lived more than 40 miles from the clinic.

NEED TO ENFORCE
ELIGIBILITY REQUIREMENTS
FOR OPT/NSC TREATMENT

Under 38 U.S.C. 612, veterans who have no service-connected entitlement to outpatient dental care may be provided care on an outpatient/nonservice-connected (OPT/NSC) basis, only as a continuation of treatment begun while they were inpatients, and only if it is reasonably necessary to complete such treatment. However, five dental clinics we visited--Seattle, Spokane, San Francisco, Chicago, and Tampa--were providing OPT/NSC dental services to many veterans (1) who received no treatment as an inpatient or (2) for whom it was not reasonably necessary to complete treatment. Treatment of ineligible veterans did not appear to be a significant problem at the Martinez and Bay Pines clinics.

At the Seattle dental clinic, 62 percent of the veterans whose OPT/NSC cases were active on September 30, 1979, were authorized outpatient dental treatments when they were not eligible. Specifically,

- 102 of 217 veterans with nonservice-connected dental conditions who were authorized outpatient dental treatment as a continuation of treatments begun while they were inpatients had received no treatment as inpatients,
- 88 veterans with nonservice-connected conditions were provided examinations and/or treatments after referral from outpatient medical clinics, and
- 22 of 35 veterans with nonservice-connected conditions who were provided emergency outpatient care were scheduled to receive continued care although they were not eligible.

We did not attempt to determine whether it was necessary to complete the treatment provided to those veterans who began

treatment as inpatients. The dental clinic at the Seattle VAMC was providing OPT/NSC dental services without requiring that the veterans' eligibility for such care be established by its MAS.

Officials from both the VAMC's Medical Administrative and Dental Services agreed that the veterans mentioned above did not meet VA's eligibility requirements for OPT/NSC dental care, and in January 1980, the director of the Seattle VAMC issued a memorandum strengthening eligibility procedures. The memorandum required that (1) all referrals to the Dental Service be made through the MAS' eligibility clerks and (2) the Dental Service insure that no ineligible person is examined or treated without authorization from the eligibility clerk.

Like Seattle, the Spokane dental clinic was providing outpatient dental examinations to nonservice-connected veterans referred to it by outpatient medical clinics. Although the Dental Service maintained no records on the patients seen as referrals from outpatient medical clinics, the chief, dental services, estimated that the clinic provides examinations to three or four such referrals weekly. At our request, the Spokane clinic identified seven nonservice-connected veterans provided dental examinations between October 22 and 29, 1979, after referral from an outpatient medical clinic.

VACO Office of Dentistry officials agreed that veterans with nonservice-connected dental conditions are not eligible for care when referred by an outpatient medical clinic but said that it is hard to tell veterans identified by a physician as needing dental treatment that they cannot be treated at a VA clinic.

According to the chief, dental services, the Spokane clinic was also providing OPT/NSC services to veterans who received only an examination and consultation or prophylaxis as an inpatient. According to a VA official, such routine services do not normally constitute initiation of care for purposes of determining eligibility for OPT/NSC treatment.

Furthermore, many veterans received only prophylaxis as outpatients. During October 1979, 15 percent of the veterans receiving OPT/NSC care at the Spokane clinic received only prophylaxis from a student hygienist.

In a November 5, 1979, sample of 307 active OPT/NSC cases at the Chicago (Westside) dental clinic, 85 veterans had not received treatment before discharge. According to the chief, dental services, a veteran whose dental condition is adjunct to his or her medical condition is given all recommended dental care regardless of when treatment started. All veterans whose treatment started after they were discharged were considered by the Dental Service to have dental conditions adjunct to the veterans' medical conditions.

The San Francisco and Tampa clinics were providing OPT/NSC treatment to many nonservice-connected veterans who had no immediate need for dental treatment. According to VA's Dentistry Manual, treatment for nonservice-connected veterans is to be continued on an outpatient basis only if completion of the treatment is necessary in relation to a medical problem for which it was prescribed. As discussed on page 15, 86 and 46 percent of the OPT/NSC treatment at the San Francisco and Tampa clinics, respectively, was being provided to veterans whose dental conditions were not related to a medical condition. Also, at the Tampa clinic, we identified 10 nonservice-connected veterans whose treatment started after they were discharged from the hospital.

CHAPTER 4

OPPORTUNITIES TO INCREASE

DENTAL CLINIC PRODUCTIVITY

In a 1973 report, 1/ we identified several factors that were limiting the productivity of VA dental clinics, including the

- high number of broken appointments,
- extensive use of VA dentists to perform clerical duties,
- limited use of hygienists and other dental auxiliaries, and
- limited use of two-chair dentistry.

Because VA has not effectively implemented the recommendations in that report, the same factors continue to limit VA dental clinic productivity.

Because of the lack of adequate standards and reliable management information to measure the productivity of VA dentists and the significant differences between VA and non-VA dental care delivery systems, we did not attempt to perform a detailed comparison of the productivity of VA and private-practice dentists. However, in a May 1977 report, 2/ the National Academy of Sciences (NAS) found that the VA dental service is not as efficient as private dental care. At the clinics we visited, VA dentists were, on the average, seeing only about half as many patients as were dentists in private practice.

NEED TO REDUCE THE NUMBER OF BROKEN APPOINTMENTS

Canceled and broken appointments were a major problem at every clinic we visited. Because the clinics often were unable to fill or did not attempt to fill broken appointments with other patients, dental clinic productivity was significantly reduced.

1/"Better Use of Outpatient Services and Nursing Care Bed Facilities Could Improve Health Care Delivery to Veterans," B-167656, April 11, 1973.

2/Farber, Saul J., M.D., Chairman, Committee on Health-Care Resources in the Veterans Administration, et al., Assembly of Life Sciences, National Research Council, National Academy of Sciences, "Health Care for American Veterans," May 1977, Washington, D.C.

Although we recommended in our 1973 report that VA establish a reminder system to notify veterans of scheduled appointments a few days in advance, VA's Office of Dentistry has not required its clinics to initiate such telephone or mail reminders. Only 3 of 11 clinics visited had established a reminder system.

Our review of broken and canceled appointments at 11 VA dental clinics showed that:

- At the Orlando outpatient dental clinic, 50 appointments were broken or canceled between August 29 and September 21, 1979, representing about 8 percent of the total appointments scheduled. The clinic was unable to fill 30 of the appointments with other patients.
- At the Sacramento outpatient clinic, there were 211 canceled appointments and 532 missed appointments in fiscal year 1979, representing about 22 percent of the scheduled appointments. Because it is not part of a VAMC, the clinic could not fill missed appointments with inpatients.
- At the Los Angeles outpatient clinic, we were told by the chief, dental services, that 50 percent of the initial appointments are broken and that veterans fail to keep from 7 to 10 percent of subsequent appointments.
- At the Tampa dental clinic, 133 (17.5 percent) of the 759 appointments scheduled between August 30 and September 26, 1979, were canceled or broken. The chief, dental services, said that the clinic attempts to fill the appointments but is often unsuccessful because of the short time available to find replacements.
- At the San Francisco dental clinic, 80 (18.3 percent) of the 436 appointments scheduled during a 2-week period in September 1979 were canceled or broken. Although dental clinic policy was to do screening examinations on the ward or call hospital patients in for treatment when appointments were broken, in most cases, the dentist was not able or did not try to get replacements.
- At the Spokane dental clinic, veterans failed to report for 13 of the 104 appointments scheduled during a 2-week period in September 1979. The clinic attempts to fill the missed appointments with bed occupants, but estimated that half of a 1-hour appointment is wasted before the clinic can find a bed occupant to fill the appointment.
- The Bay Pines dental clinics, located at the VAMC and at the Ambulatory Care Clinic in St. Petersburg, had 69 and 53 canceled or broken appointments, respectively, during

September 1979 that the clinics were unable to fill with other patients. The unfilled appointments accounted for 9.2 and 10.4 percent of the total appointments at these clinics.

- At the Seattle dental clinic, veterans failed to report for 27 (9 percent) of 299 appointments scheduled between August 20 and 31, 1979. According to the chief, dental services, bed occupants were not usually used to fill the missed appointments.
- At the Chicago dental clinic, 594 veterans were scheduled for treatment between June 18 and 29, 1979, of whom 48 canceled and 90 failed to keep their appointments. Although the chief, dental services, claimed that missed appointments were not a problem because of the availability of other veterans as replacements, the work schedules of four dentists over a 2-week period showed that from 5 to 26 percent of their available patient time was lost because of broken or missed appointments.
- At the Martinez clinic, the dentists told us that broken appointments significantly affect their productivity. They said that the clinic gives the veteran about 10 minutes to appear and then attempts to find a replacement from the hospital. If a replacement can be found, it takes an additional 10 minutes to get him or her to the clinic.

VA's Dentistry Manual requires that each clinic establish a system for scheduling appointments, but does not require a system of telephone or mail reminders. According to the director of VA's Dental Field Coordination program, no guidance has been provided to the dental clinics on establishing reminder systems. Only 3 of the 11 clinics visited--Bay Pines, Martinez, and the Los Angeles outpatient clinic--were using reminders for outpatient appointments. At Bay Pines and Martinez, patients were telephoned and reminded of their appointments. The Los Angeles outpatient clinic mailed a reminder to veterans for their initial appointment, but not for subsequent appointments.

Both VACO Office of Dentistry and MAS officials agreed that broken appointments are a serious problem, which reduce dental clinic productivity. According to an MAS official, reminder systems have been implemented at clinics where appointment scheduling has been automated. In addition, he said that veterans are shown a video tape in the waiting room emphasizing the importance of keeping appointments. The assistant chief medical director for dentistry said that clinics are encouraged to "double book" patients if they are experiencing a significant problem with broken appointments. Both MAS and Office of Dentistry officials said, however, that veterans have little incentive to keep their

appointments because they do not pay for the care and VA cannot deny them care if they repeatedly break appointments.

DENTISTS STILL PERFORM MOST FEE-PROGRAM ADMINISTRATIVE DUTIES

Despite recommendations made in 1971 and 1973 to use medical administrative personnel rather than dentists to handle most fee-program administrative duties, VA dentists at three of the four clinics of jurisdiction we visited still handled most of these duties. As a result, their ability to provide dental examinations and treatment was reduced.

A 1971 VA internal audit report emphasized the need to eliminate the involvement of VA dentists in clerical matters. The report proposed that medical administrative personnel handle communications with fee-program dentists and, within certain limitations, process and approve treatment plans. Two years later, in 1973, we reported that VA dentists were still spending much of their time on fee-program administrative duties. Like the VA internal audit report, our report recommended that administrative personnel, rather than dentists, handle the fee-program clerical duties.

Of the four clinics of jurisdiction, only Seattle had implemented the 1971 and 1973 recommendations. The Seattle clinic was using a trained employee within the hospital's MAS to handle most fee-program administrative duties. The employee determined veteran eligibility for fee-program referral, authorized examinations, reviewed treatment plans for certain types of cases, authorized treatment, and reviewed and approved payments to fee-program dentists.

A report on a July 1979 visit to the Seattle clinic by VA Office of Dentistry officials stated that the fee program:

"* * * has been excellently maintained. Regulations are well understood. Applications, authorizations for oral examinations and treatment and certification of completed case vouchers for payment are current within one or two days of receipt * * * All personnel involved in the fee dental program were commended for their knowledgeable and effective performance."

Although we identified deficiencies in the administration of the fee program at the Seattle clinic (see pp. 23 and 24), the deficiencies related to the clinic's policies for authorizing fee-basis care, not to the way the MAS employee carried out his duties. Because most fee-program administrative duties were handled by the MAS employee, the chief, dental service, estimated that about 10 percent of his time was spent on the fee program.

By contrast, dentists at the other three clinics of jurisdiction were devoting considerable time to administrative work associated with the program. The assistant chiefs of the dental service at Bay Pines and Chicago (Westside) were spending about 50 percent of their time on the fee program. At the San Francisco clinic, the assistant chief, dental service, estimated that he was spending about 30 percent of his time on fee-program administration and that another dentist was devoting about 90 percent to the program.

The chief, dental service, at the Chicago (Westside) clinic, said that an administrative assistant with a dental background could handle the fee-program administrative duties, and allow the dentists additional time to provide treatment. Paying an administrative assistant, rather than a dentist, to perform the fee-program administrative duties would also reduce the cost of administering the program.

VACO's assistant chief medical director for dentistry agreed that trained administrative personnel could handle most fee-program administrative duties, but said that the high turnover rate of such personnel and the time required to train replacements limit VA's ability to use them.

NEED TO EXPAND USE OF DENTAL AUXILIARIES

Despite the findings in our 1973 report and NAS' 1977 report that VA could improve the productivity of its dental clinics through expanded use of hygienists and other dental auxiliaries, VA has been slow to expand the use of such personnel. Furthermore, VA had not effectively implemented the recommendations in our March 1980 report ^{1/} on expanded function dental auxiliaries. As of September 1980, only 119 of VA's 198 dental clinics had a hygienist and only 4 had an EFDA. In addition, the ratio of dental assistants to dentists and residents continued to be below the national average. As a result, VA dentists continued to perform tasks that could have been done by auxiliaries.

What tasks can dental auxiliaries perform?

Dental auxiliaries include hygienists, dental assistants, and EFDAs, each performing some dental services that otherwise would be performed by a dentist. Licensed dental hygienists perform preventive services (administering a complete oral prophylaxis), therapeutic services (applying topical fluorides and other medication

^{1/}"Increased Use of Expanded Function Dental Auxiliaries Would Benefit Consumers, Dentists, and Taxpayers," HRD-80-51, March 7, 1980.

directed by the dentist), and dental health education services (instructing patients and others on techniques and practice in the maintenance of oral hygiene).

Dental assistants receive and prepare patients for dental treatment, assist the dentist in either restorative dentistry or oral surgery operations, and prepare materials and equipment for use by the dentist. They sterilize instruments and materials, perform dental X-ray work, and may assist the dentist in denture work. Dental assistants also keep records of appointments, examinations, treatments, and supplies.

EFDAs are paraprofessionals trained to perform, under a dentist's supervision, a wide range of clinical duties previously performed only by a dentist, thus freeing the dentist to (1) concentrate on more complex dental work and (2) treat more patients. Tasks that can be given to EFDAs include restorations (placing and carving fillings), placement and removal of temporary crowns, testing the vitality of tooth pulp, and making impressions of the teeth for diagnostic purposes.

Dentists perform tasks that
could be done by auxiliaries

In 1973, we reported that the effectiveness of VA dental clinic operations was somewhat impaired because dentists were performing tasks that could have been performed by dental auxiliaries or were not as productive as possible because they did not have adequate assistance from such personnel. Our findings were confirmed in the 1977 NAS report, which stated that:

"The data show that VA dentists are performing diagnostic and preventive services that in non-VA settings are normally performed by dental auxiliaries. * * * The analysis indicates that a substantial portion of VA dentists' activities could (and in the private sector would) be performed by dental hygienists or other dental auxiliaries."

The NAS conclusion was based on data developed by UCLA researchers under contract to NAS. The UCLA researchers found that:

- Dentists performed the task of scaling teeth 38.9 percent of the time for VA outpatients, but only 20.6 percent of the time in non-VA practice. Hygienists performed the remainder.
- Dentists performed 44 percent of the prophylaxes for VA outpatients, but only 14 percent of prophylaxes in non-VA practice.

- Dental assistants performed 7.9 percent of the prophylaxes in non-VA practice, but none of the VA dental assistants performed prophylaxes.
- Dentists performed 23.6 percent of the patient education tasks in VA clinics, but only 1.7 percent in non-VA practice. Dental assistants performed these tasks 34.6 percent of the time in non-VA practice, but only 9.6 percent of the time in VA clinics.
- Dental assistants performed the task of placing temporary fillings 12.3 percent of the time in non-VA practices, but VA dentists always performed the task.
- Dental auxiliaries performed the task of polishing filled restorations 67.1 percent of the time in non-VA practices, but VA dentists always performed this task.

To determine whether VA dentists were still performing tasks that could have been performed by a hygienist, dental assistant, or EFDA, we sent questionnaires to a random sample of 65 VA dentists asking them whether they were performing any tasks that should be performed by support personnel. Of the 60 dentists responding to our questionnaire, 44 said that they were performing such tasks. Their estimates of the amount of workload that could have been handled by support personnel ranged from 5 percent to over 25 percent, and averaged 17.3 percent. The tasks most frequently mentioned that could have been performed by hygienists, dental assistants, or EFDAs were:

<u>Task</u>	<u>Type of support personnel that should have performed task</u>
Administrative duties, including scheduling appointments	Clerical personnel
Dental lab work	Lab technician or dental assistant
Teeth cleaning and preventive dentistry instruction	Hygienist
Restorations	EFDA
Basic dental assistance	Dental assistant or EFDA

Of the 60 dentists responding, 38 said that they needed an additional dental assistant, 24 needed an EFDA, and 27 needed an additional hygienist.

Many clinics do not
have a hygienist

According to the NAS study:

"The most important personnel shortage is that of dental hygienists. Although not every dental clinic has a dental hygienist, the Office of Dentistry in the VA Central Office would like to have at least one hygienist at each facility."

The UCLA researchers found that there was 1 dental hygienist for every 6.7 dentists at VA dental clinics, compared to 1 hygienist for every 4.3 dentists in private practice. They said that a reasonable guide for VA staffing would be 1 hygienist for every 2 dentists.

As of September 30, 1980, VA had 148 hygienists and 892 dentists, or 1 hygienist for every 6 dentists. However, when VA's 354 dental residents are considered, the shortage of hygienists becomes more pronounced. Of VA's 198 dental clinics, 82 (41 percent) did not have a dental hygienist.

Ratio of dentists to dental
assistants has not improved

The NAS study also found that:

"There are * * * fewer dental assistants than are considered appropriate by the VA. The overall VA ratio of staff dentists to dental assistants is 1:1.2. In the private sector, the ratio is 1:2."

However, as of September 30, 1980, VA still had a ratio of staff dentists to dental assistants of 1 to 1.2 (892 dentists and 1,039 dental assistants). When VA's 354 dental residents are considered, there are only 8 dental assistants to every 10 dentists or residents.

Few EFDAs used

Employment of EFDAs was authorized by the Veterans' Administration Physician and Dentist Pay Comparability Act of 1975 (Public Law 94-123) and the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581). VA officials interpret the legislation as a mandate to employ EFDAs.

In responding to the 1977 NAS report, VA stated that it was taking steps to employ EFDAs in its dental program. However, as of September 30, 1980, VA had only four EFDAs and did not appear to be implementing the recommendations made in our March 1980 report.

Our report concluded that the use of EFDAs substantially improves dentists' productivity and allows public health dental programs to reduce costs and provide the maximum amount of dental services with limited resources. We recommended that VA expand the employment of EFDAs to complete restorations.

On May 7, 1980, the VA Administrator, in commenting on our report, advised the Senate Committee on Veterans' Affairs that:

"* * * all present EFDA programs will be closely monitored for effectiveness and applicability to VA hospital dentistry. Major expansion of EFDA utilization is anticipated but the speed and extent to which this is accomplished will be determined by overall budget priorities."

We believe VA's response fails to recognize that (1) VA dentists spend a significant amount of the patient's time placing and carving restorations, (2) effective implementation of Public Law 96-22 will significantly increase the amount of restoration work that could be performed by EFDAs, and (3) use of EFDAs rather than dentists to complete restorations would decrease, not increase dental program costs.

UCLA researchers identified the 50 tasks VA dentists perform most frequently and ranked them in terms of total time spent performing the task. They found that VA dentists, when working with an assistant, spent more time filling and carving restorations--a task that could be performed by EFDAs--than they did on any of their other duties. When working without an assistant, VA dentists spent more of their time on diagnostic procedures and denture adjustments than did dentists working with an assistant, but the filling and carving of restorations was still the fifth most time-consuming task performed.

According to a VACO Office of Dentistry official, Class II outpatients are generally younger than hospitalized veterans, and compared to inpatients, need more restorative and less prosthetic work. Because Class II outpatients comprised about two-thirds of the fee-basis cases completed in fiscal year 1980, effective implementation of Public Law 96-22 would have significantly increased the amount of restorative work done.

By hiring EFDAs rather than dentists to place and carve fillings, VA could provide dental services to the same number of veterans at a lower cost. Assuming that patient workload remained constant, the use of EFDAs to complete restorations would enable VA to reduce the number of dentists needed, because the remaining dentists would no longer be performing one of their most time-consuming tasks and could treat more patients. Because VA dentists

earn an average of \$43,800, compared to \$20,165 for an EFDA, ^{1/} program costs could be reduced through effective use of EFDAs.

According to VACO's assistant chief medical director for dentistry, VA is making progress in implementing the recommendations in our March 1980 report. He said that, as of March 1, 1981, the number of EFDAs employed by VA had risen to nine.

NEED TO EXPAND USE
OF TWO-CHAIR DENTISTRY

We reported in 1973 that VA could improve the productivity of its dental clinics by expanding the use of two-chair dentistry. In its May 1977 report, NAS stated that:

"One of the constraints on expanding the role of dental hygienists in the VA may lie in the relatively low ratio of dentists, residents, and hygienists to dental chairs. * * * The clinics with approximately 1.7 chairs per professional had a greater productivity * * * than did clinics with a chair-to-professional ratio of close to 1:1. The majority of VA dental clinics have chair-to-professional ratios close to 1:1, which results in inefficient utilization of dental professional manpower."

Despite our recommendations and the recommendation of NAS that VA expand the use of two-chair dentistry, it has made little progress in expanding such use.

As shown in the following table, only 2 of the 12 VA dental clinics we visited had 1.7 or more chairs per dentist, resident, or hygienist. However, neither of those clinics--Spokane and Tampa--was routinely using two-chair dentistry.

^{1/}These salaries are based on data supplied by VA's Office of Controller, as of September 30, 1980.

<u>Clinic</u>	Dental professionals (note a)	Chairs (note b)	Chairs per professional
Orlando	3	3	1.0
Chicago	c/16	18	1.1
Seattle	d/6	9	1.5
Spokane	d/2	6	3.0
Martinez	d/3	e/4	1.3
San Francisco	15	15	1.0
Tampa	9	16	1.8
Wadsworth	28	35	1.2
Bay Pines:	9	12	1.3
Ambulatory Care Clinic	6	7	1.2
Los Angeles OPC	8	8	1.0
Sacramento	2	3	1.5

a/Dentists, residents, and hygienists.

b/Excludes chairs reserved for X-rays.

c/Includes 7 part time.

d/Does not include student hygienists.

e/Clinic's fifth chair inoperative.

At the Spokane dental clinic, five or six treatment chairs were frequently available for use by the clinic's two dentists, but neither of them practiced two-chair dentistry. The clinic did not have a full-time hygienist, but student hygienists used three of the six treatment chairs on a part-time basis. However, during the summer, three chairs were not used. And, during the school year, an average of 2.2 chairs were idle each day. The chief, dental services, said that he did not believe that the use of two-chair dentistry could be increased with the Spokane clinic's current auxiliary staffing--two dental assistants and no hygienist.

The Tampa dental clinic had 16 chairs for use by the clinic's 8 dentists and 1 hygienist. However, the chief said that they did not make extensive use of two-chair dentistry because of the need for more dental assistants. The clinic had 11 dental assistants, but 2 of them were running the reception desk, 1 was taking X-rays and completing medical history questionnaires, and 1 was in training, leaving only 7 to give direct assistance to the clinic's 8 dentists.

Although opportunities to use two-chair dentistry at the other clinics were limited because of the low chair-to-professional ratios, we identified a potential to increase the use of two-chair dentistry at the Seattle, San Francisco, and Bay Pines clinics.

At the Seattle dental clinic, four of the nine dental chairs were generally reserved for use by dental hygiene students and the staff hygienist, but were occasionally used for examinations. According to the chief, dental services, the four hygiene chairs were not used during the summer months when the student training program was not active. Furthermore, the four chairs were used for training only 4 days a week during the school year. Although these chairs could have been used for two-chair dentistry at least 1 day a week during the school year and every day during the summer, each dentist at the Seattle clinic was assigned one chair and none of the dentists were routinely performing two-chair dentistry.

The San Francisco clinic had 15 chairs 1/ for use by the clinic's 14 dentists, but 3 of the dentists did not routinely provide patient care. Furthermore, 3 of the 15 chairs were reserved for use by the clinic's 3 oral surgeons, leaving 12 chairs for the 8 remaining dentists. According to the assistant chief, dental services, there were seldom more than 5 or 6 of the 8 dentists working at the same time, thus, there were between 1.5 and 2 chairs available for use by each dentist. However, the assistant chief said that most of the clinic's dentists seldom practiced two-chair dentistry because some of the treatment rooms were small and undesirable.

Many of the chairs at the Bay Pines clinic and its Ambulatory Care Clinic in St. Petersburg were idle part of the week and could have been used for two-chair dentistry. At the Bay Pines clinic,

--one chair was unassigned,

--the Dental Service chief's chair was not used about 20 hours a week,

--the two hygienists' chairs were not used about 40 hours a week, and

--the chair reserved for the periodontist and endodontist was not used about 20 hours a week when neither of them came to the clinic.

The unassigned chair was occasionally used by one of the clinic's five general practice dentists to practice two-chair dentistry, but the other dentists were not practicing this technique. The Dental Service chief agreed that the existing chairs could be better utilized, and said that if more dentists practiced two-chair dentistry he could increase the number of patient sittings by 25 percent with the existing staff.

1/The clinic's 16th chair was reserved for hygienist and X-ray usage.

Similarly, at the Ambulatory Care Clinic in St. Petersburg

- one of the six general treatment chairs was unassigned because one dentist who resigned had not been replaced,
- the endodontist's and periodontist's chair was not in use about 28 hours weekly, and
- the hygienist's chair was not used 24 hours weekly.

Only the assistant dental chief was practicing two-chair dentistry. He devoted about half of his time to patient care and sometimes saw two patients concurrently, one in the oral surgery chair and one in the hygienist's chair. The assistant chief said that, if all of his dentists practiced two-chair dentistry, patient sittings would probably increase by 30 percent.

WORKLOAD OF VA DENTISTS BELOW THAT OF PRIVATE DENTISTS

Because data from VA's management information system were not definitive enough to enable us to measure the productivity of VA dentists (see p. 45), we did not attempt to perform a detailed comparison of the productivity of VA and private-practice dentists. However, in its May 1977 report, NAS concluded that "it is clear that the VA dental service is not as efficient as is dental care in the community." Furthermore, VA internal reviews have questioned the productivity, during the past 3 years, of three clinics we visited. And, none of the VA dentists at the clinics we visited was seeing as many patients as the average dentist in private practice. VACO Office of Dentistry officials cited significant differences between VA and private-practice dentistry that must be considered in any productivity comparisons.

NAS study

NAS' conclusions about the productivity of VA dentists were based on the results of an Academy-sponsored study of VA's dental personnel requirements by researchers from UCLA.

While recognizing that significant differences between the VA dental care system and private dental care providers make productivity comparison difficult, the UCLA researchers compared the productivity of VA and private dental staffs using two measures. First, they compared the amount of time spent in patient care activities and found that VA dental staff (staff dentists, dental chief, dental assistants, and hygienists) were, on the average, spending only about 70 percent as much time on direct patient care daily as were their counterparts in private practice. VA dentists were found to be spending only about 65 percent as much time on patient care, whereas VA hygienists were spending about 78 percent as much time on patient care as hygienists in private practice.

Second, the UCLA researchers compared the amount of time required by VA and private dental personnel to perform specific dental procedures or tasks. They found that, on the average, the VA staff took 20 to 29 percent longer to complete the same procedures or tasks as did the private dental staff. NAS noted that the presence of dental residents in the VA dental program influenced the results of this productivity measure somewhat, because there were no residents in the private practices.

VA studies identify
low productivity

We reviewed the results of VACO studies of the operations of the seven VA dental clinics where we performed detailed review work and found that the productivity of three of the clinics had been questioned since 1977. Productivity was not addressed in VA's review of three clinics--Spokane, Chicago, and Martinez. Only at the Tampa dental clinic was staff utilization found to be adequate, and there was no quantitative measure of productivity at that clinic.

VA Office of Dentistry officials made a special visit to the Seattle dental clinic in July 1979 and found that:

"A review of individual appointment books and patient records indicated that measures must be taken to increase the amount of care provided. Numerous examples are evident regarding late start-ups in morning and afternoon appointments, canceled appointments being unfilled in meaningful pursuits, insufficient numbers of patients scheduled, minimal or relatively insignificant procedures performed during a treatment visit or early cessation of activity in late morning or late afternoon hours."

The report recommended that the clinic take steps to maximize productivity through optimal staff utilization.

At the conclusion of our review at the Seattle dental clinic in December 1979, the clinic had not taken action to implement the recommendation. However, we were later informed by the director of the Seattle VAMC in January 1980 that a number of actions were being taken to increase the dental clinic's productivity.

A March 1979 report by VA's Inspector General on the Bay Pines dental clinic and its satellite outpatient clinic stated that:

"Staff utilization was found to be inadequate. A review of the log books kept for the dentists found a high percentage of their workdays not being effectively utilized * * *."

The report recommended that the clinic develop and implement local work standards. Although the clinic later developed an effectiveness measure, the Dental Service chief told us that its usefulness was limited because of errors and inconsistencies in the data. An April 1977 Inspector General's review at the San Francisco dental clinic found that

"Dental Service staff can be better utilized. At the present time five of eight full-time staff dentists spend a collective total of 31 hours per week teaching at UCSF [University of California at San Francisco] during VA tours of duty * * * Based on the workload statistics cited for January and February 1977, and using 41 workdays and six staff dentists involved in actually seeing patients each dentist is seeing approximately four (4.28) patients a day. The workload is split about evenly between examinations and treatment, meaning each dentist is seeing an average of two patients per day for treatment and two for examination. This does not take into account the various specialties involved and the fact there are four residents who are also seeing patients."

The Inspector General's findings were confirmed in our June 6, 1978, report 1/ on VA's fee-basis program. In that report, we suggested that VA improve the productivity of the San Francisco clinic by having dental specialists work on general cases when they are not working on specialty cases. During our current review, the San Francisco clinic was averaging about five patients per dentist per day.

Workload of VA dentists
lower than private dentists

We reviewed the workload of dentists at five VA clinics over a 2-week period, and at five other clinics over a 4-week period. The chief, dental services, at each clinic agreed that the period reviewed was representative of normal clinic workload.

These dentists averaged 7.1 patients per day. By contrast, a 1977 survey by the American Dental Association (ADA) found that private-practice dentists see an average of 76 patients per week, or about 15.2 patients per day assuming a 5-day workweek. The

1/Report to the Administrator of Veterans Affairs, HRD-78-108.

average number of patients seen by individual VA dentists ranged from 3.3 to 13.2. Dentists at some clinics were seeing more patients than dentists at others. For example, the Spokane clinic averaged only 4.9 patients per dentist per day, while the Bay Pines clinic averaged 9.6 patients per dentist per day.

According to VACO Office of Dentistry officials, there are significant differences between VA and private-practice dentistry that may result in VA dentists seeing fewer patients. They said that patients seen by VA dentists are generally older and in need of more dental treatment than patients seen by private dentists.

IMPROVEMENTS NEEDED IN MANAGEMENT INFORMATION SYSTEM

Although VACO's Office of Dentistry and the individual dental clinics rely on data from AMIS to evaluate dental clinic operations, the data are not definitive enough to permit VA to (1) determine the efficiency of dental clinic operations or (2) compare the productivity of VA dentists with that of other VA, private-practice, or DOD dentists. Furthermore, much of the information contained in the AMIS reports was inaccurate, misleading, or inconsistently reported.

What is AMIS?

VA's AMIS produces multipart reports on dental clinic activities. These reports are used by the Office of Dentistry and the individual clinics to monitor dental operations. AMIS reports provide general management and planning data on (1) VA staff examination and treatment workload for inpatients, (2) staff and fee-basis workload for service-connected outpatients, (3) staffing of VA dental clinics, and (4) clinical procedures performed by VA dental staff.

Need for more definitive data on clinical procedures

AMIS data on clinical procedures performed by VA dental staff are not definitive enough to permit meaningful analysis of productivity. All clinical procedures (other than examinations) performed are reported under 1 of 29 broad classifications. The number of examinations performed is shown in another portion of the report. Significant differences exist in the complexity of and time required to complete the procedures within each classification. However, VA does not assign weighted values to the classifications or the individual procedures to enable it to effectively analyze dental clinic operations.

By 1977, all DOD dental clinics are required to report all procedures performed under 1 of 317 specific clinical or laboratory procedures, each of which has a weighted value based on the time required to perform the procedure. The DOD reporting system, which is in effect as of October 1979, is based on the ADA Code on Dental Procedures and Nomenclature, promoted by ADA for voluntary use by civilian dentists involved with third-party insurance programs. DOD developed this system because it found that the information provided under its old, 49-procedure reporting system did not provide sufficient detail to enable DOD to determine whether dental resources were being effectively used. A 1977 DOD report stated that information provided under the 49-procedure reporting system:

"* * * does not always support DOD information requirements, cannot be readily compared to other departments or to the civilian sector, and does not provide individual military dental services with adequate information for management in today's environment."

The instruction manual for this system states that, unless weighted values are assigned to the procedures performed to reflect their relative complexities and costliness, the relative workloads of DOD dentists cannot be compared.

The following example illustrates the advantages of the DOD reporting system.

Dentist A performs 10 screening examinations and 5 one-surface amalgam restorations. Dentist B performs three comprehensive examinations and one gold-foil class IV restoration. VA's reporting system would show that Dentist A examined 10 patients and performed five restorations during the day, while Dentist B examined only 3 patients and performed only one restoration. Dentist A would appear to be more productive than Dentist B.

By contrast, the DOD reporting system would show that Dentist B was actually more productive than Dentist A because he or she performed more complicated and time-consuming procedures. Dentist A would have been reported as having completed 10 screening examinations with a weighted value of 4.0 and 5 one-surface amalgam restorations with a weighted value of 5.0. The weighted value of the work performed by Dentist A totaled 9.0. Dentist B would have been reported as having completed three comprehensive examinations with weighted value of 10.8, and one gold-foil class IV restoration with a weighted value of 8.1. The weighted value of work performed by Dentist B totaled 18.9--more than twice the weighted value of work performed by Dentist A.

VACO Office of Dentistry officials agreed that more definitive data on dental clinic operations are needed and said that they are currently developing an improved reporting system. They said that effectiveness indicators are being tested at six clinics. According to Office of Dentistry officials, these indicators show what type of patients are provided what type of care by what type of providers. In addition, VA is testing a reporting system with weighted values for each procedure performed. According to an official from VACO's Medical Administrative Service, 17 dental clinics are manually compiling data using these values.

Management information
unreliable

AMIS reports cannot be effectively used as a management tool because much of their data are unreliable. We found errors and inconsistencies in the AMIS summary report, in reports on the operations of the individual clinics, and in the supporting documentation maintained by the clinics.

We identified several errors and inconsistencies in the report summarizing the first 9 months of activities in all VA dental clinics during fiscal year 1980. For example, the report showed two totals for hospital admissions differing by about 170,000. A program analyst from VA's Office of Dentistry told us that VA was aware of the inconsistencies and was attempting to eliminate them. Later, on the September 30, 1980, AMIS report, the two hospital admissions figures were the same. However, other inconsistencies had not been eliminated.

In reviewing AMIS reports on the individual clinics, we identified 28 clinics that reported more hospitalized veterans examined or treated than there were dental sittings. By contrast, several other clinics reported what appear to be excessive numbers of treatment sittings during fiscal year 1980. For example, the Wood, Wisconsin, dental clinic reported 11,685 treatment sittings to 156 veterans authorized outpatient care for service-connected dental conditions, an average of over 75 sittings per veteran.

At seven clinics, we reviewed the supporting documentation for the AMIS reports and found that, in each case, much of the information reported was misleading, inaccurate, or inconsistently accumulated. For example, 101 of the 314 dental examinations reported by the Seattle dental clinic in August 1979 had been previously reported.

Officials at the clinics said that data were not always consistently reported because they had not received adequate guidance from the Office of Dentistry on how to report specific procedures.

For example, some dentists were reporting a restoration as one procedure regardless of the number of tooth surfaces involved, whereas other dentists counted each tooth surface as a separate procedure. Dental clinic officials also said that the category "other treatment including surgical" was so broad that it served as a "catchall" for many different procedures.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS

CONCLUSIONS

Because the resources available to VA for providing dental services are limited and not all veterans needing dental treatment can be provided care at VA facilities, it is important that the available resources be effectively used. Fewer veterans with service-connected dental conditions would be referred to private dentists on a fee-for-service basis and, as a result, substantial savings would be achieved if VA (1) established priorities for the provision of dental care in accordance with Public Law 96-22, (2) insured that care was provided only to veterans eligible to receive care, and (3) fully used its dental personnel.

The fee-basis program was intended to be used only if a veteran was unable to obtain care from a VA facility because of geographical inaccessibility or because of the inability of the VA facility to provide the type of care required. VA, however, uses the fee program primarily as a means of expanding its ability to provide routine dental services to inpatients with nonservice-connected dental conditions. VA clinics give inpatients with such conditions priority over outpatients with service-connected dental conditions. The outpatients are referred to the fee program because the VA clinic cannot handle the additional workload. By following the priorities for care established by Public Law 96-22, VA would insure that outpatients with service-connected dental conditions are able to obtain care from a VA clinic, and that inpatients with an immediate need for treatment would obtain the needed care without regard to their service connection.

Also, referrals to the fee program would be reduced if VA strengthened its procedures for authorizing fee-basis and outpatient care. Outpatient dental care should be provided for non-service-connected dental conditions only if treatment was begun while the veteran was hospitalized and only if it is reasonably necessary to complete the treatment. By eliminating the provision of outpatient dental care to ineligible veterans, VA could increase its ability to treat outpatients with service-connected dental conditions, and thus reduce fee-basis referrals.

Although fee-basis dental care is to be authorized only when the veteran is unable to obtain care from a VA facility because of geographical inaccessibility or the inability of the clinic to provide the type of care needed, VA facilities have not complied with these limitations when authorizing fee-basis care. VA clinics should not (1) give veterans a choice of obtaining care from a

private dentist without regard to the availability of care at a VA facility, (2) authorize fee-basis care when a nearby VA clinic could provide the care, (3) authorize fee-basis care when the workload permits care to be provided by the VA clinic, or (4) adjust their definition of geographical inaccessibility to limit the number of service-connected outpatients treated in the VA clinic.

We reported in 1973 that VA could reduce the number of fee-program referrals by increasing the productivity of VA dental clinics. VA has made little progress in implementing the recommendations made in that report. VA also needs more definitive and accurate data on the operations of its dental clinics to enable the agency to identify needed improvements in dental clinic operations.

RECOMMENDATIONS

We recommend that the Administrator of Veterans Affairs:

- Direct the Medical Administrative Service at each VAMC to determine whether a veteran has a service-connected dental condition at the time of admission.
- Direct VA dental clinics to place a higher priority on the provision of dental care to outpatients with service-connected dental conditions than on the provision of routine dental care to inpatients with no service-connected dental condition.
- Direct VA clinics to provide dental examinations to inpatients not service connected for dental conditions only if the clinic's staff and facilities are not needed for the provision of care to veterans service connected for dental conditions unless (1) the admitting and/or attending physician determines that there are compelling medical reasons for giving the veteran an examination or (2) the veteran has a dental emergency.
- Enforce established procedures for authorizing fee-basis care, including requirements that (1) fee-basis care be authorized only if the clinic cannot schedule treatment within 60 days, considering the total clinic resources, (2) the availability of care at VA facilities near the veteran's home be determined before fee-basis care is authorized, and (3) fee-basis care not be a prerogative of the veteran.
- Establish a uniform 40-mile definition of geographical inaccessibility and require specific justification from VA clinics for any deviation from the rule.

- Strengthen procedures for authorizing outpatient dental care for nonservice-connected dental conditions to insure that such care is authorized only if treatment was begun while the veteran was an inpatient and if completion of the treatment is necessary in relation to a medical problem for which it was prescribed.
- Implement recommendations made in our 1973 report to (1) expand the use of two-chair dentistry, (2) expand the use of dental hygienists and assistants, (3) expand the use of trained medical administrative personnel to perform fee-program administrative duties, and (4) reduce the number of broken appointments.
- Implement the recommendation made in our March 1980 report that VA expand the use of EFDAs.
- Establish workload indicators for dental personnel.
- Adapt the ADA and DOD dental procedures reporting systems for use by VA dental clinics.
- Take steps to improve the reliability of data reported under the AMIS program.

AGENCY COMMENTS

VA was given the opportunity to provide comments on a draft of this report. It had not done so when the 30-day statutory comment period expired and advised us that it would withhold comment until issuance of the final report.

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