~~21755~~

118454

SUPPLEMENT TO A REPORT BY THE

Comptroller General

OF THE UNITED STATES

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

This report supplement contains GAO's analysis of and response to the Veterans Administration's comments on the issued report.

GAO/HRD-81-82S
MAY 24, 1982

022151

Request for copies of GAO reports should be sent to:

U.S. General Accounting Office
Document Handling and Information
Services Facility
P.O. Box 6015
Gaithersburg, Md. 20760

Telephone (202) 275-6241

The first five copies of individual reports are free of charge. Additional copies of bound audit reports are $3.25 each. Additional copies of unbound report (i.e., letter reports) and most other publications are $1.00 each. There will be a 25% discount on all orders for 100 or more copies mailed to a single address. Sales orders must be prepaid on a cash, check, or money order basis. Check should be made out to the "Superintendent of Documents".

REPORT SUPPLEMENT:

GAO COMMENTS ON THE VETERANS ADMINISTRATION'S REPLY TO THE JUNE 19, 1981, GAO REPORT ENTITLED "PROVIDING VETERANS WITH SERVICE-CONNECTED DENTAL PROBLEMS HIGHER PRIORITY AT VA CLINICS COULD REDUCE FEE-PROGRAM COSTS"

This supplement is an integral part of our report entitled "Providing Veterans With Service-Connected Dental Problems Higher Priority at VA Clinics Could Reduce Fee-Program Costs" (GAO/HRD-81-82, June 19, 1981). It contains the Veterans Administration's (VA's) comments on the report (see app. I) and our analysis of those comments. This supplement is in response to a request from the Chairman and the Ranking Minority Member of the Senate Committee on Veterans' Affairs.

In accordance with our policy, we asked the Administrator of Veterans Affairs on April 20, 1981, to furnish comments on a draft of the report within 30 days. The Administrator did not provide comments within the 30-day statutory comment period and advised us that VA would withhold comment until issuance of the final report. On November 10, 1981, the Administrator provided VA's comments on our final report to several congressional committees.

VA generally agreed with all but one of our recommendations, but disagreed with some of the information in our report and indicated that we did not fully understand the relevance of dental services to total health care. The Chairman and the Ranking Minority Member requested, in December 1981, that we respond to the comments. They were concerned about various VA statements relating to the need to provide both dental examinations and dental care to veterans who are hospitalized for nondental conditions. They were also concerned because VA gave no indication that it would implement or further consider our recommendations concerning the extent to which dental examinations and treatment are provided to nonservice-connected inpatients.

The Chairman and the Ranking Minority Member asked that, in analyzing VA's comments, we compare the extent of dental care currently provided to inpatients by VA with dental care provided to inpatients in military facilities and other non-VA hospitals. To do this, we visited the following hospitals in the Washington, D.C., metropolitan area:

Military hospitals

National Naval Medical Center, Bethesda, MD.
Malcolm Grow Air Force Medical Center, Andrews Air Force Base, MD.
Walter Reed Army Medical Center, Washington, D.C.

University hospitals

Georgetown University Hospital, Washington, D.C.
George Washington University Hospital, Washington, D.C.

Community hospitals (all in Washington, D.C.)

District of Columbia General Hospital, affiliated with Howard and Georgetown University medical schools
Washington Hospital Center, not affiliated with a medical school
Greater Southeast Community Hospital, affiliated with Howard University medical school

We also compared the extent to which dental care was provided under the Medicare and Medicaid programs to that provided in VA facilities.

We interviewed VA Office of Dentistry officials, reviewed directives sent to the medical centers and dental clinics, reviewed statistical data from VA's automated management information system, and contacted each dental clinic included in our earlier review to determine what actions had been taken to implement our report recommendations.

We believe our analysis of VA's comments and the supplementary data on the extent of dental care provided in non-VA hospitals provides further evidence of the validity and practicality of our prior recommendations and the need for VA to implement them. We are sending copies of this supplement to interested Members of Congress, cognizant committee and subcommittee chairmen, and the Director of the Office of Management and Budget, all of whom received copies of our June 1981 report.

Contents

ABBREVIATIONS

AMIS	Automated Management Information System
EFDA	expanded function dental auxiliary
VA	Veterans Administration

CHAPTER 1

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.)

GAO/HRD-81-82
June 19, 1981

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.

CHAPTER 2

GAO'S ANALYSIS OF AND RESPONSE TO VA'S COMMENTS

This chapter presents our analysis of and response to VA's comments. It also presents data on the extent to which dental care is provided to inpatients at military and other non-VA hospitals. We believe our analysis of VA's comments, together with the supplementary data on the extent of dental care in non-VA hospitals, provides further evidence of the validity and practicality of our prior recommendations and the need for VA to implement them.

VA'S OVERALL CRITICISM OF OUR REPORT

VA generally agreed with all but one of the recommendations in our report. The Administrator said, however, that VA did not agree with statements in our report that (1) its previous effort to reduce fee program referrals had been ineffective and (2) it had provided no formal guidance to its dental clinics on the implementation of Public Law 96-22.

VA said that some of the criticisms and recommendations in our report are valid for certain medical center dental services, but should not be applied to the entire system. According to VA, it has not neglected its responsibility but rather has made considerable progress in reducing fee program referrals.

VA disagreed with our statements that its previous effort to reduce fee program referrals was not effective and that "* * * there was little increase in services provided by VA clinics to outpatients with service-connected conditions between fiscal years 1977 and 1979." VA claimed that there was a 27-percent increase in service-connected outpatients treated in VA facilities.

VA said that between fiscal years 1976 and 1980 there was a 97-percent increase (from 40,832 to 80,316 patients) in the number of service-connected outpatients treated by VA dentists. According to VA, this increase resulted from a Central Office policy that VA staff treat as many service-connected outpatients as possible. VA said that, during the 5-year period, the number of outpatients referred to private dentists decreased from 123,419 to 71,550. VA added that, in fiscal year 1980, 8,756 more service-connected outpatients were treated by VA staff than were referred to private dentists.

Although VA maintains that the reduction in fee program referrals resulted from Central Office policy, it appears to have resulted more from an increase in dental clinic staffing than from a redirection of program resources away from nonservice-connected inpatients and outpatients. Between 1976 and 1980 VA added

67 dentists to its staff. During that time clinics increased the numbers of

--outpatients treated for nonservice-connected dental conditions (up more than 16,000),

--inpatients examined (up almost 43,000), and

--inpatients treated (up almost 25,000).

Furthermore, dental care provided by VA dentists to service-connected outpatients increased only moderately in fiscal year 1981. Referrals to the fee program dropped from 109,801 in fiscal year 1980 to 91,717 in 1981. However, according to VA records, the decrease in fee program referrals resulted primarily from a reduction in the number of veterans who sought outpatient care for service-connected dental conditions. Only about 3,800 of the 18,100 reduction in fee program referrals resulted from increases in services provided by VA clinics to outpatients with service-connected conditions.

VA also disagreed with a statement on page 17 of our report that "As of October 1, 1980, * * * VA had provided no formal guidance to its dental clinics on implementation of the act." VA said that, between January and September 1979, the Office of Dentistry conducted 14 medical district meetings, which were attended by 97 dental service chiefs. According to VA, the importance of giving priority to the service-connected outpatient program was stressed by program participants. According to VA, it published specific instructions on implementing the provisions of Public Law 96-22 concerning dental care for former prisoners of war and certain 100-percent service-connected veterans. It also said that its dentistry manual had been revised in June 1980 to list the priorities for care and for using VA resources to comply with the language and intent of Public Law 96-22.

We agree that VA has provided formal guidance on implementation of the act with respect to the new classes of veterans eligible for service-connected dental care. The discussion on pages 17 and 18 of our report related to guidance provided with respect to treatment priorities. Although the dentistry manual establishes "priorities for care" for inpatients, it does not provide guidance on the relationship between inpatient and outpatient priorities. In this regard, we question whether stressing the importance of giving priority to the service-connected outpatient program at medical district meetings was adequate guidance because the Assistant Chief Medical Director later advised his dental service chiefs in an October 17, 1979, conference call that

"We have a certain responsibility to the hospitalized veteran and on a priority basis they should be given care. * * * Again it is your perogative [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."

It was not until February 1982 that VA provided formal guidance to its medical centers on the relationship between inpatient and outpatient priorities for care. VA's Deputy Chief Medical Director stated in a February 19, 1982, circular that the following patients have equal priorities for dental care:

--Inpatients with pain, trauma, or acute infection.

--Inpatients having oral conditions with serious local or systemic implications (e.g., oral cancer, oral lesions of lupus erythematosis, pemphiqus vulgaris, and erythema multiforme).

--Inpatients who require some measure of dental treatment as an integral component of the medical care for which they have been hospitalized (e.g., patients receiving head and neck radiotherapy, diabetics, dialysis patients, patients receiving implants of any kind, and those on immuno-suppressants).

--Long-term care patients.

--Outpatients with service-connected dental treatment entitlements.

--Outpatients with nonservice-connected dental conditions who have continuing essential definitive dental needs related to the medical condition for which they were hospitalized and for whom treatment was begun during that prior period of hospitalization.

The circular also stated that nonemergency care for inpatients who have significant dental treatment needs should be provided only when all of the above primary mission requirements have been satisfied.

VA'S PROVISION OF ROUTINE DENTAL CARE TO NONSERVICE-CONNECTED INPATIENTS

VA stated that it has implemented our recommendation to direct its dental clinics to place a higher priority on dental care to outpatients with service-connected dental conditions than on routine dental care to inpatients with no such condition. However, VA questioned whether we fully understand the relevance of dental service to total health care and the long-range consequences of dental

neglect on medical conditions. VA said that it had issued a directive that, in "given situations where similar treatment needs and limited resources prevail, beneficiaries with SC [service-connected] conditions will be given priority over nonservice-connected beneficiaries." According to VA, additional emphasis, monitoring, and guidance will continue to ensure that veterans with service-connected dental entitlement are given appropriate priority for timely care, consistent with geographic accessibility and available resources.

The Administrator said that he intends to assure that VA directives are enforced so that the maximum number of veterans with service-connected entitlement are treated by VA staff dentists, but that the Dental Service's role of providing treatment integral to patients' medical care must also be preserved.

VA stated that, because minor dental disease is so prevalent, it does not intend to provide "routine" dental care to all hospitalized veterans, nor does it have sufficient resources to do so. According to VA, many patients require dental treatment because of pain, trauma, acute infection, or as part of their medical care. VA said that dental treatment of patients on this basis does not imply "complete" or "routine" dental care and that VA directives clearly state that the professionally determined type and extent of care is to be based on the patient's hospitalization requirements.

According to VA, it has provided some measure of dental treatment to 15 percent or less of the veterans hospitalized during the past few years. VA added that the care provided to hospitalized veterans has generally been limited.

We recognized in our report (pages 3, 4, and 12) that some patients require dental care as an integral part of their medical treatment and that others have immediate needs for care because of dental emergencies.

However, as we stated on pages 14 to 16, much of the care provided by VA clinics was, according to the clinics' dentists, unrelated to the medical conditions for which the patient was receiving care. In other cases, VA provided dental care although the clinic determined that patients could have waited over 6 months for the care with no adverse effect on their health.

Although VA maintains that the treatment provided to inpatients was generally limited, the Assistant Chief Medical Director for Dentistry was unable to provide support for the statement. Because the clinics do not differentiate between inpatients and outpatients in reporting specific dental procedures performed, the type and extent of care provided to inpatients could not be determined. Furthermore, according to VA records, almost 17 percent of VA's inpatients received treatment in fiscal years 1980 and 1981, not the less than 15 percent claimed by VA.

To compare VA's 17-percent inpatient treatment rate with the inpatient treatment rate at non-VA hospitals, we discussed inpatient dental treatment with officials from three military and five private-sector hospitals in the Washington, D.C., area. Although none of the non-VA hospitals could provide statistics on the percentage of inpatients provided dental treatment, officials from all of the hospitals indicated that dental treatment was very limited and was provided only when requested by physicians. They said that most of the care provided was for dental emergencies. In addition, four hospitals had established protocols for dental consultation for certain patients, such as those with head or neck cancer or diabetes and those undergoing chemotherapy or dialysis.

If the priorities for care established in the February 19, 1982, circular (see p. 7) are effectively implemented, VA should be able to significantly reduce the inpatient treatment rate and thus increase the number of outpatients with service-connected dental conditions treated in VA clinics.

VA'S INPATIENT ORAL EXAMINATION PROGRAM

VA did not agree with our recommendation that it limit its inpatient oral examination program. It stated that the oral screening program is essential and that dentists are best suited for diagnosing the hundreds of diseases that occur in the mouth. VA believes that dental examinations fulfill the essential role of identifying significant problems and evaluating their seriousness and relationship to the medical reasons for hospitalization. VA said that the examination program is its mechanism for determining the greatest needs and setting priorities for both inpatients and outpatients.

VA stated that the inpatient screening process, in which the mouth is rapidly but thoroughly evaluated, revealed over 1,000 early, previously undiagnosed cancers during fiscal year 1980.

As stated in our report, we believe that VA should provide dental examinations only when a physician has determined that there is (1) a compelling medical need for dental care or (2) a dental emergency. VA's goal of providing a dental examination to 75 percent of all inpatients is, in our opinion, inappropriate because

- --VA generally provided time-consuming full examinations, not rapid oral screenings as it claimed;
- --VA directed its dental clinics to rely on the physicians who examine outpatients with service-connected medical problems to determine the need for adjunct dental care and could, likewise, rely on examining physicians to identify inpatients' dental needs;

--non-VA hospitals we contacted provide dental examinations only on a consultation basis and view VA's examination program as a costly "luxury";

--Medicare and Medicaid generally will not pay for dental examinations;

--physicians, nurses, or physicians' assistants, rather than dentists, could perform an oral screening for undetected tumors during the admission physical; and

--Public Law 96-22 directs VA not to provide such routine care unless staff and facilities are available after all service-connected outpatients have been treated.

Although VA maintains that its oral examination program is a screening process in which the mouth is rapidly but thoroughly evaluated at the bedside, the clinics we visited were generally conducting full examinations and the patients were brought to the dental clinic. VA was unable to provide data on the number of oral screenings versus full examinations because such data were not reported under its Automated Management Information System (AMIS). However, in fiscal year 1980, VA provided dental X-rays, which are not part of a rapid oral screening, to almost 400,000 patients, the vast majority of whom were inpatients.

While VA argues that a dentist is best suited to determine whether an inpatient has a compelling medical need for dental care, it has determined that physicians should make determinations for service-connected outpatients. In its February 19, 1982, circular, VA states that adjunct care for veterans will be restricted to those having a dental condition professionally determined to be aggravating a disability from an associated service-connected medical condition or disability. The circular states that the responsible outpatient physicians must request dental care and specify the basis of medical concern. If physicians can determine the need for dental care for service-connected outpatients, physicians should be able to make that same determination for non-service-connected inpatients.

Officials from eight non-VA hospitals in the Washington, D.C., area generally stated that VA's dental examination program was a costly "luxury" and that physicians were capable of determining their patients' needs for dental examinations. Each of the hospitals provided dental examinations only on a consultation basis. According to the hospital officials, admitting or attending physicians would refer patients for examinations only if they believed there was a medical necessity to do so.

Medical directors at three non-Federal hospitals we contacted told us that they believed VA's goal of examining 75 percent of its inpatients was unreasonable. For example, the medical director at the Georgetown University Hospital said that, in his opinion, VA's oral examination program was a "medical luxury" and that VA's resources could be better used to deal with other more important health care needs of veterans. Similarly, the medical director and the chief of oral surgery at the Washington Hospital Center said that, with the limited resources of the VA health care system, dental examinations and treatment should be given only to inpatients with compelling medical reasons for needing dental care. The medical director of the George Washington University Hospital said that, with infinite resources, it would be "nice" to provide a dental examination to every inpatient but that, with limited resources, dental examinations would be low on his list of priorities.

VA could use the examining physician, a nurse, or a physicians' assistant to screen patients for oral cancer. Officials from the non-VA hospitals generally believed that such personnel could perform the screening examinations. For example, the medical director at Georgetown University Hospital said that the attending physician performing the entrance examination at that facility examines the teeth and gums, noting the state of dental hygiene. Similarly, the vice president for professional affairs at the Greater Southeast Community Hospital said that, in his opinion, it was not necessary for VA to require a dentist to examine the mouth for cancer. He said that the examining physician, a nurse, or a physicians' assistant could examine the mouth.

On the other hand, the medical director at George Washington University Hospital said that, if VA discontinues its policy of providing routine inpatient oral examinations, VA may not be able to rely on physicians to detect oral cancers. He said that most medical schools do not spend much time on the mouth and that most physicians do not perform proper oral examinations.

An examination of the mouth and throat is a part of the standard physical examination to be given to every patient admitted to a VA hospital. Accordingly, we believe VA could provide training to VA physicians and physicians' assistants on the detection of oral cancers and rely on their oral examinations as the basis for further consultation by dentists.

Although the type and amount of dental care available to patients under Medicare and Medicaid vary, the programs will not generally pay for dental examinations. Medicare will pay only for dental work provided in trauma cases, such as accidents. It will not pay for fillings, general examinations, or other routine care. The type of dental services available under Medicaid depends upon the State in which the patient resides. However, Medicaid generally will not pay for examinations or other routine care.

Public Law 96-22 directs VA to provide dental care to inpatients with nonservice-connected dental conditions only if a compelling need exists or staff and facilities are available after treatment has been provided to outpatients with service-connected dental conditions. However, VA inpatient dental examinations are not based on medical need. As stated on page 12 of our report, VA dental clinics generally scheduled examinations of hospitalized veterans without regard to the patients' service-connections or medical conditions. Although such procedures may result in examination and treatment of some patients having a compelling need for dental services, they do not ensure that all patients with compelling dental needs are provided services. We believe that the treatment priorities established by VA's February 19, 1982, circular should be applied to the examination program, and that the patients to be examined by dentists should be identified by the attending or admitting physician.

DETERMINATION OF WHETHER VETERANS HAVE SERVICE-CONNECTED DENTAL CONDITIONS

The Administrator of Veterans Affairs agreed with our recommendation that he direct VA medical centers to determine at the time of admission whether a veteran has a service-connected condition and said that it had been implemented. According to the Administrator, a newly developed Dental Index Card is completed for each patient admitted to a VA hospital, nursing home, or domiciliary, and medical administrative personnel record the patient's service-connected condition--medical, dental, or neither--on the card.

Use of the new Dental Index Card should enable VA to effectively monitor the dental services provided to nonservice-connected veterans. However, the card will be of limited benefit to VA unless it effectively implements our recommendations with respect to treatment and examination priorities for nonservice-connected care.

NEED TO ENFORCE ELIGIBILITY REQUIREMENTS FOR TREATMENT OF OUTPATIENTS WITH NONSERVICE-CONNECTED DENTAL CONDITIONS

VA said that considerable effort was underway to strengthen its procedures for authorizing outpatient dental care for nonservice-connected conditions. VA said that, although statistics for fiscal years 1979 and 1980 indicate that progress has been made in reducing the problem, the importance of our recommendation will be stressed to all dental supervisors, and Central Office dental staff will routinely monitor data to ensure effective implementation.

In its February 1982 circular, VA directed its medical centers to establish a monitoring system to assure that approval for outpatient dental care of veterans with nonservice-connected dental

conditions is given only if treatment began while the veteran was an inpatient, and only if the continuation of the treatment is medically necessary.

VA's new Dental Index Card requires clinics to document the reasons for providing dental care to inpatients for nonservice-connected dental conditions and the reasons why completion of treatment as an outpatient is medically necessary. According to VA, the documentation will permit a rapid retrospective audit of the type of inpatients receiving dental care and those authorized continuation on an outpatient basis.

According to the Office of Dentistry, these data should be incorporated into the AMIS reporting system by October 1, 1982. If properly implemented, the VA actions should strengthen authorization procedures.

VA'S ENFORCEMENT OF ESTABLISHED PROCEDURES FOR AUTHORIZING FEE-BASIS CARE

VA agreed with our recommendation and said that it had taken several actions to further enforce fee-basis authorization procedures. According to VA, more veterans are currently treated by VA staff than on a fee basis, and this trend is expected to continue unless legislative changes significantly increase current workloads. In addition, VA said that its Central Office staff monitors fee-basis policy implementation very closely.

In addition to the actions cited in the Administrator's comments, VA's February 1982 circular directed VA clinics to strengthen their procedures for authorizing fee-basis care. The circular required that facilities which receive applications for fee-basis dental care coordinate with all VA dental clinics near the veteran's home to determine whether they can provide the needed care before authorizing fee-basis care.

We contacted the VA clinics cited in our June 1981 report to determine whether they had strengthened their procedures for authorizing fee-basis care. Dental Service chiefs from the Chicago (Westside), Sacramento, and Spokane clinics told us that they are now more strictly enforcing the legislative restrictions on the authorization of fee-basis care. For example, the chief of the Sacramento clinic said that the practice of giving certain outpatients a choice of obtaining care at the VA clinic or from their own dentist was altered after we visited the clinic in 1979. He said that only cases which cannot be handled by the clinic because the backlog is too great or because a specialist is needed will be sent out on a fee basis.

The clinics at San Francisco and Seattle still send most of their outpatient cases to fee-basis dentists. At Seattle, 84.7 percent of the clinic's cases were completed on a fee basis during fiscal year 1981, while at San Francisco, 92.3 percent of the cases were completed by fee dentists.

While the actions taken by VA appear to have strengthened procedures for authorizing fee-basis care at most clinics we visited, VA should closely monitor fee-basis authorizations by the Seattle and San Francisco clinics to determine why such a high percentage of patients continue to be referred to the fee program.

ESTABLISHMENT OF A UNIFORM 40-MILE DEFINITION OF GEOGRAPHICAL INACCESSIBILITY

VA concurred with the spirit of our recommendation that it establish a uniform 40-mile definition of geographical inaccessibility but said that requiring a rigid 40-mile radius nationwide was neither feasible nor desirable. VA said that it had established a catchment radius policy at all VA health care facilities and will act to establish a uniform definition of geographical inaccessibility for all dental and medical outpatient clinics in the same VA facility and ensure that it is uniformly applied. VA said that dental services having staffing or facility constraints or those in highly populated metropolitan areas may be unable to absorb the total service-connected workload within their city limits, much less extend their outreach to 40 miles. Conversely, the workload radius could well extend beyond 40 miles in less populated areas.

We recommended that VA establish a uniform 40-mile definition of geographical inaccessibility because some VA clinics were using the definition to limit their workload of service-connected outpatients. However, rather than establish a uniform definition to prevent abuse, VA created a greater potential for abuse by directing all of its dental clinics to periodically adjust their definition of geographical inaccessibility to control dental outpatient workload. We do not believe that the definition should be used as a mechanism for controlling outpatient workload. Rather, veterans are considered geographically inaccessible if they reside at such distances from VA facilities that it is more economical to provide fee-basis care. A VA facility may be geographically inaccessible to some veterans living less than 40 miles from the VA facility because of unusual geographic or transportation barriers. However, we believe that decisions to alter a uniform 40-mile definition of geographical inaccessibility for such reasons should be reviewed by VA's Central Office to ensure uniformity between hospitals so that beneficiaries are not treated inequitably and to ensure compliance with the intent of the law. If VA follows through on its stated intention to have the same definition of geographical inaccessibility for all medical and dental outpatient clinics at

the same VA facility, the definition of geographical inaccessibility for all of its outpatient medical clinics will be governed by the dental clinic's workload.

VA ACTIONS NEEDED TO INCREASE DENTAL CLINIC PRODUCTIVITY

VA agreed with our recommendation that it implement (1) our 1973 recommendations to expand the use of two-chair dentistry, dental hygienists and assistants, and medical administrative personnel and reduce the number of broken appointments and (2) our 1980 recommendation to expand the use of expanded function dental auxiliaries (EFDAs). The Administrator said that he is committed to increasing the productivity and efficiency of VA dental clinics and that his office intends to monitor the implementation of the recommendations.

Two-chair dentistry

VA said that maximum use of two-chair dentistry will become a standard at VA dental clinics. However, the Administrator added that the lack of space and construction funds limits further expansion or alteration of existing facilities.

While we recognize that some clinics could not use two-chair dentistry because of facility limitations, our June 1981 report showed that VA was generally not using two-chair dentistry even at clinics that had adequate facilities. VA's comments do not address what actions will be taken to increase the use of two-chair dentistry at those facilities. Also, a January 1982 VA internal status report on implementation of our recommendations stated that no definitive progress had been made in expanding the use of two-chair dentistry.

Of the five clinics identified in our June 1981 report (pages 39 to 42) as having opportunities to practice two-chair dentistry within existing facilities, three told us that they still do not practice, or seldom practice, two-chair dentistry. However, Seattle clinic officials told us that they now practice two-chair dentistry whenever the dental hygiene students are not present. Spokane clinic officials said that their clinic also practices two-chair dentistry but that staffing and equipment constraints limit the extent to which it is used.

We continue to believe VA should identify opportunities to expand the use of two-chair dentistry at its clinics, similar to those identified in our June 1981 report, and direct the facilities to use two-chair dentistry to increase dental clinic productivity.

Dental hygienists, assistants, EFDAs, and administrative personnel

According to VA, its Dental Service has historically recognized the need for more dental hygienists and assistants as well as medical administrative support personnel. VA said that the Chief Medical Director will continue implementing our recommendations, consistent with priorities and resources. VA also agreed that greater use should be made of EFDAs but said that certain conditions should exist before VA dentists can effectively and efficiently employ them. According to VA, those conditions in VA clinics relate to proper staffing ratios, adequate facilities, and varying needs of veteran beneficiaries. VA said that, contingent on fulfillment of those conditions, VA fully intends to proceed with a more aggressive program.

We view VA's response as inadequate. At the same time VA argues that it is constrained by "priorities and resources" in expanding the use of dental hygienists, assistants, EFDAs, and administrative personnel, it has been expanding the number of dentists on its staff. In fiscal year 1981, VA added nine dentists to its staff, but added only seven hygienists and two EFDAs. There was a decrease of almost 50 administrative personnel and 17 dental assistants.

This trend continued in the first quarter of fiscal year 1982. VA added 11 dentists to its staff, but added only 3 hygienists and 8 dental assistants. The number of EFDAs decreased by two. Also, VA dentists were still handling most fee program administrative duties. Certain dentists at the three clinics of jurisdiction discussed in our June 1981 report were still devoting more than half of their time to administrative work associated with the fee program when we contacted them in February 1982.

The resources and facilities VA used to expand the number of dentists could have been used to expand the number of support personnel. In our opinion, VA should freeze employment of dentists at current levels and replace dentists who resign or retire with hygienists, dental assistants, EFDAs, or medical administrative personnel until the ratios of such support personnel to dentists reach an appropriate level. In this way, VA could be hiring hygienists, assistants, EFDAs, and administrative personnel and making better use of its dentists by expanding use of two-chair dentistry and decreasing their administrative duties.

Broken appointments

VA agreed with our 1973 recommendation that it adopt a reminder system and said that such a system will be established to reduce broken appointments. According to VA, some of the uncontrollable factors which contribute to broken appointments include: illnesses

which affect veterans' ability to keep appointments, lack of assistance or transportation, lack of a telephone reminder or followup contact, transient veterans, and the no-cost nature of treatment services.

We believe the actions taken by VA should help reduce the number of broken appointments. As of February 1982, 9 of the 11 clinics in our review had established a reminder system. VA's February 19, 1982, circular directed all VA dental clinics not already having a reminder system to establish one. VA's Office of Dentistry has also asked that the area of broken appointments be included in future Systematic External Review Program reviews to ensure that facilities that continue to have this problem will be identified.

ESTABLISHMENT OF WORKLOAD INDICATORS

VA agreed with our recommendations that it (1) establish workload indicators for dental personnel and (2) adapt American Dental Association and Department of Defense dental procedures reporting systems for use by VA dental clinics. The Administrator said that a new Dental Data System, which uses workload standards, is being implemented throughout VA. VA said that the system will provide more extensive dental service information than is now available, which will enable each Dental Service, each Medical Center, and the VA Central Office to better supervise dental program activities. VA stated that the new reporting system will be used systemwide by mid-1982 and that all Dental Services will thus be evaluated at several management levels.

Although all clinics had begun using the new reporting system by April 1, 1982, the information will not become a part of VA's Automated Management Information System until October 1982. In addition, index values have not been determined by VA for the various services the clinics provide. Until VA completes this work, it will not be able to evaluate each clinic's and/or dentist's productivity.

IMPROVING THE RELIABILITY OF DATA REPORTED UNDER THE AMIS PROGRAM

VA agreed with our recommendation and said that several steps have been or will be taken to correct dental data deficiencies. According to VA, actions taken include accuracy checks, monthly reviews, and development of the new Dental Data System. In addition to the steps outlined in VA's comments, audits were established for 22 major elements of the Dental AMIS report.

The steps taken by VA should improve the reliability of AMIS data.

APPENDIX I

Office of the
Administrator
of Veterans Affairs

Veterans
Administration

NOVEMBER 1 0 1981

Honorable William V. Roth, Jr.
Chairman, Committee on Governmental
Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Section 236 of the Legislative Reorganization Act of 1970 requires that I submit comments on the Comptroller General's June 19, 1981, report, "Providing Veterans with Service-Connected Dental Problems Higher Priority at VA Clinics Could Reduce Fee-Program Costs," HRD-81-82. This report states that while the Veterans Administration (VA) was giving routine care to veterans with no service-connected (SC) dental problems, most veterans with SC dental conditions were referred to private dentists. The General Accounting Office (GAO) found that in Fiscal Year (FY) 1979, VA paid to send 90,000 of the 146,000 veterans seeking outpatient care for SC dental problems to private dentists. The GAO believes, therefore, that VA has not placed enough emphasis on treating SC dental conditions in VA Clinics, as required by Public Law 96-22—Veterans Health Care Amendments of 1979.

I am concerned that GAO may not fully understand the relevance of dental services to total health care nor the long-range consequences of dental neglect on "medical" conditions. The report also implies VA has made little or no effort to improve the productivity of its Dental Services or to implement the provisions of Public Law 96-22.

Some of the criticisms and recommendations are valid for certain medical center dental services, but they should not, in my judgment, be applied to the entire system. We have not neglected our responsibilities and considerable progress has been made. The data in the enclosed table illustrate the increase in outpatients for whom VA staff completed courses of treatment. In 1976, VA staff completed treatment for 40,832 patients; this workload increased to 80,316 in 1980. This 97 percent increase resulted from a Central Office policy that dental services staff treat as many SC outpatients as possible. For example, in the same 5-year period, the number of outpatients referred to private dentists decreased from 123,419 to 71,550. In FY 1980, 8,756 more SC outpatients were treated by VA staff than were referred to private dentists.

On the basis of these data, we would have to take issue with several statements in the report such as, "Previous VA Effort to Reduce Fee Program Referrals Not Effective," page 8, and ". . . there was little increase in services provided by VA clinics to outpatients with SC conditions between fiscal years 1977 and 1979," page 7. In fact, during this period there was a 27 percent increase in SC outpatients treated in VA facilities.

APPENDIX I

On page 17, under the title, "Public Law 96-22 Not Effectively Implemented," the report states, "As of October 1, 1980. . . VA had provided no formal guidance to its dental clinics on implementation of the Act." From January through September 1979, the Office of Dentistry conducted 14 Medical District meetings which were attended by 97 Dental Service Chiefs. Participants in these meetings stressed the importance of giving priority to the SC Outpatient Program.

A September 21, 1979, Interim Issue gave instructions for providing outpatient dental care for former prisoners of war and certain 100 percent SC disabled veterans. A November 18, 1979, Department of Medicine and Surgery Circular described the listing of former prisoners of war who are newly eligible veterans under Public Law 96-22 and the procedures for determining their eligibility. Revised VA Manual M-4, published in June 1980, lists the priorities for care and for using VA resources to comply with the language and intent of Public Law 96-22.

There are a number of report recommendations which GAO believes would improve the operation and productivity of VA dental clinics. These recommendations are addressed as they appear in the report.

GAO recommends that I:

--Direct the Medical Administration Service at each VAMC to determine whether a veteran has a SC dental condition at the time of admission.

This recommendation has been implemented. A newly developed Dental Index Card is completed for each patient admitted to a hospital, nursing home care unit, or domiciliary, and Medical Administration Service personnel record the patient's SC condition--medical, dental or neither--on the card.

--Direct VA dental clinics to place a higher priority on the provision of dental care to outpatients with SC dental conditions than on the provision of routine dental care to inpatients with no SC dental condition.

This recommendation has been implemented. A directive was issued which states: "In given situations where similar treatment needs and limited resources prevail, beneficiaries with SC conditions will be given priority over nonservice-connected beneficiaries." Additional emphasis, monitoring, and guidance will continue to ensure that veterans with SC dental entitlement are given appropriate priority for timely care, consistent with geographic accessibility and available resources. In this context, the Dental Service in each medical center functions as an outpatient clinic, as well as a professional service within the hospital. Veterans admitted to the hospital, whether SC or not, are eligible for dental treatment as they are for other hospital services.

APPENDIX I

Because minor dental disease is so prevalent, there is, however, neither the intent nor sufficient resources to provide "routine" dental care to all hospitalized veterans. In the last several years, the VA has provided some measure of dental treatment to 15 percent or less of veterans who were hospitalized. For this inpatient population, the care has generally been limited in degree.

There are many patients who require dental treatment because of pain, trauma, acute infection, and/or as part of their medical care. Dental treatment of patients on this basis does not imply "complete" or "routine" dental care. VA directives clearly state that the professionally determined type and extent of care is to be based on the patient's hospitalization requirements. My intent is to ensure that the directives are enforced so the maximum number of veterans with SC dental entitlement are treated by VA staff dentists; however, the Dental Service role of providing treatment integral to the care of patients must also be preserved.

—Direct VA clinics to provide dental examinations to inpatients not SC for dental conditions only if the clinics staff and facilities are not needed for the provision of care to veterans SC 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.

Experience has convinced Department of Medicine and Surgery staff that the oral examination program is essential, and that dentists are best suited for diagnosing the hundreds of diseases that manifest in the mouth. The screening process, in which the mouth is rapidly but thoroughly evaluated, revealed over 1,000 early, previously undiagnosed cancers during Fiscal Year 1980.

The dental examination fulfills the essential role of identifying significant problems and/or evaluating their seriousness and relationship to the medical reasons for hospitalization. It is not our intent, nor do we have the resources, to treat all inpatients; consequently, we must have a mechanism for determining the greatest needs and setting priorities for both inpatient and outpatient care. For these reasons, I cannot concur in this recomendation as it is stated.

--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.

I agree. Several actions have already been taken, or are underway, to further enforce fee-basis authorization procedures. The enclosed statistics show that more veterans are currently treated by VA staff than on a fee basis, and this trend is expected to continue unless legislative changes significantly increase current workloads. In addition, the VA Central Office staff monitors fee-basis policy implementation very closely.

--Establish a uniform 40-mile definition of geographical inaccessibility and require specific justification from VA clinics for any deviation from the rule.

The VA has established a catchment radius policy at all VA health care facilities. Based on the discussion on page 26 of the report, we agree there is a need for a uniform definition of geographical inaccessibility for all clinics located in the same facility; however, requiring a rigid 40-mile radius nationwide is neither feasible nor desirable. Dental Services having staffing or facility constraints, or those found in high-density, metropolitan areas, may be unable to absorb the total SC workload within their own city limits, much less be able to extend their outreach to 40 miles. Conversely, in less populated areas, the working radius could well be extended beyond 40 miles. I concur in the spirit of this recommendation and given the mentioned constraints will take action to establish a uniform definition of geographical inaccessibility for individual facilities and ensure its uniform application.

--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.

Considerable effort to correct this problem is already underway, and statistics for FY 1979 and FY 1980 indicate that progress has been made. The importance of this recommendation will none-the-less be stressed to all dental supervisors, and the Central Office dental staff will routinely monitor data to ensure effective implementation.

--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.

Maximum use of two-chair dentistry will become a standard, but lack of space and construction funds unfortunately limit further expansion or alteration of existing facilities. The VA Dental Service has historically recognized the need for more dental hygientists and assistants,

as well as medical administrative support personnel. The Chief Medical Director assures me he will continue implementing the recommendations in the 1973 report, consistent with priorities and resources. I am also personally committed to increasing the productivity and efficiency of VA dental clinics and can assure you that my office intends to monitor the implementation of these recommendations.

Some of the uncontrollable factors contributing to broken appointments include: illnesses which affect veterans' ability to keep appointments, lack of assistance or transportation on a given day, lack of a telephone for reminder or follow-up contact, transient veterans, and the no-cost nature of treatment services. GAO's recommendation to adopt a reminder system will be implemented as a means to better control the persistent problem of broken appointments in our dental clinics.

—Implement the recommendation made in our March 1980 report that VA expand the use of EFDA's.

I concur. It is important, however, to underscore a point GAO made in Chapter 7 of their March 1980 report, "It should be recognized that certain conditions should exist before dentists can effectively and efficiently employ Expanded Function Dental Auxiliaries (EFDAs) in their practices." In the VA, those conditions relate to proper staffing ratios, adequate facilities, and varying needs of veteran beneficiaries. Contingent upon satisfactory fulfillment of these conditions, I fully intend to proceed with a more aggressive implementation of EFDA programs.

--Establish workload indicators for dental personnel.

A new Dental Data System, which uses workload standards, is being implemented throughout the VA. This system will provide more extensive dental service information than is now available; consequently, it will allow each Dental Service, each Medical Center, and the VA Central Office to better supervise dental program activities. By mid-1982, all Dental Services will thus be evaluated at several management levels.

—Adapt the ADA and DoD dental procedures reporting systems for use by VA dental clinics.

By mid-1982, a new reporting system adapting the American Dental Association and Department of Defense procedures, as appropriate to VA requirements, will be used systemwide.

--Take steps to improve the reliability of data reported under the AMIS program.

APPENDIX I

Several steps have been taken, or are in process, to correct dental data deficiencies in the Automated Management Information System (AMIS). Actions taken include accuracy checks, monthly reviews, and development of the new Dental Data System.

It is significant that the data presented in this GAO report were gathered from August through December 1979 and do not reflect the progress VA has made to date in implementing Public Law 96-22. The enclosed statistics illustrate the results of VA's continued efforts to increase staff treatment of SC veterans.

Sincerely,

ROBERT P. NIMMO
Administrator

Enclosure

APPENDIX I

Enclosure

VA STAFF AND FEE DENTAL WORKLOADS

Fiscal Year	1976	1977	1978	1979	1980
Class I-VI Applications	233,392	216,922	197,338	191,308	243,277
Exam Eligible	188,874	169,185	143,880	139,139	177,888
Class I-VI Treated					
Staff	40,832	47,211	55,585	60,101	80,316
Fee	123,419	109,643	89,440	67,902	71,550
Total	164,251	156,854	145,049	128,003	151,866
*Class IIc Treated	NA	NA	NA	NA	
Staff					1,730
Fee					2,099
*Class IV Treated	NA	NA	NA	NA	
Staff					18,752
Fee					12,471
Hospital, Domiciliary, Nursing Home Care, and Outpatient, other than Class I-VI					
Staff	220,472	224,858	280,452	280,487	265,951

*PL 96-22

(401921)

21924

AN EQUAL OPPORTUNITY EMPLOYER

UNITED STATES
GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE,$300

POSTAGE AND FEES PAID
U. S. GENERAL ACCOUNTING OFFICE

THIRD CLASS