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EXCLUSIVE REPORT

Local VA focuses on safer care after 2011 scandal

Hospital expects to hear soon if dental clinic was source of any infections.

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By Ben Sutherly, Staff Writer

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DAYTON — One year after the Dayton VA Medical Center publicly disclosed infection control lapses that risked the health of hundreds if not thousands of veterans, hospital officials soon expect the answer to a key question: Did three veterans who tested positive for hepatitis contract the disease during visits to the hospital's dental clinic?

The U.S. Department of Veterans Affairs has turned to the Centers for Disease Control and Prevention for help in answering that question. While an internal VA investigation has not identified a link between the three positive cases and the care they received at the dental clinic, a team with the CDC's viral hepatitis branch for several months has been conducting a more in-depth analysis, called "ultra-deep sequencing."

That genotype sequencing should show whether the specific hepatitis strains found in the veterans are identical or very similar to those found in other veterans seen previously in the clinic who contracted the disease elsewhere. A match would seemingly prove that poor infection control practices in the dental clinic was responsible for the spread of one patient's hepatitis infection to another patient.

The analysis is nearly complete, and VA officials expect results "within the next several weeks."

"They say they're close to getting us an answer," said Glenn Costie, who in December became director of the Dayton VA.

The Dayton VA on Feb. 8, 2011, confirmed the infection control lapses and offered testing to 535 veterans it said could be at risk for hepatitis or HIV. Those patients had been seen by Dr. Dwight Pemberton, now 82, who allegedly failed to change latex gloves and sterilize dental instruments between patients for several years until whistle-blowers reported the alleged problems to outside VA officials in July 2010.

Pemberton, who retired just days after the VA publicly acknowledged potential infections, has vehemently denied the allegations.

The scandal rocked the federal hospital, which has long been

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dogged by negative perceptions in patient and employee satisfaction surveys. The scandal spurred a Senate field hearing at the Dayton VA and was part of a House hearing held in Washington, D.C.

Costie, however, said all lingering concerns about the clinical care that patients receive in the dental clinic have been addressed. The Dayton VA recently finished addressing issues identified by the VA's Office of Inspector General and received a clean slate from that office Jan. 26.

"We've created a safer patient care environment in response to these concerns," Costie said.

The Greater Dayton Area Hospital Association is finished with its clinical review of the infection control lapses in the Dayton VA's dental clinic. Bryan Bucklew, president and CEO of GDAHA, said the Dayton VA has shown a spirit of cooperation. But he said VA officials in Washington have presented some "roadblocks" and have declined to expand testing to thousands more patients, as a GDAHA task force urged.

And Costie acknowledged there's more work to do in improving employee relations in the dental clinic.

Sen. Sherrod Brown said he is pleased with Costie and his immediate predecessor, William Montague. The scandal was a "huge blemish" on veterans hospitals, but Brown, D-Ohio, expressed optimism, too: "We know the VA can provide really good care."

U.S. Rep. Mike Turner, R-Centerville, has said the dental scandal made clear a lack of accountability within the VA system. He introduced a bill in September that would enable law enforcement to pursue charges against Veterans Health Administration employees who "willfully fail" to follow infection control practices.

The VA declined Friday to say if it is facing any legal action stemming from the clinic issues.

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