Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Delay in Hearing Aid Repairs
VA Medical Center
Atlanta, Georgia

Report No. 11-04461-162

April 18, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant concerning efficiency and timeliness of the hearing aid repair process at the VA Medical Center (VAMC) in Atlanta, GA.

We substantiated that deficient Audiology Clinic processes resulted in delayed hearing aid repairs and the possible loss of hearing aids. Specifically, we found that Audiology Clinic managers and staff did not comply with policies to maintain an accurate internal tracking system to provide hearing aid repair services in a timely, effective, and efficient manner and did not properly document the reasons for hearing aids being reported as lost or stolen.

We substantiated that the Audiology Clinic did not have sufficient processes in place to ensure the complainant's hearing aid was repaired and returned promptly to him. We also substantiated that Audiology Clinic staff and VAMC leaders were difficult to contact. The veteran made two attempts to contact the Audiology Clinic, but he encountered full voice mailboxes and staff that were too busy to assist him. When the patient was referred to the patient advocate, the patient advocate documented the encounter but closed the case without resolution. Further, VAMC leaders did not adequately respond to the complainant's written concerns.

The VAMC had already taken multiple actions to improve some of the conditions identified. However, we recommended that the VAMC Director: (1) ensure that staff monitor the status of outstanding repairs and assess the timeliness of vendor completed repairs, and (2) ensure that the staff document reasons for lost and damaged hearing aids and develop risk mitigation strategies.

The Veterans Integrated Service Network and VAMC Directors concurred with our recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, Veterans Integrated Service Network (10N7)

SUBJECT: Healthcare Inspection – Delay in Hearing Aid Repairs, VA Medical Center, Atlanta, Georgia

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an evaluation related to the efficiency and timeliness of the hearing aid repair process at the VA Medical Center (VAMC) in Atlanta, GA. The purpose of the review was to determine whether the complainant's allegations had merit.

Background

The VAMC is a tertiary care facility located in Decatur, GA, that provides a broad range of inpatient and outpatient medical, surgical, geriatric, and mental health services. Care is also provided at six VA community based outpatient clinics located in Smyrna, Lawrenceville, Oakwood Hall, East Point, Stockbridge, and Newnan, GA. The VAMC has a large Audiology and Speech Pathology Service (ASPS) that operates a busy Audiology Clinic. The VAMC is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of about 453,000 throughout 48 counties in Georgia.

Military service can entail harmful exposure to high-intensity noise from firearms, explosives, jet engines, machinery, and other sources. As such, hearing impairments represent the most common types of service-connected disability, and hearing-impaired veterans may receive hearing aids from the Veterans Health Administration (VHA) if they meet certain eligibility requirements.

The VAMC's Audiology Clinic is the third largest provider of hearing aids and assisted listening devices in the VHA. In fiscal year (FY) 2011, the Audiology Clinic served over 9,100 veterans and placed 28,000 orders for hearing aids, repairs, parts, accessories, and batteries worth $4.2 million. The Audiology Clinic is staffed with 12 audiologists who conduct hearing aid evaluations to include fitting, adjustment, and instruction on the use and care of hearing aids. The Audiology Clinic operates its own Hearing Aid Repair

Clinic (HARC), staffed with four technicians who issue batteries, complete minor repairs and adjustments, and process authorizations for vendor repairs. In this report, Audiology Clinic refers collectively to the ASPS Chief, audiologists, HARC technicians, and other staff who are responsible for customer service and/or have a role in the hearing aid repair process.

Hearing aids and associated devices are purchased through national contracts maintained by the Denver Acquisition and Logistics Center (DALC). One of DALC's responsibilities is to maintain the Remote Operating Entry System (ROES), a centralized system to record hearing aid purchases, maintain warranty information, and record repairs sent to the vendors.

In August 2011, a complainant reported that deficient processes in the Audiology Clinic resulted in waste and delay, and that VAMC staff and leaders did not respond in a timely manner to his concerns. The complainant specifically alleged that:

- Audiology Clinic staff mismanaged the process used to track and monitor hearing aid repairs, resulting in delayed repairs and the possible loss of hearing aids.
- Audiology Clinic staff did not keep an accurate log reflecting the status of the complainant's hearing aid repairs. As such, repairs to his hearing aids were twice delayed between June 1–August 15, 2011.[1]
- Audiology Clinic staff and VAMC leaders were difficult to contact. When he [the complainant] attempted to check on the status of the repairs or notify VAMC leaders about the problem, he encountered unanswered phones, full voice mailboxes, and staff that "were busy with other patients."
- VAMC leaders did not adequately respond to his written complaints, prompting him to contact the OIG.

Scope and Methodology

We conducted a site visit on November 9, 2011. Prior to our visit, we reviewed VHA Directive 2008-070,[2] VHA Handbooks 1170.02[3] and 1173.7,[4] and local procedures[5] for hearing aid repairs. We interviewed the VAMC Director, Chief of Staff (COS), Chief of ASPS, the patient's audiologist, the COS's administrative assistant and secretary, two

[1] The complainant originally alleged this occurred on May 1; however, the medical record reflects that it likely occurred around June 1.
[2] VHA Directive 2008-070, *Prescribing Hearing Aids and Eyeglasses*, October 28, 2008.
[3] VHA Handbook 1170.02, *VHA Audiology and Speech-Language Pathology Services*, March 14, 2011.
[4] VHA Handbook 1173.7, *Audiology and Speech Devices*, October 30, 2000.
[5] *Atlanta Audiology-Internal HARC Procedure Guide: Procedures for Drop-Off Repairs, Hearing Aid Repair Procedures, and Program Verification Guide.*

HARC technicians who assisted the patient, and other VAMC staff knowledgeable about the issues. We also interviewed DALC staff regarding ROES. We reviewed the patient's medical record; quality management, workload, and productivity reports; ROES reports; the HARC repair log; and email correspondence.

We performed this review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Summary of Events

The complainant has been receiving services, including hearing aids, from the VAMC Audiology Clinic since 2002. The complainant told us that on or about June 1, 2011, he mailed his left hearing aid to the Audiology Clinic for a warranty-covered repair. He contacted the Audiology Clinic on June 17 to determine the status of the repair but was unable to reach anyone and was unable to leave a message because the voice mailbox was full. He contacted the VAMC Director's Office but was told that the staff[6] were busy with other customers. The complainant left a message for his audiologist, who returned the call later that day. The audiologist reported that they had "found" the complainant's hearing aid and would be sending it to the vendor for repair.

The complainant told us he attempted to contact the Audiology Clinic on July 7 to determine the status of the repair but did not speak with anyone and was unable to leave a message because the voice mailbox was full. He called the VAMC Director's Office but was told that staff were busy helping other customers. He then mailed a complaint letter to the Audiology Clinic.

Several days later, an Audiology Clinic technician contacted the complainant to report that he was looking into the matter and would call back later that day. The complainant did not receive a follow-up call that day, and on July 14 called the COS's Office and spoke with a secretary who facilitated a conference call between the complainant and the Audiology Clinic technician. The technician contacted the complainant the following day and reported that the vendor had completed the warranty repair and the hearing aid would be mailed to him (the complainant) on Monday, July 18. The complainant received the hearing aid on July 19, but it stopped working on July 20. He was able to get it working again by rapping it on a table, but the problem persisted. He left a message for his audiologist reporting the issue on July 21.

[6] The "staff" were likely patient advocates, who typically respond first to complaints brought to the Director's Office.

He did not receive a return call, so he contacted the Audiology Clinic technician on July 27 to explain the problem and was instructed to mail the defective hearing aid to the technician's attention; it was received in the Audiology Clinic on July 29 and was immediately shipped back to the vendor for repair.

On August 5, the technician contacted the complainant to advise the repairs were complete and that he (the technician) expected to receive the aid by August 8. On August 11, the complainant called the Audiology Clinic to determine the status of his hearing aid. The technician contacted the vendor and was told that the complainant's hearing aid had been shipped back on August 8; however, the technician was unable to locate the aid anywhere in the Audiology Clinic. On August 12, the complainant faxed a letter to the COS outlining the difficulties he had encountered with his hearing aid repair. He asked for a response by August 17. The complainant told us that he never received a response.

The complainant was evaluated for new hearing aids on August 16 and received them on August 18. He is satisfied with these hearing aids and has had no further problems. The hearing aid that was allegedly shipped by the vendor on August 5 has not been located.

Issue 1: Hearing Aid Repair Processes

We substantiated that deficient Audiology Clinic processes resulted in delayed hearing aid repairs and the possible loss of hearing aids. Specifically, we found that Audiology Clinic managers and staff did not:

- Comply with policies to maintain an accurate internal tracking system to provide hearing aid repair services in a timely, effective, and efficient manner.
- Properly document the reasons for hearing aids being reported as lost or stolen.

Tracking of Hearing Aid Repairs

We found that Audiology Clinic managers and technicians did not take sufficient measures to monitor and document hearing aid repairs to ensure that veterans were served in a timely, effective, and efficient manner. The Audiology Clinic uses an electronic repair log (the log) to track the status of in-house and vendor hearing aid repairs; this log was the only means used by Audiology Clinic managers to oversee the repair process. However, the log was not well designed as it did not capture all of the meaningful data fields and could only be used by one employee at a time. Further, it was not well maintained, and there was no accountability for ensuring that it was complete and accurate. Often, the log contained blank fields or was annotated with "not applicable." From January 1 through October 15, 2011, the dates the hearing aids were returned to the veterans were missing for approximately 40 percent of the service encounters.

We also found that the Audiology Clinic:

- Did not accurately track hearing aid repair turnaround times between receipt of broken hearing aids to delivery of repaired aids back to veterans.
- Did not track the turnaround time for vendor completed hearing aid repairs even though this 10-day requirement was contractually established.
- Did not maintain an inventory of hearing aids requiring external vendor repairs which were shipped to or received from vendors.
- Did not have a reliable method to determine whether hearing aids in their custody were lost or stolen.

Since these events, Audiology Clinic managers have taken steps to improve the tracking log so that it reflects the precise location and status of hearing aids during the repair process. Several employees can now use the log simultaneously. Audiology Clinic's administrative officer monitors the log daily to ensure that staff are completing data fields correctly and the repairs are processed timely.

Lost and Damaged Hearing Aids

The Audiology Clinic did not properly document the reasons veterans provided when reporting lost or stolen hearing aids. VHA Handbook 1173.7 states that "devices may be replaced if the item was lost or destroyed due to circumstances beyond the control of the veteran" and "if negligence or willful action is suspected, the Chief of Audiology will determine whether a replacement may be issued, depending upon the circumstances." If the Audiology Clinic is unable to determine the cause of the loss, then the VAMC bears the cost of replacement.

The VAMC had a $48,000 (31 percent) increase in hearing aid replacement costs from FY 2010 ($156,000) to FY 2011 ($204,000). The Audiology Clinic had no data to indicate the cause of this increase, nor could staff determine if hearing aids were being stolen. Audiology Clinic staff did not routinely document explanations for hearing aid damage or loss in patients' medical records, and there were no other records where this information may have been collected. Furthermore, although ROES is the source for the Lost and Damaged report, there are no data fields to explain reasons for the loss or damage. As the Audiology Clinic did not collect and centrally document data related to lost or stolen hearing aids, staff could not identify trends or improvement opportunities, or develop action plans to mitigate those losses.

Issue 2: Timeliness of the Complainant's Hearing Aid Repairs

We substantiated that the Audiology Clinic did not have sufficient processes in place to ensure the complainant's hearing aid was repaired and returned promptly to him. We found:

- The repair log inaccurately showed that the complainant's hearing aid was received in the Audiology Clinic on June 17, 2011; however, the complainant told us he actually delivered the hearing aid on June 1, 2011.

- Audiology Clinic staff followed up with the vendor on July 15, 2011, only after the complainant called about the status of the repairs and nearly 30 days after initial receipt.

- The repaired aid failed a second time on July 20, 2011, requiring the complainant to send it to the Audiology Clinic for repair. Staff annotated that the hearing aid was mailed to the vendor on July 29; however, there was no shipping record that it was sent.

Due to inadequate record keeping and oversight, Audiology Clinic staff were unable to track the status and timeliness of the complainant's hearing aid repairs, nor were they able to determine where or how the first hearing aid was lost.

Issue 3: Responsiveness to a Patient's Questions and Complaints

We substantiated that Audiology Clinic staff and VAMC leaders were difficult to contact. The veteran made two attempts to contact the Audiology Clinic, but he encountered full voice mailboxes and staff that were too busy to assist him. At the time of the events, the Audiology Clinic used a telephone tree system where either designated staff would answer the telephone or it would transfer into a voicemail system. While staff were instructed to check the voicemails three times per day that did not always occur. When staff could not or did not check and delete voicemails, the voice mailboxes could no longer accept incoming messages. At the time, those calls could not be redirected to another number and ended up being "lost" calls. We also found that when calls were answered, staff did not consistently document the appropriate contact information or actions taken.

We also substantiated that VAMC leaders did not adequately respond to the complainant's written concerns. The complainant contacted the COS's Office on July 14, 2011, and was transferred to the Patient Advocate. According to the Patient Advocate's report of contact, the veteran was concerned about delayed hearing aid repairs, the inability of the Audiology Clinic to locate his hearing aids, and the inability to get through to the Audiology Clinic to leave a voicemail because the voice mailboxes were full. The Patient Advocate documented this initial contact in the Patient Advocate

Tracking System (PATS) and attempted to facilitate the hearing aid repairs. In addition, because the complainant voiced his concerns about the Patient Advocate's full voice mailbox, she outlined a plan to improve the timely retrieval of messages from the voicemail system in her comments in the PATS. There were no further documented interactions between the Patient Advocate and the complainant, and the Patient Advocate closed the case. The current Patient Advocate, who entered the position in October 2011 and was previously unaware of the case, stated that since there was no additional documentation in the PATS, there was probably no further contact.

The COS and other assigned personnel told us that when complaints come directly to the Director's Office, the issues are typically forwarded to the appropriate Service Chief for response and resolution. In this case, the written complaint was reportedly forwarded to the ASPS Chief, but there was no documentation related to the resolution. Further, we were told that administrative staff in the Director's Office should follow-up with the Service and respond to the complainant. However, staff were unable to provide any documentation to support that follow-up with this veteran occurred.

Since the events, VAMC and Audiology Clinic staff have taken action to improve the telephone voicemail and callback systems. For example, the VAMC now has a system that automatically forwards calls to another voice mailbox when encountering a full voice mailbox. In addition, VAMC staff monitor voice mailboxes to ensure calls are retrieved and take action when appropriate.

Conclusions

We substantiated that deficient processes in the Audiology Clinic resulted in waste and delay. Audiology Clinic staff did not comply with policies for tracking the status of hearing aid repair services, and did not properly document the reasons for hearing aids being reported as lost or stolen. The repair log was the only means to track and manage hearing aid repairs, but it was not maintained and was inadequate to perform reasonable oversight. Furthermore, documentation of lost or stolen hearing aids was inadequate and put the VAMC at risk for unnecessarily expending resources on replacement hearing aids. The repair log has since been improved and the Audiology Clinic administrative officer is now routinely monitoring it for data field completeness and hearing aid repair timeliness.

We confirmed that the complainant's hearing aid repairs were delayed because of inadequate tracking and oversight systems. We also substantiated that Audiology Clinic staff and VAMC leaders were difficult to contact and did not respond in a timely manner to the complainant's concerns. Systems to respond to customer service concerns have since been improved.

Recommendations

Recommendation 1. We recommended that the VAMC Director ensure that the ASPS Chief requires staff to monitor the status of outstanding repairs and assess the timeliness of vendor-completed repairs.

Recommendation 2. We recommended that the VAMC Director ensure that the ASPS Chief requires staff to document reasons for lost and damaged hearing aids and develop risk mitigation strategies.

Comments

The Veterans Integrated Service Network and the VAMC Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 9-12, for the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 21, 2012

From: Acting Director, VA Southeast Network (10N7)

Subject: **Healthcare Inspection –** Delay in Hearing Aid Repairs, VA Medical Center, Atlanta, GA

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, VHA Management Review Service (10A4A4)

1. I have reviewed and concur with Atlanta VAMC action plans and progress toward addressing OIG recommendations.

2. Thank you for the thoroughness of your review and for your assistance in helping us better serve Veterans.

3. If you have questions or require additional information, please contact Robin Hindsman, VISN 7 Quality Management Officer, at (678) 924-5733.

(original signed by)

James A. Clark, MPA

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 19, 2012

From: Acting Medical Center Director (508/00)

Subject: **Healthcare Inspection –** Delay in Hearing Aid Repairs, VA Medical Center, Atlanta, GA

To: VISN Director (10N7)

1. The Atlanta VA Medical concurs with the recommendations made by the OIG team following a recent healthcare inspection of reported delay in hearing aid repairs.

2. The Audiology Speech and Pathology Service (ASPS) has implemented actions to address the OIG recommendations. Please see attached response to recommendations.

3. If you have any questions. Please contact Mr. Ed Mills, Administrative Officer, Geriatrics and Extended Care Service Line, at 404-321-6111 extension 3040.

(original signed by)

Thomas Grace

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the VAMC Director ensure that the ASPS Chief requires staff to monitor the status of outstanding repairs and assess the timeliness of vendor-completed repairs.

Concur - Yes **Target Completion Date:** Already in place.

System's Response: With the hiring of additional ASPS staff, (namely two additional audiology health technicians, one additional clerk, and one program specialist between July 2011 and January 2012), ASPS has been able to process hearing aid repairs timely and in compliance with performance measures, which was not the case in early 2011. The program specialist monitors the log daily for timely entries and outstanding repairs and performs log audits to compile measurements for average repair processing times a minimum of once a month.

Status: Actions have already been implemented.

Recommendation 2. We recommended that the VAMC Director ensure that the ASPS Chief requires staff to document reasons for lost and damaged hearing aids and develop risk mitigation strategies.

Concur - Yes **Target Completion Date:** Already in place.

System's Response: A separate spreadsheet which lists specific information pertaining to lost and damaged hearing aids, including veteran name and last four numbers of their social security number, date the aid was reported lost or damaged, as well as whether the aid was lost by a veteran, VA staff or outside hearing aid vendor has now been created and can be accessed by audiology staff on the protected network drive. Any pertinent information pertaining to the loss is also recorded.

As before, a note is written in CPRS when a veteran or staff member reports a lost or damaged hearing aid and notation is made in the hearing aid log.

New risk mitigation strategies for reducing hearing aids lost in the clinic instituted since the time of the OIG complaint include:

- Expansion of the hearing aid log to include data pertaining to dates for drop-off, mail-out and receipts from vendors, and hand delivery or mail-outs for veterans.

- Modification of the hearing aid log such that multiple simultaneous employees are able to access it. This modification has significantly increased compliance with timely data entry.

- Hearing aid log timely entry compliance monitored daily by clerical staff or program specialist.

Status: Actions have already been implemented.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Toni Woodard, Project Leader Victoria Coates, LICSW, MBA Murray Leigh, Jr., CPA Thomas Seluzicki, CPA Robert Yang, MD

Appendix D

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