



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Audiology Leaders'
Deficiencies Responding to
Poor Care and Monitoring
Performance at the Eastern
Oklahoma VA Health Care
System in Muskogee



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Eastern Oklahoma VA Health Care System (facility) in Muskogee after receiving information from the facility that an audiologist had provided poor care and billed for unrendered services. A fact-finding review by the facility revealed billing for audiology tests not performed and poor care to eight of 43 patients reviewed, including misinforming patients who needed hearing aids that hearing aids were not needed.

The Audiology Supervisor (Supervisor), Service Chief and Chief of Staff (audiology leaders) took a human resource action against the employee. This OIG inspection focused on actions the audiology leaders took in response to the audiologist's poor clinical care. The OIG found serious and widespread breakdowns in both clinical and administrative oversight and controls. For example, the audiology leaders did not evaluate whether patients who were identified as receiving poor care from the audiologist needed clinical follow-up or determine whether additional patients were affected by the audiologist's poor care. During OIG interviews, the Supervisor and Service Chief confirmed having concerns about the patients who received poor care from the audiologist. The Service Chief explained that the need to curtail face-to-face visits due to COVID-19 made calling patients back for follow-up difficult. The Supervisor did not evaluate the need for follow-up care based on an assumption that the deficiencies would be rectified during subsequent audiology visits. Additionally, the Supervisor described workload as a barrier to reviewing health records to identify patients who needed follow-up. The Chief of Staff was aware of the poor audiology care but told the OIG that there was no need to bring patients back for assessment because the Supervisor reported no patient safety concerns and did not recommend the patients be reassessed. The Chief of Staff described that calling back patients would lead to delays in caring for current patients.

Audiology leaders failed to evaluate whether clinical disclosures were required for affected patients and did not alert the Facility Director of the fact-finding results who, therefore, was unable to initiate the process to determine the necessity of a large scale disclosure. The Chief of Staff told the OIG that disclosures were not required because patients did not experience complications; however, this is not consistent with Veterans Health Administration policy. The Supervisor and Service Chief reported being unfamiliar with the Veterans Health Administration disclosure policy and, therefore, the OIG concluded that neither had considered whether clinical disclosures were warranted.

Furthermore, instances of poor care, which met the definition of adverse events, were not reported to the Patient Safety Manager. Therefore, the Patient Safety Manager was unable to assess the adverse events to determine if patient safety interventions were indicated. The audiology leaders' failed to inform the Patient Safety Manager of the adverse events due to a lack of training and reportedly due to balancing multiple other priorities, including managing the

impact of the COVID-19 pandemic on clinical operations and determining a human resource action.

The OIG found that performance monitoring of the audiologist, and of the other six audiologists, was not conducted as required.¹ Annual competency assessments were not consistently completed by the Supervisory Audiologist. Additionally, the audiologists' annual performance appraisals were not completed timely and did not contain adequate performance standards. The Supervisor reported the shortcomings were due to a lack of guidance when the facility changed to an electronic appraisal system.

The OIG found audiology leaders failed to consider whether the audiologist's actions warranted a report to the state licensing board. During interviews, audiology leaders reported a lack of understanding of the requirements for state licensing board reporting and, therefore, the Facility Director was not informed of the need to initiate a state licensing board review.

The OIG made 10 recommendations to the Facility Director related to ensuring patients affected by poor audiology care receive follow-up and disclosures as appropriate, audiologists' performance is monitored consistent with policy, and the state licensing board review process is conducted as required. Additionally, the OIG recommended the Facility Director evaluate processes, including annual competencies, used to ensure audiology leaders' compliance with policies regarding disclosure, adverse event reporting, and state licensing board reporting.

Comments

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendations and provided acceptable action plans. (See Appendixes A and B, pages 15–21, for the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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¹ The OIG did not review the performance of the other six audiologists for this inspection.

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Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
SLB	state licensing board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Eastern Oklahoma VA Health Care System (facility) in response to a facility leader's report that an audiologist (the audiologist) provided poor care and billed for services that were not rendered.¹

Background

The facility, part of Veterans Integrated Service Network (VISN) 19, consists of a main hospital in Muskogee, Oklahoma, and four outpatient clinics. The facility provides primary, tertiary, and specialty care. According to the Veterans Health Administration (VHA) Support Service Center, between October 1, 2019, and September 30, 2020, the facility served 40,405 unique patients.

Concerns

In early 2020, after receiving a patient's report that the audiologist provided poor care and billed for services that were not rendered, the Supervisory Audiologist (Supervisor) initiated a fact-finding review with guidance from a human resource representative.² The Supervisor conducted two interviews with the audiologist who described being complacent at work, and billing for services not rendered. The Supervisor reviewed 20 electronic health records (EHRs) of patients who received care from the audiologist and confirmed the audiologist was providing poor care and billing improperly. During an OIG interview, the Supervisor reported that after sharing the results of the interviews and chart audits with the Chief of Physical Medicine and Rehabilitation (Service Chief), who informed the Chief of Staff, the Supervisor was instructed to report the findings to the OIG and to conduct a review of more EHRs. The Supervisor reviewed an additional 23 EHRs, which were sampled from the preceding nine years of the audiologist's patients, and again found the audiologist provided poor care and billed for services not rendered. Deficiencies in the audiologist's patient care included billing for tests not performed,

¹ For the purpose of this report, the term billed refers to services that the audiologist entered as completed in the electronic health record according to the facility fact-finding review. The term coding refers to the numerical code used to retrieve information about diagnosis and procedure. VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. This handbook was rescinded April 5, 2021 and replaced by VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. The 2015 handbook was applicable at the time of this review.

² Although the incumbent was referred to as the Chief of Audiology during interviews, the incumbent's official title is Supervisory Audiologist.

misinforming patients who needed hearing aids that hearing aids were not needed, and entering abnormal test results as normal.³

The OIG reviewed documentation provided by the Supervisor, which described the identified care and billing deficiencies as well as a proposed human resource action. The documentation, however, did not indicate that audiology leaders took action to resolve or disclose the poor audiology care for affected patients, manage the poor care as patient safety events, or identify and remediate the processes permitting the audiologist's poor performance.

The OIG initiated this healthcare inspection to review the facility leaders'

- Actions to resolve, disclose, and make patient safety reports regarding deficiencies in the audiologist's patient care;
- Process to monitor audiologists' clinical performance; and
- Administrative actions affecting the audiologist following discovery of poor audiology care.⁴

Scope and Methodology

The OIG initiated the inspection on September 30, 2020. A virtual site visit was conducted November 16–18, 2020, given travel and safety concerns due to the potential spread of COVID-19.⁵

The OIG interviewed the Chief of Staff, the Chief of Physical Medicine and Rehabilitation, and the Supervisory Audiologist (collectively referred to as audiology leaders); the Facility Director; the former Acting Chief of Quality; the Risk Manager; the Patient Safety Manager; a VISN human resource representative; an audiology subject matter expert from another VISN facility; the patient who reported the audiologist's poor care; and the audiologist. The OIG reviewed relevant VHA and facility policies, human resource documents, EHRs, and the Supervisor's fact-finding review.

³ While reviewing EHRs of the audiologist's patients, the Supervisor found eight instances of poor care. Two instances of poor care were only related to documentation. The OIG reviewed the remaining six instances of poor care and did not identify any patients who experienced a serious injury related to audiology care.

⁴ This inspection focuses on issues related to poor audiology care and not the issue of billing for services that were not rendered.

⁵ Centers for Disease Control and Prevention, "Domestic Travel During the COVID-19 Pandemic," accessed December 15, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html>. World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*, accessed on December 15, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 (coronavirus disease) is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Facility Leaders' Response to Poor Patient Care

The OIG determined that audiology leaders did not respond to the discovery of poor patient care in a manner consistent with policy. Although audiology leaders took action to intervene after learning of the audiologist's poor performance, they did not evaluate whether patients who received poor audiology care required clinical follow-up or disclosure. Additionally, audiology leaders failed to report incidents of poor care that were adverse events to the facility Patient Safety Manager. Based on these findings, the OIG is concerned that patients did not receive and were uninformed about needed follow-up care, and that patient safety staff were unable to assess for the need to implement patient safety improvement strategies.

Audiologists provide audiology care, which includes the diagnosis, treatment, and management of hearing loss, tinnitus, and balance disorders for people of all ages.⁶ VHA audiologists conduct testing; recommend and provide hearing aids, assistive listening, and alerting devices; determine eligibility for cochlear implants; and perform hearing rehabilitation services.⁷ VHA Audiology Services focuses on addressing activity and participation barriers that affect an individual's quality of life.⁸

⁶ American Academy of Audiology, "What is an Audiologist?," accessed December 14, 2020, <https://www.audiology.org/what-is-an-audiologist>; Mayo Clinic. "Tinnitus," accessed January 8, 2021, <https://www.mayoclinic.org/diseases-conditions/tinnitus/symptoms-causes/syc-20350156>. "Tinnitus is the perception of noise or ringing in the ears."

⁷ VHA Handbook 1170.02(1), *VHA Audiology and Speech-Language Pathology Services*, March 14, 2011. This handbook was in effect for the timeframe of the events discussed in this report. It was rescinded December 9, 2020 and replaced by VHA Directive 1170.02, *VHA Audiology and Speech Pathology Services*, December 9, 2020. The 2020 directive has the same or similar language as the 2011 handbook related to processes, procedures and requirements for Audiology and Speech-Language Pathology Services discussed in this report.

⁸ VHA Handbook 1170.02(1); VHA Directive 1170.02.

According to the Veterans Benefits Administration, tinnitus and hearing loss are the two most common disabilities for veterans receiving compensation.⁹ Untreated hearing loss can lead to people developing cognitive decline, anxiety, sadness, depression, and poor social relationships.¹⁰ The capacity to hear and communicate successfully influences overall quality of life, yet only one in four people who could benefit from a hearing aid use one.¹¹

Failure to Evaluate Need for Clinical Follow-up

In addition to expecting audiologists to render professional services independently, VHA assigns audiology supervisors the responsibility to ensure “services are provided in a timely, effective, and efficient manner.”¹² Similarly, the Service Chief and Chief of Staff’s responsibilities include ensuring that appropriate, competent, and high-quality patient care is rendered.¹³

Through document reviews and interviews, the OIG learned that the Supervisor conducted a fact-finding review, communicated the fact-finding results to the supervisory chain of command, and counseled the employee on performance expectations. However, none of the audiology leaders, including the Supervisor, reported reviewing the affected patients’ EHRs to identify whether follow-up care was needed to resolve the identified audiology care deficiencies. Furthermore, the OIG learned through interviews that although the Supervisor determined the audiologist routinely provided poor care for several years, no reviews were conducted to identify additional patients who received poor care from the audiologist and needed follow-up.

In the fact-finding review, the Supervisor indicated that the deficiencies in patient care were a concern; however, the Supervisor described the improper billing as a larger concern. During OIG interviews, the Supervisor and Service Chief confirmed having concerns about the patients who received poor care from the audiologist. The Service Chief explained that the need to curtail face-to-face visits due to COVID-19 made calling patients back for follow-up difficult. The OIG learned in an interview that the Supervisor did not evaluate the need for follow-up care based on an assumption that the deficiencies would be rectified during subsequent audiology visits. The Supervisor explained that some of the poor care identified was subject to clinical judgment. Additionally, the Supervisor described workload as a barrier to reviewing EHRs to identify patients who needed follow-up.

⁹ Veterans Benefits Administration, “Annual Benefits Report, Fiscal Year 2019,” accessed January 8, 2021, <https://www.benefits.va.gov/REPORTS/abr/>.

¹⁰ American Academy of Audiology, “Seniors and Hearing Loss,” accessed December 14, 2020, <https://www.audiology.org/consumers/seniors-and-hearing-loss>.

¹¹ American Academy of Audiology, “Guide to Adult Hearing Care,” accessed December 14, 2020, <https://www.audiology.org/public-awareness/guide-adult-hearing-care>.

¹² VHA Handbook 1170.02(1).

¹³ Facility, Bylaws and Rules of the Medical Staff of Veteran’s Health Administration (VHA), Eastern Oklahoma VA Health Care System Muskogee, Oklahoma, May 2018.

The Chief of Staff was aware of the poor audiology care but told the OIG that there was no need to bring patients back for assessment because the Supervisor reported no patient safety concerns and did not recommend the patients be reassessed. The Chief of Staff described that calling back patients would lead to delays in caring for current patients.

During interviews with the OIG, the Supervisor and Service Chief acknowledged a review to identify additional patients who did not receive appropriate audiology care would be beneficial; however, a plan to perform such a review was not in place. Audiology leaders told the OIG that quality management was not consulted for assistance in developing an action plan when the deficiencies were identified. However, the Service Chief informed the OIG of the intention to identify and provide follow-up care to high-risk individuals as well as to seek guidance from quality management.

The OIG concluded that audiology leaders failed to ensure previously identified patients who were affected by poor care received clinically-indicated follow-up. The Supervisor and Service Chief also confirmed the need to determine whether additional patients for whom the audiologist provided care had received poor care and required follow-up. Although acknowledging barriers to identifying patients who required follow-up care, the Service Chief reported the intention to identify high-risk patients and provide follow-up.

Failure to Follow Disclosure Policy

VHA defines adverse events as “untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers.”¹⁴ VHA policy requires patients receive disclosures about adverse events that “have had, or are reasonably expected to have, an effect on the patient that is perceptible to either the patient or the health care team” or “precipitate a change in the patient’s care.”¹⁵ VHA recognizes three types of disclosures of adverse events that may be used individually or combined as warranted: clinical, institutional, and large scale disclosures.¹⁶ Clinical disclosures are made during routine clinical care.¹⁷ Any member of a patient’s healthcare team may make a clinical disclosure of a minor adverse event.¹⁸ For adverse events that are considered more than minor, the patient’s responsible practitioner is charged with making the clinical disclosures.¹⁹ To avoid “unnecessarily worrying or confusing patients with inconsequential information,” clinical

¹⁴ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

¹⁵ VHA Directive 1004.08. Disclosures of adverse events are required, except in certain circumstances, based on a risk and benefit analysis.

¹⁶ VHA Directive 1004.08. An institutional disclosure informs patients of adverse events that have or are expected to lead to serious injury or death.

¹⁷ VHA Directive 1004.08.

¹⁸ VHA Directive 1004.08.

¹⁹ VHA Directive 1004.08. Adverse events that require a patient safety report are more than minor.

disclosures are not required if the discovery of a minor adverse event occurs after the patient completes the related health care and the adverse event carries no consequence for the patient's health.²⁰ Additionally, when adverse events are identified that may have impacted multiple patients due to a systemic issue, a large scale disclosure must be considered.²¹ According to VHA, the process for determining whether a large scale disclosure is warranted involves communication and coordination with the facility director as well as VISN and VA Central Office leaders.²²

Each of the audiology leaders acknowledged during interviews that examples of the poor care identified in the fact-finding review were adverse events. According to VHA policies, the Supervisor was required to consider performing clinical disclosures after identifying the adverse events during EHR reviews of the audiologist's care.²³ When determining if clinical disclosures were required, the Supervisor would have to consider whether patients needed follow-up care. The OIG determined that the adverse events needed to be evaluated for clinical disclosure because audiology patients who do not receive proper testing or treatment may: (1) experience perceptible effects, such as diminished hearing or missed conditions including acoustic neuroma or ear infections, and (2) require additional visits to diagnose and treat these conditions.

Additionally, because the adverse events affected multiple patients due to a systemic issue, the criteria were met to require initiation of the assessment and planning process for possible large scale disclosure in coordination with VA Central Office.²⁴ The Chief of Staff should have identified that adverse events required a report to the Facility Director in order to initiate the process to determine whether a large scale disclosure was warranted.

During interviews, the OIG learned that none of the audiology leaders considered disclosing the adverse events to patients. The Supervisor and Service Chief reported being unfamiliar with policies that provide guidance on how to address adverse events. The Chief of Staff told the OIG that disclosures were not required because patients did not experience complications; however, this is not consistent with the standard outlined in VHA policy.²⁵ The OIG reviewed audiology leaders' training documents and found that, although not required, none of the leaders had documented training regarding the disclosure policy.²⁶

²⁰ VHA Directive 1004.08.

²¹ VHA Directive 1004.08.

²² VHA Directive 1004.08. Appendix B, Flow Chart: Process for Assessment of Adverse Events That Might Require Large-Scale Disclosure.

²³ VHA Directive 1004.08. VHA Handbook 1170.02(1).

²⁴ VHA Directive 1004.08. The OIG identified failure to monitor the clinical performance of audiologists to be a systemic issue which is discussed in section 2.

²⁵ VHA Directive 1004.08.

²⁶ VHA Directive 1004.08.

The Supervisor and Service Chief reported being unfamiliar with the VHA disclosure policy and, therefore, the OIG concluded that neither had considered whether clinical disclosures were warranted.²⁷ The Chief of Staff's misunderstanding of the disclosure policy contributed to the failure to recognize the need to evaluate the adverse events for disclosure. The OIG did not make any determinations whether clinical or large scale disclosures were required, rather the OIG concluded that audiology leaders failed to follow mandatory processes to assess the need for adverse event disclosure.

Lack of Patient Safety Reporting

VHA requires any facility staff who discover an adverse event to report the occurrence to the patient safety manager.²⁸ The patient safety manager reviews the scope and frequency of reported adverse event(s) to determine actions required to reduce future occurrences.²⁹ Potential patient safety manager-initiated actions range from determining no action is required to performing a focused review of the adverse event's contributing factors, or reporting the problem to a higher authority such as the VISN.³⁰

VHA requires the adverse events identified by the Supervisor during EHR reviews to be reported to the Patient Safety Manager to determine required patient safety actions.³¹ However, audiology leaders informed the OIG that the adverse events were not reported to the Patient Safety Manager. The Service Chief recalled realizing the fact-finding results needed to be reported to Human Resources and the Chief of Staff due to the potential for a human resource action. The Chief of Staff explained that not reporting the adverse events to the Patient Safety Manager was due to awaiting a response from the OIG regarding the audiologist's poor care and improper billing, and facility leaders being preoccupied by the pandemic.³² The Service Chief acknowledged to the OIG that not reporting the adverse events to quality and patient safety was an oversight. The OIG team reviewed audiology leaders' training records and found that, although not a requirement, none of the leaders had documented evidence of receiving training on patient safety reporting.³³

The OIG interviewed the Patient Safety Manager who described the process for being notified of adverse events by staff, conducting patient safety reviews, and recommending patient safety

²⁷ VHA Directive 1004.08.

²⁸ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

²⁹ VHA Handbook 1050.01.

³⁰ VHA Handbook 1050.01.

³¹ VHA Handbook 1050.01.

³² The OIG did not instruct facility leaders to delay internal actions related to the audiologist's practice.

³³ VHA Handbook 1050.01.

follow-up actions. However, because audiology leaders failed to report the adverse events to the Patient Safety Manager, a patient safety review was not initiated.

The OIG concluded that audiology leaders' failed to report the adverse events to the Patient Safety Manager due to a lack of training as well as multiple other priorities including managing the impact of the COVID-19 pandemic on clinical operations, determining a human resource action, and awaiting a response from the OIG regarding the audiologist's performance.

The OIG is concerned that no action has been taken to resolve the identified deficient care or to ascertain whether additional patients were affected by the poor care. Audiology leaders failed to consider making disclosures to affected patients. As a result, there may be patients who did not receive adequate audiology care who have not yet been identified or re-evaluated by an audiologist. Furthermore, the Patient Safety Manager did not receive adverse event information from audiology leaders and, therefore, was unable to determine patient safety actions.

2. Clinical Performance Monitoring

The OIG determined that audiology leaders did not follow mandatory procedures to monitor the audiologist's clinical performance, which permitted the audiologist to provide poor care over an eight-year period without detection. Specifically, audiology leaders inadequately monitored the performance of the audiologist, and all of the six other audiologists, by failing to adhere to requirements related to annual competency assessments and performance appraisals. Thus the OIG identified the clinical performance monitoring failures as a systemic issue. After identifying the audiologist's performance deficiencies, the Supervisor took actions to improve the audiologist's performance in accordance with policies.

VHA requires the supervisory audiologist responsible for the management of the Audiology Service to evaluate the work of employees.³⁴ Staff competencies must be verified and documented annually by the service chief, or designee, and be used to create employee performance appraisals.³⁵ The facility uses performance appraisals to document audiologists' achievement of performance standards.³⁶ VHA employee performance standards are required to be "precise and specific" so that the standards are generally understood, and supervisors must consider the quality of work when assigning ratings.³⁷ At the facility, performance appraisal periods are on a fiscal year schedule (October 1 through September 30).³⁸ Supervisors are required to provide employees with progress reviews regarding performance at least once during

³⁴ VHA Handbook 1170.02(1); VHA Directive 1170.02.

³⁵ Facility Memorandum 05-06, *Staff Competency Assessment*, January 15, 2020. Facility Memorandum 05-08, Performance Management Program, March 21, 2017.

³⁶ Facility Memorandum 05-08.

³⁷ VA Directive 5013, *Performance Management Systems*, March 27, 2015.

³⁸ Facility Memorandum 05-08.

the appraisal period.³⁹ Usually, a progress review occurs at the mid-point of the appraisal period.⁴⁰ Supervisors must inform employees of unacceptable performance and provide assistance to the employee, which may include on-the-job training, counseling, or supervisory guidance.⁴¹

The Service Chief and Supervisor informed the OIG that the Supervisor was responsible for completing audiologists' competencies and performance appraisals. During an OIG interview, the Service Chief reported a plan to take responsibility of personnel folders from the Supervisor in order to improve oversight and accountability.

Uncompleted Competency Assessments

The OIG requested the audiologist's competency assessments for fiscal years 2019 and 2020. However, the facility only provided the OIG with the competency assessment for fiscal year 2018, and the Supervisor reported not completing annual competencies for any of the audiologists for fiscal years 2019 and 2020. During an OIG interview, the Supervisor explained having mistakenly believed that annual competency assessments were not required after the facility moved to an electronic performance appraisal system. The Supervisor attributed this lack of compliance to not having enough guidance on the new process. Since identifying this deficiency, the Supervisor reported being in the process of updating competency assessment standards to ensure compliance going forward.

Inadequate Performance Appraisals

The OIG reviewed the audiologist's performance appraisals for fiscal years 2018, 2019, and 2020. The documents indicated that the mid-point and end-of-year appraisals were not completed timely for fiscal year 2019.⁴² The initiation of the fiscal year 2020 performance appraisal, which should have been signed in 2019, was not signed until September of 2020, and the mid-point and end-of-year appraisals were also not completed on time. The Supervisor reported failing to ensure the audiologist signed the appraisal at the beginning of the rating period. Due to the delay in signing the fiscal year 2020 performance appraisal initiation, the Supervisor told the OIG that human resources recommended completing the 2020 mid-year and final appraisals in 45-day intervals from the September 2020 signature date.

³⁹ VA Directive 5013, *Performance Management Systems*, March 27, 2015. Facility Memorandum 05-08.

⁴⁰ Facility Memorandum 05-08.

⁴¹ Facility Memorandum 05-08.

⁴² Facility Memorandum 05-08. Time frames require a mid-point during the rating period and the end-of-year appraisals must be completed "no later than 60 days after the end of the rating period."

The OIG's review of the documentation identified the audiologist was rated favorably in 2018 and 2019, but the methods for evaluation were not documented and the standards for performance were not specific and precise.⁴³

The Supervisor described completing performance appraisals of the audiologist, as well as the other six audiologists, based on feedback from patients and staff interactions. The Supervisor told the OIG that assessing performance through direct observation of audiologists during patient visits was not feasible due to having a large portion of time dedicated to patient care. During an interview, the Supervisor did not identify EHR reviews as a method to assess clinicians' performance. As the Supervisor did not utilize adequate methods of overseeing audiologists' performance, the audiologist's poor care went unnoticed by the Supervisor from 2013 until 2020.

During an OIG interview, the Supervisor reported realizing the performance appraisal standards for audiologists were poorly written. Specifically, the Supervisor acknowledged the performance standards were not measurable, specific, and in-depth. The Supervisor reported the shortcomings were due to a lack of guidance when the facility changed to an electronic appraisal system. The Supervisor reported seeking guidance from colleagues at other facilities to make improvements to the performance appraisal criteria, and working with human resources to update performance appraisals with more specific and measurable performance standards.

Supervisor Assistance to the Audiologist

Audiology leaders informed the OIG that, after identifying the audiologist's performance deficiencies, the Supervisor counseled the audiologist on conducting exams, documentation, and improving interactions with patients. The Supervisor also began auditing the audiologist's EHR documentation to assess performance.

Audiology leaders did not ensure audiologists' annual competencies were completed in fiscal years 2019 and 2020 or that performance appraisals contained well-written performance standards and were completed on time. These failures contributed to the audiologist's poor performance going unnoticed until the fact-finding review was conducted. The Service Chief and Supervisor reported plans to ensure compliance with annual competency and performance appraisal requirements.

3. Administrative Actions

The OIG found that audiology leaders took a human resource action against the audiologist but failed to comply with the VHA requirement to consider if the audiologist's actions should be reported to the state licensing board (SLB).

⁴³ VA Directive 5013.

Human Resource Action

VA policy states that “prompt and appropriate, disciplinary or major adverse action, or other corrective action will be taken” when “an employee's performance of duty or professional competence is determined to be unsatisfactory.”⁴⁴

Through interviews and document reviews, the OIG learned that after completing the fact-finding review, which concluded the audiologist provided poor care and improperly billed for services not rendered, audiology leaders initiated a human resource action in order to elicit desired changes in the audiologist’s behavior. The OIG verified that the Service Chief proposed, and Chief of Staff issued, a human resource action to the audiologist for knowingly coding for services and procedures not completed.

Failure to Follow State Licensing Board Reporting Policy

According to VHA policy, facility directors must report to SLBs “each licensed health care professional whose behavior or clinical practice so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients.”⁴⁵ VHA mandates a multi-step review process for facility directors to determine whether a clinician meets the reporting standard.⁴⁶ The policy does not provide an all-inclusive list of occurrences requiring initiation of the process, but the policy does provide a list of examples of actions that represent a “reasonable basis for a concern for the safety of patients” including “lack of diagnostic or treatment capability,” “inability to perform clinical procedures considered basic to the performance of one's occupation,” and “intentional omission of care.”⁴⁷ According to VHA policy, facility directors are required to initiate the review process within seven calendar days of information being “received suggesting that a current employee’s clinical practice has met the reporting standard.”⁴⁸ Although the facility director has discretion to decide to report a clinician to the SLB, following the review process is not optional.⁴⁹

Through interviews, the OIG learned that audiology leaders did not recognize the audiologist’s performance as requiring initiation of the SLB review process. When questioned by the OIG, the

⁴⁴ VA Directive 5021, *Employee/Management Relations*, April 15, 2002.

⁴⁵ VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, December 22, 2005. The handbook was in effect during the time frame of the events discussed in this report; it was rescinded and replaced by VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards* on January 28, 2021. The 2021 directive has the same or similar language as the 2005 handbook related to processes, procedures and requirements for reporting and responding to state licensing boards discussed in this report.

⁴⁶ VHA Handbook 1100.18. The review process consists of five stages from initial review to reporting. Depending on what is found, the review process may conclude after the initial review or continue through additional steps.

⁴⁷ VHA Handbook 1100.18.

⁴⁸ VHA Handbook 1100.18.

⁴⁹ VHA Handbook 1100.18.

Supervisor described not being familiar with the SLB reporting process. The Service Chief, who was new to VA at the time the fact-finding review was initiated, recalled considering but not discussing an SLB report at the time. The Service Chief reported recently having discussions about SLB reporting with the Chief of Staff and Supervisor, although the discussions did not include required steps to be taken. The Chief of Staff did not consider reporting the audiologist to the SLB because the audiologist was not terminated, which is a misstatement of the reporting requirements.⁵⁰ The OIG reviewed audiology leaders' training records and found that, although not a requirement, none of the leaders had training on SLB reporting.⁵¹

The OIG learned through interviews that audiology leaders did not report the audiologist's deficient care to the Facility Director. As a result, the process to determine whether SLB reporting was required was not initiated.

The OIG concluded that none of the audiology leaders identified the need to initiate the process to consider reporting the audiologist to the SLB and failed to inform the Facility Director. The OIG makes no determination whether the audiologist should have been reported to the SLB, merely that the facility leaders should have initiated the review process to evaluate whether SLB reporting was required in this case.

Conclusion

The OIG determined that, although audiology leaders acted upon the discovery of an audiologist providing poor care by conducting a fact-finding review, taking a human resource action, and reporting to the OIG, the audiology leaders failed to take steps to identify and ensure that all patients who were affected by the audiologist's poor care received follow-up care as appropriate. Audiology leaders did not consider making clinical disclosures to affected patients, and failed to communicate the adverse events to the Facility Director who was, therefore, unaware of the need to initiate a large scale disclosure assessment process. Furthermore, audiology leaders did not notify the Patient Safety Manager of the identified poor care. As a result, the Patient Safety Manager was unable to determine whether patient safety actions were indicated.

In addition, audiology leaders failed to ensure audiologists' annual competencies were consistently completed and that performance appraisals were timely, conducted with an adequate methodology, and contained performance standards that were consistent with policy. These factors contributed to the audiologist's poor performance going unnoticed until the fact-finding review was conducted.

⁵⁰ VHA Handbook 1100.18.

⁵¹ VHA Handbook 1100.18.

The OIG concluded that audiology leaders did not identify the need to consider reporting the audiologist to the SLB and failed to inform the Facility Director. Therefore, facility leaders did not initiate the SLB reporting review process as required.

Recommendations 1–10

1. The Eastern Oklahoma VA Health Care System Director confirms the Chief of Staff, the Service Chief, and the Supervisory Audiologist have processes in place to ensure patients affected by the audiologist's poor care are identified and receive clinically-indicated follow-up.
2. The Eastern Oklahoma VA Health Care System Director evaluates processes, including annual competencies, used to ensure audiology leaders' compliance with the Veterans Health Administration's adverse event disclosure requirements, and takes action as indicated.
3. The Eastern Oklahoma VA Health Care System Director requires the Chief of Staff, the Service Chief, and the Supervisory Audiologist to complete clinical disclosures, as appropriate, for patients identified as being affected by the audiologist's poor care.
4. The Eastern Oklahoma VA Health Care System Director initiates the process to determine whether a large scale disclosure is required, in accordance with the Veterans Health Administration policy.
5. The Eastern Oklahoma VA Health Care System Director evaluates processes, including annual competencies, used to ensure audiology leaders' compliance with the Veterans Health Administration's patient safety reporting requirements, and takes action as indicated.
6. The Eastern Oklahoma VA Health Care System Director directs the Chief of Staff, the Service Chief, and the Supervisory Audiologist to notify the Patient Safety Manager of adverse events identified through the review of patients impacted by the audiologist's poor care.
7. The Eastern Oklahoma VA Health Care System Director ensures the Supervisory Audiologist verifies and documents annual competency assessments for audiologists in compliance with facility policy.
8. The Eastern Oklahoma VA Health Care System Director ensures that the Supervisory Audiologist conducts performance appraisals of audiologists in compliance with the Veterans Health Administration policy.
9. The Eastern Oklahoma VA Health Care System Director evaluates processes, including annual competencies, used to ensure audiology leaders' compliance with Veterans Health Administration's state licensing board reporting policy, and takes action as indicated.
10. The Eastern Oklahoma VA Health Care System Director initiates a review of the audiologist's conduct to determine whether a report to the state licensing board is indicated, in accordance with the Veterans Health Administration policy.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 14, 2021

From: Director, Rocky Mountain Network (VISN 19)

Subj: Healthcare Inspection—Audiology Leaders' Deficiencies Responding to Poor Care and
Monitoring Performance at the Eastern Oklahoma VA Health Care System in Muskogee

To: Under Secretary for Health, Office of the Under Secretary for Health (10)

1. I have reviewed the findings, recommendations, and action plan of the Eastern Oklahoma Health Care System, Muskogee VA. I am in agreeance with the above.

(Original signed by:)

Ralph Gigliotti
Network Director, VISN 19

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 10, 2021

From: Director, Eastern Oklahoma VA Health Care System (623)

Subj: Healthcare Inspection—Audiology Leaders' Deficiencies Responding to Poor Care and
Monitoring Performance at the Eastern Oklahoma VA Health Care System in Muskogee

To: Director, Rocky Mountain Network (VISN 19)

1. I have read and concur with the findings and recommendations in the OIG Report entitled, Audiology Leaders' Deficiencies Responding to Poor Care and Monitoring Performance at the Eastern Oklahoma VA Health Care System in Muskogee.
2. My response to each report recommendation can be found in the attached document.
3. If there are any questions regarding the response to the recommendations or any additional information is required, please contact the Chief of Quality, Safety and Value.

(Original signed by:)

Mark E. Morgan, MHA, FACHE
Medical Center Director

Facility Director Response

Recommendation 1

The Eastern Oklahoma VA Health Care System Director confirms the Chief of Staff, the Service Chief, and the Supervisory Audiologist have processes in place to ensure patients affected by the audiologist's poor care are identified and receive clinically-indicated follow-up.

Concur.

Target date for completion: September 27, 2021

Director Comments

A list of patients evaluated/treated during the preceding nine years by the subject Audiologist was obtained June 3, 2021. Subject matter experts will review each record to ensure proper evaluations and treatments were provided. Patients determined to require follow up will be contacted within 14 days of the completed review and an appointment will be scheduled for follow-up evaluation and treatment as indicated.

Recommendation 2

The Eastern Oklahoma VA Health Care System Director evaluates processes, including annual competencies, used to ensure audiology leaders' compliance with the Veterans Health Administration's adverse event disclosure requirements, and takes action as indicated.

Concur.

Target date for completion: July 9, 2021

Director Comments

Competencies were rewritten and reviewed by an Employee Relations/Labor Relations Human Resources specialist on November 10, 2020. Clinical, institutional, and large scale disclosures were added to the Audiologist Leaders' competency on June 10, 2021.

Audiology Leaders will receive training from subject matter experts on when, how to report, and expectations for reporting potential/adverse events to the Patient Safety Manager. Education will include clinical, institutional, and large scale disclosures. This training will continue annually and will include all new hire audiologists.

Training will be available on the Talent Management System beginning July 9, 2021, and will be assigned through the Talent Management System for tracking purposes. Competency will be evidenced through completion of a pre/post-test annually.

Recommendation 3

The Eastern Oklahoma VA Health Care System Director requires the Chief of Staff, the Service Chief, and the Supervisory Audiologist to complete clinical disclosures, as appropriate, for patients identified as being affected by the audiologist's poor care.

Concur.

Target date for completion: September 27, 2021

Director Comments

The Chief of Staff, Service Chief, and Supervisory Audiologist will complete clinical disclosures, as appropriate, for patients identified as being affected by the audiologist.

Recommendation 4

The Eastern Oklahoma VA Health Care System Director initiates the process to determine whether a large scale disclosure is required, in accordance with the Veterans Health Administration policy.

Concur.

Target date for completion: September 27, 2021

Director Comments

Beginning June 4, 2021, all patients identified as evaluated by the implicated audiologist will be reviewed for large scale disclosure as determined through discussions with the Veterans Integrated Service Network and VA Central Office, per Veterans Health Administration policy.

Recommendation 5

The Eastern Oklahoma VA Health Care System Director evaluates processes, including annual competencies, used to ensure audiology leaders' compliance with the Veterans Health Administration's patient safety reporting requirements, and takes action as indicated.

Concur.

Target date for completion: June 25, 2021

Director Comments

Competencies were rewritten and reviewed by an Employee Relations/Labor Relations Human Resources specialist November 10, 2020. In addition, the Audiology Leaders are scheduled to complete patient safety reporting training by June 25, 2021. Upon completion, Leaders will demonstrate competency by completing a written exam annually.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 6

The Eastern Oklahoma VA Health Care System Director directs the Chief of Staff, the Service Chief, and the Supervisory Audiologist to notify the Patient Safety Manager of adverse events identified through the review of patients impacted by the audiologist's poor care.

Concur.

Target date for completion: June 25, 2021

Director Comments

The System Director will instruct the Chief of Staff, Service Chief, and Supervisory Audiologist to notify the Patient Safety Manager of adverse events identified through the review of patients' records. This notification process will be ongoing throughout the duration of chart reviews.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 7

The Eastern Oklahoma VA Health Care System Director ensures the Supervisory Audiologist verifies and documents annual competency assessments for audiologists in compliance with facility policy.

Concur.

Target date for completion: June 18, 2021

Director Comments

Verification that the Supervisory Audiologist documents annual competency assessments for audiologists has been integrated into said provider's annual review.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 8

The Eastern Oklahoma VA Health Care System Director ensures that the Supervisory Audiologist conducts performance appraisals of audiologists in compliance with the Veterans Health Administration policy.

Concur.

Target date for completion: March 31, 2021.

Director Comments

All audiologists' performance appraisals were completed in October 2020, and midterm evaluations were completed as of March 31, 2021. Fiscal year 2021 midterm evaluations are current.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 9

The Eastern Oklahoma VA Health Care System Director evaluates processes, including annual competencies, used to ensure audiology leaders' compliance with the Veterans Health Administration's state licensing board reporting policy, and takes action as indicated.

Concur.

Target date for completion: July 9, 2021

Director Comments

The Manager of Credentialing and Privileging will educate the Chief of Staff, Deputy Chief of Staff, Chief of Physical Medicine and Rehabilitation, and Audiology Leader on Veterans Health Administration state licensing board policies. Source information regarding Veterans Health Administration policy and state licensing board requirements will be included. Competency will be assessed through the use of an annual pre/post-test.

Recommendation 10

The Eastern Oklahoma VA Health Care System Director initiates a review of the audiologist's conduct to determine whether a report to the state licensing board is indicated, in accordance with the Veterans Health Administration policy.

Concur.

Target date for completion: June 7, 2021

Director Comments

The Chief of Staff and Service Chief have been instructed to review the provider's conduct and determine potential for state licensing board reporting. Their recommendation will be presented to the Credentialing and Privileging Manager for action as appropriate.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

OIG Contact and Staff Acknowledgments

Contact For more information about this report, please contact the
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