VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Department of Veterans Affairs

Review of Alleged Mismanagement of Group Therapy Access at VA Outpatient Clinic Austin, TX

February 5, 2016
14-04501-13

Report Highlights: Review of Alleged Mismanagement of Group Therapy Access at VA Outpatient Clinic Austin, TX

Why We Did This Review

In July 2014, a VA employee contacted the VA OIG's Hotline alleging 195 veterans were waiting to get into a specific mental health group therapy session at the Austin Outpatient Clinic (AOPC).

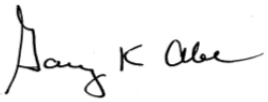
What We Concluded

We examined available compensation and pension records interchange system (CAPRI) records of a judgment sample of 40 veterans from the list of 195 veterans. We found that AOPC personnel contacted 34 out of 40 veterans. However, AOPC personnel contacted only 13 of the 34 veterans in 30 days or less. On average, it took 192 days for AOPC personnel to contact the remaining 21 veterans.

Although AOPC contacted 34 veterans to notify them that group therapy sessions were available, only 15 veterans attended. The remaining 19 signed up for the therapy sessions but did not attend. To ensure the Temple VA Medical Center completed appropriate actions to provide veterans at the AOPC the opportunity to participate in group therapy in a timely manner, our hotline division referred the findings through VHA to Veterans Integrated Service Network 17 for their review.

Management Comments

The Director, Central Texas Health Care System, indicated the staff could not replicate the pool of veterans to investigate delays in service and poor communications, but stated that the current wait time for therapy is within 1 week. Additionally, since November 17, 2014, these sessions are now open-group, with continuous courses to increase access and afford scheduling flexibility. In light of the Director of Central Texas Health Care System's response, we are closing this review without further action.



GARY K. ABE
Acting Assistant Inspector General for
Audits and Evaluations

Appendix

Methodology

OIG requested an interview with the complainant to gain a better understanding of the situation that existed at the AOPC. The complainant declined OIG's request for an interview. To ensure the complainant's confidentiality, we did not contact representatives of either the Central Texas Health Care System or the AOPC. We reviewed medical documentation contained in CAPRI.

Data Reliability

We obtained the list of 195 veterans allegedly waiting to get into a specific mental health group therapy session at AOPC. To test the reliability of the data, we compared a judgment sample of 40 veterans from the list with records in CAPRI. We verified that all 40 veterans were seeking mental health group therapy at AOPC, and concluded the data was sufficiently reliable for the purposes of this review.

Government Standards

We performed sufficient work on this hotline for the conclusions presented in this report. However, because the VA OIG hotline division referred this allegation to Veterans Integrated Service Network 17, we did not perform all of the required work to comply with all of the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

OIG Contact

For more information about this report, please contact the Office of Inspector General at (202) 461-4720.

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