ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

Psychotherapy Service, VA Medical Center in Des Moines, Iowa February 29, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based on an anonymous complaint to the Office of Inspector General (OIG) Hotline advising of a "secret waiting list" at the VA Medical Center (VAMC) for Psychotherapy Service in Des Moines, IA. The caller advised that a spreadsheet was kept on the shared drive for Psychotherapy Service and was destroyed by a VAMC Des Moines clinical psychologist, the keeper of the list, prior to Veterans of Health Administration's (VHA) May 2014 audit.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** We interviewed several persons familiar with the Psychotherapy Service, including the Chief of Health Information Management and System Redesign Coordinator, VAMC management officials, and the VAMC Des Moines Clinical Psychologist.
- **Records Reviewed:** Investigators reviewed documents and emails provided by VAMC staff, including documentation regarding the clinical psychologist's report of the existence of Psychotherapy Service spreadsheets to VAMC management.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- VAMC management officials we interviewed confirmed that they were familiar with the Psychotherapy Service spreadsheet. After media reports regarding issues at VAMC Phoenix* surfaced, VAMC Des Moines management requested all employees at the VAMC to advise if they kept any lists or spreadsheets of patients other than those officially sanctioned. VAMC management officials advised that a clinical psychologist reported the existence of the list (spreadsheets) to VAMC management and advised that he created the list in an effort to better treat veteran patients. VAMC management told the clinical psychologist to continue to use the Electronic Appointment Management System (EAMS) for all future appointments and to delete the spreadsheets from the shared drive. He agreed to do so although he argued that the previous system worked better for veterans and Psychotherapy Service staff.
- The clinical psychologist reported that, after his arrival at VAMC Des Moines, he realized that there was too long a wait for some patients seeking psychotherapy. In an effort to track how long patients waited, he created a spreadsheet to determine the

* Any reference to Phoenix in this report refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

length of the waits. After the creation of the spreadsheet, the backlog of patients waiting for appointments was eliminated. He also created a second spreadsheet to track patients' treatment progressions in the Psychotherapy Service, a more specific method of treatment. He advised this is a common practice for psychologists in Government and private practice. Both spreadsheets were kept on the Mental Health shared drive; all management and employees in Mental Health had access to the spreadsheets. After the Phoenix* investigation made headlines, VAMC Des Moines management requested all employees who had any sort of spreadsheet or list advise management of the existence of the document(s). He advised management of the existence of both spreadsheets and was told to delete the spreadsheets by the system redesign coordinator, which he did.

Records Reviewed

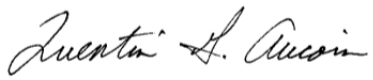
- Investigators attempted to retrieve a spreadsheet from the drive with the assistance of VAMC information technology (IT) professionals, but IT professionals were unable to recover the list as it was deleted more than 30 days prior to the search.

- Review of documents and emails provided by VAMC staff showed that information provided by staff during interviews was accurate.

4. Conclusions

The investigation did not substantiate the existence of a "secret" wait list. What was alleged to be a "secret waiting list" was in fact two spreadsheets created by the Psychotherapy Service Line to track wait times for initial consults and later for the more specific treatment of psychotherapy. VAMC management was aware of the spreadsheets.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 30, 2015.



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

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