

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



**Community Based Outpatient Clinic in  
St. Augustine, Florida  
February 26, 2016**

**1. Summary of Why the Investigation Was Initiated**

A senior manager, North Florida/South Georgia Veterans Health System (NF/SG VHS), notified the Department of Veterans Affairs (VA) Office of Inspector General (OIG) that a paper waiting list was being used at the Community Based Outpatient Clinic St. Augustine, FL. The senior manager obtained the list from an employee at this location who self-reported that she was maintaining it.

**2. Description of the Conduct of the Investigation**

- **Interviews Conducted:** A senior manager of the NF/SG VHS and the employee of CBOC St. Augustine who self-disclosed the paper waiting list
- **Records Reviewed:** A list of patients and a letter provided by the employee at CBOC St. Augustine.

**3. Summary of the Evidence Obtained From the Investigation**

**Interviews Conducted**

- An NF/SG VHS senior manager notified the VA OIG of a paper waiting list being used at the CBOC St. Augustine. A copy of the list and a letter explaining its purpose was also provided. The senior manager advised that the employee who had the list worked at CBOC St. Augustine. The employee self-reported the list when supervisors at this location asked employees with any lists to turn them over.
- The employee who self-disclosed the list explained that the list was a list of names of people who were interested in a support group that might be created at a future date. The list consisted of the names of interested caregivers in a program that did not yet exist, not veterans with related files where information about the support group could be documented. The employee further explained that she could not put the names into the Veterans Health Information Systems and Technology Architecture (VistA) scheduling system because the support group had not been created in the system. The employee also stated that she maintained the list locked in a file cabinet in her locked office that no one else accessed.

The employee stated she self-reported having this list, and provided a letter explaining why she maintained it after the Chief Medical Officer of CBOC St. Augustine advised all employees to turn in any handwritten lists. The employee stated that she took every precaution she could think of to protect the list. She also said the group was created in

VistA on the same day she reported the list, and she added all of the names to the group in VISTA. Any new additions to the group are documented in VistA and not on a paper list.

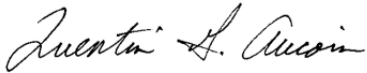
### **Records Reviewed**

A review of the list in question and the letter provided by the employee confirmed that the list was a list of 15 caregivers potentially interested in a support group.

### **4. Conclusion**

The investigation determined that the employee did not violate any Veterans Health Administration directives.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014.



QUENTIN G. AUCOIN  
Assistant Inspector General  
for Investigations

---

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

---