Department of Veterans Affairs

Office of Inspector General

SPECIAL INQUIRY

MANAGEMENT PRACTICES AND OTHER ISSUES AT THE SPARK M. MATSUNAGA VA MEDICAL AND REGIONAL OFFICE CENTER HONOLULU, HAWAII

Report No. 8PR-A19-040
Date: December 2, 1997

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

DEC 2 1997

TO: Acting Director, VA Sierra Pacific Network (10N21)

SUBJECT: Special Inquiry – Management Practices and Other Issues at the Spark M. Matsunaga, VA Medical and Regional Office Center, Honolulu, Hawaii, Report No. 8PR-A19-040, dated December 2, 1997.

1. The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted an inquiry into various management practices and other issues at the Spark M. Matsunaga VA Medical and Regional Office Center (VAMROC), Honolulu, Hawaii. The special inquiry was initiated as the result of allegations sent to the OIG Hotline Section and at the request of Senator Daniel K. Akaka.

2. We reviewed 34 allegations received from various sources, and divided the complaints into the following 4 categories:

a. Allegations of harassment and intimidation
b. Allegations of mismanagement
c. Allegations of personnel irregularities and preferential treatment
d. Allegations of discrimination

Most of the allegations were made against Mr. Barry Raff, the VAMROC Director. A few of the allegations involved other VAMROC officials such as the Acting Chief of Staff, and mid-level managers.

3. Allegations of Harassment and Intimidation – The VAMROC employees were essentially divided into two camps regarding the Director's management style and actions. Our interviews with 30 current employees and 10 former employees showed that more than 55 percent of these employees perceived the Director's management style to be brusque and insensitive and that his manner served to divide the staff and reduce the effectiveness of VAMROC operations. On the other hand, about 45 percent of current and former employees interviewed supported the Director's management actions and indicated he has been faced with difficult decisions in bringing the facility into compliance with VA policies, reorganizing the facility, and expanding VA services to the

outer islands and at Tripler Army Medical Center (TAMC) while facing diminishing resources.

Our inquiry was not a scientific sampling of VAMROC staff, however, we believe the results provide a basis for concern regarding management at the VAMROC. We recommended a thorough organizational review to determine if corrective actions are necessary at the leadership level as well as the employee level. Intervention is necessary to bring the facility staff and management closer together working towards the organization's goals. The Acting Director, Veterans Integrated Service Network (VISN) 21 (VA Sierra Pacific Network), concurred with our recommendation and provided an acceptable implementation plan. Details of our review regarding the allegations of harassment and intimidation are discussed in Chapter 1 beginning on page 4.

4. Allegations of Mismanagement – Most of the allegations related to mismanagement of resources were not substantiated. However, we did substantiate that the VAMROC purchased expensive photographic prints totaling $104,316 on a sole source basis. The VA paid as much as $4,699 for a single framed print. During times of diminishing VAMROC resources, the purchase of expensive artwork for VA buildings could be viewed as wasteful. We recommended that the Acting Director, VISN 21 take the necessary administrative actions with respect to the responsible employees and ensure that future artwork is purchased on a competitive basis. The Acting Director, VISN 21 concurred with the recommendations and provided an acceptable implementation plan. Details regarding the allegations of mismanagement of resources are discussed in Chapter 2 beginning on page 16.

5. Allegations of Personnel Irregularities and Preferential Treatment – There was a perception among employees who did not support the Director that higher graded positions at the facility were generally filled on a non-competitive basis and that higher graded positions were reclassified to the benefit of staff who were perceived to be in the Director's "inner circle." The complainants cited as examples the non-competitive promotion of front office staff members, selected service chiefs, and reclassification of positions designated for front office staff. In times of diminishing resources and limited opportunities for promotion, these actions for close associates and/or friends of the Director, created discord among the rank and file employees.

The decision by the Director to fill positions non-competitively impacted adversely on employee morale. We believe expanded use of the competitive promotion process at the VAMROC would give more employees an opportunity to at least be considered for these positions and dispel the notion of personnel violations and preferential treatment. These conditions were discussed with the Acting Director, VISN 21, who informed us he would look into these issues. Details regarding these issues are discussed in Chapter 3 beginning on page 30.

6. Allegations of Discrimination – We found the number of formal Equal Employment Opportunity (EEO) complaints filed at the VAMROC had increased significantly in Fiscal Year (FY) 1996 compared to FY 1994 and FY 1995. There were 9 formal EEO complaints filed in FY 1996, whereas 3 each were filed in FY 1994 and FY 1995. Most of the increase was attributable to what appears to be increasing tensions among employees at the Pacific Center for Post Traumatic Stress Disorder (PTSD), an operating element of the VAMROC. We believe the Director should determine the underlying causes for the increase in complaints and take appropriate corrective action. The Medical Center Director agreed to review the conditions and issues with staff at the Pacific Center, PTSD, and take actions as appropriate. Details regarding the discrimination issues and our recommendations are discussed in Chapter 4 beginning on page 40.

7. We are continuing to review allegations that a manager at the facility misused government earned frequent flyer miles. The results of this review will be discussed in a separate report. We will follow-up on all recommendations made in this report until the issues have been resolved.

(Original signed by)
JON A. WOODITCH
Acting Assistant Inspector General for
Departmental Reviews and Management Support

Enclosure

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SPECIAL INQUIRY

MANAGEMENT PRACTICES AND OTHER ISSUES AT THE SPARK M. MATSUNAGA VA MEDICAL AND REGIONAL OFFICE CENTER HONOLULU, HAWAII

REPORT NO. 8PR-A19-040
(Hotline No. 7HL-134)

INTRODUCTION

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted an inquiry into various management practices and other issues at the Spark M. Matsunaga VA Medical and Regional Office Center (VAMROC), Honolulu Hawaii. We received correspondence sent to our Hotline Section alleging abuse and mismanagement, and a congressional inquiry from Senator Daniel K. Akaka, who received similar allegations in his District Office.

Background

The VAMROC (VA facility) serves veterans in the Pacific Basin, a geographic service area of 4.8 million square miles. The VA facility's affiliations are with the University of Hawaii and Tripler Army Medical Center (TAMC).

The VA facility provides outpatient treatment through a main clinic on the island of Oahu, and through five primary care clinics on the Hawaiian islands and Guam. The Pacific Center for Post Traumatic Stress Disorder (PTSD), a division of the National Center for PTSD, is operating in Hawaii with unique capabilities for PTSD treatment, research, and education. The VA also provides a 16-bed residential rehabilitation program on the island of Hawaii, which provides in-depth inpatient PTSD treatment. A 19-bed VA-staffed psychiatric ward and a jointly staffed (VA/TAMC) 20-bed locked ward opened in 1993.

There is also a VA and Department of Defense (DoD) joint venture with TAMC targeted for completion in 1998. The venture includes construction of 60 nursing beds, an outpatient clinic, and renovation of one wing at the TAMC for VA use. The 60-bed Center for Aging (nursing home) opened in 1997. Currently, the VA provides patients' hospitalization through a sharing agreement with TAMC and community hospitals.

The VA Regional Office component of the facility processes claims for compensation, pension, and education benefits, and operates a home loan guaranty program. VA staff provide a wide variety of benefits and related services.

The Director, Mr. Barry Raff has been at the VA facility since 1988. He directs a top management team composed of three senior positions. During our review, the Associate Director was ***(b)(6)***, and the Acting Chief of Staff was ***(b)(6)***. The Assistant Director, ***(b)(6)***, was responsible for VA Regional Office benefit activities.

This current top management structure has been in effect for several years. Prior to that time, Mr. Raff served as the Director of the VA Clinic and his Chief of Staff was ***(b)(6)***. His Associate Director was ***(b)(6)***. ***(b)(6)*** independently served as the Director of the Regional Office. His Assistant Director was ***(b)(6)***. ***(b)(6)*** transferred, and ***(b)(6)*** retired in the early 1990's. Mr. Raff became the Director of the entire VAMROC, and hired ***(b)(6)*** to serve as Chief of Staff. ***(b)(6)*** and ***(b)(6)*** transferred back to the mainland, and were replaced by ***(b)(6)*** and ***(b)(6)***.

Scope

The OIG Hotline Section received correspondence from anonymous sources which contained 34 allegations of abusive treatment and mismanagement at the VAMROC in Honolulu. Senator Daniel K. Akaka's staff also contacted us regarding complaints they were receiving on similar issues.

Our Special Inquiries staff evaluated the allegations and visited the facility. During our visit, we received similar allegations of mismanagement from employees who visited us in the team room, or contacted us by telephone. Many of the complaints overlapped and focused on the Director's interactions with his managers and staff. Employees alleged that the Director harassed and intimidated his managers and staff, misused government funds and resources, promoted certain staff unfairly, and discriminated against employees and engaged in preferential treatment. We received other allegations that were too vague to review (e.g., the Director uses his influence in fiscal matters). We also received allegations concerning questionable funding expenditures by the Director, Pacific Center for PTSD.

There were two other allegations of questionable behavior by employees. There was no nexus to VA related operations, nor did we find any evidence to support the complainant's charges during preliminary inquiries. Therefore, we took no further action to review these two issues.

We also received allegations that a VA manager misused government earned frequent flyer miles. The results of this review will be discussed in a separate report.

We spoke with over 50 staff (physicians, nurses, and administrative employees) and a number of veterans during our visit. We interviewed the Director and Acting Chief of Staff under oath and took taped testimony on the issues brought to our attention. We also interviewed other applicable mid-level managers and employees. We also contacted several former top managers and service chiefs who worked at the facility with the Director in prior years.

We reviewed purchase orders, fiscal records, personnel folders, contracts for scarce medical services, fee basis procedures, time and attendance practices and other activities and records as considered necessary to complete the review. We also met with the former Director, Veterans Integrated Service Network (VISN) 21, and current Acting Director, VISN 21, and discussed the management and fiscal issues at the VA facility in Honolulu.

During our review, we met with a member of the Governor's Advisory Board which represents veterans concerns on the island of Kauai. The Board member expressed concern about the fee basis billing procedures at the VA facility and asked that we look into this area. We included this area into the scope of our review.

The Board member also discussed with us other Veterans Benefits Administration (VBA) related issues. The Board member expressed opposition to proposals to consolidate adjudication activities, and other services from Honolulu back to the mainland. These issues were discussed separately with VBA management. During our visit, we also met with several veterans and patients at the Kauai clinic to discuss the service VA provides to them and their community.

RESULTS AND RECOMMENDATIONS

CHAPTER 1

ALLEGATIONS OF HARASSMENT AND INTIMIDATION

Discussion

We received allegations that the Director harasses and intimidates his managers and staff, and uses profane language; particularly towards female employees. The details of these allegations follow.

Allegation 1a: The Director has open confrontations and uses profanity at staff meetings, particularly towards female employees.

We did not substantiate the allegation. There was no conclusive evidence to show that the Director harasses and intimidates his managers and staff. There were 18 employees and 5 former employees who we spoke with that perceived the Director's management style to be brusque and insensitive, and that his manner only served to divide his staff and reduce the effectiveness of clinic operations. However, there were 12 other employees and 5 former employees who told us the Director was straight-forward and a strong leader.

Those who did not support the Director did not have confidence in his ability to provide effective leadership during a time of budget reductions, consolidations, and staff reassignments. Those who supported the Director believed he made effective changes to the clinic's operations and several hard choices to meet the challenges facing the VA. We were not able to determine whether these perceptions (for or against) extended beyond those staff with whom we interviewed during the limited time we had on-site.

Both groups we spoke with said that Director confronted staff at meetings, but their interpretations of his style differed. The employees who believed the Director's management style to be inappropriate perceived his straight-forwardness to be humiliating and insulting, although not solely to female employees as charged in the complaint. The employees who supported the Director recognized his questioning to be necessary and valuable in his ability to understand the problems facing the facility. They informed us that while he asks direct questions, they are intended to get to the issues and potential resolutions.

The Director's supporters believed that differing attitudes between mainland employees, and local island employees may be a factor. We were told that the clinic has a history of conflict between employees who transfer into positions from the mainland, and local staff who believe that this practice leaves one less position for local staff to compete for at the facility.

We did not substantiate that the Director used vulgar profanity during his conversations. While three employees stated the Director used terms such as "god---n" and "f--k" in the course of his conversation with them, most staff interviewed said the Director did not use vulgar language at all.

The Director acknowledged that he is straight forward and does not "…beat around the bush." He also acknowledged that he gets frustrated "a lot when he rehashes issues for the fifth time with staff" or when the same issue comes up again and again. He said that at times he does not have much tolerance, and that some people that do not know him may not be comfortable with his straight-forwardness. The Director stated that he did not believe he used vulgar language when speaking to employees, especially female employees as alleged by a complainant. However, he said that he probably would say "damn" or "hell" occasionally, but he did not believe he used these terms excessively or that these words fit the definition of profanity.

The Director acknowledged that there was a small group of employees who did not support a decision to remove the ***(b)(6)*** which has caused some bad feelings. He also acknowledged that not all employees were able to adjust to his establishing controls and procedures that have been lacking in the clinic and are essential to the efficient operation of VA activities on the island. He also attributes some of the employee unrest to efforts to reorganize functions and activities. This has created discomfort and uncertainty for those employees effected by the changes. He also believed that some of the employees who complained about his management style have personnel issues with management, which may have affected their objectivity. The Director believes that they are attempting to respond to these issues by increasing communications among staff and increasing training opportunities to bring staff closer together in the working environment.

Allegation 1b: The Director humiliated the *(b)(6)* and forced him to retire.

The allegation is partially substantiated. We interviewed ***(b)(6)***, to ask him about his management relationship at the facility during his tour as ***(b)(6)*** and later as ***(b)(6)***. ***(b)(6)*** agreed that the Director publicly humiliated him during his tenure at the facility, but contrary to allegations that the Director forced him to retire, he said that he ***(b)(6)*** of his own accord.

·***(b)(6)***····· was the ·***(b)(6)***····· at the VA facility for about ·***(b)(6)***····· ·····. In 1987, the VA planned to open a VA Medical Center in Honolulu as the result of congressional concerns that the State did not have a VA inpatient presence. ·***(b)(6)***····· said the Regional Director, Mr. Robert Lindsey, approached him to determine whether he would be interested in serving as Director of the facility. ·***(b)(6)***····· said he declined the offer because his expertise was ·***(b)(6)***····· management. He informed the Regional Director that he would probably be more comfortable serving in the role of ·***(b)(6)***·····.

He said he stayed on as ·***(b)(6)***····· and was very proud of the service provided by the VA clinic prior to his leaving for the mainland. He explained that his goal was to provide quality patient care by ensuring the clinic physicians provided one-on-one service, and fostered sound physician/patient relationships. He said that they were proud of the relationships they built with the patient population, congressional offices and other Federal groups on the island.

·***(b)(6)***····· said that when Mr. Raff arrived in 1988, he brought with him different ideas on how to achieve the facility's goals. He believed the Director was more interested in numbers and process rather than patients. He characterized the Director's management style as autocratic and suppressive. ·***(b)(6)***····· said he reasoned that the Director treated him as poorly as he did because he felt the Director needed to make an example of him to the other staff at the VA facility. ·***(b)(6)***····· believed that the Director felt he needed to establish himself with the employees, and did so by making it clear during meetings that the ·***(b)(6)***····· was no longer in charge.

He recounted several instances where the Director displayed this type of behavior. ·***(b)(6)***····· recalled one meeting with visitors where it was clear that he was not welcome in the discussion. He recalled the Director saying in front of these visitors "I'm not interested in anything you have to say." ·***(b)(6)***····· said he felt Mr. Raff's comments and attitude towards him were completely inappropriate.

He also recalled a meeting where Mr. Raff expressed his irritability with him and his staff physicians. ·***(b)(6)***····· said that during the meeting the Director stated "I don't give a damn about patient care." The statement was made in the context of the Director discussing workload priorities and ·***(b)(6)***····· supporting caring for the patient as the clinic's first priority. The former ·***(b)(6)***····· believed that the Director lost some of his support from physicians at this meeting. The Director denied ever making this statement, and believed ·***(b)(6)***····· took his remarks out of context.

·***(b)(6)***····· said that it was not until he wrote a complaint letter to the Regional Director, Mr. Robert Lindsey, outlining the communication problems with the Director

that the humiliation ceased. In the letter to the Regional Director, ·***(b)(6)***····· outlined 3 conditions that needed to be met or he would step down as ·***(b)(6)***·····.

- We must have respect between the Director and ·***(b)(6)***·····.

- We must follow VA policy concerning our responsibilities which meant that the ·***(b)(6)***·····, not the Director, would be responsible for the clinical side of the facility.

- If we cannot resolve our differences, we should have someone come over and look at the leadership and management of the facility.

·***(b)(6)***····· said that after he sent that letter to the Regional Director, the humiliation stopped. He said that work went pretty smoothly until he transferred. He said that he did not transfer because the Director forced him to leave. Rather, he said he and his spouse planned retirement back on the mainland.

The Director said that the issues he had with ·***(b)(6)***····· were resolved early in his tenure at the facility. He was brought on board to increase the VA presence in Hawaii and to bring more administrative strength to the facility. The Director said that ·***(b)(6)***····· was a good clinician but not a very good administrator. The Director noted that many processes regarding eligibility, basic management reporting, referrals for care, and financial procedures were questionable or non-existent upon his arrival. He noted that ·***(b)(6)***····· personally approved each and every fee basis referral himself and that over two-thirds of the outpatient visits seen were walk-ins.

The Director stated he set out to correct these conditions, establish procedures, introduce appointment scheduling etc., which met with opposition from ·***(b)(6)***·····. However, the Director said that after an initial period of adjustment, they had worked well together. The Director also said that he worked very hard to assist ·***(b)(6)***····· in obtaining a position at a VA facility in close proximity to where he planned to retire.

Allegation 1c: The Director humiliated the former ·*(b)(6)*·····.

The allegation is under Equal Employment Opportunity (EEO) review. Consequently, we did not comment on whether or not the allegation is substantiated. The Director selected ·***(b)(6)***····· as ·***(b)(6)***····· after ·***(b)(6)***····· left the facility. We found that the Director compelled ·***(b)(6)***····· removal and reassigned him to conduct research activities in September 1996. The Director informed us that the action was based on complaints he received from 6 of the 9 members of the Medical Center Resources Board (MCRB), concerning ·***(b)(6)***····· performance at the MCRB. The Director said that he conducted a painstaking investigation into ·***(b)(6)***····· performance,

and based his decision on input from many health care professionals and managers on his staff.

(b)(6) claimed discrimination on the basis of age, race, and disability. ***(b)(6)*** supporters continue to disagree with the Director's decision to remove him, particularly in the abrupt and impersonal way it was accomplished. There was also the belief that the Director used his hand picked supporters to justify the former ***(b)(6)*** removal. The actions taken by the Director prompted an EEO investigation into the circumstances of the reassignment. An EEO investigator visited the facility in March 1997, and information was sent to VISN management for disposition action. A third complaint by ***(b)(6)*** is still in the EEO process. We did not reach a conclusion on whether ***(b)(6)*** removal was appropriate because this issue will be addressed as part of the EEO investigation in progress.

Allegation 1d: The Director harasses and humiliates the *(b)(6)*****.**

We did not substantiate the allegation. We found that the Director and ***(b)(6)*****, were at conflict with each other and that this discord was common knowledge among the staff. However, we could not confirm whether or not this discord qualified as harassment and humiliation.

Interviews with staff at the facility established that the Director has expressed concern about the ***(b)(6)***s management effectiveness to others about how capable his associate is in the performance of his duties. However, ***(b)(6)*** preferred not to comment on the issue. He acknowledged that the Director and he have different ideas of how to communicate with staff and how to proceed with the goals of the facility. ***(b)(6)*** said he discussed these issues with the VISN Director and is looking for opportunities for reassignment.

The Director confirmed he has concerns with the ***(b)(6)***s performance and said he is not confident of the ***(b)(6)***'s work. He said, however, that he was not consciously aware of making disparaging comments about ***(b)(6)*** in front of other staff or intentionally harassing him. The Director rated ***(b)(6)*** "fully successful" during the last performance period, but provided narrative comments that highlighted his concerns about him as a manager of a facility.

Allegation 1e: The Director humiliates and harasses *(b)(6)*****.**

We did not substantiate the allegation. Our review was inconclusive because we received differing opinions about the Director's interaction with his managers. We discussed this issue with 10 current managers at the facility and found that they were divided in their opinions concerning the Director and his management style. We were told by 5 managers

that they perceived the Director to exhibit inappropriate behavior in communicating with managers and staff. They described him to be "impulsive" and a "bully." However, there were 5 other managers that believed the Director had high expectations of their performance and that they dealt effectively with him. The interviews did not substantiate that managers were humiliated and harassed, even though some perceived they were.

Allegation 1f: The Director has an "inner circle" and "outer circle" of staff, and those close to him receive preferential treatment.

We did not substantiate the allegation. Staff who generally did not support the Director believed there was an "inner circle" of employees who received preferential treatment. While staff perceived this to be true, there was no evidence to support the statement.

We were told by those employees who believed the Director acted inappropriately that he keeps himself surrounded by an "inner circle" of friends who are rewarded, and that staff who do not support him are harassed and humiliated. The employees took issue with two of the Director's friends, ***(b)(6)***, and ***(b)(6)***. We did confirm that ***(b)(6)*** are long time friends of the Director, and their friendship goes back as far as 1971. However, we did not find any evidence, nor was any evidence brought to our attention, to confirm that the Director treated these two employees differently.

We asked the ***(b)(6)***, whether he believed the Director surrounded himself with an "inner circle" of managers, and whether these staff get preferential treatment. The ***(b)(6)*** did not believe there was an "inner circle" as such. He stated that the Director has a group, and he is a member of that group, who he counts on to get work done. He said that the Director knows this group will give him "straight-up" information, and that they are loyal to the VA and to the facility. However, he does not believe anyone in this group is given preferential treatment.

The Director said that he consults with staff in which he has more confidence, but denied any form of preferential treatment towards these individuals. He stated as an example that he has known his ***(b)(6)*** and ***(b)(6)*** for more than 20 years ***(b)(6)***. He believes he probably treats them more unfairly than other staff to avoid the appearance of preferential treatment.

Allegation 1g: The Director humiliated and harassed *(b)(6)*.

We did not substantiate the allegation. We were able to locate and interview 4 former service chiefs and asked them to describe their interaction with the Director during their tenure at the VA facility. Three of the former service chiefs believed the Director exhibited inappropriate behavior towards them and their staff at meetings. For example, one former service chief recounted that the Director continued to threaten her with removal and used vulgar language during his discussions with her on facility matters. The Director denied these allegations and informed us that he had serious performance issues with the employee, and was integrating her Service into other elements of the clinic. He said this may have caused her to be less than objective.

Another former service chief believed the Director was unethical in his manipulation of funding and lack of concern for VA policies and procedures. We spoke with fiscal staff at the facility and found there was one specific event during the fiscal year (FY) wherein they believed the Director knew he received duplicate activation funding and kept the money for facility use. Fiscal staff we spoke with were convinced that the facility received too much funding ($384,299) in two transfer authorities received in May 1988.

The Director disagreed with his fiscal staff's conclusion. In his e-mail to VA Central Office he wrote, "Based on my review, it appears that this is not a duplication of TDA's [Temporary Disbursement Authority] as we discussed but merely getting the FY 88 initial recurring funds into FY 89, then in addition we received the FY 89 portion. Do not make any adjustments to withdraw this funding as it will result in insufficient funds left for the IMP plan. Thanks for your support - I owe you one (or is that two?)." Fiscal did not agree with the Director's interpretation or the suggestion early in his correspondence that they discussed the issue and were in agreement. Fiscal believed that they received these funds in FY 88 and they were included again in FY 89. Fiscal staff took the Director's comments to VA Central Office to mean that he was seeking a favor from them to overlook this occurrence. The Director disagreed that the funding was duplicated, and believed that the facility would be in a deficit if they had not retained the funds. Because these events occurred a long time ago, we turned this issue over to the VISN for resolution.

One other former service chief stated the Director continually harassed him while he was at the medical center. The other former service chief acknowledged that the Director was straight-forward, but that he never encountered any problems with him. None of the former service chiefs felt the Director forced them out, but stated that their dealings with him on a day-to-day basis was a factor in their decision to relocate to another facility.

The Director informed us that some former Service Chiefs were finding it difficult to adjust to the implementation of procedures and reorganization of clinic resources. He

believes this may have hampered their objectivity concerning him as a manager. He provided us several names and phone numbers of former managers who he suggested we contact to provide balance to these allegations.

We spoke with 5 former managers who were supportive of the Director and the leadership he provided them during their tenure at the facility. We spoke with the former ·***(b)(6)***·····, and the former ·***(b)(6)***····· who currently hold leadership positions in VA on the mainland. Both managers fully supported the Director's efforts at the facility. They said that the Director was faced with enormous challenges in reorganizing the facility at Honolulu, and opening additional services on the outer islands, and in creating sharing arrangements with TAMC. We also spoke with the former ·***(b)(6)***····· and former ·***(b)(6)***·····. They also supported the Director fully and believed he was a strong leader.

Allegation 1h: The ·*(b)(6)*····· humiliates and harasses employees.

We did not substantiate that the ·***(b)(6)***·····, humiliates and harasses employees because there was no evidence to support the statements. We interviewed 12 employees who worked for or with the ·***(b)(6)***····· at the facility. Of the 12 employees who discussed the ·***(b)(6)***·····s interaction with them, 10 staff considered his behavior to be unpredictable and erratic. There was no evidence beyond that which was perceived by these employees to prove that the ·***(b)(6)***····· inappropriately humiliated and harassed them. We did not speak with employees who did not seek us out about the ·***(b)(6)***·····. Therefore, we have no measure for determining how many employees at the facility were supportive of the ·***(b)(6)***·····s management style.

·***(b)(6)***····· ardently denied the allegations against him and attributed the employee discomfort with him to the rapidly changing organizational environment at the facility, and the reassignment of the former ·***(b)(6)***·····. The Director informed us that supporters of the former ·***(b)(6)***····· only represented a fraction of the workforce at the facility, and speculated that they would not be supportive of ·***(b)(6)***····· as ·***(b)(6)***·····. The Director and ·***(b)(6)***····· also knew of a few physicians who they had previous performance issues with, and believed that these staff may have complained without merit. The Director fully supported ·***(b)(6)***····· and said he is an effective ·***(b)(6)***····· manager, and he has made significant contributions to the facility as the ·***(b)(6)***·····.

*·**(b)(6)**····· View of the Director and his interaction with employees*

The ·***(b)(6)***·····, testified that the Director has a "detailed-oriented mind." He said that if things don't make sense to the Director, he steps in and takes the initiative to try and understand the issue. He also said that when the Director does not trust someone, the intensity of his involvement increases. The ·***(b)(6)***····· said that as the ·***(b)(6)***·····, the Director lost confidence in him as a result of a poor presentation and he had to work very hard to regain his trust. He noted that as the Director developed more confidence in him, his need to know about his activities was measurably reduced. He fully supported the Director as an effective leader.

Speaking more generally about employees' perceptions at the facility, the ·***(b)(6)***····· acknowledged that there has been a history and a general atmosphere of unhappiness and mistrust in Honolulu. He said employee surveys taken in July 1995 have resulted in management interventions to try and resolve these perceptions and that plans are to resurvey again. He said the reasons behind the loss of confidence by some staff is unclear. He said they have taken steps to try and implement a code of conduct and resolve issues at the VA facility. He also said that while one could view staff concerns as a sign of a "sick organization," another could interpret the actions taken by management as a "big step forward in trying to get everybody on the same page."

Organizational Study of Employees in July 1995

The Director has recognized there are camps at the facility as well as other organizational issues that needed to be addressed. The Director contracted with a management consultant to conduct an organizational study in July 1995. The questionnaire provided employees with 40 positive statements related to the organization, management, job satisfaction, and work environment. Employees responded to the survey by indicating whether they strongly agreed with the positive statement, agreed, were neutral, disagreed, or strongly disagreed with the positive statement.

The motivational consultant used a threshold of 25 percent or more of those employees who disagreed or strongly disagreed with a statement as sign of a need for management to pay attention to the area. Using this threshold, the facility identified 8 of the 40 issues as areas of concern.

We noted however that there was a significant group of employees who submitted negative statements just under the 25 percent threshold set by the consultant. We recalculated the same data using a threshold of 20 percent of the employees who disagreed or strongly disagreed with a statement and found the number of negative statements doubled. We believed 20 percent of the workforce was still a significant number of employees, although, the Director pointed out it was not consistent with the

threshold established by the consultant. Using a 20 percent threshold, VA facility staff disagreed or strongly disagreed with 16 of the 40 positive statements (40 percent) in the survey.

The consultant's results were shared with employees at training sessions where staff were actively encouraged to provide suggestions for improvement. According to the Director, the 8 issues were looked at closely and a number of the employee suggestions were implemented along with ideas from top management. We believe the organization study was a good idea and a sincere effort by management to better understand the organizational climate at the VA facility. However, our interviews with employees showed that more needs to be done, and that the study as conducted may have missed other issues. We also noticed that there was a large number of employee responses in the survey who did not agree or disagree with the statements. The ambivalence shown in these responses could also be an indicator of problems that warrant management's attention.

We would suggest that an independent organizational survey be taken again, and this time the focus should be more related to the leadership and management at the top and mid-level echelons of the organization. This type of survey would afford the input from all VA facility employees as to whether the Director and other mid-level managers have the support of the rank and file staff. The prior survey's partial focus on pay and job quality issues is important, but not at the heart of the problems expressed to us by current and former facility employees.

Conclusion

There was no conclusive evidence that the Director harassed and humiliated managers and employees at the facility. However, some employees at the facility perceive the Director and ***(b)(6)*** to treat staff inappropriately which has effected morale. The Director and ***(b)(6)*** acknowledged that employees are separated into factions, and they provided several reasons to explain the conflict.

The Director said that historically, employees local to the island have been frustrated by the transferring of staff from the mainland; often to take mid-level and top management positions at the facility. Local employees believe this reduces their opportunity to succeed at the facility, or to have a vacancy filled by another person local to the island. He believed that this may have been exacerbated when he was required to remove the ***(b)(6)*** who had Asian-Pacific ties and local employee support.

The Director also believes that employees are concerned about the down sizing of the VA in general, budget uncertainties, and his plans to reorganize services and activities to streamline the facility's operation. This has caused anxiety among staff and may have contributed to some of the allegations made against him.

The conflict between the former ***(b)(6)*** and the Director and, to some extent, the conflict between the ***(b)(6)*** and Director have also raised employee concerns to the point of contacting congressional staff and independent reviewers for assistance. We could not determine whether this represents a small or large segment of the employee population, but there were more than just a few staff who sought us out to express concern about management. We believe the condition warrants VISN management's attention because the senior leadership at the facility and facilities in general set the tone and deportment of their employees in working effectively together, as well as providing quality service to veterans and their dependents.

Recommendation 1:

The Director, Veterans Integrated Service Network No. 21 should increase the supervision over senior managers at this facility, and take steps to ensure all management staff are working effectively towards the same goals. This would include consideration in conducting an independent organizational study to obtain specific information from all employees on their dealings with senior and mid-level management, and taking actions in response to these concerns.

Acting Director, Veterans Integrated Service Network (VISN) 21 Comments:

The Acting Director, VISN 21 concurred with the recommendation and provided a responsive implementation plan. He stated that his office would establish goals and objectives for VAMROC Honolulu, and conduct regular (video-or-tele-) conferences with senior management to monitor the progress and facilitate improvement. He also stated they would consider a subsequent general survey of employee views towards senior management after conditions stabilize.

The Acting Director, VISN 21 did not agree with our lowering the threshold of the percentage of negative comments made by staff from 25 percent to 20 percent in our discussion of the facility's organizational study conducted in July 1995. He pointed out that without a complete understanding of the survey tool and sampling technique, the proposed interpretation of the study may not be valid or could lead to an erroneous conclusion (See Appendix B).

VA Office of Inspector General Comments:

The Acting Director, VISN 21 comments and implementation plans met the intent of the recommendation. Our observation that a significant group of employees submitted negative statements just under the 25 percent threshold set by the consultant in an organizational study conducted in July 1995, was not made with the intent of changing the findings of that review. We pointed out that by recalculating the same data using a threshold of 20 percent of the employees who disagreed or strongly disagreed with one of the questions posed to staff, the number of negative statements doubled. We believe this was one additional indicator that could be considered, but acknowledged that an independent organizational study focusing on specific leadership and management issues was needed. We will continue to follow-up on the VISN implementation plan until all planned actions have been completed.

CHAPTER 2

ALLEGATIONS OF MISMANAGEMENT

Discussion

We received a number of allegations that the Director mismanaged funds at the facility. The Director allegedly wasted funds purchasing wall decorations, training facilities and materials, and expensive furniture. There were also allegations of contracting and procurement irregularities, and veteran complaints that their fee basis bills were not being paid. We also received complaints of fee basis irregularities and inappropriate payments to Tripler Army Medical Center. The allegations and review of the issues follow.

Allegation 2a: The Director wasted funds purchasing many expensive Kastner prints; so many that they had to be placed in the examination rooms because the hallway walls could not accommodate any more.

The allegation is substantiated. The facility's procurement records showed that in the past 3 fiscal years, VA has purchased, on a sole source basis, $104,316 worth of Kastner prints. The VA paid as much as $4,699.40 for a single framed print. The prints are of Hawaiian scenes and are purchased from a local artist.

VA facility records showed the following purchases of Kastner prints:

Location	Amount	Fiscal Year
Nursing Home	$58,034	1996
Mental Health Clinic	10,000	1995
Outpatient Clinic	10,000	1994
PTSD Clinic	26,282	1994,1996
Total	$104,316	

We also noticed Kastner prints in various administrative offices in the building including the Director's suite, but the VA facility could not find the purchase orders documenting the cost of these prints. Whatever the costs are, they would be in addition to the above amounts.

The sole source justification for one recent purchase stated "this particular artwork is desired by all parties concerned and these pieces possess several unique characteristics

only available from the source. Art of this particular type is already used and displayed at the VAMROC and is known to provide a more desirable effect on patients and employees aesthetically and culturally creating a more pleasant working and medical treatment environment."

The Federal Acquisition Regulations (FAR) requires contracting officers to promote competition to the maximum extent practicable to ensure that the product is advantageous to the Government. When using simplified procedures, contracting officers may solicit from one source when the contracting officer determines that only one source is reasonably available.[1]

The FAR prohibits the Government from including restrictions or conditions not necessary to satisfy the minimum procurement needs of the Government.[2] Photographs of Hawaiian scenes are not unique to one photographer, and there is no requirement to purchase only limited edition prints. We therefore concluded that the justification for limiting solicitation to one source was unjustified.

VAMROC procurement officials did not solicit competition from other, less expensive sources of local art. Therefore, we concluded that officials wasted money by not attempting to locate the best value for the Government.

We observed the display of many of the prints. While the prints are generally pleasing to the eye when placed in an appropriate setting, we observed a number of them in treatment rooms or clinic offices squeezed in between calendars, bulletin boards, and posters which greatly distracted from the charm of the prints. When the facility moves to its new location at TAMC, there may be more room to appropriately display the prints.

Conclusion

We do not believe the VA facility should be in the art collection business. The Kastner prints purchased by the facility are limited editions and must be bolted into the walls for security purposes. The VA facility is not an art gallery and spending scarce funds on individual prints costing as much as $4,699 could be viewed as wasteful by most individuals. We have brought this issue to the attention of VISN management for corrective action.

[1] 48 CFR 13-106-2.
[2] 48 CFR 11.002.

Allegation 2b: **VA dollars, which should have been used for patient care, were used to fund a management retreat at the plush Turtle Bay Hilton resort.**

This allegation is unsubstantiated because the funds were not wasted. It is true that VA facility funds in the amount of $14,170 were used to hold a management retreat at the Turtle Bay Hilton, during the period September 1st through 3rd, 1993. However management training, although obviously a lower priority than patient care, is important to the overall functioning of the VA facility staff.

There was nothing in the records to indicate that staff training funds detracted from patient care. There was also reportedly no shortfall of funds, and funding was available for the staff training. The $14,170 fee included the lodging and facility costs at the Turtle Bay Hilton and the costs of the stateside professional facilitator. The cost per attendee for the 30 VA facility employees who attended the 3 day session was about $500. This is not a significant cost considering the cost of sending employees off-island for similar training.

We were told the training covered such management subjects as strategic planning and total quality improvement. These are important subjects for managers. We understand that the overall results from this training effort were mixed and the facilitator was not hired again nor was the Turtle Bay Hilton used again for training.

Conclusion

There is no regulation that prohibits managers from holding a retreat off site to discuss current and important management issues. The approximate $500 cost per attendee at the September 1993 session held at the Turtle Bay Hilton resort was not unreasonable for this type of training. We found no evidence that the training session was held at the expense of funding patient care activities.

Allegation 2c: **Facility funds were used to pay for Hoolauna cultural sensitivity training. The training was held in a fancy hotel and lunch was included which is a waste of taxpayer dollars.**

This allegation is unsubstantiated. The VA facility has held Hoolauna training at the Pacific Beach hotel in Waikiki for at least the past 4 years. Hoolauna is Hawaiian cultural/sensitivity training and it includes instruction by Hawaiian "aunties," music by Hawaiian musicians, artifact displays, booklets, and cultural activities. The Director informed us that the sessions were attended by 284 VA facility employees.

Fiscal records showed the total cost of the Hoolauna sessions for the past 4 years was about $9,700. The training costs also included the room rental ($300-400 per session) and lunch (about $13 per attendee per session.) The sessions are for one day and attendees do not stay overnight at the Pacific Beach hotel.

While some employees may view this type of training a waste of money, others viewed it as a worthwhile experience. It is our understanding that no one is forced to attend the training.

Conclusion

The Hawaiian culture is unique, and management believes it is important for VA employees to gain a better understanding of this culture. This understanding will hopefully help the employees to adjust better to living and working in Hawaii. We would agree that this type of training is useful and is not a waste of funds as long as patient care priorities are satisfactorily met.

Allegation 2d: The VAMROC is wasting funds providing Lombardi and Covey training, complete with expensive notebooks.

The allegation is not substantiated. In 1995, the VA facility established goals for the organization as a part of its strategic planning process. The first goal was to "develop leadership skills of managers/supervisors at all levels with the objective of a culture of empowerment, fairness, equity, coaching and mentoring of all employees."

The Lombardi and Covey training efforts are designed to help management and staff achieve this goal. As shown below, the VA facility spent over $211,000 on these two training efforts:

Course	Fiscal Year	Amount
Lombardi Training	1995	$28,868
Lombardi Training	1996	21,205
Covey Training	1995	53,679
Covey Training	1996	73,326
Covey Training	1997	34,659
Total		$211,737

Both the Lombardi and Covey courses are designed for attendance by all levels of VA facility managers/supervisors and other employees. The Lombardi training effort is completed, and it is expected that about 350 of the 460 VA facility employees will have

attended the Covey training. At this point in the training cycle, VA employees who have been trained as facilitators conduct the Covey training. Therefore, the only expense is the purchase of books and other training materials from the Covey organization.

Since this is a sizable investment in training, we asked the Director how he evaluated if he was receiving a fair rate of return on the investment. He believed, based on the comments of staff, as well as his own personal experience with the training, that it was valuable in helping the facility achieve its strategic planning goal in this area. Also, in response to an anonymous e-mail he received, a survey of 120 employees who attended the Covey training was conducted in November 1996. Of the 48 employees who responded, 46 indicated that they would recommend the Covey training to coworkers. The employees' narrative comments to the survey were also generally positive.

Conclusion

Off-island leadership training for large numbers of VA facility staff would be prohibitively expensive. Therefore, bringing highly respected mainland consultants from the Lombardi and Covey organizations is more feasible for providing training to large numbers of VA facility employees. Also, by using trained VA facilitators (in lieu of consultants) for new sessions of the Covey courses, the cost of this training per employee has been reduced.

The training is also directly tied to the strategic planning goals for the organization and the overall response by employees to the training seems to be positive. Therefore, even though considerable funds have been spent on these training efforts, we do not believe the expenditure was a waste of funds.

Allegation 2e: A large surplus of funds was spent at the end of Fiscal Year (FY) 1995 on fancy furniture when the current furniture was in good condition.

This allegation is unsubstantiated. The VA facility did have a large surplus of $3,005,331 at the end of FY 1995. VA records show that $184,000 of this surplus was spent on office furniture.

We reviewed all the individual purchase orders for the furniture to determine if luxurious or non-essential items were being purchased. The two largest individual purchase orders were for Fiscal Service ($45,849) and Psychiatry Service ($12,077). Both of these purchases were made from the GSA Furniture Schedule. Most of the other orders were also from the GSA Furniture Schedule.

The Fiscal Service order was for assorted modular furniture. The space in Fiscal Service is cramped and the modular furniture makes for a more functional, but not lavish, office layout. Only part of the furniture in Fiscal Service was replaced. Both Acquisition and Materiel Management Service and Fiscal Service employees indicated the old furniture was in bad shape and needed replacing.

The $12,077 order for Psychiatry Service was for 11 small couches. The psychiatrists' offices were small and the couch in each office provided an appropriate and professional setting for treatment sessions with psychiatry patients. We did not consider the couches to be lavish.

To ensure that there were no problems with end of the year furniture purchases in general, we also reviewed the end-of-the-year purchases for FY 1996. We found no evidence that furniture was purchased with FY 1996 end-of-the-year funds.

Conclusion

Furniture purchased with FY 1995 end-of-the-year funds was not considered lavish and made for a more functional and professional setting for VAMROC employees. There were appropriate justifications to replace the old furniture.

Allegation 2f: The Director signed a contract with the Navy Hospital located on Guam that does not allow VA to question or negotiate the charges made to VA for hospitalizing veterans.

We did not substantiate that the Director did anything inappropriate in negotiating this contract. The allegation is correct that the VA has little room for negotiation on the rates charged by the Navy hospital in Guam. The only other hospital on Guam is the community hospital. It is not accredited and is known for its relatively poor quality of care. Therefore, the VA facility's only choice for care on Guam is to send VA patients to the Navy hospital which provides an acceptable level of care.

Through FY 1996, the VA facility had a very favorable agreement with the Navy on the rates charged for VA patients treated at the Navy hospital. However, according to the Director, the Navy realized in mid-1995 that they were undercharging VA for their services. The Navy established a new rate schedule with the VA facility for inpatients that was based on Diagnostic Rating Groups rates set by the Department of Defense Comptroller for all military hospitals. Also, new rates were established for the various Navy clinics providing outpatient services to veterans.

The financial impact of this new agreement is shown by the increase in billings for FY 1996 ($363,339) as compared to FY 1995 ($177,177). Some of this increase in FY 1996 was due to one very sick patient who required extensive treatment. Even though this patient's treatment costs tended to distort the comparison between the FY 1995 and FY 1996 billings, there was still a significant increase under the new agreement.

Conclusion

The Navy hospital was the only viable option on Guam for treatment of veterans and the rates are standard military hospital rates. Therefore, the Director made the only decision he could in agreeing to the new rate schedule. The Director informed us that he believes the VA is still getting a good deal for the services provided by Navy clinical staff.

Allegation 2g: The Director inappropriately hired a physician to work at the Hilo Primary Care Clinic 20 hours per week by funneling money through the University of Hawaii Residency Program.

This allegation is unsubstantiated because there is nothing wrong with the VA contractual arrangement with the University of Hawaii. The VA facility does have a contract with the University of Hawaii at Manoa to provide physician services for the Hilo Clinic. The agreement is a part of the overall Scarce Medical Specialist contract the VA has with the University Medical Department.

The VA facility pays the University of Hawaii $31,155 annually for the service for the Hilo Clinic. This service is provided by a physician on the staff of the University of Hawaii. Recently, the agreement with the University of Hawaii was expanded to provide more coverage of the Hilo clinic. The new agreement will cost the VA facility $62,330 annually. According to the Director, the new agreement doubles the physician's time devoted to the Hilo Clinic, and reduces 1 full time employee equivalent (FTEE) nurse practitioner.

Conclusion

There is nothing wrong with the VA facility having a contract with its affiliated university for physician services. Also, there was a need for these services on Hilo and the price of the contract seems reasonable.

Allegation 2h: ·(b)(6)·····, who works for the University of Hawaii under the VA facility contract for services on Hilo refers veterans to himself and bills VA for visits. These visits allegedly could have been performed during the performance of his duties at the Hilo Primary Care Clinic.

We were not able to fully confirm or disprove the allegation but current practices made it conducive for the alleged conditions to exist. We reviewed all the fee basis payments made in FY 1996 to the ·(b)(6)·····, a private practice in which ·(b)(6)·····. VA facility records showed 44 fee basis payments were made to the ·(b)(6)···· totaling $3,099 during FY 1996. ·(b)(6)····· the VA's Hilo clinic during FY 1996, so all the fee basis referrals of VA patients were made by him to the private physician practice with which he was associated.

The treatment facilities at VA's Hilo Clinic were very limited, so fee basis referrals to private physicians would be expected. On the surface, it appeared that some of the referrals were for routine medical problems such as a contusion of the finger. We discussed this issue with the Quality Manager Coordinator at the VA facility and she indicated that there was no question that at least 70 percent of the referrals should have been made to a private physician because of the treatment limitations at the Hilo Clinic. The propriety of the remaining 30 percent could not be determined without a detailed medical record review. Since these cases totaled less than $1,000, we determined that it was not cost effective to conduct such a review.

In gathering the fee basis information for us, VA facility officials recognized the potential problems caused by the fee basis referrals by ·(b)(6)····· to a private practice with which he was associated. On January 22, 1997, the Director sent a memorandum to all VA facility service chiefs and the five off-island primary care clinics that stated "to avoid potential conflict of interest (e.g. irregularities and practices) by individuals or groups participating in the Fee Basis Program, all outpatient referrals generated by on station non-VA providers at the Primary Care Clinics will be forwarded to the VA Fee Basis/MCCR UR nurse for review and authorization."

This revised procedure was effective immediately and brings the procedures for fee basis referrals in the off-island clinics in line with the procedures utilized in the Honolulu medical facility. Therefore, we made no recommendations.

Conclusion

Based on our review, the Director revised procedures for the fee basis referrals by off-island clinics. This should resolve the potential conflict of interest issues in these referrals.

Allegation 2i: **The Director, Pacific Center for Post-Traumatic Stress Disorder (PTSD) inappropriately purchased mountain bicycles, and kayaks which are being kept in employees homes. He also purchased 2 oxygen analyzers that were never used.**

We did not substantiate that the Director, Pacific Center for PTSD inappropriately purchased mountain bikes and kayaks, or that they were kept in employee homes. We did substantiate that the VA facility purchased 2 oxygen analyzers at about $26,900 that staff did not use.

With the assistance of the Chief Supply Officer, we found that the VA facility purchased 18 bicycles for the Hilo Clinic to provide veterans recreation services in 1993. The bikes cost the VA $5,318; or about $300 per bicycle. The VA facility paid another $490 for 5 bicycle helmets and 6 bicycle locks, and an additional $208 for repair materials. In total, VA spent $6,079 for the 18 bicycles. We noted that 6 of the bicycles had been stolen in March 1995. The Chief Supply Officer said the remaining 12 bicycles are secured with locks and anchored outside the clinic building. The Chief Supply Officer confirmed that there is a sign in/out log for inpatients to use the bicycles. Management said the bicycles are not used by employees for their personal or recreational activities.

The Hilo clinic also issued a request for 15 kayaks in September 1994. The Chief Supply Officer informed us that this request was later canceled and the items were not purchased.

We found there were 2 oxygen analyzers purchased for the Hilo clinic at a cost of $26,900. One unit was at the clinic and is not in use. The other unit was at the National Center on Bishop Street and is also not used by staff. The Chief Supply Officer informed us that action would be taken to relocate the equipment so that it can be used by health care staff.

Conclusion

The purchase of mountain bicycles to provide veterans recreational services did not appear to be inappropriate, and staff had not purchased kayaks. We believe that action should be taken to ensure Reports of Survey were completed on the 6 stolen bicycles. The Director should also ensure that the oxygen equipment is relocated to patient care areas to ensure better use of the items.

Allegation 2j: The Director ignored warnings that fee basis billings were not getting paid and consequently veterans have been receiving warning notices from vendors and credit agencies.

We did not substantiate the allegation that the Director ignored warnings concerning fee basis billing problems at a VA clinic on Kauai. However, we did substantiate that fee basis billings had not been processed for veterans receiving treatment from physicians on Kauai (Lihue, Hawaii) for some time. As a consequence, veterans received collection notices from the physicians' agencies, and expressed concern about their credit ratings. We were contacted by a member of the Governors Advisory Board and a resident of Kauai. The Board member is also a member of the Disabled American Veterans and serves as an advocate for veterans rights in the Pacific Basin.

We spoke with the administrative staff at the VA clinic on Kauai to determine whether fee basis billing procedures caused this problem and, if so, to what extent. The Administrative Assistant told us that veterans were authorized to seek treatment by providers in the community. However, she informed us that because of increasing workload priorities, and an accident she incurred which kept her out of work for over a month, pending bills for the services increased in volume and were not processed. Upon her return, the backlog became noticeable, and she said she informed the VA facility that she needed more help. The Administrative Assistant said she also requested overtime to try to resolve the growing backlog, but she was informed there were no funds.

The Administrative Assistant informed us that because of the delays, veterans began receiving collection notices from physicians. She said that some physicians' collection agencies began to harass the veterans receiving treatment on Kauai, which prompted the Board member to contact the Director's Office for assistance.

Management informed us they were not made aware of the extent of the problems at the clinic, and were surprised to learn of the billing problems many months later from veterans who contacted the facility's Veterans Service Officer for assistance. Management provided a sample letter dated January 7, 1997, that went to Kauai physicians explaining the VA processing delays on behalf of the veterans who received treatment. We were informed that letters of apology were also sent to the veterans who received collection notices. The Director informed us that action has been taken to conduct a thorough review of the fee basis billing process and performance related issues at the clinic.

Conclusion

There was no evidence to support the Director ignored warnings of a significant fee basis billing issue on Kauai. There were differing opinions concerning who was culpable for

the problem escalating to the point it adversely impacted on VA patients. The Director assured us that everything was being done to correct the fee basis processing and billing problems experienced at the Kauai clinic. These corrective actions began just prior to our arrival at the facility. Therefore, we made no recommendations.

Allegation 2k: An employee received approval to attend a course that was not related to working at VA.

We substantiated the allegation. An employee allegedly took a course on how to write novels which was held in Maui. The course cost $350 and had no apparent relationship to her work environment. We interviewed the Director, Pacific Center, PTSD who said that training opportunities were limited on the island and that the employee could have gained some benefit from the author because she also intends to publish her research in the future. A review of the procurement documents and justification for the training did not demonstrate to us that the training had a relationship to VA work.

Conclusion

Because the Director, Pacific Center, PTSD authorized the course and minimally justified it to improve the employee's writing skills, we did not pursue this issue further. The facility Director informed us that at the time this training was approved, the Pacific Center for PTSD maintained its own budget and training requests were approved within that organization. Beginning in Fiscal Year 1997, the PTSD budget was integrated into the facility budget and training requests are now reviewed by the Education Committee. The facility Director assured us that training of this nature would be more closely scrutinized in the future before staff are permitted to attend. Therefore, we made no recommendations.

Allegation 2l: Tripler Army Medical Center lobbied the VA to stop sending cardiac care patients to the VA Medical Center in Palo Alto CA which was more cost effective.

We did not substantiate that TAMC lobbied the VA as alleged. We found that the VA facility stopped referring cardiac care patients to VAMC Palo Alto. A complainant informed us that VA was saving significant funds by sending cardiac patients to VAMC Palo Alto. The complainant also believed the quality of care given these patients at VAMC Palo Alto/ Stanford Medical University was superior. The complainant said that the only cost to the facility was an airplane ticket for the veteran and significant other. It was alleged that the TAMC lobbied the VA for the cardiac cases to maintain an effective workload, and that VA agreed as a public relations gesture even though it would cost the VA more in contract services.

The Director disagreed. He said that in the past, TAMC would only provide the required cardiac outpatient testing for VA patients if they received a guarantee that they would also perform the surgery. He said that because TAMC was inflexible with this arrangement, action was taken to refer cardiac patients to VAMC Palo Alto for outpatient testing and surgery. The Director informed us that TAMC came under new management and recently agreed to provide outpatient testing for veterans even if the surgery is done elsewhere. He stated that they are now giving the patient the opportunity to decide whether they would prefer treatment locally, or at the VAMC Palo Alto. The Acting Chief of Staff informed us that he was just made aware of this condition and would be looking into the matter further to determine what would be more cost effective and best for the patients. There was no evidence to substantiate that the referrals to the TAMC were based solely on a public relations gesture.

Conclusion

There was no evidence brought to our attention to validate whether or not the TAMC lobbied for this additional workload. The Director and Acting Chief of Staff said they would monitor the use of TAMC and VAMC Palo Alto to perform cardiac cases and seek the best alternative for the patients and most efficient manner to provide treatment. Therefore, we made no recommendations.

Allegation 2m: Tripler Army Medical Center lobbied the VA to pay for treatments provided to retired military annuitants who presented themselves at the Army facility.

We did not substantiate that TAMC lobbied the VA to pay for treatments provided to retired military annuitants. However, we found that about 3 years ago the Director approved a large sum of money to TAMC for treatments provided to retired military annuitants who presented themselves to the Army.

A complainant informed us that the Director had additional funding at the end of fiscal year 1993, and that action was taken as a public relations gesture to reimburse the Tripler Army Medical Center for services VA had previously denied. The Director informed us that the VA received requests for payment from TAMC who provided care to retirees who were eligible for VA care as well. The Director informed us that they had originally denied the requests because TAMC did not seek pre-authorization for the services as prescribed by VA policies. The Director said when they realized funds were available at the end of the year, he made a decision to approve previously denied TAMC claims in an effort to show good faith with the joint venture partner. The Director believed this action was within his authority, because the veterans would have otherwise been eligible for VA care had a pre-authorization limitation not been in place.

A review of fiscal records showed that monthly fee basis payments surged at the VA facility around the end of the fiscal year in 1993 (e.g. Invoice B31160 September 1993 totaling $317,119; and Invoice B41173 October 1993 totaling $863,874).

Conclusion

Substantial funds were paid to the TAMC for claims that had previously been denied by the facility. The Director justified payment of the funds in an effort to show good faith with the joint venture partner and because the veterans would have otherwise been eligible for VA care had a pre-authorization limitation not been in place. We did not validate specific records or review individual billing records. We are bringing this issue to VISN management's attention for follow-up and any resolution deemed appropriate.

Recommendation 2:

The Director, Veterans Integrated Services Network No 21, in conjunction with the Director at the VA facility in Honolulu, should take the following actions:

a. Make future artwork purchases on a competitive basis to the extent possible.

b. Take appropriate administrative actions to ensure staff responsible for the sole-source artwork purchases follow prescribed procurement policies and procedures.

c. Ensure the oxygen analyzers are placed in patient care settings that would afford VA staff the opportunity to utilize the equipment.

d. Ensure Reports of Survey are completed on the 6 stolen bicycles at the VA Hilo clinic.

Acting Director, Veterans Integrated Service Network (VISN) 21 Comments:

The Acting Director, VISN 21 concurred with the recommendations. The VISN will require VAMROC Honolulu to purchase all subsequent artwork on a competitive basis, unless explicit approval is obtained from the Network Director. The VISN will also take appropriate administrative actions to ensure staff are aware of sole-source procurement restrictions and requirements. Action will also be taken to place and utilize the oxygen analyzers in an appropriate patient care setting, and reports of survey will be conducted on the missing bicycles (See Appendix B).

VA Office of Inspector General Comments:

The Acting Director, VISN 21 comments met the intent of the recommendations. We will continue to follow-up on the VISN implementation plans until all issues are resolved.

CHAPTER 3

ALLEGATIONS OF PERSONNEL IRREGULARITIES AND PREFERENTIAL TREATMENT

Discussion

We received allegations that the Director wasted staff resources and inappropriately promoted his friends and associates without competition. Employees we interviewed who did not support the Director perceived the allegations to be true, which contributed to the tension between some of the rank and file employees and management.

Allegation 3a: The Director wasted VA dollars by funding a VA neurologist to work for 5 years on a ·*(b)(6)*····· with the neurologist spending only minimal time on direct patient care.

This allegation is unsubstantiated. ·***(b)(6)***·····, a neurologist, was hired in 1991 by the facility specifically for a project titled ·***(b)(6)***····· . The project was a joint effort between the VA, the National Institute on Aging and the National Center for Nursing Research. VHA Central Office staff approved the project.

According to fiscal staff, the VA facility pays ·***(b)(6)***····· annual salary of $163,167. To date, the VA facility has paid ·***(b)(6)***····· over $725,000. The general understanding with ·***(b)(6)***····· is that he will spend 80 percent of his time on the research project and 20 percent on patient care related activities.

In April 1996 the Chief of Staff, ·***(b)(6)***·····, decided with the apparent approval of Mr. Raff to change ·***(b)(6)***····· work schedule to 80 percent patient care duties and 20 percent research. The reason for the change was that after 5 years, ·***(b)(6)***····· was not seeing any results from ·***(b)(6)***····· research efforts and he decided ·***(b)(6)***····· could spend his time more effectively by treating patients.

·***(b)(6)***····· and the Chief of Medicine, ·***(b)(6)***·····, did not agree and appealed to the Director. They stated that ·***(b)(6)***····· research efforts were just about to begin paying off and his work schedule should remain the same. The Director agreed to give ·***(b)(6)***····· until September 30, 1997, to complete his research project. The Director told us that some of ·***(b)(6)***····· work was slated in the near future to be published in an influential medical journal, which would bring credit to ·***(b)(6)***····· and the VA facility.

We were able to confirm that ***(b)(6)*** conducts patient care duties roughly 20 percent of the time in accordance with the original hiring agreement. He conducts a half-day neurology clinic each week at the VA facility. During 1996, facility records show ***(b)(6)*** treated 472 patients in that clinic. He also spends a half-day 3 out of 4 weeks at Tripler Army Medical Center(TAMC) teaching a neuropsychiatry course to residents and treating VA psychiatry inpatients at TAMC. ***(b)(6)*** also travels one day a month to 1 of the 4 outer island VA clinics and provides patient care during these visits.

There is no question that a large amount of VA facility funds (about $640,000) was spent on this research project by the end of Fiscal Year 1997. It is difficult to judge the relative rate of return on ***(b)(6)*** research effort since after more than 5 years, it is just beginning to provide suitable data for publication. However, this is a large amount of money for a small VA facility to be spending on one research project, and certainly any further extension of the project should be carefully analyzed.

Allegation 3b: The Director inappropriately promoted a *(b)(6)*** specialist from a GS-9 to a GS-12, and made him Assistant ***(b)(6)*** without competition.**

We did not substantiate that the Director inappropriately authorized the promotion of the ***(b)(6)*** specialist. However, the number of managers needed to supervise employees in the ***(b)(6)*** Division appeared excessive. Management promoted ***(b)(6)*** competitively from a GS-***(b)(6)***-09 ***(b)(6)*** specialist to a GS-***(b)(6)***-12, Assistant ***(b)(6)*** on ***(b)(6)***. The Director had the discretion to promote him to this grade because ***(b)(6)*** was a GS-12 step 5 at another agency prior to working for VA. The complainant believed that it was not cost effective for the VA to retain a ***(b)(6)***, and an Assistant ***(b)(6)*** at the GS-13 and GS-12 grades, respectively, to supervise 4 other employees.

We discussed this concern with the Chief, Human Resources Management Service. While she agreed that the supervisor-to-employee ratio was high, she also believed that the VA facility could support the grade as classified based on the employee's technical work in assisting the ***(b)(6)***.

Allegation 3c: The Chief, *(b)(6)*** Service inappropriately dealt with a problem supervisor by creating a non-supervisory job for her rather than dealing with her performance problems.**

We substantiated that an employee in a supervisory position was laterally assigned to a new position, however, management had this option. We found that the employee was not functioning well as a supervisor, and was reassigned to a non-supervisory position at the same grade level.

The Chief, ***(b)(6)***, reassigned the employee from a GS-***(b)(6)***-11 first line supervisor position in her Service to a non-supervisory internal ***(b)(6)*** GS-***(b)(6)***-11 in September 1996. The lateral reassignment was within management's prerogative and the necessary personnel procedures were followed. A different complainant said that the employee was not an effective supervisor, and rather than dealing with her performance problems, the Director and Chief, ***(b)(6)*** Service classified a new position for her at the same grade.

We discussed this issue with the ***(b)(6)*** Officer who confirmed that management reassigned the employee to more appropriately use her technical capabilities. The Chief, ***(b)(6)*** Service considered the employee an excellent technician, but said ***(b)(6)*** did not always deal effectively in a supervisory role. To maximize ***(b)(6)*** technical abilities, ***(b)(6)*** management reassigned ***(b)(6)*** as an internal ***(b)(6)*** in the Service.

According to two complainants, staff supervised by this employee believed that she was an ineffective supervisor and that management did not deal with ***(b)(6)*** performance problems. This condition contributed to perceptions that management protected their supervisors, but not rank and file staff. It also reinforced perceptions that staff do not get the opportunity to compete for new positions at the VA facility. Management disagreed. They believed the reassignment was in the best interest of the VA.

Allegation 3d: The Director selected long time friends, *(b)(6)*, and *(b)(6)* as the *(b)(6)* without proper competition.

We did not substantiate the allegation. The Director has the authority to reassign, change to lower grade at an employee's request, and promote employees competitively or non-competitively to a higher grade. Noncompetitive promotions are authorized by personnel regulations and the use of this method of promotion process is appropriate in some instances.

The facility's Merit Promotion Plan describes the policies' staff should follow when using competitive procedures to fill non-centralized positions. The Policy, No 05-96-021, dated March 22, 1996, prescribes that all actions under the plan will be based on job-related criteria and will be made without discrimination for non-merit reasons such as race, color, religion, national origin, sex, lawful political affiliation, marital status, non-disqualifying physical or mental handicap, age, labor organization affiliation, or non-affiliation.

This plan does not require or restrict management to fill positions only by promotion. Management retains the right to select from any appropriate recruitment method -- such

as reassignment, appointment, promotion, transfer, reemployment, reinstatement or demotion. While management retains these rights, they also should not engage in personal favoritism, nepotism, unlawful reprisal, or any other prohibited practice which violates merit systems principles. These principles include achieving a workforce from all segments of society, with selection and advancement solely on the basis of merit, after fair and open competition that assures equal opportunity.

Personnel records showed that the initial selection of ***(b)(6)*** as the facility's GS-***(b)(6)***-12 ***(b)(6)***, was from an open VA Central Office (VACO) nationwide announcement in 1991. ***(b)(6)*** was promoted to the GS-***(b)(6)***-13 level ***(b)(6)***, 1994, based on accretion of duties and application of new classification criteria for managerial and supervisory positions. This promotion was supported by the Director, and received the required VACO approval.

The initial selection of ***(b)(6)*** as a ***(b)(6)*** GS-***(b)(6)***-12 also appeared to be appropriate. ***(b)(6)*** accepted the position as ***(b)(6)*** in ***(b)(6)*** 1991. This was a change to a lower grade from his Chief, ***(b)(6)*** GS-13 position at the VAMC ***(b)(6)***. ***(b)(6)*** was promoted back to the GS-13 grade level based on a re-description of his duties. The applicable personnel management specialists certified that the positions met the higher classification grade and that the individuals met the necessary qualifications.

We found that the use of noncompetitive promotions for ***(b)(6)*** and ***(b)(6)*** and other staff was a subject of concern among employees, as ***(b)(6)*** were known to be long time friends of the Director. There is no indication that if the competitive process had been used to fill the ***(b)(6)*** position, ***(b)(6)*** would not have been selected. The competitive process was used to select ***(b)(6)*** as a GS-12 in 1991. However, the complaints were directed towards her GS-13 promotion which was done through an accretion of duties.

Allegation 3e: **The ***(b)(6)*****, manufactured and approved ***(b)(6)***s promotion to ***(b)(6)*****, which was a conflict of interest.**

We did not substantiate the allegation. The Director promoted ***(b)(6)*** from the facility's ***(b)(6)*** GS-***(b)(6)***-12 to ***(b)(6)*** GS-***(b)(6)***-13 on ***(b)(6)***, 1995. The Director justified the promotion on the basis of an accretion of duties. ***(b)(6)*** distanced herself from the action by not signing the new position description, and otherwise separating ***(b)(6)*** from the promotion process for ***(b)(6)***. We found no evidence that ***(b)(6)*** influenced the promotion. A personnel management specialist in the Service signed the necessary documents.

Allegation 3f: The Director hired a non-physically disabled Chief, (b)(6) Service which was an injustice to qualified disabled veterans who did not get the position.

We did not substantiate that the Director purposefully excluded qualified disabled veterans so that he could hire a non-physically disabled Chief, (b)(6) Service. While it is true that he hired a Chief, (b)(6) Services who was not physically disabled, there was no requirement for him to hire a disabled employee to this position. Management selected (b)(6) as a prosthetic representative from a VACO certificate dated July 19, 1991.

He received promotions regularly through the GS-(b)(6)-11 grade level. Management noncompetitively promoted him from GS-11 to GS-(b)(6)-12, Supervisory (b)(6) effective August 21, 1994. The promotion was the result of a reclassification of (b)(6) s position resulting from the assignment of additional duties and responsibilities.

VACO approved the reclassification on August 17, 1994. (b)(6) received a lateral transfer into the (b)(6) position in April 1996, which was also the result of a reclassification and combining of the Chief, (b)(6) position and Chief, (b)(6) position. The Director laterally transferred (b)(6) to this position, and later promoted him to a GS-13 grade level through an accretion of duties.

Physical disability was not a requirement for the incumbent, and VACO (b)(6) staff endorsed the assignment. However, employees considered the noncompetitive nature of this process as a purposeful attempt to preclude others from competing for the position so the Director could reward his close associates. The Director believed the actions he took were efficient and effective. He stated that all of (b)(6) s promotions were approved by VACO and that the consolidation of the two positions resulted in a savings of approximately $56,500 per year.

Allegation 3g: The Director engaged in cronyism with other friends and close associates.

We did not substantiate the allegation. The allegation was similar to the previous complaints about (b)(6); that the Director would promote his friends and associates without competition. The allegations extended to other close associates of the Director. We interviewed 25 employees who believed there was an "inner circle" and "outer circle" of staff at the VA facility. These employees believed that if you were in the "inner circle" you received promotions and were protected by the Director. According to the employees interviewed, if you were in the "outer circle" you had no

chance at the VA facility for advancement. The employees indicated that staff in the Director's office, ***(b)(6)***, the Director's former ***(b)(6)***, Chief, ***(b)(6)*** Service, Acting ***(b)(6)***, and a few select others were in the "inner circle."

We were not able to review the recruitment folders of these employees because the files were destroyed after 1 year. However, we did review the personnel records, and discussed the promotion process with all personnel management specialists at the facility. All of the personnel management specialists at the facility acknowledged that the noncompetitive process for promoting employees was used extensively.

One allegation concerned the Director's former ***(b)(6)*** and efforts to promote ***(b)(6)***. Management selected ***(b)(6)*** under Merit Promotion Certificate 92-075 dated July 17, 1992. She was the Director's ***(b)(6)*** at the GS-***(b)(6)***-08 grade, and was promoted to GS-***(b)(6)***-09, target GS-11, ***(b)(6)*** Specialist. Management limited the recruitment area to Hawaii applicants only, and the announcement only remained open for several days. According to the Personnel Management Specialist, ***(b)(6)*** was the only applicant and was selected. ***(b)(6)*** was promoted to the journeyman level as a career ladder promotion one year later.

The Director selected ***(b)(6)*** as the facility's ***(b)(6)*** Manager from a Merit Promotion Certificate dated July 24, 1991. She was promoted from a ***(b)(6)*** GS-***(b)(6)***-11, to ***(b)(6)*** GS-***(b)(6)***-12 effective August 8, 1991. Management promoted ***(b)(6)*** in July 1994 to GS-13, based on an accretion of duties, and application of new classification standards for managerial and supervisory positions. He also noncompetitively promoted ***(b)(6)*** as the facility's ***(b)(6)*** GS-***(b)(6)***-12 to the GS-***(b)(6)***-13 grade effective ***(b)(6)***, 1995. Management justified this promotion based on an accretion of duties as well.

The employees that did not support the Director used these examples to demonstrate that opportunities to compete for promotions to higher graded positions are limited at the facility. While we did not find that these promotions were based on anything other than merit, the Director's use of noncompetitive promotions for individuals close to him sent a negative message to those staff that did not support him, and increased the tension between rank and file employees and top management.

The Director, on the other hand, believed he was rewarding loyal and capable employees that have exhibited the ability to get the job done. The Director informed us that the employees making this complaint have not considered the many other non-competitive promotions that could not be considered rewards for an alleged "inner circle" of staff. He said he promoted many staff competitively and non-competitively such as dental assistants, file clerks, medical record technicians, accounting technicians, nursing assistants, contact representatives, library technicians, and purchasing agents. These

promotions ranged from the GS-4 to GS-5 through GS-7 to GS-9 grades. The Director informed us that during FY 1994 through 1996, there were 42 promotions based on an accretion of duties, and 93 competitive promotions and reassignments resulting from merit promotions competitions.

Allegation 3h: **The ·(b)(6)····· was selected as the Chief, ·(b)(6)····· without competition which was unfair to other physicians working at the facility.**

The allegation is not substantiated. The Chief, ·(b)(6)····· position was a Title 38, position and not subject the same competitive process as Title 5 employees.

Four complainants informed us that the University of Hawaii influenced the appointment of ·(b)(6)····· as Chief ·(b)(6)····· and that the Director specifically recommended him for the appointment without competition. There was evidence that the University of Hawaii favored ·(b)(6)····· for the position. The Deans Committee minutes dated January 21, 1993, discussed the establishment of a Chief, ·(b)(6)····· position at the facility. According to information contained in the minutes, the Chairman of the Department of ·(b)(6)····· at the University was looking for someone with a background in ·(b)(6)·····. According to the former Chief of Staff, ·(b)(6)·····, the Chairman endorsed ·(b)(6)····· who was the Associate Chief of Staff (ACOS) for ·(b)(6)·····.

In the Deans Committee minutes, the Chairman of the Department of ·(b)(6)····· at the University said, "…someone in this position should have a firm feeling for ·(b)(6)····· because how you take care of patients really affects teaching in the clinic. It is easy to teach good ambulatory ·(b)(6)····· in a clinic that is well run." The minutes also showed that ·(b)(6)····· favored a different approach supporting the model in the VA where the Chief of ·(b)(6)····· for inpatient activities was also the Chief of outpatient operations. In the minutes, he asked that the Committee consider the ACOS/·(b)(6)····· for the position.

On February 26, 1993, the Director requested the appointment of ·(b)(6)····· as Chief, ·(b)(6)····· Service to Region management. The Director informed us that the appointment was approved by the Deans Committee, the local facility, regional director's office and headquarters. The Director also said there was no objection and no issues raised whatsoever. The Director attributed the allegation to a small group who took objection to the removal of the former ·(b)(6)·····.

While the selection of ·(b)(6)····· may or may not have been an issue at the facility, Title 38 employees are not required to undergo the same competitive process as prescribed by Title 5 employees. The selection was within the Director's authority and was approved by Region management. Therefore, we did not pursue this issue further.

Allegation 3i: The Director endorsed a conflict of interest by placing his good friends on the Medical Center Resources Board.

We did not substantiate the allegation. ·***(b)(6)***····· are voting members of the Medical Center Resources Board and concern was expressed that ·***(b)(6)***····· friendship with the Director could influence the Board's decisions. There does not appear to be a conflict of interest by having ·***(b)(6)***····· and ·***(b)(6)***····· serving on the board because we could find no gain to them by serving on the board or any gain to the Director.

Allegation 3j: The Director gives his administrative and secretarial staff preferential treatment by routinely taking them on prolonged lunch breaks and none of them are ever charged annual leave.

We did not substantiate that the Director routinely took his staff on prolonged lunch breaks. He did acknowledge taking his staff on prolonged lunch breaks occasionally to celebrate staff birthdays and special occasions. The time keeper confirmed that no leave is taken during these periods. Complainants perceived this to be preferential treatment for staff in the Director's Office.

The Director informed us that he does not require them to take leave for the additional time it takes to have a group luncheon, and believes that it permitted everyone in his office to come together as a group and discuss work related activities. The Director saw nothing wrong with this practice.

Conclusion

There is no indication that if the competitive process had been used to fill all of the positions questioned by the complainants, the incumbents would not have been selected. There was also no evidence to show that personnel procedures were not appropriately followed. The complaints appear to be based more on perception.

There is the perception that higher graded positions at the facility are filled non-competitively, and that positions are reclassified to the benefit of staff who are perceived to be in the Director's "inner circle." The complainants cited positions that were reclassified or promotions that were initiated on the basis of an accretion of duties. The complainants also cited the new ·***(b)(6)***····· position, and the Assistant ·***(b)(6)***····· position as additional examples to further demonstrate their case.

The Director and Acting Chief of Staff disagree that there is an "inner circle" of employees who receive preferential treatment of any kind. The Director believes that the

staff promoted were deserving based solely on their performances and the additional responsibilities assigned to them over the years or as a result of consolidating positions.

We noted that the restructuring of the facility's operational elements may increase the number of reclassifications at the facility which may foster additional complaints. We brought this issue to the attention of the Acting Director VISN 21 for action as he deemed appropriate.

Actions taken by the Director to celebrate birthdays and special occasions prolonging lunch periods has been perceived by non-supporters of the Director to be preferential treatment. We have discussed these issues with VISN and VA Central Office management to alert them of the issues and conditions at the facility.

Recommendation 3:

The Veterans Integrated Service Network Director, No 21, in conjunction with the Director, should take the following actions:

a. Because of the large investment made by the VA over the past several years, ***(b)(6)*** research project should be strongly scrutinized. Action should be taken to determine how best to realign his time, duties, and/or need for his services.

b. Take action to downgrade the Assistant ***(b)(6)*** position once the incumbent is no longer in the position.

c. Discontinue the practice of permitting employees to extend lunch periods without taking the appropriate amount of leave to attend birthdays and special celebrations.

Acting Director, Veterans Integrated Service Network (VISN) 21 Comments:

The Acting Director, VISN 21 concurred with recommendation 3a to review ***(b)(6)*** research projects and establish expected outcomes. He also agreed to review the participation of ***(b)(6)*** time between clinical and research duties to ensure patient care needs are met. The Acting Director, VISN 21 disagreed with recommendation 3b, but provided an alternative implementation plan to critically review the position (including need, duties and grade) when the position is vacant. He also agreed with recommendation 3c and will instruct staff to take appropriate leave to attend special celebrations (See Appendix B).

VA Office of Inspector General Comments:

The Acting Director, VISN 21 concurred with the recommendations or provided alternative action plans that met the intent of our recommendations. We will continue to follow-up on the VISN's plans actions until all issues are resolved.

CHAPTER 4

ALLEGATIONS OF DISCRIMINATION

Discussion

We received allegations that EEO complaints have increased at the facility. We also received allegations that the Director discriminated against an employee, and systematically forced out minority managers to replace them with non-minorities.

Allegation 4a: EEO complaints have increased at the facility which has resulted in visits from arbitrators.

The allegation that EEO complaints have increased is substantiated. The VA facility opened 3 complaints in 1994 and 3 cases in 1995; however, the number of complaints increased to 9 cases in 1996. The basic issues of the complaints are related to race, sex, and age discrimination, and harassment and reprisal. Of the 9 cases in 1996, 2 were withdrawn, and 3 were pending an EEO investigation. Management reached a settlement agreement in one other case and no discrimination was found in 2 other cases. One case was referred to Office of General Counsel (OGC) for action. We noted that one of the pending complaints alleged the Director discriminated against the former ***(b)(6)***, on the basis of race, age, and perceived disability. An EEO investigation is currently underway.

Many of the complaints resulted from increased tensions between employees working for the Pacific Center for PTSD. The Director was aware of the growing number of personnel complaints coming from the Center, and indicated that they have begun to focus their attention on resolving these issues. Therefore, no recommendations were made.

Allegation 4b: The Director in describing *(b)(6)*** as "the black hole" offended an African-American ***(b)(6)***-specialist who asked for an apology.**

We substantiated the allegation. ***(b)(6)***, a ***(b)(6)*** specialist who is African-American, confirmed that the Director used the term "the black hole" in his description of ***(b)(6)*** activities in such a way as to be offensive.

The Director informed us that ***(b)(6)*** Service was referred to as the "Black Hole" because of the large number of documents and paperwork that were lost or

misplaced once it arrived in ***(b)(6)*** service. He said most services referred to ***(b)(6)*** service as the "Black Hole." The Director said that, as the loss of paperwork continued, the Associate Director convened a group of 5 service chiefs to try to improve the process and deal with the issues. This group called themselves the "Black Hole" committee. The incident appeared to have occurred when the Director met with the committee and confronted them concerning the inability of the ***(b)(6)*** Service to process paperwork on a timely basis.

(b)(6) represented ***(b)(6)*** at that meeting because the Chief, ***(b)(6)***, was not available. ***(b)(6)*** said that when she began to explain the problems encountered by the service, the Director became impatient, stood up, pointed his finger at her, and in a raised voice said, "No, you're the black hole" or something to that effect. She said she was offended by the Director's demeanor. She also believed his remark and gesture had a racial connotation because everyone in the room became silent. She said that the Director did come into her office later and apologized.

The Director said that his remark "you're" referred to ***(b)(6)*** service losing paperwork, not an individual, and was not intended to be racially based in any form. Rather, he recalled discussing the term "black hole" in a astronomical context; that ***(b)(6)*** were losing documents in a cosmic "black hole" that no one could recover. The Director did not recall the incident when we first discussed the issue with him, or a private conversation with the employee apologizing for his behavior later. Witnesses at that meeting corroborated ***(b)(6)***s accounting of the circumstances as they happened. In a subsequent interview with the Director, he vaguely remembered the incident and apology. ***(b)(6)*** believes that the issue was resolved when the Director met with her and apologized. We therefore plan no further review into this matter.

Allegation 4c: The Director intentionally and systematically forced out nonwhite managers and replaced them with whites.

We did not substantiate this allegation. We contacted 4 prior minority managers and asked them whether they believed the Director forced them to leave the VA facility, or believed that he may have discriminated against them because of their race.

Of the 4 former minority managers interviewed, only one perceived he was forced out and discriminated against because of his race. We also reviewed a listing of incumbents in management positions over the past several years and did not find a pattern to demonstrate that minorities were being systematically replaced by non-minorities. The facility minority distribution records also showed there was a multi-ethnic employee population.

Conclusion

We substantiated that there has been an increase in EEO complaints at the facility, particularly at the Pacific Center, PTSD. The sudden increase in complaints may be an indicator of management problems in the clinic that need to be addressed by top management. The ***(b)(6)*** does have a pending EEO complaint against the Director on the basis of race and age discrimination, which we believe has contributed to the formation of camps among employees at the facility. We did not determine the merits of this case because the issues were under review by an EEO investigator.

We also substantiated that a ***(b)(6)*** specialist believed that the Director made a racially based remark towards her during a committee meeting. According to the employee, the Director apologized, and she considers the matter closed. The Director denies that his remarks or gestures were racially based in anyway. Rather, he recalled discussing the term "black hole" in a astronomical context; that ***(b)(6)*** were losing documents in a cosmic "black hole" that no one could recover.

We reviewed a listing of incumbents in management positions over the past several years and did not find a pattern to demonstrate that minorities were being systematically replaced by non-minorities. The minority distribution records also showed there was a multi-ethnic employee mix working at the facility.

Recommendation 4:

The Director, Veterans Integrated Service Network 21, in conjunction with the Director should increase supervision over employees working at the Pacific Center, Post-Traumatic Stress Disorder to aid in resolving an increasing number of conflicts between staff (See Appendix B).

Acting Director, Veterans Integrated Service Network (VISN) 21 Comments:

The Acting Director, VISN 21 concurred with the recommendation and provided an acceptable implementation plan. According to the VISN, the recommendation has already been partially implemented with the recent reorganization of mental health services.

VA Office of Inspector General Comments:

The Acting Director, VISN 21 comments and implementation plans are responsive to the recommendation. We will continue to follow-up on the progress of the VISN's planned implementation until the issues are resolved.

VA Regional Office and Medical Center (VAMROC) Director Comments and VA Office of Inspector General Response

VAMROC Director Comments:

At the time of the current Director's arrival in 1988, the Honolulu outpatient clinic was a small independent clinic operating under the direction of the VA Regional Office in downtown Honolulu. 105 clinic staff conducted just over 52,000 visits. Current staffing exceeds 400 and fiscal year 1997 outpatient visits are expected to exceed 125,000. In the past 9 years it has grown into a Medical and Regional Office Center with a full service primary and subspecialty outpatient clinic on Oahu, 4 community based outpatient clinics on the Hawaiian Islands of Hawaii, Maui, and Kauai, and a 5th on the island of Guam. Teams of clinicians provide regular services to veterans in American Samoa and The Commonwealth of the Northern Mariana Islands. A 16 bed PTSD residential treatment facility was opened in 1994 in Hilo on the island of Hawaii and 29 inpatient psychiatry beds in leased space at the Tripler Army Medial Center under a formal VA/DoD Joint Venture. A 60 bed Nursing home and Center for Aging has just been dedicated and will begin treating patients by October 1, 1997. Construction began in July on a 97,000 square foot Ambulatory Care Center and a 4 story Tripler building is being renovated for a new Veterans Benefits Regional Office and Administrative Offices. Both of these facilities will open in two years.

Such unprecedented growth and reorganization can be expected to generate many challenges and issues among staff. The rapid creation of new positions that required skills and experience not present in the existing market place called for nation-wide recruitment and generated an influx of new faces, new ideas, and new cultural values. Assimilating these into the existing culture presented a daunting challenge that continues. The facility is undergoing a fundamental reorganization that replaces the traditional departmental organization led by Service Chiefs with line authority, to one of product lines and product line managers. Effecting these changes while simultaneously improving the organization and moving it forward have had a significant impact on the workforce.

Recognizing that a rapidly changing organization would predictably create feelings of insecurity and anxiety among employees, management initiated a number of innovative and original strategies to deal with a multi-ethnic and diverse workforce.

VAMROC Director Comments (Continued):

It is ironic that many of these initiatives such as the supervisors retreat, Hoolauna cultural sensitivity training, and the Lombardi and Covey training were cited as specific allegations of fraud, waste, and abuse. The IG found all of them unsubstantiated and concurred with management's actions. The organizational study commissioned in July 1995 was specifically intended to measure employee perceptions in an attempt to address them. The IG spent considerable time conducting interviews and assembling a report that seems to leave many questions unanswered. While it investigated 35 separate allegations, it was able to substantiate only 4 and partially substantiate 1. Throughout the report however, repeated allegations of the waste of taxpayer dollars and employee abuses by management could lead a reader to conclude there may be some truth to them. We believe however, that a careful review of these unsubstantiated allegations not only dispels these perception, but attests to the efforts of management to address the problems of a fast growing and rapidly changing organization.

The former ***(b)(6)***, while he felt that he was publicly humiliated early in the relationship, acknowledged that the basis for the conflict between he and the new Director arose from a difference in management style and goals. It is not surprising that after being the ***(b)(6)*** for ***(b)(6)*** years, ***(b)(6)*** would resist attempts by a new facility Director to change the course and direction of the organization. This period of adjustment was relatively brief however, and ***(b)(6)*** reported that after an airing of their differences with the Regional Director, "work went pretty smoothly" until he transferred to the mainland in preparation for his eventual retirement. A similar period of adjustment took place with the current ***(b)(6)***. While it is true that the Director had issues with his management effectiveness and had discussed them with the former Regional Director and the Network Director, he has improved his performance substantially and his most recent performance rating was highly satisfactory.

In response to the allegations that the Director humiliated and harassed ***(b)(6)***, the investigators interviewed 9 former managers. Only 3 of these "believed the Director exhibited inappropriate behavior…" and one of those was the former ***(b)(6)*** who filed an unsuccessful discrimination complaint. Additionally, he was the only one of 4 prior minority managers interviewed who perceived they were discriminated against. The Service Chief who indicated she was under constant threat of removal was receiving corrective feedback because of chronic poor performance. As the manager responsible for the ***(b)(6)***, she repeatedly placed the facility in an embarrassing financial position by her lack of management skills and frequent errors. In point of fact, these programs were removed from her supervision and a reorganization of her Service was underway at the time of her retirement.

VAMROC Director' Comments (Continued):

Recruiting and selecting highly qualified individuals for key positions is fundamental to the success of any organization. Nowhere in the report does it indicate that any of those alleged to belong to the "inner circle" were incompetent or unproductive. The Director used and relied on various leaders who could get the job done and there was no evidence any of these staff were treated any differently.

The allegation of discrimination by the former ***(b)(6)*** was investigated by the Office of Equal Opportunity, VA Headquarters who found no discrimination. On the contrary, they determined that the removal from his position as ***(b)(6)*** resulted from a thorough investigation that revealed there had been a serious erosion of trust and confidence in his ability to lead the ***(b)(6)*** staff. This lack of confidence and trust left the VISN Director with no alternative but to remove him from his position as ***(b)(6)***. ***(b)(6)*** continues to serve as the ***(b)(6)*** assistant to the Director, conducting ***(b)(6)*** that contributes to the treatment of veterans. There is no question that this painful but necessary decision has divided a number of managers and staff. ***(b)(6)*** continues to receive the support of a small but loyal group of employees. Management is faced with the significant challenge to bring all of the managers and staff together to move the organization forward in a time of unprecedented change in the delivery of health care within the VA and across the country.

VA Office of Inspector General Response to the Director's Comments:

The VA Medical Center Director's comments essentially confirmed that the facility was divided into two camps regarding his management style and actions. In his comments, he points out the unprecedented growth and reorganization of the work force that impacted on the staff at the VA facility. We agree that the Director's efforts to expand services should benefit VA and the veterans on the Hawaiian Islands in Hawaii. We also believe these rapid changes created significant challenges for staff which warrant close scrutiny by management in the months to follow.

We should clarify the Director's comments concerning the training he has initiated in an effort to meet some of the challenges facing his staff. We acknowledged in our report, that the costs associated with this training were not necessarily wasteful. For example, the Lombardi and Covey training offered by management focused on team building, working autonomously, and giving staff a voice in the organization. Sending VAMROC staff to this training on the mainland would be cost prohibitive.

VA Office of Inspector General Response to Director's Comments (Continued):

There is also no question that cultural sensitivity training would be a benefit to employees working at the facility in Hawaii. However, some employees believed this training was wasteful not because it was costly, but because they were not given the opportunity to put what they have learned into practice. These employees believed they were not permitted to execute many of the lessons learned from the training they received once they returned to their work setting. These concerns were shared with management at the facility and at the VISN level at the time of our review.

We also believe the Director and VISN management should be cautious in equating the number of substantiated and unsubstantiated allegations in this report to the importance, or insignificance, of the conditions identified, or attempting to reconstruct who said what about management at the facility. The fact that we were not able to substantiate certain allegations does not diminish the seriousness of the perceptions of mismanagement or waste by employees at the VA facility. In fact, there were certain issues that warranted VISN management's attention. These issues were discussed in the body of the report. Recommendations were made for some of the issues we reviewed; other issues that could not be fully developed prior to our leaving the facility were brought to the attention of the VISN for resolution actions as appropriate.

In conclusion, the Medical Center Director validated in his comments that there has been instability between him and several of his top and mid-level managers over a period of time (i.e., ***(b)(6)***, prior ***(b)(6)***). The Director commented specifically about allegations of discrimination by the former ***(b)(6)*** which were investigated by the Office of Equal Opportunity (We should note that more than one charge was filed, and not all issues have been fully resolved). The Director acknowledged this contributed to "…a division of a number of managers and staff." This further validated our conclusion that VISN management intervention is necessary because the senior leadership at the facility sets the tone and deportment of the employees in working effectively together as well as providing quality service to veterans and their dependents.

Acting Director, VA Sierra Pacific Network (VISN 21) Comments

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: November 12, 1997

From: Acting Director, VA Sierra Pacific Network (10N21)

Subj: Response to Revised Draft Report of Special Inquiry VAMROC, Honolulu (Project Number 7HL-134)

To: Director, Hotline and Special Inquiry Division (53E)
Thru: Chief Network Officer (10N)

1. I have carefully reviewed the revised draft report regarding a Special Inquiry into allegations of mismanagement at VA Medical and Regional Office Center (VAMROC) in Honolulu, Hawaii (Project Number 7HL-134). I also have reviewed a response to this draft report from the Director, VAMROC, Honolulu (copy attached) and suggest you include his response in your final report. At your request, I am providing my comments regarding the findings and recommendations in your revised draft report. In brief, I agree with most, but not all, of the recommendations and will initiate appropriate action. My remarks are primarily based on my review of these two documents.

2. My proposed actions and associated timeframes are summarized in Table 1, VISN 21 Response to Draft Special Inquiry (attached). I will determine my ultimate action plan after I have received and reviewed your final report.

(b)(6) 3. I do not agree with one of the recommendations, namely Recommendation 3.b. Recommendation 3.b. suggests the Assistant [redacted] position should be downgraded when the incumbent is no longer in the position. I believe this recommendation is overly prescriptive. Instead, I believe the position should be carefully reviewed after it becomes vacant to determine whether the position is still needed and if so, the appropriate duties and concomitant grade level.

4. In addition to this recommendation, I also do not agree with your proposed analysis of the organizational study regarding employees, which was conducted in July 1995. Specifically, you considered lowering the threshold for designating areas of concern from 25 percent of employees who disagreed with a statement to 20 percent. Without a complete understanding of the survey tool and sampling technique, I believe your proposed interpretation of the study may not be valid and could lead to an erroneous conclusion (i.e., overestimate the extent of employee dissatisfaction with management).

5. Thank you for discussing this report with me and providing an opportunity to respond to the revised draft report. As I stated above, I will defer by final action plan until I have received and reviewed your final report regarding this inquiry. If you have any questions regarding my response, please call me at (415) 744-6231.

Robert L Wiebe MD

Robert L. Wiebe, M.D., M.B.A.

Attachments

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Acting Director, VA Sierra Pacific Network VISN 21 Comments (Continued)

Table 1.
VISN 21 Response to Revised Draft Special Inquiry (7HL-134)

Recommendation	Assessment	Subsequent Action	Timetable
1. Increase Network Office supervision of senior management at VAMROC Honolulu	concur	Establish goals and objectives for VAMROC Honolulu	November 1997
		Conduct regular (video- or tele-) conferences with senior management to monitor progress and facilitate improvement	Every month for six months, beginning November 1997
		Consider subsequent general survey of employee views towards senior management	After stable Triad is in place for at least 3 months
2.a. Purchase artwork on a competitive basis	concur	Require VAMROC Honolulu to purchase all subsequent artwork on a competitive basis, unless explicit approval from Network Director	Immediately
2.b. Take administrative action regarding sole source procurement.	concur	Counsel (verbally and/or in writing) staff involved with sole source procurement	November 1997
2.c. Relocate and utilize oxygen analyzers	concur	Place and utilize oxygen analyzers in appropriate patient care settings	November 1997
2.d. Complete Reports of Survey on stolen bicycles	concur	Complete necessary documentation	November 1997
3.a. Review research project managed by [redacted] and potentially realign his clinical and academic duties	concur	Review research project and establish expected outcomes Review (with [redacted] and Chief of Staff) the partition of [redacted] time between clinical and research duties	December 1997 December 1997

(b)(6)

Acting Director, VA Sierra Pacific Network VISN 21 Comments (Continued)

Table 1.
VISN 21 Response to Revised Draft Special Inquiry (7HL-134)

(b)(6)

Recommendation	Assessment	Subsequent Action	Timetable
3.b. Downgrade Assistant [redacted] Position when vacant	disagree	Too prescriptive; instead, when position is vacant, critically review the position (including need, duties and grade)	When vacancy occurs
3.c. Discontinue extended lunches without appropriate leave	concur	Instruct staff to take appropriate leave to attend special celebrations	Immediately
4. Increase supervision over Pacific Center for PTSD	concur	Partially completed with recent reorganization of mental health services; include discussions regarding PTSD program with Network Office conferences (see Rec 1, above)	November 1997

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