

**MISMANAGEMENT ISSUES AT THE CHARLESTON,  
SOUTH CAROLINA AND PITTSBURGH, PENN-  
SYLVANIA VETERANS AFFAIRS MEDICAL  
CENTERS**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS  
OF THE  
COMMITTEE ON VETERANS' AFFAIRS  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED FIFTH CONGRESS  
FIRST SESSION

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OCTOBER 23, 1997  
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# MISMANAGEMENT ISSUES AT THE CHARLESTON, SOUTH CAROLINA AND PITTSBURGH, PENNSYLVANIA VETERANS AFFAIRS MEDICAL CENTERS

THURSDAY, OCTOBER 23, 1997

HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,  
COMMITTEE ON VETERANS' AFFAIRS,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 334, Cannon House Office Building, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett, Buyer, Clyburn, and Mascara.  
Also present: Representatives Bilirakis and Doyle.

## OPENING STATEMENT OF CHAIRMAN EVERETT

Mr. EVERETT (presiding). The hearing will come to order.

Good morning. This Subcommittee on Oversight and Investigations hearing is on mismanagement issues at Charleston, South Carolina and Pittsburgh, Pennsylvania Veterans Affairs Medical Centers. Last year Congressman Sanford requested that the VA's Office of Inspector General conduct an investigation into a VA employee's complaint that he had received about mismanagement in Charleston. Earlier this year, Mr. Bilirakis of the full committee requested hearings on both sexual harassment and mismanagement in the Virginia VA facility.

Mr. Sanford joined the call for a hearing with respect to Charleston. Senator Specter, chairman of the Senate Veterans' Affairs Committee, requested for the other IG investigation and report concerning mismanagement issues at Pittsburgh which had come to his attention. We appreciate his commitment to good government as well.

Four panels of witnesses will testify today. First, Congressman Sanford will make a statement. Then we'll hear testimony of two employees with Charleston. We will hear the testimony of the Deputy Inspector General on the IG's findings and recommendations. Finally, we will hear the testimony of two hospital directors involved in these matters, as well as testimony of the new chief network officer of the entire VA medical tier system.

I, frankly, am disturbed that two of the individuals in Charleston who were invited to testify today declined to come and give public testimony because of fear of reprisal and adverse consequences.

This alone is a sad commentary on the state of affairs surrounding the medical center even now.

These two hospital directors are in the hot seat. They are here voluntarily, not under subpoena. The allegations of mismanagement are basically directed at them or the mismanagement alleged occurred on their watch. Our objective is to stick to the facts and what happened. We do not want to hear any rumors. We will ask the directors some hard questions, and we will ask about employees' perceptions of management, conduct, and leadership because this is highly relevant.

That's what the hearing is about—good government and accountability. I have stated my concerns before about the culture problems of the VA, where there seems to be a pattern of tolerance for mismanagement and misconduct by senior officials. The VA has a longstanding and well-deserved reputation for transferring problem managers without doing anything about them. This subcommittee, during this session, has already had two hearings on sexual harassment in the VA involving senior managers. Today's hearing shifts focus somewhat to wasteful spending of taxpayers' dollars, but the culture problems are still abundantly evident, and the VA must come to grips with institutional harassment, favoritism, and reprisal.

Oh, I know that we'll hear that the amounts of money in these situations before us today are relatively small in the big scheme of things, but I think this misses the point entirely. This is about paying attention to public business and responsibilities of public service. Nowhere is that more important than when we are talking about the part of government that's supposed to be meeting the Nation's obligations to our veterans. We want the public to also judge whether \$26,000 fish tank for a hospital lobby or a \$1,400-a-day consultant and \$500 faucets for a hospital director's residence rivals the \$600 hammers and \$1,200 toilet seats at the Department of Defense. They certainly raise my temperature more than just a few degrees.

I'm offended by what the IG has found, and this subcommittee will continue to have these hearings, if need be, to expose mismanagement and waste and to impress upon the VA that it must change its ways. In the past few months, I have seen evidence that there is some change beginning. I hope it will continue, but, frankly, I'm still skeptical about it. We are looking at a culture in the VA of mismanagement. We're looking at a culture that seems to defy oversight. We're looking at a culture that protects the good old boy system, and I intend to see that stopped, if possible.

At this time I'd like to recognize my very able ranking member of this committee, Mr. Jim Clyburn.

#### **OPENING STATEMENT OF HON. JAMES E. CLYBURN**

Mr. CLYBURN. Mr. Chairman, thank you very kindly for recognizing me.

I would also like to welcome Mark Sanford to our subcommittee and thank him for his willingness to participate in today's hearing. As some of you may know, Mark and I represent the Congressional District that splits Charleston, and I appreciate his concerns for

VA employees and veterans in Charleston and the surrounding areas.

Before I continue my statement, Mr. Chairman, I want to point out that up on the wall here to our left is a portrait of William Jennings Van Dorn, who chaired this committee and was one of the best personal friends that I have, and the VA hospital in Columbia is named for him.

I also want to point out, because I looked through some of the statements, and there's a reference in one of the statements to something that hangs in the lobby of the VA Medical Center in Charleston. I want point out that that hospital is the Ralph H. Johnson Medical Center. It's named for a young man who gave his life in Vietnam. His portrait hangs in the lobby, and I notice by everybody's testimony that they don't give due deference to that. So throughout my statement I will refer to it as the Ralph H. Johnson Medical Center.

Now, Mr. Chairman, I'm reminded today of Winston Churchill's admonition that, if we open a quarrel between our past and our present, we may find that we have lost the future. Now I'm aware that Mr. Churchill's concern was for issues much more global than those that bring us here today, but as this subcommittee's ranking Democrat and as a Member of Congress who represents many of the veterans and VA employees who are served by, or work at, the Ralph H. Johnson VA Medical Center, I am both encouraged and saddened that this subcommittee is hearing testimony concerning the troubling and allegations of past mismanagement and poor decisionmaking at the Charleston facility.

Now I emphasize past not only because of Mr. Churchill's admonition, but also because I hear the present director, Mr. John Vogel, has moved decisively to address and correct the problems that have been identified, and I am encouraged by that. But I am saddened that the problems at my hometown facility have been so severe as to warrant the attention they will be receiving here today, and I am hopeful that our subcommittee's careful scrutiny will help to ensure that similar allegations of mismanagement do not resurface at the Ralph H. Johnson facility or anywhere else.

I would also like to personally thank and salute two courageous VA employees who voluntarily agreed to make the trip from South Carolina to provide testimony this morning. By virtue of their willingness to appear before us, Phil Truesdell and Kate Smith are public servants in the truest sense of the word.

Now, unfortunately, Mr. Chairman, I may not be able to hear in person all of the testimony from the panels because of other committee responsibilities this morning relating to the serious problem of sexual harassment which we've dealt with here, but seems to have cropped up in another committee as well. And so I am looking forward to reading the testimony from the other panels, and I'm hopeful that today's hearings will help quicken the pace of positive change in the VA workplace, not only at the Charleston Ralph H. Johnson facility, but throughout the VA as well.

And thank you, Mr. Chairman.

Mr. EVERETT. Thank you very much, Jim.

At this time I'll recognize Mr. Buyer for any statements he may have.

### OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Chairman. I'm going to be brief.

Actually, what I have today is to announce something that I'm not very pleased to announce, and that is I'm going to send a letter over to Arlen Specter, and what I'm going to ask the chairman is that I have very serious reservations over the nomination of Hershel Gober as the position of Secretary of the Veterans Affairs, and I'm going to send him over my reservations that he should not be named as Secretary of the VA.

I've gone over part of the file here today. I'm very concerned, and I take to heart the comments of my colleague from Charleston, both of them, I'm sure, and I look forward to your testimony.

But Mr. Gober, as the former Deputy Secretary of the VA, Mr. Gober presided as second in command over a structure whose mismanagement is only now coming fully into scope. His complacency as Deputy Secretary, and more importantly, the failure to bring these mismanagement issues to light, leaves me limited room for confidence in his fitness for Secretary of the VA.

Second, the gross mismanagement of the Secretariat is about to be eclipsed by all these recent revelations on sexual harassment that have shown signs of permeating the VA management structure to include the culture. It's a cancer that seems to be eating away at the infrastructure of the country's second-largest agency.

Finally, to exacerbate these conditions, it is truly very concerning to me, and that is that the most influential oversight medium available to the agency was the Office of the General Counsel, that was headed then by the Acting Secretary Spouse. It has been very disturbing to me that many of the allegations of sexual misconduct, that it was the agency themselves that took the victims of sexual harassment and further victimized them. And so when you had the Office of General Counsel there that should have stepped forward, instead of protecting the victims who are subject to the hostile working environment, they, in turn, became victimized because she sought to protect the agency herself, and that being her husband and the former Secretariat.

So I look forward to further testimony here today, and I appreciate the leadership of the ranking member and the chairman, and it is with sad commentary I give these comments today.

Mr. EVERETT. Thank you. Thank you, Mr. Buyer.

Now, Mr. Mascara, any comments you may have?

### OPENING STATEMENT OF HON. FRANK MASCARA

Mr. MASCARA. Good. Thank you, Mr. Chairman, and good morning to you.

I think it is important that we are holding this hearing to examine VA management practices at the VA Medical Centers in Charleston, SC and the VA Medical Center in Pittsburgh, PA. I am anxious to hear the explanation of those involved in the alleged mismanagement at these two facilities.

Over the past several evenings I have read over the testimony that is going to be presented, and I must say I found it to be very disturbing. Is no one overseeing the day-to-day operations of VA facilities?

Before coming to Congress, I was Chairman of the Board of County Commissioners in Washington County, Pennsylvania. We had various construction and remodeling projects working all the time and someone was always in charge—approving design changes, approving the bills, making sure the project was on time, if possible. While no large construction project is completed without its problems, I was amazed at the lack of coordination and miscommunication among the agencies, especially between the Real Property Management Office, RPMO, and the Pittsburgh facility. I think the problem in both of the cases we will discuss today is that the decisionmaking was not centralized.

In the case of Mr. Cappello, it appears he relied entirely too much upon the RPMO for instruction and advice. Couldn't the advice regarding the rules and regulations be verified? I hope today's testimony will shed some light on these very serious allegations. Someone in the VA should be held culpable and accountable for the gross mismanagement demonstrated at these VA facilities.

It should be noted for the record that the Pittsburgh renovation occurred in 1994, many months before the new Veterans Integrated Service Networks were established. I hope what we are discussing here today regarding mismanagement is not a microcosm of a systemwide breakdown in operations of our facilities. The point is that I fear we could probably look at any VA facility across the country and find examples of similar mismanagement difficulties. I hope that that's not the case.

Mr. Chairman, I hope we can all work together to see that the Secretary initiates the kind of systemwide changes that are obviously needed to ensure our precious VA budget dollars are spent wisely and for their intended purposes, serving those who fought for their country. Again, I look forward to the testimony, and I yield back the balance of my time.

Mr. EVERETT. Thank you very much. I think my colleague has certainly made a good point, that someone somewhere should be held accountable. That does not seem to be the case.

Also with us today we have two members of our full committee, Mr. Bilirakis for Florida and Mr. Doyle. Mr. Bilirakis, would you have a comment at this time?

**OPENING STATEMENT OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA**

Mr. BILIRAKIS. I do, Mr. Chairman, and, first, I also want to thank you for scheduling this hearing, and also thank you for allowing me the opportunity to participate even though I'm not a member of the subcommittee.

On February the 23rd, earlier this year, a paper in my district ran an article with the headline, "Big-Spending VA Officials Retain Top Jobs, Salaries." This article reported that top VA officials have routinely misspent taxpayers' dollars and mishandled personnel. However, what is even more disturbing—and others, of course, obviously have mentioned this—is that the VA's procedure for handling these employees seems to be to simply transfer them to other positions within the Department. Many times these employees are given promotions and pay raises in the process.

My constituents, and veterans in particular, were outraged that a medical center director who spent \$26,000 on a fish tank could end up with a promotion and a raise of almost \$5,000. The same employee hired a \$1,200-a-day management consultant which the VA paid \$87,750 in 1995 and \$90,117 in 1996. According to the Inspector General's report, this consultant worked 4 days each month.

In another case, a medical center director spent \$201,000 to renovate the director's residence on the VA's grounds. This renovation project exceeded its budget by \$79,000, and included faucets that cost \$500 and a \$2,200 whirlpool bathtub with a shower. The Inspector General concluded that this medical center director was personally responsible for reviewing the interior renovation project, which cost the government \$168,000. The IG found that the Pittsburgh Medical Center wasted scarce medical care funds for the project, but the VA promoted the medical center director.

For years, Mr. Chairman, veterans in Florida—and forgive me for being a little parochial in this regard—but they've been turned away from VA medical facilities because the Department lacks sufficient resources to treat them, and we can only imagine, I guess, how a veteran who has been denied care at a VA medical facility must have felt when he read that the VA spent \$26,000 on a fish tank and \$500 for faucets.

And what baffles me, is the VA's response to this type of mismanagement, rather than discipline managers who violate regulations or mismanage their facilities, the VA just transfers them to another position and rewards them with a pay raise.

Mr. Chairman, I have more here and I would unanimous consent that it be made a part of the record.

I guess I would maybe make the same comment that I made when we talked about sexual harassment. That is the concern that we have a pretty darned good health care system in general, but then if you're a veteran—and some of us are—and you read about all these things, you start to maybe develop a little bit of a doubt in your mind: Are all the dollars being spent as well as they should be and as intelligently as they should be, and is the VA really doing everything they possibly can on behalf of the veteran? And I think that's the bottom-line concern that I have. We've got to get to the bottom of all these things, but more than anything else, we've got to raise the credibility of our veteran in our VA health care facilities.

Thank you very much, sir.

Mr. EVERETT. Thank you for your statement. I've said on a number of occasions that the VA has a real credibility problem.

Mr. BILIRAKIS. Yes.

Mr. EVERETT. We must solve that.

Mr. Doyle.

**OPENING STATEMENT OF HON. MICHAEL F. DOYLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA**

Mr. DOYLE. Thank you, Mr. Chairman. Let me start by thanking you and Ranking Member Clyburn for giving me the opportunity to participate in this hearing. Although I'm not a member of this

subcommittee, I have an interest in one of the cases being presented here today.

The director's residence that was renovated at the Pittsburgh University Drive VA Medical Center is located on the Aspinall campus of that facility, which is in my Congressional District. Mr. Chairman, I'm familiar with this case, probably more so than any member in this room, with the possible exception of my colleague, Frank Mascara, who also represents a District in the Pittsburgh area.

The renovation project under scrutiny here today was initiated in 1994. Responding to a complaint passed on by a Congressional office, the Inspector General investigated this incident. The report issued in January of this year is the document that has formed the basis for today's inquiry into the Pittsburgh renovation.

Following the IG report, the Pittsburgh media revealed the details of this renovation project to the residents of my area, and for some time after the information was reported this project received considerable attention in Pittsburgh. Since that time, however, corrections in management policies have been made at the Pittsburgh VA and our community, working with the VA, has moved on to tackle other issues involved with providing health care to our veterans.

Clearly, there is little doubt that the renovation of the director's residence was mismanaged. Frankly, I am disappointed that so many oversights could have been made at multiple levels of VA management that would result in an outcome like the one detailed in this report.

For many of my constituents, the VA health care system is their only source of medical care, and it should concern all members on this committee and all veterans when that care is sacrificed due to poor management. I do think it is important to note, however, that the IG report details not only the mistakes made during the project, but it also included recommendations for management changes within the Pittsburgh facilities designed to prevent similar situations from occurring in the future. I have been assured, and progress reports issued by the IG have acknowledged, that recommendations have been followed.

What concerns me today, Mr. Chairman, is that this incident not tarnish the reputation of the Pittsburgh VA health care system in general or overshadow the positive accomplishments of its management staff, including Mr. Cappello. I've toured the VA Medical Centers in Pittsburgh many times, and because of my membership on this committee and the Health Subcommittee, I constantly hear from veterans in my district about the quality of medical care they are receiving today from the VA. While I may not agree with all the changes taking place at the VISN or the facility level in my district, the management staff in Pittsburgh have made a number of positive changes to improve the quality of health care being provided to the veterans in our area. Furthermore, they have accomplished this in a very poor budgetary climate and during a time when the entire VA health care system is undergoing drastic reorganization.

Mr. Chairman, I agree that this subcommittee should be looking into areas of mismanagement in the VA. Our goal here today

should be to ensure that the VA is putting policies in place that will eliminate the possibility of similar events like this occurring in the future. It is this action that can best serve the interest of our Nation's veterans.

Mr. Chairman, I appreciate the subcommittee giving me some time this morning to read my opening statement and look forward to hearing the testimony today.

Mr. EVERETT. Thank you very much, Mr. Doyle.

I might point out to those attending this hearing today that the targets of allegations of mismanagement are people who are making three-digit salaries. We're talking about somebody who should be competent, and we keep seeing over and over again that this is not the case. The subcommittee has seen a number of cases where the directors involved simply were not competent to hold the job that they held. I'm sorry, six-digit salaries—not three-digit salaries, but six-digit salaries.

All statements will be entered into the record, and I would ask each witness to limit your oral testimony to 5 minutes. As I said, your complete written statement will be made a part of the official hearing record today. I ask that we hold our questions until the entire panel testifies. Because of the nature of some of today's testimony, I decided to have the witness panels with direct knowledge of events or investigative activities testify under oath.

I'd now like to recognize our colleague, Mark Sanford, and, Mark, I appreciate you listening—being here today and appearing here today. Mark represents South Carolina's First District, and now we will be pleased to hear your statement.

**STATEMENT OF HON. MARSHALL "MARK" SANFORD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA**

Mr. SANFORD. Thank you, sir, and as you already suggested, both written and oral testimony will be submitted for the record. That's my understanding.

Mr. EVERETT. Yes. Without objection.

Mr. SANFORD. (A) I would just thank you very much again for holding these hearings. I appreciate that.

And, too, I would I guess pick up with what my colleague from Charleston and South Carolina said. I admire Jim Clyburn in the way that he is very measured in the way that he approaches things, and he raises a great point on: Where do we go from here? Because you can spend too much of life looking backward rather than looking forward, and yet what's interesting—and I think I'd just make two points—is that in going forward, at times we have to look back. Because if I was to ask you, Mr. Chairman, you know, is history a good thing or a bad thing, you would probably reply, well, it's neither; history is history. The question about history is: What do you do with it? What do you do about it?

In fact, we work in a city that is covered with memorials, and those memorials are not there just to take up real estate. They are there to remind us, so that we might change our lives on where we go from here, both to remind us of good points in history and to remind us of points in history that are not worth repeating.

And, in fact, in Charleston, you know, we've got Holocaust survivors, some of whom have made it their life's mission for the rest of their lives to go out into classrooms and to say: This was history; I was there, and this is what I saw. And, yet, the modern American way, if you will, is just the opposite. People at times don't want to get involved, and they say, well, I'll just look the other way because to get involved would take time; it might get messy. And, yet, Jefferson, 200 years ago, said that absolute opposite. He said that a democracy rests on the active participation of its citizens, not the passive, but the active participation of its citizens.

And so in that regard, I would simply like to praise Fletcher Truesdell and Kate Smith and Charlie Steiner, who's here but not testifying, and a host of other Veterans' employees for setting forward and saying: This is history and this is what I saw. Because too often people today won't get involved.

I would also just make one other comment, and that is that I would ask you to do something with this history. I think we can learn from history. And the points that my colleague from Florida raised on, if nothing else, the advancement process within the Veterans' Administration, wherein there can be serious charges of wrongdoing, substantiated by an IG report, wherein the only outcome seems to be advancement of that person. It just doesn't seem to pass the common-sense test back home.

And so I would simply leave you with the one request that I hear from folks back home, and that is, please do something with this piece of history. I yield back the balance of my time.

[The prepared statement of Congressman Sanford appears on p. 163.]

Mr. EVERETT. Thank you very much, Mark. I would also say it does not pass the smell test as well as the common-sense test.

Mr. SANFORD. Yes.

Mr. EVERETT. And as we have these hearings, we get deeper and deeper into that. Obviously, history is important. Our obligation is to understand history and then take some action on it that would benefit our veterans.

Your personal efforts and the interest in behalf of the veterans and employees of the Charleston VA Medical Center are a principal reason we're having this hearing today, and I want to commend you for your work that you've put forth. I'm pleased that you could be with us to give the subcommittee the benefit of your views about what's happening in Charleston, which I understand serves many of your constituents.

Let me ask you: How was employee morale and the personnel picture generally when Mr. Billik was Director, and how are things going now?

Mr. SANFORD. I think, as Jim Clyburn pointed out, morale has gone up substantially here lately with Mr. Vogel. What happened at that time—again, what happened, if you were to reconstruct history, was that a number of these employees—morale went up slightly when Mr. Billik first came onboard. Then it began to dip, and we began to get—apparently, a number of the employees placed calls to the Veterans' Administration Waste, Fraud, and Abuse Hotline, or whatever it was. They didn't seem to get much in the way of response, and then they began calling my office and

I would suppose Mr. Clyburn's office as well. And morale began to dip very substantially at that point, and, frankly, it was very, very low.

Mr. EVERETT. What do you feel like this committee can do to help you in this situation? Your previous comment about doing something with the testimony we get here today—

Mr. SANFORD. If you think about the mandate of the Veterans' hospital system, I think it's to serve those who served. And what's being called into question, the thing that's being wondered about by both the employees and those being served within the system, is: How efficiently is it doing that? Because of you think about priorities, businesses have priorities; individuals have priorities, and the thing that people kept wondering about, when they began to see fish tanks or when they began to see nursing home units that were opened—or built but never opened, or these consultant fees—were priorities. In other words, were the veterans, in fact, the priorities or was cronyism the priority?

And so I would simply say what would help the most to both the morale of the institution and to the veterans that it serves is for there to be a very clear-cut set of priorities on how money is spent within the veterans' system and, two, how people are advanced within the veterans' system.

Mr. EVERETT. What are you hearing from your constituents about the quality and timeliness of the health care there now?

Mr. SANFORD. You know, again, as I've indicated, I think that the morale is up from where it was. The question I think still continues to be, given the amount of money that goes into the veterans' system, to an extent what the veterans expect is, if not Cadillac care, something close to Cadillac care, and what they feel like is that they're not getting that level of care commensurate with the amount of money that's going into the system.

Mr. EVERETT. Thank you very much. Mr. Clyburn.

Mr. CLYBURN. Thank you, Mr. Chairman.

Congressman Sanford, I don't know that I have any questions. Let me, as I said before, thank you for being here today and for your work on this subject. But let me dwell a little bit on history. As you know, in my other life, I served a tenure as a history teacher. I don't think there's anybody in this Congress who loves history any more than I do. But I think it's one thing for us to look back and learn from our history; it's something else to dwell on the past—

Mr. SANFORD. Sure.

Mr. CLYBURN (continuing). And open up all kinds of contentiousness that may or may not do us any real good as we try to launch off into the future.

Now one of the reasons I never raised a public discussion of what was going on, the allegations at the VA, was because, as some people know, my wife retired after 29½ years as a librarian in the VA system, and she spent her time at the VA in Van Dorn. She'd never spent any time at this facility. But we were getting a lot of phone calls from her friends in the service at home, and I never spoke out publicly about it because of that bit of history. I didn't want anybody to feel that our involvement had more to do with my wife's experiences than what was really going on. And so I admire the

fact that you went public and raised those issues to the point that the public could become cognizant of them.

One last thing I want to say about this: The reason I raised the issue this morning about the Ralph H. Johnson VA Medical Center is because Monday of last week I spent the day at Courtney School in Charleston, a school that Ralph H. Johnson attended. And the reason I was spending the day at that school is because a gentleman went to a Black History Month Program last February, and he saw all these discussions about people, black people, in the Charleston area. This gentleman had been in Vietnam, and he knew Ralph had lost his life in Vietnam by saving the lives of scores of people around him, and had received the Congressional Medal of Honor, and there was no mention of it. And he thought there was something wrong with that. And so we got involved, and we were having a little essay contest at Courtney School, asking all the students in that school to write about Ralph H. Johnson and what his life and legacy mean to them today, and so that kind of history is important, and we have to deal with it. And I agree with you.

But I also ask us to take into account what Mike Doyle here has said today about what has taken place in Pittsburgh, because I have talked with people at the headquarters here at the VA, and these are people who have worked with Mr. Vogel. I have talked to veterans in the Charleston area, and they tell me, as you have said, that what is taking place at that facility today is just great. I have not heard one person complain. Now this is not to say there aren't any people complaining, and maybe they are complaining somewhere else, but all that I hear today seems to be positive.

And I've visited the facility recently, and you can feel it when you walk into the lobby, the difference in the aura there. It's different today than it was a couple of years ago. And we're talking about things that happened 4 and 5 years ago. Somebody reading the headlines tomorrow morning will think it happened yesterday. And so I think we need to be very, very careful with that.

Mr. EVERETT. Thank you very much, Jim.

Any other member wish to have any questions?

[No response.]

Mark, thank you very much. We appreciate your testimony.

Mr. SANFORD. Thank you, sir.

Mr. EVERETT. I will now ask panel two to please be seated.

Will the panel please rise and raise your right hand and repeat after me.

[Witnesses sworn.]

Thank you. Please be seated.

I believe we'll begin with you, Mr. Truesdell. Would you please describe your job at the Charleston VA Medical Center?

**TESTIMONY OF FLETCHER P. TRUESDELL, CHARLESTON VA MEDICAL CENTER EMPLOYEE, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY KATE IRENE SMITH, RN, CHARLESTON VA MEDICAL CENTER EMPLOYEE, DEPARTMENT OF VETERANS AFFAIRS**

**TESTIMONY OF FLETCHER P. TRUESDELL**

Mr. TRUESDELL. I am the full-time National Association of Government Employees president, and I'm also in engineering. I'm a utility systems operator.

Mr. EVERETT. We would be pleased to hear your testimony now.

Mr. TRUESDELL. Thank you.

Good morning, Mr. Chairman and members of the Congressional committee. Thank you for granting me this opportunity to appear before you today. My name is Fletcher P. Truesdell. I am a disabled veteran, and the president of the National Association of Government Employees, local R51-36, representing approximately 700 employees at the Department of Veterans Affairs Medical Center in Charleston, SC. My total commitment is to the American veterans and the employees who care for them. My testimony is filled with emotion and concern. There is no way to impart to you in 5 minutes everything needed to be told today.

Mr. Billik was blatant in his mismanagement and abuse of power. The system routinely transferred directors like him out of trouble, leaving behind other top management officials who continued the same management offenses. They are left in place to wreak havoc on the employees who complained of the waste, fraud, and abuse until a "don't-rock-the-boat mentality" cloaks all in fear of reprisal and retribution. We have many dedicated and excellent employees remaining at the VA Medical Center in Charleston. We do not want to lose any more due to the poor treatment they are receiving.

Mr. Billik arrived at Charleston VA Medical Center January 1992 as the Director and was assigned as Acting Director in Columbia, SC. Soon after his arrival, his entourage from Texas began arriving. He had hired and promoted his friends without competition and placed them in positions held by long-time employees. He further abused the system by giving these friends raises at the same time he was announcing hiring freezes, possible contracting-out of services, layoffs, RIFs, and cutbacks due to reduction in Federal funding. All this was done while creating a \$2.9 million deficit.

During an employee forum on June 11, 1996, when asked about the opening of the 38-bed nursing health care unit, Mr. Billik stated that President and Mrs. Clinton health care reform had changed health care overnight, and that the unit would not open. At another forum, Mr. Billik stated that he was not in the nursing home business. Gentlemen, who did he think he was fooling. The funded nursing care unit has not opened to this day.

The following actions have taken place since Mr. Billik's arrival in Charleston:

A management official informed me that one quality management employee had been demoted and another chose to leave under duress when a management consultant was hired by Mr. Billik for the VA Medical Centers in Charleston and Columbia, SC to per-

form tasks normally handled by the Director and the QM staff. This consultant was paid \$1,200 a day through medical funds.

Mr. Billik hired an interior decorator at a time when the hospital was in a deficit. Costly items ordered for the decorated areas are now elsewhere or missing.

Mr. Billik remodeled the Director's suite and the carpeting was laid twice.

During this excessive spending, essential hospital equipment and material was unobtainable due to lack of funds. During a shortage of supplies a nurse supervisor stated, "We should take one of those fish and sell it to buy paper for the copying machine." Yes, it was that bad.

Under Mr. Billik's management, we experienced \$3 million deficit while patient care projects were put on hold. This VA Medical Center received these funds. Where did they go? Will this be investigated? OSHA cited this hospital with willful safety violations such as the absence of hepa filters and unsafe exterior railings, placing patients and employees in unnecessary danger. The corrective measures were disregarded.

There was an escalation of complaints from employees in all areas. Simple complaints that could have been easily resolved ballooned into major issues due to management's refusal to acknowledge and accept responsibility for the problem.

Mr. Billik and his managers have a propensity to play the "is/is not" game. It is known that correspondence regarding this man was mailed to the Secretary of the Department of Veterans Affairs voicing a variety of concerns about the hospital. The Secretary apparently did not turn this over to the Inspector General for inquiry or investigation. Instead, he forwarded the concern to Mr. Billik, who in turn called the employee into his office and confronted her. There are many more cases of employees suffering the consequence of utilizing the confidential IG hotline. How can stamp out the waste, fraud, and abuse if no one feels safe to speak out? This same scenario is true in reporting harassment of any sort. We are told to go up the chain of command. In most cases the guilty party is in the chain or a pal of someone in the chain.

I thank you for your time, and I look forward to possible solutions to this problem. Gentlemen, I am at your service at any time. Additional examples follow, and more information is available upon request.

[The prepared statement of Mr. Truesdell appears on p. 165.]

Mr. EVERETT. Thank you, Mr. Truesdell.

Ms. Smith, would you describe your job at the hospital?

#### TESTIMONY OF KATE IRENE SMITH

Ms. SMITH. I'm a registered nurse, and 75 percent of my workday is in my department, Mental Health, and 25 percent is as the president of the RN union.

Mr. EVERETT. We'd be pleased to have your testimony.

Ms. SMITH. Good morning, Mr. Chairman and members of the Veterans' Affairs Subcommittee on Oversight and Investigations. I appreciate the invitation to come here today and give testimony before you.

My name is Kate Irene Smith. I am a registered nurse, a veteran, and the president of the National Association of Government Employees, local R-5-150, at the Ralph H. Johnson Department of Veterans Affairs Medical Center in Charleston, SC.

This is a professional unit representing title 38 registered nurses, and the testimony I gave is in our collective behalf. A statement made by our national president, Kenneth T. Lyons, is begin included in today's hearing.

The focus of this testimony is on the alleged mismanagement at the Charleston VA Medical Center, as investigated by the Office of the Inspector General. There is no question that over a lengthy recurring period of misspending and mismanagement a negative impact was felt by the nurses in our medical center. Limited to 5 minutes, I cannot bring all the issues forward, so I will concentrate on those that are of greatest concern to our nurses.

During Mr. Dean Billik's directorship in Charleston, we faced ongoing problems and adverse working conditions. We were daily faced with critical shortages in nursing staff, threats of downsizing, and reductions in force, commonly called RIFs. Many resigned under duress, and a hiring freeze compounded our problem.

Additionally, under Mr. Billik, we witnessed a money management style that left each nurse with continued cutbacks in salary. The subsequent reassignment and promotion with accompanying pay raise of Mr. Billik is something that the nurses in Charleston still ponder.

Mr. Billik explained to us, and I quote, "During lean times, raises and bonuses are not part of the job, and employees should not even expect them." It is a matter of record that during the same lean times Mr. Billik rewarded his staff, those who followed him to Charleston or were formerly acquainted, with promotion and salary advance.

During periods of critical nursing shortages in nursing staff, daily staffing adjustments were made. Nurses with specialized advanced training, competency, and certification in one area of nursing were assigned with lack of orientation or cross-training to areas of total unfamiliarity. This hardly fits the picture of the best patient care possible with efficiency and effectiveness. Mr. Billik denied this to the local media, that this was occurring, but in fact I was an eye witness and a forced participant in the management practice.

Currently, title 38 registered nurses are dependent on the annual salary survey conducted under the Nurse Pay Bill Act and other regulations for pay adjustments in pay or shift differentials. This survey is conducted exclusively by management and did little to nothing to keep the nurses in Charleston compensated for their dedicated care to our veterans.

In a memorandum dated March 31, 1994, Mr. Billik addressed the, and I quote, "significant impact that the reduction in differential pay would have on nurses." One salary survey resulted in the average pay scale nurse getting an increase of \$1 a week. We experienced continual downward adjustments.

In another memorandum dated 8 April 1996, Mr. Billik again reduced night and evening differential, citing, and I quote, "Severe budgetary restrictions." He further explained, because of the cur-

rent budgetary restrictions, a more gradual reduction will not be feasible.

We did have a large deficit variously reported between \$2.8 and \$3 million. Our lack of advancement was hard to accept in the face of what we knew was happening at the medical center. Mr. Billik's reorganization was thorough in promoting those in management, often noncompetitively, through multiple levels upwards, while nurses were losing ground.

Nursing provides care to veterans 24 hours a day, 7 days a week, and all nurses, myself included, appreciate a pleasant work environment, but fish tanks, palm trees, and costly office renovations cannot replace our mission, which is putting veterans first. No nurse I have ever spoken to can conceive of earning \$800 to \$1,200 a day, as was Mr. Billik's consultant.

It is no surprise that the results of the recently-conducted 1997 ONE-VA employee survey states that 65 percent of employees feel that pay raises do not depend on how well they perform their jobs.

It was not until January 9, 1997 that the registered nurses in Charleston were recognized for their hard work and dedication to their veteran patients. Our current Medical Director, Mr. John Vogel, was able to use the salary survey and other measures available to him, and Mr. Billik, to give us a modest, but more importantly, an equitable pay raise that mirrored our general schedule co-workers. We were grateful to him for that recognition.

What I have related are just not minor anecdotal situations, but real conditions affecting a person—oops, may I have the rest put into the written record?

Mr. EVERETT. Please go ahead and finish.

Ms. SMITH. What I have related are not just minor anecdotal situations, but real conditions affecting the person's standing directly at the bedside of the veteran, the VA registered nurse. We registered nurses are anxious to be part of the new VA with its new management, new challenges, and the reorganization that gives the stakeholder principle as defined by Dr. Kenneth Kizer, Under Secretary for Health, a chance to include us in decisions affecting our careers and the delivery of care to our patients.

I am reminded of an old German proverb that says, to change and to improve are two different things. It is something I use to tell me if I'm doing the right thing.

In closing, I want to thank the committee for giving me an opportunity to testify on behalf of an excellent, dedicated staff at the Ralph H. Johnson VA Medical Center in Charleston, SC.

[The prepared statement of Ms. Smith appears on p. 168.]

Mr. EVERETT. Thank you very much.

I have some questions that are sort of multi-layered, so the first question will be directed at both of you. As I said, it's kind of multi-layered, and I'll finish the question, then if you will, feel free to answer it.

A common complaint that the subcommittee has received about the former Director at Charleston, Mr. Billik, is that he showed favoritism toward his office staff, and one member of his staff, in particular. Do you believe he showed favoritism, and what were the employee perceptions of Mr. Billik as a manager and a leader? Did he set an appropriate example and conform to the higher standard

of conduct expected of senior management? And then, lastly, would there be employees that would not share your views on that?

Ms. SMITH. I am sure that there are many employees in management who will not share my views because they were part of that system, having been rewarded. But from my standpoint, from the general employee, there was a very negative perception. It was very, very difficult to work hard, coming in after hours and working hard, coming in and then seeing somebody brought from Texas right to the Director's suite and then promoted upward through several levels, obviously not competitively, while we were at the bedside of the veteran and losing ground. The perceptions were entirely negative.

Mr. EVERETT. Mr. Truesdell, do you have anything—

Mr. TRUESDELL. The perception of most of our employees was that he (Mr. Dean S. Billik) was in power, and that's one person that you shouldn't cross.

Mr. EVERETT. How was the morale prior to Mr. Billik's arrival at Charleston?

Ms. SMITH. Prior to Mr. Billik's arrival, we had a Director who paid close attention to both the mission he had to do and the people who had to accomplish the mission, and so the morale was much better. The work was being done. He still had problems that every Director has with how to balance the money, how to get the resources out, but the moral was much better because he took care of both things at the same time, the veteran and the person taking care of the veteran.

Mr. EVERETT. And, apparently, from your testimony, it took a nosedive on his arrival, and that continued—

Ms. SMITH. Straight down.

Mr. EVERETT (continuing). During his tenure there?

Mr. TRUESDELL. Yes.

Mr. EVERETT. How's morale now?

Ms. SMITH. Morale has improved since Mr. Vogel arrived. There are still things to be taken care of. That's an ongoing process in every hospital, but it did improve after he came. We're hoping for further improvements.

Mr. EVERETT. What are some of the things that need to be improved?

Ms. SMITH. From my perspective with the nurses, the Nurse Pay Bill Act is not an equitable system compared to the cost-of-living adjustments that the general wage schedule people get. A specific example is that recently—

Mr. EVERETT. Would you repeat that, please?

Ms. SMITH. I said that the Nurse Pay Bill Act of 1990, which authorizes VA nurses, title 38, to get cost-of-living adjustments, only through a salary survey; it is not an automatic process, and in fact your pay can be reduced. This doesn't mirror the cost of living that every other government worker gets as an automatic thing.

Now it was within Mr. Billik's power to use this, and he did not. Mr. John Vogel this last January did use that, plus other measures, to recognize us.

Mr. EVERETT. I understand that—as a matter of fact, I mentioned in my opening remarks that two individuals from the Charleston hospital were invited to testify and they declined be-

cause of fear of reprisal. If you know who they are, please do not—do not—mention their names, but please tell the subcommittee about the atmosphere of Charleston that would cause them not to want to testify.

Ms. SMITH. The employee I have most recently spoke to is concerned because she works, this employee works in a department with highly-specialized equipment that carries no maintenance contract, and yet the fish tank is on a maintenance contract of \$7,000 a year. But this highly-technical piece of medical equipment lacks a maintenance contract, and she can't rely on its function.

Mr. EVERETT. I don't think that answers the question of why she fears to come forward and testify.

Ms. SMITH. Because her supervisor or her boss has threatened to fire her if she says this.

Mr. EVERETT. I sure would like to hear some mid-level management employee threaten to fire an employee, because I'd like to get that person right in front of this subcommittee and——

Ms. SMITH. It's an ongoing thing.

Mr. EVERETT. And we do hear that. We, members of the committee, have strong feelings about that. The problem is that it's very difficult for us to get the proof. But if you can ever find the hard proof, I really, really wish you'd get it to the subcommittee, because I would enjoy getting that type of person in front of this committee.

Ms. SMITH. Would the minutes of meetings be all right?

Mr. EVERETT. I beg your pardon?

Ms. SMITH. The minutes of meetings in which those statements are made?

Mr. EVERETT. Yes, certainly, if he used the threat to fire an employee if they did a certain thing, I'd love to have that.

Do you believe the IG investigation at Charleston has been thorough and independent of VA management? And do you believe it pulled any punches, so to speak?

Ms. SMITH. I believe it pulled several punches, and, no, I don't believe it was thorough.

Mr. EVERETT. I did notice—and we'll talk to the IG group about that later—that while the titled report—I don't know if you read it or not—says, "Alleged Mismanagement," there's no direct finding of mismanagement in the report. They don't use the term, and I'm very curious about that. I would assume that if either of you had written that report, you would have had no problem using the term "mismanagement."

Mr. TRUESDELL. Yes, sir.

Mr. EVERETT. Mr. Clyburn.

Mr. TRUESDELL. Mr. Chairman?

Mr. EVERETT. Yes?

Mr. TRUESDELL. Speaking of the report, we had approximately 30-something employees that were willing to speak to the IG, and only about 21 actually spoke to the IG. We had still about another 10 or more that wanted to speak to the IG over issues. The investigation ended. We weren't informed that it was actually ended, and we never saw or heard from the IG since then.

Mr. EVERETT. Of course, one of the responsibilities of this subcommittee is to find out why those kind of things happen, and as our colleague, Mr. Mascara said, that somewhere somebody needs

to take the consequences of these actions. Now whether it's in the IG's office or upper management's office, or what, this subcommittee intends to find out.

Mr. Clyburn.

Mr. CLYBURN. Thank you, Mr. Chairman. I have a couple of questions, but, first of all, Mr. Truesdell, how would you rate Mr. Vogel's performance since December 1996?

Mr. TRUESDELL. I really can't.

Mr. CLYBURN. You can't?

Mr. TRUESDELL. No, sir.

Mr. CLYBURN. So after 10 months, you have no impression of what his performance is?

Mr. TRUESDELL. I'd say it's a neutral, from our standpoint.

Mr. CLYBURN. Who's "our?"

Mr. TRUESDELL. The employees. Nothing's happening.

Mr. CLYBURN. How would you answer that question, Ms. Smith?

Ms. SMITH. When Mr. Vogel came in, initially there was a great response to his attention to us. Since then, I feel that some of his attention has been diverted because he has an accompanying VISN assignment.

Mr. CLYBURN. He has a what?

Ms. SMITH. Accompanying VISN assignment. Each hospital director also has another duty within VISN. So he spends a great deal of time away from the medical center, and I feel that the system that started under Mr. Billik is still somewhat in effect. So that in Mr. Vogel's absence, things are still being done that he may be unaware of. There are still problems to be taken care of, and he's often not there to see what's going on.

Mr. CLYBURN. Well, let me say to both of you, as you may or may not know, this is my first elective office. Before I came to Congress, I spent all of my life, since the age of 25, as a manager and an administrator, and I took over an agency that was under severe criticism publicly and by the State legislature. And though you would like to walk in on Monday morning and turn the culture around by 5 o'clock that afternoon, it cannot be done.

And so I guess what I'm asking is whether or not there is an attempt on the part of Mr. Vogel to correct, or the right term may be to rectify the situation, at the hospital. I notice you said that Mr. Vogel used this instrument that was available to Mr. Billik but never utilized by him that gave what you thought were equitable pay raises, but Mr. Truesdell still says nothing is happening.

Ms. SMITH. We come from two different perspectives. We're representing different type schedule employees. What Mr. Vogel did was took the instrument and the information he got, and instead of accepting it, he forwarded it on to Washington for further consideration. He said, "Please override what the community salary survey says. I don't think it's right."

Mr. CLYBURN. Right.

Ms. SMITH. Mr. Billik had that option and didn't exercise it. Mr. Vogel did, and was able to give us good news.

And I will say that I've taken many things before Mr. Vogel and he has done everything he can to help rectify some problems. He has done some good things. I do think that the system in the hospital is so ingrained, leaving Mr. Billik's management style, that

there are still many more things to be corrected. I do believe he's attempting to do that.

Mr. CLYBURN. Well, thank you very much.

Ms. SMITH. We haven't seen a totally positive result yet, but it's like you said, it takes time.

Mr. CLYBURN. Maybe if he stays there as long as Mr. Billik was there, he might be able to do it.

Mr. TRUESDELL. Let me ask you, what is your function at the hospital.

Mr. TRUESDELL. I'm a full-time president of the National Association of Government Employees that was negotiated in July of this year.

Mr. CLYBURN. Oh, so you're not an employee——

Mr. TRUESDELL. I am an employee being paid through the engineering services as a utility systems operator.

Mr. CLYBURN. But you aren't working there every day?

Mr. TRUESDELL. No, sir, I work out of an office.

Mr. CLYBURN. Okay. So you are an advocate for the people who work there?

Mr. TRUESDELL. Yes, sir.

Mr. CLYBURN. Okay. Have you had discussions with the people who are working there every day as to what they feel?

Mr. TRUESDELL. I have many, many people come to me all during the day and even at night, because a lot of times I——

Mr. CLYBURN. So you don't think that any of the people that you have responsibility to as an advocate think that anything is happening of a positive nature?

Mr. TRUESDELL. They feel that nothing's happening. There's still hints over whether they're going to be contracting out, whether being RIFed. We were in a deficit earlier in the year, and we were bailed out.

Mr. CLYBURN. How were you bailed out, the deficit?

Mr. TRUESDELL. I think the money was given to us through the VISN.

Mr. CLYBURN. And you don't think Mr. Vogel had anything to do with that?

Mr. TRUESDELL. Well, I'm sure that they had what they called MCCR, and——

Mr. CLYBURN. I don't know what all those acronyms mean, but——

Mr. TRUESDELL. Okay. They were talking about funds coming back to the hospital through the MCCR program, like a third-party billing, and also through the redirection of northern patients' money (northern patients migrating to southern hospitals) to the southern cities, that we would use the money from that——

Mr. CLYBURN. Excuse me. Were you in a deficit before Mr. Billik got there?

Mr. TRUESDELL. Not that I'm aware of.

Mr. CLYBURN. So you think that he drove you to a deficit?

Mr. TRUESDELL. It's the first time that I ever heard—I've been at this hospital since 1973, and this is the first time I have heard of a deficit at this hospital.

Mr. CLYBURN. Okay, but now you're out of the deficit?

Mr. TRUESDELL. Yes, sir.

Mr. CLYBURN. So you would blame Mr. Billik for putting you there, but you don't want to give credit to Mr. Vogel for getting you out of there, the deficit situation?

Mr. TRUESDELL. Well, we were in the deficit earlier, and now we're out of a deficit. He had to be the one responsible for getting out of the deficit.

Mr. CLYBURN. Well, then, something is happening. All I'm saying to you, Mr. Truesdell, is that what we want to do, I would hope, is try to change the culture, and this is not just Charleston; it's not just the Ralph Johnson facility or the Pittsburgh facility. We're talking about something that we are finding throughout the entire VA system. It's a culture that we're trying to get to, and I think it will be very helpful if we know what's working and what's not working, if you know who is good and who is bad. But to just lead us to believe that, no matter who comes, no manager is going to make a difference is something that I have a real problem with. I thought of myself as a pretty darned good manager, and I would hate to think that it doesn't make any difference who the manager is; that the system is so ingrained or so endemic that nothing can be done about it. I would hope that you'd be helpful to us, especially the people that you advocate for, so that we will know what it is that we can recommend as a subcommittee.

When we ask you to come up and testify, we're looking for information, and we would like to know when something is working and when something is not working, but just to say that it ain't going to work, no matter what, is a problem to me as a manager, and I hope you understand where I'm coming from here.

Mr. TRUESDELL. Yes, sir.

Mr. CLYBURN. Okay, thank you. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you very much, Jim.

I would just point out, on behalf of Mr. Vogel, as former Under Secretary of Benefits for VA, I hope you can understand why he'd be a very attractive candidate to have assignments also with a VISN, as well as the directorship. I do understand your feelings and those of the people you represent that you have immediate problems that need to be solved, and that's perhaps a conflict that can be worked out.

Now I would like to turn to another member of the subcommittee, Mr. Mascara. Frank, if you will?

Mr. MASCARA. Thank you, Mr. Chairman.

Mr. Truesdell and Ms. Smith, I probably am a glutton for punishment; I read all of the testimony, including yours. And, Mr. Truesdell, there are some very serious charges in your testimony. In the first three paragraphs alone, you charge Mr. Billik with mismanagement, misappropriation of funds, abuse of the system, waste of taxpayers' dollars, abuse of employees, fraud, abuse of power. These are very serious charges.

Mr. TRUESDELL. Yes, sir.

Mr. MASCARA. They're very serious charges. Have you read the Inspector General's report?

Mr. TRUESDELL. Yes, sir, a redacted copy.

Mr. MASCARA. The redacted copy?

Mr. TRUESDELL. Yes, sir.

Mr. MASCARA. You already responded to Chairman Everett's question, but this is something I wrote last night. "Have you read the Inspector General's report," and you responded, "yes." "If so, do you think the report fairly explains the allegations," and you've already responded to Mr. Everett. My note to myself is, "I have and it does not. It does not address the charges."

In your statement, and I quote, "Will this be investigated?" That's taken from your statement. So do you think that some other independent agency outside the Department of Veterans Affairs should look into these matters?

Mr. TRUESDELL. Yes, sir, most definitely.

Mr. MASCARA. Ms. Smith—thank you, Mr. Truesdell.

Mr. TRUESDELL. You're welcome.

Mr. MASCARA. While your testimony is less volatile, you still allege misspending, mismanagement, adverse working conditions, critical shortages in nursing care; many people resigned under duress; nurses were assigned with lack of orientation or cross-training. In your opinion, on this last observation here, did that compromise the care of the patients in any way?

Ms. SMITH. I'll give you an example. I'm a psychiatry nurse with 20 years' experience, and one morning I was told I would go and work on the surgical ward. I took care of 20 surgical patients, their full care. If you were going to an operating room and they were short a doctor, your surgeon, and they said, "Well, let's go get a psychiatrist. Both of them went to medical school," would you be comfortable?

Mr. MASCARA. I would not. So you've answered my question.

Ms. SMITH. I'm not sure my surgical patients were comfortable, but I attended to their mental health needs. I could calm their fears, but I couldn't take care of their surgery.

Mr. MASCARA. Do you think that the new network organization structure that has been in place for nearly 2 years will address any of these problems that you cite?

Ms. SMITH. I believe it's started, and I believe it has a long way to go, but I believe the change has begun.

Mr. MASCARA. Because the regional directors I believe had in some instances as many as 43 facilities reporting to them, where now some as few as 3, and in fact two of the networks have only 3 facilities reporting to them, and I believe no director has more than 10 reporting to them. So we should see some benefit from the reorganization. Thank you.

Do you think somebody outside of the VA should investigate the allegations that have been made?

Ms. SMITH. Yes.

Mr. MASCARA. Thank you. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you, Frank.

A colleague of ours on the full committee, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman, and thank you, Ms. Smith and Mr. Truesdell, for appearing before the committee.

I just want to get clear, Ms. Smith, you are president of the National Association of Government Employees, local R-5-150, and that is registered nurses?

Ms. SMITH. Yes, title 38 registered nurses.

Mr. BILIRAKIS. Okay. And then Mr. Truesdell is president—what is that R-5-136? Is that all other employees or cover all other employees at the center?

Mr. TRUESDELL. Except the doctors and the dentists—

Mr. BILIRAKIS. Except the doctors.

Mr. TRUESDELL. We handle all nonprofessional title 38 hybrids and professionals—

Mr. BILIRAKIS. I see. So you're both presidents of local union groups. How long have you been presidents of those groups?

Ms. SMITH. The nurses union was certified in August of 1996, which is why I have less testimony. Mr. Truesdell has much more history—

Mr. BILIRAKIS. So you've been president since August of 1996?

Ms. SMITH. I don't have the same amount of history to bring forward.

Mr. BILIRAKIS. Well, you don't have the same amount of history as president of the union, but you have the same amount of history as an employee of the Veterans' Center and caring for veterans, et cetera.

Ms. SMITH. But not all the information has been made available to me.

Mr. BILIRAKIS. Yes, I see.

Ms. SMITH. Things I have requested, I have been denied under the premise of—

Mr. BILIRAKIS. You have requests that you have been denied?

Ms. SMITH. Yes, I have requested information that was available before we were certified as an RN union, and I've been told, no, that was before you became certified.

Mr. BILIRAKIS. You've been told no by whom?

Ms. SMITH. The Department of Human Resources—that it wasn't relevant.

Mr. BILIRAKIS. That it wasn't relevant?

Ms. SMITH. Yes.

Mr. BILIRAKIS. Mr. Truesdell, I'm sure somebody wants to follow up on that one—

Mr. TRUESDELL. Not to interrupt you, but—

Mr. BILIRAKIS. Go ahead.

Mr. TRUESDELL. I stepped out of steward shoes into the president's shoes February 5, 1996, and that was during Mr. Bilik's term there—

Mr. BILIRAKIS. February of 1996, but you were a steward for quite a while before that?

Mr. TRUESDELL. I was a steward for many years before that, and due to that fact, the election that took me through was by 21 votes shy of a unanimous vote, a majority of the votes of the members.

Mr. BILIRAKIS. All right, now you said in your testimony here, "It is known that correspondence regarding mismanagement was mailed to the Secretary of the Department of Veterans Affairs voicing a variety of concerns by the hospital. The Secretary apparently turned this over to the IG for inquiry and investigation, instead of forwarding the concerns of Mr. Bilik," et cetera, et cetera. When did that—you say it is done. What do you mean by that?

Mr. TRUESDELL. A majority of the employees had heard about it and—

Mr. BILIRAKIS. But who would have sent this correspondence?

Mr. TRUESDELL. An employee.

Mr. BILIRAKIS. An employee? All right. So we know—so there's a fact—it's a fact that an employee sent this correspondence on to the Secretary of the Veterans—the Department of Veterans Affairs?

Mr. TRUESDELL. Yes, sir.

Mr. BILIRAKIS. And that's a fact?

Mr. TRUESDELL. I was given a copy of the letter, and I also know who the employee is, and they still—

Mr. BILIRAKIS. Has that been made available to the committee? The letter, do we have a copy of that letter? When did that take place Mr. Truesdell, approximately?

Mr. TRUESDELL. I believe it was the summer before Mr. Billik left, approximately 1 year ago (1996).

Mr. BILIRAKIS. The summer of what, 1995?

Mr. TRUESDELL. Yes, sir. (1996.)

Mr. BILIRAKIS. The summer of 1995?

Sorry, Mr. Chairman. Yes?

Mr. EVERETT. Are we speaking of the letter of complaint that was given to the Secretary—

Mr. BILIRAKIS. Yes.

Mr. EVERETT (continuing). And then rerouted back to him?

Mr. BILIRAKIS. Yes.

Mr. EVERETT. By the way, a common occurrence.

Mr. BILIRAKIS. Do we have copies of that?

Mr. EVERETT. We do not, and it was felt like it would compromise the signer of the letter, but we're still working to get a copy of that.

Mr. BILIRAKIS. Well, the reason I bring these up is because, yes, you've both been presidents of your unions for a short period of time, but you've been employees there a long time. And I trust that these concerns that you have expressed here, the conduct that has taken place is conduct that hasn't just taken place during the time you've been president of your union; it's conduct that has taken place over a period of time. Is that correct?

Ms. SMITH. Yes, it is.

Mr. BILIRAKIS. All right. I guess I'm trying to get to—you have an Inspector General, and we're going to be having an opportunity to talk to that individual, but if employees have not made a real strong effort to let somebody know about mismanagement, then how in the world—you know, you indicated that things still needed to be corrected, Ms. Smith. We all know that nothing is ever perfect; nothing is ever going to be perfect; we know all that.

But I guess what I'm trying to find out: Have efforts been made on the part of employees, on the part of the staff, aside even from the union, to let somebody know about things taking place? I mean veterans' lives are being adversely affected when there aren't adequate resources to take care of them, and if those resources are misused, wouldn't you say? I mean, what's your answer to all that? The yellow light is on, but, very quickly, can you respond to my concern?

Mr. TRUESDELL. They fear retribution. The only—

Mr. BILIRAKIS. They fear retribution?

Mr. TRUESDELL. Yes, sir. The only way they could respond was to go off-station, and I agreed to that; we would have arrangements made with the Inspector General off-station, and that was the basis—

Mr. BILIRAKIS. In other words, an Inspector General—off-station meaning not located, not physically located at the facility?

Mr. TRUESDELL. We didn't trust anybody walking in and seeing them go into the office with an IG. They asked to remain anonymous, and we honored that.

Mr. BILIRAKIS. Ms. Smith?

Ms. SMITH. I would say that if there's any efforts being made, that some of that information doesn't get back to me; I have very, very limited communication with management. So some of the feedback, if attempts are being made, I'm not aware of all of them. They may be occurring. Of course, I'm only going to hear from other people's perspectives when things are not going well—

Mr. BILIRAKIS. But before you were president, I mean, you were there; you were there for so many years. You know fellow nurses, et cetera, et cetera. I mean, there's got to have been talk about mismanagement, complaints about this and that. Has there been any talk about any efforts being made to carry these complaints and these concerns up the ladder somewhere?

Ms. SMITH. People did, but they did it anonymously because they still had retribution fears.

Mr. TRUESDELL. Retribution was also on the people that did try to go to the Inspector General through the hotline and remain anonymous, and the name was given out, and the employee does not know how.

Mr. BILIRAKIS. Well, we'll continue on here, because we have other witnesses. Thank you very much. Thank you, Mr. Chairman.

Mr. EVERETT. We only have about 8 minutes to make a vote. This panel will remain seated, and, Mr. Bilirakis, I misspoke; we do have a copy of that letter. We have not made it public because of fear of reprisals toward the employee, but it is available to members of the committee.

The committee is in recess until we return from the vote. This panel will remain seated.

[Recess.]

Mr. EVERETT. We will proceed with another round of questioning with this panel. To emphasize the importance of your testimony, I emphasize that you remain under oath at this point.

Mr. TRUESDELL. Yes, sir.

Mr. EVERETT. Let me just briefly comment on the letter that went full circle, that was written to the Secretary and then found its way back down to the hospital director. This is not something that we found was uncommon; I hate to tell you that. For instance, we had a situation in our sexual harassment hearings where the people who were complaining to the EEOC officer, that officer was actually director of a hospital, and one of the complainants actually heard the director and someone else laughing about her complaint. This is what I have referred to as "the culture" that exists in VA. And it has been very difficult for us to break through that culture. But, frankly, for VA to survive, it has to break through that culture or we're going to have some really, really tough hearings, and it

doesn't make any difference if I'm in this chair or the ranking member is in this chair; this is not a partisan issue. This is an issue that we're very much concerned about, and it's one that we are struggling with to find the answer to, because we get people in front of us and they nod very politely, and tell us they're going to change course, and then they go out and do whatever it is they want to do.

You will find that this subcommittee will put more and more people under oath. We will use subpoenas when we have to, but we simply are not kidding around about trying to break through the culture that exists at VA.

Ms. Smith, do you have personal knowledge about what may have happened to some of the new carpeting which was torn up from Mr. Billik's office?

Ms. SMITH. Yes. One day I was going from the main hospital to the personnel department, and you have to cross the back of the hospital's loading dock, and there's a construction dumpster, and I saw huge sheets that filled the entire dumpster fanfolded in there, and I know it was new carpeting. It was not stained on the backing. It's the same carpeting I had seen going into the Director's office, and it was now in the dumpster. I reached over to feel how thick and plushy it was.

Mr. EVERETT. Do you have any idea why that occurred?

Ms. SMITH. No. I know rumor. I don't know fact. I only heard that the first carpeting was not satisfactory; that being black, it showed too much lint.

Mr. EVERETT. And so the carpeting was then removed and that new carpeting was dumped—

Ms. SMITH. Yes.

Mr. EVERETT (continuing). And other carpeting was ordered and paid for?

Ms. SMITH. Yes, I saw it in the dumpster.

Mr. EVERETT. And this was at the lean time?

Ms. SMITH. Excuse me, yes.

Mr. EVERETT. This was during lean—what was lean times?

Ms. SMITH. Lean to some.

Mr. EVERETT. He apparently took care of his own interests very well.

You are aware that Mr. Billik was promoted, got a pay raise, as I mentioned earlier, six figures, and was put in charge of three VA hospitals in central Texas after leaving Charleston? You're both aware of that?

Ms. SMITH. Yes, I heard the news.

Mr. TRUESDELL. Certainly.

Mr. EVERETT. How do you think that affects the employee morale at Charleston?

Mr. TRUESDELL. In my bargaining unit, it confirmed that managers get promoted when they leave, even though they're having problems, and—

Mr. EVERETT. In other words, this is the same old same old—

Mr. TRUESDELL. It gives the message that they can do whatever they want and get away with it.

Mr. EVERETT. You're seeing this time and time again, and VA employees over the country have seen this time and time again. We

found that particularly true in the sexual harassment cases. It's incredible that this has been allowed to happen, and I don't think that we can just blame directors who take advantage of the situation. I think the blame goes higher than that, quite frankly.

At this time, I'll turn it over to my able ranking member for any additional questions he may have.

Mr. CLYBURN. Thank you, Mr. Chairman. Mr. Chairman, I do have a couple of questions.

I've gone through the Inspector General's report, and I'm just, certainly as we talk today, counting the allegations, and I think in the allegations of mismanagement at the Ralph Johnson Center there were 27 allegations, and there were 12 the General substantiated. He found substantiation for 12 of the 27 and 2 others, and the Inspector General's report says that one was turned over to the proper judicial authorities, and the other to what I gleaned to be an administrative procedure. So that would bring to 14—that's more than half of the allegations the Inspector General substantiated. And so when you look at that kind of thing, I wonder why if the Inspector General found cause or substantiation in more than half of the allegations, that you still think we need to have another investigation by somebody outside? You don't give the Inspector General credit for finding on your behalf more than half of the time?

Mr. TRUESDELL. With respect to that, there was a lot of complaints that the Inspector General was informed of that was not in the IG report.

Mr. CLYBURN. Well, I noticed that you indicated at one point that there were 30-some-odd people that you had on the list to talk to, and they only talked to 20-some-odd. You know, after a while, if you talk to 10 people, and the next 10 people say the same thing as the first 10 people said, then you might ask why do I need to go to the third 10 to hear the same thing over and over again?

Do you have any information that led you to think that these 10 people would raise new issues that had not been brought to the attention of the Inspector General in these 27 instances?

Mr. TRUESDELL. In the 27 instances, there was issues that was brought up that was not in the report.

Mr. CLYBURN. Sir, you said there are some other, in addition to these 27?

Mr. TRUESDELL. Well, the 27—no, with the 27 people that was interviewed by the IG, issues was brought up—

Mr. CLYBURN. Right.

Mr. TRUESDELL (continuing). To them that was not in the report.

Mr. CLYBURN. Could you give us an example of—maybe just give me one of them that you think was important or pertinent that was not dealt with by the Inspector General.

Mr. TRUESDELL. Excuse me?

Mr. CLYBURN. Can you give me one issue outside of these 27 that you think should have been brought to the IG's before the attention or should have been dealt with in this report which was not dealt with? You're telling me that there are allegations made that the Inspector General did not pursue. Isn't that what I understand you to say?

Mr. TRUESDELL. Yes, sir.

Mr. CLYBURN. Can you give me one allegation that should have been pursued by the Inspector General which was not pursued that you can report to us here today?

Mr. TRUESDELL. The one by an employee in the operating room is not in there.

Mr. CLYBURN. What's the allegation?

Mr. TRUESDELL. The allegation that an anesthesiologist left the operating room while surgery was going on.

Mr. CLYBURN. That's an allegation that was made, and the Inspector General did not deal with that in the report?

Mr. TRUESDELL. No, sir.

Mr. CLYBURN. You don't think it's—I saw something over here, allegation No. 26, yes, allegation No. 26, where they talked about the nursing staff; that's not covered in there, is it?

Ms. SMITH. No.

Mr. CLYBURN. Okay. So are you saying that Mr. Billik refused to deal with the issue when it was brought to his attention? You certainly can't blame him for the anesthesiologist walking out of the room. Do you know whether this was brought to the attention of Mr. Billik and was not dealt with?

Mr. TRUESDELL. I can't—

Mr. CLYBURN. That would be the management issue.

Mr. TRUESDELL. I can't say that it was taken to Mr. Billik, because of the anonymity of the employee at the time.

Mr. CLYBURN. But what I'm saying to you is that the Inspector General was there to investigate allegations of mismanagement. You certainly cannot blame the manager for the negligence or stupidity of any one employee unless that negligence or stupidity was brought to the attention of management and not dealt with. So are you saying that the anesthesiologist that walked out of the room, that this problem was brought to the attention of management, and management refused to deal with it? Is that what you're saying?

Mr. TRUESDELL. No, sir. It was brought to the attention of the IG for the IG to deal with it, so the employee wouldn't have to come forward.

Ms. SMITH. The incident was taken to the attention of management.

Mr. TRUESDELL. That I didn't know.

Mr. CLYBURN. And management did not do anything about it?

Ms. SMITH. There was a report of contact written, and it was torn up and thrown back in the face of the employee.

Mr. CLYBURN. You said—please, say that again?

Ms. SMITH. The employee reported something that she thought was significant and took it to management, who tore the document up and threw it back at her.

Mr. CLYBURN. Can you identify—this is not Billik? This is a supervisor, is that what you're telling us?

Ms. SMITH. It's the same incident he's referring to.

Mr. CLYBURN. Okay. Well, Mr. Chairman, this is the kind of stuff I think we probably need to deal with. If there are things like this where management refused to respond, I think we probably may need to get maybe some written report or something; I don't know if you want to do this in open testimony, but this is the kind of stuff that I think that we may need to look at. I don't want us to

rehash the same thing over and over again, but if there's something that shows a problem, and that person is still there---

Ms. SMITH. That person is still there and isn't testifying today because that person's been threatened with being fired.

Mr. CLYBURN. No, I'm talking the manager still being there. The supervisor---

Ms. SMITH. Yes.

Mr. CLYBURN (continuing). That tore the document is still supervising, and the new management has or is cognizant of this and not doing anything about it?

Ms. SMITH. I can't answer for what management passes on to its own.

Mr. CLYBURN. Right. Well, that's what I'm saying. You know, what we want to do is get at the culture and see whether or not the new management, Mr. Vogel and his team, whoever they may be, are dealing with these problems. And so that's a problem if it's brought to his attention, whether or not he's dealt with that kind of a supervisor to see—to make sure that that kind of attitude is taken out of the system, and that kind of action will not be tolerated. So that's what I'm talking about, is whether or not we can find out whether or not that kind of issue has been dealt with by management.

Ms. SMITH. Well, I think we're singing off the same song sheet. Mr. Billik created a culture which is still there somewhat.

Mr. CLYBURN. Somewhat?

Ms. SMITH. He may be gone, but some of the culture is still behind.

Mr. CLYBURN. Oh, we understand that. We understand that maybe more problems will be there today than will be there 6 days from now, and maybe in another year from now all of it them will be gone.

Ms. SMITH. There has been---

Mr. CLYBURN. But the question is whether or not there is any systemic movement toward the eradication of that culture or whether or not the actions being taken by current management simply undergird or reinforce the culture rather than to extricate it from the system. And that's why we're here.

Ms. SMITH. Well, that's difficult to answer yes or no, because while there are significant improvements in one area, there have been instances where the same system has been going on.

Mr. CLYBURN. In other areas?

Ms. SMITH. Yes, there is.

Mr. CLYBURN. Yes.

Ms. SMITH. There's a definite incident that occurred that---

Mr. CLYBURN. My time's up, Mr. Chairman.

Mr. EVERETT. Mr. Mascara? And there are no questions for this panel?

Mr. MASCARA. Not for this panel.

Mr. EVERETT. Mr. Bilirakis.

Mr. BILIRAKIS. Well, thank you, Mr. Chairman.

Let's continue on. Mr. Clyburn made the comment earlier, I guess in his opening remarks, something about not dwelling in the past, and that certainly is true. What we want to try to do is to get at the roots of everything and try to get things straightened

out. Obviously, we have to learn from the past in order to be able to do that. So this is why we're still in the past.

But you said that this employee was threatened with the loss of her, his or her job, if they testified? And this happened today—

Ms. SMITH. No. If any information were ever told outside of that department.

Mr. BILIRAKIS. Okay, but that individual was threatened by the current administration at Charleston?

Ms. SMITH. Required to sign a document—

Mr. BILIRAKIS. Even though the occurrence that we're talking about took place under the prior administration?

Ms. SMITH. There's an ongoing problem in one department in which employees are continually reminded and being told they must sign an affidavit that says that anything in that department will not be discussed outside the department. That is not just exclusive to patients, but just personnel policies, and that if anybody crosses that line, they will be fired.

Mr. BILIRAKIS. Well, you know, we've got to be open-minded up here. We should be. Otherwise, we can't really do our job adequately.

To be a manager at any level is tough. I think in today's world it's even tougher than it ever has been. There's no question about that.

So really this—whether anybody believes it or not, this is not intended to be a witch hunt. It's intended to get to the dadblasted gist of why things are taking place, and try to improve them, and see that they are improved.

You know, what bothers me is statements like this, Mr. Chairman, where a person is being threatened with maybe being fired. What bothers me is where there is a concern about walking down the hall to the in-house IG because the concern is that that in-house IG might be sort of part of the culture, that we're talking about a pal of someone in the chain of command.

Mr. Truesdell, "there are many more cases"—I'm repeating from your testimony—"many more cases of employees suffering the consequence of utilizing the confidential IG hotline. How can we stamp out the waste, fraud, and abuse if no one feels safe to speak out? The same scenario is true in reporting harassment of any sort. We are told to go up the chain of command. In most cases the guilty parties in that chain are a pal of someone in that chain."

That really bothers me because an IG—and I was talking to the chairman walking over to the Floor to cast that very important vote that we had to cast on the journal that interrupted an important hearing, but that's the way it is up here. So maybe we need some IG work up here, too.

But I remember when I was in the military I went to the IG once, not on behalf of myself; on behalf of another soldier. And I didn't feel any trepidation in having done so. I didn't feel it was going to hurt that other military person in any way whatsoever. And I was comfortable in doing it because that was the job of the IG. And if you're not comfortable in doing something like that—I mean, you know, we're supposed to be living in a system of freedom here. And if you work under conditions of fear, there's nothing free about all that.

And you all have your job to do as presidents of the union, but I'd like to think, more importantly, you have your jobs to do as people who are concerned about veterans and who have been serving veterans for a long, long time.

So let's go back to this in-house IG. Where is his—is it a he? Is it a man, to clear up Mr. Clyburn's concern? Is it a he or a she?

Mr. TRUESDELL. It was a he.

Mr. BILIRAKIS. It's a he? All right.

Mr. TRUESDELL. Yes, sir.

Mr. BILIRAKIS. So where is his office located as against the rest of the offices? Is he in the middle of everything or——

Mr. TRUESDELL. No, he was from Washington.

Mr. BILIRAKIS. But you mentioned in-house IG. In Washington? There is no IG located at the Charleston Medical Center?

Mr. TRUESDELL. No, sir.

Mr. BILIRAKIS. Oh, there is no IG? Is that usual?

Ms. SMITH. We have no permanently assigned IG.

Mr. BILIRAKIS. You have no permanently assigned IG.

Ms. SMITH. In Charleston the IG has no office.

Mr. BILIRAKIS. Okay. Well, we——

Ms. SMITH. He came into town and——

Mr. BILIRAKIS. We will be talking to the IG's office in a couple of minutes. So I guess we can go into that.

So, basically—but you used the term, Mr. Truesdell, you have to go to an outside, or something to that effect, IG? What does that mean?

Mr. TRUESDELL. It means that they're not—that the employees don't feel that they're protected inside.

Mr. BILIRAKIS. Well, what's "inside" mean if——

Mr. TRUESDELL. Inside the VA, inside of the walls of the VA. I mean——

Mr. BILIRAKIS. Oh, inside the VA system?

Mr. TRUESDELL (continuing). It's in the management system.

Mr. BILIRAKIS. Ah, so what you're saying is that they feel that they have to go to an IG outside of the VA system?

Mr. TRUESDELL. They were reluctant to even to go to the IG, but talking to the employees and telling them that everything would be all right and they would remain anonymous—to bring the problem out, to air it, to have somebody come in and take heed to what's going on.

Ms. SMITH. I think part of the confusion might be that the employees felt more comfortable testifying to someone off the hospital compound at somewhere independent in town, so that you're not seen talking to——

Mr. BILIRAKIS. Well, all right, but Mr. Truesdell's already told us that the IG is located in Washington and not—and there is no IG located geographically on the compound.

Ms. SMITH. He came to Charleston.

Mr. BILIRAKIS. He came to—I see. But, still, they were not comfortable with talking to him?

Ms. SMITH. This Inspector General made arrangements to see people wherever they were most comfortable.

Mr. BILIRAKIS. Well, I kind of commend that. But they still weren't comfortable?

Mr. TRUESDELL. No, sir.

Mr. BILIRAKIS. Well, therein I think likes much of the problem, I think, Mr. Chairman. Thank you very much. Thank you.

Mr. EVERETT. Thank you. Mr. Doyle?

Mr. DOYLE. No, Mr. Chairman.

Mr. EVERETT. All right, before I dismiss this panel, let me ask you to furnish for the record a detailed description of all cases of mismanagement reported to the IG that were not addressed in the IG report, and any other mismanagement cases that have occurred since the first issue of allegations to the IG.

[The information follows:]



# Office of Inspector General

## SPECIAL INQUIRY

ALLEGED MISMANAGEMENT AT THE  
RALPH H. JOHNSON VA MEDICAL CENTER,  
CHARLESTON, SOUTH CAROLINA

REDACTED

Date: January 10, 1997  
Report No. 7PR-A19-029

### WARNING 5 U.S.C. § 552A, PRIVACY ACT STATEMENT

This final report contains information subject to the provisions of the Privacy Act of 1974 (5 U.S.C. § 552a). Such information may be disclosed only as authorized by this statute. Questions concerning release of this report thereof should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.

Office of Inspector General  
Washington DC 20420



DEPARTMENT OF VETERANS AFFAIRS  
Office of Inspector General  
Washington DC 20420

JAN 10 1997

TO: Director, Veterans Integrated Service Network No. 7 (10N7)  
Director, VA Medical Center, Charleston SC (00/534)

SUBJECT: Special Inquiry, Alleged Mismanagement at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina — Report No. 7PR-A19-029

1. The Department of Veterans Affairs (VA), Office of Inspector General (OIG) conducted a special inquiry at the request of Congressman Mark Sanford and House Veterans Affairs Committee staff. Congressional staff received allegations that the former Director and his staff mismanaged construction, renovations, contracts, personnel, and other activities at the Medical Center. We reviewed the complaints to determine the validity of allegations made by employees, former employees and others who wrote to congressional staff.

2. Several complainants believed that the former Director mismanaged the construction and renovation of a Nursing Home Care Unit (NHCU) and the related activation funding for the NHCU. We found that about \$2.1 million was spent for construction, renovation, and activation of the NHCU, but management never used the renovated space for a NHCU. Since its completion in February 1994, the NHCU had been used as "swing space" for specialty clinics undergoing renovation. Meanwhile, VA staff placed veterans seeking nursing home care facilities near Charleston in contract facilities or VA facilities elsewhere. Our discussions with the Director, Veterans Integrated Service Network (VISN) No. 7, helped prompt plans to open the NHCU in July 1997 for patients in the Charleston area. We understand the activation of the NHCU in July 1997 will be accomplished using the equipment and staff funding previously provided to the facility.

3. Many employees we interviewed believed that the former Director focused too much of his efforts on construction projects such as the renovation of his office suite and the inclusion of an expensive fish tank in a construction project, as well as the promotion of his friends and associates during a time when the Medical Center faced a significant budget shortfall, furloughs, and possible reductions in force (RIF). With respect to the construction projects, the Medical Center's facilities needed updating and the plans for these projects had been initiated long before the furloughs and funding shortages in Fiscal Year 1996. However, there is no question that completing these projects at about the same time the furloughs, funding shortfall and plans for a possible RIF were happening gave rise to the employees impression that management had misplaced its priorities.

4. The former Director used a noncompetitive process to promote individuals within the Director's Office and for certain service chief level positions. The former Director promoted

individuals that were his known friends and associates using this process. These actions led to allegations that the former Director promoted his staff more on the basis of friendship than merit. We found that these individuals were qualified and there was no indication that the selections would have been different, even if the former Director used a competitive process to fill these positions. However, by foregoing a competitive process, the former Director precluded anyone else at this Medical Center, or any other facility, from competing for the positions. As an example, the former Director promoted two [REDACTED] in his immediate office to [REDACTED] grade levels at about the same time he announced to the rest of the Medical Center staff serious funding shortages and possible RIFs. The timing of these events contributed to increasing the tension between employees and top management.

5. VA employees also questioned the former Director's hiring of a management consultant to work with qualified VA program assistants and quality management staff. The former Director paid the management consultant over \$90,000 and expenses in Fiscal Year 1996, to work 4 days per month. We made recommendations to reevaluate the need for this contract, and the new Director took action to discontinue the consultant's services effective December 31, 1996. This should permit the use of these funds for other health care priorities at the Medical Center.

6. Nursing staff expressed concern over the downsizing of programs, reduction of staff, and effect the reduced funding would have on the quality of patient care provided to veterans in the area. These conditions contributed to a recent vote by nursing staff to form their own union at the medical center. It also contributed to a concern by staff that management had misplaced its priorities in renovating space without intending to use it, renovating executive offices, landscaping, and protecting associates' and friends' jobs, while he subjected core professional staff and programs to reductions and closures.

7. We brought these concerns to the attention of the VISN Director, and the new Medical Center Director, and we made several recommendations. The VISN Director's and new Director's comments and implementation plans met the intent of the recommendations, and we consider them resolved. We are continuing to followup with the Director and his staff in resolving other issues brought to our attention. The VISN Director informed us that he no longer has line authority over the former Director. In our discussions with the VISN Director, he was confident that the new Director would make a significant effort to restore the confidence of employees in management at the Medical Center. We are issuing a copy of this report to the former Director's new supervisor, the Chief Network Officer, and the Undersecretary for Health to advise them of the conditions identified at the VA Medical Center in Charleston.



JACK H. KROLL

Assistant Inspector General for  
Departmental Reviews and Management Support

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**SPECIAL INQUIRY****ALLEGED MISMANAGEMENT AT THE  
RALPH H. JOHNSON VA MEDICAL CENTER  
CHARLESTON, SOUTH CAROLINA  
REPORT NO. 7PR-A19-029****INTRODUCTION****Purpose**

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted a special inquiry at the Ralph H. Johnson VA Medical Center Charleston, South Carolina. The special inquiry was initiated at the request of Congressman Mark Sanford and House Veterans Affairs Committee staff who received multiple complaints that Medical Center management was mismanaging the facility. The purpose of the inquiry was to determine the validity of the allegations made by employees of the Medical Center and other concerned persons.

**Background**

VA Medical Center (VAMC) Charleston provides comprehensive care to over 127,000 veterans in 15 counties in southeastern South Carolina and Chatham County, Georgia. The VAMC is closely affiliated with the Medical University of South Carolina and supports over 70 medical residents in 25 different medical and dental specialties as well as students from nursing, pharmacy, social work, and allied health disciplines. The Medical Center has 265 authorized beds and offers numerous special health care programs to veterans in the area.

Mr. Dean Billik began as Director of VAMC Charleston on December 27, 1992. Mr. Billik was reassigned in early September 1996, to the Veterans Integrated Service Network Office (VISN) No. 17 in Dallas, Texas, and at the time of this report was reassigned to another facility. Ms. Johnetta McKinley was Acting Director during our onsite review. Mr. R. John Vogel was appointed the new Director and arrived at the Medical Center in December 1996.

We met with Congressman Mark Sanford's staff who received numerous complaints from VAMC employees and other concerned persons. Congressional staff requested our assistance in reviewing these allegations of mismanagement and personnel irregularities at the Medical Center. Some of the complainants' allegations overlapped, and the appropriateness of the former Director's decisions and actions were common factors in

most of the issues congressional staff presented to us. Specifically, allegations were made that the former Director did not follow accepted Veterans Health Administration (VHA) procedures in construction and renovations, contracting and obtaining services, and personnel matters.

### **Scope**

We visited VAMC Charleston on three separate occasions between August 1, and October 31, 1996. We met with many of the complainants as well as Congressman Mark Sanford's staff, and reviewed the complaints presented to us at the Medical Center. We interviewed the former Medical Center Director, current Associate Director who was also Acting Director during our review, Service Chiefs, numerous current and former employees, and others concerned about the issues at VAMC Charleston. We also reviewed construction, contracting, financial, and personnel records as determined necessary to complete this review.

We reviewed the following 27 allegations brought to our attention.

### **Construction and Renovation Allegations**

- The former Director took action to renovate Ward 4A into a Nursing Home Care Unit (NHCU) and never used the space for this purpose.
- There was an unnecessary cost overrun of \$489,000 on the Ward 4A NHCU project.
- Three grandfather clocks and a treadmill purchased for the Ward 4A NHCU were missing from the Medical Center.
- Management received activation funding for the Ward 4A NHCU project even though the NHCU unit was never opened.
- The former Director renovated his suite without advance approval from VA Central Office on the renovation costs.
- The former Director's suite was unusually plush, with expensive wallpaper, gold plated bathroom fixtures, unnecessary audio-visual equipment, and expensive carpet. Also, the former Director replaced the carpet twice in one week.
- The former Director inappropriately discarded a well-known local artist's paintings as a part of the renovation of the Director's suite.

- The former Director unnecessarily purchased a \$40,000 fish tank for the Medical Center lobby.
- Management authorized a rear entrance construction project despite warnings from the contractor that the design was not safe and would result in cracks in the structure.
- Management poorly renovated the psychiatric ward and painted the walls a dismal blue, which depressed patients.

#### Contracts and Services Allegations

- The former Director hired a consultant and inappropriately paid the person \$800 daily for program analyst services.
- The former Director spent scarce funds on a maintenance contract to care for the fish tank while employees were facing layoffs, and anesthesia machines were not covered by service agreements.
- The former Director estimated a \$2.9 million shortfall in funding as an excuse to contract out services and initiate a Reduction In Force (RIF).
- The former Director misused permanent change of station (PCS) funds by including a friend's household goods in his contract to move to another facility.
- Management wasted money by spending \$3,000 for conference facilities at the Wild Dunes West resort.
- Management authorized nonessential landscaping services and redirected the old landscaping items to an employee's residence.
- The former Director and current Associate Director violated Federal and VA acquisition regulations when the medical center's contracting officer terminated a contract.
- The (b)(6) [REDACTED] inappropriately hired a cleaning firm without a formal solicitation to seek competition, and he harassed his employees.

#### Personnel-Related Allegations

- The former Director engaged in inappropriate personnel actions to reward his associates and friends.

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- The former Director created a nonessential GS-██████████ position.
  - Management inappropriately placed two employees in new respiratory therapy positions without seeking competition.
  - Prosthetic Service management required an employee to work 3,000 hours of overtime without compensation.
  - Management forced a physician to quit without just cause.
  - Management created a contract specialist position for the friend of the ██████████ ██████████, and did not permit other staff to compete for the job.

#### Scheduling/Staffing Allegations

- Management violated their own policies by requiring respiratory therapists to work without backup in the intensive care unit during the evening hours.
- There was a shortage of nursing staff to provide quality patient care.
- Management closed the medical center at night and inappropriately turned away veterans seeking emergency care.

#### Reprisal for Whistleblowing Allegation

We received several complaints from congressional staff that VAMC management reprimed against an employee. We took sworn, taped testimony from management and several employees on whether a ██████████ ██████████ suffered reprisal for whistleblowing to the OIG, and whether the supervisor of the section acted inappropriately. We found that management misinformed the OIG on actions taken to resolve disclosures made by staff, and supervisors reprimed against one employee for whistleblowing to the OIG. The reprisal issues and recommendations are discussed in a separate report "Alleged Reprisal For Whistleblowing, Ralph H. Johnson VA Medical Center, Charleston, South Carolina," Report No. 7PR-G02-028, dated January 10, 1997.

Other Related Issues

We are continuing to review several other allegations received from congressional staff, VA employees and other concerned Charleston residents. The issues presented to the OIG conveyed similar concerns such as alleged personnel irregularities and mismanagement. We are continuing to review these issues with Veterans Health Administration (VHA) officials on a case-by-case basis.

## **RESULTS AND RECOMMENDATIONS**

### **Construction and Renovation Allegations**

<b>Allegation 1:</b>	<b>The former Director took action to renovate Ward 4A into a Nursing Home Care Unit (NHCU) and never used the space for this purpose.</b>
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**Discussion:** This allegation is substantiated. Ward 4A of the Medical Center was completely renovated into a 38-bed NHCU at a reported cost of \$571,831. Construction was completed in February 1994, but the renovated space was never used as a NHCU. Instead, the space has been in nearly continuous use as "swing space" for specialty clinics displaced by other construction projects in the Medical Center.

The former Director, Mr. Billik, indicated that space was at a premium in the Medical Center and that he believed he had no choice but to use the renovated NHCU space as swing space while many of the Medical Center's specialty clinics were undergoing renovation. In his opinion, the only other choice would be to close or significantly curtail these clinics' services to veterans while the clinics were undergoing renovation. He did not believe that was a viable alternative.

The former Director expected that the NHCU would be used as swing space until at least June 1997. He stated that the use of the NHCU as swing space was coordinated with and approved by the VISN 7 Network Director's Office in Atlanta, Georgia, in March 1996.

The former Director stated that there was a strong demand for nursing home care beds in the Charleston area and he could fill the 38 NHCU beds almost immediately if the decision was made to open the NHCU. His assessment of the need for nursing home beds was supported by comments we received from staff in Congressman Sanford's office and the fact that there are 33 active nursing home care contracts for Charleston area veterans. The Charleston area has a large elderly veteran population. The closest VA nursing home care beds are in Columbia, South Carolina, which is over 110 miles from Charleston.

The former Director told us he did not like the idea of having a NHCU intermingled with patient treatment areas in the Medical Center. The NHCU was planned and approved before he became Director; therefore, he did not have any input into the planning for the NHCU. He also thought the NHCU would be costly for the Medical Center to operate. Furthermore, he stated that the decision on which facilities in VISN 7 should be providing

long term care was still "up in the air" and he was not sure if Ward 4A would ever be used as a NHCU.

While the former Director had some ideas for future uses of the NHCU space for non-NHCU activities, we did not believe there was a well defined long-term plan for the most effective use of the NHCU space. We were concerned about this issue especially in view of the significant funds that have been spent to renovate the Ward 4A space into a NHCU and the need for nursing home care beds in the Charleston area.

In early September 1996, we discussed the need for a more well defined plan for the NHCU space with the VISN 7 Director and the Acting Medical Center Director (Mr. Billik had been reassigned from the VAMC). In late September 1996, VISN 7 staff contacted VAMC Charleston on this issue and asked for additional information on the NHCU. In October 1996, letters were exchanged between the VISN and the Medical Center on this issue and telephone calls were also made to clarify the information provided in the letters.

On October 23, 1996, a final decision was made to open the NHCU in July 1997. In the meantime, the NHCU will continue to be used as swing space until the completion of the Ambulatory Care, Phase III Project.

**Conclusion:** We are satisfied that the timely action taken by the VISN 7 Director and the Medical Center in response to our inquiry will resolve the NHCU issue. In view of the money that had been spent on renovating the NHCU and the need for nursing home beds in the Charleston area, we believe the October 23, 1996 decision to open the NHCU was the right decision.

<b>Allegation 2:</b>	<b>There was an unnecessary cost overrun of \$489,000 on the Ward 4A NHCU project.</b>
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**Discussion:** This allegation is unsubstantiated. The Architect and Engineering firm estimated that the renovation of Ward 4A into a NHCU would cost \$669,927. The reported cost to renovate Ward 4A into a NHCU was \$571,832. There was no other evidence brought to our attention to support an alleged cost overrun on this project.

<p><b>Allegation 3: Three grandfather clocks and a treadmill purchased for the Ward 4A NHCU were missing from the Medical Center.</b></p>
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**Discussion:** This allegation is unsubstantiated. As part of the activation funding for the NHCU, the Medical Center purchased equipment during Fiscal Year 1995 valued at \$174,807 for the NHCU. The equipment was purchased even though the NHCU was never activated. The equipment purchased included items appropriate for a NHCU, such as electrical beds, defibrillators, nurse call systems, and items that appeared nonessential, such as grandfather clocks, treadmill, and a piano.

The equipment purchased for the NHCU has been dispersed throughout the Medical Center and the items we checked were in use along side other Medical Center equipment. We searched the Medical Center with a management official and located the two grandfather clocks (two were purchased, not three as alleged) in Ward 4A, and the treadmill was located in the prosthetic's clinic. We found the piano in the main auditorium. We received every indication from staff that the equipment purchased for the NHCU was used to supplement other Medical Center equipment mostly in the patient treatment areas, but there was no comprehensive record of where this equipment was located.

**Recommendation 1:**

We recommend the Medical Center Director ensure that all the equipment purchased for the NHCU in Fiscal Year 1995 be accounted for so that it can be reconstituted in the NHCU once it is opened.

**Medical Center Director's Comments:**

As of December 2, 1996, our A&MM [Acquisition and Materiel Management] Service has accounted for all equipment items purchased for the NHCU. Those appropriate items will [be] transferred to the NHCU once it becomes operational.

**Office of Inspector General Comments:**

The Medical Center Director's comments are responsive to the recommendation, and we consider the issue resolved.

**Allegation 4: Management received activation funding for the Ward 4A NHCU project even though the NHCU was never opened.**

**Discussion:** The allegation is substantiated. The activation funding provided the Medical Center in Fiscal Year 1995 totaled \$1,528,337. The funding was for both equipment purchases (discussed above) and for the salaries and benefits (about \$1,350,000) for 32.9 full-time employees (FTE) to staff the NHCU. Since the NHCU was not activated, the salaries and benefits portion of the activation funding in Fiscal Year 1995 was used to support general operational needs in the Medical Center. The \$1.35 million then became part of the Medical Center's base amount for future (1996 and beyond) budget years.

Since the decision has been made to activate the NHCU, the Medical Center may be faced with the need to request additional funds to pay the salaries and benefits of NHCU staff or make reductions in current Medical Center services to activate the NHCU. Some preliminary estimates we were provided showed that an additional \$379,000 may be needed to activate the NHCU. In today's austere budget climate, there is no assurance this additional funding would be available.

The OIG issued a nationwide audit report (6D2-D02-007) on activation funding in March 1996. This report contained VHA-wide recommendations for improving the management and control of activation funds. Since the findings in the recent nationwide report were similar to the events at VAMC Charleston, we are not making any additional recommendations; however, VHA top management should be aware of the potential funding problems they face now that the decision has been made to activate the NHCU.

**Allegation 5: The former Director renovated his suite without advance approval from VA Central Office on the renovation costs.**

**Discussion:** The allegation is substantiated. In March 1993, the Deputy Secretary issued a letter to Administration Heads, Assistant Secretaries, Other Key Officials and Deputy Assistant Secretaries requiring his approval on all renovations and furniture purchases for Directors' offices. The policy applied to all Central Office and field facilities, and there was no expiration date for the policy.

In accordance with this policy, on December 29, 1994, the former Medical Center Director submitted a request through the Director, Southern Region, to the Deputy Secretary requesting approval for the purchase of office furniture and the renovation of

3,100 square feet for the Director's suite. The request was approved on January 5, 1995, by the Southern Regional Director and forwarded to Facilities Management in Central Office.

No further documentation of the approval process could be found. We interviewed the former VHA Associate Chief Medical Director for Operations who stated he was positive that he also did not have the opportunity to approve or disapprove this request. Responsible officials in the Office of Facilities Management could not recall this project. We contacted the Deputy Secretary's Office and confirmed that they never reviewed the request.

(b)(6) [REDACTED] the individual who was responsible for coordinating the project for the former Director, indicated that [REDACTED] and the former Director thought the project was approved based on [REDACTED] telephone conversation with an individual in the Office of Facilities, who indicated that the project had been approved by VHA officials. The individual [REDACTED] talked with is no longer a VA employee and could not be contacted to verify what information [REDACTED] provided to [REDACTED] or the basis for [REDACTED] telling [REDACTED] the project was approved.

Since the policy requiring the Deputy Secretary's approval on furniture purchases and renovations was more than 3 years old at the time of our review, we asked the Deputy Secretary's Special Assistant if the Deputy Secretary still wanted to approve these types of requests. We also told him we were aware of a number of cases, including VAMC Charleston, where the existing policy was not being followed. The Special Assistant informed us the Deputy Secretary still wanted to be involved in the approval process. After our contact with the Deputy Secretary's Office, the Chief of Staff issued a reminder on August 13, 1996 to all Administration Heads, Assistant Secretaries, and Other Key Officials. The reminder stated that the March 1993 policy requiring the Deputy Secretary's approval for furniture purchases and renovations was still in effect and should be complied with.

**Conclusion:** We are not making any recommendations to the Medical Center on this issue. We advised the Deputy Secretary's Office of the unapproved project at this Medical Center. The Chief of Staff's recent guidance on this issue should correct the non-reporting problem.

**Allegation 6: The former Director's suite was unusually plush, with expensive wallpaper, gold plated bathroom fixtures, unnecessary audio-visual equipment, and expensive carpet. Also, the former Director replaced the carpet twice in one week.**

**Discussion:** This allegation is not substantiated. We did not find the Director's suite to be inordinately plush; however, we did find that carpet for part of the suite was ordered twice.

Approximately 3,100 square feet of Medical Center space was renovated for the Director's suite. The renovated space provided offices for 12 individuals: the Director, Associate Director, Chief of Staff, Chief Nurse, two special assistants, an administrative assistant, and five secretaries. The renovated space also included a conference room, bathroom, and a closet.

We were shown photographs of the old Director's suite, and we discussed the condition of the suite with responsible officials both at the Medical Center and the VISN. It appeared that prior to the renovation, little had been done to the space since the Medical Center had opened in 1968. We concluded that the space needed to be renovated. Medical Center records indicate the renovations cost \$58,357. Management used local funds for the renovations.

In conjunction with the renovation of the Director's suite, staff also purchased new furniture and equipment totaling \$139,254. According to responsible Medical Center officials, much of the furniture that was replaced was more than 25 years old, mismatched and not functional for a modern automated office. The new furniture and equipment purchases were made from the General Services Administration (GSA) schedule. The new furniture is mostly veneer and not unlike that found in other executive office suites.

With respect to the specific items mentioned in the allegations, we found the following.

a) *Wallpaper* — The wallpaper purchased by the Medical Center was actually a high quality wall covering (woven yarn with an acrylic backing). According to the sales representative for the manufacturer of the wall covering, this 54 inch wide wall covering retails for \$24.50 per linear yard, but they sold it to the Medical Center for the discounted price of \$9.79 per linear yard. The Medical Center purchased 310 linear yards at a total cost of \$3,035.

This wall covering was not on the GSA schedule. The sales representative said that her company had vinyl wallpapers on the GSA schedule, but they were of a lower quality than the woven yarn with acrylic backing wall covering. The company did offer vinyl wallpapers on the GSA schedule at a cost of about \$5 to \$6 per linear yard.

The wall covering purchased by the Medical Center was more upscale than one may find in many Federal offices. According to the manufacturer's representative, this type of wall covering should last longer and wear better than lower quality wallpaper. If the representations made by the manufacturer are valid, then we would not view the wallpaper purchase as wasteful.

*b) Gold-Plated Fixtures* — The gold fixtures (one set in the bathroom and one set in the break closet) were actually polished brass and the type generally stocked by a local hardware store. The Medical Center paid \$337 for the faucets and a Kohler sink in the bathroom and \$205 for the faucet and sink in the break closet. We did not view these expenditures as lavish or wasteful.

*c) Audio-Visual Equipment* — The \$30,861 spent for audio-visual equipment was to fully equip not only the Director's conference room but also the main auditorium with state-of-the-art ceiling mounted projection equipment with remote controls. The two systems (one in the Director's office and one in the auditorium) are wired together so that the same briefing could be shown simultaneously in both areas. This type of equipment certainly adds to the professionalism of presentations made by management officials and should aid them in disseminating information to the Medical Center staff. We did not find the audio-visual equipment purchases out of line with the type of equipment purchased for modern conference rooms and auditoriums.

*d) Expensive Carpet* — As a part of the renovation project for the Director's suite, the Medical Center purchased 74 square yards of carpet from the GSA Schedule for selected rooms in the Director's suite. The carpet cost \$18.77 per square yard, and the total cost of the carpet purchased was \$1,389. This carpet had a black background and, when it arrived, Medical Center officials decided that it would not be suitable for the Director's suite because it would show dirt and lint too easily. Some of this carpet was later installed in other parts of the Medical Center and the remainder was stored in the warehouse for future use. According to management officials, the black carpet was never actually installed in the Director's suite.

After rejecting the black carpet, the Medical Center then ordered 300 square yards of green carpet from the GSA Schedule at a cost of \$18.77 per square yard. This was enough carpet to cover the entire Director's suite. The total cost of this second carpet purchase was \$5,631.

Medical Center officials admitted it was a mistake to have purchased the black carpet because this color of carpet is so difficult to keep clean. The Medical Center has used some of this carpet in other parts of the Medical Center where appearance of the carpet is not so critical. The second purchase of carpet appears reasonable and the price is not out of line with carpet purchased for other Federal offices.

**Conclusion:** In summary, we did not find the renovations made to the Director's suite to be overly plush or the furniture and equipment purchased to be unnecessary (except for the black carpet discussed above). As a part of our Special Inquiries work, we visit a number of Director's suites in Medical Centers and we found the VAMC Charleston suite to be in line with many other Medical Center Director's suites.

We believe the complaints about the renovations, furniture and equipment purchased for the Director's suite stemmed from the timing of the event. The renovations were completed almost immediately after the second Federal employee furlough and only about two months before the former Director made it known to the staff that there was a large potential funding shortfall in the Medical Center's Fiscal Year 1996 budget. A number of employees thought that their jobs were being threatened by both furloughs and budget cuts. These employees believed the renovation of the Director's suite was given a high priority by the former Director when his highest priority should have been to preserve funds to meet the employee payroll.

With respect to the former Director's actions, the renovations and purchases were planned long before any Federal furloughs or shortages of Fiscal Year 1996 funds. The former Director could not have predicted these two events (furlough and fund shortage).

<b>Allegation 7:</b>	<b>The former Director inappropriately discarded a well-known local artist's paintings as a part of the renovation of the Director's suite.</b>
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**Discussion:** This allegation is partially substantiated. There was no inventory of paintings in the old Director's suite; therefore, we could not determine how many paintings were destroyed. Also, there was no way for us to place a value, if any, on these items. However, a management official admitted he discarded at least one of the paintings because it looked like a "piece of trash" to him. The fate of the remaining paintings could not be determined. Therefore, we made no recommendations.

**Allegation 8: The former Director unnecessarily purchased a \$40,000 fish tank for the Medical Center lobby.**

**Discussion:** This allegation is partially substantiated. As a part of the construction project to renovate the ambulatory care area, a large saltwater fish tank was built into a wall in the center of the main lobby/waiting room for ambulatory care patients. According to Medical Center records, the aquarium cost \$26,119, not \$40,000 as alleged in the complaint. The construction project that included the fish tank was completed in February 1996.

A fish tank is obviously not a necessity for the successful operation of a Medical Center; therefore, this part of the allegation is substantiated. The project also came at a time when employees were faced with furloughs and potential budget cuts, which heightened concern that management was not adequately prioritizing the expenditure of resources.

However, there is no question that the fish tank makes a charming lobby centerpiece and many veterans enjoy viewing the fish while they are waiting for their medical care. We observed a number of veterans walking up to the tank for a close-up view of the fish. Management officials stated that the fish in the tank have a therapeutic effect on the patients in the waiting room, many of whom have to spend time in the lobby waiting to see a physician. Furthermore, since it is now built into the lobby wall, it would be an expensive project to remove the tank and its associated plumbing and wiring.

**Conclusion:** In summary, we believe some employees perceived the former Director as placing priority on nonessential amenities such as the fish tank at the a time when employees' jobs were being threatened by a shortage of funds. A number of employees used the fish tank as a symbol of what they believed was the former Director's unsympathetic attitude towards the employees who may be subject to the RIF process or other adverse personnel actions due to the fund shortages.

**Recommendation 2:**

The Medical Center Director should carefully evaluate the options regarding the fish tank and determine whether continued use of the tank is in the best interests of the Medical Center.

**Medical Center Director's Comments:**

The Medical Center Director determined that it would cost approximately \$27,394 to remove the fish tank from its present location in the front lobby. The Director stated that due to the nature of the initial construction, removing the fish tank would destroy the

interior design and uniformity of the lobby. The Medical Center Director stated they have received numerous positive comments from patients, family members, and the general public on the lobby and fish tank. They supported keeping the fish tank as part of the lobby. The full text of the comments are shown in the Appendix of the report.

**Office of the Inspector General Comments:**

The Medical Center Director's actions met the intent of the recommendation. We consider the recommendation resolved.

<b>Allegation 9:</b>	<b>Management authorized a rear entrance construction project, despite warnings from the contractor that the design was not safe and would result in cracks in the structure.</b>
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**Discussion:** This allegation is unsubstantiated. Our discussion with the Acting Chief Engineer indicated that his staff were not aware of any problems with the rear entrance until cracks appeared in the wall about one year after construction was complete. We also discussed this issue with the President of the contracting firm for the project and he said that no one suspected that the rear entrance wall would crack like it did. His firm did not warn Medical Center staff of any potential problems regarding cracks in the rear entrance wall.

We found that a planter, which was connected to a wall leading into the rear entrance, was built on fill dirt without the proper supporting structure. As a result, the planter began to sink, causing the wall to crack. The Medical Center determined that it was a faulty design problem by the Architect and Engineer (A&E) firm. The general contractor, who followed the A&E firm's design in building the wall and planter, was not at fault on the project.

The Medical Center issued a modification in May 1996 for \$9,084 to the general contractor to provide a proper foundation for the planter and repair the wall around the crack. The Acting Chief, Engineering Service, informed us he did not consult Regional Counsel on whether to try to seek reimbursement from the A&E firm for the additional work. He said the issue was discussed with his engineers. They determined that had the original specifications required a reinforcing foundation, the cost of the project would have increased about \$6,000 anyway. The Acting Chief Engineering believed that it would cost more than the remaining \$3,000 to legally pursue the A&E firm for the difference, and there would be no assurances that VA would win a judgment against the firm. Therefore, management elected not to pursue the issue further. At the time of our visit, the problems with the rear entrance had been corrected.

**Allegation 10: Management poorly renovated the psychiatric ward and painted the walls a dismal blue, which depressed patients.**

**Discussion:** This allegation is unsubstantiated. Management officials informed us that the interior designer on loan from VAMC Columbia had plans to paint the psychiatric ward rooms purple. This plan was discussed with physicians and nurses on the psychiatric ward, and they vetoed painting the rooms purple.

It was the clinical staff that suggested the walls be painted a sky blue color. The psychiatric ward staff's suggestion was followed and the walls are indeed sky blue. We trust the psychiatric staff's judgment on this issue.

The psychiatric ward is scheduled for a complete renovation in the near future. Management officials indicated that they will again discuss the color of the paint with psychiatric staff and they will paint the walls whatever color they suggest. We therefore made no recommendations.

#### **Contracts and Services Allegations**

**Allegation 11: The former Director hired a consultant and inappropriately paid the person \$800 daily for program analyst services.**

**Discussion:** The allegation is substantiated. We received an allegation that the former Director inappropriately hired a consultant and paid the person \$800 daily for program analyst services that have been provided by VA staff.

We found that the former Director hired a management consultant, [REDACTED], beginning in Fiscal Year 1995. The former Director told us that [REDACTED] was a former employee of a firm that had a contract with VA to establish a Quality Improvement Program nationwide. [REDACTED] left the firm and began his own company, [REDACTED]. The former Director hired [REDACTED] as a management consultant, and continued using his services at the VA Medical Center after the national contract expired.

[REDACTED] received \$1,200 per day plus expenses from the Medical Center and worked 4 days per month at the time of the review. According to the Chief, Fiscal Service, the Medical Center paid [REDACTED] \$87,750 in Fiscal Year 1995, and \$90,117 in Fiscal Year 1996. The former Director used 48 - Code of Federal Regulation (CFR) 670-3 as his

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authority to contract with the consultant. According to the Chief, Fiscal Service, this authority did not require the medical center to obtain approval from the Veterans Integrated Service Network (VISN) or VA Central Office, Washington, DC.

We found that management incorrectly approved this contract using the CFR<sup>1</sup> to authorize funds. This regulation delegates “fee basis” authority to the Chief of Staff and Chief, Medical Administration Service to execute authorizations for medical, dental, and ancillary services under \$10,000 per authorization when such services are not available from existing contracts or agreements. The regulation made no provision for management consultant services or other administrative functions.

Management should have followed the procedures for obtaining consultant services prescribed in CFR 837.2.<sup>2</sup> The regulation prescribes that consultant services will normally be obtained only on an intermittent or temporary basis; repeated or extended arrangements are not to be entered into except under extraordinary circumstances. The regulation also prescribes that a competitive solicitation is the preferred method of obtaining consulting services and should be used to ensure that costs are reasonable. Sole-source contracts for consulting services resulting from unsolicited proposals are generally not appropriate. According to the regulation, contracts such as these require the approval of the Secretary, regardless of the amount.

On July 8, 1992, VA issued Circular 00-92-15 to mitigate the effort associated with the formal submission of documentation required. The Circular provided for “concept approval” procedures to secure advisory and assistance services. Although the Circular was rescinded on July 1, 1993, acquisition policy staff considered the procedures effective until further notice. All advisory and assistance service contracts over \$25,000 require the approval of the Secretary. VA staff informed us that they anticipate this ceiling will be raised to \$250,000. The concept request should be a memorandum signed by the appropriate Assistant Secretary or Administration Head and should be transmitted through the Assistant Secretary for Acquisition and Facilities to the Secretary for approval.

The former Director should have developed a concept proposal for advisory and assistance services as prescribed by the Circular to include:

- a brief description of the services contemplated:

<sup>1</sup> 48 Code of Federal Regulations, Chapter 8, Subpart 670.3

<sup>2</sup> 48 Code of Federal Regulations, Chapter 8 Subpart 837.2

- a signed statement, by the appropriate contracting officer, certifying that the requirement is for advisory and assistance services as defined by Federal Acquisition Regulation 37.201; and
- a justification of need and certification that such services do not unnecessarily duplicate any previously performed work or services.

After the proposed acquisition was approved "in concept," the former Director should then have completed a procurement request package. All procurement request packages are approved by an official one level above the requesting activity. The former Director did not follow this policy or its requirements.

(b) (6)  
 We found that the former Director did not specifically define [REDACTED]'s management consultant duties. Essentially, [REDACTED] carried out special projects assigned by the former Director. We asked management to develop a list of the consultant's accomplishments during the past fiscal year. We were informed that one of his projects was to consult with the former Director and his staff to develop a Medical Center strategic plan. He also assisted in developing a proposal for a consolidated mail-out pharmacy and met with staff on quality improvement program issues. He also provided training on quality management issues and worked with the Medical Center's Quality Management Coordinator. At the time of our inquiry, the Medical Center's contract for services with [REDACTED] continued without any specific work statements or fixed periods of service.

A number of employees we interviewed believed that the hiring of the consultant was just another example of the former Director's lack of concern about them. The employees believed that the former Director paid the consultant to perform work that could have been done by VA program analysts in the Director's Office and in the Medical Center's Quality Management Section. They pointed out that the former Director seemed to have enough money to pay his consultant (i.e., \$90,117 yearly working about 4 days per month), yet at the same time he was telling the staff assigned patient care and support responsibilities that he may not have enough money to pay them.

#### **Recommendation 3:**

We recommend the Director, Veterans Integrated Service Network No. 7 take action to ensure that the former Director, and current management at the VA medical center are aware of the appropriate procedures to follow when requesting advisory and assistance services.

**Director, Veterans Integrated Service Network No. 7 Comments:**

The Director, Veterans Integrated Service Network No. 7 stated "The former Director at Charleston VAMC no longer works in this VISN. Accordingly, I have no line of authority over him. The newly appointed Director at Charleston is aware of the appropriate procedures to follow when requesting consultative services and has terminated the present contract effective 12-31-96."

**Office of Inspector General Comments:**

We will forward a copy of the final report to the former Director's current supervisor for review and action as warranted. Action to terminate the contract was responsive to the recommendation, and we consider the issue resolved.

**Recommendation 4:**

We recommend the Medical Center Director take action to:

- a. Discontinue using the fee basis authority to pay for the management consultant's services, and reevaluate whether advisory and assistance work continues to be needed at the medical center.
- b. Develop the required "concept approval" documents and submit an official request for the consultant's services to the VISN if it is determined that these services are still needed.

**Medical Center Director's Comments:**

(b) (6)  
The Medical Center Director stated "The consultant in question, [REDACTED], will be terminated as a consultant as of 12/31/96. In the future if a consultant's services are deemed necessary, the procedures outlined in Circular 00-92-15 will be followed."

**Office of Inspector General Comments:**

The Medical Center Director's comments are responsive to the recommendations. The cancellation of the contract will permit the Medical Center to use the much needed funds (\$90,000 plus expenses) for other health care priorities. We consider the issue resolved.

**Allegation 12:** The former Director spent scarce funds on a maintenance contract for the fish tank while employees were facing layoffs, and anesthesia machines were not covered by service agreements.

**Discussion:** This allegation is substantiated. On February 12, 1996, the Medical Center issued a purchase order for maintenance of the fish tank. The maintenance contract cost \$650 per month for an annual cost of \$7,800. The contract included stocking the tank with salt water fish, feeding the fish, cleaning the tank, and replacing dead fish.

On March 13, 1996 (one month after the fish tank maintenance contract was issued), the Chief of Fiscal Service developed budget status documents that showed a projected shortfall in the Fiscal Year 1996 budget of \$2.9 million. One of the scenarios developed by the Chief of Fiscal Service to meet this budget shortfall was to RIF employees in the Environmental Management Service and Dietetics Service. This information about the RIFs was later shared with the Medical Center employees, which caused them to become very concerned about the possible loss of their jobs. Eventually the Medical Center was provided more funding by the VISN, which negated the need to RIF employees. However, a number of the other "belt tightening" measures suggested by the Chief of Fiscal Service were implemented.

In an environment where employees' jobs were threatened, the expenditure of scarce funds on the construction and maintenance of the fish tank became a "lightning rod" for attracting complaints about what some employees viewed as the former Director's misplaced sense of priorities. We suspect the construction of an aquarium for the lobby might have brought compliments from employees about its therapeutic value had significant funding shortages for the Medical Center not been an issue.

It is true that the anesthesia machines no longer have a maintenance contract. Medical Center officials explained that the anesthesia machines have not had a maintenance contract for a number of years because of a management decision that the maintenance of these machines could be accomplished more effectively by the Medical Center's biomedical staff. We could find no evidence of any problems with the in-house maintenance services for the anesthesia machines. Therefore, we did not review this issue further.

**Recommendation 5:**

We recommend the Medical Center Director consider the cost of the annual maintenance contract for the fish tank in her deliberations on the options related to the future of the fish tank.

**Medical Center Director's Comments:**

The Medical Center Director stated that the current maintenance contract for the fish tank runs through September 30, 2000. He stated that the monthly fee of approximately \$650 covered both the lease of the tank, fish and equipment, as well as on-going maintenance. The Medical Center Director noted that when the contract was sent out for bid, there were 5 inquiries. However, the Medical Center only received 2 bids. The bid not chosen was approximately double (\$1,500) the current rate. The Medical Center Director made the decision to keep the fish tank and associated maintenance contract. The full text of the comments are shown in Appendix A of the report.

**Office of Inspector General Comments:**

The Medical Center Director's comments met the intent of the recommendation. We consider the issue resolved.

<b>Allegation 13:</b>	<b>The former Director estimated a \$2.9 million shortfall in funding as an excuse to contract out services and initiate a Reduction In Force (RIF).</b>
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**Discussion:** This allegation is unsubstantiated. In March 1996, the Chief of Fiscal Service prepared a comprehensive budget status document that clearly showed a projected shortfall of \$2,988,801 in the Medical Center's Fiscal Year 1996 funding.

As an attachment to the budget shortfall document, the Chief of Fiscal Service proposed 13 budget scenarios to deal with the funding shortfall. These scenarios ranged from proposals for smaller savings, such as eliminating the nighttime urgent care coverage (\$41,000), reducing overtime and night differentials (\$116,000), reducing fee basis costs (\$75,000), to proposals for larger savings, such as implementing an employment freeze (\$300,000), initiating an across-the-board furlough (\$740,000), and conducting a RIF of employees in Environmental Service and Dietetics Service (savings undetermined).

There is no question that the \$2.9 million projected shortfall at mid-year in Fiscal Year 1996 was real. We believe the Chief of Fiscal Service did a good job of presenting the former Director with options to help ease the shortfall. The former Director took action to implement some of these options. He also used a "town hall" type forum to inform the staff about the shortfall and its consequences on Medical Center employees.

As a part of the process of searching for cost savings ideas, a proposal was developed to contract out many of the remaining Environmental Management Service functions (some Medical Center Environmental Management functions were already contracted out). We

reviewed this proposal, which projected savings in the first two years of more than \$600,000 from contracting out these services. We did not see any evidence of fraud or misrepresentation in the proposal. Some of the figures naturally were estimates, but they did not seem out of line.

This proposal was submitted to VHA Central Office for consideration. It was disapproved at that level for reasons entirely unrelated to the accuracy of the cost estimates.

**Allegation 14: The former Director misused permanent change of station (PCS) funds by including a friend's household goods in his contract to move to another facility.**

(b)(6) Discussion: We did not substantiate the allegation. We found that the former Director's date of transfer was September 1, 1996. We interviewed the contracting officer, [REDACTED] and found that the former Director's PCS move was performed by Lawrence Transportation Company. We contacted the company and spoke with the employee that visited the former Director's residence and calculated the number of boxes and truck space needed to complete the PCS move.

(b)(6) We asked the contractor whether the former Director indicated he was moving anyone else's household goods. The contractor informed us that the former Director asked the company to estimate the cost of moving [REDACTED] from [REDACTED] apartment to [REDACTED]. The contractor said the former Director asked whether they could include [REDACTED] household goods on the same truck, and pay for [REDACTED] portion of the move separately.

(b)(6) The contractor informed us that the former Director said that he needed to pay for [REDACTED]'s move separately because it was not covered under VA contract. The contractor said that he visited the former Director's residence to estimate the cost of the move and did not notice any [REDACTED] clothing in any of the closets or anything else to indicate he was moving more than one residence. The contractor said he provided the former Director a separate estimate for moving the household goods in [REDACTED]'s apartment. The contractor informed us that the former Director contacted him a few days later and said they were going to make other arrangements to move the items using U-Haul transportation.

(b)(6)  
 The Acting Director confirmed that the former Director made a request to the Medical Center contracting officer to include [REDACTED]'s household goods on the same truck. The contracting officer informed us that the former Director asked her whether he could pay for [REDACTED]'s portion of the move separately from the VA contract. She contacted the Acting Director for advise. The Acting Director said she disapproved of the idea because of the appearance it might give employees, and asked the former Director to seek other alternatives. The contractor provided us documents which showed that the former Director's move was within 7 percent of the original estimate. The estimated weight was 9,100 pounds and the actual weight was 9,760 pounds.

(b)(6)  
 We contacted the former Director and asked him to clarify this issue. The former Director denied combining [REDACTED]'s household goods with his move. He said that [REDACTED] used a Rider Truck Company in [REDACTED] to move to [REDACTED] and [REDACTED] parents helped [REDACTED] move. [REDACTED]'s move is a matter of record at the Rider Truck Company. The former Director said he recognized that even if he had paid for [REDACTED]'s portion of the move using his own funds, someone at the Medical Center would probably have complained about it given the current climate at the Medical Center.

**Allegation 15: Management wasted money by spending \$3,000 for a conference at the Wild Dunes West resort.**

**Discussion:** This allegation is unsubstantiated. On July 9 and 10, 1996, the Medical Center held an administrative conference at the Wild Dunes West resort in Mt. Pleasant, South Carolina, a suburb of Charleston. The Medical Center paid the Wild Dunes West resort \$950 for space and supplies for the conference. About 35 senior staff members attended the conference. Temporary duty costs were not an issue because the attendees did not stay overnight.

The primary purpose of the conference was to exchange ideas about the development of a strategic plan for the Medical Center. Strategic planning is a subject that is receiving considerable Congressional and Office of management and Budget (OMB) attention and all activities are required to develop such plans. We were shown a copy of the plan that was eventually developed.

Senior managers throughout VA conduct business off site from time to time where they can concentrate on important issues without the daily interruptions of the workplace. Therefore, we considered the expenditure within management's discretion.

**Allegation 16: Management authorized nonessential landscaping services and redirected the old landscaping items to an employee's residence.**

**Discussion:** This allegation is partially substantiated. The Medical Center has a very small campus and according to the former Director and others, it was poorly landscaped. The former Director essentially said to his staff "landscape it right or pave it over." Managers elected to improve the landscaping.

The Medical Center has a contract with Fast Eddies Landscaping Company for maintenance of the grounds to include sweeping the parking lots and street around the Center. The contract was awarded on a competitive basis and Fast Eddies was the low bidder at \$17,988 annually.

The Medical Center also has two current construction projects that include landscaping services. Both of these contracts are for repairing the parking lots and handicapped access to the Medical Center. The small areas around the parking lots and the handicapped access areas will be landscaped by these contractors. Once the landscaping is installed, Fast Eddies will be responsible for maintaining the landscaping.

With the amount of exterior construction projects either recently completed or still underway, we could see how some employees may have the impression that constant changes are being made to the landscaping. We did not see any evidence of wasteful spending in this area. The Medical Center's landscaping is attractive, but not overly lavish when compared with other VA medical centers.

With respect to the issue of the diversion of old plants to employees, management officials indicated that some time ago an employee had taken some old plants home with him. Staff were reminded that the old plants were Government property and were to be disposed of and not given to employees. A memorandum was issued to employees regarding removing excess and scrap Government property from the facility. Management's actions seemed to have corrected the situation and we are not aware of any other problems in this area. We therefore made no recommendations.

**Allegation 17: The former Director and current Associate Director violated Federal and VA acquisition regulations when the Medical Center's contracting officer terminated a contract.**

**Discussion:** This issue is in the appropriate administrative and judicial forum for resolution. The complainant made serious allegations regarding the former Director's and current Associate Director's involvement in contract irregularities and the improper termination of his contract with the Medical Center. The allegations and related documents have been filed with the Board of Contract Appeals (BCA). We submitted the post-hearing briefs filed by VA and the contractor to our legal staff and the information revealed substantial disagreements and disputes about the facts of the case.

Our legal staff found that a hearing has already been held before BCA. We found that the contractor's arguments made to the OIG are identical to the arguments made by the contractor's legal representative in his submissions to the BCA.

Our legal staff took the position that it would be inappropriate for the OIG to become involved in the dispute under these circumstances. They based their decision on the fact that the disputed matters are already in the appropriate administrative and judicial forum for their resolution. This incident was interpreted by some employees as another example of the former Director's mismanagement of Medical Center operations.

**Allegation 18: The [REDACTED] inappropriately hired a cleaning firm without a formal solicitation to seek competition, and harassed his employees.**

**Discussion:** We did not substantiate that the private cleaning firm's contract was inappropriately awarded, but found that some employees believe they are harassed by management. We found that [REDACTED] entered into a 7-week contract with a small business cleaning service to provide floor care prior to a Joint Commission on Accreditation of Healthcare Organizations external review on September 15, 1995. The Medical Center awarded the contract pursuant to Section 8(a) of the Small Business Act [15 U.S.C. 637(a)] and anticipated services would begin on September 15, 1995. The contract received prior approval from the Small Business Administration and was estimated to cost VA \$24,000.

On September 10, 1995, Medical Center staff requested the Small Business Administration to approve the same company to supplement janitorial services for the Medical Center. The services were requested for one year with a one year option. The estimated cost of this contract totaled \$101,000. The Small Business Administration

(b) (6)

approved the agreement for the period October 1, 1995 through September 30, 1996, for \$92,284, and approved the option year beginning October 1, 1996, through September 30, 1997, at a cost of \$94,561. VA staff followed small business set aside contracting procedures.

(b)(6) We also interviewed [REDACTED] employees who informed us that [REDACTED] harasses them on a routine basis, and continually threatens them with the prospect of fully contracting out their jobs to the private cleaning firm. They expressed concerns that the private contractor uses their supplies and locks up VA equipment making it unavailable for VA staff to complete their assignments during other shifts. They also said that they have to clean the areas the private contractor is responsible for because the work is not always done properly.

(b)(6) The [REDACTED] disagreed that supplies and equipment are unavailable to his VA staff or that the private contractor's work is inferior. He acknowledged that he is direct and forthright with his employees and believes that some of them are lazy, abuse sick leave, and are accident prone. The [REDACTED] is an advocate of contracting out for services and said he has met with staff in general meetings to alert them of the trend in this area. The [REDACTED] said that he has taken a no nonsense approach with his employees and admits that his style of management is not always tactful or sensitive.

(b)(6) Employees we spoke with were uncertain of their retention rights and were unsure of their future employment at the Medical Center. These concerns have been heightened by [REDACTED] management style, and discussions with his staff concerning the private cleaning service's work. This increasing uncertainty contributed to the overall belief that the former Director, and management in general, are unsympathetic to the employees at the Medical Center, and staff speculations that they will lose their jobs.

**Recommendation 6:**

(b)(6) The Medical Center Director should take appropriate action to ensure that the [REDACTED] employees are appropriately advised of their employment rights as they pertain to the current and future plans for retaining private cleaning services at the Medical Center.

**Medical Center Director's Comments:**

(b) (6)

The Medical Center Director communicated to [REDACTED] that he needs to improve interaction with [REDACTED] employees in keeping them informed of the current contract for private cleaning services, in addition to their rights as federal employees in these situations. The Director informed us that this would be done at [REDACTED] staff meetings. Any information communicated at these meetings will be coordinated through Human Resources Management. The Medical Center Director noted that all [REDACTED] employees have the opportunity to speak separately with [REDACTED] as well as Human Resources staff concerning this and any other issues. The full text of the Medical Director's comments is shown in Appendix A of the report.

**Office of Inspector General Comments:**

The Medical Center Director's comments met the intent of the recommendation, and we consider the issue resolved.

**Personnel-Related Allegations**

**Allegation 19: The former Director engaged in inappropriate personnel actions to reward his associates and friends.**

(b) (6)

**Discussion:** This allegation is unsubstantiated. The complainant alleged that the former Director inappropriately promoted several of his associates and friends without competition, e.g. [REDACTED] and [REDACTED]. The former Director allegedly rewarded those employees who became his personal friends or who covered up for him for some improper action at the Medical Center. The complainants also alleged that the former Director promoted staff he had a personal relationship with, and those who would willingly go along with any managerial action no matter how inappropriate it was for the Medical Center.

(b) (6)

All five of the people named in the allegation were promoted noncompetitively to a higher grade and in two cases [REDACTED] and [REDACTED], promoted twice noncompetitively. Noncompetitive promotions are authorized by personnel regulations and the use of this method of promotion process in lieu of the competitive process is a management decision.

(b)(6)

Three of the five individuals [REDACTED] and [REDACTED] were [REDACTED] and the remaining two individuals were [REDACTED] office. The former Director was the approving official on all of these promotions.

We found no evidence that these individuals were not qualified for the higher graded positions. The promotions were processed through the Medical Center's Human Resources Management Service and the Chief certified that the positions met the higher classification grade and that the individuals were qualified for the higher graded position.

We found the use of noncompetitive promotions for these individuals was a subject of concern among employees. The staff promoted were known friends and associates of the former Director. This fact undoubtedly gave rise to the allegation that the promotions were made more on the basis of friendship than merit. There is no indication even if the competitive process had been used for filling these positions, that these individuals would not have been selected. However by foregoing the competitive process no one else at this Medical Center, or any other VHA facility, had the opportunity to be considered for the positions.

(b)(6)

Also, the timing on the promotions to GS- [REDACTED] for the two [REDACTED] raised further questions from employees. The two promotions were made in April 1996, at the same time the former Director was announcing to the staff serious funding shortages, possible RIFs and other cutbacks in funding. This gave the staff the appearance that the "front" office was exempt from these budget cuts, while everybody else in the Medical Center was subject to the potential RIFs or other reductions. We received a number of complaints about the appropriateness of the promotions of these two [REDACTED] so it was apparent the staff was upset by what appeared to them to be favoritism.

While we could not validate the allegation that these promotions were based on anything other than merit, the former Director's use of noncompetitive promotions for these individuals to the exclusion of others sent the wrong message to the staff and increased the tension between rank and file employees and top management.

<b>Allegation 20:</b>	<b>The former Director created a nonessential GS- [REDACTED] position.</b>
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(b)(6)

**Discussion:** This allegation is unsubstantiated. The former Director did create a GS- [REDACTED] position in 1993. The former Director believed that with the numerous renovation projects underway or planned for VAMC Charleston, an in [REDACTED] was necessary. Prior to that time, the Medical Center had borrowed the services of an [REDACTED] assigned to VAMC Columbia, South Carolina.

(b)(6) According to Medical Center officials, that arrangement did not prove to be entirely satisfactory. Accordingly, [REDACTED] was hired to fill the [REDACTED] position at the GS [REDACTED] level. [REDACTED] was promoted to the GS [REDACTED] level in August 1994, and [REDACTED] recently transferred to another VA facility. With the current budget limitations, there are no plans at this time to hire a new [REDACTED].

(b)(6) We believe it was management's decision whether or not to hire an in-house [REDACTED]. There is nothing necessarily wasteful about that decision. A number of VA medical facilities have an [REDACTED] on their staff and others contract for [REDACTED] services. It is a valid Medical Center function, especially for those VAMCs undergoing extensive renovation.

**Allegation 21: Management inappropriately placed two employees in new respiratory therapy positions without seeking competition.**

**Discussion:** The allegation is not substantiated. The Chief, Human Resource Management Service, informed us that the two positions in question were not subject to promotion consideration or change in position description. Two respiratory therapy employees were laterally assigned to the duties.

**Allegation 22: Prosthetic Service management required an employee to work 3,000 hours of overtime without compensation.**

**Discussion:** The issue is pending resolution. The complainant alleged that management required her to work after hours, weekends and holidays. According to the complainant, she continued to work the hours until the pace became so exhausting that she became ill. She eventually suffered a work-related injury. We reviewed this issue with the Chief, Human Resources Management Service and found that the complainant has sought legal assistance in pursuing an EEO complaint and reimbursement of the overtime hours worked. VA management had made an offer to the complainant to settle the dispute, but it was rejected by the employee. The legal process continues. We took the position that it would be inappropriate for the OIG to become involved in this matter further because the matter is already in the appropriate administrative and judicial forum for resolution.

**Allegation 23: Management forced a physician to quit without just cause.**

(b)(6) **Discussion:** A settlement was reached with the physician. The physician settled with the VA and affiliation and left the Medical Center to enter a private practice. The complainant alleged that management inappropriately forced him to resign from his position in [REDACTED]. According to the physician, the problems began after a

(b)(6)

controversy over the dosage he prescribed patients on anti-anxiety medications. During the physician's vacation, one of his patients on a tricyclic antidepressant was given another drug and had a toxic reaction. The patient had severe side effects and was hospitalized. This began a series of disagreements between the physician and a new [REDACTED]

The physician informed us during a telephone interview that he accepted a settlement agreement from the VA and the University Medical School affiliation, prior to entering private practice. At that time, all parties were in agreement with the settlement. The physician contacted the congressional office because he was now asking for additional considerations beyond the original agreement, and wanted to inform the OIG of the poor management practices of the Medical Center. We took the position that it would be inappropriate for the OIG to become involved in a matter that was settled by an official agreement signed by the complainant, and that the physician could continue to pursue these issues through the appropriate legal processes.

(b)(6)

**Allegation 24: Management created a contract specialist position for the friend of the [REDACTED] and did not permit other staff to compete for the job.**

**Discussion:** The allegation is not substantiated. The contract specialist position noted in the complaint was subject to competition by other employees at the Medical Center. The [REDACTED] announced a program analyst position in October 1995. We found that the position was posted from October 12 through October 23, 1995, wherein employees at the Medical Center had an opportunity to compete for the position. There was no other evidence to suggest that the personnel process was inappropriately followed.

**Scheduling/Staffing Allegations**

**Allegation 25: Management violated their own policies by requiring respiratory therapists to work without backup in the intensive care unit during the evening hours.**

**Discussion:** The allegation was partially substantiated. We found that management did require respiratory therapists to work alone in the intensive care unit during the evening hours because of a declining inpatient workload at the Medical Center. Management

informed us that in the event another respiratory therapist would be needed, the employee on duty could obtain assistance from the respiratory therapist working in the sleep laboratory. Respiratory therapy staff expressed concern that the employee in the sleep laboratory could not leave a patient undergoing a study unattended.

We noted however, this practice was not consistent with the existing policy as alleged by the complainant. Management took action to change the policy during this review after it became the subject of a union complaint. The new policy was consistent with the practice of only retaining one full-time respiratory therapist on duty at night. We discussed the changes with our health care inspection staff, and were informed that the new policies were consistent with other VA medical centers experiencing inpatient workload reductions. The new policy provides alternative sources for backup if needed by the respiratory therapist on duty at the time. We, therefore, made no recommendations.

<p><b>Allegation 26: There was a shortage of nursing staff to provide quality patient care.</b></p>
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**Discussion:** We could not substantiate a correlation between nursing staffing reductions and quality of care. Nursing staff we interviewed stated that the RIFs by management in the Service have caused a severe shortage in the wards and they believed that this will effect patient care if the trend continues. However, we noted that the inpatient workload dropped at a rate far exceeding the drop in inpatient nurses.

The Chief, Nursing Service reported that since 1994, the overall number of registered nurses, licensed nurse practitioners (LPNs), and nursing assistants declined by about 3 percent (283 to 275). During the same period, nursing inpatient assignments declined about 14 percent (248 to 215). However, the average number of daily inpatients dropped by about 32 percent (184 to 124). The percentages have been rounded. The Chief, Nursing Service acknowledged that some nursing positions were realigned to primary care functions.

We found that 23 registered nurses separated from service between October 1, 1995, and September 30, 1996; or a turnover of registered nurses totaling 14 percent. We also found that 23 LPN's and nursing assistants were separated during the same period; a turnover rate of 23 percent. Management did not believe the turnover rate for registered nurses was atypical from prior years, but did agree that overall nursing turnover rates have increased over the past fiscal year and need to be evaluated.

We noted that from September 1994 to October 25, 1996, there were 111 nursing staff separations. Of the 111 separations, Human Resource Management Service provided us documentation on 40 exit interviews. The two main reasons given by nursing staff for

leaving the VA were that they were short of help, and they had problems with supervision. Nursing staff also indicated they left VA because training was not offered, their skills were not being used, or they took higher paying jobs. Other nursing staff retired, left because of family illness, or relocated to another area.

This information was discussed with the VISN Director to alert him to the concerns expressed to us by the nursing staff. The Chief, Human Resource Management Service also informed us that his staff would give more attention to ensure that exit interviews are completed during the separation process. We therefore made no additional recommendations.

**Allegation 27: Management closed the Medical Center at night and inappropriately turned away veterans seeking emergency care.**

**Discussion:** We did not substantiate that VA patients seeking emergency care were inappropriately turned away and not treated. The complainant expressed concern with a memorandum issued by the Medical Center's Chief of Police that instructed officers to lock down the facility after 9:00 p.m. each night. The complainant believed that veterans seeking emergency care were being inappropriately turned away.

The complainant perceived this to be the case because of the instructions issued to VA staff. The Police Chief's memorandum dated July 1, 1996, informed staff that police officers would take up their post in the ambulatory care area at 9:00 p.m. each night and would lock the doors to the facility. The emergency room doors were to be locked at 10:00 p.m. each night. From 10:00 p.m. until 8:00 p.m. all persons seeking medical treatment would be referred to the nearby Charleston Memorial Hospital (CMH). The memorandum stated that

"If a patient claims to be having a heart attack or collapses at the door, the AOD [Administrative Officer of the Day] will call 911 for assistance. Coding/Mayday of a patient in distress is not an option at this time. Signs will be posted at the doors directing patients to CMH. In the event that officers are called away to an emergency on 5BN or elsewhere in the facility persons who present at the door which require admission to the facility will just have to wait. MAS [Medical Administration Staff] staff will under no circumstances unlock the door....All persons provided with access to the facility will be documented in the Journal indicating who entered, why entered, where they went. This to track potential abuses."

The Acting Director informed us that the Medical Center was not certified to provide emergency care, and workload in the evenings was steadily declining. Because of these reasons, management entered into a contract with nearby CMH which agreed to accept all evening emergency patients on their behalf. The CMH is approximately one block from the VA Medical Center. The Acting Director said that the veteran patients seeking emergency care are provided quality emergency health care at CMH under contract, and are later transferred to the VA Medical Center once stabilized. The contract with CMH permits management to reallocate VA staff to other functions.

The Acting Director agreed that the Chief of Police's instructions could be misinterpreted and informed us she would speak with the Chief of Police on this issue. Therefore, no additional recommendations were made. Employees interviewed believed that these instructions were one more example of management's insensitivity toward patients and employees.

Director, VA Medical Center Comments

DEPARTMENT OF VETERANS AFFAIRS  
Ralph H. Johnson Medical Center  
108 Bee Street  
Charleston SC 29401-6799

18 DEC 1996.

Re: Reply Refer To:

Mr. Michael Staley  
Director, Hotline and Special Inquiries Division (S3H)  
Office of the Inspector General  
Washington, DC 20420

Dear Mr. Staley:

Pursuant to your draft report dated November 18, 1996, below are our responses to the IG's recommendations:

Recommendation 1 - The Acting Director ensure that all equipment purchased for the NHCU in FY95 be accounted for so that all can be reconstituted in the NHCU once it is operational.

**Response:** As of December 2, 1996, our A&MM Service has accounted for all equipment items purchased for the NHCU. Those appropriate items will be transferred to the NHCU once it becomes operational.

Recommendation 2 - The Acting Director should carefully evaluate the options regarding the fish tank and determine whether continued use of the tank is in the best interest of the medical center.

**Response:** After conferring with our Engineering Service, it has been determined that it would cost approximately \$27,394 to remove the fish tank from its present location in our front lobby. In addition, due to the nature of initial construction (i.e. mixing of grout, muck, coloring, etc.), it would be virtually impossible to remix any replacement ingredients to match the existing tile color scheme. Therefore, any attempt at removing the fish tank would destroy the interior design uniformity of the lobby.

Since the installation of the fish tank, Management has received numerous positive comments from patients, family members, staff, and the general public. It remains the focal point of the newly renovated lobby and we feel strongly that it provides a positive diversion for those in the lobby waiting on prescriptions or who have other business at the medical center. Therefore, Management will support keeping the fish tank a part of our lobby.

Recommendation 3 - Response to be prepared by VISN 2 Network Director.

Page two  
Mr. Michael Stalcy

Recommendation 4 - We recommend the Acting Director take action to:

- a. Discontinue using the fee basis authority to pay for the top management consultant's services, and reevaluate whether advisory and assistance work continues to be needed at the medical center.
- b. Develop the required "concept approval" documents and submit an official request for the consultant's services to the VISN if it is determined that these services are still needed.

(b) (6) Response: The consultant in question, [REDACTED] will be terminated as a consultant as of 12/31/96. In the future if a consultant's services are deemed necessary, the procedures outlined in Circular 00-92-15 will be followed.

Recommendation 5 - The Acting Director consider the cost of the annual maintenance contract for the fish tank in her deliberations on the options related to the future of the fish tank.

Response: The current maintenance contract for the fish tank runs through September 30, 2000. The monthly fee of approximately \$650 covers both the lease of the tank, fish, and equipment, as well as on-going maintenance. When the contract was sent out for bid, we initially had 5 inquiries, but actually received only 2 bids. As a point of information, the other bid received was approximately double (\$1500) the current rate. As stated above, it is Management's decision to keep the fish tank and associated maintenance contract.

Recommendation 6 - The Acting Director should take appropriate action to ensure that [REDACTED] employees are appropriately advised of their employment rights as they pertain to the current and future plans for retaining private cleaning services at the medical center.

(b) (6) Response: It has been communicated to the [REDACTED] that he needs to improve interaction with [REDACTED] employees in keeping them informed of the current contract for private cleaning services, in addition to their rights as federal employees in these situations. At a minimum, this should take place at [REDACTED] staff meetings. Any information communicated at these meetings will be coordinated through Human Resources Management. All [REDACTED] employees always have the opportunity to speak separately with [REDACTED] as well as Human Resources staff concerning this and any other issues.

Page three  
Mr. Michael Staley

If you have any further questions regarding these responses, please do not hesitate to contact me at 803-577-5011, ext. 7200.

Sincerely,

  
R.T. VOGEL  
Director

Director, Veterans Integrated Service Network No. 7 Comments

DEPARTMENT OF VETERANS AFFAIRS  
Veterans Integrated Service Network #7  
2200 Century Parkway  
Suite 260  
Atlanta, GA 30345

December 20, 1996

In Reply Refer To: 10N7

Mr. Michael L. Staley  
Director, Hotline and Special Inquiries Division (53E)  
Office of the Inspector General  
Washington, DC 20420

Dear Mr. Staley:

This is in response to your letter of November 18, 1996, concerning the draft report on the Charleston VAMC Special Inquiry. In your letter, you asked that I respond to Recommendation 3 on page 18 of that report. My response to that recommendation follows:

**Recommendation 3 - We recommend the Veterans Integrated Service Network Director take action to ensure that the former Director, and management at the VA medical center are aware of the appropriate procedures to follow when requesting advisory services.**

**Response:** The former Director at the Charleston VAMC no longer works in this VISN. Accordingly, I have no line authority over him. The newly appointed Director at Charleston is aware of the appropriate procedures to follow when requesting consultative services and has terminated the present contract effective 12-31-96.

If you have any questions regarding this response, please call me at 404-728-4101.

Sincerely,



Larry K. Deal  
Director, Atlanta Network

**Monetary Impact**  
**In Accordance with IG Act Amendments**

Report Title: **Special Inquiry, Alleged Mismanagement, Ralph H. Johnson VA Medical Center, Charleston, SC**

Report Number: **7PR-G02-029**

<b>Recommendation Number</b>	<b>Category/Explanation of Benefits</b>	<b>Better Use of Funds</b>	<b>Questioned Costs</b>
4.	<b>Improved Use of Resources.</b> Amount of funds that can be reallocated to other activities.	\$90,117	-0-
	<b>TOTALS</b>	<u>\$90,117</u>	<u>-0-</u>

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# Office of Inspector General

## SPECIAL INQUIRY

**ALLEGED MISMANAGEMENT OF THE HOUSEKEEPING  
QUARTERS AT UNIVERSITY DRIVE,  
VA MEDICAL CENTER,  
PITTSBURGH, PENNSYLVANIA**

(REDACTED COPY)

**Date: January 10, 1997  
Report No. 7PR-A19-027**

### **WARNING 5 U.S.C. § 552A, PRIVACY ACT STATEMENT**

**This final report contains information subject to the provisions of the Privacy Act of 1974 (5 U.S.C. § 552a). Such information may be disclosed only as authorized by this statute. Questions concerning release of this report thereof should be coordinated with the Department of Veterans Affairs, Office of Inspector General. The contents of this report must be safeguarded from unauthorized disclosure and may be shared within the Department of Veterans Affairs on a need-to-know basis only.**

**Office of Inspector General  
Washington DC 20420**



DEPARTMENT OF VETERANS AFFAIRS  
Office of Inspector General  
Washington DC 20420

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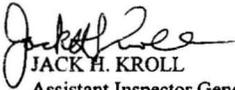
TO: Under Secretary for Health (10)  
Director, Veterans Integrated Service Network No. 4 (10N4)

SUBJ: Alleged Mismanagement of the Housekeeping Quarters at University Drive,  
VA Medical Center, Pittsburgh, Pennsylvania — Report Number 7PR-A19-027

1. The Department of Veterans Affairs (VA) received an inquiry from Senator Arlen Specter about a constituent's complaint regarding the University Drive VA Medical Center in Pittsburgh. According to the complainant, the Medical Center Director authorized wasteful spending on his government quarters. The Office of Inspector General (OIG) Special Inquiries staff conducted an inquiry to determine the validity of the allegations.
2. We found that the Medical Center spent approximately \$201,000 for repairs and renovations on the Director's Residence. VA policy requires the cost of maintaining and operating housekeeping quarters be recoverable through their rental income. The expenditures on the Director's Residence exceeded the Medical Center's estimate of rental income available for renovations and repairs by about \$79,000.
3. Several factors contributed to the overspending in Pittsburgh. The former Medical Center Director and the Eastern Region approved a nonrecurring maintenance project for quarters without ensuring that quarters income could support these expenditures. The Real Property Management Office (RPMO) in Central Office told Medical Center officials they could authorize significantly higher expenditures on quarters than allowed by VA policy. RPMO also did not provide Medical Center officials with an accurate model to determine quarters spending limits, and VA did not implement uniform design standards required by the Office of Management and Budget (OMB). We also found that local management of the interior renovation project and the Director's selection of nonstandard quarters amenities increased spending over planned levels.
4. During our review, we identified additional issues related to the process used to establish quarters rents. We found that RPMO permitted the Medical Center to make unauthorized reductions to quarters rents without ensuring that the reductions were consistent with OMB guidelines. We also found that Medical Center did not initiate timely action to obtain new appraisals on renovated quarters. As a result, employees benefited from rents which appeared lower than market levels.

5. We recommended that the Veterans Health Administration (VHA) issue policies to implement revised OMB quarters requirements and to establish a current rent adjustment procedure. We also recommended that VHA ensure that appropriate officials review and approve quarters management decisions in accordance with relevant policies and regulations. We recommended that the VISN take appropriate action to improve the performance of responsible Medical Center officials, to obtain historic preservation orientation, and to recover lost rental income.

6. You agreed with our findings and recommendations. We will continue to follow-up on these issues until all recommendations are implemented. Thank you for the courtesy and cooperation your personnel extended to my staff during this review.



JACK H. KROLL

Assistant Inspector General for  
Departmental Reviews and Management Support

Enclosure

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**SPECIAL INQUIRY****ALLEGED MISMANAGEMENT OF THE  
HOUSEKEEPING QUARTERS AT UNIVERSITY DRIVE  
VA MEDICAL CENTER, PITTSBURGH  
Report No. 7PR-A19-027****INTRODUCTION****Purpose**

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) Special Inquiries staff reviewed a complaint concerning the University Drive VA Medical Center in Pittsburgh. The complainant raised issues concerning personnel practices and housekeeping quarters management at the Aspinwall Division. The OIG received the allegations from the complainant by letter and through Senator Arlen Specter.

**Background**

The University Drive Medical Center has two divisions, University Drive and Aspinwall. At the Aspinwall Division, the Government constructed the original Georgian Revival buildings during the period from 1924 to 1932. In 1981, the Department of the Interior designated a group of original buildings at Aspinwall, including the housekeeping quarters, as eligible for inclusion in the National Register of Historic Places. From 1988 through 1990, VA completed the process of obtaining approval to demolish some of the buildings at Aspinwall to make way for a new hospital building. The Medical Center has 18 housekeeping quarters units.

In the spring of 1994, Mr. Thomas A. Cappello learned he would be the new Director in Pittsburgh. In July 1994, the Medical Center management notified the Regional Director that they intended to renovate Building 13 with local funds for Mr. Cappello's use. Building 13 is a two story, four bedroom unit included in the Aspinwall historic district.

In August 1994 an employee's family vacated Building 13 in part due to its condition. Changes in temperature had cracked the plaster covering the exterior walls, and lead paint was chipping and peeling. Medical Center officials noted additional maintenance concerns at the time. Maintenance crews had patched portions of the hardwood floors with plywood. The baseboards in some rooms were missing and replaced with aluminum foil. The roof over the sun porch leaked and workers had removed its flooring, exposing the flooring adhesive. The basement had a mold problem, and there was a musty odor on the first floor. The ceramic tile in the upstairs bathrooms had leaked, causing water

damage to the ceilings below. One bathroom had problems with the shower and drain switches, and another had drain problems. The dishwasher, washing machine, and clothes dryer were reportedly worn out.

Another reason Building 13 was vacated is that it traditionally was made available to the Director for his quarters. When Mr. Cappello arrived at Pittsburgh in August 1994, he moved into quarters unit 16W at Aspinwall. He lived there until March 1995, when he moved into the renovated Building 13 (Director's Residence). Mr. Cappello vacated the Director's Residence in April 1996.

#### Scope

In August 1995, we received an anonymous complaint and a related inquiry from Senator Specter concerning the Director at the University Drive Medical Center in Pittsburgh, Pennsylvania. According to the complainant, the Medical Center inappropriately transferred two employees from Florida and spent too much money renovating the Director's Residence for Mr. Cappello. We reviewed official personnel documents and found the employee transfers did not violate personnel regulations. Therefore, we did not pursue those issues further. We reviewed the complainant's allegation that the expenditures on the Director's Residence were excessive. We also reviewed the process used to establish rents.

We took sworn, taped testimony from Mr. Cappello and employees in Engineering, Environmental Management, and Acquisition and Materiel Management Services. We also interviewed the previous resident and an officer of a construction company that helped renovate the Director's Residence. We reviewed the renovation contract, the available maintenance and expenditure records, and the rent and appraisal records on the Director's Residence. We reviewed the historic preservation and property management files on the Director's Residence found in Central Office (CO). We also reviewed policies and regulations concerning government housing quarters, historic preservation, and VA construction management.

## RESULTS AND RECOMMENDATIONS

<b>Allegation 1: The Veterans Health Administration (VHA) Spent Too Much Money to Renovate the Director's Residence.</b>
--

According to the complainant, Mr. Cappello spent more than \$150,000 to renovate the Director's Residence, and the project escalated due to the decorating preferences of Mr. Cappello [REDACTED]. We found total expenditures on the Director's Residence were about \$201,000 or about \$79,000 more than the calculated spending ceiling for this property.<sup>1</sup> We found that the responsibility for spending extended beyond Mr. Cappello, although he and his managers were responsible for about \$46,000 in unplanned spending. We concluded that VHA quarters maintenance procedures needed to be improved locally and at headquarters.

### VHA Officials Approved One Quarters Project and Told the Medical Center to Overlook VHA Policy on Other Projects

The former Medical Center Director initiated the original plans to repair and improve quarters at Aspinwall, including the Director's Residence. As part of the project to construct the new hospital, some quarters received new water mains. In November 1990, the former Director applied for a project to waterproof the basements and replace the water and sewage systems of the remaining quarters buildings, including the Director's Residence. VHA did not approve this project. The former Director resubmitted this project in March 1994, and VHA Eastern Region approved it as a Non-Recurring Maintenance (NRM) project for fiscal year 1995. According to management, \$33,132 of this project's costs were for the Director's Residence.<sup>2</sup>

VHA Supplement MP-3, Part I, paragraph 4.04, required Regions to review NRM project submissions for accuracy, completeness, and appropriateness. Paragraph 3.19 required the costs of operating quarters be offset with income derived from the units. In this case, the Region approved the NRM project without an analysis of the economic impact on the quarters units. We therefore concluded that the Region approved the NRM project without sufficient analysis of the appropriateness of the project.

In May 1993, the former Medical Center Director requested approval to renovate and upgrade the interior of the Director's Residence. VHA did not approve this request. In July 1994, after the former Director retired, the Acting Director at Pittsburgh obtained instructions on what procedures to follow when renovating quarters. A Real Property

<sup>1</sup> For readability, dollar figures are frequently rounded in this report.

<sup>2</sup> Our draft report contained a higher cost estimate which we changed based on the more specific information management provided in response to our draft report.

Management Office (RPMO) official in Washington told the Acting Director in Pittsburgh to use the income and expense model in the expired VHA Directive 10-93-014, rather than the current VHA Supplement MP-3, paragraph 3.20, "Restrictions on the Use of Operating Funds." Relying on the expired Directive's income and expense model, Mr. Cappello approved \$122,000 in local funds to renovate the Director's Residence.

VHA Supplement to MP-3, paragraph 3.20, requires CO approval before facility directors may approve annual expenditures exceeding \$8,600 per quarters for non-routine maintenance and improvements. VHA Directive 10-93-014, Attachment D, stated that CO "approval for expending funds on the quarters will only be required when an analysis of income and expenses indicates the expenditure for the individual unit cannot be recaptured in the ensuing 10-year period" using the provided model. The Medical Center management supervised the NRM project and told the Regional Director they intended to follow the VHA Directive when renovating the interior of the Director's Residence.

We found officials spent \$33,000 in NRM funds on the Director's Residence, and approximately \$168,000 for the interior renovation. In total, VHA has spent about \$201,000 on the Director's Residence, about \$79,000 more than the calculated spending limit.

Mr. Cappello told us he decided to fund quarters renovations with money from his medical care appropriations budget because it would help increase the Medical Center's future funding. He said that since the Medical Center received the rental income from the properties, improving the quarters would be a good investment for the facility. Mr. Cappello used this method to fund three quarters renovations exceeding \$50,000 each. An official with RPMO told the Medical Center to follow the VHA Directive which did not specify which appropriation medical centers may use to improve quarters.

VHA Supplement to MP-3, paragraph 3.20, requires medical centers to finance minor improvements to quarters involving \$50,000 or more with construction appropriation funds. MP-3, Part I, paragraph 11.02, defines improvements to include the complete renovation or updating of a building or facility. Management exceeded \$50,000 to renovate the interior of each of three quarters units, including the Director's Residence, using medical care appropriation funds rather than the construction appropriation money. We concluded the Director inappropriately exceeded the limitation on local approval for quarters spending and inappropriately used medical care funds because RPMO told him to follow the expired Directive instead of the appropriate VA policy.

### Medical Center Officials Mismanaged the Interior Renovation of the Director's Residence

When Mr. Cappello arrived at Aspinwall in August 1994, he moved into quarters 16W. He told us he moved into quarters to spend more time at the Aspinwall Division, since his office is at the other division. Mr. Cappello told VHA officials in July 1995 that he planned to move to a private residence by September 1996.

Mr. Cappello asked Engineering Service and the Interior Design Section to make plans to renovate the interior of the Director's Residence for his use. Engineering Service calculated that the Medical Center could spend up to \$122,000 on the renovation without CO approval. Mr. Cappello finalized plans to spend about \$112,000 for the interior renovation. The plans divided the work between VA employees and a construction contract. Mr. Cappello told us that he was willing to discuss any kind of renovation to the Director's Residence as long as they did not exceed the budget limit of \$122,000. He told us he was consulted on almost everything in the renovation. The final cost of the interior renovation of the Director's Residence was approximately \$168,000.

We found that actual renovation expenditures exceeded the estimated spending limit by \$46,000 based on three factors: contracting practices, management supervision, and nonstandard quarters amenities.

**Contracting Practices**—The Medical Center used a small and disadvantaged construction company<sup>3</sup> to perform the renovation contract. Informal negotiations with the construction company began in December 1994 and ended in March 1995 when the Medical Center received the construction company's final offer. The Small Business Administration (SBA), as the primary contractor, accepted the offer on March 30, 1995. The Contracting Officer signed the contract on April 5, 1995, and notified the construction company to proceed on April 14.

The construction company began renovating the Director's Residence in January 1995, at least two months prior to obtaining approval on the project specifications and pricing. The Acting Engineering Chief told us that it was likely the construction company began working before signing a contract because the Director had imposed a March 15, 1995, target date to move into the renovated quarters. [REDACTED] (b)(6) permitted the construction company to work during negotiations to help the company retain workers from another recent quarters renovation project.

<sup>3</sup> As defined by 15 USC §637(a).

During the initial negotiations, the contractor proposed prices in excess of the VA budget. As a result, VA officials eliminated some items from the approved plan and undertook other items with station labor. Station employees also performed additional work when the company ran into unexpected difficulties with their work. Thus, VA officials kept the contract price approximately the same as originally estimated by decreasing the amount of work performed by the contractor and increasing the work performed by station labor. Most of the renovation work was completed by the time Mr. Cappello moved into the Director's Residence on March 17, 1995.

Federal Acquisition Regulations (FAR) state that contracting officers are responsible for safeguarding the interests of the United States. The FAR requires contracting officers to ensure that no contract shall be entered into before all legal and regulatory requirements have been met.<sup>4</sup> Title 48 CFR §819.8 requires VA contracting officers to provide complete project plans for a small and disadvantaged business construction procurement to the SBA and receive SBA approval before notifying the SBA subcontractor to proceed.

The FAR does not authorize an arrangement in which construction contractors perform services without having a legal agreement on specifications and prices. In order to utilize the small and disadvantaged business procurement method, Federal regulations required the Department to obtain the SBA's approval before letting the construction company proceed. In this instance, the [REDACTED] let the construction company start work before reaching an agreement or receiving SBA approval. As a result, Medical Center officials committed themselves to this construction company before realizing that the renovation costs were not in line with their budget estimate. Due to unexpected contract costs, officials performed additional work with station labor. Thus, contracting practices contributed to overall cost overruns on the project. (b)(6)

*Project Approval and Management*—The Director approved the project budget in late 1994, but there was no written record of a management review of project plans after that. The Director told us that he believed that instructions from RPMO authorized him to spend up to \$122,000 on the Director's Residence. The Director told us that he did not assign anyone the responsibility to coordinate the renovation activities among different hospital services, but that he assumed this function was handled by Engineering Service. During the construction period the Associate Director was temporarily assigned out-of-state, and there was no permanent Engineering Officer. The Director personally involved himself in the renovation, meeting with Engineering officials, interior designers, the construction company, and vendors.

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<sup>4</sup> 48 CFR §1.602.

The renovation project file did not contain a formal project proposal, a complete set of drawings, or detailed specifications for the interior renovation. The only comprehensive plans for the interior renovation we found were two undated, unsigned cost estimate spreadsheets. There were no records to indicate the original specifications, approved changes in the scope, or specific responsibility for the work performed. The project file did contain a final drawing of the work to be performed under contract and various proposals from a vendor.

The renovation was a station-level project. Most VA employees who worked on the project reported to Engineering Service. The Acting Engineering Chief told us that he was not aware that they spent so much money prior to our review. However, the Acting Engineering Chief also told us he was aware that the Government performed some work originally assigned to the contract, such as plumbing, electricity, air conditioning, and enclosing the sun porch. The Director told us that he approved shifting the air conditioning and sun porch conversion to station labor and he thought this change was within spending limits.

Besides the original plan, the Medical Center spent additional resources on the renovation, including VA interior design services and window and wall treatments. Mr. Cappello was aware of some of these additional expenditures because he [REDACTED] (b)(6) met with employees and vendors providing them. In other instances, Mr. Cappello personally made incomplete budget adjustments by eliminating some items but not allowing for replacement costs. For instance, he eliminated work on hardwood floors but did not allow for the carpeting expense to cover the unrepaired floors. The Director told us that this overspending occurred in part because he mistakenly understood that the expenditures for equipment and furnishings did not count directly toward project spending limits.

We found that the Medical Center shifted work from the contract to station labor and spent additional funds on work not specified in the original plan. VA assumed responsibility for \$32,000 of work that the Director originally slated for the construction contract. In addition, Engineering Service did not include about \$26,000 of the interior renovation expenses in the original projects plans.

The Medical Center divided the responsibility for approving and making expenditures on quarters among services. Engineering Service was responsible for maintenance, Environmental Management Service designed the interior, and Acquisition and Materiel Management supported purchases and contracting. An accounting technician in Engineering Service tracked cost transfers prepared by engineering supervisors. The Acting Engineering Chief provided this information to the Director and told us that before our review he thought this information represented the total expenditures on the

Director's Residence. However, we found that this information was incomplete. This information did not reflect expenditures by all services, and supervisors had not initiated cost transfer entries for all renovation expenditures.

VHA Supplement to MP-3, Part 1, Chapter 4, provides that all maintenance, repair, equipment replacement, and improvements in excess of routine quarters expenditures will be prepared as a Non-Recurring Maintenance (NRM) project. This policy also applies to a project containing more than \$25,000 in minor improvements. NRM projects require a formal project application above the station level and detailed cost estimates. The Engineering chief serves as project manager for all station level projects and is responsible for project drawings, specifications, and cost estimates. There were essentially no formal project plans for the interior renovation of the Director's Residence, and the Acting Engineering Chief told us he did not track changes and additions to the project.

VHA Supplement MP-3, paragraph 3.19, requires that the Director evaluate and approve non-routine work on housekeeping quarters in writing prior to the initiation of work. Paragraph 3.20 provides that the Medical Center will maintain appropriate records to control maintenance and minor improvement costs for each housekeeping unit.

The Director told us he was aware of all of the quarters work done, but that he did not approve the work in writing. We found that the Director and Acting Engineering Chief were aware of some additional work performed by VA employees that exceeded the original project plan. Despite their knowledge of additional work performed by VA employees, there was no evidence that the Director requested or the Acting Engineering Chief submitted updated plans and cost estimates for approval. In addition, the Director did not assign anyone the responsibility of tracking project costs among multiple services to ensure that the Medical Center did not exceed spending limits. The Director told us that he thought they could increase the scope of work performed by VA employees because he thought VA employees could perform the work more economically than the construction company. The Director told us that he did not become aware that the project exceeded spending limits until we began our review.

*Nonstandard Quarters Amenities*—The [REDACTED] told us they planned the new interior for the building to be a "showpiece" because Mr. Cappello was a man of stature, and they wanted to give him what he wanted. An [REDACTED] told us that he wanted the house to be an impressive place to entertain because VA medical center directors were prominent people in Pittsburgh. The interior designer told us that he met with [REDACTED] Cappello on more than one occasion to incorporate [REDACTED] personal preferences into his design recommendations. [REDACTED] Cappello visited several vendors and picked out contents for [REDACTED] new residence, such as a new kitchen design and

(6) new bathroom fixtures. A vendor's employees designed the new kitchen, based on the Cappello input. VA designers told us that they were not aware of several of the Cappello selections until after installation, such as custom drapes and light fixtures.

We identified a number of upgraded amenities in the Director's Residence that contributed to unplanned renovation expenditures. Examples include:

- *Kitchen appliances*—Engineering Service replaced all of the kitchen appliances in the Director's Residence, although it already had a new cooking stove and refrigerator when they planned the renovations. The Director's Residence received a new smooth cook-top range and a new double oven with convection. This cooking equipment, which had features not found on an average kitchen stove, cost about \$1,500 more than a gas range recently purchased for another quarters unit. The Medical Center also replaced a new microwave oven in the Director's Residence with a built-in microwave oven/vent hood unit which cost \$439. Department policy does not authorize the Medical Center to provide microwave ovens in housekeeping quarters.
- *Cabinets and floors*—Engineering Service removed the existing kitchen cabinets, even though they appeared to be serviceable. The new cabinets contained cherry hardwood fronts and special features like mullion doors. The kitchen renovation included a new kitchen island with a sink and electricity, which added at least \$1,000 to the project. The construction company also replaced the linoleum in the kitchen with a new hardwood floor. Employees told us no other quarters at Aspinwall have new cherry cabinets, kitchen islands, or new hardwood kitchen floors.
- *Plumbing Fixtures*—Engineering Service demolished the bathrooms, expanded the size of two of them, and did the plumbing rough-ins. The construction company installed new plumbing fixtures, and the costs of many of these fixtures exceeded the industry average costs of basic fixtures. For example, according to published industry survey averages, the remodeling costs of a basic vanity sink faucet range from \$75-125. The cost of the new vanity faucets in the Director's Residence was \$500 each, which falls in the luxury category according to Consumers Union guidelines.<sup>5</sup> The sinks and faucets for three bathrooms cost \$2,950, which is about \$2,100 more than the industry average for basic remodeling costs for these items. In addition, the construction company replaced a bathtub with a whirlpool bathtub with shower costing \$2,200. This whirlpool cost more than twice the remodeling costs of a basic bathtub with faucet and shower and fell into the luxury category according to Consumers Union guidelines. No other quarters had a whirlpool or \$500 lavatory faucets like the Director's.

<sup>5</sup> Barb Machowski, et al., *The Complete Book of Bathroom Design*, (Yonkers, New York: Consumers Reports Books, September 1993), page 15.

The Director personally selected many of the higher cost amenities for the Director's Residence. The Director told us he discussed everything in the house with the interior design staff. He told us that he went to pick out items whenever someone asked him to, but that he was not always sure who was paying for what. He told us that when he picked out items, he did not have any budget guidelines to ensure that his selections were within the original estimates. He told us that he wanted to choose tasteful, middle-of-the road items that were between the least expensive and the most expensive.

Office of Management and Budget (OMB) Circular A-45, section 8, requires agencies to consult industry standards when planning employee housing. The Circular requires officials to ensure that housing is appropriate but does not impose an uneconomical burden on the Government. VA Handbook 7125 sets equipment and furnishing standards for employee quarters in VHA. We found no evidence that VA provided guidance to field stations specifying which building standards to follow to comply with the OMB Circular.

Mr. Cappello told us that he asked an officer with the construction company if some items were too expensive, but the officer told him they were okay. Since the construction company had not signed a contract at that time, it could pass on the expenses of any items that exceeded the project budget to VA. We found the construction company charged about \$30,000 more than originally approved for kitchen remodeling, bathroom remodeling, and the interior painting.

While researching building standards for the quarters renovations, we learned that many of the quarters at Aspinwall, including the Director's Residence, were listed by the Department of Interior as eligible for the National Register of Historic Places. The National Historic Preservation Act of 1966 and its implementing regulations required the Medical Center to follow certain procedures when considering action affecting the Director's Residence and other Aspinwall properties. In 1990, VA entered into an agreement with the Advisory Counsel on Historic Preservation requiring additional steps to protect the historic Aspinwall properties in exchange for permission to demolish certain buildings. During our review, Medical Center officials told us they no longer had records of the historic properties or related agreements. However, former Medical Center officials with responsibilities in this area stationed at Pittsburgh in 1995 told us that the Medical Center management knew the quarters contained historic properties. Previous renovation proposals for the Director's Residence acknowledged its historic status. Mr. Cappello and the Acting Engineering Chief told us that when they approved renovating the quarters they were unaware of historic preservation requirements. We concluded that current Medical Center officials were not consistently maintaining the quarters in compliance with historic preservation requirements.

### VHA Needs to Revise Guidance on Quarters Renovations

During our review, we found issues concerning the implementation of OMB requirements and reliability of the quarters income and expense model. OMB Circular A-45 requires agencies to appoint agency housing officers and maintain sufficient centralized information to inform agency management and to monitor the administration of OMB quarters requirements, including design standards and authority for special features.

In March 1993, the Deputy Secretary requested the Under Secretary for Health to keep his office informed of all proposals to renovate or remodel living quarters at VHA facilities. In this case, RPMO officials did not maintain information on the scope of the Aspinwall renovations and did not provide guidance on building standards and authority for special features. RPMO officials also told local management they could use the income and expense model to determine whether it was necessary to get project approval from CO. We therefore concluded that RPMO did not consistently maintain sufficient centralized information to monitor implementation of OMB requirements or comply with the Deputy Secretary's request.

Following the guidance in VHA Directive 10-93-014, Engineering Service completed the VHA income and expense model for the Director's Residence prior to Mr. Cappello's arrival. Based on the results, Mr. Cappello approved the renovation of the Director's Residence and two other quarters units. He also planned to renovate additional quarters buildings until funding was no longer available.

We found that portions of the model caused an overstatement of income available for the Director's Residence renovations because the model's instructions were not specific enough. The model did not define terms like "rent" well enough to exclude other charges like utilities. The model did not instruct managers to include all quarters operations costs in projections, and it did not explain how to handle estimated costs of concurrent projects like the NRM project. The model also told managers to add projected income losses due to vacancy without specifying that the losses were negative numbers.

In another instance, the income and expense model potentially underestimated the amount of money available for major maintenance projects. VHA Supplement to MP-3, paragraph 3.19f, authorizes prorating expenditures for certain major maintenance projects, such as new roofing and plumbing systems, over a period up to 20 years. The expired VHA Directive 10-93-014, Attachment D, paragraph 1b, required quarters units to recapture expenditures over a 10 year period. Since the income and expense model cut the time for cost recovery for some quarters expenditures in half, it underestimated the amount of money available for quarters renovations under the VA manual. We concluded that VHA needed to revise instructions for the quarters income and expense model.

### **Excessive Quarters Renovation Expenditures Threaten Their Financial Sustainability**

The VHA supplement to MP-3 requires quarters to be self-sustaining and restricts the authority of facility directors to approve annual expenditures for quarters. Following RPMO guidance, Mr. Cappello believed he could spend up to \$122,000 on the Director's Residence renovations. We found that VHA spent \$79,000 more than the estimated limit of what could be recouped with rental income over the next ten years. In addition, we found that the model used by the Medical Center overestimated the amount of rental income available for renovating quarters. As a result, it is doubtful whether employee rents will fully reimburse the Department for the medical care funds expended on these projects. Mr. Cappello told us he would have reduced the scope of the renovation had he realized it was beyond spending limitations.

The Aspinwall Division has 18 quarters units, most of which are vacant or occupied by employees not required to live on station. VA Manual M-1, Part I, requires three employees to live on hospital grounds when quarters are available. VHA Supplement MP-3, paragraph 3.19, requires the Director to exercise prudence in evaluating capital value, rental income, and the actual need for quarters prior to making or approving expenditures for maintenance, repair, or minor improvement to housekeeping quarters. This paragraph also requires facilities to discontinue quarters units whenever their maintenance and renovation costs exceed reasonably expected rental receipts.

In this case, Mr. Cappello followed instructions from RPMO when approving three interior renovation projects. During our review, we identified issues concerning the rental income,<sup>6</sup> the reliability of the income and expense model, and maintenance and repair standards that Mr. Cappello did not previously know. These issues are relevant factors in the evaluation process to determine whether to maintain or dispose of quarters buildings. These issues require further action, such as a new market survey for rents and new guidance from VHA officials. We therefore concluded management should re-evaluate plans for Aspinwall quarters units.

### **Conclusion**

We found that VHA spent approximately \$201,000 on the exterior and interior of the Director's Residence, and this spending level exceeded authorized levels. We found that officials other than Mr. Cappello were responsible for some of this excess spending and that VHA needed to improve its headquarters support for quarters operations.

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<sup>6</sup> We discuss problems with the rental income in Allegation 2.

We found no evidence in our review that Mr. Cappello would have initiated renovations of Aspinwall quarters in excess of the limits provided by VHA Supplement to MP-3 if RPMO had not provided the Medical Center with incorrect guidance. Based on instructions from RPMO, Mr. Cappello believed that he had liberal authority to spend medical care dollars on the Aspinwall quarters. We concluded that RPMO's instructions led him to believe that he had greater authority and discretion in approving quarters renovations than policy authorized.

However, Mr. Cappello was personally responsible for reviewing the interior renovation project, which cost the Government \$168,000. The renovation spending increased, in part, because Mr. Cappello did not evaluate and approve expenditures in writing, and he requested more costly quarters amenities. In addition, [REDACTED] did not maintain accurate project records, and [REDACTED] permitted the construction company to work prior to receiving a contract. As a result, in an era of budget tightening, the Medical Center wasted scarce medical care funds by spending more on the Director's Residence than could reasonably be recouped by employee rents. (b)(6)

We also concluded that Medical Center needed to review the financial feasibility of its quarters program based on more accurate information and updated guidance from headquarters.

#### Recommendation 1

We recommend that the Under Secretary for Health:

- a. Update VHA policies concerning operation and maintenance of housekeeping quarters to comply with OMB Circular A-45, including building standards and accurate central monitoring of program administration.
- b. Provide guidance to approving officials to ensure they evaluate expenditures for quarters using an accurate income and expense model, including clarified limits on amortizing major expenditures, such as plumbing systems.
- c. Take appropriate action to ensure officials in the Veterans Integrated Service Networks and the Real Property Management Office review proposals for non-routine spending on quarters in accordance with Department policies and guidance.

### Under Secretary for Health Comments

Concur. The Under Secretary agreed to develop revised VHA guidance to address concerns raised in the report, in consultation with General Counsel and other Department organizations. The primary responsibility for ensuring facility compliance with quarters policies will be the VISN and facility directors. VHA agreed to some form of central monitoring. The RPMO will work on program accountability with the Chief Network Officer, the Chief Financial Officer, and individual VISNs.

### Office of Inspector General Comments

The Under Secretary's comments are responsive to the recommendation. We will continue to follow-up with VHA until it finalizes guidance to address these issues.

### Recommendation 2

We recommend that the Veterans Integrated Service Network No. 4 Director:

- a. Take appropriate action to ensure that Mr. Cappello effectively supervises the quarters program, including requiring that non-routine quarters expenditures be submitted in writing for his review and approval in accordance with VHA policy.
- b. Take appropriate action to ensure that the [REDACTED] effectively (b)(6) manages the quarters maintenance program, including submitting appropriately detailed maintenance plans for approval and accurately tracking expenses.
- c. Take appropriate action to ensure that the [REDACTED] does not (b)(6) permit contractors to proceed before contracts have been signed.
- d. Require the Medical Center to update the expense records for quarters to reflect work from all projects and expenses.
- e. Take appropriate action to ensure that the Medical Center maintains the quarters contained in the Aspinwall historic district in accordance with historic preservation laws and regulations.

### VISN Director Comments

The VISN Director concurred with the findings and recommendations and said the review "should result in producing guidance that will allow VHA to take steps to make cost-effective decisions regarding the protection of government assets" throughout the Department.

The VISN Director agreed to initiate action to improve the facility's performance in this area, including:

- Semi-annual monitoring of the Director's supervision of the quarters program
- Appointment of a Chief Engineer for the VA Pittsburgh Healthcare System
- Implementing a new system to track quarters expenses
- Counseling the Supervisory Contracting Officer
- Updating quarters expense records
- Improving compliance with historic preservation laws and regulations

In response to the draft report, the VISN Director also related additional information to us from the Medical Center. This information contained a detailed estimate of the portion of the Repair Water Mains and Drains project that benefited the Director's Residence. The response also expressed that the station labor costs for the renovation appeared to be excessive and suggested that a consultant should be used to determine a reasonable estimate of the renovation costs. The response also said that garage expenses should be deleted for accuracy, and that the management of the housekeeping quarters units should be turned over to a management company.

#### **Office of Inspector General Comments**

We incorporated the Medical Center's estimate of the portion of the Repair Water Mains and Drains project benefiting the Director's Residence into our final report.

We disagree that the expense records for Building 13 should be adjusted based on industry estimates. We relied on the routine cost transfer records created by Engineering Service supervisors during the renovation project and reviewed by management and Fiscal Service accountants. There was no evidence that any cost transfer contained erroneous information, although some labor costs for the project reportedly increased because of unanticipated problems. VA Policy MP-4, Part V, Section 4E.01, requires that all expenses attributable to the operation and maintenance of quarters shall be identified and recorded. Since the costs transfers provided by management identify renovation expenses for this project and there is no evidence than any of these routine records is erroneous, VA policy requires that these costs be recorded for quarters income and expense determinations. There is no need to expend additional resources to obtain an independent consultant's estimate of what the Medical Center should have spent because policy requires the Medical Center to use the actual costs.

In response to our inquiries concerning the comments about removing charges for the garage repairs, Medical Center officials told us that they could not clearly determine if these expenses were actually included in the Building 13 expense records, as originally asserted in the response. We therefore made no adjustment for these expenses.

We did not review or recommend contracting for property management services for the quarters.

The VISN Director concurred with the findings and recommendation and offered acceptable implementation plans. We will continue to follow-up with this recommendation until it is fully implemented.

Copies of the Under Secretary's and the VISN Director's responses appear in the Appendix.

<b>Allegation 2: VHA Officials Charged Quarters Residents Inappropriate Rental Rates.</b>
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We found that management made unjustified reductions to market-based rents and, for three quarters units, did not establish new rents that included the market value of major renovations.

In August 1992, RPMO approved administrative rent reductions for the Aspinwall housekeeping quarters due to a construction project to build a new hospital building. The approved rent reductions ranged from 3 to 12 percent and did not include the Director's Residence. The last rent appraisal before our review occurred in December 1992, when an independent appraiser determined the fair market, base rent for the Director's Residence was \$825 per month. The appraisal report stated that the appraiser considered the effect of the new hospital construction on the Director's Residence:

The design and layout of the complex have been significantly altered due to the current construction of a 400 bed full care facility that has necessitated the need to adjust for institutional atmosphere, disturbing noises, general attractiveness of neighborhood, including lawns, trees and landscaping.

In January 1993, the previous Medical Center Director submitted the December appraisal to RPMO for approval. The Director's letter indicated that they would continue the 1992 rent reductions, due to ongoing construction. In April 1994, the Acting Director told RPMO that they suspended construction but that rent reductions would continue unless otherwise directed by RPMO. In April 1995, Mr. Cappello told RPMO that they scheduled construction to resume in June 1995 and that they intended to keep the rent reductions. Throughout this period, there was no record that RPMO responded to the Medical Center's declared intent to continue rent reductions.

#### **The Rent Adjustment Process Needs Improvement**

We found problems with the appropriateness, timeliness, and authority for rent reductions for the Aspinwall quarters since the December 1992 appraisal.

*Appropriateness*—VHA Directive 10-93-014 required appraisers to make adjustments for neighborhood conditions in establishing the base rent and authorized administrative reductions only for conditions not considered in the appraisal.<sup>7</sup> The December 1992 appraisals of the Aspinwall quarters indicated the appraiser considered the effects of the new hospital construction when evaluating the rents. Management continued to apply the

<sup>7</sup> The subject of VHA Directive 10-93-014 was rental rate adjustments. The Directive expired in February 1994 and was not reissued. In August 1994, an official with RPMO told the Director at Pittsburgh that the Directive continued to be the operating guidance for management of housekeeping quarters.

August 1992 administrative reductions for construction after receiving the new appraisal. VHA guidance only authorized administrative reductions for conditions not reflected in the appraised base rent and the new appraisal considered the construction cited in the August 1992 administrative reductions. We concluded that extending the 1992 reductions after the new appraisal was inappropriate because the appraiser already considered the effects of construction in determining the December 1992 rental rates.

To justify the reductions, management told RPMO that the new work involved "demolition [to old hospital buildings], disruption to site utilities, noise, dust, vehicular traffic, and essentially all of the elements for which the rents were originally adjusted." OMB Circular A-45, paragraph 7c, provides specific conditions and limits for rent reductions. The OMB regulations do not support administrative reductions for demolition to nearby buildings, temporary disruption of utilities, or changes in traffic. The OMB regulations limit administrative rent reductions for noise and odors to three percent. In this case, management granted rent reductions from 8 to 12 percent for 13 employees. Since the only conditions cited by management for which OMB authorized adjustments were noise and dust, management did not have justification to reduce rents in excess of three percent.

**Timeliness**—The OMB Circular requires that when agencies learn of changes in conditions requiring administrative adjustments, they should normally implement new adjustments within 30 days. According to file documents, the contractor completed the construction of the new hospital by April 1994, and officials anticipated beginning the next construction project in June 1995. During this time, the Medical Center continued to reduce rents as if the construction were still in progress. Since OMB regulations require agencies to implement new adjustments within 30 days, we concluded that management did not take timely action to eliminate administrative adjustments for completed construction. As result, management inappropriately reduced rents for over a year for conditions that no longer existed.

**Authority**—The VHA Directive delegated directors of healthcare facilities the authority to make annual cost-of-living adjustments to quarters rents. The Directive reserves the authority to approve administrative adjustments other than for inflation to CO. According to Medical Center records, RPMO last approved administrative rent reductions at Aspinwall in August 1992. Since then, the Medical Center informed RPMO that they intended to extend the 1992 rent reductions unless otherwise directed. The Medical Center kept RPMO informed of plans to continue using the 1992 reductions after the new appraisal for new conditions such as traffic and during periods between construction projects. We found no record that RPMO either approved or disapproved the Medical Center's decisions. We therefore concluded that RPMO did not fulfill its responsibility to review rent adjustments in accordance with OMB guidelines and left the process of approving rent adjustments to local officials.

**The Medical Center Needs to Obtain Timely Appraisals on Renovated Quarters**

In March 1995, Mr. Cappello moved into the renovated Director's Residence. The inflation-indexed monthly base rent on the Director's Residence was \$861. The rent amount computed by Engineering Service was \$792, which was eight percent less than the indexed appraised value. Management also reduced the rent on the Director's Residence below the indexed appraised value in March 1996. The Director moved out of the Director's Residence in the beginning of April 1996.

VHA Directive 10-93-014, Attachment C, paragraph 4c, states that housekeeping quarters should be re-appraised every five years or when alterations or improvements affect their value. In Fiscal Year 1995, the Medical Center renovated the interiors of three quarters units, including Mr. Cappello's residence. Medical Center officials told us they expected the renovations to increase quarters rents. Mr. Cappello occupied the renovated quarters from March 1995 until April 1996. At the beginning of our review, Mr. Cappello and two other employees continued to pay rents based on the adjusted 1992 appraisal, rather than the market value of the renovated quarters. Since the Medical Center was required to obtain new appraisals for the 1995 renovations and had not done so at the time of our review, we concluded that the new appraisals are not timely.<sup>8</sup>

**Below Market Rents Inappropriately Benefited Employees**

During our review, we found that the Medical Center made improper rent reductions and did not obtain new appraisals, as required. OMB Circular A-45 requires that rental rates for quarters reflect the prevailing market rates, unless the agency makes an adjustment for specific factors not reflected in the appraisal. According to OMB regulations, officials may not set quarters rents so as to provide a housing subsidy. From 1993 through the time of our review, the Medical Center made inappropriate reductions to the market valued rents, including for Mr. Cappello. We therefore concluded that these employees received an inappropriate benefit from inaccurately determined rental rates.

Untimely appraisals also wrongly benefited employees. According to the contractor, his company completed the quarters renovations by May 8, 1995. VHA Directive 10-93-014 requires officials to obtain new appraisals when alterations and reconditioning improve their value. We therefore concluded that the Medical Center should have initiated new appraisals in May 1995.

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<sup>8</sup> While our report was in draft, the Medical Center obtained a new quarters appraisal which concluded that the market-based rent value of the renovated quarters was significantly higher than the current rents. Medical Center officials appealed this appraisal to RPMO, and the current market value of quarters rents had not been determined when this report was finalized.

In June and July 1995, the Medical Center converted a sun porch in the Director's Residence to a den. In July 1995, the Director conferred with the Acting Engineering Chief in response to public allegations concerning wasteful spending on the Director's Residence.<sup>9</sup> The Acting Engineering Chief told the Director in writing that they planned to obtain a new appraisal on the Director's Residence as soon as Engineering completed current work. There are no records of additional project expenditures after July 1995.

Mr. Cappello told us that he learned an appraisal was required at this time and he expected his rent to increase based on the renovations. We were not able to reliably determine who was responsible for the decision to further delay obtaining the appraisal. However, it is clear that Mr. Cappello should have known the appraisal did not occur because he continued to pay rent based on the 1992 appraisal. As the Medical Center Director, Mr. Cappello was responsible for ensuring that he and his subordinates function within the rules. By failing to ensure that the Medical Center secured a timely reappraisal, Mr. Cappello did not fulfill an important quarters responsibility. He also benefited from his inaction by continuing to pay rents based on the unrenovated quarters.

### Conclusion

We found that before Mr. Cappello's arrival, the Medical Center began inappropriately reducing quarters rents for different construction project conditions. As part of this practice, management inappropriately granted reductions for conditions inconsistent with OMB guidance. We found that the Medical Center kept RPMO informed of these practices, and the office did not respond. After Mr. Cappello arrived, the Medical Center continued this practice and also delayed obtaining a required market appraisal for renovated quarters, including Mr. Cappello's. This resulted in unauthorized, below-market rental charges, in violation of the OMB Circular.

During our review, we also found that VHA did not have current official policies to ensure that officials set rents in accordance with Federal rules and regulations.

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<sup>9</sup> The VA Hotline also received this complaint and referred it to Special Inquiries.

**Recommendation 3**

We recommend that the Under Secretary for Health:

- a. Issue quarters policies establishing a rent adjustment process in compliance with OMB Circular A-45 and Federal ethics regulations.
- b. Ensure that RPMO officials review proposed rent adjustments in accordance with VHA policies and Federal ethics regulations.

**Under Secretary for Health Comments**

Concur in principle. RPMO is implementing the Department of Interior's Quarters Management Information System (QMIS) for VHA and is working with the VISNs to develop interim field guidelines. The QMIS system will provide improve compliance with OMB requirements for rents and rent adjustments but requires less administrative workload.

**Office of Inspector General Comments**

The Under Secretary concurred in principal and offered acceptable implementation plans. We will follow-up on this recommendation until VHA issues appropriate field guidance.

**Recommendation 4**

We recommend that the Veterans Integrated Service Network No. 4 Director:

- a. Take appropriate action to ensure that the Mr. Cappello and the Acting Engineering Chief improve their quarters rent management performance.
- b. Direct the Medical Center to make rent reductions only after they are explicitly approved in accordance with VHA guidance and to obtain a new appraisal of the quarters at Aspinwall from a qualified independent appraiser.
- c. Take appropriate action to recover lost rental income from Mr. Cappello and other residents caused by inappropriate reductions for construction.
- d. Using the new appraisal, initiate action to recover lost rental income from Mr. Cappello and other residents caused by untimely reappraisal of the renovated quarters.

**VISN Director Comments**

The VISN Director agreed to take action to improve the quarters rent management and agreed that future rent reductions would require explicit, written instructions. The VISN Director agreed to implement new rents within 30 days of receiving a current market appraisal. He also agreed to recover from Mr. Cappello rents lost due to untimely appraisals. Since the employee-tenants of the rental units most likely did not know of the improper rent reductions or the delay in getting new appraisals, the VISN nonconcurred in the other recommended collection actions.

**Office of Inspector General**

After receiving the initial VISN response on these recommendations, we contacted the VISN Office and suggested that appropriate collections be made. Then, VHA could assist the employees in filing any waiver claims prompted by the collection actions. The VISN Office reconsidered their original response and agreed to all collections as recommended. We will continue to follow-up with the VISN Director on recommendations 4c and 4d until they are fully implemented. We consider the remaining issues resolved.

Copies of the Under Secretary's and the VISN Director's responses appear in the Appendix.

Comments by the Under Secretary for Health and  
Director, Veterans Integrated Service Network No. 4Department of  
Veterans Affairs

## Memorandum

DATE: DEC 3 1997

FROM: Under Secretary for Health (10/105F)

SUB: OIG Draft Report: *Special Inquiry About Alleged Mismanagement of  
the Housekeeping Quarters at University Drive, VAMC Pittsburgh,  
Penn.*TO: Assistant Inspector General for Departmental Reviews and Management  
Support (53)

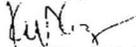
1. The findings of this Special Inquiry have been reviewed by relevant Headquarters program officials, who concur in those recommendations that specifically address intervention at this level. The attached action plan provides a comprehensive response to Recommendations 1 and 3.
2. The Real Property Management Office (RPMO) is in the process of completely revising and updating the VHA directive on operating and maintaining facility housekeeping quarters. The directive, which is anticipated to be completed for distribution to all field facilities by June 1997, will be significantly broader in scope and detail than the existing document. Many of the issues identified in your report will be addressed in the new guidance. Included among our initiatives to streamline quarters maintenance processes throughout the system are potential plans to implement the Quarters Management Information System (QMIS) that is utilized by the Department of Interior. This computer model is compatible with OMB directives and has been pilot tested in three of our facilities with very positive results in terms of resource savings. The model, which uses a regional survey methodology to determine rental adjustments, is still being evaluated prior to formal approval. If implemented, it should greatly enhance our ability to validly and objectively determine rental rates in a more efficient manner.
3. Your report implies need for more accountability control at the Headquarters level. As you know, our reorganizational efforts are still quite young, and one of the challenges that we are working through is achieving the right balance between systemwide discipline, conformity and consistency while at the same time encouraging local and regional flexibility, innovation and entrepreneurship. We recognize need for some degree of central oversight in cases like this, and are

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working with the individual VISNs and treatment facilities to identify the most effective and practical ways to accomplish such oversight.

4. Thank you for the opportunity to respond to this report. If additional assistance is required, please contact Paul C. Gibert, Jr., Director, Management Review Service (105E), Office of Policy, Planning and Performance (105), at 273-8355.



Kenneth W. Kizer, M.D., M.P.H.

Attachment

Department of  
Veterans Affairs

## Memorandum

Date: November 7, 1996  
 From: Network Director, VSN 4 (10/N4)  
 Subj: Draft OIG Report, Project 5HL-57/2  
 To: Director, Hotline and Special Inquiries Division, Office of Inspector General (53E)

1. I reviewed the subject report and discussed the content with management at the VA Medical Center in Pittsburgh. This draft report appears to be a very comprehensive review of housekeeping quarters. The audit should result in producing guidance that will allow VHA to take steps to make cost-effective decisions regarding the prioritization of government assets; namely, the many housekeeping units throughout VSN 4 and the entire Department of Veterans Affairs.

2. With regard to ISSUE M1 recommendations:

a. We concur that appropriate action should be taken to ensure Mr. Cappello supervises quarters maintenance in accordance with existing policies and in accordance with forthcoming VHA updated policies. This supervision includes requiring that non-routine quarters expenditures be submitted in writing for his review and approval, in accordance with VHA policy. Mr. Cappello's activity in this area will be monitored by the VSN 4 office semi-annually.

b. We concur that appropriate action should be taken to ensure the Chief, Engineering Service manages the quarters maintenance program in accordance with VHA policy and in particular submits appropriately detailed maintenance plans for approval and accurately tracks expenses.

- A Chief of Engineering Service has been appointed for the newly consolidated VA Pittsburgh Healthcare System. Quarters maintenance will be an element in his performance plan, and will be monitored by the medical center director semi-annually.

- A new system for approving all work done in quarters and the tracking of all expenses has been implemented. This new system of checks and balances will ensure that work cannot occur without appropriate approvals, and will more accurately account for the time and expenses of station labor.

c. We concur that [REDACTED] in the future will not permit contractors to proceed before contracts have been signed. (b)(6)

[REDACTED] is aware that [REDACTED] as aware that contractors will not be permitted to proceed until contracts have been signed. (b)(6)

d. We concur that expense records for quarters should reflect work from all projects and expenses. All quarters expense records will be updated by January 31, 1997.

e. We concur that medical center management should maintain the quarters contained in the Aspinwall historical district in accordance with historic preservation laws and regulations.

- Medical center records will be updated to ensure that all buildings in the historic district are clearly and prominently identified and quarters will be maintained in accordance with historic preservation laws and regulations.

3. With regard to ESSUR #2 recommendations:

a. We concur that action should be taken to ensure that the quarters rent management program performance is improved. The rent management program performance will be addressed in both the Director's and Chief, Engineering Service's performance plans, and will be monitored by the VSN 4 office semi-annually.

b. We concur. Future rent reductions will only be executed with written, explicit approval. After independent reappraisals have been secured for all quarters on the Aspinwall Campus, these new rents will be implemented following a 30 day notice to tenants.

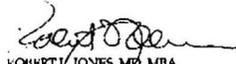
c. We do not concur that lost rental accrued in rent reductions for consideration of construction should be recovered from Mr. Cappello and other residents. Medical center management reasonably informed the Real Property Management Office that it intended to implement these reductions and would consider the intention approved unless they heard otherwise. Having received no response (either orally or in writing) to these requests, it was reasonable to assume the proposed actions were approved. These reductions were in effect since 1992 and each year the Real Property Management Office was notified. Many of the individuals who lived in these units during this time period have since transferred, resigned, or retired, making collection efforts difficult and costly.

We do concur that lost rent caused by untimely reappraisals of renovated quarters should be recovered from Mr. Cappello. The lost rents from the other occupants of renovated quarters should be forgiven because these tenants had no responsibilities with regard to quarters rents or maintenance and paid rents in good faith, according to what they were told was the effective rent for their quarters. Rent collections from Mr. Cappello can be effected through payroll deductions once the new rental rates are approved and implemented.

4. We have attached an analysis conducted by medical center management of the draft report and work papers provided by your office. We particularly agree that adjustments to the final costs allocated for the centrally approved project of Repair Water Mains and Drains be adjusted to \$33,132.33. We also concur that the costs transferred for station labor are excessive and should be adjusted to what are reasonable labor costs for work completed. It would appear that 2305 hours are excessive by any standard. We believe the medical

center's suggestion of obtaining an independent cost estimation would surely result in a more meaningful cost transfer. I concur with medical center management that garage expenses should be deleted for accuracy purposes. We also agree with the recommendation to turn VA Housekeeping Units over to a land management company to manage, in accordance with the principle of ensuring they are maintained properly and are self-sustaining.

5. We appreciate the opportunity to review the draft report. This report has the potential to produce sound guidance and rules for the VHA quarters maintenance program and will certainly improve the VA Pittsburgh Healthcare System's performance regarding quarters maintenance.



ROBERT L. JONES, MPA, MBA

Mr. EVERETT. And at this point we thank you very much for your testimony, and this panel is dismissed.

We will now ask for panel three to be seated—Mr. Merriman. Let me ask you to rise again and raise your right hand.

[Witnesses sworn.]

Thank you. Please be seated.

**TESTIMONY OF WILLIAM T. MERRIMAN, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MAUREEN REGAN, COUNSELOR TO THE VETERANS AFFAIRS INSPECTOR GENERAL, AND MICHAEL STALEY, DIRECTOR, HOTLINE AND SPECIAL INQUIRIES**

Mr. EVERETT. Mr. Merriman, if you'll introduce your staff, and then please feel free to start.

Mr. MERRIMAN. Mr. Chairman and members of the committee, I am pleased to be here today to discuss two reviews conducted by the IG of alleged mismanagement by senior officials. These reviews involve the VA Medical Centers in Charleston, SC and Pittsburgh, PA. With your permission, I'd like to enter my prepared statement into the record, which addresses these reports, and use this opportunity to discuss the IG's role and responsibility when reviewing and reporting on allegations of mismanagement.

Mr. EVERETT. Without objection.

Mr. MERRIMAN. I'd like to start by saying that the IG takes allegations of mismanagement by senior managers very seriously, and when such allegations are brought to our attention, they are pursued vigorously. In doing so, our goal is to perform an independent, objective review of the facts surrounding each allegation in order to determine whether the allegation is true or not.

Substantiated allegations can sometimes lead to recommendations for appropriate administrative action. For example, incidents of misconduct involving violations of law, rule, or regulation would generally give rise to a recommendation for appropriate administrative action. However, in accordance with standard practice in the IG community, we do not recommend the specific punishments. The decision whether to take action and the specific action that is appropriate is the responsibility of the management official who supervises the employee in question. In our view, it would compromise the IG's independence if the IG recommended specific penalties or disciplinary actions.

The IG function of objective oversight makes it especially important that the line between VA management responsibilities and the IG responsibilities be respected. Decisions concerning specific disciplinary are a management responsibility vested in the deciding management official who must consider the Douglas factors and whether the action is consistent with the Department's prescribed table of penalties for specific conduct violations. The Douglas factors include such things as the nature and seriousness of the offense, past disciplinary, and work records, the employee's grade level, penalties previously imposed for similar behavior, and other considerations.

On the other hand, substantiated allegations of mismanagement do not often result in recommendations for appropriate administrative action. For example, a finding that doesn't give rise to discipli-

nary actions, such as a poor management decision, is a performance-based problem that is more appropriately dealt with by VA management in performance evaluations. In such situations the IG's role is to identify the facts, present them to the Department, and make recommendations for corrective action to prevent the identified problem from recurring. A decision to take a performance-based action based on an IG finding is once again a management responsibility.

And I'd like to add that just because the IG does not make a recommendation for appropriate administrative action for performance-related problems, it does not relieve VA management of their responsibility to deal effectively with problem employees. IG managers have been asked why we don't make judgment calls on the overall management of an individual when there are substantiated allegations against that individual. I believe the answer to this is relevant to the two special inquiry reports that are the focus of today's hearings.

The reason we do not make a judgment call on whether an individual is a satisfactory or unsatisfactory manager, is that our reviews are confined to the evidence that can be collected on specific allegations. Our reviews do not extend to the countless other decisions made by managers in fulfilling their duties and responsibilities, which form the overall basis for evaluating total performance. Even if the IG substantiates allegations, the IG is not in a position to evaluate or comment on an individual's total performance, nor is it the IG's responsibility. Assessing overall employee performance is the responsibility of the managers. The IG's responsibility is to examine the circumstances relevant to the allegations it receives, draw conclusions concerning these allegations, and report the results, along with recommendations for appropriate action or corrective action, if warranted.

Thank you, Mr. Chairman, for the opportunity to provide my views on this matter. I'll be pleased to respond to any questions you or the committee members may have concerning my statement or the work of the IG office concerning the VA medical centers at Charleston and Pittsburgh.

[The prepared statement of Mr. Merriman appears on p. 170.]

Mr. EVERETT. I hardly know where to begin, but let me start by perhaps repeating and say, did you find mismanagement at Charleston VA Medical Clinic, or waste or abuse?

Mr. MERRIMAN. In certain instances that we looked at, we found the evidence of poor management. Whether Mr. Billik is a poor manager, I can't answer, for the reasons I described in my statement. I don't know his overall performance as a manager.

Mr. EVERETT. State for me again the reasons, if you find incidents where poor management took place, if you can't describe whoever is responsible for that as being guilty of mismanagement.

Mr. MERRIMAN. Well, I—

Mr. EVERETT. That sounds like a bureaucratic runaround—

Mr. MERRIMAN. Well, I really don't think it is, Mr. Chairman.

Mr. EVERETT (continuing). After the fact that it's identified.

Mr. MERRIMAN. I understand what you're saying, and I understand the frustration of the issue. But if we look at a decision he made and we find it to be a bad decision, and there was waste in-

volved, we call it that. We expect his supervisors to take that into account with his total performance as a manager of that facility. I can't say that he hasn't improved care to veterans in other things he's doing that we haven't been asked to look at or haven't considered. We expect management to do that. I am not a surrogate for the Department's managers.

Mr. EVERETT. If management is doing the mismanagement, how can you expect management to do that?

Mr. MERRIMAN. Well, I expect that the director of a facility may make some poor decisions. We may call him on that. I would expect his supervisors, the VISN directors, to take this into account when they perform his annual performance rating.

Mr. EVERETT. Would you describe poor management as mismanagement?

Mr. MERRIMAN. In the instances involved, yes.

Mr. EVERETT. Well, again, I get back to what my colleague, Mr. Mascara said: Somewhere it seems to me that we're going to have to find somebody somewhere responsible. And it's getting more and more difficult to do that. We can't pin the tail on the donkey. I don't know what's happening, but apparently, if we're ever going to change the culture in the VA—as a matter of fact, if the VA is going to survive, it has got to change that culture. It cannot continue to exist in its present form. It cannot do that. It's losing the patience of this Congress, of this committee. It's losing the patience of the veterans. It's losing the patience of the public, and unless it wakes up, has a big awakening, it's just not going to survive. Now that's about as plain as I can put it.

Now I don't know if the rules and regulations that have to be followed by the VA office need to be re-evaluated, but somehow somewhere we're going to have find somebody that takes responsibility for this stuff. I am convinced there are millions of dollars wasted each year by the VA. There's no question in my mind about that. And I think that any career employee would tell you that it's probably true.

We cannot continue to pump taxpayer dollars into the VA and tolerate this kind of mismanagement. We just can't do it. These people are making six-figure salaries. Now you ought to be able to expect some degree of capability from people who are making that kind of salary. And this committee has found on occasion after occasion where these people who are making that kind of salary are poor managers, guilty of sexual harassment, and they're just moved to another place—in some cases one was given a \$25,000 buyout. This is incredible.

Like my colleague, I come out of a business background, and I tell you what, these people couldn't survive 2 minutes in a business background, but under the bureaucratic situation that we have, the culture we have in the VA, they apparently not only survive, but prosper. And I find that, frankly—it's just despicable. It really is.

Let me mention also, in response to certain requests, you interviewed the former Director and some other VAMC Charleston employees were interviewed, and you determined that the former Director was having a close personal relationship, to use your words, with an employee at the time who was promoted to the GS-13 level. "Results of these interviews were," and I'm reading from your

report, "were reviewed by the OIG counsel to determine whether the relationship created a hostile work environment as defined under title 7 of the Civil Rights Act." It was determined that a hostile work environment, as described under title 7, was not created. That is obviously in direct contrast to the testimony that we received from the employees this morning testifying from the Charleston VA facility.

Mr. MERRIMAN. I'll let Ms. Regan, who's with me as my counsel, address that in a minute, but I think there's a differentiation here between what is merely a hostile work environment. Clearly, the employees did not like the situation. It created a hostile environment with the employees, but for title 7 purposes of the Civil Rights Act, and whether a person can be prosecuted for a violation of it, it didn't meet the requirements. We're not saying that the employees liked the situation or it didn't have an impact on the employees. We're saying that to take action against him under title 7 of the act, it didn't meet those criteria.

Ms. REGAN. I think there's a difference between a hostile work environment, because people don't like—

Mr. EVERETT. Please state your name for the record.

Ms. REGAN. Maureen Regan. I'm the counselor to the Inspector General.

The term you're using "a hostile work environment," under title 7 is strictly limited, and according to the Supreme Court—has to do with a sexually-charged, unwelcome sexually-charged environment. That's not what was alleged in this environment. There was a relationship. But the case law is replete with quotes from the EEO guidelines that state that, the preferential treatment of a par-amour or somebody else based on an intimate relationship does not give rise to a title 7 claim, because everybody, both genders, not having the relationship is treated equally. It may be preferential treatment; it may fall under other statutes. It does not create a hostile environment under title 7.

And nobody complained to us about unwelcome sexual behavior or anything else while we were down there. So the hostile environment issue is not a title 7 claim.

Mr. EVERETT. I noted that an information letter sent last June by Dr. Kizer, the Under Secretary for Health, on the relationship between managers and subordinates, states that the standards require that even creating the appearance of using public office for private gain violates the standard. Is this the situation with Mr. Billik? Did he create that?

Ms. REGAN. We looked at every law that could possibly apply to what occurred in this case. We went down the list, and now we're looking at ethics regulations. We put that together; we have sent the issue to the Office of General Counsel, and they are reviewing it because they are the ethics officer for the agency. If there's a violation, they're the ones to make the call. It would be a public office for private gain under the ethics rules, the standards of ethical conduct for Executive Branch employees.

Mr. EVERETT. Could you give me an example of what would violate title 7? For instance, did you explore whether or not Mr. Billik and this employee were living in the same house?

Ms. REGAN. It would not have made a difference under title 7, and in fact I could not find a single case where because of an individual having a relationship with another, that a third party could claim hostile work environment. They allude to it in the case law if there was a sexually-charged environment. If there was a lot of touching going on at work, if they were kissing in front of other people, whatever they were doing in the work environment that was sexual in nature, that offended other people, it might give rise to a hostile work environment, but not preferential treatment no matter what the relationship was. That might fall into other legal violations.

For example, we looked at whether it a violation of 2302(b)(6), the promotion. It didn't fall into that. We went down the list. We could not find that there was a title 7 violation, and nobody complained about discrimination to us.

Mr. EVERETT. Of course, we have testimony from employees that the employees were well aware of this relationship and were upset by this relationship. Did you talk to employees who said that to you?

Ms. REGAN. We've talked to employees about the relationship, but that relationship, under the EEO guidelines, does not give rise to a title 7 claim, because the men and the women would both feel they were discriminated against, based on that relationship. It does not give rise to a title 7 claim. It may give rise to other problems, management issues, an ethics violation, but not a title 7 claim.

Mr. EVERETT. In other words, although these employees felt that the relationship caused a promotion that was undue and promoted this individual above other individuals, that does not under title 7 create a hostile environment?

Ms. REGAN. It doesn't create a hostile environment, and it does not create a cause of action for discrimination. As the case law and the guidelines say, both genders are equally discriminated against because they're not involved in the relationship.

Mr. EVERETT. In other words, if I discriminate against a man and a woman, then I'm not guilty?

Ms. REGAN. Of a title 7 action. It does not give rise to a title 7 claim. I mean, the guidelines are fairly——

Mr. EVERETT. Remarkable.

Ms. REGAN (continuing). Clear. It says, "Preferential treatment may be unfair, but it is not discrimination under title 7." And that's the EEOC's guidelines. And the case law—I believe it's all the way up to the Supreme Court—cites that in cases.

Mr. EVERETT. Thank you. My time has run out. We may have a second round.

Now, Mr. Clyburn?

Mr. CLYBURN. Mr. Chairman, let me go to Mr. Merriman first, but I think I want to come back to this issue because I'm missing something.

Mr. Merriman, Mr. Truesdell indicates that your office failed to interview people who you should have interviewed, and that you watered-down some of the complaints; and, thirdly, that the confidentiality of your hotline was compromised. Now can you address those three issues for me, please?

Mr. MERRIMAN. Sure. I'm not aware of the confidentiality of our hotline being compromised. It is possible that as we start to review allegations, people may guess who gave them to us. We take great pride in defending the confidentiality of the people who come in with a hotline complaint. As a matter of fact, as you may be aware, there's a companion report on Charleston that we issued after somebody claimed retaliation for dealing with IG. We went in and we looked at, and we found they were retaliated against. We issued a report and action was taken.

Mr. CLYBURN. Yes.

Mr. MERRIMAN. So we protect the confidentiality of people. Sometimes it's impossible—well, people will assume who made the claim and perhaps pursue action against them, but not because we released the name.

With respect to who we interviewed and who we didn't, what I'd like to do is let Mr. Mike Staley, who's the Director of our Hotline Special Inquiries Group, speak to that question. I'd like to have him explain to you what he and our other reviewer did down in Charleston, how many they talked to, and what efforts they took to make themselves available to people.

Mr. STALEY. Yes, sir. We talked to about 50 people at least down there in three separate visits. We went down in August. We went down again in September. We also went down in late October.

We published a report on 27 of the allegations, and in page 5 of the report, we did indicate in the scope of our review that we were continuing to look at other issues, which we have done and which we are continuing to do.

So—

Mr. MERRIMAN. We had 27 items in the report. We probably looked at another 13 or 14 after we got back. We have two criminal investigations ongoing with allegations that were brought to us. Mr. Staley interviewed people off-campus or on-campus, whatever made them most comfortable. We called people who we thought were interested in talking to us. Some of them didn't show up. Some of them chose not to talk to us. We've talked to others subsequently who had nothing to contribute. So I think we've made an effort to touch the people that had an interest or knowledge in the situation existing in Charleston.

Mr. CLYBURN. Okay. Mr. Chairman, I want to get back to—is it Ms. Regan?—

Ms. REGAN. Regan.

Mr. CLYBURN (continuing). Ms. Regan's understanding of title 7. Now unless I missed something in my other life, my memory tells me that in a workplace, if—and I'm going to be a little bit vivid here, if I may, in order to make my point, because I don't want anybody to misunderstand what I'm saying—if a gentleman with authority over the workplace gives favorable treatment to a lady because they have a relationship away from the workplace, and that favorable treatment works to the detriment of other people in the workplace who should have gotten the promotion, now that's a violation. And you're telling me that it's not?

Ms. REGAN. I'm telling you that the 1990 EEOC guidelines specifically state that preferential treatment based on an intimate relationship—I think they even used the word "paramour"—does not

give rise to a title 7 claim. There are multiple cases on that, which I'd be happy to send to you, because I've pulled up every single one of them. And it's over and over again. When that started, I'm not sure, but I do know that since 1990—in fact, there was something similar in place just before that. In every case in which a title 7 claim has been brought based on preferential treatment because of an intimate relationship between two individuals, the claim's been denied. And these are Federal court cases.

Mr. CLYBURN. Okay. I certainly would like for you to submit that to me——

Ms. REGAN. Sure.

Mr. CLYBURN (continuing). Because I certainly operated differently.

But you told me that preferential treatment—I thought that language, that term, is in fact in title 7?

Ms. REGAN. I believe it's preferential treatment based on gender, but the problem, and what the courts have found, is that members of both genders who are not part of the relationship are treated equally. In other words, they're both discriminated against. Therefore, it doesn't give rise to a title 7 claim. It wouldn't be that just women would be discriminated against and men wouldn't, but that's the case law——

Mr. CLYBURN. So you're telling me if a gentleman there says, hey, wait a minute, I want you to treat me the same way; I want you to have a close relationship with me, too, then that's what it would take?

Ms. REGAN. Both women and men not involved in the relationship would not be entitled to the promotion. Therefore, both genders are equally discriminated against, and it doesn't give rise to a title 7 claim.

Mr. CLYBURN. You're going to have to show me that because——

Ms. REGAN. I'd be happy to submit the cases to you. I've got a stack of them.

(The information is retained in committee file.)

Mr. CLYBURN. Well, okay. Let me take this one step further. Why is it, then, that your office would have to limit itself to concerns of what may or may not violate title 7? Why can't you look at the 1983 statute? Why do you have to limit it to title 7? It certainly violates equal protection.

Ms. REGAN. We looked at it under every law we could find, and what happened——

Mr. CLYBURN. So, then, did you pursue this, then—you keep talking about title 7. I looked at this report here——

Ms. REGAN. That was the question to me. The question to me, the hostile work environment comes under title 7.

Mr. CLYBURN. Okay. I want to go beyond title 7. I want to go beyond title 7. I want to go to section 1983. Does this violate the 1983 statute? Would this kind of behavior violate 1983?

Ms. REGAN. In 1983 it may not have, but in the 1990——

Mr. CLYBURN. Did you pursue that?

Ms. REGAN. No, because——

Mr. CLYBURN. No, wait a minute. I'm not talking about the year 1983; I'm talking about section 1983 of the Civil Rights Act, the code that——

Ms. REGAN. I don't believe I looked at that specifically.

Mr. CLYBURN. I'm sorry?

Ms. REGAN. I don't believe I looked at that specifically. I may have, and I looked at all the cases in which they talked about a hostile work environment; they talked about preferential treatment based on a relationship, and could not find cases where it was found to be a violation of title 7. Hostile work environment is part of that. That's why we looked at it, because that was the allegation.

Mr. CLYBURN. Okay. Well, let's forget about hostile work environments and talk about all this language that's drawn up around this since even before the Civil Rights Act of 1966. Let's look at what's been there since 1868—I'm sorry, maybe 1877, when the United States Congress created a cause of action based upon the 14th Amendment which drew out of contract law, that I think the law had to do with black people having the same rights to enter into contracts that white people had. That's called section 1983. Now out of that, and since the employment situation is in fact a contract, we have had all kinds of law to have drawn up here in the past 30 years around this issue, and in many instances when title 7, the statute, has not been adequate, most of these issues have been pursued under section 1983, because it deals with equal protection of the law. And you're telling me that the people in this work environment who did not get treated the same way that the person who participated in the preferential sexual activity, that they did not have their constitutional rights in the contract violated?

Ms. REGAN. First of all, there was no individual that claimed that they were entitled to any promotion that this individual got based on the relationship. That was No. 1. I have researched all of the cases on this issue and cannot find a case in which they have sustained the plaintiff's claim. So I'll go back and look at it specifically on the issue that you're citing, but I don't believe there's a case that supports that position under these circumstances.

That's why we went on to look at prohibited personnel practices and ethics violations, which specifically talk about preferential treatment and friendships because we were moving down as we researched the various case laws.

Mr. EVERETT. Would the gentleman yield?

Mr. CLYBURN. Yes, sir, I'll yield.

Mr. EVERETT. In this particular situation the female was promoted noncompetitively. I understand the Director had the discretion to do that. The question is, since he obviously was not able to make an impartial decision, should he have done that, and did you make a judgment on it?

Ms. REGAN. We looked at it from the issue of whether or not it was a prohibited personnel practice under 2302(b)(6), and we found that it was done according to the government's rules and regulations, that the individual was doing the work of a 13, and it was classified by an individual, not the Director, at that point in time. That's what we looked at.

We've also looked at it where I think you might be coming into, whether or not he as the Director having the relationship should have done it. That would come under an ethics violation, and that's why we referred it to the Department's Ethics Officer.

Mr. CLYBURN. Mr. Chairman, I don't want to beat a dead horse here, and I'm not going to, but since this horse may not be dead, let me take another stab.

I would like very much for this panel to step outside of the vacuum that it's operating in because in my experiences in this area the courts will rule on situations brought under statute without taking into account that the very same fact situation, even admitting—if you remember the case of *McLean v. Patterson*—what was it?—Patterson Credit Union. In that case, there was a clear violation, but because a young lady brought her claim under title 7, the Court said, well, no, this is not a title 7 violation. If you had come here under 1983, it might have been different.

All I'm saying to you, if these allegations that come to you—you know, a lot of people working in these workplaces, they don't know that title 7 of the Civil Rights Act may or may not be limited to statutory construction. I mean, they know when they are receiving unfair treatment or they know when somebody's getting preferential treatment that should have gone to them, and I think that those of us in authority with the power, if you please, ought to really help these people along sometimes, especially when you know that's right.

I don't think that anybody on this panel thinks it's right for any supervisor to bring a paramour in, promote them up around everybody else who's been there toiling in the vineyards, waiting on that promotion, but because he or she is not sleeping with the supervisor, they can go ahead and suffer detrimental treatment because of it, and that's right, just because the statute doesn't address it.

But we've got something called the Constitution in this country, and the 14th Amendment of the Constitution deals with due process and equal protection of the law.

Ms. REGAN. I wouldn't disagree with you, but from a factual standpoint, we did not determine that a paramour was brought in. In fact, the only thing we've been able to substantiate is the last promotion might be related to a relationship.

Mr. CLYBURN. I only used that term because you used it in dealing with what the EEOC guidelines were.

Ms. REGAN. Okay, but the factual is nobody was brought in because of a relationship. I don't disagree with you, but nobody has alleged to us that they were denied something because of this relationship. What's been said is that people knew it was going on, and initially it was that the whole office—and, in fact, I thought I heard that today—was getting preferential treatment over other people in the hospital, and not specifically because of this relationship. This was one out of five people that were brought to our attention.

And I don't disagree with you. But, our job under the IG Act is supposed to be looking at violations of law, rule, or regulation, and that's what we try to look for. And if we find other problems, then we'll bring them to management's attention, but that's not where our focus is because of the statute. And like I said, we looked at it from all angles and we were left with the ethics violation, or potential ethics violation, which is why we referred it to the Department, which is what we're supposed to do.

Mr. MERRIMAN. We put some time into this, Mr. Clyburn. I testified on a sexual harassment hearing and we went down this same

path, and I knew you were going to have your blowtorch on me on the point again. [Laughter.]

But we really tried to take a look at it. I mean, you can turn it around. You can say that he promoted some other people through accretion of duties. Two of those five, they did go outside the Department, at least outside the hospital, to get advice from either somebody in Central Office, I think, for a fiscal officer job, and the district office for the engineering job. They were all found to be qualified for it. No one said that this lady didn't have the qualifications. Now if you went ahead and promoted the other ones for accretion of duty, does she have a cause of action if she doesn't get promoted, if she's doing the work?

Once you enter this environment where you have a relationship with somebody, whether it's an intimate relationship or whether you're just personally involved with them—seen as playing golf with them all the time; a prudent manager would do something to protect himself—

Mr. CLYBURN. Absolutely.

Mr. MERRIMAN (continuing). From these kinds of allegations. I would like to think most managers would have found a way to build some separation in and avoided the kind of allegations that we have to deal with here. That certainly was—

Mr. CLYBURN. Mr. Merriman, you're absolutely correct. I agree with you totally—with the exception of the fact that I don't have a blowtorch. [Laughter.]

But the rest of it I agree with.

I don't have a problem with that. My only problem is I would hate for this subcommittee to go through all of this, look at your statement and this whole section—and I didn't raise it here today; my good friend, Mr. Everett, raised this issue, though I had it underlined to raise, I might note. [Laughter.]

But for us to go through all of this, and then for the employees back at the Ralph H. Johnson Medical Center to think that this subcommittee dismissed it, ignored it, didn't even pursue it, when it's obviously unfair—and I agree with you, Ms. Regan, there are a lot of things that are unfair that may not be unlawful. And in my 18 years of managing the agency dealing with this, I can tell you I've been beaten up a lot of times for confining my findings to unlawful activity as opposed to what people felt may have been unfair. I understand all of that.

But there are some unfair things that are in fact unlawful, and I want this committee to do its job and address these things that we know could very well be unlawful if you look beyond the statute or behind the statute and look at the constitutional rights that people have in the workplace. That's all.

So I want to make sure that's on the record, so when I go back down to Charleston, as I will next year, talking to these employees, they won't be pulling this out and saying, you know, "We had a problem here that you refused to address," because I'm going to address it, and I think that we need to make sure that we put it in the proper context.

Mr. EVERETT. My friend, Mr. Clyburn, has expressed the concerns of the chairman very well. Before I turn it over to Mr. Mascara, it seems to me that it is obviously—I know it's unfair, but it

seems to me it would also be the cause for some sort of action, in a noncompetitive promotion, where someone has a close relationship with the person that they promote, if other people are equally qualified, it seems to me that they've been discriminated against.

And I have a problem with the fact that when you discriminate against a man—as long as we discriminate against a woman, then it's okay, and essentially that's what title 7—you're telling me title 7 says.

At this time let me turn it over to our long-suffering friend, Mr. Mascara. [Laughter.]

Mr. MASCARA. Thank you, Mr. Chairman.

Mr. Merriman, I have more questions than I have time. So perhaps some of your responses can be brief, where appropriate.

First, your statement is replete with references to the former Director. I never saw one time where the name Mr. Billik was mentioned. Is there any reason for the esoteric reference or third person to Mr. Billik rather than a former Director? I'm just curious.

Mr. MERRIMAN. No.

Mr. MASCARA. Okay, fine. I want to talk a little bit about the nursing care unit not used for nursing care activities. I guess they refer to that as "swing space"?

Mr. MERRIMAN. Yes, sir.

Mr. MASCARA. Does that bother you, as somebody from the Inspector General's Office, that this was used for something other than its intended purposes?

Mr. MERRIMAN. Yes, it bothers me that, apparently, a decision was made that there would be a nursing home care unit at the facility, funds were spent to provide it, equipment was brought in to facilitate it, and they made a judgment to do otherwise; Mr. Billik did.

Mr. MASCARA. Do you know whether or not the Director has that latitude to change the intended purposes of the renovated nursing home care unit?

Mr. MERRIMAN. I believe he has the latitude to use the resources that he got for activation funds. I mean, the place was renovated for a nursing home. Then the activation funds came in, a goodly portion of them, I believe, for FTEE—in other words, to hire employees, which were hired into other areas of the hospital. I'm sure he has that authority.

Mr. MASCARA. But the funding was activated for the nursing care home?

Mr. MERRIMAN. That was the intent, yes, sir.

Mr. MASCARA. And is the Director limited as to how he can spend those funds, given that they were for nursing home care?

Mr. MERRIMAN. No, I don't believe he was limited. As a matter of fact, he could probably make the case that, by applying those 30-some FTEs to other areas in the hospital, he took care of some of the problems that people were complaining about.

Mr. MASCARA. Well, the nearest nursing home, where I guess they had to use other facilities——

Mr. MERRIMAN. That's correct.

Mr. MASCARA (continuing). Contracted and other better nursing care units——

Mr. MERRIMAN. Right.

Mr. MASCARA (continuing). The closest one was 110 miles in Columbia, SC. Didn't that pose a problem? And the amount—do you know what amount had to be spent as a result of contracting out to these homes that were private? I mean, did anybody do any computations as to what costs were borne by the South Carolina facility as a result of not having activated that unit?

Mr. MERRIMAN. I don't—

Mr. STALEY. No, we did not, sir.

Mr. MASCARA. So in today's market, what, \$3,000 a month—

Mr. MERRIMAN. I really don't know.

Mr. MASCARA (continuing). Per person? So we're talking about—I think there were 38—

Mr. MERRIMAN. That was my own personal experience when I had to deal with a situation in my family.

Mr. MASCARA. So that's a lot of money, and so we used it for something else. Does anybody calculate whether that was the right thing to do?

Mr. MERRIMAN. Well, we felt that the nursing home should have been activated. I think we're fairly clear about that.

And I think it was largely through our efforts in dealing with the District Director or VISN Director that it was put back on track.

Mr. MASCARA. I want to get to the cost. In reading your statement, under nursing home care unit, you say that, "Our report substantiated that there was an unreasonable delay in activating a nursing home care unit," which we just talked about.

Mr. MERRIMAN. Yes, sir.

Mr. MASCARA. We found that about \$2.1 million was spent for construction, renovation, and activation of the unit in February 1994, and what I'm trying to do is reconcile that with the Inspector General's report on page 7, where it restates the allegation that there was a cost overrun of about \$489,000 and that in the discussion it's pointed out in the report that the actual cost was \$669,927, and then there was a reported cost to renovate Ward 4-A at \$571,000, approximately, \$572,000, which looks to me like it came in under \$98,000. But when you look at the \$2.1 million, there's a big disparity there. Can anybody explain what—

Mr. MERRIMAN. Let me take a shot at it, and then Mr. Staley can fill in the blanks for me. The first cost you deal with is the renovation of the space to accommodate the nursing home. I believe the estimate was something like \$600,000. They came under the estimate to do the actual renovation. It cost about \$500,000 or so.

Mr. MASCARA. That was about \$100,000 savings there? Rather than overspending—

Mr. MERRIMAN. Yes, sir.

Mr. MASCARA (continuing). We're looking at \$98,000?

Mr. MERRIMAN. They came in under estimate, yes; right. Then the balance of the money, about 1.6, was broken down between supplies and equipment, the electric beds, stuff like that, for the patients, and about 33 FTE; I think it was \$1.3 million to pay for the staff that would work in the nursing home. Staff were hired; they simply weren't put in the nursing home. I think that gets you to the 2.1

Mr. STALEY. Sir, \$571,000 was the construction and renovation; the \$1.52 million was the equipment and salaries. Of the \$1.52 mil-

lion, the equipment for the nursing home was \$174,000. The \$1.5 million and the \$500,000-plus came to the \$2.1 million.

Mr. MASCARA. Where did the money go for the salaries, since we didn't activate it?

Mr. MERRIMAN. Salaries for people who worked elsewhere in the hospital.

Mr. MASCARA. Well, that's what the nurse was talking about this morning, that there was a lack of cross-training and orientation of nurses being used. So this is another example of nurses being used in other parts of the facility that really were not trained to do that?

Mr. MERRIMAN. I don't—

Mr. MASCARA. I would imagine you would have somebody in gerontology working in the nursing care units rather than some psychiatrist or rather than some nurse who works in psychiatry?

Mr. MERRIMAN. I don't know just where the FTE went. They weren't hired for the nursing home and then moved. There was money available to hire people for the nursing home. FTE were hired. I don't know exactly where in the hospital they would fit.

Mr. MASCARA. Mr. Chairman, I'm running out of time, but can I have a few more minutes to pursue one other question?

Mr. EVERETT. Yes, you may or you may come back for the second round, if you'd like.

Mr. MASCARA. I have a plethora of questions I would like to send to you, Mr. Merriman—

Mr. MERRIMAN. Yes, sir.

Mr. MASCARA (continuing). And perhaps you can get back to me in writing.

Mr. MERRIMAN. Yes, sir, I will.

Mr. MASCARA. The next question is about the consultant that was paid \$90,000 for 1 fiscal year—

Mr. MERRIMAN. Right.

Mr. MASCARA (continuing). For 4 days a month, which breaks down, if my arithmetic is correct, to about \$1,875 per day. Is that a normal fee for a consultant?

Mr. MERRIMAN. It's about \$1,200—\$1,200 a day? Twelve hundred dollars a day. For what he provided, I think you'd have trouble substantiating that cost.

Mr. MASCARA. The report that I read said something about that this same individual is doing work across the country. Has the Inspector General gone to these other facilities around the country to ascertain what he is being paid or she's being paid or his firm's being paid at all of these other facilities?

Mr. MERRIMAN. Two parts to that: I think the report says that he worked for a firm that was providing services around the country. He then went into service for himself, but we do have allegations that he's worked elsewhere in the Department. We have about four or five locations that we're looking at to see what's involved.

Mr. MASCARA. So you're pursuing that?

Mr. MERRIMAN. Yes, sir.

Mr. MASCARA. I have a hundred questions. [Laughter.]

So I will—

Mr. EVERETT. We'll come back for the second round.

Mr. MASCARA. Thank you.

Mr. EVERETT. On this subject, let me just ask, if the gentleman would allow me, you found that this consultant was working at a number of different hospitals?

Mr. MERRIMAN. We have an allegation—we believe he's working at four or five other hospitals that he has contracts with. That's part of an investigation that we have going.

Mr. EVERETT. And, of course, if that provides true, that would be roughly a half million dollars, between \$400,000 and \$.5 million a year.

Mr. MERRIMAN. At this point I have no idea what he's paid, what he's doing, or what the circumstances are. I have no feel whether it's valid, invalid, or anything.

Mr. EVERETT. Do you know what he actually provided?

Mr. MERRIMAN. At Charleston?

Mr. EVERETT. Yes.

Mr. MERRIMAN. As far as we can tell, it was basically in the form of advice. He apparently gave them advice on mail-out pharmacies, strategic plans; some training was involved, some—

Mr. EVERETT. Do you have any written reports of anything—

Mr. MERRIMAN. I don't believe we've been given any products that he—

Mr. EVERETT. In other words, they just sat down and had a chat?

Mr. MERRIMAN. Well, I wouldn't—I'd think—

Mr. EVERETT. That's my characterization.

Mr. STALEY. He seemed to perform service at the direction of Mr. Billik.

Mr. EVERETT. All right, thank you.

Mr. MASCARA. Mr. Chairman.

Mr. EVERETT. Yes, sir.

Mr. MASCARA. In Mr. Merriman's statement, it's pointed out that there is a possibility of contracts at other VA facilities, and they're looking at agreements the consultant had with the VA Medical Center in Columbia, SC; Little Rock, AR; Asheville, NC, and a community in California. So there are indications—and I would hope that the Inspector General's Office would pursue this.

Mr. EVERETT. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Mascara was on a roll, and it's criminal to have interrupted him, but I guess you probably won't have any trouble getting back to your points, Frank.

Mr. Merriman, with all due respect—and I mean this sincerely—I don't know that you can personally be hit for what appear to be indiscretions, maybe a lack of an appropriate investigation, a lack of appropriate decisionmaking on the part of the IG's office, and that's why I say, "appear to be." But I take a look at the sign in front of you on the desk there. It says, "Mr. Merriman, DVA," Department of Veterans Affairs. It doesn't say, "Inspector General."

Mr. MERRIMAN. It's not my sign.

Mr. BILIRAKIS. I know it's not your sign, but the title. I mean, here's the organizational chart. I'll get to that in a minute.

Let me ask you, sir, you have been—you conduct special inquiries of alleged mismanagement of our senior officials at VA facilities. That is the job?

Mr. MERRIMAN. Part of the job.

Mr. BILIRAKIS. Part of the job. Is this special inquiries of alleged mismanagement after they have been requested?

Mr. MERRIMAN. After they have been requested? No. We will react to hotlines or sometimes we have spinoffs from our other work. We will be doing an audit. We have some indication that there's a problem. We can initiate a review. There's self-initiated work also.

Mr. BILIRAKIS. So there is self-initiated? I guess that's what I was getting at.

Mr. MERRIMAN. It's all—

Mr. BILIRAKIS. And that's what bothers me now. You know, I know that you're the Deputy Inspector General, and you have been in that capacity for at least a couple of years, I guess; right?

Mr. MERRIMAN. Seven years.

Mr. BILIRAKIS. How much?

Mr. MERRIMAN. Seven.

Mr. BILIRAKIS. Seven years? But you haven't had an Inspector General for a couple of years?

Mr. MERRIMAN. Twenty-two months.

Mr. BILIRAKIS. Twenty-two months that's been vacant? Including the job with the Program Assistant, whatever that function would be, to the Inspector General, that's been vacant?

Mr. MERRIMAN. The Program Assistant?

Mr. BILIRAKIS. Yes. That's vacant now, isn't it?

Mr. MERRIMAN. Well, that's correct.

Mr. BILIRAKIS. Well, you know, there's so many questions—Mr. Clyburn, Mr. Mascara, the chairman, Mr. Doyle, et cetera—and I haven't gone into some of these details that they have gone into, but I suggest to you that probably they wouldn't be going into so much detail if there weren't a perception, at least a perception, maybe even fact, of the IG being a part of this good old boy network that has been mentioned, a part of the culture that has been mentioned so many times. You were in here not too long ago testifying, and really there's a lot of respect toward you, so please don't take it the wrong way. And it's not your fault, as far as I'm concerned—I'm using the word "fault"—that this perception is taking place. Now I can't speak for every other member of the committee when I say that, but, you know I take a look at this chart. The Department of Veterans Affairs, and then we have the Secretary and we have the Deputy Secretary in the block, and then offshoots from that is—what?—Chairman, Board of Contract Appeals; Director, Office of Small and Disadvantaged Business Utilization, et cetera; General Counsel; Special Assistant to the Secretary of Veterans' Service Organizations Liaison, et cetera, et cetera. But we have the Inspector General right up there with the rest of them. Now small wonder that there is a perception that we have the fox guarding the hen house. Any comment?

Mr. MERRIMAN. Sure. I'd hate to think people draw that perception from a wiring diagram; if that was the problem, it could be wired differently. I can guarantee only one thing with our reports—that someone isn't going to like it. We've come full circle now. The committee's questioning the—the title of our report says, "Mismanagement at Charleston," but we're not willing to say that Mr. Billik is totally a poor manager. The VISN Directors, as I go before

them, they don't like the title of our reports because it draws attention to the allegation. They would prefer that we had something that said we've taken a look at Charleston, various issues. So we generally please no one in this area.

I doubt that you'd find a perception within the Department that we're part of the good old boy network. I'd point out that in sexual harassment it's our work that resulted in the zero tolerance policy through out reports and our initiative, our special inquiries of Atlanta some years ago. It's our report that brought up the Fayetteville issue. It wasn't what the Department had to do. It's that we were persistent; we looked at the issues of sexual harassment. We kept it on the burner and brought attention to it.

We try to be objective. I have to try to sell my calls in the Department. Everything isn't black and white, particularly when we're doing our audits or where we're pursuing management improvements. The Department has to feel that they get a fair shake, too; many of them don't. Some of them think we're head-hunters, but we try to be fair. We try to be objective, and we try to do our job. And sometimes people are going to perceive it—

Mr. BILIRAKIS. But doesn't it bother you, sir, that—you heard the testimony—I think you were in the room when those other two employees testified, and they talked about the feeling is that we've got to go outside of—and I took that to mean an IG physically located outside of the particular, you know, VA center, thinking in my mind that there was an IG actually located in the Center when they said, "outside of it." But they didn't even really mean that. They meant outside of the VA system—outside of the VA system, another IG. I don't even know if that's available to them, if that's a remedy that's available to them.

Mr. MERRIMAN. No, I—

Mr. BILIRAKIS. But doesn't that bother you that there are people who feel this way?

Mr. MERRIMAN. It bothers me that they testify to that, yes. I would like to think there are people in that hospital that feel free to talk to us; at least 45 or 50 did. Part of what they seem to be alluding to is that if we set up an office in—

Mr. BILIRAKIS. Excuse me, sir. Those people that did—forgive me for interrupting—

Mr. MERRIMAN. Yes, sir.

Mr. BILIRAKIS. Those people that did, you initiated that conversation, did you not?

Mr. MERRIMAN. Well, we—

Mr. BILIRAKIS. I mean, as a result of your investigation?

Mr. STALEY. No—well, we opened up an office and we invited people to come and see us—

Mr. BILIRAKIS. Yes, you came down there; you may it convenient for them, and you invited them to come. So you initiated that. I mean, those are not people that—

Mr. MERRIMAN. All I'm talking about is the onsite visit in Charleston—

Mr. BILIRAKIS. Yes.

Mr. MERRIMAN (continuing). And I can tell you that 20,700 people didn't feel noninclined to call our hotline last year. We have the busiest hotline in the Federal Government. We opened something

like 700 hotline cases. We only have enough staff to do about 8 percent of those ourselves. We limit them to the most visible cases, but it's a fairly active hotline. We have helped many employees, and we have looked at many issues. And we have found that many of these issues we can give to management and have them looked at accurately and correctly. It isn't that management cannot be trusted to look at them—I mean, if we've reached that point, then there's no hope, and I don't think we're there.

Mr. BILIRAKIS. Yes, God willing, we're not there, but, on the other hand, geez, we get—you know, look at the time that we all are spending, valuable time that we're spending on something that you would think would not really be necessary.

Mr. MERRIMAN. Yes, sir.

Mr. BILIRAKIS. Ms. Regan, I guess—Mr. Chairman, just to allow Ms. Regan to respond here, I guess.

Ms. REGAN. I think one of the things I heard this morning was the perception that we didn't look at things that people allegedly brought to our attention. Unfortunately, because of confidentiality, we don't tell everybody what allegations we have. Somebody sitting back, a union president or another employee, might think we were told about something when, in fact, we were not. And we don't go back and tell them and the person who told us, or didn't tell us, may not go back. So they may have a perception we did or did not do something that we did do or we did look at. We also don't go back to the complainants every time because of Privacy Act violations. They can come to us with a complaint. We get this all the time, that we don't come back to people and tell them what happened, but if it's a complaint about an individual, we can't go back and tell them the results. We'd be violating somebody else's right to privacy, which is a different statute.

I've heard one issue here today about an employee in the OR coming forward with something, and I think Mr. Staley should address that, because I think the individual who testified did not have all the facts about what we were told or not told about it. We did run down some issues, but other issues we were not told about. And that was a perfect example of where perception is one thing and—

Mr. BILIRAKIS. That was one of the complaints that was not—that complainant was not interviewed by you. That was at least the claim.

Mr. MERRIMAN. We're very familiar with that case in the operating room.

Ms. REGAN. But the perception and reality are two different things there. I also heard some complaints here about abusive employees, and I'm not certain that we got any allegations about abusive employees. I was a little surprised at that particular one.

There was another one in the statement here about an employee, about abuses and things. The whole story's not here, either, and that's because of confidentiality.

Mr. BILIRAKIS. Well, you know, I'm an employee with the VA; I've got a problem, right? I mean, there may be some merit to it; there may not be some merit to it. But I have this feeling on the basis of maybe talking to other employees, history, perception—there's that word again—that if I go through the VA chain of com-

mand, it's going to come back to bite me, and not—that good things aren't going to take place, et cetera. And the IG is part of that chain of command. And so I'm just going to be frightened to do so, and I'm going to go—I'm just not going to do anything, I guess. I mean, you know, it's got to bother you.

And I realize we make the laws and we have established your position on this chart. So I appreciate that. It's not your fault that this is the case, but still there's a perception there, I think, isn't it? Wouldn't you agree that there are—these two people who testified, I don't know what you got when you interviewed these people, when you went down there and what they really told you. I would suspect that probably these were not the only two who made comments like, well, we're afraid of our jobs, and people are afraid of their jobs, and they want to go maybe to an outside—using their term—to an outside IG rather than inside, or in-house, or whatever the term was that they used.

Mr. MERRIMAN. Well, sure, it bothers me that there's a perception—I can't beat down all perceptions.

Mr. BILIRAKIS. No, of course not.

Mr. MERRIMAN. I like to think that we've done a good job in Charleston. We've kept on it, and we've brought to light some of the issues there. People aren't always going to be satisfied with what we do. Some of them have agendas; some of them have complaints which aren't valid. Some of them are pursuing other things. They do have other outlets. Some choose not to come to us, and they write to Congress. We have tons of Congressional—tons of hotlines inquiries that are initiated by referrals from Congressional offices. So there's other vehicles available to people. I mean, a lot of it comes back to us, and we have to be held accountable for our job; I understand that. But I think we do a good job.

Mr. BILIRAKIS. Do you think that same perception—one last question, Mr. Chairman, please; I appreciate your indulgence, sir. I'm not even a member of the subcommittee, although I am a member of the full committee.

Do you think that that perception would still exist if the IG's office were completely independent, organizationally, chartwise, and location-wise, and everything else, from the VA, and you're an IG office, Inspector General overall?

Mr. MERRIMAN. That might take care of that type of a perception, but I think it injects other problems. I think that the IG Act was fairly specific in building in some protections for independence, making us responsible both to Congress and to the Department. We're under the general supervision of the Secretary, but I have a lot of authorities of my own that the Secretary holds also that I don't have to go to him on.

If we were totally put in a different building, different wiring diagram, I didn't sit at the staff meetings, I think it would hurt our other areas, our audit work, areas like that, where it's important to be able to sell our call, to work with managers and have a feel for their problems, and to have their perception of us, that we're not there simply out to get them, that we have understanding of some of the problems they have to deal with—so it works both ways.

Mr. EVERETT. I'd ask the gentleman to hold his thought at this particular time—

Mr. BILIRAKIS. I think in terms of the GAO and the job that they have and the credibility that they have, and that sort of thing, and they're completely separate and completely independent. Well, maybe we'll talk about that.

Mr. EVERETT. We can come back to this—

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. EVERETT (continuing). And I ask the panel to remain seated. I understand that it's a vote on the rule, and we have about 6 minutes, I think, to make the vote.

[Recess.]

Mr. EVERETT. The committee will come to order.

Mr. Bilirakis, did you finish your line of questioning? We'll have a second round. Some members mentioned that they would like to make some comments or have brief additional questions.

I recognize—

Mr. BILIRAKIS. Excuse me, sir. Mr. Doyle, I know, hadn't had his—

Mr. EVERETT. Oh, I'm sorry. Forgive me. I looked over there a minute ago and you weren't there. So please.

Mr. DOYLE. Thank you, Mr. Chairman.

Let me first compliment you on your rather liberal use of the time clock there for the members of this subcommittee. I've found my subcommittee chairman hasn't been quite as generous, and I want to compliment you upfront before I begin to speak.

Mr. EVERETT. Well, I will point out that I do like the 5-minute rule, but at least these questions all lead to other questions, which tie into the overall problem that we're having. I would say, for instance, in this particular case, that we obviously—title 7's a problem, and I can understand that. I can understand how employees at the Medical Center cannot understand that title 7 is a problem. But from your viewpoint, I understand that it is a problem. I was not aware of that before, but I am allowing the liberal use of the time because of the fact that so many of these questions do lead to other questions, and a lot of them are very technical.

Mr. DOYLE. Thank you, Mr. Chairman.

I've been reading the IG's report with great interest. I want to focus a little bit on Pittsburgh because the facility in question sits in my Congressional District. I read here that in May of 1993 the former Medical Center Director—that is, the Director there prior to Mr. Cappello—requested approval to renovate and upgrade the interior of the Director's residence. VHA did not approve this request. In July of 1994, after the former Director retired, the Acting Director at Pittsburgh obtained instructions on what procedures to follow when renovating the quarters. And then we've got this agency called the Real Property Management Office. An official from that office in Washington told the Acting Director in Pittsburgh to use the income and expense model in the expired VHA Directive 10-93-014 rather than the current VHA Supplement MP-3, paragraph 3.20, which talks about restrictions on the use of operating funds.

I see later in the testimony that, following the guidance of VHA Directive 10-93-14, "Engineering Service completed the VHA income and expense model for the Director's residence prior to Mr.

Cappello's arrival, and based on the results, Mr. Cappello approved the renovation of the Director's residence and two other quarters."

You go on to say, "We found that portions of the model caused an overstatement of income available for the Director's residence renovation because the model's instructions were not specific enough. The model did not define terms like 'rent' well enough to exclude other charges, like utilities. The model did not instruct managers to include all quarters' operation costs and projections, and it did not explain how to handle costs of concurrent projects like the NRM project, the non-recurring maintenance project, associated with that particular facility.

The model also told managers to add projected income losses due to vacancy without specifying that the losses were negative numbers. In other instances, the income and expense model potentially underestimated the amount of money available for major maintenance projects."

You go on to say in the conclusions that, "We found no evidence in our review that Mr. Cappello would have initiated renovations of Aspinall quarters in excess of the limits provided by VHA Supplement MP-3 if this RPMO office had not provided the Medical Center with incorrect guidance. Based on instructions from RPMO, Mr. Cappello believed that he had liberal authority to spend medical care dollars on Aspinall quarters. We concluded that RPMO's instructions led him to believe that he had greater authority and discretion in approving quarter renovations than the policy actually authorized."

It seems to me that we're here today talking about the Pittsburgh Center and they've done a lot of good things down in Pittsburgh, and they continue to do that. We're talking about something that happened 4 years ago, but we're here today, it seems to me, because an incoming Director relied on information from an office here in Washington, DC that led him to believe he had more money to spend than he actually did, and had he received this correct supplement, this VHA supplement MP-3, chances are we would just be discussing Charleston, SC here today, and not Pittsburgh, PA.

Can you comment on what has taken place since this time in Central Office, here in this Office of—what is this acronym, RPMO?

Mr. MERRIMAN. Real Property Maintenance Office.

Mr. DOYLE. The Real Property Management Office—what is happening—I don't know who the official was in the Real Property Management Office that passed this information down through the line. He's not identified in the report, but what has been done since that time to make certain that something like this couldn't happen in the future?

Mr. MERRIMAN. They just—

Mr. STALEY. They're in the process now of revising and updating all of the policies that you've mentioned, sir, and—

Mr. MERRIMAN. As a matter of fact, I think we've just seen the revised handbook lately, that came to us, I believe, to react to or to see whether it had some of the fixes in it. So there has been some movement there to correct some of the bad guidance that they had provided these people.

Mr. MASCARA. If the gentleman would yield—

Mr. DOYLE. Yes, I'd yield to my colleague.

Mr. MASCARA. Thank you. Thank you, Congressman.

Has anybody spoken to the RPMO about these incidents that Mr. Doyle speaks about? I mean, has anybody been identified in that agency who gave the erroneous information to the Pittsburgh Director? Did that cover part of your work that you were doing as an Inspector General? Did you go that far?

Mr. STALEY. I don't believe we did, sir.

Mr. MASCARA. Aren't you curious? I mean, here's a man that's being charged with mismanagement as a result of someone else's actions, and it just bothers me that nobody followed up—I mean, I think the RPMO should be in here today answering questions to us, Mr. Chairman.

Thanks, Mr. Doyle.

Mr. DOYLE. Thank you.

And we're going to get to Mr. Cappello, too. He's here and he's going to be testifying later, and he can speak to some of these interior renovations. But it is troubling.

I also see that there was an allegation about the Director and others who had government quarters benefitted from rents that were lower than market levels. The conclusion from the IG is, "We did not find intentional misconduct in obtaining these benefits by the Director. The lower rents continued because RPMO did not fulfill its responsibility to review rent adjustments in accordance with the Office of Management and Budget guidance, even after RPMO was informed by the Director that he planned to use the existing rental rates until construction was completed, unless otherwise directed."

I think my colleague, Frank Mascara, said earlier in his testimony, at some point that we have to decide who's responsible and what we do about it. I'm not sitting here to defend the Director from Pittsburgh. I think he needs to answer some questions about his taste in interior decorating, and we'll ask them when he gets here at his panel.

But it seems to me that if we want to really look where the source of this is, we don't have to look much further than the beltway here, Mr. Chairman. Right here in Washington, DC, this RPMO I think needs some further looking at, and I'm just very distressed that, if it weren't for some bad directions coming from Washington, DC, my Center—and when I say, "my Center," I mean the people in Pittsburgh, PA and the veterans who take great pride in the facilities in Pittsburgh, PA—wouldn't have to be looking at news stories tonight, unfortunately, that would lead them to believe that we've got widespread mismanagement there, when in fact this appears to be an isolated incident, where the Central Office has given some very bad information to a new, incoming Director. It's just very unfortunate. We ought to make sure this can't happen again.

Thank you.

Mr. EVERETT. Well, I would agree with the gentleman, and think that might be a line of questioning that he might want to submit for the record. And I would also point out that this goes back to my contention about culture. Culture is set at the top. That's the only place it's set. If you ignore things, then people below recognize

that you're going to ignore it, and this is part of the problem that we have.

We will have a second round of questioning, as I indicated. Some of the members would like to explore some details with you. I had mentioned a little earlier that I do understand that, in a sense, you're damned if you do and damned if you don't. I understand that. Having spent 30-something years in the newspaper business, I very much understand that.

However, I would point out that, for instance, in the case of Fayetteville, that your investigation did come up short there, in my estimation. As a matter of fact, to eventually discharge Mr. Calhoun from the VA, you had to go back in and do an investigation not related to the first investigation. I'm not dragging this all up again, and I do—

Mr. MERRIMAN. I'd be happy to address that one way or another.

Mr. EVERETT. Well, you don't have to address it, and I appreciate that. I do appreciate the work you do, but I am, as you recall from the meeting, sometimes Members are frustrated that it does not go as far as it should have. In this particular case, it may have worked in our favor, because in going back, we were able to find other things that led to the dismissal of Mr. Calhoun.

As I understand, the consultant contract that we've talked a lot about here—Mr. Mascara talked a lot about it, and Mr. Bilirakis—was that not medical fee money?

Mr. MERRIMAN. Yes, it was fee-based money.

Mr. EVERETT. In other words, over 2 years, we're looking at \$180,000 worth of medical fee money?

Mr. MERRIMAN. That's correct.

Mr. EVERETT. Was this money used correctly or incorrectly?

Mr. MERRIMAN. I think we point out that that was incorrect.

Mr. EVERETT. And that would not be mismanagement?

Mr. MERRIMAN. In that instance, yes.

Mr. EVERETT. That would be mismanagement?

Mr. MERRIMAN. I would say it was, yes, mismanagement of that—

Mr. EVERETT. You stated in the testimony that \$26,000 in fish tank funds came from construction money that had to be used for construction and could not be used for nonconstruction purposes. What was not done in the way of construction in order to spend the money on the fish tank?

Mr. MERRIMAN. I can't say.

Mr. EVERETT. Was any other construction not done or delayed to make the money available for the fish tank?

Mr. STALEY. Not that we know of.

Mr. EVERETT. Would you say that spending \$26,000 on a fish tank would be mismanagement?

Mr. MERRIMAN. Well—

Mr. EVERETT. If you wouldn't, how would you justify spending \$26,000—especially when it was money that was supposed to have been used in construction?

Mr. MERRIMAN. Managers have some discretion. I saw a newsclip just recently from local Charleston newspapers where the veterans seemed to be lining up in support of this fish tank. He had many things he could have spent the money on other than that. I would

think many managers, most would not have chosen to do that. I suspect I could put a fish tank in the IG's office, if I wanted to, but I have other things that I'd put the money on. But it was his discretion to do that. I can't call it mismanagement. I'd say it was a poor choice of use of resources.

Mr. EVERETT. Out of curiosity, were rods and reels furnished for this \$26,000 fish tank? [Laughter.]

Mr. MERRIMAN. Not to my knowledge.

Mr. EVERETT. In terms of waste of taxpayers' dollars, maybe \$5,000 is minor waste, as you state, but tearing up brand-new carpeting, bought with the taxpayers' money, because the color doesn't suit the hospital's Director, to me shows a lack of regard for the efficiency and economy that the people of this country, the taxpayers, expect from their government. Would you agree or disagree with that?

Mr. MERRIMAN. Well, let me put the facts straight at least, to start with. I don't think the carpet was installed and torn up. They bought that black carpet for about 74 yards of installation. It cost, I think, \$1,300. They looked at it; they found that it didn't suit them. I'd say, hey, they should have made that determination going in; that money was wasted. They didn't need it for that. They should have had better management of what kind of carpet they wanted. They went and then spent \$5,000, I think it was, for 300 yards of carpet for the entire executive suite. My understanding is that perhaps it ended up in the dumpster initially; somebody caught that; it was pulled out. My understanding is some of that carpet was used in Engineering Service and some other rooms. I'm not justifying that they should buy carpet, take a look at it, not like it, throw it away or use it otherwise. Obviously, the money should have been better managed.

Mr. EVERETT. You understood it was used in the Engineering Department?

Mr. MERRIMAN. Some of the carpet, it is my understanding, was used in some other area of the hospital, maybe not all of it.

Mr. EVERETT. As my friend, Mr. Mascara, has recognized and commented on, we've got a lot more questions than we have time, but at this time I'll yield to him for any additional questions he may have.

Mr. MASCARA. Thank you, Mr. Chairman.

Let's get back to this fish tank again. Meanwhile back at the fish tank—it started out as \$80,000; then it—there's someplace in here that someone made that—there was an allegation——

Mr. MERRIMAN. Yes.

Mr. MASCARA. And then someone said, well, it cost \$26,000, and then there was a monthly fee for maintenance. I read in there someplace where they said, we don't even own, the government doesn't even own, the fish tank, that we leased it, so that, as September 30 in the year 2000 comes near, at the time of the expiration of that lease, we don't own that tank. So I think the record should indicate, Mr. Chairman, that after paying \$26,000 and after paying the maintenance fees, that this was a lease and not an outright purchase. Am I correct?

Mr. MERRIMAN. I'm not sure that's correct.

Mr. MASCARA. Well, it says it in the IGO's report here.

Mr. MERRIMAN. That it was leased?

Mr. MASCARA. It was a lease. I mean, that further exacerbates at least—

Mr. MERRIMAN. There was a lease—there was a contract for the maintenance of it. I'm not sure—

Mr. MASCARA. Look at the report, sir. I spent most of last night and the night before going through this, and that thing jumped out at me, that this is was a lease and not an outright purchase.

Explain to me the function of the IG. Do you engage in actual audits or are you just an investigatory arm for the VA? I mean, do you have staff onboard that are certified to do accounting?

Mr. MERRIMAN. Yes, sir, we have auditors.

Mr. MASCARA. And did anybody audit the actual cost of the renovation of the facility, took the contract and sat down? Because we have all of these figures that we discussed, and they seemed to balance out after you explained what that \$1.2 million was, but did someone literally audit the renovation of that, go through the invoices to make sure that the government received what it paid for in that renovation? Or is your information coming just as information received from someone who said, well, we paid \$1.2 million; no one looked to see whether that was paid and who it was paid to, and when it was paid to them?

Mr. STALEY. The hard documents that generated the cost were looked at by a reviewer. Whether a detail audit of all of the line items, line by line, was—I don't believe that was done.

Mr. MASCARA. So nobody did any tests, random sampling of the expenditures to verify that those were the actual amounts? That's information provided you, and you're taking their word that that's the case rather—

Mr. MERRIMAN. No.

Mr. MASCARA (continuing). Having a certified audit?

Mr. MERRIMAN. There was no certified audit done of the invoices. I believe our reviewer pulled the actual invoices and looked at them to come up with the price, but in terms of what we would consider an audit, no.

Mr. MASCARA. Good. Thank you, Mr. Chairman.

Mr. EVERETT. Mr. Bilirakis.

Mr. BILIRAKIS. Mr. Chairman, I don't have any questions. I would just merely ask, Mr. Merriman, you indicated that if the IG, if the process was changed so that the IG was no longer working as a part of any particular department or agency, or whatnot, that it might be helpful in some areas, but there could be problems with it in terms—you mentioned auditing and that sort of thing. I would appreciate it if you would submit to me, anyhow—I don't know whether the committee would want it or not—some of your points that you wish to make in that regard that should be taken into consideration, if one is thinking in terms of changing the process.

Mr. MERRIMAN. I would be happy to do that, and I'd also like to point out that the—I believe it's the House Government Reform and Oversight Committee has recently asked the General Accounting Office to look at IG functions in terms of the 20th anniversary of the IG, to make recommendations as to how IGs in Federal Government might be—if there's any changes that might be required, and they'll be having hearings on that.

Mr. BILIRAKIS. Yes, I appreciate that. Thank you. Thank you, Mr. Chairman.

Mr. EVERETT. Mr. Doyle.

Mr. DOYLE. I just have one quick, follow-up question, Mr. Chairman.

In the process of you investigating this situation in Pittsburgh, did you actually speak to the official at the RPMO who issued the directive—I guess the Pittsburgh people got a directive that was expired instead of the one that they should have gotten, and some person in that office was responsible for sending that down. I mean, did you ever interview the person that was responsible for sending the expired directive to Pittsburgh?

Mr. STALEY. I'd have to go back to find out whether that specific person was interviewed or whether that person was no longer at that job assignment, but we did speak to the people in the RMPO office to try to get clarification on issues.

Mr. DOYLE. Okay, but you're not sure if you spoke to that particular individual?

Mr. STALEY. That particular person, I'm not sure.

Mr. DOYLE. And I was going to follow up to ask you, what happened to that person who sent this erroneous directive down? Where is that person today?

Mr. MERRIMAN. We'll have to—I have a—

Mr. DOYLE. Still working for the VA?

Mr. STALEY. I'd have to go back and find out. We can certainly get that information to you, sir.

Mr. DOYLE. Thank you.

(Subsequently, the Department of Veterans Affairs provided the following information:)

In response to Congressman Doyle's question as to whether any action was taken against employees in the VA Real Property Management Office (RPMO) for advising the Director at VA Medical Center Pittsburgh to follow an expired policy directive, the Office of Inspector General (OIG) concluded that there was no basis for taking any appropriate administrative action against RPMO employees because there was no evidence of misconduct or mismanagement. The basis for this conclusion is as follows. The most recent instructions for VA medical center quarters management were issued in February 1993. The rescission date for this directive lapsed in February 1994. When Medical Center officials in Pittsburgh asked for policy clarification in July 1994, a RPMO official told them to continue to follow the expired directive while new policy was under development. OIG staff discussed this issue with the RPMO employee responsible for telling Pittsburgh officials to follow the expired directive. The RPMO employee explained that recommended revisions to the expired directive were under Consideration and had to undergo a rigorous departmental concurrence process. In the meantime, RPMO did not have the authority to issue new Department policies without the required input and concurrence from all responsible agency officials. Consequently, RPMO was left with the use of the expired directive as stop-gap instructions until a new policy was available. Recognizing the vulnerability of the circumstances, the OIG recommended that Veterans Health Administration (VHA) Central Office officials expedite its efforts to issue current, consistent quarters guidance. Based on our recommendation, VHA has issued a new directive and a draft handbook. As a result, we believe the conditions that led to the problem have been corrected, and we consider the matter resolved.

Mr. EVERETT. I want to thank this panel for enduring this. It's part of the job; I recognize that, like town meetings are part of the job.

We understand a lot of what you said. I hope you understand that what the Subcommittee on Investigations and Oversight is spotlighting, we're trying to penetrate into the VA's system to learn

how to change it, because it's the feeling of, I'd say, every member of this committee that there's a culture that exists in VA that has for years defied oversight, and we certainly have to have the full cooperation, the full, independent cooperation of the IG's office to achieve that.

So I thank you again for your being here today, and we will now dismiss this panel, and we'll ask for panel four to come up, please.

Mr. Clark—now that you're all comfortably seated, I'll ask you to rise and raise your right hands, please.

[Witnesses sworn.]

Thank you. Please be seated.

Mr. Clark, if you would please, introduce your panel.

**TESTIMONY OF KENNETH CLARK, CHIEF NETWORK OFFICER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DEAN S. BILLIK, DIRECTOR, CENTRAL TEXAS VETERANS HEALTHCARE SYSTEM, VETERANS INTEGRATED SERVICES NETWORK 17, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS, AND THOMAS A. CAPPELLO, DIRECTOR, PITTSBURGH VA HEALTHCARE SYSTEM, VETERANS INTEGRATED SERVICES NETWORK 4, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS**

**TESTIMONY OF KENNETH CLARK**

Mr. CLARK. To my left is——

Mr. EVERETT. You may proceed at that point.

Mr. CLARK. To my left is Mr. Dean Billik; to my right, Mr. Tom Cappello.

Mr. EVERETT. You will, please, proceed with any testimony anyone may have.

Mr. CLARK. Thank you.

Mr. Chairman, members of the subcommittee, I appreciate the opportunity to appear before you to testify this afternoon. My name is Kenneth Clark, and in August I assumed my current duties as Chief Network Officer in the Veterans Health Administration. One of my primary responsibilities is to ensure the integrity and the effectiveness of the day-to-day operations of our medical facilities. I believe that the structure and the tools that we're putting in place will enable me to provide this essential oversight, and I'd like to describe them to you very briefly.

The cornerstone of this system is the new VHA network organizational structure, which creates 22 separate Veterans Integrated Service Networks comprised of from three to ten separate facilities, each under the direction of a Network Director. The 22 Network Directors have a smaller span of supervisory control than did the four Regional Directors in the former organization, who were responsible for as many as 43 facilities. This simple difference in span of control enables the Network Directors to maintain closer contact with the facilities and its stakeholders and review its operations in greater detail.

The Network Directors are able to intervene at the first evidence of problem and regularly send site-visit teams to review, investigate, and evaluate allegations of improper or ineffective manage-

ment or behavior. They are better informed about their facilities, and at the same time can be more accessible to groups or individuals that wish to point out concerns. I intend to work very closely with the Network Directors to ensure that they do perform this vigorous, aggressive oversight role.

The Network Directors have been given a very clear, challenging set of performance measures that set forth measurable, objective standards of achievement. Network Directors are able to evaluate the performance of each medical center and its management team using these objective tools and quickly identify out-of-line situations. These measures are a powerful tool for VHA senior management and we're using them to upgrade performance across the system.

Additionally, VHA is developing a new dimension to their performance appraisal system to more comprehensively evaluate executive performance. This 360-degree evaluation system provides each executive with feedback on specific skills and behavior, not only from their supervisors, but from their peers, their subordinates, and their customers or stakeholders. We expect that this system will help us in our efforts to strengthen our culture of performance and accountability and assist executives to align their individual behavior with organizational values and objectives.

Secretary-designate Goyer has recently implemented several other initiatives to improve our ability to provide oversight and take effective action. Earlier this year, he issued instructions that in all actions involving senior management officials, representatives from the Office of Human Resources, the General Counsel, and the Office of Public Affairs, as well as the line operating officials, will meet to discuss the case, develop comprehensive strategy for taking action, and implement the decisions in a coordinated manner. This will eliminate any possibility that the VA's case will be either compromised through lack of cooperation or not fully developed as possible.

As you know from his previous testimony before you, Secretary-designate Goyer has also developed a new approach to handling equal employment opportunity complaints. Under the terms of this new framework, Medical Center Directors will no longer serve as EEO officers, and a new, independent Office of Employee Complaints Resolution will have counselors and investigators assigned to it.

EEO counselors will no longer report to facility Directors, and this should make employees feel freer in initiating complaints against the senior officials at the local level. I believe this new, independent level of review will make management officials even more accountable for their behavior and their decisions.

Our executives must be effective leaders, not just competent managers. It's not enough that they steer clear of specific violations, but rather we expect that they'll be sensitive to the appearance of their actions.

There is one other important element to be considered in connection with the focus on accountability. We're asking our executives to make tough decisions and take bold actions in a very difficult environment. Our Medical Center Directors have helped us make dramatic improvements in quality and the cost-effectiveness of our

care, using objective measures. They're displaying a remarkable ability to innovate and a robustly entrepreneurial spirit. They have restructured and reorganized the health care delivery system in cases in which there was no clear right or wrong decision, and they have had to take these actions in the best interest of their facilities, when it may have had an adverse impact on individual employees or groups of employees. And I applaud their willingness to take on these difficult tasks.

It's not surprising that some stakeholders will disagree with their decisions or even mischaracterize them. Under our system, these employees have the right to allege wrongdoing or mismanagement, and it's healthy that they can do so, as it's a constructive check and balance on management.

However, I urge that these allegations be considered just that—allegations—until they can be proven, and that an executive is considered to be legitimately and conscientiously exercising his or her best judgment until the facts indicate otherwise. If we intend to hold our executives accountable for their misconduct, then I believe we must support them fully in those instances in which they are not at fault. I'm concerned that if we do not, our executives will not continue to embrace the essential changes VHA is making to ensure it provides the highest quality of care in a timely and effective manner.

Mr. Chairman, this concludes my formal statements, and the other members of the panel would also like to make statements.

[The prepared statement of Mr. Clark appears on p. 175.]

Mr. EVERETT. All right. It doesn't make any difference—just whichever one, proceed, please.

#### TESTIMONY OF DEAN S. BILLIK

Mr. BILLIK. Mr. Chairman, my name is Dean Billik. I'm currently the Director of the Central Texas Healthcare System and formerly the Director of the Ralph H. Johnson Medical Center in Charleston. It is an honor and a privilege to appear before you today to testify regarding alleged mismanagement practices while I was the Director at Charleston.

The VA Inspector General completed a thorough investigation of 27 allegations of mismanagement on January 10, 1997. They found no substantial evidence of mismanagement. Of the 27 allegations ranging from gold fixtures to fish tanks, 5 were substantiated, 4 were partly substantiated, and 6 recommendations were made, and I'll briefly address each of those.

Ward 4-A, which was renovated in the nursing home care unit and never used for that purpose at the conclusion of the renovation award for a project to remodel another acute medical care unit, had been funded. Rather than reduce the capacity of our acute care patients, we utilized 4-A to care for those. If we had not been able to use 4-A as swing space, we would either have to reduce the number of acute patients we were taking care, close clinics, or not complete necessary improvements. To me, none of those were viable. My intent to use 4-A as a nursing home would have fallen through as soon as the renovations in other parts of the facility were concluded.

The general operating and construction funding was received for the project and it was utilized for that project, but funds enabled us also to avoid, if you will, the reduction in employment over that period of time without incurring a reduction in force. We would have had to activate that nursing home care unit when it came time within our existing resources.

The allegation concerning the renovation of my Director's office without approval, it had—the Director's office had not been renovated in many, many years, and they were renovated. However, before the renovation began, the appropriate request was submitted through my supervisor, the then-Regional Director, and submitted to Central Office. A verbal approval to proceed was received from Central Office, which was documented.

On issues concerning the consultant, Charleston was blessed to have been included in a VA Central Office national contract with APQC to implement a total quality improvement program throughout the VA. When that contract expired, and I met with our staff and we discussed our progress on total quality improvement, it was concluded that the services of this individual would be considered valuable to continue the process of training and educating our individuals, the program people, in the practices of total quality improvement, and I concurred.

The other allegation, scarce funds on a maintenance contract for a fish tank, the maintenance contract for the fish tank was \$7,800 per year, which included stocking and feeding the fish, cleaning and replacing them. The projected budget shortfall for 1996 did not materialize.

The perception may have been that the money was being spent frivolously while employees were facing layoffs. However, construction money for renovating the lobby or installing the fish tank, we couldn't have spent on employees' salaries.

It was also true that the anesthesia machines no longer have a maintenance contract because it was determined that the maintenance of these machines could be accomplished more effectively by the Medical Center's Biomedical Engineering staff.

Other partly substantiated allegations—one was that a well-known artist paintings were inappropriately discarded as part of the renovation of the suite, and we were never able to determine the source of that or the object in question.

The allegation about the fish tank costing \$40,000—it was actually \$26,119, and it was included in a plan that was created by a designer as a part of a master facility plan for the entire Medical Center. She considered other things as a focal point for this lobby renovation, such as a sculpture or a painting, but she chose the fish tank as being appropriate in a seaport, and we agreed. While it was not necessary, it was included as part of the overall lobby renovation.

Another allegation was management authorized the nonessential landscaping services and redirected old landscaping items to employee residences, and that was partly substantiated because it was, in fact, we determined one employee had taken some old plants home with him. Staff were reminded all the plants were government property and were to be disposed of and not given to employees. A memorandum was issued to employees and the IG

was satisfied that the problem had been corrected, and no recommendations were made.

Management violated its own policy by requiring respiratory therapists to work without backup in the intensive care unit during evening hours—the allegation was partly substantiated. Respiratory therapists were required to work alone in the ICU during the evening hours because of declining inpatient workload. However, in the event another respiratory therapist was needed, that person could come from the sleep lab. That was not consistent with existing policy, and the policy has since been changed.

There are other recommendations, and I'll be happy to address any questions that the members may have.

[The prepared statement of Mr. Billik appears on p. 182.]

Mr. EVERETT. Thank you, Mr. Billik. Thank you.

### TESTIMONY OF THOMAS A. CAPPELLO

Mr. CAPPELLO. Mr. Chairman, I'm Thomas Cappello, the Director of the Pittsburgh VA Healthcare System. It is a pleasure to be invited to this hearing today and given an opportunity to share my knowledge of the Pittsburgh project and answer any questions you may have of me on this subject.

As the Director of the VA Pittsburgh Healthcare System, I take full responsibility for all that occurs on our three campuses. I'm pleased to report that the positive stories greatly outnumber any negative stories you may have heard, and the reason for this is that I am blessed with the most wonderful staff in the whole VA system.

Over the past year, our health care system has integrated two Medical Centers situated on three campuses into one system. We have reorganized in such a manner that expenditures over the past year have been decreased by \$8 million, and we have reduced by 318 FTE. At the same time, we have treated 9,000 more patients. We have increased our services to the veterans of Pittsburgh in record numbers, and provide the highest levels of tertiary care, including liver transplantation.

When I entered on duty in Pittsburgh in 1994, I found a brand-new, state-of-the-art VA Medical Center on the Aspinall campus, flanked by a series of older buildings that were in desperate need of rehabilitation. The quarters buildings, in particular, were unacceptable. The subject building, No. 13, was in the most disrepair, and this fact has been well-documented.

I was faced with an issue of either repairing these government assets or closing them. A cost-benefit analysis was conducted, and it determined that nearly \$3 million had been collected in rents over the past 15 years, and if rehabilitated, these units would provide a positive cash flow that could be reinvested in patient services. In fact, the very reason for the disrepair of these units was directly related to the lack of maintenance and repair over the years. It was decided to renovate three vacant units and to continue this process until all units were completed.

It is important to note that I personally never had any long-range plans to live on campus. Thus, the renovations would not be associated with me, but only with the reality that the repairs were desperately needed.

Various options for rehab were discussed ranging from cost-prohibitive restorations to more cost-effective updating. Shortly after this decision was made to renovate, our Associate Director/Chief Engineer had transferred to other stations and our contracting section consolidated with the Highland Drive contracting section. These key vacancies and changes had a great deal to do with the poor project management that occurred at the operational level.

I also had never worked on a campus with quarters and was not knowledgeable about the rules and regulations on this subject. I did receive guidance that I could expend up to \$126,000 to rehabilitate this structure, and a project was developed whose costs conformed to this budget number.

When the IG arrived in April 1996, I was pleased and confident that the review would prove that we had followed all applicable guidance and that we had protected the government assets as appropriate. As the IG report indicates, it was determined the guidance used was incorrect and the costing of the project was in error.

Forty-five thousand dollars of station labor was used on this project and was not appropriately costed to the project. This occurred because of inadvertent, and not malicious, poor cost accounting and an improper interpretation of the rules. It is important to note that this is costing information and not actual cost.

Over 2,300 hours of labor was charged to this project. I had an independent estimator go through the project and indicate that 540 hours was a more reasonable estimate for the work accomplished. In fact, I was informed that roughly 2,100 hours is the industry estimate to complete the construction of a 2,500-square-foot home. This fact does not mean that VA labor is inefficient. It means that our past systems for tracking cost was done anecdotally and after the fact. We have corrected this problem at Pittsburgh by now insisting on a work order for all work on quarters, to ensure a proper estimate and an accurate cost accounting.

Finally, and probably the most publicized aspect of this renovation, is the issue of above-standard amenities. I can assure everyone here that I am conservative by nature and most certainly a conservative manager. I can also assure you I would never have knowingly selected any faucet or bathtub whirlpool that was anything other than mid-grade, tasteful, and serviceable. I believed that all selections that were made were within the budget of the contractor which was \$86,000, and I was not aware of the cost of the individual line items until the time of the audit. This was an oversight.

In closing, I want to assure you, and most importantly, I want the veterans of Pittsburgh to know that I take very seriously the trust placed in me. I assure everyone that the important story about Pittsburgh is not one of project mistakes, but one of stretching resources to provide as many services as possible and to take care of our veterans within the budget. The VA Pittsburgh Healthcare System over the past 3 years has served 10,000 more veterans, reduced costs by \$10 million, and increased outpatient visits by 85,000, while at the same time improving customer service.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Cappello appears on p. 189.]

Mr. EVERETT. Let me start with you, Mr. Billik. We've heard sworn employee and the IG testimony. The IG has found that you had a close personal relationship with a female on your office staff, and that you promoted her after the relationship began. How do you think that appeared to the Medical Center employees?

Mr. BILLIK. I had a close personal relationship with a staff assistant that I would term as being one of a very close friend. Her progression in the Department was based upon legitimate accretion of duties, and those duties were reflected in a position description which was classified. Our relationship became personal at the time that I discovered that I would be leaving Charleston. The promotion had at that time already been delayed for more than 3 months. I felt it was in the interest of fairness to her, as well as to the other employees in my office whose promotions had been delayed, to allow those to proceed like any other employee.

Mr. EVERETT. You very skillfully did not answer my question. My question to you was: How do you think that made the other employees feel?

Mr. BILLIK. Given some of the statements that I've heard today, Mr. Chairman, I can understand that there would be concern.

Mr. EVERETT. Well, do you think that's an example and leadership that employees should expect from managers?

Mr. BILLIK. No, sir.

Mr. EVERETT. I notice you didn't even mention that in your written testimony. Is there any particular reason you chose to avoid it?

Mr. BILLIK. No, sir.

Mr. EVERETT. Is it a fact that during this relationship that you and this female employee rode to work together frequently?

Mr. BILLIK. There was occasion where that occurred. We did not cohabitate. We on occasion would carpool, yes, sir. We lived in the same general neighborhood in Charleston.

Mr. EVERETT. And so you found it convenient to ride to work together?

Mr. BILLIK. When there was a car that needed to be repaired or dropped off or a problem like that, yes, sir.

Mr. EVERETT. Mr. Billik, I'm going to tell you straight out and on the record that, as far as I'm concerned, what you have set here is a totally unacceptable example of how someone ought to manage. The leadership, frankly, is a disgrace to civil service. You ought to be ashamed of yourself, and as far as I'm concerned, you have no business being a manager in any place in the Federal Government. This is a horrible leadership example. And I don't simply condemn you for it; I also condemn those who promoted you after this example was set at Charleston.

Let me ask you, on the \$90,000-a-year consulting contract, the IG essentially found, at pages 16 through 19 of the report, that the contract did not use proper funding source, did not follow procedures for obtaining consulting services, and did not have proper approval. Do you disagree with that?

Mr. BILLIK. In retrospect, yes, sir. At the time that that action took place, I directed our contracting people to sit down with this particular individual that we had been using and to negotiate a contract. And I was informed that that was done, and the price of

that contract was considerably less than what it had been under the centralized contract.

Mr. EVERETT. Where did the money come from used to pay for this consulting?

Mr. BILLIK. It came from the hospital general operating budget, sir.

Mr. EVERETT. Medical fee fund?

Mr. BILLIK. I determined that later, yes, sir. It's general medical care appropriation, yes, sir.

Mr. EVERETT. Do you think veterans' services suffered because of taking this \$90,000 a year, \$180,000 over the 2 years, out of medical fee funds?

Mr. BILLIK. No, sir, I do not.

Mr. EVERETT. Well, I'd say that's a pretty good difference. If you had that much extra money, why put it in there?

Mr. BILLIK. Sir, it was a choice that I made at the time that it was extremely important to the VA Medical Center in Charleston that we implement a total quality improvement program in that facility.

Mr. EVERETT. In other words, this is \$100,000, almost \$100,000 a year, that actually didn't need to operate the medical facility?

Mr. BILLIK. No, sir, we needed every dollar to operate, but it was my belief that these funds expended would come back to us in—multiplied by a large number with our—in our ability to do our work in an improved way.

Mr. EVERETT. And he met with you how often?

Mr. BILLIK. He worked directly with our Quality Assurance Department and with the individual service chiefs in our Medical Center to train and to implement the total quality improvement program at each of the services.

Mr. EVERETT. Again, you've avoided answering my question. He met with you how often each month?

Mr. BILLIK. He would report to me at the conclusion of his visit and with the Quality Assurance folks and let me know what they had accomplished and what the plans were for the next—for his next visit.

Mr. EVERETT. Well, let's try it another way. Tell me how many actual days he worked a month at your facility.

Mr. BILLIK. There was not a fixed number of days, sir. It would vary from 3 days to 5 days.

Mr. EVERETT. Per month?

Mr. BILLIK. Usually, yes, sir.

Mr. EVERETT. Do you have a record of what days he was there?

Mr. BILLIK. I do not have a record in front of me, sir.

Mr. EVERETT. Do you have any record of written reports that he submitted to you?

Mr. BILLIK. Oh, yes, sir. He worked very diligently with us and was the prime author in the strategic planning document for the Medical Center at Charleston.

Mr. EVERETT. He was the author of that?

Mr. BILLIK. He was the primary author of that document.

Mr. EVERETT. Okay. Are there any other things other than that document?

Mr. BILLIK. None specifically that come to mind, sir.

Mr. EVERETT. How lengthy is that document?

Mr. BILLIK. Well, I don't—I don't recall the length of the document, sir, but it took an enormous amount of effort to work with our staff to produce that document.

Mr. EVERETT. Well, did the staff produce the majority of it or did the consultant produce the majority of it?

Mr. BILLIK. He took the information and he collated that information into a usable document.

Mr. EVERETT. In essence, he typed it up?

Mr. BILLIK. No, I don't believe——

Mr. EVERETT. Well, I'm searching—it's very difficult for me to understand, first of all, why this man was hired; secondly, why you funded it the way you did, in addition to the other things the IG has found. And we're now getting reports that this consultant may have worked for three or four or five different VA hospitals, at the same time. I'm finding it very difficult to determine from your testimony exactly what it was that he did.

Mr. BILLIK. Sir, he was involved every day that he was there and also in between——

Mr. EVERETT. Okay. He did everything——

Mr. BILLIK (continuing). In training our staff.

Mr. EVERETT. You still have not given me specifically what you paid this man \$90,000 a year from medical fee funds from the hospital to do, and I would ask you to provide that to us for the record.

[The information follows:]

**Department of  
Veterans Affairs**

**Memorandum**

Date: January 26, 1998

From: Director (00), Central Texas Veterans Health Care System, Temple, TX

Subj: Inquiry by Congressman Everett

To: Chief Network Officer (10N), VHA, Washington, DC  
ATTN: Neal McBride (DATA) (10NA)

*MMB*

1. The following information is provided in response to an inquiry from Congressman Everett, Chairman of the House Veterans Affairs Committee.
2. In response to Congressman Everett's question of "What account did the money come from?", the answer is Medical Care Recurring Operating Funds.
3. In response to the request for a copy of the products delivered, the products range from Strategic Plans for the Medical Center and individual services, to training materials and manuals, formal presentations, graphs, flow charts, class syllabus, and minutes of meetings. The amount of material is voluminous. However, a complete set of all materials is available and has been provided to the VA Inspector General, South Carolina Office.
4. In response to a request for a narrative of exactly what was provided for the funds that were allocated, the following information is a summary of the key activities which Management Directions, Inc. provided the Ralph H. Johnson VA Medical Center (VAMC), Charleston, S.C. from January 1995 to September 1996.
  - a. In 1994, VHA launched an initiative to implement Total Quality Improvement (TQI) within the VHA. As part of this initiative, the American Productivity and Quality Center (APQC) was hired to implement TQI within a number of VA Medical Centers. Charleston was one of these medical centers and Mr. Fuller, an employee of APQC, was the Chief consultant for these services. Charleston was one of the last facilities in this program to receive APQC's services, and at the conclusion of their contract the Charleston VAMC did not feel they could adequately implement TQI. It was at this point that the contract to complete implementation of TQI was extended to Management Directions, Inc.

2.

Chief Network Officer (10N), VHA, Washington, DC

b. Management Directions, Inc. provided the guidance, education, facilitation, and consultation necessary to successfully launch, complete charters and implement 11 multidisciplinary TQI Process Action Teams and Process Assessment Teams. There were no Process Action Teams or Assessment Teams to improve patient care and quality of care at the Charleston VAMC prior to the arrival of Management Directions, Inc. These teams significantly improved patient care and employee programs. Management Directions, Inc. developed training for and trained team members, team leaders, and facilitators. They taught these teams how to be a process action team, how to collect data, how to analyze data, how to put the data into a usable form, how to implement the recommendations, and how to track and trend the results. They taught leadership how to develop a Quality Leadership Team and use CQI tools.

c. The teams which were developed include:

(1) Admissions Implementation Team. This team dramatically improved the admissions process. Prior to the implementation of this team, it would take 4-5 hours for completion of the admissions process. This team streamlined and improved the process, and currently a patient is processed and in his/her hospital bed 15 minutes after arriving. Extensive pre-admission work is accomplished before the patient arrives, and services are brought to the patient instead of the patient going to the service. This has not only increased efficiency but also dramatically improved customer satisfaction. The process developed by this team under the guidance of Management Directions, Inc. is being used as a model for other VA medical centers in the VISN and probably at other VAMCs across the country.

(2) Customer Satisfaction Team. This team developed a survey tool which can be adapted for use by any service in the VAMC to measure customer satisfaction for that service.

(3) Employee Recognition Team. Prior to the development of this team, there was no employee recognition other than annual performance appraisals. This team developed an employee recognition program which emphasized customer service. They modeled their program after successful programs in the business sector, and currently there are individual awards, team awards, and group awards, and employees may award other employees for outstanding customer service. Given the current focus on becoming an "Employer of Choice," successful recognition and reward systems are critical to success in VHA.

3.

Chief Network Officer (10N), VHA, Washington, DC

(4) Performance Appraisal Team. This team was looking into an employee pass/fail appraisal system. Before they could fully develop their plan, the VA adopted a pass/fail system for all VA employees.

(5) Coronary Artery Bypass Critical Pathway Team. This team developed and implemented the first Critical Pathway for coronary bypass patients. This has resulted in a significantly reduced length of stay for these patients.

(6) Ancillary Testing Team. This team looked at all ancillary services and coordinated the support these services provided clinics. Tests are now completed in a single day in lieu of multiple visits.

(7) Mammography Team. This team identified a problem with the followup on mammography tests and the communication of the results of these tests to patients. Because of this team, these problems have been resolved.

(8) Discharge Process Team and Discharge Pilot Team I and II. This team and the pilot teams which followed significantly improved discharge planning, discharge process, and followup.

d. Management Directions, Inc. also facilitated the operational concept and implementation of Primary Care at the Charleston VAMC. Prior to the arrival of Management Directions, Inc. there were no Primary Care Teams at this VAMC. They also developed computer simulation models to identify and improve work flow in the ambulatory care and pharmacy areas. The development of Primary Care has significantly enhanced patient care at Charleston VAMC.

e. Additionally, Management Directions, Inc. assisted in initiating service quality deployment activities in several services including Medical Administration, Environmental Management, Information Management, Pharmacy, Acquisition and Materiel Management, Radiology, Engineering, and Human Resources. Their assistance included team training, guidance, and ongoing consultation with leaders and facilitators.

4.

Chief Network Officer (10N), VHA, Washington, DC

f. Management Directions, Inc. developed Charleston's first Medical Center Strategic Plan with input from Medical Center personnel. This included designing the strategy for implementation of the strategic plan, actual writing and organizing the plan, and delivering a finished product. They also assisted individual services in the development of service-level plans.

g. Management Directions, Inc. assisted the Medical Center Director in developing a plan which resulted in the Charleston VAMC being awarded a regional Consolidated Mail-Out Pharmacy (CMOP). This CMOP serves the majority of pharmacy needs for approximately 23 VA Medical Centers in the south and covers an area which includes Florida, Georgia, Alabama, North Carolina, and all of South Carolina.

h. Management Directions, Inc. improved employee programs, employee morale, and professionalism. They assisted an ad hoc group in designing a series of workshops on Coaching and Mentoring for Supervisors. They taught the team how to design and conduct focus groups. They developed and conducted a series of training for all nurse managers on collecting and analyzing data.

i. Management Directions, Inc. was crucial in preparing for the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) visit in 1995. The Charleston VAMC received accolades and very high scores for the work accomplished and programs developed in TQI.

5. I hope this answers all of Congressman Everett's questions. I will be happy to provide any additional information Congressman Everett may require.



Dean S. Billik, FAAMA

Mr. EVERETT. Now, Mr. Billik, I must observe that your rendition of the IG report in your written testimony is, in my view, self-serving and selective, to say the least, if not downright misleading. And what I'd encourage is for folks, and particularly the press, to read that report because it speaks for itself, and they can draw their own conclusions rather than taking my word for it.

You heard the IG testify on this just a little while ago that there was mismanagement. How do you answer that?

Mr. BILLIK. That's the first time I've heard that term used, sir, that it was in fact mismanagement.

Mr. EVERETT. Let me suggest to you that anybody who can't read the IG report, which you profess to have read, and not come to the conclusion that there was mismanagement does not deserve to be in a management position. This is part of what we're trying to get at in this committee, and I must tell you that somebody making six figures a year should perform at a higher level than you have obviously performed.

Mr. Cappello, in your testimony you admitted mistakes were made, such things as the \$500 faucet and \$1,200 whirlpool bathtub, and it caused serious problems to the VA as an institution because of public concern about the government in general. Money that could have helped veterans was wasted, frankly. It appears that you accept responsibility for the cost overruns on the renovations of the Director's quarters in Pittsburgh. Am I right in making that assumption?

Mr. CAPPELLO. That's correct, sir.

Mr. EVERETT. Well, I respect your acceptance of the responsibility, and I sincerely hope your career as a senior management will go forward and will benefit veterans after this.

Mr. Clark, if my colleagues will allow me, I'm going to finish up my questions, and then we'll let each person finish up their questions, since this is the last set of witnesses.

You know, I'm not from Missouri, but you're going to have to show me. I've heard this kind of bureaucrat tap dancing before. We've heard quite often, a problem crops up, and then all of a sudden we get all these changes and plans, as we did, for instance, with zero tolerance, and they never materialize. The thing that concerns me is the very people that will run the organization now that you've reorganized it are the same people that have promoted incompetent people over the years. They're the very same people. So I'm not at all impressed with your testimony—not at all. As I said, as far as I'm concerned, you're going to have to show me.

And I want you to know right off the bat that this subcommittee will continue to look at this, and we're going to start doing it in a little different way. When these type abuses are reported, we're going to find out who made the abuse, and then we're going to track it upward and find out why nobody's accepted responsibility. As my colleague said earlier, somewhere somebody's got to accept responsibility, and there's complete refusal in this organization to do that at any level.

I have mentioned I think there are actually millions of dollars of taxpayers' money wasted each year, and we have a bunch of bureaucrats that decide that they're not going to do anything about it. And then we're asked to put—the Congress is asked to put more

money into VA every year, and nobody seems to have regard for how that money is being spent. And that's going to stop. If this subcommittee chairman has anything to do with it, that is going to stop.

Now I'll just say that I've got great respect for some of the people I met in VA. I think anybody that has appeared before my committee, either at this committee or the Compensation and Pensions Subcommittee in the last term, will tell you that I'm direct, but I'm fair. And we all should be responsible for taxpayers' money, and I don't see that happening in the VA.

As hard as some of us have tried to penetrate the culture that exists in VA, we've not been able to do it. And if we have to have hearings every day and put people under sworn testimony and subpoena people, then that's what we'll end up doing. But I want to see somewhere somebody along the line take responsibility for promoting bad managers to six-figure salaries that shouldn't be promoted, or giving managers \$25,000 buyouts that have been accused of sexual harassment, or promoting managers or moving them to other places. It has got to stop. I hope somebody will hear this. It's got to stop. And if it doesn't stop, we're going to have hearings and we're going to flesh this thing all out. We're going to put some sunshine on top of it. That's the best way. I hope we can embarrass the VA into having somebody somewhere along the line take responsibility for what's happening.

Now having said that, I'll now turn to my able ranking member for his comments.

Mr. CLYBURN. Thank you, Mr. Chairman. Mr. Chairman, I do want to ask Mr. Billik a question. One of the things that's bothering me swirls around this decision that was made not to use a newly-renovated nursing home care unit for its intended purpose. Now were you aware at the time that you made that decision that the available nursing home beds in Charleston were in short supply?

Mr. BILLIK. The only way that I can address that, sir, is that at the time that we made that decision there were no veterans in our beds who could not be placed in community nursing homes. In other words, we did not have a waiting list of veterans needing care.

Mr. CLYBURN. So you didn't know that the beds were in short supply?

Mr. BILLIK. The only way that it would have been revealed to me, sir, would be that I wouldn't be able to place—

Mr. CLYBURN. All you have to do is say yes or no. So you didn't know. Now will you tell me the authority under which you are empowered to make such a decision unilaterally?

Mr. BILLIK. I can't cite a specific authority.

Mr. CLYBURN. You just acted on your emotions?

Mr. BILLIK. No, sir, we acted on what we believed to be the best course to take at that time.

Mr. CLYBURN. Did you inform superiors that, because of whatever your information was, that you were not going to use this facility for its intended purpose?

Mr. BILLIK. Absolutely.

Mr. CLYBURN. Now why didn't you make that decision before the renovation was done?

Mr. BILLIK. Because the renovation—I think the project to do that project and the funding for that preceded my time at Charleston.

Mr. CLYBURN. Yes, the authorization preceded your time?

Mr. BILLIK. Yes, sir.

Mr. CLYBURN. But did the work? Now maybe I have it wrong, but, as I understand it from what I've seen in this testimony, that this renovation took place after you arrived. I didn't say the authorization for it. You see, what I'm getting to is that if you can decide after the renovation is done that you don't need the facility, why can't you make that decision before the money is spent on the renovation?

Mr. BILLIK. I would agree with you, sir. I believe the project had begun just as I arrived. I don't think that, you know, I had the opportunity when that project had begun to fully evaluate the future, if you will. The decision to use that for swing space came when a second project to renovate a medical unit—I mean, the funding came for that second project, and as I said earlier, in order to do that project, we had to move those patients to another unit or close the unit and reduce our capacity to treat acute care patients. So the decision was made at that time to continue to treat acute care patients.

Mr. CLYBURN. Let's look at another issue. What is the VA policy or procedure that will govern any facilities Director's ability to enter into the kind of contract that you entered into that is being talked about here so much today, this \$90,000 a year contract that we don't seem to have any kind of written report on what was done or not done?

Mr. BILLIK. The Directors are prohibited from negotiated contracts, and our contracting officer negotiates those contracts.

Mr. CLYBURN. So this contract, this \$90,000 was not negotiated by you?

Mr. BILLIK. Yes, that's exactly right, sir.

Mr. CLYBURN. So the person who was selected to carry out the contract was selected by somebody else?

Mr. BILLIK. No, sir, the contracting officer in the Medical Center negotiated the contract.

Mr. CLYBURN. Okay. So you've got a contract here; now you've got to go and get somebody to implement the contract? I'm listening.

Mr. BILLIK. I'm not sure of your question, sir.

Mr. CLYBURN. My question is this: How was this contract entered into? I thought you had to bid these contracts. I thought the regulations would require that such a contract as this would have to be bidden competitively. You're telling me——

Mr. BILLIK. Often that's the case. In this case my contracting people informed me that they could continue this individual under contract. You know, my purpose here was that we had begun a process under a broad VA total quality improvement contract. We had made significant progress in the implementation of total quality improvement, and it seemed to me to make sense at that time that, if we needed to continue to have that kind of outside support, it

should be with the same individual or firm, if you will, that had begun the process.

Mr. CLYBURN. So you kept someone who had been there when you got there, is what you're telling me?

Mr. BILLIK. I kept someone who was—who came to Charleston under a VA Central Office contract, sir.

Mr. CLYBURN. But the person came to Charleston before you got there?

Mr. BILLIK. No, sir.

Mr. CLYBURN. Well, what are you trying to tell me? You keep trying to tell me that you find it necessary to keep somebody—

Mr. BILLIK. There was a national VA contract let with a firm to bring to various medical centers a total quality improvement program. Charleston was one of those facilities that had been selected for that program. And so at the conclusion of that contract year, which had been negotiated here in the Central Office, it was my decision to continue to use that same individual. It appeared to me to be the most reasonable thing to do at the time.

Mr. CLYBURN. Continue to use the same individual to implement this—the contract had come to a close that this person was originally hired under?

Mr. BILLIK. Yes, and—

Mr. CLYBURN. So rather than let that contract close, you decided to open up a new relationship with someone, this person, who had finished this contract? So this contract that he was operating under was a contract that you implemented?

Mr. BILLIK. Yes, sir.

Mr. CLYBURN. Well, that's what I was asking you. I was asking about the contract. I'm not asking about the person. But you implemented this contract and you made the decision to keep this guy, who had already finished the contract with the VA that they originally hired him for?

Mr. BILLIK. Yes, sir.

Mr. EVERETT. Would the gentleman yield?

Mr. CLYBURN. Yes, I'd yield.

Mr. EVERETT. Let me make sure I understand. In other words, you directed that the contract go to Fuller; is that correct? I remind you that you're under oath.

Mr. BILLIK. Yes, sir, I asked our folks to continue this individual under contract.

Mr. EVERETT. How about at Columbia?

Mr. BILLIK. Yes, sir, we used him at Columbia for a couple of days, in my recollection.

Mr. EVERETT. Under your direction?

Mr. BILLIK. Yes, sir.

Mr. EVERETT. Thank you, Jim.

Mr. CLYBURN. Oh, well, my time is up. I don't want to take away from these other two gentleman. So maybe, Mr. Chairman—this is the last panel. So I don't want to infringe upon their time. Let me let them go, but I may want to pursue this, because of all the things I see here, I've got a real problem with the IG's office and its interpretation of what title 7 does or does not mean, but when you make these kind of unilateral decisions, as you have made with these nursing home beds, because that affects the people I'm here

to represent, whether or not they can get a bed and whether or not they can get a service in Charleston without having to go all the way to Columbia—though I'm pleased to have them come up there, too, because that's also my Congressional District; that's fine, too, but they want to stay near home; I'm concerned about those unilateral decisions, as well as a decision to enter into a contract with somebody that was supposed to be going on his or her merry way, and you decide to keep them to do something else that we can't seem to find out what it is they were doing. Because you don't have any kind of written report. I have never seen anybody work for this much money 4 days a month—that leaves that person 26 days to write the report, and we don't see anything, any written document that this person was doing anything but getting paid.

So I may want to come back to this, but I'm going to let them go ahead, Mr. Chairman.

Mr. EVERETT. Thank you, Frank?

Mr. MASCARA. Good. Thank you, Mr. Chairman.

I resist the temptation to make light of these very serious charges, but it reminds me of a sitcom that Larry Storch played in called "F Troop." You know, these are very serious charges, but then I had to look to other alternatives. You know, was it total ignorance, incompetence, or by design in some instances, which could be very serious, as it relates to perhaps a further investigation of the allegations here.

But I'll get to one of the many questions I'd like to submit to you, Mr. Billik, some questions that maybe perhaps you could reduce to writing and respond to me at a later date?

Mr. BILLIK. Sure.

Mr. MASCARA. Getting back to Ward 4-A, which was renovated into a nursing home care unit and never used for that purpose, my question is: Who ultimately had the authority to use these renovated spaces for acute care patients? And as I said earlier, the closest one (nursing home) was 110 miles away in Columbia, SC.

And the other part of that question is: Were you able to ascertain—did you ask the people in your fiscal department the cost involved in contracting out those services as a result of not using those 38 spaces as a nursing home care facility?

Mr. BILLIK. No, sir, there was not a discussion about the contract cost for nursing home care. As stated earlier, we did not have patients waiting for placement in a nursing home care unit. The decision was a decision to continue to keep the number of acute care beds at the same level while the construction of a medical unit took place. The decision to do that was made in concert with my supervisors and concurred with.

Mr. MASCARA. Without regard to the cost? Didn't somebody—in today's environment it costs about \$3,000 a month or more, depending on where the home care facilities are located. Were you able to ascertain what the costs were involved in that decision that you made, or whoever made it? Did someone ever say to you, it's all right not to use this as a nursing home care unit rather than an acute care facility?

Mr. BILLIK. Yes, sir.

Mr. MASCARA. Who? Who was that?

Mr. BILLIK. Well, first, it would have been Dr. Higgins, who was then the Regional Director, but, subsequently, when Mr. Deal, who was the new Network Director, came to Charleston, we had a lengthy discussion about this very, very unit.

Mr. MASCARA. Were you suspect that something was wrong when they activated the funding for the unit and the unit was not a nursing home care facility? And what were those funds used for? And how much did they amount to?

Mr. BILLIK. The funds to construct the unit were used to do exactly that. The personal—all of the funds that were identified for the equipment were used to buy equipment for that unit. The funds for personal services or people, dollars were used specifically for people.

At the time that the projects, the renovation projects, that were going on in the Medical Center were concluded, we would have activated that nursing home care unit with our existing resources, sir.

Mr. MASCARA. Do you have unilateral authority to spend funding for operations other than what their intended uses were?

Mr. BILLIK. Not—no, sir, not generally.

Mr. MASCARA. So to whom do you speak in that regard? Is there some immediate superior that—

Mr. BILLIK. Yes, sir, in this case now it would be my Network Director.

Mr. BILIRAKIS. Would the gentleman yield at this point?

Mr. MASCARA. Yes.

Mr. BILIRAKIS. And you can take some of my time, Frank.

Back to the—continuing with the nursing home thing, Mr. Billik, you made the comment that there was need—you determined that there was no need for nursing home use, but in taking a look at the Attorney General's—the Inspector General's report here, allegation one, they stated that—let's see, "the former Director stated that there was a strong demand for nursing home care beds in the Charleston area and he could fill the 38 NHCU beds almost immediately if a decision was made to open the NHCU." And it says, "His assessment of the need for nursing home beds was supported by comments we received from staff in Congressman Sanford's office and the fact that there are 33 active nursing home care contracts for Charleston area veterans."

So I guess it seems to belie, if you will, your statement that there was no need for them at that point in time, and therefore, you used it for another purpose.

Mr. BILLIK. May I speak to that, sir?

Mr. BILIRAKIS. Well, by all means—Mr. Mascara has the time, but yes.

Mr. BILLIK. What I referred to was, again, going back to a waiting list. The truth on nursing home beds in Charleston, that Charleston in fact had the greatest deficit of nursing home beds in that particular network, and the deficit was identified in community nursing home beds, in VA nursing home beds, you know, and State veteran home beds I think was the third factor that was looked at.

Yes, there was a need for nursing home beds in the city of Charleston; no question about it. At the time we made the decision

to not activate this unit, it was based upon the fact that we were placing successfully those veterans requiring nursing home care at other sites, using other resources, whether it be the resources at Columbia or whether it be the contract sources.

Mr. MASCARA. I'm just wondering whether, you know, that made fiscal sense, given that you're talking about 38 beds at \$3,000 a month; you're talking \$114,000 a month or \$1,300,000-and-some annually, whether that decision was the right decision to make, given that you had a deficit in the beds in that region and that people would have to travel 110 miles to get a bed. I have a problem with that.

Let me ask one more question, Mr. Chairman, to Mr. Clark.

Mr. EVERETT. Please go ahead, and if the gentleman will yield, I'll give extra time.

Mr. MASCARA. Thank you, sir.

Mr. EVERETT. I'm trying to get something square in my mind, too. Did you use the activation money in any other way?

Mr. BILLIK. No, sir.

Mr. EVERETT. No, activation money was not used to cover budget shortfalls?

Mr. BILLIK. No, sir.

Mr. EVERETT. And activation money is still there and they will not need additional money?

Mr. BILLIK. As I said earlier, Mr. Chairman, when the unit was activated, it was our intention that we would activate that unit with the resources that were there, present at Charleston at the time. We would have not asked for any more resources.

Mr. EVERETT. And those resources that were originally intended for that are still at Charleston—

Mr. BILLIK. Yes, sir.

Mr. EVERETT (continuing). And have not been used for anything else?

Mr. BILLIK. Yes, sir.

Mr. EVERETT. I appreciate the gentleman yielding to me. Please continue.

Mr. MASCARA. I'm generally disappointed after reading the Inspector General's reports and given the information that we've had here today—it appears to be, and I say it with tongue in cheek, that we've let the "fox in the hen house," that we need to talk to somebody that doesn't have a "DVA" in front of them. But, Mr. Clark, I assume you read the statements being presented here today? Have you read those?

Mr. CLARK. Yes, sir.

Mr. MASCARA. Including the reports of the Office of the Inspector General?

Mr. CLARK. Yes, sir.

Mr. MASCARA. Are you concerned about these findings?

Mr. CLARK. The findings regarding Charleston and Pittsburgh? Of course I'm concerned. I did read them thoroughly. I think clearly in both instances there were decisions made that, were they given the opportunity to do it over again, would probably do it differently. There are corrective measures that need to be taken and have been taken. So, yes, I was concerned.

Mr. MASCARA. Would you recommend further investigations or looking into these matters, especially as they relate to South Carolina.

Mr. CLARK. I think things have come up in the hearing today that seem to be revelations or new accusations that I was not aware of before that probably warrant a review by the OIG or some other office.

Mr. MASCARA. So some people should be reprimanded and fired and perhaps we should go forward with an investigation, and as our Chairman said, if we need to put people under oath and take depositions, that we should do that to get to the bottom of this? I'm just totally uncomfortable today in the outcome of these hearings. I mean, they've been revealing, but I just don't see anybody stepping forward and saying—with the exception of Mr. Cappello who has said, "hey, I was involved; I take responsibility,"—and that's the kind of things I like to hear, to admit that they made mistake, are going to correct those mistakes, and I'm hoping that the new network system will certainly correct some of these problems, but I'm waiting for someone to say, "We did it. We made a mistake." Thank you, Mr. Chairman.

Mr. EVERETT. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Well, Mr. Chairman, that word "accountability," it seems like everybody uses it, but not too many practice it.

Mr. Clark, you just made the comment, the same sort of thing, I guess, we keep hearing, that "I wasn't aware of some of the problems until the hearing here today." You know, it makes me wonder. We all have a job to do. Some of it is written in a job description; most of it is not. Particularly when one reaches a point of leadership, everything should not have to be down there in black and white. We have a job to do, and you're the head of a Medical Center, and you're supposed to know everything that's going on in that Medical Center, everything takes place in an efficient manner, and there's no perfection. It definitely doesn't exist, but it is certainly a lot better than what we've been hearing. And the primary concern should be the veteran. And, still, nothing—nothing is done, and over and over and over again.

I've been—this is my 15th year on this committee; I have 15 years in the Congress, and we just keep hearing these things.

Mr. Clark, you—and really I'm going to the top, because if there's a culture problem, I think that's basically where the problem lies. But you stated—it was in your written testimony and you stated orally also—"If we intend to hold our executives accountable for the misconduct, I believe we must support them fully in those instances in which they are not at fault." And I commend you for that statement because it's true; you've got to stand by your people, and I don't disagree with that.

But how about in instances where they are found to be at fault? I mean, can that statement be expanded to include transferring and giving a pay raise to an executive found guilty of sexual harassment? Is that holding him accountable for his actions? Is promoting someone with a salary increase, I might add, a proper means of holding that individual accountable for misconduct? I mean, hell, let's penalize him; let's send him down to St. Peters-

burg, FL, particularly, or let's send him to Texas, or whatever the case may be. My God, is that accountability?

I commend you on the one hand where they're found to be, you know, where they're found to be innocent, standing by your people, and you should; I think that's great.

Mr. EVERETT. Will the gentleman yield?

Mr. BILIRAKIS. I'll be glad to yield.

Mr. EVERETT. Mr. Clark, I refer you to page 9 of the IG report, the bottom half of the first paragraph. You heard Mr. Billik's testimony under oath about my questioning on activation funding being used, and I will quote from the IG report that says, "Since NHCU was not activated, the salaries and benefits portion of the activation funding in fiscal year 1995 was used to support general operational needs in the Medical Center. The \$1.35 million then became part of the Medical Center's base amount for future, 1996 and beyond, budget years."

How do you reconcile that with Mr. Billik's statement?

Mr. CLARK. Well, the activation funds are separate from construction funds. Activation funds become part of the budget, and as you heard in the earlier testimony, that money remains in the budget, and that's why the answer was given to you as it was earlier, that once that nursing home is opened in the end of next month—or the end of the year, I should say—the money to support the staff to open that unit is there in the budget. That's why the VA will not be asking for additional funds to support the nursing home when it does become operational. The money is there in the budget.

Mr. EVERETT. I appreciate the gentleman yielding.

Mr. BILIRAKIS. Please continue, Mr. Chairman.

Mr. EVERETT. I guess I'm being a little thick-headed today; I'm having a problem understanding how the IG, on the one hand, says the money was used and how, on the other hand, you're testifying that the money was not used.

Mr. CLARK. The money was in fact used to support other medical center services. It was not used for the nursing home as it was intended.

Mr. EVERETT. Well, Mr. Billik had just testified that the money was not used.

Mr. CLARK. It was not used for nursing home staff because the nursing home was not opened.

Mr. EVERETT. I'm sorry, but that's not what I asked. I asked was it used for operation of the hospital.

Mr. CLARK. It was, in fact, used for the operation of the hospital, not for the nursing home.

Mr. EVERETT. I'll yield back my time. I appreciate the gentleman allowing me—

Mr. BILIRAKIS. Mr. Clark, you recently assumed the current duties as Chief Network Officer, a big job, to be sure. What was your job—you had been with the VA quite a while?

Mr. CLARK. Twenty-three years.

Mr. BILIRAKIS. Twenty-three years. Prior to then, this particular function, what was—were you ever Director of a health care center?

Mr. CLARK. Twice before. For the last 5½ years I was the Director of the West Los Angeles VA Medical Center, and 3 years prior to that, the Director of the Reno VA Medical Center.

Mr. BILIRAKIS. I see. So you've got some experience. Well, sir, do you believe that transferring and giving a pay raise to an executive found guilty of sexual harassment is holding him accountable for his actions?

Mr. CLARK. It would seem not, not someone who is guilty of sexual harassment.

Mr. BILIRAKIS. Did you—you didn't have any input at all into the transfer of this one particular individual to Bay Times, FL? A couple of them were actually transferred down there, one for sexual harassment.

Mr. CLARK. I don't—I'm not sure I know which individual you are referring to, but I guess to answer your question more broadly, I would not have been involved in any personnel actions prior to assuming my duties at the end of August.

Mr. BILIRAKIS. Well, but when these things take place, certainly you all are aware of it. I'm not saying—you're not the head of the VA or anything of that nature, but you certainly are aware of it. I mean, does that rub you wrong, to have heard that—you know, I don't want to really go into names here, and whatnot, but I think you know what I'm referring to.

Mr. CLARK. Stated as you have, yes, it rubs me wrong. I don't know, the details of that case, and, obviously, each case has to be considered separately. Philosophically, if you're asking me, do I believe that executives should be rewarded if they've been found lacking in character or performance, certainly I don't think they should be.

Mr. BILIRAKIS. Why in the hell does it take place then? I mean, you've been a part of the system all of these years. Why is done that way then? Why? I mean, is it—and we talked about this in the last hearing. Is it basically a lot of the laws that we, Congress, has put on the books which kind of forces some of these deals to take place, some of these termination deals to take place, and this sensitivity about being—you know, violating somebody's rights and that sort of thing? Is that what does this, these things?

Mr. CLARK. Some of the laws that are created to provide protections for individuals do make it difficult for the agency to operate with as much swiftness or flexibility as we'd like. Clearly, that's the case.

Mr. BILIRAKIS. And, yet, you know, a lot of us go into the field, visit the centers, et cetera—I don't know, has anyone ever been taken aside and say, "Hey, Mike, we could function a heck of a lot better if some changes were made here maybe to improve things."?

You know, the thing that bothers me, that really grabs me badly here, Mr. Chairman, is you all have gone into these details which are so very important, and I'm not belittling those—forgive me; I don't mean to insinuate that, but really I think what it comes down to is the President of the United States, as powerful as he is, is accountable. We have a little bit of power; we're damned accountable. The president of a corporation, all the officers of a corporation are accountable to the stockholders. It seems like practically everybody in the world is accountable except maybe some of our depart-

ments here, where it seems like you have this culture thing that Mr. Clyburn keeps referring to, rightly so, and there's almost a feeling of lack of accountability. "Well, I don't have to bother to answer to anybody because my peers are going to basically always be there for me or else I'm going to kind of get rewarded, in spite of my conduct." And that really grabs me pretty darn badly.

And I guess we tried to cure that, and hopefully, we have cured it, or are in the process of curing it, when it came to the sexual harassment situations, through our legislation, which is something that we tried to do years ago and we were convinced by the VA that there was no need for it. They tried to do it again, didn't they; they tried to convince it there wasn't a need for it, and it seems like something like that's got to be done here now. And I know I keep talking about the IG, and only because I know if the people in the field feel a little more confident that they have somebody to go to to complain or blow the whistle, if you will, without hazard to their job, losing their job, that they might be a little more forthcoming. And that's why I keep offering the IG, and maybe some sort of a change there.

Mr. Chairman, again, I can't thank you enough for holding this hearing. But here we go again; you know, I don't think I'll be here another 5 years, but if I were, I think we'd probably—I've got the feeling—why do I have the feeling we'd be sitting here 5 years from now covering the same stuff?

Mr. EVERETT. That's certainly what frightens this chairman, and I would have to agree with the gentleman and point out about the current system that any fair-minded person would take a look at what's happened with the current management system, and I'm talking about the entire system, and, frankly, it promotes this kind of action. It promotes this kind, and encourages this kind, of terrible management power. I mean, you do something bad and you get promoted—just move on.

At this time, Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman.

Let me start by thanking you. I know that Mr. Bilirakis and I, as members of the full committee, appreciate you giving us the opportunity to participate today, even though we're not members of the subcommittee. I'll be brief, too.

Mr. Cappello, I don't want you to feel lonely sitting there. So I've got a few questions. But it seems to me that, according to this IG's report, we've had several factors that contributed to this situation in Pittsburgh. We've got a former Medical Director in the Eastern Region approving a nonrecurring maintenance project for quarters without ensuring that the quarters' income could support the expenditures. We've got some nameless, faceless official in the Real Property Management Office in Central Office telling Medical Center officials that they could authorize significantly higher expenditures on quarters than allowed by VA policy. This same individual, who we don't know who that person is, did not provide you and Medical Center officials with an accurate model to determine the quarters' spending limits, and the VA didn't implement uniform design standards required by OMB.

We also found that your local managers in Pittsburgh were local management of the interior renovation project, and you, the Direc-

tor, your selections of nonstandard quarters amenities increased spending over the planned levels. It seems to me we've got four culprits in varying levels of culpability in this situation, and that the real culprits seem to be sitting here in Washington, DC. Yet, those people aren't here today, but you are.

And I've read your testimony, and I see that you take responsibility for all that occurred under your watch. That's admirable. That's refreshing. We don't see it that much here on this committee and elsewhere in life.

And I've watched your performance as Director of this Medical Center, being intimately involved in that Center. Being a member of the Veterans' Committee, having a father that was 100 percent service-connected disabled veteran, and really caring about just what goes on in Pittsburgh, I have to say that, aside from this single incident here, you've done a good job in Pittsburgh, and I think Frank Mascara and I and others have recognized that.

I want you to speak specifically to the part that you've played in this. I think we've documented quite clearly that you got some bad direction from Washington, and that's why this overrun took place. But you have been specifically singled out for selecting non-standard amenities, and we heard testimony about faucets and a whirlpool. Did you personally select these amenities, and had you to do it all over again, Mr. Cappello, would you have done it differently?

Mr. CAPPELLO. If I had a chance to do it all over again, I would have done it differently. I did have input into these selections, and I was under the impression, if they didn't fit into the parameters of the contract that they would have been deleted. I had no idea, as I've pointed out, of the cost of those amenities. I would not have done it.

And I would say that I think we've taken action, including myself—my supervisor put specific language in my performance plan to ensure that I would do a better job of quarters management. I think I've learned a lot about it; I didn't know much about it at the time, and we've also taken action so that we could control these things better in the levels of management beneath me as well.

With regard to those amenities, I had input into those selections and I thought they fit within the parameters of the contract.

Mr. DOYLE. You know, they say that hindsight is 20/20, and I would just hope that in the future—and I'm convinced from what I've seen in the IG's report and the recommendations that have been followed that this situation has been corrected in Pittsburgh and can't occur again. I hope you can appreciate the pain that this causes veterans in Pittsburgh, and all of us that work on behalf of veterans and those of us that feel strongly about veterans here on this committee, that these are the types of instances that bring down the whole system.

We have people, not members of this committee, but we've got Members of this Congress that don't think we should have VA hospitals anymore, that that should all be folded into the private sector. I disagree with them drastically. They don't understand the special needs that VA hospitals and the special needs of veterans that are taken care of in VA hospitals. But things like this is what helps bring this whole system down.

And I'm going to just focus on you, Mr. Cappello, because I'm not a member of the Oversight Subcommittee and I'm just here because Pittsburgh's been mentioned and the facility's in my community. I think there's been plenty of comment on the other people on this panel today.

I hope you've learned from this. I think you're a good manager in Pittsburgh. I think this is an isolated incident. I think your performance since that time has been admirable. I think it says a lot about you that you've had the courage to come here today and say you were wrong and you've made mistakes, and I know members of this committee appreciate that also. I hope I don't ever have to see you or anybody from the Pittsburgh VA in front of this committee again for a situation such as this.

Mr. MASCARA. Will the gentleman yield?

Mr. DOYLE. Yes, I would.

Mr. MASCARA. I just have one question, Mr. Cappello. And when I made reference to the "F Troop"—on page 5 of the IGO's report, there was a construction company that literally began construction without a signed contract?

Mr. CAPPELLO. Yes, sir.

Mr. MASCARA. How? It says here that "the contracting officer told us, the IG, "that he permitted the construction work to go forward during negotiations to help the company retain workers." Now what kind of excuse is that?

Mr. CAPPELLO. They were already working on two of the sets of quarters, and the thought was—and this is after the fact, I didn't know this at the time because I didn't involve myself in the actual contract—

Mr. MASCARA. And the other part of the question—

Mr. CAPPELLO. The idea was that he could stay onsite there.

Mr. MASCARA. But you don't begin a construction project without a signed contract.

Mr. CAPPELLO. I agree.

Mr. MASCARA. Never. And the other is that, apparently, the contractor was not doing a good job or couldn't complete some work, and that station employees also performed work on that project. Was the contract that was signed, somehow the cost of the station employees, was that deducted from the contract, from the original contract, or did he receive full payment?

Mr. CAPPELLO. What—

Mr. MASCARA. If you don't have the answer, you can get back to me, but I—

Mr. CAPPELLO. Well, what was projected is that the contract, as I understood it, was for \$86,000 to do probably 80 percent of the work in the house. What was supposed to happen is our station labor, we thought, could do it more economically, and so that the total cost of the renovation was supposed to be around \$107,000, \$86,000 to the contractor and the rest by station labor. And I think in my testimony I showed how the costing practices of the VA system at that time led to what I think were inaccurate cost estimates by our people.

Mr. MASCARA. Well, there are a lot of people culpable all over the place, but I thank you for your response.

Mr. CAPPELLO. I would only just say one thing, that I appreciate anything good that's happened in Pittsburgh under my watching, and my greatest regret is in any way that I let anybody down.

Mr. EVERETT. I'd like to thank all of the members of the committee and all the panelists for appearing here today.

I have a couple of housekeeping things. Under Secretary Kenneth Kizer in July issued an information letter on relationships between managers and subordinates. I ask unanimous consent that it be made part of the record.

[The information follows:]

IL 10-97-029

In Reply Refer To: 10N

July 25, 1997

**UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER  
RELATIONSHIPS BETWEEN MANAGERS AND SUBORDINATES**

1. This information letter discusses issues which can arise when close personal relationships develop between managers and their subordinates.
2. Managers at any level who develop intimate relationships with subordinates incur very substantial management burdens. This is true even if the relationship is not one that qualifies as "unbecoming an employee." Separating one's private relationships from one's public responsibilities becomes extremely difficult when one is involved intimately with a subordinate.
3. The Standards of Conduct for Executive Branch Employees require that employees "act impartially and not give preferential treatment to any individual." More specifically, the Standards stipulate that no employee shall use a title or authority for the private gain of anyone with whom the employee is affiliated in a non-governmental capacity. Further, the Standards require that they avoid creating the appearance of violating that principle.
4. Having an intimate personal relationship with a subordinate makes it very difficult, if not impossible, for most people to make decisions affecting the subordinate without considering the relationship. Whether or not the decision affects the financial interests of the subordinate, or even the program that the subordinate works in, the decisions are fraught with adverse implications under those rules.
5. One irony associated with being an executive or manager in the preceding situation is that the higher the executive or manager is in the organization's management structure, the bigger are executive or manager's decisions. The result is that the manager's decisions are likely to have a bigger effect on a subordinate with whom a close personal relationship exists. Also relevant is that hundreds of employees, as opposed to none or a few, have a claim on, and expectation of, the objectivity of executives and managers.
6. The more regard the manager has for the subordinate, the more the manager is inclined to benefit him or her. People understand that, and yet the Standards of Conduct give people the right to expect that the relationship won't change the decisions. It's obvious why other subordinates are so likely, whether justified or not, to feel that their work environment may be a hostile one.
7. When a personal relationship evolves to the point of living together, the Standards governing "the appearance of a conflict of interest" apply. Sharing a household sets up a "covered

**IL 10-97-029**  
**July 25, 1997**

relationship.” Under the rule, the superior should not participate in a matter affecting the “housemate” unless a reasonable person would not question the superior’s impartiality.

8. These relationships place at risk the confidence of other subordinates. The manager in such a relationship who intends to be professional is faced with the job of explaining the decisions that impact on the other person. The difficulty of explaining makes clear that such a relationship is a mistake of judgment. The relationship is virtually certain to limit effectiveness as a leader. The manager who carries on such a relationship is obligated, at a minimum, to recuse from decisions affecting the subordinate financially.

9. As government employees, we are held to the highest standards of conduct. I encourage careful consideration of the points raised in this letter when it becomes obvious that friendships are deepening and may progress to a point where manager/subordinate relationships may be adversely affected in your organization.

10: References: Title 5 Code of Federal Regulations 735.203; 2635.101(b)(8); 2635.702; 2635.101 (B)(14);2635.502.

**Kenneth W. Kizer, M.D., M.P.H.**  
**Under Secretary for Health**

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Mr. EVERETT. In addition to that, let me just state for the record that Mr. Calhoun retired after additional charges were brought against him.

Mr. BILIRAKIS. Mr. Chairman—

Mr. EVERETT. Yes?

Mr. BILIRAKIS (continuing). If you will yield for—now that's—I read that housekeeping, that sensitivity letter by Kizer. Kizer. Where in the world has all this been all these years? All of a sudden, the newspapers pick up and broadcast this stuff, you know, and all these things are taking place and all of that, and all of a sudden, the head of the VA, his assistant, the doctor in charge, the heads of the Medical Centers, all of a sudden, they're issuing all of these edicts and changing all of these management practices, and whatnot. I mean, these are supposed to be intelligent, educated people, trained, many years in the system, many years in management, and then, all of a sudden, a sensitivity letter is issued regarding a relationship among a supervisor and an employee. I just—it's hard to accept.

Mr. EVERETT. The gentleman's point is well taken.

Members have indicated that they would have additional questions for all the panels to respond to.

Well, we've been here right on 5 hours. I hope we've learned something and accomplished something.

As I have stated earlier, we will continue to have these hearings as long as it takes to reform the VA. Certainly, I do recognize there are many dedicated managers and directors who adhere to the high standards expected from them and who are very careful with taxpayers' dollars. However, I do point out that I am not comfortable, as many of my colleagues, that we have penetrated the culture within the VA that finally says we're really going to correct ourselves.

And, Mr. Clark, I say to you that, again, you'll have to show me. I've taken this at face value now for going on 5 years, and I don't intend to take it at face value any longer.

As Mr. Doyle pointed out, we believe in VA hospitals. There are many who do not. And the examples that we see being set with 12 Directors transferred to other jobs, 1 given a \$25,000 buyout, charged with sexual harassment—this does not go unnoticed by the employees of VA, and it's beginning not to go unnoticed by the public in general. We want the VA to survive, but I must tell you that the VA is going to have to learn to spend its money much better than it's spending its money, and it's going to have to certainly change some management styles, and, again, the culture—the word that we all use—within VA that pretty much listens to these 5-hour meetings and then goes out and changes nothing. I hope this committee meeting is different, but that will remain to be seen.

Members will have 5 legislative days to revise and extend their remarks and to submit questions to the witnesses for the record.

Testimony will be available following the hearing on the committee website, WWW.HOUSE.GOV/VA.

The hearing is adjourned.

[Whereupon, at 2:27 p.m., the subcommittee adjourned subject to the call of the chair.]

**A P P E N D I X**

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Statement by Congressman Mark Sanford  
Subcommittee on Oversight and Investigations  
House Committee on Veterans' Affairs  
October 23, 1997

Thank you, Mr. Chairman. Each year, millions of our veterans and their families turn to VA hospitals to service their health care needs. Over 200,000 dedicated men and women have committed themselves to raising the standard of care in veterans hospitals around the country. Now, some of those folks will come before you to share their experiences with the hope that Congress can help them in their cause. I want to applaud them for their caring, their professionalism and their dedication.

A plaque in the lobby of the Charleston VA reads, "The mission of the 'new VA' is to improve the health of the served veteran population by providing primary care, specialty care, extended care and related social support services through an integrated health care delivery system." This plaque binds us to fulfill a pledge to those who have sacrificed for their country.

Today, Fletcher Truesdell and Kate Smith will detail for you examples of mismanagement that go well beyond the now infamous "fish tank." In total, 30 current and former employees of the Ralph H. Johnson VA Medical Center courageously stepped forward to point out questionable practices by the former director of Charleston's VA Medical Center. They can share how limited resources were squandered rather than spent on the care of our veterans, which is supposed to be the number one mission of the VA hospital.

To quote the Inspector General's report, "We believe some employees perceived the former Director as placing priority on nonessential amenities such as the fish tank at a time when employees' jobs were being threatened by a shortage of funds. A number of employees used the fish tank as a symbol of what they believed was the former Director's unsympathetic attitude towards the employees who may be subject to the RIF process or other adverse personnel actions due to the funds shortages."

Veterans deserve the very best health care possible. Those who work at VA hospitals are already stretched thin. Should we sacrifice valuable nursing staff for expensive renovations? Absolutely not. Yet those are the stories we have heard in the Inspector General's report and will hear again today.

I would like to thank Mr. Truesdell, Ms. Smith and Mr. Charles Steinert, who traveled to Washington to share their experiences with this Committee. These hearings, combined with other investigations, must strengthen our resolve that those things that have happened in Charleston never happen again. Let this process serve as our guide to improving the VA's management process.

Mr. Chairman, I thank you and my fellow colleagues on this Committee for your interest and your expediency in investigating these charges. For every veteran, it is imperative that these problems are no longer overlooked.

Testimony of Fletcher P. Truesdell  
 Subcommittee on Oversight and Investigations  
 House Committee on Veterans' Affairs  
 October 23, 1997

Good morning Mr. Chairman and members of this Congressional Committee. Thank you for granting me this opportunity to appear before you today.

My name is Fletcher P. Truesdell. I am a disabled veteran and the President of the National Association of Government Employees, Local R5 136, representing approximately 700 employees at the Department of Veterans Affairs Medical Center in Charleston, South Carolina. My total commitment is to the American veteran and the employees who care for them. My testimony is filled with emotion and concern. There is no way to impart to you in five minutes everything needed to be told.

Our concern here today is the mismanagement of our former director, Mr. Dean S. Billik. This resulted in misappropriation of funds, abuse of the system, waste of our tax dollars, and abuse of our employees. Mr. Billik lost focus of the VA mission, which is to care for our veteran patients. We promised, gentlemen, to care for them in their time of need. We hear all the time how we need to cut expenses. I state here, for the record, if we attend to those persons in positions of authority who continually abuse the system, much of the problem of waste, fraud and abuse will cease.

Mr. Billik was blatant in his mismanagement and abuse of power. The system routinely transfers directors like him out of trouble, leaving behind other top management officials who continue the same management offenses. They are left in place to wreck havoc on the employees who complained of the waste, fraud and abuse until a "don't-rock-the-boat mentality" cloaks all in fear of reprisal and retribution. We have many dedicated and excellent employees remaining at the VAMC in Charleston. We do not want to lose any more due to the poor treatment they are receiving.

Mr. Billik arrived at the Charleston VAMC in January of 1992, as the new Director and was assigned as Acting Director in Columbia, South Carolina. Soon after his arrival, his entourage from Texas began arriving. He had hired and promoted his friends without competition and placed them in positions held by long-time employees. He further abused the system by giving these friends raises at the same time he was announcing hiring freezes, possible contracting out of services, layoffs, RIFs and cutbacks due to reduction in federal funding. All this was done while creating a \$2.9 million deficit.

During an employee forum on June 11, 1996, when asked about the opening of the 38-bed Nursing Health Care Unit, Mr. Billik stated that President and Mrs. Clinton's health care reform had changed health care overnight and that the unit would not open. At another forum, Mr. Billik stated that he "was not in the nursing home business." Gentlemen, who did he think he was fooling? The funded Nursing Care Unit has not opened to this day.

The following actions have taken place since Mr. Billik's arrival in Charleston:

- \* A management official informed me that one Quality Management (QM) employee had been demoted and another chose to leave under duress when a management consultant was hired by Mr. Billik for the VAMCs in Charleston and Columbia, SC to perform tasks normally handled by the Director and the QM staff. This consultant was paid \$1200 a day through medical funds.
- \* Mr. Billik hired an interior decorator at a time when the hospital was in a deficit. Costly items ordered for the decorated areas are now elsewhere or missing.
- \* Mr. Billik remodeled the Director's suite and the carpeting was laid twice. During this excessive spending, essential hospital equipment and material was unattainable due to "lack of funds." During a shortage of supplies a nurse supervisor stated "We should take one of those fish and sell it to buy paper for the copy machine." Yes, it was that bad.
- \* Under Mr. Billik's management, we experienced a \$3 million deficit while patient care projects were put on hold. This VAMC received these funds. Where did they go? Will this be investigated?
- \* OSHA cited this hospital with willful safety violations such as the absence of hepa filters and unsafe exterior railings, placing patients and employees in unnecessary danger. The corrective measures were disregarded.

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\* There was an escalation of complaints from employees in all areas. Simple complaints that could have been easily resolved ballooned into major issues due to management's refusal to acknowledge and accept responsibility for the problem. Mr. Billik and his managers have a propensity to play the "is, is not" game.

It is known that correspondence regarding mismanagement was mailed to the Secretary of the Department of Veterans Affairs, voicing a variety of concerns about the hospital. The Secretary apparently did not turn this over to the Inspector General (IG) for inquiry or investigation. Instead, he forwarded the concerns to Mr. Billik who, in turn, called the employee into his office and confronted her.

There are many more cases of employees suffering the consequence of utilizing the "confidential" IG Hotline. How can we stamp out the waste, fraud and abuse if no one feels safe to speak out? The same scenario is true in reporting harassment of any sort. We are told to go up the chain of command. In most cases, the guilty party is in that chain or a "pal" of someone in that chain.

I thank you for your time, and I look forward to possible solutions to the problems. Gentlemen, I am at your service at any time. Additional examples follow and more information is available upon request.

#### ADDITIONAL EXAMPLES:

\* One employee worked extremely late hours under duress. She felt it necessary to take work home. While recovering from surgery, the employee was harassed in returning to work early for fear of losing her job. The employee's children were assaulted with vulgar language as threats were hurled through the telephone by the employee's service chief. The same harassment occurred when the employee was recovering from an on-the-job injury and could not walk. This employee continued to work long hours with untreated injuries, one of which was a grapefruit-sized hernia, another injury being exacerbated by returning to work too soon after a surgery. This employee was a 40% disabled veteran. According to the information I have received, the employee is now a 100% disabled veteran. The employee received a disability retirement from the VAMC at a young age due to the emotional and mental abuse and injuries received while employed. Management was well aware that the employee worked a great number of hours of overtime. This employee worked over 3600 hours overtime within the span of two years. The employee had to fight the usual system for over two years to have the fact officially recognized. Added to the problems of this employee, was the fact that the same employee had blown the whistle on exorbitant waste, fraud and abuse and a possible kick-back operation by the supervisor/department Chief. He left employment. Was he allowed to resign or was he fired? The reason given for his leaving was that he failed a JACHO inspection.

\* An employee in another area became aware of abuses of the system and became a whistleblower. She became the object of demeaning statement and recurrent harassment. We, as American citizens, are encouraged to blow the whistle on waste, fraud and abuse. There is even a supposedly confidential system in which to inform the powers that be. That system failed this employee. This employee was harassed and intimidated. Requests for leave were only approved after grievance action took place. The long-standing work schedule for this one employee was altered and the duty assignment was changed. The work environment became ever-increasingly petty and hostile. Hostile statements during departmental meetings were made while the supervisor stared directly at this employee. Demeaning statements and rumors were circulated which nearly destroyed this employee's morale, credibility, reputation and health. The supervisor was granted a disability retirement while the employee struggles to regain health and reputation. Is there any question why employees are so reluctant to complain about even the most obvious abuses? It is simple. You see the abuse, you "confidentially" inform the proper authorities, then your life is destroyed.

\* An employee reported to the IG that a service Chief changed supply vendors without authority. The change increased the cost. Was this investigated? Was there a connection between the vendor and the Chief?

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\* Mr. Jeff Milligan, Acting Chief Engineer, has been cited for taking a government vehicle out of state on "company time" to play golf under the guise of attending a meeting. He later put in for annual leave for the time spent. Mr. Vogle, the current Director, stated that administration action was taken. A short time later, Mr. Milligan was promoted to Chief Engineer. According to Title 5, USC, the minimum penalty for Mr. Milligan's action is a 30-day suspension. We note here that he was instead promoted. In the past, non-management employees have been penalized, one with a 30-day suspension and the other was dismissed. Title 5, USC does not have a provision for a double standard.

The IG was in Charleston for an investigation in August of 1996. Only a portion of the people scheduled to speak were actually given the chance. The IG reported on fewer still. Some complaints were watered down as to gloss over the seriousness of the situation.

An independent, impartial investigation is needed in these areas not addressed in the IG report:

- \* How problems are actually addressed versus published guidelines.
- \* How whistleblowers are not protected versus published guidelines.
- \* Preselection versus Open competition for positions.
- \* Inequitable distribution of training/educ opportunities, in particular training necessary to the performance of duties.
- \* Contracted Services and Contract content.
- \* Harassment of employees and the double standard.
- \* Hostile environment and resignations under duress
- \* EEO system's ineffectiveness.
- \* Valid Workman's Compensation claims being denied due to possible erroneous statements or action by management.
- \* The Nursing Health Care Unit and its proposed opening.
- \* An in-depth financial audit.
- \* Total inventory accountability.

Testimony of Kate Irene Smith  
 Subcommittee on Oversight and Investigations  
 House Committee on Veterans' Affairs  
 October 23, 1997

Good morning Mr. Chairman and members of the Veterans' Affairs Subcommittee on Oversight and Investigations. I appreciate the invitation to come here today and give testimony before you.

My name is Kate Irene Smith. I am a registered nurse, a veteran and president of the National Association of Government Employees, local R5-150 at the Ralph H. Johnson Department of Veterans' Affairs Medical Center in Charleston South Carolina. This is a professional unit representing Title 38 registered nurses and the testimony I give is in our collective behalf. A statement made by our National President, Kenneth T. Lyons, is being included in today's hearings.

The focus of this testimony is on the "Alleged Mismanagement" at the Charleston VA Medical Center as investigated by the Office of the Inspector General.

There is no question that over a lengthy recurring period of misspending and mismanagement, a negative impact was felt by the nurses in our medical center. Limited to five minutes, I cannot bring all issues forward so I will concentrate on those that are of greatest concern to our nurses.

During Mr. Dean Billik's directorship in Charleston, we faced ongoing problems and adverse working conditions. We were daily faced with critical shortages in nursing staff, threats of downsizing and reductions in force, commonly referred to as "RIF'S." Many resigned under duress and a hiring freeze compounded our problem.

Additionally, under Mr. Billik we witnessed a money management style that left each nurse with continued cutbacks in salary. The subsequent re-assignment and promotion, with accompanying pay raise, of Mr. Billik is something the nurses in Charleston still ponder. Mr. Billik explained to us, "during lean times raises and bonuses are not part of the job and employees should not even expect them." It is a matter of record that during the same "lean times" Mr. Billik rewarded his staff, those who followed him to Charleston or were formerly acquainted, with promotion and salary advancements.

During periods of critical shortages in nursing staff, daily staffing adjustments were made. Nurses with specialized advanced training, competency and certification in one area of nursing were assigned with lack of orientation or crosstraining to areas of total unfamiliarity. This hardly fits the picture of the best patient care possible with efficiency and effectiveness. Mr. Billik denied to the local media that this was occurring, but in fact I was an eyewitness and a forced participant in the management practice.

Currently, Title 38 registered nurses are dependent on the annual salary survey conducted under the Nurse Pay Bill Act and other regulations for any adjustments in pay or shift differentials. This survey is conducted exclusively by management and did little to nothing to keep the nurses in Charleston compensated for their dedicated care to our veterans.

In a memorandum dated March 31, 1994 Mr. Billik addressed the "significant impact" that the reduction in differential pay would have on nurses. One salary survey resulted in the average pay scale nurse getting an increase of one dollar (\$1.00) a week. We experienced continued downward adjustments.

In another memorandum dated April 8, 1996, Mr. Billik again reduced night and evening differentials citing "severe budgetary restrictions." He further explained "because of the current budgetary restrictions a more gradual reduction will not be feasible." We did have a large deficit variously reported between \$2.8 and \$3 million. Our lack of advancement was hard to accept in the face of what we knew was happening at the medical center.

Mr. Billik's reorganization was thorough in promoting those in management, often non-competitively through multiple levels upwards while nurses were losing ground. Nursing provides care to veterans twenty-four hours a day, seven days a week and all nurses, myself included appreciate a pleasant work environment. But fish tanks, palm trees and costly office renovations cannot replace our mission which is "Putting Veterans First."

No nurse I have ever spoken to can conceive of earning \$800 to \$1200 dollars a day, as was Mr. Billik's consultant.

It is no surprise that the results of the recently conducted 1997 ONE-VA employee survey states that 65% of employees feel that pay raises do not depend on how well they perform their jobs.

It was not until January 9, 1997 that the registered nurses in Charleston were recognized for their hard work and dedication to their veteran patients. Our current medical center director, Mr John Vogel, was able to use the annual salary survey and other measures available to him (and Mr. Billik) to give us a modest, but more importantly an equitable pay raise that mirrored our general schedule co-workers. We were grateful for that recognition.

What I have related are not just minor anecdotal situations but real conditions affecting the person standing directly at the bedside of the veteran, the VA registered nurse. We registered nurses are anxious to be part of the "New VA" with its new management, new challenges and the reorganization that gives the stakeholder principle as defined by Dr. Kenneth Kiser, Under Secretary for Health, a chance to include us in decisions affecting our careers and the delivery of care to our patients.

I am reminded of an old German proverb that says "to change and to improve are two different things." It is something I use to tell me if I am doing the right thing.

In closing I want to thank the committee for giving me an opportunity to testify on behalf of an excellent dedicated staff at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina.

STATEMENT OF  
 WILLIAM T. MERRIMAN, DEPUTY INSPECTOR GENERAL  
 BEFORE THE  
 HOUSE VETERANS' AFFAIRS COMMITTEE  
 SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS  
 HEARINGS ON MISMANAGEMENT AT VA MEDICAL FACILITIES

October 23, 1997

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducts special inquiries of alleged mismanagement by senior officials at VA facilities. We take allegations of mismanagement by senior VA managers very seriously and have worked with the Department to notify them when we identify conditions warranting their immediate attention. The Subcommittee has asked that we comment on two of these reviews: one at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina, and the other at VA University Drive Medical Center, Pittsburgh, Pennsylvania.

**VA MEDICAL CENTER, CHARLESTON, SOUTH CAROLINA**

In the fall of 1996, we conducted a special inquiry at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina. The review was at the request of Congressman Mark Sanford and House Veterans' Affairs Committee staff. Congressional staff were receiving complaints from employees that the former Director and his staff mismanaged construction, renovations, contracts, and other activities at the facility. In total, 27 allegations were reviewed, which included the following issues:

**Nursing Home Care Unit**

Our report substantiated that there was an unreasonable delay in activating a Nursing Home Care Unit for veterans. We found that about \$2.1 million was spent for construction, renovation, and activation of the Unit in February 1994, but management never used the renovated space for nursing home care activities. Rather, the former Director elected to use the renovated area as "swing space" for other areas undergoing renovation. Meanwhile, VA staff placed local veterans seeking nursing home care in contract facilities or VA facilities elsewhere. Our discussions with the former Director's supervisor in the Network Office in Atlanta, Georgia, prompted the Network Office to refocus on opening the Nursing Home Care Unit. Follow-up with the Network Office found that they plan to open the Unit by December 1997.

**Management Consultant**

VA employees also questioned the former Director's hiring of a management consultant to work with VA program assistants and quality management staff. The former Director paid the management consultant over \$90,000 plus expenses in Fiscal Year 1996, to work 4 days per month. We found that the former Director incorrectly approved this contract using "fee basis" funds, which are set aside for medical, not administrative, services. We also found that the former Director had not followed the appropriate procedures for obtaining the consultant's services. In response to our recommendation, the contract was discontinued in December 1996.

In response to additional concerns raised recently by this committee involving contracts with the same management consultant at other VA facilities, we are looking at agreements the consultant had with VA Medical Centers (VAMC) in Columbia, South Carolina; Little Rock, Arkansas; Asheville, North Carolina; and

Sepulveda, California. We also inquired into whether the management consultant had contracted with VAMC Temple, Texas, now under the direction of the former Director of VAMC Charleston. We found no evidence of any such contract or agreement or that the Director's spouse worked for the management consultant, which was also alleged.

#### Noncompetitive Promotions

We reviewed allegations that the former Director used a noncompetitive process to promote individuals within the Director's Office and for certain service chief positions. Federal personnel laws and regulations provide the authority to promote through any appropriate recruitment method, such as reassignments, appointments, transfers, or promotions through an accretion of duties. The former Director promoted known friends and associates through the "accretion of duties" process. While these actions led to allegations that the former Director promoted his staff more on the basis of friendship than merit, we found that these individuals were qualified for the higher graded positions, and that the promotions were processed and classified appropriately.

Staff reaction to the promotions of the former Director's associates was compounded by the fact that two promotions in his office were announced at about the same time employees were informed that the facility faced serious funding shortages and possible Reductions-in-Force. One of these promotions went to an employee who was alleged to have been personally involved in a close, personal relationship with the former Director.

At the time of our review, we did not pursue this latter issue because the former Director had left VAMC Charleston for reassignment elsewhere in VA, and the employee had resigned from Federal service. Also, no one to our knowledge had filed a formal complaint that they had been discriminated against or otherwise denied an employment opportunity because of the alleged relationship. With the exception of rumors heard by employees we interviewed, no one was able to provide any specific evidence to substantiate the allegation. Moreover, the individual's promotion was just one of five promotions by accretion of duties and there was no evidence that any of the other individuals were involved in a close personal relationship with the former Director.

Subsequent to issuing our report, Congressman Sanford's office requested that we further inquire into the relationship of the Director and the former employee because the two had gotten married and it was believed that a relationship had to be going on for some time. More recently, this committee also contacted us with concerns that the relationship of the Director and the former employee may have created a "hostile work environment."

In response to these requests, we interviewed the former Director and other VAMC Charleston employees. Based on these interviews, we determined that the former Director was having a close personal relationship with the employee at the time she was promoted to the GS-13 level. The results of these interviews were reviewed by OIG Counsel to determine whether the relationship created a "hostile work environment," as defined under Title VII of the Civil Rights Act. It was determined that a "hostile work environment," as defined in Title VII, was not created.

Our review of the relevant case law revealed no cases in which there was a finding of "hostile work environment" solely because another employee received preferential treatment because of a personal relationship. The Equal Employment Opportunity Commission guidelines specifically state that close, personal relationships that give rise to preferential treatment do not support a claim under Title VII of the Civil Rights Act, which

would include "hostile work environment." A "hostile work environment" is defined as a form of sexual harassment that exists when there is severe or pervasive verbal or physical harassment of the complainant due to the complainant's membership in a protected class. The situation involving the former Director and the employee does not satisfy this requirement because there is no evidence that there was verbal or physical harassment of any complainant that was based on the complainant's membership in a protected class.

We then looked to see if the former Director violated any other law or regulation because of his close, personal relationship with the employee. We found that the promotion approved by the former Director was not in violation of the nepotism statute, because the individuals were not married or blood relatives. Also, none of the actions taken by the former Director on behalf of the employee were prohibited personnel practices under the provisions 5 U.S.C. 2302 (b) (6), because the promotions were authorized and done in accordance with applicable laws and regulations.

Next, we considered whether the promotion of the employee was in violation of the Standards of Ethical Conduct for employees of the Executive Branch, as defined in regulations promulgated by the Office of Government Ethics. Our review raised the question as to whether the former Director's involvement in the promotion of an employee who he had a close, personal relationship with constituted a violation of the regulation that prohibits using public office for private gain, which includes the private gain of friends or persons with whom the employee is affiliated in a non-Government capacity (5 C.F.R. Section 2635.702). The information concerning this matter has been referred to VA's Ethics Officer in the Office of General Counsel for review and action, if necessary.

#### Fish Tank

Complainants alleged that the Director spent funds to build a fish tank in the lobby of the hospital when employees were facing potential Reductions-in-Force due to anticipated budget shortfalls. While we substantiated that the fish tank was built, we did not substantiate that the funding source for the construction of the fish tank came from salaries. The funds came from construction money that had already been obligated and could not be diverted to salaries or to supplement the medical center's budget.

Complainants also provided estimates that the fish tank cost as much as \$80,000. We reviewed engineering and fiscal records, and found that the total cost to construct the fish tank was \$26,119.

In our report, we were critical of the timing of the decision to build the fish tank and acknowledged the effect that it had on some employees who thought they might be faced with a potential Reductions-in-Force due to the anticipated funding shortfalls facing the medical center. However, given the fact that the fish tank had been built, that Reductions-in-Force never materialized, and the fact that the fish tank had therapeutic value for veteran patients and their families, we did not find that the decision to construct the fish tank violated any law, rule or regulation, or constituted a gross waste of funds.

#### Nurse Staffing

Our review did not substantiate an allegation that there was a correlation between nurse staffing reductions and quality of care. We determined that the overall number of nurses declined from 283 in 1994 to 275 in 1996, a decline of only 2.8 percent. The drop in inpatient nurses for the same time period

was more dramatic, with a decline from 248 to 215 nurses, a 13.6 percent decline. However, 10 percent of the 13.6 percent was shifted to outpatient care. As a result, the actual decline in nurses was only 3.6 percent. Moreover, we found that the decline was consistent with the drop in inpatient visits, which declined 32.4 percent from 1994 to 1996. Although the allegation alluded to quality of care, no specific instances of poor quality care related to nursing shortages were brought to our attention.

#### Renovation of Director's Suite

Renovations to the Director's suite occurred at about the same time that the Director was announcing potential employee Reductions-in-Force due to a budget shortfall. Understandably, this led to perceptions and allegations that the Director placed a higher priority on renovating his suite than he did on the staff. While our report was critical of the timing of the renovation in relationship to the Director's announcement, we determined that plans to renovate the suite and to purchase needed furniture and equipment was initiated in December 1994. At that time, there was no way to predict that there was going to be a potential funding shortfall. Regardless, we recognize that the actual renovations were ill-timed, and that staff tensions were high because of the anticipated cut-backs.

The report concluded that the renovations were needed, and that the costs associated with the renovations and the purchase of furniture and equipment for the Director's suite were appropriate. We did note, however, that some minor waste did occur in purchasing carpet that was not used for the suite.

We made several recommendations concerning these and other matters discussed in our report. VA management concurred with our recommendations and provided acceptable implementation plans.

#### VA MEDICAL CENTER, PITTSBURGH, PENNSYLVANIA

We conducted a special inquiry at the request of Senator Arlen Specter based on a constituent's complaint regarding the University Drive Medical Center in Pittsburgh. According to the complainant, the Director authorized wasteful spending on his Government quarters. We concluded that the medical center spent \$79,000 more than it should have on renovating the Director's quarters.

Several factors contributed to the overspending, including the approval of a nonrecurring maintenance project for the quarters without ensuring that the quarters' income could support the expenditures. VA policy requires that quarters' renovation, maintenance and operating expenses be recouped through rents. The overspending occurred because the Real Property Management Office (RPMO) in Central Office erroneously told medical center officials they could authorize significantly higher expenditures on quarters than allowed by VA policy. This contributed to about \$33,000 of the overspending. We determined that local management of the interior renovation contributed to the remaining \$46,000 in overspending. Local problems included improper contracting practices, lack of coordination among cost centers, and the Director's selection of nonstandard amenities.

We also found that the Director and others who occupied Government quarters benefited from rents that were lower than market levels. We did not find intentional misconduct in obtaining these benefits by the Director. The lower rents continued because RPMO did not fulfill its responsibility to review rent adjustments in accordance with Office of Management and Budget guidelines, even after RPMO was informed by the Director that he planned to use existing rental rates until construction was completed, unless otherwise directed.

We recommended that the Department issue policies to implement revised Office of Management and Budget quarters requirements and to establish a current rent adjustment procedure. We also recommended that appropriate action be taken to improve the performance of responsible medical center officials managing the program, and to recover back rental charges owed the Government. VHA agreed with the findings and provided acceptable implementation plans. We are continuing to follow-up on the Department's implementation plans. I would like to add that the Director's quarters, now called the Patriot House, is currently used for the families of patients undergoing liver transplant operations.

Thank you, Mr. Chairman, for the opportunity to comment on the work of the OIG in this area. I would be glad to respond to any questions you or the Committee members may have in this matter.

**STATEMENT OF  
MR. KENNETH CLARK  
CHIEF NETWORK OFFICER  
BEFORE THE  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS  
COMMITTEE ON VETERANS' AFFAIRS  
HOUSE OF REPRESENTATIVES  
OCTOBER 23, 1997**

Mr. Chairman and members of the Subcommittee:

I appreciate the opportunity to appear before you to testify this morning. My name is Kenneth Clark, and in August I assumed my current duties as the Chief Network Officer in the Veterans Health Administration.

As Chief Network Officer, one of my primary responsibilities is to ensure the integrity and effectiveness of the day-to-day operations of our medical facilities. I believe that the structure and tools that are in place will enable me to provide this essential oversight, and I would like to describe them to you very briefly.

The cornerstone of this system is the new VHA Network organizational structure, which was put into place almost two years ago. The organization creates 22 separate Veterans Integrated Service Networks each under the direction of a Network Director. The 22 Network Directors have a much smaller span of supervisory control than the four Regional Directors whom they replaced, and they are able to provide a much more focused level of control and supervision.

The former Regional Directors had as many as 43 facilities reporting to them. By contrast, two Networks have only three facilities reporting to them, none have more than ten facilities, and the majority have seven facilities or less. This simple difference in size enables the Network Directors to maintain closer contact with the facility and its stakeholders, and review its operations in greater detail. The Network Directors are able to intervene at the first evidence of a problem, and regularly send site teams to review, investigate and evaluate allegations of improper or ineffective management or behavior. They are better informed than the former Regional Directors, and at the same time more accessible to groups or individuals that wish to point out their concerns.

I intend to work with the Network Directors to ensure they do perform this vigorous, aggressive oversight role.

The Network Directors have been given a very clear, challenging set of Performance Measures that set forth measurable, objective standards of achievement. They address such crucial measures as reduction in Bed Days of Care, increases in Ambulatory Surgery, and patient satisfaction. Network Directors are able to evaluate the performance of each medical center and its management team using these objective tools, and quickly identify out-of-line situations. We are committed to refining these measures, and will continue to emphasize the development of clear, data-driven, outcome focused criteria for evaluating performance. These measures are a powerful tool for VHA senior management, and we will use them to upgrade performance across the system.

VHA is developing an additional dimension to the Performance Appraisal System to complement these Performance measures. Working

with a contractor, it intends to pilot a new Multi-Assessment Feedback System, commonly known as a 360 Degree Appraisal for all of its Network Directors and senior officials in Headquarters. It will also be piloted on all the medical center directors, associate directors, and chiefs of staff in four Networks.

The 360 Degree Appraisal provides each covered executive with feedback on specific skills and behavior not only from their supervisors, but from their peers, their subordinates, and their “customers” or stakeholders. Management literature indicates this broad range of evaluation can be a powerful tool in assisting executives to recognize and improve their performance. We expect that this system will help us in our efforts to strengthen our culture of performance and accountability, and assist executives to align their individual behavior with organizational values and objectives.

The Network Directors also play a major role in the selection of directors and associate directors in their Networks, enlisting the members of their Executive Leadership Council to evaluate, interview, and recommend candidates for appointment or promotion. These councils typically are composed of medical center directors, and chiefs of staff. Input is customarily obtained from external representatives as well, including Veterans Service Organization leaders and medical school affiliates. Some Network Directors have also engaged Partnership Council members in the process.

In assessing candidates, these Executive Leadership Councils assess the individual’s record of integrity and honesty, as well as technical skill and knowledge, recognizing the nominee will become a part of their team, and that character is as important as competence in a

leadership role. This process provides another opportunity to screen out individuals who have not clearly demonstrated their fitness for advancement.

Secretary-Designate Gober has recently implemented several other initiatives to improve our ability to provide oversight and take effective action. In April 1997, he issued instructions that in all actions involving a senior management official, representatives from the Office of Human Resources, the Office of the General Counsel, the Office of Public Affairs, and the line operating officials will meet to discuss the case, develop a comprehensive strategy for taking action, and implement the decisions in a coordinated manner. This will eliminate any possibility that VA's case will either be compromised through lack of cooperation, or not developed as fully as possible.

VHA recently took action against a senior management official, separating him for having engaged in sexual harassment, and followed these procedures very carefully. They enabled the Agency to identify an out-of-line situation, investigate the allegations thoroughly, and develop a strong case against the individual.

We expect to follow these guidelines in all future cases, with similar results.

As you know from his previous testimony before you, Secretary-Designate Gober has also developed a new approach to handling Equal Employment Opportunity (EEO) Complaints. Under the terms of this new framework, medical center directors will no longer serve as EEO Officers, and a new, independent Office of Employee Complaints Resolution will have EEO Counselors and EEO Investigators assigned to

it. EEO Counselors will no longer report to facility directors and this should make employees more comfortable in initiating complaints against senior officials at the local level. This independent level of review will make management officials more accountable for their behavior and decisions.

I also intend to emphasize greater accountability for one's actions, and make it absolutely clear that there will be consequences for failing to adhere to the highest personal and professional standards. I will do this out of a sense of obligation to the great majority of our executives who conduct themselves in an impeccable manner, and who should not be subjected to unfair criticism based on the actions of a few.

To do this, I will use every tool available to me, including performance data, site team reviews, and Inspector General Reports. I will review and assess this information and findings, and ensure that appropriate action is taken. These actions may involve disciplinary action, or performance rating, or may require intensive training or other management interactions.

It is clear, from some of the information contained in recent Inspector General reports, that we cannot accomplish everything we need to do simply by communicating high expectations and then enforcing adherence to them. The relationships between our field facilities and our Headquarters elements are not as clearly defined as they need to be, and we will work to better define their relative roles and expectations. It is also obvious that some of our policies are not as clearly and comprehensively stated as they should be to avoid confusion, and we will improve them. We cannot punish field executives for our failure to clearly articulate our own policies and expectations, and that improved

communication will have a higher priority as we continue to implement our Network structure.

I want to make it clear that I am not saying that we will only take action in those cases in which an executive is guilty of breaking a clearly established, written rule. Certainly, we will act aggressively when an individual is guilty of some impropriety. However, my expectations are higher than that. Our executives must be effective leaders, not just competent managers. It is not enough that they steer clear of specific violations, and that various investigations or reviews do not find they have broken the law or violated policy. Rather, we expect that they will be sensitive to the appearance of their actions, and empathize with their employees and stakeholders. We want them to be able to articulate the challenges the facility is facing clearly to these groups, and communicate the basis for their actions. Employees should not feel they have to invoke third-party review to ensure that the director's actions are in the best interest of the facility.

There is one other important element to be considered in connection with this focus on accountability. We are asking our executives to make tough decisions and take bold actions in a very difficult environment. In spite of the many challenges they face, our medical center directors have helped us make dramatic improvements in the quality and cost-effectiveness of our care, using objective measures. They are displaying a remarkable ability to innovate, and a robustly entrepreneurial spirit. They have restructured and reorganized the health care delivery system in cases in which there was no clearly right or wrong decision, and they have had, however reluctantly, to take actions that have had adverse impact on individual employees, or groups

of employees, and I applaud their willingness to take on these difficult tasks.

It is not surprising that some stakeholders will disagree with their decisions, and mischaracterize them out of malice or ignorance. Under our system, these employees have the right to allege wrongdoing or mismanagement. It is healthy that they can do so, and I support their right to raise these issues. It is a constructive check and balance on management. However, I urge that these allegations be considered just that – allegations - until they can be proven, and that an executive is considered to be legitimately and conscientiously exercising his or her best judgment until the facts indicate otherwise. If we intend to hold our executives accountable for their misconduct, I believe we must support them fully in those instances in which they are not at fault. I am concerned that if we do not, our executives will not continue to embrace the essential changes VHA is making to ensure it provides the highest quality care in a timely, effective manner.

Mr. Chairman, this concludes my formal statement. My colleagues and I are available to answer any questions you may have.

**STATEMENT OF  
DEAN S. BULLIK, FAAMA, DIRECTOR  
CENTRAL TEXAS VETERANS HEALTH CARE SYSTEM  
BEFORE THE  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS  
COMMITTEE ON VETERANS' AFFAIRS  
U. S. HOUSE OF REPRESENTATIVES**

**OCTOBER 23, 1997**

Mr. Chairman and Members of the Committee:

It is an honor and a privilege to appear before you today to testify regarding alleged mismanagement practices while I was Director of the Charleston VA Medical Center.

I welcome the opportunity to address these allegations.

The VA Inspector General completed a thorough investigation of 27 allegations of mismanagement on January 10, 1997. They found no evidence of mismanagement. Of the 27 allegations ranging from gold fixtures in the bathroom of my office to spending \$40,000 on a fish tank, five (5) were substantiated and four (4) others were partially substantiated. Of these, a total of six (6) recommendations were made. I will now address each substantiated and partially substantiated allegation and the six (6) recommendations.

Substantiated allegations:

1. Ward 4A was renovated into a Nursing Home Care Unit and never used for this purpose.

At the conclusion of the renovation of Ward 4A, a project to remodel another medical unit had been funded. Rather than reduce capacity for acute care patients we utilized 4A to care for those patients. Had we not been able to use Ward 4A as a "swing space," we would have either had to reduce the number of patients we were taking care of, close clinics, or not complete necessary improvements. None of these were viable options to me. My intent was to use Ward 4A as a Nursing Home as soon as renovations to the other parts of the hospital were complete.

2. Management received activation funding for the Ward 4A NHCU project even though the NHCU was never opened.

General operating and construction funding was received for this project. This money was utilized for the renovation of Ward 4A and for the operation of the Medical Center. These funds enabled us to reduce employment to a level which the budget could support without incurring a reduction in force.

3. The Director's suite was renovated without advance approval from VA Central Office on the renovation costs.

The Director's offices, which had not been renovated in many, many years, were renovated. However, before renovation began, the appropriate request was submitted through the Director of the Southern Region to VA Central Office. A verbal approval was received from VA Central Office on January 5, 1996, which is documented.

4. A consultant was hired and inappropriately paid \$800 daily for program analyst services.

VA Central Office had a national contract with APQC to implement Total Quality Improvement (TQI) programs in various VA hospitals across the country. Charleston was one of those selected. When this contract expired, it was felt that we were not ready or able to implement our TQI program without continued support. Supply Service was requested to extend the contract for another year. The rate was not set by me, nor did I select the original contractor. The original contract, which seemed to be reasonable at the time, was merely extended.

5. Scarce funds were spent on a maintenance contract for the fish tank while employees were facing layoffs and anesthesia machines were not covered by service agreements.

a. The maintenance contract for the fish tank was \$7,800 per year, which included stocking, feeding the fish, cleaning, and replacing dead fish. A projected budget shortfall in FY 1996 did not materialize. The perception may have been that money was being spent frivolously while employees were facing layoffs. However, construction money for renovating the lobby or installing the fish tank could not have been spent on employee salaries, no matter how desirable this would have been.

b. It is also true that the anesthesia machines no longer have a maintenance contract because it was determined that the maintenance of these machines could be accomplished more effectively by the Medical Center's biomedical staff and thereby save money.

Partially substantiated allegations:

1. A well-known local artist's painting was inappropriately discarded as a part of the renovation of the Director's suite.

I don't know anything about this painting.

2. A \$40,000 fish tank was unnecessarily purchased for the Medical Center lobby.

The cost of the fish tank was actually \$26,119. An interior designer who developed a hospital master plan included the tank as a focal point in the lobby project. She considered paintings or a sculpture, but she felt a fish tank would be nice and appropriate since Charleston is a seaport. While it is not a necessity, it was part of an overall Project. It is pleasing to all who visit, the old and the young, and we have received nothing but compliments from patients and family members on the fish tank.

3. Management authorized nonessential landscaping services and redirected the old landscaping items to an employee's residence.

This is partially substantiated because at one time an employee had taken some old plants home with him. Staff were reminded that all plants were Government property and were to be disposed of and not given to employees. A memorandum was issued to employees; the IG was satisfied that the problem had been corrected; and no recommendations were made. The IG also stated in their report that "with the amount of exterior construction projects either recently completed or still underway, we could see how some employees may have the impression that constant changes are being made to the landscaping. We did not see any evidence of wasteful spending in this area." The Medical Center's landscaping is attractive, but not lavish considering how little greenery there is on the grounds.

4. Management violated its own policies by requiring respiratory therapists to work without backup in the intensive care unit during the evening hours.

This allegation was partially substantiated. Respiratory therapists were required to work alone in the intensive care unit during the evening hours because of a declining inpatient workload at the Medical Center. However, in the event that another respiratory therapist was needed, assistance could be obtained from the respiratory therapist working in the sleep laboratory. This was not consistent with existing policy, and the policy has since been changed. The new policy is consistent with other VA medical centers.

**Recommendations:**

1. The Medical Center Director ensure that all equipment purchased for the NHCU in FY 1995 be accounted for so that it can be reconstituted in the NHCU once it is opened.

As of December 2, 1996, the Acquisition and Materiel Management Service of the Medical Center had accounted for all equipment items purchased for the NHCU. These items will be transferred to the NHCU once it becomes operational.

2. The Medical Center Director should carefully evaluate the options regarding the fish tank and determine whether continued use of the tank is in the best interests of the Medical Center.

The current Medical Center Director has determined that it would cost approximately \$27,394 to remove the fish tank from its present location in the front lobby. Due to the nature of the initial construction, removing the fish tank would also destroy the interior design and uniformity of the lobby. Additionally, many positive comments from patients, family members, and the general public have been received regarding the fish tank. They support keeping the fish tank as part of the lobby.

3. We recommend the Director, Veterans Integrated Service Network 7, take action to ensure that the former Director and current management at the VA Medical Center are aware of the appropriate procedures to follow when requesting advisory and assistance services.

Both the current Director of the Charleston VAMC and I are aware of the appropriate procedures to follow when requesting consultative services. It is my understanding that the contract for the consultant was terminated effective December 31, 1996.

4. We recommend the Medical Center Director take action to:

a. Discontinue using the fee basis authority to pay for the management consultant's services, and re-evaluate whether advisory and assistance work continues to be needed at the Medical Center.

b. Develop the required "concept approval" documents and submit an official request for the consultant's services to the VISN if it is determined that these services are still needed.

It is my understanding that the consultant in question was terminated effective December

31, 1996. If a consultant's services are deemed necessary in the future, the procedures outlined in Circular 00-92-15 will be followed.

5. We recommend the Medical Center Director consider the cost of the annual maintenance contract for the fish tank in deliberations on the options related to the future of the fish tank.

The current maintenance contract for the fish tank runs through September 30, 2000. I am sure other alternatives for maintaining the tank will be explored when this contract expires:

6. The Medical Center Director should take appropriate action to ensure that the employees are appropriately advised on their employment rights as they pertain to current and future plans for retaining private cleaning services at the Medical Center.

It is my understanding that this is the current practice, and it will continue to be communicated at staff meetings.

Allegations that excessive amounts of money were spent for remodeling the Director's office and allegations related to the remodeling of the Director's office were thoroughly investigated and not substantiated.

Allegations that friends were non-competitively promoted were thoroughly investigated by the IG and not substantiated.

There has been concern expressed about the hiring of Ms. Shannon Falcone. Ms. Falcone was an Administrative Resident at the VA Medical Center in San Antonio, Texas. As the Associate Director of that center from 1985 through 1992, I had the opportunity to work with and know more than 18 such residents.

Due to turnover of staff in my office in Charleston, I recruited Mrs. Mary Bowrin to fill a vacant administrative assistant position. Included in Mrs. Bowrin's experience was the Director of Personnel for the Secretary of Housing and Urban Development in Washington, D.C. In that position she was a GM-14.

The next position which became vacant was that of my staff assistant. I first asked an experienced person, Mr. Tom Balderach of the Big Spring VA Medical Center, to consider transferring; however, he declined. I then asked Ms. Falcone to consider the position, which she eventually did. Her appointment was consistent with many other residents that were appointed during my tenure in San Antonio.

Ms. Falcone's progress from a GS-11 to GS-12 to GS-13 was consistent with past practice for employees in such positions. The journeyman grade for Health Systems Specialists at hospitals like Charleston was GM-13. Her performance was fully successful, and she should have been promoted.

I learned of my future reassignment from Charleston in early 1996 (February or March). I discussed this with Ms. Falcone. We concluded that we cared for each other to the point that we did not wish to be separated. She decided at that time to leave the VA as soon as was reasonable. I left Charleston in September 1996, and Ms. Falcone left Government service at the end of October 1996. We were married in December 1996.

In conclusion, there is NO evidence of mismanagement. This matter has been thoroughly investigated by the VA Inspector General and is well documented in their final report dated January 10, 1997. Everything I did at Charleston VA Medical Center was always for the benefit of our veterans and for the benefit of the Medical Center. I never have, and never will, do anything to hurt a veteran. I have done nothing illegal nor inappropriate.

I appreciate the opportunity you have given me to explain the facts in this matter and to address you today. Thank you.

**STATEMENT OF  
MR. THOMAS A. CAPPELLO  
DIRECTOR, VA PITTSBURGH HEALTHCARE SYSTEM  
BEFORE THE  
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS  
COMMITTEE ON VETERANS' AFFAIRS  
U. S. HOUSE OF REPRESENTATIVES  
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It is a pleasure to be invited to this hearing today and given an opportunity to share my knowledge of the Pittsburgh project, and answer any questions you may have of me on this subject. As I have noted in the past, I feel the Office of the Inspector General has conducted a thorough review, and I will not further review their findings, but will address some issues not contained in their report.

As the Director of the VA Pittsburgh Healthcare System I take full responsibility for all that occurs on our three campuses. I am pleased to report that the positive stories greatly outnumber any negative stories you may have heard. Over the past year our Healthcare System has integrated two Medical Centers situated on three campuses into one system. We have reorganized in such a manner that expenditures over the past year have been decreased by \$8 million and we have reduced by 318 FTEE. We have treated 9000 more patients this year, and this performance amounts to a decrease in the cost per patient treated of 25%. We have increased our services to the veterans of Pittsburgh in record numbers and provide the highest levels of tertiary care of any Healthcare System within and outside the VA. We continue to serve as a National Referral Center for Liver Transplantation and a Regional Referral Center for other services.

When I entered on duty in Pittsburgh in 1994, I found a brand new, state of the art VA Medical Center on the Aspinwall Campus flanked by a series of older buildings that were in desperate need of rehabilitation. The quarters buildings in particular were unacceptable. The subject Building #13 was in the most disrepair and this fact has been well documented. I was faced with an issue of either repairing these government assets or closing them. A cost-benefit analysis was conducted and it was determined that nearly \$3 million had been collected in rents from 1979 to 1994, and if rehabilitated, these units would provide a positive cash flow that could be reinvested in patient services. In fact, the very reason for the disrepair of these units was directly related to the lack of maintenance and repair over the years. It was decided to renovate three vacant units and to continue this process until all of the units were completed. It is important to note that I personally never had any long range plans to live on campus, thus the renovations would not be associated with me, but only with the reality that the repairs were desperately needed. Various options for rehab were discussed ranging from cost-prohibitive restorations to more cost-effective updating. Shortly after this decision was made to renovate these units our Associate Director was detailed as Acting Director to the Bath VAMC, our Chief Engineer transferred to Bay Pines, FL, and our Contracting Section consolidated with the Highland Drive Contracting Section. These key vacancies and changes had a great deal to do with the poor project management that occurred at the operational level. I had never worked on a campus with quarters and was not very knowledgeable on the rules and regulations on this subject. I did receive guidance that I could expend up to \$126,000 to rehabilitate this structure, and a project was developed whose costs conformed to this budget number. As late as July 27, 1995, three months after I had moved into the home, I was informed the total expenditures amounted to \$115,000. I felt assured that all rules had been followed. When the IG arrived in April, 1996 I was pleased, and confident this review would prove that we had followed all applicable guidance and our protection of these government assets was appropriate.

As the IG report indicates, it was determined that the guidance used was incorrect and the costing of the project was in error. I cannot comment on the issues surrounding the

guidance on quarters renovation in 1994, but I can comment on the costing of this project. As we all know the project exceeded the allowable limitation by \$79,000. This occurred primarily because \$33,000 of a \$400,000 project to repair the watermains and drains on the campus was not costed to each of the quarters buildings. In addition \$45,000 of station labor used on this project was not appropriately costed to this project. In each of these instances this occurred because of inadvertent and not malicious poor cost accounting and improper interpretation of the rules. It is important to note that this is costing information and not the actual cost. With regard to the costing of station labor of \$45,000, it is important to note that 2305 hours of labor were costed to this project, and an independent cost estimator indicated that 540 hours was a more appropriate estimate of the hours required for the work accomplished. In fact, I was informed that roughly 2100 hours is the industry estimate for the complete construction of a 2500 square foot home. This fact does not mean VA labor is inefficient, it means our past systems for tracking cost was done anecdotally and after the fact. We have corrected this problem at Pittsburgh by now insisting on a work order for all work in quarters and the Canteen to ensure a proper estimate of work and accurate cost accounting.

Finally and probably the most publicized aspect of this renovation is the issue of above-standard amenities. I can assure everyone here that I am conservative by nature and most certainly a conservative manager. For example, I drive a ten year old car and intend to drive it for several more years. I can also assure you that I would never have knowingly selected any faucet or bathtub/whirlpool that was anything other than mid-grade, tasteful, and serviceable. I believed that all selections were within the budget of \$86,000 submitted by the contractor who completed the work and I was not aware of the cost of individual line items until the time of the audit. This was an oversight.

In closing, I want to assure you and most importantly I want the veterans of Pittsburgh to know that I take very seriously the trust placed in me. I assure everyone that the important story about Pittsburgh is not one of project mistakes, but one of stretching resources to provide as many services possible and to take care of our veterans within our budget. The VA Pittsburgh Healthcare System over the past three years has served over 10,000 more veterans, reduced costs by \$10 million, increased outpatient visits by 65,000, and greatly improved service to our customers.

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