



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON DC 20420

December 7, 2015

The Honorable Carolyn N. Lerner  
Special Counsel  
U.S. Office of Special Counsel  
1730 M Street, NW, Suite 300  
Washington, DC 20036

OSC File No. DI-15-2216

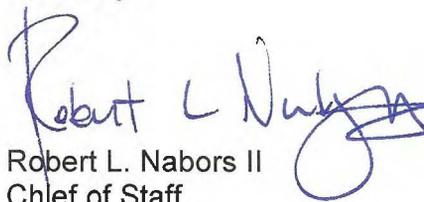
Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the New Mexico Department of Veterans Affairs (VA) Health Care System, Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico. The anonymous whistleblower made two allegations: that Building 1 on the Medical Center campus lacks appropriate access controls; and that the Health Care for Homeless Veterans (HCHV) Program lacks sufficient resources to complete its mission. These allegations possibly resulted in conduct that may constitute violations of law, rule, or regulation; gross mismanagement; and a substantial and specific danger to public health and safety. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Veterans Health Administration's Office of the Medical Inspector (OMI) conducted an investigation into these allegations. OMI substantiated the whistleblower's first allegation and made seven recommendations for the Medical Center to address Building 1 security and access controls, staff training on security measures, and related personnel actions. OMI did not substantiate the allegation that the HCHV Program lacks sufficient Federal Government vehicles for employees to provide appropriate service to clients but did make four recommendations for the Medical Center to improve its vehicle fleet management. Findings from the investigation are contained in the enclosed report.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in blue ink that reads "Robert L. Nabors II". The signature is stylized and includes a large, sweeping flourish at the end.

Robert L. Nabors II  
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS  
Washington, DC**

**Report to the  
Office of Special Counsel  
OSC File Number DI-15-2216**

**Department of Veterans Affairs  
Raymond G. Murphy VA Medical Center  
Albuquerque, New Mexico**



**Report Date: September 28, 2015**

**TRIM 2015**

## Executive Summary

The Under Secretary for Health (USH) requested that the Director, Health Care for Homeless Veterans (HCHV) Program assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Raymond G. Murphy VA Medical Center (hereafter, the Medical Center) located in Albuquerque, New Mexico. An anonymous whistleblower made allegations that Building 1 on the Medical Center campus lacks appropriate access controls and that the Health Care for Homeless Veterans (HCHV) Program lacks sufficient resources to complete its mission. OSC states that these allegations possibly resulted in conduct that may constitute violations of law, rule, or regulation; gross mismanagement; and a substantial and specific danger to public health and safety. VA conducted a site visit to the Medical Center on August 11-13, 2015.

### Specific Allegations of the Whistleblowers:

1. Building 1 lacks proper security controls, allowing public access to the building's interior and compromising employee safety; and
2. The HCHV Program lacks sufficient Federal Government vehicles for employees to provide appropriate service to clients, which directly impacts the health of homeless Veterans who are otherwise unable to obtain transportation for medical care.

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, VA makes the following conclusions and recommendations.

### Conclusions for Allegation 1

- VA **substantiated** that Building 1 lacks proper security controls, allowing public access to the building's interior and compromising employee safety.
- VA confirmed that all staff members are not familiar with the Lynx Duress System.

### Recommendations to the Medical Center

1. Complete the following recommendations made by the Office of Security and Law Enforcement (OSLE) team as part of its site visit conducted May 3-5, 2015:
  - a. Review VA Handbook 0730/4, Appendix B, and reinforce to all employees that they must follow VA Handbook 0730/4, outlined physical security rules and regulations. All employees must take appropriate action to report

- security violations to their leadership, and leadership must follow-up appropriately.
- b. VA Police need to provide more rigorous oversight of individual building managers to ensure that they are complying with VA Handbook 0730/4, Appendix B. Use of an established badging system for all contracted construction workers would enhance access control during normal working hours and after hours.
2. Implement recommendations cited in the April 2015 Vulnerability Assessment Survey.
  3. Properly secure all stairwell doorways in Building 1.
  4. Ensure that sufficient personnel are available to greet and escort Veterans in Building 1, especially on the third floor.
  5. Ensure that all HCHV Program staff members are sufficiently trained in proper use of the Lynx Duress System.
  6. Investigate the situation where a provider gave a patient permission to sleep in Building 1 and determine if any administrative or disciplinary action is warranted. If so, take action as necessary and appropriate.
  7. The Veterans Health Administration (VHA) review the circumstances surrounding the failure to address the Vulnerability Assessment Survey and determine whether there is any senior leadership accountability for this matter.

### **Conclusions for Allegation 2**

- VA **did not substantiate** the allegation that the HCHV Program lacks sufficient Federal Government vehicles for employees to provide appropriate service to clients, which directly impacts the health of homeless Veterans who are otherwise unable to obtain transportation for medical care.
- VA confirmed that the HCHV Program had a sufficient amount of vehicles to complete the mission but was inappropriately managing its assigned vehicles. We identified utilization issues with the overall fleet management of the assigned Medical Center vehicles. There were also two vehicles assigned to the HCHV Program that were underutilized due to unsuitability and protracted history of mechanical problems.
- VA is not able to substantiate that access to Federal Government vehicles has been so problematic as to impact the health of homeless Veterans, as we found no evidence of missed or cancelled VA health care appointments due to this reason.

### **Recommendations to the Medical Center**

1. Develop a more efficient fleet management system to more effectively manage Medical Center vehicles to better meet all program needs throughout the facility.
2. Ensure that the Chief of Engineering continues to explore options to appropriately manage fleet vehicles.
3. Ensure that HCHV Program staff members comply with established reservation and other procedures to enable workers to maintain timely access to assigned vehicles and develop a reliable system to monitor compliance.

4. Assess the use of the 1991 Monte Carlo and van for functionality and safety, and take appropriate action as warranted. Review the utilization of the van to determine whether another vehicle would be more suitable for individual patient use.

### **Summary Statement**

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule, or regulation; engaged in gross mismanagement and abuse of authority; or created a substantial and specific danger to public health and safety. In particular, VA's Office of General Counsel (OGC) has provided a legal review, and VA's Office of Accountability Review (OAR) has examined the issues from a Human Resources (HR) perspective to establish accountability, when appropriate, for improper personnel practices. VA found violations of VA Handbook 0730/4.

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## **I. Introduction**

The USH requested that the Director, HCHV Program, assemble and lead a VA team to investigate allegations lodged with OSC concerning the Medical Center, which is located in Albuquerque, New Mexico. An anonymous whistleblower made allegations that Building 1 on the Medical Center campus lacks appropriate access controls and that the HCHV Program lacks sufficient resources to complete its mission. OSC states that these allegations possibly resulted in conduct that may constitute violations of law, rule, or regulation; gross mismanagement; and a substantial and specific danger to public health and safety. VA conducted a site visit to the Medical Center on August 11-13, 2015.

## **II. Facility and VISN Profile**

The Medical Center, part of Veterans Integrated Service Network 18, a VHA complexity level 1a, tertiary care referral center, provides a full range of primary and secondary health care services to Veterans at a main facility in Albuquerque and at 13 community-based outpatient clinics (CBOC). The Medical Center is authorized to operate 310 beds, which includes 184 acute hospital beds (including a 26-bed Spinal Cord Injury Center); 90 residential rehabilitation treatment program beds (including a 26-bed Psychosocial Residential Rehabilitation Treatment Program (RRTP), a 24-bed Substance Abuse RRTP, and a 40-bed Domiciliary RRTP); and a 36-bed Community Living Center.

VA-staffed CBOCs are located in Artesia, Farmington, Gallup, Silver City, Raton, Santa Fe, and Northwest Metropolitan, with contract CBOCs in Alamogordo, Truth or Consequences, Espanola, Las Vegas, and Taos, New Mexico; and Durango, Colorado.

The Medical Center's affiliation with the University of New Mexico School of Medicine includes 122.1 resident physician full-time employee equivalents currently rotating through 33 clinical residency training programs. In addition, the Medical Center is affiliated with the University of New Mexico for nursing, the Albuquerque Technical Vocational Institute, and nearly 70 other academic institutions for various types of training. The Medical Center reported a total of 64,257 unique Veterans.

## **III. Specific Allegations of the Whistleblowers**

1. Building 1 lacks proper security controls, allowing public access to the building's interior and compromising employee safety; and
2. The HCHV Program lacks sufficient Federal Government vehicles for employees to provide appropriate service to clients, which directly impacts the health of homeless Veterans who are otherwise unable to obtain transportation for medical care.

#### IV. Conduct of Investigation

The VA team conducting the investigation consisted of [REDACTED], Director, HCHV Program; [REDACTED], RN, Clinical Program Manager, Office of the Medical Inspector (site visit advisor); and [REDACTED], HR Specialist, Cheyenne VA Medical Center, Cheyenne, Wyoming. The team reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured Buildings 1 and 96, HCHV Program temporary offices located in trailers on site, and several Medical Center campus parking lots where assigned HCHV Program vehicles were parked. The team held entrance and exit briefings with Medical Center leadership.

The following employees attended the Entrance Briefing:

[REDACTED], Medical Center Director  
[REDACTED], Acting Chief of Staff of Patient (CoS)  
[REDACTED], Acting Associate Director (AD)  
[REDACTED], Acting Associate Director Care Services (ADPCS)  
[REDACTED], Acting Assistant Director  
[REDACTED], Acting Chief, Performance Improvement (PI)  
[REDACTED], Administrative Officer, PI

We interviewed these Medical Center employees:

[REDACTED], Acting CoS  
[REDACTED], AD  
[REDACTED], Chief, Behavioral Health Care Line  
[REDACTED], Chief, Engineering Service  
[REDACTED], Acting Chief, Engineering  
[REDACTED], Engineering Transportation Assistant  
[REDACTED], Chief of Police  
[REDACTED], Social Work Executive  
[REDACTED], HCHV Director/Program Coordinator  
[REDACTED], HCHV Social Worker  
[REDACTED], HCHV Social Worker  
[REDACTED], HCHV, Peer Support  
[REDACTED], Housing and Urban Development-Veteran Assisted Housing (HUD\_VASH) Program Coordinator  
[REDACTED], HUD-VASH Social Worker  
[REDACTED], HUD-VASH Social Worker  
[REDACTED], Mental Health Intensive Case Management (MHICM) Program Coordinator  
[REDACTED], MHICM RN Case Manager  
[REDACTED], MHICM Social Worker

The following employees attended the Exit Briefing:

██████████ Medical Center Director  
██████████ Acting COS of Patient  
██████████ Acting AD  
██████████ Acting ADPCS  
██████████ Acting Assistant Director  
██████████, Acting Chief, PI  
██████████ Administrative Officer, PI

Subsequent to the site visit, on August 20, 2015, the team interviewed ██████████, HCHV Program Support Assistant, via teleconference.

## V. Background

The Medical Center's Behavioral Health Care Line (BHCL) is comprised of five components: Psychiatry Services; BHCL Nursing Services; Psychology Services; Community Care Services, and Administrative Operations. As part of Community Care Services, the HCHV Program serves as the umbrella for many component programs that provide an integrated network of services for homeless Veterans. These components include (HUD-VASH); Veterans Justice Outreach; Grant and Per Diem; Low Demand/Safe Haven; Substance Use Disorder Treatment (SUD); Employment Services; and Peer Support. The program uses HCHV Contracted Residential Services in community locations to engage under-served homeless Veterans. Many of these Veterans would benefit from mental health and SUD treatment, but do not use these services without encouragement from outreach workers.

VA established the HCHV Program to address the needs of homeless Veterans, many who are chronically mentally ill. The mission of the program is to end homelessness among Veterans through outreach efforts and community partnerships. VA social workers, medical staff, and mental health clinicians identify VA-eligible homeless Veterans, and assist these Veterans in accessing appropriate health care, benefits, and contract with community resources to provide residential treatment and services. Services include referrals to medical and psychiatric assessments; alcohol and drug treatment; case management; and assistance with basic needs such as food, clothing, and temporary shelter. HCHV Program staff members also provide linkage to transitional housing through VA and community providers, and assist Veterans with finding affordable housing and employment. Staff members also perform rural outreach to homeless Veterans throughout New Mexico. According to the BHCL organizational chart, the HCHV program is authorized 31 FTEE. At the time of the VA team visit, 11 of these positions were vacant.

## VI. Findings, Conclusions, and Recommendations

### Allegation 1

Building 1 lacks proper security controls, allowing public access to the building's interior and compromising employee safety.

### Background

Building 1 at the Medical Center has four floors and has been undergoing construction renovation (seismic rehabilitation) for over a year. Under normal configuration, the building serves as the location for BHCL program outpatient clinics on the first and second floors, homeless Veteran programs on the third floor, and the Medical Center Chief of Police office on the first floor. Until the renovation is completed, the Chief of Police office has been relocated to the fourth floor. The construction renovations have involved each of the four floors, requiring temporary relocation of the program staff, on a rotating basis to offices located in temporary trailers on the Medical Center grounds.

At the time of the VA team's visit, staff had moved back into their offices on the first floor and patients were being seen for scheduled appointments. The second floor was under construction. The SUD program staff, who shares office space on the third floor with the HCHV Program staff, had relocated back to their offices and were also seeing patients. During this time, the Chief of Police office remained on the fourth floor. The plan was to move the BHCL staff back into Building 1, during the week of August 17, 2015, a week after the VA team's visit. Building 1 will be a temporary site for the HCHV Program, since the entire staff will be relocated to the newly constructed site, Building 96.

The police staff conducted Vulnerability Assessments of Building 1 in March 2015 and April 2015. In March 2015, the Medical Center conducted its own Active Threat Vulnerability Assessment, and as a result of their findings, installed and implemented a Lynx Duress and Emergency Notification System to replace a previous panic button system that enabled staff to notify the police or each other of a threat or pending threat of harm. All but one HCHV Program staff member reported receiving training on the new system; however, while many staff members indicated that they had received training, they also reported they still did not fully understand how the process worked. One staff member reported that he had not received the training and thought he could still use the panic button.

In April 2015, a member of the police staff conducted a Vulnerability Assessment Survey of Building 1. An April 13, 2015, memorandum to the Chief, BHCL and Medical Center leadership shared the survey results and annotated the following deficiencies:

- a. Issue: The main entrance door to the second floor East hallway does not lock, allowing access and walk-ins to all the clinics and offices situated on the

East side of the building. Staff members are unable to control access to the East wing and expressed concerns for their safety.

Response: The police advised staff at that time that the area would undergo renovation and construction in the near future. The survey noted plans to consult with engineering to ensure that the door replacing the current main door to the East hallway is equipped with locking capabilities or mechanisms in order to limit access to the BHCL clinics and offices in the area and to ensure staff safety.

- b. Issue: The main entrance door to the second floor West hallway remains unlocked during clinic hours. However, the door is equipped with a key lock, but staff members do not lock it due to the inconvenience of having to use a key for access to and from the unit when escorting patients from their intake/screening room which is located outside the unit entrance door. Staff members are concerned for their safety, yet believe the current lock in place imposes delay and inconvenience in patient care on a daily basis. Staff members also are aware the area will undergo renovation and construction in the near future and are unsure if the door will remain in its current place.

Response: Police advised staff to keep the door locked at all times to limit access to the BHCL clinics and offices and ensure staff safety, and to consult with engineering for future installation of a different lock to improve and facilitate the ingress and egress to and from the unit, while maintaining quality and fluency in patient care and expedited service with minimal interruptions.

- c. Issue: The North exit door located at the second floor by the waiting room is permanently locked prohibiting access to the exterior cat walk. Staff stated they do not have a key to the door and have safety concerns in the event of an emergency situation requiring evacuation. The door does not meet proper safety codes for access control.

Response: Recommendation made to consult with the safety office to ensure the North exit door of the second floor meets proper safety code and access control.

- d. Issue: The main entrance door to the SUD and Homeless Program Clinics located on the third floor does not lock and staff is unable to control access to the clinic area in order to provide patients with privacy and quality care service and to ensure a safe environment for both staff and patients.

Response: Recommendation made to consult with engineering to place a locking device on the door in order to control or limit access to the SUD and Homeless Program Clinics, which is a high-risk area, and to alleviate interruption in patient care, improve quality service, provide privacy to patients who are being seen at the clinic, and to ensure staff and patient safety.

## Findings

There was insufficient evidence for the VA team to confirm that any of the recommendations in the April 2015 Vulnerability Assessment Survey had been implemented.

The VA team toured Building 1 on August 11, 2015, the first day of the visit, then again on the April 13, 2015. On April 13, 2015, immediately prior to the exit briefing, the VA team requested and conducted an unannounced walkthrough of Building 1, accompanied by a member of the Medical Center's engineering staff. The VA team made this visit as a direct result of specific security concerns identified during the initial tour and during the course of interviews. During this second walkthrough, the team found that the South rear entrances were opened, providing access to rear vestibule areas where homeless Veterans could sleep overnight. This was not a part of the construction area.

The VA team also conducted a walk-through of a newly constructed building, Building 96, with Medical Center engineering staff. The floor plan and office configuration in Building 96 addresses the existing safety and security concerns found in Building 1. The new building has a Veteran check-in area behind glass windows and an open waiting area where the Veteran waits to be called to go behind locked doors to see the providers. All HCHV Program staff will move to this building upon its completion.

During interviews, HCHV Program staff consistently confirmed that Building 1 security has been an ongoing concern, particularly on the third floor where the elevator opens to a lobby. The third floor lobby is not staffed with a Medical Service Assistant (MSA) to greet the Veteran and guide or direct him/her to their proper provider or appointment location, a scenario confirmed by numerous interviewees. This situation has led to incidents of Veterans becoming angry and irate, largely due to the lack of direction. Several staff reported feeling unsafe because unaccompanied Veterans can access the third floor by the elevator, continue through the lobby, and enter into the HCHV Program office area through an electronic door that does not restrict their access. As there is no check-in desk or staff located in the third floor lobby to direct or escort patients once they get off the elevator, patients typically go through and beyond the electronic door, even though it bears a sign directing Veterans to stop and not go beyond that point. HCHV Program staff asked why the electronically operated door could not be replaced by a locked door or one where only use of a personal identity verification card would allow access. Staff interviewed stated that prior to the start of construction in Building 1, a MSA had been posted in a booth in the lobby of the third floor to check patients in after they entered and direct them to their appointment location, but the Medical Center's Space Committee reassigned the booth space, originally assigned to the HCHV Program, to another service. In addition, several HCHV Program staff interviewed reported that they did not have confidence in the newly implemented Lynx Duress System, a system where Lynx messaging is used to alert the police of a pending patient escalation or other unsafe situation, since at least one staff person had

not been trained and those who received the education had never had an opportunity to use the system.

In addition to the above issues, several staff members interviewed reported that they had heard of Veterans sleeping in Building 1. Two of the interviewees stated that they had personally observed Veterans sleeping on the back staircase. The Medical Center Chief of Police and AD confirmed one incident of a Veteran sleeping in Building 1 by email correspondence. An additional incident was confirmed through findings reported as part of a site visit conducted by OSLE on May 3-6, 2015.

Per VA Directive 0730, *Security and Law Enforcement*, and VA Handbook 0730 through 0730/5, *Security and Law Enforcement*, OSLE has jurisdiction on all physical security matters of concerns at VA facilities. As part of this investigation, OSLE conducted a site visit, on May 3-6, 2015. This site visit included review of relevant VA policies, standard operating procedures (SOP) for the Medical Center Police Department, and Handbook 0730/4, Appendix B, referenced by the whistleblower. OSLE agents conducted unannounced site visits to Building 1 and their findings, conclusions, and recommendations follow. OSLE officers conducted face-to-face interviews with the following individuals at the Medical Center:

[REDACTED] Security Assistant Police Services  
[REDACTED] Albuquerque VAMC Police  
[REDACTED], Assistant Chief of Police Albuquerque VAMC Police

OSLE, through interviews with the above staff, confirmed that on one occasion, VA police received a report that a Veteran was sleeping on a couch in the third floor area of Building 1. The responding officers did find a homeless man sleeping on the couch. The Veteran explained to the police that his physician had allowed him to sleep there until permanent housing could be secured for him. The physician had not informed fellow staff and coworkers that he had approved this arrangement. In response to the VA team's preliminary findings, on August 14, 2015, the Medical Center Director ordered the following corrective actions to be taken:

- Instructing construction lead to check locks upon entry/exit and not prop doors open, and increase the frequency of VA Police security check of the building after normal business hours (between the hours of 9 p.m. and midnight) to ensure that there are no unauthorized persons in the building;
- Ensuring that LYNX Duress System and testing handouts are manually distributed to employees of Building 1 on August 14, 2015; and
- Hiring a new Physical Security Specialist who would assume duties by August 24, 2015.

According to follow-up correspondence dated October 1, 2015, from the Medical Center Director, these three corrective actions have all been taken.

## Conclusions for Allegation 1

- VA **substantiated** that Building 1 lacks proper security controls, allowing public access to the building's interior and compromising employee safety.
- VA confirmed that all HCHV Program staff members are not familiar with the Lynx Duress System.

## Recommendations to the Medical Center

1. Complete the following recommendations made by the OSLE team as part of its site visit conducted from May 3-5, 2015:
  - a. Review VA Handbook 0730/4, Appendix B, and reinforce to all employees that they must follow 0730/4, which outlines physical security rules and regulations. All employees must take appropriate action to report security violations to their leadership, and leadership must follow up appropriately.
  - b. VA Police need to provide more rigorous oversight of individual building managers to ensure that they are complying with VA Handbook 0730/4, Appendix B. Use of an established badging system for all contracted construction workers would enhance access control during normal working hours and after hours.
2. Implement recommendations cited in the April 2015 Vulnerability Assessment Survey.
3. Properly secure all stairwell doorways in Building 1.
4. Ensure that sufficient personnel are available to greet and escort Veterans in Building 1, especially on the third floor.
5. Ensure that all HCHV staff members are sufficiently trained in the proper use of the Lynx Duress System.
6. Investigate the situation where a provider gave a patient permission to sleep in Building 1 and determine if any administrative or disciplinary action is warranted. If so, take action as necessary and appropriate.
7. VHA reviews the circumstances surrounding the failure to address the Vulnerability Assessment Survey and determines whether there is any senior leadership accountability for this matter.

## Allegation 2

The HCHV Program lacks sufficient Federal Government vehicles for employees to provide appropriate service to clients, which directly impacts the health of homeless Veterans who are otherwise unable to obtain transportation for medical care.

## Background

Under 38 United States Code (U.S.C.) § 111A, VA has the authority to transport any person to or from a VA facility or other place in connection with the VA vocational rehabilitation program; counseling required under 38 U.S.C. Chapter 34 or 35; and for the purpose of examination, treatment, or care. VHA Handbook 1162.09, *Health Care for Homeless Veterans*, at section 18 permits facilities to develop local program

operating guidelines that address, among other things, position description or functional statements, duties, staff transportation, and education policies. Section 5.c.(4) of the Handbook provides, in part, that the case manager will ensure the availability of mental health and SUD counseling, either through linkage to available resources or directly, if necessary. Further, section 6. d. of the Handbook requires each medical facility Director to designate a HCHV Coordinator, who is charged with ensuring outreach services are provided by HCHV teams with sufficient resources to support literal street outreach, Stand Down participation, and collaboration with other VA and community-based homeless programs, as well as related health care and social agencies that serve homeless Veterans.

VHA Handbook 1162.05, *Housing and Urban Development (HUD)-Department of Veterans Affairs Supported Housing (VASH) Program (2011)*, at Section 34, likewise permits local policies and standard operating procedures to be developed by HUD-VASH Program sites. Local documents may address position descriptions and duties, staff transportation and education policies, etc. These procedures are also encouraged to be integrated with other facility homeless programs, such as HCHV. Section 9. c. of this Handbook also requires each medical facility Director to provide appropriate administrative support and resources to ensure the HUD-VASH Program is able to accomplish its stated mission, goals, and objectives. This includes office space, Information Technology equipment, and *car allocations*. Section 17(e) of this policy further states that HUD-VASH case managers and staff must have the freedom and flexibility to develop innovative approaches to reach out to the community and assist homeless Veterans; in addition, staff independence may necessitate medical facilities to recognize additional considerations for program safety, employee security, and job effectiveness, such as “available vehicles for outreach and case management activities.”

We note that the Albuquerque HCHV team, under BHCL, encompasses the facility’s entire homeless Veteran program team, including HUD-VASH. So vehicles assigned to HCHV are more broadly utilized for purposes other than those strictly described in the HCHV Handbook referenced above. Again, the HCHV team is responsible for conduct of the HUD-VASH Program as well.

## **Findings**

According to the Engineering Service and Fleet Manager, the Medical Center operates with a fleet of 117 total vehicles, assigned to its programs throughout the facility. BHCL has been assigned a total of 26 Federal Government vehicles used for: Vocational Rehabilitation (1 vehicle); Psychosocial Rehabilitation and Recovery Center (2 vehicles); the Psychosocial Residential Rehabilitation Treatment Program located in Gallup (2 vehicles), and MHICM (5 vehicles). Sixteen vehicles are specifically assigned to HCHV (11 in Albuquerque and 5 in the various CBOCs). The Medical Center Engineering staff reported that 117 vehicles are sufficient to meet the facility’s needs based on the utilization statistics. The review of records by the Chief of Engineering indicated underutilization of vehicles by the facility. The underutilization reports indicate a consistent trend of greater than 5 percent (March 2015 – 17.2 percent,

April 2015 – 19.8 percent, and May 2015 – 26.7 percent). As long as the underutilization rate remains over 5 percent, no new vehicles can be authorized.<sup>1</sup> A spreadsheet provided by Engineering Service showed underutilization of vehicles assigned and managed by the BHCL, which includes the HCHV Program. Interviews with BHCL and Engineering staff confirmed that this vehicle availability was a recurring issue as HCHV Program staff often only has short notice as to when they will require a vehicle.

Additionally, HCHV does not efficiently manage the assignment of vehicles used by its program(s). In particular, the system developed by HCHV to monitor its own use of vehicles is ineffective and not fully understood by program staff. Interviews indicate that there were times when staff failed to follow procedures to reserve vehicles in advance. As a result, vehicles were not always available at the time they needed. While this periodic non-compliance appears to have resulted in inconvenience for staff, we did not find that it had a negative impact on patient care because we found no evidence that Veterans' VA health care appointments were missed or cancelled for this reason. A public transport system exists that makes free access available for Veterans from various points in the metro area to and from the Medical Center when needed.

There are, however, problems with two particular vehicles assigned to HCHV: a 1991 Monte Carlo (a two-door vehicle with a reported history of extensive mechanical problems, including a broken driver's seat belt, requiring repeated repairs) and a large van that seats up to eight passengers that, outside of group events such as Stand Downs and recreational group activities, is highly inefficient when transporting a single homeless Veteran to his/her community medical appointments. Several staff interviewed indicated they are reluctant to drive either vehicle for these reasons. Engineering, the service that manages the vehicle motor pool, is exploring options to improve this situation. These include: distributing a monthly utilization report to all services to assure accurate reporting of vehicle usage; realigning vehicles between/among lines of service as needed; and approving funding to purchase GPS data logging equipment to ensure real time data on all vehicles. The Chief of Engineering reports that she is also researching best practices on vehicle usage from other VA Medical Centers.

## **Conclusions for Allegation 2**

- VA **did not substantiate** the allegation that the HCHV Program lacks sufficient Federal Government vehicles for employees to provide appropriate service to clients, which directly impacts the health of homeless Veterans who are otherwise unable to obtain transportation for medical care.
- VA confirmed that the HCHV Program had a sufficient amount of vehicles to complete the mission but was inappropriately managing its assigned vehicles.

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<sup>1</sup> The terms of VA Handbook 0637, "VA Vehicle Fleet Management Program," at Chapter 4, paragraphs 2.a.(1) and (5) call for each VA organization to establish additional policy and procedures, as needed, to manage the fleet under its jurisdiction and to avoid the permanent assignment of motor vehicles to individuals or program offices.

We identified utilization issues with the overall fleet management of the assigned Medical Center vehicles. There were also two vehicles assigned to the HCHV Program that were underutilized due to unsuitability and protracted history of mechanical problems.

- VA is not able to substantiate that access to Federal Government vehicles has been so problematic as to impact the health of homeless Veterans, as we found no evidence of missed or cancelled VA health care appointments due to this reason.

### **Recommendations to the Medical Center**

1. Develop a more efficient fleet management system to more effectively manage Medical Center vehicles to better meet all program needs throughout the facility.
2. Ensure that the Chief of Engineering continues to explore options to appropriately manage fleet vehicles.
3. Ensure that HCHV Program staff members comply with established reservation and other procedures to enable workers to maintain timely access to assigned vehicles and develop a reliable system to monitor compliance.
4. Assess the use of the 1991 Monte Carlo and van for functionality and safety and take appropriate action as warranted. Review the utilization of the van to determine whether another vehicle would be more suitable for individual patient use.

### **Summary Statement**

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, OGC has provided a legal review, and OAR has examined the issues from a HR perspective to establish accountability, when appropriate, for improper personnel practices. VA found violations of VA Handbook 0730/4.

## Attachment A

Documents reviewed:

Report to the Office of Special Counsel, OSC File Number DI-15-2216 from Department of Veterans Affairs, Office of Operations, Security and Preparedness Office of Security and Law Enforcement, Washington, DC, Report Date: June 23, 2015.

VA Handbook 0730/4.

VHA Handbook 1162.09, Health Care For Homeless Veterans (HCHV) Program, May 2, 2014.

VA Handbook 0637, VA Vehicle Fleet Management Program, May 10, 2013.

Medical Center Behavioral Health Care Line Policy and Procedure # 4-1, *Policy for Health Care for Homeless Veterans Program (HCHV)*, March 2015.

Medical Center Behavioral Health Care Line Policy and Procedure # 4-2 *Use of Health Care for Homeless Veterans (HCHV) Program Vehicles*, March 2012.

Medical Center Behavioral Health Care Line Policy and Procedure # 4-3, *Health Care for Homeless Veterans Program (HCHV) Management of Violent or Aggressive Behavior/Staff Safety*, March 2015.

Medical Center Behavioral Health Care Line Policy and Procedure # 4-15, *Health Care for Homeless Veterans Program (HCHV) Outreach at Health Care for Homeless Medical Clinic and Outreach in the HCHV Walk-In Clinic*, March 2015.

Medical Center Memorandum 122-10, *Social Work Scope of Practice*, January 22, 2013.

Medical Center Behavioral Health Care Line Organizational Chart.

Medical Center HCHV Program Staff Meeting Minutes August 6, 2014, October 1, 2014, January 7, 2015, and April 1, 2015.

Medical Center Police SOP, Chapter II, Section E, 2-E-1.

Educational folders on all Behavioral Care Line staff interviewed.

Behavioral Health Patient Advocate Tracking System complaints, January 2014-2015.

Congressional, February 11, 2015, Senator Martin Heinrich (attachment to Building 1 Security Timeline).

Building 96 floor plan design, SMM10114-1, July 2, 2014.

Building 1 floor plans, Seismic Rehabilitation for Building 1, AE 100A&B; AE 101A&B;  
AE 102 A&B; AE 103 A&B.

Email correspondence, from Medical Center Director to [REDACTED], August 14, 2015,  
and October 1, 2015.