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# **Management and Fiscal Audit of the Hawaii State Hospital**

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A Report to the  
Governor  
and the  
Legislature of  
the State of  
Hawaii

Report No. 95-34  
December 1995

**THE AUDITOR**  
STATE OF HAWAII

# OVERVIEW

THE AUDITOR  
STATE OF HAWAII

## Management and Fiscal Audit of the Hawaii State Hospital

### Summary

The Hawaii State Legislature directed the Office of the Auditor to conduct a management, fiscal, and staffing audit of the Hawaii State Hospital through Section 31 of Act 218, 1995 Regular Session. The impetus of the audit stemmed from years of negative media attention on the hospital's poor condition and poor patient care, the U.S. Department of Justice's settlement agreement with the hospital, and most recently, the federal court's decision holding the hospital in contempt for not fulfilling the settlement agreement.

We reviewed whether the hospital is managed to reflect its mission, functions, and responsibilities. We contracted with the certified public accounting firm of KPMG Peat Marwick LLP to conduct a fiscal review of the state hospital to determine whether the hospital's fiscal activities are appropriate and reasonable and provide useful financial information.

We found that past administrations failed to properly manage the Hawaii State Hospital. Personnel management has been allowed to deteriorate to the point that employee absenteeism is rampant and discipline unenforceable. Stewardship of state property and funds has been non-existent, and repeated warning flags went unheeded or ignored. Detrimental practices are so ingrained in the fabric of hospital operations as to put the new hospital superintendent at a severe disadvantage in making changes. The new superintendent has made some improvements in personnel management and other areas, but many problems remain.

We found that the hospital lacked sufficient personnel policies and procedures. Chronic absenteeism has contributed to excessive overtime costs. The lack of personnel policies and procedures has made it impossible to discipline employees. We also found that the state hospital's financial management is weak. Hospital management does not administer and thus is not accountable for its purchasing and payroll functions. The hospital's business and personnel staff are underutilized.

Additionally, the state hospital has not exercised prudence in its heavily subsidized employee meals program which costs the State \$300,000 a year. Hospital employees have enjoyed 40 cent meals while meal service costs have risen to more than \$5 per meal.



Inventory controls are lacking for gasoline, janitorial, and food services and supplies. Gasoline use is self-service on an honor system. Patient clothing and linen supplies are not monitored or verified for inventory control levels. There are no inventory records for supplies which allow for determination of unjustifiable and unexplainable inventory shortages. Finally, the hospital needs to address problems associated with its forensic (court-ordered) population.

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## Recommendations and Response

We recommend that the Department of Health and the Hawaii State Hospital strengthen their personnel policies and procedures to reduce absenteeism and grievances and to better guide hospital employees in their work. Employees' pay should be discontinued when leave is unauthorized and forms are unsigned.

The department and the hospital should evaluate the current purchasing and payroll processes for inefficiencies and make improvements. Purchased professional services from the University of Hawaii should be negotiated by the hospital superintendent for better results. We also recommend that the hospital better utilize its business and personnel office staff and improve the supervisory and record-keeping controls of the industrial therapy program.

We recommend that the department and the hospital reconsider the perquisite practice of subsidized meals for hospital employees. Additionally, the hospital should strengthen its inventory controls by controlling access to the hospital's gasoline pump and requiring appropriate inventory recordkeeping at the housekeeping and dietary units. Finally, the hospital should continue its efforts in addressing the problems associated with its forensic patient population.

The Department of Health responded that, overall, it agrees with the report's summary and findings, as well as its recommendations. The department commented that the report seems objective and fairly presented. It also added comments and clarified information provided in the draft, some of which we incorporated in the report.

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Conducted by

The Auditor  
State of Hawaii  
and  
KPMG Peat  
Marwick LLP

Submitted by

**THE AUDITOR**  
STATE OF HAWAII

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## Foreword

The Hawaii State Legislature directed the Office of the Auditor to conduct a management, fiscal, and staffing audit of the Hawaii State Hospital through Section 31 of Act 218, 1995 Regular Session. The impetus for the audit stemmed from years of negative media attention and federal sanctions as well as the costly contract nursing services to meet federally mandated staffing ratios.

The audit evaluated whether the hospital is managed to reflect its mission, functions, and responsibilities. We contracted with the firm of KPMG Peat Marwick LLP to conduct a fiscal review of the state hospital to determine whether the hospital's fiscal activities are appropriate and reasonable and provide useful financial information.

We wish to express our appreciation for the cooperation and assistance extended to us by the staff of the Hawaii State Hospital. We would also like to acknowledge the cooperation provided by the staff of the Department of Health and state agencies who assisted us in this review.

Marion M. Higa  
State Auditor

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# Chapter 1

## Introduction

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The Hawaii State Legislature directed the Office of the Auditor to conduct a fiscal, management, and staffing audit of the Hawaii State Hospital through Section 31 of Act 218, 1995 Regular Session. The impetus for the audit stemmed from the numerous concerns about the hospital's operations over the years. These included negative media attention on the hospital's poor condition and poor patient care, the U.S. Department of Justice's settlement agreement with the hospital, and most recently, the federal court's holding of the hospital in contempt for not meeting the settlement agreement.

Additionally, concern was expressed over the management and propriety of costly contract nursing services to meet the federally mandated staffing ratios. An additional \$2.9 million in general funds was requested for both FY1995-96 and FY1996-97 to cover the cost of these contracted services.

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## Background

The Hawaii State Hospital was built in 1930 to replace the Oahu Insane Asylum. It is a psychiatric facility licensed by the Department of Health for the care of mentally ill persons and persons who are both mentally ill and drug-addicted. Chapter 334, Part III, Hawaii Revised Statutes (HRS), sets out the hospital's responsibilities.

Persons may be admitted voluntarily to Hawaii State Hospital according to the hospital's admissions standards. Persons may also be involuntarily examined and hospitalized. Emergency examinations can be initiated by police officers with the concurrence of a mental health emergency worker, by judges issuing orders for emergency examinations, or by licensed physicians or psychologists. The grounds for involuntary examination and hospitalization include imminent danger to self or others, grave disability, or obvious illness. Statutes also provide that persons who reside at a state correctional facility and are in need of hospital treatment for the primary diagnosis of mental illness will be transferred to the state hospital for care and treatment. Additionally, Section 704-403, HRS, provides for examinations and hospital commitments of defendants in criminal proceedings.

## *Mission*

In addition to its statutory mandates, the Hawaii State Hospital has developed an internal mission statement. The hospital's strategic plan states that "the mission is to promote and provide quality psychiatric treatment, in the spirit of aloha (compassion), lokahi (harmony), and ohana (teamwork)."

## ***Organization***

The Hawaii State Hospital is a branch under the Adult Mental Health Division which is under the Behavioral Health Administration in the Department of Health. The operations of the hospital are organized into three sections: clinical services; administrative and support services; and quality management services. Each of these sections is comprised of specific services referred to as units. An organizational chart is shown in Exhibit 1.1.

The hospital is headed by a superintendent who is responsible for its day-to-day operations. According to the department's organizational chart, the hospital superintendent should report to the chief of the Adult Mental Health Division who in turn reports to the deputy director of Behavioral Health Administration. During the audit, the hospital superintendent reported directly to the deputy director of Behavioral Health Administration. We have been informed that this position has been abolished and the superintendent now reports to the chief of the Adult Mental Health Division.

The hospital is organized by three areas of services with a total of 611 staff positions. Exhibit 1.2 summarizes the units, staff, and types of services in each section.

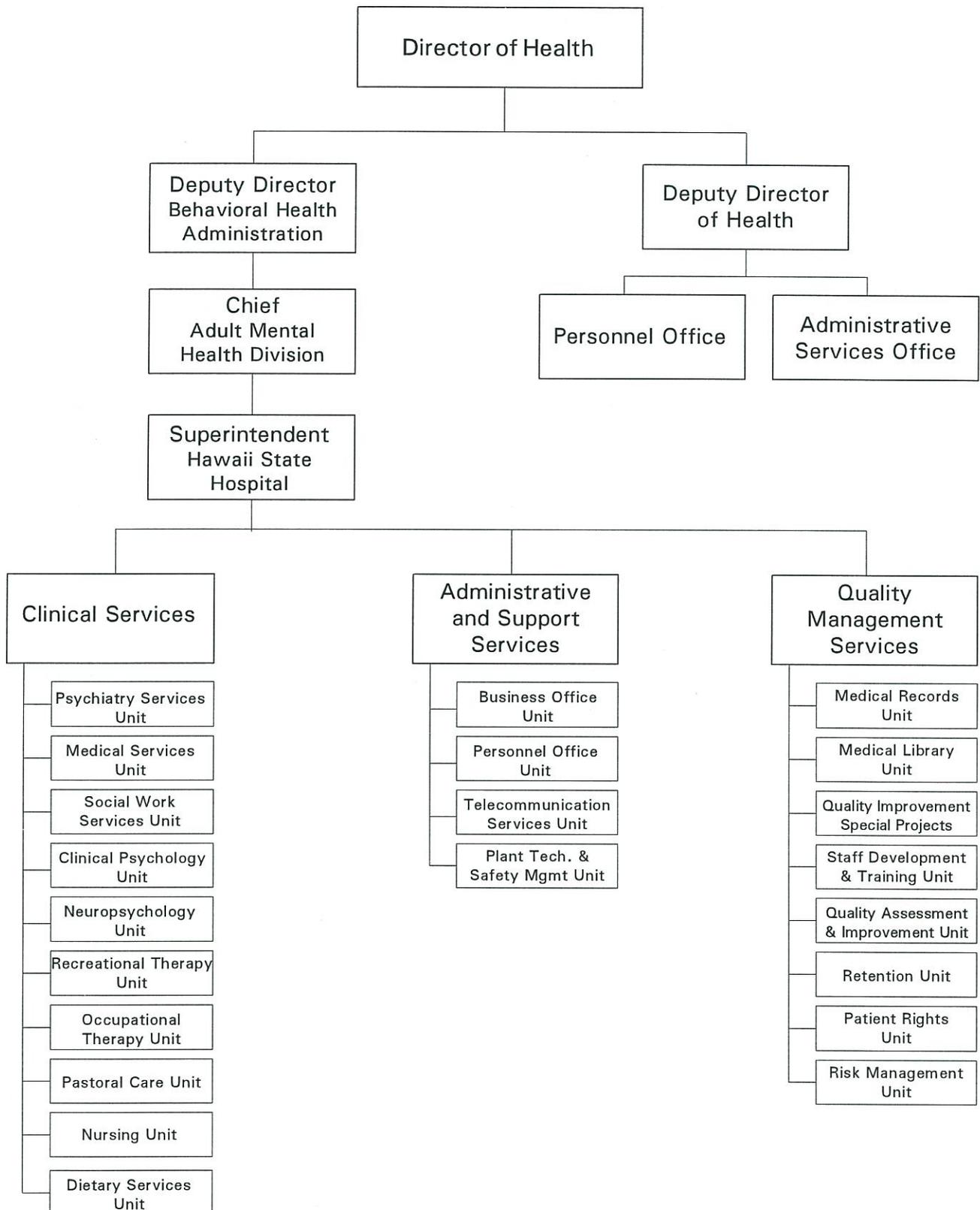
## ***Patient characteristics***

The Hawaii State Hospital has a 187-bed capacity. A total of 121 beds are for the forensic mentally ill (committed by the courts through the criminal justice system) and 66 are for the non-forensic mentally ill. The non-forensic mentally ill include voluntary commitments as well as long-term geriatric patients. Of the 66 non-forensic beds, about 15 are designated for acute care or short-term patients, 40 are for long-term care patients, and the balance are for those awaiting placement in a less restrictive intermediate care facility.

## ***Budget***

The Legislature appropriated \$32,324,182 in general funds for the hospital's operating costs each year for the fiscal biennium 1995-97. This represents an average increase of \$5,752,472 from the prior biennium. Funds were appropriated to the hospital's program ID, HTH 430. In the prior biennium, the hospital's funding was included in the program ID for the Adult Mental Health Division, HTH 420. Under HTH 420, appropriations identified as hospital operating costs were \$26,331,023 for FY1993-94 and \$26,812,398 for FY1994-95. In addition, in FY1994-95, \$2,281,776 was transferred to HTH 420 from other Department of Health programs to cover emergency action work and contract nurses for the hospital.

**Exhibit 1.1**  
**State Hospital Organizational Chart**



**Exhibit 1.2  
Hospital Services Units**

<p align="center"><b>Clinical Services</b> 10 units/452 staff</p>	<p align="center"><b>Administrative Support Services</b> 4 units/129 staff</p>	<p align="center"><b>Quality Management Services</b> 8 units/30 staff</p>
<p>Provides direct psychiatry services, medical services, social work services, clinical psychology, neuropsychology, and recreational therapy, occupational therapy, pastoral care, nursing, and dietary services to patients</p>	<p>Includes business office, personnel office, plant technology and safety management unit (including housekeeping), and telecommunication</p>	<p>Maintains medical records and a medical library, provides staff development and training, and is responsible for quality assessment and improvement, provide staff retention services, patient rights and risk management services</p>

***Hospital historically plagued with problems***

The past twenty years have been the most tumultuous in the hospital’s 65+ year history. In 1974, the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) revoked the hospital’s accreditation. The Joint Commission judged the hospital facilities inadequate and the hospital unable to provide patient care and treatment at a level required for accreditation.

The Joint Commission also found deficiencies in personnel management and recordkeeping. The Joint Commission stated that the hospital needed to conduct an annual review of personnel policies, staff development programs, and job descriptions. The Joint Commission also recommended that the hospital’s budget be “sufficient” and that “appropriate records” be kept for the procurement of supplies, equipment, and inventory.

The hospital’s reputation continued to deteriorate in the 1980s. In 1986, the U.S. Health Care Financing Administration denied the hospital its certification. The loss of certification meant the hospital could not collect Medicare reimbursements for any care or treatment provided to Medicare-eligible patients.

Other groups also found the hospital’s practices wanting. The Public Citizen Health Research Group and the National Alliance for the Mentally Ill, both patient rights advocacy groups, published three editions of their survey *Care of the Seriously Mentally Ill: A Rating of the State Programs* in 1986, 1988, and 1990. All three reports, which covered all 50 states and the District of Columbia, ranked Hawaii 51st in the nation. Citing deficiencies which were formally laid out by the Department of Justice in 1990, the 1990 report described the Hawaii State Hospital as “going nowhere.”

### ***U.S. Department of Justice Settlement Agreement***

The seriousness of the hospital's condition came to a head in 1990 when the U.S. Department of Justice issued a scathing report on hospital conditions that violated the constitutional rights of patients. Patients were not provided with adequate food, clothing, and personal hygiene supplies, nor an environment free from unreasonable risks to patients' personal health and safety. Procedures for administering psychotropic ("mind-altering") medication to patients were seriously deficient and were significant departures from generally accepted medical standards. Additionally, the report cited the hospital for abuse of such measures as seclusion and restraint of patients and the use of chemical restraints to deal with more difficult patients.

The report linked these conditions to a shortage of staff and lack of staff training. In an effort to remedy these violations, the federal government imposed a wide-scale settlement agreement in 1991 that detailed operational requirements for Hawaii State Hospital. The agreement is spelled out in *United States of America v. State of Hawaii et al.* (Civil No. 91-00137). The requirements of the settlement agreement left the Department of Health with little discretion in the hospital's major operations.

### ***Contempt action and remedial plan***

The department did not meet the operational requirements as required by the settlement agreement and the Department of Justice brought action against the department. On January 10, 1995, the State of Hawaii was found to be in contempt of the 1991 settlement agreement. The State entered into another settlement agreement, a remedial plan, to address the contempt action. The hospital has to meet 42 specific requirements including mandated staffing ratios, new policies on investigations of alleged abuse, clear lines of clinical authority, and values system training. The remedial plan also set numerous but specific deadlines for meeting certain requirements. For example, the hospital was required to ensure adequate staffing of each of the patient units by February 3, 1995. Another specific deadline was to hire and deploy 72 additional permanent nursing staff by November 10, 1995.

Failure to comply with these new requirements could be grounds for a possible federal take over of the hospital's administration with the State still responsible for all costs. The hospital believes it has met the requirements of the remedial plan.

### ***Current administration's efforts***

The director of health, in response to the contempt action, hired several new staff who have expressed a serious commitment to meeting all of the Justice Department's mandates as well as obtaining accreditation for the hospital by October 1996. Key people include the superintendent who started work in March 1995 and the associate administrator for administrative and support services who started in February 1995.

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## Objectives

1. Determine whether the Hawaii State Hospital is managed to reflect its mission, functions, and responsibilities.
  2. Determine whether the Hawaii State Hospital's fiscal activities are appropriate, reasonable, and provide useful financial information.
  3. Make recommendations as appropriate.
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## Scope and Methodology

We reviewed federal statutes and rules, state statutes and rules, and other relevant literature. We reviewed relevant hospital and departmental memoranda, meeting minutes, documents, and forms. We also reviewed the Department of Justice settlement agreement, the remedial plan, and the Joint Commission on the Accreditation of Healthcare Organizations standards.

We conducted a review of the hospital's operations which included a focus on staffing issues. The primary focus of the review was the period of July 1, 1994 to the present. We interviewed hospital administrators and all department/unit heads. We also solicited the input of each staff member of the hospital through a brief survey which focused on personnel and staffing issues. We reviewed employee attendance and leave records and conducted a review of a sample of official personnel files at the Department of Health's personnel office.

We engaged the certified public accounting firm of KPMG Peat Marwick LLP to conduct a fiscal review of the Hawaii State Hospital. The primary focus of the fiscal review was the period July 1, 1993 to the present.

Our work was performed from June 1995 through October 1995 in accordance with generally accepted government auditing standards.

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# Chapter 2

## Findings and Recommendations

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This chapter presents the findings and recommendations of our audit. We found that past administrations failed to properly manage the Hawaii State Hospital. Personnel management has been allowed to deteriorate, leading to rampant employee absenteeism and unenforceable discipline. Stewardship of state property and funds has been non-existent, and repeated warning flags went unheeded or ignored. Detrimental practices are so ingrained in the fabric of hospital operations as to put the new hospital superintendent at a severe disadvantage in making changes. The new superintendent has made some improvements in personnel management and other areas, but many problems remain.

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### Summary of Findings

1. The Hawaii State Hospital has a history of poor personnel management. Chronic absenteeism has contributed to excessive overtime costs and the lack of personnel policies and procedures has made it impossible to discipline employees.
2. The state hospital's financial management is weak. Management does not administer and thus is not accountable for its purchasing and payroll functions. The hospital's business and personnel staff are underutilized.
3. The state hospital has not exercised prudence in its heavily subsidized employee meals program which has cost the State \$300,000 a year. Hospital employees have enjoyed 40 cent meals while meal service costs have risen to more than \$5 per meal.
4. The state hospital's stewardship of state property is weak. Inventory controls are lacking for gasoline, janitorial supplies, and food services and supplies. Gasoline use is self-service on an honor system. Patient clothing and linen supplies are not monitored or verified for inventory control levels. There are no inventory records for supplies in which inventory counts can be measured against initial counts to determine if there are unjustifiable and unexplainable inventory shortages.
5. The hospital needs to address problems associated with its forensic (court-ordered) population. Almost 70 percent of the hospital's patients have been placed there by the courts. Mixing forensic patients with other patients creates potential security problems. The hospital needs to work with the courts and other hospitals on how to accommodate both the forensic and non-forensic patient populations.

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## **State Hospital Has a History Of Poor Personnel Management**

The Hawaii State Hospital's poor personnel management has negatively impacted hospital operations. It has difficulty controlling excessive overtime and personal leave and dealing with employee grievances. Other problems such as staff abuses of patients and drug abuse by patients have been reported by the media. The hospital cannot be effectively administered because it lacks formal personnel policies and procedures.

Hospital management practices, policies, and procedures should ensure that patients receive proper and adequate care and treatment. In the absence of such practices and procedures, the hospital management cannot be assured that employees consistently provide proper care and treatment.

The hospital's personnel management problems were pointed out in 1974 by the Joint Commission on Accreditation of Healthcare Organizations when it revoked the hospital's accreditation. Problems were noted again in 1986 when the hospital lost Medicare certification. In 1990, a consultant recommended that the hospital designate a specific person to develop job descriptions, recruit staff, and perform other human resources-related duties. In 1991, personnel problems were a key issue in the consent decree with the federal government.

Staffing needs and personnel policies and procedures were not adequately addressed. Personnel matters were assigned to employees with other responsibilities that were considered primary to their personnel responsibilities. Only since April 1995 has the hospital had a full-time personnel manager with expertise in the area of human resources.

### ***Employee absenteeism is rampant***

We found an excessive amount of absenteeism among certain employees on the day shift. They called in sick, never showed up for work, or never called in to give leave notice. They "took" leave without pay yet continued to get paid.

The hospital has historically had problems with overtime, sick leave, and leave without pay. The 1990 consultant's report noted that the excessive use of sick leave unnecessarily burdened other staff who were required to work overtime to cover for absent co-workers. The report recommended immediate action be taken to reduce the possible impact on patient care. The Department of Health took no action to remedy the situation and chronic absenteeism is still a problem.

### **Sick and other leave are abused**

In our review of attendance records for nine different months, we found that employees were absent from work on sick leave, on leave without

pay, or by simply not showing up or calling in. A normal work month is about 21 days; a nine-month period would consist of about 190 work days. Data from three employees' attendance records illustrates the extent to which personnel leave had been abused. These three employees worked only .52 to 2.2 days for every day of leave taken. Abuse and excessiveness of leave disrupts and impacts the delivery of care and services to patients.

Exhibit 2.1 summarizes combined leave records of these three sampled employees. Employee "A" used 12 days of sick leave, did not call in or show up 14 days, and took 33 days of leave without pay, a total of 59 days absent. Employee "B" used 38 days of sick leave, did not show up or call in 18 days, and took 69 days of leave without pay, a total of 125 days absent. Yet another employee used 6 days of sick leave, did not show up or call in 33 days, and took 61 days of leave without pay, a total of 100 days absent.

**Exhibit 2.1**  
**Sample of Employee Leave Days Taken During Nine Months**

	3 Types of Leave			Total Leave Days	Total 9 Months	Total Days of Work	Work to Leave Days Ratio
	(1) Sick	(2) No Show	(3) LWOP*				
Employee A	12	14	33	59	190	131	2.20
Employee B	38	18	69	125	190	65	.52
Employee C	6	33	61	100	190	90	.90

\*Leave without Pay

### **Leave pay continues to be issued for leave without pay**

Employees who are on leave without pay continue to receive paychecks even though vacation and sick leave hours have been exhausted. The department's personnel office informed us that leave without pay cases have escalated in the past year.

The Department of Health's informal leave without pay procedures may have contributed to this abuse. In the past, the hospital would process stop pay paperwork when employees were not coming to work. Paperwork would then be processed for back pay or adjustments when leave with pay was warranted. The department's new procedures minimize the amount of paperwork by withholding pay only if employees have signed leave forms requesting leave without pay. Employees have taken advantage of this new procedure by not signing their leave forms.

In our sample review of leave forms for the past fiscal year, we noted numerous employees who took leave without pay but continued to receive

full pay. Of these, 15 received paychecks totaling more than \$100,000 while absent from work. One employee has not worked in six months and refuses to sign the leave form. That employee received paychecks totaling approximately \$26,500 as of September 1995. The hospital is currently pursuing job abandonment procedures against that employee. However, the department should immediately stop paying employees who do not come to work and have no signed and authorized leave forms.

### **Resulting overtime costs are high**

Overtime payments to hospital employees, due in large part to other employees' excessive absenteeism, totaled approximately \$2 million in FY 1994-95. Additional overtime costs incurred by contracted nursing agency personnel are estimated to be in excess of \$300,000 for the same period. Minimum staffing levels for patient care are required by the settlement agreements. With high absenteeism, overtime costs are significant as the hospital is required to maintain minimum staffing levels for patient care. High absenteeism has also resulted in costly overtime for staff who do not provide direct patient care.

### ***Personnel policies and procedures are lacking***

Formal personnel policies and procedures are essential to effective personnel management. They codify acceptable standards of employee behavior and work responsibilities. They lay out procedures to be followed, assurances that employees understand these procedures, and resulting actions when employees violate them. Without codified policies and procedures, personnel actions can vary from supervisor to supervisor resulting in confused roles and responsibilities.

The hospital management is responsible for developing personnel policies and procedures. The health department's personnel office provides guidelines and reviews draft policies and procedures to ensure they are consistent with departmental and state personnel guidelines. Until recently, standardized, written personnel policies and procedures for the hospital were virtually non-existent. Most guidelines were verbal or in memo form.

### **New superintendent at a severe disadvantage without policies**

The lack of written personnel policies and procedures has contributed to chronic absenteeism and the hospital's inability to defend itself when employees file grievances. These problems, in turn, lower staff morale. Also, without written policies and procedures, the role of the new superintendent is hardly supportable when dealing with personnel matters.

***Employee work standards are unenforceable***

Weak personnel management is also evident in the hospital's inability to discipline employees. Employees have won almost all grievance cases against hospital management.

**Disciplinary actions are weak**

The employer has a responsibility to discipline employees and employees have the right to file grievances challenging improper discipline procedures. However, the hospital has no written discipline guidelines leaving discipline procedures open to interpretation and susceptible to abuse.

The hospital currently is drafting discipline guidelines. Past disciplinary problems could have been avoided had written policies and procedures been in place. We urge the department and the hospital to formalize and implement these procedures as soon as possible.

**The probationary period is ineffective**

New employees serve a six-month probationary period during which they are closely supervised to determine whether they will contribute to the effective operation of the hospital. Employees who received "less than satisfactory" job performance ratings or took leave without pay during this period have nevertheless been appointed permanent status and continue to work. They also continue to perform below satisfactory levels and continue to take leave without pay.

The hospital has evidently granted permanent status because it does not want to risk having employees file grievances. We learned from the health department's personnel office records that no probationary employee had ever been denied permanent status. However, we were informed by the hospital personnel officer that recently, one person, who did not meet standards during the probationary period, would be denied permanent status. That person then voluntarily resigned.

We encourage the hospital to develop and follow guidelines to more effectively screen probationary employees.

**Hospital personnel records are not official**

Due to improper personnel practices, the hospital management no longer has custody of its permanent personnel records. The hospital had been cited for keeping derogatory information on employees in unofficial records or a "black book" without the employees' knowledge or input. A "black book" is personnel jargon for a separate, unofficial record concerning employee conduct. Authorized personnel files contain official records of employee conduct and such records are filed only after the conduct has been discussed with the employee in question. The discussion must be documented in the personnel file.

The Department of Health removed hospital personnel files to its downtown personnel office to prevent future “black book” incidents. All official personnel files are now maintained at the department while the hospital keeps an unofficial duplicate set with photocopies of personnel actions. Maintaining duplicate files is wasteful. Further, maintaining the official personnel jackets downtown does nothing to eliminate the practice of keeping “black books.” It is also inconvenient and less efficient when hospital management needs to access complete and permanent files.

### **Poor employee morale is noted**

Morale problems were evident from our survey of the hospital staff. Out of 500 surveys we distributed, we received 354 comments from 182 responding employees. Morale problems were mentioned 40 times and 104 other comments reflected concerns about understaffing and overstaffing of units and the hiring and retaining of unqualified staff. Concerns about co-workers taking excessive sick leave and abusing overtime were expressed 30 times. Some very specific comments related to management’s inability to deal with employee leave status and disciplinary actions concerning workers who were suspended and allowed to return to work.

### ***Improvements are forthcoming***

The hospital is developing corrective measures to alleviate excessive leave and overtime problems. In May 1995, the hospital issued a memo requiring employees to notify their supervisors of lateness or absence from work. Additionally, employees are required to obtain a doctor’s note for sick leave after a specified number of days. Actions are being taken to discharge employees whose performance is unsatisfactory during their probationary period.

The hospital superintendent issued a memo in August 1995 to all operating units noting the excessive use of overtime. Overtime in non-direct patient care areas now requires advance written authorization. Overtime in direct care areas will need advance justification statements. It is too soon, however, to evaluate the effectiveness of these new requirements.

The hospital should implement clear personnel policies and procedures which should be codified in a personnel manual after being reviewed and approved by the health department’s personnel office and by the Department of Human Resources Development. The Department of Health should provide any support necessary to expedite adoption of personnel policies and procedures for the hospital. Once adopted, they should be disseminated to all staff.

## **State Hospital's Financial Management Controls Are Weak**

The entire \$32 million annual cost of operating the state hospital is borne by the State's general fund. It is imperative that the hospital operate in a fiscally prudent manner. Chapter 334, Hawaii Revised Statutes, which defines the Department of Health's responsibilities for providing a statewide mental health system, requires the department to "promote and conduct a systematic program of accountability for all services provided, funds expended, and activities carried out under its direction or support in accordance with sound business, management, and scientific principles." Financial management controls assure that operations are conducted with sound business principles. Controls are policies, practices, and procedures that management uses to ensure that funds are properly spent for necessary goods and services, and that moneys received are properly safeguarded and deposited into the state treasury. Controls help ensure that program objectives are met.

We find that existing financial management controls do not safeguard the State's assets. Responsibilities for the oversight and administration of purchasing and payroll are inappropriately split between the hospital and the department. Because of these deficiencies, hospital management is unable to control costs. Furthermore, the hospital's personnel and business office staff could be better utilized.

Sound financial management is not only a statutory requirement but also necessary for accreditation. To be accredited, the hospital must have financial and management information systems that meet the Joint Commission's criteria. The criteria include controls such as a financial information system with coding and retrieval functions to process and measure outcomes and assess performance. The hospital must demonstrate its ability to gather accurate, timely information for both operational decision making and planning purposes. The hospital is a long way from meeting those criteria.

### ***Oversight and accountability of purchasing is needed***

Purchasing procedures for the state hospital are blurred because both the health department and the hospital share purchasing responsibility. The department's Administrative Services Office (ASO) historically has been responsible for processing and approving (1) purchases of supplies and equipment, (2) payroll, and (3) contracts. The department's ASO prepares and submits all required purchase, payroll, and contract documentation to the Department of Accounting and General Services (DAGS). DAGS then records encumbrances, pays vendors, processes payroll, records contracts, and prepares monthly financial reports of expenditures for the hospital.

However, the hospital administration is preempted from reviewing and approving purchase orders, payroll, and contracts with its vendors such as the University of Hawaii. Hospital management should be allowed to review and approve all purchases, payroll charges, and contracts necessary to operate the hospital. The hospital should be the final approval for disbursements in order to control and account for its costs.

### **Hospital units do their own purchasing**

The hospital's different operating units prepare their purchase orders. The hospital's business office reviews the purchase orders and reviews them for accuracy only, not for content such as propriety, reasonableness, and least cost. The office then records the purchase order information on a monthly listing and sends the purchase orders to the departmental ASO for approval. If the purchase order is for equipment, it must be first approved by the hospital superintendent before it is sent to the department's ASO. For other purchases and expenditures, hospital management's first review of the information happens after the fact when purchase order information is reviewed at the end of the month. Hospital management is thus bypassed for the majority of its purchases.

Sound financial management principles require management to be accountable for its purchases. Accountability is blurred if hospital management is precluded from approving purchases for hospital operations. Hospital management, not the health department's ASO, should be authorizing all purchase orders. Hospital management is in the best position to know what is needed and what should be purchased. Its review should not come at month's end and after the fact, but before the purchases are made. Bypassing hospital management weakens management's ability to control costs and blurs accountability for assuring that the expenditures are proper.

### **Settlement agreement mandates UH professional services**

The 1991 settlement agreement also preempted the hospital management's oversight and accountability of purchasing professional services from the University of Hawaii. The agreement requires the hospital to have an affiliation with the university. The health department's Adult Mental Health Division negotiated the contracts with the university on behalf of the hospital. We were informed that the Adult Mental Health Division negotiations sought input from the affected operating units of the hospital but found no evidence of input from the hospital superintendent. The health department's ASO provided contracting services for the division.

For future negotiations, the hospital superintendent should decide which services should be contracted. The superintendent should establish the parameters of services, the timeframe of the contract, and the reporting obligations of the contractors. The department's ASO can provide such

support services as drafting contract specifications, requests for proposals, advertisements and solicitations for proposals, and evaluation of proposals. The ASO could then recommend a contractor to the superintendent based on its review of the proposals.

***Oversight and administration of payroll duties is deficient***

Hospital management also does not review or approve its payroll processes. The department's ASO performs this function. Without the hospital's oversight of payroll functions, critical information such as overtime and sick leave usage are not subject to point-of-origin review and approval. Without the hospital's administration of payroll, verification of reported to actual hours cannot be made. Furthermore, the current procedures require duplicative manual transcribing of key payroll information.

Key payroll information is transcribed on employee time sheets which become the basis for preparing payroll. Information on time sheets includes overtime and vacation hours worked and night shift and other pay differentials. These standardized state forms are transmitted to the Department of Accounting and General Services (DAGS) for processing state payroll. The hospital staff neither prepare nor approve these forms. Forms are prepared and approved by the department's ASO and are forwarded to DAGS for payroll processing.

**Duplicative transcription is not necessary**

Transcribing the same time sheet information is done by both the hospital and the ASO staff. Twice a month, the department's ASO sends a batch of "Organizational Time Sheets - Fringe" (State of Hawaii - Form D-56) to the hospital's personnel office. Every regular employee's name, social security number, department, payroll number, and branch are preprinted on this three-part time sheet. The form does not include the employee's rate of pay. The hospital payroll clerk manually records the overtime hours worked, the related pay codes, and total hours for employees' overtime claims. Because the rate of pay is not included, payroll calculations cannot be made by the hospital payroll clerk.

The department's ASO receives these forms from the hospital and the ASO clerk manually transcribes the same information to a duplicate employee form that includes the employee's rate of pay. The clerk manually computes the amount to be paid, and the ASO then reviews the form and sends it to DAGS for processing.

Much employee effort and transcribing time could be saved if the information were completed at the hospital and sent directly to DAGS for processing. This would eliminate the ASO's role of transcribing information. The role of the ASO could be to test a sample of forms for completeness and accuracy, then forward them to DAGS.

***Accountability does not reflect organization chart***

Accountability for hospital operations is blurred also by the ASO's bypassing hospital management for information from operating units. Whether information sought is personnel and payroll issues or purchases of supplies and equipment, this bypassing practice questions the authority and the role and responsibilities of the hospital management.

The department's organization chart (see Exhibit 1.1) shows that hospital units report to management—the hospital superintendent, not the ASO. However, operating units are being quizzed by the ASO, not the superintendent. The chart also shows the hospital superintendent reporting to the chief of the Adult Mental Health Division so questions concerning hospital operations should come from the director of that office rather than the ASO.

***Cost controls for patient work program are needed***

Controls for patient work programs are also weak. As part of the patient treatment program, qualified patients can participate in the hospital's industrial therapy program. The program's primary objective is to assist patients in their recovery by preparing them for employment in the community. To become employable, patients need to develop good work habits, interpersonal skills, and specific vocational skills.

Patients can work in the program if the attending physician approves and if a hospital employee is willing to supervise the patient. Patients work in the plant technology and safety management unit, the machine shop, and the plumbing shop. Payments to patients in the industrial therapy program were \$88,800 and \$78,800 in FY1993-94 and FY1994-95, respectively. Depending on the diagnosis, the patient may go unescorted to the workstation and complete his or her own time sheet.

Each participant works a set amount of hours and is paid on a scale that ranges from \$1.20 to almost \$10.00 per hour. Rates are calculated in accordance with the U.S. Department of Labor and with the terms of the sub-minimum wage certificate issued to the hospital. Hospital employees must supervise the patients and approve time sheets for each patient. We found evidence that errors on patients' time sheets may go unnoticed and that supervisory responsibilities may not be enforced. The hospital management lacks sufficient controls over these costs.

**Hourly time sheets are not properly monitored**

We reviewed seven patients' time sheets on August 31, 1995 at 2 p.m., for the work period of August 16 to 31, 1995. We found problems with two time sheets. The first time sheet showed the patient signed in and out for a total of 20 working hours. However, 44 hours were claimed for pay. The second time sheet showed the patient sign out at 4:30 p.m. on August 31st—*two and one half hours after the time of our review*. The time sheet had been approved by the supervising employee responsible for the

patient. We noted no supervisory review on other time sheets as well, although the head of the industrial therapy program said the time sheets should be reviewed.

To verify the patient's time sheet that claimed work until 4:30 p.m., we visited the patient's assigned work area at 3 p.m. We found the patient outside the work area, apparently unsupervised, and smoking a cigarette. The supervisor who approved the time sheet had left at 2 p.m.

The hospital employee did not directly supervise the patient in the work area and did not complete the time sheet properly and responsibly. Our auditing found that the Hawaii State Hospital does not have sufficient management controls to verify that patients have worked the hours paid and that the patients received proper supervision.

***Business and personnel  
office staff are  
underutilized***

Improvements in financial control and administration are possible if existing staff are better utilized. The hospital's business office has nine staff who principally process purchase orders and prepare internal financial reports such as periodic schedules of purchases. The business office staff could be responsible for assuring that all purchases are properly recorded and approved by hospital management.

The personnel office has a staff of six who do the initial transcribing of payroll information and maintain personnel files. Personnel staff could maintain official personnel files, process payroll for hospital management approval, and transmit the required documentation directly to DAGS. All financial information relating to purchases and payroll would then be readily available at the hospital and management could have access to it as needed.

Financial reports generated by DAGS that currently flow down to the hospital through the department's ASO could go directly to the hospital for review and analysis. Corrections to payroll errors and accounting information could be processed more timely. Further, staff could use the information to conduct cost/benefit analysis of hospital operations.

**Timely financial data needed for cost/benefit analysis**

The hospital's business office staff can be trained to conduct cost/benefit analysis. When the hospital was built in 1930, it was fairly isolated from support services such as maintenance and laundry. Today, the hospital is no longer isolated and, in fact, it is a short 15-20 minute drive from downtown Honolulu. In 1995, the hospital's on-site maintenance services cost \$927,000 and laundry and linen services cost \$143,000. Alternatives such as contracted services rather than on-site maintenance, laundry, and linen services may be more cost effective.

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## **Heavily Subsidized Employee Meals Program Is Questionable**

The hospital annually serves about 60,000 subsidized meals that the State is not obligated to provide to hospital employees. We estimate that the 60,000 subsidized meals cost the State about \$300,000 each year. The hospital was charging only 40 cents for each meal but we computed the cost per meal served to be more than \$5.00. We computed that employees paid less than 10 percent of the meal cost and the State subsidized the balance. The hospital does provide about 9,000 free meals to food service employees as part of their collective bargaining agreement. However, the subsidized meals provided to other employees is a perquisite not available to other state employees and we question whether it should be provided at all.

The cost of this subsidized meal program was also impacted by the lack of control over the number of meals employees could have and the cost of containers used for employee take-out meals.

### ***Number of employee meals is not controlled***

The hospital management has no controls over the number of subsidized meals provided to employees. Financial management controls are practices, policies, and procedures that ensure that physical assets such as food supplies and equipment are properly managed and maintained and are legitimately used. We noted that employee meal ticket counts ranged from 99 to 312 for weekdays and 37 to 127 for weekends. These wide ranges significantly impact food planning, preparation, labor, and costs. The hospital is unable to forecast meal demand, resulting in potentially wasteful preparation of unneeded meals. Poor planning and controls over meal services have also impacted the patients. There have been instances when there were insufficient original menu items for all patients.

### ***Take-out meals increase costs***

Employees have the option of taking out the meals instead of eating them in the cafeteria resulting in additional cost to the hospital. The food service director estimated that these take-out meals increased costs by \$30,000 a year for the containers. The ready availability of the take-out option, coupled with the lack of controls over the number of employee meals, increase the possibility that employees purchased more subsidized meals than they could consume while on duty.

### ***Recent improvements are noted***

The hospital recently requested authority to increase the price of employee meals from 40 cents to \$1.00. The director of health stipulated that the new price be \$1.50. The hospital is curtailing the practice of providing disposable containers for take-out meals and will monitor the sale of employee meal tickets. We estimate these actions will save the State about \$106,000 a year, but the cost of the meal subsidy will still exceed \$200,000 annually. In a period of cost containment, this \$200,000 subsidy is a questionable expenditure.

## **State Hospital's Stewardship of State Property is Weak—Inventory Controls are Inadequate**

The hospital maintains inventories of consumable supplies at the automotive, housekeeping, and dietary units. The automotive unit keeps gasoline for hospital and other state vehicles. The housekeeping unit handles clothing for patients as well as personal hygiene supplies such as shampoo, toothpaste, and bath towels. The dietary unit keeps an inventory of food supplies.

These types of inventory items are susceptible to waste, fraud, or abuse. The potential for loss is great and controls over these types of consumable goods are essential. We found inventory controls to be inadequate in these three units.

### ***Poor controls over gasoline use; "honor system" is in place instead***

The hospital operates more than 60 vehicles and has its own gasoline tank located in its automotive area under the Plant Technology and Safety Management Unit. In addition to supplying gas to its own vehicles, the hospital allows Windward Community Health Center, Windward Community College, and the Department of Accounting and General Services to use the gas for their vehicles.

Between 2,000 - 2,500 gallons of gasoline are dispensed monthly under a self-service "honor system." If it is a hospital vehicle, the automobile's driver pumps the gas and is expected to record the amount of pumped gas and the car license number on a daily gas log. Drivers from other agencies are expected to record the amount pumped on a separate gas receipt form. Non-hospital agencies are billed from these receipts.

In our review of gas logs and receipts, we found discrepancies between the gasoline actually dispensed and the gasoline amount charged. The hospital's log was not consistently accurate or complete. The gas pump meter could not be reconciled to the totals on the daily logs and to the other agencies' receipts. Investigation of unreconciled differences is impossible because of the self-service nature of the operation.

We urge the hospital to immediately improve its controls over gasoline usage. The simplest control would be to lock the gas pump and designate employees responsible for dispensing the gas, logging the pumped amounts, and filling out receipts properly. Differences between daily usage records and the actual amount pumped at the gas pump should then be investigated.

### ***No inventory reconciliation for supplies and food is done***

The housekeeping area purchased janitorial, household, and laundry supplies, clothing and linens costing \$114,000 in 1995. The dietary unit purchased foodstuffs costing \$462,000 during the same period. The only inventory procedure in housekeeping and dietary units is ordering goods

and re-ordering when needed. Both units count inventory on hand at year's end but the counts are not used as an inventory control. No inventory records are kept to compare "in" quantities against "out" to determine whether the "in" inventory is short and items are missing. We noted that the dietary unit has written inventory recordkeeping procedures; however, they are not followed.

Sound management practices require that inventory be recorded, purchases and usages be recorded as increases and decreases to the inventory, and a continuous record of the inventory balance be maintained. Periodic inventory counts should be made and compared to the inventory balances per inventory records. Differences noted can then be investigated and corrective actions taken.

***No inventory controls for linen supplies are in place***

The housekeeping unit maintains supplies of linen and clothing for patients. It issues the supplies to patients' wards when the wards request them. It should be monitoring usage and question unusual requests for supplies. We found that supplies have always been issued upon request, without question or review for reasonableness, and, apparently, without concern for the cost to the State for these supplies.

The questionable inventory count for bath towel supplies is one example of no controls. The housekeeping unit sets the number of clean towels that the wards should have on hand any given day. Each day, janitors call the housekeeping unit from the wards with a count of clean towels and a request for additional clean towels. On one day, janitors called in a count of 309 clean towels and requested an additional 1,140 towels for the wards. The 1,140 towels were issued—even though the hospital's standard for that day was set at 660 clean towels. If housekeeping had reviewed and applied its standard, only 351 towels should have been issued.

The hospital's purchase of 3,600 new towels in one year for only 187 beds is also questionable. We question whether the purchase was warranted based only upon patients' use. We were informed that towels are often used as mops. Stronger controls over the issuance of towels could reduce their misuse and accordingly, reduce the number and costs of towels purchased.

***No record or limits on patient-issued clothing are established***

We also found a lack of hospital controls on street clothing issued to patients. Nurses at the wards simply call housekeeping for clothing for the patients, and the clothing is issued. The housekeeping unit doesn't require the clothing be replaced or returned. It does not keep records of numbers of shoes, slippers, etc. issued to the wards. We found no evidence of issuance standards set for patients. Standards for clothing

issued would allocate specific numbers of shoes, slippers, pants, shorts, etc. issued to patients. Standards could be used to monitor usage and strengthen controls over clothing issuance.

We urge the hospital administration to attend to inventory controls. Lax practices, or no controls at all, encourage employees and patients to abuse, waste, or appropriate state goods. Regaining control over inventory should help the new hospital administration demonstrate its commitment to operating a facility in accordance with sound financial practices and the State's ethical standards.

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## **Management Problems Posed by the Forensic Population Need To Be Addressed**

One of the concerns of the health department is the state hospital's increasing population of the forensic mentally ill. The department testified in its fiscal biennium 1995-97 budget testimony that hospital programs have been affected by this increase.

Forensic patients (i.e., court-ordered commitments) currently make up 70 percent of the hospital's population. The forensic population of the hospital increased slowly during the late 1970s with the revision of the Hawaii Mental Health Law in 1976. The law made civil commitments more difficult and court commitments increasingly have been used to remove disruptive individuals from the streets.

The increase in the forensic population affected the hospital in three areas. The hospital has to 1) turn away non-forensic patients, 2) place forensic patients with non-forensic patients, and 3) increase its security. Better coordination with other state agencies is needed to alleviate the impact of this population increase.

### ***Non-forensic patients cannot be accommodated***

The state hospital provides long-term, psychiatric care for the mentally ill. The state community hospitals and private hospitals refer their non-forensic patients to the state hospital. Over the past year, the state hospital had no beds to accept these patients. The Department of Justice mandated that the hospital actively attempt to reduce its overall patient census. Since the hospital has no control over court-ordered commitments, it has not admitted the non-forensic mentally ill to maintain its mandated census. This has impacted both the public and the private hospitals.

For example, a patient at Hilo Medical Center in need of long-term psychiatric care was refused admission to the State Hospital. As of June 30, 1995, this patient's bill at Hilo Medical Center was \$221,000 and will probably not be collected. The State will probably shoulder the financial

burden for long term care at Hilo Medical Center, an acute care facility. The transfer to the more appropriate long term care state hospital is not feasible at this time.

Private hospitals are also unable to transfer patients in need of long-term psychiatric care to the state hospital. The state hospital had informally agreed to accept one patient each month from the private hospitals. However, private hospital representatives stated that they have not been able to transfer any of their psychiatric patients to the state hospital.

***Mixed patient population requires additional security***

In the past, forensic patients were kept apart from the other patients. Other states still segregate forensic patients from non-forensic patients. Some states have completely separate facilities while others house the patients within one facility, but keep forensic patients separated from the non-forensic patients.

The new state hospital facilities were completed in the spring of 1992. However, they were not designed to segregate forensic patients from non-forensic patients. The facilities were designed for different levels of patient care. As a result, all patients are placed according to treatment needs and not according to legal status. Therefore, forensic patients are placed with non-forensic patients.

The State Department of Labor and Industrial Relations' Occupational Safety and Health Administration (OSHA) inspector toured the hospital and noted that the mixed population contributed to a hostile work environment. The inspector raised concerns about staff and patient safety because of the patient mix. This concern led the hospital to place security guards on the patient wards, spending approximately \$289,000 on security guard services this past year.

***Coordination with the Judiciary and other state agencies is needed***

The Joint Commission on Accreditation of Healthcare Organizations states that mental health institutions with forensic services must develop a mechanism to facilitate inter-agency communication with any agencies or individuals involved in the decision making process for critical aspects of care. Currently, little formal coordination exists between the Department of Health or the state hospital with other state agencies or individuals.

As forensic patients are placed in the state hospital by the courts, or transferred from the prisons for care and treatment, the hospital should work with the various sectors—the Judiciary, the Department of the Attorney General, and the Department of Public Safety to address problems associated with forensic patients.

### **Coordination efforts have begun**

The hospital is hoping to improve the situation beginning in early 1996. The hospital believes certain forensic patients have been stabilized and can be returned to the community with the courts' permission. The hospital superintendent stated that plans with the courts to return forensic patients to the community are underway. The plan is for an independent contractor to provide transitional services in four cottages on the hospital grounds. Patients would be closely supervised and receive therapy during their transitional stay in the cottages. Patients would still be the hospital's responsibility but would not be occupying hospital beds. It is hoped that this program will open up 20 beds for non-forensic patients. The superintendent stated also that the hospital recently has admitted voluntary patients from three private hospitals and may admit a patient from a fourth.

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## **Conclusion**

The Department of Health and state hospital management have begun to address the myriad problems that plague the hospital. Codification of clear personnel policies and procedures for the hospital should be given top priority. Management should use hospital administrative staff more effectively. The health department should train hospital management to oversee and approve all hospital purchases, payroll, and contracts. Lax inventory practices should cease and stronger controls instituted. Improvements require continuous efforts by hospital management and support from the department.

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## **Recommendations**

1. The Department of Health and the Hawaii State Hospital should strengthen their personnel policies and procedures to reduce employee absenteeism and grievances and to better guide hospital employees in their work.
2. Employees' pay should be discontinued when leave is unauthorized and forms are unsigned.
3. The department and the hospital should improve the hospital's financial management system. In doing so they should:
  - a. evaluate the current purchasing and payroll processes for inefficiencies and make improvements. Purchased professional services from the University of Hawaii should be negotiated by the hospital superintendent for better results;
  - b. better utilize the hospital's business and personnel office staff; and

- c. improve the supervisory and record keeping controls of the industrial therapy program.
4. The department and the hospital should reconsider the perquisite practice of subsidized meals for hospital employees.
5. The hospital should strengthen its inventory controls to include:
  - a. controlling access to the hospital's gasoline pump;
  - b. requiring appropriate inventory recordkeeping at the housekeeping and dietary units, which includes comparing inventory counts for possible abuse and taking action on the reasons for inventory differences; and
  - c. monitoring the issuance and usage of linen and clothing used in the wards for patients.
6. The hospital should continue its efforts in addressing the problems associated with its forensic patients.

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## Response of the Affected Agency

### Comments on Agency Response

We transmitted a draft of this report to the Department of Health on December 14, 1995. A copy of the transmittal letter to the Department of Health is included as Attachment 1. The response from the department is included as Attachment 2.

The Department of Health stated that, overall, it agrees with the report's summary and findings, as well as its recommendations. The department commented that the report seems objective and fairly presented. It made note that we credited the current hospital administration for pursuing and making change. The department also added comments, clarifications, and updated information, some of which we incorporated into the report.

We did not change our statement about the lack of controls over gasoline usage. Our testing revealed that at least one contractor's vehicle had been supplied gasoline. We do not know if the contractor subsequently paid for the gasoline.

ATTACHMENT 1

STATE OF HAWAII  
OFFICE OF THE AUDITOR  
465 S. King Street, Room 500  
Honolulu, Hawaii 96813-2917



MARION M. HIGA  
State Auditor  
(808) 587-0800  
FAX: (808) 587-0830

December 14, 1995

*COPY*

The Honorable Lawrence H. Miike  
Director of Health  
Department of Health  
Kinau Hale  
1250 Punchbowl Street  
Honolulu, Hawaii 96813

Dear Dr. Miike:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Management and Fiscal Audit of the Hawaii State Hospital*. We ask that you telephone us by Tuesday, December 19, 1995, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Tuesday, December 26, 1995.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

A handwritten signature in cursive script that reads 'Marion M. Higa'.

Marion M. Higa  
State Auditor

Enclosures

BENJAMIN J. CAYETANO  
GOVERNOR OF HAWAII



**STATE OF HAWAII**  
DEPARTMENT OF HEALTH  
P.O. BOX 3378  
HONOLULU, HAWAII 96801

LAWRENCE MIIKE  
DIRECTOR OF HEALTH

In reply, please refer to:  
File: AMHD/HSB

35210

December 26, 1995

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OFF. OF THE AUDITOR  
STATE OF HAWAII

Ms. Marion Higa  
State Auditor  
Office of the Auditor  
465 S. King Street, Room 500  
Honolulu, Hawaii 96813

Dear Ms. Higa:

**SUBJECT:** Draft Report: Management and Fiscal Audit of the Hawaii State Hospital

Thank you for the opportunity to provide a response to the above draft report. Overall, the Hawaii State Hospital agrees with the report's summary and findings, as well as its recommendations. Despite some factual errors that don't alter its basic findings and conclusions, the report seems objective and fairly presented. The current hospital administration is given credit for pursuing and making change.

Specific comments on the report is as follows:

**Page 5**, Chapter 1, section, "Contempt action and remedial plan", first paragraph, last sentence beginning, "Another specific deadline..."

- Change "32" to a "total of 72".

**Page 5**, Chapter 1, section. "Contempt action and remedial plan", second paragraph, first sentence beginning, "Failure to comply..."

- Change "requirements would" to "requirements could".

**Page 7**, Chapter 2, section, "Summary of finding", paragraph number 4, third sentence beginning, "Gasoline use..."

Ms. Marion Higa  
Page 2  
December 26, 1995

- This sentence sounds as if all vehicles, public and private, are being gassed. Perhaps changing the sentence to read, "Gasoline use in state vehicles is self-service on an honor system", would be more appropriate.

**Page 8**, Chapter 2, section, " State Hospital has a history of poor personnel management", first paragraph, third sentence beginning, "Other problems such as staff..."

- This sentence would mean that if one reads or hears something in the media, then by definition it must be true. We don't agree.

**Page 21**, Chapter 2, section, "Management problems posed by the forensic population need to be addressed"

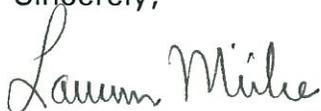
- Clarification is needed about issues raised regarding the "Mixed Patient Populations". Hawaii State Hospital is the only facility of its kind in the Hawaiian Islands. Unlike other states, Hawaii has only one state mental health facility. We serve patients from the outer islands. Because we are a treatment facility and not a correctional or specialized forensic hospital, patient assignments are determined by their clinical needs rather than legal status. To assume that court ordered patients are more violent or dangerous than voluntary or non-court ordered patients **is wrong**. The issue of violence in psychiatric patients is a very complex one and cannot be generalized as such. For example, we have patients who are highly assaultive secondary to their dementia's. These patients are voluntary patients admitted to the hospital in need of treatment rather than being court ordered. If in fact, we strictly followed the rule of assigning patients to units because of their legal status, it would require more of our resources and the patient would pay the biggest price by not receiving the most appropriate treatment available. A geriatric patient who is admitted to the hospital following an acquittal of murder charges as a result of mental illness must not remain in our "forensic units" because his treatment needs are best met by being in our geriatric unit. Besides these reasons, we are obligated to provide the least restrictive alternative available to patients who are in the process of being returned to the community. These programs are provide in our psychosocial rehabilitation units.

Ms. Marion Higa  
Page 3  
December 26, 1995

Page 22, Chapter 2, section, "Non-forensic patients cannot be accommodated", second paragraph on the page beginning, "However, private hospital representatives..."

- In terms of our restriction of admissions, I would like to provide some clarification. It is true that the Remedial Plan mandated a reduction in census and a restriction on admissions. Earlier on in the year as we were waiting improvement in our staffing levels, we gave priority to court-ordered patients. However, beginning in August 1995, we have been working with representatives from community hospitals in planning for patients who could benefit from hospitalization at Hawaii State Hospital. To date we have admitted voluntary patients from Queens, Castle, and Kaiser. We are currently reviewing a possible admission from St. Francis West.

Sincerely,



LAWRENCE MIIKE  
Director of Health