Administrative Closure
Alleged Mismanagement of Resources
VA Montana Health Care System] (436/00)
Fort Harrison, Montana
MCI# 2012-02154-HI-0372

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) received allegations from a complainant regarding inappropriate management of the VA Montana Health Care System, Fort Harrison, MT (facility).

Purpose. The purpose of this oversight review is to determine whether the Veterans Integrated Service Network (VISN) adequately addressed the allegation of inappropriate management that resulted in staff resignations, poor employee morale, delays in opening an inpatient psychiatric unit, and staffing shortages.

Allegation. On March 8, 2012, the OIG's Hotline Division received an anonymous letter alleging that the facility Director's management style had undermined employee morale and caused strain between the Director and the clinical staff. The complaint alleged that staff had left employment at the facility due to dissatisfaction with the work environment, resulting in delays in opening an inpatient psychiatric unit and staffing shortages. On March 22, 2012, OIG was informed that the VISN Director had initiated an Administrative Investigation Board (AIB) to review the Director's behavior and management. OHI suspended its review until the AIB completed its investigation.

Background. The March 8, 2012, letter was the second hotline complaint the OIG had received regarding staffing issues at this facility. On September 12, 2011, the OIG received a congressional complaint concerning staffing shortages and the impact of those shortages on patient care at the facility. Specifically the complainant reported that the resignations and retirements of clinical providers had resulted in understaffing at the facility. This information was partially based upon a spreadsheet sent by facility leadership to Senator Testor's office showing that provider resignations had increased from 5 in 2010 to 11 in 2011.

After discussions between Senator Jon Testor, the Undersecretary of Health, and the VISN 19 Director, the VISN developed a plan to address these issues. The plan was reviewed with Senators Testor and (Max) Baucus and subsequently approved. The VISN Director submitted updates to Senator Testor's office on October 24, November 10, and November 29, 2011, detailing the VISN's progress in meeting the plan. Specific plan accomplishments included several successful new physician hires between June 2011 and November 2011, meetings with nursing staff and VISN 19 Quality Management Officer (QMO), and two veteran focus group meetings with Veteran Service Officer (VSO)/ non-VSO users and VISN leadership. No AIB review was requested; however, according to the plan, the facility Director, who was hired in 2010, would receive coaching through the National Center for Organizational Development (NCOD) to enhance her communication and management skills. The Senators were satisfied

with the VISN response and therefore, OHI administratively closed the congressional hotline on February 3, 2012.

Scope and Methodology. To complete this oversight review, OIG reviewed the VISN initiated AIB to assess the Director's behavior and management, the VISN plan to address staffing shortages and employee morale, employee satisfaction data, and other relevant documents. . OIG also reviewed e-mails and their attachments sent between OIG, the facility, and VISN 19.

Issue 1: Staff Resignations/Low Facility Staff Morale. In February 2012, there were two staff complaints that alleged coercion and inappropriate employee termination procedures by the facility Director. In addition, the VISN and facility received information from the NCOD that employee satisfaction rates at the facility were significantly declining. Though NCOD reported that for FY 2008 and 2009 the total employee satisfaction mean for the facility remained relatively stable and within normal limits for VISN 19, in FY 2010, there was a drop in overall employee satisfaction, including satisfaction with leadership. By FY 2011, facility employee satisfaction measures for civility, leadership, safety, and customer focus had dropped below accepted normal values, and the facility had the lowest overall employee satisfaction rates in the VISN.

Based upon the February complaints, plus the additional factor of low employee satisfaction, the VISN appointed an AIB on March 16, 2012, to conduct a review of facility leadership and report to the VISN Director no later than May 4, 2012. The AIB was to examine the two February staff complaints as well as conduct a thorough investigation to determine "whether the medical center director through her actions, management/communication style, or other interpersonal interactions has created, or contributed to the creation of a punitive or hostile work environment at Fort Harrison VA Medical Center, particularly in connection with management and clinical staff." A request was made by the VISN Director and approved by the Undersecretary of Health to remove the Director from her present position during the investigation and reassign her to the VISN for a special project assignment. The Salt Lake City VA Medical Center Director agreed to act as the Interim Medical Center Director in her absence.

On April 4, 2012, the AIB completed its investigation and found that the Director used coercion and inappropriate termination procedures to remove the two employees named in the February complaints. [1] The AIB also found that in multiple circumstances facility managers felt "coerced and uncomfortable" with the Director's involvement and decisions regarding issues that the managers usually controlled or were consulted about. This management approach directly contributed to the creation of a "punitive and hostile work environment" especially for clinical staff and managers. For example, the Human Resources Department (HR) received instructions from the Director that she wanted to review all performance appraisals that exceeded the fully successful level. In some of these cases, the supervisors had already met with employees. The

[1] VA Handbook 5021, *Employee/Management Relations, Part 1, Chapter 3,* April 15, 2002, updated November 20, 2007.

Director downgraded all these appraisals to a fully successful level. The HR Director reviewed these cases and responded to the Director, who eventually reinstated the original levels the supervisors had given employees.

The AIB recommended to the VISN that "appropriate action should be considered for the Director." According to a memo from the VISN Director dated August 31, 2012, the facility Director accepted a reassignment, and the VISN is actively recruiting a new facility Director.

On May 2, 2012, Senator Testor visited the facility to welcome the Interim Director and review concerns, including the opening of the acute mental health inpatient unit, employee morale, and opening doors for employees who may have left due to the previous organizational climate. During a June 12, 2012, meeting with the Senator's office, the facility reported on the mental health hiring initiative. At that point, there were 23 positions open. The facility reported that it was actively recruiting and felt the positions could be filled within the next 6 months.

Senator Testor's office will continue to conduct meetings and address ongoing issues with the Interim Facility Director at least once a month.

Issue 2: Inpatient Mental Health Care Unit Unable To Open Due to Staffing Issues. Though there was concern in the allegation that the inpatient mental health unit had not been opened at the time of the complaint, according to the facility web site, the inpatient unit is open. Senator Testor's office has asked the facility to regularly report to his office on the unit's staffing and progress.

Conclusion: The VISN Director has followed the September 2011 plan. In March 2012, because of two staff complaints and poor employee satisfaction rates, the VISN Director initiated an AIB concerning the facility leadership. The AIB concluded that the issues presented for investigation were founded and that appropriate actions should be taken by the VISN. The facility Director accepted a reassignment and the VISN is searching for a replacement. Senator Testor's office has continued to have regular contact with the VISN Director as well as the facility's Interim Director concerning staff morale, opening the inpatient mental health unit, and staff hiring.

A teleconference was held with OHI and VISN/facility management on August 20, 2012, to determine the progress made by the VISN. At OHI's request, the VISN and facility provided additional documentation to show the following goals were achieved: leadership has changed and organizational structure is stabilizing, internal and external stakeholder relationships have significantly improved, and, VISN 19 is aggressively recruiting for a new facility director.

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