



THE AMERICAN LEGION



2018 REPORT

SYSTEM WORTH SAVING

Denise H. Rohan, *National Commander*

The American Legion



OFFICE OF NATIONAL COMMANDER

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Dear Legionnaires and advocates for veterans:

Although the name of this report is System Worth Saving, The American Legion believes just as strongly that it is also a System Worth Improving. While we believe that VA consistently provides the best health-care options for veterans, important steps must still be taken for the system to fully modernize and serve our heroes in a manner consistent with that of a grateful nation.

For starters, VA must address labor shortages that have left the department understaffed and created delays with access and benefit delivery.

The American Legion does not oppose the Choice program when it comes to veterans' health care. We just want it to be a sensible Choice, which includes timely payment of services, efficient scheduling, record-sharing and user-friendliness. For too long, the Choice program has been fraught with problems, and they are finally starting to be addressed.

What we do oppose is privatization – paring down or dismantling the health-care system that was created for veterans. The shortcomings and mistakes made by VA are publicized widely and loudly, with little attention given to the many more things VA does well. Moreover, its private-sector counterparts only receive a fraction of the scrutiny, thus giving the public an often-distorted view of VA.

We believe an already strong system will get even better thanks to the VA Mission Act of 2018. This new law will consolidate VA community care programs and transform the current Choice program from a burdensome administrative process to a clinical driven process designed to put the patient first. The Mission Act will ensure VA's community care programs operate under one authority and open patient access to walk-in clinics for less urgent care. It will also provide scholarships to medical students in exchange for services to VA and help reduce educational debt.

Especially relevant to my Family First theme is the new eligibility of caregivers for pre-911 veterans to receive the same benefits that were previously reserved only for caregivers of more recent veterans. We welcome this overdue development.

Please read the recommendations cited in this report and become a local advocate for your VA. Through thoughtful data-gathering and constructive solutions, we will continue to ensure that Congress and the White House listen to the concerns of our American Legion Family.



Respectfully,

Denise H. Rohan
National Commander

CHAIRMAN'S STATEMENT FOR EXECUTIVE SUMMARY 2017-2018

Dear Legionnaires,

As chairman of The American Legion Veterans Affairs and Rehabilitation Commission (VA&R), I am pleased to present the System Worth Saving (SWS) 2017-2018 Executive Summary. During the first six months of 2018, commission members and staff have conducted a combined 13 site visits to Department of Veterans Affairs (VA) Medical Centers and VA Regional Offices (VAROs). As of July 1, we have seven remaining SWS visits and five Regional Office Action Review (ROAR) visits planned for 2018.

On May 31, 2017, former Secretary of Veterans Affairs Dr. David Shulkin outlined his top priorities for the Department of Veterans Affairs. His five top priorities were: Greater Choice; Improve Timeliness; Modernize Systems; Suicide Prevention; and Focus Resources More Efficiently. The American Legion has testified on several occasions calling on VA to improve access to care; become a leader in providing quality health care; hold VA employees accountable; eliminate waste, fraud, and abuse in the VA system; and ensure VA's capital assets are sufficient to meet the needs of our nation's veterans.



To identify trends within VA, national VA&R staff members have been tracking VA Office of Inspector General (VAOIG), Government Accountability Office (GAO) reports and media releases, as well as meeting with the House Veterans' Affairs Committee's Subcommittee on Oversight and Investigations (HVAC-O&I) and listening to American Legion members to identify VA medical centers with significant challenges in providing veterans access to timely health-care services. This information is reported to VA&R Commission leadership and used to plan System Worth Saving site visits and town hall meetings. Based on the 2018 System Worth Saving cycle, VA&R health policy staff looked at VA health-care facilities that had challenges in the areas deemed priorities by the VA secretary. Based on those tracking mechanisms and additional research, staff compiled a list of 15 VA health-care facilities to visit, through consideration by the VA&R Commission members and leadership. The focus of the 2018 SWS site visits were aligned with those priorities.

As The American Legion travels across the country to VA health-care facilities in urban and rural areas, the SWS team continues to see challenges in recruitment and retention, lengthy HR onboarding processes, space constraints and failures of the Choice program to include timely payment of services, scheduling challenges and lack of patients' medical records transference. Through these System Worth Saving visits, The American Legion has worked with VA to identify challenges, best practices and offer recommendations to help improve the VA health-care delivery system for our nation's veterans and their family members eligible for VA care.

It has been an honor and pleasure serving another year as chairman of The American Legion's Veterans Affairs & Rehabilitation Commission. As VA continues its effort to reform the delivery of health care for veterans, The American Legion must ensure the VA health-care system is the best in the nation. I encourage all veterans and fellow Legionnaires to share their personal experiences with The American Legion's Government and Veterans Affairs staff throughout the year. Only through open and honest dialogue and shared accountability can we safeguard a health-care system dedicated to not only serving our nation's veterans but also providing it at the highest possible standards.

A handwritten signature in black ink that reads "Ralph F. Bozella". The signature is written in a cursive, flowing style.

Ralph Bozella
Chairman, Veterans Affairs & Rehabilitation Commission
The American Legion

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2017-2018 SYSTEM WORTH SAVING SITE VISITS (COMPLETED)

Aleda E. Lutz VA Medical Center, *Saginaw, Mich.*
Iowa City VA Health Care System, *Iowa City, Iowa*
Clement Zablocki VA Medical Center, *Milwaukee, Wis.*
Chalmers P. Wylie VA Ambulatory Care Center, *Columbus, Ohio*
Montana VA Health Care System, *Ft. Harrison, Mont.*
Manchester VA Medical Center, *Manchester, N.H.*
Memphis VA Medical Center, *Memphis, Tenn.*
Eastern Oklahoma VA Health Care System, *Muskogee, Okla.*
VA Eastern Colorado Health Care System, *Denver, Col.*
Central Arkansas VA Health Care System, *Little Rock, Ark.*
Durham VA Medical Center, *Durham, N.C.*

2018 SYSTEM WORTH SAVING SITE VISIT (SPECIAL PURPOSE) (COMPLETED)

Lee County VA Health Care Center, *Cape Coral, Fla.*

2018 FUTURE SWS SITE VISITS

VA Northern Indiana Health Care System, *Ft. Wayne, Ind.*
VA Southern Oregon Rehabilitation Center and Clinics, *White City, Ore.*
Miami VA Medical Center, *Miami, Fla.*
John Dingell VA Health Care System, *Detroit, Mich.*
Minneapolis VA Health Care System, *Minneapolis, Minn.*
Atlanta VA Medical Center, *Atlanta, Ga.*
VA Central Western Massachusetts Health Care System, *Leeds, Mass.*
Marion VAMC, *Marion, Ill.*
El Paso VA Health Care System, *El Paso, Texas*
Southern Arizona VA Health Care System, *Tucson, Ariz.*

2017-2018 REGIONAL OFFICE ACTION REVIEW (ROAR) SITE VISITS (COMPLETED)

San Juan, Puerto Rico
Albuquerque, N.M.
Ft. Harrison, Mont.
Denver, Colo.
Houston, Texas
Manchester, N.H.
Boston, Mass.

2018 FUTURE REGIONAL OFFICE ACTION REVIEW SITE VISITS

Los Angeles, Calif.: (June 25-28)
Wilmington, Del.: (July 16-19)
Philadelphia, Pa.: (July 16-19)
New York, N.Y.: (Sept. 17-19)
Newark, N.J.: (Oct. 15-17)
Muskogee, Okla.: (Nov. 12-15)
Huntington, W.Va.: (Dec. 10-12)

Reports from the site visits can be found on www.legion.org/systemworthsaving/reports

Out of Turmoil Evolves a Stronger VA Health Care System

By **Ralph P. Bozella**

Chairman, The American Legion Veterans Affairs & Rehabilitation Commission

Background and History

Since the 2014 wait time scandal, the Veterans Health Administration has been in constant turmoil. Access issues, staffing challenges, lack of accurate supplies and equipment inventories at VA medical centers and nursing home residents going hours without food or languishing in bed wearing only soiled sheets are all signs that the VA health-care system is facing serious leadership and staffing challenges.

The American Legion was pleased when on Feb. 13, 2017, the U.S. Senate unanimously confirmed Dr. David Shulkin as Secretary of Veterans Affairs in a 100-0 vote. To run the Veterans Health Administration, Dr. Shulkin appointed Dr. Alaigh Poonam, MD, as Acting Under Secretary of Health. The American Legion believed finally there were leaders in charge who understand how to move VA/VHA in the right direction. However, the Legion was disappointed when on Oct. 7, 2017, Dr. Poonam stepped down as VHA's Under Secretary of Health and on March 28, 2018, President Trump announced that Dr. Shulkin had been removed as VA secretary.

On May 30, 2018, the President appointed Peter O'Rourke

as the department's acting secretary. Dr. Carolyn Clancy has been in the role of Executive in Charge of VHA since Dr. Poonam's departure.

While The American Legion is concerned about stable leadership at the highest level of the organization, we are equally concerned what our System Worth Saving and Regional Office Action Review teams are seeing when they visit VA medical centers and regional offices. At some VA medical centers, executive leadership teams are constantly changing, which does not allow for continuity of leadership. To further compound the problem, at some VA medical centers, significant vacancies exist, and the facilities are finding it difficult to back-fill behind these positions.

The American Legion believes the SWS and ROAR visits offer an invaluable service for American Legion staff members who prepare and give testimony before the Senate Veterans' Affairs Committee and the House Committee on Veterans' Affairs. Issues raised by the committees typically call for a clear understanding of current issues confronting the Department of Veterans Affairs.



Ralph Bozella, Veterans Affairs and Rehabilitation Commission chairman, answers a question during a joint session of the House and Senate Committees on Veterans' Affairs. Photo by Lucas Carter

System Worth Saving Site Visit Selections

The Veterans Affairs and Rehabilitation Commission identified 15 VA health-care facilities for SWS site visits in the 2018 calendar year. These locations were submitted and approved during the 2017 Fall American Legion National Executive Committee meeting. To date, the health-policy staff and VA&R Commission members have conducted 11 SWS site visits to include one special-purpose site visit.

Completed site visits to date:

- Aleda E. Lutz VA Medical Center, Saginaw, Mich.
- Iowa City VA Healthcare System, Iowa City, Iowa
- Clement Zablocki VA Medical Center, Milwaukee, Wis.
- Chalmers P. Wylie VA Ambulatory Care Center, Columbus, Ohio
- Montana VA Health Care System, Ft. Harrison, Mont.
- Manchester VA Medical Center, Manchester, N.H.
- Memphis VA Medical Center, Memphis, Tenn.
- Eastern Oklahoma VA Health Care System, Muskogee, Okla.
- VA Eastern Colorado Health Care System, Denver, Colo.
- Central Arkansas VA Health Care System, Little Rock, Ark.
- Lee County VA Health Care Center, Cape Coral, Fla. (Special Purpose)

Regional Office Action Review (ROAR) Visits

Like the SWS program, The American Legion visits VA Regional Offices (VAROs) to review the quality of VA claims adjudications, interview VA employees and discuss concerns with local American Legion claims representatives. The primary mission of the ROAR visit is to improve the accuracy and delivery of disability compensation benefits to veterans. The American Legion dispatches a team of accredited representatives and seasoned attorneys to the VAROs to review a percentage of randomly selected claims adjudications and the overall processing of VA claims at selected facilities.

- Durham VA Medical Center, Durham, N.C.

The remaining scheduled site visits include the VA Northern Indiana Health Care System, Ft. Wayne, Ind.; VA Southern Oregon Rehabilitation Center and Clinics, White City, Ore.; Miami VA Medical Center, Miami, Fla.; John Dingell VA Health Care System, Detroit, Mich; Minneapolis VA Health Care System, Minneapolis, Minn.; Atlanta VA Medical Center, Atlanta, Ga.; VA Central Western Massachusetts Health Care System, Leeds, Mass.; Marion VAMC, Marion, Ill.; El Paso VA Health Care System, El Paso, Texas; and Southern Arizona VA Health Care System, Tucson, Ariz.

The purpose of the System Worth Saving site visit is to identify progress made since the last visit (if any), understand what works best at the medical centers, identify any challenges and make recommendations to help overcome them. The site visit covers two and a half days, beginning with a veterans town hall meeting on the first day. The second and third days, the Veterans Affairs and Rehabilitation (VA&R) Commission members and national staff visit the local VA health-care facility and meet with the executive leadership team and departmental staff to discuss challenges, best practices, and to offer recommendations. At the end of each System Worth Savings site visit, a report is issued that is shared with the medical center, the VA secretary and under secretary of health, congressional members and the President of the United States.

The ROAR team, as of July 1, 2018, visited seven VAROs: San Juan, Puerto Rico (February 2017); Albuquerque, N.M. (March 2017); Ft. Harrison, Mont. (April 2017); Denver (May 2017); Houston (September 2017); Manchester, N.H. (June 2017 & May 2018), and Boston (May 2018), with an additional seven site visits to include: Los Angeles; Wilmington, Del.; Philadelphia; New York City; Newark, N.J.; Muskogee, Okla.; and Huntington, W.Va.

System Worth Saving Site Visit Summaries

ALEDA E. LUTZ VAMC | SAGINAW, MICH.

Date: June 5-7, 2017

Veterans Affairs & Rehabilitation (VA&R) Commission Member: Brett Holt

National Executive Committee: Roger Webster

Assistant Director for Health Policy, Veteran Affairs and Rehabilitation (VA&R) Division: Edwin Thomas

BEST PRACTICES

1. Mental Health/Patient Engagement

The AELVAMC has improved access to mental health services by streamlining operations and establishing enhanced treatment protocols. The new improvements and remarkable results have garnered national attention within the Veterans Health Administration. AELVAMC is now one of the few VHA medical centers capable of accommodating a veteran's request for both primary care and mental health services in the same day.

Additionally, leaders of the medical center implemented a patient-engagement model that measured satisfaction, physicians and staff communication, and environmental factors such as cleanliness of AELVAMC and its Community-based Outpatient Clinics (CBOCs). Since its implementation of the model, AELVAMC has consistently exceeded national averages among VHA medical facilities in the areas of Environmental Care, Physician-Patient Communication, Specialty Care and Trust Among Veterans. AELVAMC is included in VISN 10.

2. Reduction in High Cancellation Rates for Surgery

Dr. Creasman and staff developed a method of reducing the high cancellation rate for surgeries. According to one staff member, the cancellation rate for surgeries before the implementation of the education intervention was 30 percent. Additionally, more than 10 percent of same-day surgery patients travel up to 200 miles to receive surgery and care at AELVAMC.

3. Equine-Assisted Therapy

The medical center has an Equine-Assisted Therapy (EAT) program that takes veterans who have experienced Military Sexual Trauma on a two-day retreat. While AELVAMC does not have a formal women's clinic, 1,358 women veterans receive care through 31 Designated Women Health Providers. However, EAT has become a Best Practice as the retreat is located in a serene setting where veterans can enjoy riding horses over 283 acres.

4. Homeless Veterans Program

Despite their expansive geographical catchment area, the homeless program has demonstrated its capability to find and house veterans in all 35 counties. The program's leadership works feverishly to create and maintain excellent community partnerships, keeping staff turnover at a minimum, and offering same-day access. The homeless program at AELVAMC believes veterans should receive housing first and administrative considerations follow meeting that basic need. The leadership has managed to operationalize that philosophy into their program in all 35 counties.

CHALLENGES WITH RECOMMENDATIONS

Challenge 1: Span of Geographic Catchment Area

The executive staff believes the scarcity of physician specialists and the reluctance of general practitioners to live and work in rural communities limits the medical center's effectiveness and efficiency in more rural areas outside of Saginaw without the utilization of telehealth services.

Recommendation: The medical center was effective in getting market cap increases for physicians. The American Legion recommends doing a market survey with a focus on identifying what it would take to attract physician specialists and non-specialists to rural areas.

Recommendation: The American Legion recommends forming a search committee of VA physicians living and working in rural communities who could provide to medical center recruiters information about their reasons for wanting to live and work in rural Michigan. This would allow recruiters to conduct additional research and formulate recruiting/marketing campaigns with communication materials that target a composite medical professional persona.

Challenge 2: Veterans Choice Program

The absence of timely payments makes a complex situation even more challenging with the shortage of specialty care to coordinate services for veterans who need them. The staff is concerned the Choice program is not working for either veterans or for the health-care delivery systems.

Recommendation: The American Legion recommends AELVAMC wait for forthcoming changes under the Veterans' Coordinated Access Rewarding Experience (CARE) Program. Although details regarding the newly proposed program have not been released, officials at the Department of Veterans Affairs stipulate the new program will not subject veterans to capricious referral rules, slow payments to providers or, perhaps, the same third-party administrators.

***Note:** On June 6, 2018, President Donald Trump signed the VA Maintaining Systems and Strengthening Integrated Outside Networks Act or MISSION Act into law signaling the end of one community care program at VA and the beginning of another.

Challenge 3: Outdated Physical Facilities/Lack of Space to Deliver Patient Care

Although the medical center does not offer acute mental health inpatient services, medical staff use observation rooms and mental health clinicians have literally used closets to conduct counseling both in-person and in telehealth consults. The American Legion recognizes this challenge as systemic to the Veterans Health Administration.

Recommendation: The American Legion recommends leadership at AELVAMC continue identifying the need for space through the Strategic Capital Investment Program and leverage relationships with local posts of The American Legion to champion their cause.

The SCIP process includes four components perhaps with the most important, in this and many other cases, of conducting a gap analysis. Leadership at AELVAMC should review the latest Annual SCIP Call Memorandum for additional insights.

Challenge 4: Nursing Shortage/Physician Turnover

Nursing and physician shortages represent another U.S. national health system challenge that affects commercial and public health delivery systems as well as VA. The problem acutely affects the VHA because of salary scales for physicians and nurses considering employment at the VA are not competitive with private sector salary offerings. While the president and the Congress consider a plethora of ideas related to physician and nursing shortages throughout the VHA, there are no readily apparent solutions to a problem that is now several decades old.

Recommendation: The American Legion recommends the VA consider reviewing Public Service Loan Forgive-

ness Program (PSLFP) and the Education Debt Reduction Program (EDRP) in ways that could enhance and complement salary offerings. For instance, under PSLFP, the VA could pay physicians' or nurses' first 60 payments in addition to a regular salary if they served in a rural area of Michigan over that time period. Additionally, the VA could amend the EDRP that raises the amount of the education debt repayment ceiling from \$120,000 to \$200,000.

Recommendation: The American Legion recommends AELVAMC seek non-traditional sources for nursing talent. Men are often overlooked by many nurse recruiters and face barriers in seeking employment after graduation from nursing school. Although men face barriers both in nursing schools and recruitment circles, they are still entering the profession at rates that could help improve the nursing shortage. Canada is also exploring this option as a means of closing the shortage in nursing.

At the very least, it would serve the AELVAMC and VA to look at current recruitment tactics to determine if men are sought for vacancies.

Recommendation: Aligned with Resolution 22, "Public/Private Partnership with the Department of Veterans Affairs to Expand Reach with Local Hospitals," The American Legion recommends that VA and AELVAMC seek relationships with commercial hospitals to seek physician volunteers. The American Legion understands that physician or medical volunteerism requires a long timeline to physicians but could prove valuable to veterans and VA.

Challenge 5: Multiple Vacant Positions

There are 96 staffing positions not filled at the facility. Of those, 56 are for new programs, leaving 40 to be filled for existing direct patient care and support positions.

Recommendation: While all positions either directly or indirectly affect patient care, The American Legion recommends using the Hire Fast Hire Right program to identify and employ first all candidates where access and quality of care can be improved.

Recommendation: In addition to Hire Fast, Hire Right, The American Legion recommends AELVAMC implement a Rapid Process Improvement Workgroup at the facility level. The concept was implemented in VISNs 8, 15 and 23. The workgroup could identify ways to streamline hiring and other work processes or make policy and legislative recommendations when they cannot bring about change internally. Leadership at the facility has implemented this recommendation and is closely monitoring progress.

IOWA CITY VA HEALTH CARE SYSTEM | IOWA CITY, IOWA

Date: June 19-21, 2017

Veterans Affairs & Rehabilitation (VA&R) Commission Member:

Past National Commander David K. Rehbein

Assistant Director for Health Policy, Veteran Affairs and Rehabilitation (VA&R) Division: Warren J. Goldstein

BEST PRACTICES

1. Facility Space:

General Services Administration (GSA): The ICVAHCS has an agreement with the GSA to transfer funds to purchase and design an unoccupied post office building in downtown Iowa City. This space will be converted into an outpatient health-care facility. This will allow the ICVAHCS to improve veteran access to needed health care on an outpatient basis.

2. Employee Programs:

ICARE/ITRUST Core Value Program: The ICVAHCS developed a program that extends VA's Integrity, Commitment, Advocacy, Respect, and Excellence (ICARE) model. The ICARE, I-TRUST cultural transformation program is based on personal credibility and team behaviors that strengthen relationships, build team unity, and empower employees to have crucial conversations and build their personal and professional communication skills. The health-care system has trained more than 1,500 employees including all of the CBOCs and off-site locations on the I-TRUST model. The I-TRUST model works to build an environment of trust and collaboration among all employees to work together to provide outstanding patient care and services. The ICVAHCS is the first in VA to incorporate this framework and is the leader in the process.

Certified Registered Nurse Anesthetist (CRNA) program: The ICVAHCS developed this Veteran Integrated Services Network (VISN) systemwide program to serve as an aid to recruit and retain CRNAs to be employed at the ICVAHCS as well as at health-care facilities within VISN 23. Recently, the program has graduated four nurses with the plan to request more to participate in the program.

3. Complementary and Alternative Medical (CAM) treatments:

Chiropractic Care Clinic, Acupuncture clinic, and yoga classes are embedded within the Pain Management Clinic: The ICVAHCS offers chiropractic care, acupuncture services and yoga classes to their enrolled veterans who are suffering from pain caused by neuromusculoskeletal and other conditions.

4. Care in the Community (CITC):

Time Out for Consults: CITC conducts a timeout anytime that multiple consults are received for one veteran. In the current set-up, staff members are assigned by specialty, allowing staff to quickly huddle and discuss the veteran's consult status. This typically ends with the veteran having one point of contact for all consults, preventing confusion and delays in care.

5. Nursing:

Patient Care Simulation Lab: The ICVAHCS has a nationally certified interactive simulation center, allowing for full mock codes, ACLS and BLS certification of staff and residents, training, and development for clinic staff and support for trainees who are rotating through the ICVAHCS such as nursing students, medical students, respiratory therapy students, etc.

6. Specialty Services:

Direct Scheduling for Audiology and Optometry: Patients utilizing the audiology or optometry clinics no longer need a consult from primary care physicians for routine visits, such as annual exams. Patients can call the clinic directly at the published phone numbers and schedule appointments with clinic clerks.

7. Surgery Services:

Paired Kidney Donation Program (KDP): The Iowa City VA is the only VA in the nation to provide access to the UNOS (United Network for Organ Sharing) KDP program, which increases the possibility of an organ match by leveraging a network of living donors across the country that can draw from the network of registered kidney donors who are willing to donate but may not be a match for the loved one or friend to whom they originally intended to donate an organ.

8. Human Resources:

Hire Right, Hire Fast: The Hire Right, Hire Fast program allows Medical Support Assistants (MSAs) to be hired quickly through community referrals when supervisors are made aware of a veteran who qualifies for the position, without navigating the USA Jobs process. This allows supervisors to quickly fill critical scheduling posi-

tions with qualified candidates to ensure direct patient care is uninterrupted.

Onboarding Redesign: The ICVAHCS Human Resources Department redesigned the onboarding process, working with education, supervisors, HR specialists and new employees to reduce onboarding times. Current onboarding times are 30-60 days, depending on the complexity of the hire.

9. Communications:

Stakeholder Communications: The ICVAHCS holds monthly communication rhythms with the community, including a quarterly director's stakeholders call, a quarterly stakeholder face-to-face meeting, and a quarterly town hall event that rotates among the nine communities with CBOCs. The ICVAHCS also has implemented a Tele-Town Hall event annually that allows the health-care system to reach more than 3,000 veterans on a live interactive teleconference to provide updates, information, and take calls from veterans.

10. Suicide Prevention:

Medication Overdose Alert: A medical alert has been implemented that is placed in a patient's chart when a medication overdose has occurred. This alerts physicians who then prescribe only two-week intervals of medications to prevent the recurrence of a suicide attempt.

11. Health Care Treatments:

Hepatitis C: The ICVAHCS has treated more than 450 veterans with a 93-percent cure rate. Dr. Villalvazo has patients who are willing to tell their story about how thankful they are and how good they now feel. The ICVAHCS has great team effort with pharmacy, medicine and nursing.

Pulmonary Nodules: Dr. Sanchez, Shannon Fessler, and their team have done an outstanding job tracking veterans with nodules and have stories of catching cancer early. Dr. Hoffman is a national expert on lung cancer screening and the risk/benefits and is part of that team funded by the Office of Rural Health (ORH).

CHALLENGES WITH RECOMMENDATIONS:

Challenge: Better definition/accurate reporting of wait times

Recommendation: The Department of Veterans Affairs needs to develop a better mechanism for defining, collecting, and reporting accurate wait time data. The American Legion's Department of Iowa is currently having prelimi-

nary discussions to draft a resolution urging VA to work with the VSOs and other stakeholders in a transparent manner to write standard definitions on wait times and to develop a consistent, understandable method for calculating the various wait times.

Challenge: Veterans Choice Program (HealthNet)

Recommendation: If Third-Party Administrators (TPAs) are not meeting the needs of veterans, VA should hold them accountable for violating and/or not meeting their contractual obligations. The American Legion will continue to hold meetings with the TPA to express what is being identified from our SWS visits and what is said from our members.

Challenge: Recruiting and Retention

Recommendation: To improve recruiting of veterans into the health-care system, VA needs to do a better job through its communications department counteracting negative publicity and showing veterans and the American public why the VA health-care system is a good place to work. Also, VA needs to improve its incentives to recruit and retain top talented health-care providers to work specifically in rural communities.

Challenge: Ability to communicate positive health-care system messages

Recommendation: VA needs to empower local leadership in the health-care systems and medical centers to get positive messages out into the community in a timely fashion. This allowance will eliminate layers of bureaucratic red tape.



CLEMENT J. ZABLOCKI VAMC | MILWAUKEE, WIS.

Date: July 10-12, 2017

Veterans Affairs & Rehabilitation (VA&R) Commission Member: Dale Oatman

National Executive Committee: Bob Shappelle

Department Commander, Wisconsin: Dan Seehafer

Assistant Director for Health Policy, Veteran Affairs and Rehabilitation (VA&R) Division: Edwin Thomas

BEST PRACTICES

Spinal Cord Injury Center – The Spinal Cord Injury Center has gained national recognition through the leadership of its doctors, clinicians and therapists. It is a state-of-the-art equipment facility that has provided specialized care to nearly 500 patients from more than 22 states. The program has developed many innovative approaches to serving veterans with spinal cord injuries that have been adopted by other VA medical centers and hospitals in the commercial sector. In fact, Dr. Kenneth Lee, the program's manager, has been invited to speak at events across the country on rehabilitative processes for patients with spinal cord injuries. Dr. Lee is also the recipient of 2016 Wisconsin State Disabled Veteran of the Year award from the Disabled American Veterans (DAV) for excellence in serving veterans and the community.

Patient Engagement with Primary Care Physicians – According to the administration and clinical management team, Zablocki VA Medical Center enjoys exceptional patient clinical outcomes. They attribute the outcomes to the primary care physicians who establish and maintain excellent relations with patients. The claim suggests a herculean undertaking by the chief of staff to ensure patient ex-



periences and health outcomes for the more than 800,000 outpatient visits, nearly 5,000 surgical procedures, and 7,789 inpatient admissions in the fiscal year 2016.

Community Engagement and Support – Zablocki staff actively participate in a variety of community events. This includes local parades honoring veterans to state events to end homelessness among veterans. For instance, the program manager of the Spinal Cord Injury Center participated in 15 community partnerships and took 13 veterans with spinal cord injuries to the National Wheelchair Games in 2016. Their efforts have reaped great benefits as donations and gifts surged in 2016. The director of Community Engagement reported to the SWS team that as of July 2017 community donations and gifts totaled \$2 million. Total gifts and donations in 2016 reached \$9 million.

CHALLENGES WITH RECOMMENDATIONS

Challenge 1: Nurse Recruitment

Recommendation: The American Legion recommends expanding recruiting efforts to other states and cities where experienced nurses find difficulty obtaining employment. Nurses in states like New Jersey, California, Nevada, and Florida have complained about the difficulty of finding jobs there. Some have expressed interests in relocating even though they may face the prospect of losing their home state license.

Moreover, some national groups such as the National Council of State Boards of Nursing offer a potential solution through the Enhanced Nurse Licensure Compact (eNLC) for experienced nurses seeking multi-state licensure in “eNLC States.” However, Wisconsin Statute § 441.50 (4) offers recruiters additional guidance about licensing nurses with valid credentials from other states.

Recommendation: The American Legion also offers recommendations with a longer-term focus but with the potential of benefitting Zablocki VAMC: recruiting more men for nurse training and employment. According to the National Center for Health Workforce Analysis, men comprise 9.1 percent of Registered

Nurses and 7.6 percent of Licensed Practical Nurses. A plethora of surveys and literature exists outlining barriers males face in nursing schools and clinical settings. Additionally, many organizations often overlook this demographic in active nurse recruitment campaigns.

Challenge 2: Aging Infrastructure (physical plant)

Recommendation: Leadership should continue identifying the need for space through the Strategic Capital Investment Program (SCIP) and leverage relationships with local veterans service organizations to champion their cause. However, the medical center completed a business case under the SCIP for FY2018 to FY 2027. The business case proposed 52 projects with a total projected monetary outlay of \$439.1 million. The Veterans Health Administration amended its policies on the types of projects that could be submitted that required Zablocki leadership to reduce the number of projects. The medical facility re-submitted seven business cases with a projected budget of nearly \$24 million. Leadership awaits the approval of those seven projects by VHA. The leadership staff did not

disclose the nature of the projects to the SWS team.

Challenge 3: Multiple Personnel Systems

Recommendation: The HR staff discussed during the SWS visit the difficulty of managing four separate Human Resources Management Systems and various policies associated with those systems and associated requirements. Title 5 for Senior Executive Service or SES staff, Title 38 for about 67 percent of VHA employees including health-care professionals, a so-called Title 38 Hybrid for other VA health professionals, and Title 38-7306 for IT-related and technical positions.

The American Legion recommends the medical center wait for the outcome of the special commission initiated by the 115th Congress – VA Commission on Care. The Commission is looking into creating a single personnel system for the VA and other issues across the Veterans Health Administration. The commission was initiated in 2016 and has already proposed the alternative personnel management system that is more streamlined, less cumbersome, and with consideration for market-based compensation.



CHALMERS P. WYLIE VA AMBULATORY CARE CENTER | COLUMBUS, OHIO

Date: Sept. 12-14, 2017

Veterans Affairs & Rehabilitation Commission: Patrick Grzybowski

National Executive Committee (Alternates): George Mussi, Suzette Price-Heller

Department of Ohio Commander: Stanley Pleasant

Veteran Affairs and Rehabilitation Division, Assistant Director, Health Policy: Edwin Thomas

BEST PRACTICES

Cardiology Department: The Cardiology Department allows its trained physician specialists and surgeons to travel to outlying facilities to conduct consultations. The medical center considers this a best practice because of the scarcity of cardiologists in the area to meet the demand for cardiology-related services – consultations, surgeries and post-operative care. The practice permits veterans to gain access to cardiologists when they normally would not.

Mental Health Provider Training: All new mental health providers must spend a minimum of six weeks in the primary care department. The six-week period allows new mental health clinicians to shadow primary care physicians to understand the acute care delivered to veterans. Veterans gain by having a mental health provider who understands the acute care process and its challenges. Additionally, mental health clinicians are better prepared to initiate Cognitive-Behavioral Therapy in veteran populations. “Cognitive-Behavioral Therapy (CBT) is a form of psychotherapy that treats problems and boosts happiness by modifying dysfunctional emotions, behaviors and thoughts. Unlike traditional Freudian psychoanalysis, which probes childhood wounds to get at the root causes of conflict, CBT focuses on solutions, encouraging patients to challenge distorted cognitions and change destructive patterns of behavior.”

During the System Worth Saving sessions with the executive leadership team at Wylie VAACC, they identified the following as their “Top Challenges.”

CHALLENGES

Challenge 1: Lack of Space

The executive team and clinical line managers identified a lack of space to accommodate and provide care to a growing veteran population. Although recently renovated, the leadership team feels that the facility has already outgrown its capacity to serve patients. Some clinicians and administrative staff must travel across town to see patients or attend meetings. Staff also suggested that their request through the Strategic Capital Investment Planning (SCIP)

process has an elongated timeline that actually compounds another issue: inefficiency.

According to executive staff, the Columbus metropolitan area does not need another acute-care hospital. The director believes the area has sufficient coverage. However, the director believes the area needs another long-term care facility. She also believes VAACC should “increase its footprint” in the ambulatory care sector by increasing space and offerings to accommodate the growing number of veterans in the area. The need for space is critical for quality, direct patient care and efficiency.

Challenge 2: Inefficiency

As the SWS team toured the medical facility, doctors, nurses, and Medical Support Assistants (MSAs) voiced complaints about how inefficient processes contribute to low morale and frustration. Physicians cited an overload of paperwork in addition to large patient panels. A physician did state she felt the lack of space exacerbates the inefficiency. MSAs cited a lack of defined processes that contribute to morale problems because they are overworked and never given recognition or shown any appreciation for their hard work. Some MSAs expressed a desire to leave the medical center for lack of advancement opportunities; one minority expressed disappointment and frustration after nearly 10 years working at the medical center as an MSA and passed over for promotion. We asked the MSAs why inefficiency exists at the medical center and, “Why do you feel there is a lack of career advancement opportunities at the VAMC?” They responded with “bad first-line supervisors” and “lack of sensitivity at the executive level for diversity in the managerial ranks.” The Human Resources and Behavioral Health units also spoke of the difficulty of not having staff in the same building and the travel time needed to meet with staff in offsite facilities.

Challenge 3: Inhibitive and Labor-Intensive Accounting Practices

The executive team feels the current accounting system/line item allocation process does not allow enough flexibility. Staff repeatedly mentioned the inability to transfer money between “special projects” to other line items

when needed. Staff within the finance department also spoke about how labor-intensive it is to track expenditures related to special projects, especially construction projects.

Challenge 4: Veterans Choice Program

Staff at the facility were disappointed the current Choice program was not meeting the expectations of veterans or their families. The staff was especially concerned about balance billing and lack of coordination of documentation in the program. Local providers would rather enter a Provider Agreement directly with the VAACC rather than with HealthNet, specifically.

Many of the staff believes the Department of Veterans Affairs should return critical program activities to the medical center. Such activities could include scheduling, coordinating care and pre-referral consultations with veterans before consulting with providers outside the VA medical center, and payments (Health Plan Model). The American Legion talked with MSAs who believed the VA Central Office must bring back outsourced operations to third-party vendors because the medical center is better equipped to serve veterans. They also believed doing so might improve strained relationships with community physicians.

CHALLENGES WITH RECOMMENDATIONS

Challenge 1: Lack of Space

Recommendations: The American Legion recognizes that a lack of space is a systemic issue across a majority of Veterans Integrated Service Networks. The Department of Veteran Affairs is building new facilities while spending millions of dollars in the process. The problem is the Strategic Capital Investment Planning (SCIP) process. Many facilities complete their SCIP Business Plans and must wait three to five years before approval. At the completion of the original approval process, designs are approved, bids received and approved, and actual construction begins and ends, the facility often does not meet the space requirements it was originally intended to resolve.

- The System Worth Saving (SWS) site visit team recommends the Department of Veterans Affairs/Veterans Health Administration explore means of reducing the length of time needed to approve budgets for special construction projects. As the executive team explained, the budget process that includes the submission of the facility's SCIP budget and business plan and SCIP budget took one year for approval. The SWS site visit team recommends the VA consider moving quickly toward a solution because this problem has affected the orga-

nization's ability to provide proper access and quality of care.

- The SWS site visit team recommends that accompanying bidding processes are also considered for process improvement efforts through Lean Six Sigma and Engaged Team Performance® organizational development tools.
- The SWS site visit team recommends the National Headquarters of The American Legion take a more active role in collaborating with, and assisting, the Department of Veterans Affairs with reaching a viable resolution to shorten the timeline for the SCIP and bidding process for vendors.
- The SWS site visit team recommends VAACC continue submitting requests for facility expansions and renovations through the SCIP process when appropriate.

Challenge 2: Inefficiency

Recommendations: Typically, The American Legion does not address employee issues. However, inefficiency affects physician attrition and increases burnout. Medical Scheduling Assistants leave their positions in such numbers that it disrupts access to care for veterans and subsequently the quality of care at Wiley Columbus VAACC.

- The SWS site visit team recommends the leadership team host a town hall meeting with staff to address concerns.
- The SWS site visit team recommends the executive staff consider using scribes to assist primary care physicians and certain specialists where the burden of administrative work serves as a barrier to quality care and efficiency.
- The SWS site visit team recommends the Department of Veteran Affairs determine how to classify medical scribes within current HR systems – Title 38 or Title 38 Hybrid – to hasten the use of the positions to increase efficiency, lessen the administrative burden on physicians, improve quality of care and prevent unnecessary physician turnover and burnout. This recommendation aligns with H.R. 1848, known as the Veterans Affairs Medical Scribe Pilot Act of 2017.
 - » H.R. 1848 would “create a two-year medical scribes pilot program under which VA will increase the use of medical scribes at 10 VA medical centers. Under this legislation, VA would be required to report to Congress every 180 days regarding the effects the pilot program has had on provider satisfaction, pro-



vider productivity, patient satisfaction, average wait time and the number of patients seen per day. The bill requires the secretary to select at least four medical centers located in rural areas, at least four medical centers located in urban areas and two located in areas where a need for increased access exists. Additionally, it requires four scribes be assigned to each medical center, with two scribes assigned to each of two physicians. Thirty percent of scribes will be employed in emergency care, and 70 percent of scribes will be employed in specialties with the longest patient wait times or lowest efficiency ratings. It also requires VA to hire 20 new employees as medical scribes, and to enter into contracts with outside entities in order to employ 20 additional scribes.”

- The SWS team recommends the Department of Veterans Affairs provide adequate space to care for veterans in harmony with recommendations found under Challenge 1.
- The SWS team recommends the Veterans Administration Central Office (VACO) increase awareness of employee issues regarding the lack of diversity in managerial positions particularly to reflect the patient population served by the facility.

Challenge 3: Inhibitive and Labor Intensive Accounting Practices

Recommendations: The SWS team recommends the Department of Veterans Affairs review its accounting practices across all Veteran Integrated Service Networks and determine the need for improvements that enhance the ability of facilities to transfer funds concerning special projects.

- The SWS site visit team also recommends the finance department or project management office for process improvement and conduct a process map exercise that identifies what makes VA contracting and accounting activities at the VAACC so labor intensive.
- The SWS site team recommends the medical center share its completed accounting process map and narrative with The American Legion.

Challenge 4: Veterans Choice Program

Congress passed legislation and the Department of Veterans Affairs hastily implemented the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146) in response to the scheduling scandal at the Phoenix, Ariz., VA Medical Center in 2014.

Recommendations: The SWS site visit team recommends Congress work diligently to pass new legislation that is clear, succinct, unfettered with other pieces of legislation that attempt to drive the VA toward privatization, and implementable by VISNs and VA medical facilities.

- The SWS site visit team recommends that Congress and leaders of the Department of Veterans Affairs select Third-Party Administrators capable of building a network of providers educated about veteran physical and mental health issues, unique circumstances surrounding veteran health, claims and balance billing practices.
- The SWS site visit team recommends the Department of Veterans Affairs strongly adheres to Title 31 › Subtitle III › Chapter 39 – Prompt Payment and related Code of Federal Regulations (CFR) 5 CFR Part 1315 - PROMPT PAYMENT §1315.10, unless where the Department of Veterans Affairs disputes a claim made by a vendor.

MONTANA VA HEALTH CARE SYSTEM | FT. HARRISON, MONT.

Date: Oct. 23-25, 2017

Veterans Affairs & Rehabilitation (VA&R) Commission Member: VA&R Commission Vice Chairman Kelly L. Ackerman and **VA&R Commission Consultant** Steven Kleinglass

Assistant Director for Health Policy, Veteran Affairs and Rehabilitation (VA&R) Division: Warren J. Goldstein

BEST PRACTICES

Business office staff attend Veteran Service Organization (VSO) meetings: Staff from the MTVAHCS business office have attended 49 of 55 American Legion district meetings to assist veterans with enrolling for VA health care and assist with scheduling health care appointments. Fort Harrison staff attends these district meetings in support of their members and their families. This allows for immediate remedies to those veterans' needs. It also allows the opportunity to pass along information regarding programs, processes and deficiencies in care. By having VAMC staff at these meetings, instant solutions to veteran needs are met.

CHALLENGES:

1. Choice Program:

- The MTVAHCS continues to experience delays and receives poor customer service with their assigned Choice Program Third-Party Administrator (TPA). HealthNet is experiencing difficulties in scheduling Choice appointments timely.
- The MTVAHCS experiences delays in providing follow-up care after a veteran has seen a Choice provider due to the length of time it takes to return the medical documentation to HealthNet.
- Network Providers are experiencing significant delays in receiving payment for services rendered.
- Physicians do not want to enroll and/or are dropping out as Choice Network Providers. This has created problems for the TPA enrolling new providers into their network.

2. Recruitment Challenges:

- Montana is considered a rural/highly rural state. As such, the MTVAHCS experiences significant barriers to recruitment and retention of health-care providers and is working diligently to attract the best talent possible to support the health-care system. Montana's rural makeup, remoteness, limited air service and severe winters are the main reasons providers and their families are unwilling to accept positions at the MTVAHCS.
- The MTVAHCS is not affiliated with a medical school, which is another reason why it is extremely difficult to recruit and retain quality health-care providers.

- The size of the MTVAHCS and the medical center complexity level make it difficult to recruit experienced providers, nurses, clinical staff and management. Less experienced health-care providers and management staff are attracted to the MTVAHCS to gain the necessary health-care experiences that allow them to move on to other larger health-care systems either in the VA or in the community.
- VA health-care providers pay rates cannot compete with the private sector to include offering better recruitment and retention incentive packages.
- The vice chairman of The American Legion's Veterans Affairs & Rehabilitation Commission voiced concerns that the MTVAHCS in the past lost 18 medical providers and numerous nursing staff members. In FY 2017, the health-care system had 46.4 medical professionals leave the organization. The positions were as follows: 16.1 physicians, 2.9 nurse practitioners and 27.4 nurses. While there seems to be a plan in place that will abate this issue in the near future, it is an ongoing issue. Every available means should be considered. Consideration of special salary rates and other recruitment and retention incentives should be considered. The MTVAHCS plans to fill all of the vacancies for primary care providers by the end of FY 2017, which will help reduce wait times accessing primary care services. As of January 2018, MTVAHCS has six FTEE open positions for primary care across the state of Montana. The health-care system is currently recruiting and has made several tentative offers to primary care physicians.

The VAMTHCS stated that the Montana VA has experienced significant provider turnover in primary and specialty care over the past year. Aggressive recruitment efforts have been successful in replacing the majority of these individuals. Given the size of the organization, there will always be some degree of turnover with departures resulting from retirement, personal and family issues, and the pursuit of other job opportunities. The recruitment of nurse practitioners (NPs) has increased significantly and physician assistant (PA) recruitment is receiving special attention. Increased salaries and financial incentives have been implemented for difficult-to-recruit positions, and feedback is solicited from all

departing providers to ascertain the reasons for leaving so, when possible, these can be addressed.

3. Health-care System Space:

- Fort Harrison was built in 1929 and has an aging infrastructure. Facility space is needed to meet the increased demands of the VA mission that have certain implementation times that the health-care system cannot always efficiently meet. It was stated that the MTVAHCS has three construction projects planned to increase veteran access to care. For example, in FY 2018, the health-care system is planning to build an 18,000-square-foot primary care building totaling \$10 million. In FY 2019, the health-care system is planning to build a 14,000-square-foot outpatient mental health building totaling \$10 million and a major construction project to build an 80,000-square-foot clinical building and correct seismic deficiencies in current buildings over a 5-10-year timeframe. Current estimates for the major construction projects are being reviewed this fiscal year with design and architect review to refine the cost estimates and seismic corrections costs; but as of now, the rough estimate is greater than \$100 million. The MTVAHCS will not have a firm answer until the analysis is done.
- The MTVAHCS also needs increased clinical space at facilities in Great Falls, Havre, and Missoula to provide better services to enrolled veterans who receive their health care at those facilities. The MTVAHCS is currently looking at additional leasing options to increase space for the CBOCs in Havre and Great Falls.
- On Aug. 7, 2017, President Trump signed into law S. 114, the VA Choice and Quality Employment Act of 2017, which authorized the secretary of VA to carry out 28 major medical facility leases nationwide to include a replacement outpatient clinic in Missoula, in an amount not to exceed \$6,942,000.

4. Executive Leadership Turnover

- Since 2009, the MTVAHCS has had 11 directors, nine chiefs of staff, 14 associate directors and three associate directors for Patient Care Services in permanent and acting roles. The health-care system has been in a continual state of turmoil due to the constant changing of the senior leadership team. This situation creates all sorts of operational challenges and for employees and diminishes staff morale. While there is a stable leadership team in place, currently it is uncertain how long this will last. VHA leadership should review this matter and use of its authority to offer retention bonuses and

other tools available to retain competent qualified staff. Also, the current leadership team should be extremely visible throughout the facility. This will demonstrate to everyone that the MTVAHCS has a unified team.

5. VA Foundational Services:

- Being a rural and highly rural/frontier health-care system, the MTVAHCS faces unique changes that only exist in rural health-care settings, such as lack of community resources, travel distances and recruiting professional staff.

6. Veterans Equitable Resource Allocation (VERA) Model:

- VERA is a capitated funding model, not a reimbursement system, meaning that facilities are not reimbursed for the amount they spend on a patient. The reimbursement rate is established by the Allocation Resource Center based on patient-care workload encountered. It is based on a workload from the previous two years (i.e., workload produced in FY 2018 will be attributed to FY 2020 funding disbursement). Therefore, new unfunded requirements are not covered under VERA. This places the facility in an unfortunate position having to choose between administrative support and direct patient care.

7. White House VA Hotline:

- The White House VA Hotline is very time-consuming. The MTVAHCS patient advocate staff which consists of two staff members, as well as the Congressional Liaison for the health care system, are spending 25 to 40 percent of their time resolving veteran issues and/or complaints that are received from the White House VA Hotline.

CHALLENGES WITH RECOMMENDATIONS

Challenge: Recruiting and Retention

Recommendation:

- Turnover at the provider level for both primary care and specialty care is a challenge. While there seems to be a plan in place that will abate this issue in the near future, it is ongoing. Every available means should be enacted to help solve this issue so that continuity of care is constant. Consideration of special salary rates, incentives, and using physician assistants and nurse practitioners should always be under discussion.
- To improve enrolling more veterans into the VA Health-care System, VA needs to do a better job through their communications department counteracting negative publicity and showing veterans and the American public why the VA health-care system is a good place to work.

- VA needs to improve their incentives to recruit and retain top talented health care providers and management staff to work and live in rural and/or highly rural areas where VA medical systems are located.

Challenge: Communication with External Stakeholders

Recommendation:

- The Montana VA Health Care System is extremely fortunate to have a broad-based coalition of veterans service officers and veterans service organizations both on campus and in the surrounding area. It is highly recommended that the MTVAHCS leadership maximize to the extent possible their relationship with these individuals and organizations.

Challenge: Stability of Executive Leadership Team

Recommendation:

- The health-care system has been in a continual state of turmoil due to the constant changing of the senior leadership team. This situation creates all sorts of challenges within the continuity of operation of the facility and can negatively affect staff morale. While there is a stable leadership team in place, it is uncertain how long this will last. VA leadership should review this matter and make efforts to retain leadership staff in place for reasonable lengths. Also, the MTVAHCS leadership team should be extremely visible throughout the facility. This will demonstrate to everyone they have a unified team.

Challenge: Providing Adequate Health Care in a Rural or Highly Rural State

Recommendation:

- The MTVAHCS is located in a highly rural state and is comprised of 17 access points of care spread out geographically across Montana. The sites of care are often far apart and more rural than the parent facility. This unique factor leads to numerous challenges with regard to operating a health-care system. Therefore, senior leadership should further explore avenues to fully connect with the greater health-care community in their geographic location. Efforts like this should lead to more awareness about VA and, in turn, perhaps help with more sharing of resources.

Challenge: Veterans Equitable Resource Allocation (VERA) Model

In FY 2017, the national average for patients with billable insurance was 22.40 percent, VISN 2019 average was 23.53 percent, and Montana has 28.98 percent of their patients with billable insurance. Though they have a higher than av-

erage number of patients with billable insurance, their collections from billing other insurance has steadily declined in recent years. Billing is done at a central location that is located off station. For FY2017, the MTVAHCS reached 82 percent of their target collection goal. For FY 2018, the collection target was reduced by 23 percent from FY 2017 and currently, collections are projected at 127 percent of target.

Recommendation:

- VA should allocate more resources and technology to assist with the numerous barriers of providing quality state-of-art health care to veterans living in rural and/or highly rural states.

Challenge: The Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017

The Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 has created challenges for the MTVAHCS executive leadership team. Recruiting and retaining good VA employees to continue to serve veterans or even accept jobs at MTVAHCS is a challenge. The Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 provides the VA secretary more power to discipline or fire employees and would shorten an appeals process that can last years. The legislation prohibits employees from being paid while they appeal. The act also provides new protections against retaliation for VA staffers who expose corruption. It establishes an Office of Accountability and Whistleblower Protection within the department and forbids the VA secretary from retaliating against whistleblowers who have filed a complaint with the VA general counsel's office. The leadership team stated that the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 added a new layer of complexity for dealing with personnel issues.

Recommendation:

- The American Legion will continue to monitor how the legislation will impact VA's ability to recruit and retain qualified health-care providers to work at VA health-care systems nationwide.

Challenge: Veterans Choice Program (HealthNet):

Recommendation:

- If Third Party Administrators (TPAs) are not meeting the needs of veterans, VA should hold them accountable for violating and/or not meeting their contractual obligations. The American Legion will continue to hold meetings with VA and the TPAs to express what is being identified from our SWS visits and what is said from our members.

MANCHESTER VA MEDICAL CENTER | MANCHESTER, N.H.

Date: Nov. 13-15, 2017

Veterans Affairs & Rehabilitation (VA&R) Commission Member: National Executive Committeeman William Roy
Assistant Director of Women & Minority Veterans Outreach, National Security Division: Keronica C. Richardson

Deputy Director, Veterans Employment and Education (VE&E): Mark Walker

BEST PRACTICES

Public/Private Partnerships:

The Manchester VAMC established a first-of-its kind community partnership with Catholic Medical Center (CMC) in Manchester, allowing Manchester VAMC health-care providers and staff to utilize CMC space, supplies and equipment for endoscopic and same-day procedures. Several veterans have received procedures through this model, resulting in no interruptions of care or services. The VAMC has created other partnerships across New Hampshire to provide their enrolled veterans surgery, orthopedics, intervention pain management and urology services.

On Aug. 16, 2017, New Hampshire Gov. Chris Sununu signed an executive order to benefit veterans living in New Hampshire. The executive order allows physicians at the Manchester VAMC to provide medical care to VA patients outside the facility and for VA physicians who are licensed outside the state to practice in community hospitals. Like the CMC community partnership, the Manchester VAMC is developing a health-care model that can be used at other health-care organizations in the community to better meet the needs for veterans where medical centers cannot provide more timely and efficient services.

Manchester VAMC Office of Community Care:

In order to improve the overall patient experience and veterans access to care, the Manchester VAMC established an internal Office of Community Care (OCC) to case manage care in the community and to support a seamless transition in and out of VA care for enrolled veterans. The OCC at the medical center was established to address continued difficulties that the medical center was experiencing with the Choice Program including coordination of health-care services for veterans enrolled at the Manchester VAMC, reducing the number of outstanding medical consults, as well as assisting those veterans who only want to receive their care through the Choice Program.

Veteran Homeless Community Partnerships:

Mark Walker, Deputy Director, VE&E toured a local community service provider, Harbor Homes, in Nashua. Har-

bor Homes is a nonprofit community-benefit organization that provides low-income, homeless, and disabled New Hampshire community members with affordable housing, primary and behavioral health care, employment and job training and supportive services. Harbor Homes offers a unique, holistic approach to care that results in better outcomes for its clients and the community. The American Legion staff was briefed and taken to several different sites by Peter Kelleher, chief executive officer and president of Harbor Homes.

In addition to the direct services provided by Harbor Homes, clients have access to a full continuum of care through the Partnership for Successful Living member-agencies, a collaboration of six affiliated nonprofit organizations. Harbor Homes is able to better coordinate and deliver a comprehensive array of interventions designed to empower low-income individuals and families, and ultimately build a stronger community. Outcomes are enhanced through this partnership model.

Harbor Homes maintains its status as a leader in ending homelessness (to include veterans) within New Hampshire and nationally, by:

- Establishing and maintaining high standards of housing, health care, and supportive services that are evidence-based, best-practices; and
- Advocating for the needs of low-income community members, veterans, individuals with mental illness, and other vulnerable populations; and,
- Generating community awareness, education, understanding and support around homelessness, poverty, health care, and mental health.

Services at Harbor Homes include:

- Affordable housing with supportive services provided on-site to more than 700 households, through more than 400 units of emergency, transitional, permanent supportive and income-based rental housing
- Harbor Care Health and Wellness Center: Greater Nashua's community health-care center offering primary and preventive health care at no cost to homeless and

low-income community members

- Mental health and behavioral health care, including crisis interventions
- Workforce development and employment assistance
- Case management
- Veterans FIRST: a combination of housing, employment, and supportive services for veterans and their families
- Homeless-prevention services and rapid rehousing services

The partnership model shown by Kelleher has been the most impressive. The American Legion national team has seen throughout the country. There has been a real community effort (to include the governor's office) to assist homeless veterans in reintegrating successfully back into mainstream society in New Hampshire.

The American Legion continues to place special priority on the issue of veteran homelessness. With veterans making up approximately 11 percent of our nation's total adult homeless population, there is plenty of reason to give the cause special attention. The American Legion's goal is to ensure that every community across America has programs and services in place to get homeless veterans into housing (along with necessary health care/treatment) while connecting those at-risk veterans with the local services and resources they need.

CHALLENGES WITH RECOMMENDATIONS

The executive leadership team and The American Legion SWS team discussed the main challenge that the Manchester VAMC is experiencing, which is to regain the trust of veterans and the public.

Other challenges include:

Stability of Executive Leadership Team

Recommendation:

Based on the SWS team's observations, The American Legion Department of New Hampshire wrote a letter to VA Secretary Shulkin recommending making the director's position of the Manchester VAMC into an associate director's position under the umbrella of the director of the White River Junction VAMC. For continuity purposes, The American Legion Department of New Hampshire supports combining leadership at the director level to provide cohesiveness and streamlined oversight at the Manchester and White River Junction VAMC to best serve the veteran

population in New Hampshire.

Communication with External Stakeholders

Recommendation

The Manchester VAMC is fortunate to have a broad-based coalition of Veteran Service Officers and Veteran Service Organizations such as The American Legion Department of New Hampshire leadership who receive their health care at the medical center and want to see the Manchester VAMC succeed to provide the best health care for veterans of New Hampshire. It is highly recommended that the leadership maximize to the extent possible their relationship with these individuals and organizations.

Medical Center not Performing Exit Interviews with Staff

Recommendation

The American Legion recommends that the medical center conduct exit interviews on all employees who are leaving the medical center. The purpose of conducting exit interviews is to solicit feedback from employees in order to improve aspects of the organization, better retain employees and reduce turnover.

Electronic Funds Transfer (EFT) for their Beneficiary Travel Payments

Financial management staff reported that there are more than 3,000 enrolled veterans who do not have electronic funds transfer (EFT) for their beneficiary travel payments and still receive paper checks.

On Dec. 21, 2010, The Department of Veterans Affairs issued a press release entitled "VA Urges Veterans to Sign Up for Direct Deposits." VA announced that on March 1, 2013, VA will stop issuing paper checks. People who do not have electronic payments for their federal benefits by that time will receive their funds via a pre-paid debit card.

According to information on the U.S. Treasury webpage, if you are still receiving a paper check for your Social Security or other federal benefit payments, you are out of compliance with the law. The Treasury Department requires federal benefit payments to be made electronically.

Recommendation

The American Legion recommends the executive leadership team ask the chief of financial management to confirm if VA is required to issue veterans a Direct Express® Debit MasterCard® card, or similar instrument in place of issuing them a paper check. If yes, the financial manager should be required to develop an action plan to convert all

veterans receiving paper checks to an express debit card or similar instrument.

Veterans Choice Program (VCP)

The VCP at the medical center has not been without issues. Veterans and community providers have voiced concerns regarding the referral and billing processes. VA providers also have expressed concerns about not always receiving information back from community providers when veterans are referred to a Choice participating provider. The OCC staff reported physicians are dropping out of the network due to physicians not being compensated for provided services in a timely manner.

Recommendation

The American Legion recommends that if the Veteran Choice Program Third-Party Administrators (TPAs) are not meeting the needs of veterans, VA should hold them accountable for violating and/or not meeting their contractual obligations. The American Legion will continue to meet with VA Central Office Community Care leadership to express what is being identified from our SWS visits and what VA can do to address these concerns.

Shortage of Women Health Care Providers

The Manchester VAMC currently has only one women's health-care provider who works one day a week with an approximate wait time of one week for patients to be seen. The provider at the Manchester VAMC only sees current patients and is not accepting new patients. The Portsmouth VA has one full time provider who sees men and women veterans alike with an approximate wait time of two weeks for patients to be seen. Veterans enrolled at the Manchester VAMC can receive services at the Portsmouth VAMC. Currently, the Somersworth CBOC has been without a designated women's health care provider and continues to be without one, as of this site visit. The Manchester VAMC Women's Program Manager has requested several times to leadership that one is needed to provide gender-specific health-care services to women veterans who choose to receive their care at the Somersworth CBOC.

Recommendation

The American Legion recommends that the Manchester VAMC hire a full-time female health care provider who works five days a week at the Manchester VAMC. A provider on staff five days a week at the Manchester VAMC will allow female veterans to receive gender-specific services specifically at the Manchester VAMC instead of always being referred to community health-care providers.

The Veterans Equitable Resource Allocation (VERA) Model

VERA is a capitated funding model, not a reimbursement system. This means that facilities are not reimbursed for the amount they spend on a patient. The reimbursement rate is established by the Allocation Resource Center (ARC) based on patient-care workload encountered. It is based on two years ago, workload (i.e., workload produced in FY 2018 will be attributed to FY 2020 funding disbursement). New unfunded requirements therefore, are not covered under VERA. This places the facility in an unfortunate position of choosing between program office administrative staffing requirements and patient care.

The crisis that occurred at the Manchester VAMC was fiscally driven. The current VERA model does not give medical center directors the flexibility needed for a changing environment. For example, in FY 2017, the medical center had 7 percent patient growth with no additional funding.

Funding for Aging Infrastructure

Due to a 67-year-old building, the medical center needs more capital funding for re-investing in outdated and aged mechanical systems, to include replacing aging chilled water pipes, heating and air conditioning, lighting, etc. The medical center stated that there are a variety of construction projects forecast in the out years to address individual utility systems. There is no single project to address all of them, which would be classified as a Major Construction project. The medical center has been directed not to submit projects that fall into that category.

Since July 2017, the medical center has created 102 new positions but has not increased the overall blueprint of the medical center. Therefore, space to create new work areas for the new hires is a challenge.

Suicide Prevention Program

In response to the article reported in the Free Bacon on Feb. 4, 2016, and noted in the Sept. 30, 2015, VAOIG Combined Assessment Program Review of the Manchester VAMC, the medical center has completed the two recommendations listed in the report to include: (a) the facility assigning the Suicide Prevention Coordinator to be full-time to oversee all suicide prevention activities and (b) to ensure new employees are receiving necessary suicide-prevention training.

The SWS site visit team did not list any recommendations for the above four challenges, but will leave it up to the medical center executive leadership team to determine the best ways to address staff concerns.

MEMPHIS VA MEDICAL CENTER | MEMPHIS, TENN.

Dates: Jan. 9-11, 2018

Veterans Affairs & Rehabilitation (VA&R) Commission Member: Chairman Ralph P. Bozella

Veterans Affairs & Rehabilitation (VA&R) Commission Member: James Hartshorn, observer.

Veterans Affairs & Rehabilitation (VA&R) Commission, National Staff: Deputy Director Roscoe G. Butler and Assistant Director Warren J. Goldstein

Veterans Employment & Education (VE&E) Commission, National Staff: Deputy Director Mark Walker

BEST PRACTICES

Mammography Tracker Stoplight Process

The purpose of the mammography tracker spreadsheet used at the MVAMC is to help improve quality of scheduling mammogram consults in a timely manner. An employee noticed that the medical center needed a tracking system in place for following up on mammogram consults. Therefore, the medical center sought to develop a system that would help simplify the process of tracking mammograms. The sustainability and ease of use were also important factors.

The conditions function in Excel is used to help manage follow-ups. The conditions can be set to user preference and to the standards of Mammography Quality Standards Act (MSQA) guidelines. For example, all outsourced mammogram reports must be returned to the VA provider within 30 days as per the *VHA Handbook 1105.3: Mammography Program Procedures and Standards*, which is in accordance with the MSQA guidelines. The stoplight function gives a visual and alerts the user of patients who may need immediate follow up.

One Touch Process for Care in the Community (CITC) Consults

The One Touch process was the creation of nurses in the Care in the Community (CITC) program office. The nurses identified issues with staff opening consults and closing them without taking the necessary action to complete the required request. As a result, the MVAMC put forth the communication standard operating procedure (SOP) and process for expediting the completion of the consult with as few “touches” as possible.

If a Medical Support Assistant (MSA-admin staff) opens a consult and determines he or she needs medical records they must request them and then follow up to make sure the records are received, or contact the patient, if needed, to make sure the veteran kept the appointment. Once the information is received, the support assistant must complete the consult. If the MSA cannot complete the consult, he or she must request assistance from the appropriate per-

son to do so. There are triggers to the One Touch process such as: a physician may call looking for a clinical record (test result); the consult has been open for greater than 30 or 60 days; or it may be a high-risk test in which case the medical center needs the clinical records (potential cancer diagnosis, mammogram and the nurse is tracking it on the tracker spreadsheet). When that occurs, the nurse takes the request, contacts the community provider, requests the results be faxed as soon as possible, scans the document and links the consult, closes the consult and the record and contacts the provider to review the document. Thus, One Touch is a one-person process as the nurse follows the consult from request to completion and notification to the provider. The goal is to complete the process by doing whatever one can do to complete an episode of care so that the VA provider has the clinical information needed to continue the veteran’s care.

Memphis VAMC Business Office Assisting Veterans with the Choice Provider Process

One of the best practices discussed was when veterans call the MVAMC business office in the event of a problem with the community provider. This started when the MVAMC staff began educating them on how to navigate the Choice Program. The MVAMC advised veterans to contact the medical center if their provider wanted to refer them to another provider. Many of the veterans were referred out, to see other specialists by the Choice provider without coming back to the medical center. This generated an invoice to the veteran from the other provider. After receiving numerous phone calls and complaints, about 15 months ago, the MVAMC began educating the veteran to contact the business office for any additional care that was recommended by the provider. This is why veterans now call the medical center before they do anything else. The MVAMC changed its practice and now has this discussion with veterans as they are opted in for the Choice Program.

The Community Partnership between the Memphis VAMC and Local Law Enforcement

The MVAMC has community partnerships with the Mem-

phis Police Department Crisis Intervention Team (CIT), the Shelby County Sheriff Department, and multiple other Mid-South Law Enforcement agencies. Mental Health Service staff provides training on PTSD and TBI (including a combat veterans/military sexual trauma veterans dialogue group with CIT Officers at the MVAMC) four times a year. Mental health staff provides verbal de-escalation training for CIT Officers. Memphis Police Department provides four training slots per year for the MVAMC Police Officers. One mental health staff member has traveled to various cities and regions of the United States to train CIT law enforcement officers in de-escalation with a focus on veteran crisis issues. In 2015, MVAMC mental health staff provided in-service training on suicide for over 400 CIT officers with an emphasis on veteran and police suicide from the Mid-South. Additionally, mental health service line staff has provided de-escalation training along with training on PTSD, TBI and suicide prevention to law enforcement agencies in the MVAMC Mississippi catchment area.

System Improvements Made from Hospital Sentinel Events

As a result of a veteran incident that took place in the catheterization laboratory when a piece of plastic packaging was left embedded in a critical artery after surgery, the medical center immediately conducted a root cause analysis (RCA) and found that a problem was not only in the surgery department but in logistics (supply purchasing) and training. The MVAMC developed a time-out procedure whereby three people inspect all equipment and supplies prior to starting a surgical procedure, to ensure incidents harmful to veterans should not happen again.

The medical center has learned from this incident by creating a culture of open reporting, especially in the surgery and emergency departments, by overcoming a structure that had employees in the past working in silos. This has also opened a culture where whistleblowers are not seen as negative, and a new culture is emerging where staff members want to come forward and are encouraged by leadership to do so. Medical Center Director Dunning mentioned that the VA Office of Accountability and Whistleblower Protection in Washington, D.C. is maturing and is committed to providing immediate investigative services at the medical center to ensure that the medical center is improving quality of services.

CHALLENGES

During the meeting with the MVAMC executive leader-

ship team, the medical center director identified the following as the MVAMC top four challenges.

Parking

During The American Legion's 2015 visit, the SWS team was informed that the MVAMC was faced with a significant parking challenge and received approval for a minor construction project to construct a 525-space parking garage in the west lot of the campus at a project cost of \$9.614 million. The medical center was to receive design funding in FY 2016 and construction funding was to be received in FY 2018. The MVAMC leadership stated that the architect and engineering design is complete. According to Director Dunning, the request for proposals is prepared by the Acquisition Department and the solicitation for the parking garage construction bids was posted May 1, 2018. According to the MVAMC, the current project cost is \$8.366 million.

Since parking is one of the major patient displeasures, the MVAMC added valet parking to help alleviate frustration. Valet parking allows the veteran to pull up close to the medical center and exit the vehicle without having to spend hours searching for a parking space. The veteran is provided a ticket and contact number to call when the appointment is completed so valet services can have the vehicle waiting at the entrance. The MVAMC added valet parking to increase access and decrease patient dissatisfaction with parking.

Telephone System

Director Dunning identified the telephone system as one of his top challenges. One issue identified was calls were being referred to staff voice mail, and the veterans expressed dissatisfaction about the lack of returned calls. To ensure the MVAMC is providing better customer service to veterans and their families calling the medical center, the leadership decided to deactivate voice mail on all medical center phones so all incoming calls can be routed to a person to assist veterans and their families more efficiently. The medical center is in the process of upgrading its telephone system to replace the current system.

The telephone system is another one of the most common customer complaints. A new phone system is being explored, but that purchase would be in the future. To alleviate some of the current phone issues there are teams working to help improve the existing system. The first step in the process was to update phone extensions and names to ensure that phone numbers were connected to a person and to the network. Dunning has worked with medical

center supervisors to ensure all active phones are turned on and attended.

The medical center stated that the replacement of the phone system would be a distant future project. The current phone system is upgraded as new technology comes in. Recently, the switches were upgraded to decrease dropped calls and improve tracking of speed of answer and length of hold times in the call centers. The system is upgraded as the manufacturer provides upgrades. Supporting servers for voice mail and auto attendant have had hardware and software server upgrades. The MVAMC is currently in the process of upgrading the Global Navigator system monitors and reports on speed of answer and length of hold times in call centers. The MVAMC has upgraded the PBX Operators systems to include Automatic Call Distribution software in addition to providing more robust reporting of activity and also informs the caller of answer expectation based on call activity. The MVAMC implemented the call-back feature for the Telephone Care Nursing Call Center that allows a caller the option of not holding, and for the system calling them back when their time in queue is reached.

Medical Center Culture

Over the years, the medical center has developed a closed silo atmosphere where staff did not feel like they were part of a team. In addition, incident reporting was limited due to employees fearing they may lose their jobs. The medical center director is working daily to break down those closed silos and is encouraging staff to report incidents at the time of occurrence to help identify system challenges and improve medical center practices and procedures.

During our site visit, the SWS team asked all program service chiefs if the culture of VA staff has improved since the new executive leadership team took over. All of the service chiefs stated collectively that they were encouraged, excited and have seen immediate improvements since the new executive leadership has taken over. The new medical center director is instilling a culture change from a bureaucracy-based process to a value-based process model that empowers service chiefs to make decisions that are best for staff and the veterans they serve. Value Based Management (VBM) focuses on better decision making at all levels of the organization. It recognizes that top-down command and control structures do not work well. VBM calls on managers to use value-based performance metrics for making better decisions.

Leadership

Since 2016, the MVAMC has had three interim directors, six associate directors and an interim chief of staff. The only stable leader within the Pentad was the associate director of patient care services. In May 2017, VA announced the hiring of a former commander of the Tripler Army Medical Center, in Honolulu, Hawaii, U.S. Army Col. (ret.) David Dunning. While at Tripler, Dunning managed a budget of \$440 million and 508,000 enrolled beneficiaries.

Before the new leadership was put in place, the medical center normally functioned in crisis mode. The leadership team is identifying problems and making significant strides to improve the overall perception of the medical center and how it delivers high-quality health care to enrolled veterans.

The current leadership makes daily rounds throughout the medical center to engage staff, veterans and their families. The medical center director is often stopped while making rounds by veterans, family members and staff to comment on the positive changes being made at the MVAMC and how staff attitudes have changed as a result of his leadership. It was noted by staff that the medical center director leads by example, and he expects the same from his leadership team and staff.

Other challenges identified during the meetings with the medical center's program offices:

Staffing

Human Resources staff reported that the MVAMC has 396 open positions, with every program office reporting staffing shortages. Due to the many health-care opportunities offered within the city of Memphis, the MVAMC is located in a highly competitive hospital district with many facilities competing for highly qualified health-care professionals. This poses serious challenges for the MVAMC in recruiting highly qualified physicians and nurses. Currently, the MVAMC has seven clinical service lines that do not have permanent service line chiefs.

To combat the staffing shortages, the medical center hosts several job fairs throughout the year to hire clinical staff. During the job fairs, HR screens, interviews and temporarily hires on the spot eligible candidates until the onboarding process is completed. Unfortunately, due to the long VA onboarding process the medical center often loses many good eligible candidates to other opportunities.

Lack of a Community Living Center (CLC)

The CLC at the Memphis VAMC closed in 1997. The reasons given were cost, staffing, and availability of sufficient

community resources. The medical center director in place made the decision at the time without input from geriatrics. The space now houses surgical and medical specialty clinics and the Women's Health Center. The MVAMC is one of only two level 1A facilities that does not have a CLC.

According to the MVAMC, it is one of the few class 1a VA medical centers without a CLC. As a result, Chief of Geriatrics and Extended Care Dr. Mark Brint and his team at the MVAMC have developed a proposal to document the need to build and activate a CLC to be located in Memphis. The acute hospital care, physical rehabilitation and palliative care activities at the MVAMC are currently challenged by having no VA-staffed, limited-stay, or subacute facility on campus for veterans in need of those specific care and services. A transitional care unit (TCU) with an intramural hospice facility would allow for more efficient utilization of limited care beds at the medical center and would streamline the continuum of care for recently injured, debilitated, or terminally ill veterans. The local medical center and VISN 9 leadership have reviewed the proposal. Currently, the medical center does not know the status of the proposal; however, The American Legion Department of Tennessee will continue to advocate for the need of a CLC to be built in Memphis.

RECOMMENDATIONS

Medical Center Strategic Plan

When the director was asked about the MVAMC strategic plan, he stated that while the plan has not been established, it is one of his major concerns, and he committed to put in place a strategic plan that would highlight the medical center's mission, vision, values, achievements and goals for the upcoming years.

The American Legion recommends that the MVAMC leadership team, with input from medical center service line chiefs and their staff, develop a comprehensive medical center strategic plan. The strategic plan, at a minimum, needs to address how the medical center will improve veterans' access to health-care services and programs, outreach, cultural and institutional change. The strategic plan also needs to address the facility operational plans in order to meet the requirements of the VHA national strategy plan.

At the drafting of the report, The American Legion learned that the medical center completed its first strategic planning retreat under the new leadership on March 6, 2018, at Freed-Hardeman University in Memphis. All service

chiefs and medical center leaders were invited to the one-day retreat. All participants assisted in identifying the medical center's five priorities and will continue working with the leadership team to finalize and execute the Memphis VAMC strategic plan.

VA Onboarding Process for Health Care Providers and Staff

The American Legion SWS team was informed that the medical center is losing qualified candidates to other community health-care organizations due to the lengthy VA onboarding process.

The American Legion SWS team requested a meeting with VHA Central Office Workforce Management Services to better understand the onboard process at VAMC's and health-care systems nationwide. The American Legion will also stress to VHA that the agency look at strategies to shorten the onboarding process to reduce the shortages of critical need occupations.

Utilizing the Veterans Choice Program (VCP) for Primary Care

Due to the medical center not having enough primary care providers, the MVAMC has decided to utilize the VCP by sending newly enrolled veterans out in the community to receive needed health-care services. VA has a number of policies requiring veterans be screened for health related issues like Military Sexual Trauma, Post-Traumatic Stress Disorder, etc. VHA Directive 2010-003 states: "all veterans and potentially eligible individuals seen in VHA facilities and associated CBOCs must be screened for experiences of MST." This must be done using the MST Clinical Reminder in the Computerized Patient Record System (CPRS), (see subpar. 4c (5)). Screening is to be conducted in appropriate clinical settings by providers with an appropriate level of clinical training; screenings are not to be conducted by clerks or health technicians." When new veterans are referred outside the VA system to a PCP under the Choice program, a Choice network provider is under no obligation to screen veterans for any of VA's health issues like MST, PTSD, etc. Therefore, many veterans who may suffer from these health conditions may not receive the appropriate health care for these conditions.

Other concerns for veterans receiving VA-approved primary care in the community occur when community providers don't have veterans' medical histories at the time of care and when community providers do not return veterans' medical documentation back to VA in a timely manner.

The American Legion recommends that if VA continues to refer new veterans outside the VA system to a PCP, a comprehensive process is developed for the veteran to come back into the VA health-care system for clinical reminder screenings to be completed.

Communication with External Stakeholders

The MVAMC is fortunate to have a broad-based coalition of veterans service officers and veterans service organizations, such as The American Legion Department of Tennessee leadership, many of whom receive their health care at the medical center and want to see the MVAMC succeed to provide the best care possible for veterans who live in the tristate area of Tennessee, Arkansas and Mississippi.

The American Legion highly recommends that the medical center leadership maximize, to the extent possible, their relationship with these individuals and organizations to help communicate their messages, through town hall

meetings and other significant medical center events.

Service Recovery

Based on the SWS team observation, a number of the reoccurring issues at the MVAMC are due to a failure to have a well-defined service recovery model in place. Service recovery is the action a service provider takes in response to service failure.

During our visit to the VA Montana Health Care System, officials there discussed service recovery as a best practice. The medical center posted pictures of the service line chief for that area outside the clinical waiting areas to familiarize veterans and their families who to contact in case they need assistance. The American Legion recommends that the MVAMC consider implementing a Service Level Patient Advocacy Program similar to that of the VA Montana Health Care System.



EASTERN OKLAHOMA VA HEALTH CARE SYSTEM | MUSKOGEE, OKLA.

Dates: Feb. 20-22, 2018

Veterans Affairs & Rehabilitation (VA&R) Commission Member: Scott Tafoya

American Legion Department of Oklahoma Leadership: National Executive Committeeman Tim Smith and Adjutant Carl Kuykendall

Veterans Affairs & Rehabilitation (VA&R) Commission, National Staff: Assistant Director for Health Policy Warren J. Goldstein

BEST PRACTICES

Prosthetics Department: The EOVAHCS has an efficient system for processing Home Improvement Structural Alteration (HISA) projects for their enrolled veterans. From start to finish, it takes approximately 30 days. All incoming consults have actions taken in less than three days. All clothing allowances are entered throughout the fiscal year, which assists the VA Regional Office in issuing clothing allowances in a timely manner.

Social Work Homeless Program-Collaborative Community Outreach: The EOVAHCS has an effective and efficient collaborative community outreach to homeless veterans by working with four Native American tribes (Cherokee, Muscogee Creek, Osage and Choctaw) in the EOVAHCS catchment area to implement Tribal Housing Urban Development-Veterans Affairs Supportive Housing (HUD/VASH) vouchers for Native American veterans. The EOVAHCS had a successful 2017 Stand Down serving 306 veterans alongside 50 community agencies/partners with 311 volunteers.

Traditionally, Native Americans have had an inherent distrust of the federal government, especially VA for their health care. This collaboration is a partnership between VA and the tribes that helps bridge the historical gap and helps build trust with Native American veterans and their families. Gaining the trust of Native American veterans communities builds stronger relationships with the tribes as a whole. Increasing communication and educating the tribes on programs and resources available to Native American veterans provides opportunities for better health outcomes and increased economic stability. This collaboration provides an opportunity to honor the military service of homeless Native Americans by offering housing stability while respecting customs and tribal traditions.

Logistics Department: The EOVAHCS uses desktop delivery utilizing the Federal Supply Schedule Initiative Office Supply 3rd year (FSSI-OS3). This has enabled the facility to cut down on work processes and streamline customer service and confidence in office supply ordering. It has

worked to improve hoarding of office supplies; under this initiative it allows for next-day delivery of supplies including not only basic office supplies, but paper and toner as well. This has increased equipment accountability by having the personal property management (PPM) staff take over scanning of Equipment Inventory Listings (EILs) and has reduced the number and amounts of report of surveys (ROS) as a result. This allows the facility to convert from a logistics-based way of thinking to a supply-chain management process in line with VAC Central Office's restructure of the Veterans Health Administration's supply system. This enables the clinical staff to focus on veteran care and not mundane practices that are antiquated and do not coincide with counterparts in the private sector, which is also a detractor from being able to bring on qualified health-care professionals who want to focus on patient care and not equipment accountability and ordering processes.

Environmental Management Service (EMS): The EOVAHCS uses state-of-the art disinfecting robot machines referred to as Xenex X4 Light Strike Robots to kill microscopic germs that cause hospital-acquired (HAI) infections. The portable room-disinfection robotic system uses a pulsed high-intensity ultraviolet light that flashes Ultra Violet-C (UVC) energy through the cell walls of bacteria, viruses and bacterial spores. These robots are effective in reducing contagious bacteria, which provides safer hospitalization and reduces the infection rate. The Xenex X4 Light Strike robotic system also kills microorganisms such as methicillin-resistant staphylococcus aureus (MRSA), vancomycin-resistant enterococci (VRE) clostridium difficile (C-diff), norovirus, influenza, anthrax and the Ebola virus. By using this modernized system, the EOVAHCS has been recognized for reduction in overall infection rates. The EOVAHCS has won several awards for the operation of these systems.

Inpatient Palliative Care: The EOVAHCS has an inpatient 10-bed Palliative Care Unit (PCU) that helps support the family and the veteran for end-of-life care. Over 90 percent of the veterans who pass away on the PCU have had education, counseling and discussions with medical and

clinical staff regarding their personal goals in end-of-life planning and decision-making. The EOVAHCS has been recognized for the quality of care provided to veterans and families. Over 63 percent of the families who completed the bereaved family survey indicated that they believed the care of the veteran and support provided by the staff for the family was excellent, which is well above the national average. EOVAHCS has developed a Palliative Care Outpatient clinic to help veterans and their families with treatment planning and discussions concerning end-of-life planning.

Staff, patients, friends and families at the EOVAHCS found a way to honor those veterans who pass away at the medical center. They initiated a program to provide a tribute to their veterans called The Honor Walk. The Honor Walk is announced over the medical center's public announcement (PA) system stating the following: "Attention VA medical center staff, visitors, and families, please join us in our Honor Walk as we honor a fallen veteran." Everyone in the medical center lines up along the hallways, stands at attention and veterans salute while the veteran's casket is escorted by pastoral care to the lobby and out the front door of the hospital into the transporting vehicle.

Environment of Care (EOC): During weekly EOC rounds, the associate director requires that the facilities staff carry the necessary tools, supplies, ladders and equipment to perform on-the-spot corrections to any deficiencies found during the rounds. This practice ensures that deficiencies found during EOC rounds are corrected when found to ensure that the medical center is always survey-ready.

Case Management: The Case Manager Supervisor was hired in 2011 from the private sector and built a strong case-management team that focuses on high-quality standards that are utilized in the highest functioning private hospitals. The EOVAHCS was awarded a Best Practice for the creation of the DASH (Discharge, Access, Safety, and Hold-ups) program. The DASH is a meeting at 8:30 a.m. every day to discuss every patient's discharge plan, medical needs and follow-up appointments.

EOVAHCS case management has specific strong practices that are characteristic of high-functioning hospitals to include the following:

- Having a Full-time Bed Czar that reviews every admission to determine if admission meets the proper level criteria
- Discharge planning starts upon admission
- Working with social workers for safety in the home, and social environment

- Review continued stay to ensure the patient is discharged at the proper time.
- Inpatient stays have concurrent continued stay reviews
- Emergency Department (ED) admissions reviewed prospectively
- Surgical admissions reviewed prospectively
- Interdisciplinary team involvement
- Leadership support for Utilization Management
- Pre-admission screening
- Integrate Physician Utilization Management reviews

CHALLENGES

During the meeting with the EOVAHCS ELT, the medical center director identified the following as challenges.

Recruitment of Key Leadership Positions:

Recruitment and retention in clinical and administrative areas alike continue to be significant challenges for the health-care system. The lack of consistent leadership severely limits the ability to implement needed process improvements. For example, the EOVAHCS in the past has rotated a chief of staff every 60 to 90 days as well as program service chiefs who served in those roles temporarily.

Location of the EOVAHCS in Muskogee:

Because of the health-care system's location in a rural area of eastern Oklahoma, the EOVAHCS is hindered in its ability to recruit quality physicians, nursing staff and other health-care providers. Salary rates are not competitive to entice providers to commute from the Tulsa metro area, which is approximately 50 miles from Muskogee. Staff from every program office briefing addressed this as a main impediment to recruiting and retaining quality staff to work at the EOVAHCS.

Mr. Morgan has recently actively been working with his executive leadership team on increasing the financial incentives to recruit medical providers. EOVAHCS now has a smaller margin in pay difference between the VA and the private sector. At this immediate time, the location of the medical center appears to be the greatest barrier to physician recruitment. Examples of salary comparisons for medical provider with the Veterans Health Administration (VHA) are as follows:

Primary Care – There is a nationwide shortage of primary care providers. Salary is competitive with the private sector due to "no on-call or hospital rounding" being re-

quired. The EOVAHCS is competitive with the private sector for primary care providers.

Hospitalist – The VA starting pay for a hospitalist is \$240,000 per year. The salaries for hospitalists in the private sector range between \$240,000 and \$260,000. The salaries for nocturnists in the private sector range between \$300,000 and \$310,000. (A nocturnist is a hospital-based physician who only works overnight. Most nocturnists are trained in internal medicine or family medicine and have experience in hospital medicine. However, there are nocturnists trained in other specialties).

Psychiatry – VA starting pay for psychiatrists ranges between \$225,000 and \$250,000. The private sector pays psychiatrists \$300,000 plus.

Access to Quality Specialty Providers:

The hospital's rural location can cause delays in health care and create care coordination challenges with health-care providers in the community. Unfortunately, the state of Oklahoma is experiencing a critical shortage of specialty and primary care providers accepting new patients, especially in the more rural areas. Veterans and non-veterans who reside in rural areas often have to travel long distances for primary care and specialty care services. For example, there are very few psychiatrists and rheumatologists in Oklahoma who are accepting new patients, regardless of a patient's insurance status. Fortunately, EOVAHCS veterans have the option of seeing specialty care through VA facilities and through Non-VA Care and Choice Program options.

Aging Veteran Population with a Lack of Sufficient Nursing Homes:

The Muskogee area lacks either a nursing home or an assisted living center, which makes post-hospitalization placement very challenging and can be a burden to families living in eastern Oklahoma. The state of Oklahoma has seven state veterans homes; however, none is close to the EOVAHCS. There are two state veterans homes in the EOVAHCS catchment area to include the Claremore Veterans Center in Claremore, Okla., which is a one-hour drive from Muskogee and the Oklahoma Veterans Center in Talihina, Okla., which is a two-hour drive from Muskogee. At the time of the February visit, the SWS team was informed that the Oklahoma Veterans Center in Talihina was currently not placing any more veterans.

After the SWS visit concluded, the medical center provided the following updated information relating to the Oklahoma Veterans Center in Talihina. The EOVAHCS

informed The American Legion that on March 13, 2018, the medical center director, chief of staff, chief of nursing, and chief of social work visited the Oklahoma Veterans Center in Talihina. Currently, veterans may be placed in Talihina Veterans Center; however, the EOVAHCS placed a hold on placing veterans from the health-care system due to the multiple reports of staffing issues and quality of care. The medical center director could not in good conscience allow veterans in their care be discharged to a facility that he knew first hand was struggling with safety and staffing issues. After the visit, it was determined that numerous quality and staffing issues have been resolved. Mr. Morgan had other meetings with the medical staff to determine if it is safe to start discharging veterans from the medical floor to the Talihina Vet Center at this time. On March 16, 2018, the medical center director informed the SWS team that he decided to lift the hold on placing veterans at the Talihina Veterans Center. Mr. Morgan's primary reason for placing the hold was due to nursing staff-to-patient ratio was not at a level that he felt was safe for the veterans. After the meeting that took place at the Talihina Veterans Center it was determined that the facility now has adequate staff and facility doctors in place to provide care to veterans needing those services.

Attracting Mental Health Providers to Work at the EOVAHCS in Muskogee:

Another challenge for the EOVAHCS is the inability to attract mental health care providers to work at the EOVAHCS and for the health care system to not have the ability to address increased inpatient capacity to meet the current and expected demand for mental health services.

Staffing Recruitment and Retention:

Currently, the EOVAHCS has 172 open positions, with every program office reporting staffing shortages. Due to the rurality of the EOVAHCS, it is extremely difficult to recruit highly skilled health-care providers. Larger facilities in the Oklahoma area, such as those in Tulsa or Oklahoma City are more attractive for health-care providers to work due to better professional opportunities. VA is not as competitive in pay with the private sector when compensating administrative or skilled health-care workers. Due to the nursing shortages at the EOVAHCS and the inability to entice skilled nurses to come work at the medical center, it costs the facility \$40,000-\$60,000 per month in overtime.

These situations combined pose serious challenges for the EOVAHCS, which has difficulties in recruiting qualified administrative and professional staff, physicians, nurses,

mental health providers and other health-care professionals. To combat the staffing shortages, the medical center hosts job fairs throughout the year to hire clinical staff. During one recent job fair, the EOVAHCS screened, interviewed and made initial offers to 22 eligible nursing candidates to fill some of the 38 open nursing positions. All 22 nurses were hired by the health-care system and are going through the onboarding process as of the writing of this report.

The SWS team was informed during the briefings that administrative positions are under the Title 5 Authority and fall under the General Scale (GS). Therefore, they are stuck being classified by outdated Office Personnel Management (OPM) standards and the pay is not commensurate with the position or competitive with the market. For example, HR specialists, administrators, engineers and housekeepers have salaries that are not comparable to the private sector.

The EOVAHCS has difficulty recruiting for the following positions; engineers, a human resources chief, a logistics chief or numerous other administrative positions because the salaries they offer are not competitive with the private sector. Nurses and doctors are under the Title 38 Authority and therefore, the EOVAHCS can adjust pay to compete with the local market.

RECOMMENDATIONS

Recruitment and Retention

Every available means needs to be enacted to help solve this critical issue at the EOVAHCS so that continuity of care and leadership continues to stay constant. To improve enrolling more veterans into the VA health-care system, VA needs to do a better job through its communications department counteracting negative publicity and showing veterans and the American public why the VA health-care system is a good place to work.

VA needs to improve its incentives to recruit and retain top talented health-care providers, management and professional staff to work and live in rural and/or highly rural areas where VA medical systems are located. VA needs to take under consideration special salary rates, updating administrative, service-line and professional staff in order to stay competitive with the private sector.

Moving all Veterans Health Administration (VHA) jobs to the Title 38 Authority and having the ability to set pay based on the local health-care market would allow for the recruitment of highly qualified candidates to work in administrative positions.

Through American Legion Resolution No. 115: Department of Veterans Affairs Recruitment and Retention, The American Legion supports legislation addressing the recruitment and retention challenges that the Department of Veterans Affairs has regarding pay disparities among those physicians and medical specialists who are providing direct health care to our nation's veterans. The Veterans Health Administration should continue to develop and implement staffing models for critical need occupations; and, that VA work more comprehensively with community partners when struggling to fill critical shortages within VA's ranks.

Medical Center Strategic Plan

When the director was asked about the EOVAHCS strategic plan, he stated that while the plan has not been officially established, the EOVAHCS does have a strategic-priorities flow chart. The EOVAHCS strategic priorities flow chart highlights the EOVAHCS plan to improve the veteran experience by putting the veteran in the center of all decisions made at the medical center. The EOVAHCS strategic priorities flow chart includes: Access to Care, Trust in VA, Employee Engagement, High Performing Networks, and Best Practices.

The American Legion recommends that the EOVAHCS leadership team, with the input from medical center service line chiefs and their staff, develop a comprehensive medical center strategic plan. Their strategic plan at a minimum needs to address how the medical center will improve veteran access to health-care services and programs, outreach, cultural and institutional change. The strategic plan also needs to address the facility operational plans in order to meet the requirements of the VHA national strategy plan.

Medical Center Signage

During the site visit and tour of the medical center, it was noticed that there was no signage of medical center leadership, patient advocates and/or service line chiefs for veterans and family members seeking assistance or service recovery regarding issues and concerns that are raised. The EOVAHCS through the patient advocate program has service liaisons; however, it does not have service-line patient advocates to assist in service recovery.

During the SWS visit to the VA Montana Health Care System, officials discussed service recovery as a best practice. The medical center posted pictures of the service line chief for that area outside the clinical waiting areas to familiarize veterans and their families who to contact in case they

need assistance. The American Legion recommends that the EOVAHCS consider implementing a Service Level Patient Advocacy Program similar to that of the VA Montana Health Care System.

VA Onboarding Process for Health Care Providers and Staff

During the meeting with the service line chiefs, The American Legion SWS team was informed that the medical center is losing some qualified candidates to other community health-care organizations due to the lengthy VA onboarding process for new employees who were hired to work at the medical center.

The American Legion SWS team will meet with the VHA Office of Workforce Services to better understand the reasons why it takes so long to bring staff on board at the EOVAHCS and at VA health-care systems nationwide. The American Legion will also stress to VA that they look at

strategies to shorten the onboarding process to reduce the shortages of critical need occupations.

Communication with External Stakeholders

The EOVAHCS is fortunate to have a broad-based coalition of veterans service officers and veterans service organizations, such as The American Legion Department of Oklahoma leadership, who receive their health care at the medical center. The American Legion wants to see the EOVAHCS succeed to provide the best health care for veterans who live in Eastern Oklahoma and within the catchment area of the health care system.

The American Legion highly recommends that the medical center leadership maximize to the extent possible their relationship with these individuals and organizations to help communicate their messages, through town hall meetings and other significant medical center events.



VA EASTERN COLORADO HEALTH CARE SYSTEM | DENVER, COLO.

Dates: March 5-8, 2018

Veterans Affairs & Rehabilitation (VA&R) Commission Member: Chairman Ralph P. Bozella

Veterans Affairs & Rehabilitation (VA&R) Commission Member: Vice Chairman Health Committee James Stanko

Veterans Affairs & Rehabilitation (VA&R) Commission Member: James Hartshorn, observer.

Veterans Affairs & Rehabilitation (VA&R) Commission, National Staff: Assistant Directors for Health Policy Warren J. Goldstein and Melvin Brown

BEST PRACTICES

Partnership with the Colorado Regional Health Information Organization Health Information Exchange (CORHIO-HIE)

CORHIO-HIE is a nonprofit, public-private partnership that is improving health-care quality for all Coloradans through cost-effective and secure implementation of health information exchange (HIE). The CORHIO-HIE is a network for health information exchange comprised of 74 hospitals to include the VA ECHCS and more than 11,000 health-care participants including physicians, hospitals, behavioral health, emergency medical services, public health, long-term care, laboratories, imaging centers, health plans and other community organizations. The VA ECHCS is a partner in the health information exchange that assists physicians to get faster, easier access to patient health information when care is provided outside VA. Information is delivered in real time to an electronic healthy record (EHR), or can be searchable through a web-based portal.

Women's Health Primary Care Providers

In primary care services, the VA ECHCS has 72 (36 female and 36 male) Women's Health Primary Care Providers (WH-PCPs) at the VA ECHCS in Denver and at the nine Community Based Outpatient Clinics (CBOCs) that have been trained in women's health-care services to provide health care to enrolled women veterans.

Maternity Coordinator

The VA ECHCS has a maternity coordinator within the women veterans program responsible for organizing expectant mothers' care inside and outside the health-care system. The VA ECHCS conducts several baby showers each year for enrolled expectant mothers. These baby showers allow other women veterans to network and share similar experiences. The expectant mothers receive bags of necessary supplies to care for their newborn children.

Recruiting Health-care Providers

In order to combat the recruiting challenges of health-care providers that the system faces, the VA ECHCS currently

sends out letters to all licensed health-care providers within the state of Colorado to highlight the benefits of working at the health-care system.

CHALLENGES

During the meeting with the VA ECHCS leadership, team and staff identified the following as their top challenges:

Access to Care

Due to having five military bases within the VA ECHCS catchment area, new patient access in Primary Care and Specialty Care has been a continual challenge due to increased growth of veterans within the VA ECHCS catchment area. For example, the PFC Floyd K. Lindstrom CBOC in Colorado Springs, Colo., averages 25 new patients per day. The health-care system does not have enough providers to meet the demand of veterans enrolling at the health-care system. Rapid growth of the veteran population in the VA ECHCS is putting great strain on staff. In addition, the current infrastructure of aging buildings and lack of space within the system are not meeting the health-care system's needs to provide care for the increased veteran population.

Activation of the Rocky Mountain Regional VA Medical Center

The VA ECHCS staff is currently running a health-care system with 13 sites of care and activating a new facility in Aurora, which is 30-45 minutes away from Denver. Employees are stretched between two sites and subsequently are working two jobs to activate the RMRVAMC. Employees at the health-care system are not able to focus on performance measures and Strategic Analytics for Improvement and Learning (SAIL) fully, due to their activation responsibilities.

Increased and continual media and congressional attention

Due to the increased wait times for veterans to receive health-care services at the VA ECHCS and the increased oversight by Congress regarding the RMRVAMC there has been considerable media and congressional attention placed on the health-care system, causing staff satisfaction to decrease.

Staffing

At the time of the visit, the VA ECHCS employed 3,402 employees and had 816 open positions, a (24 percent vacancy rate) with every program office reporting staffing shortages. During the town hall meeting, a veteran stated that the mental health clinic does not have enough staff to spend needed time with veterans requiring services.

The health-care system is prioritizing hiring toward filling the various positions that are needed to start providing services when the RMRVAMC opens in August 2018. With activating the RMRVAMC, the Human Resources Department has been pushed to the limit with hiring for two campuses. The VA ECHCS is in a competitive health-care market and competes with private sector health-care organizations like Kaiser Permanente. The health-care system has high turnover due to the higher wages offered in the community and due to having a number of federal agency opportunities within the Denver metro area.

RECOMMENDATIONS

Recruitment and Retention

Every available means needs to be enacted to help solve critical recruitment and retention issues at the VA ECHCS so that continuity of care and leadership continues to stay constant. To improve enrolling more veterans into the VA health-care system, VA needs to do a better job through its communications department counteracting negative publicity and showing veterans and the American public why the VA health-care system is a good place to work.

VA also needs to improve incentives to recruit and retain top talented health-care providers, management and professional staff to work and live in rural and/or highly rural areas where VA medical systems are located. VA needs to take under consideration special salary rates, updating the antiquated General Scale (GS) pay scale and using incentives to help recruit and retain administrative, service-line and professional staff in order to stay competitive with the private sector.

The American Legion supports legislation addressing the recruitment and retention challenges that the Department of Veterans Affairs has regarding pay disparities among those physicians and medical specialists who are providing direct health care to our nation's veterans.

The Veterans Health Administration continues to develop and implement staffing models for critical need occupations; and, that VA work more comprehensively with community partners when struggling to fill critical shortages within VA's ranks.

VA Onboarding Process for Health-care Providers and Staff

During the meeting with service line chiefs, The American Legion SWS team was informed that the medical center is losing some qualified candidates to other health-care organizations within the community due to the lengthy VA onboarding process for new employees who were hired to work at the medical center.

The American Legion SWS team will meet with the VHA Office of Workforce Services to better understand the reasons why it takes so long to bring staff on board at the VA ECHCS and at VA health-care systems nationwide. The American Legion will also stress to VA that they look at strategies to shorten the onboarding process to reduce the shortages of critical need occupations.

Communication with External Stakeholders

The VA ECHCS is fortunate to have a broad-based coalition of veterans service officers and veterans service organizations (VSOs) such as The American Legion Department of Colorado leadership who receive their health care at the medical center. The American Legion wants to see the VA ECHCS succeed to provide the best health care for veterans who live in Colorado and within the catchment area of the health-care system.

The American Legion highly recommends that the medical center leadership maximize, to the extent possible, their relationship with these individuals and organizations to help communicate their messages, through town hall meetings and other significant medical center events.

Increase Veterans Access

At the time of the site visit, the VA ECHCS was using 10 examination rooms at the PFC Floyd Lindstrom CBOC in Colorado Springs, for Compensation and Pension (C&P) services for veterans. This space can be better utilized to increase veteran access to primary care services. The administration is looking into this potential solution to alleviate the primary care access issue.

To increase veteran access to health-care services such as primary care, The American Legion recommends that the VA ECHCS utilize all available space before contracting those health-care services in the community.

Activation of the Rocky Mountain Regional VA Medical Center

The American Legion recommends that the ELT be completely transparent with Congress, VA leadership, media outlets, and the veterans' community if challenges or barriers poses an issue with meeting the August opening.

CENTRAL ARKANSAS VA HEALTH CARE SYSTEM | LITTLE ROCK, ARK.

Dates: March 26-28, 2018

Veterans Affairs & Rehabilitation (VA&R) Commission Member: National Executive Committee Member Mary Erdman

American Legion Department of Arkansas: Commander Michael Westergren and Adjutant Bob Renner

Veterans Affairs & Rehabilitation (VA&R) Commission, National Staff: Assistant Director for Health Policy Warren J. Goldstein

BEST PRACTICES

Strategic Planning

- In preparation for developing its strategic plan, the CAVAHCS held a Strategic Management Planning Retreat in October 2017. The retreat involved 130 participants, including 33 veteran stakeholders from various veterans service organizations. Several members of The American Legion Department of Arkansas' leadership attended. Other participants attending the retreat included state veteran offices and congressional staff. The CAVAHCS plans to develop strategic initiatives in conjunction with the VA secretary's five priorities including Greater Choice, Modernize Systems, Focus Resources, Improve Timeliness, and Suicide Prevention. The planning session produced 90 recommendations. Of the 90 recommendations identified, the CAVAHCS has implemented approximately 10 percent and several others are in various stages of development and implementation. The recommendations implemented are: improve active listening, red vest program information providers, VSO newsletters, expanded telehealth capability, improved customer service standards, adopt and socialize the red coats ambassador program, implement talent management modules on war-related illness and injury, and veterans treatment court. The remainder of the recommendations will be further analyzed for feasibility. The CAVAHCS chartered a strategic planning workgroup to formalize the plan.

Women's Health Services

- **Breast Imaging Center:** The CAVAHCS has a breast-imaging center that offers enrolled women veterans comprehensive breast imaging health-care services, including 3D and 2D Tomosynthesis, Automated Whole Breast Ultrasound Biopsies, etc.
- **On-site Certified Lactation Counselor (CLC):** The CAVAHCS has a CLC within the Women's Health Center (WHC) dedicated to the promotion, protection and support of breastfeeding and human lactation to prevent and solve breastfeeding problems. The counselor

promotes the belief that breastfeeding works best when it is the cultural norm and when the provider of lactation support and services is culturally competent.

- **Women Health Pharm D:** The CAVAHCS has a women's health center Doctor of Pharmacy (Pharm D) within the WHC assigned to every pregnant enrolled veteran. This pharmacist reviews all medications and alerts all providers regardless of the specialty or location. The Women's Health Pharm D provides recommendations back to the provider when medications prescribed and are not recommended for use while the veteran is pregnant or is breastfeeding.

Honoring Veterans Program

- **World War II "Wall of Honor" and coin presentation:** The CAVAHCS has a wall in the lobby of the medical center dedicated to honor veterans from Arkansas who served in World War II. The health-care system also conducts a ceremony honoring those veterans who served during World War II by hanging their pictures on the wall with other World War II veterans from Arkansas. During the ceremony, the health-care system presents them with commemorative coins. The health-care system follows traditional military protocol when presenting the coins to the honored veterans. The coins are marked with the phrase "where veterans come first" and have an emblem for each branch of the military. Feedback that the CAVAHCS has received from their media platforms and in person from veterans and family members participating in the coining ceremony and views of the honor wall has been positively overwhelming.

Leadership Rounding/Employee Engagement

- The medical center director works daily to ensure that the 3,200 employees who work at the CAVAHCS are on the same page and stays engaged through robust communications. The medical center director and the ELT are continuing to communicate from the top down to ensure all staff members are aware of happenings within the CAVAHCS. Dr. Scott and the ELT believe

if employees engage more with their patients they will deliver better health care. The medical center director meets with every new employee to make sure he or she understands that there is no higher mission than serving our nation's veterans.

- After meeting with several program office staff, it was evident that the ELT is accessible through multiple avenues. For example, the medical center and the ELT conduct weekly rounds to engage employees to learn what is working and to solicit feedback on improvements needed to improve the health-care system. Program service chiefs indicated that the medical center director and the ELT are supportive, accessible, engaging and value input from all levels of the staff. The ELT conducts employee listening sessions at each care delivery site to include all of the CAVAHCS CBOCs, veterans day treatment center, home-based health care and quality management staff located in West Little Rock.

Military Sexual Trauma Recovery Training Program (MSTRP)

- The CAVAHCS implemented a MSTRP for interns and fellows on how to provide health care to veterans who experienced Military Sexual Trauma (MST). The program offers specialized services to survivors of MST, as well as survivors of non-MST. The program participants undergo a sexual trauma assessment during which time appropriate treatment options are discussed. MSTRP staff are members of the medical center's MST Committee, promoting MST awareness and best clinical practices related to MST. It is common for MSTRP providers to consult with other health-care providers and practitioners about the care of veterans in the program.

Communication and Training

- Due to the CAVAHCS having two health-care campuses and eight CBOCs throughout central Arkansas, communication and training staff on new regulations, policies and procedures coming out of VA Central Office (VACO) can be challenging. In the past, staff worked in silos and did not perform warm hand-offs for veterans needing other services. The ELT is breaking down the silos with staff by stressing that they need to be veteran centric. The ELT implemented a training program called "Own the Moment" by communicating to staff what can be done to best serve veterans. "Nothing I can do to help" is the wrong answer. The ELT and program service chiefs are educating and communicating to staff to say, "Let me find out who can help you." The

training program is part of new employee orientation and continues to be an integral part of the CAVAHCS educational and training programs.

CHALLENGES

The CAVAHCS leadership team and staff identified the following as their top challenges:

Recruitment and Retention

The CAVAHCS has difficulties recruiting and retaining qualified health-care professionals. The CAVAHCS is located in a competitive health-care market consisting of five large tertiary health-care organizations within a five-mile radius of the health-care system. The private-sector health-care organizations are competing for the same health-care professionals such as physicians, registered nurses, and sub-specialty medical and surgical providers making it difficult to recruit and retain health-care providers.

Running two inpatient health-care campuses

The CAVAHCS consist of two health-care campuses separated by approximately 20 minutes, requiring duplication on both campuses for services such as primary care, laboratory, radiology, pharmacy, mental health, respiratory services, women's health and patient advocacy. Medical center leadership and program service chiefs split their time between the two campuses. This results in additional operational costs that are not factored into the Veterans Equitable Resource Allocation (VERA) budgeting model for VA health-care operations. VERA is largely based on the complexity of the diagnosis and procedures the CAVAHCS provide to patients. Patients whose conditions are more complex bring higher reimbursements.

Computerized Patient Record System (CPRS) Alerts Response

VHA's electronic medical record system, CPRS, was revolutionary in the 1990s when it was developed. However, over time, some of its once-revolutionary features have rendered it burdensome and inefficient for today's fast-paced clinical setting. Currently, the alerting mechanism in CPRS impedes the flow of patient care. Many of the alerts are auto-generated and the providers are unable to determine, at a glance, the priority level of the alert without fully opening the patient's chart. These actions decrease the face-to-face time that providers spend with patients and result in unnecessary, wasted clinician time and lowered job satisfaction. The CAVAHCS is working on internal processes to decrease the number of alerts they are sending to each other.

Supply Chain Management

The Generic Inventory Package (GIP) was originally developed in the early 1980s and is still used as the primary system of record for Supply Chain Management. The GIP manages all the receipts, distribution, and maintenance of all stock items received for the supply warehouse from outside vendors and distributed to primary inventory points. Several GIP modernization initiatives have been implemented over the past several years including a Desktop Micro-Focus Reflections Windows GIP access icon and the use of a graphics user interface (GUI), Above Par. However, the GIP system remains an old, cumbersome system based upon 1970s technology and seriously lacks the ability to produce reusable reports and transform researchable data into useful products essential for effective 21st Century Supply Chain Management Operations.

RECOMMENDATIONS

Recruitment and Retention

CAVAHCS executive leadership must ensure that HR is utilizing every option available to ensure prospective employees see the CAVAHCS as an employer of choice. This often requires creative thinking, examining what works or not, and making adjustments when needed. VA needs to improve incentives to recruit and retain top health-care providers, management, administrative, service-line and professional staff to work and live in rural and/or highly rural areas. VA also needs to consider special salary rates and encourage the Office of Personnel Management (OPM) to update the antiquated General Scale (GS) pay scale to make salaries more competitive with the private sector.

The CAVAHCS is using recruitment and relocation incentives to attract highly qualified candidates and have been successful in the use of these tools. By using the full flexibility allowed regarding amounts, payment schedules and service periods, these incentives provide not only a means of hiring new staff, but of retaining them for one to four years as part of the obligation agreement.

Funding specifically for incentives is not received at the station level but is paid from the system's operating budget. While no funding is received, caps on the total award amounts in the area of recruitment, relocation, and retention incentives are set each fiscal year for VA and rolled down to the VISN and station levels.

The FY 2017 ceiling for recruitment/relocation incentives for CAVAHCS was \$460,629. The areas approved for incentives in FY17 included physicians and nurses in most

areas of the facility, as well as mental health providers, dental specialties and key leadership positions.

In FY 2018 (to date), CAVAHCS has made recruitment/relocation incentive commitments in the amount of approximately \$670,000. These commitments are related to actual hires made and do not include those still pending selection. This amount also includes installment payments continuing from previous years. The areas approved for incentives in FY 2018 include physicians and nurses in most areas of the facility, as well as mental health providers, dental specialties and key leadership positions.

The American Legion supports legislation addressing the recruitment and retention challenges that the Department of Veterans Affairs (VA) has regarding pay disparities among those physicians and medical specialists who are providing direct health care to veterans.

The American Legion also supports the Veterans Health Administration as it continues to develop and implement staffing models for critical need occupations and encourages VA to work more comprehensively with community partners when struggling to fill critical shortages within VA's ranks.

VHA Onboarding Process for Health Care Providers and Staff

During the meeting with the service line chiefs, The American Legion SWS team was informed that the medical center is losing qualified candidates to other community health-care organizations due to the lengthy VHA onboarding process for new employees who were hired to work at the medical center.

American Legion national staff will meet with VHA's Office of Workforce Management Service to better understand why VHA's onboarding process takes so long and to determine if Workforce Management is doing anything to improve and/or shorten the process time.

Communication with External Stakeholders

The CAVAHCS is fortunate to have a broad-based coalition of veterans service officers and veterans service organizations (VSOs) such as The American Legion Department of Arkansas leadership who receive their health care at the medical center. The American Legion wants to see the CAVAHCS succeed to provide the best health care for veterans who live in Arkansas and within the catchment area of the health-care system.

The American Legion highly recommends that the medical center leadership maximize relationships with these

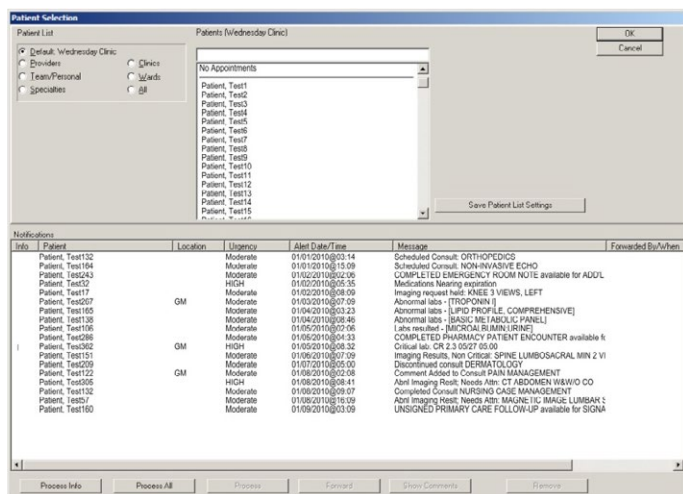
individuals and organizations to help communicate their messages, through town hall meetings and other significant medical center events.

The American Legion Department of Arkansas will assist the CAVAHCS in advertising job listings by putting links to VA job postings on the American Legion department website, advertising in department mailings and inviting the local VA to future job and employment seminars and fairs.

Computerized Patient Record System (CPRS) Alerts Response

Physicians and health-care providers at the CAVAHCS spend excessive amounts of time responding to unnecessary patient alerts that take them away from spending quality time with their patients. Alerts received through CPRS require doctors to open every alert to see what information is necessary for their patients. Alerts received often give little or no status updates as relates to direct patient care. Physicians cannot filter out informational alerts that have no bearing on the patient's status.

Following the site visit, national staff engaged in additional research to determine how VHA uses CPRS alerts. Based on information we learned, CPRS uses the "View Alert" notification system to communicate test results (as well as other important clinical information) to practitioners through an inbox. The View Alert system also displays notifications as alerts with various priorities. Practitioners see their patients' alerts each time they log in to the system or switch between patient records (Figure 1).



(Figure 1)

Alerts remain within the inbox until read by the practitioner, but they may be removed automatically if unopened after a certain time (e.g., 14 or 30 days). Although this

functionality is used across VA, individual facilities have discretion over which types of alerts practitioners must receive (e.g., they can allow flexibility for practitioners to turn off certain notifications, such as normal test results).

It was recommended that the CPRS alert system be upgraded to allow physicians the ability to select essential messages, filter out procedure alerts and for the CPRS to be reprogrammed to build in a filter selection by adding color-coding for low, medium and high alerts. Based on this information, The American Legion will request a meeting with VHA Central office staff responsible for management of the CPRS Alerts to discuss the concerns raised during the site visit and see if the suggested recommendation would help.

Supply Chain and Equipment Management System

The Generic Inventory Package (GIP) inventory and supply management system currently utilized throughout the VA health-care system is an aging tool that requires manual input of information by medical center staff for accounting, material and supply management purposes.

The American Legion recommends that VHA look into another inventory and supply management system such as the one used by the Department of Defense (DoD), the Defense Medical Logistics Standard Support (DMLSS). The DMLSS delivers an automated and integrated information system with a comprehensive range of medical logistics management functions. DMLSS is a local server-based application that supports medical logistics functions. DMLSS supports all local medical logistics business practices including catalog research and purchase decisions, customer-inventory management, medical inventory management, biomedical equipment maintenance, property management, facility management, assemblage management, plus distribution and transportation functions. Since the DoD uses it, there is a significant off-the-shelf benefit plus cost-sharing possibilities by VA adopting the software.

DURHAM VA MEDICAL CENTER | DURHAM, N.C.

Date: April 2-4, 2018

Chairman of the Veterans Affairs & Rehabilitation Commission: Ralph Bozella (ex-officio)

Veterans Affairs & Rehabilitation Commission: National Executive Committeeman William “Bill” Kile

National Executive Committee: Jeff Joyner and Patricia Harris

Veterans Affairs & Rehabilitation Commission, National Staff: Edwin D. Thomas

BEST PRACTICES

Real-Time Location System (RTLS) (Areas: Patient Safety, Quality, Patient Experience)

DVAHCS uses a state-of-the-art tracking system for all of its patient surgical assets. The tracking system use of barcode technology mitigates the risk of having the wrong surgical instruments, not enough surgical instruments and unclean utensils that potentially cause hospital-acquired infections. Furthermore, the application has the potential to improve patient satisfaction, quality, sterile processing and patient safety by reducing medical errors. DVAHCS serves as a pilot site for the RTLS technology program. Presently, DVAHCS uses the tracking technology to track surgical instruments and Sterile Supply Processing, but RTLS has many other applications ranging from patient tracking to reducing patient wait times.⁴

Stroke – Tracking Model (Areas: Patient Outcomes, Quality, Access)

Physicians involved with ambulatory care spoke of using encrypted messaging for patients who suffered strokes. Physically locating the patient requires the model to combine the use of Advance Encryption Stanford (AES) Cipher Block Chaining (CBC) mode and Quick Response (QR) Code. Advanced Encryption Standard (AES) and CBC algorithm encrypt the URL. Only the patient knows the Uniform Resource Locator (URL) and receives the QR Code. System administrators create a QR code based on patient identification and system encrypted URL to track the patient’s location for messaging and functional progress.

We Care Rounds (Areas: Employee Morale, Patient Experience)

Senior leaders and managers conduct monthly “We Care Rounds” throughout the hospital. The director and line managers walk around the hospital talking with veterans and their families. Veterans can provide feedback about services. Families can also voice their opinions about service and perceived quality of care rendered by physicians and nurses.

The “Rounds” also include conversing with staff. Lead-

ers talk with employees about challenges. Leaders also give employees “on the spot” recognition or awards. The employee “on the spot recognition” can potentially lead the employee toward participating in a bigger Employee Awards ceremony and a monetary incentive.

Environmental Care: Tru-D Smart UVc (Areas: Patient Safety, Patient Experience, and Quality of Care)

When the Chief of Environmental Services spoke about a state-of-the-art procedure to help combat hospital-acquired infections using ultraviolet light, the SWS team had never heard of any other facility with the same capability. Tru-D SmartUVc produces a UVc short wavelength. UVc short wavelength creates enough radiation or energy necessary to kill microorganisms, whereas other ultraviolet wavelengths do not – UVa and UVb.

The environmental care staff uses Tru-D after every normal room cleaning activity or even surgical procedures. The Tru-D device is the only one of its kind in the market that delivers a “guaranteed, scientifically-validated efficacy and efficiency.”⁵ The environmental staff believes Tru-D not only prevents infections but also offers a safe, efficient and effective robot that disinfects patient areas.

Coronary Care Unit (CCU) (Areas: Quality, Patient Care, Patient Experience, Patient Outcomes)

The American Association of Critical Care Nurses or AACN awarded DVAHCS its gold-level Beacon Award for Excellence. The CCU houses advanced practice nurses who care for up to eight veterans with serious cardiac problems ranging from bypass surgery to myocardial infarction. The CCU uses several practices such as timeout and secure medication administration. Nurses can lock the medication area from the inside so others cannot enter or disturb them when retrieving drugs for patients. This practice eliminates potential errors that might result in an adverse patient event.

Most CCUs do not allow the family to stay in rooms with patients or permit it for a set number of hours. Yet, the nursing staff allows the family to stay in the unit with the patient for as long as they want because they believe it helps in the curative process. Other novel ideas include

having several hours of quiet time where even nurses must keep chatter to a minimum. The effort promotes relaxation and reduces the stress level in patients.

CHALLENGES WITH RECOMMENDATIONS

Budgeting Decision Timeline and Budget Allocation Process

The Department of Veterans Affairs designed the Veterans Equitable Resource Allocation (VERA) model two decades ago to allocate congressional budget appropriations. VA believed an allocation model served health-care financing needs of veterans through an “equitable and efficient”⁶ distribution of the fixed amounts received through congressional appropriations. The Department of Veteran Affairs/Veterans Health Administration has adjusted the model numerous times over the past three years to include prospective patients, expanded cost categories/case-mix and labor indices for local VHA facilities.

However, the changes still do not hasten the decision-making at the VISN level, which makes it difficult for administrators and staff to estimate and plan for increased demand for health services, costs and other services related to the delivery and quality of care. Furthermore, in terms of equity and efficiency, VHA still operates on a fixed sum. Essentially, when VHA increases one VISN’s budget, another VISN must absorb a decrease in its allotment. The consequences of such an outdated “allocative model” cause inequities and inefficiencies. Congress exacerbates those inefficiencies by delaying approval of the federal budget for various political reasons. Although VA is one of few agencies that receive advanced appropriations – a form of budget authority that becomes available one or more fiscal years after the budget year covered by the appropriations act⁶ - one senior official at VHA described the advanced appropriation as “a blessing and a curse.”

Recommendations

- Given the dynamic growth of demand for health-care services and associated changes needed to meet that demand, The American Legion recommends that VA sanction another study to determine methods that further enhance the VERA and Medical Center Allocation System (MCAS) to avoid unnecessary delays when disbursing funds to medical facilities.
- Most importantly, The American Legion recommends the study explore an alternate legislative process that hastens the federal budget approval. In January of 2001, at the request of Congress, the Veterans Health

Administration (VHA) asked RAND National Defense Research Institute (NDRI), a division of the RAND Corp., to study the VERA system. The VA/VHA commissioned a similar study a decade ago, but the study stopped short of recommending process improvements and congressional delays.^{7,8} However, rapid changes in veteran population growth, particularly among women veterans, warrants a new study that not only identifies process improvements but also:

- » Adequacy and accuracy of Enrollee Health Care Projection Model
- » New information technology capable of providing accurate, consistent and complete data demand forecasting and ultimately budget projections in light of the frequent changes in eligibility, utilization, and costs including community care⁹
- » Currently, the Department of Defense has a one year gap in its budget cycle and does not receive advance appropriations even though it provides health care to, or funding for, 9.5 million active, reserve, and retired military personnel.^{10,11}

- The American Legion also recommends VA/VHA disburse all funds for patient research at hospitals closely affiliated with research and a teaching hospital like DVAHCS is with Duke University Medical Center. Presently, Congress may appropriate more funding for patient research, but the size of the VERA allocation for that research often remains unchanged from one fiscal year to the next. Typically, VA/VHA research hospitals affiliated with other research and teaching facilities care for sicker patients than other VA/VHA facilities.
- The American Legion recommends VA/VHA clearly identify clinical and financial scenarios that MCAS does not address, including accounting for stark differences inherent in the delivery of health-care services in rural and highly rural areas.

Access to Care – Space and Physician Shortages

Shortages of medical professionals exist throughout the United States. Yet, the VA/VHA integrated delivery system appears as the only Integrated Delivery Network (IDN) plagued by lack of space to house primary care physicians and specialists. Congress has addressed the problem by setting aside large blocks of funds for “Major and Minor Construction.” For example, Congress has earmarked \$1.1 billion for Major Construction and over \$700 million for Minor Construction for FY 2019. Nonetheless, the capability of VA/VHA facilities to keep pace with the demand

for health services varies among the 23 VISNs. Yet, as RAND identified in its 2008 report, “medical facilities with space constraints often understate demand for health services.”¹¹ Likewise, the space constraint not only impedes patient access but also accurate demand and budget forecasting. The VA/VHA space constraint persists across all VISNs and has for at least two decades.

Recommendations

- Note: While writing this report, the legislative and executive branches of the U.S. government enacted The VA Mission Act. The new law establishes a nine-member committee to review the closing of, modernizing and realignment of VA’s medical facilities. The Asset and Infrastructure Review or AIR Commission will review recommendations to improve infrastructure from VHA.
 - » **NOTE:** The ceiling for Non-recurring Maintenance (NRN) for repairs and modernization will rise from \$10 million to \$20 million in FY2019. However, NRN requests or work cannot significantly expand square footage.
- The American Legion recommends VA/VHA incorporate more market-based planning to adapt to the rapidly changing local market conditions and demand for health services.
- The American Legion recommends the VA/VHA continue modernizing facilities and systems that will facilitate delivery of highly enhanced quality of health-care services by the VA.

Care in the Community/Veterans Choice Program

VA initiated the Veterans Choice Program that gave veterans access to medical care in the private sector when care was unavailable at a VA/VHA. While VA/VHA has submitted a draft proposal of the new Coordinated Access & Rewarding Experiences or C.A.R.E. program, Congress has yet to take any legislative action regarding the proposal. Meanwhile, VA/VHA medical facilities continue experiencing very strained relationships with non-VA/VHA providers who continue with aged account receivables dating back to 2016.

Note

While writing this report, the legislative and executive branches of the U.S. government enacted The VA Mission Act. The new law consolidates the VA Choice Program with other VA programs that provide medical care to veterans outside VA’s medical network. The Vet-

erans Community Care Program is a one-year extension of the Choice Program and provides an additional \$5.2 billion to pay for care in the community.

1. Front-desk staff/receptionists/staff at informational desks not trained to identify veterans with mental health issues.

Veterans who attended the town hall meeting and a member of the American Legion Department of North Carolina noticed that staff in reception areas at the hospital did not appear knowledgeable about recognizing veterans with suicide ideation. However, the director noted staff attends VA/VHA mandatory training on suicide but suggested more training on identifying patients with suicide ideation might prove beneficial.

Recommendation

- The American Legion recommends VA regular employees and volunteers who staff hospital information and clinic reception desks not only attend mandatory VA/VHA training on suicide but also on identifying patients with suicide ideation at the point of care.
 - » While The American Legion does not endorse any public organization or private company, we recognize The Joint Commission offers resources including a web-based training program and infographic that offers staff in Acute Care and Non-Acute Care settings additional means of detecting suicide ideation. One can find the link to that training and resources on The Joint Commission’s website. The title of the module is “Sentinel Event Alert #56: Detecting and treating suicide ideation in all settings.”¹²

2. DVAHCS sends veterans who become victims of sexual assault to Duke University Medical Center.

Some state laws dictate the practice of transferring victims of sexual assault, including veterans, to hospitals or clinics trained to collect forensic evidence.

Recommendations

- If emergency personnel brings a veteran victim of sexual assault to DVAHCS or the veteran self-presents, The American Legion recommends the medical center designate either a nurse or licensed clinical social worker to accompany the veteran to the Duke University Medical Center.
- If the veteran requests it, The American Legion recommends the hospital’s designee stay with the veteran until released or the veteran indicates a preference for receiving medical treatment at DVAHCS at the conclusion of

processes at Duke University Medical Center.

3. Mental Health Access Center Requests for Clinical Pharmacists

The previous VA secretary made suicide prevention and access to mental health services among his top priorities. Additionally, the former secretary also championed evidence-based services such as Cognitive Behavioral Therapy. However, VA/VHA use of clinical pharmacists is not widespread despite evidence suggesting these professionals have added tremendous value to the delivery of health care and improving access at VA/VHA facilities in Madison, Wis.; El Paso, Texas; and Kansas City, Mo.¹³

Recommendations

- The American Legion recommends hiring clinical pharmacists for the Mental Health Access Center at DVAHCS.
- The American Legion recommends VA/VHA use the “Hire Fast, Hire Right” model to identify, recruit, and quickly onboard clinical pharmacists specifically for the Mental Health.
 - » **NOTE:** If evidence-based practices, positive patient outcomes and access remain priorities of VA/VHA, clinical psychiatrists will prove a valuable addition to the team of mental health professionals and can serve as “the primary source of scientifically valid information on the safe, appropriate, and cost-effective use of medications.”¹⁴

LEE COUNTY VA HEALTH CARE CENTER | CAPE CORAL, FLA.

Date: April 6, 2018

Veterans Affairs & Rehabilitation National Director: Louis Celli

Veterans Affairs & Rehabilitation National Deputy Director for Health Care: Roscoe Butler

On Feb. 12, 2018, American Legion National Adjutant Daniel Wheeler received an e-mail from Mike McDaniel, Adjutant, The American Legion Department of Florida, concerning an alleged scheduling issue at the VHA Lee County Healthcare Center, Cape Coral, Fla. Mr. Wheeler referred the request to The American Legion National Headquarters office in Washington, D.C., for appropriate action.

The American Legion believes the meeting was positive and informative. Based on our understanding, we are confident the Lee County Healthcare Center staff is adhering to the National Scheduling and Consult policies, but communication and training of clinical staff in relationship to changes to the consult and scheduling policies is inadequate and must be improved.

CONCLUSION

Ensuring stability of the VA health-care system is The American Legion’s top priority and through the Legion’s System Worth Saving program, the organization continues to identify and report on challenges, best practices and make recommendations to help improve the system.

To this end, The American Legion calls on Congress and VA Central Office to review the challenges, best practices and recommendations of this report, and those to follow,

The American Legion does not believe this is an isolated issue at the Bay Pines/Lee County Healthcare Center but may exist at other VHA health-care facilities and requests notification if the issue does exist elsewhere.

RECOMMENDATIONS

- The American Legion recommends VA Central Office look into this issue and ensure training on VA Scheduling and Consult policies for clinical staff is appropriate and sufficient to meet their needs.
- The American Legion also recommends the health-care facility consider hosting a town hall meeting to allow veterans who have been voicing concerns about clinic cancellation and the Bay Pines/Lee County Healthcare Center leadership talk about what is being done to address concerns.

to help shape policy and legislation to help our nation best fulfill its sacred mission, “To care for him who shall have borne the battle and for his widow, and his orphan.”

The American Legion System Worth Saving program and Legionnaires will continue to work with VA/VHA to ensure the VA health-care system remains a 21st century, integrated health care system that is capable of meeting the health-care needs of our nation’s veterans.



THE AMERICAN LEGION

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