The American Legion

System Worth Saving

September 23rd-September 26th, 2024

Fort Harrison

Helena, Montana

Veteran Affairs & Rehabilitation Commission: Alan Cohen (FL), Vice Chairman
Veterans Affairs & Rehabilitation, National Staff: Matthew Cardenas (DC), Nicole Bathan
Department of Montana: Duane Cunningham, Adjutant

It is important to reiterate that The American Legion conducts site visits, NOT inspections.

The System Worth Saving (SWS) program was created to ensure the Department of Veterans Affairs (VA) Medical facilities are providing high quality and timely veteran healthcare. The program also looks at the Veterans Health Administration's (VHA) ability to remain equipped with the resources and staff to meet the needs of every eligible veteran seeking healthcare, and to provide feedback from veterans on their received level of care. Facilities are selected through review and analysis of government reports, media coverage, and veteran feedback.

Purpose

The American Legion conducted a System Worth Saving (SWS) visit to the Fort Harrison VA Medical Center, with the intended purpose of determining the quality of care provided to veterans in the catchment area of this facility. This visit was used to gain insight into how the facility serves veterans and to recognize best practices as well as identify challenges. In these visits, the American Legion representatives serve as visitors, in partnership with VA, not facility inspectors.

Scope

The American Legion conducts between 5 and 8 SWS visits per year. To choose facilities, national staff creates a list of possible locations by looking at government and congressional reporting, media stories, veteran feedback, and VA hospital public data. They synthesize the information to create a complete picture of a facility and then look at the possible impact from conducting a visit. Once approximately 10 locations have been identified, the list is reviewed again by The American Legion volunteer staff who narrow down the list to make the final decision on locations for the year.

Each SWS visit follows a triangular review model. The American Legion requests data from the VA Medical Center (VAMC) via emailed questionnaires which cover 18 - 20 offices, depending on location. Also requested are reports such as the employee and patient satisfaction survey results, among others, for review. This information is then analyzed and allows the SWS team the ability to construct a comprehensive in-person questionnaire which is used during the interview sessions with the executive leadership team, department managers, and other staff.

The SWS visit starts with a town hall meeting at a local American Legion post where veterans gather to tell the SWS volunteer team about the successes and obstacles in receiving care from the selected medical center. Typically, there will be representatives from the VAMC, the regional benefit office, local American Legion posts, and when available, Congressional staff may be in attendance. The town hall is followed by two days of structured interviews, a facility tour, and completed with an exit brief.

Chairman's Statement

In 2003, Ron Conley, The American Legion's National Commander visited and assessed the delivery of healthcare at over 60 Department of Veterans Affairs' medical facilities across the country. Commander Conley wanted to assess healthcare delivered to the nation's veterans to determine if the VA healthcare system was truly a "System Worth Saving." The following year,

The American Legion passed a Resolution making System Worth Saving (SWS) a permanent program under the National Commander.

After nearly two decades, The American Legion has conducted more than 300 System Worth Saving visits to VA/Veterans Health Administration (VHA) medical facilities in the United States, its territories, and the Philippines. Over the course of those visits, The American Legion has played an integral role in shaping federal legislation that improves the delivery and quality of healthcare at VA/VHA medical facilities. Furthermore, each System Worth Saving visit culminates with a report that informs members of the American Legion and provides additional insight to the President of the United States, members of Congress, Secretary of Veterans Affairs, and other senior leaders at the Department of Veterans Affairs/Veterans Health Administration about the challenges and best practices at VA medical centers (VAMC).

Overview

The American Legion Team began with an entrance briefing with the Executive Leadership Team (ELT), representatives from several departments, and Rocky Mountain Veterans Integrated Service Network (VISN 19) leadership.

VISN 19 serves veterans in an expansive catchment area of 540,000 square miles including Montana, Colorado, Oklahoma, Utah, and Wyoming. Fort Harrison is the only VAMC in the state of Montana, which spans about 147,000 square miles. First established as a military post in 1892 in honor of Benjamin Harrison, it was renamed in 1906 after his grandson, President William Henry Harrison. After World War I, Fort Harrison opened a tuberculosis treatment center, and the hospital was later rebuilt in 1935 after earthquakes in Helena. As of August 2020, Fort Harrison's budget was over $300 million. A Level 2 facility that provides moderate to intermediate care, Fort Harrison currently has 34 acute care beds and 24 residential mental health beds. There are 13 community-based outpatient clinics (CBOC) in the state, with 5 other sites of care, including 3 Accessing Telehealth through Local Area Stations (ATLAS) sites.

Today, there are approximately 70,000 veterans eligible, 49,000 enrolled, and 40,000 actively receiving VA care in Montana. The Montana VA employs approximately 1,200 staff across the state, one third of which are veterans themselves. Montana, which has one of largest veteran populations per capita in the country, faces unique challenges to the delivery of healthcare due to its rural geography. The passage of the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in 2018, which established the community care program and subsequent mileage and drive time standards, as well as the COVID-19 pandemic, which highlighted the impact of telehealth, required the VA to adapt quickly to ensure that veterans continue to receive high quality care.

Kim Adkins, Associate Medical Center Director, underscored how VA Montana strives to tackle these issues to make care more accessible to veterans. Fort Harrison is focusing on strategic hiring and growth, opening more clinics to reach veterans in rural areas. However, the significant uptick in community care has increased the need for coordination by the VA with outside

providers. The ELT reported that in many cases, veterans will pass Fort Harrison on the way to community care appointments, wait longer for an open appointment slot, and/or schedule a telehealth appointment which could've been scheduled within the VA. While telehealth has been beneficial, many veterans still prefer to meet face-to-face and/or do not have the necessary equipment or connectivity.

Following the ELT entrance briefing, the SWS Team attended the Town Hall on Monday, September 23rd at American Legion Post 2 in Helena with assistance from the Department of Montana. The site visit continued with meetings with VA staff and a tour of the Fort Harrison campus. Locations visited included the Pharmacy, Inpatient Medical/Surgical Unit, Emergency Department, Surgical Outpatient, Primary Care, and Residential Rehabilitation Treatment Program (RRTP).

Town Hall Meeting

Veterans, family members, VA employees, and staff from Senators Jon Tester and Steve Daines were in attendance at Post 2 in Helena. While VA representatives attended in their place, ELT members were not in attendance. The American Legion leaders in attendance included the Department of Montana Adjutant Duane Cunningham and Post 2 Commander Kenneth Rosenbaum.

One of the main concerns highlighted was the poor retention of primary care providers — veterans expressed concerns with the lack continuity in their care. This was echoed by current and former VA staff members, who cited staffing issues, overwhelming workloads, and lack of incentives to keep clinicians at the VA. While patient care in the Montana VA health system is generally positive, veterans are disappointed by the lack of staff consistency to build a rapport with trusted providers.

Additionally, frustration with overall access to care was expressed. While extended wait times and availability of specialists are not issues unique to veterans in Montana, attendees noted that there is only one VAMC in the state. Veterans often must spend hours on the road to get to an appointment at Fort Harrison or a CBOC. While ATLAS sites are available in Bozeman, Missoula, and Eureka, the VA still hears overwhelming feedback that veterans want to see their providers in-person, on-site.

Accountability was another major concern, as attendees expressed dissatisfaction with communication from VA Montana leadership. Some attributed staff attrition to mistrust of leaders and lack of communication. Difficulty obtaining answers to important questions about inadequate staff and retention, Congressional inquiries, Office of Inspector General (OIG) reports, and unfair labor practices were highlighted as issues. Veterans felt that leaders are inaccessible and unaccountable.

Overall, attendees shared that the care provided by the Fort Harrison VAMC is positive and effective when it works as intended. However, inconsistent staff and leadership coupled with geographical challenges reveal clear opportunities for improvement.

Interviews

Summary

The SWS team interviewed staff and leadership from the following offices: Patient Advocate; Specialty Care; Suicide Prevention and Mental Health; Community Care; Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ), Minority, Military Sexual Trauma (MST), Rural, and Native American Coordinators; Women Veterans; Polytrauma; and Nursing and Surgical Teams. Through these interviews with Helena VA staff, TAL gained insight into how the hospital operated as an individual entity and as part of the larger VA system.

Areas of Focus

Patient Advocate

Patient Advocate Best Practice: Patient Advocates are required to return calls within 48 hours. Complaints or concerns are handled in the order that they are received; if a veteran walks-in to Fort Harrison, a designated Patient Advocate is assigned to assist them as soon as possible.

Patient Advocate Challenges: The substantial increase of veterans eligible for community care has led to a large volume of billing issues. TriWest is the third-party administrator that manages payment to community providers; however, the Montana Veterans Experience Office is tasked with coordinating care. This is not just a VA Montana issue and needs to be addressed on a national level through the VISN or the Office of Integrated Veteran Care (IVC). Additionally, there are only 3 Patient Advocates at Fort Harrison and none in the CBOCs throughout the state. Therefore, if veterans would like to escalate a concern in-person, they'd potentially have to drive to Helena to speak to a Patient Advocate.

Recommendation: Education to veterans on community care is imperative. VA staff need to continue engagement and improve outreach efforts to guide veterans through the process and set expectations. VA should also focus their efforts on improving veteran follow-up to ensure their needs are adequately addressed.

Innovation

Innovation Best Practice: Telehealth services provide veterans with an alternative to on-site care, eliminating travel to Fort Harrison or a CBOC. All telehealth is done in house by the VA, preventing the need for coordination with outside community care providers. For instance, if a veteran needs a specialty care consult that is not available at Fort Harrison, he or she can virtually see an out-of-state VA provider.

Innovation Challenge: While telehealth services have increased access to care, online connectivity and provider capacity remain significant challenges. Veterans who live "off the grid" do not have broadband and cannot access virtual services. Infrastructure must be improved

to increase access to high-speed internet. These improvements should include internet expansion potentially through non-traditional means like Starlink; establishment of community telehealth hubs; device distribution; clinician telehealth training; technical support networks, and; expansion of digital literacy initiatives. While ATLAS sites can assist veterans in setting up care, there are only 3 locations in the state, and utilization is not substantial. Additionally, due to the VA's strategic hiring plan, the telehealth program has been unable to fill open positions, which were ultimately removed. The Montana VA previously had 8 care coordinators and 20-23 full-time equivalent (FTE) technicians, now reduced by 2 but 4, respectively. While the team adapted and covered staffing deficiencies to prevent appointment cancellation, they are working to secure support for additional positions in the next fiscal year.

Recommendation: The VA offers a Digital Divide consult to provide veterans with devices, internet plans, or information about ATLAS sites to mitigate infrastructure challenges. However, Congress must continue to evaluate the program's efficacy and utilization for rural and remote veterans. Congress must also explore non-traditional approaches to rural internet expansion, potentially through things like Starlink. While VA Central Office leadership has consistently denied a department hiring freeze, the "strategic" pause prevents positions that are needed to improve healthcare. It is imperative that Congress evaluates current VA staffing and the subsequent disruptions in and/or reduced access to care.

Collaboration

Collaboration Best Practice: The Polytrauma Support Clinic (PSCT) and the Women Veterans Program are multidisciplinary teams that champion collaboration to provide veterans with well-rounded services and resources. The Montana VA Polytrauma Support Clinic (PSCT) supports veterans on an outpatient basis, providing traumatic brain injury (TBI) care that includes comprehensive evaluations, development of a care plan, and specialized rehabilitation interventions. As the top ranked program in VISN 19, the PSCT does not focus solely on the TBI diagnosis and service-connection, but on veteran engagement and follow-on care as well. The program is highly collaborative, as the multidisciplinary team is comprised of neurologists, Registered Nurse (RN) case managers, vocational rehabilitation specialists, creative arts therapists, speech pathologists, and many others. Each week, the entire team meets to complete an extensive 60-minute chart review to determine what recommendations are best for the individual veteran. A RN case manager works with a veteran throughout the 6-month program to provide education, coordination of care, and resources.

The Women Veterans team is comprised of the following: Women Veterans Program Manager; maternity, breast health, and cervical health nurse navigators; Women's Mental Health Champion; Clinical Pharmacist; and Program Support Assistant and Specialist. VA staff work together to connect women veterans to services, educate them on next steps, and provide support through groups, outreach, and traveling baby showers. Team huddles are conducted daily, fostering cohesion and open communication, and was also identified as a best practice by VISN 19.

Collaboration Challenge: Because community care has increased rapidly since the passage of the MISSION Act in 2018, maintaining continuity of care has become challenging across all of Montana VA. There have been issues with coordination of care, dropped or delayed referrals, and problems with getting signoffs on care in the community. The Veterans Experience/Patient Advocate Office is tasked with coordinating this care, and individual staff members, such as the Maternity, Breast Health, and Cervical Nurse Navigators are responsible for following up with veterans about their appointments, results, and next steps. Community Care Providers should have the ability to share patient records with VA as this is critical to maintaining continuity of care. Moreover, the VA must continue to refine the reimbursement process for community care providers to ensure timely payments are received.

Mental Health

Mental Health Best Practice: Due to the influx of veterans utilizing community care, coordination with outside providers, especially in regard to mental health, is even more imperative. The Suicide Prevention and Mental Health staff at Fort Harrison highlighted the Nurse Navigator Program, which facilitates and coordinates transitions of mental health care. Nurses, who are employed by the VA and embedded in private hospitals throughout the state, ensure that veteran needs are met and resources for next steps are provided.

Mental Health Challenge: Inpatient placement for veterans with behavioral health needs, dementia, or a history of violence is extremely challenging. There are not enough facilities to keep up with the volume of patients being discharged, and VA staff do not want to transfer veterans to facilities that are subpar. Improving behavioral health inpatient availability and services would help alleviate this issue.

Recommendation: Congress should assess the need for additional facilities in Montana, whether that be continued expansion of the Fort Harrison VAMC or construction of additional State Veterans Homes or Community Living Centers.

Transportation

Transportation Best Practice: Fort Harrison has 14 paid Veterans Transportation Service (VTS) employees and 1 potential vacancy, as well as Disabled American Veterans (DAV) Volunteer Drivers. Per Human Resources (HR) staff, there is great engagement and dedication of drivers. TAL staff noted multiple DAV and VA transportation vehicles parked outside of Fort Harrison's Administration building.

Transportation Challenge: Fort Harrison is the only VAMC in the state of Montana, which poses a challenge to veterans accessing care at the facility and/or at other CBOCs. While VTS and DAV drivers are available at the VAMC, veterans outside of this area may need to drive hours just to attend an appointment.

Recommendation: The Veterans Health Administration (VHA)-Uber Health Connect (VUHC) Initiative is a program that provides supplemental transportation support for veterans to travel to

and from their VA medical appointments. While rideshare services such as Uber and Lyft are limited in Helena, VA Montana staff should consider the feasibility of implementation in more populated areas such as Billings and Missoula. This service could reduce the burden for veterans who don't have access to a vehicle, decreasing the number of missed appointments and increasing satisfaction with care.

Training and Education

Training and Education Challenge: Women veterans require gender-specific, tailored care; there is not a "one-size fits all" approach that works for all veterans. Therefore, it is imperative that all providers receive training on women and their specific needs. The Women Veterans Program at Fort Harrison underlined the importance of providing education to all clinical staff to ensure a safe, welcoming environment.

Recommendation: Standardized training on caring for women veterans must be implemented for all staff, not just those who are women-designated providers.

Staffing & HR Process

Staffing & HR Process Best Practice: The Human Resources (HR) Department has organized meetings with local military bases and National Guard/Reserve units to discuss transition out of active duty service and into a career at the VA. The goal is to educate servicemembers on the value and dispel the stigma around what it means to work at a VA facility. With assistance from the Public Affairs Office, HR is striving to attract those with a mission-centered attitude.

Staffing & HR Process Challenge: The rural location of Fort Harrison makes it challenging to recruit staff, especially clinical providers. Because budgetary resources are limited, financial incentives to recruit staff are limited. For this reason, many primary care officers fill positions with Nurse Practitioners instead of physicians. Post COVID-19 pandemic, Montana saw a large influx of people moving to the state, causing high demand for housing and driving up costs cost of living. Per a discussion with HR, the high cost of living and unadjusted pay scales to reflect it is a main reason why people decline positions at Fort Harrison. Furthermore, there are few partnerships with universities and medical schools, preventing a pipeline of students from becoming future VA employees. Retention is a concern repeatedly highlighted at the TAL Town Hall. Veterans expressed frustration with the lack of continuity of providers, preventing the establishment of trust and rapport. One attendee described the loss of providers, especially those in primary care, as "catastrophic."

Recommendation: Congress should re-evaluate locality pay and consider not just urban areas, but rural areas with high costs of living.

Security

Security Challenge: The SWS Team observed very few security personnel throughout the site visit – only 2 staff members were noted near Fort Harrison's main entrance. According to a Town Hall attendee, security at Fort Harrison is not adequately staffed and some are not properly

credentialed. When reportedly escalated to the ELT, no action was taken, and it is unclear what support the security team is given. Additionally, there were very little to no designated spaces for women veterans. The RRTP, which has secure entrances/exists and requires staff to badge in, is a unit that has single-occupancy rooms. While there is a recreational room for women, there lacks a separate women-dedicated wing; instead, staff strive to place them near the nurse's station. Furthermore, no women-only waiting rooms or entrances were available or designated across the Fort Harrison campus.

Recommendation: Congress should identify VA facilities that require separate spaces for women veterans.

Conclusion

The Fort Harrison VA Medical Center faces unique challenges – the rural setting highlights the importance of access to high quality, timely care. All Departments expressed that the expansion of community care through the MISSION Act has necessitated additional support, education, and coordination. Limited resources, whether they be related to infrastructure or staff, hinder the care that the VAMC is capable of providing to veterans.

Frequent executive leadership changes also contribute to instability at Fort Harrison — mistrust of the facility by staff and veterans was repeatedly discussed by veterans. A February 2024 OIG Report found that the former Chief of Staff (COS) was practicing outside of defined privileges and provided deficient surgical and post-operative care.[1] Leadership failed to ensure proper oversight and accountability of the COS. Additionally, a January 2023 investigation found mistreatment and abuse of a patient at both the Miles City Community Living Center and Fort Harrison; the patient ultimately died.[2]

As stated during the TAL Post 2 Town Hall, veterans are satisfied with the care at the VA facility when they can get it, but there is a lack of consistency due to recruitment/retention issues. This was the most common complaint by attendees, and while the ELT acknowledged this issue, it is unclear what additional strategies will be taken to attract staff to Fort Harrison.

Overall, the Fort Harrison VA Medical Center is taking steps to improve care and access to Montana veterans. Correcting the aforementioned deficiencies will continue to ensure that veterans receive the world-class, innovative care that they deserve. The American Legion had an informative visit and appreciated the opportunity to learn about Fort Harrison's strengths and areas of improvement.

[1] Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena (vaoig.gov)
[2] Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison. (vaoig.gov)