



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi

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Figure 1. G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi.

Source: <https://www.va.gov/jackson-health-care/locations> (accessed October 18, 2022).

Abbreviations

ADPCS	Associate Director of Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the G.V. (Sonny) Montgomery VA Medical Center and multiple outpatient clinics in Mississippi. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the G.V. (Sonny) Montgomery VA Medical Center during the week of March 13, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted an opportunity for improvement and issued one recommendation to the Director in the Mental Health area of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered with the delivery of quality health care. The result is detailed in the report section, and the recommendation is presented in appendix A on page 15.

VA Comments

The Veterans Integrated Service Network Director and Medical Center Director agreed with the comprehensive healthcare inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, pages 17–18, and the response within the body of the report for the full text of the directors’ comments). The OIG considers recommendation 1 closed.



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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the G.V. (Sonny) Montgomery VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so they can make informed decisions to improve care.¹

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.² Effective leadership has been cited as “among the most critical components that lead an organization to effective and successful outcomes.”³

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:⁴

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

¹ VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

² Anam Parand et al., “The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review,” *British Medical Journal* 4, no. 9 (September 5, 2014): 13, <https://doi.org/10.1136/bmjopen-2014-005055>.

³ Danae F. Sfantou et al., “Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review,” *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, <https://doi.org/10.3390/healthcare5040073>.

⁴ CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The G.V. (Sonny) Montgomery VA Medical Center includes multiple outpatient clinics in Mississippi. General information about the medical center can be found in appendix B.

The OIG inspected the medical center the week of March 13, 2023.⁵ During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁶ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendation for improvement addresses a problem that can influence the quality of patient care significantly enough to warrant OIG follow-up until medical center leaders complete corrective actions. The Medical Center Director's response to the report recommendation appears within the associated topic area. The OIG accepted the action plan that leaders developed based on the reasons for noncompliance.

The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁵ The OIG's last comprehensive healthcare inspection of the G.V. (Sonny) Montgomery VA Medical Center occurred in May 2018. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in February 2023.

⁶ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.⁷ High-impact leaders should be person-centered and transparent, engage front-line staff members, have a “relentless focus” on their organization’s vision and strategy, and “practice systems thinking and collaboration across boundaries.”⁸ When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.⁹

To assess this medical center’s leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and medical center leaders’ responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Medical Center Director (Director), Chief of Staff, Associate Director of Patient Care Services (ADPCS), Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, all five leadership positions were permanently assigned, and the team had worked together for approximately one year. The most tenured executive leader was the Director, who had served in the position for about 18 months.

⁷ Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

⁸ Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

⁹ Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care*, Institute for Healthcare Improvement White Paper, 2017.

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, acting ADPCS, Associate Director, and Assistant Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.¹⁰

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of \$526,260,359 had increased over 7 percent compared to the previous year's budget of \$489,886,084.¹¹ The executive leaders stated the budget was adequate for medical center operations. However, the Director said that Jackson, Mississippi, has historically been a difficult geographic area for recruiting, and the situation was worse during the COVID-19 pandemic. The Director and Chief of Staff further reported multiple staff left the medical center to become traveling providers during the height of the pandemic, requiring leaders to consider offering recruitment incentives such as remote flexibilities, despite veterans' ongoing need for face-to-face patient care visits. The Associate Director and Assistant Director agreed about the recruiting difficulties and added that VISN staff provided support when unplanned issues arose with infrastructure and aging equipment.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."¹² Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.¹³ Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

The medical center's survey scores remained slightly lower than VHA's all three years and were stable in FYs 2021 and 2022. The Director said the patient safety managers, Equal Opportunity Manager, and Chief of Communications and Experience had worked to ensure staff felt safe reporting all safety events. The Chief of Staff reported training and having discussions with staff

¹⁰ The permanently assigned ADPCS was on leave at the time of the inspection, so the OIG interviewed the acting ADPCS.

¹¹ Veterans Health Administration (VHA) Support Service Center.

¹² "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

¹³ The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

on the topic of empowerment. The acting ADPCS reported holding monthly safety forums and town hall meetings and resuming visits to patient care areas in March 2022.

**Table 1. All Employee Survey Question:
Ability to Disclose a Suspected Violation
(FYs 2020 through 2022)**

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
G.V. (Sonny) Montgomery VA Medical Center	3.7	3.8	3.8

Source: VA All Employee Survey (accessed November 15, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients’ healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.¹⁴ The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

Survey scores indicated that inpatient, primary care, and specialty care patients were less satisfied with their experiences than VHA patients nationally. The Director reported recognizing the lack of focus on patient experiences after working at the medical center for a few months. The Director described subsequently developing a service focused on the overall patient experience that included the Chief of Communications and Experience, the Veteran and Employee Experience Officer, the Communications Department, and the Patient Advocate Department. The Chief of Staff reported working directly with staff to encourage patients to ask questions during visits and complete surveys to indicate their level of satisfaction.

¹⁴ “Patient Experiences Survey Results,” VHA Support Service Center.

**Table 2. Survey of Healthcare Experiences of Patients
(FYs 2020 through 2022)**

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: <i>Would you recommend this hospital to your friends and family?*</i>	69.5	67.2	69.7	58.5	68.9	60.1
Patient-Centered Medical Home: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	82.5	76.9	81.9	74.6	81.7	77.2
Specialty Care: <i>Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?†</i>	84.8	80.2	83.3	73.5	83.1	74.7

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

*The response average is the percent of “Definitely yes” responses.

†The response average is the percent of “Very satisfied” and “Satisfied” responses.

Identified Factors Related to Possible Lapses in Care and Medical Center Leaders’ Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.¹⁵ According to The Joint Commission’s standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.¹⁶ A VA medical facility’s culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

¹⁵ Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; “Quality and Patient Safety (QPS),” Department of Veterans Affairs, accessed January 20, 2023, <https://www.va.gov/QUALITYANDPATIENTSAFETY/>.

¹⁶ The Joint Commission, *Standards Manual*, E-edition, January 1, 2022. A culture of safety is “the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization’s health and safety management.” “Hospital Survey on Patient Safety Culture: User’s Guide,” Agency for Healthcare Research and Quality, July 2018, <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf>.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.¹⁷

“A sentinel event is a patient safety event (not primarily related to the natural course of a patient’s illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).”¹⁸

Additionally, an institutional disclosure is “a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient’s personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”¹⁹ Lastly, a large-scale disclosure is “a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue.”²⁰ To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.²¹

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. The Director and acting ADPCS stated staff alert the leadership team to serious adverse events through daily morning reports, telephone calls, emails, and in-person meetings. The acting ADPCS said staff enter safety events into the reporting system, and Quality, Safety, Improvement staff evaluate each event to decide whether it qualifies as a sentinel event per The Joint Commission’s definition. The Chief, Quality, Safety, Improvement explained that because patient safety managers were new in their roles, they consulted with the VISN Patient Safety Officer, VISN Chief of Staff, and VISN Risk Manager to discuss cases and determine the follow-up actions as needed.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

¹⁷ Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

¹⁸ The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission’s definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

¹⁹ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

²⁰ VHA Directive 1004.08.

²¹ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.²² To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.²³ Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.²⁴

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.²⁵ According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.²⁶

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.²⁷ Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."²⁸ Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.²⁹

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports. The team also reviewed 12 deaths that occurred within 24 hours of inpatient admission, and staff reported that no suicides had occurred within 7 days of discharge from inpatient mental health care during FY 2022.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

²² Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

²³ VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

²⁴ VHA Directive 1100.16.

²⁵ VHA Handbook 1050.01; VHA Directive 1050.01(1).

²⁶ The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

²⁷ A peer review is a "critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

²⁸ VHA Directive 1190.

²⁹ VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently.”³⁰ These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care “without supervision or direction, within the scope of the individual’s license, and in accordance with individually-granted clinical privileges.”³¹

Privileges need to be specific and based on the individual practitioner’s clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP’s credentials and service chief’s recommendation to determine whether “clinical competence is adequately demonstrated to support the granting of the requested privileges,” and submits the final recommendation to the facility director.³² LIPs are granted clinical privileges for a limited time and must be repriviledged prior to their expiration.³³

VHA states the Focused Professional Practice Evaluation (FPPE) is a defined period during which service chiefs assess LIPs’ professional performance. The FPPE process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP’s performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.³⁴

VHA’s credentialing process involves the assessment and verification of healthcare practitioners’ qualifications to provide care and is the first step in ensuring patient safety.³⁵ Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

³⁰ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

³¹ VHA Handbook 1100.19.

³² VHA Handbook 1100.19.

³³ VHA Handbook 1100.19.

³⁴ VHA Handbook 1100.19.

³⁵ VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.³⁶

The OIG interviewed key managers and selected and reviewed the privileging folders of 27 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

As part of the privileging process, VHA requires service chiefs to define, and LIPs to accept, objective FPPE criteria in advance.³⁷ The OIG found that all FPPEs reviewed lacked evidence service chiefs made LIPs aware of evaluation criteria before initiating the process. When FPPE criteria are not defined in advance, LIPs could misunderstand expectations. The Chief of Staff stated there had been no firm process to notify LIPs and obtain evidence they accepted FPPE criteria prior to the evaluation; however, in June 2022 staff reviewed the FPPE process and revised FPPE forms to ensure documentation of the LIPs' notification and acceptance of evaluation criteria in advance. The OIG did not make a recommendation, but without VHA requiring documentation that LIPs were informed of the criteria used to evaluate their performance, facility leaders cannot effectively monitor compliance.

³⁶ Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

³⁷ VHA Handbook 1100.19; VHA Directive 1100.21(1).

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."³⁸ The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.³⁹

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.⁴⁰

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected seven patient care areas:

- Community living centers (Dogwood Trail and Hickory Way)
- Emergency Department
- Intensive care unit
- Medical/surgical inpatient unit (4C)
- Mental health inpatient unit (3L)
- Women's health clinic (Pink Clinic)

Environment of Care Findings and Recommendations

The OIG made no recommendations.

³⁸ VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

³⁹ VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

⁴⁰ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.⁴¹ Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.⁴² The suicide rate for veterans was higher than for nonveteran adults during 2020.⁴³ “Congress, VA, and stakeholders continue to express concern over seemingly limited progress made...to reduce veteran suicide.”⁴⁴

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.⁴⁵ VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.⁴⁶

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.⁴⁷

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

⁴¹ VA Secretary memo, “Agency-Wide Required Suicide Prevention Training,” October 15, 2020.

⁴² “Suicide Prevention: Facts about Suicide,” Centers for Disease Control and Prevention, accessed November 25, 2022.

⁴³ VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

⁴⁴ Congressional Research Service, “Veteran Suicide Prevention,” IF11886 version 2, July 29, 2021.

⁴⁵ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy),” November 13, 2020. (This memo was superseded by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy),” November 23, 2022.)

⁴⁶ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);” Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Suicide Behavior and Overdose Reporting,” July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, “Update to Suicide Behavior and Overdose Reporting,” May 9, 2023.)

⁴⁷ VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. “Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year.” VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.) During the period reviewed, the G.V. (Sonny) Montgomery VA Medical Center did not have any very large community-based outpatient clinics.

Mental Health Findings and Recommendations

VHA requires the suicide prevention coordinator to perform at least five outreach activities each month.⁴⁸ The OIG found the suicide prevention coordinator did not complete a minimum of five outreach activities for one month between April and September 2022. To determine whether the coordinator complied during the next few months, the OIG requested and reviewed outreach activities for October 2022 through February 2023 and found the coordinator did not conduct the required monthly outreach activities for one of the months. This resulted in missed opportunities for staff to build relationships with community organizations and educate veterans, their families, and communities about suicide prevention initiatives. The Suicide Prevention Coordinator and Mental Health Social Work Supervisor reported suicide prevention team vacancies resulted in staff's limited availability to conduct outreach activities. Additionally, the Suicide Prevention Coordinator stated social distancing restrictions diminished the team's ability to meet with community partners.

Recommendation 1

1. The Medical Center Director ensures the Suicide Prevention Coordinator conducts at least five outreach activities each month.⁴⁹

Medical center concurred.

Target date for completion: Completed

Medical center response: The Medical Center Director will ensure that the Suicide Prevention Team conducts the required number of outreach activities each month. The Suicide Prevention Manager will be responsible for tracking and monitoring outreach activities each month. Prior to the OIG visit, in January of 2023, the Suicide Prevention Team began internal reporting to the Associate Chief of Staff, Mental Health and to VISN 16 Mental Health leadership monthly via an Action Item. The Suicide Prevention team has met the minimum requirement of 5 outreach activities per month and sustained 100% compliance for ten consecutive months, from April 2023 through January 2024.

Closure requested for this recommendation.

⁴⁸ VHA Directive 1160.07.

⁴⁹ The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided one recommendation on a systemic issue that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's finding highlights an area of concern, and the recommendation is intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. The recommendation is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines one OIG recommendation aimed at reducing a vulnerability that may lead to adverse patient safety events. The recommendation is attributable to the Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	<ul style="list-style-type: none">• None
Quality, Safety, and Value	<ul style="list-style-type: none">• None
Medical Staff Privileging	<ul style="list-style-type: none">• None
Environment of Care	<ul style="list-style-type: none">• None
Mental Health: Suicide Prevention Initiatives	<ul style="list-style-type: none">• The Suicide Prevention Coordinator conducts at least five outreach activities each month.

Appendix B: Medical Center Profile

The table below provides general background information for this mid-high complexity (1c) affiliated medical center reporting to VISN 16.¹

**Table B.1. Profile for G.V. (Sonny) Montgomery VA Medical Center (586)
(October 1, 2019, through September 30, 2022)**

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	\$455,463,396	\$489,886,084	\$526,260,359
Number of:			
• Unique patients	40,702	40,894	41,416
• Outpatient visits	422,378	453,097	433,754
• Unique employees§	1,548	1,475	1,394
Type and number of operating beds:			
• Community living center	86	86	86
• Domiciliary	27	27	27
• Hospital	77	77	77
Average daily census:			
• Community living center	42	33	29
• Domiciliary	14	9	11
• Hospital	50	49	45

Source: VHA Support Service Center and VA Corporate Data Warehouse.

Note: The OIG did not assess VA's data for accuracy or completeness.

*October 1, 2019, through September 30, 2020.

†October 1, 2020, through September 30, 2021.

‡October 1, 2021, through September 30, 2022.

§Unique employees involved in direct medical care (cost center 8200).

¹ VHA medical facilities are classified according to a complexity model; a designation of "1c" indicates a facility with "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 7, 2024

From: Director, South Central VA Health Care Network (10N16)

Subj: Comprehensive Healthcare Inspection of the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi

To: Director, Office of Healthcare Inspections (54CH00)
Director, GAO/OIG Accountability Liaison (VHA 10B GOAL Action)

1. The South-Central VA Health Care Network (10N16) has reviewed and concurs with the responses provided for the open recommendations contained in the Comprehensive Healthcare Inspection report for the G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS.
2. If you have questions regarding the information submitted, please contact [the] VISN 16 Accreditation Specialist.

(Original signed by:)

Skye McDougall, PhD
Network Director

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: March 5, 2024

From: Director, G.V. (Sonny) Montgomery VA Medical Center (586)

Subj: Comprehensive Healthcare Inspection of the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review the draft report of the G.V. (Sonny) Montgomery VA Medical Center Inspection. I have reviewed the document and concur with the recommendations.
2. A corrective action plan has been implemented as detailed in the attached report.
3. I would like to thank the OIG Inspection team for a thorough review of the G.V. (Sonny) Montgomery VA Medical Center in Jackson.

(Original signed by:)

Kai D. Mentzer
Medical Center Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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