US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Montana VA Healthcare System in Fort Harrison

Healthcare Facility Inspection	25-00258-217	August 13, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the Montana VA Healthcare System (the facility) from October 6 through 9, 2025. The facility is rated as *medium complexity* and in fiscal year 2025, provided direct care to about 40,845 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG issued one recommendation for addressing minor to moderate wall damage, dirty refrigerator seals, and soiled items in clean storage areas identified by the inspection team.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness, or recently incarcerated. The OIG made no recommendations.

[1] VHA classifies facilities based on their complexity level. Medium-complexity facilities have "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2025 Through July," VHA Support Service Center, last updated August 28, 2025, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer. (This web page is not publicly accessible.)

[2] See appendix A for a description of the OIG's inspection methodology.

[3] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

What the OIG Recommended

1. The Associate Director keeps patient care areas clean and stores dirty and clean items separately.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendation and provided an acceptable action plan (see the response in the report body and appendixes B and C). Based on information provided, the OIG considers recommendation 1 closed.

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for Healthcare Inspections

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
MRI	magnetic resonance imaging
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[4] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[5]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[6]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[7]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[8]

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[4] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[5] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

[6] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[7] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[8] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The Montana VA Healthcare System (the facility) includes the Fort Harrison VA Medical Center (Fort Harrison), Miles City VA Community Living Center (Miles City), and 16 community-based outpatient clinics.[9] The facility had 29 inpatient, 14 community living center, and 24 domiciliary beds, and its fiscal year (FY) 2025 medical care budget was approximately $763 million.[10]

Figure 1. *Facility photo.*
Source: "Fort Harrison VA Medical Center," VA, last updated April 11, 2025, https://www.va.gov/montana-health-care/locations.

The OIG inspected the facility from October 6 through 9, 2025. The executive leaders referred to throughout this report include the Medical Center Director (Director), Assistant Director, Associate Director, Associate Director for Patient Care Services, and Chief of Staff. At the time of the inspection, most of these leaders had been a team for several years: The Director was appointed in June 2024; the Assistant Director in January 2023; the Associate Director in March 2024; the Associate Director for Patient Care Services in December 2024; and the Chief of Staff in February 2023.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations) and both employees' and veterans' experiences.[11] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

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[9] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated June 3, 2025, https://www.va.gov/VA_CLC.

[10] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv.

[11] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

[12] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[13] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

System Shocks

In response to an OIG questionnaire, facility leaders described an extended closure of the facility's magnetic resonance imaging (MRI) service, which began in April 2025, as a significant operational disruption.[14] Leaders planned to replace outdated MRI equipment during an anticipated two-month shutdown. However, interviews with executive and facility leaders revealed that MRI services had not resumed at the end of that time because the facility's only certified MRI technician had resigned unexpectedly in July 2025. In response, facility leaders

- temporarily rehired their former certified technician on a fee basis (paid by the task) to work when needed,
- created two new positions to perform MRI scans, and
- offered salary increases to encourage current employees to pursue MRI technician certification to have more employees certified to complete MRIs.[15]

During the extended closure, executive leaders also referred approximately 400 veterans to community providers for MRI scans; they stated no veteran harm occurred because of the shutdown.[16] The OIG reviewed entries in the Joint Patient Safety Reporting system (the database used at VHA facilities to report patient safety events) related to MRIs from April through June 2025 and found several related to complaints about community MRI scheduling, but none referred to patient harm.[17]

Figure 2. *Leaders' efforts to mitigate facility system shocks. Source: The Salt Lake City VA Medical Center MRI technician's temporary assignment letter.*

Employee Experiences

Most respondents to the OIG questionnaire indicated they felt comfortable reporting patient or employee safety concerns. However, about half of those responding expressed concern that the facility's culture was not improving and were nearly evenly split about whether they were comfortable suggesting changes to the work environment, as indicated in figure 3. In an

[14] Magnetic resonance imaging "uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues" of the body. "MRI," Mayo Clinic, September 29, 2023, https://www.mayoclinic.org/mri/pac-20384768.

[15] VHA uses fee-basis staff when "health services are not otherwise readily available" and are "compensated by the task or service…not on a time basis." VA Handbook 5007/64, *Pay Administration*, May 14, 2024.

[16] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

[17] Patient safety events include adverse events, harm directly associated with care, or close calls (an event could have caused harm but did not because of chance or some intervention). VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, *Version 6.0*, October 2025.

interview, executive leaders described efforts to build trust through appreciation events such as an annual pancake breakfast and barbeques, which helped employees feel comfortable and connected to leaders. The employee engagement officer also distributed a questionnaire in May 2025 asking how leaders could better support employees. Based on the feedback, leaders initiated activities, such as holiday celebrations and sports events, and evaluated their impact through follow-up surveys. The OIG reviewed one event's follow-up questionnaire and found all respondents gave positive feedback.

Leaders used several strategies to promote open communication with employees:

- Weekly facility-wide emails to disseminate information, such as upcoming events and updates from VHA
- Twice-a-month town halls, which are recorded, to share updates and respond to employees' questions
- Annual visits to community-based outpatient clinics to directly engage employees

Executive leaders said these methods were effective, citing positive feedback during town halls and visits to employee work areas. Responses to the OIG questionnaire indicated leaders changed their communication methods, but respondents offered mixed views on whether these changes improved communication.

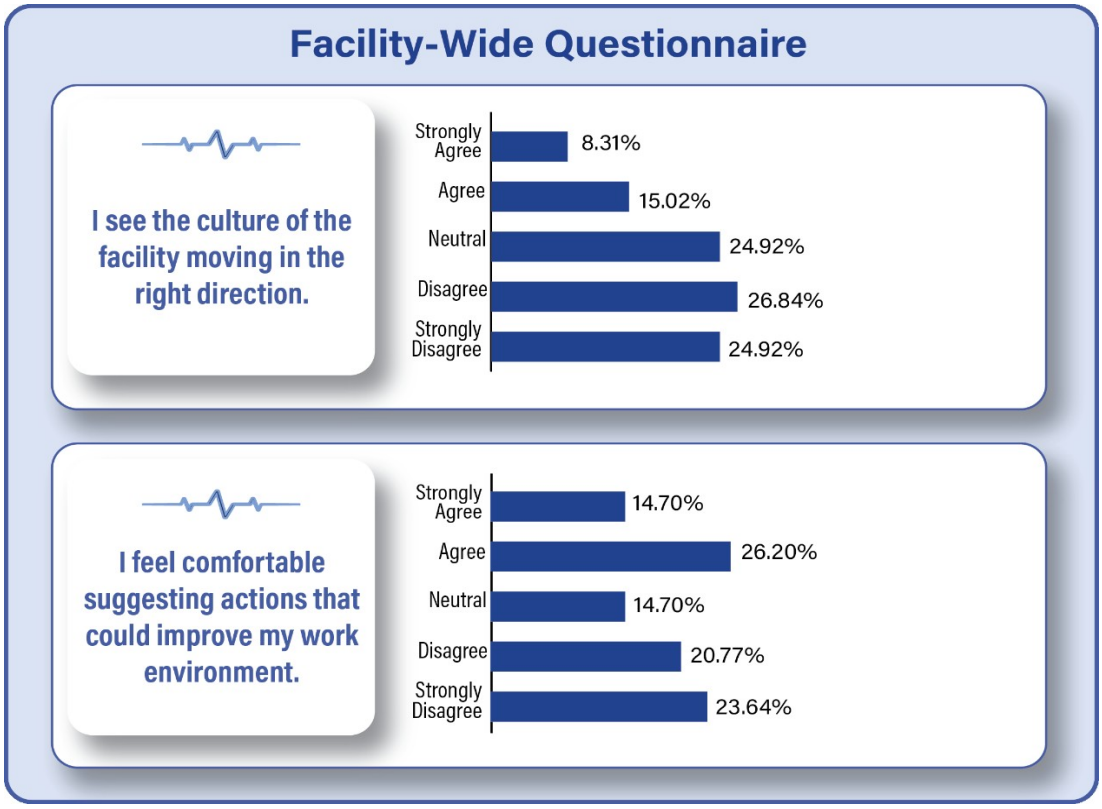

Figure 3. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

The Director also implemented an internal system of direct messaging from employees for leaders to proactively address employee concerns and ensure they feel personally acknowledged. Leaders reported that employees appreciated the system, and the Director considered it successful.

Veteran Experiences

In an OIG questionnaire, facility patient advocates reported that veterans most often complained about telephone wait times. Based on the facility's care in the community call center data, the inspection team found the facility lost 11 employees (24 percent of the 46 total) from February to September 2025 who answered phone calls and scheduled appointments. These losses followed and were attributed by executive leaders to staff responses to the January 2025 presidential memorandum to return to in-person work.[18] Further, from May to September 2025, community care call center employees answered fewer calls and had a higher number of callers hang up than from January to April 2025. The decline in performance was attributed to their inability to effectively manage the workload after the employees resigned. To address this drop in call-taking performance, executive and facility leaders reported ongoing efforts to hire more administrative employees.

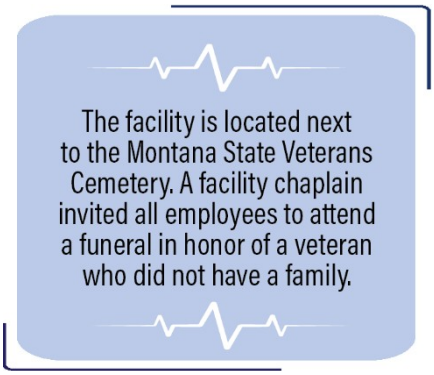

Figure 4. *Unique employee experience. Source: OIG review of the facility chaplain's email to all employees.*

The OIG reviewed the facility's veteran trust scores and found they had improved from FY 2024 through the first three quarters of FY 2025. When asked about the scores, the Director said leaders used them as the primary measure of veterans' experiences and satisfaction with their care.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[19] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

[18] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025). For more information on scheduling delays, see the Community Care Staffing and Access to Care section of this report.

[19] "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[20]

General Inspection

The OIG team used a navigation link on the facility's website to travel to Fort Harrison (medical center) and Miles City (community living center), located approximately 350 miles apart. The team easily located the main entrance at each site and observed clear signs with directions to both parking lots and building entrances.

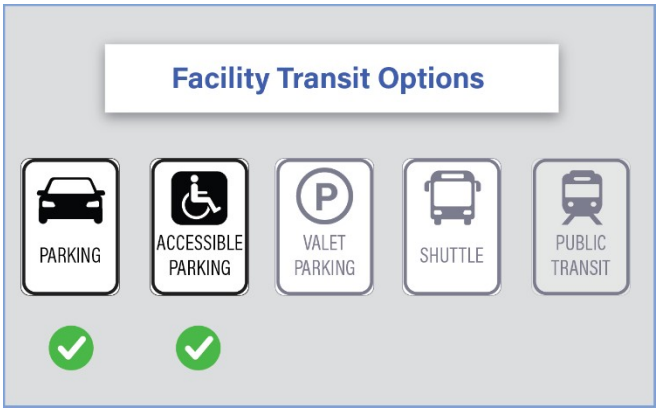

Figure 5. *Transit options for arriving at the facility. Source: Facility liaison questionnaire responses and OIG observations.*

The facility did not have public transit, valet service, or parking lot shuttles. However, the inspectors observed an adequate number of parking spaces, including several accessible spaces, and security cameras monitored by VA police. Facility staff also provided information regarding their snow removal program, which ensures that building entrances, roads, and sidewalks remain passable during snow and ice storms.

Fort Harrison's front entrance featured an overhang canopy and detectable warning surfaces that alert visually impaired pedestrians to potential hazards before they transition onto a roadway. Just beyond the doors, the lobby had an ample number of seating areas, volunteers to answer questions and escort veterans, and a nearby café where veterans can congregate and socialize. There were large maps at the front desk and clear signs throughout the facility. In an OIG questionnaire, facility staff indicated the availability of assistive listening devices, such as personal amplifiers, for veterans with hearing loss and braille signs for those with visual impairments.

The OIG team inspected the emergency department, medical-surgical unit, intensive care unit, and a primary care clinic. There were clear exit paths and undamaged furniture and equipment. The inspectors did not see any safety concerns or privacy violations, such as identifiable patient information, visible on computers or paper records.

[20] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10*, *Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

However, the team observed minor to moderate wall damage in the medication rooms at the Fort Harrison emergency department and Miles City community living center. Facility staff fixed the damage and provided evidence of the repairs during the OIG visit. Additionally, inspectors found dirty refrigerator door seals and soiled items in clean storage areas at several Fort Harrison locations. According to VHA Directive 1608(1), *Comprehensive Environment of Care Program*, healthcare facilities must maintain a clean environment to avoid infection sources and transmission. Facility leaders acknowledged that staff had received insufficient education about keeping clean and dirty items separate, despite information presented at town halls and huddles, and these conditions increased contamination risks. In response, an infection prevention leader said they will educate housekeeping staff on proper cleaning procedures. To ensure those measures are effective and to make certain that staff separate clean and dirty items, the following OIG recommendation is warranted.

Recommendation 1

The Associate Director keeps patient care areas clean and stores dirty and clean items separately.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Montana VA Healthcare System concurs with this recommendation. The following actions were taken to address the identified deficiencies:

Immediately, two facility tracer audits were implemented to monitor compliance with cleanliness standards and proper storage protocols in patient care areas. Housekeeping Leaders, in conjunction with quality staff conducted follow-up environment of care rounds, including elevation of refrigerators and clean storage areas. Just in time training was completed during the audit cycles. Data was reported to the Quality and Patient Safety Committee. A compliance rate equal to or greater than 94% was maintained across both tracer audits for two consecutive quarters.

In addition, the Infection Prevention leader continues to provide annual targeted refresher education to housekeeping staff on proper cleaning procedures, with specific emphasis on maintaining separation of clean and dirty items in storage areas. The most recent training was completed July 2026, when 97% of staff were re-trained.

Numerator: Number of compliant tracer audit observations

Denominator: Number of total tracer audit observations

Measured by: Tracer audit data of patient care areas clean, and the separation clan and dirty items correctly stored separately.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

In an interview, leaders identified cleanliness issues, expired supplies, and improperly hung signs without protective coverings as the most common problems their staff found during the facility's own environment of care rounds in FY 2025. To correct the issues, leaders said they educated staff on cleanliness and proper sign mounting and collaborated with logistics staff to replace expired supplies. The OIG team did not find expired supplies or improperly hung signs in the areas inspected.

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The facility had a policy to communicate test results to both healthcare providers and patients, including after hours and during the transfer of care from one provider to another, as well as how to assign backup staff when needed.[21] The facility also had service-level workflows that clearly outlined staff members' roles in the process to communicate test results.

During an interview, quality management staff indicated they review data from the External Peer Review Program to determine whether providers communicated actionable results within seven days, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[22] The acting chief of quality management said staff report the data monthly to the Performance Measures and Performance Improvement Committee and quarterly to the Quality and Patient Safety Council. The OIG's data review showed improvement in providers communicating actionable test results within seven days, with higher scores in the first quarter of FY 2025 (91.7 percent) than in FY 2024 (72.5 percent).

[21] Montana VA Health Care System, MCP [medical center policy] Number 11-27-148, *Communication of Test Results*, April 22, 2025.

[22] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

Action Plans and Process Improvements

The inspection team did not identify any unimplemented recommendations from the last OIG comprehensive healthcare inspection report published in 2021.[23] Facility staff said strong oversight and regular monitoring by the Continuous Readiness Committee led to their success in implementing all corrective actions. This committee uses a dashboard to track every action plan from receipt of a recommendation through completion. Quality management staff shared that the committee updates the Quality and Patient Safety Council monthly, which checks how well the plans are working. That council then updates the Executive Leadership Board quarterly to keep leaders informed and involved.

Facility leaders also discussed a recent process improvement project to reduce the number of unnecessary electronic health record notifications providers receive. After completing the project, the facility ranked among the top 20 percent of all VA facilities in FY 2025 for successfully lowering the quantity of unnecessary alerts.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[24] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

Primary care leaders informed the OIG of vacancies for 7 providers, 9 registered nurses, 16 licensed practical nurses, and 15 medical support assistants across 16 primary care teams at the time of the inspection in October 2025. The leaders approved a process to hire fee-basis providers to maintain necessary staffing and planned to temporarily fill a position through the Clinical Resource Hub, a Veterans Integrated Service Network (VISN) program that provides

[23] VA OIG, *Comprehensive Healthcare Inspection of the Montana VA Health Care System in Fort Harrison*, Report No. 21-00232-205, August 19, 2021.

[24] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.

staff when local facilities have vacancies.[25] At the time of the inspection in October 2025, leaders indicated that three registered nurses were in the hiring process. Leaders emphasized that a competitive medical support assistant special salary rate contributed to successful recruitment efforts, with 112 applications under review.

The OIG team reviewed facility data and found the average wait time for a new patient appointment in VA primary care was 32 days in the first quarter of FY 2025 but improved to 24 days in the third quarter. Leaders said a streamlined process to schedule new patients, and an electronic system that automatically notifies patients when appointments become available before their original appointment date, helped reduce wait times.

The inspection also found that 6 of the 16 community-based outpatient clinics had larger-than-expected panel sizes (the number of patients assigned to a team). VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, recommends that full-time primary care teams manage panels with a baseline of 1,200 patients.[26] Facility leaders attributed the excessive sizes to several provider departures, which also led to longer appointment wait times and increased risks of staff burnout. In response, leaders made ongoing attempts to reassign patients to balance the panels and recruit new providers. Although wait times decreased in the third quarter of FY 2025, leaders reported that staffing levels remained a concern. The OIG did not make a recommendation because facility leaders undertook multiple efforts to address the vacancies and implemented ongoing strategies to improve patient access and reduce wait times.

Community Care Staffing and Access to Care

The OIG team reviewed facility-provided data and found 108 authorized community care positions, including 29 nurses and 79 medical support assistants. At the time of the October 2025 inspection, community care leaders reported vacancies for 1 nurse and 16 medical support assistants; however, 7 medical support assistants were in the onboarding process. Leaders shared that medical support assistants worked mandatory overtime to handle their workload. Additionally, primary care nurses received cross-training in these responsibilities and covered medical support assistant tasks during extended hours.

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[25] "Clinical Resource Hubs (CRH)," VA, last updated March 20, 2024, https://www.patientcare.va.gov/CRH; VISNs are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visn. In December 2025, VA announced plans to reorganize and consolidate its VISNs from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

[26] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) For Primary Care*, June 20, 2017, amended April 16, 2026.

Community care leaders stated that wait times for community care appointments varied based on the type of service and the provider's location within the state. They also said that about 90 percent of community care referrals were due to drive-time eligibility. The team found that veterans waited an average of 38 days for staff to schedule an appointment in the community. VHA's *Consult Timeliness Standard Operating Procedure* directs program staff to schedule appointments within seven days after a provider refers a patient for community care.[27] Leaders reported that administrative vacancies contributed to scheduling delays. To improve efficiency, leaders implemented a three-way call process to connect community care staff, the veteran, and the community provider in a single conversation. This approach allows real-time coordination and immediate resolution of scheduling questions.

The OIG reviewed Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH), and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The inspection team analyzed enrollment and performance data and interviewed facility program staff.

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[28]

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[29] HCHV2 measures the percentage of veterans who are discharged from the contracted emergency residential services or

[27] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," updated October 2, 2025.

[28] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[29] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[30]

Performance and Improvement Highlights

- Facility program staff explained that Montana's rural landscape and extreme weather conditions can make it difficult to locate veterans experiencing homelessness. For example, some individuals live in remote forest encampments to avoid other people.
- Staff found it effective to build relationships with trusted community members who often alert them when they see a veteran who appears unhoused. This approach has helped them connect with veterans who might otherwise remain hidden.
- The program did not meet the discharge to permanent housing (HCHV1) target for FY 2025. Staff explained that many veterans chose housing programs that offered longer stays, greater privacy, and calmer environments that they reported were more conducive to recovery than those HCHV staff could offer for emergency residential services and safe haven programs. They also said Montana's shortage of affordable housing contributed to the challenge, citing high market rental rates and inability to meet landlords' income requirements.
- Staff did not keep negative exits (HCHV2) below the target for FY 2025. They reported that mental health or substance use issues often led to voluntary departures or discharges due to rule violations. Staff added that one shelter's location near an interstate attracts veterans who are transient and use HCHV-contracted emergency residential services or low-demand safe haven beds for immediate shelter but may not stay long enough to complete services.

After living in the wilderness for 30 years, a veteran struggling with mental health issues called the National Homeless Hotline for help. Staff enrolled the veteran in the HCHV case management program and stayed in touch until housing was available. With support from community partners, the veteran moved into a home within a week, remained in case management, and was still in the home one year later.

Figure 6. *Example of HCHV outreach.*
Source: HCHV staff questionnaire responses.

[30] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[31] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[32]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[33]

Performance and Improvement Highlights

- The facility program did not meet the voucher use (HMLS3) target for FY 2025. Program staff attributed the shortfall to Montana's limited rental market, high housing costs, and challenges finding landlords willing to rent to veterans with poor credit or criminal histories.
- Staff noted they were able to build strong relationships with some individual landlords. For example, in September 2025, a staff member noticed construction on a four-unit building, spoke with the owner, and secured housing for a veteran. Later, the owner offered another unit for a veteran using a voucher.
- Program staff managed 546 housing vouchers across Montana, many issued through the Montana Department of Commerce with flexibility to house veterans in various locations statewide. The facility program had access to two housing sites: a 42-unit complex at the Fort Harrison campus and a 17-unit community site in Missoula dedicated to housing veterans with vouchers. Staff also described a tribal program on the Blackfeet Reservation, which provided 20 housing units.
- The facility met the employment (VASH3) target for FY 2025. Staff said VA employment specialists provided coaching, assisted with résumés, and connected veterans with community agencies that offered employment.
- Staff provided transportation when needed and worked with veterans to understand the root causes of their homelessness. In one case, a staff member rode the bus with

[31] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[32] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[33] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

a disabled veteran because the veteran cited transportation as a barrier to employment. Staff also regularly referred veterans to community resources like senior centers and coffee socials.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[34] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[35]

A veteran struggling with anger management and substance use was referred to a Montana veterans treatment court through the legal system. The veteran began chemical dependency treatment, met regularly with a mental health provider, and completed a Batterers Intervention group. After 18 months in the program, the veteran achieved sobriety, learned how to manage anger, and developed healthy coping skills. The veteran graduated from the veterans treatment court, continued VA treatment, and following a year of sobriety, became a trained veterans treatment court mentor.

Figure 7. *Best practice.*
Source: Veterans Justice Program staff questionnaire responses.

Performance and Improvement Highlights

- The facility program reported that data did not meet the enrollment (VJP1) target for FY 2025. Program staff explained they did not consistently document their activities in the national database, which affected their reported performance numbers.
- Program staff said they conducted outreach in jails, prisons, and courts. They also gave presentations on their available program services at events related to crime control, drug courts, and suicide prevention. This included the Veterans Navigation Network that supports military service members, veterans, and their families during the transition to civilian life.

[34] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[35] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

- The program supported five veterans treatment courts located in Missoula, Great Falls, Butte, Bozeman, and Billings.[36] Program staff shared that some of the state's veterans treatment courts had earned the designation of mentor courts (a competitive status) that help other jurisdictions expand access to diversion from incarceration and support for veterans.

Conclusion

To assist leaders in evaluating the quality of care at the Montana VA Healthcare System in Fort Harrison, the OIG conducted an inspection across five domains. The OIG made one recommendation related to environmental cleanliness and storage of clean and dirty items. Facility leaders have started to implement corrective actions, which resulted in the OIG closing the recommendation. The single recommendation does not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendation may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

[36] A veterans treatment court is "a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[37] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The team inspected the facility from October 6 through 9, 2025. The OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[38] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[39]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[40] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

[37] The accreditation reports covered the time frame of October 1, 2022, through September 30, 2024—the most recent available at the time of the inspection.

[38] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[39] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[40] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[41] 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.

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.

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 16, 2026

From: Director, VA Rocky Mountain Network (10N19)

Subj: Healthcare Facility Inspection of the Montana VA Healthcare System in Fort Harrison

To: Director, Office of Healthcare Inspections (54HF01)

Chief Integrity and Compliance Officer (10OIC)

Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Montana VA Healthcare System in Fort Harrison.

Based upon a thorough review of the report by VISN 19 leadership, I concur with the findings, recommendations and submitted action plans of Montana VA Healthcare System. As we remain committed to ensuring our Veterans receive exceptional care, VISN 19 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.

If you have any questions or require further information, please contact the VISN 19 Quality Management Officer.

(Original signed by:)

Sunaina Kumar-Giebel
VISN 4: Health Service Area 4.2 Director (10N19)

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 15, 2026

From: Director, Montana VA Healthcare System (436)

Subj: Healthcare Facility Inspection of the Montana VA Healthcare System in Fort Harrison

To: Director, VA Rocky Mountain Network (10N19)

Thank you for the opportunity to review and respond to the draft report of the Healthcare Facility Inspection of the Montana VA Healthcare System in Fort Harrison. I appreciate the collaboration and professionalism demonstrated by the OIG and the Healthcare Facility Inspection team throughout the inspection process.

I concur with the draft report and with the OIG's recommendation.

The Montana VA Healthcare System remains committed to delivering the highest quality of care to our Nation's Veterans and has readily incorporated this recommendation as part of our ongoing journey towards high reliability.

Questions or comments regarding the contents of this memorandum may be directed to the Chief of Quality and Patient Safety for the Montana VA Healthcare System.

(Original signed by:)

Kim S. Adkins, MSSL
Executive Director, Montana CVA Healthcare System

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.