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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania

Mental Health Inspection | **24-01862-151** | **June 26, 2025**

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Executive Summary

The mission of the VA Office of Inspector General (OIG) Mental Health Inspection Program is to evaluate VA's continuum of mental healthcare services. This inspection addresses the mental health care delivered in the acute inpatient setting at the Corporal Michael J. Crescenz VA Medical Center, part of the VA Philadelphia Healthcare System (facility) in Pennsylvania.

The OIG evaluated acute inpatient mental health care across six domains. The OIG assessed processes in each of the domains and identified successes and challenges that affected the quality of care on the inpatient mental health units (inpatient units). The OIG issued 20 recommendations to facility leaders.

For background information on each domain, see appendix A.[1] For information on the OIG's data collection methods, see appendix B.

Domain	OIG Summary
Leadership and Organizational Culture	Healthcare system leaders can nurture a positive, safety-oriented culture by building effective reporting and communication structures, incorporating stakeholder feedback, and supporting continuous performance improvement. The OIG evaluated reporting channels, committee structures, oversight and monitoring provided by leaders, and staffing practices. The Chief of Staff and Deputy Associate Director of Patient Care Services supervised the Associate Chief of Staff for Behavioral Health and the Associate Chief Nurse of Behavioral Health, respectively. At the time of the inspection, the Associate Chief of Staff oversaw mental health staff throughout the facility. The division director, acute psychiatric services served as the facility's required inpatient mental health program manager and had oversight of unit operations. The facility did not establish a formalized local mental health executive council during the 12-month review period. The Veterans Integrated Service Network (VISN) Chief Mental Health Officer reported providing oversight of and support for inpatient unit operations within the network. Additionally, the VISN Chief Mental Health Officer co-chaired the VISN Mental Health Executive Council, which had responsibility for monitoring quality and access across the network's continuum of mental health care. OIG recommendation: • The Facility Director establishes a mental health executive council that operates in accordance with Veterans Health Administration requirements.

[1] The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

Domain	OIG Summary
High Reliability Principles 	High reliability principles promote high sensitivity to potential failures. The Veterans Health Administration (VHA) considers staff responsible for identifying and addressing risks by empowering them to keep veterans safe. The OIG surveyed staff and leader perceptions of psychological safety and performance improvement. The OIG also evaluated whether leaders and staff engaged in continuous process improvement and solicited veteran input on mental health care. Questionnaire results related to medical center staff's and leaders' perceptions of psychological safety and performance improvement were generally positive. Mental health leaders reported collecting veteran input for process improvements, as required, and identified an example of incorporating staff's feedback into process improvement efforts. The OIG made no recommendations for this domain.
Recovery-Oriented Principles 	Recovery-oriented mental health treatment is personalized to a veteran's abilities, preferences, and values, and empowers the veteran to make decisions and meet treatment goals. To assess the inpatient units' integration of recovery-oriented principles, the OIG examined aspects of leadership, programming, and the care environment. The OIG found that the facility had a required local recovery coordinator. However, facility leaders had not established a local plan across the mental health care continuum for continued transformation to recovery-oriented services, as required. Inpatient unit staff did not provide at least four hours of recovery-oriented, interdisciplinary programming on weekdays or weekends, as required by VHA. Veterans were introduced to recovery-oriented principles through a handbook and program offerings. The two inpatient units had some aspects of a recovery-oriented environment; however, not all areas met VHA standards for a safe, hopeful, and healing setting. The OIG observed examples of maintenance issues such as broken vinyl tiles, scuffed walls, and chipped paint. On both units, the observation window on the restraint room door allowed individuals in the hallway to view inside the room, potentially compromising veteran privacy. Further, the facility did not have a dedicated safe and secure outdoor space for inpatient unit veterans. Facility leaders did not establish local written processes for safe outdoor access. OIG recommendations: • The Facility Director ensures development and implementation of a multi-year recovery transformation plan. • The Associate Chief of Staff for Behavioral Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekdays and weekends on the inpatient mental health units. • The Facility Director ensures inpatient mental health units are in good repair and the environment reflects recovery-oriented principles. • The Facility Director ensures veterans' privacy in restraint rooms on the inpatient mental health units.

Domain	OIG Summary
	• The Associate Chief of Staff for Behavioral Health develops written guidance to ensure staff and veterans' safety during outdoor breaks.
Clinical Care Coordination 	Care coordination, which involves intentionally sharing a veteran's information and organizing healthcare activities among participants concerned with a veteran's care, is crucial for those with complex health and social needs. To assess the quality of clinical care coordination, the OIG reviewed access to services, local procedures for involuntary treatment, interdisciplinary treatment planning, medication management, and discharge planning. The OIG found that facility leaders established standard operating procedures for inpatient mental health unit admission, as well as processes for veterans on an involuntary hold. Although facility policy included guidelines for involuntary hospitalization, facility leaders did not have formal written guidance to monitor and ensure compliance with state laws. The facility had written guidance for the transition of care following an inpatient unit discharge. The OIG found that, in records reviewed, inpatient unit staff did not consistently document a completed treatment plan. Inpatient unit staff did not comply with required documentation for medication risks and benefits discussions. Mental health inpatient unit providers did not include mental health treatment coordinators in care coordination, as required. Additionally, many discharge instructions included abbreviations and acronyms for outpatient appointments and medications that could be difficult for veterans and caregivers to understand. Further, the discharge instructions did not consistently include the reason for prescribed medications, and many contained both trade and generic names with no explanation that the medications were the same. OIG recommendations: • The Facility Director formalizes processes to monitor and track compliance with state involuntary commitment laws. • The Chief of Staff ensures the completion of comprehensive inpatient mental health treatment plans and monitors for compliance. • The Chief of Staff ensures documentation of discussions between prescribers and veterans on the risks and benefits of newly prescribed medications and monitors for compliance. • The Chief of Staff ensures the inclusion of mental health treatment coordinators in care coordination. • The Chief of Staff ensures discharge instructions for veterans include appointment locations written in easy-to-understand language. • The Chief of Staff ensures discharge instructions for veterans include the purpose for each listed medication in easy-to-understand language. • The Chief of Staff ensures discharge instructions for veterans include an explanation when both trade and generic names are used for the same medication.

Domain	OIG Summary
Suicide Prevention 	The underlying causes of suicide can be complex and multifactorial, and suicide prevention may require coordinated systems, services, and resources to effectively support veterans at risk of suicide. To evaluate suicide prevention activities on the inpatient unit, the OIG reviewed compliance with required suicide risk screening and evaluation, safety planning, and training. Staff did not consistently complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge. Additionally, the safety plans reviewed did not consistently address ways to make a veteran's environment safer from potentially lethal means beyond access to firearms and opioids. Inpatient unit staff were compliant with required Skills Training for Evaluation and Management of Suicide and lethal means safety training, but nonclinical staff were not compliant with VA S.A.V.E. (signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment) training. OIG recommendations: • The Chief of Staff ensures staff complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors for compliance. • The Chief of Staff ensures safety plans address ways to make the veteran's environment safer from potentially lethal means and monitors for compliance. • The Facility Director ensures staff comply with timely completion of VA S.A.V.E. training requirements and monitors for compliance.
Safety 	The primary goal of inpatient mental health services is to stabilize veterans who are experiencing acute distress by providing a safe, secure environment with staff trained to recognize and minimize the potential for self-harm. The OIG evaluated aspects of safety, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. Although leaders and staff conducted Mental Health Environment of Care Checklist inspections at the required frequency, the OIG found the established Interdisciplinary Safety Inspection Team did not record meeting minutes and membership did not include the suicide prevention coordinator, as required. The OIG observed multiple safety hazards that were not identified in the Patient Safety Assessment Tool and likely existed during the most recent Mental Health Environment of Care Checklist inspection. Interdisciplinary Safety Inspection Team staff failed to comply with Mental Health Environment of Care Checklist processes, incorrectly categorized some standards as met or not applicable, and did not have mitigation plans for identified hazards. Further, the Interdisciplinary Safety Inspection Team did not follow guidance for resolving identified deficiencies within the required time frames. The OIG found that inpatient unit staff were generally compliant with VHA-required Mental Health Environment of Care Checklist annual training; however, Interdisciplinary Safety Inspection Team staff responsible for conducting safety inspections on the inpatient units did not consistently complete the training. OIG recommendations: • The Facility Director ensures the Interdisciplinary Safety Inspection Team adheres to Veterans Health Administration requirements, including recording

Domain	OIG Summary
	meeting minutes and including all required members, and monitors for compliance. • The Facility Director implements processes to ensure Interdisciplinary Safety Inspection Team staff accurately identify and document safety hazards within the Patient Safety Assessment Tool and monitors for compliance. • The Facility Director ensures staff address identified Mental Health Environment of Care Checklist deficiencies in accordance with Veterans Health Administration guidelines and monitors for compliance. • The Facility Director ensures Interdisciplinary Safety Inspection Team members comply with Mental Health Environment of Care Checklist training requirements and monitors for compliance.

VA Comments and OIG Response

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion.[2] For this report, VHA provided the OIG comments in the Facility Director memorandum during the draft phase. The OIG considered and reviewed the comments. Based on the review, an insubstantial change was made to a recommendation for clarification, but no changes were made to OIG findings. The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes D and E). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

[2] VA OIG Directive 306, *Comments to Draft Reports*, April 10, 2024, amended April 24, 2019.

Contents

Abbreviations

ACOS	Associate Chief of Staff for Behavioral Health
C-SSRS	Columbia-Suicide Severity Rating Scale
CMHO	Chief Mental Health Officer
EHR	electronic health record
FY	fiscal year
HCS	healthcare system
ISIT	Interdisciplinary Safety Inspection Team
LRC	local recovery coordinator
MHEC	Mental Health Executive Council
MHEOCC	Mental Health Environment of Care Checklist
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The mission of the VA Office of Inspector General (OIG) is to conduct meaningful independent oversight of VA. The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care through 1,380 healthcare facilities to over 9.1 million enrolled veterans.[1] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services.[2] The OIG conducted an inspection from August 19 through September 12, 2024, to evaluate acute inpatient mental health care provided at the Corporal Michael J. Crescenz VA Medical Center, part of the VA Philadelphia Healthcare System (facility) in Pennsylvania.[3]

VHA's "mental health services are organized across a continuum of care" and "in a team-based, interprofessional, patient-centered, recovery-oriented structure" (see figure 1).[4] VHA healthcare system (HCS) leaders are expected to ensure all veterans who are eligible for care have access to recovery-oriented inpatient, residential, and outpatient mental health programs.[5]

All HCSs must provide assessment, diagnosis, and treatment for the full range of mental health illnesses. Required services include psychological and neuropsychological evaluation, evidence-based individual and group psychotherapy, pharmacotherapy, peer support, and vocational rehabilitation counseling.[6]

[1] "Mission, Vision, Values," OIG, accessed June 10, 2024, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed January 8, 2025, www.va.gov/health/aboutvha.asp.

[2] For the purposes of this report, the OIG defines the term "healthcare system" as a parent facility and its associated medical centers, outpatient clinics, and other related VA services or programs. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[3] "About us," VA, accessed December 17, 2024, https://www.va.gov/philadelphia-health-care/about-us/.

[4] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023; VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019.

[5] VHA Directive 1160.01. In this report, the OIG refers to veterans instead of patients to support recovery-oriented language.

[6] VHA Directive 1160.01. If an HCS does not offer required services, those services must be available through another VA resource.

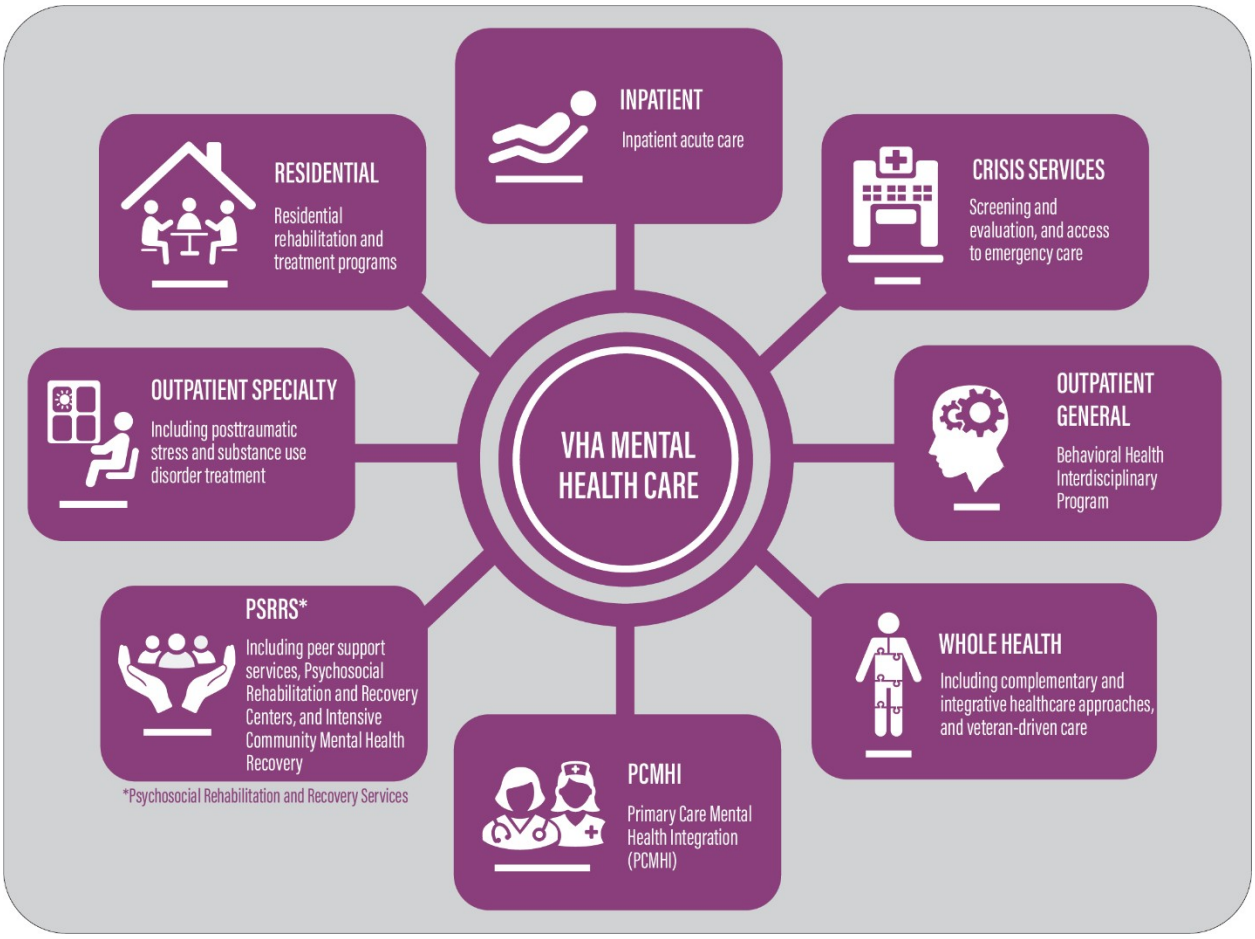


Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163.

According to VHA, inpatient mental health services are considered the most intensive level of mental health care used to treat veterans safely and effectively during periods of acute mental distress.[7] In fiscal year (FY) 2023, VHA HCSs delivered inpatient mental health care to 62,966 veteran stays.[8]

To evaluate the quality of inpatient mental health care at the medical center, the OIG assessed specific processes across six domains: leadership and organizational culture, high reliability

[7] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023.

[8] VHA identifies a "patient stay" as a distinct instance of a veteran staying on a specific unit for a defined time frame. "ADT Using NUMA," VHA Support Service Center, accessed April 30, 2024, https://vssc.med.va.gov/webrm/vssc_links.aspx?rpt_id=1552&index=1. (This site is not publicly accessible.); The fiscal year for the federal government is a 12-month period from October 1 through September 30 of any given year and is designated by the calendar year in which it ends. 49 C.F.R. § 1511.3 (2023).

recovery-oriented principles, clinical care coordination, suicide prevention, and safety. For background information and related requirements, refer to appendix A and appendix B.[9]

About the VA Philadelphia HCS

The facility, part of Veterans Integrated Service Network (VISN) 4, has two acute inpatient mental health units (inpatient units) as well as outpatient mental health care.[10] Outpatient care is also offered at five community-based outpatient clinics located in New Jersey and Pennsylvania.[11] In FY 2023, the facility provided health care to 62,736 veterans; 20,021 received outpatient mental health care. Inpatient unit staff cared for 476 veterans, and the facility maintained an approximate average daily census of 23 between inpatient units. Facility staff submitted four consults for inpatient mental health care in the community.[12] Facility data indicated the inpatient unit had 41 authorized beds (discussed further in the Access to Care section).[13]

[9] The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[10] VA administers healthcare services through a nationwide network of 18 regional systems referred to as VISNs. "Veterans Integrated Services Networks (VISNs)," VHA, accessed April 15, 2024, https://www.va.gov/HEALTH/visns.asp.

[11] The two inpatient mental health units are 7 East and 7 West. Three community-based outpatient clinics are in New Jersey, and two are in Pennsylvania.

[12] The average daily census was rounded from 23.38.

[13] "Corporate Data Warehouse," VA Health Systems Research, accessed March 24, 2025, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm.

Leadership and Organizational Culture

"Leaders usually impose structure, systems, and processes [on an organization], which, if successful, become shared parts of the culture. And once processes have become taken for granted, they become the elements of the culture that may be the hardest to change."[14] Healthcare system leaders can nurture a positive, safety-oriented culture by building effective reporting and communication structures, incorporating stakeholder feedback, and supporting continuous performance improvement.[15]

The OIG reviewed the facility's leadership structure, inpatient unit staffing practices, and VISN oversight. The OIG evaluated how these elements support inpatient unit operations, compliance with requirements, and delivery of quality care.

Leadership Structure

The facility's executive leadership team consisted of the Director, Deputy Director, Chief of Staff, Associate Director, Assistant Director, and Associate Director for Patient Care Services.[16] The OIG learned that the Chief of Staff supervised the Associate Chief of Staff for Behavioral Health (ACOS) and the Deputy Associate Director of Patient Care Services supervised the Associate Chief Nurse of Behavioral Health. The ACOS served as the facility's required chief mental health lead and oversaw mental health staff throughout the facility.[17] (See appendix C for a detailed organizational structure.)

The OIG found that facility leaders did not establish a formalized local mental health executive council (MHEC), as required by VHA, during the 12-month review period.[18] The ACOS reported being unaware of the requirement. Without an MHEC, the facility lacked a formal mental health governance body to oversee care delivery and quality improvement.[19]

[14] Edgar H. Schein, *Organizational Culture and Leadership, 4th Edition, 2010.*

[15] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, May 2024, accessed June 25, 2024, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/HRO%20Assessment%20and%20Planning%20Resources.aspx?id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Leaders%20Guide%20to%20Foundational%20HRO%20Practices%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This website is not publicly accessible.)

[16] "Leadership," VA, accessed September 30, 2024, https://www.va.gov/philadelphia-health-care/about-us/leadership/.

[17] VHA Directive 1160.01.

[18] VHA Directive 1160.01. Medical center leaders provided documentation of an MHEC charter effective April 30, 2024.

[19] VHA Directive 1160.01.

Inpatient Unit Staffing

The division director, acute psychiatric services, who also served as the facility's required inpatient mental health program manager (program manager), provided programmatic oversight of unit operations and supervised the inpatient unit psychiatrists. Other mental health professionals working on the inpatient units, such as nurses and social workers, were supervised by their respective discipline leads.

At the time of the inspection, leaders identified staffing challenges; however, the ACOS reported that current staffing levels had not negatively affected inpatient unit admissions and attributed this to a lower census (see Access to Care for additional information). Facility leaders reported the use of recruitment tools such as residency programs to hire newly graduated nurses and psychiatrists, and retention incentives, such as an education debt reduction program.

VISN Oversight

In compliance with VHA requirements, the VISN Chief Mental Health Officer (CMHO) co-chaired a VISN-level MHEC that included participation from each of the VISN's HCS chief mental health leads (see figure 2).[20] Additionally, the VISN CMHO reported monitoring census and occupancy data and described mechanisms to provide support of inpatient unit operations, including site visits, action plans, monthly VISN MHEC meetings, and daily huddles with HCS directors and the VISN Chief Medical Officer.[21] The VISN CMHO also stated the VISN inpatient mental health lead was responsible for disseminating information such as new directives and processes to mental health staff.

[20] VHA Directive 1160.01.

[21] A huddle is a brief meeting that includes "appropriate discipline-specific team members to communicate information about the patient care work for a specified period of time." VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

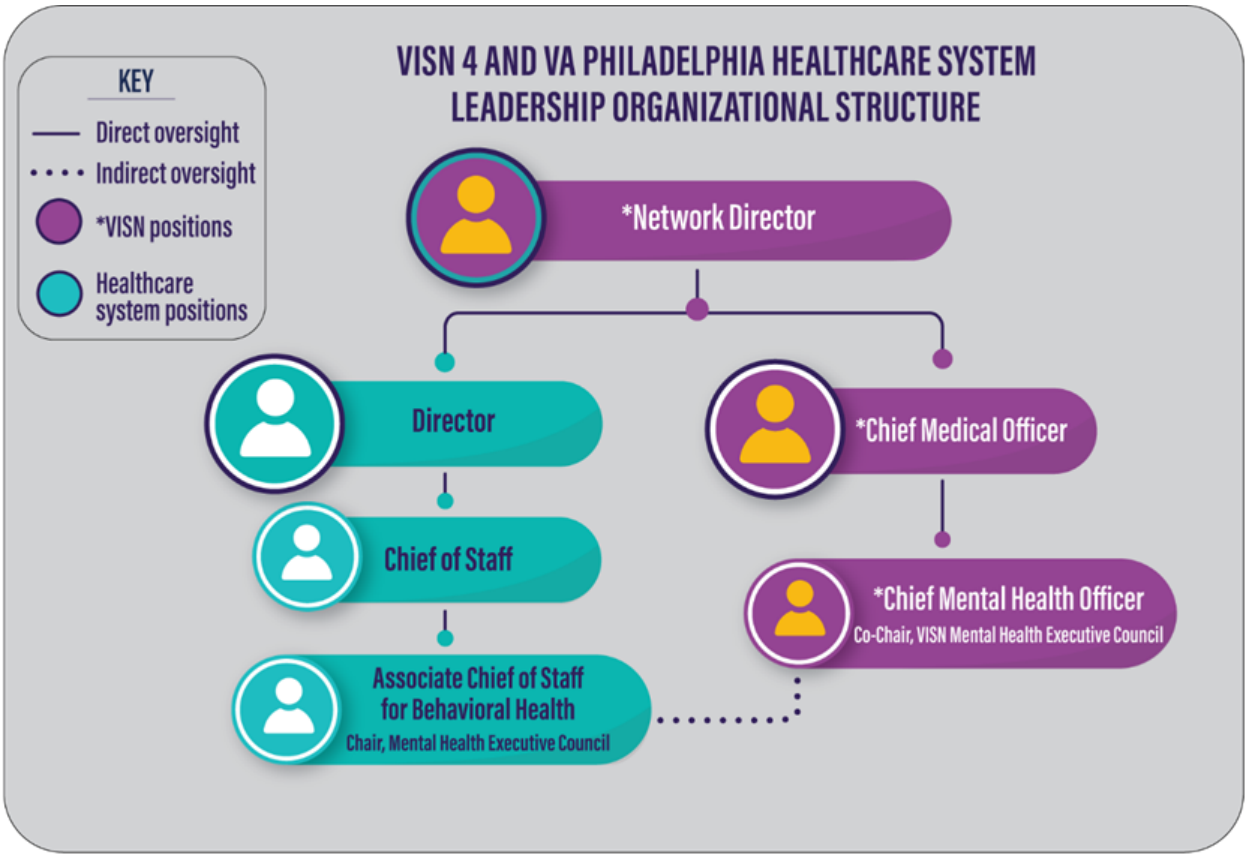


Figure 2. *VISN 4 and VA Philadelphia Healthcare System leadership organizational structure.*
Source: OIG analysis of facility documents received from August 21 through September 6, 2024; VHA Directive 1160.06.
Note: This figure represents the facility and network leadership positions relevant to this inspection.

Recommendation

1. The Facility Director establishes a mental health executive council that operates in accordance with Veterans Health Administration requirements.

For a detailed action plan, see appendix E.

High Reliability Principles

High reliability organization principles promote "a 'high sensitivity' approach towards potential failures and prioritize their identification and mitigation."[22] VHA considers staff responsible for identifying and addressing risks by empowering them to "keep Veterans the safest they can be on our watch." VHA asserts that "a strong culture of safety will positively impact Veterans, their family members, and caregivers."[23]

The OIG disseminated a questionnaire to evaluate staff's and leaders' perceptions of psychological safety and performance improvement activities. In addition, the OIG determined whether staff and leaders engaged in process improvements and solicited veteran input on mental health care, as required.[24]

[22] Chris Ekai, "What Are The 5 principles Of Hro," *Risk Publishing* (blog), January 11, 2024, https://riskpublishing.com/what-are-the-5-principles-of-hro/.

[23] "VHA's HRO journey officially begins," VHA National Center for Patient Safety, March 29, 2019, https://www.patientsafety.va.gov/features/VHA_s_HRO_journey_officially_begins.asp.

[24] VHA Directive 1160.01; The Joint Commission, *Standards Manual e-dition*, PI.04.01.01, January 2024. "The hospital uses improvement tools or methodologies to improve its performance"; The Joint Commission accredits and certifies healthcare organizations and programs in the United States. "The Joint Commission (TJC)," VHA Office of Quality and Patient Safety, accessed June 13, 2024, https://vaww.qps.med.va.gov/divisions/qm/ea/jointcommission.aspx. (This site is not publicly accessible.)

Psychological Safety

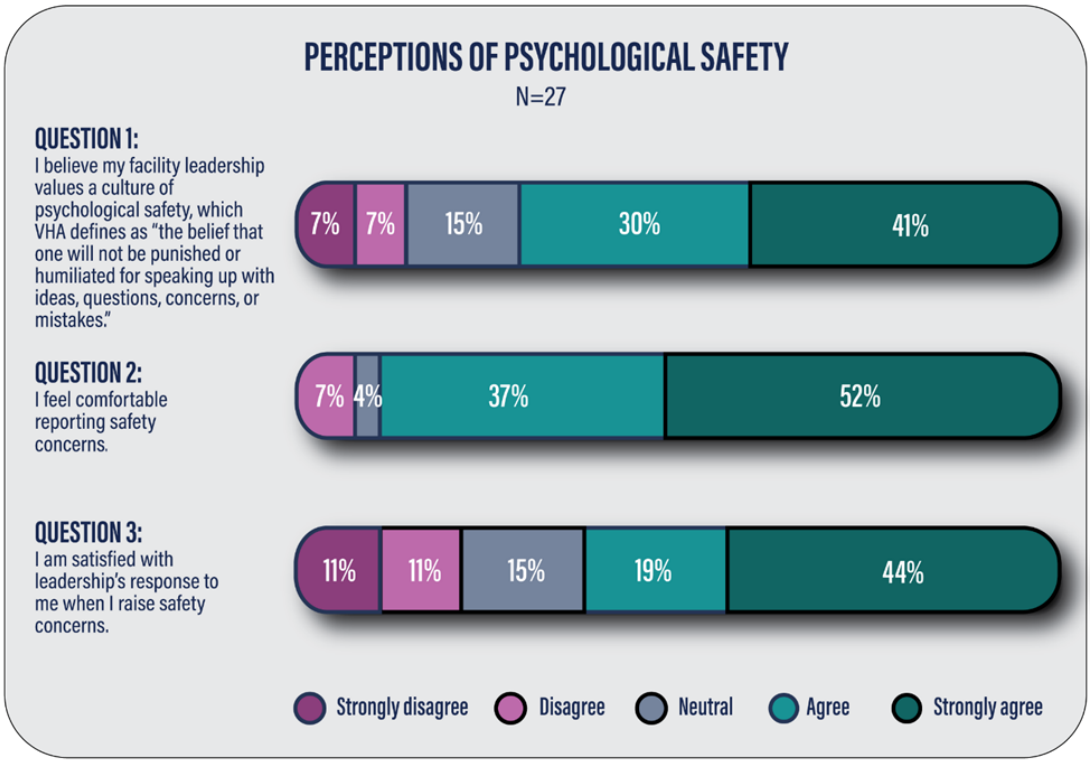


Figure 3. *Mental health staff and leader perceptions of psychological safety.*
Source: OIG analysis of staff questionnaire responses. VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)," September 2022, updated September 2024.
Note: The order of the colors in the key corresponds to the order in the scales above.

Most respondents agreed or strongly agreed with statements regarding a culture of safety, reporting safety concerns and leaders' responses to safety concerns (see figure 3).

Performance Improvement

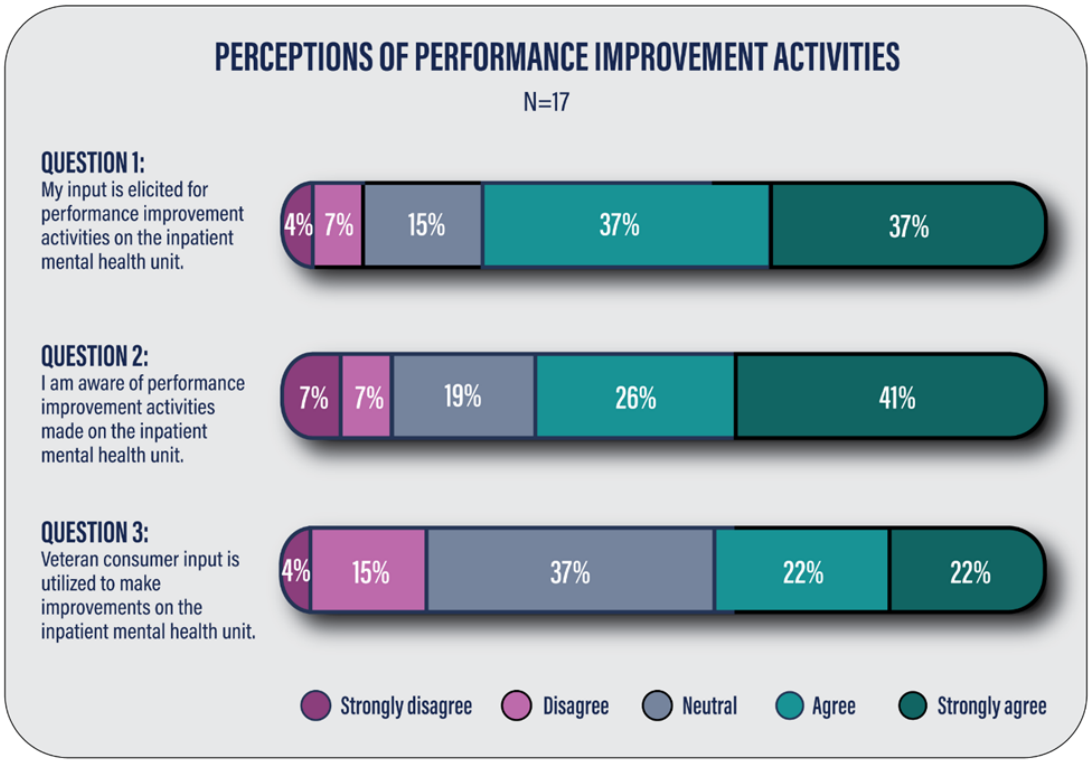


Figure 4. *Mental health staff and leader perceptions of performance improvement activities.*
Source: OIG analysis of questionnaire responses.
Note: The order of the colors in the key corresponds to the order in the scales above.

Most respondents agreed or strongly agreed with statements related to input and awareness of performance improvement activities. Most responded neutrally to the statement regarding veteran input for improvements on the inpatient units (see figure 4).

Mental health leaders reported collecting inpatient unit staff's input, as required, through team meetings to discuss improvement opportunities.[25] Additionally, mental health leaders described incorporating staff feedback into process improvement efforts and shared an example of input that resulted in improved medication orders.

Mental health leaders reported implementing hospital-wide patient experience surveys, a suggestion box, and other tools to solicit input from veterans who used mental health services.[26] Mental health leaders also shared plans to develop another survey tool specifically for veterans who have received inpatient mental health care. The OIG made no recommendations for this domain.

[25] VHA Directive 1160.01.
[26] VHA Directive 1160.01.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent values."[27] When a veteran understands the risks and benefits of treatment options and the provider understands the veteran's preferences and values, the veteran is empowered to make decisions and meet treatment goals.[28]

The OIG examined aspects of leadership, programming, and the physical care environment to evaluate the facility's integration of recovery-oriented principles, as required, on the inpatient unit.[29]

Leadership

VHA expects the inpatient mental health program manager "to coordinate and promote consistent, sustained, high-quality therapeutic programming" on the inpatient unit.[30] As described in Leadership and Organizational Culture, the program manager oversaw inpatient clinical care and supervised psychiatry staff.

The facility met the VHA requirement to have a full-time local recovery coordinator (LRC) who had responsibilities within and beyond the inpatient units.[31] However, the OIG found that facility leaders had not established a local plan across the mental health care continuum for continued transformation to recovery-oriented services, as required.[32] Without a recovery transformation plan, leaders and staff may fail to implement recovery-oriented care on the inpatient units and throughout the facility.

[27] "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, accessed September 19, 2022, https://www.samhsa.gov/find-help/recovery.

[28] "Shared Decision-Making in Mental Health Care," Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, accessed May 12, 2022, https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4371.pdf.

[29] VHA Directive 1160.06.

[30] VHA Directive 1160.06. The inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services.

[31] VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019; "Local Recovery Coordinators – Home," VA Central Office, accessed November 21, 2024, https://dvagov.sharepoint.com/sites/VACOMentalHealth/LRC. (This site is not publicly accessible.)

[32] VHA Directive 1163. The LRC provided the OIG with a recovery transformation plan dated August 26, 2024, after the start of the OIG inspection.

Recovery-Oriented Programming

The LRC reported that staff introduced veterans to recovery-oriented principles through a veteran handbook and program offerings. However, the OIG found inpatient unit staff did not offer at least four hours of recovery-oriented, interdisciplinary programming on weekdays or weekends, as required by VHA.[33] The LRC acknowledged staffing as a barrier to support additional recovery-oriented programming.

The program manager reported that vacancies in specialized areas such as recreational therapy and pharmacy contributed to an inability to consistently offer the required programming. The Chief of Psychiatry discussed with the OIG plans for inpatient unit nursing staff and outpatient mental health staff to provide additional group coverage. Mental health leaders also reported staff worked scheduled overtime to support inpatient unit operations. Insufficient programming may limit opportunities for veterans to work on recovery goals while receiving inpatient mental health care.

Physical Environment

The OIG found both inpatient units had aspects of a recovery-oriented environment; however, not all areas met VHA standards for a safe, hopeful, and healing setting.[34] In general, both inpatient units were clean, although the OIG observed examples of maintenance issues such as broken vinyl tiles, scuffed walls, and chipped paint.

[33] VHA Directive 1160.06.

[34] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities,* January 2021, accessed March 27, 2024, https://dvagov.sharepoint.com/:b:/r/sites/VACOMentalHealth/mhrrtp/Resources/Program%20Development/MH%20RRTP%20and%20Inpatient%20Design%20Guide%202021.pdf?csf=1&web=1&e=ow3N0D. (This site is not publicly accessible.)

Figure 5. *Veteran's bedroom (with displayed artwork) and multipurpose room (lacked artwork), both with natural lighting.*
Source: Photos of the facility's inpatient units taken by OIG staff, September 10 through 11, 2024.

The OIG observed natural lighting in bedrooms and general common areas, with artwork displayed on the walls of veterans' bedrooms and some bathroom doors; however, hallways and multipurpose room walls were mostly bare (see figure 5).[35] A recovery-oriented environment that incorporates hopeful and healing elements, such as artwork, while ensuring safety can create a therapeutic and welcoming setting for veterans.

Veterans have the "right to be treated with dignity in a humane environment that affords them both reasonable protection from harm and appropriate privacy."[36] The OIG noted that on both inpatient units, restraint rooms lacked an adjoining anteroom; consequently, the observation window on the restraint room door allowed individuals in the hallway to view inside the room.[37] In the absence of an anteroom or other deterrents to unauthorized observation from the hallway, veteran privacy and dignity could be compromised.

The facility did not have a dedicated safe and secure outdoor space for inpatient unit veterans. The acting Associate Chief Nurse of Behavioral Health reported staff had accompanied veterans for outdoor breaks. However, the OIG found facility leaders did not establish local written guidance to ensure safe outdoor access.[38] In the absence of a secure outdoor space, the OIG would expect clearly defined written processes for staff use when taking veterans outdoors.[39]

[35] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities.* Per VHA guidance, "Controlled natural lighting should be provided wherever possible to reduce glare and to promote a healing and energy-efficient environment." Further, facility leaders should "avoid excessive illumination in spaces such as corridors or exterior courtyards that reinforce an institutional image."

[36] Patients' Rights, 38 C.F.R. § 17.33 (2005).

[37] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, April 10, 2023. "A vestibule or anteroom can provide separation, safe access, and increase patient privacy."

[38] VHA Directive 1160.06; VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

[39] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

Recommendations

2. The Facility Director ensures development and implementation of a multi-year recovery transformation plan.
3. The Associate Chief of Staff for Behavioral Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekdays and weekends on the inpatient mental health units.
4. The Facility Director ensures inpatient mental health units are in good repair and the environment reflects recovery-oriented principles.
5. The Facility Director ensures veterans' privacy in restraint rooms on the inpatient mental health units.
6. The Associate Chief of Staff for Behavioral Health develops written guidance to ensure staff and veterans' safety during outdoor breaks.

For detailed action plans, see appendix E.

Clinical Care Coordination

"Care coordination involves deliberately organizing patient care activities and sharing information among all the participants concerned with a patient's care to achieve safer and more effective" treatment.[40] For veterans with "complex health and social needs, care coordination is crucial for improving access to services, clinical outcomes, and care experiences."[41] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a less-intensive level of care.[42]

The OIG evaluated the quality of clinical care coordination for veterans receiving inpatient mental health treatment and assessed access to services, local procedures for involuntary treatment, interdisciplinary team treatment planning, medication management, and discharge planning.

Access to Care

Successful coordination of mental health care requires well-defined screening and admission processes that ensure veterans have timely "access to mental health evaluation and clinically appropriate treatment provided in a safe and secure environment."[43] The OIG found facility leaders established standard operating procedures for inpatient unit admission processes and interfacility transfers that met VHA requirements.[44]

At the time of the inspection, mental health leaders reported having 20 beds available for veteran care on each of the two inpatient units with an average daily census of 23.[45] To ensure timely access to care, facility leaders reported tracking daily inpatient mental health census through a bed coordinator and huddles.

[40] "Care Coordination," Agency for Healthcare Research and Quality, accessed April 30, 2024, https://www.ahrq.gov/ncepcr/care/coordination.html.

[41] Denise M. Hynes et al., "Understanding Care Coordination for Veterans with Complex Care Needs: Protocol of a Multiple-Methods Study to Build Evidence for an Effectiveness and Implementation Study," *Frontiers in Health Services* 3, no. 3 (August 14, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[42] VHA Directive 1160.06.

[43] VHA Directive 1160.01; VHA Directive 1160.06.

[44] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023; The OIG learned from the Director of VHA Risk Management that, as of April 25, 2024, the Office of Mental Health and Suicide Prevention was formally separated into two offices and operating independently as the Office of Mental Health and the Office of Suicide Prevention, with staff realigned to the respective offices; Corporal Michael J. Crescenz VAMC SOP BH-059, "Inpatient Psychiatric Admission Procedure," June 26, 2023; Corporal Michael J. Crescenz VA Medical Center MCP 11-54, "Interfacility Patient Transfers," August 19, 2021.

[45] Although facility data indicated 41 operating beds, leaders reported the facility actually had 40 operating beds.

Facility staff submitted four consults for inpatient mental health care in the community in FY 2023. The inpatient mental health program manager explained that inpatient care was accessible at the facility, therefore, veterans did not need to be transferred to the community.[46]

Involuntary Hospitalization and Treatment

Facility policy included guidelines for involuntary hospitalization.[51] Mental health leaders and staff shared with the OIG and provided documentation that the inpatient unit social worker informally monitored and tracked involuntary hospitalizations. However, facility leaders had not established written guidance to define a process to oversee compliance with state laws.[52] The absence of written processes to monitor involuntary hospitalizations may result in failure to align facility practice with state laws, potentially contributing to the illegal hospitalization of veterans.

VHA policy requires documentation of voluntary or involuntary legal status to the inpatient unit. The OIG found all reviewed electronic health records (EHRs) included the required documentation of legal status.[53]

An involuntary hold "is a brief involuntary detention of a person presumed to have a mental illness in order to determine whether the individual meets criteria for" involuntary hospitalization.[47]

An involuntary hospitalization is the "legal intervention by which a judge, or someone acting in a judicial capacity, may order that a person with symptoms of a serious mental disorder, and meeting other specified criteria, be confined in a psychiatric hospital."[48]

Standards and procedures for civil commitment are provided by state law and vary by state.[49] VHA requires that HCS leaders consult with legal counsel, as necessary, to ensure that processes are consistent with applicable laws.[50]

Treatment Planning

Facility leaders established VHA-required written guidance on inpatient mental health treatment planning processes that included recovery-oriented elements such as veterans' involvement in setting individualized goals. Corresponding

[46] The program manager reported that typically non-veterans would be transferred to non-VA facilities.

[47] Leslie C. Hedman et al., "State Laws on Emergency Holds for Mental Health Stabilization," *Psychiatric Services* 67 no. 5 (May 2016): 529–535, https://doi.org/10.1176/appi.ps.201500205.

[48] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," Substance Abuse and Mental Health Services Administration, accessed July 27, 2023, https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf.

[49] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," Substance Abuse and Mental Health Services Administration.

[50] VHA Directive 1160.01.

[51] VHA Directive 1160.06; Corporal Michael J. Crescenz VA Medical Center MCP 116-04, "Management of Involuntary Patients," June 29, 2020.

[52] VHA Directive 1160.06.

[53] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure," September 20, 2022, updated November 2, 2023.

with VHA's requirement for specified timelines, the standard operating procedure incorporated guidance for staff to develop mental health treatment plans.[54]

Sixty-two percent of reviewed EHRs had a treatment plan. Ninety-seven percent of completed treatment plans included documentation that the veteran was involved in developing the plan, and all treatment plans noted interdisciplinary treatment team participation.[55] Failure to develop treatment plans may contribute to staff's incomplete awareness of veterans' individualized needs and limit communication between veterans and providers.[56]

Medication Treatment

VHA requires a discussion between the prescriber and veteran on the risks and benefits of medication treatment. The OIG found only 22 percent of reviewed EHRs included prescriber documentation of the required discussion.[57] When providers do not communicate the risks and benefits of medication use, veterans may be deprived of the information needed to make informed decisions on treatment options.

Discharge Planning

Facility leaders established written guidance on care coordination processes for veterans discharged from inpatient unit care, per VHA requirements.[58] When asked about barriers to discharge planning, facility leaders and staff identified limited transportation resources for

[54] Acting Deputy Under Secretary for Health for Operations and Management (10N), "Mental Health Treatment Planning and Software Tools," memorandum to Veterans Integrated Service Network (VISN) Director (10N1-23) et al., May 3, 2019; Crescenz VA Medical Center SOP, "Mental Health Treatment Planning."

[55] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The policies contain similar language related to interdisciplinary treatment team collaboration with the veteran in treatment planning; The handbook was in place during the time frame of the EHR review.

[56] Maria E. Theodorou, Bruce L. Henschen, and Margaret Chapman, "The comprehensive care plan: A patient-centered multidisciplinary communication tool for frequently hospitalized patients," *The Joint Commission Journal on Quality and Patient Safety* 46, no. 4 (April 2020): 217–226, https://doi.org/10.1016/j.jcjq.2020.01.002.

[57] VHA Directive 1108.07(1), *General Pharmacy Service Requirements*, November 28, 2022, amended October 4, 2023. The directive states that a prescriber is a provider who is "authorized by law or VA policy to prescribe medications in accordance with their facility approved privileges or scope of practice."; VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 17, 2021; VHA Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023; The OIG reviewed for documentation of a risk and benefit discussion specific to veterans who were newly prescribed central nervous system medication during the inpatient stay; John A. Gray, "Introduction to the Pharmacology of CNS Drugs," chap. 21 in *Basic & Clinical Pharmacology*, 14th edition, ed. Bertram G. Katzung: McGraw-Hill Education, 2017, https://accesspharmacy.mhmedical.com/content.aspx?bookid=2249&sectionid=175218675. Central nervous system medications are used for the treatment of "a wide range of neurologic and psychiatric conditions."

[58] VHA Directive 1160.01; Corporal Michael J. Crescenz VA Medical Center MCP: 122-11, "Care Coordination – Discharge Planning," April 1, 2022.

veterans who were being discharged from the inpatient unit and attending follow-up outpatient appointments.

Mental health leaders and staff shared that mental health treatment coordinators were not included in care coordination, as required by VHA.[59] Failure to include mental health treatment coordinators in care coordination may result in veterans not having support during the transition from discharge to outpatient care.

All reviewed EHRs included a discharge summary, and 98 percent were completed within two days of the veteran's discharge.[60] All EHRs included the required outpatient mental health follow-up appointment scheduled prior to discharge, with an average of four days between discharge and the first scheduled appointment.[61] Additionally, all reviewed EHRs included documentation of discharge instructions and indication that the veteran was offered a copy, as required.[62]

In 96 percent of the reviewed EHRs, the discharge instructions included contact information for the outpatient appointments. However, the OIG found many discharge instructions included abbreviations and acronyms for outpatient appointments that could be difficult for veterans and caregivers to understand (see figure 6).[63] The ACOS reported the appointment section on the discharge instructions was automated and was uncertain if the appointment information could be changed. Missing or unclear details in discharge instructions may create barriers for veterans to attend follow-up appointments and receive timely mental health care.

[59] VHA Directive 1160.06.

[60] VHA Health Information Management Program Office, *Health Record Documentation Program Guide 1.1*, November 29, 2022; VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023. The policies contain similar language related to discharge summary requirements.

[61] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The policies contain similar language related to scheduling outpatient mental health follow-up appointments; The handbook was in place during the time frame of this inspection.

[62] VHA Health Information Management Program Office, *Health Record Documentation Program Guide 1.1*; VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.2*. The policies contain similar language related to discharge summary requirements; VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."; The handbook was in place during the time frame of this inspection.

[63] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The handbook was in place during the time frame of this inspection.

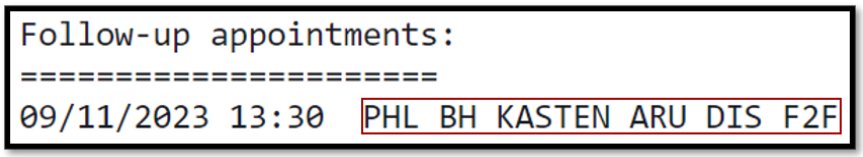


Figure 6. *Example from discharge instructions with difficult-to-understand appointment information outlined in red.*
Source: OIG review of veterans' EHRs.

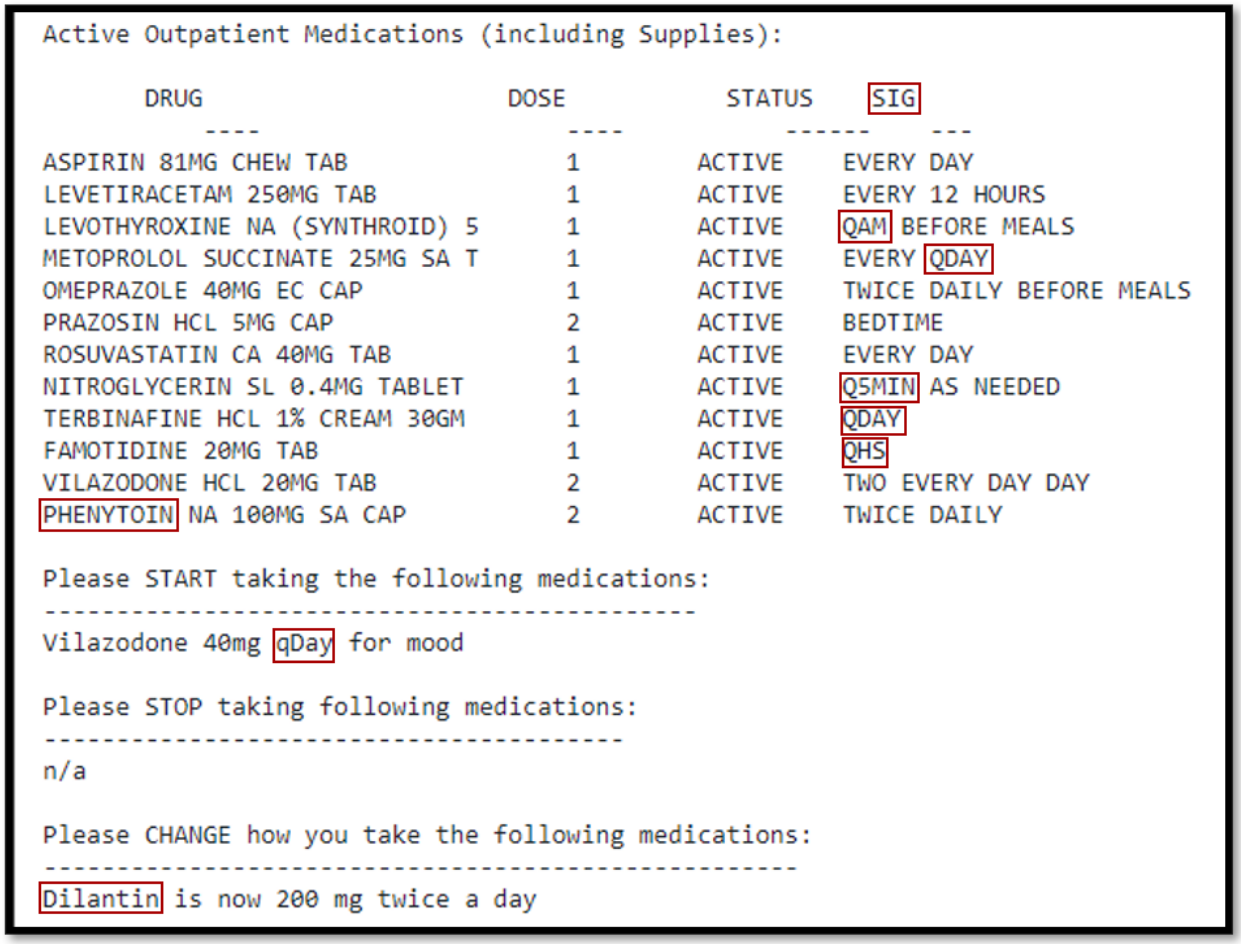
All reviewed EHRs included documentation that a medication list was provided at discharge. However, only 37 percent of the EHRs had discharge instructions that included the reason for the medication.[64] Sixty-one percent of the EHRs had discharge instructions free of medical abbreviations. Abbreviations included in discharge instructions could be difficult for nonmedically trained individuals to understand.[65]

Additionally, 45 percent of the EHRs included discharge instructions with generic and trade medication names used interchangeably without an explanation that they are the same medication (see figure 7). Accurate and easy-to-understand discharge instructions may prevent veterans from making medication errors at home following hospitalization.[66]

[64] VHA Directive 1345, *Medication Reconciliation*, March 9, 2022.

[65] Randa Hilal-Dandan and Laurence L. Brunton, "Appendix I: Principles of Prescription Order Writing and Patient Compliance," in *Goodman and Gilman's Manual of Pharmacology and Therapeutics* (McGraw-Hill Education, 2016), https://accesspharmacy.mhmedical.com/content.aspx?bookid=1810&sectionid=124489535.

[66] VHA Directive 1345.



Active Outpatient Medications (including Supplies):

DRUG	DOSE	STATUS	SIG
ASPIRIN 81MG CHEW TAB	1	ACTIVE	EVERY DAY
LEVETIRACETAM 250MG TAB	1	ACTIVE	EVERY 12 HOURS
LEVOTHYROXINE NA (SYNTHROID) 5	1	ACTIVE	QAM BEFORE MEALS
METOPROLOL SUCCINATE 25MG SA T	1	ACTIVE	EVERY QDAY
OMEPRAZOLE 40MG EC CAP	1	ACTIVE	TWICE DAILY BEFORE MEALS
PRAZOSIN HCL 5MG CAP	2	ACTIVE	BEDTIME
ROSUVASTATIN CA 40MG TAB	1	ACTIVE	EVERY DAY
NITROGLYCERIN SL 0.4MG TABLET	1	ACTIVE	Q5MIN AS NEEDED
TERBINAFINE HCL 1% CREAM 30GM	1	ACTIVE	QDAY
FAMOTIDINE 20MG TAB	1	ACTIVE	QHS
VILAZODONE HCL 20MG TAB	2	ACTIVE	TWO EVERY DAY DAY
PHENYTOIN NA 100MG SA CAP	2	ACTIVE	TWICE DAILY

Please START taking the following medications:

Vilazodone 40mg qDay for mood

Please STOP taking following medications:

n/a

Please CHANGE how you take the following medications:

Dilantin is now 200 mg twice a day

Figure 7. *Example of discharge instructions provided to a veteran, which include abbreviations and use of both generic and trade names (outlined in red).*
Source: OIG review of veterans' EHRs.
Note: Phenytoin is an antiseizure medication with a trade name of Dilantin. The abbreviations QAM, QDAY, Q5MIN, QHS, and SIG describe when and how medications should be taken.

Recommendations

7. The Facility Director formalizes processes to monitor and track compliance with state involuntary commitment laws.
8. The Chief of Staff ensures the completion of comprehensive inpatient mental health treatment plans and monitors for compliance.
9. The Chief of Staff ensures documentation of discussions between prescribers and veterans on the risks and benefits of newly prescribed medications and monitors for compliance.

10. The Chief of Staff ensures the inclusion of mental health treatment coordinators in care coordination.
11. The Chief of Staff ensures discharge instructions for veterans include appointment locations written in easy-to-understand language.
12. The Chief of Staff ensures discharge instructions for veterans include the purpose for each listed medication in easy-to-understand language.
13. The Chief of Staff ensures discharge instructions for veterans include an explanation when both trade and generic names are used for the same medication.

For detailed action plans, see appendix E.

Suicide Prevention

The underlying causes of death by suicide can be complex and multifactorial. Preventing suicide may require coordinated systems, services, and resources to effectively support at-risk veterans[67]

VA is dedicated to preventing suicide and defines prevention as "participating in activities that are implemented prior to the onset of suicidal events and are designed to reduce the potential for suicidal events." [68] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[69]

To evaluate suicide prevention activity on the inpatient unit, the OIG assessed compliance with required suicide risk screening and evaluation, safety planning, and training (see appendix B for methodology).

Suicide Risk Screening and Evaluation

VHA requires staff to complete the Columbia-Suicide Severity Rating Scale (C-SSRS) for all veterans within 24 hours prior to discharge from inpatient mental health units.[70] Ninety-four percent of reviewed EHRs had documentation of a completed C-SSRS; however, only 80 percent were completed within the required time frame.[71] The suicide prevention coordinator described not having a role in ensuring inpatient unit staff completed C-SSRSs and was unaware of the barriers for timely completion. Staff reported challenges with completing the C-SSRSs due to veterans being discharged before interdisciplinary treatment team members could meet with them to conduct the screening. Failure to complete a suicide risk assessment within the required time frame may result in lack of awareness of a veteran's suicide risk, leading to an insufficient understanding of readiness for discharge and post-discharge care coordination needs.

[67] VA, *National Strategy for Preventing Veteran Suicide 2018–2028.*

[68] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

[69] VA, *National Strategy for Preventing Veteran Suicide 2018–2028*.

[70] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," updated May 10, 2023; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), et al., November 23, 2022.

[71] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," November 4, 2021; VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," updated May 10, 2023; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), et al., November 23, 2022. While VHA requires staff to complete C-SSRSs within 24 hours before discharge, the OIG also considered C-SSRSs compliant if completed on the day of discharge; The OIG used 90 percent as the expected level of compliance for EHR reviews.

Safety Planning

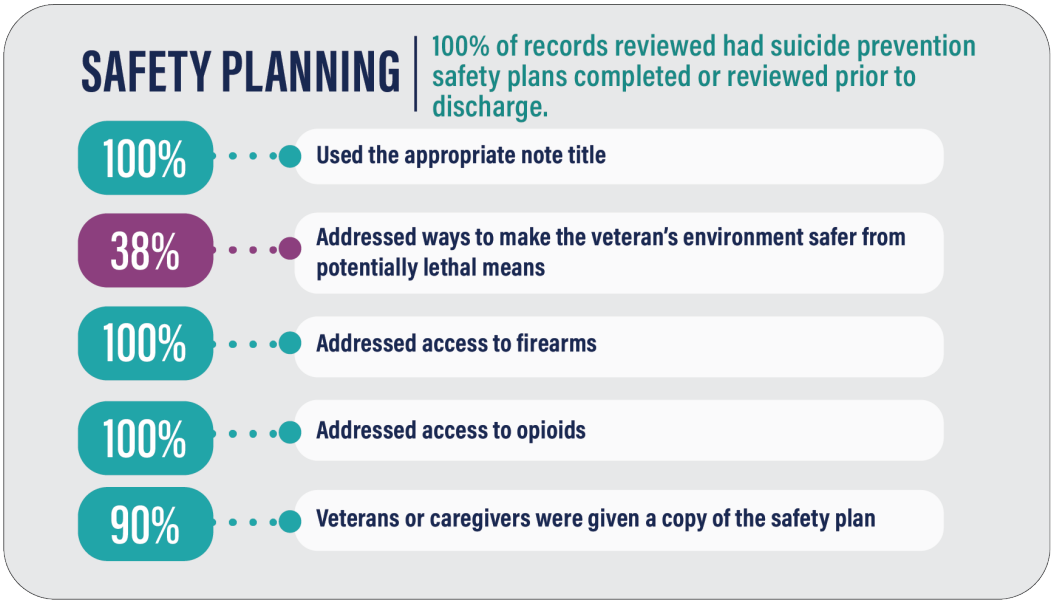


Figure 8. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' EHRs.

The OIG found that all reviewed EHRs reflected that staff documented using the required standardized safety planning note title and completed most select safety elements.[72]

The OIG identified that staff were deficient in addressing ways to make veterans' environments safer from potentially lethal means, including safety considerations beyond access to firearms and opioids (see figure 8).[73] The ACOS reported staff lacked awareness of the requirement. The identification of all potential lethal means in the environment, beyond firearms and opioids, may reduce the risk of veterans' self-harm.[74]

Training

Skills Training for Evaluation and Management of Suicide (STEMS) and VA S.A.V.E. help clinicians and non-clinical staff, respectively, identify the warning signs of suicide risk and

[72] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements Under VHA Directive 1160.06." The SOP uses similar language related to providing veterans a written copy of the safety plan as the rescinded handbook; The handbook was in place during the time frame of this inspection; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Update to Use of National Standardized Suicide Prevention Safety Plan Progress Notes," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., August 17, 2022.

[73] VA, *VA Safety Planning Intervention Manual*, February 23, 2022.

[74] VA, *VA Safety Planning Intervention Manual.*

appropriate interventions.[75] Lethal means safety training provides guidance on how to work with veterans and their families to reduce suicide risk, which includes "firearm and medication safe storage practices."[76]

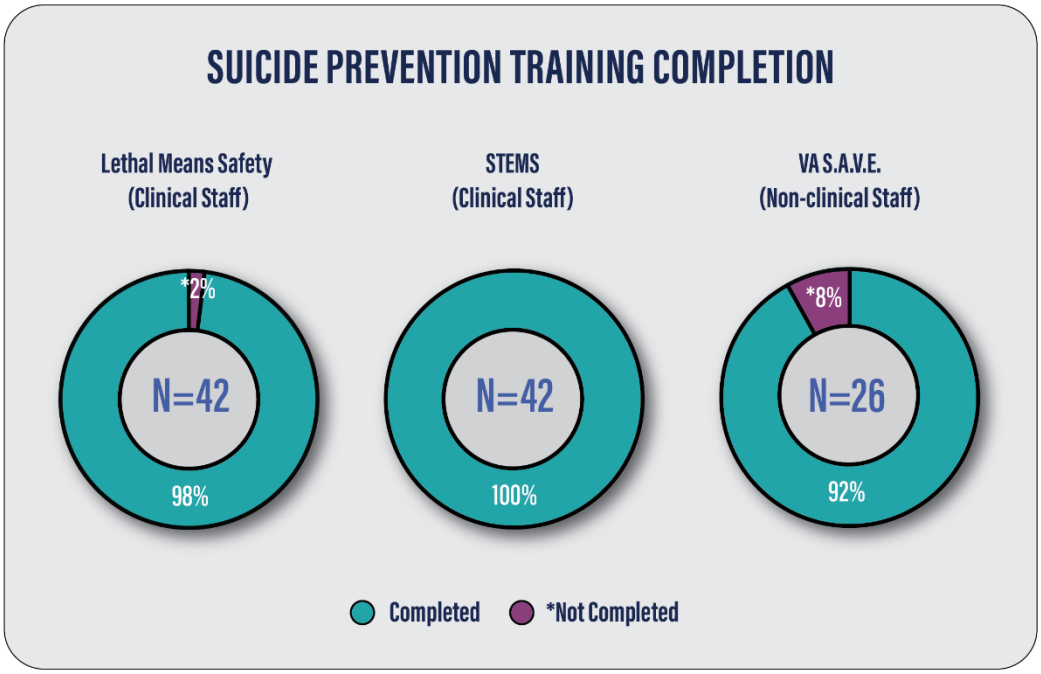


Figure 9. *Inpatient unit staff completion of mandatory suicide prevention trainings.*
Source: OIG document review of clinical and non-clinical staff training certificates.
Note: The OIG considered completion of STEMS and VA S.A.V.E. trainings during the time frame of August 19, 2023, through August 19, 2024. The OIG also evaluated whether clinical staff completed Lethal Means Safety training once during employment.

Inpatient unit clinical staff were compliant with required STEMS and Lethal Means Safety trainings; however, some non-clinical staff were not compliant with the required VA S.A.V.E.

[75] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; "Suicide prevention webinar: VA S.A.V.E.," VA, accessed August 12, 2024, https://vaww.insider.va.gov/suicide-prevention-webinar-va-s-a-v-e/. (This site is not publicly accessible.) VHA identifies the acronym for VA S.A.V.E. acronym as: signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment; Skills Training for Evaluation and Management of Suicide (STEMS) is a suicide risk and intervention training for VHA health care providers.

[76] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), March 17, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network Directors (10N1-23), May 2, 2024. Both memoranda have similar language related to Lethal Means Safety Education and Counseling training requirements.

training (see figure 9).[77] When non-clinical staff do not complete suicide prevention training, they may fail to identify suicide risk factors and may lack awareness of resources and interventions to keep veterans safe.

Recommendations

14. The Chief of Staff ensures staff complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors for compliance.
15. The Chief of Staff ensures safety plans address ways to make the veteran's environment safer from potentially lethal means and monitors for compliance.
16. The Facility Director ensures staff comply with timely completion of VA S.A.V.E. training requirements and monitors for compliance.

For detailed action plans, see appendix E.

[77] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., June 9, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), March 17, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network Directors (10N1-23), May 2, 2024. Both memoranda have similar language related to Lethal Means Safety Education and Counseling training requirements.

Safety

The primary goal of inpatient mental health care is to stabilize veterans experiencing acute distress through the provision of a safe and secure therapeutic environment.[78] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[79]

To assess the inpatient mental health environment, the OIG evaluated aspects of compliance with ongoing assessment of suicide hazards and completion of mandatory staff training.

Mental Health Environment of Care

The OIG found the facility had an established Interdisciplinary Safety Inspection Team (ISIT) responsible for using the Mental Health Environment of Care Checklist (MHEOCC) to "identify and abate suicide hazards" on inpatient mental health units (see figure 10).[80]

Although the ISIT conducted environment of care inspections at the required frequency, the team did not record meeting minutes or include the suicide prevention coordinator as a member.[81] The patient safety manager reported not including the suicide prevention coordinator was an oversight. The absence of a key member on the ISIT may result in staff's failure to identify and mitigate safety hazards.

In a physical inspection of randomized MHEOCC safety elements, the OIG found both inpatient units had shatter resistant dishes, secured storage cabinets, semiannual examination of ceiling tiles, and collapsible trash cans free of plastic liners, as required.[82] However, the OIG observed multiple safety hazards that were likely present during the most recent MHEOCC inspection. These safety hazards included ligature risks in veterans' rooms and hallways, unsecured items that could be used for harm to self or others, furniture and flooring that could lead to injury, and

[78] VHA Directive 1160.06.

[79] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, rescinded and replaced by VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. Unless otherwise specified, the two directives contain the same or similar language related to the inpatient mental health environment and inspections. The ISIT is responsible for conducting environment of care inspections and monitoring compliance with the MHEOCC.

[80] VHA Directive 1167, May 12, 2017. The MHEOCC "consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff work stations."

[81] The ISIT is responsible for conducting environment of care inspections and monitoring compliance with the MHEOCC. VHA Directive 1167, May 12, 2017.

[82] VHA Directive 1167, May 12, 2017; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," April 10, 2023.

multiple blind spots where staff could not visualize and monitor patients.[83] Staff's failure to accurately and timely identify and mitigate environmental hazards could place veterans and staff at risk for harm.

The OIG found that facility staff did not follow processes to accurately document, mitigate, or resolve identified safety concerns. Specifically, facility staff failed to meet VHA requirements to have corrective action plans for all identified deficiencies, track and monitor all corrective action plans to resolution, and follow guidance for resolution within the required time frames for identified deficiencies.[84]

Figure 10. *MHEOCC categories. Source: OIG analysis of VHA Directive 1167, and Mental Health Environment of Care Checklist.*

The patient safety manager and Chief of Engineering reported that MHEOCC items were not always documented in the Patient Safety Assessment Tool, as the ISIT accepted verbal assurance that facility staff would resolve deficiencies timely. By not enforcing accountability for potential and identified environmental deficiencies, leaders may expose veterans and staff to unsafe conditions when staff fail to follow MHEOCC processes.

At the request of the OIG, facility leaders reported taking immediate action to resolve the safety risks identified during the OIG's physical inspection of both inpatient units. These actions included developing corrective action and risk mitigation plans and creating processes to monitor plan compliance and deficiency resolution.

[83] The Joint Commission, "Special Report: Suicide Prevention in Health Care Settings," *Perspectives* 37, no. 11 (November 2017): 1–16. The Joint Commission defines the term "ligature resistant" as, "Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life."; VHA Directive 1167, May 12, 2017; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety. Blind spots are configurations of space resulting in areas that are not visible from the nurses' station.

[84] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Electronic Mental Health Environment of Care Checklist (MHEOCC) Waiver Request and Attestation Process," memorandum to Veterans Integrated Service Network (VISN) Director (10N1-23) et al., December 1, 2021.

The facility had a MHEOCC-compliant physical restraint room in accordance with VHA requirements and a standard operating procedure for the use of restraints.[85]

Training

VHA requires staff training on environmental hazards and orientation to the "content and proper use" of the MHEOCC and the Patient Safety Assessment Tool to identify and correct safety risks.[86] Each of the inpatient MHEOCC categories listed above includes multiple individual items that staff must evaluate during semiannual inspections (see figure 10).[87]

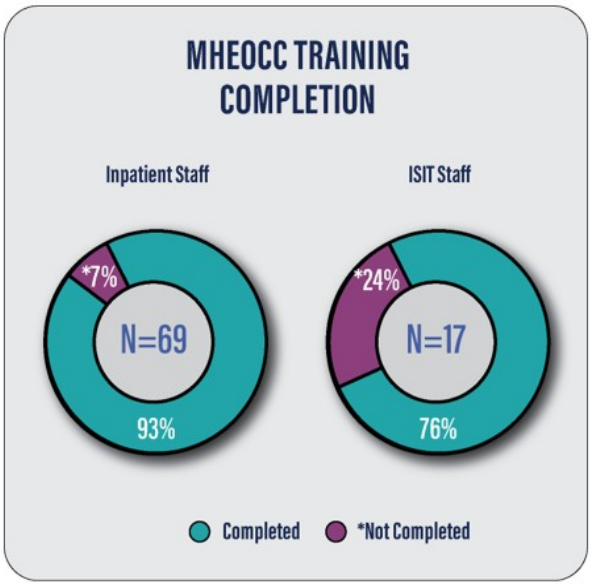


Figure 11. *MHEOCC training completion, August 19, 2023, through August 19, 2024. Source: OIG document review of staff training certificates.*

The OIG found staff on the inpatient units were generally compliant with required annual MHEOCC training; however, ISIT staff did not consistently complete the training (see figure 11). Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.[88]

[85] The Joint Commission, *Standards Manual e-dition*, PC.03.05.09, January 2024. "The hospital has written policies and procedures that guide the use of restraint or seclusion."; VHA Directive 1106.06. The directive specifies the room used for physical restraint must be MHEOCC-compliant; Corporal Michael J. Crescenz VA Medical Center MCP: 11-70, "Restraint Policy," July 15, 2020.

[86] VHA Directive 1167, May 12, 2017. Staff assigned to the inpatient unit and staff conducting MHEOCC inspections are required to complete the training.

[87] VHA Directive 1167, May 12, 2017.

[88] VHA Directive 1167, May 12, 2017.

Recommendations

17. The Facility Director ensures the Interdisciplinary Safety Inspection Team adheres to Veterans Health Administration requirements, including recording meeting minutes and including all required members, and monitors compliance.
18. The Facility Director implements processes to ensure Interdisciplinary Safety Inspection Team staff accurately identify and document safety hazards within the Patient Safety Assessment Tool and monitors for compliance.
19. The Facility Director ensures staff address identified Mental Health Environment of Care Checklist deficiencies in accordance with Veterans Health Administration guidelines and monitors for compliance.
20. The Facility Director ensures Interdisciplinary Safety Inspection Team members comply with Mental Health Environment of Care Checklist training requirements and monitors for compliance.

For detailed action plans, see appendix E.

Conclusion

The facility demonstrated compliance with some, but not all, evaluated VHA inpatient mental health unit requirements. The VISN had an MHEC for monitoring quality and access across the VISN's continuum of mental health care. However, during the 12-month review period, the facility did not have an established MHEC for local oversight.

Facility leaders did not have a plan for continued transformation to recovery-oriented services, and inpatient staff did not offer the required hours of interdisciplinary programming on weekdays and weekends.

Both inpatient units were generally clean; however, the OIG observed maintenance issues such as broken tiles and chipped paint. Additionally, on both inpatient units, the restraint room's observation window allowed individuals in the hallway to view inside the room, which could compromise veteran privacy. The facility did not have a dedicated safe and secure outdoor space and did not establish local written processes for staff to accompany veterans on outdoor breaks.

Facility policy included guidelines for involuntary hospitalization, but facility leaders did not have formal written guidance to monitor and ensure compliance with state laws.

Not all EHRs reviewed included documentation of a treatment plan. However, most veterans and all interdisciplinary treatment team staff were involved in treatment planning. Most EHRs did not have evidence of required discussions with veterans on the risks and benefits of prescribed medications.

All EHRs reviewed included a discharge summary, and all discharge instructions included documentation of a medication list and an outpatient mental health follow-up appointment. However, staff provided discharge instructions with missing or unclear details for appointment follow-up and medication management.

Some EHRs did not have evidence of timely suicide risk screenings. While all reviewed EHRs had documentation of a safety plan, most plans did not address ways to make the environment safer from potentially lethal means beyond access to firearms and opioids. Additionally, non-clinical staff did not consistently complete required suicide prevention training.

Although staff conducted environment of care inspections at the required frequency, the ISIT did not record meeting minutes and did not include the suicide prevention coordinator as a member of the team. Additionally, the ISIT failed to ensure staff accurately documented deficiencies and developed corrective action plans. While inpatient unit staff were generally compliant with annual environmental safety hazards training, ISIT staff were not compliant with the required training.

The OIG issued 20 recommendations to the Facility Director, Chief of Staff, and ACOS. These recommendations, once addressed, may improve the quality and delivery of veteran-centered, recovery-oriented care on the inpatient mental health units.

Appendix A: Background

Inpatient Mental Health Services

VHA offers acute inpatient mental health services as a "high-intensity" treatment option for veterans experiencing "acute and severe emotional or behavioral symptoms" that pose a safety risk or result in compromised mental function. When a healthcare provider determines that inpatient mental health care is appropriate, the veteran should be immediately admitted to ensure safety and stabilization.[89]

VHA requires inpatient unit staff use a veteran-centered, evidence-based, recovery-oriented approach that incorporates evaluation and monitoring, interdisciplinary treatment, discharge planning, adequate staffing, privacy, and respect.[90] To evaluate the quality of recovery-oriented care provided at the facility, the OIG assessed compliance with VHA requirements in the six domains described below.

Leadership and Organizational Culture

Organizational structure plays a critical role in the quality of healthcare delivery. Elements such as formal reporting channels, committee structures, and staffing practices should support inpatient unit operations and align with care delivery needs.

According to VHA's requirements, the HCS director is responsible for overseeing inpatient mental health services. The chief of staff, in collaboration with the associate director of patient care services, should ensure that inpatient units have adequate staffing to establish interdisciplinary teams, provide services, and fully implement program requirements.[91]

Each HCS must have a dedicated mental health lead with overall responsibility for mental health service operations, including mental health services that may be aligned under a different department. The mental health lead may also be referred to as the mental health service line director, chief of mental health, or other comparable title. The mental health lead serves as the chair of the HCS MHEC, which ensures staff provide high-quality care and are responsive to veterans' preferences.[92] Each MHEC must include at least one veteran, ideally one who is receiving mental health services and not employed at the HCS. The MHEC should meet quarterly and "record minutes that are accessible to all mental health clinical staff."[93]

[89] VHA Directive 1160.06.
[90] VHA Directive 1160.06.
[91] VHA Directive 1160.06.
[92] VHA Directive 1160.01.
[93] VHA Directive 1160.01.

The VISN Director is responsible for ensuring that inpatient mental health services "are accessible without delay to all eligible Veterans in the VISN" and that the programs offered on the inpatient unit are compliant "with relevant state laws governing inpatient mental health care, hospital accreditation regulations, and VISN and facility level procedures."[94]

VHA requires the appointment of a full-time VISN CMHO to "ensure transparency of decision-making and to promote communication between the field and central office."[95] The CMHO chairs the VISN MHEC; each HCS's mental health lead is expected to participate. The VISN MHEC oversees and monitors quality, identifies areas of concern, and communicates critical matters to VISN and senior VHA leaders.[96]

The HCS mental health lead must assign an inpatient mental health program manager who coordinates programming and ensures it is effectively integrated into the inpatient unit setting.[97] In addition, each HCS is required to have an LRC who spends 75 percent of their time ensuring that mental health services demonstrate recovery-oriented principles and "no more than 25 percent" of their time providing direct clinical care. The LRC collaborates with local mental health leaders to implement a continuous recovery improvement plan that must be updated every three years.[98]

VHA employs peer support staff, veterans who are actively engaged in their own personal recovery, to serve as role models for other veterans receiving healthcare services.[99] "Peer Specialists help Veteran patients develop skills to manage their recovery from illness, improve their quality of life, support their individualized goals, facilitate support from others, and achieve independence from institutional setting."[100] Peer support staff must be available for veterans when clinically indicated and may serve as members of an interdisciplinary treatment team.[101]

[94] VHA Directive 1160.06.

[95] "Mental Health Required Staff Listing," VA Office of Mental Health, accessed February 8, 2023, https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.aspx. (This site is not publicly accessible.)

[96] VHA Directive 1160.01.

[97] VHA Directive 1160.06.

[98] VHA Directive 1163.

[99] VHA Directive 1163. Peer support staff may also be referred to as peer specialists.

[100] VHA Directive 1163.

[101] VHA Directive 1160.06; VHA Directive 1163.

High Reliability Principles

VHA expects VISN and HCS directors to integrate the high reliability concepts of psychological safety and continuous process improvement into care delivery.[102] A high reliability organization focuses on patient safety, "zero harm," and continual process improvement.[103] Psychological safety is "the belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes" and continuous process improvement includes the actions to improve processes within the organization that affect veteran care.[104]

Recovery-Oriented Principles

The Substance Abuse and Mental Health Services Administration "defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."[105]

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit.[106]

VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care, and therefore, requires HCSs to create a hopeful and healing environment while maintaining safety.[107] When a patient has access to an outdoor environment, the patient "may experience shorter periods of illness, fewer symptoms of anxiety and depression, and a higher degree of well-being."[108] VHA requires inpatient unit staff to provide "evidence- based medication management, psychosocial rehabilitation, evidence-based psychotherapy, patient education, medical care" and other therapies using recovery-oriented methods.[109]

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[102] VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)," September 2022, updated September 2024. Both versions contain similar language related to psychological safety and continuous process improvement.

[103] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

[104] VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)"; VA, "VHA High Reliability Organization (HRO) Reference Guide," April 2023, updated September 2024.Both versions contain similar language related to continuous process improvement.

[105] "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration, accessed September 19, 2022, https://www.samhsa.gov/find-help/recovery.

[106] VHA Directive 1160.06; VHA Directive 1163; VHA Directive 1160.01.

[107] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

[108] VA, Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities; Mikkel Hjort et al., "The Importance of the Outdoor Environment for the Recovery of Psychiatric Patients: A Scoping Review," *International Journal of Environmental Research and Public Health* 20, no. 3 (January 27, 2023): 2240, https://doi.org/10.3390/ijerph20032240.

[109] VHA Directive 1160.06.

Clinical Care Coordination

Care coordination poses a major challenge to healthcare safety, especially for chronically ill individuals who receive services from multiple providers in a variety of settings.[110] VHA requires inpatient units to have an interdisciplinary treatment team composed of individuals who are responsible for the assessment, planning, and implementation of a veteran's care. An interdisciplinary approach is critical to ensure comprehensive, coordinated, and holistic care.[111]

VHA requires HCSs to have standard operating procedures outlining admission processes, and to provide access to mental health treatment for veterans who are either voluntarily or involuntarily held on an inpatient unit.[112] When treatment is not available within the HCS, staff may transfer a veteran to another VHA or non-VHA HCS for inpatient mental health care.

The federal government does not have civil commitment laws; therefore, HCS leaders are required to have clear guidelines that align with state civil commitment laws.[113] HCS staff must be aware of the veteran's legal status (voluntary or involuntary admission) to safeguard against potential civil rights violations, including illegal detainment in a locked inpatient unit.[114]

The interdisciplinary treatment team must ensure that the recovery-oriented treatment plan is completed in collaboration with the veteran and includes the veteran's personally identified goals.[115] The interdisciplinary treatment team must also ensure outpatient mental health care is coordinated with the veteran prior to discharge, including follow-up appointment information.[116]

VHA requires that veterans receive a copy of the written discharge plan and a copy of the safety plan, as applicable, at discharge. The written discharge plan must include the provider's name if available, as well as scheduling information for the follow-up appointments.[117]

[110] The Joint Commission, *Standards Manual e-dition,* PC.02.02.01, January 2024. "The hospital coordinates the patient's care, treatment, and services based on the patient's needs."

[111] VHA Directive 1160.06.

[112] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."; The Joint Commission, *Standards Manual e-dition*, PC.01.01.01.

[113] VHA Directive 1160.06.

[114] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," revised April 5, 2023.

[115] VHA Directive 1160.06.

[116] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[117] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOP uses the term *written discharge plans* when inpatient unit staff must provide the veteran with information regarding the written discharge plans.

Suicide Prevention

According to the *2023 National Veteran Suicide Prevention Annual Report*, "suicide was the 13th-leading cause of death for Veterans overall, and the second-leading cause of death among Veterans under age 45" in 2021. Immediately following inpatient hospitalization, there is an increased risk for suicide attempt or death by suicide.[118] Therefore, there is a critical need for suicide risk assessment prior to discharge from inpatient mental health care, as well as linkage to follow-up mental health care.[119]

Inpatient unit clinical staff are to complete the C-SSRS, an evidence-based risk assessment tool, for veterans within 24 hours prior to discharge, as required. A positive C-SSRS then requires the "timely completion of the [CSRE]."[120] Staff may complete the CSRE in lieu of the suicide risk screening prior to discharge.[121]

VHA requires providers to collaborate with veterans to create a suicide prevention safety plan, a written document emphasizing coping skills and sources of support, used to prevent and manage a crisis.[122] These plans must include, but are not limited to, discussion of environmental safety strategies; safety options; and access to firearms, opioids, and other potential lethal means, such as medications, ropes, or household toxins.[123]

VHA requires healthcare providers complete STEMS and non-clinical staff complete VA S.A.V.E. training within 90 days of entering the position and annually.[124] In addition, all VHA healthcare providers must complete a one-time Lethal Means Safety Education and Counseling

[118] VA Suicide Prevention Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*, November 2023.

[119] Deputy Under Secretary for Health for Operations and Management, "Eliminating Veteran Suicide: Enhancing Acute Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up," memorandum to Network Directors (10N1-23) et al., June 12, 2017.

[120] VA, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020.

[121] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting," updated November 4, 2021; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., November 23, 2022. VHA's two-phase process to screen and assess for suicide risk in clinical settings includes the C-SSRS and subsequent completion of the Comprehensive Suicide Risk Evaluation (CSRE) when the screen is positive; VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Frequently Asked Questions (FAQ)," updated December 13, 2022.

[122] VHA Directive 1160.07.

[123] VA, *VA Safety Planning Intervention Manual*.

[124] VHA Directive 1071(1).

training within 90 days of entering the position.[125] In June 2022, VHA issued a memorandum indicating a target of at least 95 percent completion for mandatory suicide prevention trainings.[126]

Safety

In VHA HCSs, inpatient mental health units must be designed to ensure veteran safety while still integrating recovery-oriented principles into the environment. ISIT members and all inpatient unit staff are responsible for ensuring a safe environment. Additionally, the ISIT is required to assess the inpatient unit every six months for suicide hazards using the MHEOCC and the patient safety manager or other designated mental health staff track corrective actions taken for identified environmental risks.[127] The ISIT is required to track deficiencies and actions in the Patient Safety Assessment Tool.[128]

An ISIT is a mandatory subcommittee of the HCS environment of care committee, with membership and date of members' last MHEOCC training documented in the ISIT meeting minutes. The ISIT "should include the Suicide Prevention Coordinator, a Patient Safety Manager, a Facility Safety Officer, a Mental Health Unit Nurse Manager, a non-mental health Unit Nurse Manager, an inpatient Licensed Independent Practitioner, the Local Recovery Coordinator, an outpatient mental health provider (e.g., an outpatient case manager, clinician, or Peer Specialist), a representative from Engineering, a representative from Environmental Services and a Pharmacist."[129]

[125] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), March 17, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network Directors (10N1-23), May 2, 2024. Both memoranda have similar language related to Lethal Means Safety Education and Counseling training requirements.

[126] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification." As of June 2022, VHA required at least a 95 percent compliance with mandatory suicide prevention trainings.

[127] VHA Directive 1167, May 12, 2017. The MHEOCC is a "checklist designed to help identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide. It consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff work stations."

[128] VHA Directive 1167, May 12, 2017. The Patient Safety Assessment Tool is a "web-based assessment tool managed by the VHA National Center for Patient Safety (NCPS)."

[129] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The new directive included the inpatient mental health unit program director and excluded the local recovery coordinator from required ISIT membership.

Appendix B: Methodology

The Mental Health Inspection Program reviews began in FY 2024 and focused on the quality of care provided by VHA's inpatient mental health services.[130] The OIG randomly selected the VHA HCSs included in FY 2024 reviews from all HCSs with inpatient mental health beds.[131]

The OIG conducted a virtual and on-site review at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania from August 19 through September 13, 2024. The OIG did not receive any complaints beyond the scope of this review that required referral to the OIG hotline.

The OIG reviewed data specific to the facility, prior OIG reports related to the inpatient unit, documents and EHR reviews. Additionally, the OIG distributed a questionnaire to mental health staff and leaders, conducted a physical inspection of the inpatient unit, and interviewed key staff and leaders. Except for a 95 percent threshold for mandatory suicide prevention training completion, the OIG used 90 percent as the expected level of compliance in record review.

The OIG's analysis relied on inspector identification of salient information based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* The OIG did not analyze compliance with individual HCS policies.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. Leaders' responses to the report recommendations appear within each domain and in appendix D and appendix E.

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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[132] 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.

[130] The OIG conducts cyclic reviews of select areas of focus within VHA's continuum of mental health care.

[131] The OIG identified HCSs with inpatient mental health beds using the Monthly Program Cost Report (MPCR) code of 1310 (High Intensity General Psychiatric Inpatient Unit). For FY 2024, the OIG excluded inpatient mental health beds visited in FY 2023 for preliminary research. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

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

Electronic Health Record Review

The OIG reviewed 50 randomly selected EHRs of veterans discharged from an acute inpatient mental health stay of more than 48 hours at the Corporal Michael J. Crescenz VA Medical Center from October 1, 2022, through September 30, 2023.[133] As previously discussed, the OIG used 90 percent as the expected level of compliance for record review.

Table B.1. EHR Review Results

Domain	Topic	Inspection Element Reviewed	Number of Records Included	Percent Compliant (%)
Clinical Care Coordination	Voluntary or involuntary treatment status	Documented within 24 hours of admission	50	100
	Inpatient mental health treatment plan	Completed	31	62
		Veteran involved in development or offered opportunity	31	97
		Included interdisciplinary treatment team input	31	100
	New Central Nervous System medication	Risk and benefits discussed with veteran	32	22
	Discharge summary	Completed	50	100
		Completed within two business days of discharge	50	98
	Outpatient mental health follow-up appointment	Scheduled prior to discharge	48	100
	Discharge instructions	Completed	49	100
		Included outpatient mental health appointment	48	96
		Copy offered to veteran	49	100
		Included location of follow-up appointment in easy-to-understand language	46	39
		Included medication list	49	100

[133] The OIG identified the EHR sample from a list of all individuals with a Monthly Program Cost Report discharge code of 1310 (High Intensity General Psychiatric Inpatient Unit) and excluded all other records. For veterans with multiple admissions during the review period, the OIG included the veteran's first admission only.

Domain	Topic	Inspection Element Reviewed	Number of Records Included	Percent Compliant (%)
		Included reasons for prescribed medications	49	37
		Free of medication abbreviations that could be difficult to understand by a nonmedically-trained individual	49	61
		Free of generic and medication trade names used interchangeably with no explanation that they are the same medication	22	45
Suicide Prevention	Columbia-Suicide Severity Rating Scale	Completed before discharge	49	94
		Completed within 24 hours prior to discharge	49	80
	Suicide Prevention Safety Plan	Completed or reviewed prior to discharge	48	100
		Used appropriate note title	49	100
		Addressed ways to make the veteran's environment safe from potentially lethal means	48	38
		Addressed access to firearms	48	100
		Addressed access to opioids	48	100
		Offered veteran or caregiver a copy	48	90

Source: OIG review of the facility Mental Health Inpatient Unit EHRs.
Note: The OIG considers the words "addressed" and "completed" to be equivalent related to the reviewed inspection elements. Due to exclusion criteria, the number of included records does not always equal 50.

Questionnaire

To assess perceptions of psychological safety and performance improvement activities, the OIG sent a questionnaire to 72 individuals identified as facility staff and leaders who had interactions with the inpatient units. Additionally, all questions in the report appear as written in the questionnaire and the OIG did not provide respondents with instructions on how to interpret questions. The OIG found that 27 of the 72 staff completed the questionnaires (38 percent).[134] For recipients who had not completed the questionnaire upon the initial request, the OIG provided another reminder.

[134] The percentage of completed questionnaires was rounded from 37.5.

OIG Inspection of the Physical Environment

The OIG inspected selected areas of the inpatient unit to evaluate if facility leaders and staff provided a therapeutic, recovery-oriented environment and maintained veteran safety.[135] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as natural lighting, artwork, and calming paint colors. The OIG also observed the unit for general cleanliness and veteran access to private and outdoor space.[136] Further, the OIG's physical inspection of areas in the inpatient units focused on additional selected safety elements specific to this HCS.

The OIG reviewed the Patient Safety Assessment Tool for MHEOCC inspections completed in FY 2022, FY 2023, and FY 2024, and assessed corrective actions taken for deficiencies unresolved for more than six months.

[135] VHA Directive 1160.06; A unit is an "area in a medical facility and especially a hospital that is specially staffed and equipped to provide a particular type of care." *Merriam-Webster.com Dictionary*, "unit," accessed August 9, 2022, https://www.merriam-webster.com/dictionary/unit.

[136] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

Appendix C: Organizational Structure and Staffing

The OIG evaluated the leadership organizational structure within VISN 1 and the facility, including reporting authority and delineation of direct or indirect oversight responsibilities.

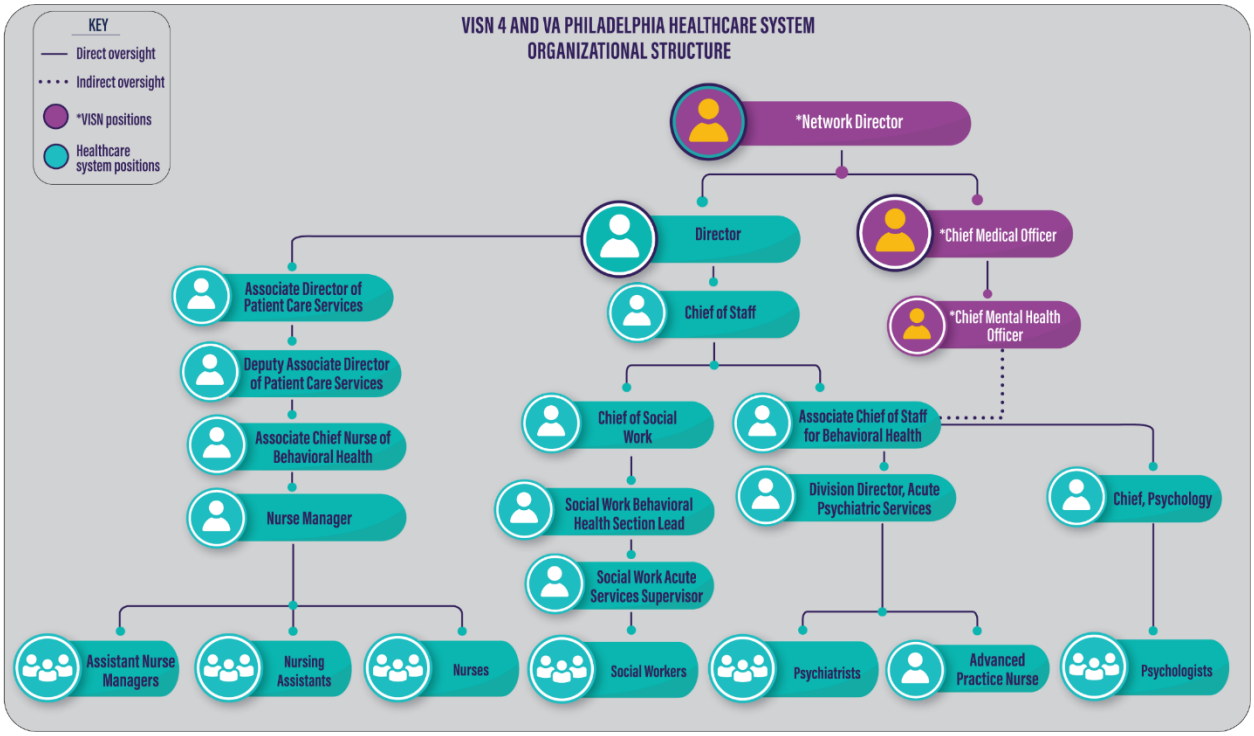

Figure C.1. *VISN 4 and facility organizational structure.*
Source: OIG analysis of the facility documents (received August 22 through September 6, 2024); OIG analysis of VHA Directive 1160.06 and VHA Directive 1160.01.
Note: The OIG considers the direct supervisor of each position to be the equivalent of "direct oversight." The division director, acute psychiatric services, also served as the inpatient mental health program manager. The ACOS reported that the program manager provided programmatic oversight of the unit operations. The program manager and Acting Nurse Manager, as well as staff disciplines identified in the last row, were assigned to the inpatient unit; however, the figure does not represent all inpatient unit staff.

The OIG examined the facility's inpatient unit staffing, which reflected an interdisciplinary team approach.

Table C.1. Inpatient Unit Staffing

Discipline	FTEE	Percent Dedicated Per FTEE
Medical Support Assistants	4	50
Nurses*	31	100
Nursing Assistants‡	20	100
Peer Specialist	1	40
Pharmacist	1	100
Psychiatry§	4	100
Psychologists	3	20–100
Recreational Therapist	1	100
Social Workers	3	20–100

Source: OIG Review of the facility's Mental Health Inpatient Unit Staffing Spreadsheet (received August 26, 2024).
Note: FTEE represents full-time equivalent employee.
**Nursing staff includes: a nurse manager, two assistant nurse managers, and 28 additional registered nurses.*
‡Nursing assistant staff include 20 certified nursing assistants.
§Psychiatry staff includes 3 psychiatrists and an advanced practice nurse.

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 28, 2025

From: Interim Director, Department of Veterans Affairs (VA) Healthcare (VISN 04)

Subj: VA OIG Draft Report: Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania

To: Program Director, Office of Healthcare Inspections (54MH00)
Executive Director, Office of Integrity and Compliance (10OIC)

1. I have reviewed the responses provided by the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, PA and I am submitting to your office as requested. I concur with their responses.

2. Should you need further information, please contact the VISN 4 Quality Management Officer.

(*Original signed by:*)

Denise Boehm
Acting Network Director, VISN 4

[OIG comment: The OIG received the above memorandum from VHA on May 30, 2025.]

Appendix E: Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 28, 2025

From: Director, VA Philadelphia Healthcare System (642/00)

Subj: VA OIG Draft Report: Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania

To: Acting Director, Department of Veterans Affairs (VA) Healthcare (VISN 04)

1. We appreciate the opportunity to review and comment on the OIG draft report, Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania. The Philadelphia Healthcare System concurs with the recommendations and will take corrective action.

2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

3. Should you need further information, please contact the Chief of Quality Management.

(*Original signed by*:)

Karen Flaherty-Oxler

[OIG comment: The OIG received the above memorandum from VHA on May 30, 2025.]

Healthcare System Director Responses

Recommendation 1

The Facility Director establishes a mental health executive council that operates in accordance with Veterans Health Administration requirements.

__X _Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

Prior to the OIG inspection, the Associate Chief of Staff (ACOS) for Mental Health (MH) conducted ongoing informal meetings with the MH team to oversee care delivery and quality improvement. A review of the VHA Directive 1160.01 was conducted, and a Mental Health Executive Committee (MHEC) Charter was established on April 30, 2024. Since implementation of the charter, the MHEC met in July 2024, September 2024, January 2025, February 2025, and April 2025, with minutes recorded and attendance tracked. Moving forward, agendas will be provided, draft minutes sent to committee for comment and approved/signed minutes will be forwarded to the Medical Executive Board (MEB) per directive. The MEB will monitor submission of the minutes with a goal of 90% compliance.

Recommendation 2

The Facility Director ensures development and implementation of a multi-year recovery transformation plan.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

During the MHIP inspection in September 2024, the Local Recovery Coordinator (LRC) shared the recovery transformation plan with the OIG as requested. The recovery transformation plan will be updated to include MH leadership, nursing, social work and other relevant disciplines. The revised plan will be presented to the MHEC for approval, and then to the Medical Executive Board (MEB) for final approval. To ensure ongoing implementation, the plan will be reviewed by MH leadership for progress and presented at MHEC on a quarterly basis until completion.

Recommendation 3

The Associate Chief of Staff for Behavioral Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekdays and weekends on the inpatient mental health units.

_X __Concur

_____Nonconcur

Target date for completion: November 2025

Director's Comments

Division Director of Acute Psychiatric Services will ensure the implementation of a recovery-oriented interdisciplinary programming plan that includes a minimum of four hours of recovery-oriented, interdisciplinary programming seven days a week in collaboration with the inpatient unit psychologists, social work, recreation therapy, and nursing. To meet the minimum required programming hours, the schedule will be reviewed and approved monthly by the Division Director of Acute Psychiatric Services and the group facilitators. The ACOS of MH will monitor the compliance of required programming hours with a goal of 90% compliance.

Recommendation 4

The Facility Director ensures inpatient mental health units are in good repair and the environment reflects recovery-oriented principles.

_X __Concur

_____Nonconcur

Target date for completion: March 2026

Director's Comments

All identified environmental issues were promptly corrected and addressed in response to the OIG request on September 12, 2024. Evidence of compliance was provided to the OIG on September 18, 2024. Since that time, we have enhanced our twice daily EOC rounding process to ensure all environmental issues are identified and addressed in a timely manner. As part of the multi-year recovery transformation plan, a collaborative effort involving the LRC, chief engineer, interior designer, MH leadership, and veterans is underway to redesign the nursing stations, public spaces, and corridors to reduce an "institutional" feel and to promote a therapeutic, healing and safe environment. Progress will be reported by MH Leadership to MHEC on a quarterly basis until completion.

Recommendation 5

The Facility Director ensures veterans' privacy in restraint rooms on the inpatient mental health units.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

A review of the MCP:11-70 Restraint Policy was conducted by the MH Leadership and Quality Management. The policy delineates that patient rights, dignity, and safety are maintained at all times when a veteran is in restraints, however, "privacy" and specific strategies to ensure privacy are not listed. The Restraint Policy will be updated to include clear guidance to ensure veteran's privacy when using the restraint rooms on the inpatient mental health units.

Recommendation 6

The Associate Chief of Staff for Behavioral Health develops written guidance to ensure staff and veterans' safety during outdoor breaks.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

Due to the location and footprint of our current facility in the inner city of Philadelphia, PA, we do not have a designated safe outdoor space for MH veterans. However, in special circumstances, i.e. long-term patients awaiting placement, medically cleared veterans, and/or is considered therapeutic for the veteran, the MH staff has accompanied veterans on outdoor breaks. MH Leadership is in the process of creating a Standard Operating Procedure (SOP) delineating the special circumstances and safety measures to provide a guideline for this practice.

Recommendation 7

The Facility Director formalizes processes to monitor and track compliance with state involuntary commitment laws.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

The Division Director of Acute Psychiatric Services in collaboration with the Acute Care Behavioral Health Social Work Supervisor, are in the process of reviewing the current medical center policy, 116-04 Management of Involuntary Patients, to ensure it meets all required components per VHA Directive 1160.06 as well as Pennsylvania state law. The policy will be revised to ensure there is a written process to oversee compliance with state laws.

Recommendation 8

The Chief of Staff ensures the completion of comprehensive inpatient mental health treatment plans and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: November 2025

Director's Comments

The Division Director for Acute Psychiatric Services and the Associate Chief Nurse of MH are developing an SOP regarding the comprehensive inpatient mental health treatment plan process to align with VHA Directive 1160.06. Once the SOP is finalized, all staff responsible for completing MH treatment plans will be educated on the requirements. Random charts will be conducted by Mental Health Leadership with a goal of 90% compliance.

Recommendation 9

The Chief of Staff ensures documentation of discussions between prescribers and veterans on the risks and benefits of newly prescribed medications and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: September 2025

Director's Comments

The Associate Chief of Mental Health, or designee will collaborate with the Clinical Applications Coordinator (CAC) to develop a new required medication prompt within the electronic medical record. This prompt will include questions to help guide the provider's review of the medications and prompt for discussion points on risks and benefits, which will be included in prescriber's progress notes anytime a medication is started or changed. Once the prompt is

installed into the Electronic Health Record (EHR), randomized chart reviews will be conducted by Mental Health Leadership with a goal of 90% compliance.

Recommendation 10

The Chief of Staff ensures mental health treatment coordinators are included in care coordination.

_X __Concur

_____Nonconcur

Target date for completion: September 2025

Director's Comments

The Division Director for Acute Psychiatric Services and the Associate Chief Nurse of MH will develop a process to ensure that Social Workers and MH providers alert Mental Health Treatment Coordinators (MHTC) to all MH admissions or discharges. This will be achieved by communicating through the Electronic Health Record (EHR). This process will be included in the SOP being developed for treatment plans. Randomized chart reviews will be conducted by Mental Health Leadership with a goal of 90% compliance.

Recommendation 11

The Chief of Staff ensures discharge instructions for veterans include appointment locations written in easy-to-understand language.

_X __Concur

_____Nonconcur

Target date for completion: September 2025

Director's Comments

The ACOS for MH, Chief Health of Informatics and the BH [Behavioral Health] Health Scientist Specialist, will review the facility's compliance with the Clinic Profile Manager Guidebook for patient-friendly clinic names and update any clinic name that does not meet this naming convention to ensure discharge progress notes are written in an easy-to-understand language for the veteran's follow up appointments. Once implemented, the BH Health Scientist will provide a report to the MHEC with an update of all changes. Once correction to EHR is complete, random charts will be conducted by Mental Health Leadership with a goal of 90% compliance.

Recommendation 12

The Chief of Staff ensures discharge instructions for veterans include the purpose for each listed medication in easy-to-understand language.

_X __Concur

_____Nonconcur

Target date for completion: September 2025

Director's Comments

The Division Director of Acute Psychiatric Services collaborated with the Clinical Applications Coordinator to update the discharge instructions note template in the EHR to ensure that the medication list includes the purpose for each medication listed in simple verbiage. The Division Director of Acute Psychiatric Services, or designee, will conduct monthly audits of discharge summaries with medication lists, ensuring instructions for each medication's documented purpose and use of easy-to-understand language is present. Results of the compliance audits will be reported to the MHEC with a goal of 90% compliance.

Recommendation 13

The Chief of Staff ensures discharge instructions for veterans include an explanation when both trade and generic names are used for the same medication.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

The Division Director of Acute Psychiatric Services educated all mental health providers to list all medications only in generic name, as opposed to trade name in the discharge instructions note template for enhanced veteran understanding. The Division Director of Acute Psychiatric Services is conducting monthly audits of discharge summaries to ensure all medications are listed as generic for Veteran understanding with a goal of 90% compliance.

Recommendation 14

The Chief of Staff ensures staff complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: September 2025

Director's Comments

The Division Director of Acute Psychiatric Services will conduct a review of a random sample of MH discharges over the past year to identify specific areas of concern and providers who were non-compliant. Focused re-education will be done with those providers regarding completion of the CSSR [Columbia-Suicide Severity Rating Scale] within 24 hours of discharge. Random chart audits will be conducted by Mental Health Leadership with a goal of 90% compliance.

Recommendation 15

The Chief of Staff ensures safety plans address ways to make the veteran's environment safer from potentially lethal means and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

The Division Director of Acute Psychiatric Services educated all providers and social workers to include documentation of a discussion about all potential lethal means within the veteran's home within the designated Behavioral Health (BH) Safety Plan on March 19, 2025. Since then, Quality Management is conducting audits of all veteran's charts with updated or new BH Safety Plans with a goal of 90% compliance.

Recommendation 16

The Facility Director ensures staff comply with timely completion of VA S.A.V.E. training requirements and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: September 2025

Director's Comments

The Suicide Prevention Program Manager (SPPM) developed standardized processes to ensure all required staff complete the VA S.A.V.E training such as following up on all new employees to ensure training complete and reaching out to all employees that are due for the refresher course within 10 days. Timely completion of initial and refresher VA S.A.V.E training will be monitored with a goal of 90% compliance.

Recommendation 17

The Facility Director ensures the Interdisciplinary Safety Inspection Team adheres to Veterans Health Administration requirements, including recording meeting minutes and including all required members, and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

The Interdisciplinary Safety Inspection Team (ISIT) Committee Charter was reviewed and revised to align with the VHA Directive 1167 dated November 4, 2024. ISIT committee meetings are held bi-annually in preparation for the MHEOCC. An ISIT Committee meeting was held on November 8, 2024, and minutes were recorded, and attendance taken. Moving forward the minutes from the ISIT Committee, along with the attendance record will be reported up to the facility Environment of Care Committee per VHA Directive. Compliance will be monitored to ensure meeting minutes are recorded with all required ISIT members in FY 2025.

Recommendation 18

The Facility Director implements processes to ensure Interdisciplinary Safety Inspection Team staff accurately identify and document safety hazards within the Patient Safety Assessment Tool and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

The Patient Safety Manager (PSM) reviewed the OIG inspection findings related to hazards that were omitted from the July 2024 MHEOCC and re-educated the ISIT committee members on the MHEOCC process at the last committee meeting in November 2024, to ensure staff can accurately identify safety hazards. During the January 2025 MHEOCC, all safety hazards, including those not identified in the July 2024 MHEOCC, were documented within the PSAT. The Deputy Chief of Quality Management will review each MHEOCC and PSAT submission to ensure compliance prior to presentation to the Executive Leadership Team (ELT).

Recommendation 19

The Facility Director ensures staff address identified Mental Health Environment of Care Checklist deficiencies in accordance with Veterans Health Administration guidelines and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: August 2025

Director's Comments

In addition to the bi-annual MHEOCC to identify safety hazards and deficiencies, the facility SOP: BH-132 Environmental Rounds Checklist for Inpatient Behavioral Health was updated to align with the VHA Directive 1160.06.01 which includes a more comprehensive checklist and completion twice daily. Nursing staff were educated on the SOP revisions and requirements, and it was implemented in October 2024. The interim Associate Chief Nurse is monitoring compliance of the checklists and ensuring all deficiencies are addressed with a goal of 90% compliance.

Recommendation 20

The Facility Director ensures Interdisciplinary Safety Inspection Team members comply with Mental Health Environment of Care Checklist training requirements and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: September 2025

Director's Comments

The PSM educated all ISIT team members on Mental Health Environment of Care Checklist training requirements. Compliance will be monitored to ensure at least 90% team members are compliant with Mental Health Environment of Care Checklist training requirements.

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