



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection Summary Report:
Evaluation of Mental Health
in Veterans Health
Administration Facilities,
Fiscal Year 2021



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Figure 1. Veterans Affairs Building, Washington, DC.

Source: <https://www.gsa.gov/real-estate/gsa-properties/visiting-public-buildings/veterans-administration-building> (accessed on June 24, 2021).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
OIG	Office of Inspector General
VHA	Veterans Health Administration



Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year.

The purpose of this evaluation was to determine whether VHA staff complied with selected mental health program requirements for emergency department and urgent care center suicide risk screening and evaluation processes.

The OIG initiated unannounced inspections and performed this evaluation at 44 VHA medical facilities with an emergency department or urgent care center from November 30, 2020, through August 23, 2021.¹ Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2021 OIG inspections and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.²

Inspection Results

The OIG found general compliance with most of the selected requirements. However, the OIG identified a weakness with the completion of mandatory training by staff who develop suicide safety plans. Lack of training could prevent staff from providing optimal treatment to veterans who are at risk for suicide.

Conclusion

The OIG conducted detailed inspections at 44 VHA facilities to ensure leaders implemented selected mental health program processes. The OIG subsequently issued one recommendation for improvement to the Under Secretary for Health in conjunction with Veterans Integrated Service Network directors and facility senior leaders. VHA leaders should use the results in this report to improve operations and clinical care at the facility level. The recommendation addresses a finding that may eventually interfere with the delivery of quality health care.

¹ The OIG did not perform this inspection at the VA Central Western Massachusetts Healthcare System (Leeds) because it did not have an emergency department or urgent care center.

² Fiscal year 2021 began October 1, 2020, and ended September 30, 2021.

VA Comments

The Under Secretary for Health concurred with the comprehensive healthcare inspection finding and recommendation and provided an acceptable improvement plan (see appendix C, pages 9–10, and the response within the body of the report for the full text of the executive’s comments). The OIG considers the recommendation closed.

A handwritten signature in black ink, reading "John D. Daigh, Jr., M.D." in a cursive script.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
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Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

While the OIG selects and evaluates specific areas of focus on a rotating basis each year, the evaluation of VHA facilities' mental health programs is an ongoing review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.¹ These leaders are directly accountable for program integration and communication within their level of responsibility.

Suicide prevention remains a top priority for VA. Suicide is "among the top 9 leading causes of death," with almost 46,000 lives lost across the United States in 2020.² The suicide rate for veterans was over 52 percent greater than for nonveteran adults in the United States during 2019.³ However, suicide rates among veterans decreased four times more in 2019 compared to the United States adult population in 2019.⁴

VHA has implemented various evidence-based approaches to reduce veteran suicides. In addition to expanded mental health services and community outreach, VHA adopted a three-phase process in 2018 to screen and assess for suicide risk in most clinical settings. The phases included primary and secondary screens and a comprehensive assessment. However, screening for patients seen in emergency departments or urgent care centers began with the secondary screen, the Columbia-Suicide Severity Rating Scale, and subsequent completion of the Comprehensive Suicide Risk Assessment when screening was positive.⁵ In November 2020, VHA revised the process to eliminate the need for the primary screen in all clinical settings. The OIG examined whether staff initiated the Columbia-Suicide Severity Rating Scale and completed selected required elements.

¹ Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. 111-163, § 505 (2010).

² "Suicide Prevention: Facts About Suicide," Centers for Disease Control and Prevention, accessed June 9, 2022, <https://www.cdc.gov/violenceprevention/suicide/fastfact.html>.

³ VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*, September 2021.

⁴ VA Office of Mental Health and Suicide Prevention, *2021 National Veteran Suicide Prevention Annual Report*.

⁵ Deputy Under Secretary for Health for Operations and Management (DUSHOM) memo, "Suicide Risk Screening and Assessment Requirements," May 23, 2018; Department of Veterans Affairs, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting*, December 18, 2019.

Additionally, VHA requires intermediate, high-acute, or chronic risk-for-suicide patients to have a suicide safety plan completed or updated prior to discharge from the emergency department or urgent care center.⁶ The OIG assessed VHA medical facilities for their adherence to the following requirements for suicide safety plans:

- Completion of suicide safety plans by required staff
- Completion of mandatory training by staff who develop suicide safety plans

The OIG initiated unannounced inspections at 44 VHA medical facilities with an emergency department or urgent care center from November 30, 2020, through August 23, 2021.⁷ The results in this report are a snapshot of VHA performance at the time of the fiscal year 2021 OIG inspections.⁸ The findings may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

⁶ DUSHOM memo, “Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives,” October 17, 2019.

⁷ The OIG did not perform this inspection at the VA Central Western Massachusetts Healthcare System (Leeds) because it did not have an emergency department or urgent care center.

⁸ Fiscal year 2021 began October 1, 2020, and ended September 30, 2021.

Methodology

The OIG evaluated compliance with selected mental health program requirements during fiscal year 2021 at 44 VHA medical facilities with emergency departments or urgent care centers. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks.

To determine whether VHA facilities complied with selected requirements for suicide risk screening and evaluation within emergency departments and urgent care centers, the OIG inspection teams interviewed key employees and reviewed clinical and administrative processes using

- relevant documents,
- the electronic health records of 2,072 randomly selected patients who were seen in the emergency department or urgent care center from December 1, 2019, through August 31, 2020, and
- staff training records.

The OIG published individual CHIP reports for each facility. For this report, the OIG analyzed data from the individual facility reviews to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendation for improvement targets a problem that can influence the quality of patient care significantly enough to warrant OIG follow up until VHA leaders complete corrective actions. The comments and action plan submitted by the Under Secretary for Health in response to the OIG's recommendation appear within the report. The OIG accepted the action plan that the Under Secretary for Health developed based on the reason for noncompliance.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁹ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

⁹ Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

The OIG found that VHA facilities had comprehensive screening and assessment processes to identify patients at risk for suicide and noted general compliance with most of the selected requirements. However, the OIG examined whether staff completed selected required elements of the Columbia-Suicide Severity Rating Scale, suicide safety plans, and mandatory training and identified a weakness with the completion of training by staff who develop suicide safety plans.

VHA requires staff to complete mandatory suicide safety plan training prior to developing suicide safety plans with patients.¹⁰ The OIG reviewed the training records for 945 staff responsible for suicide safety plan development and found that 126 (13 percent) lacked evidence that the staff had completed the required training. Lack of training could prevent staff from providing optimal treatment to veterans who are at risk for suicide. A reason for noncompliance was lack of oversight.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that staff complete mandatory suicide safety plan training prior to developing suicide safety plans.¹¹

¹⁰ DUSHOM memo, “Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives.”

¹¹ The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before publication of the report.

VHA concurred.

Target date for completion: Completed

Under Secretary for Health response: The Office of Mental Health and Suicide Prevention (OMHSP) identified this training completion concern, independent of OIG's recommendation, as part of our Veterans Integrated Services Network (VISN) site visits which began in October 2021. OMHSP now includes a staff completion review of all required suicide prevention training, including safety plan training, as part of the visits. This Fiscal Year, OMHSP has performed four VISN site visits, including VISNs 22, 19, 8 and 15. In addition, OMHSP has included, in its communications with VISN Chief Mental Health Officers, VISN Suicide Prevention Leads and facility Suicide Prevention Teams, a special emphasis on the need for facilities to both assign and monitor completion of this training for its staff to improve and maintain compliance. OMHSP has completed its work to address this recommendation and asks OIG to consider closure.

Additionally, OMHSP is presently updating safety plan training requirements. VHA Health Care Providers are required to take Talent Management System (TMS) VA 43820 Skills Training for Evaluation and Management of Suicide (STEMS) within 90 days of hire and annually thereafter. This STEMS training focuses on providing supporting information and competency-based micro-simulations for discussing suicide risk with Veterans, determining both acute and chronic risk levels, and incorporating safety planning as an intervention to mitigate suicide risk. The STEMS safety plan content includes the required elements of safety planning which incorporates helping a Veteran identify warning signals to indicate they may be in crisis through how to seek help when needed. Within the training scenarios, providers can practice how to engage Veterans with completing a new safety plan and reviewing existing safety plans, including steps Veterans can take to make their environment safe. Steps are underway to streamline training requirements into one required training in STEMS, which would focus on safety planning. This will remove the separate safety plan training as a requirement from current operational memorandums and utilize the STEMS mandatory training for ongoing safety plan training.¹² OMHSP will continue to update content within STEMS moving forward to ensure training across providers.

¹² Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Use of National Standardized Suicide Prevention Safety Plan Progress Notes (VIEWS 7316620)," April 13, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions (VIEWS 5957889)," October 1, 2021.

Appendix A: Comprehensive Healthcare Inspection Program Recommendation

The table below outlines one OIG recommendation aimed at reducing a vulnerability that may lead to adverse events. The recommendation is attributable to the Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders. The intent is for these leaders to use the recommendation to help improve operations and clinical care. The recommendation addresses a systems issue that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health: Emergency Department and Urgent Care Center Suicide Risk Screening and Evaluation	<ul style="list-style-type: none">• Columbia-Suicide Severity Rating Scale initiation and completion of selected requirements• Suicide safety plan completion• Staff training requirements	<ul style="list-style-type: none">• Staff complete mandatory suicide safety plan training prior to developing suicide safety plans.	<ul style="list-style-type: none">• None

Appendix B: Parent Facilities Inspected

**Table B.1. Parent Facilities Inspected
(October 1, 2020, through September 30, 2021)**

Names	City
Bay Pines VA Healthcare System	Bay Pines, FL
Beckley VA Medical Center	Beckley, WV
Charles George VA Medical Center	Asheville, NC
Cheyenne VA Medical Center	Cheyenne, WY
Durham VA Health Care System	Durham, NC
Eastern Oklahoma VA Health Care System	Muskogee, OK
Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA
Fayetteville VA Coastal Health Care System	Fayetteville, NC
Hampton VA Medical Center	Hampton, VA
Hershel "Woody" Williams VA Medical Center	Huntington, WV
Hunter Holmes McGuire VA Medical Center	Richmond, VA
James A. Haley Veterans' Hospital	Tampa, FL
James J. Peters VA Medical Center	Bronx, NY
Louis A. Johnson VA Medical Center	Clarksburg, WV
Manchester VA Medical Center	Manchester, NH
Martinsburg VA Medical Center	Martinsburg, WV
Miami VA Healthcare System	Miami, FL
Montana VA Health Care System	Fort Harrison, MT
North Florida/South Georgia Veterans Health System	Gainesville, FL
Northport VA Medical Center	Northport, NY
Oklahoma City VA Health Care System	Oklahoma City, OK
Orlando VA Healthcare System	Orlando, FL
Providence VA Medical Center	Providence, RI
Salem VA Medical Center	Salem, VA
Samuel S. Stratton VA Medical Center	Albany, NY
Sheridan VA Medical Center	Sheridan, WY
Syracuse VA Medical Center	Syracuse, NY
VA Boston Healthcare System	Jamaica Plain, MA
VA Caribbean Healthcare System	San Juan, PR

Names	City
VA Connecticut Healthcare System	West Haven, CT
VA Eastern Colorado Health Care System	Aurora, CO
VA Finger Lakes Healthcare System	Bath, NY
VA Hudson Valley Health Care System	Montrose, NY
VA Maine Healthcare System	Augusta, ME
VA Maryland Health Care System	Baltimore, MD
VA New Jersey Health Care System	East Orange, NJ
VA New York Harbor Healthcare System	New York, NY
VA Salt Lake City Health Care System	Salt Lake City, UT
VA Western Colorado Health Care System	Grand Junction, CO
VA Western New York Healthcare System	Buffalo, NY
W.G. (Bill) Hefner VA Medical Center	Salisbury, NC
Washington DC VA Medical Center	Washington, DC
West Palm Beach VA Medical Center	West Palm Beach, FL
White River Junction VA Medical Center	White River Junction, VT

Source: VA OIG.

Appendix C: Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: September 9, 2022

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report:
Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal
Year 2021 (VIEWS # 8024906)

To: Office of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Comprehensive Healthcare Inspection (CHIP) Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2021. The Veterans Health Administration (VHA) concurs with the recommendation and provides an action plan in the attachment.
2. VHA respectfully notes that, since the drafting of this report, the Office of Mental Health and Suicide Prevention (OMHSP) reemphasized safety plan training as an operational requirement for clinical staff completing safety plans and believes OIG's concern was addressed at the time of the CHIP evaluation.
3. For background, this content has been included in four Veterans Integrated Service Network (VISN) site visits to date, including VISNs 8, 15, 19 and 22. In April 2022, this content was addressed during the monthly National Suicide Prevention Coordinator call and shared by email announcement sent to VISN Chief Mental Health Officers, VISN Suicide Prevention Leads and facility Suicide Prevention Teams. Facilities have been encouraged to review both assignment of the training and tracking of training completion to improve compliance.
4. Although OMHSP requests closure of this recommendation through the Action Plan, OMHSP is in the process of updating safety plan training requirements. The current training is primarily procedural for completing the template in the electronic health record and not a clinical training for safety plan intervention. VHA Health Care Providers are required to take Talent Management System (TMS) Skills Training for Evaluation and Management of Suicide (STEMS) within 90 days of hire and annually thereafter. This STEMS training focuses on providing supporting information and competency-based micro-simulations for discussing suicide risk with Veterans, determining both acute and chronic risk levels, and incorporating

safety planning as an intervention to mitigate suicide risk. The STEMS safety plan content includes the required elements of safety planning which incorporates helping a Veteran identify warning signals to indicate they may be in crisis through how to seek help when needed. Within the training scenarios, providers can practice how to engage Veterans with completing a new safety plan and reviewing existing safety plans, including steps Veterans can take to make their environment safe.

5. Steps are underway to streamline training requirements, removing the separate safety plan training as a requirement from current operational memorandums and utilize the STEMS mandatory training for ongoing safety plan training.¹ Applicable clinical safety plan training, including TMS Advanced Training in the Safety Planning Intervention, has been and will continue to be encouraged per those same memorandums for providers to complete. Once the memorandums have been updated and are ready for re-publication, the field will be notified of the removal of the separate safety plan training requirement and replaced with safety plan training in STEMS. OMHSP continues to review safety plan training and practices and will update content within STEMS moving forward to ensure training across providers.
6. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal, M.D., MBA

¹ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Use of National Standardized Suicide Prevention Safety Plan Progress Notes (VIEWS 7316620);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Safety Planning in the Emergency Department (ED): Suicide Safety Planning and Follow-up Interventions (VIEWS 5957889)."

OIG Contact and Staff Acknowledgments

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