US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA NY Harbor Healthcare System in New York

Mental Health Inspection | **25-00729-23** | **December 18, 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. The OIG conducted this inspection from January 27 through February 13, 2025, to address the mental health care delivered in the acute inpatient mental health unit (inpatient unit) at the Margaret Cochran Corbin VA Campus (facility). The facility is part of the VA NY Harbor Healthcare System (NY Harbor HCS) in New York.

The OIG evaluated acute inpatient mental health care across five domains. The OIG assessed processes in each of the domains and identified successes and challenges that affected the quality of care provided on the inpatient unit. The OIG issued 17 recommendations to the Under Secretary for Health and 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, staffing practices, and oversight and monitoring provided by leaders. The Associate Chief of Staff, Mental Health oversaw all mental health programs, including the inpatient unit. At the time of the inspection, the Associate Chief of Staff, Mental Health was also serving as acting Chief of Staff. The facility had a local mental health executive council chaired by the Associate Chief of Staff, Mental Health, as required. The Veterans Integrated Service Network Chief Mental Health Officer reported providing support for inpatient unit operations through site visits to monitor environment of care compliance. The OIG made no recommendations in this domain.
Recovery-Oriented Principles	Recovery-oriented mental health treatment is personalized to a veteran's abilities, resources, preferences, and values, and empowers the veteran to make decisions and meet treatment goals. To assess the inpatient unit's integration of recovery-oriented principles, the OIG examined aspects of leadership, treatment planning, interdisciplinary programming, and the care environment. At the time of the inspection, the facility's local recovery coordinator position had been vacant for at least a year. Although mental health leaders established a workgroup that divided some of the position's responsibilities among its participants, key strategic aspects of the role went unfulfilled. The facility's required multiyear plan to direct

[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
	veteran-centered, recovery-oriented care did not have local recovery coordinator input. Further, facility leaders did not establish a required standard operating procedure for the "education, staff training and implementation of recovery-oriented care" on the inpatient unit until after the on-site inspection. Inpatient unit staff provided at least four daily hours of recovery-oriented, interdisciplinary programming for veterans. The inpatient unit was generally clean with recovery-oriented elements such as artwork, warm paint colors, and natural lighting. Additionally, the inpatient unit had a day room and a quiet room; however, both rooms were locked and therefore inaccessible to veterans unless there were staff to monitor. OIG recommendations: • The Associate Chief of Staff, Mental Health ensures compliance with Veterans Health Administration requirements for a full-time local recovery coordinator. • The Associate Chief of Staff, Mental Health ensures the implementation of written processes for staff training, education, and recovery-oriented services. • The Facility Director identifies and addresses barriers to communal room access for veterans on the inpatient unit.
Clinical Care Coordination 	Care coordination, which involves intentionally sharing a veteran's information and organizing healthcare activities, is crucial for those with complex health and social needs. To assess the quality of clinical care coordination, the OIG reviewed access to services, facility procedures for involuntary treatment, interdisciplinary treatment planning, medication management, and discharge planning. The OIG found discrepancies between reports from mental health leaders and facility data related to the number of operating inpatient mental health beds; mental health leaders reported fewer beds in comparison to facility data. Facility policy outlined written processes for involuntary hospitalization but did not include expectations to monitor and track compliance with state laws. Staff also did not consistently document veterans' legal commitment statuses. All reviewed electronic health records included a discharge summary and discharge instructions. All reviewed records included evidence that follow-up appointments were scheduled prior to discharge, and a copy of the discharge instructions was offered to the veteran or caregiver. Most reviewed records did not include documentation of informed consent discussions between prescribers and veterans on risks and benefits of medication treatment. Staff did not consistently document veterans' follow-up appointment locations in easy-to-understand language. Although all reviewed electronic health records reflected that staff provided medication lists to veterans at discharge, most discharge instructions did not include the reasons for prescribed medications. Additionally, most discharge instructions included medical abbreviations that could be difficult for a non-medically trained individual to understand. OIG recommendations: • The Facility Director ensures accurate reporting of inpatient mental health beds and implements processes to monitor.

Domain	OIG Summary
	• The Facility Director formalizes written processes to monitor and track compliance with state involuntary commitment requirements. • The Facility Director ensures staff document veterans' legal commitment status in the electronic health record 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 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 medication listed and are free of medical abbreviations.
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, a suicide risk screening and evaluation tool, within 24 hours before discharge. Safety plans did not consistently address ways to make veterans' environments safer from potentially lethal means beyond access to firearms and opioids (previously described in four other reviews with published reports). In addition, staff did not consistently provide copies of these plans to veterans or caregivers. Not all staff completed Skills Training for Evaluation and Management of Suicide or VA S.A.V.E. (signs of suicidal thinking, ask questions, validate the person's experience, and encourage treatment and expedite getting help) training requirements. OIG recommendations: • The Chief of Staff directs staff to complete and document the Columbia-Suicide Severity Rating Scale within 24 hours before veterans' discharge and monitors for compliance. • The Chief of Staff directs staff to complete suicide prevention safety plans and provide copies of the plans to veterans or caregivers and monitors for compliance. • The Chief of Staff directs staff to address ways to make veterans' environments safer from potentially lethal means, beyond firearms and opioids, in safety plans and monitors for compliance. • The Under Secretary for Health identifies barriers to, and ensures documentation of, discussions specific to making the environment safer from identified lethal means in veterans' safety plans. • The Facility Director directs staff to comply with suicide prevention training requirements and monitors for compliance.

Domain	OIG Summary
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 mitigate 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 staff conducted biannual environment of care inspections, the OIG could not confirm if the facility had a formalized Interdisciplinary Safety Inspection Team as attendance was not recorded and there were no meeting minutes. The OIG identified deficiencies that were likely present but not documented during the most recent inspection, including inpatient unit fire doors with three-point hinges and a nonfunctional panic button in the sally port, which posed safety risks for veterans and staff. Additionally, inpatient unit staff were noncompliant with Veterans Health Administration-required annual Mental Health Environment of Care Checklist training. OIG recommendations: • The Facility Director ensures compliance with Veterans Health Administration requirements for the Interdisciplinary Safety Inspection Team, including recording of meeting minutes, membership, and attendance, and monitors for compliance. • The Facility Director implements processes to ensure the Interdisciplinary Safety Inspection Team applies Mental Health Environment of Care Checklist standards on the inpatient mental health unit and monitors for compliance. • The Facility Director directs inpatient unit staff and Interdisciplinary Safety Inspection Team members to comply with Mental Health Environment of Care Checklist training requirements and monitors for compliance.

VA Comments and OIG Response

The Acting Under Secretary for Health and the Interim Veterans Integrated Service Network and Facility Directors concurred with recommendations 1–17 and provided acceptable action plans (see appendixes D, E, and F). Based on information provided, the OIG considers recommendation 1 closed. For the remaining open recommendations, the OIG will follow up on the planned actions and recently implemented actions to ensure that they have been effective and sustained.

The Facility Director reported ensuring implementation of processes to enhance staff's knowledge of recovery-oriented care. Additionally, the Facility Director committed to: formalize written processes for tracking compliance with involuntary commitment laws to prevent the illegal hospitalization of veterans; ensure complete electronic health record documentation to support safe and recovery-oriented care for veterans and staff's completion of required trainings that enhances understanding of potential safety risks to veterans; and oversee the Interdisciplinary Safety Inspection Team functions to reduce safety hazards on the inpatient unit.

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

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Abbreviations

ACOS	Associate Chief of Staff
C-SSRS	Columbia-Suicide Severity Rating Scale
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
S.A.V.E.	signs of suicidal thinking, ask questions, validate the person's experience, encourage treatment and expedite getting help
STEMS	Skills Training for Evaluation and Management of Suicide
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The mission of the VA Office of Inspector General (OIG) is to conduct 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. The OIG conducted an inspection from January 27 through February 13, 2025, to evaluate acute inpatient mental health care provided at the Margaret Cochran Corbin VA Campus (facility), part of the VA NY Harbor Healthcare System (NY Harbor HCS) in New York.[2]

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).[3] 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.[4]

All HCSs must provide diagnosis, evaluation, and treatment for the full spectrum of mental health conditions. Required services include psychological and neuropsychological evaluation, evidence-based individual and group psychotherapy, pharmacotherapy, peer support, and vocational rehabilitation counseling.[5]

[1] "Mission, Vision, Values," OIG, accessed June 10, 2024, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VHA, 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. In this report, the OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[3] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

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

[5] VHA Directive 1160.01. If an HCS does not provide required services, those services must be offered through another VA facility or program.

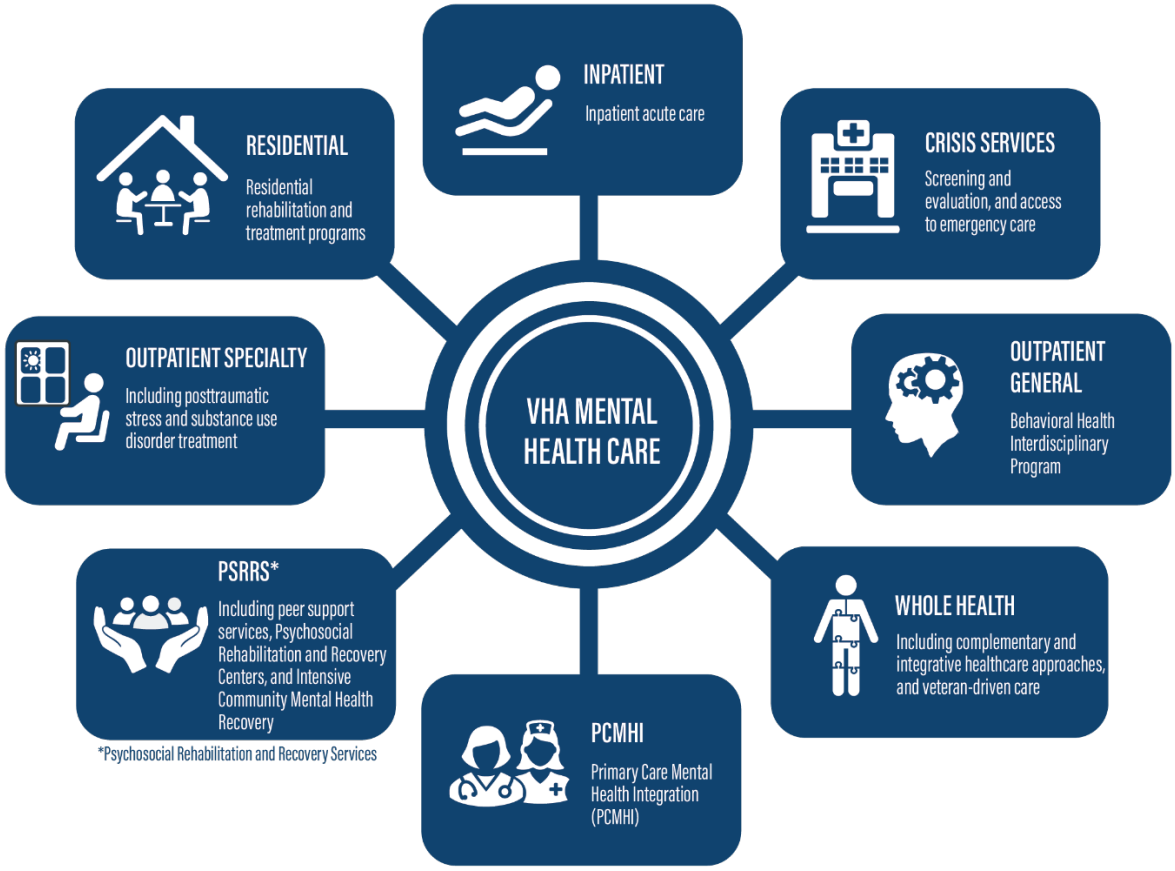

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services*, August 13, 2019, amended to VHA Directive 1163(1) on March 7, 2025. This directive was rescinded and replaced with VHA Directive 1163,* Psychosocial Rehabilitation and Recovery Services*, on August 14, 2025. For the purpose of this inspection, the directives contain the same or similar language related to psychosocial rehabilitation and recovery services.*

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.[6] In fiscal year (FY) 2024, VHA HCSs delivered inpatient mental health care for 64,298 veteran stays.[7]

[6] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, was amended to VHA Directive 1160.06(1) on December 27, 2024. Unless otherwise specified, the policies contain similar language related to inpatient mental health unit requirements.

[7] 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, http://vharamp.vssc.med.va.gov/VSSCSearch/Pages/results.aspx?k=ADT%20using%20NUMA. (This site is not publicly accessible.); The fiscal year for the federal government is a 12-month period from October 1 through September 30 and is identified by the calendar year in which it concludes. 49 C.F.R. § 1511.3 (2003).

To evaluate the quality of inpatient mental health care at the facility, the OIG assessed specific processes across five domains: leadership and organizational culture, recovery-oriented principles, clinical care coordination, suicide prevention, and safety. For background information and related requirements, refer to appendix A.[8]

About the NY Harbor HCS

The NY Harbor HCS, part of Veterans Integrated Service Network (VISN) 2, includes three medical centers and two community-based outpatient clinics in New York.[9] Inpatient mental health care is offered on the inpatient mental health unit (inpatient unit) at the Manhattan facility.[10] In FY 2024, the NY Harbor HCS provided health care to 41,133 veterans; 16,290 received outpatient mental health care. Inpatient unit staff cared for 467 veterans, and the facility maintained an average daily census of 11 on the unit. Staff did not submit any consults for inpatient mental health care in the community during the FY. At the time of inspection, facility data indicated the inpatient unit had 42 operating mental health beds (discussed further in Access to Care).[11]

[8] 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.

[9] VA administers healthcare services through a nationwide network of 18 regional systems referred to as VISNs. "Veterans Integrated Services Networks (VISNs)," VHA, accessed November 18, 2024, https://www.va.gov/HEALTH/visns.asp; The three medical centers are the Margaret Cochran Corbin VA Campus in Manhattan, Brooklyn VA Medical Center, and St. Albans VA Medical Center in Queens. The two community-based outpatient clinics are in Harlem and Staten Island. "Locations," VA, accessed February 26, 2025, https://www.va.gov/new-york-harbor-health-care/locations/.

[10] "Mental health care," VA, accessed February 28, 2025, https://www.va.gov/new-york-harbor-health-care/health-services/mental-health-care/.

[11] "VA Health Systems Research, Corporate Data Warehouse (CDW)," VA, 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."[12] HCS leaders can nurture a positive, safety-oriented culture by building effective reporting and communication structures, incorporating stakeholder feedback, and supporting continuous performance improvement.[13]

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

At the time of the OIG's inspection, the NY Harbor HCS executive leadership team included the Facility Director; acting Associate Director, Patient Care Services; and acting Chief of Staff.[14] The acting Chief of Staff supervised the office of the Associate Chief of Staff, Mental Health, (ACOS, Mental Health) and the acting Associate Director, Patient Care Services supervised the mental health care line manager. The ACOS, Mental Health served as the facility's required mental health lead and oversaw all mental health programs throughout the facility, including the inpatient unit.[15]

Facility leaders reported the organizational structure worked well for communication and collaboration among leadership and staff. Additionally, the VISN Chief Mental Health Officer reported providing a supportive role with the facility's mental health staff and operations; for example, through site visits to monitor environment of care compliance (see figure 2).

VHA requires HCSs to establish a mental health executive council (MHEC) to ensure quality mental health care is delivered.[16] The HCS MHEC was chaired by the ACOS, Mental Health and

[12] Edgar H. Schein, *Organizational Culture and Leadership,* 4th ed., (San Francisco, CA: Jossey-Bass, 2010), https://ia800809.us.archive.org/14/items/EdgarHScheinOrganizationalCultureAndLeadership/Edgar_H_Schein_Organizational_culture_and_leadership.pdf.

[13] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 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.)

[14] The executive leaders listed have supervisory responsibility over the inpatient unit and do not represent the HCS's full executive leadership team.

[15] VHA Directive 1160.01; At the time of the inspection, the Associate Chief of Staff, Mental Health also served as the Acting Chief of Staff.

[16] VHA Directive 1160.01.

included required representation from inpatient unit staff, the suicide prevention coordinator, and a veteran. Although VHA requires the local recovery coordinator (LRC) to be a member of the MHEC, the position was vacant and the facility did not have a designee for meeting participation.[17] Without input from an LRC, the MHEC may miss opportunities for improvement in the environment and recovery-oriented care on the inpatient unit.

Inpatient Unit Staffing

The section chief, inpatient psychiatry (section chief) also served as the required inpatient mental health program manager.[18] The ACOS, Mental Health reported the section chief provided programmatic oversight of unit operations and supervised the inpatient unit psychiatrists (see appendix C for information on current staffing levels and structure).

Facility leaders described the use of recruitment tools such as hiring fairs, an education debt reduction program, and competitive salary restructuring for various clinical positions. Additionally, facility leaders reported using retention strategies such as career growth opportunities, salary reviews, and employee appreciation events to maintain staffing levels.

The OIG made no recommendations in this domain.

[17] VHA Directive 1160.01; The OIG reviewed meeting minutes from October 1, 2023, through September 30, 2024. The NY Harbor HCS refers to its MHEC as the Mental Health Council.

[18] VHA Directive 1160.06; VHA Directive 1160.06(1).

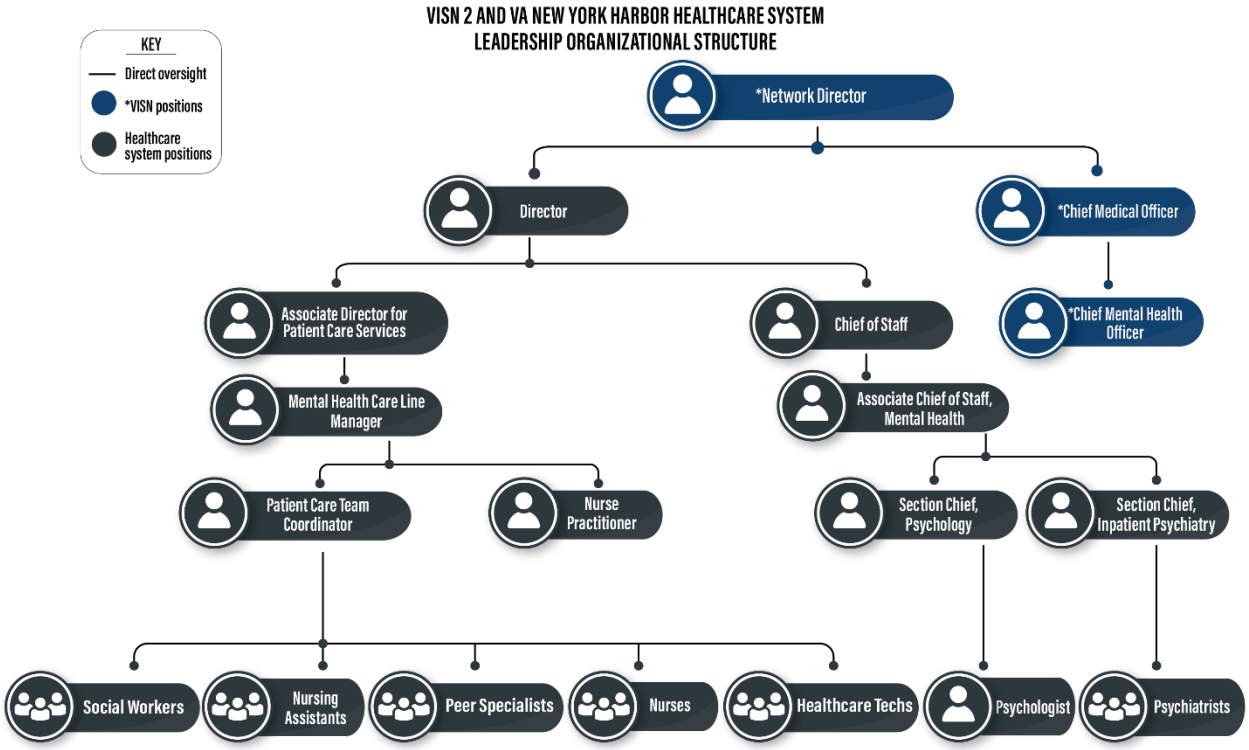

Figure 2. *VISN 2 and NY Harbor HCS organizational structure.*
Source: OIG analysis of interviews, facility documents, VHA Directive 1160.06, and VHA Directive 1160.06(1).
Note: The figure does not represent all inpatient unit staff.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent values." [19] 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.[20]

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.[21]

Leadership

LRCs play an important role at VA HCSs. They are considered collaborative mental health leaders who ensure recovery-oriented principles are integrated into care delivery. Their role is primarily nonclinical in nature, which allows them to dedicate most of their time to activities such as training, consultation, and education.[22]

The VISN Chief Mental Health Officer reported the LRC position had been vacant for at least one to two years at the time of the OIG's inspection. Mental health leaders established a workgroup that divided some of the position's responsibilities among its participants as additional workload. The facility met the requirement for a multiyear plan to direct veteran-centered, recovery-oriented care, but the plan did not have LRC input.[23] Forty-one days after the on-site inspection, facility leaders established a standard operating procedure for the "education, staff training and implementation of recovery-oriented care" on the inpatient unit.[24]

The long-standing absence of a dedicated LRC who could strategically lead, observe, and advise staff on incorporating recovery-oriented principles may have limited the inpatient unit's adoption

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

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

[21] VHA Directive 1160.06; VHA Directive 1160.06(1).

[22] VHA Directive 1163, 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.)

[23] VHA Directive 1163, August 13, 2019; NY Harbor HCS, "Recovery Oriented Care 3-5 Year Strategic Plan," December 30, 2024. Mental health leaders signed the plan on January 28, 2025, during the OIG's inspection.

[24] VHA Directive 1160.06; VHA Directive 1160.06(1); NY Harbor HCS, "Inpatient Mental Health: Recovery-Oriented Care Standard Operating Procedure," March 2025. Facility leaders provided OIG with the standard operating procedure (SOP) on March 31, 2025, after the on-site inspection.

of these elements. This was reflected in the OIG's observations of the physical environment and corresponding staff-patient interactions (more detail provided later in this domain).

Recovery-Oriented Programming

Inpatient unit staff offered at least four daily hours of recovery-oriented interdisciplinary programming, as required.[25] According to the section chief, staff contributed to recovery-oriented programming through art, music, and recreation therapy. The patient care team coordinator stated veterans received an orientation handbook during admission that provided required education on recovery-oriented care.[26] The section chief described weekly meetings between mental health leaders and staff on how to continually integrate recovery-oriented services into the programming. A social work supervisor shared an example of a process improvement project that resulted in the addition of virtual groups provided by outpatient staff. Mental health leaders reported using patient experience survey responses to enhance veterans' care experiences.[27]

Physical Environment

The inpatient unit was generally clean with recovery-oriented elements such as artwork and warm paint colors.[28] The unit was T-shaped and had a nursing station positioned in the middle of the hallway. Located at the end of the hallway was a large day room with natural lighting and amenities such as television, music, and reading materials for veterans' use. In addition, the unit had a designated quiet room with weighted rocking chairs and headphones for music.

However, the OIG observed that both rooms were locked and therefore inaccessible to veterans. A staff nurse explained that access to the communal areas depended on the acuity of the veterans on the unit and whether nurses were reassigned to other areas of the facility.[29] The section chief acknowledged veterans did not have access to outdoor space and, ideally, the day room would be accessible for veteran use (see figure 3).

Consequently, veterans were limited to their bedrooms, which contained only a bed, and hallways. The OIG observed veterans pacing the hallways and nursing staff in the nursing station with their backs to the unit. Restricted access to communal areas and limited staff interactions with veterans may result in missed opportunities to engage veterans in recovery-oriented care.

[25] VHA Directive 1160.06; VHA Directive 1160.06(1).

[26] VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure For Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06," September 29, 2023.

[27] VHA Directive 1160.01.

[28] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities,* January 2021.

[29] According to a staff nurse, the inpatient nursing staff accommodated temporary reassignments to other areas of the facility based on need.

Figure 3. *Top row: inpatient unit hallway and a veteran's bedroom with a mattress and bedframe. Bottom row: day room.*
Source: Photos of the facility's inpatient unit taken by OIG staff, February 12, 2025.

Recommendations

1. The Associate Chief of Staff, Mental Health ensures compliance with Veterans Health Administration requirements for a full-time local recovery coordinator.
2. The Associate Chief of Staff, Mental Health ensures the implementation of written processes for staff training, education, and recovery-oriented services.
3. The Facility Director identifies and addresses barriers to communal room access for veterans on the inpatient unit.

For detailed action plans, see appendix F.

Clinical Care Coordination

"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective" treatment.[30] For veterans with "complex health and social needs, care coordination is crucial for improving their access to [services], clinical outcomes, [and] care experiences."[31] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a lower level of care.[32]

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 inpatient mental health care requires well-defined screening and admissions processes that ensure veterans are evaluated and receive clinically appropriate treatment.[33] The OIG found facility leaders established standard operating procedures for inpatient admission and transfer processes that met VHA requirements.[34]

The OIG found discrepancies between reports from mental health leaders and facility data related to the number of operating inpatient mental health beds. According to facility data, the facility had 42 operating inpatient mental health beds. At the time of the inspection, the OIG learned that one unit with 19 beds was closed due to construction, and a second unit was open

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

[31] 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, (August 14, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[32] VHA Directive 1160.06; VHA Directive 1160.06(1).

[33] VHA Directive 1160.01; VHA Directive 1160.06; VHA Directive 1160.06(1).

[34] 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 SOP updated the requirement to include procedures and processes for facility staff responsible for admission of veterans to the inpatient units; VA NY Harbor Healthcare System MH SOP-11, "Procedure for Emergency Department Evaluation and Admission of Psychiatric Patients and for Inter-ward Transfer to Inpatient Psychiatry Units," July 2007, recertified January 1, 2024; VA NY Harbor Healthcare System Policy No. 11-116, "Inter-facility Transfer," March 2024.

with 23 operating beds. Facility leaders did not follow processes to ensure accurate reporting of all inpatient mental health beds.[35]

Inaccurate reporting of the number of beds may impede timely access and care coordination for veterans in need of inpatient mental health care.

Involuntary Hospitalization and Treatment

Facility policy outlined written processes for involuntary hospitalization, but did not include procedures for monitoring and tracking ongoing compliance with state laws.[40] Mental health leaders described informal processes such as huddles, nursing reports, and rounds to monitor and track veterans' legal (voluntary or involuntary) commitment statuses.[41] The absence of written processes to monitor commitment status may result in staff confusion and potentially contribute to the illegal hospitalization of veterans.

Not all electronic health records (EHRs) included evidence that nursing staff recorded veterans' legal

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" hospitalization.[36]

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."[37]

Standards and procedures for civil commitment are provided by state law and vary by state.[38] VHA requires that HCS leaders consult with legal counsel, as necessary, to ensure that processes are consistent with applicable laws.[39]

[35] VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, November 28, 2017.

[36] Leslie C. Hedman et al., "State Laws on Emergency Holds for Mental Health Stabilization," *Psychiatric Services*, 67, no. 5 (February 29, 2016): 529–535, https://doi.org/10.1176/appi.ps.201500205.

[37] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," US Department of Health and Human Services, 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.

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

[39] VHA Directive 1160.01.

[40] VHA Directive 1160.06; VHA Directive 1160.06(1). The amended directive added the word applicable to the requirement that "each VA medical facility must develop clear guidelines for involuntary hospitalization in accordance with applicable state and local civil commitment laws; VA NY Harbor Healthcare System Policy No. 11M-04, "Involuntary Commitment," December 2024.

[41] 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.

commitment status in the appropriate note template.[42] When staff have accurate information regarding veterans' legal commitment status, it may ensure that veterans' civil rights are not violated.

Treatment Planning

In alignment with VHA requirements, the facility's standard operating procedure outlined the inpatient unit treatment planning process, including recovery-oriented elements such as veterans' involvement in setting individualized goals.[43] The section chief and an inpatient psychiatrist shared providers regularly reviewed treatment plans to oversee the quality of treatment planning. Mental health leaders and staff also stated the interdisciplinary treatment team routinely met to implement and review treatment plans in collaboration with veterans and outpatient providers.[44]

Medication Treatment

The OIG found only 19 percent of reviewed EHRs included documentation of informed consent discussions between prescribers and veterans on risks and benefits of medication treatment, as required.[45] 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.

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[42] VHA Office of Nursing Services, VHA-ONS-NUR-22-01, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," revised April 5, 2023, November 2, 2023, and September 10, 2024. All three versions were in effect during the EHR review period. Unless otherwise noted, all versions contain similar language related to documentation of voluntary or involuntary legal status.

[43] 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; VA NY Harbor Healthcare System, "Treatment Planning" (standard operating procedure), January 2006, recertified January 15, 2024.

[44] VHA Directive 1160.06; VHA Directive 1160.06(1).

[45] VHA Directive 1108.07(1), *General Pharmacy Service Requirements*, November 28, 2022, amended October 4, 2023. VHA Directive 1108.07(1) 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, amended January 12, 2024, and February 22, 2024; VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, amended May 1, 2024. The directives contain similar language related to medication risks and benefits discussion; 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; Central nervous system medications are used for the treatment of "a wide range of neurologic and psychiatric conditions." John A. Gray, "Introduction to the Pharmacology of CNS [Central Nervous System] Drugs," chap. 21 in *Katzung's Basic & Clinical Pharmacology*, 16th edition, ed. Todd W. Vanderah, (McGraw Hill, 2024), https://accesspharmacy.mhmedical.com/content.aspx?sectionid=281750155&bookid=3382&Resultclick=2.

Discharge Planning

Facility leaders established required written guidance on care coordination processes for veterans transitioning out of inpatient care that included involvement of veterans, mental health treatment coordinators, and relevant outpatient providers.[46] Inpatient unit staff provided an example of care coordination in which specialty and outpatient mental health providers conducted intake for veterans while on the unit prior to discharge.

All reviewed EHRs included the required discharge summary and evidence that outpatient mental health follow-up appointments were scheduled prior to discharge. Additionally, all reviewed records included discharge instructions and evidence that a copy was offered to the veteran or caregiver (see figure 4).[47]

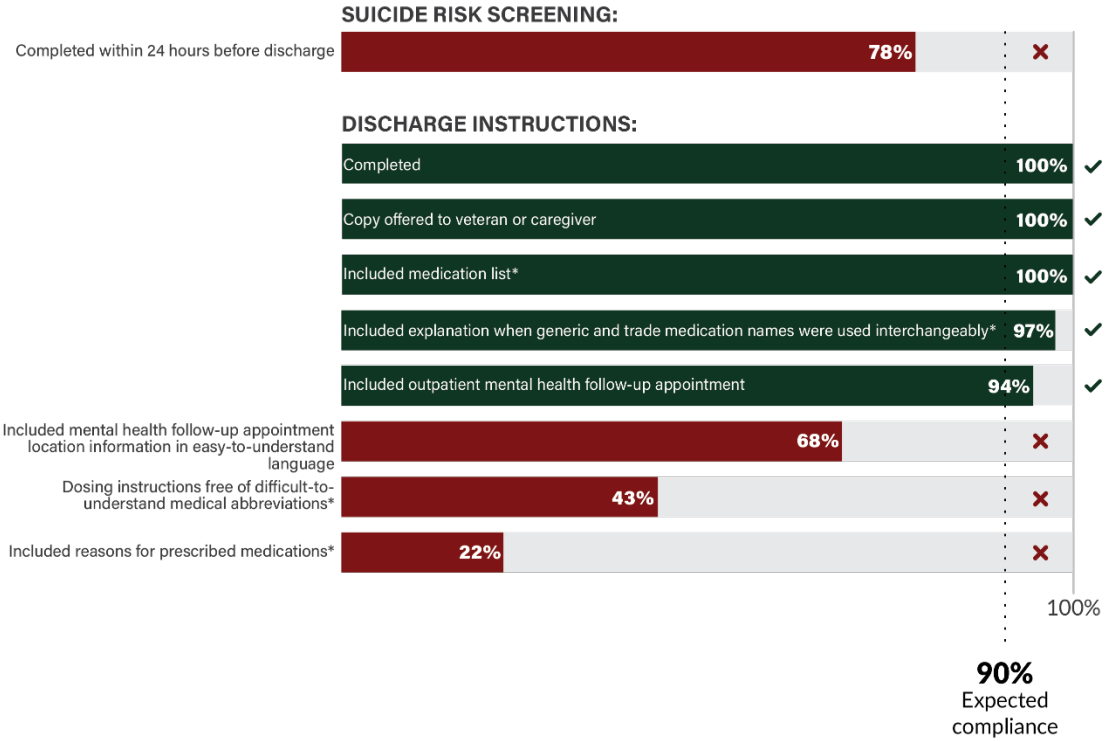


Figure 4. *Discharge-related screening and documentation.*
Source: OIG review of inpatient unit EHRs.
Note: Based on analysis of 50 EHRs. Suicide risk screening discussed in Suicide Prevention (below).
**Corresponds to a subset of records with a completed medication list (n = 49).*

[46] VHA Directive 1160.01; VA NY Harbor Healthcare System, "Assuring Continuity of Care in MH" (standard operating procedure), November 1, 2020, recertified January 1, 2024.

[47] VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023, replaced by VHA Health Information Management, *Health Record Documentation Program Guide Version 1.3,* February 13, 2025. Unless otherwise specified, the program guides contain similar language related to documentation requirements; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

Staff did not consistently document veterans' follow-up appointment locations in easy-to-understand language.[48] Discharge instructions with abbreviated location information may create barriers for veterans to attend follow-up appointments and receive timely mental health care (see figure 5).

Figure 5. *Example from discharge instructions with abbreviated appointment information outlined in red.*
Source: OIG review of veterans' EHRs.

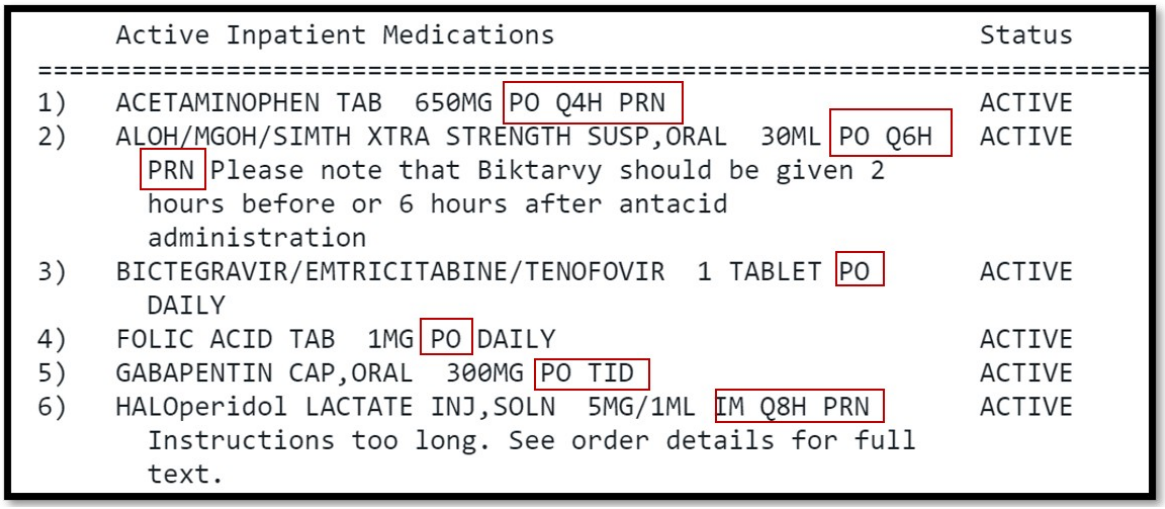
All reviewed EHRs included documentation that a medication list was provided at discharge. However, most discharge instructions did not include the reasons for prescribed medications.[49] Mental health leaders and staff reported relying on templated discharge instructions that did not include the reasons for all listed medications.

Most discharge instructions included medical abbreviations that could be difficult for a non-medically trained individual to understand (see figure 6).[50] Accurate and easy-to-understand discharge instructions could prevent veterans from making medication errors at home following hospitalization.

[48] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," May 24, 2023; VHA Directive 1160.06; VHA Directive 1160.06(1).

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

[50] "When included in information provided to patients (for example, consent forms), abbreviations and acronyms must be explained in language that the patient can understand." VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*; Randa Hilal-Dandan and Laurence L. Brunton, "Principles of Prescription Order Writing and Patient Compliance," appendix I in *Goodman and Gilman's Manual of Pharmacology and Therapeutics*, 2nd ed., (McGraw Hill Education, 2016), https://accesspharmacy.mhmedical.com/content.aspx?bookid=1810&sectionid=124489535.



	Active Inpatient Medications	Status
1)	ACETAMINOPHEN TAB 650MG PO Q4H PRN	ACTIVE
2)	ALOH/MGOH/SIMTH XTRA STRENGTH SUSP,ORAL 30ML PO Q6H PRN Please note that Biktarvy should be given 2 hours before or 6 hours after antacid administration	ACTIVE
3)	BICTEGRAVIR/EMTRICITABINE/TENOFOVIR 1 TABLET PO DAILY	ACTIVE
4)	FOLIC ACID TAB 1MG PO DAILY	ACTIVE
5)	GABAPENTIN CAP,ORAL 300MG PO TID	ACTIVE
6)	HALOperidol LACTATE INJ,SOLN 5MG/1ML IM Q8H PRN Instructions too long. See order details for full text.	ACTIVE

Figure 6. *Example of difficult-to-follow discharge instructions. Latin abbreviations for medication instructions are outlined in red. The instructions do not include the reasons for prescribed medications. Source: OIG review of veterans' EHRs.*
Note: The Latin terms po, prn, and tid are used to describe how and when medications should be taken.

Recommendations

4. The Facility Director ensures accurate reporting of inpatient mental health beds and implements processes to monitor.
5. The Facility Director formalizes processes to monitor and track compliance with state involuntary commitment requirements.
6. The Facility Director ensures staff document veterans' legal commitment status in the electronic health record and monitors for compliance.
7. 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.
8. The Chief of Staff ensures discharge instructions for veterans include appointment locations written in easy-to-understand language.
9. The Chief of Staff ensures discharge instructions for veterans include the purpose for each medication listed and are free of medical abbreviations.

For detailed action plans, see appendix F.

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.[51]

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."[52] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[53]

To evaluate suicide prevention activity on the inpatient unit, the OIG assessed compliance with required suicide risk screening and evaluation, safety planning, and training.

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. Inpatient unit clinical staff did not complete C-SSRSs within the required time frame (see figure 4, above).[54] According to the section chief, staff typically avoid completing the C-SSRS the day of discharge as the veteran is eager to leave the unit; however, this resulted in completion outside the required time frame.[55] Not completing 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 discharge readiness and post-discharge care coordination needs.

Safety Planning

The OIG found inpatient staff did not consistently complete or review safety plans prior to discharge and did not consistently provide a copy of the plan to veterans or caregivers.[56] However, for completed or reviewed safety plans, staff used the appropriate standardized safety

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

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

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

[54] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting," updated May 10, 2023; Assistant Under Secretary for Clinical Services/Chief Medical Officer (11), "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum to Veterans Integrated Service Network Director (10N1-23), January 7, 2025; 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.

[55] The OIG found that 88 percent of reviewed EHRs had a completed C-SSRS during the admission stay.

[56] VA, *VA Safety Planning Intervention Manual*, February 23, 2022; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

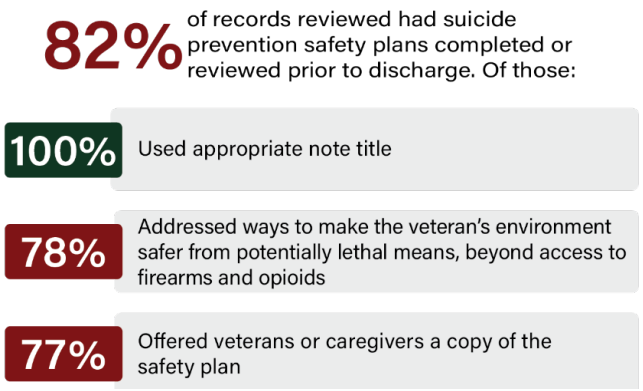


Figure 7. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' EHRs.

planning note title.[57] Veterans may be more likely to engage coping skills when discharged with a copy of the safety plan (see figure 7).

Inpatient unit staff were deficient in addressing ways to make veterans' environments safer from potentially lethal means, including safety considerations beyond access to firearms and opioids.[58] Mental health leaders acknowledged the free text field was "left blank" and suggested it should be required in the suicide prevention safety template (see figure 8).

The OIG expects providers to discuss access to other lethal means with veterans to reduce the likelihood of adverse outcomes and considers this to be good clinical practice and in alignment with VHA guidance.[59]

In four other reviews with published reports, the OIG found that staff also did not consistently complete the other lethal means text field in safety plans.[60] All reports included recommendations for the respective HCS Chief of Staff to ensure safety plans addressed ways to make the environment safer, beyond access to firearms and opioids.[61] The identification of other potential lethal means in the environment, beyond access to firearms and opioids, may reduce the risk of veteran harm.[62]

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[57] 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.

[58] VA, *VA Safety Planning Intervention Manual*. "Making the environment safer is another strategy for lowering suicide risk. If Veterans have identified a potentially lethal method, then restricting access to this method, particularly during periods of risk (e.g., the months following a suicide attempt) is helpful because the more time that it takes to obtain or use this method, the greater the likelihood that they will reconsider attempting suicide, and instead, use one of the strategies or resources in the plan to lower suicide risk."

[59] VA, *National Strategy for Preventing Veteran Suicide 2018-2028*, 2018; VA, VA Safety Planning Intervention Manual.

[60] VA, *Safety Plan Reminder Dialogue Template: Instruction Guide*, February 2022.

[61] VA OIG, *Mental Health Inspection of the VA Augusta Health Care System in Georgia*, Report No. 24-00675-259, September 26, 2024; VA OIG, *Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*, Report No. 24-01859-62, March 5, 2025; VA OIG, *Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*, Report No. 24-01862-151, June 26, 2025; VA OIG, *Mental Health Inspection of the VA Salem Healthcare System in Virginia*, Report No. 24-01861-144, June 26, 2025.

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

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                    Step 6: Making the Environment Safe
--------------------------------------------------------------------------------
Ways to make my environment safer and barriers I will use to protect
myself from these potentially lethal means:
  ....
Veteran has access to firearms in their home or elsewhere: No
Veteran has access to opioids: No
```

Figure 8. *Example from a safety plan that did not address ways to make the environment safer from potentially lethal means (outlined in red), beyond access to firearms and opioids.*
Source: OIG review of veterans' EHRs.

Training

Skills Training for Evaluation and Management of Suicide (STEMS) and VA S.A.V.E. help clinicians and nonclinical staff, respectively, identify the warning signs of suicide risk and appropriate interventions.[63]

The OIG found some inpatient unit clinical staff did not complete required STEMS training. Although 93 percent of nonclinical staff completed VA S.A.V.E. training, VHA requires at least 95 percent completion for all mandatory suicide prevention trainings (see figure 9).[64] When staff do not complete suicide prevention training, they may not identify suicide risk factors and may lack awareness of resources and interventions to keep veterans safe.

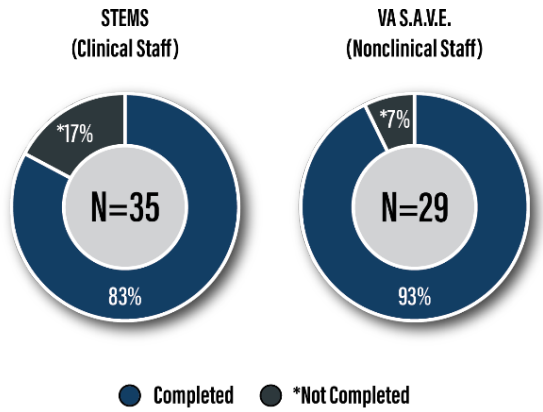

Figure 9. *Inpatient unit staff completion of mandatory suicide prevention trainings.*
Source: OIG document review of clinical and non-clinical staff training certificates.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings from January 27, 2024, through January 27, 2025.

[63] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; The acronym "S.A.V.E" summarizes the steps needed to take in recognizing and responding to a veteran in suicidal crisis: signs of suicidal thinking, ask questions, validate the person's experience, encourage treatment and expedite getting help; VA, "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis"(fact sheet), June 2025.

[64] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification," memorandum to Veterans Integrated Services Network Directors (10N1-23) et al., June 9, 2022; VHA Directive 1108.13(1), *Provision and Use of Nursing Medication Management Protocols in Outpatient Team-based Practice Settings*, February 6, 2019, amended on March 13, 2019; VHA Directive 2013-006, *The Use of Unlicensed Assistive Personnel (UAP) in Administering Medication*, March 5, 2013.

Recommendations

10. The Chief of Staff directs staff to complete and document the Columbia-Suicide Severity Rating Scale within 24 hours before veterans' discharge and monitors for compliance.
11. The Chief of Staff directs staff to complete suicide prevention safety plans and provide copies of the plans to veterans or caregivers and monitors for compliance.
12. The Chief of Staff directs staff to address ways to make veterans' environments safer from potentially lethal means, beyond firearms and opioids, in safety plans and monitors for compliance.
13. The Under Secretary for Health identifies barriers to, and ensures documentation of, discussions specific to making the environment safer from identified lethal means in veterans' safety plans.
14. The Facility Director directs staff to comply with suicide prevention training requirements and monitors for compliance.

For detailed action plans, see appendix D and appendix F.

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."[65] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[66]

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 interdisciplinary safety inspection team (ISIT), comprised of both mental health and other facility staff, is responsible for conducting environment of care inspections using the Mental Health Environment of Care Checklist (MHEOCC).[67] The National Center for Patient Safety continually updates the MHEOCC "based on reports from the field of hazards or adverse events encountered at the local level."[68] ISIT members are required to use this comprehensive checklist of over 150 detailed environmental elements to "identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide."[69]

Although staff completed the biannual environment of care inspections, meeting minutes or attendance were not recorded.[70] As a result, the OIG could not determine whether the facility had a formalized ISIT. This may have led to missed opportunities to identify potential environmental hazards.

In a physical inspection of the unit, the OIG observed compliance with the majority of OIG randomized MHEOCC safety elements. However, the OIG identified deficiencies that were likely present but not documented during the most recent inspection, including inpatient unit fire doors with three-point hinges that posed ligature risks and a nonfunctional panic button in the

[65] VHA Directive 1160.06; VHA Directive 1160.06(1).

[66] 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.

[67] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[68] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, accessed June 5, 2025, https://www.patientsafety.va.gov/features/Mental_Health_Environment_of_Care_Checklist.asp.

[69] 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 workstations."

[70] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

sally port.[71] At the OIG's request, facility leaders implemented a risk mitigation plan for the fire doors and replaced the three-point hinges with the required hardware. Facility leaders also provided the OIG with a risk mitigation plan for the nonfunctional panic button. When staff do not accurately identify and mitigate environmental hazards, they may place veterans and staff at risk for harm.

Training

VHA requires staff training on environmental hazards and orientation to the "content and proper use" of the MHEOCC.[72] The OIG found that not all inpatient unit staff completed the annual MHEOCC training requirement (see figure 10).[73] Additionally, the OIG could not confirm if staff responsible for conducting environment of care inspections had completed the training. Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.

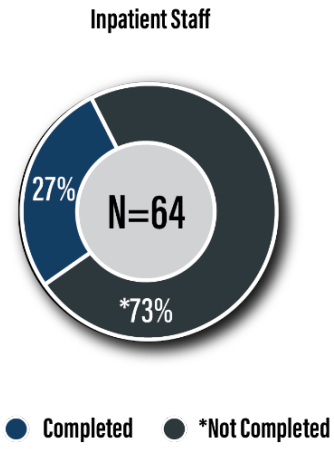

Figure 10. *MHEOCC training completion, January 27, 2024, through January 27, 2025.*
Source: OIG document review of staff training certificates.

Recommendations

15. The Facility Director ensures compliance with Veterans Health Administration requirements for the Interdisciplinary Safety Inspection Team, including recording of meeting minutes, membership, and attendance, and monitors for compliance.

[71] Katie Byrne et al., "Special Report: Suicide Prevention in Health Care Settings"; The Joint Commission *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 sustain-able point of attachment that may result in self-harm or loss of life."

[72] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024; The policies contain similar language related to training requirements.

[73] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, updated December 2022; VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024; The policies contain similar language related to training requirements.

16. The Facility Director implements processes to ensure the Interdisciplinary Safety Inspection Team applies Mental Health Environment of Care Checklist standards on the inpatient mental health unit and monitors for compliance.
17. The Facility Director directs inpatient unit staff and Interdisciplinary Safety Inspection Team members to comply with Mental Health Environment of Care Checklist training requirements and monitors for compliance.

For detailed action plans, see appendix F.

Conclusion

To assist leaders in impactful quality of care improvements, the OIG conducted a review across five domains to evaluate acute inpatient mental health care provided at the facility.

At the time of the inspection, the inpatient unit was clean, with recovery-oriented elements such as artwork, warm paint colors, and natural lighting. The OIG observed communal rooms that were locked and therefore inaccessible to veterans unless there were staff available to monitor, which may have resulted in missed opportunities to engage in recovery-oriented care and interact with staff.

The LRC position had been vacant for at least a year. Mental health leaders established a workgroup that divided some of the position's responsibilities among staff as additional workload. The facility met the requirement for a multiyear plan to direct veteran-centered, recovery-oriented care, but the plan did not have LRC input. Forty-one days after the on-site inspection, facility leaders established a standard operating procedure for the "education, staff training and implementation of recovery-oriented care" on the inpatient unit. Inpatient unit staff offered at least four daily hours of recovery-oriented interdisciplinary programming, as required.

Although facility policy included guidelines for involuntary hospitalization, facility leaders did not have formal written processes to ensure compliance with state laws. Inpatient unit staff did not consistently complete required suicide prevention or annual MHEOCC trainings.

All reviewed EHRs included the required discharge summary, as well as evidence that follow-up outpatient mental health appointments were scheduled prior to discharge and the veteran or caregiver was offered a copy of the discharge instructions. Some EHRs did not include evidence of timely suicide risk screenings or safety plans. Staff did not consistently document veterans' follow-up appointment locations in easy-to-understand language, and most discharge instructions included medical abbreviations that could be difficult for a non-medically trained individual to understand. Most reviewed records did not include documentation of informed consent discussions between prescribers and veterans on risks and benefits of medication treatment.

In four other reviews with published reports, the OIG found that staff also did not consistently complete the safety plan text field for addressing ways to make the veterans' environment safer from potentially lethal means beyond access to firearms and opioids.

The OIG could not determine whether the facility had a formalized ISIT. Additionally, the OIG observed inpatient unit fire doors with three-point hinges that posed ligature risks and a nonfunctional panic button that were likely present in the most recent mental health environment of care inspection. The lack of a formalized ISIT and staff noncompliance with MHEOCC training may have resulted in missed opportunities to identify potential environmental hazards.

The OIG issued 17 recommendations to the Under Secretary for Health; Facility Director; Chief of Staff; and ACOS, Mental Health.[74] In response to these recommendations, the Under Secretary for Health committed to ensuring documentation of discussions on making the environment safer from identified lethal means in veterans' safety plans. The Facility Director reported ensuring implementation of processes to enhance staff's knowledge of recovery-oriented care. Additionally, the Facility Director committed to: formalize written processes for tracking compliance with involuntary commitment laws to prevent the illegal hospitalization of veterans; ensure complete electronic health record documentation to support safe and recovery-oriented care for veterans and staff's completion of required trainings that enhances understanding of potential safety risks to veterans; and oversee the Interdisciplinary Safety Inspection Team functions to reduce safety hazards on the inpatient unit.

These recommendations may improve the quality and delivery of veteran-centered, recovery-oriented care on the inpatient mental health unit and beyond.

[74] These recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

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.[75]

VHA requires inpatient unit staff use a veteran-centered, "evidence-based, recovery-oriented approach" that incorporates evaluation and monitoring, interdisciplinary treatment, discharge planning, sufficient staffing, privacy, and dignity.[76] To evaluate the quality of recovery-oriented care provided at the HCS, the OIG assessed compliance with VHA requirements in the five 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.[77]

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 sufficient staffing to form interdisciplinary teams, ensure veterans' access to mental health care, and fully implement program requirements.[78]

Each HCS must have a dedicated chief 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.[79] Each MHEC must include "at least one Veteran, and ideally one who is receiving mental health services" and not employed at the local HCS.[80] The MHEC is required to

[75] VHA Directive 1160.06; VHA Directive 1160.06(1).
[76] VHA Directive 1160.06; VHA Directive 1160.06(1).
[77] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*.
[78] VHA Directive 1160.06; VHA Directive 1160.06(1).
[79] VHA Directive 1160.01.
[80] VHA Directive 1160.01.

meet quarterly and "record minutes that are accessible to all mental health clinical staff."[81] The HCS mental health lead must assign an inpatient mental health program manager "to coordinate and promote consistent, sustained, high quality therapeutic programming" in the inpatient unit setting.[82]

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."[83] VHA requires the appointment of a full-time VISN chief mental health officer to "ensure transparency of decision making and to promote communication between the field and central office."[84]

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. "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."[85]

Recovery-Oriented Principles

The President's *New Freedom Commission on Mental Health* report, published in 2003, outlined a vision for the delivery of recovery-oriented mental health care.[86] 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."[87]

To support veterans' recovery, VHA requires HCSs to have a plan across the mental health care continuum for continued transformation and implementation of recovery-oriented services.[88] Additionally, VHA requires the LRC, in collaboration with the inpatient mental health program

[81] VHA Directive 1160.01.

[82] VHA Directive 1160.06; VHA Directive 1160.06(1).

[83] VHA Directive 1160.06; VHA Directive 1160.06(1).

[84] "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.)

[85] VHA Directive 1163, August 13, 2019. Peer support staff may also be referred to as peer specialists.

[86] "Achieving the Promise: Transforming Mental Health Care in America," President's New Freedom Commission on Mental Health, accessed June 11, 2024, https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/InsideCover.htm.

[87] "Recovery and Recovery Support," Substance Abuse and Mental Health Services Administration.

[88] VHA Directive 1163, August 13, 2019.

manager, to establish a standard operating procedure that includes processes for staff training, education, and implementation of recovery-oriented services on the inpatient unit.[89]

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit.[90]

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.[91] For VA medical facilities with a MHEOCC-compliant secure outdoor space, daily programming should include dedicated time for veterans to be outdoors.[92]

Clinical Care Coordination

Care coordination poses a major challenge to healthcare safety for chronically ill individuals who receive services from multiple providers in a variety of settings.[93] VHA requires inpatient units to have an interdisciplinary treatment team composed of individuals who are responsible for the veteran's care. An interdisciplinary approach is critical to ensure "comprehensive, coordinated, and holistic care."[94]

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.[95] When treatment is not available within the HCS, staff may transfer the veteran to another VHA or non-VHA HCS for inpatient mental health care.[96]

There are no federal civil commitment laws; therefore, HCS leaders are required to have clear guidelines that align with state and local laws for civil commitment.[97] HCS staff must be aware

[89] VHA Directive 1160.06; VHA Directive 1160.06(1).

[90] VHA Directive 1160.06; VHA Directive 1160.06(1); VHA Directive 1163, August 13, 2019; VHA Directive 1160.01.

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

[92] VHA Directive 1160.06; VHA Directive 1160.06(1). For VA medical facilities with a MHEOCC-compliant outdoor space, "designated time for Veterans to be outdoors should be incorporated into the daily programming as permitted by staffing, individual Veteran interest, safety observation level of the Veteran, weather and as determined by the patient's [Interdisciplinary Treatment Team], clinical condition, and any other relevant contingency factors."

[93] The Joint Commission, *Standards Manual,* PC.02.02.01, August 2024. "The hospital coordinates the patient's care, treatment, and services based on the patient's needs."

[94] VHA Directive 1160.06; VHA Directive 1160.06(1).

[95] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Directive 1160.06; VHA Directive 1160.06(1).

[96] VHA Directive 1160.06; VHA Directive 1160.06(1).

[97] VHA Directive 1160.06; VHA Directive 1160.06(1).

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.[98]

The interdisciplinary treatment team must ensure the recovery-oriented treatment plan includes the veteran's personally identified goals and is completed in collaboration with the veteran. The interdisciplinary treatment team must also ensure outpatient mental health care is coordinated with the veteran prior to discharge, including follow-up appointment information.[99]

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 follow-up appointment information.[100]

Suicide Prevention

According to the *2024 National Veteran Suicide Prevention Annual Report*, "suicide was the 12th-leading cause of death for Veterans in 2022," and the second-leading cause of death for veterans under age 45.[101] Suicide risk is elevated after a suicide attempt, including the period following discharge from an inpatient psychiatric setting.[102] 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.[103]

Inpatient unit clinical staff are to complete the C-SSRS, a risk assessment tool, for veterans within 24 hours prior to discharge.[104] A positive C-SSRS then requires the "timely completion of the Comprehensive Suicide Risk Evaluation (CSRE)."[105] Staff may complete the CSRE in lieu of the suicide risk screening prior to discharge.[106]

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[98] VHA Office of Nursing Services VHA-ONS-NUR-22-01, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)."

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

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

[101] VA Office of Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report*, December 2024.

[102] VA, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[103] 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.

[104] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting."

[105] Assistant Under Secretary for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum.

[106] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Frequently Asked Questions (FAQ)," updated December 13, 2022.

When veterans are determined to be at risk for suicide, providers are expected to engage them in safety planning.[107] Safety planning is an intervention in which "patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time" and "involves eliminating or limiting access to any potential lethal means in the environment."[108] According to VHA, all patients in a VHA inpatient mental health setting "must be offered the opportunity to create or update a Safety Plan as part of the discharge plan. This should be documented in the patient's medical record."[109]

In 2018, VA published its 10-year strategic plan for preventing veteran suicide, which outlines the objective of reducing access to lethal means. The document discusses provider education for veterans on safe storage and access to firearms, as well as "storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons."[110] The *VA Safety Planning Intervention Manual*, a guide to help VHA providers develop safety plans with veterans, further emphasizes identification of access to potentially lethal means such as firearms, opioids, medications, ropes, and household toxins.[111]

VHA requires healthcare providers complete STEMS and nonclinical staff complete VA S.A.V.E. training annually.[112] In June 2022, VHA issued a memorandum indicating a target of at least 95 percent completion for mandatory suicide prevention trainings.[113]

Safety

In VHA HCSs, inpatient mental health units must be designed to ensure veteran safety while still integrating recovery-oriented principles into the environment.[114] ISIT members and all inpatient unit staff are responsible for ensuring a safe environment.[115] Additionally, an ISIT is required to assess the inpatient unit twice annually for suicide hazards using the MHEOCC and the patient

[107] VA, VA Safety Planning Intervention Manual.

[108] Barbara Stanley and Gregory K. Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice* 19, no. 2 (May 2012): 256-264, https://doi.org/10.1016/j.cbpra.2011.01.001.

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

[110] VA, *National Strategy for Preventing Veteran Suicide 2018-2028*.

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

[112] VHA Directive 1071(1).

[113] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification."

[114] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to integrating recovery-oriented principles into the environment.

[115] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to all staff members' responsibility to ensure safety on the inpatient unit.

safety manager or other designated mental health staff track corrective actions taken for identified environmental risks.[116]

An ISIT is a mandatory subcommittee of the HCS environment of care committee, with team membership documented as part of MHEOCC inspection rounds summary. The ISIT should include an inpatient mental health unit program director and inpatient unit nurse manager, the suicide prevention coordinator, a patient safety manager, a representative from engineering/facilities management, and an "additional clinical staff from any discipline or work area."[117]

[116] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to ISIT and use of MHEOCC; VHA Directive 1160.06; VHA Directive 1160.06(1). The MHEOCC is a "checklist designed to help identify and abate suicide hazards on mental health units and other areas treating Veterans 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/physical restraint rooms, and staff workstations."

[117] VHA Directive 1167, November 4, 2024.

Appendix B: Methodology

The Mental Health Inspection Program inspections focused on the quality of care provided by VHA's inpatient mental health services.[118] The OIG randomly selected the VHA HCSs included in FY 2025 reviews from all HCSs with inpatient mental health beds.[119]

The OIG conducted a virtual and on-site review at the facility from January 27, 2025, to February 13, 2025. The OIG did not receive any complaints beyond the scope of this review that required referral to the OIG hotline.

The OIG reviewed VHA and facility policies, standard operating procedures, and guidance documents in effect at the time of the inspection. Additionally, the OIG reviewed HCS Mental Health Executive Committee meeting minutes from FY 2024. The OIG reviewed data specific to the facility, prior OIG reports related to the inpatient unit, documents, and EHRs. Additionally, the OIG conducted a physical inspection of the inpatient unit and interviewed key staff and leaders.

The OIG reviewed select staff's certificates for annual completion of STEMS, VA S.A.V.E, and MHEOCC trainings.[120] Except for a 95 percent threshold for mandatory suicide prevention training completion, the OIG used 90 percent as the expected level of compliance for record review.

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

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 in appendix D, appendix E, and appendix F.

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

[119] 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 2025, the OIG excluded inpatient mental health beds visited in FY 2024. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

[120] VHA Directive 1071(1); VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

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.[121] 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.

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 facility from October 1, 2023, through September 30, 2024. The OIG used 90 percent as the expected level of compliance for record review.

OIG Inspection of the Physical Environment

The OIG inspected selected areas of the inpatient unit to evaluate if the facility provided a therapeutic, recovery-oriented environment and maintained veteran safety.[122] 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 secure outdoor space.[123] Further, the OIG's physical inspection of areas in the inpatient unit focused on additional selected safety elements specific to this facility.

The OIG reviewed the MHEOCC data documented in the Patient Safety Assessment Tool for inspections completed in FY 2024 and FY 2025, and assessed corrective actions taken for deficiencies unresolved for more than six months.

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

[122] 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 10, 2022, https://www.merriam-webster.com/dictionary/unit.

[123] VHA Directive 1160.06; VHA Directive 1160.06(1); VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

Appendix C: Inpatient Unit Staffing

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

Table C.1. Inpatient Unit Staffing

Discipline	FTEE	Percent Dedicated Per FTEE
Advanced Practitioner	1	80
Nurses*	24	100
Nursing Assistants/Healthcare Technicians‡	21	100
Peer Specialists	2	100
Pharmacist	1	30
Psychiatrists	3	75–100
Psychologist	1	50
Recreation Therapists§	3	20–50
Social Workers‖	4	5–100

Source: OIG review of the facility's mental health inpatient unit staffing spreadsheet (received January 28, 2025).
Note: FTEE indicates full-time equivalent employee.
**Nursing staff includes a nurse manager, 22 registered nurses, and a licensed practical nurse. VHA includes certified nurse practitioners and clinical nurse specialists within the role of advanced practitioner.*
‡Nursing assistant and healthcare technician staff include nine nursing assistants and 12 health technicians.
§Recreation therapy staff include a creative arts therapist (art), a creative arts therapist (music), and a recreation therapist.
‖Social work staff include a suicide prevention coordinator and a suicide prevention case manager.

Appendix D: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: October 23, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Mental Health Inspection of the Veterans Affairs (VA) NY Harbor Healthcare System in New York

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Mental Health Inspection of the VA NY Harbor Healthcare System in New York. The Veterans Health Administration (VHA) concurs with the recommendation made to the Under Secretary for Health and provided an action plan in the attachment.

2. The insights and recommendations provided are appreciated. Our commitment to excellence and dedication to providing the highest quality health care for the Nation's Veterans remains paramount. Significant improvements are planned and underway to enhance our mental health care services. We are taking decisive steps to enhance the effectiveness of our safety plans and prevent access to lethal means among Veterans. These measures underscore our commitment to the well-being and safety of Veterans.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(*Original signed by:*)

Steven Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG initially received the above memorandum from VHA on October 8, 2025. The OIG received a final memorandum on October 23, 2025.]

Office of the Under Secretary for Health Response

Recommendation 13

The Under Secretary for Health identifies barriers to, and ensures documentation of, discussions specific to making the environment safer from identified lethal means in veterans' safety plans.

_X __Concur

_____Nonconcur

Target date for completion: March 2026

Under Secretary for Health's Comments

Concur. VHA concurs and has identified that the narrative text box for Step 6 of the Suicide Prevention Safety Plan national note template is not set as a mandatory field. VHA agrees to update the Suicide Prevention Safety Plan template in the electronic health record by making "Step 6: Making the Environment Safe" a required field. This update will mitigate barriers in documenting discussions specific to making the environment safer from the patient's identified lethal means.

Appendix E: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 2, 2025

From: Interim Network Director, New York/New Jersey Department of Veterans Affairs (VA) Healthcare Network (10N2)

Subj: The Office of Inspector General (OIG) report, Mental Health Inspection of the VA New York (NY) Harbor Healthcare System in New York

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

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. I concur with the report findings and recommendations of OIG report, Mental Health Inspection of the VA NY Harbor Healthcare System in New York.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Bruce Tucker, LCSW-R

[OIG comment: The OIG received the above memorandum from VHA on October 8, 2025.]

Appendix F: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 19, 2025

From: Director, Department of Veterans Affairs (VA) New York (NY) Harbor Healthcare System (630)

Subj: The Office of Inspector General (OIG) Report, Mental Health Inspection of the VA NY Healthcare System in New York

To: Interim Network Director, New York/New Jersey VA Healthcare Network (10N2)

1. We appreciate the opportunity to review and comment on the OIG report, Mental Health Inspection of the VA NY Harbor Healthcare System in New York. VA New York Harbor Healthcare System concurs with the recommendations and will take corrective action.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, contact the Performance Improvement Manager.

(*Original signed by*:)

Rosemary Cancel-Santiago
Deputy Director
for
Timothy H. Graham J.D., LL. M

[OIG comment: The OIG initially received the above memorandum from VHA on October 8, 2025. The OIG received a final memorandum on November 20, 2025.]

Facility Director Responses

Recommendation 1

The Associate Chief of Staff, Mental Health ensures compliance with Veterans Health Administration requirements for a full-time local recovery coordinator.

__X _Concur

_____Nonconcur

Target date for completion: March 2025

Director's Comments

The NY Harbor Local Recovery Coordinator (LRC) was on-boarded in March 2025. The LRC has developed standard operating procedures (SOPs) for staff education on recovery-oriented care.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

The Associate Chief of Staff, Mental Health ensures the implementation of written processes for staff training, education, and recovery-oriented services.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

A written process for staff training, education, and recovery-oriented services as required by VHA Directive 1160.06, Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements, was established by the Associate Chief of Staff, Mental Health (ACOS/MH) and implemented in March 2025. The SOP includes the TMS courses that meet the requirements for staff education on the recovery-oriented model. The Section Chief will monitor compliance with completion of TMS for all Inpatient Psychiatry clinical staff until 90% compliance is maintained for six consecutive months. The Section Chief will report to ACOS/MH and document this information in the NYH Mental Health (MH) Integrated Clinical Communities (ICC) monthly minutes. The MH ICC reports monthly to the Clinical Executive Board (CEB), chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 3

The Facility Director identifies and addresses barriers to communal room access for veterans on the inpatient unit.

__X _Concur

_____Nonconcur

Target date for completion: December 2025

Director's Comments

Effective October 1, 2025, the Nursing Service Care Line Manager will develop and implement a written log that will track date, time, patient who requested communal room access, and the outcome of the request. The log will be maintained for a period of 30 days. The 30-day analysis will be used to assess the degree of unmet requests and identify the barriers to lack of access to the communal room. The Nursing Service Care Line Manager will use the analysis to support the development of a process for the room use for patients' needs.

The Nursing Service Care Line Manager will report the complete analysis to NYH MH ICC. The MH ICC reports monthly to the CEB, chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director

Recommendation 4

The Facility Director ensures accurate reporting of inpatient mental health beds and implements processes to monitor.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

During the daily Enterprise morning huddle, chaired by the Director, BMS data is reviewed. The facility is currently in the process of generating a bed letter consistent with the number of operating beds. The Data Manager participates in the daily Enterprise morning huddle and will be made aware of any bed changes and ensure accuracy in the bed management system.

The Data Manager will be monitoring the process monthly and report quarterly to the Executive Council regarding any pending and approved bed letter requests. The Executive Council is chaired by the Director.

Recommendation 5

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

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

VA New York Harbor has an Involuntary Admission Healthcare System Policy that was vetted through the Office of General Counsel and is compliant with New York State Law. Effective October 1, 2025, upon initiation of a period of involuntary commitment, the Attending Physician on the acute inpatient psychiatric unit will place a "nursing communication order" in CPRS explicitly stating the period of involuntary commitment. The ACOS/MH informed all MH attendings and the Nursing Mental Health Care Line Manager of this requirement.

This order will remain active and visible in CPRS orders for the duration of the commitment period. This will ensure that all staff working with the Veteran have ongoing knowledge of the commitment parameters.

Effective October 1, 2025, Quality Management (QM) will conduct monthly audits of admission notes to assess a rate of 90% or greater compliance for 6 consecutive months. The QM audit will be reported monthly to MH ICC. The MH ICC reports monthly to the CEB, chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 6

The Facility Director ensures staff document veterans' legal commitment status in the electronic health record and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

In March 2025, Nursing and Physician staff were educated on the requirement that the nursing and physician document Veterans' legal status in the corresponding admission discipline's admission note.

Effective October 1, 2025, QM will conduct monthly audits of admission notes to assess a rate of 90% or greater compliance for 6 consecutive months. The QM audit will be reported monthly to MH ICC. The MH ICC reports monthly to the CEB, chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 7

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: April 2026

Director's Comments

Documentation of discussions between prescribers and Veterans on the risks and benefits of newly prescribed medications will be ensured as follows:

In September 2025, acute psychiatry intake template and inpatient progress notes were revised to include documentation of benefits, alternatives, and risks of newly prescribed medications discussed with the Veteran.

Ongoing compliance will be measured through monthly monitoring by QM as part of their ongoing chart reviews. QM will audit the presence of documented discussions between the prescriber and the Veteran on the risks and benefits of newly prescribed medications in the electronic health record, with a goal of attaining 6 months at 90% compliance. QM audit will be reported to the ACOS/MH and documented in facility MH ICC monthly minutes. The MH ICC reports monthly to the CEB, chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 8

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: April 2026

Director's Comments

The Clinic Profile Manager will review the facility's compliance with the Clinic Profile Manager Guidebook for patient-friendly clinic names and update any clinic name that falls outside this naming convention, to be completed in October 2025.

The Section Chief for Inpatient Psychiatry/MH will collaborate with the Clinical Application Coordinator (CAC) team to update inpatient mental health discharge progress notes with this naming convention, to be completed by October 15, 2025. A discharge checklist has already been created to guide staff in completing the required documentation. A unit nurse will meet with all patients prior to discharge to review the discharge instructions and clarify any concerns.

QM will conduct monthly audits of discharge instructions to assess that any mental health appointment location information is written in easy-to-understand language at a rate of 90% or greater compliance for 6 consecutive months. QM audit will be reported to the ACOS/MH and documented in facility MH ICC monthly minutes. The MH ICC reports monthly to the Clinical Executive Board (CEB), chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 9

The Chief of Staff ensures discharge instructions for veterans include the purpose for each medication listed and are free of medical abbreviations.

__X _Concur

_____Nonconcur

Target date for completion: May 2026

Director's Comments

As of September 2025, the Psychiatry Unit Chief has educated all providers on the psychiatry unit regarding the requirements for the medication list and medication reconciliation portion of the discharge instructions.

The Section Chief for Inpatient Psychiatry/MH will collaborate with the CAC team to update the discharge instructions note template in Electronic Health Record (EHR) to ensure that the medication list includes the purpose for each medication listed in simple language and is free of medical abbreviations. The revisions to the template will be completed by October 2025.

QM will conduct monthly audits of discharge instructions that list medications with a rate of 90% or greater for 6 consecutive months. QM audit will be reported to the ACOS/MH and documented in facility MH ICC monthly minutes. The MH ICC reports monthly to the CEB, chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 10

The Chief of Staff directs staff to complete and document the Columbia-Suicide Severity Rating Scale within 24 hours before veterans' discharge and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

In March 2025, all inpatient providers were educated on the required documentation prior to discharge from the inpatient Mental Health unit. In March 2025 the Inpatient Mental Health primary team and on-call manuals were revised to include this requirement in the discharge protocol. In addition, a discharge checklist was created to guide staff in completing the required documentation.

QM will conduct monthly audits of charts for completion of the Columbia-Suicide Severity Rating Scale within 24 hours before veteran's discharge, with a rate of 90% or greater compliance for 6 consecutive months. QM audit will be reported to the ACOS/MH and documented in facility MH ICC monthly minutes. The MH ICC reports monthly to the Clinical Executive Board (CEB), chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 11

The Chief of Staff directs staff to complete suicide prevention safety plans and provide copies of the plans to veterans or caregivers and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

In March 2025, all inpatient providers were educated by a Suicide Prevention Coordinator on the required documentation prior to discharge from the inpatient Mental Health unit. The Inpatient Mental Health primary team and on-call manuals were revised by the Unit Chief to include this requirement regarding discharge protocol. In addition, a discharge checklist was created to guide staff in completing the required documentation.

QM will conduct monthly audits, with a rate of 90% or greater compliance for 6 consecutive months. QM audit will be reported to the ACOS/MH and documented in facility MH ICC monthly minutes. The MH ICC reports monthly to the Clinical Executive Board (CEB), chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 12

The Chief of Staff directs staff to address ways to make veterans' environments safer from potentially lethal means, beyond firearms and opioids, in safety plans and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

In January 2025, the NYH Suicide Prevention Team implemented recurring training on the inpatient unit to ensure providers are educated on the expectation to document a discussion of all pertinent potential lethal means.

In March 2025, the Unit Chief revised the Inpatient Mental Health primary team on-call manuals to include this requirement regarding discharge protocol. In addition, a discharge checklist was released to ensure compliance with completion of a safety plan that addresses documentation of making the environment safe, including safety considerations beyond access to firearms and opioids.

QM will conduct monthly audits of suicide prevention safety plan notes to ensure that staff has documented discussion of ways to make veterans' environments safe from potentially lethal means, beyond firearms and opioids, with a rate of 90% or greater compliance for 6 consecutive months. QM audit will be reported to the ACOS/MH and documented in facility MH ICC monthly minutes. The MH ICC reports monthly to the CEB, chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 14

The Facility Director directs staff to comply with suicide prevention training requirements and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

The Director notified employees of the suicide prevention training requirements at employee town halls. Staff compliance with mandatory training requirements will be monitored by the ACOS/MH and the Designate Leaning Officer for 6 months with a goal of 90%. This will be

documented in NYH MH ICC monthly minutes. The MH ICC reports monthly to the CEB, chaired by the Chief of Staff. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 15

The Facility Director ensures compliance with Veterans Health Administration requirements for the Interdisciplinary Safety Inspection Team, including recording of meeting minutes, membership, and attendance, and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

An Interdisciplinary Safety Inspection Team (ISIT) was chartered in March of 2025. As per the charter the ISIT meets quarterly and reports to the Environment of Care Committee (EOC) quarterly. The EOC Committee reports quarterly to the Executive Council. The Executive Council is chaired by the Director. The team had its first meeting on April 30, 2025, and reported to the Environment of Care Committee in May 2025.

Recommendation 16

The Facility Director implements processes to ensure the Interdisciplinary Safety Inspection Team applies Mental Health Environment of Care Checklist standards on the inpatient mental health unit and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: August 2026

Director's Comments

The ISIT co-chairs will ensure full attendance of mandatory members and will meet a minimum of quarterly to ensure timely completion of the bi-annual Mental Health Environment of Care Checklist (MHEOCC) and track closure of all MHEOCC findings. The ISIT reports quarterly to the EOC Committee. The EOC Committee reports quarterly to the Executive Council. The Executive Council is chaired by the Director.

Recommendation 17

The Facility Director directs inpatient unit staff and Interdisciplinary Safety Inspection Team members to comply with Mental Health Environment of Care Checklist training requirements and monitors for compliance.

__X _Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

The facility Director will ensure all MHEOCC training requirements are met consistently with the VHA Directive 1167. Overall training compliance will be reported quarterly to the MH ICC.

Targeted compliance at 90% for 6 consecutive months will be reported monthly to MH ICC which reports to the CEB. The CEB reports monthly to the Executive Council. The Executive Council is chaired by the Director.

OIG Contact and Staff Acknowledgments

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