US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Kansas City Healthcare System in Missouri

Mental Health Inspection | **25-03939-259** | **September 2, 2026**

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To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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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 November 24, 2025, through December 11, 2025, to assess the mental health care delivered in the acute inpatient mental health unit (inpatient unit) at the Kansas City VA Medical Center (facility). The OIG completed the on-site portion from December 9 through 11, 2025. The facility is part of the VA Kansas City Healthcare System in Missouri. At the conclusion of the on-site visit, the OIG provided the acting Facility Director with preliminary findings and observations from the inspection.

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. Eight recommendations were issued to facility leaders.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

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

Domain	OIG Summary
Leadership and Organizational Culture	The OIG assessed leadership structures and aspects of inpatient unit operations as they related to the delivery of quality care. There were no findings in this domain.

[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
Recovery-Oriented Principles 	To assess the inpatient unit's integration of recovery-oriented principles, the OIG examined aspects of leadership, treatment planning, therapeutic and interdisciplinary programming, and the care environment. The facility had a plan for continued transformation to recovery-oriented services across mental health, which did not have concurrence from executive leaders as required by Veterans Health Administration (VHA) Directive 1163, *Psychosocial Rehabilitation and Recovery Services*. In response to the OIG, facility leaders provided an updated, signed plan.[2] Additionally, facility leaders did not establish a standard operating procedure for staff training, education, and implementation of recovery-oriented services, as required by VHA Directive 1160.06(1), *Inpatient Mental Health Services,* until during the on-site inspection.[3]
Clinical Care Coordination 	To assess the quality of clinical care coordination, the OIG reviewed access to services, facility procedures for involuntary treatment, medication management, and discharge planning. Although veterans received mental health services on inpatient medical units, leaders did not establish written processes to ensure mental health treatment is provided as clinically indicated, as required in VHA Directive 1160.06(1).[4] The facility did not meet the requirement in VHA Directive 1160.06(1) for having processes to ensure compliance with state laws on involuntary hospitalization.[5] Only 43 percent of reviewed electronic health records included documentation of prescribers having medication risk and benefit discussions with veterans prior to first medication administration, as required by VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.[6] Eighty two percent of discharge instructions had evidence of scheduled outpatient mental health follow-up appointments for veterans; however, only 3 percent included locations in easy-to-understand language. Eighty nine percent of reviewed discharge instructions included the reasons for prescribed medications; however, only 9 percent were free of medical abbreviations that could be difficult for non-medically trained individuals to understand.
Suicide Prevention 	To evaluate suicide prevention activities on the inpatient unit, the OIG reviewed compliance with required suicide risk screening and evaluation, safety planning, and training. Inpatient staff complete or review veterans' suicide prevention safety plans for 71 percent of the records reviewed, as required under VHA Office of Mental Health and Suicide Prevention standard operating procedure (SOP) 1160.06.2. "Standard Operating

[2] VHA Directive 1163*, Psychosocial Rehabilitation and Recovery Services*, August 14, 2025.

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

[4] VHA Directive 1160.06(1).

[5] VHA Directive 1160.06(1).

[6] VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, amended May 1, 2024.

Domain	OIG Summary
	Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06."[7]
Safety 	The OIG evaluated aspects of safety practices, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. Not all required Interdisciplinary Safety Inspection Team members attended environment of care inspections, and attendance records were not provided to the Comprehensive Environment of Care Committee, as mandated by VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.[8] Appeals (requests to address safety issues with a mitigation plan) were not resubmitted within the required time frames. Not all Interdisciplinary Safety Inspection Team staff completed the annual Mental Health Environment of Care Checklist training as required by VHA Directive 1167.[9]

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes B and C).

The Facility Director committed to formalizing written processes for delivering mental health care to veterans on medical units and procedures for involuntary commitment legal compliance. The Facility Director described plans to enhance documentation practices for discharge instructions, suicide prevention safety plans, and informed consent discussions for medications. Facility leaders outlined plans for adherence to interdisciplinary safety inspection team requirements and staff completion of safety training. The Facility Director presented documentation of names, location, and contact information for clinics in easy-to-understand language, however also described challenges adding this information to discharge instructions. The Facility Director also provided documentation that discharge instructions avoided medical abbreviations and demonstrated compliance with Mental Health Environment of Care Checklist training. Based on information provided, the OIG closed recommendations 5 and 8. For the

[7] 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, updated on December 19, 2024, and in effect at the time of inspection. These versions were rescinded and replaced with SOP 1160.06.2(1) on February 17, 2026. Unless otherwise specified, the three policies contain similar language regarding safety planning processes.

[8] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, rescinded and replaced with VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. Unless otherwise specified, the policies contain similar language related to the inpatient mental health unit interdisciplinary safety inspection team and Mental Health Environment of Care Checklist inspections and training requirements. The older directive was in place for part of the mental health environment of care checklist and training documentation reviews.

[9] VHA Directive 1167.

remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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Abbreviations

OIG	Office of Inspector General
SOP	standard operating procedure
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 nine million enrolled veterans.[10] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. On November 24, 2025, the OIG announced an inspection to evaluate acute inpatient mental health care provided at the Kansas City VA Medical Center (facility), part of the VA Kansas City Healthcare System in Missouri. The OIG conducted inspection activities from November 24 through December 11, 2025, and completed the on-site portion from December 9 through 11, 2025.[11] At the conclusion of the on-site visit, the OIG team provided the acting Facility Director with preliminary findings and observations from the inspection.

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).[12] Under VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, VHA healthcare system leaders are expected to ensure all veterans who are eligible for care have access to recovery-oriented inpatient, residential, and outpatient mental health programs.[13] All VHA healthcare systems 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.[14]

[10] "Mission, Vision, and Values," VA OIG, accessed December 15, 2025, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed December 15, 2025, https://www.va.gov/health/aboutvha.asp. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[11] 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.

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

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

[14] VHA Directive 1160.01. If a healthcare system does not provide required services, those services must be offered through another VA facility or program.

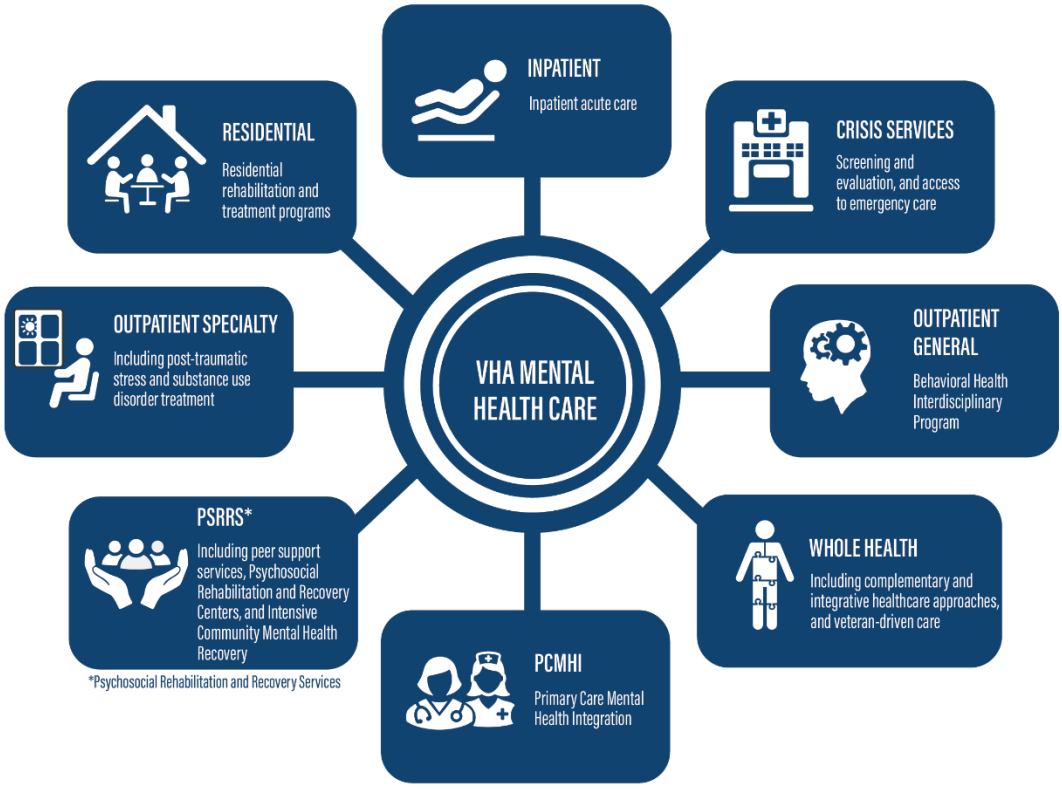

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, August 14, 2025.

In fiscal year 2025, VHA healthcare systems delivered inpatient mental health care for 63,240 veteran stays.

VHA Directive 1160.06(1) 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.[15]

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.

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

About VA Kansas City Healthcare System

VA Kansas City Healthcare System is part of Veterans Integrated Service Network (VISN) 4. [16] At the time of the inspection, the health care system was part of former 15; all VISN references in this report reflect the previous organizational structure. VA Kansas City Healthcare System provides acute inpatient mental health care at the facility and operates 10 community-based outpatient clinics in Belton, Cameron, Excelsior Springs, Kansas City, Nevada, and Warrensburg in Missouri; and the cities of Lenexa, Overland Park, Paola, and Shawnee in Kansas.

From July 1, 2024, through June 30, 2025, VA Kansas City Healthcare System provided outpatient health care to 52,372 veterans. Of those, 42,868 received outpatient mental health care. Inpatient mental health unit (inpatient unit) staff cared for 494 veterans and maintained an average daily census of 10.[17] According to facility data, staff did not submit consults for inpatient mental health care in the community during this period. Facility data indicated that the inpatient unit had 10 operating mental health beds (discussed further in Access to Care).

[16] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

[17] "VHA Support Service Center Capital Assets (VSSC)," VA, accessed July 18, 2025, https://www.data.va.gov/dataset/VHA-Support-Service-Center-Capital-Assets-VSSC-/2fr5-sktm/about_data; "VA Information Resource Center (VIReC), VHA Corporate Data Warehouse (CDW)," VA, accessed August 17, 2026, https://vaww.virec.research.va.gov/CDW/Overview.htm#FAQs. (This site is not publicly accessible.)

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."[18] 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.[19]

The OIG assessed leadership structures and aspects of inpatient unit operations as they related to the delivery of quality care.

Leadership Structure

At the time of the OIG's inspection, facility staff reported the healthcare system executive leadership team included the Facility Director, Chief of Staff, and Associate Director for Patient Care Services.[20] In accordance with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service,* the Chief of Mental Health served as the required mental health lead and oversaw all mental health programs, including the inpatient unit while also fulfilling several administrative and direct care roles.[21] The Chief of Mental Health identified working closely with the chief nurse of mental health and reported communicating regularly throughout the day. Inpatient unit leaders described the organizational structure as collaborative among leadership and staff and reported using multi-tiered huddles (brief meetings on patient care) to communicate needs of the unit.[22]

According to VHA Directive 1160.01, healthcare systems are required to establish a mental health executive council to ensure quality mental health care is delivered and includes treatment that is responsive to veteran preferences.[23] The facility's Mental Health Executive Council was chaired by the Chief of Mental Health and included inpatient unit staff, the local recovery

[18] 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.

[19] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024.

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

[21] VHA Directive 1160.01.

[22] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[23] VHA Directive 1160.01.

coordinator, and the suicide prevention coordinator, and met the requirement for veteran representation.[24]

Inpatient Unit Operations

VHA Directive 1160.06(1) requires facilities to have an inpatient mental health program manager to coordinate and promote consistent, sustained, high-quality therapeutic programming on the inpatient unit.[25] The inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services.[26] At the time of the inspection, the Chief of Mental Health, in addition to primary duties, also served as the acting inpatient mental health program manager for approximately five months due to a vacancy.[27]

The Chief of Staff described challenges with recruiting psychiatrists and identified the inability to offer remote and hybrid work schedules as a barrier. Facility leaders reported using incentives such as an education debt reduction program, competitive pay, and a cohesive work environment to recruit and retain employees.

The inpatient nurse manager described a culture of engaged employees who offer feedback and ideas for continuous process improvement. VHA Directive 1160.01 requires facilities to have mechanisms for collecting feedback from veterans who obtain mental health services. Inpatient unit leaders reported staff collected veterans' feedback for improvement through daily community groups, statements to staff, and the patient advocate tracking system.[28]

The OIG made no recommendations for this domain.

[24] VHA Directive 1160.01.
[25] VHA Directive 1160.06(1).
[26] VHA Directive 1160.06(1).
[27] VHA Directive 1160.06(1).
[28] VHA Directive 1160.01.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent value." [29] 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. [30]

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

Leadership

Local recovery coordinators play an important role in VA healthcare systems. 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.[31]

To support veterans' recovery, VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services,* requires healthcare systems to have a full-time local recovery coordinator and a plan across the mental health care continuum for continued transformation and implementation of recovery-oriented services.[32] Additionally, VHA Directive 1160.06(1) requires the local recovery coordinator, in collaboration with the inpatient mental health program manager, to establish a standard operating procedure (SOP) that includes processes for "the education, staff training, and implementation of recovery-oriented care" on the inpatient unit.[33]

Facility leaders met the requirement to have a full-time local recovery coordinator.[34] The facility had a local recovery plan across mental health services, which did not have concurrence from executive leaders as required by VHA Directive 1163. However, after OIG feedback, facility leaders provided an updated signed plan.[35]

At the time of the inspection, mental health leaders reported that the facility did not have an SOP for staff training, education, and implementation of recovery-oriented services on the inpatient

[29] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *SAMHSA's Working Definition of Recovery, 10 Guiding Principles of Recovery*, 2012.

[30] US Department of Health and Human Services, HHS Publication No. SMA-09-4371, *Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions,* 2011.

[31] VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, on August 14, 2025.

[32] VHA Directive 1163.

[33] VHA Directive 1160.06(1).

[34] VHA Directive 1163.

[35] VHA Directive 1163.

unit as required by VHA Directive 1160.06(1).[36] The local recovery coordinator reported being unaware of the requirement. During the on-site inspection, in response to OIG feedback, mental health leaders provided an SOP.[37] The OIG observed that mental health leaders responded promptly to address these OIG-identified gaps in processes.

Recovery-Oriented Treatment

In alignment with VHA Directive 1160.01, facility leaders established written guidance for the inpatient mental health treatment planning process that incorporates recovery-oriented elements such as veterans' involvement in setting goals.[38] An inpatient psychologist reported the interdisciplinary treatment team met regularly and worked collaboratively with veterans during treatment planning meetings and rounds.

Inpatient unit staff offered veterans at least six daily hours of recovery-oriented interdisciplinary programming on each weekday and at least four hours daily on weekends, consistent with VHA Directive 1160.06(1).[39] VHA's "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06" requires inpatient unit staff to orient veterans to the unit and recovery-oriented care.[40] Additionally, VHA requires the interdisciplinary treatment team to develop, implement, and monitor progress on each veteran's treatment plan.[41] According to the inpatient unit staff psychologist, programming on the inpatient unit included recovery-oriented groups, and nurses educated veterans by using the patient orientation brochure.[42] Additionally, peer support staff led weekly groups to help ensure veterans' understanding of recovery concepts.[43] During the on-site inspection, the OIG observed that most group programming occurred as scheduled.

Physical Environment

VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care. The *Design Guide for Inpatient Mental Health & Residential Rehabilitation*

[36] VHA Directive 1160.06(1).

[37] Facility SOP 116A-024, "Recovery-Oriented Care at the Inpatient Mental Health Unit," December 11, 2025.

[38] VHA Directive 1160.01; Facility SOP 11-027, "Interdisciplinary Treatment Plan, Care Coordination, and Discharge Planning," April 27, 2025.

[39] VHA Directive 1160.06(1).

[40] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.3, "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06," September 29, 2023.

[41] VHA Directive 1160.06(1).

[42] VHA SOP 1160.06.3.

[43] VHA SOP 1160.06.3.

Treatment Program Facilities provides standards for healthcare systems to create hopeful and healing environments while maintaining safety.[44]

The OIG found that the inpatient unit had aspects of a recovery-oriented environment, including natural light, a communal area with amenities such as a television, books, and games.[45] Additionally, the unit offered sensory and family visitation rooms. Veterans' bedrooms had warm paint colors, artwork, along with built-in shelves and desks. (See figure 2.)

Figure 2. *Veteran bedroom features built-in furniture and artwork; the common area/dining area offers natural light and weighted furniture.*
Source: Photos of the facility's inpatient unit taken by OIG staff, December 9 through 10, 2025.

A secure outdoor space was available and according to the inpatient psychologist, when weather permitted, it was used for group programming, which aligns with VHA Directive 1160.06(1) requirements.[46]

The OIG made no recommendations for this domain.

[44] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021.
[45] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities.*
[46] VHA Directive 1160.06(1).

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.[47] For veterans with "complex health and social needs, care coordination is crucial for improving their access to [services], clinical outcomes, [and] care experiences."[48] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a lower level of care.[49]

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 hospitalization and treatment, medication management, and discharge planning.

Access to Care

Successful coordination of mental health care requires well-defined screening and admissions processes that ensure veterans are evaluated and receive clinically appropriate treatment.[50] The OIG found facility leaders established SOPs for inpatient unit admissions and transfer processes, as required by VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."[51]

Facility data recorded fewer operating inpatient mental health beds than were reported by facility leaders. According to facility data, the inpatient unit had 10 operating beds, and 15 designated as unavailable due to construction.[52] The Chief of Mental Health confirmed to the OIG that there were 16 operating beds and 9 unavailable beds. VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities* states that the VISN Director is responsible for ensuring that reporting of bed availability is "current, complete,

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

[48] 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*, volume 3 (August 14, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[49] VHA Directive 1160.06(1).

[50] VHA Directive 1160.01.

[51] 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, updated on December 19, 2024, and in effect at the time of inspection. These versions were rescinded and replaced with SOP 1160.06.2(1) on February 17, 2026. Unless otherwise specified, the three policies contain similar language regarding safety planning processes; Facility SOP 116-070, "Management and Disposition of Patients Requiring Mental Health Support in the Emergency Department," May 10, 2022; Facility MCP 11-11-004, "Inter-Facility Transfer," August 22, 2022.

[52] "VHA Support Service Center Capital Assets (VSSC)," VA.

and accurate."[53] The VISN Chief Mental Health Officer stated that bed counts were not consistently accurate, but did not provide the OIG with a rationale. After the on-site inspection, facility leaders provided the OIG with an approved formal bed change request, therefore, a recommendation was not made. Accurate reporting of the number of authorized and available beds can assist in timely access for veterans in need of inpatient mental health care.

Of the OIG's randomly selected electronic health records, five veterans who required medical and psychiatric care were admitted to psychiatry service on a medical unit. VHA Directive 1160.06(1) requires facilities to have "a standardized process to ensure timely response to mental health consults and treatment as clinically indicated."[57] The Deputy Chief of Staff reported not having written processes for veterans receiving mental health services on medical units. Clearly defined written processes could ensure veterans on medical units receive appropriate mental health care.

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."[54]

Standards and procedures for civil commitment are provided by state law and vary by state.[55] VHA requires that healthcare system leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[56]

Involuntary Hospitalization and Treatment

Facility policy "Involuntary Hospitalization" included written processes for involuntary hospitalization but did not include guidelines for oversight to ensure compliance with state laws as required in VHA Directive 1160.06(1).[58] Mental health leaders described use of methods, such as huddles (brief meetings on patient care) and an electronic huddle board, to monitor and track veterans' voluntary or involuntary commitment statuses. The absence of clearly defined written processes to ensure compliance with state commitment laws can contribute to the illegal hospitalization of veterans.

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

[54] "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 September 10, 2025, https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf.

[55] "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.

[56] VHA Directive 1160.01.

[57] VHA Directive 1160.06(1).

[58] VHA Directive 1160.06(1); Facility MCP 11-116-023, "Involuntary Hospitalization," June 21, 2022.

The facility met requirements under VA's memorandum "For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts." Facility leaders assigned a subject matter expert as a point of contact to consult with facility staff and leaders who oversaw processes related to involuntary commitment.[59] A psychiatrist reported that the Chief of Psychiatry was assigned as the point of contact.

VHA policy "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" requires a registered nurse to record a review of documents required for admission, including voluntary or involuntary legal commitment status, prior to veterans' arrival on the inpatient unit.[60] Ninety percent of reviewed electronic health records included documentation of veterans' commitment status in the appropriate note template. When staff have accurate information regarding veterans' legal commitment status, it may ensure that veterans' civil rights are not violated.

Medication Treatment

VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures,* requires documentation of informed consent discussions between prescribers and veterans on newly prescribed central nervous system medications used to treat a wide range of neurologic and psychiatric conditions.[61] The OIG found only 43 percent of reviewed health records included documentation that informed consent discussions for newly prescribed neurologic and psychiatric medications occurred prior to the first administration.

Mental health leaders reported that the informed consent discussions occurred during veterans' inpatient unit stays; however, the OIG found that many were not documented until discharge. The psychiatry executive reported that additional training is needed regarding timely documentation. When providers do not communicate the risks and benefits of medication, veterans may not have sufficient information needed to make informed decisions about their treatment options.

[59] Acting Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts," memorandum to Veterans Integrated Services Network Directors (10N1-23), July 30, 2025.

[60] 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), September 20, 2022, revised November 2, 2023, and September 10, 2024. Both versions were in effect during the health record review period. Unless otherwise noted, the versions contain similar language related to documentation of voluntary or involuntary legal status.

[61] VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, amended May 1, 2024.

Discharge Planning

Facility leaders established written guidance for care coordination when veterans are discharged from the inpatient unit, as required by VHA Directive 1160.01.[62] Mental health leaders and staff described a multi-disciplinary approach that included pharmacy, psychology, psychiatry, and social work. Additionally, leaders and inpatient staff reported coordinating discharges with outpatient mental health providers and requesting assignment of a mental health treatment coordinator when appropriate.

All reviewed electronic health records included discharge instructions and documentation that the veteran was offered a copy of the instructions, as indicated in VHA's *Health Record Documentation Program Guide Version 1.2*.[63]

However, the inpatient unit pharmacist reported that veterans were also given pharmacy discharge instructions not housed in the primary electronic health records. The pharmacist reported that the additional discharge instructions included more detailed information for follow-up appointments. Having multiple discharge instructions, some of which are not included in the primary medical record, may lead to communication gaps between providers and affect continuity of care after discharge.

[62] VHA Directive 1160.01; Facility SOP 11-027, "Interdisciplinary Treatment Plan, Care Coordination, and Discharge Planning."

[63] VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023, was updated and replaced with VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.3*, on February 13, 2025. Unless otherwise specified, the program guides contain similar language related to documentation requirements.

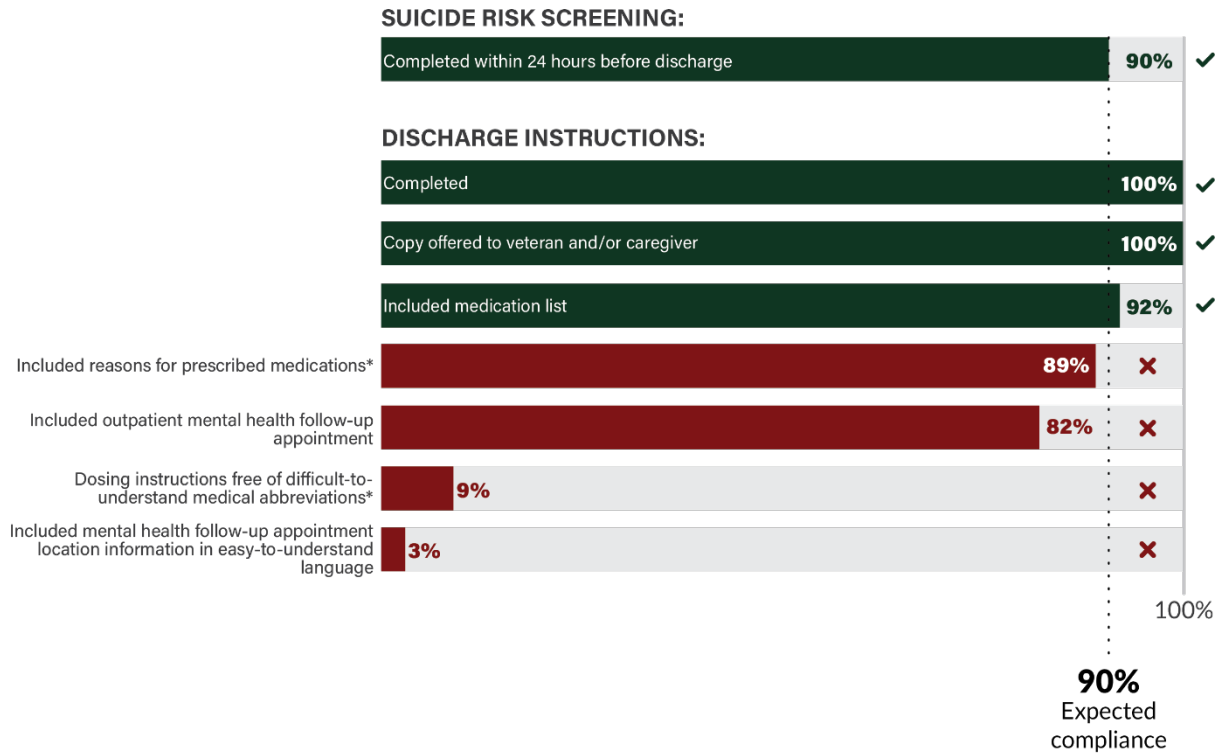

Figure 3. *Discharge-related screening and documentation.*
Source: OIG review of inpatient unit electronic health records.
Note: Based on analysis of 50 records. Suicide risk screening discussed in Suicide Prevention (below).
**Corresponds to a subset of records with a completed medication list (n = 45).*

Not all discharge instructions reflected documentation of scheduled outpatient mental health follow-up appointments, as required by VHA SOP 1160.06.2.[64] VHA's "Clinic Profile Management Business Rules," specify follow-up outpatient locations and services should be in easy-to-understand language and free from abbreviations and acronyms.[65] The OIG found that in discharge instructions with documented appointments, the listed locations were not in easy-to-understand language (see figure 4). Discharge instructions with abbreviated location information can create barriers for veterans to attend follow-up appointments and receive timely mental health care.

[64] VHA SOP 1160.06.2, September 29, 2023; VHA SOP 1160.06.2, December 19, 2024. These policies were rescinded and replaced with SOP 1160.06.2(1) on February 17, 2026.
[65] VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," May 24, 2023.

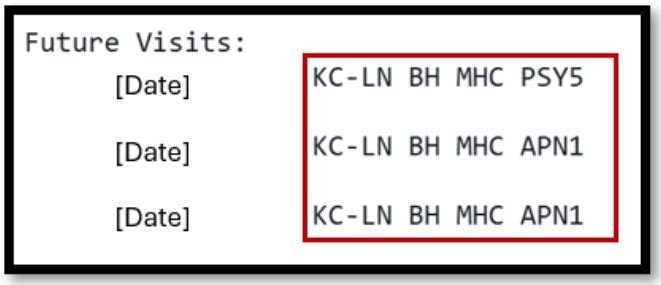

Figure 4. *Example based on discharge instructions with abbreviated appointment information outlined in red.*
Source: OIG review of veterans' electronic health records.

Most reviewed health records indicated that a medication list was provided at discharge (see figure 3). However, not all discharge instructions identified the reasons for the prescribed medications.[66] Most discharge instructions included medical abbreviations that could be difficult for non-medically trained individuals to understand (see figure 5), contrary to VHA's *Health Record Documentation Program Guide*.[67] Including reasons for prescribed medications and easy-to-understand discharge instructions could prevent medication errors following hospitalization.

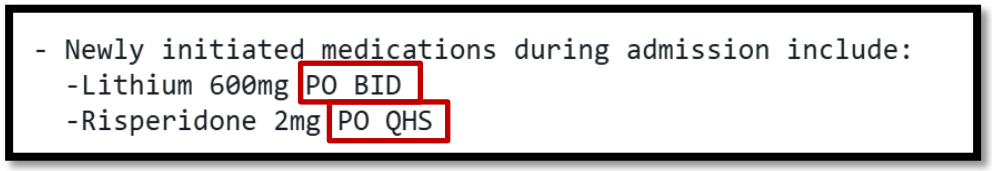

Figure 5. *Example of discharge instructions with use of medical abbreviations provided to a veteran.*
Source: OIG review of veterans' electronic health records.
Note: The Latin terms PO, BID, and QHS (outlined in red) describe when and how medications should be taken.

Recommendations

1. The Facility Director develops and implements clearly defined written processes for providing mental health care to veterans on medical units as required by Veterans Health Administration Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*.

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

[67] Health Record Documentation Program Guide Version 1.2; Health Record Documentation Program Guide Version 1.3.

2. The Facility Director develops and implements written processes to ensure compliance with state involuntary commitment requirements in adherence to Veterans Health Administration Directive 1160.06(1), *Inpatient Mental Health Services*.
3. The Chief of Staff requires documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications prior to administration and develops a plan to monitor for sustained compliance, in accordance with Veterans Health Administration Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.
4. The Chief of Staff ensures veterans' discharge instructions include the appointment location in easy-to-understand language consistent with Veterans Health Administration's "Clinic Profile Management Business Rules."
5. The Chief of Staff ensures discharge instructions are free of medical abbreviations as outlined in Veterans Health Administration's *Health Record Documentation Program Guide* and includes the purpose for each listed medication as required by Veterans Health Administration Directive 1345, *Medication Reconciliation* and develops a plan to monitor for sustained compliance.

For detailed action plans, see appendix C.

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.[68]

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."[69] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[70]

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

Suicide Risk Screening and Evaluation

The "Department of Veteran Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting" requires staff to complete the Columbia-Suicide Severity Rating Scale (suicide risk screening) for all veterans within 24 hours prior to discharge from inpatient mental health units.[71] Inpatient unit clinical staff completed suicide risk screenings within the required time frame for most reviewed electronic health records (see figure 3, above).

VHA memorandum "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update" requires facility directors or designees to implement an SOP for suicide risk screening and evaluation and directs executive leaders to identify a champion to ensure staff stay informed of national updates.[72] The suicide prevention coordinator reported having an additional role as the facility's suicide risk identification strategy champion. The suicide prevention coordinator described providing consultation and education to inpatient unit staff and offering VA S.A.V.E. (signs of suicide, asking about suicide, validating feelings, and encouraging help and supporting next steps) training to new employees. Facility leaders established a local

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

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

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

[71] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting" (fact sheet), updated May 10, 2023, February 25, 2025, and October 30, 2025. All three versions contain similar language regarding inpatient mental health requirements. While VHA requires staff to complete Columbia-Suicide Severity Rating Scales within 24 hours before discharge, the OIG also considered suicide screenings compliant if completed on the day of discharge.

[72] Assistant Under Secretary for Health 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.

SOP and identified a facility champion, per the facility SOP and the memorandum requirements.[73]

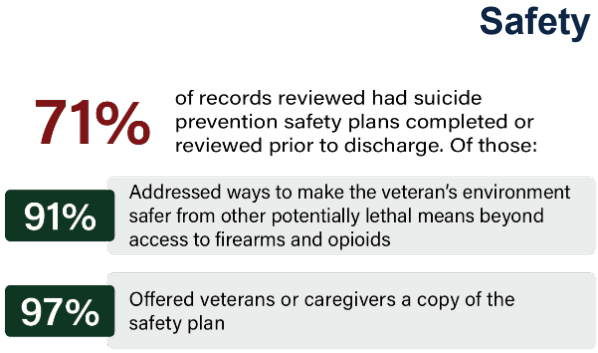

Figure 6. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' electronic health records.

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."[74]

The OIG found that inpatient staff did not consistently complete or review suicide prevention safety plans prior to discharge, which is a requirement by VHA Office of Mental Health SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06"[75] Mental health leaders responded that safety plans were only required for veterans who were flagged as high risk for suicide.

Most reviewed safety plans had documentation that staff provided a copy of the plan to veterans or caregivers. [76] Additionally, most reviewed plans documented that staff addressed ways to make the environment safer from potentially lethal means beyond access to firearms and opioids (see figure 6).

[73] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum; Facility SOP 119-62, "Management of Care for Patients at Suicide Risk," February 28, 2025.

[74] Barbara Stanley and Gregory K. Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice* volume 19, issue 2 (May 2012): 256-264, https://doi.org/10.1016/j.cbpra.2011.01.001.

[75] VHA SOP 1160.06.2.

[76] VHA SOP 1160.06.2.

Training

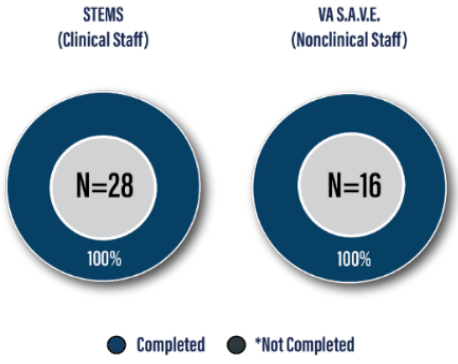

Figure 7. *Inpatient unit staff completion of mandatory suicide prevention trainings. Source: OIG document review of clinical and nonclinical staff training records. Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings from November 24, 2024, to November 23, 2025.*

Skills Training for Evaluation and Management of Suicide (STEMS) and VA S.A.V.E. (signs of suicide, asking about suicide, validating feelings, and encouraging and supporting next steps) help clinicians and nonclinical staff, respectively, identify the warning signs of suicide risk and appropriate interventions.[77]

The OIG determined the facility met the 95 percent target for inpatient unit staff completion of STEMS and VA S.A.V.E training established in the "Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ [Frequently Asked Questions]" (see figure 7).[78]

Recommendation

6. The Chief of Staff directs staff to complete or review veterans' suicide prevention safety plans prior to discharge from the acute inpatient mental health unit in accordance with Veterans Health Administration Office of Mental Health SOP [Standard Operating Procedure] 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06" and develops a plan to monitor for sustained compliance.

For a detailed action plan, see appendix C.

[77] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; VA, "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis" (fact sheet), June 2025.

[78] VHA Office of Suicide Prevention, "Suicide Prevention Mandatory Training Dashboard FAQ," accessed April 15, 2026, https://dvagov.sharepoint.com/sites/vhasuicidepreventioncoordinators/SitePages/Education-and-Training.aspx. (This site is not publicly accessible.)

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."[79] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[80]

To assess the inpatient mental health environment, the OIG evaluated ongoing assessments of suicide hazards and completion of staff training.

Mental Health Environment of Care

VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients,* outlines expectations for environment of care inspections.[81] The Interdisciplinary Safety Inspection Team (safety inspection team), 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.[82] The National Center for Patient Safety continually updates the checklist "based on reports from the field of hazards or adverse events encountered at the local level."[83] Inspection team members are required to use this comprehensive checklist with more than 140 detailed environmental elements to "identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide."[84]

As outlined in VHA Directive 1167, the safety inspection team should include an inspection lead, inpatient mental health unit program director, inpatient unit nurse manager, suicide prevention coordinator, patient safety manager, representative from engineering or facilities management, and "one additional clinical staff from any discipline or work area."[85] The safety

[79] VHA Directive 1160.06(1).

[80] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients,* May 12, 2017, rescinded and replaced with VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients,* November 4, 2024. Unless otherwise specified, the policies contain similar language related to the inpatient mental health unit interdisciplinary safety inspection team and Mental Health Environment of Care Checklist inspections and training requirements. The older directive was in place for part of the mental health environment of care checklist and training documentation reviews.

[81] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[82] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[83] "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.

[84] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, November 18, 2025.

[85] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

inspection team is required to report to the facility environment of care committee, with team membership, attendance, and findings documented as part of the inspection rounds summary.[86]

The facility had an established safety inspection team led by the Chief of Mental Health. The inpatient nurse manager served as the co-lead, and the team completed the required biannual environment of care inspections of the unit.[87] Although the Interdisciplinary Safety Inspection Team recorded meeting minutes and provided them to the Comprehensive Environment of Care Committee, attendance at the biannual inspections was not included, limiting senior leaders' ability to monitor required attendance.[88] Additionally, not all required inspection team members attended inspections.[89] When inspection team members do not attend Mental Health Environment of Care Checklist inspections, environmental hazards may go unrecognized and unabated.

In a physical inspection of the unit, the OIG observed adherence to all selected safety elements.[90] In accordance with VHA SOP 1167.1, and at the time of the inspection, facilities "must submit an appeal request with a mitigation plan" when Mental Health Environment of Care Checklist items are partially or not met and cannot be fully corrected within six months of submitting inspection results. The SOP outlines approved appeals needing additional time to resolve the deficiency requires facilities to submit a new appeal request three months before the expiration date of the original appeal request.[91] The facility had two appeals with risk mitigation plans in place that were due to expire. The OIG shared with facility leaders that updated appeals had not been submitted in the required time frame. Leaders then submitted requests to the Office of Mental Health Mental Health Environment of Care Checklist Review Board. Resubmitting appeals in a timely manner provides the facility an opportunity to reevaluate risk mitigation plans and update the progress toward correcting deficiencies.

[86] VHA Directive 1167, May 12, 2017, was rescinded and replaced with VHA Directive 1167, November 4, 2024. The new directive revised the reporting requirements for the safety inspection team.

[87] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[88] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[89] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[90] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[91] VHA Office of Mental Health SOP 1167.1, "Standard Operating Procedure for Submission of MHEOCC Inspections and Appeals Under VHA Directive 1167," November 5, 2024.

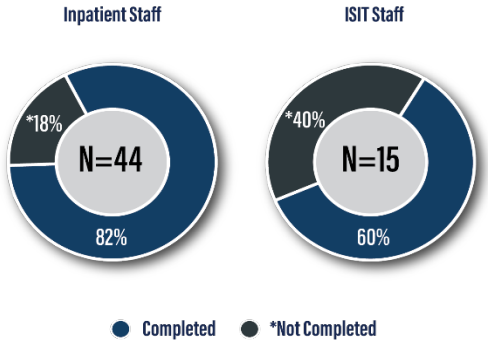

Figure 8. *Mental Health Environment of Care Checklist training completion.*
Source: OIG document review of staff training certificates for inpatient unit and Interdisciplinary Safety Inspection Team staff.
Note: The OIG evaluated completion of the training from November 23, 2024, through November 24, 2025. Interdisciplinary safety inspection team staff who were also inpatient unit staff are included in the denominator training completion.

Training

VHA Directive 1167 requires staff to be trained on environmental hazards and oriented to the use of the Mental Health Environment of Care Checklist.[92] Additionally, VA medical facility leadership must attest that required staff have completed the training, per VHA SOP 1167.2.[93]

Many inpatient unit staff completed the annual training. However, not all safety inspection team staff completed the annual training (see figure 8). Facility leaders completed the required attestation of training completion during the time frame of May 4 through November 23, 2025.[94] Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.

Recommendations

7. The Facility Director ensures the Interdisciplinary Safety Inspection Team adheres to Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients* requirements, including attendance at environment of care inspections, record of required members' attendance at inspections in meeting minutes, and develops a plan to monitor for sustained compliance.
8. The Facility Director directs staff to complete the required Mental Health Environment of Care Checklist training in accordance with Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.

For detailed action plans, see appendix C.

[92] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.
[93] VHA Office of Mental Health SOP 1167.2, "Standard Operating Procedure for Submission of MHEOCC Attestations Under VHA Directive 1167."
[94] VHA Office of Mental Health SOP 1167.2, "Standard Operating Procedure for Submission of MHEOCC Attestations Under VHA Directive 1167."

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.

The OIG observed a veteran-centric culture in which staff and veterans were encouraged to provide feedback and mental health leaders promptly implemented changes for process improvements. The facility demonstrated compliance with some, but not all, VHA requirements evaluated for inpatient mental health care. Veterans who received inpatient mental health treatment at the facility experienced a physical environment that incorporated recovery-oriented elements such as natural lighting throughout the inpatient unit, communal areas, as well as sensory and family visitation rooms.

Facility leaders had an established Mental Health Executive Council that included veteran representation. Mental health leaders had an established plan for continued transformation to recovery-oriented services across the mental health continuum. During the on-site inspection, mental health leaders provided the OIG with an SOP for staff training, education, and implementation of recovery-oriented services on the inpatient unit. All inpatient unit staff completed required suicide prevention training, and many completed required annual Mental Health Environment of Care Checklist training.

Facility data recorded fewer operating inpatient mental health beds than were reported by facility leaders. After the on-site inspection, facility leaders provided an approved bed change request.

Facility policy included guidelines for involuntary hospitalization, but facility leaders did not have written processes for oversight to ensure compliance with state laws. Staff completed required documentation of legal (voluntary or involuntary) commitment status. However, facility leaders did not have well-defined written processes for veterans receiving mental health services on medical units.

Inpatient unit staff offered the required hours of interdisciplinary daily programming on weekdays and weekends for veterans. However, only 43 percent of reviewed electronic health records included documentation of informed consent discussions between prescribers and veterans on risks and benefits of newly prescribed medication treatment prior to first administration.

Inpatient unit clinical staff completed suicide risk screenings within the required time frame for 90 percent of reviewed health records. However, only 71 percent of reviewed electronic health records reflected that staff completed or reviewed suicide prevention safety plans.

All reviewed health records included evidence of discharge instructions and that the veteran or caregiver was offered a copy of the instructions. Eighty nine percent of discharge instructions reflected documentation of scheduled outpatient mental health follow-up appointments, and, when appointments were included, the listed locations were not described in easy-to-understand

language. Eighty nine percent of reviewed discharge instructions included the reasons for prescribed medications; however, and only 9 percent were free of medical abbreviations that could be difficult for non-medically trained individuals to understand.

The facility had an established Interdisciplinary Safety Inspection Team that conducted environment of care inspections at the required frequency. However, not all required inspection team members attended inspections or completed the annual environmental safety hazards training.

The OIG issued eight recommendations to the Facility Director and the Chief of Staff. These recommendations may improve the quality and delivery of veteran-centered, recovery-oriented care on the inpatient mental health unit and beyond.

The Facility Director committed to formalizing written processes for delivering mental health care to veterans on medical units as well as procedures for monitoring and tracking compliance with state involuntary commitment laws. The Facility Director described plans to ensure adherence to interdisciplinary safety inspection team requirements and facilitate staff completion of safety training. Facility leaders also reported plans to enhance documentation practices for suicide prevention safety plans and informed consent discussions regarding medications. The Facility Director presented documentation of names, location, and contact information for clinics in easy-to-understand language but also described challenges adding this information to discharge instructions. The Facility Director also provided documentation that discharge instructions avoided medical abbreviations and demonstrated compliance with Mental Health Environment of Care Checklist training. Based on information provided, the OIG closed recommendations 5 and 8. For the open recommendations, the OIG will follow up on the planned actions until they are completed.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Appendix A: Methodology

The Mental Health Inspection Program inspections focused on the quality of care provided by VHA's inpatient mental health services.[95] The OIG randomly selected the VHA healthcare systems included in fiscal year 2026 reviews from all systems with inpatient mental health beds.[96] The OIG conducted a virtual and on-site review at the facility and did not receive 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 12 months of healthcare system Mental Health Executive Committee meeting minutes. The OIG reviewed data specific to the facility, prior OIG reports related to the inpatient unit, documents, and electronic health records. Additionally, the OIG conducted a physical inspection of the inpatient unit and interviewed key staff and leaders.

The OIG reviewed select staff's training records for annual completion of Skills Training for Evaluation and Management of Suicide (STEMS), VA S.A.V.E (signs of suicide, asking about suicide, validating feelings, and encouraging help and supporting next steps), and Mental Health Environment of Care Checklist trainings.[97] Staff were excluded from analysis of STEMS and VA S.A.V.E. trainings if identified as being employed in their position less than 90 days. 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 and Mental Health Environment of Care Checklist training.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[98] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. Office of

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

[96] The OIG identified health care systems with inpatient mental health beds using the Monthly Program Cost Report (MPCR) code of 1310 (High Intensity General Psychiatric Inpatient Unit). For fiscal year 2026, the OIG excluded facilities with inpatient mental health beds that the OIG inspected in fiscal years 2024 and 2025. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

[97] VHA Directive 1071(1); VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024; VA, "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis" (fact sheet), June 2025.

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

Healthcare Inspections teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust"[99]

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 B and appendix C.

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.[100] 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 electronic health records of veterans discharged from an acute inpatient mental health stay of more than 48 hours at the facility from July 1, 2024, through June 30, 2025.[101] The OIG reviewed for documentation of a risk and benefit discussion specific to veterans who were newly prescribed central nervous system medications (used for treatment of "a wide range of neurological and psychiatric conditions") during the inpatient stay.[102] 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.[103] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as

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

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

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

[102] VHA Directive 1004.01(3); John A. Gray, "Introduction to the Pharmacology of CNS [Central Nervous System] Drugs," chap. 21 in *Katzung's Basic & Clinical Pharmacology*, 16th ed., Todd W. Vanderah: (McGraw Hill, 2024), https://accesspharmacy.mhmedical.com/content.aspx?sectionid=281750155&bookid=3382&Resultclick=2.

[103] VHA Directive 1160.06(1).

natural lighting, artwork, and calming paint colors. The OIG also observed the unit for cleanliness and veteran access to secure outdoor space.[104] Further, the OIG's physical inspection of areas in the inpatient unit focused on selected safety elements specific to this facility.

The OIG reviewed the Mental Health Environment of Care Checklist data documented in the Patient Safety Assessment Tool, the software tool VHA uses to document these types of inspections and assessed corrective actions taken for unresolved deficiencies for more than six months.[105]

[104] VHA Directive 1160.06(1); VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*; VHA Directive 1850.01(1), *Health Care Environmental Sanitation Program*, March 29, 2023.

[105] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety; VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 2, 2026

From: Interim Director, Department of Veterans Affairs (VA) Heartland Network (10N15)

Subj: VA Office of Inspector General (OIG) Report, Mental Health Inspection of the VA Kansas City Healthcare System in Missouri (VIEWS 14871326)

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

1. Thank you for the opportunity to review the draft report. I reviewed the action plan provided by the facility and concur with the response. The facility is requesting closure of recommendations 4, 5, 7 and 8.
2. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Ahmad Batrash, MD, FACP
Interim Network Director
Legacy VA Heartland Network, VISN 15

[OIG comment: The OIG received the above memorandum from VHA on July 9, 2026.]

Appendix C: Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 2, 2026

From: Acting Executive Medical Center Director, Department of Veterans Affairs (VA) Kansas City Healthcare System (589/00)

Subj: VA Office of Inspector General (OIG) Report, Mental Health Inspection of the VA Kansas City Healthcare System in Missouri (VIEWS 14871326)

To: Director, VA Heartland Network (10N15)

1. We appreciate the opportunity to review and comment on the OIG report Mental Health Inspection of the VA Kansas City Healthcare System in Missouri. Kansas City 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, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Paula Roychaudhuri, FACHE
Acting Executive Medical Center Director

[OIG comment: The OIG received the above memorandum from VHA on July 9, 2026.]

Healthcare System Director Responses

Recommendation 1

The Facility Director develops and implements clearly defined written processes for providing mental health care to veterans on medical units.

__X__Concur

_____Nonconcur

Target date for completion: July 2027

Director's Comments

Inpatient Medicine will serve as the primary service for all patients admitted to a medical-surgical floor. For any patient with identified mental health needs, a formal consult will be placed with Inpatient Mental Health Services. Inpatient Mental Health, Medicine, and Social Work will collaborate to develop a formal service line agreement to ensure consistent, coordinated, and integrated care for patients with mental health needs. The service line agreement will be reviewed and updated at least annually with outcomes reported to the Executive Council of Medical Staff.

The Chief of Mental Health will audit 100% of Kansas City Psychiatry Inpatient Consult patients admitted to inpatient medicine units to verify that the elements of the service line agreement are met, with a target compliance rate greater than or equal to 90% sustained over six months. The Chief of Mental Health will report outcomes to the Kansas City VA Medical Center's Executive Council of Medical Staff and the Quality Patient Safety Council.

Recommendation 2

The Facility Director develops and implements written processes to ensure compliance with state involuntary commitment requirements.

__X__Concur

_____Nonconcur

Target date for completion: June 2027

Director's Comments

The Kansas City VA Medical Center's Involuntary Hospitalization Policy is currently being updated to ensure alignment with Missouri State Law. The existing monitoring and tracking processes for involuntary commitments are already in place and functioning. The current Policy will be routed to the Office of General Counsel for review and approval by July 2026 to ensure all elements of Missouri State Law are accurately reflected.

Ongoing compliance monitoring of the Policy will continue through established processes already overseen and trended by the Mental Health Executive Committee for a minimum of two consecutive quarters to ensure sustained adherence and achievement of the 90% compliance target.

Recommendation 3

The Chief of Staff ensures documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications prior to administration and develops a plan to monitor for sustained compliance.

__X__Concur

_____Nonconcur

Target date for completion: August 2026

Director's Comments

The Psychiatry Executive collaborated with Kansas City VA Medical Center's Clinical Application Coordinators to implement a designated health factor to document the discussion between the prescriber and the Veteran regarding the risks and benefits of newly prescribed medications before administration. Associated documentation templates were updated to reflect this requirement. The Psychiatry Executive also partnered with the Veterans Integrated Service Network (VISN) 15 Clinical Informatics team to develop a report to monitor compliance with this health factor.

A chart audit process was initiated in January 2026, and the Psychiatry Executive has continued to complete 30 chart audits per month to evaluate adherence. A dedicated health factor, Kansas City Mental Health Risks vs Benefits of Treatment Discussed, was created in April 2026 and incorporated into compliance monitoring processes beginning in May 2026.

The Psychiatry Executive has reviewed monthly compliance reports and maintained a compliance rate of at least 90% for six consecutive months. All findings were reported to the Kansas City VA Medical Center's Mental Health Executive Committee, with documentation maintained in meeting minutes.

Recommendation 4

The Chief of Staff ensures veterans' discharge instructions include the appointment location in easy-to-understand language.

__X_Concur

____Nonconcur

Target date for completion: May 2026

Director's Comments

Mental Health Services and Business Operations Services conducted a comprehensive review of all Kansas City VA Medical Center Mental Health clinics. Using the VHA Office of Integrated Veteran Clinical Profile Management Business Rules, dated May 2023, Mental Health Services evaluated 430 clinics and provided Business Operations Services with recommendations regarding clinic names, locations, and contact information. Business Operations Services subsequently updated all clinics in accordance with the business rule requirements. All updates were completed in May 2026.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of additional documentation to support closure.

Recommendation 5

The Chief of Staff ensures discharge instructions are free of medical abbreviations and includes the purpose for each listed medication and develops a plan to monitor for sustained compliance.

__X__Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

In December 2025, Pharmacy Informatics reviewed the non-compliance and determined that a national Electronic Health Record patch, a small software update applied to correct system issues or modify functionality, had impacted certain data objects (code that pulls in data points) to change what data is displayed to the end user. These changes are often made without the knowledge of the end user. The issue had been escalated nationally by Pharmacy Informatics subject matter experts.

Kansas City VA Medical Center Pharmacy Informatics subsequently implemented corrections within the Electronic Health Record to ensure that discharge instructions are free of medical abbreviations and that the purpose of each medication is clearly communicated to the Veteran at discharge. Pharmacy Informatics also established a hard stop and technical fix to prevent recurrence of the issue.

In a random monthly audit of ten psychiatry patients, including inpatient Mental Health and Mental Health patients admitted to Medicine units, 100% received discharge instructions that included the purpose of all medications and contained no abbreviations for six consecutive months. The Kansas City VA Medical Center sustained a six-month period of 90% or greater compliance. Request closure based on information provided.

OIG Comments

The OIG closed the recommendation as leaders completed improvement actions before publication of the report.

Recommendation 6

The Chief of Staff directs staff to complete or review veterans' suicide prevention safety plans prior to discharge from the acute inpatient mental health unit and develops a plan to monitor for sustained compliance.

__X__Concur

_____Nonconcur

Target date for completion: July 2027

Director's Comments

The Chief of Mental Health is responsible for the completion and sustainment of safety plans for mental health inpatients. The Suicide Prevention Coordinator and team members have worked with key stakeholders to ensure the plans are completed prior to discharge. The Suicide Prevention Coordinator will review monthly reports of all inpatient mental health patients and maintain a compliance rate of greater than or equal to 90% for six consecutive months. The Chief of Mental Health will report all findings to the Kansas City VA Medical Center's Executive Council of Medical Staff and the Quality Patient Safety Council.

Recommendation 7

The Facility Director ensures the Interdisciplinary Safety Inspection Team adheres to Veterans Health Administration requirements, including attendance at environment of care inspections, record of required members' attendance at inspections in meeting minutes, and develops a plan to monitor for sustained compliance.

__X__Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

In December 2025, the Mental Health Environment of Care Committee Co-Chair updated all meeting minutes and reports to include documentation of attendance at Environment of Care inspections, verification of required members' participation in inspections, attestation deadlines for the Patient Safety Assessment Tool, and training compliance. In January 2026, the Committee began reporting these elements consistently during its monthly meetings. All required components have been reported, documented, and tracked for sustainment with 100%

compliance for the past six months. The Committee sustained compliance for a six-month period of 90% or greater compliance. The Mental Health Environment of Care Committee reports quarterly to the Kansas City VA Medical Center Environment of Care Committee and has documented all required elements as mandated. Request closure based on information provided.

Recommendation 8

The Facility Director directs staff to complete the required Mental Health Environment of Care Checklist training.

__X__Concur

_____Nonconcur

Target date for completion: June 2026

Director's Comments

The Medical Center Director is accountable for training compliance at the Kansas City VA Medical Center. The Chief of Mental Health is responsible for ensuring that all inpatient mental health staff and all Mental Health Environment of Care Committee (MHEOCC) members meet required training standards. The MHEOCC Co-Chair monitors and reports completion of Mental Health Environment of Care Checklist training.

From January 2026 through June 2026, 100% of MHEOCC members completed the required Mental Health Environment of Care Checklist training. From January 2026 through June 2026, 96% of inpatient mental health staff completed the required Mental Health Environment of Care Checklist training.

The Kansas City VA Medical Center has sustained training compliance at or above 90% for six consecutive months.

OIG Comments

The OIG closed the recommendation as leaders completed improvement actions before publication of the report.

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