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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Tampa Healthcare System in Florida

Mental Health Inspection | **24-03542-57** | **February 24, 2026**

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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. On April 28, 2025, the OIG announced an inspection to address the mental health care delivered in the acute inpatient mental health unit (inpatient unit) at the James A. Haley Veterans' Hospital (facility). The facility is part of the VA Tampa Healthcare System (Tampa HCS) in Florida. The OIG conducted inspection activities from April 28 through May 16, 2025, and completed the on-site portion of the inspection from May 13 through May 16, 2025.

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 provision of the quality of care provided on the inpatient unit. The OIG issued seven recommendations to facility leaders.

The OIG is aware of VA's transformation in the Veterans Health Administration's (VHA's) management structure. 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 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 looked at reporting channels, committee structures, staffing practices, and oversight and monitoring provided by leaders. At the time of the inspection, the Associate Chief of Staff, Mental Health oversaw all mental health programs, including the inpatient unit. The local Mental Health Executive Council was chaired by the Associate Chief of Staff, Mental Health. However, the council did not include veteran representation as required by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*.[2] The Veterans Integrated Service Network Chief Mental Health Officer reported providing consultation and support for inpatient unit operations within the network, for example, through weekly meetings with facility mental health leads and community of practice calls.

[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.

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

Domain	OIG Summary
	OIG recommendation: • The Facility Director ensures the Mental Health Executive Council includes veteran representation.
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, therapeutic programming, and the care environment. Mental health leaders had a local recovery coordinator and a plan across the mental health care continuum for continued transformation to recovery-oriented services, as required under VHA Directive 1163(1), *Psychosocial Rehabilitation and Recovery Services*.[3] However, at the time of the inspection, inpatient unit leaders did not have the standard operating procedure with processes for staff training, education, and implementation of recovery-oriented services outlined in VHA Directive 1160.06, *Inpatient Mental Health Services*.[4] Inpatient unit staff provided veterans with at least four daily hours of recovery-oriented, interdisciplinary programming on weekdays but did not offer four programming hours on weekends. Inpatient unit staff introduced veterans to recovery principles through an orientation handbook and programming. The inpatient unit was clean and followed aspects of VA's inpatient unit design guide for a recovery-oriented environment, such as painted murals on some walls and a designated outdoor space for veterans' use. OIG recommendations: • The Associate Chief of Staff, Mental Health ensures the development and implementation of written processes for staff training, education, and recovery-oriented services. • The Associate Chief of Staff, Mental Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends on the inpatient mental health 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.

[3] VHA Directive 1163(1), *Psychosocial Rehabilitation and Recovery Services*, March 7, 2025, was rescinded and replaced with VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 14, 2025. For the purpose of this inspection, the directives contain the same or similar language related to psychosocial rehabilitation and recovery services.

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

Domain	OIG Summary
	Facility leaders established standard operating procedures for inpatient mental health unit admission, as well as processes for interfacility transfers. Although facility policy included guidelines for involuntary hospitalization, facility leaders did not have formal written processes to oversee compliance with state laws as required by VHA Directive 1160.06.[5] Pursuant to VHA Directive 1160.01, facility leaders had written guidance for inpatient unit treatment planning processes and coordination of care for veterans transitioning out of the inpatient unit.[6] Inpatient unit staff complied with required documentation of legal (voluntary or involuntary) commitment status, as well as informed consent discussions between prescribers and veterans on the risks and benefits of medication treatment. All reviewed electronic health records included a discharge summary required by VHA's *Health Record Documentation Program Guide*.[7] Health records also included discharge instructions per VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06.[8] All discharge instructions included a medication list and documented that the veteran was offered a copy of the instructions. Most reviewed discharge instructions identified the reasons for prescribed medications, and all discharge instructions were free of medical abbreviations. Most instructions included an outpatient mental health follow-up appointment; however, outpatient appointments included abbreviations and acronyms that could be difficult for veterans and caregivers to understand. OIG recommendations: • The Facility Director develops and implements written processes to monitor and track compliance with state involuntary commitment requirements. • The Chief of Staff ensures discharge instructions for veterans include appointment locations in easy-to-understand language.

[5] 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."

[6] VHA Directive 1160.01.

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

[8] VHA SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023, rescinded and replaced by VHA SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," December 19, 2024. Unless otherwise specified, the two SOPs contain the same or similar language related to clinical processes on the inpatient unit.

Domain	OIG Summary
Suicide Prevention 	The underlying causes of suicide can be complex and multifactorial, and suicide prevention may require coordinated systems, services, and resources to effectively support veterans at risk for 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 completed the Columbia-Suicide Severity Rating Scale, a suicide risk screening and evaluation tool, within 24 hours before discharge in most of the reviewed records—as indicated in VA's suicide risk identification strategy.[9] However, the safety plans reviewed did not always address ways to make the veteran's environment safer from potentially lethal means. Nearly all inpatient unit clinical staff completed Skills Training for Evaluation and Management of Suicide required by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*; however, not all nonclinical staff completed VA S.A.V.E. (signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment) training requirements.[10] OIG recommendation: • The Facility Director directs staff to comply with VA S.A.V.E. training requirements and monitors for compliance.
Safety 	The primary goal of inpatient mental health services is to stabilize veterans who are experiencing acute distress by providing a safe, secure environment with staff trained to recognize and 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. The facility had an established Interdisciplinary Safety Inspection Team that conducted environment of care inspections at the frequency required by VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*.[11]

[9] VA, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting*, updated May 10, 2023, February 25, 2025, and October 30, 2025. All three versions contain similar language regarding inpatient mental health requirements.

[10] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022.

[11] The ISIT is responsible for conducting environment of care inspections. 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.

Domain	OIG Summary
	The Interdisciplinary Safety Inspection Team recorded meeting minutes that included attendance of required members. In a physical inspection of the unit, the OIG observed compliance with randomized Mental Health Environment of Care Checklist safety elements. The OIG observed a small shelf in a veteran's room that posed a safety risk; at the OIG's request, facility leaders completed a risk mitigation plan that resulted in the removal of the shelf on the same day. However, not all staff who perform work on the inpatient unit, including a volunteer and Interdisciplinary Safety Inspection Team members, completed annual Mental Health Environment of Care Checklist training. OIG recommendation: • The Facility Director directs inpatient unit staff, volunteers, 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 Veterans Integrated Service Network and Facility Directors concurred with the seven recommendations and provided acceptable action plans (see appendixes D and E). Based on information provided, the OIG considers recommendations 2 and 5 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 inviting a veteran representative to the Mental Health Executive Council. Additionally, the Facility Director committed to formalizing written processes for staff training, education, and recovery-oriented services and tracking compliance with involuntary commitment laws to prevent the illegal hospitalization of veterans. The Facility Director also described plans for recovery-oriented, interdisciplinary weekend programming, discharge instructions in easy-to-understand language, and staff completion of required safety trainings.

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Contents

Abbreviations

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
SOP	standard operating procedure
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.[1] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. On April 28, 2025, the OIG announced an inspection to evaluate acute inpatient mental health care provided at the James A. Haley Veterans' Hospital (facility), part of the VA Tampa Healthcare System (Tampa HCS) in Florida.[2] The OIG conducted inspection activities from April 28 through May 16, 2025, and completed the on-site portion of the inspection from May 13 through May 16, 2025.

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). Under VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, VHA 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.[3]

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.[4]

[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. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[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.

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

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

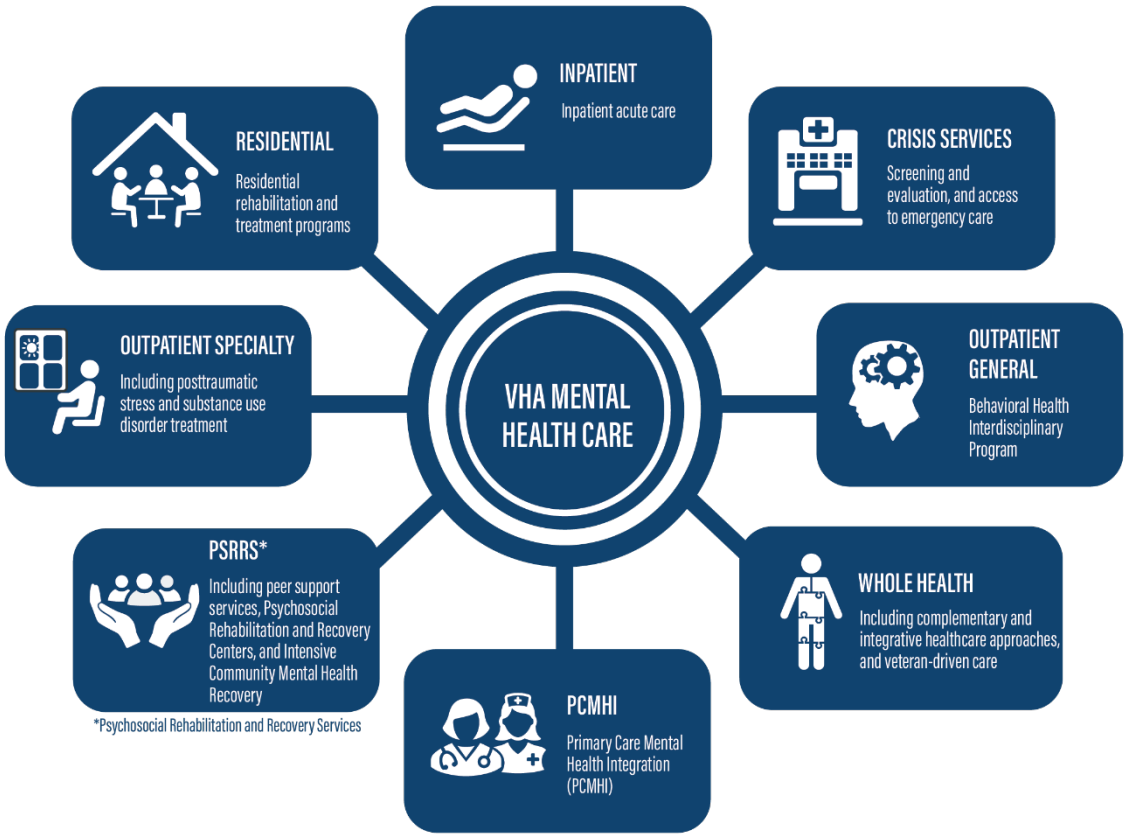

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163(1), Psychosocial Rehabilitation and Recovery Services, March 7, 2025. This directive was rescinded and replaced with VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, 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 Directive 1160.06, *Inpatient Mental Health Services*, these services are considered the most intensive level of mental health care used to treat veterans safely and effectively during periods of acute mental distress.[5] In fiscal year (FY) 2024, VHA HCSs delivered inpatient mental health care for 64,298 veteran stays.[6]

[5] 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.

[6] 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.[7] For information on the OIG's data collection methods, see appendix B.

About Tampa HCS

Tampa HCS, part of Veterans Integrated Services Network (VISN) 8, provides acute inpatient mental health care at the facility and operates 13 community-based outpatient clinics in Florida.[8]

In FY 2024, Tampa HCS provided health care to 112,743 veterans and 37,013 received outpatient mental health care. Inpatient mental health unit (inpatient unit) staff cared for 689 veterans and the facility maintained an average daily census of 19 on the inpatient unit.[9] Staff did not submit any consults for inpatient mental health care in the community during the FY. At the time of this inspection, the inpatient unit had 40 authorized beds.

[7] 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.

[8] 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 13 community-based outpatient clinics are in the cities of Brooksville, Tampa, Lakeland, Lecanto, New Port Richey, Riverview, Temple Terrace, and Zephyrhills.

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

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."[10] HCS leaders can nurture a positive, safety-oriented culture by building effective reporting and communication structures, incorporating stakeholder feedback, and supporting continuous performance improvement.[11]

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 Tampa HCS executive leadership team included the Facility Director, Chief of Staff, and Associate Director for Patient Care Services.[12] The Chief of Staff and the Associate Director for Patient Care Services oversaw patient care and supervised service directors and program chiefs. VHA Directive 1160.01 indicates facilities are required to have a mental health lead. The Associate Chief of Staff, Mental Health (ACOS, Mental Health) served in this role and oversaw all mental health programs, including the inpatient unit.[13]

Facility leaders described a collaborative leadership and staff structure. Additionally, the acting VISN Chief Mental Health Officer reported supporting the facility's mental health staff and unit operations through attendance at weekly meetings with mental health leads and community of practice calls.

VHA requires HCSs to establish a mental health executive council (MHEC) to ensure quality mental health care is delivered.[14] The facility MHEC was chaired by the ACOS, Mental Health.[15]

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[10] 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.

[11] 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 site is not publicly accessible.)

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

[13] VHA Directive 1160.01.

[14] VHA Directive 1160.01.

[15] VHA Directive 1160.01; The facility refers to its MHEC as the Mental Health Integrated Clinical Community; The OIG reviewed meeting minutes from October 1, 2023, through September 30, 2024.

Additionally, the MHEC included representation from inpatient unit staff, the local recovery coordinator (LRC), and the suicide prevention coordinator.[16] However, the council did not meet the requirement for a veteran representative, which could lead to missed opportunities to obtain and incorporate critical stakeholder input for quality of care improvements.[17]

Inpatient Unit Staffing

The hospital psychiatry program supervisor served as the inpatient mental health program manager, a role required under VHA Directive 1160.06.[18] The ACOS, Mental Health reported the hospital psychiatry program supervisor oversaw inpatient unit operations and supervised unit psychiatrists. (For information on current staffing levels and structure, see appendix C.)

Facility and mental health leaders described recruiting staff from residency programs affiliated with the facility and using incentives such as an education debt reduction program and competitive pay to recruit and retain employees. At the time of the inspection, facility and mental health leaders did not identify staffing challenges for the inpatient unit.

The Chief of Staff depicted a positive organizational culture with supportive and stable leaders and continuous process improvement efforts that contributed to the facility's ability to attract and retain staff. Further, the Associate Director of Patient Care Services described collaboration and open communication between disciplines with ongoing efforts to solicit staff feedback. Inpatient mental health leaders described a culture of safety in which employees were encouraged to report concerns and stated that leaders were responsive to feedback and encouraged continuous process improvement efforts. (See Recovery-Oriented Principles for further information.)

Recommendation

1. The Facility Director ensures the Mental Health Executive Council includes veteran representation.

For detailed action plans, see appendix E.

[16] VHA Directive 1160.01.
[17] VHA Directive 1160.01.
[18] VHA Directive 1160.06; VHA Directive 1160.06(1).

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 facility met requirements under VHA Directive 1163(1), *Psychosocial Rehabilitation and Recovery Services* to have an LRC and a local plan across the mental health continuum for continued transformation to recovery-oriented services.[23] However, the LRC and the inpatient mental health program manager reported that the inpatient unit did not establish a standard operating procedure (SOP) for "education, staff training, and implementation of recovery-oriented care" as required by VHA Directive 1160.06.[24] The absence of an SOP to advise staff on incorporating recovery-oriented principles may have limited the inpatient unit's implementation of these elements.

[19] "Recovery and Recovery Support," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, accessed September 9, 2025, 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 September 9, 2025, 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(1), March 7, 2025, was rescinded and replaced with VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 14, 2025. For the purpose of this inspection, the directives contain the same or similar language related to psychosocial rehabilitation and recovery services; "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(1).

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

The OIG also evaluated whether leaders solicited input on inpatient mental health care from staff and veterans. Mental health leaders reported collecting inpatient unit providers' feedback through program manager stakeholder meetings and huddles to discuss process improvement opportunities.[25] Additionally, mental health staff provided a patient experience survey to veterans prior to discharge from the inpatient unit. Mental health leaders reported implementing veteran suggestions such as improvement in food choices and the addition of music therapy.

Recovery-Oriented Programming

Inpatient unit leaders reported nurses introduced veterans to recovery-oriented principles at time of admission through a veteran handbook and program offerings. This is required by VHA's "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06."[26] Inpatient unit staff offered between five to six hours of recovery-oriented, interdisciplinary programming on weekdays but lacked the four-hour daily minimum on weekends.[27] Mental health leaders stated that psychology staff also offered individual sessions for veterans who did not prefer groups. Insufficient programming may limit opportunities for veterans to work on recovery goals while receiving inpatient unit care.

Physical Environment

The inpatient unit was comprised of two areas separated by a locked door that allowed flexibility to care for specific populations, such as female and geriatric veterans, when needed. The unit was clean and had aspects of a recovery-oriented environment, such as painted murals on some walls, as outlined in VA's inpatient mental health design guide.[28]

[25] 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.

[26] 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.

[27] VHA Directive 1160.06; VHA Directive 1160.06(1). Inpatient unit staff must offer veterans "a minimum of 4 hours of interdisciplinary, therapeutic and recovery-oriented programming daily including weekends and holidays, with 5–6 hours of programming recommended."

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

Figure 2. *Secured, outdoor space (screened-in atrium with natural light and weighted furniture) and a day room.*
Source: Photos of the facility's inpatient unit taken by OIG staff, May 13 and 14, 2025.

Both areas had a day room with televisions and games; these rooms were unlocked and accessible for veteran use. The areas shared a dedicated nursing station, room for group therapy, and a large outdoor space used for fresh air and programming. (See figure 2 for relevant images.) Each area contained a restraint room, and one area had a quiet room. Although veterans had unrestricted access to these recovery-oriented common areas, bedrooms lacked calming paint colors and had minimal artwork.[29]

Beyond the physical environment, the inpatient unit demonstrated a recovery-oriented culture and veteran-centric care through staff's presence and engagement with veterans in the hallways and common areas. For example, the OIG observed staff going from bedroom to bedroom to dispense medications using a computer on wheels and to inform veterans of group therapy and activities.

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

Recommendations

2. The Associate Chief of Staff, Mental Health ensures the development and implementation of written processes for staff training, education, and implementation of recovery-oriented services.
3. The Associate Chief of Staff, Mental Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends on the inpatient mental health unit.

For detailed action plans, see appendix E.

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 mental health care requires well-defined screening and admissions processes that ensure veterans are evaluated and receive clinically appropriate treatment.[33] Facility leaders established SOPs for inpatient unit admission and interfacility transfers, per VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."[34]

[30] "Care Coordination," Agency for Healthcare Research and Quality, accessed on 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*, no. 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, rescinded and replaced 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," on December 19, 2024. Unless otherwise specified, the two SOPs contain the same or similar language related to clinical processes on the inpatient unit; James A. Haley Veterans' Hospital and Clinics SLA 116A-03, "Admission Procedure for Acute Inpatient Psychiatry," December 2024; James A. Haley Veterans' Hospital and Clinics SLA 11-52, "Inter-facility Transfer Policy," May 2022.

Involuntary Hospitalization and Treatment

Facility policy included guidelines for involuntary hospitalization; however, leaders had not established written processes for compliance oversight with state laws as required in VHA Directive 1160.06.[38] Facility and mental health leaders reported being in the process of developing a centralized tool for monitoring and tracking veterans' legal (voluntary or involuntary) commitment statuses. Additionally, the chief of psychiatry reported the mental health law coordinator position was recently established and responsibilities to ensure staff adherence to state laws had been temporarily assigned to another staff member until the position was permanently filled. The absence of written processes for monitoring compliance may result in staff confusion about veterans' legal statuses and could contribute to the illegal hospitalization of veterans.

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."[35]

Standards and procedures for civil commitment are provided by state law and vary by state.[36] VHA requires that leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[37]

VHA's policy "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," requires a registered nurse to conduct and record a review of documents required for admission, including voluntary or involuntary legal commitment status, prior to arrival on the inpatient unit.[39] The OIG found 90 percent of reviewed electronic health records (EHRs) included the required documentation of legal (voluntary or involuntary) commitment statuses.

[35] "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.

[36] "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.

[37] VHA Directive 1160.01.

[38] 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."; James A. Haley Veterans' Hospital and Clinics SLA 116A-06, "Voluntary and Involuntary Admissions to the Hospital," May 2025.

[39] 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.

Treatment Planning

In alignment with VHA Directive 1160.01 requirements, facility leaders established written guidance for the inpatient mental health treatment planning process that included recovery-oriented elements such as veterans' involvement in setting their own goals.[40] Mental health leaders reported the interdisciplinary treatment team met regularly and collaborated with veterans to set individual treatment goals based on veteran preference.[41] The chief of psychiatry described existing processes to oversee the quality of treatment planning, such as ongoing supervisory review of health records.

Medication Treatment

All reviewed EHRs included documentation of informed consent discussions between prescribers and veterans on the risks and benefits of medication treatment, as specified by VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.[42]

Discharge Planning

Facility leaders established written guidance on processes for coordination of care when veterans are discharged from the inpatient unit.[43] The guidance outlined processes for scheduling follow-up outpatient mental health appointments and discharge coordination that involved the veteran, the interdisciplinary treatment team, and relevant outpatient providers.[44] Additionally, facility leaders established written guidance to ensure that veterans who are discharged from non-VA hospitals receive timely follow-up appointments.[45] An inpatient social worker reported some

[40] VHA Directive 1160.01; James A. Haley Veterans' Hospital and Clinics SOP 116Aa-11, "Documentation," May 2025.

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

[42] 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. All versions were in effect during the EHR review period. Unless otherwise noted, all versions 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 ed., Todd W. Vanderah, (McGraw Hill (2024)), https://accesspharmacy.mhmedical.com/content.aspx?sectionid=281750155&bookid=3382&Resultclick=2.

[43] VHA Directive 1160.01; James A. Haley Veterans' Hospital and Clinics SOP 116Af-01, "ARC Discharge Follow-Up," December 2024.

[44] James A. Haley Veterans' Hospital and Clinics SOP 116Af-01, "ARC Discharge Follow-Up"; James A. Haley Veterans' Hospital and Clinics SLA 122-02, "Discharge Planning," March 2023.

[45] James A. Haley Veterans' Hospital and Clinics SOP 116Aa-02, "Discharge Follow-Ups for Veterans in Community Hospitals," March 2022.

challenges with discharge planning due to limited homeless shelters and substance use disorder residential programs in the area.[46]

All reviewed EHRs included a discharge summary per VHA's *Health Record Documentation Program Guide*.[47] Additionally, all EHRs included discharge instructions as required under VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06" with evidence that the veteran or caregiver was offered a copy.[48] Most reviewed discharge instructions included the follow-up appointment location and—per VHA Directive 1345, *Medication Reconciliation*—identified the reasons for prescribed medications.[49] As indicated in VHA's *Health Record Documentation Program Guide*, all reviewed EHRs included documentation of the medication list in the discharge instructions. Additionally, discharge instructions were free of medical abbreviations that could be difficult for nonmedically trained individuals to understand (see figure 3).[50]

[46] Inpatient unit staff reported one VA residential treatment program and one community homeless shelter in Tampa.

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

[48] VHA SOP 1160.06.2, September 29, 2023; VHA SOP 1160.06.2, December 19, 2024.

[49] VHA Directive 1345, *Medication Reconciliation*, March 9, 2022; VHA SOP 1160.06.2, September 29, 2023; VHA SOP 1160.06.2, December 19, 2024.

[50] VHA, *Health Record Documentation Program Guide Version 1.2*; VHA, *Health Record Documentation Program Guide Version 1.3*; Randa Hilal-Dandan and Laurence L. Brunton, "Appendix I: Principles of Prescription Order Writing and Patient Compliance," in *Goodman and Gilman's Manual of Pharmacology and Therapeutics* (McGraw Hill Education, 2016), https://accesspharmacy.mhmedical.com/content.aspx?bookid=1810&sectionid=124489535.

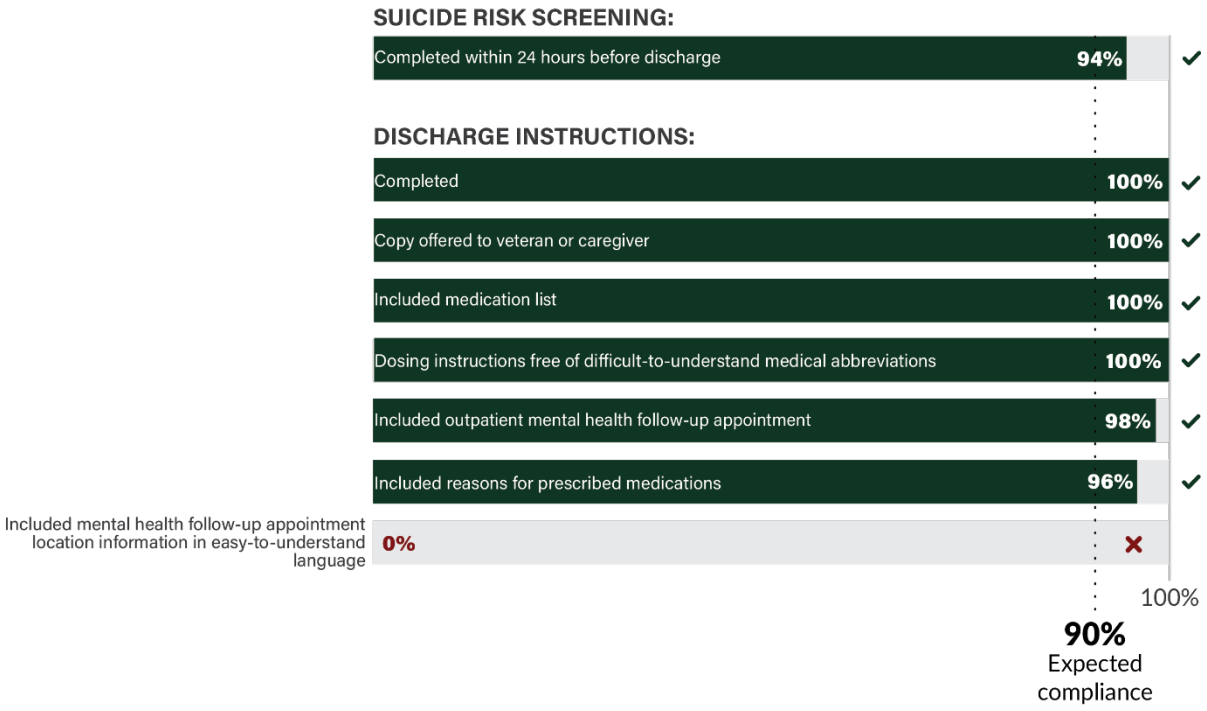

Figure 3. *Discharge-related screening and documentation.*
Source: OIG review of the inpatient unit EHRs.
Note: Based on analysis of 50 EHRs. Suicide risk screening discussed in Suicide Prevention (below).

However, discharge instructions included abbreviations and acronyms for appointment locations that could be difficult for veterans and caregivers to understand.[51] Missing or unclear details in discharge instructions may create barriers for veterans to attend follow-up appointments and receive timely mental health care (see figure 4 for an example).

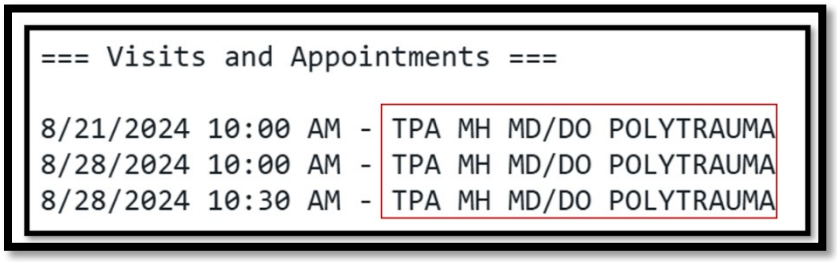

Figure 4. *Example from discharge instructions with difficult-to-understand appointment location information outlined in red.*
Note: Per the Chief of Mental Health, TPA refers to Tampa, MH refers to mental health clinic, MD/DO refers to providers' credentials, and polytrauma refers to the specialty.
Source: OIG review of veterans' EHRs.

[51] VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," May 24, 2023.

Recommendations

4. The Facility Director develops and implements written processes to monitor and track compliance with state involuntary commitment requirements.
5. The Chief of Staff ensures discharge instructions for veterans include appointment locations written in easy-to-understand language.

For detailed action plans, see appendix E.

Suicide Prevention

The underlying causes of death by suicide can be complex and multifactorial. Preventing suicide may require coordinated systems, services, and resources to effectively support at-risk veterans.[52]

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."[53] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[54]

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

VA's suicide risk identification strategy 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.[55] Staff completed C-SSRSs within the expected time frame in most of the reviewed EHRs (see figure 3).[56]

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

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

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

[55] VA, *Department of Veterans Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting*, updated May 10, 2023, February 25, 2025, and October 30, 2025. All three versions contain similar language regarding inpatient mental health requirements.

[56] VA, *Department of Veterans Affairs* (*VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting*; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), et al., November 23, 2022, was replaced by Assistant Under Secretary for Clinical Services/Chief Medical Officer (11), "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum on 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.

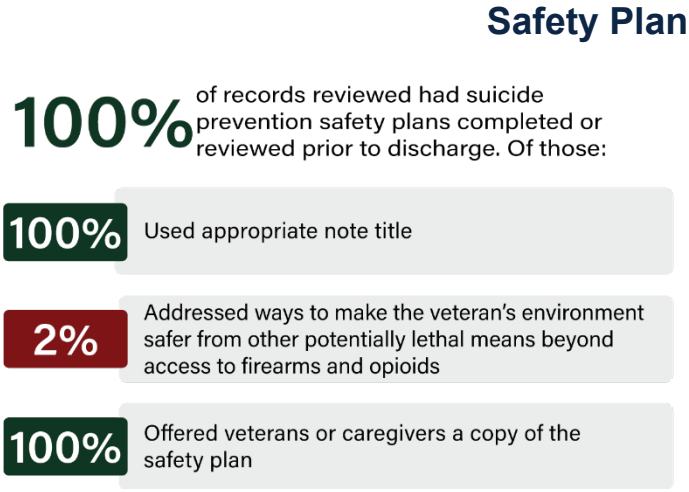

Figure 5. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' EHRs.

All reviewed EHRs reflected that staff completed or reviewed suicide prevention safety plans using the standardized safety planning note title required under VA's memoranda for safety plan progress notes.[57]

However, only 2 percent of the safety plans followed *VA Safety Planning Intervention Manual* guidance to address ways to make the environment safer from potential lethal means beyond firearms and opioids (see figure 5).[58] Mental health leaders reported believing the requirement would be met if staff addressed lethal means in a separate templated note. The identification of other potential lethal means in the safety plan may reduce the risk of self-harm (see figure 6).

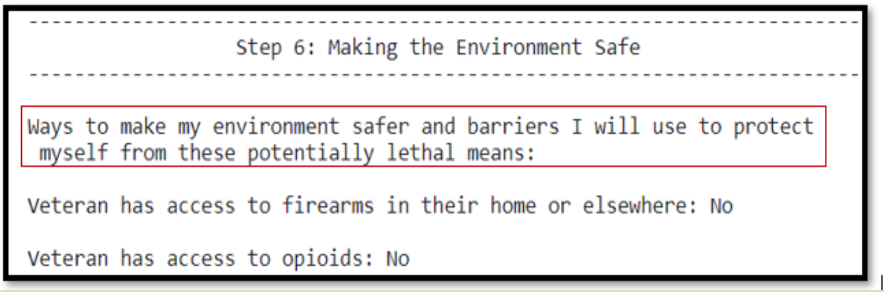

Figure 6. *Example from a safety plan. The required element "Ways to make my environment safer and barriers I will use to protect myself from these potentially lethal means" was left blank in the free text field (outlined in red).*
Source: OIG review of veterans' EHRs.

[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, was replaced by "For Action: Update to Use of National Standardized Suicide Prevention Safety Plan Progress Notes" memorandum on November 18, 2024. Unless otherwise specified, the updated memo contains similar language related to documentation of suicide prevention safety plans requirement.

[58] VA, *VA Safety Planning Intervention Manual*, February 23, 2022; "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."

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.[59] In a recent publication, the OIG made one recommendation related to safety plan completion:

> 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.[60]

The OIG does not make any further recommendations on safety planning documentation in this report.

Training

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 help and expediting treatment) assist clinicians and nonclinical staff, respectively, in identifying the warning signs of suicide risk and appropriate interventions.[61]

Inpatient unit clinical staff met STEMS training requirements in VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*; however, some nonclinical staff did not complete the required VA S.A.V.E. training (see figure 7).[62] When staff do not complete suicide prevention training, they may not identify signs of suicidality and may lack awareness of resources and interventions to keep veterans safe.

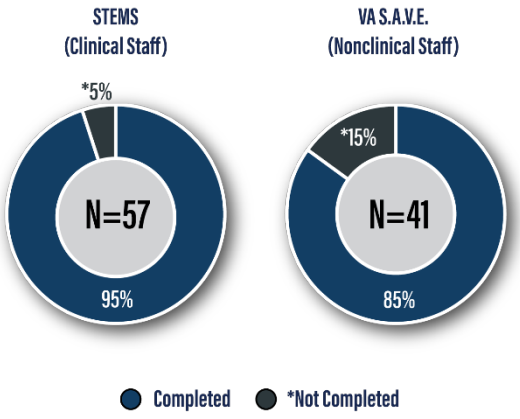

Figure 7. *Inpatient unit staff completion of mandatory suicide prevention training.*
Source: OIG document review of clinical and nonclinical staff training certificates and "For Action: Local Monitoring and Compliance of Mandatory Suicide Prevention Training," memo.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings from April 28, 2024, through April 28, 2025. VHA established a "target for compliance" of 95 percent threshold for mandatory suicide prevention training completion.

[59] 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.

[60] VA OIG, *Mental Health Inspection of the VA NY Harbor Healthcare System in New York*, Report No. 25-00729-23, December 18, 2025.

[61] 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.

[62] VHA Directive 1071(1).

Recommendation

6. The Facility Director directs staff to comply with VA S.A.V.E. training requirements and monitors for compliance.

For a detailed action plan, see appendix E.

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."[63] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[64]

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). The MHEOCC is described in VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*.[65] 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."[66] 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."[67]

The facility had an established ISIT and completed the required twice annual environment of care inspections of the unit. Attendance for the inspections was recorded and included required ISIT members.[68] In a physical inspection of the unit, the OIG observed compliance with all OIG

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

[64] 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 policies contain the same or similar language related to the design of the inpatient unit and staff training requirements.

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

[66] "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.

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

[68] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The rescinded directive was in place from October 1, 2023, through November 3, 2024. The updated directive requires the patient safety manager, inpatient mental health nurse manager, inpatient mental health program director, engineering/facilities management representative, suicide prevention coordinator, and another clinical staff from any discipline or area to be included as ISIT members.

randomized MHEOCC safety elements.[69] However, the OIG observed a small shelf in a veteran's room that posed a ligature risk. At the request of the OIG, facility leaders ensured veterans did not have access to the room until the risk was mitigated, which occurred on the same day.[70]

Training

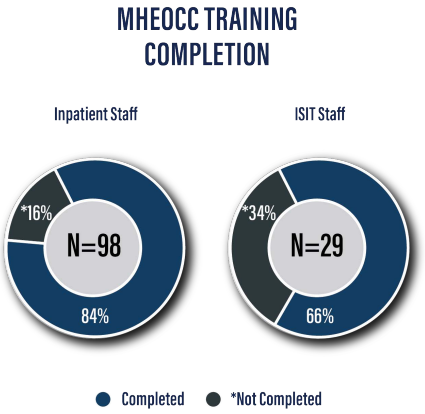

Figure 8. *MHEOCC training completion.*
Source: OIG document review of training certificates for inpatient unit and ISIT staff, and a volunteer.
Note: The OIG evaluated completion of MHEOCC training from April 28, 2024, through April 28, 2025. ISIT staff who were also inpatient unit staff are included in the denominator for both document reviews. The OIG used 90 percent as the expected level of compliance for MHEOCC training completion.

VHA Directive 1167 requires staff training on environmental hazards and orientation to the "content and proper use" of the MHEOCC.[71] The OIG found that not all ISIT members, staff, and a volunteer who performed work on the inpatient unit were compliant with required annual MHEOCC training (see figure 8).[72] VHA requires "non-VA employees, such as contractors and VA medical facility-approved volunteers, who perform work on inpatient mental health units" to also complete the required training.[73] Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.

[69] Randomized MHEOCC safety elements included shatter resistant dishes, Sentinel Event Reduction bathroom doors, required hardware and window coverings without ligature points, shatter proof mirrors, locked cabinets with secured under-sink storage, collapsible trash cans in veteran areas, and institutional type fire sprinklers.

[70] Katie Byrne et al., "Special Report: Suicide Prevention in Health Care Settings," *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."

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

[72] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024; VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, updated December 2022.

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

Recommendation

7. The Facility Director directs inpatient unit staff, volunteers, 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 E.

Conclusion

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

The OIG observed a recovery-oriented culture and veteran-centric care through staff's presence and engagement with veterans on the inpatient unit; for example, staff going from bedroom to bedroom to dispense medications and inform veterans of group therapy and activities. Inpatient mental health leaders and staff described a culture of safety in which employees were encouraged to report concerns and leaders were responsive to feedback. Leaders did not identify staffing challenges.

The inpatient unit was clean, with recovery-oriented common spaces such as a day room with television and games and a large outdoor space available for fresh air and activities. While veterans had unrestricted access to these spaces, bedrooms lacked recovery-oriented elements such as calming paint colors and had minimal artwork.

Although the facility had an established MHEC, the council did not have a veteran representative. Additionally, mental health leaders did not establish a SOP for staff training, education, and implementation of recovery-oriented services on the inpatient unit.

Facility policy included guidelines for involuntary hospitalization, but facility leaders did not have formal written processes to oversee compliance with state laws. Not all inpatient unit staff completed suicide prevention or annual environmental safety hazards training.

Staff complied with required documentation of legal (voluntary or involuntary) commitment status, as well as informed consent discussions between prescribers and veterans on risks and benefits of medication treatment.

Most reviewed EHRs included evidence of timely suicide risk screenings and safety plans. 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 veteran's environment safer from potentially lethal means beyond access to firearms and opioids. All reviewed EHRs included documentation of the discharge summary and discharge instructions, and evidence that the veteran or caregiver was offered a copy of the instructions. However, discharge instructions

included abbreviations and acronyms that could be difficult for veterans and caregivers to understand.

The facility had an established ISIT and staff conducted environment of care inspections at the required frequency. The ISIT recorded meeting minutes that included attendance of required members.

The OIG issued seven recommendations to the Facility Director, Chief of Staff, and Associate Chief of Staff, Mental Health. The Facility Director reported inviting a veteran representative to the Mental Health Executive Council. Additionally, the Facility Director committed to formalizing written processes for staff training, education, and recovery-oriented services and tracking compliance with involuntary commitment laws to prevent the illegal hospitalization of veterans. The Facility Director also described plans for recovery-oriented, interdisciplinary weekend programming, discharge instructions in easy-to-understand language, and staff completion of required trainings.

These recommendations may improve the quality and delivery of veteran-centered, recovery-oriented care on the inpatient mental health unit and beyond. Additionally, the OIG hopes the successful practices highlighted in this report will be used by other VHA facility leaders to improve their inpatient mental health unit operations.

The OIG is aware of VA's transformation in VHA's management structure. 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: 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.[74]

VHA Directive 1160.06 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.[75] 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.[76]

According to VHA Directive 1160.06 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 full implementation of program requirements.[77]

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. According to VHA Directive 1160.01, 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.[78] Each MHEC must include veteran representation, preferably one currently receiving mental health treatment and not employed at

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

the local HCS. The MHEC should meet quarterly and "record minutes that are accessible to all mental health clinical staff."[79]

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."[80] 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."[81]

Under VHA Directive 1163(1), 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."[82]

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.[83] 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."[84]

LRCs are considered collaborative mental health leaders who ensure recovery-oriented principles are integrated into care delivery. The role is primarily nonclinical in nature, which allows them to dedicate most of their time to activities such as training, consultation, and education.[85] To support veterans' recovery, VHA Directive 1163(1) requires the LRC, in collaboration with local

[79] VHA Directive 1160.01.

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

[81] "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.)

[82] VHA Directive 1163(1).

[83] "Achieving the Promise: Transforming Mental Health Care in America," President's New Freedom Commission on Mental Health, accessed October 25, 2022, https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm; "President's New Freedom Commission on Mental Health: Report to the President: Inside Cover," Mental Health Commission, accessed June 11, 2024, https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/InsideCover.htm.

[84] "Recovery and Recovery Support," Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[85] VHA Directive 1163(1).

mental health leaders, to have a continuous recovery improvement plan.[86] Additionally, VHA Directive 1160.06 requires the LRC, in collaboration with the inpatient mental health program manager, to establish an SOP that includes processes for staff training, education, and implementation of recovery-oriented services on the inpatient unit.[87]

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit. 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.[88] Inpatient unit staff must offer veterans "a minimum of 4 hours of interdisciplinary, therapeutic and recovery-oriented programming daily including weekends and holidays, with 5 – 6 hours of programming recommended."[89]

VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care and therefore provides design guidelines for HCSs to create a hopeful and healing environment while maintaining safety.[90] For VA medical facilities with a MHEOCC-compliant secure outdoor space, daily programming should include dedicated time for veterans to be outdoors.[91]

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.[92] VHA Directive 1160.06 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.[93]

VHA SOP 1160.06.2 recommends HCSs have SOPs outlining admission processes, and VHA Directive 1160.06 requires HCSs to provide access to mental health treatment for veterans who

[86] VHA Directive 1163(1).

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

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

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

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

[91] 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."

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

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

are either voluntarily or involuntarily held on an inpatient unit.[94] 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.[95]

The federal government lacks civil commitment laws; therefore, HCS leaders are required to have clear guidelines that align with state and local laws for civil commitment.[96] HCS staff must be aware of the veteran's legal status (voluntary or involuntary admission) to safeguard against potential civil rights violations, including illegal detainment in a locked inpatient unit.[97]

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 prior to discharge, including follow-up appointment information.[98]

VHA requires that veterans receive a copy of the written discharge plan and a copy of the safety plan, as applicable, at discharge. The written discharge plan must include the provider's name if available, as well as scheduling information for the follow-up appointments.[99]

Per VHA's "Clinic Profile Management Business Rules" guidance, the "Patient Friendly name is entered for the patient to clearly know where the appointment is located, and the service offered must be easy to understand." Additionally, VHA guidance indicates that patient friendly names must be "desensitized without any abbreviations or acronyms."[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

[94] VHA SOP 1160.06.2, September 29, 2023; VHA SOP 1160.06.2, December 19, 2024; VHA Directive 1160.06; VHA Directive 1160.06(1).

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

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

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

[98] VHA SOP 1160.06.2, September 29, 2023; VHA SOP 1160.06.2, December 19, 2024.

[99] VHA SOP 1160.06.2, September 29, 2023; VHA SOP 1160.06.2, December 19, 2024.

[100] VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," updated May 24, 2023.

[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*.

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, as required by VA's suicide risk identification strategy.[104] According to VHA's suicide risk screening memoranda, 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]

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]

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."[109] 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.[110]

According to VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," all patients in a VHA inpatient mental

[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 Health 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.

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

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

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."[111]

VHA Directive 1071(1) requires healthcare providers to complete STEMS and nonclinical staff to complete VA S.A.V.E. training annually.[112] 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 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. According to VHA Directive 1167, 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]

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

[112] VHA Directive 1071(1).

[113] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Local Monitoring and Compliance of Mandatory Suicide Prevention Training," memorandum.

[114] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to incorporating recovery and ensure safety on the inpatient unit.

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

[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. 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 work stations."

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

Appendix B: Methodology

The Mental Health Inspection Program reviews 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 April 28 through May 16, 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, SOPs, 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.

The OIG reviewed select staff's certificates for annual completion of STEMS, VA S.A.V.E, and MHEOCC trainings.[120] 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.

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 and appendix E.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[121] The OIG reviews available evidence within a specified

[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 facilities with inpatient mental health beds that the OIG inspected 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.

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

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.[122] As previously discussed, 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 facility leaders and staff provided a therapeutic, recovery-oriented environment and maintained veteran safety.[123] 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.[124] 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 MHEOCC data documented in 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.

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

[123] VHA Directive 1160.06; VHA Directive 1160.06(1); 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 September 11, 2025, https://www.merriam-webster.com/dictionary/unit.

[124] 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
Chaplain	1	70
Dietitians	2	25
Mental Health Counselor	1	100
Nurses*	45	100
Occupational Therapists‡	2	15
Pharmacist	1	100
Psychiatric Nursing Assistants	31	100
Psychiatrists	4	100
Psychologists	2	100
Recreation Therapists	2	50
Rehabilitation Counselor	1	15
Social Workers§	5	5-100

Source: OIG reviewed the facility's mental health inpatient unit staffing spreadsheet (received May 5, 2025), email correspondence, and information obtained from interviews; OIG analysis of VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, January 18, 2023.

Note: FTEE indicates full-time equivalent employee. The unit included a volunteer and an outpatient peer specialist.

**Includes two nurse managers, two assistant nurse managers and 41 registered nurses.*

‡Includes an occupational therapist at 10–15 percent and an occupational therapist "as needed" for percent dedicated time on the unit.

§Includes a suicide prevention coordinator.

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 30, 2025

From: Interim Network Director, Department of Veterans Affairs (VA) Sunshine Healthcare Network (10N8)

Subj: Mental Health Inspection of the VA Tampa Healthcare System in Florida

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

1. I appreciate the partnership with the VA Office of Inspector General (OIG) in ensuring the Veterans we proudly serve receive exceptional health care services. I have reviewed the VA OIG's draft report and concur with the findings and recommendations as well as the Acting Medical Center Director's action plans.

2. Veterans Integrated Service Network (VISN) 8 is committed to assisting the VA Tampa Health Care System's leadership in completing all actions timely. For questions, please contact the VISN 8 Quality Management Officer.

(*Original signed by:*)

David Dunning, MPA

[OIG comment: The OIG received the above memorandum from VHA on November 5, 2025.]

Appendix E: Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 29, 2025

From: Interim Medical Center Director, Department of Veterans Affairs (VA) Tampa Healthcare System (673/00)

Subj: Mental Health Inspection of the VA Tampa Healthcare System in Florida

To: Interim Network Director, Veterans Sunshine Healthcare Network (10N8)

1. We appreciate the opportunity to review and comment on the Office of Inspector General's draft report, Mental Health Inspection of the James A. Haley Veterans' Hospital and Clinics (JAHVH) in Tampa, Florida. JAHVH 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*:)

David J. VanMeter, FACHE, MHA
Interim Medical Center Director

[OIG comment: The OIG received the above memorandum from VHA on November 5, 2025.]

Healthcare System Director Responses

Recommendation 1

The Facility Director ensures the Mental Health Executive Council includes veteran representation.

_X__ Concur

_____Nonconcur

Target date for completion: February 2026

Director's Comments

Concur. Mental Health and Behavioral Science Service (MH&BSS) previously invited a Veteran representative to Mental Health Executive Leadership Council meetings who often was unable to attend and was unaccounted for, which led to this OIG finding. Following the OIG visit, MH&BSS staff first invited an additional Veteran to the August 26, 2025 Council meeting. This Veteran receives primary and specialty care at the VA Tampa Healthcare System. MH&BSS provided the Veteran with invitations and a schedule for upcoming Council meetings through FY2026. The Veteran acknowledged and expressed her intention and commitment to attend. Veteran was unable to attend August 26 meeting due to a conflicting appointment, but informed staff that she would be able to attend future meetings. Document ("Recommendation 1_MH ELC Min 8.26.2025") demonstrates that MH&BSS invited the new Veteran representative, who was excused due to scheduling conflicts. It is noted that there are also several staff members, who are Veterans and attend the Council meetings; they are permanent members of the committee.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure, including a minimum of two quarters of meeting minutes that reflect the inclusion of veteran(s) in the monthly Mental Health Executive Committee.

Recommendation 2

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

_X__ Concur

_____Nonconcur

Target date for completion: October 2025

Director's Comments

Concur. On October 1, 2025, the Service Line Agreement (SLA) 116A-07 Recovery-Oriented Care at the Acute Recovery Center (ARC) was published. This policy addresses staff training, education, and recovery-oriented services. On October 10, 2025, ARC staff received a copy of the policy electronically and service chiefs included instructions in staff meetings. Document "Recommendation 2_SLA 116A-07 Recovery-Oriented Care at the Acute Recovery Center (ARC) -es" demonstrates compliance.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 3

The Associate Chief of Staff, Mental Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends on the inpatient mental health unit.

_X__ Concur

_____Nonconcur

Target date for completion: May 2026

Director's Comments

Concur. MH&BSS ARC staff scheduled and implemented a minimum of 4 hours of programming on the weekends in the ARC beginning July 19, 2025. ARC nurse managers will monitor with a goal of 90% compliance over 6 months.

Recommendation 4

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

_X__ Concur

_____Nonconcur

Target date for completion: April 2026

Director's Comments

Concur. A written process regarding monitoring and tracking compliance with state involuntary commitment requirements, Standard Operating Procedure (SOP) 11-06 Baker Act, was finalized and signed June 18, 2025, through the Chief of Staff. On July 25, 2025, an MH&BSS sub-committee consisting of psychiatrists was created to develop and implement a written process to

monitor and track compliance with involuntary commitment requirements. On October 1, 2025, an Access file was finalized to monitor involuntary commitment requirements. This file is monitored by the MH&BSS sub-committee and identifies appropriateness of the type of legal status and appropriate documentation related to the status. The sub-committee will monitor with a goal of 90% compliance over 6 months.

Recommendation 5

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

_X__ Concur

_____Nonconcur

Target date for completion: May 2025

Director's Comments

Concur. On May 2, 2025, MH&BSS administrative staff updated all patient discharge instruction letter templates, including upcoming appointments and locations, in easy-to-understand language. Included document ("Recommendation 5_ Easy to Understand Language") demonstrates compliance; the document is a screenshot of the discharge instruction letter that is sent to this test patient who has a demo appointment scheduled. This is templated and the easy-to-understand language automatically populates for all Veterans.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 6

The Facility Director directs staff to comply with VA S.A.V.E. training requirements and monitors for compliance.

_X__ Concur

_____Nonconcur

Target date for completion: September 2026

Director's Comments

Concur. Quality Patient Safety Service communicated the required Talent Management System (TMS) training for providers who enter the ARC to appropriate service chiefs on October 16, 2025. ARC nursing will update the ARC sign-in sheet to inquire if the staff member or volunteer has completed the required training. MH&BSS administrative staff will complete a monthly

audit to ensure each staff member or volunteer has completed the TMS training. MH&BSS will revoke ARC Personal Identity Verification (PIV) card access for those who have not completed the training so they cannot access the ARC unit without completing the required training. Access will be restored when training is complete. MH&BSS administrative staff will monitor with a goal of 95% compliance over 6 months.

Recommendation 7

The Facility Director directs inpatient unit staff, volunteers, 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: September 2026

Director's Comments

Concur. Quality Patient Safety Service communicated the required TMS training for providers who enter the ARC to appropriate service chiefs on October 16, 2025. ARC nursing will update the ARC sign-in sheet to inquire if the staff member or volunteer has completed the required training. MH&BSS administrative staff will complete a monthly audit to ensure each staff member or volunteer has completed the TMS training. MH&BSS will revoke ARC PIV card access for those who have not completed the training so they cannot access the ARC unit without completing the required training. Access will be restored when training is complete. MH&BSS administrative staff will monitor with a goal of 90% compliance over 6 months.

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