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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Ann Arbor Healthcare System in Michigan

Mental Health Inspection | **25-00732-113** | **May 19, 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 July 21, 2025, the OIG announced an inspection to address the mental health care delivered in the acute inpatient mental health unit (inpatient unit) at the Lieutenant Colonel Charles S. Kettles VA Medical Center (facility). The facility is part of the VA Ann Arbor Healthcare System in Michigan. The OIG conducted inspection activities from July 21 through August 8, 2025, and completed the on-site portion of the inspection from August 5 through 7, 2025. At the conclusion of the on-site visit, the OIG team provided the Facility Director with preliminary findings and observations from the inspection.

The OIG evaluated acute inpatient mental health care across five domains. The OIG assessed processes in each of the domains and identified successes and challenges that affected the quality of care provided on the inpatient unit. Fourteen recommendations were issued to Veterans Integrated Service Network and 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	The OIG looked at reporting channels, committee structures, staffing practices, and oversight and monitoring provided by leaders. The OIG found that the Mental Health Executive Council did not include the veteran representation required by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*.[2] The OIG found inconsistencies in the number of available inpatient unit beds as reported in facility data and by leaders at various facility and Veterans Integrated Service Network levels.

[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
Recovery-Oriented Principles 	To assess the inpatient unit's integration of recovery-oriented principles, the OIG examined aspects of leadership, treatment planning, interdisciplinary programming, and the care environment. Inpatient unit staff provided veterans with at least four daily hours of recovery-oriented, interdisciplinary programming on weekdays but did not meet the four-hour daily weekend requirement under VHA Directive 1160.06, *Inpatient Mental Health Services*.
Clinical Care Coordination 	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. Facility policy outlined written processes for involuntary hospitalization but did not address VHA Directive 1160.06 expectations to monitor and track compliance with relevant state laws.[3] Staff also did not document veterans' legal commitment statuses in the required note template. Staff did not consistently follow VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures* requirements to document medication risks and benefits discussions.[4] Some discharge summaries were not completed within two business days of discharge.[5] Discharge instructions included follow-up mental health appointments; however, appointment information was not in easy-to-understand language.
Suicide Prevention 	To evaluate suicide prevention activities on the inpatient unit, the OIG reviewed compliance with required suicide risk screening and evaluation, safety planning, and training. Staff did not consistently complete the Columbia-Suicide Severity Rating Scale, a suicide risk screening and evaluation tool, within 24 hours before discharge as indicated in VA's suicide risk identification strategy.[6] Although most inpatient unit clinical staff completed Skills Training for Evaluation and Management of Suicide, not all nonclinical staff completed VA S.A.V.E. (Signs of suicide,

[3] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, amended to VHA Directive 1160.06(1) on December 27, 2024. The amended directive added the word "applicable" to the requirement that "each VA medical facility must develop clear guidelines for involuntary hospitalization in accordance with applicable state and local civil commitment laws"; VA Ann Arbor Healthcare System Policy 116-03, "Involuntary Hospitalization/Treatment of Patients with Mental Illness/Disorder," November 25, 2024.

[4] VHA Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, was amended on January 12, 2024, and February 22, 2024; VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, amended May 1, 2024. The directives contain similar language related to medication risks and benefits discussions.

[5] 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*, February 13, 2025. Unless otherwise specified, the program guides contain similar language related to documentation requirements.

[6] 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. Unless otherwise specified, all three versions contain the same or similar language related to suicide risk screening processes on the inpatient unit.

Domain	OIG Summary
	Asking about suicide, Validating feelings, and Encouraging help and expediting treatment) training required by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*.[7]
Safety	The OIG evaluated aspects of safety, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. Although staff conducted safety inspections, the OIG could not confirm if the facility had a formalized interdisciplinary safety inspection team as required by VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*. Additionally, not all inpatient unit staff completed annual Mental Health Environment of Care Checklist training.[8]

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans (see appendixes D and E). Based on information provided, the OIG considers recommendation 10 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

The Facility Director reported inviting a veteran representative to the Mental Health Executive Council. Additionally, the Facility Director committed to formalizing written processes for tracking compliance with involuntary commitment laws to prevent the illegal hospitalization of veterans and ensuring staff implement Mental Health Environment of Care Checklist standards on the inpatient unit. Facility leaders also described plans for recovery-oriented, interdisciplinary weekend programming, discharge instructions in easy-to-understand language, and staff completion of required safety training.

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[7] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Local Monitoring and Compliance of Mandatory Suicide Prevention Training," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., December 18, 2023.

[8] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, rescinded/replaced by VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. The policies contain similar training requirement language. VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, updated December 2022.

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Abbreviations

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 July 21, 2025, the OIG announced an inspection to evaluate acute inpatient mental health care provided at the Lieutenant Colonel Charles S. Kettles VA Medical Center (facility), part of the VA Ann Arbor Healthcare System in Michigan.[2] The OIG conducted inspection activities from July 21 through August 8, 2025, and completed the on-site portion of the inspection from August 5 through 7, 2025. At the conclusion of the on-site visit, the OIG team provided the Facility Director with preliminary findings and observations from the inspection.

VHA's "mental health services are organized across a continuum of care" and "in a team-based, interprofessional, patient-centered, recovery-oriented structure" (see figure 1).[3] Under VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, VHA healthcare system leaders are expected to ensure all veterans who are eligible for care have access to recovery-oriented inpatient, residential, and outpatient mental health programs.[4]

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

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

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

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

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

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

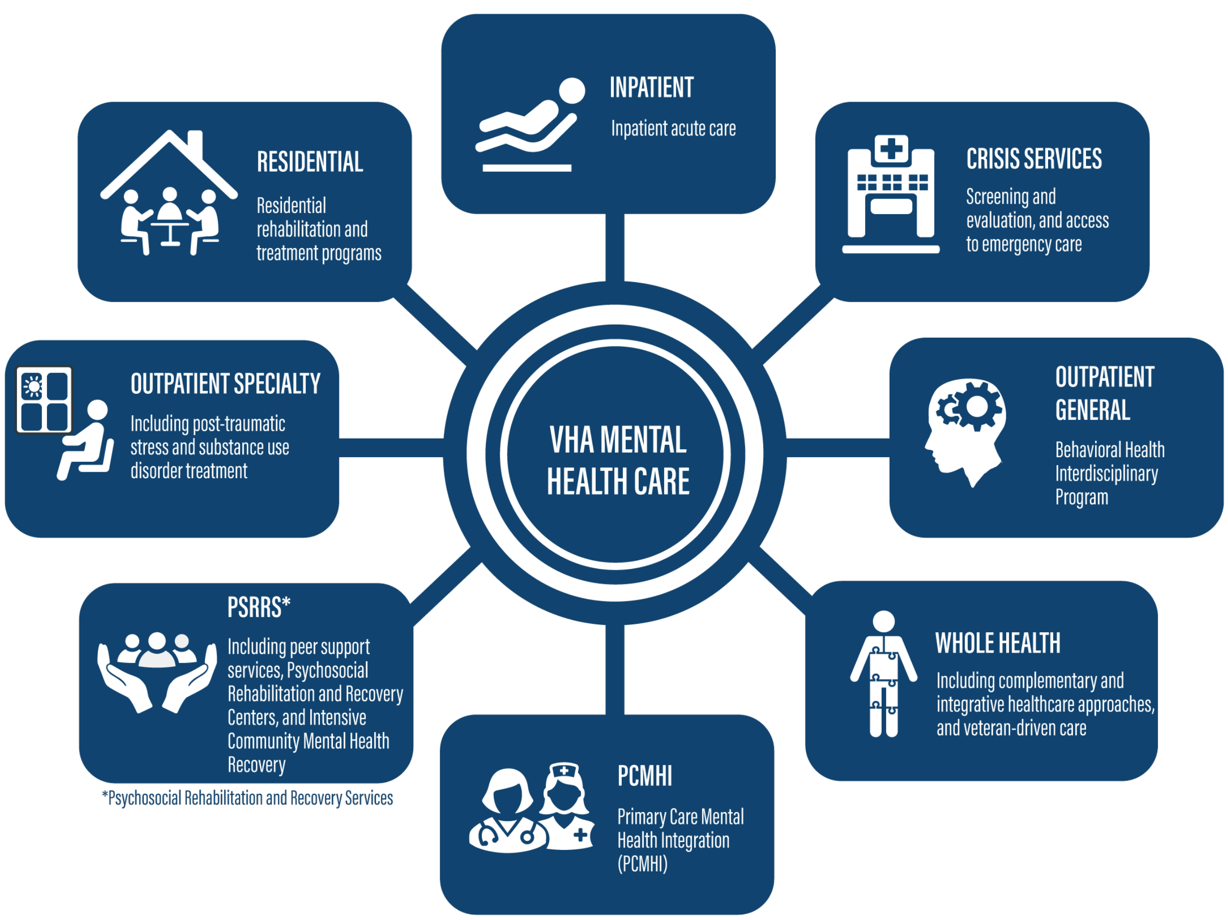

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, August 13, 2019, amended to VHA Directive 1163(1) on March 7, 2025. This directive was rescinded and replaced with VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, on August 14, 2025. For 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*, inpatient mental health services are considered the most intensive level of mental health care used to treat veterans safely and effectively during periods of acute mental distress.[6] In fiscal year 2024, VHA healthcare systems delivered inpatient mental health care for 64,298 veteran stays.[7]

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[6] 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.

[7] VHA identifies a "patient stay" as a distinct instance of a veteran staying on a specific unit for a defined time frame. "ADT Using NUMA," VHA Support Service Center, accessed January 14, 2026, http://vharamp.vssc.med.va.gov/VSSCSearch/Pages/results.aspx?k=ADT%20using%20NUMA. (This site is not publicly accessible.); The fiscal year for the federal government is a 12-month period from October 1 through September 30 and is identified by the calendar year in which it concludes. 49 C.F.R. § 1511.3 (2003).

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

About VA Ann Arbor Healthcare System

VA Ann Arbor Healthcare System, part of Veterans Integrated Service Network (VISN) 10, provides acute inpatient mental health care at the facility and operates nine community-based outpatient clinics in Adrian, Flint, Ann Arbor, Howell, Michigan Center, and Canton, Michigan; and Toledo, Ohio.[9]

In fiscal year 2024, VA Ann Arbor Healthcare System provided health care to 74,737 veterans; 15,105 received outpatient mental health care. Inpatient mental health unit (inpatient unit) staff cared for 320 veterans, and the facility maintained an average daily census of 11 on the inpatient unit. Staff submitted one consult for inpatient mental health care in the community during the fiscal year.[10] At the time of inspection, facility data indicated the inpatient unit had 13 operating mental health beds (discussed further in Access to Care).[11]

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

[9] VHA Directive 1217(1), *VHA Operating Units*, August 14, 2024, amended January 19, 2025; 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; "Locations," VA, accessed August 15, 2025, https://www.va.gov/ann-arbor-health-care/locations/; "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.

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

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

Leadership and Organizational Culture

"Leaders usually impose structure, systems, and processes [on an organization], which, if successful, become shared parts of the culture. And once processes have become taken for granted, they become the elements of the culture that may be the hardest to change."[12] 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.[13]

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

Leadership Structure

At the time of the OIG's inspection, the VA Ann Arbor Healthcare System executive leadership team included the Facility Director, Chief of Staff, and Associate Director for Patient Care Services.[14] VHA Directive 1160.01 requires facilities to have a mental health lead. The Chief of Mental Health served as the mental health lead and was responsible for all mental health programs, including the inpatient unit.[15]

According to the Chief of Mental Health, service line leaders provided oversight through a layered structure that included the Associate Chief of Operations, the Acute Care Section Chief, and the inpatient medical director. The Chief of Mental Health reported supporting the Acute Care Section Chief and the inpatient medical director through regular meetings in which pertinent information was shared. However, despite the facility's multiple leadership levels, including four mental health service managers below the Chief of Staff, the OIG found gaps in oversight that may have contributed to noncompliance with several VHA requirements. This is discussed in further detail below under Inpatient Unit Operations and also in the Safety domain.

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

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

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

[15] VHA Directive 1160.01.

The facility had an established local mental health executive council.[16] The Mental Health Executive Council was chaired by the Chief of Mental Health and included membership representation from inpatient unit staff, a local recovery coordinator, and a suicide prevention coordinator.[17] 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 inpatient unit improvements.[18]

Inpatient Unit Operations

The inpatient medical director served as the inpatient mental health program manager, a role required under VHA Directive 1160.06.[19] The inpatient medical director oversaw inpatient unit operations but did not formally supervise unit staff (see appendix C for additional information on current staffing levels). The Associate Director for Patient Care Services acknowledged challenges with turnover among nursing leadership and staff, noting the nurse manager position had been occupied by four different individuals over the prior three years. At the time of the inspection, the inpatient unit nurse manager reported being in the role for approximately four months.[20]

The OIG found discrepancies between perceptions of staffing needs for the inpatient unit among executive and inpatient unit leaders, as well as the Chief of Mental Health. The Associate Director for Patient Care Services stated the inpatient unit was sufficiently staffed and the Chief of Mental Health reported vacancies had not affected inpatient unit operations. However, the nurse manager shared concerns about nursing assistant staffing and the increased use of overtime to support unit operations.

Correspondingly, the OIG found inconsistencies in the number of available inpatient unit beds as reported in facility data and by leaders at various facility and VISN levels. A formal bed change request through the VISN in August 2023 identified 13 operating beds and 5 unavailable beds due to construction to renovate the unit (see Physical Environment for further details).[21] At the time of the inspection, mental health leaders identified 15 available beds for veterans. However, inpatient unit leaders stated that, due to staffing challenges and safety concerns, they had capped the number of available beds at 12 for the previous seven months.

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[16] VHA Directive 1160.01.

[17] VHA Directive 1160.01; The OIG reviewed meeting minutes from October 1, 2023, through September 30, 2024.

[18] VHA Directive 1160.01.

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

[20] The inpatient unit nurse manager worked as a staff nurse on the inpatient unit for several years prior to stepping into the nurse manager position.

[21] Facility data is aggregated by the VISN. Facility leaders are expected to submit a formal request to the VISN to change the number of available beds. VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010.

The acting VISN Director reported a need to improve monitoring and tracking of bed availability and provided the OIG with an updated accurate bed change request during the on-site inspection.[22] Ongoing oversight and accurate bed reporting ensures operational efficiencies and is particularly important considering this facility's current construction status and staffing levels.

Mental health leaders reported collecting inpatient unit providers' input through meetings, whiteboards, and performance improvement projects identified by the inpatient team in collaboration with the Associate Chief of Quality. Mental health leaders stated staff solicited input from veterans who have used mental health services through a patient experience survey and informal collaboration on the unit.[23]

Recommendations

1. The Facility Director ensures the Mental Health Executive Council includes veteran representation.
2. The Veterans Integrated Service Network Director provides oversight and monitoring of bed utilization.

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

[22] The VISN Director is responsible for ensuring that reporting of bed availability is "current, complete, and accurate." VHA Directive 1002, *Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities*, November 28, 2017.

[23] VHA Directive 1160.01; The Joint Commission, *Standards Manual e-dition*, PI.04.01.01, August 2024. "The hospital uses improvement tools or methodologies to improve its performance."

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent value."[24] 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.[25]

The OIG examined aspects of leadership, programming, and the physical care environment to evaluate the facility's integration of recovery-oriented principles on the inpatient unit.[26]

Leadership

Facility leaders met requirements under VHA Directive 1163(1), *Psychosocial Rehabilitation and Recovery Services* to have a full-time local recovery coordinator and a local plan across the mental health continuum for continued transformation to recovery-oriented services.[27] Mental health leaders established a standard operating procedure (SOP) for "education, staff training and implementation of recovery-oriented care" on the inpatient unit, as required by VHA Directive 1160.06.[28]

The local recovery coordinator reported having responsibilities within and beyond the inpatient unit. Additionally, the local recovery coordinator discussed the use of a recovery-oriented acute inpatient assessment tool that included an observation of the physical environment, evaluation of the setting, and input obtained from veterans and unit staff. The local recovery coordinator described conducting recovery-oriented activities on the inpatient unit such as group facilitation, staff consultation, and review of veteran surveys.

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[24] "SAMHSA's Working Definition of Recovery," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, accessed January 20, 2026, https://library.samhsa.gov/sites/default/files/pep12-recdef.pdf.

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

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

[27] VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019, amended to VHA Directive 1163(1) on March 7, 2025. 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; The local recovery coordinator assumed the role approximately six months prior to the inspection.

[28] VHA Directive 1160.06; VHA Directive 1160.06(1); VA Ann Harbor Healthcare System SOP 116-019, "Recovery-Oriented Care Provision in the Acute Inpatient Mental Health Unit (AIMH)," April 2, 2025.

Recovery-Oriented Programming

Inpatient unit staff offered at least four daily hours of recovery-oriented programming on weekdays but lacked the four-hour daily minimum on weekends required under VHA Directive 1160.06.[29] The inpatient nurse manager reported that ensuring weekend programming was a challenge. Mental health leaders stated the unit previously had a social worker for weekend coverage; however, the position was not backfilled after staff vacated the role. Insufficient programming may limit opportunities for veterans to work on recovery goals while receiving inpatient unit care.

VHA's "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06" requires inpatient unit staff to provide veterans with an orientation to the unit and recovery-oriented care, to include an "overview of the general unit services such as therapeutic programming, activities, and structure of the day."[30] The inpatient medical director reported facilitating a weekly recovery group to introduce recovery concepts on the unit. The inpatient unit programming schedule also included a weekly recovery action planning group for ongoing veteran education. The local recovery coordinator stated veterans received an orientation handbook during admission that provided education on recovery-oriented care.[31]

Physical Environment

The OIG found the newly renovated inpatient unit had a safe, hopeful, and healing environment, as outlined in the *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.[32] The spacious inpatient unit included multiple communal areas for veteran socialization, rooms available for veteran and staff use, and hallways leading to veteran bedrooms. Veteran bedrooms had windows providing natural light, furniture beyond a bed, built-in night-lights, and optional music.

The inpatient unit had decorative lighting and warm paint colors. The day room had amenities for veterans such as a television, books, and puzzles. The communal areas included recovery-oriented elements such as rocking chairs, artwork, and a fish tank (see figure 2). The inpatient medical director reported veterans had access to individual phones and the internet as needed. Additionally, the inpatient unit had two open nurses' stations and staff used a computer on wheels to dispense medications directly to veterans. Staff described future plans to enhance the

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

[30] 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.

[31] VHA SOP 1160.06.3.

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

space that included a gym and family visitation room. A portion of the unit remained under renovation, and staff reported construction was restricted to normal business hours to minimize disruption to veterans. The inpatient medical director acknowledged that veterans did not have a dedicated secure outdoor area for fresh air breaks.

The OIG frequently observed veterans sitting in communal areas with limited staff engagement, which may result in missed opportunities to engage veterans in recovery-oriented care.

Figure 2. *Day room (with natural lighting, warm paint colors, television, and activities); veterans' bedroom (with warm paint colors, red night-light, and additional furniture out of frame); nurses' station (open area with decorative lighting, warm paint colors, and artwork).*
Source: Photos of the facility's inpatient unit taken by OIG staff, August 5–6, 2025.

Recommendation

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

For a detailed action plan, 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.[33] For veterans with "complex health and social needs, care coordination is crucial for improving their access to [services], clinical outcomes, [and] care experiences."[34] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a lower level of care.[35]

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

Access to Care

Successful coordination of inpatient mental health care requires well-defined screening and admissions processes that ensure veterans are evaluated and receive clinically appropriate treatment.[36] The OIG found facility leaders established standard operating procedures for inpatient admission and transfer processes, per VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."[37]

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

[34] Denise M. Hynes et al., "Understanding Care Coordination for Veterans with Complex Care Needs: Protocol of a Multiple-Methods Study to Build Evidence for an Effectiveness and Implementation Study," *Frontiers in Health Services*, volume 3 (August 14, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

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

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

[37] 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, was replaced with 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. The SOP clarified the requirement to include procedures and processes for facility staff responsible for admission of veterans to the inpatient mental health units; VA Ann Harbor Healthcare System SOP 11A-0907, "Admission Process," February 1, 2024; VA Ann Arbor Healthcare System SOP 11A-0906, "Interfacility Transfer-Out," May 1, 2024.

Involuntary Hospitalization and Treatment

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."[38]

Standards and procedures for civil commitment are provided by state law and vary by state.[39] VHA requires that healthcare system leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[40]

Facility policy included guidelines for involuntary hospitalization; however, leaders had not established the written processes required by VHA Directive 1160.06 for monitoring and tracking ongoing compliance with state laws.[41]

The inpatient medical director described informal processes such as treatment team meetings and use of a whiteboard in the nurses' station to monitor and track veterans' legal (voluntary or involuntary) commitment statuses. The absence of written processes to monitor commitment status may result in staff confusion and potentially contribute to the illegal hospitalization of veterans.

VHA's policy "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," requires that a registered nurse conducts and records a review of documents required for admission, including voluntary or involuntary legal commitment status, prior to a veteran's arrival on the inpatient unit. Inpatient unit staff did not use the required note template to document legal commitment statuses in reviewed electronic health records.[42] The inpatient unit nurse manager reported the admission note template was not used as it duplicated other nursing documentation. Use of the required admission note template provides a centralized location for staff to access information for critical decision making.

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

[39] "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.

[40] VHA Directive 1160.01.

[41] VHA Directive 1160.06; VHA Directive 1160.06(1). The amended directive added the word "applicable" to the requirement that "each VA medical facility must develop clear guidelines for involuntary hospitalization in accordance with applicable state and local civil commitment laws"; VA Ann Arbor Healthcare System policy 116-03, "Involuntary Hospitalization/Treatment of Patients with Mental Illness/Disorder," November 25, 2024.

[42] VHA Office of Nursing Services, VHA-ONS-NUR-22-01, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," revised April 5, 2023, November 2, 2023, and September 10, 2024. All three versions were in effect during the health record 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 unit treatment planning process that included recovery-oriented elements such as veterans' involvement in setting their own goals.[43] The Chief of Mental Health reported that quality management staff regularly reviewed treatment plans to oversee the quality of treatment planning. Mental health leaders and staff also shared that the interdisciplinary treatment team routinely met to implement and review treatment plans in collaboration with veterans and outpatient providers.[44]

Medication Treatment

The OIG found only 20 percent of reviewed health records included documentation of informed consent discussions between prescribers and veterans on the risks and benefits of medication treatment. These discussions are specified by VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.[45] When providers do not communicate the risks and benefits of medication use, veterans may be deprived of the information needed to make informed decisions on treatment options.

Discharge Planning

Facility leaders established written guidance on processes for care coordination when veterans are discharged from the inpatient unit. The guidance outlined processes for discharge coordination that involved the veteran, the interdisciplinary treatment team, mental health treatment coordinators, and relevant outpatient providers.[46] Inpatient unit staff provided an

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[43] VHA Directive 1160.01; VA Ann Arbor Healthcare System SOP 116-019, "Recovery-Oriented Care Provision in the Acute Inpatient Mental Health Unit (AIMH)," April 2, 2025.

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

[45] VHA Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, was amended on January 12, 2024, and February 22, 2024; VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, amended May 1, 2024. The directives contain similar language related to medication risks and benefits discussion; VHA Directive 1108.07(1), *General Pharmacy Service Requirements*, November 28, 2022, amended October 4, 2023. VHA Directive 1108.07(1) states that a prescriber is a provider who is "authorized by law or VA policy to prescribe medications in accordance with their facility approved privileges or scope of practice"; 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 & Clinical Pharmacology*, 16th ed., ed. Todd W. Vanderah: (McGraw Hill, 2024), https://accesspharmacy.mhmedical.com/content.aspx?sectionid=281750155&bookid=3382&Resultclick=2.

[46] VHA Directive 1160.01; VA Ann Arbor Healthcare System SOP 116-019, "Recovery-Oriented Care Provision in the Acute Inpatient Mental Health Unit (AIMH)"; VA Ann Arbor Healthcare System policy 11-42, "Acute Care Discharge Planning," October 1, 2024.

example of care coordination in which mental health treatment coordinators met with veterans while on the unit prior to discharge.

All reviewed health records included discharge instructions, and most records included evidence that a copy was offered to the veteran or caregiver, as indicated in VHA "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06" (see figure 3).[47]

All reviewed records included evidence that outpatient mental health follow-up appointments were scheduled prior to discharge.[48] A discharge summary for coordination of care between providers was included in all reviewed records; however, 18 percent of discharge summaries were not completed within two business days of discharge. According to VHA's *Health Record Documentation Program Guide*, discharge summaries must be available to providers within two business days of the veteran's release to support a seamless transition to post-discharge care.[49]

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[47] VHA SOP 1160.06.2, September 29, 2023; VHA SOP 1160.06.2, December 19, 2024; Unless otherwise specified, the SOPs contain similar language related to documentation requirements.

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

[49] 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*, February 13, 2025. Unless otherwise specified, the program guides contain similar language related to documentation requirements.

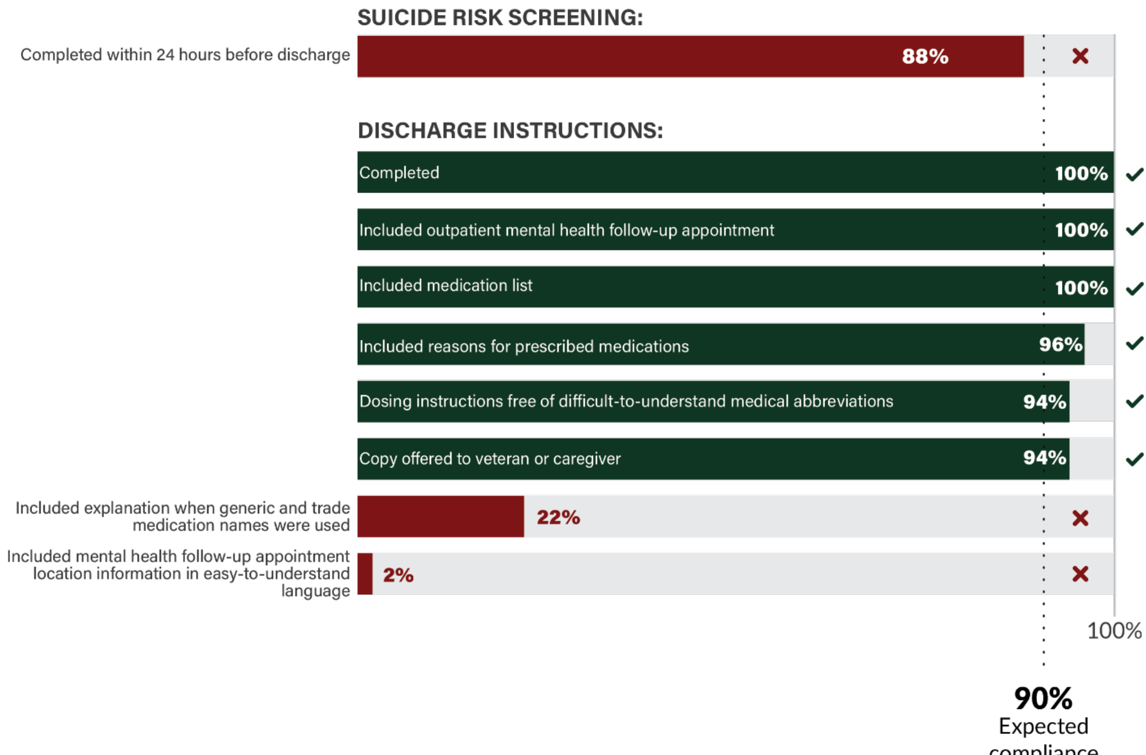

Figure 3. *Discharge-related screening and documentation.*
Source: OIG review of inpatient unit electronic health records.
Note: Based on analysis of 50 records. Suicide risk screening discussed in Suicide Prevention (below). Of the veterans who received the earliest mental health follow-up appointment, only 2 percent of the discharge instructions were in easy-to-understand language.

Staff did not consistently document veterans' follow-up appointment locations in easy-to-understand language.[50] Discharge instructions with abbreviated location information may create barriers for veterans to attend follow-up appointments and receive timely mental health care (see figure 4).

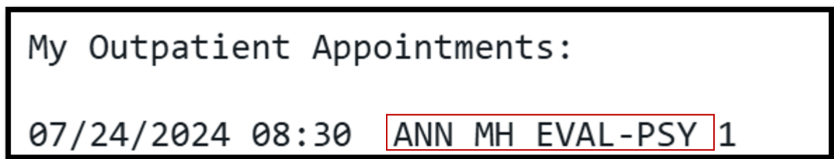

Figure 4. *Example from discharge instructions with abbreviated appointment location information outlined in red.*
Source: OIG review of veterans' electronic health records.
Note: Per the Chief of Mental Health, ANN refers to Ann Arbor, MH refers to Mental Health, EVAL refers to evaluation, and PSY refers to the provider's credential.

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

All reviewed health records included documentation that a medication list was provided at discharge, and most records included the reasons for prescribed medications.[51] However, many discharge instructions contained both trade and generic names of medications with no explanation that the medications were the same (see figure 5).[52] Accurate and easy-to-understand discharge instructions could prevent medication errors at home following hospitalization.

A

```
Things to discuss with my mental health providers:
1. Schizophrenia
- Please continue taking risperidone 3 mg at night, Ativan 0.5 mg three times a
day, and Cogentin 0.5 mg once a day.
```

B

```
                              New Medications:
---------------------------------------------------------------------------

BENZTROPINE MESYLATE 0.5MG TAB
   Take one tablet by mouth once daily for drug-induced extrapyramidal
   symptoms
   Usually Taken for: Neurologic/Mood

CYANOCOBALAMIN 1000MCG TAB
   Take one tablet by mouth once daily for vitamin b-12 supplement
   Usually Taken for: Supplement

LORAZEPAM 0.5MG TAB
   Take one tablet by mouth three times a day for catatonia
   Usually Taken for: Mood
```

Figure 5. *Example of generic and name brand medications listed in different areas of the same discharge instructions that outline next steps for veterans. A describes central nervous system medications using the brand names (outlined in red). B describes the same medications using the generic names (outlined in red).*
Source: OIG review of veterans' electronic health records.
Note: Ativan is the brand name of Lorazepam and Cogentin is the brand name of Benztropine.

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 staff use the required admission note template to document legal commitment status.

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

[52] VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2;* VHA Health Information Management, *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*, 2nd ed. (McGraw Hill Education, 2016), https://accesspharmacy.mhmedical.com/content.aspx?bookid=1810§ionid=124489535.

6. The Chief of Staff ensures documentation of discussions between prescribers and veterans on the risks and benefits of newly prescribed central nervous system medications.
7. The Chief of Staff ensures discharge summaries are completed within two business days of discharge.
8. The Chief of Staff ensures discharge instructions for veterans include appointment locations written in easy-to-understand language.
9. The Chief of Staff ensures discharge instructions for veterans include an explanation when both trade and generic names are used for the same medication.

For detailed action plans, see appendix E.

Suicide Prevention

The underlying causes of death by suicide can be complex and multifactorial. Preventing suicide may require coordinated systems, services, and resources to effectively support at-risk veterans.[53]

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."[54] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[55]

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 and document the Columbia-Suicide Severity Rating Scale (suicide risk screening) for all veterans within 24 hours prior to discharge from inpatient mental health units. Inpatient clinical staff completed suicide risk screenings within the required time frame in 88 percent of reviewed electronic health records.[56] If staff do not complete suicide risk assessment within the required time frame, they may be unaware of the veteran's suicide risk and have an insufficient understanding of discharge readiness and post-discharge care coordination needs.

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

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

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

[56] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," updated May 10, 2023, February 25, 2025, and October 30, 2025. Unless otherwise specified, all three versions contain the same or similar language related to suicide risk screening processes on the inpatient unit; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (RISK ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director, et al., November 23, 2022, was rescinded and replaced by "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum on January 7, 2025. While VHA requires staff to complete Columbia-Suicide Severity Rating Scales within 24 hours before discharge, the OIG also considered risk screenings compliant if completed on the day of discharge; The OIG used 90 percent as the expected level of compliance for health record reviews.

Safety Planning

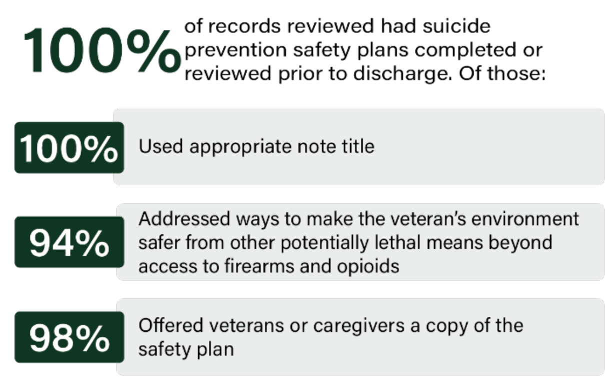

Figure 6. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' electronic health records.

All reviewed electronic health records reflected that staff completed or reviewed suicide prevention safety plans using the standardized safety planning note title required under VA's memorandum "For Action: Update to Use of National Standardized Suicide Prevention Safety Plan Progress Notes."[57] Most reviewed safety plans had documentation that staff provided a copy of the safety plan to veterans or caregivers.[58]

Most reviewed safety plans addressed ways to make the environment safer from other potentially lethal means beyond firearms and opioids, as specified in the *VA Safety Planning Intervention Manual* (see figure 6).[59] When providers ensure all elements of the safety plan are addressed, including discussion of other lethal means, veterans are better equipped to recognize potential risks and identify preventative actions.

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) training help clinicians and nonclinical staff, respectively, identify the warning signs

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

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

of suicide risk and appropriate interventions.[60] The acronym "S.A.V.E" summarizes the steps needed to recognize and respond to a veteran in suicidal crisis: "spot the signs" of suicidal thinking, ask questions, validate the person's experience, encourage treatment and expedite getting help.[61] Most inpatient clinical staff completed STEMS training; however, not all inpatient nonclinical staff completed the VA S.A.V.E training requirements outlined in VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training* (see figure 7).[62] When staff do not complete suicide prevention training, they may not be able to identify signs of suicidality and may lack awareness of resources and interventions to keep veterans safe.

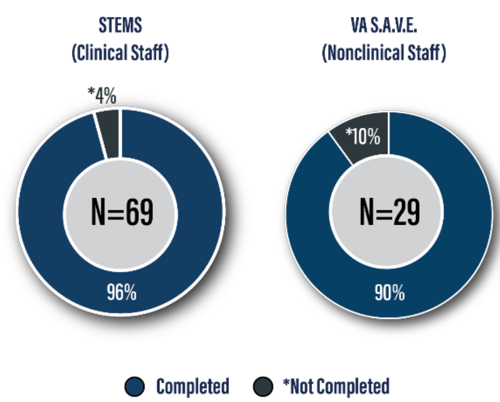

Figure 7. *Inpatient unit staff completion of mandatory suicide prevention training.*
Source: OIG document review of clinical and nonclinical staff training certificates.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. training from July 21, 2024, through July 21, 2025. VHA established a "target for compliance" of 95 percent threshold for mandatory suicide prevention training completion.

Recommendations

10. The Chief of Staff directs staff to complete and document the Columbia-Suicide Severity Rating Scale within 24 hours before veterans' discharge.
11. The Facility Director directs nonclinical staff to complete VA S.A.V.E. training requirements.

For detailed action plans, see appendix E.

[60] 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.

[61] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Local Monitoring and Compliance of Mandatory Suicide Prevention Training," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., December 18, 2023.

[62] VHA Directive 1071(1).

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 is comprised of both mental health and other facility staff. The team is responsible for conducting environment of care inspections using the Mental Health Environment of Care Checklist, as stated in VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*.[65] The National Center for Patient Safety continually updates the checklist "based on reports from the field of hazards or adverse events encountered at the local level."[66] Interdisciplinary safety inspection team 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]

Although staff completed the biannual environment of care inspections, the OIG could not determine whether the facility had a formalized interdisciplinary safety inspection team.[68] The facility did not have an inspection team lead and meeting minutes or summaries were not recorded, as required.[69] Additionally, the Facility Director reported being unfamiliar with the requirement for an interdisciplinary safety inspection team. Executive leaders are responsible for providing oversight and ensuring requirements are met.

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[63] 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, was rescinded and replaced with VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. Unless otherwise specified, the two directives contain the same or similar language related to the inpatient mental health environment and inspections.

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

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

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

In a physical inspection of the unit, the OIG found compliance with all OIG randomized safety elements. Although the OIG observed that the sally port doors were not synchronized, as required by the Mental Health Environment of Care Checklist, the facility did have a mitigation plan in place which included posted signage alerting staff to this deficiency.[70] A "Sally Port is the space between two locked doors that must be traversed to enter the unit. When entering the unit, the first door is unlocked to enter the Sally Port and the second door remains closed and locked."[71]

Training

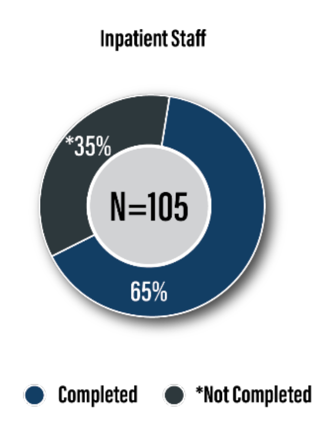

Figure 8. *Mental Health Environment of Care Checklist training completion.*
Source: OIG document review of training certificates for inpatient unit staff.
Note: The OIG evaluated completion of the training from July 21, 2024, through July 21, 2025. The OIG used 90 percent as the expected level of compliance.

VHA requires staff training on environmental hazards and orientation to the "content and proper use of the Mental Health Environment of Care Checklist."[72] Not all inpatient unit staff completed the annual training requirement (see figure 8).[73] Additionally, the OIG could not confirm which staff responsible for conducting the biannual environment of care inspections had completed the required training due to a lack of documentation. Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.

Recommendations

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

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[70] "Mental Health Environment of Care Checklist for Mental Health and Emergency Rooms," VHA National Center for Patient Safety, September 18, 2024.

[71] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety.

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

[73] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, updated December 2022.

13. The Facility Director implements processes to ensure the Interdisciplinary Safety Inspection Team applies Mental Health Environment of Care Checklist standards on the inpatient mental health unit.
14. The Facility Director directs inpatient unit staff and Interdisciplinary Safety Inspection Team members to complete Mental Health Environment of Care Checklist training requirements.

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 identified gaps in facility leaders' oversight that may have contributed to noncompliance with several VHA requirements, including having a veteran representative participate in the Mental Health Executive Council. The OIG found discrepancies between perceptions of inpatient unit staffing needs among leaders at various levels. Correspondingly, the OIG identified inconsistencies in the number of operating inpatient mental health beds reported in facility data and by mental health leaders. VISN leaders did not ensure facility leaders accurately reported the number of available beds.

Facility policy included guidelines for involuntary hospitalization; however, facility leaders did not have formal processes to ensure compliance with state laws. Additionally, staff did not document veterans' legal commitment statuses in the required admission note template.

Facility leaders had a plan for continued transformation to recovery-oriented services and processes for the "education, staff training, and implementation of recovery-oriented care" on the inpatient unit. Staff offered veterans the required amount of interdisciplinary programming on weekdays but did not have the four-hour daily minimum programming on weekends.

Veterans who received inpatient mental health treatment at the facility experienced a physical environment that incorporated decorative lighting, warm paint colors, and artwork. Additionally, the unit had multiple communal areas for socialization, which included rocking chairs. However, the OIG observed that the unit's sally port doors were not synchronized, as required.

Not all nonclinical staff completed required VA S.A.V.E. training, and not all inpatient unit staff completed environmental safety hazards training. Additionally, some electronic health records did not include evidence of timely suicide risk screening. All reviewed records included the required discharge summary; however, some discharge summaries were not completed within two business days of discharge. Veterans were typically offered discharge instructions that were

difficult to understand and lacked important details for appointment follow-up and medication management.

Although staff conducted biannual environment of care inspections, the OIG could not determine whether the facility had a formalized interdisciplinary safety inspection team.

The OIG issued 14 recommendations to the Veterans Integrated Service Network Director, Facility Director, Chief of Staff, and Chief of Mental Health. These recommendations may improve the quality and delivery of veteran-centered, recovery-oriented care on the inpatient mental health unit and beyond. The OIG closed recommendation 10 based on the information provided. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

The Facility Director reported inviting a veteran representative to the Mental Health Executive Council. Additionally, the Facility Director committed to formalizing written processes for tracking compliance with involuntary commitment laws to prevent the illegal hospitalization of veterans and ensuring staff implement Mental Health Environment of Care Checklist standards on the inpatient unit. Facility leaders also described plans for recovery-oriented, interdisciplinary weekend programming, discharge instructions in easy-to-understand language, and staff completion of required safety trainings.

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 healthcare system, 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 healthcare system 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 VHA healthcare system 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 healthcare system mental health executive council, which ensures staff provide high-quality care and are responsive to veterans' preferences.[78] Each mental health executive council must include "at least one Veteran, and ideally one who is receiving mental health services" and not employed at the local

[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.

healthcare system.[79] The council is required to meet quarterly and "record minutes that are accessible to all mental health clinical staff."[80]

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."[81] 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."[82]

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.[83] "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."[84]

Recovery-Oriented Principles

The President's *New Freedom Commission on Mental Health* report outlined a vision for the delivery of recovery-oriented mental health care.[85] 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."[86]

LRCs are considered collaborative mental health leaders who ensure recovery-oriented principles are integrated into care delivery. The role is primarily non-clinical in nature, which allows most of their time dedicated to activities such as training, consultation, and education.[87] To support

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[79] VHA Directive 1160.01.

[80] VHA Directive 1160.01.

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

[82] "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.)

[83] VHA Directive 1163(1). Peer support staff may also be referred to as peer specialists.

[84] VHA Directive 1163(1).

[85] "Achieving the Promise: Transforming Mental Health Care in America," President's New Freedom Commission on Mental Health, accessed September 15, 2025, https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm; "Achieving the Promise: Transforming Mental Health Care in America," President's New Freedom Commission on Mental Health, accessed June 11, 2024, https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/InsideCover.htm.

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

[87] VHA Directive 1163(1).

veterans' recovery, VHA requires healthcare systems to have a plan across the mental health care continuum for continued transformation and implementation of recovery-oriented services.[88] Additionally, VHA requires the local recovery coordinator, in collaboration with the inpatient mental health program manager, to establish a standard operating procedure (SOP) that includes processes for staff training, education, and implementation of recovery-oriented services on the inpatient unit.[89]

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit.[90] The healthcare system 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.[91] 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."[92]

VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care and, therefore, requires healthcare systems to create a hopeful and healing environment while maintaining safety.[93] For VA medical facilities with a Mental Health Environment of Care Checklist-compliant secure outdoor space, daily programming should include dedicated time for veterans to be outdoors.[94]

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.[95] VHA requires inpatient units to have an interdisciplinary treatment team composed of individuals who are responsible for the veteran's care. An interdisciplinary approach is critical to ensure comprehensive, coordinated, and holistic care.[96]

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[88] VHA Directive 1163(1).

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

[90] VHA Directive 1160.06; VHA Directive 1160.06(1); VHA Directive 1163(1); VHA Directive 1160.01.

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

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

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

[94] VHA Directive 1160.06; VHA Directive 1160.06(1). For VA medical facilities with a Mental Health Environment of Care Checklist-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."

[95] 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."

[96] VHA Directive 1160.06.

VHA SOP 1160.06.2 recommends healthcare system leaders have SOPs outlining admission processes, and VHA Directive 1160.06(1) requires healthcare systems to provide access to mental health treatment for veterans who are either voluntarily or involuntarily held on an inpatient unit.[97] When treatment is not available within the healthcare system, staff may transfer the veteran to another VHA or non-VHA system for inpatient mental health care.[98]

There are no federal civil commitment laws; therefore, VHA healthcare system leaders are required to have clear guidelines that align with state and local laws for civil commitment.[99] 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.[100]

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.[101]

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.[102]

Per VHA requirement, 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 business rules indicates that patient friendly names must be "desensitized without any abbreviations or acronyms."[103]

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.[104] Suicide risk is elevated after a suicide attempt, including the period following discharge from an inpatient psychiatric setting.[105] Therefore, there is a critical need for

[97] 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).

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

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

[100] 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)."

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

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

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

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

[105] 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.[106]

Inpatient unit clinical staff are to complete the Columbia-Suicide Severity Rating Scale (suicide risk screening), a risk assessment tool, for veterans within 24 hours prior to discharge, as required by VA's suicide risk identification strategy.[107] According to VHA's memorandum "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," a positive suicide risk screening then requires completion of the Comprehensive Suicide Risk Evaluation within 24 hours.[108] Staff may complete the risk evaluation in lieu of the suicide risk screening prior to discharge.[109]

When veterans are determined to be at risk for suicide, providers are expected to engage them in safety planning.[110] 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."[111]

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."[112] 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.[113]

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

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[106] 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.

[107] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting."

[108] 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.

[109] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Frequently Asked Questions (FAQ)," updated December 13, 2022; VA, "Office of Suicide Prevention Suicide Risk Identification (Risk ID) Strategy: Frequently Asked Questions (FAQ)," updated January 12, 2026. Unless otherwise specified, both versions contain the same or similar language related to suicide risk screening processes on the inpatient unit.

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

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

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

[113] 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."[114]

VHA Directive 1071(1) requires healthcare providers complete Skills Training for Evaluation and Management of Suicide (STEMS) and nonclinical staff complete VA S.A.V.E. (Skills Training for Evaluation and Management of Suicide) training annually.[115] VHA issued a memorandum indicating a target of at least 95 percent completion for mandatory suicide prevention trainings.[116]

Safety

In VHA healthcare systems, inpatient mental health units must be designed to ensure veteran safety while still integrating recovery-oriented principles into the environment.[117] Interdisciplinary safety inspection team members and all inpatient unit staff are responsible for ensuring a safe environment.[118] Additionally, an inspection team is required to assess the inpatient unit twice annually for suicide hazards using the Mental Health Environment of Care Checklist and the patient safety manager or other designated mental health staff track corrective actions taken for identified environmental risks.[119]

An interdisciplinary safety inspection team is a mandatory subcommittee of the healthcare system environment of care committee, with team membership documented as part of the inspection rounds summary. According to VHA Directive 1167, the inspection team 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."[120]

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

[115] VHA Directive 1071(1).

[116] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Local Monitoring and Compliance of Mandatory Suicide Prevention Training," December 18, 2023.

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

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

[119] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024; VHA Directive 1160.06. The Mental Health Environment of Care Checklist 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."

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

Appendix B: Methodology

The Mental Health Inspection Program inspections focused on the quality of care provided by VHA's inpatient mental health services.[121] The OIG randomly selected the VHA healthcare systems included in fiscal year 2025 reviews from all systems with inpatient mental health beds.[122]

The OIG conducted a virtual and on-site review at the facility from July 21 through August 7, 2025. The OIG did not receive any complaints beyond the scope of this review that required referral to the OIG hotline.

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

The OIG reviewed select staff's certificates for annual completion of STEMS, VA S.A.V.E, and Mental Health Environment of Care Checklist trainings.[123] Except for a 95 percent threshold for mandatory suicide prevention training completion, the OIG used 90 percent as the expected level of compliance for record review.

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

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[124] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The Office of Healthcare Inspections teams do not use AI as the principal basis for decision-making or

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

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

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

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

actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."[125]

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.[126] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

Electronic Health Record Review

The OIG reviewed 50 randomly selected electronic health records of veterans discharged from an acute inpatient mental health stay of more than 48 hours at the facility from October 1, 2023, through September 30, 2024.[127] The OIG used 90 percent as the expected level of compliance for record review.

OIG Inspection of the Physical Environment

The OIG inspected selected areas of the inpatient unit to evaluate if the facility provided a therapeutic, recovery-oriented environment and maintained veteran safety.[128] The OIG team visually assessed the inpatient unit environment for warm paint colors and inviting design elements such as natural lighting and artwork. The OIG also observed the unit for general cleanliness and veteran access to secure outdoor space.[129] Further, the OIG's physical inspection

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

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

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

[128] VHA Directive 1160.06. A unit is an "area in a medical facility and especially a hospital that is specially staffed and equipped to provide a particular type of care." *Merriam-Webster.com Dictionary*, "unit," accessed September 11, 2025, https://www.merriam-webster.com/dictionary/unit.

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

of areas in the inpatient unit focused on additional selected-safety elements specific to this facility.

The OIG reviewed mental health environment of care data documented in the Patient Safety Assessment Tool for inspections completed in fiscal years 2024 and 2025, and assessed corrective actions taken for deficiencies unresolved for more than six months.

Appendix C: Inpatient Unit Staffing

Table C.1. Inpatient Unit Staffing

Discipline	FTEE	Percent Dedicated Per FTEE
Chaplain	1	70
Dietitian	1	25
Nurses*	35	100
Nurse Practitioners	2	100
Nursing Assistants	24	100
Pharmacist	1	100
Psychiatrists‡	4	20–100
Occupational Therapists§	2	15–30
Social Workers	3	100

Source: OIG review of the facility's mental health inpatient unit staffing spreadsheet (received July 23, 2025).

Note: FTEE indicates full-time equivalent employee. Staff reflected in staffing table represent only those employees with >5 percent time dedicated to the inpatient unit.

Nursing staff includes a nurse manager, assistant nurse manager, and 33 registered nurses.

‡*Psychiatry staff include inpatient medical director, a full-time psychiatrist, and two on-call psychiatrists.*

§*Occupational therapy staff include an occupational therapist and an occupational therapy assistant*

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 1, 2026

From: Interim Network Director, Department of Veterans Affairs (VA) Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

Subj: VA Office of Inspector General (OIG) Report, Mental Health Inspection of the VA Ann Arbor Healthcare System in Michigan

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

1. Thank you for the opportunity to review and comment on the OIG report Mental Health Inspection of the VA Ann Arbor Healthcare System in Michigan. I have reviewed the documentation and concur with recommendation 2. Additionally, I concur with recommendations 3-14 made to the Ann Arbor Healthcare System.
2. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Jill Dietrich Mellon, JD, MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on April 2, 2026.]

VISN Director Responses

Recommendation 2

The Veterans Integrated Service Network Director provides oversight and monitoring of bed utilization.

__X _Concur

_____Nonconcur

Target date for completion: September 2026

Director's Comments

The Veterans Integrated Service Network Director oversees and monitors bed utilization. The VISN 10 Planner will provide a monthly report to the VISN Network Director for beds listed as "Out of Service" compared to the National Bed Control report to identify any discrepancies. The VISN Network Director will validate beds listed as "Out of Service." If discrepancies arise at the facility level, the Network Director will communicate to the facility to submit a bed change request for beds expected to be out of service for over 60 days. Evidence of the need for a bed change request and any necessary follow-up will be monitored monthly by the VISN through Healthcare Operations Committee's meeting minutes for two consecutive quarters with a compliance rate of 90%.

Appendix E: Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 1, 2026

From: Medical Center Director, VA Ann Arbor Healthcare System (506/00)

Subj: VA Office of Inspector General (OIG) Report, Mental Health Inspection of the VA Ann Arbor Healthcare System in Michigan

To: Interim Network Director, Department of Veterans Affairs (VA) Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. The VA Ann Arbor Healthcare System is committed to honoring Veterans by ensuring they receive high-quality health care services. I appreciate the opportunity and always look to improve the care provided by VA Lieutenant Colonel Charles S. Kettles VA Medical Center acute inpatient mental health unit.

2. I have reviewed and concur with recommendations 1 and 3-14. Recommendation 2 will be answered by the VISN 10 Network Director (ND).

3. Please find the attached response to each recommendation included in the report. The VA Ann Arbor Healthcare System completed or is in the process of completing the recommended OIG actions to strengthen the care we provide.

4.Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Ginny L. Creasman, Pharm.D., FACHE
Medical Center Director

[OIG comment: The OIG received the above memorandum from VHA on April 2, 2026.]

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: September 2026

Director's Comments

The Healthcare System Director will ensure the Mental Health Executive Council includes veteran representation. The Mental Health Executive Council identified a veteran representative in October 2025, and held a meeting on December 2, 2025, with this person in attendance. Attendance is recorded in the meeting minutes. The healthcare system will send an email invite for each meeting to the Veteran in advance. Veteran's attendance will continue to be monitored quarterly and reported to the Executive Committee of the Medical Staff, with a compliance target of 100% for two consecutive quarters.

Recommendation 3

The Chief of 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: October 2026

Director's Comments

The Chief of Mental Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming daily on the inpatient mental health unit. The plan for compliance involves 1) training the Registered nurse staff on the unit in delivery of recovery based groups to improve confidence in ability to deliver groups effectively, completed March 13, 2026; 2) bolstering the group schedule to increase the number of hours programming is offered to reduce risk of dropping below minimum programming if a group should need to be cancelled by May 31, 2026; 3) implementing a new coverage plan for staff absences, completed January 2026; 4) improving documentation to make attendance (or non-attendance) clear in the medical record, complete January 2026; and 5) conducting audits of the hours of group programming offered daily with detailed information to allow supervisors to address any patterns of non-adherence to expected offerings, started March 2026. The Chief of Mental Health will continue to monitor

recovery group hours/day until we reach 6 months of 90% or higher adherence to the minimum of 4 hours/day standard. Results will be reported quarterly to the Mental Health Executive Committee which reports to the Executive Committee of the Medical Staff.

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: July 2026

Director's Comments

The Facility Director is finalizing the standard operating procedure (SOP) to monitor and track compliance with state involuntary commitment requirements. The SOP will be submitted to the Office of General Counsel, Executive Committee of the Medical Staff, and Healthcare system director for approval by June 2026; and implemented by July 2026.

Recommendation 5

The Chief of Staff ensures staff use the required admission note template to document legal commitment status.

__X _Concur

_____Nonconcur

Target date for completion: May 2026

Director's Comments

The Chief of Staff ensured staff's use of the admission note template (VA-Approved Enterprise Standardization (VAAES) Template) to document the required legal commitment status beginning in September 2025. Chart auditing began shortly after and indicates the expected performance of 90% or higher adherence for the past 4 months. Auditing will continue until at least 6 consecutive months of 90% or higher adherence is observed. Results will be reported quarterly to the Mental Health Executive Committee which reports to the Executive Committee of the Medical Staff.

Recommendation 6

The Chief of Staff ensures documentation of discussions between prescribers and veterans on the risks and benefits of newly prescribed central nervous system medications.

__X _Concur

_____Nonconcur

Target date for completion: Request Closure (February 2026)

Director's Comments

The Chief of Staff ensured documentation of discussions between prescribers and Veterans on the risks and benefits of newly prescribed central nervous system medications and observed 90% or higher compliance for the past 6 consecutive months from October 2025 to March 2026. Documentation is attached. The healthcare system requests this recommendation be closed.

OIG's Comments

The OIG considers this recommendation open to allow the facility time for the submission of appropriate chart audit documentation to demonstrate sustained improvement.

Recommendation 7

The Chief of Staff ensures discharge summaries are completed within two business days of discharge.

__X _Concur

_____Nonconcur

Target date for completion: Request Closure (February 2026)

Director's Comments

The Chief of Staff ensured discharge summaries were completed within two business days of discharge and observed 90% or higher compliance for the past 6 consecutive months from October 2025 to March 2026. Documentation is attached. The healthcare system requests this recommendation be closed.

OIG's Comments

The OIG considers this recommendation open to allow the facility time for the submission of appropriate chart audit documentation to demonstrate sustained improvement.

Recommendation 8

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

__X _Concur

_____Nonconcur

Target date for completion: July 2026

Director's Comments

The Chief of Staff ensured discharge instructions for Veterans include appointment locations written in easy-to-understand language and observed 90% or higher compliance for the past 2 months covering January 2026 to February 2026. Audits will continue until 6 months of consecutive audits are at 90% or higher. Results will be reported quarterly to the Mental Health Executive Committee which reports to the Executive Committee of the Medical Staff.

Recommendation 9

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

__X _Concur

_____Nonconcur

Target date for completion: Request Closure (February 2026)

Director's Comments

The Chief of Staff ensured discharge instructions for Veterans include an explanation of when both trade and generic names were used for the same medication and observed 90% or higher compliance for the past 6 consecutive months from October 2025 to March 2026. Documentation is attached. The healthcare system requests this recommendation be closed.

OIG's Comments

The OIG considers this recommendation open to allow the facility time for the submission of appropriate chart audit documentation to demonstrate sustained improvement.

Recommendation 10

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

__X _Concur

_____Nonconcur

Target date for completion: Request Closure (February 2026)

Director's Comments

The Chief of Staff directed staff to complete and document the Columbia Suicide Severity Rating Scale within 24 hours before Veterans' discharge. Documentation reminders were posted for residents at their workstations about this requirement, and education was provided to 100% of the attending psychiatrists in March 2026. The healthcare system observed 90% or higher compliance for the past 6 consecutive months from September 2025 to February 2026 on the

RiskID report. Documentation is attached. The healthcare system requests this recommendation be closed.

OIG's Comments

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

Recommendation 11

The Facility Director directs nonclinical staff to complete VA S.A.V.E. training requirements.

__X _Concur

_____Nonconcur

Target date for completion: October 2026

Director's Comments

The Healthcare System Director directed nonclinical staff to complete VA S.A.V.E. training requirements. The Inpatient Nurse Manager and Acute Section Chief will conduct monthly monitoring of VA S.A.V.E. completion rates with proactive prompting before due dates for staff until a standard of 90% or higher completion rates are maintained for 6 consecutive months. Education completion is reported in the Quality and Patient Safety Committee, which reports to the Healthcare System Director; and Mental Health leadership reports quarterly to the Mental Health Executive Committee which reports to the Executive Committee of the Medical Staff.

Recommendation 12

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

__X _Concur

_____Nonconcur

Target date for completion: Request Closure (February 2026)

Director's Comments

The Healthcare System Director ensured compliance with Veterans Health Administration requirements for the Interdisciplinary Safety Inspection Team (ISIT), by assigning the ISIT team leadership to the Associate Chief of Mental Health for Quality in November 2025. The ISIT met in December 2025 and February 2026 and meeting minutes and membership attendance are attached. Additionally, a Charter has been drafted for the ISIT and is in the final stages of approval. The healthcare system requests this recommendation be closed.

OIG's Comments

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

Recommendation 13

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

__X _Concur

_____Nonconcur

Target date for completion: July 2026

Director's Comments

The Healthcare System Director implemented processes to ensure the Interdisciplinary Safety Inspection Team (ISIT) applies Mental Health Environment of Care Checklist (MHEOCC) standards on the inpatient mental health unit. This process included having the ISIT conduct the MHEOCC inspection in December 2025 and reviewing this inspection with the VISN MHEOCC Oversight Team later the same month. Inspection results are also presented at the healthcare system's Quality and Patient Safety Committee, which reports to the Healthcare System Director biannually. The attached inspection results were submitted by Patient Safety in January 2026, as required. The healthcare system will continue to monitor the use of the MHEOCC standards until two consecutive inspections have been completed.

Recommendation 14

The Facility Director directs inpatient unit staff and Interdisciplinary Safety Inspection Team members to complete Mental Health Environment of Care Checklist training requirements.

__X _Concur

_____Nonconcur

Target date for completion: October 2026

Director's Comments

The Healthcare System Director directed inpatient unit staff and members of the ISIT team to complete the MHEOCC training prior to the MHEOCC inspection in December 2025. The ISIT team was 100% compliant with training at the time of the inspection. The Inpatient Nurse Manager and Acute Section Chief will conduct monthly monitoring of MHEOCC completion rates for inpatient unit staff with proactive prompting before due dates for staff until a standard of 90% or higher completion rates are maintained for 6 consecutive months.

OIG Contact and Staff Acknowledgments

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