US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Augusta Health Care System in Georgia

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Executive Summary

The mission of the VA Office of Inspector General's (OIG's) Mental Health Inspection Program is to evaluate VA's continuum of mental healthcare services. This inspection addresses the mental health care delivered in the acute inpatient setting at the VA Augusta Health Care System (Augusta HCS) in Georgia.

The OIG evaluated acute inpatient mental health care across six topic domains, summarized below.[1] The OIG assessed processes in each of the domains, and identified successes and challenges that affected the provision of quality care on the inpatient mental health unit (inpatient unit).[2]

Domain	OIG Summary
Leadership and Organizational Culture 	Healthcare system (HCS) leaders can nurture a positive, safety-oriented culture by building effective reporting and communication structures, incorporating stakeholder feedback, and supporting continuous performance improvement. The OIG looked at reporting channels, committee structures, oversight and monitoring provided by leaders, and staffing practices. The Chief of Staff and Associate Director for Patient Care Services are the HCS executive leaders who oversee patient care and supervise service directors and program chiefs, including the Chief of Mental Health. The Chief of Mental Health oversees all mental health programs, including the inpatient unit. Nurses, social workers, and other staff on the inpatient unit are supervised by their respective discipline leads; however, the Inpatient Mental Health Medical Director coordinates the unit's operations. The Veterans Integrated Service Network (VISN) Chief Mental Health Officer reported providing oversight of and support for inpatient unit operations within the network. Although the Augusta HCS had a local Mental Health Executive Council chaired by the Chief of Mental Health that included inpatient unit staff, the council did not meet the requirement for veteran representation, which could provide critical stakeholder input. The Chief of Mental Health reported that a veteran would be included in council meetings starting February 2024. The VISN Mental Health Executive Council is responsible for monitoring quality and access across the VISN's continuum of mental health care. The OIG identified that a VISN leader was aware of low bed utilization at Augusta HCS, which could adversely affect access, but could not define underlying causes. The OIG also found a discrepancy between facility leaders' statements about capacity and documented staffing levels. At the time of the review, mental health leaders identified the ability to care for 23 veterans; however, nurse staffing levels supported a capacity to care for 12 veterans.

[1] For more information on the background of each domain, see appendix A.

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

Domain	OIG Summary
	OIG recommendations: • The Healthcare System Director ensures that the Mental Health Executive Council includes veteran representation. • The Veterans Integrated Service Network Director implements processes to strengthen oversight and monitoring of bed utilization. • The Associate Director for Patient Care Services ensures that inpatient mental health unit staffing supports authorized bed capacity.
High Reliability Principles 	High reliability principles center on empowering workers to find and report issues before they cause harm to veterans or the organization. The OIG surveyed staff and leaders' perceptions of psychological safety and performance improvement. The OIG also evaluated whether leaders and staff engaged in continuous process improvement and solicited veteran input on mental health care. Survey results related to staff and leaders' perceptions on psychological safety and performance improvement were generally positive. Augusta HCS leaders solicited veteran input as required; however, they had no mechanism in place to use the information for process improvement efforts. OIG recommendation: • The Healthcare System Director develops and implements processes to incorporate veteran input for process improvements.
Recovery-Oriented Principles 	Recovery-oriented mental health treatment is personalized to an individual's abilities, resources, and values, and empowers the veteran to make decisions and meet treatment goals. To assess the inpatient unit's integration of recovery-oriented principles, the OIG examined aspects of leadership, programming, and the care environment. The OIG found that the Local Recovery Coordinator was not fully integrated into infrastructure change and recovery-oriented activities. Additionally, inpatient unit staff did not provide a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends, as required. The inpatient unit had some aspects of a recovery-oriented environment, but other aspects did not meet VHA standards for a safe, hopeful, and healing environment. OIG recommendations: • The Chief of Mental Health develops processes to ensure integration of the Local Recovery Coordinator into the inpatient mental health unit to support recovery-oriented care. • The Chief of Mental Health ensures a minimum of four hours of recovery-oriented, interdisciplinary programming on weekends on the inpatient mental health unit. • The Healthcare System Director ensures continued implementation of a recovery-oriented environment on the inpatient mental health unit.

Domain	OIG Summary
Clinical Care Coordination 	Care coordination, which involves intentionally sharing a veteran's information and organizing healthcare activities, is crucial for those with complex health and social needs. To assess the quality of clinical care coordination, the OIG reviewed access to services, local procedures for involuntary treatment, interdisciplinary treatment planning, medication management, and discharge planning. The OIG found inconsistencies with the reported number of operating beds on the inpatient unit, as well as communication gaps and information discrepancies among leaders at multiple levels regarding low census and use of community care. The high volume of community referrals contrasted with Augusta HCS's low bed utilization. An Augusta HCS standard operating procedure identified involuntary status as an exclusion for admission; however, the HCS had a separate written process to admit or transfer veterans on an involuntary hold to the inpatient unit for treatment. The OIG identified insufficient documentation to confirm staff routinely tracked compliance with state laws. The OIG found that Augusta HCS redirected veterans in need of involuntary treatment to other VHA or community hospitals. Augusta HCS did not implement written guidance for the transition of care following inpatient mental health unit discharge. The OIG found that veterans were involved in treatment planning, but HCS staff did not comply with required documentation for medication discussions, discharge summaries, and discharge instructions. OIG recommendations: • The Healthcare System Director ensures accurate reporting of inpatient operating beds and implements processes to monitor. • The Healthcare System Director identifies and addresses barriers to admission for veterans on involuntary holds for mental health treatment. • The Healthcare System Director ensures alignment between involuntary commitment policies and practices, consistency with state laws, and implementation of monitoring processes. • The Chief of Staff ensures assignment of ongoing responsibilities for monitoring timely documentation of the change in veterans' voluntary or involuntary legal status, consistent with VHA policy and state laws. • The Chief of Staff ensures timely documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications and monitors for improvement. • The Healthcare System Director ensures the development and implementation of clearly defined written processes for transition of care when veterans are discharged from the inpatient mental health unit. • The Chief of Staff ensures discharge summaries are completed within two business days of discharge and monitors for compliance. • The Chief of Staff ensures discharge instructions for veterans include appointment location and contact information in easy-to-understand language.

Domain	OIG Summary
	• The Healthcare System Director ensures that medications listed in discharge instructions include the purpose for each medication and are written in easy-to-understand language.
Suicide Prevention 	The underlying causes of suicide can be complex and multifactorial; suicide prevention may require coordinated systems, services, and resources to effectively support veterans at risk of suicide. To evaluate suicide prevention activities on the inpatient unit, the OIG reviewed compliance with required suicide risk screening and evaluation, safety planning, and training. The OIG found noncompliance with suicide risk screening and evaluation. The Columbia-Suicide Severity Risk Scale Screener was not consistently addressed within 24 hours prior to discharge, and safety plans did not consistently document ways to make the veteran's environment safer, as required. Further, the OIG determined noncompliance with staff's completion of lethal means safety and suicide risk training requirements. OIG recommendations: • The Chief of Staff identifies barriers to completing the Columbia-Suicide Severity Risk Scale Screener within 24 hours prior to discharge, implements processes, and monitors to ensure compliance. • The Chief of Staff ensures that safety plans address ways to make the veteran's environment safer from potentially lethal means and monitors for compliance. • The Healthcare System Director ensures staff comply with lethal means safety training and suicide risk training requirements and monitors for compliance.
Safety 	The primary goal of inpatient mental health services is to stabilize veterans who are experiencing acute distress by providing a safe, secure environment with staff who are trained to recognize and minimize the potential for self-harm. The OIG evaluated aspects of safety, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. Although Mental Health Environment of Care Checklist inspections were conducted twice per year, the OIG found that the required Interdisciplinary Safety Inspection Team was not established. Further, the OIG observed toilets with ligature points that posed a safety risk in veterans' bathrooms on the inpatient unit. The OIG concluded Augusta HCS leaders' actions to mitigate the ligature point risks were delayed and insufficient. Additionally, 93 percent of inpatient unit staff and Augusta HCS staff responsible for conducting inpatient unit safety inspections were noncompliant with VHA required annual Mental Health Environment of Care Checklist training. OIG recommendations: • The Healthcare System Director ensures compliance with VHA requirements for the Interdisciplinary Safety Inspection Team, including environment of care subcommittee structure, and Mental Health Environment of Care Checklist training completion. • The Chief of Staff ensures mental health leaders update inpatient unit toilets to meet safety requirements and implement processes to reduce associated safety risks.

VA Comments and OIG Response

The Veterans Integrated Service Network and Healthcare System Directors concurred with recommendations 1–2, 4–17, and 19–21 and concurred in principle with recommendations 3 and 18. The OIG will follow up on the planned actions until they are completed (see appendixes D and E).

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Contents

Abbreviations

C-SSRS	Columbia-Suicide Severity Risk Scale Screener
CMHO	Chief Mental Health Officer
EHR	electronic health record
FY	fiscal year
HCS	healthcare system
ISIT	interdisciplinary safety inspection team
LRC	local recovery coordinator
MHEC	Mental Health Executive Council
MHEOCC	mental health environment of care checklist
OIG	Office of Inspector General
PSAT	Patient Safety Assessment Tool
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The mission of the VA Office of Inspector General (OIG) is to conduct meaningful independent oversight of the VA. The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care through 1,321 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. Fiscal year (FY) 2024 cyclic reviews focus on acute inpatient mental health care at select healthcare systems (HCSs).[2] This cyclic review, which was conducted by the OIG from January 8 through February 2, 2024, addressed care provided at the VA Augusta Health Care System (Augusta HCS) in Georgia.

VHA's "mental health services are organized across a continuum of care" and "in a team-based, interprofessional, patient-centered, recovery-oriented structure" (see figure 1).[3] VHA HCSs are expected to ensure all veterans who are eligible for care have access to recovery-oriented inpatient, residential, and outpatient mental health programs.[4]

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

[1] "Mission, Vision, Values," OIG, accessed June 10, 2024, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed April 30, 2024, www.va.gov/health/aboutvha.asp.

[2] For the purposes of this report, the OIG defines the term "healthcare system" as a parent facility and its associated medical centers, outpatient clinics, and other related VA services or programs. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility; A fiscal year is a "12-month operating cycle" that runs from October 1 to September 30 of the following year. VA, "VA Finance Terms and Definitions," enclosure 14 in *VA/VHA Employee Health Promotion Disease Prevention Guidebook*, July 2011, accessed May 3, 2024, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf.

[3] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023; VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019.

[4] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015; VHA Directive 1160.01. The policies contain similar language related to recovery-oriented mental health programs; In this report, the OIG refers to veterans instead of patients to support recovery-oriented language.

[5] VHA Directive 1160.01. If an HCS does not offer required services, those services must be available through another VA resource.

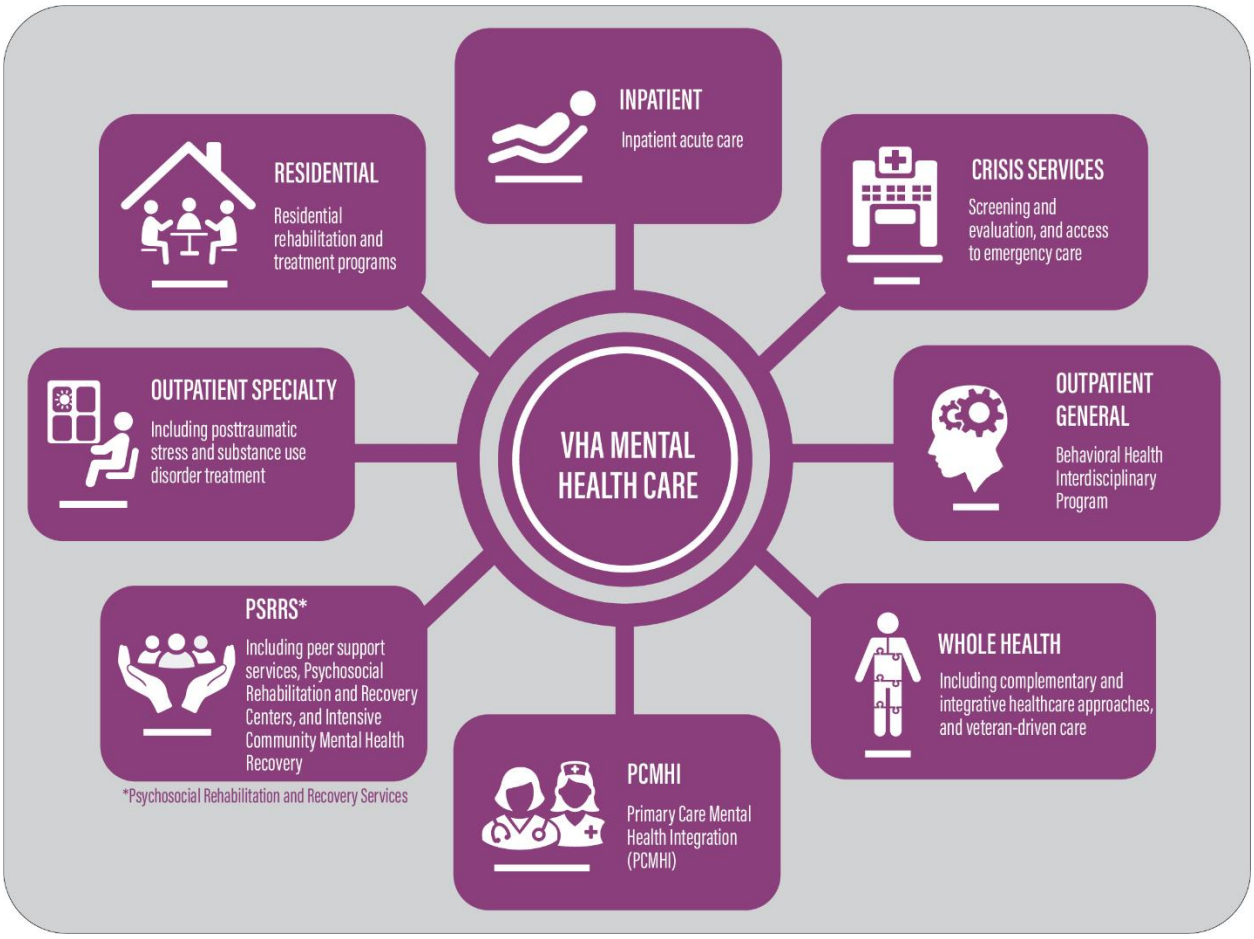

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163.

According to VHA, inpatient mental health services are considered the most intensive level of mental health care used to treat veterans safely and effectively during periods of acute mental distress (see appendix A for additional background).[6] In FY 2023, VHA HCSs delivered inpatient mental health care for 62,966 veteran stays.[7]

To evaluate the quality of inpatient mental health care at the Augusta HCS, the OIG assessed specific processes across six topic domains: leadership and organizational culture, high reliability principles, recovery-oriented principles, clinical care coordination, suicide prevention, and safety.

[6] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023. 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.

[7] VHA identifies a "patient stay" as a distinct instance of a veteran staying on a specific unit for a defined time frame. "ADT Using NUMA," VHA Support Service Center, accessed April 30, 2024, https://vssc.med.va.gov/webrm/vssc_links.aspx?rpt_id=1552&index=1. (This site is not publicly accessible.)

About the VA Augusta Health Care System

The Augusta HCS consists of an Uptown Division that provides inpatient mental health care and a Downtown Division that provides other inpatient care. Both divisions are located in Augusta, Georgia. Three community-based outpatient clinics are in Athens and Statesboro, Georgia; and Aiken, South Carolina. In FY 2023, the Augusta HCS provided health care to 47,005 veterans, with approximately 13,003 receiving mental health care. During FY 2023 the average daily census for acute inpatient mental health was 8.68; during this time, Augusta HCS staff cared for 345 veterans on the inpatient unit and submitted 154 consults for inpatient mental health care in the community. At the time of the OIG's review in January 2024, the inpatient unit had 34 approved operating beds.

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."[8] 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.[9]

The OIG reviewed Augusta HCS's leadership structure, Veterans Integrated Service Network oversight, and inpatient unit staffing practices. The OIG evaluated how these elements support inpatient unit operations, compliance with requirements, and delivery of quality care.

Leadership Structure

Augusta HCS's executive leadership team consisted of the Director, Assistant Medical Center Director, Deputy Executive Director, Chief of Staff, Associate Director, and Associate Director for Patient Care Services.[10] The OIG learned that the Chief of Staff and the Associate Director for Patient Care Services oversee patient care and supervise service directors and program chiefs, including the Chief of Mental Health and Chief of Social Work. The Chief of Mental Health serves as Augusta HCS's required mental health lead and has oversight of all mental health programs, including the inpatient unit.[11]

The Augusta HCS's mental health organizational structure included both formal and informal reporting lines (see figure 2 for the executive leadership organizational structure). According to the Chief of Mental Health, disciplines such as nurses and social workers on the inpatient unit were supervised by their respective discipline leads; however, the Inpatient Mental Health Medical Director (Inpatient Medical Director) has oversight of the unit operations (see appendix C).

[8] Edgar H. Schein, *Organizational Culture and Leadership, 4th Edition, 2010*, accessed June 25, 2024, https://ia800809.us.archive.org/14/items/EdgarHScheinOrganizationalCultureAndLeadership/Edgar_H_Schein_Organizational_culture_and_leadership.pdf.

[9] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, May 2024, accessed June 25, 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).

[10] "Leadership," VA, accessed June 18, 2024, https://www.va.gov/augusta-health-care/about-us/leadership/. The Director is also referred to as the HCS Director and Augusta HCS Director throughout this report.

[11] VHA Directive 1160.01.

The Chief of Mental Health stated that the reporting structure posed challenges for communication; for example, a lack of clarity regarding who made final decisions when there were multiple leaders from different disciplines. However, inpatient unit staff used daily huddles to communicate needs and concerns of the unit.[12]

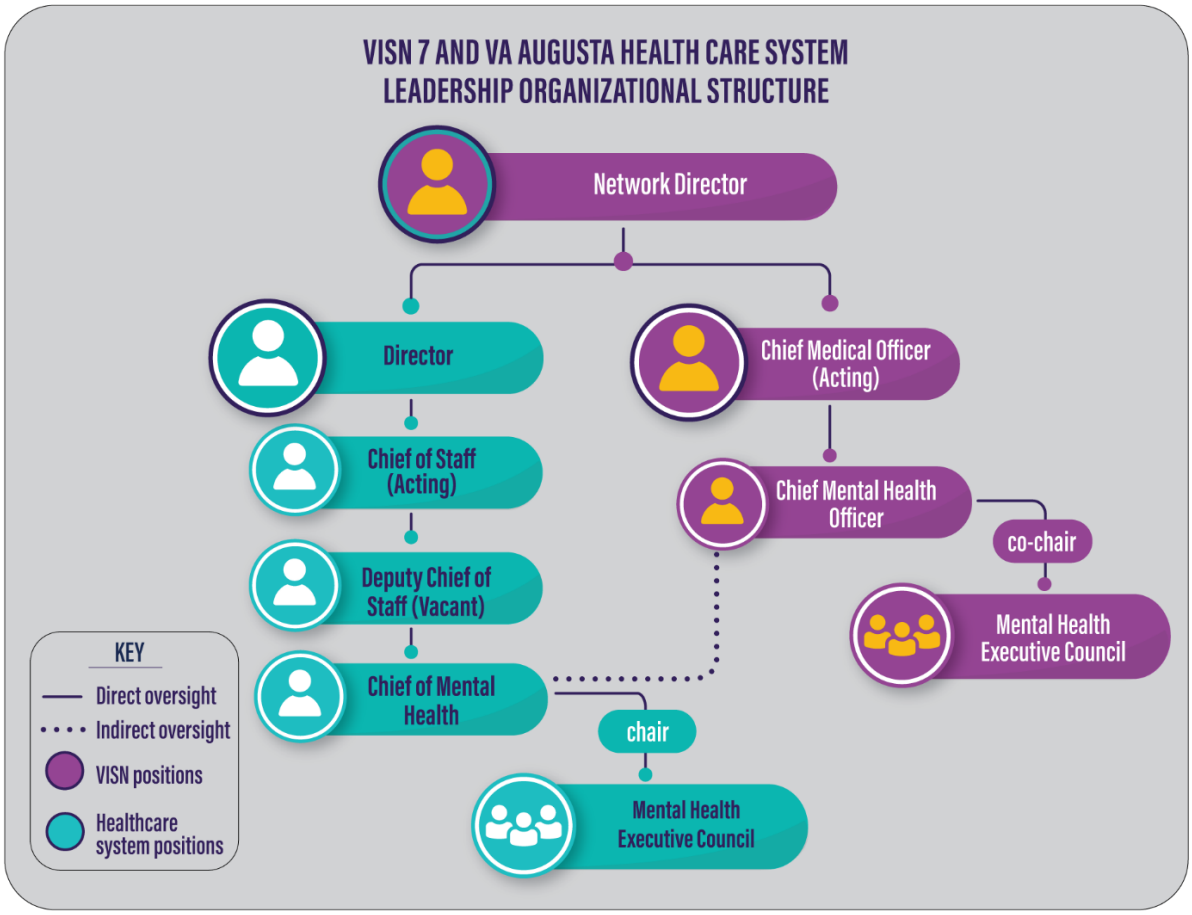

Figure 2. *VISN 7 and Augusta HCS leadership organizational structure.*
Source: Augusta HCS documents (received from January 10, 2024, through February 29, 2024) and OIG analysis of VHA Directive 1160.06.

The Augusta HCS had a local Mental Health Executive Council (MHEC) responsible for overseeing the quality of mental health care, as required.[13] The MHEC was chaired by the Chief of Mental Health and included representation from inpatient unit staff, in alignment with VHA

[12] "A huddle is a brief (less than 10 minutes, and typically 3–5 minutes) meeting of the teamlet and appropriate discipline-specific team members to communicate information about the patient care work for a specified period of time (usually a clinic session)." VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[13] VHA Directive 1160.01. Augusta HCS refers to its MHEC as the Mental Health Services Committee.

requirements.[14] However, the council did not meet the requirement for veteran representation.[15] Although an April 2023 VHA directive required veteran representation, the Chief of Mental Health reported that a veteran identified for MHEC membership would be included in council meetings starting February 2024.[16] Without veteran representation, the council missed opportunities to obtain and incorporate critical stakeholder input for operational and quality of care improvements.[17]

VISN Oversight

In compliance with VHA requirements, the Veterans Integrated Service Network (VISN) Chief Mental Health Officer (CMHO) co-chaired a VISN-level MHEC, which was incorporated into VISN governance, included participation from each of the VISN's HCS chief mental health leads, and was responsible for monitoring quality and access across the VISN's continuum of mental health care.[18] The VISN CMHO reported additional mechanisms to provide oversight and support of inpatient unit operations, including action item tracking and monthly meetings with HCS and VISN leaders.

The OIG identified concerns with low bed utilization on the inpatient unit (discussed further in the Access to Care section). The VISN CMHO acknowledged awareness of and concerns with Augusta HCS's low bed utilization and reported regularly tracking the census to ensure access to inpatient unit services.[19] However, the VISN CMHO reported that while VISN leaders review bed utilization, they do not look at underlying causes such as unavailable beds.[20] The VISN CMHO also shared an understanding that the review is completed at the HCS level. Failure to identify underlying causes may contribute to VISN leaders' incomplete understanding of the low bed utilization issue and delay timely resolution.

Inpatient Unit Staffing

The OIG found a discrepancy between leaders' statements about unit capacity and documented staffing levels. At the time of the review, mental health leaders identified the ability to care for

[14] VHA Directive 1160.01. The OIG reviewed meeting minutes from April through September 2023.

[15] VHA Directive 1160.01.

[16] VHA Directive 1160.01.

[17] VHA Directive 1160.01.

[18] VHA Directive 1160.01. VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks (VISNs). VISN 7 refers to its MHEC as the VISN 7 Mental Health Integrated Clinical Community Committee.

[19] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to "timely access" for inpatient unit services.

[20] VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010. Out-of-service beds are "unavailable beds that are closed for any reason."

23 veterans; however, nurse staffing levels supported a capacity of 12 veterans.[21] The Chief of Mental Health reported that new providers will assist with expanding weekend programming for veterans on the inpatient unit. Insufficient staffing can affect access, quality of care, and safety on the inpatient unit.

Augusta HCS leaders reported that recruitment and retention incentives, such as financial and relocation benefits, were utilized. However, an inpatient unit leader noted that evenings and nights have a higher volume of admissions, and those shifts are impacted by nursing staff vacancies. (Detailed staffing information is provided in appendix C.)

Recommendations

1. The VA Augusta Health Care System Director ensures that the Mental Health Executive Council includes veteran representation.
   VHA concurred with the recommendation and provided an action plan to be completed by November 2024.
2. The Veterans Integrated Service Network Director implements processes to strengthen oversight and monitoring of bed utilization.
   VHA concurred with the recommendation and provided an action plan to be completed by November 2024.
3. The VA Augusta Health Care System Associate Director for Patient Care Services ensures that inpatient mental health unit staffing supports authorized bed capacity.
   VHA concurred in principle with the recommendation and provided an action plan to be completed by November 2024.

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

[21] The Augusta HCS Facility Expert Panel recommended 30.64 full-time equivalent nursing staff to support an average daily census of 14.10 veterans. In review of the HCS document, the OIG assessed that the inpatient unit had 26 full-time equivalent nursing staff to support a capacity of 12 veterans; The Facility Expert Panel is "an advisory group comprised of individuals with knowledge of factors and variables impacting staffing needs at the point of care" who provide staffing recommendations. VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, January 18, 2023.

High Reliability Principles

High reliability principles center on "collective mindfulness" that empowers staff to find and report issues, without fear of blame, before they cause harm to veterans or the organization.[22] VHA has committed to prioritizing high reliability across its extensive delivery system and expects staff to "promot[e] a culture of continuous process improvement."[23]

The OIG disseminated a questionnaire evaluating staff and leaders' perceptions related to psychological safety and performance improvement activity (see appendix B for methodology). In addition, the OIG determined whether staff and leaders engaged in process improvements and solicited veteran input on mental health care, as required.[24]

[22] Stephanie Veazie et al., "Evidence Brief: Implementation of High Reliability Organization Principles," VA, May 2019, https://www.ncbi.nlm.nih.gov/books/NBK542883/.

[23] "Quality and Patient Safety (QPS)," VA, accessed May 1, 2023, https://www.va.gov/QUALITYANDPATIENTSAFETY/qm/index.asp.

[24] VHA Directive 1160.01; The Joint Commission, *Standards Manual e-dition*, PI.04.01.01, January 2024. "The hospital uses improvement tools or methodologies to improve its performance"; The Joint Commission accredits and certifies healthcare organizations and programs in the United States. "The Joint Commission (TJC)," VHA Office of Quality and Patient Safety, accessed June 13, 2024, https://vaww.qps.med.va.gov/divisions/qm/ea/jointcommission.aspx. (This site is not publicly accessible.)

Psychological Safety

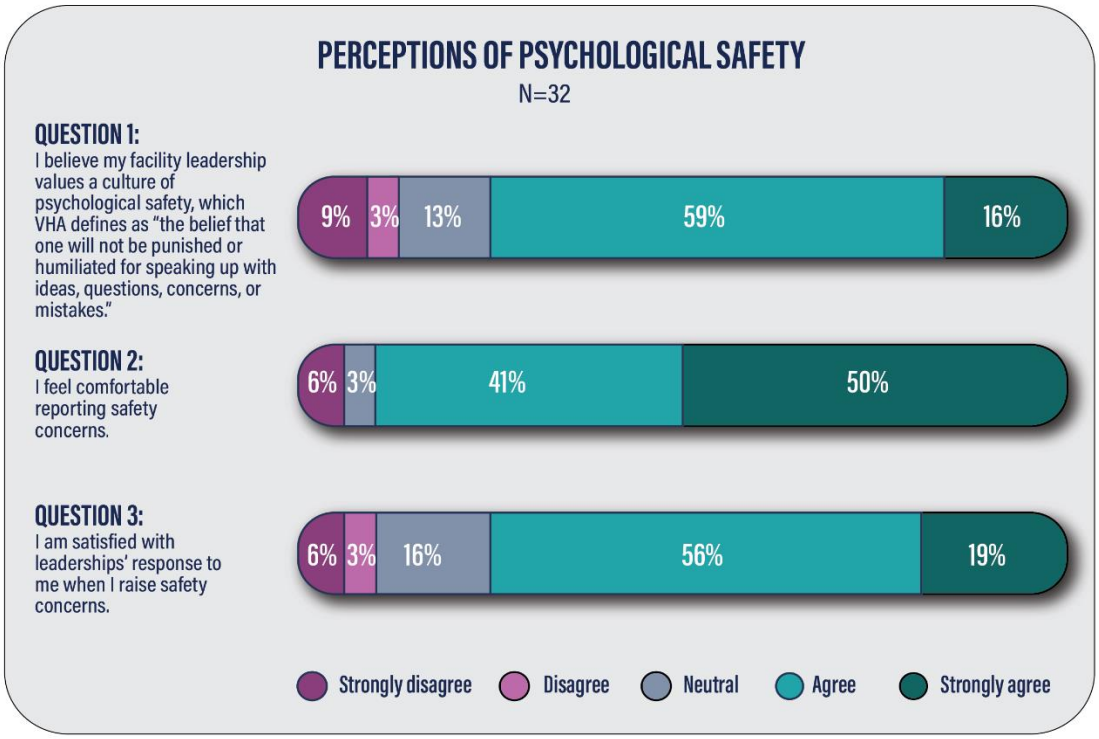

Figure 3. *Mental health staff and leaders' perceptions on psychological safety.*
Source: OIG analysis of staff questionnaire responses. VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)," September 2022.
Note: Values may not add to 100 percent due to rounding. The order of the colors in the key corresponds to the order in the scales above.

The majority of respondents agreed or strongly agreed with statements regarding culture, reporting, and leaders' responses to safety concerns (see figure 3).

Performance Improvement

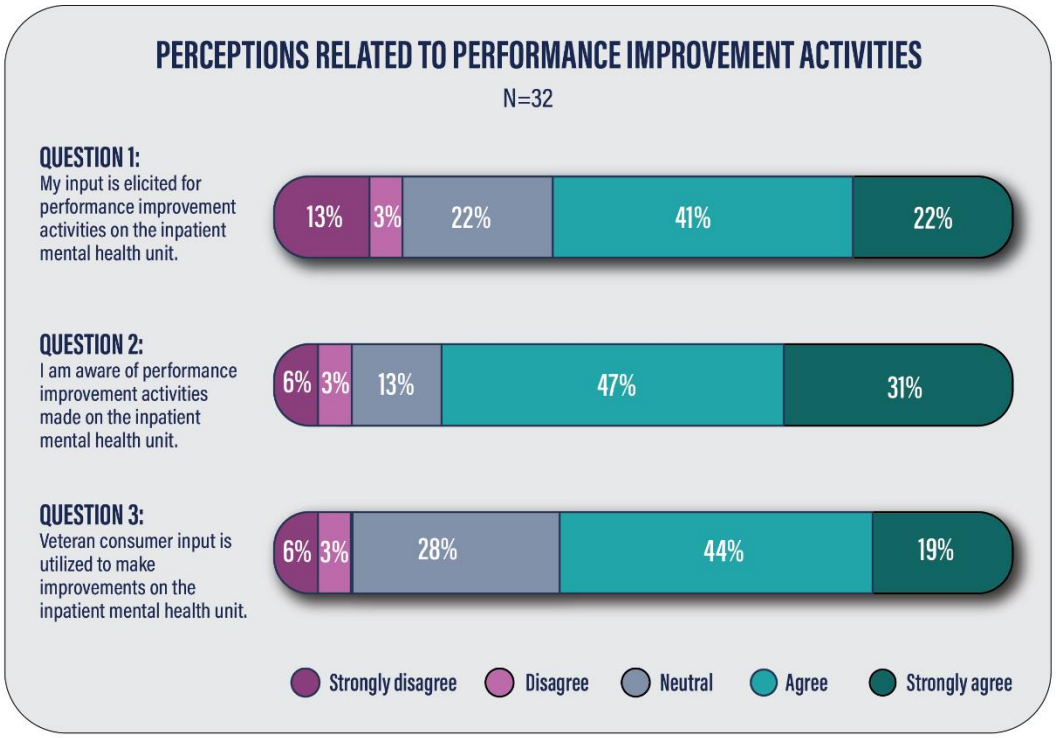

Figure 4. *Mental health staff and leaders' perceptions on performance improvement activities.*
Source: OIG analysis of staff questionnaire responses.
Note: Values may not add to 100 percent due to rounding. The order of the colors in the key corresponds to the order in the scales above.

Most respondents agreed or strongly agreed with two statements related to staff's input and awareness of performance improvement activities, and the majority were neutral or agreed with the statement that veteran input is used for improvements on the inpatient unit (see figure 4).

The OIG found Augusta HCS leaders solicited veteran input, as required, through patient experience surveys and other tools; however, they had no mechanism to use the information for process improvement efforts.[25] Mental health leaders reported collecting mental health providers' input through interdisciplinary treatment team meetings and inpatient unit-specific huddles to discuss improvements needed. Utilizing veteran input to improve processes may lead to meaningful changes in healthcare delivery and increase patient satisfaction.

[25] VHA Directive 1160.01.

Recommendation

4. The VA Augusta Health Care System Director develops and implements processes to incorporate veteran input for process improvements.

   VHA concurred with the recommendation and provided an action plan to be completed by November 2024.

For a detailed action plan, see appendix E.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent values."[26] 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.[27]

The OIG examined aspects of leadership, programming, and the physical care environment to evaluate the healthcare system's integration of recovery-oriented principles, as required, on the inpatient unit (see appendix B for methodology).[28]

Leadership

Augusta HCS's Inpatient Medical Director served as the Inpatient Mental Health Program Manager (program manager), in addition to primary duties overseeing inpatient unit clinical care and staff.[29] VHA requires the program manager to "coordinate and promote consistent, sustained, high quality therapeutic programming" on the inpatient unit.[30]

Beyond the inpatient unit, Augusta HCS met the VHA requirement to have a full-time local recovery coordinator (LRC).[31] The OIG found that the LRC was not fully integrated into infrastructure change and recovery-oriented activities, such as the design of a new inpatient mental health unit, inpatient unit staff training, and attendance at treatment team meetings and huddles.

The OIG also found that the LRC did not contribute to the patient orientation handbook used to introduce veterans to the inpatient unit. For example, the handbook included non-recovery-oriented concepts emphasizing the veteran's compliance with treatment versus collaboration in

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

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

[28] VHA Directive 1160.06.

[29] VHA Handbook 1160.06; VHA Directive 1160.06. Per the directive, the inpatient mental health program manager is defined as a leadership position and can be filled by the full range of core mental health disciplines. The inpatient mental health program manager was previously referred in the handbook to as the inpatient program coordinator.

[30] VHA Handbook 1160.06; VHA Directive 1160.06. Per the handbook, the inpatient program coordinator was responsible for coordination of inpatient unit "therapeutic programming." Per the directive, the inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services.

[31] VHA Directive 1163.

their care. Increased LRC involvement may strengthen the implementation of recovery-oriented principles and activities on the inpatient unit.

The OIG found Augusta HCS was compliant with the requirement to have a plan across the mental health care continuum for continued transformation to recovery-oriented services, which must be updated a minimum of every three years.[32] Augusta HCS's three-year plan was developed and updated by the LRC, and mental health leadership approved the plan.

VHA requires HCSs to obtain input from veterans who have utilized mental health services.[33] The LRC reported surveys are completed annually by five randomly selected veterans who had received services on the inpatient unit, asking for their opinions on the program schedule and content. The LRC noted veterans' survey responses on inpatient unit programming were positive overall, and acknowledged this minimal veteran feedback was shared with national and Augusta HCS mental health leaders but not disseminated to the inpatient unit staff.

Recovery-Oriented Programming

The OIG found the inpatient unit offered at least four hours of recovery-oriented programming on weekdays but lacked the required four hours of programming on weekends. The Inpatient Medical Director reported the lack of weekend programming was due to insufficient staffing.[34] The Chief of Mental Health recognized the need for weekend programming and reported plans to hire additional providers. Lack of weekend programming may limit opportunities for veterans to work on recovery goals while on the inpatient unit.

VHA requires inpatient unit staff to educate veterans on recovery-oriented principles.[35] The inpatient unit nurse manager reported nursing staff educate veterans by reviewing the mental health treatment planning process and the patient orientation handbook.

Per the inpatient unit staff psychologist, peer support staff led a weekly group, Orientation to Recovery, to help ensure veterans' understanding of recovery concepts.[36] Inpatient unit staff

[32] VHA Directive 1163.

[33] VHA Directive 1160.01.

[34] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to programming hours.

[35] VHA Handbook 1160.06; VHA Directive 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06," September 29, 2023. The standard operating procedure (SOP) uses similar language related to orientation to recovery-oriented care as the rescinded handbook; As of April 25, 2024, the Office of Mental Health and Suicide Prevention was formally separated and operating independently as the Office of Mental Health and the Office of Suicide Prevention, with staff realigned to the respective offices.

[36] Peer support is "a system of giving and receiving help by a person who is actively engaged in personal recovery, founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful." VHA Directive 1163.

reported perceptions that having consistent inpatient unit programming available had increased veterans' engagement in treatment.

Physical Environment

The OIG found that although the inpatient unit had aspects of a recovery-oriented environment, there were other areas that did not meet VHA standards for a safe, hopeful, and healing environment.[37]

In general, the inpatient unit was clean and had a colorful painted mural in the dining area (see figure 5). The unit also had an open nurses' station free from plexiglass or other barriers and a female-only common area. The general common area used to conduct groups had natural lighting. Veterans on the inpatient unit had access to an outdoor space, as required; however, the area lacked furniture.[38]

Figure 5. *Dining area mural and a veteran's bedroom.*
Source: Photo taken by OIG staff, Augusta, GA, January 30, 2024.

Although there were aspects of recovery-oriented elements present, the inpatient unit lacked artwork in the hallway, warm paint colors, and natural lighting, which is inconsistent with VHA guidance.[39] Additionally, sleeping rooms had minimal furniture and scuffed walls (see figure 5). A recovery-oriented environment that incorporates hopeful and healing elements while ensuring safety can promote veterans' engagement in their personal recovery.

Recommendations

5. The VA Augusta Health Care System Chief of Mental Health develops processes to ensure integration of the Local Recovery Coordinator into the inpatient mental health unit to support recovery-oriented care.

[37] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021, accessed March 27, 2024, https://dvagov.sharepoint.com/:b:/r/sites/VACOMentalHealth/mhrrtp/Resources/Program%20Development/MH%20RRTP%20and%20Inpatient%20Design%20Guide%202021.pdf?csf=1&web=1&e=ow3N0D. (This site is not publicly accessible.)

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

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

VHA concurred with the recommendation and provided an action plan to be completed by November 2024.

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

   VHA concurred with the recommendation and provided an action plan to be completed by January 2025.

7. The VA Augusta Health Care System Director ensures continued implementation of a recovery-oriented environment on the inpatient mental health unit.

   VHA concurred with the recommendation and provided an action plan to be completed by September 2024.

For detailed action plans, see appendix E.

Clinical Care Coordination

"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective" treatment.[40] For veterans with "complex health and social needs, care coordination is crucial for improving their access to care, clinical outcomes, care experiences."[41] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a less-intensive level of care.[42]

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 (see appendix B for methodology).

Access to Care

The OIG found Augusta HCS had standard operating procedures for inpatient unit admission processes, as required by VHA.[43] Exclusions for admission included, but were not limited to, veterans in need of involuntary hospitalization and those solely awaiting community care placement.[44] Successful coordination of mental health care requires well-defined screening and admissions processes that ensure veterans have timely "access to mental health evaluation and clinically appropriate treatment in a safe and secure environment."[45]

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

[41] Denise M. Hynes et al., "Understanding Care Coordination for Veterans with Complex Care Needs: Protocol of a Multiple-Methods Study to Build Evidence for an Effectiveness and Implementation Study," *Frontiers in Health Services* 3, no. 3 (August 15, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[42] VHA Directive 1160.06.

[43] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to admission for acute inpatient care; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023. The SOP updated the requirement to include procedures and processes for facility staff responsible for admission of veterans to the inpatient mental health units. The Joint Commission, *Standards Manual e-dition*, PC.01.01.01, August 2023. "The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient's needs."

[44] Charlie Norwood VA Medical Center SOP 6402.509, "Admission to Acute Inpatient Mental Health Services from the Emergency Department," April 1, 2021; The VA Augusta Health Care System is comprised of two main medical centers located in Georgia, the Charlie Norwood VA Medical Center and the Augusta VA Medical Center – Uptown. "About Us," VA, accessed June 20, 2024, https://www.va.gov/augusta-health-care/about-us/#about-va-augusta-health-care-s.

[45] VHA Directive 1160.01; VHA Directive 1160.06.

According to Augusta HCS leaders, veterans excluded from admission to the inpatient unit are referred to other VHA HCSs or community hospitals.[46] However, the Inpatient Medical Director reported difficulties accessing timely transportation to the Downtown Division or to another facility for veterans in need of involuntary hospitalization. Although the Augusta HCS Director and the Chief of Mental Health reported plans to admit veterans in need of involuntary hospitalization, neither provided a definitive time frame.

The Chief of Mental Health and Augusta HCS Facility Expert Panel reported 23 of the 34 operating beds were available.[47] Mental health leaders cited various explanations for 11 beds that were out of service, including work orders, issues with beds or bed mattresses, and office space use. The Chief of Mental Health acknowledged that an approval related to operating beds could be requested from the VISN through the HCS Director. The VISN CMHO reported being unaware of any requests for a formal change in operating beds from Augusta HCS. Inaccurate reporting of the number of operating beds, and exclusion of veterans in need of inpatient mental health care, may impede timely access to VHA care and create challenges with coordinating care.

In FY 2023, Augusta HCS had an average daily census of 8.68 despite having 34 operating beds. During the same time frame, Augusta HCS submitted 154 consults for inpatient mental health care in the community.[48]

The OIG found communication gaps and information discrepancies among leaders at multiple levels. Leaders provided different reasons for low daily census and the use of community inpatient mental health care, including decreased demand following the COVID-19 pandemic and admission exclusions of veterans in need of involuntary hospitalization.

The Augusta HCS Director shared that a Rapid Process Improvement Workshop (RPIW) had been initiated to assess bed utilization on the inpatient unit. However, the Chief of Mental Health reported being unaware of the RPIW, despite being included as a process owner on the RPIW charter.[49] Low bed utilization may indicate inefficient use of resources and pose barriers to accessing care.

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[46] The Inpatient Medical Director reported referring veterans in need of involuntary hospitalization to the VA Atlanta Healthcare System.

[47] Operating beds are beds "that are staffed and available for admission of patients" and "are to exclude unavailable beds that are closed for any reason." VHA Handbook 1000.01.

[48] "Corporate Data Warehouse," VA Health Services Research and Development, accessed April 8, 2020, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm.

[49] Rapid Process Improvement Workshop is a quality improvement strategy utilized in health care that should result in an action plan to address identified barriers. James O.E. Pittman et al., "Adaptation of a quality improvement approach to implement eScreening in VHA healthcare settings: innovative use of the Lean Six Sigma Rapid Process Improvement Workshop," *Implementation Science Communications* 2, no. 37 (April 7, 2021), https://doi.org/10.1186/s43058-021-00132-x.

Involuntary Hospitalization and Treatment

The OIG found that the practices described by Augusta HCS leaders did not align with HCS policy, and various policies were inconsistent.[54] An Augusta HCS standard operating procedure identified involuntary status as an exclusion for admission, and another identified that a veteran on an involuntary status would be placed in a different facility.[55] However, the HCS had a separate written process to admit or transfer veterans on an involuntary hold to the inpatient unit for treatment.[56]

The Chief of Mental Health reported that Augusta HCS has never accepted veterans on involuntary status, based on the premise that it would require the HCS to accept non-veterans on involuntary status as well.

Mental health leaders reported monitoring and tracking compliance with involuntary commitment state laws through various methods, such as electronic health record (EHR)

An involuntary hold "is a brief involuntary detention of a person presumed to have a mental illness in order to determine whether the individual meets criteria for" involuntary hospitalization.[50]

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."[51]

Standards and procedures are provided by state law and vary by state.[52] VHA requires that leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[53]

[50] Leslie C. Hedman et al., "State Laws on Emergency Holds for Mental Health Stabilization," *Psychiatric Services*, 67, no. 5 (May 1, 2016): 475–581, https://doi.org/10.1176/appi.ps.201500205.

[51] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," 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.

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

[53] VHA Directive 1160.01.

[54] Charlie Norwood VA Medical Center SOP 6406.509, "Treatment of Veterans with Involuntary Admission Status," December 28, 2020; Charlie Norwood VA Medical Center Memorandum No. 6014, "Management of Committable Psychiatric Patients," November 6, 2019; Charlie Norwood VA Medical Center SOP 6402.509, "Admission to Acute Inpatient Mental Health Services from the Emergency Department."

[55] Charlie Norwood VA Medical Center SOP 6402.509, "Admission to Acute Inpatient Mental Health Services from the Emergency Department."

[56] Charlie Norwood VA Medical Center SOP 6402.509, "Admission to Acute Inpatient Mental Health Services from the Emergency Department"; Charlie Norwood VA Medical Center SOP 6406.509, "Treatment of Veterans with Involuntary Admission Status SOP"; Charlie Norwood Veterans Affairs Medical Center Policy Memorandum No. 6014, "Management of Committable Psychiatric Patients"; Charlie Norwood VA Medical Center SOP 6408.509, "Admission to Acute Inpatient Psychiatry from Downtown Division Acute Care Inpatient Services," August 26, 2022.

alerts, huddles, consults, and emails.[57] However, the OIG found insufficient documentation to confirm Augusta HCS staff routinely monitor and track compliance with state laws.[58]

Despite a standard operating procedure identifying a legal status manager as responsible for indicating the "type of legal status, the date and time the legal status was initiated, and the date and time of expiration," the Inpatient Medical Director reported that the consultation liaison team had overall responsibility during the week, while mental health providers were responsible on weekends.[59] The Chief of Mental Health shared that the legal status manager position was not filled. Failure to monitor regulatory compliance, and inconsistent HCS policies and practices, may result in staff confusion about state law requirements and could potentially contribute to the illegal hospitalization of a veteran.

The OIG found 92 percent of veteran EHRs reviewed had voluntary or involuntary legal status documented within 24 hours of admission to the inpatient unit, as required by VHA.[60] However, the Inpatient Medical Director stated that documentation was not generally updated when a veteran's legal status changed from voluntary to involuntary during hospitalization, as required by VHA and consistent with applicable state laws.[61] Augusta HCS policy identified the legal status manager as responsible for entering legal status in the EHR.[62] However, as previously noted, this position was not filled at the time of the inspection. Failure to accurately document veterans' legal status may contribute to decisions based on inaccurate information.

Treatment Planning

As required by VHA, Augusta HCS's standard operating procedure outlined the inpatient unit treatment planning process including recovery-oriented elements such as veterans' involvement

[57] An EHR alert notifies providers of clinical information in the computerized patient record system. VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023.

[58] Charlie Norwood VA Medical Center SOP 6406.509, "Treatment of Veterans with Involuntary Admission Status."

[59] The consultation liaison team members include a nurse practitioner, licensed clinical social worker, and the inpatient medical director, who are notified by consult and EHR alerts that the team needs to evaluate the veteran. Charlie Norwood VA Medical Center SOP 6406.509, "Treatment of Veterans with Involuntary Admission Status SOP."

[60] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" (SOP), September 20, 2022, updated November 2, 2023.

[61] Charlie Norwood VA Medical Center SOP 6406.509, "Treatment of Veterans with Involuntary Admission Status." A legal status order indicates the type of legal status and the dates and times of initiation and expiration; VHA Health Information Management, *Health Record Documentation Program Guide Version 1.1*, November 29, 2022; VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023. The policies contain similar requirements? for health record documentation to be "complete, accurate, timely. . . and facilitate performance improvement processes and legal requirements"; VHA Directive 1160.01.

[62] Charlie Norwood VA Medical Center SOP 6406.509, "Treatment of Veterans with Involuntary Admission Status."

in setting individualized goals.[63] This document also included expectations to develop a mental health treatment plan within 24 hours of admission, corresponding with VHA's requirement for a specified completion time frame.[64]

The OIG found all reviewed veteran EHRs included documentation that staff offered or involved the veteran in the development and completion of a treatment plan. Generally, treatment plans were completed in less than 24 hours from admission.[65] In addition, 98 percent of records reviewed had evidence that the interdisciplinary treatment team contributed to the mental health treatment plan.[66]

Medication Treatment

Although VHA requires a discussion between the prescriber and veteran on the risks and benefits of medication treatment, the OIG found 73 percent of EHRs reviewed included prescriber documentation of the required discussion.[67] The Chief of Mental Health stated that the templated note in use may not prompt prescribers to document the discussion. Veterans who do not have the opportunity to discuss medication risks and benefits with the prescriber may be deprived of the ability to make an informed decision.

Discharge Planning

Although Augusta HCS had a draft policy for veterans transitioning from inpatient to another level of care, the OIG found the HCS did not have written guidance implemented, per VHA

[63] Acting Deputy Under Secretary for Health for Operations and Management (10N), "Mental Health Treatment Planning and Software Tools," memorandum to Veterans Integrated Service Network (VISN) Director (10N1-23) et al., May 3, 2019; Charlie Norwood VA Medical Center SOP 6109.509, "Mental Health Treatment Planning," March 15, 2021.

[64] Acting Deputy Under Secretary for Health for Operations and Management (10N), "Mental Health Treatment Planning and Software Tools," memorandum; Charlie Norwood VA Medical Center SOP 6109.509, "Mental Health Treatment Planning."

[65] Charlie Norwood VA Medical Center SOP 6109.509, "Mental Health Treatment Planning."

[66] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The policies contain similar language related to interdisciplinary treatment team collaboration with the veteran in treatment planning.

[67] VHA Directive 1108.07(1), *General Pharmacy Service Requirements*, November 28, 2022, amended October 4, 2023. Directive 1108.07(1) states that a prescriber is a provider who is "authorized by law or VA policy to prescribe medications in accordance with their facility approved privileges or scope of practice"; VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 17, 2021; VHA Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023; 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 Drugs," chap. 21 in *Basic & Clinical Pharmacology*, 14th edition, ed. Bertram G. Katzung: McGraw-Hill Education, 2017, https://accesspharmacy.mhmedical.com/content.aspx?bookid=2249&sectionid=175218675.

requirements.[68] Inadequate care coordination may contribute to a veteran's lack of engagement following inpatient hospitalization.

All records reviewed included a discharge summary, which is required by VHA and used by clinicians to coordinate the veteran's transition of care.[69] However, only 84 percent were completed within two business days of discharge, as required.[70] Discharge summaries should be available when the veteran is released or soon after to support a seamless transition of care.[71]

The OIG found 92 percent of the records included the required outpatient mental health follow-up appointment scheduled prior to discharge, with an average of nine days between discharge and the first scheduled mental health appointment.[72] Additionally, as required by VHA, all EHRs reviewed included documentation of discharge instructions and of the veteran being offered a copy.[73]

However, in 89 percent of the EHRs reviewed, the discharge instructions included contact information for the clinic or provider of the outpatient mental health follow-up appointment, as required by VHA.[74] Only 24 percent of the EHRs reviewed included the appointment location in the discharge instructions in easy-to-understand language.[75] The OIG found that some discharge instructions included abbreviations and acronyms that may have been difficult for veterans to interpret; for example, appointment locations were listed using difficult-to-understand abbreviations (see figure 6). Missing or indecipherable details in discharge instructions may create barriers for veterans to attend follow-up appointments and receive timely mental health care.

[68] VHA Directive 1160.01.

[69] VHA Health Information Management Program Office, *Health Record Documentation Program Guide 1.1*, November 29, 2022; VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023. The policies contain similar language related to discharge summary requirements.

[70] VHA Health Information Management Program Office, *Health Record Documentation Program Guide 1.1*; VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*.

[71] Sharma Kattel et al., "Information Transfer at Hospital Discharge: A Systematic Review," *Journal of Patient Safety* 16, no. 1 (March 2020): 25–33, https://doi.org/10.1097/pts.0000000000000248.

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

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

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

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

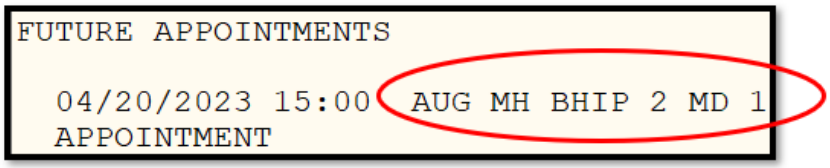

Figure 6. *Example of appointment information in discharge instructions.*
Source: OIG review of veterans' EHRs.

The OIG found that all EHRs included the medication list in discharge instructions, as required by VHA. However, only 36 percent of the records identified the reason for prescribing the medication.[76] Consistent with recovery-oriented principles, providing clear and easy-to-understand language about the reason a medication is prescribed supports veterans' participation in their care.[77]

Seventy-seven percent of the reviewed EHRs had discharge instructions with medication abbreviations written in Latin (see figure 7).[78] Seventy-two percent of the EHRs included discharge instructions with generic and trade medication names used interchangeably without an explanation that they are the same medication (see figure 7). Forty-nine percent of the EHRs included unclear or potentially misleading medication information in the discharge instructions. For example, discharge instructions included different doses for the same medication as well as for medications discontinued during hospitalization. Accurate and easy-to-understand discharge instructions can help veterans navigate next steps in their treatment planning following hospitalization.[79]

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

[77] VHA Directive 1345.

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

[79] VHA Directive 1345.

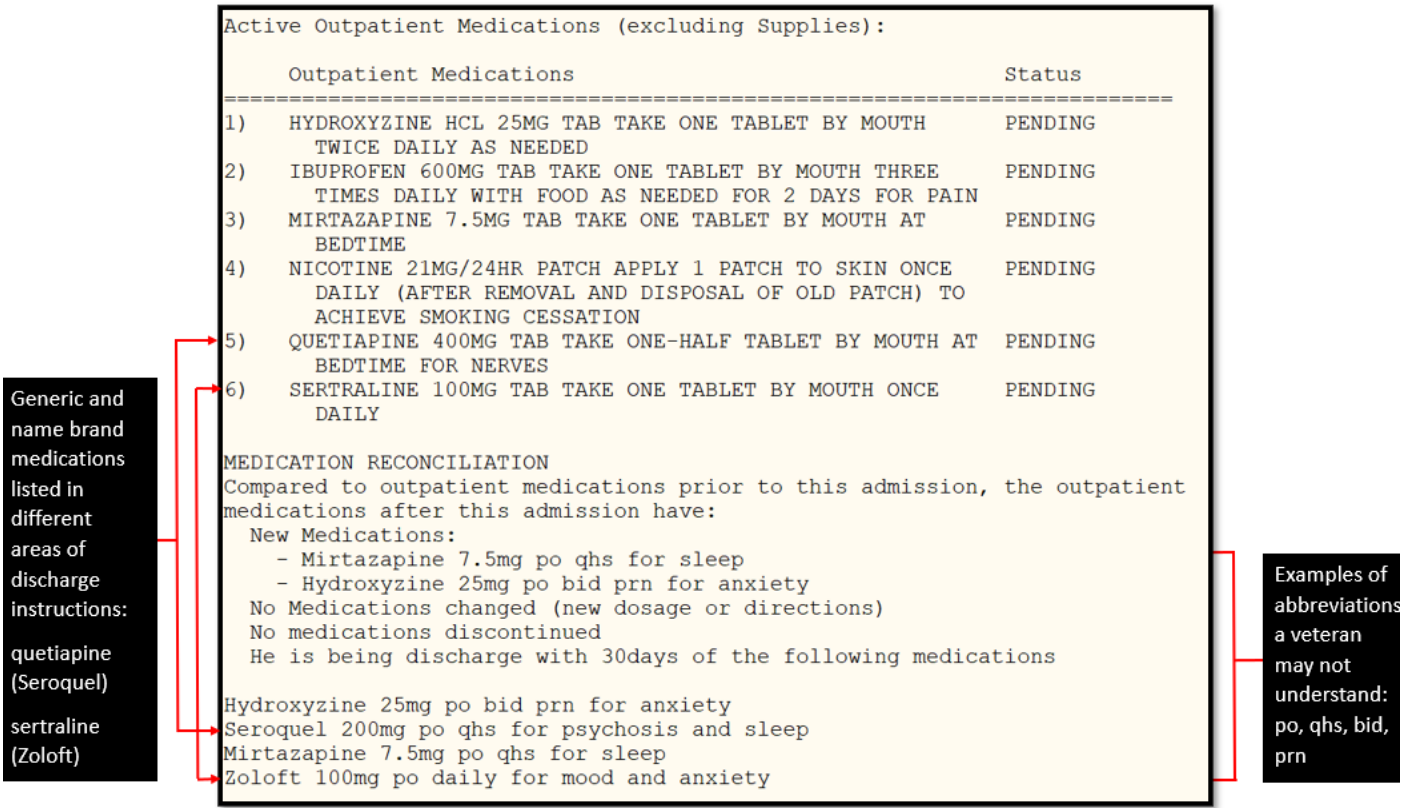

Figure 7. *Example of discharge instructions provided to a veteran.*
Source: OIG review of veterans' EHRs.
Note: Quetiapine is an antipsychotic medication with a trade name of Seroquel and sertraline is an antidepressant medication with a trade name of Zoloft. The terms po, qhs, bid, and prn are used to describe how and when medications should be taken.

Recommendations

8. The VA Augusta Health Care System Director ensures accurate reporting of inpatient operating beds and implements processes to monitor.

   VHA concurred with the recommendation and provided an action plan to be completed by November 2024.

9. The VA Augusta Health Care System Director identifies and addresses barriers to admission for veterans on involuntary holds for mental health treatment.

   VHA concurred with the recommendation and provided an action plan to be completed by October 2024.

10. The VA Augusta Health Care System Director ensures alignment between involuntary commitment policies and practices, consistency with state laws, and implementation of monitoring processes.

VHA concurred with the recommendation and provided an action plan to be completed by February 2025.

11. The VA Augusta Health Care System Chief of Staff ensures assignment of ongoing responsibilities for monitoring timely documentation of the change in veterans' voluntary or involuntary legal status, consistent with VHA policy and state laws.

    VHA concurred with the recommendation and provided an action plan to be completed by November 2024.

12. The VA Augusta Health Care System Chief of Staff ensures timely documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications and monitors for improvement.

    VHA concurred with the recommendation and provided an action plan to be completed by November 2024.

13. The VA Augusta Health Care System Director ensures the development and implementation of clearly defined written processes for transition of care when veterans are discharged from the inpatient mental health unit.

    VHA concurred with the recommendation and provided an action plan to be completed by November 2024.

14. The VA Augusta Health Care System Chief of Staff ensures discharge summaries are completed within two business days of discharge and monitors for compliance.

    VHA concurred with the recommendation and provided an action plan to be completed by January 2025.

15. The VA Augusta Health Care System Chief of Staff ensures discharge instructions for veterans include appointment location and contact information in easy-to-understand language.

    VHA concurred with the recommendation and provided an action plan to be completed by September 2024.

16. The VA Augusta Health Care System Director ensures that medications listed in discharge instructions include the purpose for each medication and are written in easy-to-understand language.

    VHA concurred with the recommendation and provided an action plan to be completed by January 2025.

For detailed action plans, see appendix E.

Suicide Prevention

The underlying causes of death by suicide can be complex and multifactorial.[80] Preventing suicide may require coordinated systems, services, and resources to effectively support at-risk veterans.[81]

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."[82] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[83]

To evaluate suicide prevention activity on the inpatient unit, the OIG assessed compliance with required suicide risk screening and evaluation, safety planning, and training (see appendix B for methodology).

Suicide Risk Screening and Evaluation

The OIG reviewed EHRs of veterans who received care on the inpatient unit and found 88 percent included evidence of a completed Columbia-Suicide Severity Risk Scale Screener (C-SSRS); however, 42 percent of the C-SSRSs were not completed within the 24 hours prior to discharge, as required.[84] The Chief of Mental Health reported being unaware of the reason the C-SSRSs were not conducted within 24 hours prior to discharge. Failure to complete suicide risk assessments prior to inpatient unit discharge may result in lack of awareness of a veteran's suicide risk, leading to an insufficient understanding of readiness for discharge and post-discharge care coordination needs.

Safety Planning

Of the records reviewed, the OIG found the majority of safety plans were documented in a nationally standardized note title with most required elements completed or reviewed, and a copy

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

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

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

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

[84] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," November 4, 2021; VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," updated May 10, 2023. The OIG considered EHRs compliant if C-SSRS documentation was completed within 24 hours of discharge or on the date of discharge.

was provided to the veteran at discharge, as required by VHA (see appendix A for more detail on requirements).[85]

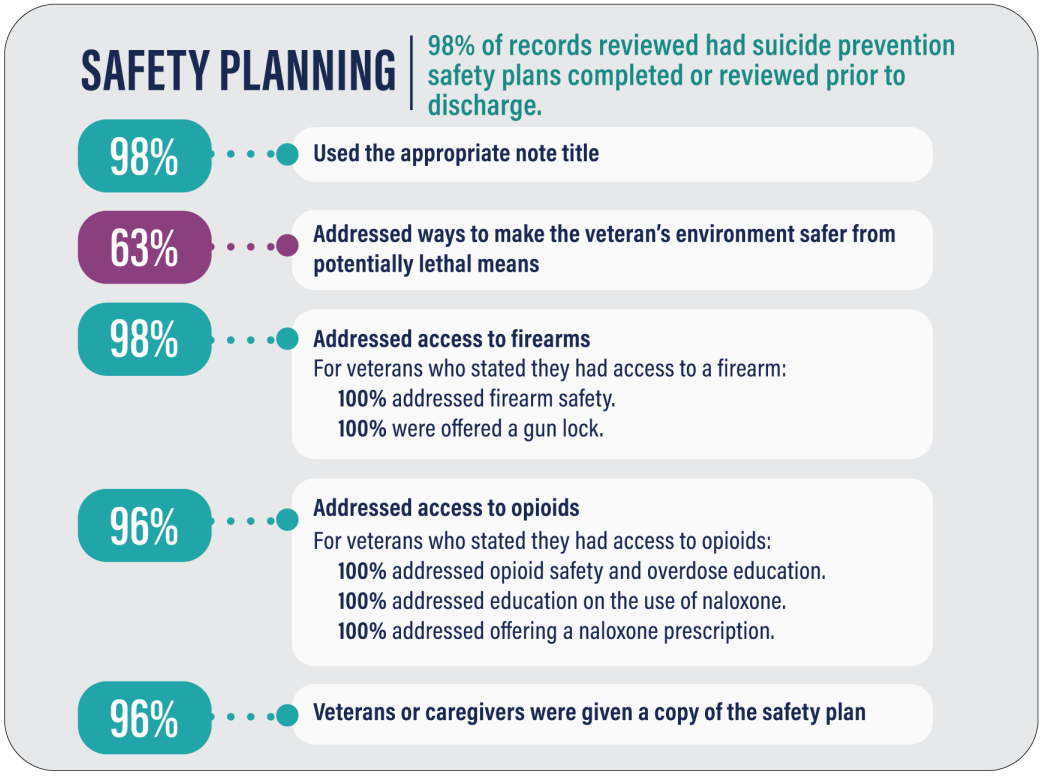

Figure 8. *Augusta HCS staff's compliance with safety planning expectations.*
Source: OIG review of veterans' EHRs.

The OIG found that 63 percent of the safety plans reviewed addressed ways to make the environment safer from potentially lethal means (see figure 8), including safety considerations beyond access to firearms and opioids.[86]

The Chief of Mental Health reported uncertainty on the reasons providers did not address ways to make the environment safer. The identification of all potential lethal means in the environment, beyond firearms and opioids, may reduce the risk of veteran harm.[87]

[85] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOP uses similar language related to providing veterans a written copy of the safety plan as the rescinded handbook; 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.

[86] VA, *VA Safety Planning Intervention Manual*, February 23, 2022.

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

Training

Skills Training for Evaluation and Management of Suicide (STEMS) and VA S.A.V.E. help clinicians and staff, respectively, identify the warning signs of suicide risk and appropriate interventions.[88] Lethal means safety training provides guidance on how to work with veterans and their families to reduce suicide risk, which includes "firearm and medication safe storage practices."[89]

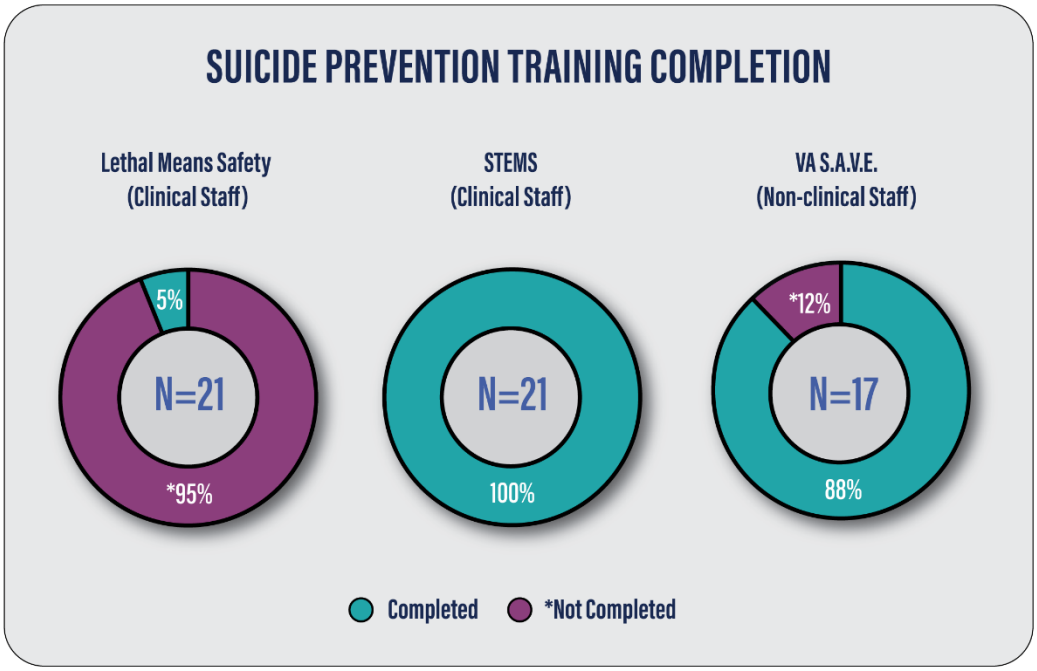

Figure 9. *Inpatient mental health staff completion of mandatory suicide prevention training.*
Source: OIG document review of clinical and non-clinical staff training certificates.
Note: The OIG considered completion of STEMS and VA S.A.V.E. trainings during the time frame of January 8, 2023, through January 8, 2024; and Lethal Means Safety Training was completed once during the clinical staff's employment.

[88] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; The acronym "S.A.V.E" summarizes the steps needed to take in recognizing and responding to a veteran in suicidal crisis: signs of suicidal thinking, ask questions, validate the person's experience, encourage treatment and expedite getting help. VA, "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis" (fact sheet), September 2023.

[89] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), March 17, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network Directors (10N1-23), May 2, 2024. Both memorandums have similar language related to Lethal Means Safety Education and Counseling training requirements.

The OIG found Augusta HCS compliant with completion of STEMS but noncompliant with completion of VA S.A.V.E. and lethal means safety training requirements (see figure 9).[90] The Chief of Mental Health reported staff's training completion may not be accurately reflected in the system used to track trainings. When staff fail to complete required suicide risk training, they may miss critical signs of suicide risk and be unaware of resources and interventions to keep veterans safe.

Recommendations

17. The VA Augusta Health Care System Chief of Staff identifies barriers to completing the Columbia-Suicide Severity Risk Scale Screener within 24 hours prior to discharge, implements processes, and monitors to ensure compliance.

    VHA concurred with the recommendation and provided an action plan to be completed by February 2025.

18. The VA Augusta Health Care System Chief of Staff ensures that safety plans address ways to make the veteran's environment safer from potentially lethal means and monitors for compliance.

    VHA concurred in principle and provided an action plan to be completed by February 2025.

19. The VA Augusta Health Care System Director ensures staff comply with lethal means safety training and suicide risk training requirements and monitors for compliance.

    VHA concurred with the recommendation and provided an action plan to be completed by January 2025.

For detailed action plans from VHA, see appendix E.

[90] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., June 9, 2022; VHA Directive 1108.13(1), *Provision and Use of Nursing Medication Management Protocols in Outpatient Team-based Practice Settings*, February 6, 2019, amended on March 13, 2019; VHA Directive 2013-006, *The Use of Unlicensed Assistive Personnel (UAP) in Administering Medication*, March 5, 2013.

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.[91] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[92]

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 (see appendix B for methodology).

Mental Health Environment of Care

As required, the Augusta HCS inpatient unit was locked.[93] In accordance with VHA policy, the inpatient unit had a restraint room with a bed bolted to the floor and a seclusion room.[94] The Augusta HCS had a written policy that outlined the use of the restraint and seclusion room.[95] However, an inpatient unit staff member informed the OIG that the seclusion room had never been used and the restraint room had not been used since 2020. Therefore, the OIG did not evaluate data for process improvement efforts to reduce seclusion and restraint usage. Additionally, the inpatient unit had a staff office, which was locked when not in use, as required.[96] The Mental Health Environment of Care Checklist (MHEOCC) is used to "identify and abate suicide hazards" on inpatient mental health units (see figure 10).[97]

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[91] VHA Directive 1160.06.

[92] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

[93] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to requirements for a locked inpatient unit.

[94] VHA Handbook 1160.06; VHA Directive 1106.06. The policies contain similar language related to designated seclusion and restraint room. The policies specify that every inpatient unit must have a room available for physical restraint and seclusion when a veteran's behavior "presents an imminent risk of harm to self or others" and "de-escalation interventions and therapeutic communication are ineffective"; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, March 7, 2022, accessed June 17, 2024, https://dvagov.sharepoint.com/:x:/r/sites/vhavalbengineeringservice/_layouts/15/Doc.aspx?sourcedoc=%7B326C8873-B567-4C18-9B1F-261BBE89FFD9%7D&file=VA-NCPS-Mental-Health-Environment-of-Care-Checklist-20220307%20(1).xlsx&action=default&mobileredirect=true&DefaultItemOpen=1. (This site is not publicly accessible.)

[95] Charlie Norwood VA Medical Center Policy 6008.509, "Restraint and Seclusion Use," September 30, 2022.

[96] VHA Directive 1167; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety. March 7, 2022.

[97] VHA Directive 1167. The MHEOCC is a "checklist designed to help identify and abate suicide hazards on mental health units and other areas treating patients 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 rooms, and staff work stations."

Figure 10. *MHEOCC categories.*
Source: OIG analysis of Augusta HCS MHEOCC documents (received January 16, 2024), VHA Directive 1167, and National Patient Safety Center guidance.

The Interdisciplinary Safety Inspection Team (ISIT) is the "team that conducts the inspection of the mental health unit using the MHEOCC" at least every six months, tracks deficiencies and actions in the Patient Safety Assessment Tool (PSAT), and records ISIT meeting minutes.[98]

Although MHEOCC inspections were conducted twice per year in FY 2022 and FY 2023 and the patient safety manager reported being responsible for entering the information into the PSAT, the OIG found that the required ISIT was not established (see appendix A). MHEOCC trainings were not consistently completed as required by VHA, and meeting minutes were not recorded.[99] The lack of compliance with all required features of an ISIT may result in failure to identify and mitigate safety hazards.

The OIG observed toilets in several veterans' rooms on the inpatient unit had ligature points that posed a safety risk for veterans.[100] In the January 2024 PSAT, Augusta HCS staff documented the risk level for ligature points on toilets as "catastrophic."[101] The OIG concluded Augusta HCS leaders' actions to mitigate the "catastrophic" risk, which involved routine 15-minute checks of veterans' rooms and replacement of select toilet components, were delayed and insufficient.

The OIG also reviewed PSAT information from FY 2022 and FY 2023 and found that toilets on the inpatient unit were not identified as safety hazards. Mental health leaders verbalized

[98] VHA Directive 1167. The Patient Safety Assessment Tool is a "web-based assessment tool managed by the VHA National Center for Patient Safety (NCPS)."

[99] VHA Directive 1167.

[100] Katie Byrne et al., "Special Report: Suicide Prevention in Health Care Settings," *The Joint Commission Perspectives* 37, no. 11 (November 2017): 1–16. Per The Joint Commission, "definition of ligature resistant: "Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustain-able point of attachment that may result in self-harm or loss of life"; VA, *Environmental Programs Service Mental Health Guide*, 2014.

[101] VA, *Environmental Programs Service Mental Health Guide*, 2014.

awareness of the toilet seat ligature risk.[102] The inpatient nurse manager reported the routine 15-minute checks would mitigate the ligature risk. Following the on-site inspection, Augusta HCS leaders implemented a mitigation plan at the request of the OIG; however, the OIG determined that the safety issue was not fully resolved and a long-term solution was needed. Leaders' failure to take effective actions to identify and mitigate environmental risks on the inpatient unit could result in veteran harm.

Training

MHEOCC training orients staff on the "content and proper use" of the tool to identify and correct environmental risks.[103] Each of the inpatient MHEOCC categories listed above includes multiple individual items that must be evaluated during semi-annual inspections.[104]

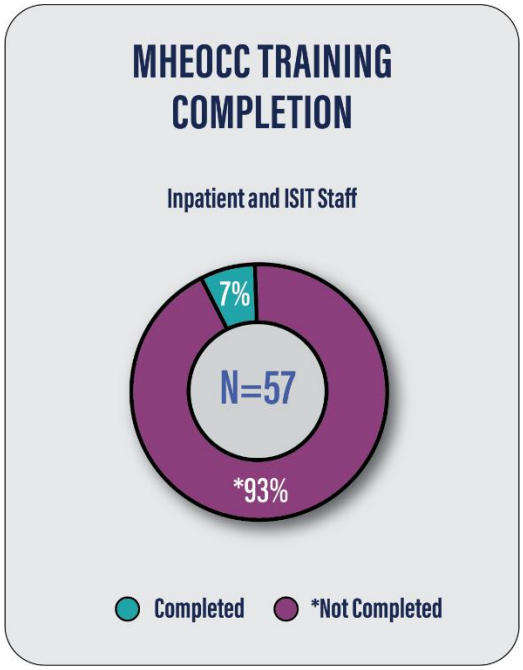

Figure 11. *MHEOCC training completion. Source: OIG document review of staff training certificates.*

[102] Memorandum from Augusta HCS Director to the OIG, February 8, 2024. According to the memorandum, "the installation date of the current toilets on 2G: The original 2G floor plan was designed on 15 September 1986 and in 1991 the toilets were installed on the 2G unit before it became activated in 1993."

[103] VHA Directive 1167. ISIT members not assigned to the inpatient unit are still required to complete the training.

[104] VHA Directive 1167.

The OIG found inpatient unit staff and Augusta HCS staff responsible for conducting inpatient unit safety inspections were noncompliant with VHA required annual MHEOCC training (see figure 11).[105] Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.[106]

Recommendations

20. The VA Augusta Health Care System Director ensures compliance with VHA requirements for the Interdisciplinary Safety Inspection Team, including environment of care subcommittee structure, and Mental Health Environment of Care Checklist training completion.

    VHA concurred with the recommendation and provided an action plan to be completed by November 2024.

21. The VA Augusta Health Care System Chief of Staff ensures mental health leaders update inpatient unit toilets to meet safety requirements and implement processes to reduce associated safety risks.

    VHA concurred with the recommendation and provided an action plan to be completed by September 2024.

For detailed action plans, see appendix E.

[105] VHA Directive 1167.

[106] VHA Directive 1167.

Conclusion

Augusta HCS met some of the VHA requirements for inpatient mental health units, such as the presence of an MHEC, completion of twice-yearly environment of care inspections, and a plan for continued transformation to recovery-oriented services. Most mental health staff and leaders responded positively to survey questions about psychological safety and continuous process improvement. Additionally, EHR reviews indicated veterans and the interdisciplinary treatment team were involved in treatment planning, and most veterans had documented safety plans.

However, the OIG was concerned about access to inpatient mental health care. The HCS had conflicting policies and practices regarding inpatient admission of veterans on an involuntary status. The high volume of community referrals contrasted with Augusta HCS's low bed utilization. Augusta HCS accommodated fewer than nine patients at a given time, despite having 34 approved operating beds. The OIG identified communication gaps between HCS and mental health leaders regarding the explanations for beds being out of service, causes of low bed utilization, and process improvement efforts to address these concerns.

Veterans who received inpatient mental health treatment at Augusta HCS experienced a physical environment that incorporated natural sunlight in some common areas but was lit with fluorescent lighting, and in need of cosmetic improvements and additional furnishings in the outdoor and sleeping areas. The inpatient unit contained toilets with ligature points that posed a safety risk, and Augusta HCS leaders' responses were delayed and insufficient.

Many staff who treated veterans on the inpatient unit did not have evidence of completed trainings on environment of care inspection requirements or suicide prevention strategies and some electronic health records did not include evidence of timely suicide risk screening. When released from inpatient hospitalization, veterans were typically offered discharge instructions that were difficult to understand and lacked important details for appointment follow-up and medication management.

The OIG issued 21 recommendations to Augusta HCS and VISN leaders. These recommendations, once addressed, may improve the quality and delivery of veteran-centered, recovery-oriented care on the inpatient mental health unit and beyond.

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.[107]

VHA requires inpatient unit staff use a veteran-centered, evidence-based, recovery-oriented approach that incorporates evaluation and monitoring, interdisciplinary treatment, discharge planning, adequate staffing, privacy, and respect.[108] To evaluate the quality of recovery-oriented care provided at the Augusta HCS, the OIG assessed compliance with VHA requirements in the six 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.

According to VHA's requirements, the HCS director is responsible for overseeing inpatient mental health services.[109] The chief of staff, in collaboration with the associate director of patient care services, should ensure that inpatient units have adequate staffing to establish interdisciplinary teams, provide services, and fully implement program requirements.[110]

Each HCS must have a dedicated mental health lead with overall responsibility for mental health service operations, including mental health services that may be aligned under a different department.[111] The mental health lead may also be referred to as the mental health service line director, chief of mental health, or other comparable title.[112] The mental health lead serves as the chair of the HCS MHEC, which ensures staff provide high-quality care and are responsive to veterans' preferences.[113] Each MHEC must include at least one veteran, ideally one who is

[107] VHA Handbook 1160.06; VHA Directive 1160.06.

[108] VHA Handbook 1160.06; VHA Directive 1160.06.

[109] VHA Handbook 1160.06; VHA Directive 1160.06.

[110] VHA Handbook 1160.06; VHA Directive 1160.06. The directive assigns the responsibility of ensuring adequate staffing of the inpatient unit to the chief of staff in collaboration with the associate director of patient care services.

[111] VHA Directive 1160.01.

[112] VHA Directive 1160.01.

[113] VHA Directive 1160.01.

receiving mental health services and not employed at the HCS. The MHEC should meet quarterly and "record minutes that are accessible to all mental health clinical staff."[114]

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 law, regulation, policy, and procedures."[115]

VHA requires the appointment of a full-time VISN CMHO to "ensure transparency of decision-making and to promote communication between the field and central office."[116] The CMHO chairs the VISN MHEC; each HCS's mental health lead is expected to participate. The VISN MHEC oversees and monitors quality, identifies areas of concern, and communicates critical matters to VISN and senior VHA leaders.[117]

The HCS mental health lead must assign an inpatient mental health program manager who coordinates programming and ensures it is effectively integrated into the inpatient unit setting.[118] In addition, each HCS is required to have an LRC who spends 75 percent of their time ensuring that mental health services demonstrate recovery-oriented principles and "no more than 25 percent" of their time providing direct clinical care.[119] The LRC collaborates with local mental health leaders to implement a continuous improvement plan that must be updated every three years.[120]

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.[121] "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."[122] Peer support staff must be available for veterans when clinically indicated and may serve as members of an interdisciplinary treatment team.[123]

[114] VHA Directive 1160.01.

[115] VHA Handbook 1160.06; VHA Directive 1160.06.

[116] "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.)

[117] VHA Directive 1160.01.

[118] VHA Handbook 1160.06; VHA Directive 1160.06.

[119] VHA Directive 1163.

[120] VHA Directive 1163.

[121] VHA Directive 1163. Peer support staff may also be referred to as peer specialists.

[122] VHA Directive 1163.

[123] VHA Directive 1160.06; VHA Directive 1163.

High Reliability Principles

VHA expects VISN and HCS directors to integrate the high reliability concepts of psychological safety and continuous performance improvement into care delivery.[124] A high reliability organization focuses on patient safety, "zero harm," and continual process improvement.[125] Psychological safety is "the belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes" and continuous process improvement includes the actions to improve processes within the organization that affect veteran care.[126]

Recovery-Oriented Principles

The 2003 President's "New Freedom Commission on Mental Health" report outlined a vision for the delivery of recovery-oriented mental health care.[127] 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."[128]

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit.[129] VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care, and therefore, requires HCSs to create a hopeful and healing environment while maintaining

[124] VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)," September 2022, accessed October 26, 2023, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/HRO%20Assessment%20and%20Planning%20Resources.aspx?id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Enterprise%20Operating%20Plan%20Guidance%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This site is not publicly accessible.)

[125] VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

[126] VA, "VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)"; VA, "VHA High Reliability Organization (HRO) Reference Guide," April 2023, accessed October 26, 2023, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/Edit_View.aspx?viewid=d00dd726%2D93d3%2D4e54%2Db90b%2D2c82cada6a83&id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Reference%20Guide%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This site is not publicly accessible.)

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

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

[129] VHA Directive 1160.06; VHA Directive 1163; VHA Directive 1160.01.

safety.[130] VHA requires inpatient unit staff to provide "evidence-based medication management, psychosocial rehabilitation, evidence-based psychotherapy, patient education, medical care" and other therapies using recovery-oriented methods.[131]

Clinical Care Coordination

Care coordination poses a major challenge to healthcare safety, especially for chronically ill individuals who receive services from multiple providers in a variety of settings.[132] VHA requires inpatient units to have an interdisciplinary treatment team composed of individuals who are responsible for the assessment, planning, and implementation of a veteran's care. An interdisciplinary approach is critical to ensure comprehensive, coordinated, and holistic care.[133]

VHA requires HCSs to have standard operating procedures outlining admission processes, and to provide access to mental health treatment for veterans who are either voluntarily or involuntarily held on an inpatient unit.[134] When treatment is not available within the HCS, a veteran may be transferred to another VHA or non-VHA HCS for inpatient mental health care.[135]

The federal government does not have civil commitment laws; therefore, HCSs are required to have clear guidelines that align with state civil commitment laws.[136] HCS staff must be aware of the veteran's legal status (voluntary or involuntary admission) to safeguard against potential civil rights violations, including illegal detainment in a locked inpatient unit.[137]

The interdisciplinary treatment team must ensure that the recovery-oriented treatment plan includes the veteran's personally-identified goals and is completed in collaboration with the

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

[131] VHA Handbook 1160.06; VHA Directive 1160.06. Per the directive, "A patient-centered recovery-oriented approach must be reflected in all VHA inpatient mental health units, including the services and treatments provided, language in new and existing inpatient documents and in the environment of care."

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

[133] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to the role of the interdisciplinary treatment team.

[134] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The directive and rescinded handbook contain similar language related to requirements for a locked inpatient unit that can also "accommodate involuntary" veterans; The Joint Commission, *Standards Manual e-dition*, PC.01.01.01."

[135] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to timely access and admission to inpatient mental health care.

[136] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to treatment access for veterans with involuntary status.

[137] VHA Handbook 1160.06; VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," revised April 5, 2023.

veteran.[138] The interdisciplinary treatment team must also ensure outpatient mental health care is coordinated with the veteran prior to discharge, including a scheduled post-discharge outpatient follow-up appointment.[139]

VHA requires that veterans receive a copy of the written discharge plan and a copy of the safety plan, as applicable, at discharge.[140] The written discharge plan must include the provider's name if available, as well as scheduling information for the follow-up appointments.[141]

Suicide Prevention

According to the *2023 National Veteran Suicide Prevention Annual Report*, "suicide was the 13th-leading cause of death for Veterans overall, and the second-leading cause of death among Veterans under age 45" in 2021.[142] Immediately following inpatient hospitalization, there is an increased risk for suicide attempt or completion.[143] Therefore, there is a critical need for suicide risk assessment prior to discharge from inpatient mental health care, as well as linkage to follow-up mental health care.[144]

Inpatient unit clinical staff are required to complete the C-SSRS, an evidence-based risk assessment tool, for veterans within 24 hours prior to discharge. A positive C-SSRS then requires

[138] VHA Handbook 1160.06; VHA Directive 1160.06. The policies contain similar language related to the veteran's input in treatment plan goals.

[139] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOP contains similar language related to post-discharge care as the rescinded handbook.

[140] VHA Handbook 1160.06; VHA Directive 1160.06. VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOP uses the term *written discharge plans* instead of *discharge instructions* when inpatient unit staff must provide the veteran with information regarding follow-up appointments.

[141] VHA Handbook 1160.06; VHA Directive 1160.06; VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." The SOP uses the term *written discharge plans* instead of *discharge instructions* when inpatient unit staff must provide the veteran with information regarding the written discharge plans.

[142] VA Suicide Prevention Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*, November 2023.

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

[144] 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.

the "timely completion of the [CSRE]."[145] The CSRE can be completed in lieu of the suicide risk screening prior to discharge.[146]

VHA requires providers to collaborate with veterans to create a suicide prevention safety plan, a written document emphasizing coping skills and sources of support, used to prevent and manage a crisis.[147] These plans must include, but are not limited to, discussion of environmental safety strategies, safety options, access to firearms and lethal medications.[148]

VHA requires healthcare providers complete STEMS and non-clinical staff complete VA S.A.V.E. training within 90 days of entering the position and annually.[149] In addition, all VHA healthcare providers must complete a one-time Lethal Means Safety Education and Counseling training within 90 days of entering the position.[150] In June 2022, VHA issued a memorandum indicating a target of at least 95 percent completion for mandatory suicide prevention trainings.[151]

Safety

In VHA HCSs, inpatient mental health units must be designed to ensure veteran safety while still integrating recovery-oriented principles into the environment.[152] ISIT members and all inpatient

[145] VA, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020.

[146] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting," updated November 4, 2021; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., November 23, 2022. VHA's two-phase process to screen and assess for suicide risk in clinical settings includes the C-SSRS and subsequent completion of the Comprehensive Suicide Risk Evaluation (CSRE) when the screen is positive; VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Frequently Asked Questions (FAQ)," updated December 13, 2022.

[147] VHA Directive 1160.07.

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

[149] VHA Directive 1071(1).

[150] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), March 17, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Lethal Means Safety (LMS) Education and Counseling," memorandum to Veterans Integrated Services Network Directors (10N1-23), May 2, 2024. Both memorandums have similar language related to Lethal Means Safety Education and Counseling training requirements.

[151] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Lethal Means Safety (LMS) Education and Counseling," memorandum; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification." As of June 2022, VHA required at least a 95 percent compliance with mandatory suicide prevention trainings.

[152] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

unit staff are responsible for ensuring a safe environment.[153] Additionally, the ISIT is required to assess the inpatient unit every six months for suicide hazards using the MHEOCC and the patient safety manager or other designated mental health staff track corrective actions taken for identified environmental risks.[154]

The ISIT is a mandatory subcommittee of the HCS environment of care committee, with membership and date of members' last MHEOCC training documented in the ISIT meeting minutes.[155] The ISIT "should include the Suicide Prevention Coordinator, a Patient Safety Manager, a Facility Safety Officer, a Mental Health Unit Nurse Manager, a non-mental health Unit Nurse Manager, an inpatient Licensed Independent Practitioner, the Local Recovery Coordinator, an outpatient mental health provider (e.g., an outpatient case manager, clinician, or Peer Specialist), a representative from Engineering, a representative from Environmental Services and a Pharmacist."[156]

[153] VHA Directive 1167.

[154] VHA Directive 1167. The MHEOCC is a "checklist designed to help identify and abate suicide hazards on mental health units and other areas treating patients 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 rooms, and staff work stations."

[155] VHA Directive 1167.

[156] VHA Directive 1167.

Appendix B: Methodology

The Mental Health Inspection Program reviews began in FY 2024 and focused on the quality of care provided by VHA's inpatient mental health services.[157] VHA HCSs included in FY 2024 reviews were randomly selected from all HCSs with inpatient mental health beds.[158]

The OIG conducted a virtual and on-site review at the Augusta HCS in Georgia from January 8 through February 2, 2024. The OIG did not receive any complaints beyond the scope of this review that required referral to the OIG hotline.

The OIG reviewed Augusta HCS level data, conducted document and EHR reviews, distributed a questionnaire to mental health staff and leaders, conducted a physical inspection of the inpatient unit, and interviewed key staff and leaders. Except for a 95 percent threshold for mandatory suicide prevention training completion, the OIG used 90 percent as the expected level of compliance in record review. The OIG also reviewed open recommendations from prior OIG reviews that were determined to be applicable to the inpatient unit.

The OIG's analysis relied on inspector identification of salient information based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* The OIG did not analyze compliance with individual HCS policies.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. Leaders' responses to the report recommendations appear within each domain and in appendix F.

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.[159] 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.

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

[158] The OIG identified HCSs with inpatient mental health beds using the Monthly Program Cost Report (MPCR) code of 1310 (High Intensity General Psychiatric Inpatient Unit). For FY 2024, the OIG excluded inpatient mental health beds visited in FY 2023 for preliminary research. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

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

Electronic Health Record Review

The OIG reviewed 50 randomly selected EHRs of veterans discharged from an acute inpatient mental health stay of more than 48 hours at the Augusta HCS from October 1, 2022, through September 30, 2023.[160]

Table B.1. EHR Review Results

Domain	Topic	Inspection Element Reviewed	Number of Records Included	Percent Compliant (%)
Clinical Care Coordination	Voluntary or involuntary treatment status	Documented within three days of admission	50	92
	Inpatient mental health treatment plan	Completed	50	100
		Veteran involved in development or offered opportunity	50	100
		Included interdisciplinary treatment team input	50	98
	New medication	Risk and benefits discussed with veteran	37	73
	Discharge summary	Completed	50	100
		Completed within two business days of discharge	50	84
	Outpatient mental health follow-up appointment	Scheduled prior to discharge	50	92
	Discharge instructions	Completed	50	100
		Included outpatient mental health appointment	50	91
		Copy offered to veteran	50	100
		Included contact information of follow-up appointment	46	89
		Included location of follow-up appointment in easy-to-understand language	46	24
		Included medication list	47	100

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

Domain	Topic	Inspection Element Reviewed	Number of Records Included	Percent Compliant (%)
		Included reasons for prescribed medications	47	36
		Free of medication abbreviations that could be difficult to understand by a non-medically trained individual	47	23
		Free of generic and medication trade names used interchangeably with no explanation that they are the same medication	47	28
		Free of medication information that could be unclear or misleading	47	51
Suicide Prevention	Columbia-Suicide Risk Scale Screener	Completed prior to discharge	50	88
		Completed within 24 hours prior to discharge	50	42
	Suicide Prevention Safety Plan	Completed or reviewed prior to discharge	49	98
		Used appropriate note title	49	98
		Addressed ways to make the veteran's environment safe from potentially lethal means	48	63
		Addressed access to firearms	48	98
		Addressed firearm safety	6	100
		Offered a gun lock	6	100
		Addressed access to opioids	48	96
		Addressed opioid safety and overdose education	2	100
		Addressed education on the use of naloxone	2	100
		Addressed offering a naloxone prescription	2	100
		Offered veteran or caregiver a copy	46	96

Source: OIG review of the VA Augusta Mental Health Inpatient Unit EHRs.
Note: The OIG considers the words "addressed" and "completed" to be equivalent related to the inspection elements that were reviewed. Due to exclusion criteria, the number of included records does not always equal 50.

Questionnaire

To assess perceptions of psychological safety and performance improvement activities, the OIG sent a questionnaire to 55 individuals identified by Augusta HCS as staff and leaders who had interactions with the inpatient unit. Additionally, all questions in the report appear as written in the questionnaire and respondents were not given instructions on how to interpret questions. The OIG received 32 completed questionnaires (58 percent).[1]

OIG Inspection of the Physical Environment

The OIG inspected selected areas of the inpatient unit to evaluate if Augusta HCS provided a therapeutic, recovery-oriented environment and maintained veteran safety.[161] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as natural lighting, artwork, and calming paint colors. The OIG also observed the unit for general cleanliness and veteran access to private and outdoor space.[162]

The OIG reviewed the PSAT for MHEOCC inspections completed in FY 2022, FY 2023, and January 2024, and assessed corrective actions taken for deficiencies unresolved for more than six months.

[161] VHA Handbook 1160.01; VHA Handbook 1160.06; VHA Directive 1160.06. Handbook 1160.06 and Directive 1160.06 contain similar language related to expectations for a safe and recovery-oriented environment; A unit is an "area in a medical facility and especially a hospital that is specially staffed and equipped to provide a particular type of care." *Merriam-Webster.com Dictionary*, "unit," accessed August 9, 2022, https://www.merriam-webster.com/dictionary/unit.

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

Appendix C: Organizational Structure and Staffing

The OIG evaluated the leadership organizational structure within VISN 7 and the Augusta HCS, including reporting authority and delineation of direct or indirect oversight responsibilities.

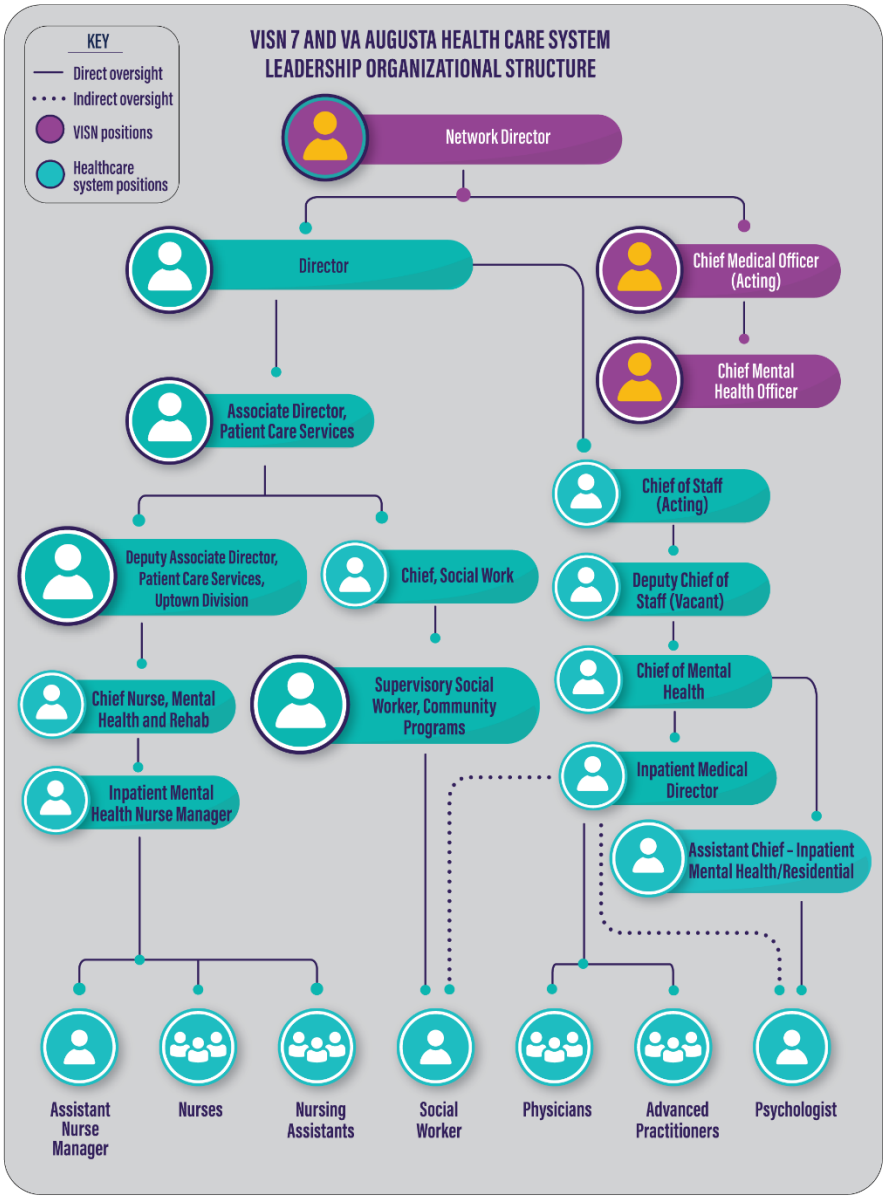

Figure C.1. *VISN 7 and Augusta HCS organizational structure.*
Source: Augusta HCS documents (received January 10, 2024, through March 5, 2024); OIG analysis of VHA Directive 1160.06 and VHA Directive 1160.01.
Note: The Inpatient Medical Director also served as the Inpatient Mental Health Program Manager. The OIG considers the direct supervisor of each position to be the equivalent of "direct oversight," and programmatic oversight of identified positions as the equivalent of "indirect oversight."

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

Table C.1. Inpatient Unit Staffing

Discipline	Number of Employees	Percent Dedicated Per Employee
Advanced Practitioner	2	100
Internist	1	75
Nurse*	14	100
Nursing Assistant/Health Technician‡	12	100
Medical Director	1	50
Psychiatrist	5	70–75
Psychologist	1	95
Social Worker	1	100

Source: OIG review of the Augusta HCS Mental Health Inpatient Unit Staffing Spreadsheet (received from January 10, 2024, through February 16, 2024).

Note: percentage of time dedicated to inpatient mental health care.

**Nursing staff includes 1 nurse manager, 1 assistant nurse manager, 9 registered nurses and 3 licensed practical nurses.*

‡ *Nursing assistant/health technician staff include 11 nursing assistants and 1 health technician.*

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: [Date of signed memo]

From: Veterans Integrated Service Network (VISN) 7 Network Director, VA Southeast Network (10N7)

Subj: Office of Inspector General (OIG) Draft Report: Mental Health Inspection of the VA Augusta Health Care System in Georgia

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

1 Thank you for the opportunity to review and comment on the draft report regarding the Mental Health Inspection of the VA Augusta Health Care System in Georgia.

2. I concur with recommendations 1-2, 4-17, and 19-21, concur in principle with recommendations 3 and 18, and provide action plans submitted by the VISN and VA Augusta Health Care System in Georgia. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

3. If you have any questions or require further information, please contact the VISN 7 Quality Management.

(*Original signed by:*)

Benita K. Miller
Deputy Network Director
for
David M. Walker, MD. MBA, FACHE
Network Director

[OIG comment: The OIG received the above memorandum from VHA on August 30. 2024.]

Appendix E: Health Care System Director Memorandum

Department of Veterans Affairs Memorandum

Date: August 30, 2024

From: Executive Director, VA Augusta Health Care System (509/00)

Subj: Office of Inspector General (OIG) Draft Report: Mental Health Inspection of the VA Augusta Health Care System in Georgia

To: Veterans Integrated Service Network (VISN) 7 Network Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review and comment on the draft report regarding the Mental Health Inspection of the VA Augusta Health Care System in Georgia.

2. I concur with recommendations 1-2, 4-17, and 19-21, concur in principle with recommendations 3 and 18, and provided action plans in the attachment.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans. We will continue to partner with the Office of Inspector General, VISN, and VA Augusta Leadership to implement corrective actions as we are committed to ensuring Veterans we serve receive exceptional service at our health care system.

4. Comments regarding the contents of this memorandum may be directed to the High Reliability Organization/Quality and Patient Safety Manager.

(*Original signed by*:)

Robin E. Jackson, PhD
Executive Director

[OIG comment: The OIG received the above memorandum from VHA on August 30, 2024.]

Health Care System Director Responses

Recommendation 1

The VA Augusta Health Care System Director ensures that the Mental Health Executive Council includes veteran representation.

_X __Concur

_____Nonconcur

Target date for completion: November 2024

Director Comments

The Chief of Mental Health will ensure that Veteran representatives are solicited by the Local Recovery Coordinator (LRC) from various sources, including the Veterans Mental Health Council, Mental Health program interdisciplinary teams, and notices posted in Mental Health areas. Interested Veterans will contact the LRC, who will discuss the timeline and requirements for the role. Selected Veteran(s) will receive an electronic invite to upcoming meetings. An update on the progress and status of Veteran representation on the committee will be provided monthly in each Mental Health Executive Committee meeting and documented in minutes. In April 2024, the Mental Health Service at the VA Augusta Health Care System (VAAHCS) identified a Veteran for this role and extended invitations to the meetings. Alternate participants will be identified by November 2024.

Recommendation 2

The Veterans Integrated Service Network Director implements processes to strengthen oversight and monitoring of bed utilization.

_X __Concur

_____Nonconcur

Target date for completion: November 2024

Director Comments

As of June 2024, Veterans Integrated Service Network (VISN 7) developed a huddle board for all VISN 7 facilities to update daily. The intent is to provide the VISN 7 Bed Management System coordinator with an overview of each facility's bed statuses and strengthen oversight and monitoring of bed utilization. VAAHCS Bed Management System Coordinators provide information on, but not limited to, daily bed availability, total facility census (Uptown and Downtown combined), and uses heat mapping to indicate instances of diversion or "out of service" beds throughout the facility (positive reports will change the area from green to red).

Comments regarding all discrepancies or issues are explained in the comments section of the huddle board. The VISN coordinator meets with all Bed Management System coordinators weekly and as needed to discuss the discrepancies listed. The VISN Chief Mental Health Officer will monitor the huddle board and summarize actions in the monthly Mental Health Integrated Clinical Community, which reports up through the VISN Healthcare Delivery Council to the VISN Executive Leadership Council.

Recommendation 3

The VA Augusta Health Care System Associate Director for Patient Care Services ensures that inpatient mental health unit staffing supports authorized bed capacity.

_X __Concur in Principle

_____Nonconcur

Target date for completion: November 2024

Director Comments

The Associate Director for Patient Care Services will apply nursing staffing methodology per VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, based upon the daily census of the inpatient Mental Health unit. Authorized bed capacity is taken into consideration; however, it does not determine nursing staffing as the need to meet the daily census. The demand for Mental Health services is the driving force for nurse staffing of the inpatient Mental Health unit. As the average daily census increases or decreases, staffing will be reviewed and adjusted accordingly to support inpatient Mental Health care using the nursing staffing methodology appropriately. Education will be provided to the Chiefs of Nursing and the Deputy Directors of Patient Care Services by the Associate Director of Patient Care Services. In addition, the Chiefs will educate the Nurse Managers and Assistant Nurse Managers for their specific services and document in their meeting notes. The Chiefs will also attend front-line staff meetings with documentation of attendance and conversation concerning the current staffing model and following the Staffing Methodology elements. These meetings began on July 1, 2024. The Associate Director of Patient Care Services will also present the current staffing methodology during the nursing staff Town Hall meeting. The Town Hall will be recorded should staff be unable to attend.

Recommendation 4

The VA Augusta Health Care System Director develops and implements processes to incorporate veteran input for process improvements.

_X __Concur

_____Nonconcur

Target date for completion: November 2024

Director Comments

The Inpatient Mental Health Program Manager, in coordination with the LRC, will create a brief survey for distribution to patients on the day of discharge, soliciting Veteran input on how the service and care can be improved. The LRC will summarize findings for discussion and additional input from the Veterans Mental Health Council and document the discussion in the Council's minutes. Improvements will be reviewed and identified areas for improvement will be implemented by the Inpatient Mental Health Program Manager and Chief of Mental Health. Opportunities for improvement and actions associated with Veteran feedback will be presented quarterly by the LRC to the Mental Health Executive Committee and captured in the minutes.

Recommendation 5

The VA Augusta Health Care System Chief of Mental Health develops processes to ensure integration of the Local Recovery Coordinator into the inpatient mental health unit to support recovery-oriented care.

_X __Concur

_____Nonconcur

Target date for completion: November 2024

Director Comments

The LRC position will be realigned to the Mental Health Service. As of July 25, 2024, the LRC is included as a participant in all inpatient treatment team meetings and process improvement workgroups established to address inpatient Mental Health care and ensure the integration of recovery principles and recovery-oriented services into inpatient Mental Health care. The LRC will also be responsible for assisting in the creation of Standard Operating Procedures needed to ensure recovery-oriented care. The LRC will also be responsible for collecting, reviewing, and coordinating process improvements needed to support recovery-oriented care. The Chief of Mental Health will ensure the LRC reports monthly to the Mental Health Executive Committee on process improvements and the integration of recovery-oriented care. A local Standard of Work will be created to document specific duties for which the LRC is responsible for on the inpatient Mental Health unit.

Recommendation 6

The VA Augusta Health Care System 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: January 2025

Director Comments

The Chief of Mental Health will ensure the implementation of a recovery-oriented interdisciplinary programming plan that includes a minimum of four hours of recovery-oriented, interdisciplinary programming on the weekends in coordination with the inpatient Mental Health Program Manager and unit Psychologist. The programming schedule will be updated and approved monthly by the inpatient Mental Health unit Program Manager and Chief of Mental Health. Group offering and attendance will be tracked and monitored by the unit Psychologist.

Recommendation 7

The VA Augusta Health Care System Director ensures continued implementation of a recovery-oriented environment on the inpatient mental health unit.

_X __Concur

_____Nonconcur

Target date for completion: September 2024

Director Comments

In July 2024, interior design submitted a furniture package to contracting for the purchase of outdoor furniture consisting of lounge chairs, tables, and stools for the inpatient Mental Health outdoor patio. New soft seating, behavior health furniture will be installed in the dayroom. Furniture placement will begin in August 2024. The wall colors are to be updated with a soothing palette color.

OIG Comments

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

Recommendation 8

The VA Augusta Health Care System Director ensures accurate reporting of inpatient operating beds and implements processes to monitor.

_X __Concur

_____Nonconcur

Target date for completion: November 2024

Director Comments

VA Augusta has 68 authorized Mental Health beds and 34 designated as operational. The current bed letter, dated 2019, reflects 68 Authorized Beds and 34 operational. The bed letter identified that 34 beds on the 2F Unit are closed due to the construction of the new Mental Health Unit. Several of the current Mental Health Unit rooms are designed for four persons. To strengthen patient privacy and to provide a recovery based therapeutic environment, the Mental Health Unit prioritizes the use of single and two-person room accommodations before placing three or more Veterans in a room. A written Mental Health Standard Operating Policy that outlines the process for room assignments and removes any confusion surrounding the number of operational beds will be published. Additionally, education will be provided for all Mental Health Leadership and Mental Health Inpatient Unit staff on authorized versus operational beds and the use of the bed-board which reflects the authorized and operational bed from every unit across VAAHC on a daily basis.

Recommendation 9

The VA Augusta Health Care System Director identifies and addresses barriers to admission for veterans on involuntary holds for mental health treatment.

_X __Concur

_____Nonconcur

Target date for completion: October 2024

Director Comments

The Facility Director has engaged with the Office of General Counsel and two of three identified barriers have been removed to allow for full implementation of involuntary admissions to the Inpatient Mental Health Treatment Unit. The remaining barrier is the recruitment of the Legal Status Manager to ensure the viability and compliance of the program with Georgia state laws. The position has been authorized for recruitment.

Recommendation 10

The VA Augusta Health Care System Director ensures alignment between involuntary commitment policies and practices, consistency with state laws, and implementation of monitoring processes.

_X __Concur

_____Nonconcur

Target date for completion: February 2025

Director Comments

The Standard Operating Procedures for admissions to the inpatient Mental Health unit were consolidated and the one final Standard Operating Procedure has been completed and approved by Chief Mental Health and the Medical Center Director. A Legal Status Manager will be designated while a permanent position is recruited. The Legal Status Manager's primary responsibility will be to monitor involuntary holds and commitments in the facility and ensure compliance with state laws regarding involuntary commitments as noted in the Standard Operating Procedure. Ten admission audits will be conducted monthly with a rate of 90% or greater compliance for three consecutive months.

Recommendation 11

The VA Augusta Health Care System Chief of Staff ensures assignment of ongoing responsibilities for monitoring timely documentation of the change in veterans' voluntary or involuntary legal status, consistent with VHA policy and state laws.

_X __Concur

_____Nonconcur

Target date for completion: November 2024

Director Comments

The Chief of Mental Health will hire a Legal Status Manager with the responsibility to monitor timely documentation of the change in Veteran's voluntary or involuntary legal status consistent with VHA policy and state laws. A Legal Status Manager will be designated, while a permanent position is recruited.

Recommendation 12

The VA Augusta Health Care System Chief of Staff ensures timely documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications and monitors for improvement.

_X __Concur

_____Nonconcur

Target date for completion: November 2024

Director Comments

A revised progress note template with a required field prompting patient education regarding medication risks and benefits was created and all medication providers were notified to use this note on February 2, 2024. Ten audits of prescriber medication documentation of risks and

benefits of newly prescribed medications will be conducted monthly, with a rate of 90% or greater compliance for three consecutive months.

Recommendation 13

The VA Augusta Health Care System Director ensures the development and implementation of clearly defined written processes for transition of care when veterans are discharged from the inpatient mental health unit.

_X __Concur

_____Nonconcur

Target date for completion: November 2024

Director Comments

The Chief of Mental Health in collaboration with inpatient Mental Health Program Manager will update the discharge Standard Operating Procedure to clarify processes for transition of care from acute inpatient to outpatient care. In addition, a Standard Operating Procedure describing the process for initial engagement of patients in outpatient care after discharge will be created and implemented. An audit of engagement after discharge will be completed on ten charts per month until compliance of 90% or greater is met for three consecutive months.

Recommendation 14

The VA Augusta Health Care System Chief of Staff ensures discharge summaries are completed within two business days of discharge and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: January 2025

Director Comments

All providers were educated on the expectation to complete discharge summaries within two business days in July 2024. This requirement will be incorporated into a Standard Operating Procedure. The Mental Health inpatient Program Manager will conduct discharge summaries audits to ensure they are completed within two business days and report to the Mental Health Executive Committee monthly. Thirty chart audits will be conducted monthly until compliance rate of 90% or greater is met for three consecutive months.

Recommendation 15

The VA Augusta Health Care System Chief of Staff ensures discharge instructions for veterans include appointment location and contact information in easy-to-understand language.

_X __Concur

_____Nonconcur

Target date for completion: September 2024

Director Comments

The Chief of Mental Health will collaborate with the Clinic Profile Manager to modify outpatient Mental Health clinics to include a "patient friendly" clinic name per the Clinic Profile Manager guideline book. In addition, a discharge checklist will be created to guide staff in completing the required documentation. A unit social worker will be assigned to meet with all patients prior to discharge to review the discharge instructions and clarify any concerns.

OIG Comments

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

Recommendation 16

The VA Augusta Health Care System Director ensures that medications listed in discharge instructions include the purpose for each medication and are written in easy-to-understand language.

_X __Concur

_____Nonconcur

Target date for completion: January 2025

Director Comments

The Chief of Mental Health and the Mental Health Inpatient Director will provide education to all providers regarding the requirements for the medication list and medication reconciliation portion of the discharge instructions. The education will include that all medications in the medication reconciliation list must be written in the same naming convention, either brand or generic, as that of the Outpatient Medications, all abbreviations utilized in the medication reconciliation list must be written out in easy-to-understand language, and all medications must have the purpose of the medication listed. The Mental Health inpatient Medical Director will conduct periodic audits of discharge summaries that list medications, including the purpose for each medication, and are written in easy-to-understand language monthly, with a rate of 90% or greater compliance for three consecutive months.

Recommendation 17

The VA Augusta Health Care System Chief of Staff identifies barriers to completing the Columbia-Suicide Severity Risk Scale Screener within 24 hours prior to discharge, implements processes, and monitors to ensure compliance.

_X __Concur

_____Nonconcur

Target date for completion: February 2025

Director Comments

In July 2023, all inpatient providers were educated on the required documentation prior to discharge from the inpatient Mental Health unit. In July 2023, the inpatient discharge note was revised to require completion of the Columbia-Suicide Severity Risk Scale. The Inpatient Mental Health discharge Standard Operating Procedure will be revised to include this requirement. In addition, a discharge checklist will be created to guide staff in completing the required documentation. A periodic audit will be conducted to review all discharges with a rate of 90% or greater compliance for three consecutive months.

Recommendation 18

The VA Augusta Health Care System Chief of Staff ensures that safety plans address ways to make the veteran's environment safer from potentially lethal means and monitors for compliance.

_X __Concur in Principle

_____Nonconcur

Target date for completion: February 2025

Director Comments

In August 2024, all inpatient providers were educated on the expectation to document a discussion of all potential lethal means. The Inpatient Mental Health discharge Standard Operating Procedure will be revised to include this requirement. In addition, a discharge checklist will be created to ensure the compliance with completion of a safety plan that addresses documentation of making the environment safe, including safety considerations beyond access to firearms and opioids. A periodic audit will be conducted of safety plans for a rate of 90% or greater compliance for three consecutive months.

Recommendation 19

The VA Augusta Health Care System Director ensures staff comply with lethal means safety training and suicide risk training requirements and monitors for compliance.

_X __Concur

_____Nonconcur

Target date for completion: January 2025

Director Comments

The Chief of Mental Health will ensure all staff assigned to the inpatient Mental Health unit complete safety training requirements in the Talent Management System for lethal means safety training for clinical staff and VA S.A.V.E. suicide risk training for non-clinical staff. Clinical staff will complete a one-time lethal means safety training during the onboarding process. The status of suicide prevention training for inpatient Mental Health staff will be reported quarterly by the inpatient Mental Health Program Manager to the Mental Health Executive Committee. Audits of all inpatient staff will be conducted monthly to ensure a rate of 90% compliance for six consecutive months.

Recommendation 20

The VA Augusta Health Care System Director ensures compliance with VHA requirements for the Interdisciplinary Safety Inspection Team, including environment of care subcommittee structure, and Mental Health Environment of Care Checklist training completion.

_X __Concur

_____Nonconcur

Target date for completion: November 2024

Director Comments

On March 18, 2024, a team was put together and met to discuss establishing a formal Interdisciplinary Safety Inspection Team as a sub-committee of the Comprehensive Environment of Care Committee according to VHA Directive 1167, Mental Health Environment of Care Checklist (MHEOCC) for Mental Health Units Treating Suicidal Patients, published in May 2017. In June 2024, an Interdisciplinary Safety Inspection Team subcommittee charter was presented and approved in the Environment of Care Committee. The Interdisciplinary Safety Inspection Team subcommittee met on May 14, 2024, and June 18, 2024. The Interdisciplinary Safety Inspection Team will meet a minimum of four time annually. The participation of all required members on the Interdisciplinary Safety Inspection Team as well as the date of the last MHEOCC training will be documented in the Interdisciplinary Safety Inspection Team minutes and reported to the Environment of Care EOC Committee on a quarterly basis by the Interdisciplinary Safety Inspection Team Chair.

Recommendation 21

The VA Augusta Health Care System Chief of Staff ensures mental health leaders update inpatient unit toilets to meet safety requirements and implement processes to reduce associated safety risks.

_X__Concur

_____Nonconcur

Target date for completion: September 2024

Director Comments

On July 15, 2024, floor mounted toilets with associated parts arrived at the VA Augusta Health Care System. The installation of the toilets began on July 22, 2024, with an anticipated completion by September 2024.

OIG Comments

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

OIG Contact and Staff Acknowledgments

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