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BEFORE THE
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US SENATE
HEARING ON
MEDICATION MANAGEMENT IN VA HEALTH CARE
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Chairman Moran, Ranking Member Blumenthal, members of the Committee, thank you for the opportunity to testify on oversight conducted by the Office of Inspector General (OIG) regarding the Department of Veterans Affairs' (VA) medication management practices.

One of the most fundamental activities in healthcare management is ensuring providers and patients are informed of all medications that a patient is prescribed and taking. This process of medication reconciliation—where a provider and a patient or caregiver carefully review prescription and over-the-counter medications, and supplements—can be time-consuming and labor intensive. Ultimately, it ensures not only that patients are taking their medications as prescribed, but that potential drug interactions are eliminated or discussed, and patients are educated about the potential side effects. This critical discussion can reveal or prevent misunderstandings, duplicative treatments, contraindications due to allergies, and potentially dangerous drug interactions. Medication reconciliation is most critical during transitions of care, such as at discharge or when a patient moves between different levels of care, or receives care from VA and community providers. These transitions increase the risk of medication-related errors due to miscommunication. To reduce this risk, healthcare teams must ensure that, at each transition point, the patient or caregiver clearly understands the treatment plan.

Older patients and those with multiple chronic conditions are often prescribed many medications. Polypharmacy, or the prescribing of numerous medications to a patient, is common in patients being treated for complex and treatment-resistant mental health conditions. Veterans are at greater risk than the general population for *psychotropic* polypharmacy—the concurrent use of two or more medications that affect the mind, mood, and behavior—due to their unique military experiences that often lead to complex mental health diagnoses. Polypharmacy, psychotropic or otherwise, is not in itself a sign of an error or an oversight, but it does increase the risk of adverse outcomes.

The OIG has published numerous healthcare inspections and other reports that highlight the challenges VA faces in caring for veterans with complex mental health needs who are also prescribed multiple psychotropic medications. This statement will describe several findings in those reports specific to critical deficiencies in medication management of these veterans.

PATIENTS DISCHARGED FROM ACUTE MENTAL HEALTH CARE SETTINGS MUST RECEIVE CLEAR MEDICATION INSTRUCTIONS

Patients admitted to mental health units are at high risk for suicide in the months following discharge, with approximately 40 percent of suicidal behaviors occurring within 90 days of completion of inpatient care.[1] For this reason, the OIG's mental health inspection program examines staff compliance with required processes designed to ensure that patients discharged from an acute inpatient mental health unit receive appropriate education and instructions regarding their medications. In the four acute inpatient unit inspections completed by the OIG since September 2024, the OIG teams have found repeated noncompliance with these practices.[2] For example, at the VA Philadelphia Healthcare System in Pennsylvania, inspectors found that only 22 percent of electronic health records (EHRs) reviewed included required discussion with patients about medication risks and benefits and only 37 percent had discharge instructions documenting the reason for the medication.[3] Only 61 percent of the EHRs had discharge instructions free of technical medical abbreviations, which can be difficult for patients, caregivers, or family members to understand. Additionally, 45 percent of the EHRs included discharge instructions in which generic and brand names were used interchangeably without clarification that they refer to the same medication. The OIG made several recommendations to improve medication treatment and discharge instructions to help prevent veterans from making medication errors at home following hospitalization. While the facility has taken satisfactory actions to address several recommendations, the OIG will monitor their compliance until all of the report's recommendations can be closed.[4]

VA PROVIDERS MUST EDUCATE PATIENTS ON THE RISKS ASSOCIATED WITH PRESCRIBED MEDICATIONS

All medications carry some risk. Providers are obligated to inform their patients about potential risks and benefits of medications and collaborate with patients to determine the best management plan. All prescription antidepressant medications carry a "black box" warning, the strongest warning issued by the

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[1] Forte, Alberto MD et al., "Suicidal Risk Following Hospital Discharge: A Review," *Harvard Review of Psychiatry*, 27, no. 4 (July/August, 2019): 209–216, https://journals.lww.com/hrpjournal/fulltext/2019/07000/suicidal_risk_following_hospital_discharge__a.1.aspx.

[2] All mental health inspection reports published by the OIG as of the hearing date can be found on the OIG's webpage.

[3] VA OIG, *Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*, June 26, 2025.

[4] The OIG follows up on open recommendations at quarterly intervals commencing 90 calendar days from the date of the report's issuance to determine what corrective action VA has taken to address the findings. VA is provided 30 calendar days to respond. This process continues until all recommendations are implemented with supporting documentation indicating sustained compliance of corrective actions.

Food and Drug Administration, for a potential increased risk of suicidal thoughts and behaviors, particularly in children and young adults. These warnings are not intended to limit use of these medications when treatment is needed, but rather to ensure providers and patients are aware of these risks and patients are educated to recognize and respond to specific symptoms that can be life-threatening. The following summary illustrates the serious consequences that can result when patients are not adequately informed.

In 2022, a veteran, in their twenties, presented at the VA Tuscaloosa Healthcare System and screened positive for traumatic brain injury, posttraumatic stress disorder, and depression.[5] A nurse practitioner diagnosed the patient with unspecified trauma- and stressor-related disorder, and prescribed mirtazapine for depression. About fifty days after beginning the medication, the patient died by suicide.

The OIG conducted a healthcare inspection to evaluate allegations related to the patient's care and found that the nurse practitioner did not directly inform the patient about the increased risk of suicidal thoughts and behaviors associated with mirtazapine, despite this medication having a black box warning for increased risk of suicide in young adults.[6] This failure to educate the patient regarding the boxed warning of the medication's specific risks likely resulted in the patient's insufficient awareness of the need to self-monitor for suicidal thoughts and seek medical attention.

Additionally, the OIG found that the nurse practitioner did not address the need for close monitoring after initiating mirtazapine. When interviewed, the nurse practitioner said the patient was told to call the clinic, a suicide crisis hotline, or present to a walk-in clinic if experiencing suicidal ideation or a worsening of mental health symptoms, however these instructions were not documented and the patient was scheduled for an appointment four months later. The failure to closely monitor the patient after initiating mirtazapine prevented a timely evaluation of worsening symptoms or emerging adverse medication effects, including suicidal thoughts and behaviors.

In total, the OIG made 14 recommendations in this report, including several directed at the medication management and quality assurance processes. Notably, the recommendation for the facility director to create "processes to ensure that providers provide patient education about applicable boxed warnings when prescribing psychiatric medication" remains open.

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[5] VA OIG, *Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama,* September 26, 2024.

[6] US Food and Drug Administration, "REMERON® (mirtazapine) tablets, for oral use." VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, August 14, 2009, amended September 17, 2021. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1004.01(2), Informed Consent for Clinical Treatments and Procedures, December 12, 2023, amended May 1, 2024. Unless otherwise specified, the 2024 directive contains the same or similar language regarding informed consent discussion as the rescinded 2021 handbook. At the time of the patient's care, VHA required that "all treatment and procedures require the prior, voluntary informed consent of the patient," including "the expected benefits and known risks associated with the recommended treatment or procedure."

VETERANS MUST RECEIVE PROPER MEDICATION MANAGEMENT AND QUALITY OVERSIGHT FROM COMMUNITY CARE PROVIDERS

The OIG's Office of Healthcare Inspections has reported on the many challenges VA faces in providing seamless coordination and quality oversight for veterans referred to the community for care. Meeting veterans' healthcare needs in the community requires coordinating highly skilled multidisciplinary teams through efficient processes that prioritize the safety and timely delivery of that care. Oversight of care delivered in the community requires a different level of monitoring and communication than care provided within Veterans Health Administration (VHA) facilities. These findings highlight clear gaps in VA's contracts and processes, particularly in ensuring that community providers deliver and document health care in accordance with VA's standards. From the findings discussed below, the OIG has issued recommendations that can inform future community care procurement efforts.

VA Did Not Provide Necessary Oversight of Opioid Prescriptions Written by Community Care Providers

Veterans are at an elevated risk of opioid overdose, often due to higher rates of chronic pain and co-occurring mental health conditions such as posttraumatic stress disorder and military sexual trauma.[7] When veterans receive care in the community, opioid prescriptions must be tracked and coordinated with VA. The failure to do so puts patients at increased risk of opioid misuse and overdose.

The MISSION Act of 2018 requires VA to ensure that community providers who prescribe opioids to veterans receive and certify their review of VA's Opioid Safety Initiative (OSI) guidelines.[8] VA also requires these providers to query state prescription drug monitoring programs to determine whether veterans have existing opioid prescriptions before issuing a new one.

An OIG healthcare inspection team assessed care coordination for patients of the VA Eastern Kansas Health Care System (VA Eastern Kansas) who received community care and were dually prescribed opioids and benzodiazepines from community care network providers.[9] The inspection team also reviewed compliance with public law and VHA policies and guidelines specific to the oversight of community providers' opioid prescribing practices. The OIG found issues related to incomplete and delayed community provider documentation, including the use of OSI prescribing risk-mitigation strategies, prescriptions dispensed at VA versus community pharmacies, and lack of medication

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[7] John Hudak, "Assessing and improving the government's response to the veterans' opioid crisis," Brookings Institution (July 2020); VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, May 2022.

[8] P.L. 115-182, The VA MISSION Act of 2018 is also known as the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018. It established a permanent community care program for veterans.

[9] VA OIG, *Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and Leavenworth*, September 26, 2023.

reconciliation and VHA medication profile updates.[10] Additionally, the team identified two examples in which patients received multiple controlled substance prescriptions from a mix of providers from VA Eastern Kansas, other VA facilities, and the community care network. The OIG found the veterans integrated service network director and medical center staff were not conducting oversight of the community providers' opioid prescribing practices as required under the MISSION Act and as recommended by the OIG in 2019. In addition, they were not reporting concerns of unsafe community care network provider practices to the third-party administrators.

The OIG made seven recommendations to the under secretary for health related to community care provider documentation, evidence of network providers' training and use of OSI risk-mitigation strategies, state prescription drug monitoring program queries, and the capture of community-provider-prescribed medications in EHRs. The OIG made two recommendations to the VISN director related to ensuring VA Eastern Kansas has processes to conduct oversight of community care network providers' prescribing practices. The OIG made four recommendations to the VA Eastern Kansas director related to documenting OSI risk-mitigation strategies, capturing community-provider-prescribed medications in the EHR, filling vacant pain management positions, and educating staff on reporting patient safety concerns involving community care providers. Two recommendations to the under secretary for health remain open, regarding the need for community care providers to document prescriptions and the use of opioid risk mitigation strategies and to conduct and document state prescription drug monitoring program queries.

CONCLUSION

Every day, qualified and dedicated clinical staff provide high-quality, compassionate care to veterans with complex clinical needs. Each veteran's experiences and challenges are unique, and addressing their medical and mental health needs requires an individualized approach that considers their best interests and their treatment preferences. When medications are prescribed, the instructions, indications, expected outcomes, and potential side effects must be clearly communicated among veterans, their caregivers, and the healthcare teams supporting their recovery.

The OIG remains steadfast in its mission to provide independent oversight of VA, ensuring veterans, their families, and caregivers receive the high-quality services and benefits they have earned. With its team of dedicated medical professionals, the Office of Healthcare Inspections is uniquely positioned to drive meaningful impacts to care by continuing to issue evidence-based reports and recommendations to enhance the quality of care veterans receive from VA and community providers.

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[10] A separate OIG team assessed whether (1) VA ensured community providers received and certified their review of the OSI guidelines, (2) a sample of community providers conducted the required queries, and (3) the medical records of sampled veterans included opioid prescriptions, as required by the MISSION Act. Two recommendations to improve compliance with MISSION Act requirements and OSI guidelines remain open. VA OIG, *Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans*, September 26, 2023.

Chairman Moran, Ranking Member Blumenthal, and members of the Committee, this concludes my statement. The OIG looks forward to working with you and this Congress to advance the provision of care to veterans. I would be happy to answer any questions you may have.