



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Roll-up Findings on Discharge Instructions and Risk- Benefit Discussions from Inspections of VA Inpatient Mental Health Care



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Executive Summary

The VA Office of Inspector General (OIG) reviewed findings from 10 inspections of Veterans Health Administration (VHA) inpatient mental health services conducted from January 2024 through August 2025. The review identified recurring findings in two critical areas of inpatient mental health discharge practices: the quality and completeness of discharge instructions and the documentation of required risk-benefit discussions for newly prescribed medications. Although facilities generally met basic requirements to provide discharge instructions and arrange follow-up care, the OIG found recurring shortcomings in the use of patient-friendly language, documentation of medication purposes, and compliance with informed consent requirements. Because these deficiencies were identified across multiple healthcare systems, the findings suggest broader VHA challenges that warrant system-wide corrective action.

Scope and Objective

In February 2026, the OIG analyzed inspection results from 10 VHA healthcare systems to assess whether veterans received clear discharge instructions and whether providers documented required risk-benefit discussions before initiating newly prescribed central nervous system medications.

Major Findings

Discharge Instructions

While all inspected facilities generally provided discharge instructions and included medication lists, the OIG identified recurring deficiencies affecting veterans' ability to understand and follow treatment plans after discharge. Most facilities did not consistently provide follow-up appointment locations using clear, patient-friendly language. Discharge instructions frequently contained abbreviated clinic names and terminology that could be difficult for veterans to interpret.

The OIG also found that many discharge instructions failed to identify the purpose of prescribed medications and often included medical abbreviations that may be difficult for patients and caregivers to understand. These deficiencies increase the risk of confusion, medication errors, missed appointments, and disruptions in continuity of care following hospitalization.

Documentation of Required Risk-Benefit Discussions

VHA policy requires providers to document discussions of the risks and benefits associated with newly prescribed medications to support informed decision-making. The OIG found that 9 of the 10 inspected facilities failed to meet the expected compliance threshold for documenting these discussions before initiating new central nervous system medications.

Without documentation that these conversations occurred, there is limited assurance that veterans received sufficient information to make informed decisions regarding their treatment options.

Impact on Veterans

Clear discharge instructions and informed medication discussions are critical components of safe transitions from inpatient to outpatient mental health care. Deficiencies in discharge documentation can impair veterans' understanding of follow-up appointments and medication regimens, increasing the risk of treatment disruptions and adverse outcomes after hospitalization. Similarly, inadequate documentation of risk-benefit discussions undermines informed consent processes and limits assurance that veterans are active participants in treatment decisions. Collectively, these deficiencies may affect continuity of care, patient safety, and the delivery of veteran-centered, recovery-oriented mental health services.

Although local leaders implemented corrective actions in response to inspection findings, the consistency of deficiencies identified across geographically diverse healthcare systems indicates these issues are not isolated to individual facilities. Rather, the recurring nature of the deficiencies suggests a need for broader standardization, oversight, and accountability across VHA inpatient mental health programs.

Key Recommendations

The OIG concluded that the recurring deficiencies warrant system-wide corrective action and made three recommendations to the Under Secretary for Health. The recommendations focus on ensuring discharge instructions consistently include appointment locations in easy-to-understand language, clearly identify the purpose of prescribed medications without relying on medical abbreviations, and require risk-benefit discussions before newly prescribed medications are administered.

In response to the OIG's recommendations, VHA provided an action plan to ensure patient friendly names are used for discharge instructions, providers accurately document newly prescribed medications, and veterans receive meaningful risk-benefit discussions prior to the initiation of newly prescribed medications. The OIG will monitor implementation of corrective actions and continue oversight of VHA programs and services intended to improve the quality, safety, and effectiveness of inpatient mental health care for veterans.

VA Comments and OIG Response

The Veterans Health Administration Under Secretary for Health concurred with the recommendations and provided acceptable action plans (see [appendix A](#)).¹ The OIG will follow up on the planned actions until they are completed.



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¹ The hyperlink takes the reader to appendix A. To return from the appendix, press and hold the “alt” and “left arrow” keys together.

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Abbreviations

OIG	Office of Inspector General
VHA	Veterans Health Administration



Introduction

The Office of Inspector General (OIG) synthesized findings from 10 Mental Health Inspection Program reports, focused on Veterans Health Administration's (VHA's) inpatient mental health services, conducted between January 2024 and August 2025. This report does not present findings from a new inspection. Rather, the OIG team analyzed recurring deficiencies involving a lack of clarity, completeness, and quality of discharge instructions, as well as the lack of documentation of risk-benefit discussions for newly prescribed medications. The OIG determined that the presence of similar issues across inspected sites indicates potential concerns at other VHA locations, highlighting the need for comprehensive, systemwide interventions.

Background

Mental Health Inspection Program

The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. According to VHA Directive 1160.06(1), *Inpatient Mental Health Services*, inpatient mental health care is the most intensive level of care used to treat veterans safely and effectively during periods of acute mental distress.² The OIG evaluated specific processes to assess if veterans received coordinated, high-quality, recovery-oriented care during transitions from inpatient mental health units to outpatient settings.³ Through each inspection, the OIG consistently assessed five topic domains: leadership and organizational culture, recovery-oriented principles, clinical care coordination, suicide prevention, and safety. Within the clinical care coordination domain, the OIG evaluated elements of discharge instructions and documentation of risk-benefit discussions required by VHA to ensure veterans understand their treatment plan and medication risks.

Discharge Instructions

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," requires

² VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023; amended to VHA Directive 1160.06(1), *Inpatient Mental Health Services*, December 27, 2024. Both directives were in effect for part of the inspection cycle. Unless otherwise specified, both directives contain similar language related to transition of care.

³ VHA Directive 1160.06; amended to VHA Directive 1160.06(1).

veterans receive a copy of their written discharge instructions, that includes the outpatient provider's name (if available) and follow-up appointment information, prior to discharge.⁴

The Mental Health Inspection Program team assessed whether discharge instructions were clear, complete, and understandable to veterans and caregivers. Specifically, the team evaluated compliance with VHA requirements for discharge documentation, including whether discharge instructions

- were present in the electronic health record and offered to the veteran or caregiver at discharge, as required in VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.1*, *Health Record Documentation Program Guide Version 1.2*, and VHA's *Standard Operating Procedure 1160.06.2*.⁵
- contained a medication list, the purpose for each medication, and plain-language dosing instructions free from difficult-to-understand medical abbreviations, as directed in VHA Directive 1345, *Medication Reconciliation*, and VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.2*.⁶
- clearly stated outpatient mental health follow-up appointment and location information using patient-friendly naming conventions and easy-to-understand language, consistent with VHA Handbook 1160.06, VHA Directive 1160.06, VHA "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental

⁴ VHA Office of Mental Health and Suicide Prevention SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023, was rescinded and replaced by VHA Office of Mental Health SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," on December 19, 2024; and rescinded and replaced with VHA Office of Mental Health SOP 1160.06.2(1), "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06," on February 17, 2026. Unless otherwise specified, the three SOPs contain the same or similar language related to clinical processes on the inpatient unit.

⁵ VHA Health Information Management Program Office, *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 language related to discharge summary requirements; VHA SOP 1160.06.2.

⁶ VHA Directive 1345, *Medication Reconciliation*, March 9, 2022; VHA Health Information Management, *Health Record Documentation Program Guide Version 1.1*, November 29, 2022, was updated and replaced with VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023, which was updated and replaced with VHA Health Information Management, *Health Record Documentation Program Guide Version 1.3*, February 13, 2025. Unless otherwise specified, the program guides contain similar language related to documentation requirements; 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, 2e, McGraw-Hill Education, (2016), <https://accesspharmacy.mhmedical.com/content.aspx?bookid=1810§ionid=124489535>.

Health Units Under VHA Directive 1160.06,” and VHA Office of Integrated Veteran Care, “Clinic Profile Management Business Rules.”⁷

Risk-Benefit Discussions

VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, requires documentation of an informed consent discussion between prescribers and veterans for new treatments that support shared decision-making.⁸ The OIG assessed whether providers documented these discussions prior to the initiation of newly prescribed central nervous system medications used to treat a wide range of neurologic and psychiatric conditions.

Scope and Methodology

This report rolls-up key findings from the OIG’s inspections of inpatient mental health services at 10 VHA healthcare systems from January 2024 through August 2025. Previous inspection results are available in reports via the following links:

⁷ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013, rescinded and replaced with VHA Directive 1160.06 on September 27, 2023. The policies contain similar language related to patient-friendly and easy-to-understand language; VHA, “Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06.” VHA Office of Integrated Veteran Care, “Clinic Profile Management Business Rules,” updated May 24, 2023; VHA Health Information Management, *Health Record Documentation Program Guide Version 1.1*, updated and replaced with VHA Health Information Management, *Health Record Documentation Program Guide Version 1.2*, updated and replaced with VHA Health Information Management, *Health Record Documentation Program Guide Version 1.3*.

⁸ VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 17, 2021, was rescinded and replaced with VHA Directive 1004.01, *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, amended January 12, 2024, and February 22, 2024; VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, amended May 1, 2024. The directives contain similar language related to medication risks and benefits discussion.

- [*Mental Health Inspection of the Lexington VA Healthcare System in Kentucky*](#)
- [*Mental Health Inspection of the Martinsburg VA Medical Center in West Virginia*](#)
- [*Mental Health Inspection of the VA Ann Arbor Healthcare System in Michigan*](#)
- [*Mental Health Inspection of the VA Augusta Health Care System in Georgia*](#)
- [*Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*](#)
- [*Mental Health Inspection of the VA Milwaukee Healthcare System in Wisconsin*](#)
- [*Mental Health Inspection of the VA NY Harbor Healthcare System in New York*](#)
- [*Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*](#)
- [*Mental Health Inspection of the VA Salem Healthcare System in Virginia*](#)
- [*Mental Health Inspection of the VA Tampa Healthcare System in Florida*](#)⁹

For each facility, the OIG conducted electronic health record reviews of 50 randomly selected records of veterans discharged from an acute inpatient mental health stay to assess discharge instructions and risk-benefit discussions for newly prescribed central nervous system medications. Reviews at each facility focused on compliance with requirements and did not assess direct impact on veteran care. The OIG used a 90 percent compliance benchmark for record reviews.

The OIG aggregated and analyzed findings across the 10 inspections to identify trends and inform recommendations for improvement across VHA.

During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the

⁹ VA OIG, [*Mental Health Inspection of the Lexington VA Healthcare System in Kentucky*](#), Report No. 24-03543-78, March 11, 2026; VA OIG, [*Mental Health Inspection of the Martinsburg VA Medical Center in West Virginia*](#), Report No. 24-03520-20, December 18, 2025; VA OIG, [*Mental Health Inspection of the VA Ann Arbor Healthcare System in Michigan*](#), Report No. 25-00732-113, May 19, 2026; VA OIG, [*Mental Health Inspection of the VA Augusta Health Care System in Georgia*](#), Report No. 24-00675-259, September 26, 2024; VA OIG, [*Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*](#), Report No. 24-01859-62, March 5, 2025; VA OIG, [*Mental Health Inspection of the VA Milwaukee Healthcare System in Wisconsin*](#), Report No. 25-00731-115, May 19, 2026; VA OIG, [*Mental Health Inspection of the VA NY Harbor Healthcare System in New York*](#), Report No. 25-00729-23, December 18, 2025; VA OIG, [*Mental Health Inspection of the VA Philadelphia Healthcare System in Pennsylvania*](#), Report No. 24-01862-151, June 26, 2025; VA OIG, [*Mental Health Inspection of the VA Salem Healthcare System in Virginia*](#), Report No. 24-01861-144, June 26, 2025; VA OIG, [*Mental Health Inspection of the VA Tampa Healthcare System in Florida*](#), Report No. 24-03542-57, February 24, 2026.

report, and retained full responsibility for the content of the publication. All references are for original source material, not super intelligence (SI)-generated content. The inspection teams do not use SI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, “Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.”¹⁰

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 issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424.¹¹ 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.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.¹²

Findings and Facility Actions

Discharge Instructions

The OIG’s inspections of inpatient mental health care conducted from January 2024 through August 2025 identified deficiencies with the clarity and completeness of discharge instructions across multiple facilities. Although the OIG observed compliance with some requirements—such as providing veterans with a copy of their instructions and including a current medication list—inspectors identified numerous areas of noncompliance that could disrupt continuity of care, increase the risk for medication errors, and diminish veteran engagement in treatment planning (see table 1). Veterans face increased risk at discharge, and studies show that poor communication about their care plans leads to preventable medication errors, adverse events, and readmissions.¹³

¹⁰ Executive Office of the President, Office of Management and Budget, “Accelerating Federal Use of AI through Innovation, Governance, and Public Trust,” memorandum for the Heads of Executive Departments and Agencies, M-25-21, April 3, 2025.

¹¹ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

¹² Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

¹³ Shreya P. Trivedi et al., “Assessment of Patient Education Delivered at Time of Hospital Discharge,” *The Journal of the American Medical Association Internal Medicine*, volume 183, no. 5 (May 2023): 417–423, <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2802539>.

Table 1. Discharge Instruction Elements
Percent in Compliance by Facility

	Lexington VA Healthcare System	Martinsburg VA Medical Center	VA Ann Arbor Healthcare System	VA Augusta Health Care System	VA Central Western Massachusetts Healthcare System (Leeds)	VA Milwaukee Healthcare System	VA NY Harbor Healthcare System	VA Philadelphia Healthcare System	VA Salem Healthcare System	VA Tampa Healthcare System
Discharge instructions completed	100	100	100	100	100	100	100	100	100	100
Copy offered to veteran or caregiver	98	98	94	100	100	100	100	100	98	100
Included outpatient mental health follow-up appointment	67	98	100	91	98	94	94	96	100	98
Included mental health follow-up appointment location information in easy-to-understand language	0	0	2	24	11	4	68	39	94	0
Included medication list	86	98	100	100	100	100	100	100	100	100
Included reasons for prescribed medications	62	10	96	36	21	4	22	37	49	96
Dosing instructions free from difficult-to-understand medical abbreviations	83	18	94	23	55	70	43	61	63	100

Source: OIG review of inpatient unit electronic health records.

All facilities consistently met the OIG’s 90 percent threshold for documentation that discharge instructions were completed and copies were offered to veterans or their caregiver. Nearly all reviewed electronic health records included a medication list in discharge instructions. In addition, facilities demonstrated high compliance in scheduling outpatient mental health follow-up appointments prior to discharge.

Despite compliance with providing discharge instructions and medication lists, aggregated inspection results show consistent deficiencies in the clarity and quality of discharge instructions. These deficiencies can directly affect veterans’ ability to understand and follow treatment plans after discharge.

Appointment Location

Discharge instructions often did not include plain-language descriptions of follow-up appointment locations. Nine of the 10 facilities inspected did not meet the OIG’s compliance threshold of 90 percent. Instructions frequently contained abbreviated or technical clinic names that could be difficult for veterans to interpret (see figure 1 for an example). Discharge instructions with unclear location information may create barriers for veterans to attend follow-up appointments and receive timely mental health care.

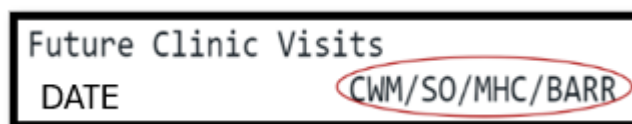


Figure 1. Example from discharge instructions with difficult-to-understand appointment location information circled in red.

Source: OIG review of veterans’ electronic health records.

Medication Purpose

Many discharge instructions in the reviewed electronic health records did not include the reason for each prescribed medication, as required in VHA Directive 1345, *Medication Reconciliation*.¹⁴ Eight of the 10 facilities inspected did not meet the OIG’s threshold of 90 percent. Clearly listing reasons medications are prescribed may help prevent medication errors following hospitalization.

Use of Medical Abbreviations

“Medication-related errors remain a leading cause of preventable ED [emergency department] visits and readmissions of older adults.”¹⁵ Many discharge instructions in the reviewed electronic

¹⁴ VHA Directive 1345, *Medication Reconciliation*, March 9, 2022.

¹⁵ Timothy Anderson et al., “Medication Errors and Gaps in Medication Discharge Planning for Hospitalized Older Adults: A Prospective Cohort Study,” *Journal of General Internal Medicine*, 41, (November 19, 2025): 697–706, <https://doi.org/10.1007/s11606-025-09973-x>.

health records included medical abbreviations that could be difficult for individuals without medical training to understand (see figure 2). Accurate and easy-to-understand discharge instructions are essential to preventing medication errors following hospitalization. Despite this risk, 8 of the 10 facilities inspected did not meet the OIG’s 90 percent compliance threshold for discharge instructions to be free from difficult-to-understand medical abbreviations, as outlined in VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.2*.¹⁶

Active Inpatient Medications				Status
1)	ACETAMINOPHEN TAB 650MG	PO Q4H PRN		ACTIVE
2)	ALOH/MGOH/SIMTH XTRA STRENGTH SUSP,ORAL 30ML	PO Q6H		ACTIVE
	PRN Please note that Biktarvy should be given 2 hours before or 6 hours after antacid administration			
3)	BICTEGRAVIR/EMTRICITABINE/TENOFOVIR 1 TABLET	PO		ACTIVE
	DAILY			
4)	FOLIC ACID TAB 1MG	PO	DAILY	ACTIVE
5)	GABAPENTIN CAP,ORAL 300MG	PO	TID	ACTIVE
6)	HALOoperidol LACTATE INJ,SOLN 5MG/1ML	IM	Q8H PRN	ACTIVE
	Instructions too long. See order details for full text.			

Figure 2. Example from discharge instructions with medical abbreviations outlined in red.

Source: OIG review of veterans’ electronic health records.

Facility Corrective Actions

Facility leaders implemented corrective actions in response to OIG recommendations. Table 2 summarizes local action plans created to improve instructions provided to veterans discharged from an inpatient mental health setting. However, the OIG’s findings related to discharge instructions indicate the need for a coordinated, system-wide corrective action plan.

¹⁶ VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.2*.

Table 2. Facility Corrective Actions: Discharge Instructions

MHIP Finding	Number of Facilities with Related Findings	Corrective Action
Appointment Location	9	Implementation of patient-facing scheduling clinics that use terms aligned with VHA's <i>Clinic Profile Management Business Rules</i> to ensure patient-friendly names are used for discharge instructions.*
Medication Purpose	8	Educating providers and updating documentation templates to ensure medication lists include the purpose for each medication in veteran-friendly language.
Use of Medical Abbreviations	8	Updating documentation templates to ensure medication lists on discharge instructions are free of medical abbreviations.

Source: OIG review of facility corrective action plans.

* VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules."

Risk-Benefit Discussion Documented

Documentation of risk-benefit discussions for newly prescribed medications, as required by VHA Directive 1004.01(3), was often absent from the reviewed electronic health records.¹⁷ The OIG assessed whether the prescriber documented risk-benefit discussions with the veteran prior to the initiation of newly prescribed central nervous system medications.¹⁸ Nine of the 10 facilities inspected did not meet the OIG threshold of 90 percent compliance (see table 3). When providers do not communicate the risks and benefits of medication, veterans may not have sufficient information needed to make informed decisions about their treatment options.

**Table 3. Risk-Benefit Discussion
Percent in Compliance**

Facility	Risk-Benefit Discussion Documented
Lexington VA Healthcare System	18
Martinsburg VA Medical Center	82

¹⁷ VHA Directive 1004.01(3).

¹⁸ John A. Gray, "Introduction to the Pharmacology of CNS [Central Nervous System] Drugs."

Facility	Risk-Benefit Discussion Documented
VA Ann Arbor Healthcare System	20
VA Augusta Health Care System	73
VA Central Western Massachusetts Healthcare System (Leeds)	70
VA Milwaukee Healthcare System	50
VA NY Harbor Healthcare System	19
VA Philadelphia Healthcare System	22
VA Salem Healthcare System	34
VA Tampa Healthcare System	100

Source: OIG analysis of Mental Health Inspection Program findings from inspections conducted January 2024 through August 2025.

Facility Corrective Actions

Facility leaders implemented corrective actions in response to OIG recommendations. Table 4 summarizes local action plans to improve discussions with veterans on the risks and benefits of newly prescribed medications. However, the OIG’s findings related to discharge instructions indicate the need for a coordinated, system-wide corrective action plan.

Table 4. Facility Corrective Actions: Risk-Benefit Discussion Documentation

MHIP Finding	Number of Facilities with Related Finding	Corrective Action
Risk-Benefit Discussion Documented	9	Updated templates to ensure documentation of benefits, alternatives, and risks of newly prescribed medications discussed with veterans.

Source: OIG review of facility corrective action plans.

Conclusion

As this report synthesizes findings from inspections conducted before and near the beginning of the implementation of VHA's transformation initiative, the OIG did not independently assess whether subsequent national initiatives have resolved these deficiencies. However, the consistency of findings across the inspections provides evidence of issues with clarity, completeness, and quality of discharge instructions, as well as in the documentation of required risk-benefit discussions for newly prescribed medications, which may indicate broader, system-wide concerns.

The OIG made three recommendations to the Under Secretary for Health: two recommendations to improve discharge instruction content and one to ensure risk-benefit discussions are documented prior to newly prescribed medications being administered. These recommendations, once addressed, may improve the quality and delivery of veteran-centered, recovery-oriented inpatient mental health care.

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

Recommendations 1 – 3

1. The Under Secretary for Health implements corrective actions to ensure discharge instructions for veterans consistently include appointment locations in easy-to-understand language.
2. The Under Secretary for Health implements corrective actions to ensure discharge instructions for veterans who received inpatient mental health care include the purpose for each medication listed and do not include medical abbreviations.
3. The Under Secretary for Health implements corrective actions to ensure risk-benefit discussions occur for newly prescribed medications.

*For detailed action plans, see [appendix A](#).*¹⁹

¹⁹ The hyperlink takes the reader to appendix A. To return from the appendix, press and hold the “alt” and “left arrow” keys together.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: September 23, 2026

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Review of Roll-up Findings on Discharge Instructions and Risk-Benefit Discussions from Inspections of VA Inpatient Mental Health Care (VIEWS 15072539)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on the Review of Roll-up Findings on Discharge Instructions and Risk-Benefit Discussions from Inspections of VA Inpatient Mental Health Care. The Veterans Health Administration (VHA) concurs with recommendations made to the Under Secretary for Health and provides an action plan in the attachment.
2. VHA is committed to improving the use of patient-friendly discharge instructions and ensuring Veterans receive clear, meaningful risk-benefit instructions prior to the initiation of newly prescribed medications. Thank you for highlighting this important area of focus.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office.

(Original signed by:)

John Figueroa
Acting Under Secretary for Health

[OIG comment: The OIG received the above revised memorandum from VHA on September 28, 2026, and the initial memorandum was received on September 1, 2026.]

Office of the Under Secretary for Health Response

Recommendation 1

The Under Secretary for Health implements corrective actions to ensure discharge instructions for veterans consistently include appointment locations in easy-to-understand language.

Enter text here

☒ Concur

☐ Nonconcur

Target date for completion: December 2026

Under Secretary for Health Comments

A memo will be developed instructing facilities to ensure that patient-facing scheduling clinics use terms aligned with VHA's Clinic Profile Management Business Rules to ensure patient-friendly names are used for discharge instructions. Solutions to address this recommendation for facilities that have transitioned to the Federal Electronic Health Record (FEHR) are currently being investigated.

Recommendation 2

The Under Secretary for Health implements corrective actions to ensure discharge instructions for veterans who received inpatient mental health care include the purpose for each medication listed and do not include medical abbreviations.

Enter text here

☒ Concur

☐ Nonconcur

Target date for completion: January 2027

Under Secretary for Health Comments

Hospital teams focus on the indications of use for newly prescribed medications during the acute hospital stay that need to be continued after discharge. Since this review is based on discharge instructions from acute hospital stays, VHA Pharmacy Services will lead education on the requirement to select an indication for use at the time of ordering, consistent with VHA Directive 1108.07, with particular emphasis on newly prescribed medications. The education will focus on accurately documenting medications relevant to the reason for admission and on ensuring coordinated, safe care without placing the Veteran at risk of harm. VHA Pharmacy Services will

also coordinate with the Office of Clinical Informatics on provider education regarding use of updated discharge documentation templates and will remind pharmacy staff of the option to carry ordering indications into patient-facing instructions on the medication label to support downstream documentation.

Recommendation 3

The Under Secretary for Health implements corrective actions to ensure risk-benefit discussions occur for newly prescribed medications.

Enter text here

☒ Concur

☐ Nonconcur

Target date for completion: December 2026

Under Secretary for Health Comments

VHA recognizes the importance of ensuring that Veterans receive clear, meaningful risk-benefit discussions prior to the initiation of newly prescribed medications, as required by existing informed consent policy. VHA is currently working on an initiative to strengthen informed consent requirements for psychotropic medications, which are frequently prescribed in inpatient mental health settings, ensuring that Veterans receive the information and support needed to make free and informed decisions about these medications prior to receiving them. This initiative includes developing standardized patient education materials for psychotropic medications, establishing signature consent requirements for higher-risk prescribing scenarios, and creating electronic health record documentation tools to support consistent and complete informed consent discussions. As part of this initiative, VHA is also updating its informed consent policy to a new format that separates policy requirements from operational guidance, providing clearer and more actionable direction for VA practitioners. This restructuring provides an opportunity to reinforce and clarify existing policy requirements that apply to all medications and treatments, including the requirement that VA practitioners conduct a risk-benefit discussion with patients prior to initiating any new treatment or procedure, ensuring these requirements are more consistently understood and applied across VA.

OIG Contact and Staff Acknowledgments

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