US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Facility Leaders and Staff Have Concerns about VA's New Electronic Health Record

Management Advisory Memorandum | 24-02874-256 | September 23, 2024

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QUALITY STANDARDS
The Office of Inspector General (OIG) has released this management advisory memorandum to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation except for the standard of reporting.

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
WASHINGTON, DC 20001

August 20, 2024[1]

MANAGEMENT ADVISORY MEMORANDUM

TO: Dr. Shereef Elnahal, Under Secretary for Health
Veterans Health Administration (10)

FROM: Dr. John D. Daigh, Jr., Assistant Inspector General
VA Office of Inspector General, Office of Healthcare Inspections

SUBJECT: Facility Leaders and Staff Have Concerns about VA's New Electronic Health Record

The VA Office of Inspector General (OIG) is issuing this management advisory memorandum to inform the Veterans Health Administration (VHA) Under Secretary for Health of concerns facility leaders and staff have expressed to OIG staff regarding VA's new electronic health record (EHR) during Healthcare Facility Inspections. This memorandum is meant to convey the information necessary for VA to determine whether additional actions are warranted.[2] The OIG is taking no additional steps on these concerns at this time.

The OIG's mission is to serve veterans and the public by conducting meaningful independent oversight of VA. Furthering that mission, and building on prior evaluation methods, the OIG established Healthcare Facility Inspections, a cyclical review program. Healthcare Facility Inspection teams review VHA medical facilities on a three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety. The inspections incorporate VHA's high-reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

The OIG conducted Healthcare Facility Inspections of the VA Southern Oregon Healthcare System and the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington during the weeks of March 4 and June 3, 2024, respectively.

[1] This memorandum was sent to VHA on August 20, 2024, to provide the opportunity for review and comment.

[2] This memorandum provides information that has been gleaned from OIG inspections. The OIG issues management advisory memoranda when exigent circumstances or areas of concern are identified through OIG hotline allegations or in the course of its oversight work, particularly when immediate action by VA can help reduce further risk of harm to veterans or significant financial losses. Memoranda are published unless otherwise prohibited from release or to safeguard protected information.

New Electronic Health Record

In June 2017, former VA Secretary David Shulkin announced VA's determination and findings, a prerequisite to taking contract actions with Cerner to develop an interoperable EHR platform across VA and the Department of Defense that would "keep pace with the improvements in health information technology and cybersecurity."[3]

VA executed "a five-year contract with Cerner in 2018 to replace its legacy health record system."[4] In 2023, VA renegotiated the contract "to include more performance metrics in the agreement and to change the contract from a 5-year term to five 1-year terms as part of an effort to enhance oversight of the software's rollout."[5]

VA deployed the new EHR at the Jonathan M. Wainwright Memorial VA Medical Center and the VA Southern Oregon Healthcare System in March 2022 and June 2022, respectively.[6]

Previous OIG Report Findings

Since 2020, the OIG has reported on various issues with the new EHR deployment, including

- the need for mitigation plans as workarounds for unavailable system functions;
- insufficient end-user training prior to deployment;
- deficiencies with the migration of patient information, processing medication orders, and medication reconciliation;
- care coordination deficiencies related to patient record flags, scheduling appointments, referral management, laboratory orders, and documentation processes;
- unavailability of metrics related to organizational performance, quality and patient safety, and access to care;
- significant risk created by the unknown queue caused harm to multiple patients;
- a system error resulted in staff's failure to complete required minimum scheduling efforts following a patient's missed mental health appointment, which may have contributed to

[3] VA, "VA Secretary announces decision on next-generation Electronic Health Record," news release, June 5, 2017, https://www.va.gov/opa/pressrel/includes/viewPDF.cfm?id=2914.

[4] Edward Graham, "VA extends Oracle's EHR contract for 1 month," *Nextgov/FCW*, May 23, 2024, https://www.nextgov.com/acquisition/2024/05/va-extends-oracles-ehr-contract-1-month/396848/#:~:text=VA%20renegotiated%20its%20contract%20with,oversight%20of%20the%20software%27s%20rollout. The article also notes that in 2022, Oracle acquired Cerner and inherited VA's EHR project.

[5] "VA extends Oracle's EHR contract for 1 month," Nextgov/FCW.

[6] "Deployment Schedule," VA EHR Modernization, accessed July 9, 2024, https://dvagov.sharepoint.com/sites/vaehrmio/SitePages/Deployment-Schedule.aspx. (This SharePoint site is not publicly accessible.)

the patient's disengagement from mental health treatment and ultimately the patient's substance use relapse and death; and

- unmitigated high-risk patient safety issues; unresolved usability challenges; inaccurate medication data; numerous workarounds to provide patient care; overwhelming educational materials for pharmacy-related functions; and pharmacy staff burnout, low morale, and decreased job satisfaction.[7]

Healthcare Facility Inspections Findings

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on the organization.[8] The OIG reviewed whether facility staff experienced system shocks that affected the VA Southern Oregon Healthcare System and the Jonathan M. Wainwright Memorial VA Medical Center.

During interviews, staff at both medical facilities described the new EHR as a system shock. Leaders at the VA Southern Oregon Healthcare System described the implementation of the new EHR as "the single largest challenge that we have here," noting that the new EHR has impacted "every system" and resulted in "rewriting the way VA does business." The director at the Jonathan M. Wainwright Memorial VA Medical Center described multiple challenges, including timing of deployment, which overlapped with dealing with the effects of the pandemic; limited

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[7] VA OIG, *Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 19-09447-136, April 27, 2020; VA OIG, *Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 20-01930-183, July 8, 2021; VA OIG, *Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00656-110, March 17, 2022; VA OIG, *Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-109, March 17, 2022; VA OIG, *Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-03020-168, June 1, 2022; VA OIG, *The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm*, Report No. 22-01137-204, July 14, 2022; VA OIG, *Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death*, Report No. 23-00382-100, March 21, 2024; VA OIG, *Electronic Health Record Modernization Caused Pharmacy-Related Patient Safety Issues Nationally and at the VA Central Ohio Healthcare System in Columbus*, Report No. 23-01450-114, March 21, 2024. Other OIG reports have addressed EHR deployment, including *The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule*, Report No. 21-02889-134, April 25,2022. A complete list of the OIG reports addressing EHR deployment is attached as Appendix A.

[8] Valerie Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Qual Saf* 2019, no. 28 (July 25, 2018): 74–84, https://dx.doi.org/10.1136/bmjqs-2017-007573.

training; and enterprise-wide communication deficiencies. Additionally, leaders and staff at both medical facilities described notable concerns related to (1) efficiency and loss of productivity, (2) staffing, (3) financial impacts, and (4) patient safety.

Efficiency and Loss of Productivity

Staff described various impacts of the new EHR on primary care operations. Staff at the VA Southern Oregon Healthcare System reduced clinician panel sizes due to continuous barriers created by the new electronic health record. Primary care staff expounded on issues such as

- slow system connectivity,
- system lag times,
- loss of information due to system reset,
- click fatigue,
- cumbersome documentation process,
- limitations with order entry and documentation permissions, and
- closure of help desk tickets without resolution.

A staff member at the Jonathan M. Wainwright Memorial VA Medical Center described monitoring key performance indicators of primary care providers and finding that providers required almost an hour to complete appointments in the new EHR that took 30 minutes to complete in the legacy EHR system. A pharmacy staff member at the Jonathan M. Wainwright Memorial VA Medical Center described not being able to meet Veterans Integrated Service Network expectations of seeing 10 patients per day due to lag times with the new EHR.

VA Southern Oregon Healthcare System staff reported challenges with referring veterans for toxic exposure screening (TES) navigator appointments due to new EHR system issues.[9] According to a TES navigator, if an appointment was scheduled with a TES navigator, the new EHR required a billable charge; otherwise, the appointment could not be closed and remained open. However, the deputy chief of staff reported that TES navigator appointments cannot be billed. The identified workaround was to refer the veteran to TES navigators outside of the new EHR system via the facility's navigation message center or email and recategorize existing appointments to "between visit encounters" so the new EHR system would not require a billable charge.

[9] Toxic exposure screenings are performed during routine healthcare appointments or TES navigator appointments. "The PACT Act and your VA benefits," VA, accessed July 11, 2024, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/#toxic-exposure-screenings.

Staffing

A VA Southern Oregon Healthcare System psychologist told the OIG that All Employee Survey responses listed the new EHR as the number one stressor and reason employees were leaving the facility. In response to the OIG's survey of system staff, most responses mentioned the new EHR as the foremost system shock and expressed frustration with its negative impacts, including a decrease in staff morale and increases in stress and burnout.

Similarly, staff at the Jonathan M. Wainwright Memorial VA Medical Center described multiple staffing challenges associated with deployment of the new EHR, including that there was a 30 percent vacancy rate over the last two years. A facility staff member described the loss of providers and nurses due to the pandemic and new EHR deployment. The Chief of Staff expressed disappointment with the inability to address primary care staff burnout and leadership turnover by hiring additional staff due to a hiring freeze to maintain the number of full-time employee equivalent staff. The Associate Director for Patient Care Services also reported an inability to utilize traveling nurse services because available staff do not have experience with the new EHR.

Financial Impact

VA Southern Oregon Healthcare System staff described how the new EHR has resulted in lost revenue. System staff shared that it was the first VA facility in the nation to implement the new EHR in a residential rehabilitation treatment program, and the system allegedly lost millions of dollars in revenue due to EHR limitations in capturing workload.

Staff at the Jonathan M. Wainwright Memorial VA Medical Center also described how the new EHR has affected the facility's resources and budget. For example, a facility leader stated that patient Care Assessment Need (CAN) scores are not updated as needed and give the impression that facility staff are unproductive, resulting in no resource or budgetary increase and the inability to hire new staff.[10]

Patient Safety

The OIG learned that hundreds of tickets have been submitted by VA Southern Oregon Healthcare System staff identifying EHR problems related to the homeless program; specifically, the new EHR lacks a view alert system, which limits staff's ability to meet veterans' needs timely and efficiently. In this context, view alerts are notifications "designed to transmit

[10] "Care Assessment Need (CAN) Score Reports," VHA Support Service Center (VSSC), accessed July 11, 2024, https://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=4554. (This website is not publicly accessible.) According to VA, "The Care Assessment Need (CAN) score reflects the estimated probability of hospital admission or death within a specified time frame (90 days or 1 year)" using demographic and clinical data.

important information and to help the users follow-up on items that need attention such as unsigned documents and orders, abnormal test results, consult results, etc."[11]

A patient aligned care team (PACT) nurse at the Jonathan M. Wainwright Memorial VA Medical Center described how residential rehabilitation patients require follow-up with their primary care providers for their 30-day prescriptions.[12] However, patients are not seen in that time frame and some medications cannot be renewed by PACT nurses without the patients being seen by a primary care provider. The PACT nurse asserted that this is poor care and does not support patients' needs in early sobriety.

Conclusion

Since 2020, the OIG has reported on various issues with the new EHR. Interviews of leaders and staff during Healthcare Facility Inspections of the VA Southern Oregon Healthcare System and the Jonathan M. Wainwright Memorial VA Medical Center demonstrate that new and previously-identified issues persist in 2024.

Requested Action

The OIG requests the Under Secretary for Health evaluate whether the issues cited in this memorandum warrant process reviews and/or contract enhancements to improve efficiency, user experiences, and patient safety.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

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[11] "Communication of Test Results Toolkit Appendix C," VA Office of Primary Care, accessed August 16, 2024, https://dvagov.sharepoint.com/sites/VHAOPCOps/Policy/CTR/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FVHAOPCOps%2FPolicy%2FCTR%2FShared%20Documents%2FCommunication%20of%20Test%20Results%20Toolkit%20and%20Appendices%20%28published%20June%202012%29%2FAppendix%20C%2DReducing%20Redundant%20CPRS%20View%20Alerts%2Epdf&viewid=7124bd69%2D9437%2D4b47%2Db727%2D0cd539b9b220&parent=%2Fsites%2FVHAOPCOps%2FPolicy%2FCTR%2FShared%20Documents%2FCommunication%20of%20Test%20Results%20Toolkit%20and%20Appendices%20%28published%20June%202012%29. (This SharePoint site is not publicly accessible.)

[12] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014 (amended February 29, 2024). "The Patient Aligned Care Team (PACT) is a team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s)) and manages and coordinates comprehensive health care services consistent with agreed upon goals of care."

Appendix A: OIG Reports addressing Deployment of VA's New Electronic Health Record

VA OIG, *Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System*, Report No. 19-08980-95, April 27, 2020.

VA OIG, *Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 19-09447-136, April 27, 2020.

VA OIG, *Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program*, Report No. 20-03178-116, May 25, 2021.

VA OIG, *Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program*, Report No. 20-03185-151, July 7, 2021.

VA OIG, *Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 20-01930-183, July 8, 2021.

VA OIG, *New Patient Scheduling System Needs Improvement as VA Expands Its Implementation*, Report No. 21-00434-233, November 10, 2021.

VA OIG, *Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-109, March 17, 2022.

VA OIG, *Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00656-110, March 17, 2022.

VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-108, March 17, 2022.

VA OIG, *The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule*, Report No. 21-02889-134, April 25, 2022.

VA OIG and Department of Defense OIG, *Joint Audit of the Department of Defense and the Department of Veterans Affairs Efforts to Achieve Electronic Health Record System Interoperability*, VA OIG Report No. 18-04227-91, Department of Defense OIG Report No. DODIG-2022-089, May 5, 2022.

VA OIG, *Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-03020-168, June 1, 2022.

VA OIG, *Senior Staff Gave Inaccurate Information to OIG Reviewers of Electronic Health Record Training*, Report No. 21-02201-200, July 14, 2022.

VA OIG, *The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm*, Report No. 22-01137-204, July 14, 2022.

VA OIG, *VA Should Ensure Veterans' Records in the New Electronic Health System Are Reviewed before Deciding Benefits Claims*, Report No. 22-03806-162, August 30, 2023.

VA OIG, *The Electronic Health Record Modernization Program Could Strengthen Its Process for Reviewing Task Order Progress*, Report No. 21-03290-159, September 6, 2023.

VA OIG, *Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death*, Report No. 23-00382-100, March 21, 2024.

VA OIG, *Electronic Health Record Modernization Caused Pharmacy-Related Patient Safety Issues Nationally and at the VA Central Ohio Healthcare System in Columbus*, Report No. 23-01450-114, March 21, 2024.

VA OIG, *Scheduling Challenges Within the New Electronic Health Record May Affect Future Sites*, Report No. 23-03295-80, March 21, 2024.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: September 5, 2024

From: Under Secretary for Health (10)

Subj: OIG Management Advisory Memorandum, Facility Leaders and Staff have Concerns about VA's New Electronic Health Record (VIEWS 12132238)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft MAM on Facility Leaders and Staff have Concerns about VA's New Electronic Health Record. The Veterans Health Administration has no comments at this time and appreciates the OIG's thorough review.

2. Comments regarding this memorandum may be directed to the GAO OIG Accountability Liaison Office at vha10oicgoalaction@va.gov.

(Original signed by:)
Shereef Elnahal, M.D., MBA

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