Congress of the United States
Washington, DC 20515

April 27, 2022

The Honorable Secretary McDonough
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary McDonough:

We write to express our concerns with the prospective Electronic Health Record (EHR) system to be implemented at Department of Veterans Affairs Medical Centers (VAMCs). Although the intended goal of the EHR implementation is to provide a streamlined, seamless process for veterans receiving care, the rollout in the Mann-Grandstaff Department of Veterans Affairs (VA) Medical Center resulted in confusion, frustration and alarming situations for many veterans and their medical providers.

On March 17, 2022, the Office of Inspector General (OIG) released a report detailing the coordination deficiencies following the EHR rollout at the Mann-Grandstaff VAMC in Spokane, Washington. The report enumerates 24 system deficiencies that negatively impacted the quality of care veterans received at the Mann-Grandstaff VAMC. These deficiencies included, but were not limited to, providers not being alerted when patients were flagged as high risk for suicide, limited access to suicide prevention and assessment tools, EHR-caused delays in scheduling primary care appointments and lab orders "disappearing" before reaching the facility laboratory. At the time of the OIG report's release, one-third of these issues remain unresolved. Despite knowledge of these problems, the VA continues to rollout the new EHR system at other VAMCs, including a proposed June rollout at the Boise VAMC.

An additional OIG report released in July 2021, details the insufficient training for the new EHR system. Prior to the rollout, OIG found that Veterans Health Administration (VHA) leaders identified significant concerns with training and implementation; however, the VA Office of Electronic Health Record Modernization (OEHRM) leaders resisted delays and continued to push for it to go-live at the Spokane facility.

Furthermore, the July 2021 report states that after all training was complete and after more than two months of EHR use at the Mann-Grandstaff VAMC, 95 percent of VAMC staff reported they were unable to use at least one of the four core functions of the new health records system. This decreased provider productivity and damaged employee morale. Additionally, patient advocates did not receive direction or training to consistently track, trend and report patient complaints about the new EHR system.

Compounding rollout problems, the VA OEHRM hindered the OIG's investigation by withholding training evaluation data and altering other data prior to sending it to the OIG. While the VA and VHA have submitted corrective action plans that are responsive to the OIG recommendations, data on implementation has not yet been released.

Despite numerous unresolved system deficiencies, inadequate training practices for medical providers and a performance record that required formal corrective action, the VA has continued to rollout the new EHR system. The Walla Walla VAMC went live on March 26, 2022, and the VA plans to roll out the EHR system at the Boise VAMC on June 25, 2022. With these issues in mind, we request that you answer the following questions:

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1. Why did the VA continue with the rollout at the Walla Walla VAMC with unresolved issues continuing to affect the EHR system?

2. Has the VA considered delaying implementation at the Boise VAMC until the above issues have been addressed? If not, under what conditions would the VA consider delaying implementation at the Boise VAMC?

3. What training will the VA provide to the Boise VAMC staff to ensure adequate understanding of the new system? Does the VA intend to offer training both prior to and after the rollout?

4. What support will be put in place post rollout to ensure the Boise VAMC continues to have the necessary resources to provide timely care to veterans?

5. What steps are being taken to ensure that veteran care is not further impacted by the system rollout?

6. How will the VA respond to new issues that arise in order to ensure they are addressed in a timely manner with full transparency?

7. Moving forward, what measures will be taken to ensure software workarounds are temporary, and permanent solutions are developed?

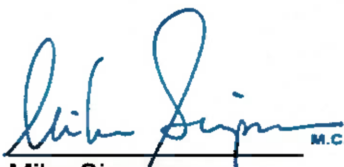
8. What measures are being taken to ensure unauthorized parties utilizing the system are not accessing medical records?

Our country has committed to providing quality care and support for our nation's veterans. The rollout of the EHR system continues to fall short. We eagerly await your prompt response to these questions.

Thank you,

Mike Crapo
U.S. Senator

James E. Risch
U.S. Senator


Mike Simpson
U.S. Congressman

Russ Fulcher
U.S. Congressman