DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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 Spokane, Washington

NATIONAL REVIEW | REPORT # 19-09447-136 | APRIL 27, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review of the VA's transition to a new electronic health record (new EHR) at the Mann-Grandstaff VA Medical Center (facility) in Spokane, Washington. The facility was scheduled to be the first Veterans Health Administration (VHA) medical center to implement the new EHR system with an initial go-live date of March 28, 2020.[1] On February 10, the facility's go-live date was postponed.

On May 17, 2018, then Acting VA Secretary Robert Wilkie announced that VA, the largest integrated healthcare system in the United States, had signed a $10 billion contract with the Cerner Corporation to transition to a new EHR system.[2] The transition is one of VA's top priorities and scheduled to occur over a 10-year period, beginning in the Pacific Northwest in 2020. The OIG focused this review on the new EHR system's implementation at the facility to evaluate the potential impact of the transition on access to care, as well as the capabilities that will be initially available.[3]

VA strives to actively evaluate and manage access to care, with the goal of providing patient care when and where they need it. Legislation, including the 2018 VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, directs VHA to meet standards for patients' timely access to care. During the transition, the new EHR system may affect the facility's ability to provide timely care due to multiple factors: lack of system stability, need to use work-arounds, poor usability, and lack of familiarity with the system.[4]

The OIG recognizes the enormous and challenging effort to convert EHR systems and acknowledges the significant work and commitment of VA staff to accomplish this task. The OIG found that facility leaders consulted with Department of Defense colleagues who had transitioned to the Cerner system in 2017 and experienced a 30 percent decrease in productivity 18 months following their transition. As a result, facility leaders used a 30 percent decrement in productivity over a 12 to 24-month period to generate a plan to mitigate the impact of the

[1] Per OEHRM, "go-live" is the event when on-site staff begin to use the new EHR system in order to deliver health care.

[2] Cerner Corporation works with healthcare facilities to develop EHRs that are based upon its *Millennium*® and *HealtheIntent*® template platforms.

[3] The VA Office of Electronic Health Record Modernization defines capabilities as features of the EHR available to users.

[4] The MISSION Act was signed into law on June 6, 2018, and among other goals, seeks to increase access to health care in VA facilities and the community, to expand benefits for caregivers, and to strengthen VA's ability to recruit and retain medical providers.

transition. The facility plan included adding staff, enhancing clinical space, changing clinic processes, and increasing the use of community care.

Facility leaders told the OIG that VHA's Office of Healthcare Transformation (OHT) provided strong support to help prepare for decreased access to care. Yet, while the OIG found that the Office of Electronic Health Record Modernization (OEHRM) made multiple efforts to evaluate and address productivity decreases, facility leaders were not provided written guidance to address them.[5] Facility leaders, therefore, relied on their own planning to address the anticipated impact on access to care. However, the OIG found that the facility leaders' plan to mitigate access to care with hiring was affected by the Veterans Integrated Service Network's budgetary concerns and its request to the facility to evaluate current provider efficiency in lieu of hiring new staff. The OIG identified that facility leaders addressed recent in-house access to care challenges within primary care, but a significant backlog of 21,155 care in the community consults remained as of January 9, 2020.

OEHRM and Cerner determined in July 2019 that not all anticipated capabilities of the new EHR would be available for the initially proposed facility go-live date (March 28, 2020). For example, online prescription refills, the most popular form for refilling prescriptions at the facility, was identified as a capability that would be absent when going live. Facility leaders worked with OHT and OEHRM to generate mitigation strategies to prepare for decreased capabilities. The OIG determined that, at the initially planned go-live date, facility staff and administrators would enact as many as 84 distinct mitigations for the 62 systems that were determined to be either at moderate or high risk for being unavailable.

The OIG determined that the multiple work-arounds needed to address the removal of an online prescription refill process presents a patient safety risk. Although the facility's initial go-live date has been postponed, the OIG determined that going live at a later date with decreased capabilities and the need to employ necessary mitigation strategies still presents a significant risk to patient safety beyond the inherent risk of deployment of an EHR system.

The OIG made three recommendations to the Under Secretary for Health related to (1) the impact of the new EHR system implementation on productivity and the provision of operational guidance and required resources to facilities prior to going live; (2) identification of the impact of the mitigation strategies on user and patient experience when going live; and (3) a reevaluation of the EHR modernization deployment timeline to minimize the number of required mitigation strategies when going live.[6]

[5] OEHRM proposed the development of a "Productivity, Planning, and Implementation Guide" in May 2019; however, the facility had not received the guide.

[6] The recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

The OIG made one recommendation to the Executive Director of the Office of Electronic Health Records Modernization related to ensuring clear guidance is given to facility staff on what electronic health record capabilities will be available at the go-live date.

The OIG made two recommendation to the Veterans Integrated Service Network Director related to (1) collaborating with facility leaders to implement all VA operational guidance and to support required resource needs during the EHR transition, and (2) ensuring that positions required for the transition to the new EHR system are filled by staff who are trained prior to going live.

The OIG made two recommendations to the Facility Director related to making sure that (1) community care consults are managed through the go-live period to ensure accuracy and completeness, and to avoid the need for manual reentry after going live; and (2) patients receive medication refills in a timely manner throughout the transition to the new EHR system.

Comments

The Executive in Charge for the Office of the Under Secretary for Health and the Executive Director for the Office of Electronic Health Record Modernization concurred in principle and provided acceptable action plans for recommendations 1–4. The Veterans Integrated Service Network and Facility Directors concurred and provided acceptable action plans for recommendations 5–8. (See appendixes A, B, C, and D for comments from the Executive in Charge and Directors.) The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

EHR	electronic health record
EWL	electronic wait list
IOC	initial operational capability
JLV	Joint Legacy Viewer
JOC	Joint Operations Center
MHS GENESIS	Military Health System GENESIS
OEHRM	Office of Electronic Health Record Modernization
OHT	Office of Healthcare Transformation
OIG	Office of Inspector General
OIT	Office of Information and Technology
Set 1	Capability Set 1
Set 2	Capability Set 2
VistA	Veterans Health Information Systems and Technology Architecture

Introduction

The Mann-Grandstaff VA Medical Center in Spokane, Washington (facility), was initially scheduled to be the first Veterans Health Administration (VHA) medical center to implement the new VA electronic health record (new EHR) system beginning on March 28, 2020. On February 10, 2020, however, a VA spokesperson announced that the new EHR system's deployment would be postponed because, at six weeks prior to the initial go-live date (when on-site staff can use the new system to deliver healthcare), it was only 75 to 80 percent ready.

The purpose of this review was to evaluate the progress to date of the new EHR system's timely and safe implementation. The OIG specifically examined the potential impact of the transition to the new EHR system on access to care and the capabilities planned to be initially available at the facility.[1]

Facility Background

The facility, part of Veterans Integrated Service Network (VISN) 20, comprises the Mann-Grandstaff VA Medical Center and four community clinics located in Ponderay and Coeur d'Alene, Idaho; Libby, Montana; and Wenatchee, Washington. The facility operates 36 hospital beds, 34 nursing home beds, and coordinates referrals and tertiary care with the VA Puget Sound Health Care System and the VA Portland Health Care System. From October 1, 2018, through September 30, 2019, the facility served over 35,000 patients. VHA classifies the facility as a Level 3, low complexity facility.[2]

VA Electronic Health Record Modernization Project

In the 1980s, VA developed one of the earliest EHR systems that became Veterans Health Information Systems and Technology Architecture (VistA) in 1996.[3] VistA is a comprehensive health information system and EHR that provides all capabilities required for VA clinical, business, and administrative processes, and serves an essential role in VA's healthcare delivery mission. By 2017, in order to maintain and improve VistA's operational capability, substantial

[1] The VA Office of Electronic Health Record Modernization defines capabilities as features of the EHR system available to users.

[2] The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex. Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing.

[3] Office of Information and Technology, *History of IT at VA*. https://www.oit.va.gov/about/history.cfm. (The website was accessed on January 31, 2020.) Office of Information and Technology, *VA Monograph*. https://www.va.gov/VISTA_MONOGRAPH/VA_Monograph.pdf. (The website was accessed on February 5, 2020.)

investment was required to keep pace with advancements in healthcare technology and cybersecurity. Further, after many years of attempting to achieve EHR interoperability, VA and the Department of Defense have been unable to adopt the same EHR system or create a congressionally required interoperable medical record platform.

In February 2017, the Department of Defense began deployment of its novel EHR system, known as Military Health System (MHS) GENESIS. MHS GENESIS is based on a commercial EHR system, which the Cerner Corporation developed.[4] On June 1, 2017, then VA Secretary David Shulkin announced it to be in the public's interest to have a common EHR platform across VA and the Department of Defense.[5] In this announcement, Secretary Shulkin determined that VA may issue a solicitation directly to Cerner for the acquisition of the EHR system, which the Department of Defense had begun to deploy.

On May 17, 2018, then Acting VA Secretary Robert Wilkie announced that VA had signed a $10 billion contract with the Cerner Corporation to transition to a new EHR system. Since the new VA-wide EHR system would share the same commercial software platform and data-hosting environment as the Department of Defense EHR, VA would further benefit from the Department of Defense's recent early deployment experience.[6] The MHS GENESIS rollout began in Spokane, Washington, on February 7, 2017, at Fairchild Air Force Base and continued at additional sites in the Pacific Northwest. The Department of Defense's early EHR system deployments faced multiple delays and setbacks, which were shared with VA to assist and guide VA in its own deployment strategy.

To oversee the VA task, the VA Office of Electronic Health Record Modernization (OEHRM) was established.[7] The Deputy Secretary of VA directs OEHRM, whose leadership includes an executive director, chief medical officer, and chief technology integration officer.[8] OEHRM is to work in close coordination with the VA Office of Information and Technology (OIT) and VHA to develop and deploy the new EHR system (see figure 1).

[4] Cerner Corporation works with healthcare facilities to develop EHRs that are based upon its *Millennium*® and *HealtheIntent*® template platforms.

[5] Department of Veterans Affairs, Office of the Secretary, *Determination and Findings,* June 1, 2017.

[6] The United States Senate confirmed Robert Wilkie as the Secretary of Veterans Affairs on July 23, 2018. Mr. Wilkie was the Acting Secretary from March 28 to May 29, 2018.

[7] Department of Veterans Affairs, *VA Establishes Office of Electronic Health Record Modernization to Support Transition from Legacy Patient Data System.* https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5084. (The website was accessed on September 18, 2019.)

[8] Office of Electronic Health Record Modernization, *Leadership.* https://www.ehrm.va.gov/about/bios. (The website was accessed on January 17, 2020.)

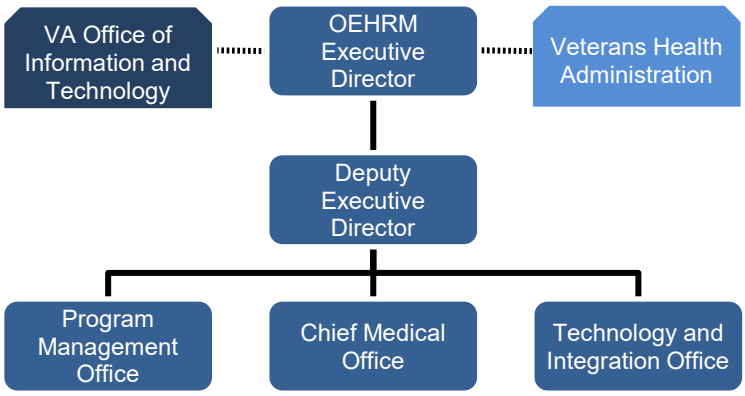

Figure 1. OEHRM leadership

Source: OEHRM organizational chart

Note: Figure 1 provides a hierarchical display of the organization of OEHRM leadership. The top tier displays the lateral relationships of the OEHRM Executive Director with leaders from VA OIT and VHA. The Deputy Executive Director in the middle tier, reports to the OEHRM Executive Director. The third tier of OEHRM leadership is composed of three offices: the Program Management Office, the Chief Medical Office, and the Technology and Integration Office.

OEHRM is responsible for providing a single EHR system over a 10-year period to 174 medical centers and 1,577 stand-alone sites including community-based outpatient clinics, healthcare centers, community living centers, residential care programs, vet centers, and other locations. The deployment was to begin with Initial Operating Capability (IOC) sites in the Pacific Northwest.[9] VA leaders chose this geographic region as the Department of Defense deployed MHS GENESIS within the same region and believed efficiency would be maximized through Department of Defense's lessons learned.

The facility was initially scheduled to be the first IOC site, with a go-live date of March 28, 2020, which was postponed in February 2020. Per OEHRM, "go-live" is the event when on-site staff begin to use the new EHR system in order to deliver health care. Once the facility goes live, providers and administrators will use the new EHR for clinical and administrative work and will rely on the Joint Legacy Viewer (JLV) to view all records not contained in the new EHR system, to include records from VA medical centers that do not have the new EHR system.[10] Similarly,

[9] IOC is a point in time during the production and deployment phase where a system can meet the minimum operational capabilities for a user's intended need.

[10] The JLV is a web application with an interface that provides an integrated, read-only view of EHR data by VA, Department of Defense, and some community partners through the Veterans Health Information Exchange, a program that allows participating community providers to securely share health information.

all staff from VA that do not have the new EHR will be required to view facility patient information through JLV.

The Facility Go-Live Event

At the go-live date, there will be a "cutover" from VistA to the new EHR. The cutover event is an orchestrated process in which tasks are performed based on a specified and rehearsed cutover plan. Once VistA is turned off, facility staff will begin to conduct clinical operations through the new EHR system. Not all historical patient data and information will be moved to the new EHR. Facility staff will be required to switch back and forth between the new EHR system and JLV to ensure that all clinical and administrative information is correctly captured.

On the day of go-live, in addition to adjusting to and using the new EHR system for tasks associated with taking care of patients, providers will have to view consult referrals, active inpatient orders and active outpatient laboratory and imaging orders in JLV and manually re-enter them into the new EHR to ensure action. For example, if a clinician ordered an x-ray for a patient in VistA prior to the go-live date and it has not yet been acted upon, the clinician must find the order in JLV and manually re-enter it into the new EHR so that the study is documented, scheduled, and completed.

Development of the New EHR System

The Electronic Health Record Modernization project establishes standards for VHA clinical processes. OEHRM and Cerner worked with VA OIT and VHA toward the development of the required clinical, technical, and structural readiness deployment requirements for the new EHR system. This process included the establishment of 18 clinical councils with subject matter experts from VA, VHA, Cerner, and the Department of Defense. They reviewed functions available in MHS GENESIS and determined what functions needed to be further developed to meet VHA's clinical and administrative requirements.

At eight national and eight local workshops, clinical councils configured the new EHR. Within a workshop session, each council compared the VHA standards with the commercial Cerner software. If the council identified gaps, the council worked with Cerner subject matter experts to design a specific workflow that best met VA needs. Workflows describe business or clinical steps from beginning to end, including key tasks and the roles of the individuals who perform the tasks. The final workflows were collected into a series of design decision memorandums.[11] Once completed, Cerner grouped a series of workflows into a capability.

[11] A specific workflow might describe the entire process from the time a patient presents to the outpatient pharmacy window in need of a prescription refill to the successful completion of the task. A different workflow might describe from start to finish, the steps required by both patient and provider to renew a prescription.

For example, the separate functions of medication refill and renewal are part of the outpatient pharmacy capability, while the functions of the inpatient pharmacy would be a different capability. Capabilities are further organized under a series of "solutions," such as the pharmacy solution that would contain all pharmacy functions including the outpatient and inpatient capabilities. This process is depicted in figure 2.

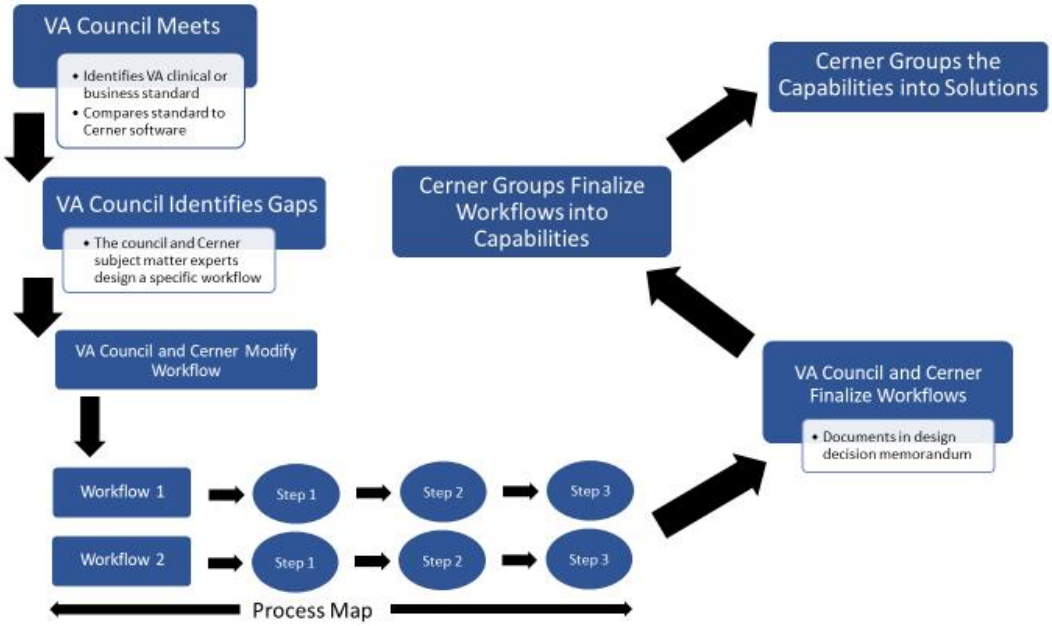

Figure 2. Workflows, capabilities, and solutions development

Source: OIG analysis

Note: Figure 2 provides a depiction of the process used to define the functions of the new EHR. The process begins with the VA Council meeting in which VA clinical or business standards are identified and compared to Cerner software. In the next step, the VA Council identifies gaps and designs a specific workflow to address the gap. The VA Council and Cerner staff work together to identify the workflow steps to create a process map. The VA Council and Cerner then finalize workflows and group them into capabilities. Cerner completes the process by grouping those capabilities into solutions.

The new EHR includes approximately 40 solutions composed of capabilities that were created through more than 1,500 mapped workflows and decisions. As the facility approaches going live, Cerner representatives train clinical and administrative staff on how to use the new EHR system and test its integration and validation. The integration and validation testing, based on actual patient scenarios, is intended to ensure that the new EHR system functions correctly. The testing also serves as a rehearsal for the go-live event and provides input into go-live readiness assessments.

Capability Sets

As early as July 2019, OEHRM determined that not all EHR functions would be available for a planned March 2020 go-live date. In response, OEHRM leaders made the decision to deploy the new EHR functions in separate blocks at separate times. The separate blocks of functions are called "capability sets." Capability Set 1 (Set 1) was scheduled to be deployed in March 2020 and Capability Set 2 (Set 2) was scheduled for deployment six months later, after October 1, 2020. The 40 available solutions comprise more than 300 capabilities: 232 in Set 1, 57 in Set 2, and 18 additional capabilities that will be deployed at a future, yet-to-be-determined date after Sets 1 and 2. While the majority of capabilities are included in Set 1, there are some significant gaps in function between Set 1 and Set 2. One example, discussed later in this report, is the absence of an online patient portal for medication refill requests in Set 1.

In July and August 2019, OEHRM presented the capabilities in Set 1 and Set 2 to leaders at the facility and the VA Puget Sound Health Care System, respectively. The facility and the VA Puget Sound Health Care System were both originally scheduled for spring 2020 deployment. Due to the absence of some required functions in Set 1, the VA Puget Sound Health Care System leaders decided to delay their IOC rollout until the completion of Set 2 out of concern for the clinically sophisticated nature of their healthcare system. At that time, facility leaders decided to continue with the March 2020 go-live date and began to develop work-arounds or mitigation strategies to cover the gaps in clinical and administrative functions between the deployments of Set 1 and Set 2.

Change Management

Change management is a coordinated approach to shifting an enterprise from the current state to the desired future state.[12] Change management requires all users to transition from preparation, to management, and finally reinforcement of the change. OEHRM recognized the need for an emphasis on change management through the new EHR system implementation and created an Office of Change Management whose focus "is to facilitate a successful EHRM [Electronic Health Record Modernization] transformation by driving awareness and desire" of the user. Additionally, organizational adoption of change management concepts supports user education of the new EHR and assists in strengthening and maintaining the change.

Prior OIG Reports

In a January 8, 2020, report, *Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center, Spokane, Washington*, the OIG evaluated a complaint that expressed concerns with the departure of providers, inadequate staffing leading to intensive care unit closure,

[12] Association for Project Management. *What Is Change Management?* https://www.apm.org.uk/body-of-knowledge/delivery/scope-management/change-management. (The website was accessed on January 23, 2020.)

decreased operating room availability, and a temporary leadership appointment. The OIG found the identified concerns were not problematic as facility leaders were aware and had made management decisions to address them. The OIG recommended that the Facility Director ensure that patients have timely access to care. As of January 24, 2020, this recommendation remains open.[13]

A December 6, 2018, OIG report, *Comprehensive Healthcare Inspection Program Review of the Mann-Grandstaff VA Medical Center, Spokane, Washington*, reviewed leadership and organizational risks along with eight areas of clinical operations with no recommendations relevant to this report. As of October 11, 2019, no recommendations remain open.[14]

Rationale for Review

Secretary Wilkie identified the replacement of the VA EHR as one of VA's top priorities, stating that, "[t]he Electronic Health Record has the potential to change the way our Veterans are treated, but also change the way we do business, to make the delivery of our services more efficient, make it more timely."[15] Remarking on the importance of a successful transition of the EHR, a facility leader reported, "I think failure in Cerner [the new EHR] represents a risk to the further existence of VHA as a healthcare system. I truly do."

The OIG focused its review on the new EHR's implementation at the facility, scheduled to be the first IOC site, in order to evaluate the potential impact of the EHR transition on facility operations, staff, and patients. In this report, the OIG reviewed two potential issues with the new EHR's implementation: access to care and the planned initial capabilities of the new EHR system.

[13] VA Office of Inspector General, *Review of Staffing and Access Concerns at the Mann-Grandstaff VA Medical Center, Spokane, Washington*, Report No. 19-09017-64, January 8, 2020. VHA is scheduled to submit its next follow-up response in late April 2020.

[14] VA Office of Inspector General, *Comprehensive Healthcare Inspection Program Review of the Mann-Grandstaff VA Medical Center, Spokane, Washington*, Report No. 18-01144-24, December 6, 2018. The Comprehensive Healthcare Inspection Program reviews focus on key clinical and administrative processes and are performed approximately every three years for each facility.

[15] Department of Veterans Affairs, *Department of Veteran Affairs FY 2018–2024 Strategic Plan*, refreshed May 31, 2019.

Scope and Methodology

The OIG initiated its review on August 29, 2019, and conducted a site visit November 12–14, 2019. The review included examining data and documents from April 1, 2018 through February 11, 2020.

The OIG interviewed facility leaders including the Facility Director; Chief of Staff; Deputy Chief of Staff; the Chiefs of Pharmacy, Primary Care, Health Care Administration Service, Quality, Safety & Value, and Care in the Community; and the Assistant Chief, Health Care Administration Service. The OIG also interviewed the Chief Health Informatics Officer, a Nurse Informaticist, the Patient Safety Manager, the Group Practice Manager, as well as the VISN 20 Chief Financial Officer.

Relevant OEHRM, VHA, and facility policies and procedures were also reviewed. The OIG examined documents specifically related to the development of the new EHR including meeting minutes, council agendas, SharePoint site content, decision memorandums, PowerPoint presentations, briefings, and evaluations. The OIG did not assess VHA data for accuracy or completeness.

The OIG evaluated the real and potential risk to patients, staff, and healthcare operations in relation to planning, preparation, and implementation of the new EHR. The OIG recognized the hard work of all personnel involved and the challenges associated with implementing the new EHR for the largest integrated healthcare system in the United States.[16]

Within the context of this report, the OIG considered risk as a process that will likely result in a delay in patient access to care, lack of staff training and competency, negative impact on clinical care from equipment availability and readiness, and deficiencies in patient safety readiness. Risk may or may not result in an actual adverse clinical outcome and unavoidable risks may occur.

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).

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

[16] Veterans Health Administration. *About VHA*. https://www.va.gov/health/aboutvha.asp. (The website was accessed on January 23, 2020.)

Review Results

The OIG's findings are related to two primary areas of concern. They are associated with patients' access to care and the capabilities of the new EHR system when it goes live. The access to care section examines how the facility managed access risks, the guidance provided facility leaders on access issues, how staffing affects access, and such factors as prior wait times and community capacity. It is followed by a discussion of the new system capability limitations, including the adequacy of specific information prior to going live and the effect of mitigation strategies on patient care and safety.

Access to Care

VA strives to actively evaluate and manage access to care, with the goal of providing patients with care when and where they need it. As of February 11, 2020, facility leaders had not been provided with written guidance on how to address access to care risks. Facility leaders estimated that the new EHR implementation would result in a 30 percent decline in access to care, which might last for 12 to 24 months after going live. This decline will impose access to care risks that require mitigation strategies.

Facility leaders developed strategies that include increasing facility staffing, extending clinic hours, and expanding use of community care. Each of these mitigation strategies carries its own risk. For example, as of February 5, 2020, facility leaders had only hired 48.5 (includes part-time staff) of 108 planned additional staff. Also, the facility's local medical community does not have provider capacity to meet the current clinical demand. With increased patient referrals to the community at the go-live time, facility leaders and staff are concerned about inadequate staffing and new system requirements to manage consult referrals and claims that fall within the care in the community department.

Patients' access to care in VA begins with entry into the system through determination of eligibility and enrollment, followed by the assignment of a primary care provider.[17] If a patient requires specialty care, such as cardiology, the primary care provider places a consult to a cardiologist and an appointment is scheduled in coordination with the patient's preference for date and time.[18] For initial and follow-up appointments, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act requires patient access, through a scheduled appointment, to primary and outpatient mental health care within 20 days of the

[17] Merriam-Webster, *Definition of primary care.* Primary care refers to health care provided by a medical professional with whom a patient has initial contact and by whom the patient may be referred to a specialist. https://www.merriam-webster.com/dictionary/primary%20care. (The website was accessed on January 22, 2020.). VHA Directive 1601A.02, *Eligibility Determination,* November 21, 2018.

[18] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017.

appointment request date and 28 days for outpatient specialty care.[19] If facility staff cannot offer a patient an appointment within this time frame, the patient may be eligible for a referral to a local community provider.[20] The VHA Office of Community Care monitors the time it takes from when a community appointment is requested to when a patient has a scheduled appointment with a community provider. The appointment scheduling target is for 90 percent of a facility's community consults (requests for patients to receive clinical services) to be in

- Pending status less than seven days from the request date,
- Active status less than 30 days from the request date, and
- Scheduled status less than 90 days from the request date.[21]

Facility leaders anticipate that the transition to the new EHR will affect the facility's ability to provide timely care to patients as required. For example, prior to the go-live date, preparation for this transition requires significant hours from facility leaders and staff through weeks of required training on the new EHR, planning for the changes in patient care and facility operations, and the attendance at multiple national and local workshops and meetings.[22] Moreover, following the go-live period of the EHR system, access to care can be compromised through system instability, time-intensive work-arounds, poor usability, and lack of familiarity with the system.[23] This highlights the importance of a plan to mitigate the potential impact of the EHR transition on access to care.

[19] Department of Veterans Affairs, *MISSION Act Strengthens VA Care. https://missionact.va.gov/.* (The website was accessed January 22, 2020.) Department of Veterans Affairs, *Veteran Community Care Eligibility*. https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VA-FS_CC-Eligibility.pdf. (The website was accessed on January 13, 2020.) The MISSION Act was signed into law on June 6, 2018, and among other goals, seeks to increase access to health care in VA facilities and the community, to expand benefits for caregivers, and to strengthen the VA's ability to recruit and retain medical providers.

[20] Department of Veterans Affairs, *Community Care*. https://www.va.gov/COMMUNITYCARE/programs/veterans/General_Care.asp#Eligibility. (The website was accessed on January 22, 2020.)

[21] VHA Directive 1232(2), *Consult Processes and Procedures,* August 23, 2016. Consults are requests for clinical services on behalf of patients and are placed in different statuses. When a consult is in pending status, it has been sent but not yet acted on; when in active status, it has been received and scheduling efforts are underway; and when in scheduled status, an appointment has been made.

[22] Michael A. Tutty et al., The Complex Case of EHRs: Examining the Factors Impacting the EHR User Experience, *Journal of the American Informatics Association*, 26, No. 7. (2019): 673–677. https://doi.org/10.1093/jamia/ocz021. (The website was accessed on January 24, 2020.)

[23] DoD Joint Interoperability Test Command, *Military Healthcare System (MHS) GENESIS Initial Operational Test and Evaluation (IOT&E) Report,* April 30, 2018. The Department of Defense conducted an evaluation of MHS GENESIS and found these factors affected access to care at IOC sites.

Facility Management of Access to Care Risks

The OIG learned that facility leaders continually monitored access to care risks related to the transition to the new EHR system. The OIG found that based on the experiences of the MHS GENESIS rollout, facility leaders anticipated a 30 percent decrease in access to care "lasting at least for 12 to 24 months following go-live" and devised a plan to mitigate the anticipated loss. Facility leaders documented the access to care risks in a white paper sent to VISN leaders on three occasions—the first version was drafted on June 10, 2018, with an updated version on June 24, and a third version in September 2018. Facility leaders identified specific access to care concerns that included the need for financial investment to expand facility personnel and space, potential loss of clinical staff, and local community saturation of VA referrals for primary and specialty care. The white paper detailed a series of mitigation strategies to address the identified concerns.

In February 2019, to track risks, a facility leader identified the need to develop a risk registry for the facility. The facility's Clinical Informatics Committee managed the internal registry and used it to capture facility staff concerns, including access to care risks and developed a plan to move the identified concerns forward for inclusion in the all-encompassing OEHRM risk registry that had been established to review and address such concerns.

In July 2019, VA Office of Healthcare Transformation (OHT) staff visited the facility to assess and assist with preparations for implementing the new EHR.[24] Facility leaders told the OIG of "great support" from OHT, that "OHT is basically watching our backs to make sure that we don't fail." At the July visit, OHT personnel and facility leaders and staff worked together to further identify and develop mitigation strategies for access to care and provider productivity risks in relation to the transition to the new EHR. Based on facility input and understanding of operations, the impact of the new EHR system on patient access to care was determined to be a moderate risk and required development of a mitigation strategy.

Following the visit, OHT developed a dashboard that captured identified risks including those related to access to care, workforce productivity, and provider panel capacity. The August 2019 OHT visit's debrief indicated that one of the facility staff's major concerns was a substantial impact on productivity "leading to delays/increased community referrals." A VISN 20 leader told the OIG that OHT continues to act as the go-between to work with OEHRM and the facility on topics such as mitigation of productivity loss. In September 2019, OHT met again with facility leaders to update and review mitigation strategy progress and to further identify potential risks associated with a March 2020 go-live date.

[24] OHT organized under the Principal Deputy Under Secretary for Health, supports VHA through program and project management, systems engineering, program and initiative implementation, and execution of complex projects with multiple stakeholders.

In September 2019, facility leaders began participating in a newly formed thrice weekly Joint Operations Center (JOC) Update Briefing. The VHA Executive in Charge activated the JOC. Members include representatives from the facility, VHA, VISN 20, OEHRM, Office of Information Technology, the VA Office of Acquisition, Logistics and Construction, VA Office of Management, VA Office of Enterprise Integration, and the Department of Defense. The overarching objective of the JOC is to provide a common operations picture among the members and to align and support the modernization effort so that it is successful.

The OIG reviewed JOC briefing minutes from September 11, 2019, through January 13, 2020. The OIG found that in an October 11, 2019, briefing, facility productivity concerns and mitigation strategies began appearing as a weekly line-item discussion. The October 11 meeting also reflected the need for "surge support" at IOC sites as a VHA leader reported "anticipation of 30% productivity reduction for nine-month period due to training requirements" and "great concern about Spokane's ability to absorb/handle increased referrals to the community." An OHT leader informed the JOC participants that a "team will start development of evaluation plan for surge support as well as productivity loss." The JOC participants also discussed the need for hiring additional clinical and non-clinical facility staff.

In subsequent JOC Update Briefings, an OHT leader discussed the creation of productivity mitigation strategy dashboards that included productivity loss due to training, planned decrease in clinical workload, and decreased efficiency. Facility mitigation strategies included

- Adding facility staff,
- Enhancing clinical space,
- Optimizing clinic grids and patient panels,
- Adding clinic sessions,
- Extending clinic hours, and
- Increasing use of community care.

Facility leaders told the OIG that they planned to increase the time for each appointment and reduce the number of patient appointments, thus decreasing the overall number of available in-house appointments. This would allow providers to have more time, albeit with fewer patients, as they become familiar with the new EHR system.

As of the January 8, 2020, JOC briefing, access to care mitigation strategies were reported as still in process and no facility actions had been completed. Although facility leaders have identified and continued to address access to care risks, the OIG noted the following challenges that the facility was experiencing due to the impending implementation of the new EHR system, such as lack of

- Access to care guidance provided to facility leaders,
- Adequate staffing, and
- Timely patient access to care in the community.

Lack of Access to Care Guidance Provided to Facility Leaders

When asked about guidance received related to access to care issues, facility leaders told the OIG of "robust and frequent discussion" between the facility, VISN, and OHT regarding the anticipated drop in access to care. The OIG found that the discussions did not provide specific actions that facility leaders could take to ensure patient safety once access to care decreased. Facility leaders stated that much of the discussion focused on their local Spokane Department of Defense colleagues' experience with transition to the Department of Defense version of Cerner's EHR and their decrease in access to care, which continued 18 months following their going live.

Facility leaders also reported completion of a templated productivity planning document at OEHRM's request in June 2019. This planning document was based on facility leaders and staff knowledge and served as a data-gathering tool for managing access to care and productivity during the transition to the new EHR. Facility leaders received no feedback from OEHRM after the document was submitted.

The OIG found that OEHRM anticipated decreases in productivity due to the new EHR system and engaged in multiple efforts to evaluate and plan for those decreases. However, the OIG's review of OEHRM activities listed below did not reveal evidence of operational guidance to the facility on the matter:

- In April 2018, research was initiated to evaluate clinician productivity and how it affected post-EHR implementation in order to strategize and limit the potential impacts on clinician productivity.
- In July 2018, a review was conducted by VA data experts to assess Spokane provider staffing for a Provider Workload Planning project to "clarify data to inform a productivity impact model."
- In October 2018, work began on a model to determine the impact of the new EHR on provider productivity.
- In May 2019, the decision to develop a "Productivity, Planning, and Implementation Guide" was confirmed.
- In June 2019, collaboration with Cerner was coordinated to identify productivity reduction data from past implementations in order to inform IOC site productivity plans.

As of January 17, 2020, facility leaders reported they had not received written guidance since submitting the June 2019 templated productivity planning document, which the OIG does not consider to be guidance. Absent guidance from OEHRM, the facility assessed the challenge of access to care and acted on its own plan.

Lack of Adequate Staffing

In June 2018, facility leaders recognized in a white paper that a projected staffing shortage might prevent the facility from meeting the access to care challenges of the new EHR implementation. As a result, in September 2018, facility leaders requested hiring 102 employees (over time this request increased to 108). More than a third of the proposed hires included physicians and nonphysician healthcare providers, a quarter included nurses, and the remainder included administrative support. Facility leaders pursued this plan to hire staff and recognized the challenge of the lengthy hiring process. A facility leader told the OIG that it routinely takes four to six months for an employee to start work at the facility after an interview.

In April 2019, despite facility leaders' concerns about staffing levels for the new EHR implementation, a VISN 20 analysis of fiscal resources led facility leaders to initiate a hiring pause with an aim to meet a VISN goal to decrease overall staffing by 88 positions.[25] The Facility Director saw that an attrition of staff from the baseline level created "a significant risk to Veteran access during the Cerner transformation [EHR transition]." Facility leaders reported that they attempted to address the impact of the hiring pause on going live with VISN leaders. The OIG learned of facility leaders' opinions that VISN leaders considered this to be a facility problem and that staffing needed to be addressed through performance improvement projects and examination of providers' patient panel sizes. The hiring pause continued until October 2019 and ended following the involvement of OHT. A VISN leader added that as of December 20, 2019, the VISN did not have funding for EHR positions at the facility; despite this, the VISN was told to cover the facility's deficit. As of February 5, 2020, 48.5 (includes part-time) of 108 staff had been onboarded at the facility for the staff augmentation effort.

Prior Wait Times and Community Capacity

To evaluate whether the likely decreased productivity when going live would affect timely care, the OIG reviewed wait times for new patients to see primary care providers from July 1, 2019, through January 8, 2020. The OIG focused on the provision of primary care to new patients as it is the primary point of entry for patients into the VHA system. Additionally, primary care access to care challenges were highlighted in the facility white paper previously discussed. To evaluate whether the increase in referrals to the community that is likely to occur when going live will affect timely care in the community, the OIG also reviewed the facility's compliance with VHA Office of Community Care metrics for timely access as of January 8, 2020.

[25] A VISN leader reported that in fiscal year 2018, substantial hiring by the facility led to a budget deficit. The OIG learned that facility leaders acknowledged to the VISN that budget planning errors for the 2019 fiscal year led to a projected deficit, which exceeded $20 million for personnel. These events complicated planning for adequate staff hires during the EHR transition.

The OIG found that facility providers met MISSION Act guidelines with in-house primary care new patient appointments.[26] However, the facility did not meet VHA Office of Community Care metrics for timely access to care in the community.[27]

In-House Access

At the time of the site visit, the OIG determined that new patients were able to timely access primary care but learned of previous access to care challenges. From July through September 2019, new patients seeking primary care waited an average of 35 days with 255 patients on the primary care electronic wait list (EWL).[28] From October through December 2019, the OIG found that the facility's performance for new patient access to primary care improved. New patients seeking primary care waited an average of 11 days. As of January 8, 2020, there were no patients on the EWL (see table 1).

[26] Department of Veterans Affairs, *MISSION Act Strengthens VA Care. https://missionact.va.gov/.* (The website was accessed on January 22, 2020.) Department of Veterans Affairs, *Veteran Community Care Eligibility*. https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/VA-FS_CC-Eligibility.pdf. (The website was accessed on January 13, 2020.) The MISSION Act was signed into law on June 6, 2018, and among other goals, seeks to increase access to health care in VA facilities and the community, to expand benefits for caregivers, and to strengthen the VA's ability to recruit and retain medical providers.

[27] Department of Veterans Affairs, *Community Care*. https://www.va.gov/COMMUNITYCARE/programs/veterans/General_Care.asp#Eligibility. (This website was accessed on January 22, 2020.)

[28] VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures,* July 15, 2016, amended copy, January 22, 2020. The EWL is the official wait list used by VHA. The EWL contains requests for new patient appointments and for appointments for established patients with new complaints that were not able to be scheduled within 90 calendar days of the date when clinically indicated. Facility Policy, *Scheduling Management Business Rules 136-56-19,* August 22, 2019. "Veterans applying for benefits and requesting care will be scheduled with an appointment within 14 days, if not, the patient's name is immediately placed on the EWL for the clinic and preferred location."

Table 1. Primary Care Access for New Patients (July 1, 2019, to January 8, 2020)

Month	Average Days for New Patient Wait Time from Create Date	Patients on EWL
July	31.6	32
August	40.9	162
September	32.7	255
Average	**35.1**	**149.7**
October	9.9	289
November	8.6	302
December	14.5	10
January	Not Available	0
Average	**11.0**	**150.3**

Source: OIG analysis of VHA Support Service Center data

Facility leaders told the OIG that, prior to its site visit, primary care access challenges existed due to a variety of reasons:

- Not enough primary care providers to meet the demand
- Not enough appointments in primary care staff's schedules
- Patients' preferences to wait for an appointment at the facility rather than going to see a community care provider

The OIG learned that the October 2019 improvement in primary care access for new patients occurred after the facility implemented a performance improvement project with the goal of helping the facility prioritize patients' needs and access to quality care. Additionally, a VISN 20 leader told the OIG of working with the facility in October 2019 to increase the number of patients assigned to primary care provider panels.

Care in the Community

Facility leaders have identified an access to care mitigation strategy that refers patients in need of timely medical treatment to community providers. However, the OIG found that the facility is not meeting Office of Community Care metrics and has a significant number of open community care consults. The OIG found that as of January 9, 2020, the facility had over 21,000 open consults and the wait time was an average of 56.2 days (see tables 2 and 3).

Table 2. Facility Community Care Consult Metrics

Status	Target	Score
Consults in Pending Status <=7 Days	90%	70.6%
Consults in Active Status <=30 Days	90%	45.7%
Consults in Scheduled Status <=90 Days	90%	32.9%

Source: OIG analysis of VHA Support Service Center data

Table 3. Facility Community Care Consult Data

Area	Completed Consults	Average Wait Time (in Days) for Completed Consults	Open Consults	Average Wait Time (in Days) for Open Consults
Primary Care	1,959	34.6	2,428	50.2
Entire Facility	20,456	36.2	21,155	56.2

Source: OIG analysis of VISN 20 data analytics group[29]

VA and facility leaders were aware of the community care challenges and attributed them to

- Oversaturation of medical care referrals in the Spokane, Washington, community,
- Increased patient demand for care in the community in 2019,[30]
- Inadequate staffing in the facility's care in the community service line, and
- New VHA system requirements to manage the referral of consults to the community as well as claims management within community care office.

The OIG found that facility staff have been working additional hours since December 2019 to reduce the backlog of open community care consults. As of January 15, 2020, facility staff have been asked to work an additional eight to ten hours per week outside their normal tour of duty until the backlog of community care consults are cleared. In addition to the increased work hours to address the backlog of consults, care in the community staff will face other challenges when going live due to increased manual work needed to schedule consults in the community. Facility staff will need to access multiple systems to retrieve patient records, as well as manually copy and paste patient information from one system to another to process consults. The facility continues to work through the challenges of the interface and manual requirements for community care consults.

[29] Data are shown for consults completed from January 1, 2019, through January 8, 2020. Open consults are the total number of pending, active, and scheduled, and are shown at a point in time of January 9, 2020.

[30] Facility leaders told the OIG that they anticipate an increased demand for patients to be seen in the community at the go-live time due to the lack of facility providers' availability. Changes in patient eligibility for community care pursuant to the MISSION Act may further increase the demand.

Capability Limitations

In July 2019, OEHRM and Cerner staff met with facility leaders to review the functionality being proposed for going live. OEHRM, Cerner, and facility leaders and staff determined that based on the facility's size and complexity, 51 of the 57 Set 2 capabilities were needed to meet the facility's operational goals and patient care needs. To identify gaps in function between Set 1 and Set 2, facility leaders and staff assigned a risk level to operations of low, moderate, or high based on their understanding of the facility and potential impacts. While the majority of capabilities are included in Set 1, there are some significant gaps in function between the two sets that required mitigation planning.

By August 2019, both OHT and facility staff developed mitigation-tracking processes. The facility's mitigation tracker is composed of 84 strategies required to minimize the impact of the missing moderate and high risk capabilities. In September 2019, a follow-up meeting occurred with OHT and facility leaders to update and review mitigation strategy progress, and to further identify potential patient safety risks associated with a March 2020 go-live date. Since then, and with the development of the JOC, facility risks and mitigations have been regularly followed and tracked with recurring scheduled progress updates reported to the wider group of project stakeholders.

Facility leaders and staff told the OIG of concerns related to the deployment of capability sets:

- Not knowing what capabilities would be available at IOC site at go-live date
- Changing capabilities to meet the go-live timeline, instead of changing the go-live timeline to meet the completion of capabilities
- Developing training with incomplete information on which capabilities would be available at the IOC site
- Feeling limitations in Set 1 present as "significant handicaps at day zero"
- Requiring facility staff to access two systems (JLV and the new EHR) while providing patient care
- Feeling compelled to go live in March 2020, although the full capability set would not be ready
- Being unable to accurately predict patient safety risks because of incomplete information on which capabilities would be available at IOC site on the go-live date

In November 2019, a facility leader expressed concern to the OIG regarding the process because a final list of what capabilities would be available at the go-live time had yet to be determined, which further limited mitigation planning.

At the go-live date, facility staff and administrators will immediately begin enacting as many as 84 distinct mitigation plans developed as work-arounds for 62 unavailable system functions that were deemed either moderate or high risk for being unavailable at go-live (see table 4).[31]

Table 4. Number of Functions Unavailable at Go-Live Time and Risk Mitigation Strategies

Solution Area	Number of Functions Unavailable at Go-Live Date Deemed Moderate to High Risk	Number of Strategies Required to Mitigate Risks
Primary Care	13	10
Pharmacy	9	10
Community Care Referrals	7	11
Lab	7	6
Telehealth	6	7
Gastroenterology	4	4
Cardiology	3	5
Referral Management	3	5
Radiology	2	9
Ophthalmology	2	2
Emergency Medicine	2	2
Audiology	1	5
Patient Accounting	1	3
Training	1	5
Total	**62**[32]	**84**

Source: OIG analysis of facility mitigation tracker

Examples of mitigation plans include the need for

- Care in the community staff to navigate between the new EHR, JLV, and other third-party software to determine patient eligibility, and track consult approval and status;
- Primary care teams to manually enter all patient medications prescribed by non-VA providers to ensure a complete record of active medications in the new EHR; and

[31] The OIG identified 84 mitigation strategies from the facility mitigation tracker.

[32] Although the capability gap between Set 1 and Set 2 is 57, the facility identified other risks associated with gaps in function. Additionally, some singular gaps were counted twice as each solution area may require an area-specific mitigation. For example, the absence of patient portal refill ability is tracked by both primary care and pharmacy.

- Patients, who previously ordered refills of medications through the MyHealtheVet portal, to use alternative means of refill requests.[33]

Mitigation Risks

There are inherent risks associated with the deployment of any new EHR system, and both OEHRM and the facility developed risk registries to capture, track, and address risk-related concerns, including patient safety risks.[34] Risk management and mitigation is a strategy used to identify concerns and reduce the potential negative effects on patient care.[35] VHA requires facilities to review vulnerabilities that could result in patient harm and develop solutions to mitigate risk in order to reduce or prevent adverse clinical outcomes.[36] Once identified, risks may be controlled or reduced by targeted solutions in a process called risk mitigation.[37]

Mitigating the lack of functionality of Set 1 with work-arounds for the new EHR system has the potential to introduce patient safety risk. An example of an anticipated patient safety risk created by going live with the limitations of Set 1 is the planned work-arounds for the absence of an online prescription refill process, as described below. The 84 mitigations required for the missing capabilities may introduce a separate level of risk.[38]

Outpatient Prescription Refills

In 2003, VA launched the MyHealtheVet portal in order to improve patient accessibility to health information with online prescription refills being the most applied feature. Electronic prescription refill systems are known to increase patient medication compliance and improve

[33] MyHealtheVet is an online personal health portal in which patients can schedule appointments, view medical records, refill prescriptions, and send secure messages to their providers.

[34] Dean Sittig and Hardeep Singh, "A Red-Flag-Based Approach to Risk Management of EHR-Related Safety Concerns," *Journal of Healthcare Risk Management* 33, No. 2 (2013): 21-26. Known EHR-related patient safety concerns can include patient misidentification, unavailability of the EHR, and system interface errors. https://onlinelibrary.wiley.com/doi/epdf/10.1002/jhrm.21123. (The website was accessed January 6, 2020.)

[35] Ali Yawar Alam, "Steps in the Process of Risk Management in Healthcare," *Journal of Epidemiology & Preventative Medicine* 2, No. 2 (October 2016): 118. https://doi.org/10.19104/jepm.2016.118. (The website was accessed January 10, 2020.)

[36] VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was scheduled for recertification on or before the last working date of March 2016 but has not been recertified.

[37] Yawar Alam, "Steps in the Process of Risk Management in Healthcare." Examples of risk mitigation include redesigning systems and processes to reduce the potential of negative outcomes, reducing the probability a risk will occur, and/or reducing the severity or impact of the risk.

[38] V. Blijleven et al., "Workarounds Emerging from Electronic Health Record System Usage: Consequences for Patient Safety, Effectiveness of Care, and Efficiency of Care," *Journal of Medical Internet Research Human Factors* (October 2017). https://www.ncbi.nlm.nih.gov/pubmed/28982645. (The website was accessed on January 29, 2020.) Derek Meeks et al., "An Analysis of Electronic Health Record-Related Patient Safety Concerns," *Journal of the American Medical Informatics Association*, 21 (2014): 1053-1059. https://academic.oup.com/jamia/article/21/6/1053/2909293. (The website was accessed on January 29, 2020.)

health outcomes.[39] Per VA, as of August 2019, over 4.9 million veterans have registered to use MyHealtheVet to "refill their prescriptions, download and share their medical records, schedule and view appointments, and send secure messages to their health care teams."[40] The OIG reviewed facility refill requests from January 2019 through December 2019, and determined that the MyHealtheVet portal was the most utilized method for patients placing requests for prescription refills (see table 5).[41]

Table 5. Facility Prescription Refill Requests (from January 2019 through December 2019)

Modality	Number of Prescription Refills
MyHealtheVet	115,758
AudioCARE[42]	96,918
In-Person/Other	90,322

Source: OIG analysis of facility refill requests

The OIG found that electronic prescription refills through the MyHealtheVet portal would no longer be available to facility patients at the March 2020 go-live date and although the function exists in the new EHR patient portal, activation will not occur until future capability sets go live.

One of the 18 clinical councils was responsible for assessing the suitability of all portal options within the new EHR. At the May 2019 National Workshop 5, the council discussed the

[39] Courtney R. Lyles, et al., "Refilling Medications Through an Online Patient Portal: Consistent Improvements in Adherence Across Racial/Ethnic Groups," *Journal of the American Medical Informatics Association*, 23 (2016): e28-e33. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4954621/pdf/ocv126.pdf. (The website was accessed on January 14, 2020.). Chandra Y. Osborn, et al., "Understanding Patient Portal Use: Implications for Medication Management," *Journal of Medical Internet Research*, 15, No. 7 (2013): e133. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3713921/?report=printable. (The website was accessed on January 14, 2020.)

[40] VAntage Point, *Veterans: Your Time is Valuable – Make the Most of It.* https://www.blogs.va.gov/VAntage/64979/veterans-your-time-valuable-make-most/. (The website was accessed on January 16, 2020.)

[41] MyHealtheVet, *Get to Know Rx Refill Options*, https://www.myhealth.va.gov/mhv-portal-web/ss20180423-prescription-refill-options-for-veterans. (The website was accessed on January 17, 2020.) VA medical facilities provide patients with several methods to refill VA prescribed medications: online through the MyHealtheVet portal, by phone through the automated telephone refill line, in person at a VA pharmacy, and by mail through the VA mail order pharmacy.

[42] AudioCARE provides a health information technology solution that automatically handles both inbound and outbound communications between a VA healthcare facility and its patients. For medication refills, the system requires the patient make a phone call, select the pharmacy refill option and manually enter their social security number as well as the prescription number(s).

healthcare record component of the new EHR portal called HealtheLife.[43] The council identified a number of gaps in functions between the new EHR electronic prescription refill portal under HealtheLife and the current electronic prescription refill portal under MyHealtheVet. In September 2019, an OEHRM leader authorized a decision that "refills and renews should be turned off" in the HealtheLife portal as the portal capability in Cerner did not meet VA standards.

A facility leader told the OIG that facility leaders had to develop mitigation strategies to address the approximately 10,000 monthly prescriptions filled through the MyHealtheVet portal and that the "biggest concern was to uphold veterans' safety first with whatever they are going to do." As of January 15, 2020, proposed strategies included

- Patient education on how to refill prescriptions,
- Patient use of AudioCARE,
- Patients calling the VISN 20 call center, and
- Hiring clinical staff at the facility and at the VISN call center.

Facility leaders and staff told the OIG of safety concerns related to the loss of the MyHealtheVet electronic refill portal and that mitigation strategies seemed insufficient to meet patient needs. This mitigation plan requires patient involvement, and as of January 15, 2020, facility leaders had not deployed any communication to patients pertaining to their role in the change to the electronic prescription refill process.

Another mitigation strategy that facility leaders and staff told the OIG would place patients at safety risk is the increased use of AudioCARE. Patients who previously used MyHealtheVet to refill prescriptions will be redirected to call prescriptions in through AudioCARE. AudioCARE requires the prescription refill number, which is not a requirement in MyHealtheVet. Concerns regarding the mitigation strategy of AudioCARE's use at the time of the site visit included

- Patients who do not know their prescription refill numbers or cannot "punch in" the number due to physical or mental health conditions will have the call transferred to the VISN 20 call center,

[43] Cerner, *Patient Engagement HealtheLife.* https://www.cerner.com/solutions/patient-engagement. (The website was accessed on January 17, 2020.) "HealtheLife" is a web-based Cerner product that combines the concept of a traditional EHR patient portal with other tools to engage patients in proactive health management. In the new EHR, this patient portal is known as "My Health Veterans Portal." Like the current MyHealtheVet portal, the My Health Veterans Portal will give patients access to health record information.

- The VISN call center had only administrative staff who could not assist with prescription refills without the prescription number and so will send an electronic message to the patient's primary care team for assistance,
- Increased messaging from the call center to primary care teams may overwhelm the primary care staff's ability to respond and further impede timely refill requests.[44]

Additionally, the OIG learned that the VHA legacy version of AudioCARE is incompatible with the new EHR platform, which increased its risk to functionality at the March 2020 go-live date. VHA and facility leaders became aware of this incompatibility in January 2020 and are working to address the issue.

Although, the new EHR's mitigation strategies required for going live were developed to fill the gap in functions between capability sets, the risk to patient safety remains significant. Even the AudioCARE mitigation strategy described above must immediately and successfully address approximately 10,000 monthly MyHealtheVet medication refills at and after the go-live date.

Conclusion

The OIG found that facility leaders were planning to go live in March 2020 with an incomplete set of system capabilities. As of February 10, 2020, the facility's go-live date has been postponed. The OIG concluded that should VA decide to go live at a future date with only Set 1 capabilities rather than both Set 1 and Set 2, necessary and required mitigation strategies still present a significant risk to patient safety beyond the inherent risk of a new EHR deployment. The OIG was unable to determine all patient safety risks associated with the new EHR system; however, the work-arounds for the electronic prescription refill process alone constitute an example of a significant, potential patient safety risk.

The OIG found that other aspects of the new EHR transition may also risk negatively affecting patients' access to care. There is no indication that VA provided facility leaders with a documented plan to address the anticipated impact on provider and other personnel productivity that can decrease appointment availability. It is also unknown if the facility's staffing plan will adequately address patients' timely access to healthcare services before, during, and after the new EHR system's implementation.

The OIG identified that while primary care access for new patients was sufficient at the time of this review, if a 30 percent degradation in productivity occurs and adequate hiring is not completed, the facility may not meet MISSION Act requirements for primary care access. Patients would then be offered the option to receive care in the community, which may strain the

[44] A facility leader told the OIG that prescription numbers can be up to nine digits and some patients have up to 20 prescriptions requiring monthly refills, leading to patient frustration using AudioCARE if having to input the prescription number on their phone pad.

facility's community care referral resources and further overload healthcare resources in the community, likely extending wait times for appointments. The OIG made eight recommendations to which VA concurred (or concurred in principle). The full text of VA's responses can be found in the appendixes.

Recommendations 1–8

1. The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, evaluates the impact of the new electronic health record implementation on productivity and provides operational guidance and required resources to facilities prior to go-live.[45]

2. The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, identifies the impact of the mitigation strategies on user and patient experience at go-live and takes action, as needed.

3. The Executive Director, Office of Electronic Health Records Modernization, in conjunction with the Under Secretary for Health, ensures that clear guidance is given to facility staff on what electronic health record capabilities will be available at go-live.

4. The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, reevaluates the electronic health record modernization deployment timeline to minimize the number of required mitigation strategies at go-live.

5. The Veterans Integrated Service Network Director collaborates with facility leaders to implement VA-provided operational guidance and supports required resources needed throughout the transition to the new electronic health record system.

6. The Veterans Integrated Service Network Director ensures that positions required for the transition to the new electronic health record system are staffed and trained prior to go-live.

7. The Mann-Grandstaff VA Medical Center Director ensures that community care consults are managed through go-live to ensure accuracy, completeness, and to avoid the need for manual reentry after go-live.

8. The Mann-Grandstaff VA Medical Center Director ensures that patients receive medication refills in a timely manner throughout the transition to the new electronic health record system.

[45] The recommendations directed to the Under Secretary for Health were submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: March 26, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: Healthcare Inspection—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

To: Director, Office of Healthcare Inspections (54HL10)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Healthcare Inspection, 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. I concur in principle with recommendations 1, 2 and 4. In the attached documents, the Veterans Affairs (VA) Office of Electronic Health Records Modernization (OEHRM) provides a response to recommendation 3, the Veterans Integrated Service Network (VISN) 20 provides a response to recommendations 5 and 6, and the Mann-Grandstaff VA Medical Center (VAMC) provides a response to recommendations 7 and 8.
2. I appreciate the concerns regarding mitigation strategies and capabilities of the new electronic health records (EHR) system. The Veterans Health Administration (VHA) is working with VA OEHRM, VA Office of Information and Technology (OIT), and other relevant VA program offices to ensure Veterans receive the care they need, in an efficient manner.
3. I'm pleased by the stakeholder interest and engagement in the EHR transition. VHA is sensitive to this approach and is supporting the clinicians and front line staff in their journey, as well as leadership at the VAMCs and VISNs. Along with OEHRM and Cerner, VHA is continuously providing on-site support to the VAMCs and VISN 20.
4. Care providers are at the heart of the system mission and their feedback, engagement, and training are vital to deploying a fully functional system. VHA is working with OEHRM to communicate with providers to understand the EHR capabilities and ensure all staff are trained to the new system. Training and engagement at all staff levels (front line, supervisors, and leadership) ensures that the end users, those providing care, are fully prepared to use the new system at Go-Live and beyond.
5. As the Go-Live date was approaching, Secretary Wilkie received feedback from clinical and technical staff. He decided to postpone the Go-Live so that the system can provide the greatest functionality at Go-Live and VHA staff are confident in providing care with the new system with the least mitigation strategies. In close collaboration with OEHRM and OIT, VHA will continue the implementation process and provide support to our staff.
6. Many hospital systems may experience a decreased level of productivity at Go-Live of new EHR implementation. VHA is committed to ensuring access to care at all VAMCs and has been evaluating readiness at the Go-Live sites along with our partners in OIT and OEHRM. An interdisciplinary team meets weekly to assess readiness and monitor progress leading up to

Go-Live. VA will continue to monitor productivity and the effectiveness of the mitigation strategies for lessons learned for future site implementation.

7. If you have any questions, please email Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison Office at VHA10EGGOALAction@va.gov.

(Original signed by:)

Richard A. Stone, M.D.
Executive In Charge, VHA

Executive in Charge Response

Recommendation 1

The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, evaluates the impact of the new electronic health record implementation on productivity and provides operational guidance and required resources to facilities prior to go-live.

Concur in principle.

Target date for completion: Initial response at IOC Go-Live; Revised versions at subsequent Go-Live dates

Executive in Charge Comments

The Initial Operating Capability (IOC) sites are the leaders and trailblazers for the electronic health record (EHR) implementation. The Veterans Health Administration (VHA) and the Office of Electronic Records Modernization (OEHRM) are working together with IOC sites to develop lessons learned for future sites. IOC is intended to be a "learning phase" and continuous process improvement will be applied to the implementation as we move forward. Although the traditional approach would be for VHA to provide guidance to the sites and manage the implementation at the enterprise leadership level, VHA understands that the clinicians and front-line staff own the process and will drive results with collaboration and support from VHA and OEHRM. VHA will defer to the subject matter experts and continue to seek feedback from the sites and support as the sites request.

VA has convened EHRM Joint Operations Center (JOC) Update Meetings to coordinate EHRM efforts across the many stakeholders at VA. At the EHRM JOC Update Meetings, IOC site leadership and Veterans Integrated Service Network (VISN) 20 leadership brief VA, VHA, and OEHRM leadership and stakeholders on potential productivity issues that may occur before and during go-live. The briefings include proposed mitigation strategies, their associated readiness status (e.g., red, yellow, green), risks and necessary resources required to mitigate the productivity issue. We will continue to have these briefings and increase frequency as required.

Outside of the weekly briefings, VHA is working in collaboration with VISN 20 leadership and staff to implement the productivity mitigation strategies and monitor progress and risks. To complement this, VHA is developing a Productivity Evaluation Plan and an associated dashboard to monitor productivity and the effectiveness of the mitigation strategies for lessons learned for future site implementation. Moving forward, VHA will identify an office responsible for managing national strategy and support of productivity mitigation. While we fully expect the needed support for post-IOC deployments sites to lessen, there will always be a need to support

training and other deployment events, and it is recognized that an enterprise versus site to site approach will be more efficient.

Recommendation 2

The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, identifies the impact of the mitigation strategies on user and patient experience at go-live and takes action, as needed.

Concur in principle.

Target date for completion: Initial response at IOC Go-Live; Revised versions at subsequent Go-Live dates

Executive in Charge Comments

As VHA continues to operationalize mitigation strategies, user and patient experience is at the forefront of our considerations. Prior to any go-live decision, it is of the utmost importance that Veterans Integrated Service Network 20 facility staff and leadership are 100 percent comfortable that go-live will not negatively impact patients and users. Each site has Change Leadership Teams comprised of trained personnel who engage directly with users and patients to ensure their understanding of the electronic health records implementation and the positive changes it will bring to enhance their patient experience. Change management teams engage peers at all levels of the organization and coordinate with the Office Electronic Health Records Modernization to share lessons learned and any concerns. This two-way communication allows for real-time feedback and continuous process improvement. At go-live, patient satisfaction will continue to be monitored and as issues arise, the Change Leadership Teams will work with the appropriate facility personnel to address the issue and apply lessons learned at future sites.

Recommendation 4

The Under Secretary for Health, in conjunction with the Office of Electronic Health Records Modernization, reevaluates the electronic health record modernization deployment timeline to minimize the number of required mitigation strategies at go-live.

Concur in principle.

Target date for completion: Based on delivery of Capability Set 1.1 Build and Veteran Facing Interface Configuration Completion Date, Targeted May 2020

Executive in Charge Comments

VHA is committed to doing no harm and implementing the electronic health record (EHR) in a thoughtful way. We realize this is a significant undertaking with multiple complexities. Secretary Wilkie, with feedback from many of our clinical and technical stakeholders, postponed training

events and the initial go live date until we are fully confident that the new EHR system is as complete as possible. The schedule adjustment will allow for greater functionality and less mitigation strategies at go live. Our doctors, nurses, and end users who provide the care for our Veterans will continue to provide feedback. We will reevaluate our deployment methodology to ensure VHA can provide adequate resource support to sites as they deploy. This will include considering size and complexity of sites, site capacity, and community care saturation. Along with our OEHRM partner, we will continue to monitor the deployment timeline and adjust the timeline and the associated mitigation strategies as necessary to provide the best care for our Veterans.

Appendix B: Office of Electronic Health Record Modernization

Department of Veterans Affairs Memorandum

Date: March 27, 2020

From: Executive Director, Office of Electronic Health Record Modernization (00EHRM)

Subj: Healthcare Inspection—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

To: Director, Office of Healthcare Inspections (54HL10)

1. The Department of Veterans Affairs (VA) Office of Electronic Health Record Modernization (OEHRM) appreciates the opportunity to review the Office of Inspector General's (OIG) draft report regarding access to care and capabilities of VA's new electronic health record (EHR) solution. OEHRM concurs with OIG's findings and recommendations, and provided input in the Action Plan to address these recommendations (Attachment).
2. Throughout the Electronic Health Record Modernization effort, OEHRM has worked to ensure that clear guidance is communicated to facility staff regarding the EHR capabilities. OEHRM completed a series of workshops to support design and configuration of the new EHR solution. Additionally, OEHRM conducted a series of roadshows to provide early education, demonstrate core EHR functionality, and promote user adoption. OEHRM conducts weekly progress briefings with initial operating capability (IOC) site supervisors and meetings with IOC facility staff to share information about the EHR capabilities. OEHRM closely monitors the status of the capability sets and consistently communicates with IOC facility staff to ensure stakeholders understand which EHR capabilities will be available at Go-Live.
3. OEHRM has already identified process improvements aligned to OIG Recommendation 3 and progress toward completion of the recommendation is underway.
4. Please contact Mr. Fred Mingo, OEHRM Program Control Director, at Fred.Mingo@va.gov with questions regarding this memorandum.

(Original signed by:)

John H. Windom
Executive Director

Office of Electronic Health Record Modernization

Executive Director Response

Recommendation 3

The Executive Director, Office of Electronic Health Records Modernization, in conjunction with the Under Secretary for Health, ensures that clear guidance is given to facility staff on what electronic health record capabilities will be available at go-live.

Concur in principle.

Target date for completion: Based on delivery of Capability Set 2.0 Build Completion Date, Targeted November 2020

Director Comments

Facility staff, to include Initial Operating Capability (IOC) and subsequent implementation sites, across VHA have participated in multiple workshops to understand the Electronic Health Record (EHR) capabilities. VHA, OEHRM, Office of Information and Technology, and other relevant VA Program Offices conduct on-site workshops to work with facility staff to test and refine initial EHR capabilities. OEHRM, with support from VHA Central Office, is in regular contact with VISN 20 and facility leadership and staff to ensure their full understanding and buy-in on the critical EHR capabilities that will be available at go-live.

Cerner has multiple touch points with the IOC site staff on capabilities. There were roadshows and demonstrations in a more formal setting. Cerner also meets weekly with supervisors to check progress and has multiple formal and informal meetings with staff to ensure staff are comfortable with the capabilities. VHA closely monitors the status of each capability set and consistently communicates with facility staff to ensure their understanding of what capability will be available come go-live.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 3, 2020

From: Director, Northwest Network (10N20)

Subj: Healthcare Inspection—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

To: Director, Office of Healthcare Inspections (54HL10)

Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the findings from the Healthcare Inspection - 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.
2. Veterans Integrated Service Network (VISN) 20 concurs with the findings and recommendations for the VISN. In addition, we concur with the recommendations for Mann-Grandstaff VA Medical Center and responses provided by the Medical Center Director.
3. It should be noted that because the report references VISN support to the two IOC sites, we also included the second IOC site, Puget Sound VA Health Care System (American Lake and Seattle), in our response since they are scheduled to go-live in the Fall 2020.
4. If you have any questions or need additional information, please let me know.

(*Original signed by*:)

John A. Mendoza
Deputy Network Director for Michael J. Murphy, Network Director

VISN Director Response

Recommendation 5

The Veterans Integrated Service Network Director collaborates with facility leaders to implement VA-provided operational guidance and supports required resources needed throughout the transition to the new electronic health record system.

Concur.

Target date for completion: Puget Sound deployment plus nine months

Director Comments

At the early stages of engagement with Cerner, Veterans Integrated Service Network 20 (VISN) established ongoing communication and coordination with the two initial operating capability (IOC) sites (Mann-Grandstaff and Puget Sound) in the development of a Productivity and Mitigation Plan. Through ongoing engagement with the Office of Electronic Health Records Modernization (OEHRM), VHA program offices, Cerner and various electronic health record (EHR) National Councils, VISN 20 adjusts the Productivity and Mitigation Plan to support the IOC sites, when indicated.

The Productivity and Mitigation plan includes not only additional staff resources to be hired by each IOC site (108 FTE for Mann-Grandstaff and 264 for Puget Sound) but also incorporates augmented national and VISN resources such as the Traveling Nurse Corp (30 Traveling nurses assigned to Mann-Grandstaff), utilization of the VISN 20 Clinical Resource Hub (CRH), which is based in Boise and provides virtual telehealth care to VISN 20 sites (augmented with 49 additional staff specifically for support to the IOC sites) and with details of staff throughout VHA (clinical resources and ancillary support staff such as Lab Technicians, Pharmacy Technicians and Medical Support Assistants).

At the EHRM Joint Operations Center (JOC) Update Meetings, VISN 20 regularly briefs VA, VHA, and OEHRM leadership and stakeholders on the ongoing status of the Productivity and Mitigation Plan.

The target completion date is based on deployment of Puget Sound plus nine months.

Recommendation 6

The Veterans Integrated Service Network Director ensures that positions required for the transition to the new electronic health record system are staffed and trained prior to go-live.

Concur.

Target date for completion: Puget Sound deployment plus nine months

Director Comments

VISN 20, in collaboration with the Office of Electronic Health Record Modernization (OEHRM) Change Management Team, continue to work with the IOC sites to ensure identification of all staff that will require training pre go-live. This includes not only the staff identified in the Productivity and Mitigation Plan but also those existing staff that will support IOC during go-live. These include remote staff functioning in virtual Call Centers both within VISN 20 and outside of VISN 20 (Nurse Triage and After-hours support from VISN 22 and VISN 10 Call Centers).

The Productivity and Mitigation Plan also included resources required to support ongoing work at the IOC site while staff were being trained on the new EHR. As noted previously, VISN 20 briefs on status of the Productivity and Mitigation Plan in the JOC.

The target completion date is based on deployment of Puget Sound plus nine months.

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 30, 2020

From: Director, Mann-Grandstaff VA Medical Center (668/00)

Subj: Healthcare Inspection—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

To: Director, Northwest Network (10N20)

1. I am thankful for the opportunity to review the draft report on access to care and capabilities during transition to the new electronic health record (EHR) at Mann-Grandstaff Veterans Affairs Medical Center (MGVAMC). The hard work and diligence of Dr. Etherage and his team is very much appreciated.

2. There is little to no published evidence-based research on quantifying impact to access to care when a large federal health care system initially implements a new EHR. This is especially true for the largest integrated health care system in the United States, Veterans Health Administration. The only other large federal health care system to initially adopt and transition to a new EHR was the Department of Defense (DoD). The first Initial Operating Capability (IOC) site was the Medical Group (outpatient clinic), Fairchild Air Force Base in Spokane. Their experience with significant impact to access to care served as the model developed by leaders at MGVAMC. The subsequent mitigation plan developed by MGVAMC was fully vetted by the Veterans Integrated Service Network (VISN), Veterans Health Administration (VHA) and the Office of Electronic Health Record Modernization (OEHRM) and represents an early and collaborative effort between the facility, program office, central office and service network. The model will continue to mature and evolve reflecting experience with each successive IOC implementation. The common thread among all electronic health records modernization (EHRM)-related surveys and inspections to date, including the present one, is recognition of the dedication and commitment to EHRM from leadership to front-line staff. A facility-centric and developed mitigation strategy is empowering to staff and significantly furthers engagement, adoption and free communication so necessary to ensure success at the first VHA facility to go live with HealtheIntent and Cerner Millennium. The OIG draft report rightfully identified that facility leaders devised a plan to mitigate anticipated loss of access to care which included financial investment to expand facility personnel and space as well as compensate for the potential loss of clinical staff often seen in commercial transitions to a new EHR. The mitigation strategy also recognized community saturation of VA referrals for community primary and specialty care and detailed a series of mitigation strategies to review and address such concerns.

3. The recent decision to delay go-live occurred at a propitious time immediately following a second round of Integration Validation testing at the facility and an initial round of training for EHR Superusers. The OEHRM Chief Medical Officer and I convened a round-table meeting with superusers to assess their experience with the first round of training and identified a gap between EHR design solutions and training content identified in both recent testing and training. For that reason, these concerns were quickly elevated to executive leadership in

OEHRM and VHA and presented to the Secretary of Veterans Affairs thereby avoiding over 20,000 hours of suboptimal end-user training. The delay will enable the hiring of over 90% of the 108 EHR mitigation positions at the facility, improve hiring at the Clinical Resource Hub for virtual (telehealth) care, facilitate complete resolution of the Office of Community Care (OCC) open consult backlog cited in the report as well as integrate virtually 100% of EHR design solutions into Superuser and End-User training and extend Veteran facing functional capabilities such as on-line prescription refills; all by go live.

4. Transition to the new EHR necessarily occurs without abatement of ongoing and traditional medical center operations. In consideration of a substantial facility budget deficit identified in February of 2019, a pause in business-as-usual recruitment and hiring was instituted at my direction. Guidance directed continued hiring for all positions for which a tentative or final offer had been made to date, all Cerner-mitigation positions, all national or special funded positions and all Office of Community Care positions regardless of funding source. There was a total of 46 recruitment actions that were continued for recruitment due to tentative and final offers given. The hiring pause required an additional degree of scrutiny for general purpose-funded positions by the Resource Management Board and Medical Center Director to ensure these positions were critical to medical center operations prior to approval. In July of 2019, guidance was amended to automatically fill all Sterile Processing Service positions. A second amendment was enacted in August of 2019, to permit all housekeeping aids, MSA positions, PACT positions (RN, LPN and Providers), Phlebotomists and Cook positions to be hired. Between March and October of 2019, the duration of the pause identified above, 143 general purpose-funded positions were approved for hire. In the prior 16 months, 22 new positions have been added with an additional 50 Cerner mitigation positions to be added to payroll by June 2020. In November 2020, following an FY19 balancing of the books and six months prior to the IOC go live, all restraints imposed by the hiring pause were formally lifted.

5. The backlog in community care consults pending closure has been identified as a highest priority issue for resolution by the facility. These consults largely represent community care referrals where care has been delivered but results are pending upload for administrative closure. A combination of voluntary all-hands overtime and compensation time as well as use of traveling nurses to augment OCC and detailed VISN OCC staff will result in a projected resolution of this backlog by June of 2020. The impact of the MISSION Act and Station IOC preparation has seen the volume of monthly community care consults requested go from 2,349 in February of 2019 to 5,110 in January of 2020 with a peak of 6,291 in October of 2020. This represents an increase of 118% in the past 12 months. In the last two years, staffing for the OCC has increased by 48% (65 to 96 positions). A recent request for an additional 46 positions has been forwarded to VISN20 for review and approval to maintain steady-state operations owing to the rapid increase in workload experienced by the OCC.

6. As outlined in a letter to Dr. Etherage dated February 12, 2020, there are numerous and ongoing formal and informal meetings with leadership of OEHRM, VHA, VISN 20, Office of Healthcare Transformation, Office of Enterprise Integration, Office of Information and Technology, Puget Sound Health Care System, third-party contractors, Cerner Corporation and MGVAMC. There are no less than 46 recurrent formal management meetings involving MGVAMC leadership and key stakeholders from VA and, in select cases, Cerner Corporation. It is my belief that OEHRM efforts in all areas of preparation for and execution of the new EHR for the first IOC site in VA are nothing less than breathtaking in one of the most complex undertakings in healthcare. The degree of collaboration and consensus achieved

among the numerous administrative, Information Technology, and program offices and progress made to date is a testament to the quality of leadership and front-line staff throughout VA.

7. For any questions related to this memorandum, please contact Karen Rasmussen, MD, Director for GAO-OIG Accountability Liaison at VHA10EGGOALAction@va.gov.

(*Original signed by*:)

Robert J. Fischer, MD
Director, Mann-Grandstaff Veterans Affairs Medical Center

Facility Director Response

Recommendation 7

The Mann-Grandstaff VA Medical Center Director ensures that community care consults are managed through go-live to ensure accuracy, completeness, and to avoid the need for manual reentry after go-live.

Concur.

Target date for completion: Go Live

Director Comments

In order to avoid manual re-entry of community care consults into Cerner Millennium at go live, select local community care office staff will have CPRS read/write access. The Office of Electronic Health Records Modernization (OEHRM), Cerner Corporation, and the VHA Office of Community Care (OCC) have collaborated to ensure legacy active consults are tracked monthly and will be processed in the Computerized Patient Record System (CPRS) until they are closed; moving them from active to scheduled to complete. At go live, when the active consults are scheduled, they will automatically create an encounter in Cerner Millennium through its interface with HealthShare Referral Manager (HSRM). The staff will use that encounter to initiate documentation, in Millennium, on further actions regarding the referenced original consult as processing proceeds. Legacy consults in a scheduled status at go live will be tracked until completion in CPRS. Following go live, all new consult orders will be entered and processed in Cerner Millennium. There are only between 200 and 400 consults in pending status that will require manual input by trained registered nurses during cutover activities prior to go live.

Recommendation 8

The Mann-Grandstaff VA Medical Center Director ensures that patients receive medication refills in a timely manner throughout the transition to the new electronic health record system.

Concur.

Target date for completion: Go Live.

Director Comments

The decision to adjust go live has allowed pursuit of additional Capability Set 1 functionality that enhance Veteran's experience of care. In addition to a fully functional consolidated mail order pharmacy (CMOP) delivered as part of Capability Set 1, the Cerner Patient Portal design update enabling on-line prescription refill is being aggressively pursued by Cerner Corporation in time

for go live. Until such time as these additional capabilities are better defined and incorporated, additional staff will be provided to Call Centers and pharmacy to assist with medication refills. There are no viable mitigation strategies available if CMOP is not comprehensively and successfully tested for full functionality prior to go live.

OIG Contact and Staff Acknowledgments

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