VETERANS HEALTH ADMINISTRATION

New Patient Scheduling System Needs Improvement as VA Expands Its Implementation

Executive Summary

In 2020, VA began implementing its new electronic health record (EHR) system, including a new patient scheduling component, to replace an antiquated system that Veterans Health Administration (VHA) medical facilities have used since the 1980s. The EHR modernization efforts are intended to provide veterans with a lifetime comprehensive health record that builds on the system used by the Department of Defense. As part of VA's $10 billion EHR contract with Cerner, the new scheduling system is expected to provide many advantages to VHA personnel and patients.[1] Proposed improvements include enhancing efficiency and the user experience, minimizing disruptions in the delivery of care, and offering enhanced appointment request and management tools. The new system should also allow schedulers to facilitate patients' access to care, standardize workflows that improve patient access, and empower veterans to participate in their own care.

As of May 2021, the VA Office of Inspector General (OIG) had issued and was conducting several other reviews on various aspects of EHR system implementation efforts. Expanding further on that work, the OIG conducted this review to determine whether VHA and the Office of Electronic Health Record Modernization (OEHRM) effectively implemented the new scheduling system. Specifically, the review team assessed whether VHA and OEHRM (1) ensured that schedulers received required end-user training, (2) identified any system or process weaknesses, and (3) made necessary improvements. In addition, the review team examined plans to deploy the scheduling system at other facilities.

Both VHA and OEHRM are supporting the new scheduling system's implementation. VHA and OEHRM first implemented the new scheduling component separate from the full EHR system at the Chalmers P. Wylie VA Ambulatory Care Center in Columbus, Ohio, in August 2020, and in October 2020, they implemented the full EHR suite, including the new scheduling system, at the Mann–Grandstaff VA Medical Center in Spokane, Washington. Before implementing the new scheduling system at the Columbus and Spokane facilities, Cerner trained schedulers and care providers to use the system. VHA, OEHRM, and Cerner also completed various testing and pre-implementation assessments to ensure these facilities were ready to deploy the system.

What the Review Found

The new scheduling system has the potential to transform VHA scheduling. However, the OIG found that VHA and OEHRM knew of significant system and process limitations before or after implementing the new scheduling system at the Columbus and Spokane facilities without fully

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[1] On May 17, 2018, former 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.

resolving them. These limitations reduced the system's effectiveness and risked delays in patient care.[2]

Scheduling Staff Reported Some Positive Experiences with the New Scheduling System

VHA staff told the OIG team that the new system should help VHA greatly, and schedulers reported positive experiences. For example, schedulers praised the system for being more user-friendly, and making video visits easier to schedule, among other upgrades. However, the OIG found that Columbus and Spokane staff faced a number of challenges once the new EHR scheduling system was implemented. VHA and OEHRM should learn from these challenges so that they may more efficiently and effectively implement the new scheduling system at other VA medical facilities.

Schedulers Reported Training Did Not Fully Prepare Them for the New Scheduling System

Cerner initiated training for Columbus and some Spokane schedulers and providers in February 2020 and January 2020, respectively, but paused it shortly after due to the COVID-19 pandemic. As Columbus prepared to implement the system in August 2020, an OEHRM internal document that summarized training-related survey feedback revealed Columbus schedulers' concerns. They felt that they had not been trained to handle real, complex scheduling scenarios; that their training was not tailored to their roles; and that they did not have enough time to practice using the system. Cerner resumed training, and then VHA and OEHRM pressed forward with implementation in the summer of 2020.

VHA and OEHRM Did Not Address Known Performance and Oversight Issues before the New System's Implementation

From November 2018 through July 2020, OEHRM, VHA, and Cerner conducted pre-implementation assessments, testing events, and various national workshops at Columbus and Spokane to identify performance and oversight issues.[3] These efforts helped OEHRM identify

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[2] The review team considers "system issues" to be those that require modifications to the new scheduling system, and "process issues" to be those that require modifications to pre- and post-implementation efforts, such as training, pretesting, posttesting, and oversight. Appendix A details the review scope and methodology.

[3] OEHRM established 18 EHR councils to review, adjudicate, and document the requisite clinical and business decisions that informed Cerner of the workflow configuration and overall design of VA's new EHR. According to a March 2019 memorandum, OEHRM's chief medical officer directed the councils to participate in national workshops hosted by Cerner. During these workshops, EHR council members reviewed Cerner design decision recommendations and workflow recommendations and provided their feedback and decisions. The memorandum stated that "the participating subject matter experts are provided the authority to make design and configuration decisions on behalf of the entire enterprise, for the purpose of facilitating standardization within VA and deploying a new EHR at VA." OEHRM's chief medical officer was the approving official for design and workflow decisions.

and resolve some potential issues related to the new scheduling system. However, the review team determined that OEHRM was aware of additional scheduling issues, including the four discussed below, but did not fully address them before implementation in Columbus:

1. **Pre-implementation Issue 1—Inability to Mail Appointment Letter Reminders Automatically.** Unlike the old scheduling system, the new system did not have the capability to automatically mail letters to patients to remind them of upcoming appointments. As of June 2021, schedulers needed to do so manually.

2. **Pre-implementation Issue 2—Difficulties Changing Appointment Type.** In the new system, schedulers cannot simply change the modality of care (face-to-face or via VA Video Connect or telehealth) for an existing appointment. Instead, they must manually create a new appointment or ask the provider to submit a new order.

3. **Pre-implementation Issue 3—No Guidance on How to Measure Patient Wait Times and Potential Inaccuracies When Changing Modalities.** Scheduling supervisors said they were confused about how to track and record patient wait times in the new system because of new naming conventions for date fields.

4. **Pre-implementation Issue 4—Key Oversight Reports and Tools Not Available in the New System.** The new scheduling system lacks oversight reports formerly available to track and monitor patient wait times and the accuracy of patient scheduling, impeding Columbus and Spokane from conducting these evaluations after implementation.

VHA and OEHRM Missed Opportunities to Gain and Apply Valuable Feedback from Schedulers and Identify Additional Issues before Implementing the New Scheduling System

OEHRM leaders did not provide scheduling staff with adequate chances to identify limitations in the new scheduling system before implementation. For example, schedulers for certain clinics did not know their clinics were not set up to enable appointment scheduling in the new system (some community-based outpatient clinics were excluded, for example) until after the system was implemented. Facility employees said this issue prevented them from scheduling appointments for those clinics until corrected, which generally took at least one week. Of the 213 schedulers who responded to an OIG survey that they had used the new system, only 123 schedulers (about 58 percent) reported being able to provide feedback before implementation. Of those, only 9 percent reported their stated concerns resulted in scheduling system changes; the others did not know if changes had been made, or knew they had not.

New Issues Arose after Implementation

Additional issues began appearing once the new scheduling system was implemented at the Columbus facility in August 2020. The following three issues were not resolved before VHA and OEHRM implemented the new system at Spokane in October 2020, and risked delaying patient care:

1. **Post-implementation Issue 1—System Not Configured Completely.** The new scheduling system did not include certain clinics, appointment types, or providers.[4] Some schedulers also lacked the permissions needed to schedule appointments. Facility staff said it generally took more than a week for Cerner to close help tickets, unnecessarily delaying some patients' care.

2. **Post-implementation Issue 2—Inaccurate, Incomplete Data Migration.** Data from VHA's old system were not accurately or completely transferred to the new scheduling system when deployed at Columbus and Spokane. Schedulers had to manually "scrub" provider schedules and veteran data for accuracy.

3. **Post-implementation Issue 3—Misleading Appointment Reminder Calls.** The appointment reminder calls that the system generated for telehealth appointments had to be turned off by the facilities because of confusing information, such as stating those patients should check in at a front desk when on-site care was not available or advised.

Lack of Guidance and Effective Troubleshooting Processes Has Hampered Corrective Actions Overall

After the new scheduling system was implemented in the summer and fall of 2020, VHA and OEHRM faced an array of issues to be corrected, some of which could delay patient care. Because of a lack of guidance and inadequate training on how to respond to identified but unresolved system limitations, schedulers developed work-arounds. VHA employees also began working with Cerner to try to correct the most pressing issues using a ticketing process that was ineffectively managed. Schedulers told the review team they experienced long delays in resolving tickets without status updates. The OIG team learned OEHRM lacked a mechanism to assess whether Cerner was complying with its contract's timeliness requirements.

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[4] For this report, the OIG uses "configure" to discuss how the new scheduling system was set up for operation.

VHA and OEHRM Are Pausing Future Deployment While VA Conducts a Strategic Review of the Full EHR Program

VHA and OEHRM were planning to implement the new scheduling system at all Veterans Integrated Service Network (VISN) 20 facilities by December 2021.[5] However, OEHRM paused future deployment in March 2021 while VA conducts a strategic review of the full EHR program based on reported site challenges. Final preparation activities were on hold at all sites pending timeline updates from VA leaders.

What the OIG Recommended

VA needs to ensure VHA and OEHRM take appropriate steps to resolve issues identified in this report and through its strategic review as soon as possible, ideally before deploying any part of the new EHR system at future facilities. The OIG issued eight recommendations to help VHA and OEHRM address problems with the new scheduling system and improve deployment at other VHA facilities related to (1) improving training for scheduling; (2) better engaging schedulers in testing and improvements; (3) issuing guidance on measuring patient wait times in the new system; (4) tracking help tickets, consistent with Cerner contract terms; (5) developing a strategy to promptly resolve identified issues; (6) developing mechanisms to assess schedulers' accuracy; (7) evaluating patient care timeliness; and (8) providing guidance to schedulers to consistently address system limitations until problems are resolved.

Management Comments

The acting under secretary for health concurred with recommendations 1–7 and concurred with VA's OEHRM executive director's comments and plan to address recommendation 8.[6] OEHRM concurred with recommendation 8 but did not send the OIG a separate action plan. Instead, OEHRM's executive director stated the action plan for all recommendations provided to the OIG by the acting under secretary for health was developed collaboratively to address all eight recommendations. VA also provided technical comments, acknowledging the scheduling issues and problems that occurred during implementation of the new EHR system at Columbus and Spokane. VA stated that, based on the results of its strategic review, it is establishing an enterprise-wide approach to EHR system deployment that will better judge a site's preparation and help ensure the success of future deployments of the new EHR system. The full text of the acting under secretary for health's comments and the joint VHA and VA action plan appear in appendix B, and the OEHRM executive director's comments are included in appendix C.

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[5] VHA's 18 VISNs are regional networks for healthcare delivery. These networks work together to meet local healthcare needs and provide access to care. VISN 20 includes 11 medical centers.

[6] OEHRM included its planned actions to address recommendation 8 as part of one consolidated joint action plan from VA (OEHRM and VHA).

OIG Response

The acting under secretary for health's and OEHRM executive director's proposed actions are responsive to the recommendations. The OIG will monitor implementation of all planned actions and will close the recommendations when it receives sufficient evidence demonstrating meaningful progress in addressing the recommendations and the risk areas identified in this report.

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Contents

Abbreviations

DEERS   Defense Enrollment and Eligibility Reporting System

EHR   electronic health record

OEHRM   Office of Electronic Health Record Modernization

OIG   Office of Inspector General

VHA   Veterans Health Administration

VISN   Veterans Integrated Service Network

Introduction

The Office of Inspector General (OIG) conducted this review to determine whether the Veterans Health Administration (VHA) and the Office of Electronic Health Record Modernization (OEHRM) effectively implemented a new patient scheduling system at two VA medical facilities before expanding its deployment. They are the Chalmers P. Wylie VA Ambulatory Care Center in Columbus, Ohio, and the Mann–Grandstaff VA Medical Center in Spokane, Washington. Specifically, the review team examined whether VHA and OEHRM (1) ensured that schedulers received required training on the new system, (2) identified any system or process weaknesses, and (3) made improvements as necessary. The team also considered plans to deploy the scheduling system at other facilities.

Former VA Secretary Robert Wilkie identified the replacement of the VA electronic health record (EHR) system 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."[7] On May 17, 2018, former VA Secretary 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, including a new scheduling component. The full EHR transition is scheduled to occur over a 10-year period, starting in the Pacific Northwest. The new scheduling component will replace an antiquated one that VHA medical facilities have been using since the 1980s.

The OIG's review of this new scheduling system will help ensure veterans receive timely care. This report is meant to help VA make needed improvements at facilities that will implement the new scheduling system after the Columbus and Spokane facilities.

The New Scheduling System

The new scheduling system is expected to make medical appointment scheduling more efficient and user-friendly for veterans and healthcare providers, minimize patients' wait times, minimize disruptions in the delivery of care, offer enhanced appointment request and management tools, and optimize access to critical health care.[8] The new system should also standardize workflows

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[7] VA, Department of Veterans Affairs FY 2018–2024 Strategic Plan, refreshed May 31, 2019.

[8] OEHRM officials told the review team that the term "Centralized Scheduling Solution" should only be used to describe the new scheduling system at the Columbus facility. This is because the Columbus facility implemented only the scheduling component of the EHR suite in August 2020. OEHRM said the Spokane facility implemented the full EHR suite, which included a new scheduling system. In this report, the OIG uses the term "new scheduling system" to describe the system at both the Columbus and Spokane facilities.

and empower veterans to participate in their own care. According to one of Cerner's contract task order deliverables, the new scheduling system should provide several benefits, including[9]

- enhanced patient access;

- improved provider productivity;

- increased scheduler efficiency;

- reduced scheduling errors;

- the ability to manage other important resources, such as rooms and staff; and

- the use of one scheduling system for patients, providers, and schedulers.

VHA and OEHRM began deploying the new scheduling system in 2020. In August 2020, they implemented the new scheduling system at the Columbus facility, and in October 2020 implemented the full EHR suite, including the new scheduling system, at the Spokane facility. Before implementing the new systems at these two facilities, Cerner trained schedulers and providers to use them. VHA, OEHRM, and Cerner also completed various testing and pre-implementation assessments to help ensure these facilities' readiness.

VHA and OEHRM were planning to implement the full EHR suite, including the scheduling component, at all facilities in Veterans Integrated Service Network (VISN) 20 by the end of 2021.[10] The next two sites scheduled in that region were the VA medical center in Walla Walla, Washington, for around May 2021, and the VA rehabilitation center in White City, Oregon, for around June 2021. However, in March 2021, OEHRM paused the implementation of the new EHR system, including the scheduled rollout, while the Department conducts a strategic review of the program.[11]

Cerner Responsibilities

According to the VA contract, Cerner is required to host and deploy the EHR system, including the scheduling component, across the VA enterprise. These activities include (1) project management, (2) change management, (3) training, (4) testing, (5) deployment services, (6) sustainment, and (7) software and hardware incidental to the solution. The contract also

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[9] Centralized Scheduling Solution (CSS) Project Management, *CSS Workflow Development, Configuration and Normalization Plan*, Task Order Deliverable 13-1012A, July 29, 2020.

[10] VHA's 18 VISNs are regional networks for healthcare delivery. These networks work together to meet local healthcare needs and provide access to care. VISN 20 includes 11 medical centers.

[11] According to VA, the strategic review is "a full assessment of the ongoing electronic health record modernization program to ensure continued success for all future EHR deployments. This assessment period will not exceed 12 weeks." VA's announcement is at https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5647.

requires Cerner to coordinate scheduling and go-live activities with OEHRM to ensure all stakeholders are informed of risks, timelines, and tasks.[12]

Cerner trained Columbus and Spokane schedulers on the new system by providing four training courses. The curriculum included one computer-based training course (100 level), two classroom instructional training courses (200 and 300 levels), and one self-paced learning course (400 level). The learning objectives included understanding terminology, setting user preferences, scheduling, checking patients in and out, managing appointment queues, modifying existing appointments, and recording patient contact attempts.

Office of Electronic Health Record Modernization

In July 2018, VA established OEHRM to support the transition to the new EHR system, including implementing its scheduling functions. OEHRM is responsible for providing oversight of the EHR system over a 10-year period at 170 VA medical centers and over 1,000 outpatient sites.

OEHRM is also responsible for ensuring VA successfully prepares for, deploys, and maintains the new EHR system. One of OEHRM's goals is to offer an improved and consistent patient scheduling experience through the new system at VA medical facilities and for community care partners nationwide.

While the executive director from OEHRM reports directly to the VA deputy secretary, the office also is expected to work in collaboration with VHA to ensure successful implementation of the EHR.

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[12] VHA and OEHRM used the term "go-live" to describe the implementation dates of the new scheduling system at the Columbus facility and the full EHR suite at the Spokane facility.

Results and Recommendations

Finding: VHA and OEHRM Did Not Resolve All Known Issues before or after Implementing the New Scheduling System, Risking Delays in Patient Care

VHA's scheduling staff reported to the OIG that the new scheduling system has the potential to transform VHA scheduling. To achieve that potential, VHA and OEHRM need to address known issues with the new scheduling system before implementing it at additional facilities. In August 2020, VHA and OEHRM implemented the new scheduling system at the Columbus facility without resolving many of the training, system, and process weaknesses identified through pre-implementation assessments and workshops.[13] For example, schedulers were unable to automatically send appointment reminder letters to veterans (which they could from the legacy system), and they lacked guidance on measuring patient wait times. Additionally, for one of the pre-implementation issues—difficulties changing appointment modalities (in-person vs. video or telehealth)—a health systems specialist said OEHRM knew of this issue before implementing the system in Columbus but said it could not be corrected. VHA and OEHRM then implemented the new scheduling system at the Spokane facility in October 2020 without resolving the reported issues.

Some of the system and process weaknesses detailed in this report had been previously addressed by improvements to VHA's legacy system in response to prior OIG audit recommendations, but those solutions were not carried over and integrated into the new scheduling system.[14] Those solutions included updating various scheduling requirements and requiring supervisors to perform biannual scheduling audits. Before implementation at both facilities, VHA and OEHRM also missed opportunities to learn from the scheduling staff and correct limitations that could have been identified through assessments and workshops.[15] For example, schedulers from some clinics were not given the chance to fully test the scheduling capabilities of their clinics during the readiness assessments or participate during the workshops to ensure the system met their needs. Schedulers might have uncovered and resolved limitations that only came to light after

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[13] The review team considers "system issues" those that require modifications to the new scheduling system, and "process issues" those that require modifications to the pre- and post-implementation efforts, such as training, pretesting, posttesting, and oversight.

[14] VA OIG, *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6*, Report No. 16-02618-424, March 2, 2017; VA OIG, *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15*, Report No. 17-00481-117, March 13, 2018.

[15] For this report, the review team defines pre-implementation issues as those OEHRM was aware of before implementing the new scheduling system at the Columbus facility. The review team defines post-implementation issues as those OEHRM or VHA identified after implementing the new system at the Columbus facility.

implementation, such as configuration issues that excluded certain clinics, services, and care providers that needed to be scheduled from within the system.[16]

After implementation at Columbus, VHA identified other issues that diminished the effectiveness of the new scheduling system, such as issues related to data migration and misleading appointment reminder calls. As of June 2021, many of the pre- and post-implementation system and process issues remained unresolved.

In Columbus and Spokane, the scheduling issues could lead to unnecessary delays in patient care and failure to offer community care when appropriate. It is critical that VHA and OEHRM resolve the new scheduling system's limitations as soon as possible, ideally before the system is deployed at other facilities to prevent replication.

This report describes both positive experiences with the new scheduling system and the deficiencies that need to be addressed to avoid scheduling delays or complications that could affect VA patients' access to care. Specifically, the OIG found schedulers face the following difficulties revealed by implementation in Columbus and Spokane:

- Schedulers reported training did not fully prepare them for the new scheduling system.

- Known performance or oversight issues were not addressed before VHA and OEHRM deployed the new scheduling system.

- Schedulers lacked opportunities to provide valuable feedback and identify any additional issues before implementing the new system.

- Three significant issues were identified after implementation involving system configuration, data migration, and appointment reminders.

- Lack of guidance and effective troubleshooting processes has hampered corrective actions overall.

VA paused all future deployment while it conducted a strategic review of the full EHR program.

What the OIG Did

The review team interviewed leaders within OEHRM, VHA, VISNs, and facilities. The team also engaged scheduling staff, VA contracting staff, and contractors. Team members analyzed various contract and pre- and post-implementation documentation related to the new scheduling system at the Columbus and Spokane facilities. Documentation was also examined related to future deployment of the EHR suite, including the new scheduling system. In addition, an electronic survey was sent to 287 Columbus and Spokane schedulers to obtain more information

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[16] For this report, the OIG uses "configure" to discuss how the new scheduling system was set up for operation.

related to training, opportunities to test the new system before implementation, and the ticketing process used to capture concerns after implementation.[17] (More information about the scope and methodology for this review can be found in appendix A.)

Scheduling Staff Reported Some Positive Experiences with the New Scheduling System

While VHA and OEHRM need to resolve issues identified in the initial use of the new scheduling system, VHA staff anticipate that it will have many positive outcomes when fully and successfully implemented. The Spokane assistant chief of health care administration services stated in an email to the review team that the new scheduling system had the potential to be an "amazing transformation for the VA." Eventually, once "all the kinks are worked out," schedulers should be able to schedule appointments more efficiently. Scheduling staff also reported the following positive experiences with the new scheduling system:

- "The VVC [VA Video Connect] appointments … when it works[,] it is far easier to schedule the video visits. Scheduling in general is more user friendly. Updating demographics also tends to be easier and it puts hard stops (most of the time) so that we don't miss anything. It is nice only opening one program rather [than] 7."

- "From personal experience, blocking clinics [is] much easier in the Cerner system. Instead of having to block each spot for each day (MTGS [meetings] or leave requests), this system allows up to a year to be blocked. This has saved [s]chedulers a lot of time maintaining their providers clinics."

- "The Audit history of appointments is AWESOME, even if the appointment is accidentally moved, then moved back, it tracks ALL actions with date and time."

- "The system seems very capable[;] [we] just need training/workflows/fixes in place and I can see the system improving our quality of life and standard of care significantly."

The new scheduling system thus should have significant advantages for VA, VHA, and the patients they serve. However, the system's rollout in Columbus and Spokane identified a number of challenges. The Spokane assistant chief also wrote that the Department has "a ways to go to get this product working for the way the VA delivers healthcare." The OIG maintains that VHA and OEHRM should learn from the challenges described in this report and any issues identified through VA's strategic review as they implement the new system in additional facilities.

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[17] Of the 242 schedulers who responded to the survey, 213 reported having used the new scheduling system. The review team's analysis was based on those 213 responding users of the new system.

Schedulers Reported Training Did Not Fully Prepare Them for the New Scheduling System

Cerner initiated training for both Columbus and some Spokane schedulers and providers in February 2020 and January 2020 respectively, but paused it shortly after due to the COVID-19 pandemic. After this delay, Cerner resumed training and then VHA and OEHRM pressed forward with implementation in the summer of 2020.[18] An August 2020 OEHRM internal document revealed that there had been some negative feedback on the training that schedulers received; this feedback was collected through a survey of Columbus schedulers. Respondents expressed concerns that they had not been trained to handle real and complex scheduling scenarios, that their training was not tailored to their roles, and that they did not have enough time to practice using the system. Despite voicing their concerns, the respondents still rated their overall satisfaction with the course as an average of 3.9 of 5.0. This rating was based on the effectiveness of the training, overall experience, materials, instructors, pace, and duration of the scheduling-related training courses.

A Spokane scheduling leader told the OIG review team that Spokane schedulers had raised similar concerns on training weaknesses to the VA medical center director, the OEHRM director, and OEHRM Change Management staff. Despite negative feedback, Cerner did not make changes to the training. Like the Columbus schedulers, Spokane staff who took the scheduling-related training (either resumed or for the first time) continued to experience challenges. For example, Spokane staff provided the following feedback:

- "The confidence level I feel for go-live is approx. 10%. I need a little more time in the programs and to practice doing releases before I can be comfortable with our day to day processes."

- "Test did not work properly and functions within it (such as right click) do not work thus do not reinforce actual program learning."

- "The training environment does not show that a document includes the signature requirements in 1907.01."

Additionally, 15 of the 16 Columbus and Spokane scheduling leaders and staff interviewed said they did not find the training on the new scheduling system as helpful as they had hoped.

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[18] As previously mentioned, Columbus implemented the new scheduling system independent of the full EHR suite. Spokane implemented the full EHR suite, including the new scheduling system.

The January 2021 survey of 213 schedulers who responded that they had used the new system revealed that 89 (about 42 percent) reported the training was not sufficient to do their job, noting concerns like the following:[19]

- "As we began working after 'go-live' we realized we didn't know how to do about 25% of our normal tasks, i.e.[,] check who went to urgent care, enter a contact attempt in patient's chart, print a list of future appointment requests."

- "The training was not geared toward the tasks that are required of AMSA [Advanced Medical Support Assistant] staff here at the VA. The training was geared toward inpatient and a private/community facility."

That same month, the OIG review team briefed VHA and OEHRM leaders on these concerns and asked what steps had been taken to improve the training. In February 2021, OEHRM sent the review team a document that indicated it had improved some portions of the scheduler-related training as early as January 2021, based on feedback that OEHRM collected after the system was implemented at Spokane. OEHRM needs to continue to make improvements to the scheduling-related training to address scheduler feedback.

An OEHRM representative reported that Cerner started training schedulers at the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington, in March 2021. OEHRM and Cerner planned to start training schedulers at the White City VA Rehabilitation Center in Oregon in April 2021. However, in June 2021, an OEHRM representative reported that only certain schedulers at this facility had been trained before VA's strategic review started in March 2021, and that all other training activities had been paused. The OIG maintains that OEHRM and Cerner must improve the training so that schedulers at future deployment sites are better prepared to schedule patient appointments in the new scheduling system.

VHA and OEHRM Did Not Address Known Performance or Oversight Issues before Implementing the New Scheduling System

From November 2018 through July 2020, OEHRM, VHA, and Cerner identified potential risks and issues with the new scheduling system through pre-implementation assessments, testing events, and various national workshops in Columbus and Spokane. These efforts helped OEHRM identify and resolve some potential issues related to the new scheduling system, such as challenges with information technology infrastructure, cybersecurity, and workflow processes. While OEHRM resolved some scheduling system or process issues, the review team determined

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[19] Of the 213 schedulers who responded to the survey that they had used the new scheduling system, about 54 percent of the schedulers from Columbus (61 of 113) and about 28 percent of the schedulers from Spokane (28 of 100) reported the training was not sufficient to do their job.

that OEHRM was aware of additional user concerns, including the four discussed below, but did not fully address them before the new system was implemented in Columbus.

Pre-implementation Issue 1—Inability to Mail Appointment Letter Reminders Automatically

Using VHA's Veteran Support Service Center data, the review team found the Columbus and Spokane facilities completed an average of about 1,040 and 640 appointments per day, respectively, during fiscal years 2019 and 2020.[20] Before Columbus and Spokane implemented the new scheduling system, schedulers had the option to automatically mail appointment reminder letters to patients regarding their upcoming appointments. While schedulers were still able to send individual appointment letter reminders if the veteran requested it, the new scheduling system did not have the capability to do this automatically. Instead, one scheduling supervisor said schedulers would have to print appointment reminder letters in a separate system and then manually write the veteran's address on a blank envelope. This supervisor said this process should be less manual since veterans often request these reminder letters. Due to the large number of daily appointments, sending individual appointment letter reminders can be time-consuming, and since some veterans relied on those letters to remind them of their appointments, removing this capability to automatically send reminder letters presented a risk that patients would miss their appointments. Missing appointments delays care for the patients themselves and can result in other patients not seeing a provider sooner. An OEHRM health systems specialist said veterans are accustomed to receiving appointment reminder letters, and the letters help reduce no-show rates.

An OEHRM health systems specialist said OEHRM was aware of this issue before implementing the new scheduling system in Columbus. Additionally, in a document distributed in May 2020 to answer Columbus schedulers' frequently asked questions, VHA acknowledged that appointment letter reminders could not be automatically sent to patients from the new scheduling system. To address this issue, in January 2021, this health systems specialist said OEHRM planned to ask Cerner to make appointment letter reminders available to schedulers in the new scheduling system but had not yet made that request. As of June 2021, schedulers still could not automatically mail appointment reminder letters to patients through the new system.

Pre-implementation Issue 2—Difficulties Changing Appointment Type

Before Columbus and Spokane implemented the new scheduling system, schedulers were able to change the modality of care (whether the appointment would be face-to-face or via VA Video

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[20] Appointment reminder letters would not be sent for all these appointments, such as when patients receive same-day appointments. Appointment counts are for all facilities associated with the Columbus and Spokane facilities (such as community-based outpatient clinics).

Connect or telehealth) relatively easily. However, in the new system, schedulers cannot make that change for an existing appointment. Instead, a scheduler must manually create a new appointment with a different modality of care or request that the provider submit a new order specifying how care will be delivered. In the old system, schedulers could simply select a different modality of care without creating a new appointment or requesting a new order. Not only is the new process administratively burdensome for both schedulers and providers, but the work-around also could unintentionally result in VA understating patients' actual wait times. There is also greater risk of introducing inaccurate information in new appointment entries. According to the May 2020 document Columbus schedulers received answering their frequently asked questions, VHA was aware of the additional steps schedulers would have to take to change appointment modalities in the new scheduling system. Example 1 illustrates the difficulty associated with changing appointment modalities in the new scheduling system.

Example 1—Changing Modalities

If a care provider determined after a July 2020 appointment that a patient did not need to be seen again until December 2020, the provider would submit an order to return to the clinic in five months and set the modality of care as an in-person appointment. However, if the patient wanted a telehealth appointment due to COVID-19 risks, the modality of care could not be easily changed. At that point, the scheduler could request that the provider resubmit the order with the new modality of care, an option that is administratively burdensome for the provider. Alternatively, the scheduler could create a new appointment with the correct modality of care. These approaches create a risk of inapplicable orders—the original ones—remaining in the scheduling system. They would need to be deleted. One facility doctor said multiple orders in the system have resulted in patients being seen twice for the same reason. This issue also presents a risk that schedulers may inappropriately delete orders they incorrectly believe are duplicates.

An OEHRM health systems specialist acknowledged that schedulers are unable to easily update the modality of care through the new scheduling system unless they create a new order. The health systems specialist said OEHRM knew of this issue before implementing the system in Columbus but that the system could not be changed. As of February 2021, the review team determined based on an email from an Office of Veterans Access to Care leader that the work-around process for changing appointment modalities was still being discussed and a solution had not been finalized. The OIG recognizes that scheduling patient appointments should remain a priority and continue while VHA improves its process to change appointment modalities. As discussed in the section that follows, the modality change problems can also affect the accuracy of recorded wait times.

Pre-implementation Issue 3—No Guidance on How to Measure Patient Wait Times and Potential Inaccuracies When Changing Modalities

VHA's scheduling policy requires that veterans' appointments be scheduled timely, accurately, and consistently. VHA's wait-time goal is no more than 30 calendar days from either (1) the date that an appointment is deemed clinically appropriate by a VA healthcare provider (the clinically indicated date) or, in the absence of a clinically indicated date, the date the veteran requests outpatient care.[21] When the new scheduling system was implemented, the fields that captured key appointment dates were different than in the old system; these new fields were labeled the "request begin date," "grace period," and "date placed on list."[22] Scheduling supervisors told the OIG review team they were confused as to which of these new date fields they should use to measure patient wait times because schedulers had received no guidance on how these fields were defined. Based on the training materials provided by OEHRM, the review team determined the scheduling-related training did not provide any additional guidance on these date fields.

In February 2020, about six months before implementing the new scheduling system in Columbus, scheduling leaders met with contracting personnel to discuss identified risks and implementation concerns, including the inability to accurately track and record patient wait times. In December 2020, about two months after the new scheduling system was implemented at the Spokane facility, a scheduling supervisor indicated that schedulers still did not know how to appropriately determine patient wait times in the new system. This information is important for assessing community care eligibility. According to an Office of Veterans Access to Care leader, VHA planned to issue an updated scheduling directive before implementation but were unable to because the system was not fully built, and additional steps were necessary before they could finalize a directive. As of June 2021, VHA had not finalized guidance detailing which date field in the new system schedulers should use to measure patient wait times.

The challenges associated with changing modalities discussed in the prior section also exacerbate problems with accurately tracking wait times, as example 2 demonstrates.

Example 2—Understating Wait Times

> *Changes in the modality of care could also result in VA understating wait times. If a primary care provider, on January 25, 2021, orders a face-to-face appointment for a patient to be seen by a specialist and annotates a clinically appropriate date of January 25, 2021 (i.e., as soon as possible), the wait time should begin*

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[21] VHA Directive 1230 (3), *Outpatient Scheduling Processes and Procedures,* July 15, 2016, amended January 7, 2021. The directive provides guidance to schedulers nationwide for booking patient appointments.

[22] The review team noticed the names of these date fields during scheduling supervisors' demonstrations of the new system.

accruing on January 25, 2021, when requested. Because of the volume of appointments to be made, a scheduler is not able to address the referral and create an appointment until February 9, 2021, and schedules the patient's appointment for February 14, 2021. The patient's wait time would be 20 days (from the clinically appropriate date).

If the veteran decides telehealth would be preferable instead, the scheduler must first confirm with the specialty care provider that changing the modality is clinically appropriate and then either receive a new order from the provider with telehealth indicated or manually schedule the veteran for the telehealth appointment. When an appointment is manually scheduled, the wait time starts accruing on the date on which the scheduler makes the new appointment (February 9, 2021). If the new appointment is also scheduled for February 14, 2021, the system would show the patient's wait time as five days. In this example, the patient's wait time would be understated by 15 days.

The OIG concluded that the software issue described in example 2 could result in considerably understated wait times. The inability to accurately capture patient wait times is a significant vulnerability that could prevent VHA staff from complying with the VA MISSION Act of 2018, which requires VA to collect accurate wait-time data to ensure prompt access to care.[23]

Pre-implementation Issue 4—Key Oversight Reports and Tools Not Available in the New System

The new system did not provide VHA and facility leaders with oversight reports and tools to effectively oversee the accuracy of scheduling practices or patient wait times—information they were accustomed to seeing in their old systems. VHA and OEHRM were aware of these issues before implementation. Scheduling leaders developed an emerging risks document with an OEHRM contractor in February 2020 that included a lack of oversight reports.

In March 2020, the former VHA executive in charge wrote in a notice to VHA that "there are expected conflicts between the applications and workflows of the new EHR configuration and existing policies and other documents, such as standard operating procedures and clinical guidelines. VA and Veterans Health Administration (VHA) offices, VISNs, and deployment sites must attempt to amend these documents to resolve these conflicts before deployment."[24] However, instead of amending its scheduling directive or developing a work-around, an OEHRM

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[23] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSON) Act of 2018, Pub L. No. 115-182, § 2372 (2018). The act allows veterans to receive community care when they meet certain wait-time and driving distance eligibility requirements.

[24] VHA Notice 2020-07, "Mandatory Use of The Electronic Health Record and Process to Resolve Identified Concerns," March 2, 2020. This notice was updated in May 2021 and replaces the March 2020 version. However, the May 2021 version includes the same language as discussed in this report.

health systems specialist sent Columbus facility leaders an email that stated their scheduling supervisors did not need to complete scheduling audits, as required by the directive, once the new system was implemented. An Office of Veterans Access to Care employee emailed that same message to Spokane facility leaders. Supervisors at the Columbus and Spokane facilities confirmed they did not conduct scheduling audits when they implemented the new scheduling system.

VHA's scheduling directive requires that supervisors evaluate schedulers by performing audits to assess the timeliness and appropriateness of their actions and the accuracy of patient wait times.[25] An OEHRM health systems specialist said the audit tool that supervisors were required to use to conduct these evaluations in the legacy system is not compatible with the new system. Consequently, as of June 2021, Columbus and Spokane supervisors have not been able to conduct the required audits. VHA needs to develop an oversight mechanism to assess whether facility employees accurately scheduled patient appointments in the new system, and then ensure facility leaders can confirm performance measures using routine audits. If VHA does not complete these scheduling audits, the agency runs the risk that inaccurate or inappropriate scheduling practices in the new system will go undetected. Similarly, without the oversight reports previously used to track and monitor patient wait times, VHA and facility leaders cannot detect and resolve excessive wait times and ensure that patients are offered community care when eligible.

These issues reflect, in fact, a regression to problems found during two previous OIG scheduling audits of VHA's legacy system. As previously mentioned, in 2017 and 2018, the OIG conducted two VISN audits that identified similar scheduling vulnerabilities and issued recommendations to correct them. In response to the recommendations, VHA took corrective actions that were not integrated into the new scheduling system. These actions included updating various scheduling requirements and requiring supervisors to perform biannual scheduling audits.

VHA and OEHRM Missed Opportunities to Gain and Apply Valuable Feedback from Schedulers and Identify Additional Issues before Implementing the New Scheduling System

OEHRM leaders did not provide scheduling staff with adequate chances to identify limitations in the new scheduling system so they could be corrected before implementation. In August 2020, OEHRM, VHA, and Cerner conducted a pre-implementation assessment for Columbus, as required by the contract, to identify and address concerns. Columbus employees who participated in the assessments of the system said they were not given the opportunity to fully test the scheduling capabilities for their clinics before implementation to ensure the new system met their needs. Had some schedulers from each clinic conducted these tests, they might have identified

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[25] VHA Directive 1230 (3).

some of the problems. For example, some schedulers did not know their clinics (community-based outpatient clinics, for example) were not set up in the new system until they used it. Facility employees said this prevented them from making appointments until the matter was corrected, which generally took at least one week. When asked for assessments done before implementation at Spokane, OEHRM reported, "There are no records specific to scheduling." Spokane was the first facility to implement the full EHR suite, including the new scheduling component.

Similarly, OEHRM, VHA, and Cerner missed opportunities to learn from scheduling staff at the national pre-implementation workshops, as schedulers did not attend these workshops to test the system and provide feedback.[26] An OEHRM representative reported that only one scheduling supervisor attended the workshops. Instead, VHA leaders (such as from the Office of Veterans Access to Care) without hands-on responsibilities participated. The assistant chief of health care administration services said it would have been beneficial to include schedulers in the national councils' workshops, as they are the employees who use the system and have the most insight regarding their hands-on needs and requirements.

The January 2021 OIG survey revealed that about 123 of the 213 schedulers (about 58 percent) who responded that they had used the new system reported that they were given the opportunity to provide feedback on the scheduling system before implementation.[27] Of these 123 schedulers, 97 (56 from Columbus and 41 from Spokane) reported they provided feedback on the new scheduling system, but

- 61 (about 63 percent) reported they did not know if their feedback resulted in any changes,

- 27 (about 28 percent) reported that their feedback did not result in any changes, and

- nine (just over 9 percent) reported their feedback resulted in a change to the scheduling system.

As previously mentioned, the OIG review team briefed VHA and OEHRM leaders on schedulers' concerns related to the ticketing process for resolving identified issues. As of

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[26] OEHRM established 18 EHR councils to review, adjudicate, and document the requisite clinical and business decisions that inform Cerner of the workflow configuration and overall design of VA's new EHR. According to a March 2019 memorandum, OEHRM's chief medical officer directed the councils to participate in national workshops hosted by Cerner. During these workshops, EHR council members reviewed Cerner design and workflow recommendations and then provided their feedback and decisions. The memorandum stated that "the participating subject matter experts are provided the authority to make design and configuration decisions on behalf of the entire enterprise, for the purpose of facilitating standardization within VA and deploying a new EHR at VA." OEHRM's chief medical officer was the approving official for design and workflow decisions.

[27] Of the 213 schedulers who responded to the survey that they had used the new scheduling system, about 63 percent of the schedulers from Columbus (71 of 113) and about 52 percent of the schedulers from Spokane (52 of 100) reported that they were given the opportunity to provide feedback before the scheduling system was implemented.

March 2021, an OEHRM representative stated in an email that OEHRM and Cerner were developing additional opportunities for schedulers to learn the new system before future deployment.

VHA and OEHRM Identified Three Potential Significant Issues after Implementation

VHA and OEHRM identified additional issues that began appearing once the new scheduling system was implemented at the Columbus facility in August 2020, but these were not resolved before implementing the new system at Spokane in October 2020. Related to system configuration, data migration, and appointment reminders, these issues increase the risk of delays in patient care.

Post-implementation Issue 1—System Not Configured Completely

Upon system implementation in Columbus and Spokane, schedulers were not able to make certain appointments because the new scheduling system was not configured or set up to include certain clinics, appointment types, or providers. For example, one scheduler said she had to submit a ticket (request for assistance or corrective action) because primary care schedulers were unable to schedule and process referrals for social work and pharmacy. Additionally, some personnel were not initially given the permissions needed to schedule appointments.

Other facility staff also submitted tickets explaining what was missing in the system (e.g., care providers, clinics, appointment types). They said Cerner generally took more than a week to resolve their configuration issues, during which time some patients could not be scheduled for their appointments. For example, a Spokane scheduling supervisor said that staff were unable to make appointments in the system for a couple of their community-based outpatient clinics for about a week.

Example 3 illustrates a case in which an appointment type was not properly built into the new scheduling system.

Example 3

> *The team learned during an interview that a telephone clinic was not initially set up in the scheduling system for a mental health care provider. The scheduler explained that because of this configuration oversight, employees were unable to schedule telehealth appointments with this provider. To work around this issue, the scheduler would enter appointments as face-to-face and indicate in the comments that they were for telephone appointments. This issue may have caused unnecessary delays for patients needing an appointment with this provider. Moreover, the scheduler noted that this work-around caused the appointment to be billed incorrectly.*

Example 4 illustrates a case in which particular clinics were not included in the new scheduling system.

Example 4

> *The Columbus VA medical center service chief of specialty medicine stated that about seven to 10 of his specialty clinics were not built into the new scheduling system. He said some providers would tell him they "had nobody on their schedule" for the day because schedulers could not schedule patients for appointments with those providers. The service chief of specialty medicine said he submitted a ticket to remedy the issue, and although he was not clear on how it was addressed, the resolution took longer than he expected.*

According to an OEHRM health systems specialist, the facility is responsible for verifying that the correct scheduling options are included in the new system before implementation. Documentation provided by OEHRM shows that several configuration issues such as unavailable clinics within scheduling grids and an incomplete search function were identified and resolved through testing events. Additionally, the health systems specialist also stated that some, but not all, configuration issues were found during testing events on-site and that all the known issues were resolved before implementation.

The OIG recognizes that these issues have been resolved at Columbus and Spokane, but VHA and OEHRM need to make certain all scheduling options are available before implementing the system at future sites.

Post-implementation Issue 2—Inaccurate and Incomplete Data Migration

Once the new scheduling system was turned on at the Columbus facility, OEHRM learned that data from VHA's old systems were not accurately and completely transferred. The Spokane facility also experienced data migration challenges. For example, Spokane facility employees said previously canceled appointments reverted to scheduled appointments. To correct these errors, schedulers had to manually "scrub" provider schedules to ensure they were accurate and complete.

Additionally, an OEHRM health systems specialist and scheduling staff reported that veterans' addresses and some last names did not accurately transfer during system implementation at the Columbus and Spokane facilities. An OEHRM health systems specialist said some of the data migration issues were caused by the connection between the new scheduling system and the Department of Defense's Defense Enrollment and Eligibility Reporting System (DEERS). The health systems specialist said that patient addresses and last names stored in DEERS were transferred into the new scheduling system instead of drawn from VA. However, the health systems specialist explained that DEERS is often incomplete and outdated, resulting in incorrect

patient addresses and names in the new scheduling system. OEHRM reported that VA and the Department of Defense decided to transfer VA information through DEERS because Cerner was already connected to that system. OEHRM also reported that VA data in the new system might have been unintentionally overwritten by DEERS data during the transfer. In March 2021, OEHRM reported that "there is a heavy data quality effort underway to minimize the variations from VA and DoD [Department of Defense] identity traits."

The OIG determined that the inaccurate and incomplete data migration may have contributed to delays in scheduling patient appointments because Columbus and Spokane scheduling staff reported that scrubbing data manually was time-consuming. Additionally, as schedulers worked to scrub appointments, they were at risk of canceling the wrong ones or introducing new errors.

In January 2021, the OEHRM health systems specialist said VA is working with the Department of Defense to address this issue for both facilities. However, as of June 2021, OEHRM had not provided the OIG documentation to show any progress made toward resolution.

Post-implementation Issue 3— Misleading Appointment Reminder Calls

The automated appointment reminder calls generated by the new system sometimes contained confusing information. For example, a Columbus computer specialist stated that an appointment reminder call for a telehealth appointment would instruct a patient to "check in" at the front desk, implying incorrectly that the patient had a face-to-face appointment. Schedulers told the OIG review team that some patients showed up at a facility for appointments they could not attend on-site, which delayed their care and unnecessarily brought them into a VA facility during the COVID-19 pandemic.

To prevent the confusion caused by these automated reminders, in January 2021, an OEHRM health systems specialist said the Columbus and Spokane facilities turned off the automated appointment reminder calls for telehealth appointments. However, given that appointment reminder letters cannot be sent automatically in the new scheduling system, this action kept patients with telehealth appointments from receiving any automated appointment reminders. In contrast, patients with face-to-face appointments continued to receive reminder calls through the new scheduling system.

Lack of Guidance and Effective Troubleshooting Processes Has Hampered Corrective Actions Overall

After the new scheduling system was implemented in the summer and fall of 2020, VHA and OEHRM were facing an array of issues to be corrected. Because of the lack of guidance, schedulers developed their own work-arounds to system limitations. VHA employees began

working with Cerner to try to correct the most pressing issues, using a ticketing process that personnel interviewed by the OIG team felt was cumbersome and lacked transparency.

Lack of Guidance for Unresolved Issues

VHA and OEHRM leaders did not always develop clear guidance or establish consistent ways for schedulers to navigate around limitations in the new scheduling system. Schedulers often improvised temporary solutions that were inconsistently applied within and between facilities.

Example 5

> *Prior to system implementation at Columbus, facility leaders developed guidance on how schedulers should respond to the problems with changing appointment types (such as in-person vs. telehealth). That guidance stated that, to change the modality of care, the provider needed to cancel the original order and then create a new order. However, once the scheduling system was implemented at Columbus, the chief of patient business service disseminated conflicting guidance, indicating that schedulers could cancel the original order and then create a new order themselves (instead of the provider). This guidance stated that we "eventually want to get to the point of only scheduling off of the provider orders, but know we are in a reactive state right now."*

Furthermore, while the review team's survey did not specifically ask about work-arounds, 17 schedulers reported needing them because their scheduling issues were not timely resolved, could not be resolved, or because they did not know how to comply with scheduling policies in the new system.[28] Below are four examples of concerns schedulers had regarding work-arounds to meet scheduling needs or compliance with VA guidance:

- "As we went through the training, the workflows did not line up with VA policies and procedures which resulted in work-arounds and decreased patient satisfaction."

- "There have been a ton of "bugs" and work-arounds that we have had to come up with on the fly, and that has been tremendously frustrating."

- "Training scenarios were very basic and simple. In our day to day scheduling we have to do work arounds to get some things scheduled correctly."

- "Letters that use to be standard to mail to patients are now not being mailed. Too many work arounds causing huge delays in patient care."

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[28] Of these 17 schedulers, 11 were from the Columbus facility and six were from the Spokane facility.

Ticketing Process Was Not Well Managed

OEHRM did not implement a formal procedure to report issues through an information technology ticketing process until after the August go-live date at the Columbus facility. Once OEHRM and Cerner did implement a formal ticketing process, several problems occurred related to the transparency of processing those tickets and the timeliness of correcting the issues reported.

Lack of Transparency during the Ticketing Process

Once the Columbus and Spokane facilities implemented the new scheduling system, facility employees were able to report system issues and limitations through information technology tickets—electronically or by calling Cerner. However, both facility leaders and schedulers said they did not always know the status of their reported issues. One scheduler said that Cerner staff did not always notify employees when they resolved tickets, but when they did, they generally notified facility leaders instead of the employees who submitted the tickets. The scheduler said facility leaders did not always inform the schedulers that the tickets were closed or how they were resolved.

Similarly, a facility leader corroborated that employees did not always know what issues were being worked on or what had been resolved as there was a lack of communication between Cerner and facility employees throughout the ticketing process. The facility leader said schedulers had low morale because they did not know if their issues were being taken seriously.

Of the 213 schedulers who responded to the review team's survey that they had used the new system, 178 (about 84 percent) said they raised concerns.[29] Of those, 68 schedulers (about 38 percent) said they did not know if their issue had been resolved, and 66 schedulers (about 37 percent) indicated their issues had not been resolved.[30] Schedulers reported being told that their issues could not be resolved because the contract did not support the work or that the resolution would not be supported at the national level. Others were told that the new scheduling system lacked the necessary capabilities.

The lack of transparency in Cerner's processing of tickets meant OEHRM did not have a mechanism to effectively track and monitor reported issues. One employee stated OEHRM "had

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[29] Schedulers indicated they raised concerns verbally or through emails to VHA leaders, administrative officers, their supervisors, or Cerner employees. Schedulers also indicated they raised concerns through the electronic ticketing process after the new scheduling system was implemented. Of the 213 schedulers who responded to the survey that they had used the new scheduling system, about 86 percent of the schedulers from Columbus (97 of 113) and about 81 percent of the schedulers from Spokane (81 of 100) reported that they raised concerns.

[30] Of the schedulers who raised concerns, about 38 percent of the schedulers from both Columbus (37 of 97) and Spokane (31 of 81) reported that they did not know if their issue had been resolved, and 31 percent of the schedulers from Columbus (30 of 97) and 44 percent of the schedulers from Spokane (36 of 81) indicated their issues had not been resolved. A scheduler could be included in both totals—68 schedulers and 66 schedulers. Therefore, the number of schedulers that make up these results may not be 134.

to go to Cerner" to obtain an OIG-requested list of these reported issues. The list the OIG received from OEHRM over a month later was uninformative.[31]

According to an internal document provided by the Columbus chief of patient business services, staff submitted about 150 scheduling tickets from September to November 2020. According to OEHRM's list, Spokane staff submitted about 180 scheduling tickets from November 2020 to January 2021.[32] During the review team's interim briefing in January 2021, an OEHRM leader said various ticketing metrics are available through Cerner. When asked if OEHRM had analyzed Cerner's management of the tickets, including the timeliness of ticket resolution, the leader responded that doing so would require additional information from Cerner; the information OEHRM provided did not show evidence it had completed these analyses.

No Oversight of Ticket Resolution Timeliness

According to the contract, Cerner is required to resolve tickets within various time frames based on priority levels: critical, high, moderate, and minor. For example, Cerner is required to resolve critical tickets within 24 hours, and 80 percent of moderate tickets within four business days. The contract also states that the contractor is responsible for coordinating the "ticket grouping, severity assignment, categorization, and ticket classification."

However, schedulers told the review team they experienced long delays (more than a week to address configuration issues, for example) in having their tickets resolved or could not recall any tickets that had been fixed. Schedulers were not always aware of how Cerner prioritized their tickets. For a change to be made to the scheduling software, Cerner had to request approval from OEHRM (and sometimes the Department of Defense), which caused delays. For example, a lead scheduler said she submitted a ticket on behalf of her schedulers because they could not schedule appointments in her clinic or process referrals for social work. This scheduler also said the facility's chief of staff had to present this type of issue to Cerner. Similarly, the Columbus facility service chief of specialty medicine said it took too long for tickets to be resolved. For example, he said that in August 2020, he sent Cerner two new providers to add to the system to be configured to their respective clinics, and it took four weeks for this issue to be resolved.[33] During this four-week period, these providers were not operating at full capacity, and some patients waited longer than necessary to receive care.

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[31] The OIG team determined this list of issues was uninformative because it did not include specific details pertaining to the reasons for the tickets, how they were resolved, or what severity level the ticket was assigned.

[32] The OIG team did not categorize the types of these tickets. These tickets could contain repeat or similar complaints.

[33] According to the contract, "The Contractor shall also provide 24x7x365 Post Go-Live support remotely via the Millennium Service Desk (MSD) and Application Management (AMS) to assist with basic resolution, troubleshooting and configuration as it relates to the Contractor solutions being provided." Based on the contract language, the review team determined Cerner is responsible for resolving configuration-related issues through the end of the contract.

When review team members mentioned they had not seen evidence that OEHRM had evaluated whether Cerner was complying with the timeliness metrics outlined in the contract, an OEHRM leader stated that Cerner's system did track how long tickets took to be resolved. However, despite several requests, OEHRM did not provide the OIG with documentation to show Cerner's system had this tracking capability. Additionally, OEHRM did not have its own mechanism in place to evaluate compliance with timeliness measures outlined in the contract. As a result, the team also could not assess whether Cerner resolved problems in a timely manner.

VHA and OEHRM Are Pausing Future Deployment While VA Conducts a Strategic Review of the Full EHR Program

VHA and OEHRM were planning to implement the new scheduling system at all VISN 20 facilities by the end of 2021. However, in light of the reported challenges at Spokane, OEHRM paused future deployment while VA conducts a strategic review of the full EHR modernization program. In March 2021, the acting under secretary for health stated in an email message to all VHA staff:

> Secretary Denis McDonough conducted an initial assessment of the program within his first month in office and has directed a more in-depth strategic review of our electronic health record modernization efforts. This strategic review, beginning March 24, 2021, will consist of a full assessment of the ongoing electronic health record modernization program to ensure continued success for future EHR deployments, and will not exceed 12 weeks.[34]

> VA's ongoing analysis of the Mann-Grandstaff VA Medical Center initial operating capability (IOC) post-deployment activities have precipitated the need for a schedule shift. While the VA Central Ohio Healthcare System is currently scheduled to remain the next "go-live" site, the order of subsequent deployments may also be revised as a result of this strategic review. A new date for the VA Central Ohio Healthcare System's go-live will be announced as the strategic review process allows.

In April 2021, the House Committee on Veterans' Affairs, Subcommittee on Technology Modernization, held a hearing on VA's strategic review to evaluate concerns about the ongoing deployment of the EHR modernization program. When asked how VA will ensure that the challenges with the EHR are not experienced in future facilities, the acting deputy secretary for veterans affairs stated, "I think that is a major purpose not the only purpose but certainly a major important part of this strategic review." In April 2021, an OEHRM representative reported that

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[34] During the review team's interim briefing with VHA and OEHRM leaders in June 2021, an OEHRM official stated the assessment portion of the strategic review had been completed and was being reviewed by VA leaders. The OEHRM official stated dates for resuming deployment of the new EHR had not been determined.

VA's strategic review would assess all components of the EHR suite. Also, "final go-live preparation activities such as Mock Go-Live, Cutover Implementation, and Go-Live Readiness Assessment are on hold at all sites pending timeline updates from VA leadership. Deployment activities that are not aligned with a specific go-live date remain ongoing."

In July 2021, the assistant under secretary for health discovery, education and affiliate networks, testified before the House Committee on Veterans' Affairs, Subcommittee on Technology Modernization, that VA would continue its pause of the EHR effort to focus on technical infrastructure upgrades and on establishing an integrated test and training environment. VA would also continue to evaluate the functionality of the system before the next go-live event. In addition, VA plans to shift the deployment schedule from the initially planned geographical progression to an approach that considers the readiness of each facility prior to deployment. VA expects the new EHR deployment schedule to be in place by the end of the 2021 calendar year.

Prior to the announcement of VA's strategic review, the Spokane facility established "tiger teams" to help resolve issues the facility experienced with the new system. As part of that effort, Cerner organized and facilitated an "optimization meeting" in December 2020 for the Spokane facility. According to a draft document provided by OEHRM, the purpose of the meeting was to review top concerns with OEHRM, national council members, VA solution experts, Cerner consultants, and leaders. OEHRM took the following steps after the meeting:

- Compiled and sent meeting notes to national council members and Cerner consultants for review

- Identified all EHR-related issues, including scheduling issues, that require follow-up

- Developed action plans, assigned owners, and identified appropriate "tiger teams" to manage issues in various EHR implementation areas, including the new scheduling system

In February 2021, OEHRM sent these items to the OIG review team. An OEHRM representative sent the team a spreadsheet that included 169 topics or issues that were discussed during the optimization event. VA needs to ensure VHA and OEHRM take appropriate steps to resolve issues identified in the optimization meeting, this report, and its strategic review. Those steps should help avoid the recurrence of these issues at future sites.

Conclusion

VHA and OEHRM implemented the new scheduling system at the Columbus and Spokane facilities without fully addressing known issues and without taking appropriate steps to identify additional system limitations. Schedulers from all clinics were not given an opportunity to fully test the scheduling capabilities of their clinics, and not all were allowed to provide feedback

based on the testing. The resulting implementation problems risk delaying patient care and undermining effective oversight of patient-scheduling practices and wait times. Before expanding deployment of the new scheduling system to additional facilities, VHA and OEHRM need to develop a strategy to resolve the scheduling issues encountered in Columbus and Spokane.

Recommendations 1–8

The OIG recommends that the under secretary for health coordinate with the VA Office of Electronic Health Record Modernization's executive director, who should take the following actions:

1. Continue to make improvements to the scheduling training as needed to address feedback from schedulers.

2. Require that some schedulers from each clinic fully test the scheduling capabilities of their clinics, solicit feedback from the schedulers to identify system or process issues, and make improvements as needed.

3. Issue guidance to facility staff on which date fields in the new system schedulers should use to measure patient wait times.

4. Develop a mechanism to track and then monitor all tickets related to the new scheduling system, and then ensure the Office of Electronic Health Record Modernization evaluates whether Cerner effectively resolved the tickets within the timeliness metrics established in the contract.

5. Develop a strategy to identify and resolve additional scheduling issues in a timely manner as the Office of Electronic Health Record Modernization deploys the new electronic health record at future facilities.

6. Develop a mechanism to assess whether facility employees accurately scheduled patient appointments in the new scheduling system, and then ensure facility leaders conduct routine scheduling audits.

7. Evaluate whether patients received care within the time frames directed by Veterans Health Administration policy when scheduled through the new system.

The OIG recommends that the VA Office of Electronic Health Record Modernization's executive director take the following action:

8. Provide guidance to schedulers to consistently address system limitations until problems are resolved.

VA Management Comments

The acting under secretary for health concurred with recommendations 1–7, and with the OEHRM executive director's comments and plan to address recommendation 8 as part of the overall joint VHA–OEHRM corrective action plan. The OEHRM executive director also concurred with recommendation 8. The OEHRM executive director noted that OEHRM will work with VHA to address recommendation 8 "to ensure that any administrative burdens associated with current system limitations are understood and minimized."

A summary of the actions proposed by the acting under secretary for health and the executive director of OEHRM in response to the recommendations follows (see full text in appendix B):

Recommendation 1: VHA will develop protocols necessary to adjudicate potential content changes and improvements to scheduler training based on feedback from end users. VHA will coordinate with stakeholder program offices to enhance communication to ensure end users are aware of content changes made as a result of their feedback.

Recommendation 2: VHA will review existing processes for selecting end users to participate in system testing events and will then work with stakeholder program offices to improve processes based on the review outcomes.

Recommendation 3: VHA has established a workgroup to finalize wait time and consult management workflows in the new electronic health record. Once these are approved, they will be incorporated into the existing written guidance for facility staff.

Recommendation 4: VA is working to develop a dashboard for the ticketing system in use since June 1, 2021, that will display daily data metrics pertinent to timely resolution of tickets in the new scheduling system.

Recommendation 5: OEHRM will continue to refine its processes to expedite ticket resolution and identification of issues. VA will also work collaboratively to address any issues and escalate decisions to council for final decision.

Recommendation 6: VHA will incorporate metrics from the new scheduling system into existing policy and audit guidance—asserting that VHA has clear regulatory, policy guidance, and procedures for affected staff.

Recommendation 7: VHA will incorporate metrics from the new scheduling system into existing policy guidance—which VHA reports is clear on consult review, processing, and healthcare delivery—to be sure VISNs and medical centers can evaluate the metrics related to healthcare delivery. VHA also continues to work to ensure staff provide the best information available to veterans about care options.

Recommendation 8: VA's OEHRM reported that in providing guidance to schedulers on consistently addressing system limitations, facilities can use letter, telephone, or text message reminders to address veteran communication preferences. In addition, VHA is investigating a

workflow change to reduce administrative burdens when changing appointment types and to ensure reportable data are accurate.

VA also provided technical comments, acknowledging the scheduling issues and problems that occurred during initial EHR implementation at Columbus and Spokane. VA stated that, based on the results of its strategic review, it is establishing an enterprise-wide approach to EHR system deployment that will better judge a site's preparation to help ensure the success of future deployments of the new EHR system. It also stated the focus will be on patient safety first and rigorous training for frontline clinicians before future go-live events.

The full text of the acting under secretary for health's comments with the joint VHA and VA proposed action steps appears in appendix B, and the OEHRM executive director's comments are included in appendix C.

OIG Response

The corrective action plans provided by VHA and VA are responsive to the intent of the recommendations. While OEHRM will be responsible for addressing and closing out recommendation 8, the OIG understands OEHRM may need VHA's help to satisfy the requirements of this recommendation. Specifically, as noted by the OEHRM executive director, OEHRM will work with VHA to ensure that any administrative burdens associated with current system limitations are understood and minimized. While OEHRM will need to work with VHA on this recommendation, the recommendation was made to OEHRM based on a June 2021 meeting with VHA and OEHRM leaders, during which the OEHRM chief medical operations director stated OEHRM should be responsible for this recommendation because OEHRM knows how system limitations should be addressed and could provide guidance to schedulers on how to do so as part of training on the EHR system workflows.

The OIG will monitor implementation of all planned actions and will close the recommendations when it receives sufficient evidence demonstrating progress in addressing the recommendations and the specific risk areas identified in this report.

Appendix A: Scope and Methodology

Scope

The review team performed its work from November 2020 through July 2021. This review focused on VHA's implementation and oversight of the new scheduling system at both the Columbus and Spokane VA medical centers from pre-implementation efforts to May 2021.[35] The scope of the review focused on assessing whether VHA and OEHRM effectively implemented the new scheduling system at these facilities, including whether they ensured that schedulers received required user training, identified any system or process weaknesses, and made any improvements as necessary. In addition, the review team examined plans to deploy the scheduling system at other facilities.

Methodology

The review team identified and reviewed VHA and OEHRM assessments, evaluations, internal email communications, contract documentation, scheduling training materials, applicable laws and regulations, VA policies and procedures, and guidelines related to VHA and OEHRM's implementation of the new scheduling system at the Columbus and Spokane facilities. The review team also interviewed leaders within OEHRM, Office of Veterans Access to Care, and the Columbus and Spokane facilities. Other facility staff (scheduling personnel and providers) and VA contracting personnel were engaged as well. Interviews (all conducted virtually due to pandemic precautions) helped the team gain an understanding of the processes, risks, internal controls, and general governance structure used to manage the EHR implementation, including the new scheduling system. The review team conducted virtual site visits as well to the Columbus and Spokane facilities to observe the use of the new scheduling system.

The team obtained and analyzed reported concerns from scheduling personnel on the new scheduling system to determine whether VHA and OEHRM were aware of scheduling issues before implementation and whether they resolved them. Team members also assessed whether the new scheduling system provided VHA leaders with key oversight reports to ensure staff accurately and timely scheduled patient appointments.

An electronic OIG survey was distributed to 287 schedulers at the Columbus and Spokane facilities to obtain information related to training on scheduling, pre-implementation testing, and

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[35] The review team also assessed if the scheduling system was implemented effectively at community-based outpatient clinics affiliated with either the Columbus or Spokane medical centers. The centers in question are formally known as the Chalmers P. Wylie Ambulatory Care Center (Columbus) and the Mann–Grandstaff VA Medical Center (Spokane).

opportunities for them to provide feedback on the new scheduling system.[36] Of the 287 schedulers, 242 responded to the survey. Of those who responded,

- 213 schedulers reported they had used the new scheduling system (and were given the opportunity to respond to the rest of the OIG survey questions) and

- 29 schedulers reported they had not used the system and did not participate further.

The review team's analysis is based on the 213 respondents who responded to the survey and had used the new scheduling system. The numerator and denominator used to calculate question response percentages are detailed in the report.

Survey results are self-reported data, which the review team could not verify without conducting site visits or observing all schedulers while they took the survey. However, the team took steps to protect the data, which included limiting respondents from submitting survey responses more than once. Respondents could not change their answers once the survey was submitted without OIG staff assistance. Access to the survey was limited to a list of preprogrammed email addresses.

Internal Controls

The review team determined that internal controls relevant to control environment, risk assessment, control activities, information and communication, and monitoring were applicable to this review.[37] Based on the work performed, the team identified deficiencies related to (1) the tracking and monitoring of scheduling tickets to ensure effective and timely resolution, (2) the resolution of known issues before implementation, (3) the ineffectiveness of the scheduling training provided to schedulers, (4) the lack of guidance to ensure that schedulers accurately and consistently scheduled patient appointments, and (5) a mechanism to evaluate whether schedulers accurately scheduled patient appointments using the new scheduling system.

Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators during the course and scope of their review. The OIG did not identify any instances of fraud or potential fraud during this review.

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[36] Of these 287 schedulers, 132 were from the Columbus facility, and 155 were from the Spokane facility. The review team took steps detailed in the data reliability section to validate this list of schedulers.

[37] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO 14 704G, September 2014.

Data Reliability

The review team obtained data from various sources during the audit and assessed the reliability of the data that was used to support findings, conclusions, or recommendations related to the audit objectives. The team requested a list of Columbus and Spokane staff assigned as schedulers in the new system. An OEHRM government information specialist provided a list to the review team. To verify the accuracy of this list, the review team sent emails to those employees to verify they were schedulers. Then, the review team asked scheduling leaders at the Columbus and Spokane facilities to ensure the team's final list was accurate and complete.

The review team requested ticketing information from VHA and OEHRM, and then took steps to validate whether the provided ticketing information was complete. Specifically, the team compared ticketing documents from these two sources, but was unable to verify the completeness of the contents because the documents did not include the same information. The team determined that the inability to verify the ticketing information across the documents was immaterial and did not warrant additional review work since the data were not solely relied upon to derive the finding.

The review team concluded that the data obtained and relied upon were sufficiently reliable for the purposes of this review.

Government Standards

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

Appendix B: Veterans Health Administration Management Comments

Department of Veterans Affairs Memorandum

Date: September 21, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, New Patient Scheduling System Needs Improvement as VA Expands Its Implementation (VIEWS #5510724)

To: Assistant Inspector General for Audits and Evaluations (52)

Thank you for the opportunity to review and comment on the Office of the Inspector General (OIG) draft report New Patient Scheduling System Needs Improvement as VA Expands Its Implementation. The Veterans Health Administration (VHA) concurs with recommendations 1-7. We provide an action plan to address recommendations 1-7 in the attachment. VHA concurs with Office of Electronic Health Record Modernization's comments and action plan to address recommendation 8.

The OIG removed point of contact information prior to publication.

(Original signed by)

Steven L. Lieberman, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
New Patient Scheduling System Needs Improvement as VA Expands Its Implementation

OIG recommends that the Under Secretary for Health coordinate with the VA Office of Electronic Health Record Modernization's Executive Director, who should:

Recommendation 1. Continue to make improvements to the scheduling training as needed to address feedback from schedulers.

VHA Comments: Concur
VHA will develop protocols necessary to adjudicate potential content changes and improvements to scheduler training based on feedback from end users as part of the larger content maintenance process. VHA will also coordinate with stakeholder program offices to enhance communication pathways to ensure end users have visibility into content changes made as a result of their feedback.

Status: In progress   Target Completion Date: January 2022

Recommendation 2. Require that some schedulers from each clinic fully test the scheduling capabilities of their clinics, solicit feedback from the schedulers to identify system or process issues, and make improvements as needed.

VHA Comments: Concur
VHA will review existing processes for selecting end users to participate in system testing events and will increase both the numbers and expertise of individuals and enhance communication pathways as determined to be needed. VHA will work with stakeholder program offices to improve processes as applicable based on the outcomes of the review.

Status: In progress   Target Completion Date: November 2021

Recommendation 3. Issue guidance to facility staff on which date fields in the new system schedulers should use to measure patient wait times.

VHA Comments: Concur
VHA currently has clear regulatory and policy guidance and standard operating procedures for Veterans Integrated Service Networks (VISNs) and Medical Center staff involved in consult/referral management. VHA has established a workgroup to finalize wait time and consult management workflows within the new EHR. Upon approval from VHA leadership, VHA will incorporate this into existing written guidance for facility staff.

Status: In Progress   Target Completion Date: February 2022

Recommendation 4. Develop a mechanism to track and then monitor all tickets related to the new scheduling system, and then ensure the Office of Electronic Health Record Modernization evaluates whether Cerner effectively resolved the tickets within the timeliness metrics established in the contract.

VHA Comments: Concur
VA moved to the ServiceNow ticketing system on June 1, 2021. VA is working with the ServiceNow team to develop a dashboard that will display data metrics pertinent to timely resolution of tickets related to the new scheduling system.

VA will continue to streamline processes and communications to both Cerner and the field related to the ticketing system.

Status: In Progress   Target Completion Date: December 2021

Recommendation 5. Develop a strategy to identify and resolve additional scheduling issues in a timely manner as the Office of Electronic Health Record Modernizations deploys the new electronic health record at future facilities.

VHA Comments: Concur
VA will continue to refine its processes to expedite ticket resolution and identification of issues. As all parties involved become more knowledgeable, including end users, tickets will better define the problem resulting in streamlined communication between solution experts and end users. VA will continue to work collaboratively and address any issues and escalate decisions to the EHRM council for final decision and system changes.

Status: In progress   Target Completion Date: December 2021

Recommendation 6. Develop a mechanism to assess whether facility employees accurately scheduled patient appointments in the new scheduling system, and then ensure facility leaders conduct routine scheduling audits.

VHA Comments: Concur
VHA currently has clear regulatory and policy guidance and standard operating procedures for Veterans Integrated Service Networks (VISNs) and Medical Center staff involved in consult management, including routine audits of front-line staff by facility management. VHA will incorporate metrics from the new scheduling system into existing policy and audit guidance.

Status: In progress   Target Completion Date: July 2022

Recommendation 7. Evaluate whether patients received care within the time frames directed by VHA policy when scheduled through the new system.

VHA Comments: Concur
VHA has clear regulatory and policy guidance for VISNs and Medical Centers related to consult review, processing, and health care delivery to meet the varied needs of the Veteran population it serves. VHA continues to work to ensure staff provide the best information available to inform Veterans about options for care. VHA will incorporate metrics from the new scheduling system into existing policy guidance to assure VISNs and Medical Centers can evaluate the metrics of health care delivery to Veterans.

Status: In progress   Target Completion Date: July 2022

OIG recommends that the VA Office of Electronic Health Record Modernization's Executive Director

Recommendation 8. Provide guidance to schedulers to consistently address system limitations until problems are resolved.

VA Comments: Concur
Facilities can utilize letter, telephone and text message reminders to Veterans to meet a wide range of Veteran communication preferences. VHA anticipates that these options will remain as part of the new EHR. VHA is investigating a change to the workflow to reduce the administrative burdens in changing appointment types and to ensure reportable data is accurate.

Status: In progress   Target Completion Date: December 2021

Department of Veterans Affairs
Technical Comments

OIG Draft Report: "New Patient Scheduling System Needs Improvement as VA Expands Its Implementation" (2021-00434-AE-0012)

Date of Draft Report: July 13, 2021

Draft Location: Page 4

Finding: VHA and OEHRM Did Not Resolve All Known Issues before and after Implementing the New Scheduling System, Risking Delays in Patient Care

Comment and justification: The Department of Veterans Affairs (VA) acknowledges the scheduling issues and problems that occurred during the initial implementation of the electronic health record (EHR) system's scheduling component in Columbus and the following implementation of the full EHR suite in Spokane that the Inspector General identifies in this report. As a result of its comprehensive strategic review of the Electronic Health Record Modernization (EHRM) program earlier this year, VA is establishing an enterprise-wide approach to EHRM that will engage key clinical, technical, acquisition and other stakeholder leadership to strengthen governance and management processes and facilitate better judgement of a site's preparation level before an EHRM implementation moves forward. To ensure the success of future deployments, VA will continue to focus on patient safety first and foremost and will also provide a rigorous training environment (the EHRM sandbox) for frontline clinicians to hone their skills in before future go-lives. VA is confident that this approach will positively impact the EHRM effort and that more VA sites will soon experience the benefits that this new system has to offer to Veterans, providers and schedulers.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix C: Office of Electronic Health Record Modernization Management Comments

Department of Veterans Affairs Memorandum

Date: October 5, 2021

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

Subj: Response to Draft Report "New Patient Scheduling System Needs Improvement as VA Expands Its Implementation" (Project Number 21-00434-AE-0012) (VIEWS 5510724)

To: Assistant Inspector General for Audits and Evaluations, Office of Inspector General (52)

1. Thank you for the opportunity to review the Department of Veterans Affairs (VA) Office of Inspector General (OIG) draft report "New Patient Scheduling System Needs Improvement as VA Expands Its Implementation." The report contains one finding for the Office of Electronic Health Record Modernization (OEHRM) and the Veterans Health Administration (VHA), one recommendation for OEHRM and seven recommendations for VHA.

2. I concur with the finding and the recommendations in this report. I have included as attachment of the action plan developed in conjunction with VHA to address the recommendations.

3. Regarding the recommendation directed at OEHRM, I note that while OEHRM can provide technical guidance regarding the capabilities of the scheduling system, VHA is responsible for determining how its schedulers will utilize the system. OEHRM will work with VHA to ensure that any administrative burdens associated with current system limitations are understood and minimized.

The OIG removed point of contact information prior to publication.

(Original signed by)

John H. Windom

Attachments

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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