DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON, DC 20420

March 6, 2023

The Honorable Matt Rosendale
Chairman
Subcommittee on Technology Modernization
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to a request from Subcommittee staff on March 2, 2023 in anticipation of the Subcommittee's hearing on March 7, 2023 regarding the Veterans Health Information Systems and Technology Architecture (VistA). Subcommittee staff asked that the Office of Inspector General (OIG) provide a list of OIG reports discussing VistA.

While challenges with existing software programs, such as VistA, have been generally discussed in OIG reports, the OIG has, in line with requests from the House and Senate Committees on Appropriations, focused on VA's electronic health record modernization program (EHRM) because of the financial and programmatic issues expected in a modernization effort. Recognizing EHRM's centrality and complexity, the OIG began monitoring and assessing the EHRM program after VA signed the sole-source contract with Cerner in May 2018. To date, the OIG's Offices of Audits and Evaluations, Healthcare Inspections, and Special Reviews have published 14 reports on EHRM.

The OIG's reports have discussed gaps in VistA while reviewing other issues, such as the finding in 2014 that scheduling audit trails in VistA were not being utilized at that time, which potentially limited the OIG and VA's ability to determine if VistA's information was being improperly manipulated. The OIG's Office of Healthcare Inspections focuses on providing oversight and recommendations for improvement of health care quality and access, but addresses software or configuration issues when they are identified. For example, a particular challenge noted in VistA is that view alerts, a tool for communicating patient test results to providers including laboratory tests, diagnostic imaging procedures, and diagnostic procedures, are configured and managed in a way that can lead to breakdowns in the coordination of care for a patient.

The Honorable Matt Rosendale

Please find below a selection of reports discussing issues with VistA:

- Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington, March 17, 2022.

- Failure of a Primary Care Provider to Complete Electronic Health Record Documentation and Inadequate Oversight at the Charlie Norwood VA Medical Center in Augusta, Georgia, July 1, 2021

- View Alert Process Failures and the Impact on Patient Care at the Central Alabama Veterans Health Care System in Montgomery, March 11, 2021

- Delays and Deficiencies in Management of Selected Radiology and Nuclear Medicine Outpatient Exams, October 19, 2019

- Delayed Radiology Test Reporting at the Dwight D. Eisenhower VAMC, Leavenworth, Kansas, March 7, 2019

- Interim Report: Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System, May 28, 2014

Thank you for your interest in the OIG.

Sincerely,

MICHAEL J. MISSAL

cc: Ranking Member Sheila Cherfilus-McCormick