Congress of the United States
Washington, DC 20515

November 15, 2022

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

Dear Secretary McDonough:

We write to express our grave concerns with the Oracle-Cerner electronic health record (EHR) system at the Chalmers P. Wylie Ambulatory Care Center in Columbus and its clinics. When we visited the facility on September 2nd, the staff thoroughly explained how the system has undermined health care delivery, safety, operations, and morale. The prevailing opinion is that the situation is unsustainable and the EHR should be removed as quickly as possible. There have been two recent deaths of Columbus VA patients. Both involved system errors that may have contributed to these horrible outcomes. These deaths are tragedies and demand your personal attention.

As we understand the most recent situation, the veteran was admitted in a civilian hospital when a prescription for an antibiotic was ordered at the Columbus VA. After he was discharged, the VA attempted to fill the prescription order. However, the EHR provided erroneous tracking information for the prescription, and despite several calls from the family to VA attempting to locate the medication, the veteran never received it. It is unclear where, if anywhere, the prescription was mailed. His condition worsened while at home, and he was admitted to the civilian hospital again and died of hypoxia. While the exact series of events and causation are unclear, it seems multiple human and system errors occurred.

This follows another reported incident when a veteran missed an appointment, his information was not transferred into the system's cancellation/no-show list, and no outreach was attempted to reschedule the appointment. His wellbeing apparently deteriorated after that time. Several months later, he returned to VA urgent care with alcohol withdrawal symptoms and was transferred to a civilian hospital, where he died.

As you are well aware, the EHR has been plagued by safety risks and technical problems in addition to exorbitant costs. These two incidents involved different combinations of system and human error. While mistakes undoubtedly happen in health care, the EHR is clearly compounding and worsening the potential for human error.

It was irresponsible to subject our veterans to such a flawed and dangerous system, and the situation in Columbus and the other VA medical centers using Cerner is unacceptable.

We appreciate that you have decided to notify tens of thousands of veterans in Ohio, Oregon, and Washington that their care was potentially delayed or otherwise impacted due to problems with the EHR. This was long overdue.

In addition, we urge you to get to the bottom of these patient deaths in Columbus as quickly as possible. We request copies of all investigative reports or analyses, and all recommendations that are made and implemented. Our understanding is that VA has already determined—even before completing any investigation into the root cause—that the veteran's death due to hypoxia was not a "sentinel event," which VA defines as a patient safety event that results in death, permanent harm, or severe temporary harm. This conclusion appears premature.

We also request that you answer the following questions:

1) Where, if anywhere, was the veteran's prescription for the antibiotic mailed, and why was it sent to the wrong address?

2) Why were the VA staff unable to find the prescription when the veteran's family called to locate it? What other information besides tracking numbers is available in the EHR or other VA systems indicating where prescriptions are sent, and was that information also inaccurate?

3) What other mistakes were made in this veteran's care, such as in discharge planning or care coordination?

4) In the other veteran's case, what procedures does VA have to follow up with patients who miss appointments, in addition to the EHR's automated alerts?

5) What steps are VA and Oracle-Cerner taking to make sure that events like this, where the patient receives no information, inaccurate information, or no outreach from VA regarding medication or appointments never happen again?

6) How will you determine if the Oracle-Cerner EHR is safe and effective to roll out at any additional sites, or to retain it at current sites?

7) What information has VA provided to the veterans' families about their rights to seek malpractice compensation?

8) Have there been any other sentinel events or deaths related or attributed to the Oracle-Cerner EHR's errors, in Ohio or any other state?

We request that you respond to this letter by December 2, 2022. Veterans in Central Ohio deserve the safest, highest-quality health care, and to know what it is happening so they can make informed decisions.

If you have any questions, please do not hesitate to have your staff contact William Mallison, Republican staff director for the Veterans' Affairs Subcommittee on Technology Modernization,

at (202) 225-3527, Michael Lundquist, legislative assistant in Rep. Carey's office, at (202) 225-2015, and John Kohler, legislative assistant in Rep. Balderson's office, at (202) 225-5355. Thank you for your time and we look forward to your response.

Sincerely,

Mike Bost
Ranking Member
Committee on Veterans' Affairs

Mike Carey
Member of Congress

Troy Balderson
Member of Congress