Congress of the United States

Washington, DC 20515

December 19, 2025

The Honorable Doug Collins
Secretary of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20420

Dear Secretary Collins:

We are writing with regards to the Department of Veterans Affairs' (VA) plans to move forward with the deployment of the Electronic Health Record (EHR) modernization program at 13 new sites in 2026. VA embarked on the EHRM program in October 2020 with the goal of improving the quality of care for veterans by updating the outdated VistA system to allow for better communication between the Department of Defense, VA, and community care providers. While we should always strive to innovate and improve the quality of care for veterans, in practice, the rollout of EHRM has been so problematic that it created life-threatening problems and ongoing upheaval for veterans' ability to get the health care they need. The Mann-Grandstaff VA Medical Center in Spokane, Washington was the first VA site to implement the new system and since then, EHRM has expanded to several other hospitals in Washington state, Ohio, Oregon, and Illinois.

The initial EHR rollout was plagued with significant issues that have harmed both providers and their veteran patients. VA providers continue to report that they struggle to learn the new system, and that when they try to seek help, they have difficulty accessing the helpline and communicating with support staff. While user satisfaction has slightly improved since the system was first implemented, a March 2025 Government Accountability Office (GAO) report revealed that only 13 percent of users believed that the modernized system made VA as efficient as possible.[1] In addition, 58 percent of users believed the new system increased patient safety risks.[2]

A March 2024 VA Office of Inspector General (OIG) report found that the new EHR system was causing scheduling-related patient safety issues at the VA site in Columbus, Ohio.[3] Specifically, the OIG pointed to an error in the scheduling function that resulted in staff not following up with patients who missed their appointments. According to the OIG report, these issues played a role in the 2022 death of a veteran who failed to receive adequate outreach from the hospital system to reschedule a missed appointment. The OIG report also found unmitigated high-risk patient safety issues, patient medication inaccuracies, unresolved usability challenges, inaccurate medication data, the creation of numerous workarounds to provide patient care, overwhelming

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[1] U.S. Government Accountability Office. (2025*). VA Making Incremental Improvements in New System but Needs Updated Cost Estimate and Schedule (*GAO-25-106874). https://files.gao.gov/reports/GAO-25-106874/index.html
[2] U.S. Government Accountability Office. (2025*). VA Making Incremental Improvements in New System but Needs Updated Cost Estimate and Schedule (*GAO-25-106874). https://files.gao.gov/reports/GAO-25-106874/index.html
[3] Department of Veterans Affairs Office of Inspector General. (2024). *Scheduling Error of the New Electronic Health Record and Inadequate Mental Health Care at the VA Central Ohio Healthcare System in Columbus Contributed to a Patient Death.* (23-00382-100). https://www.vaoig.gov/sites/default/files/reports/2024-03/vaoig-23-00382-100_1.pdf

educational materials for pharmacy-related functions, and pharmacy staffing challenges.[4] None of this is acceptable—implementing a new electronic health record should not result in dire staff burnout nor should it endanger VA patient safety.

In March, VA announced that it would expand its 2026 EHR deployments beyond the planned four sites in Michigan to nine additional VA medical centers and their associated clinics in Kentucky, Ohio, Indiana, and Alaska. We have serious concerns that the issues and system defects identified by GAO and the VA OIG have yet to be adequately addressed, ahead of this more aggressive rollout timeline. Our top priority is—and has always been—patient safety. VA and Oracle Cerner must ensure that the new EHR system is ready to integrate into VA, and those who are using the system are trained and ready to implement it, before it is deployed in more locations.

We have all seen how the deployment of new technology without adequate planning, training, and support can have disastrous consequences for patients and providers alike. In Spokane and Walla Walla, the rushed deployment of the new EHR system was nothing short of a disaster for veterans and their health care providers—increasing wait times, leading to serious errors in veterans' treatment, and eroding productivity. We cannot afford to repeat these mistakes. VA providers should be supported in learning to confidently operate within the system before the system is deployed at more facilities.

Our veterans need an electronic health system that works with and for them—not against them. After sacrificing so much for our nation, they deserve to have the best health care experience possible. We request you provide our staff a briefing and answer the following questions by January 19, 2025:

1. Earlier this year, you said you were going to make the implementation of EHR a "priority." Please explain what actions VA is taking to make a successful EHR rollout a priority within the Department and what this means in terms of oversight and support of new rollout sites.
2. How many super users are being assigned to the new sites?
    a. Please describe what the training will look like and how it is different from prior trainings.
3. Have you received any feedback from VA providers on expanding the system? If so, what was that feedback?
4. The most recent GAO report, which was published in March 2025, made three recommendations, but only one has been implemented. What is the status of the other two recommendations?
    a. Does VA have plans to implement the remaining two recommendations? If not, why?

[4] Billy Mitchell, "Watchdog Report Ties Veteran Death to Scheduling Error in VA's New Electronic Health Record System," *FedScoop*, March 25, 2024, https://fedscoop.com/va-ehr-patient-death-ig-report-2024/.

5. What guardrails does VA have in place to ensure patient safety and health care performance metrics are preserved as it accelerates EHR deployment to new sites?
6. What are the projected Federal VA staffing levels, contract support, and other relevant activities required to meet the accelerated deployment schedule?
7. How does VA plan to ramp up staffing levels and training to meet the accelerated deployment schedule?
8. Given the VA OIG's findings regarding medication inaccuracies, pharmacy workflow disruptions, and overwhelming training materials at EHR deployment sites, what specific corrective actions has VA taken to ensure medication orders, reconciliation, and dispensing are accurate and safe before expanding EHR implementation to additional facilities?

As VA continues its deployment of the new EHR system, we respectfully remind you that patient safety must always be the number one priority. Veterans' lives are on the line—VA cannot afford to get this wrong and we stand ready to work with you to ensure the best outcomes for the veterans we all serve. Thank you for your attention to this important matter, and we look forward to your prompt and thorough response.

Sincerely,

Patty Murray
United States Senator

Richard Blumenthal
Ranking Member, Committee on Veterans' Affairs

Elissa Slotkin
United States Senator