

ELECTRONIC HEALTH RECORD U-TURN: ARE VA AND DOD HEADED IN THE WRONG DIRECTION?

HEARING BEFORE THE COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED THIRTEENTH CONGRESS FIRST SESSION

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ELECTRONIC HEALTH RECORD U-TURN: ARE VA AND DOD HEADED IN THE WRONG DIRECTION?

Wednesday, February 27, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 9:15 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Lamborn, Roe, Denham, Runyan, Huelskamp, Coffman, Wenstrup, Cook, Walorski, Michaud, Takano, Brownley, Kirkpatrick, McLeod, Kuster, O'Rourke, Walz.

OPENING STATEMENT OF CHAIRMAN MILLER

The CHAIRMAN. The Committee will come to order.

I want to thank everybody for being with us this morning to our hearing entitled Electronic Health Record U-Turn: Are VA and DoD Headed in the Wrong Direction?

Today's hearing is prompted by the recent announcement by the Departments of Defense and Veterans Affairs that they would no longer be developing a single integrated electronic health record or IEHR.

The announcement earlier this month was surprising to this Committee and Congress given the number of previous statements that the health record was coming along as planned even on an accelerated timeline.

And the other surprise about VA and DoD's announcement was that this Committee heard about this the very first time by published news reports.

While it is not the first time this has happened, it is equally disappointing given the number of times that this Committee has pledged to work with both departments in support of making the electronic record a reality.

Now, in late 2010, both departments co-announced an integrated electronic health record as a single solution to our common requirements.

In June 2012, the two departments set an expected timeline of a 2017 rollout for that record.

In July of 2012, both secretaries testified before this Committee and the Armed Services Committee that reinforcing a single integrated record was the way forward and that their respective departments would achieve that goal together.

This past December, it was stated that VA and DoD could roll out the health record even faster without much supporting detail.

The latest news, a mere two months later, has us asking again whether even the original 2017 timeline is a realistic timeline.

The end project, will it deliver the same level of integration for transitioning servicemembers? Interoperable is not the same as integrated.

While I understand that information can still be shared, VA and DoD have to explain to this Committee, to this Congress, and, most importantly, to the servicemembers how this new way forward is going to deliver what has been mandated, something that is badly needed and has been talked about for over a decade.

I am concerned that this new approach is a step backwards towards the model that had been previously tried and failed, namely maintaining two different systems between two different departments and wishfully thinking that the two systems will eventually talk to one another.

I am further concerned about the stewardship of taxpayer dollars over the last several years. I find it hard to think of another description than down the drain funding that may have produced little results, the same funding that could have gone toward taking care of active and former servicemembers.

Assistant Secretary Baker, I understand that you are leaving very soon and you won't be directly overseeing the joint electronic health record's development very much longer.

While I wish more progress had been made during your tenure, I can only hope that your successor doubles down on his or her efforts to make this a reality. The need for a seamless record has now been discussed for over a decade with the mere expectation that we will just continue to discuss it.

The time for action is long passed. Each time the objective changes or the goal posts move, it is servicemembers and veterans who lose the most. It is unacceptable to this Committee and should be to VA and to the Department of Defense as well.

I truly look forward to hearing more today about how, when, and in what form VA and DoD will finally bring about a joint electronic health record.

And with that, I yield to my good friend from Maine, the Ranking Member, Mr. Michaud.

[THE PREPARED STATEMENT OF CHAIRMAN MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. MICHAUD

Mr. MICHAUD. Thank you very much, Mr. Chairman.

We as a Nation have a "sacred trust" to care for those who have served and sacrificed. To do this, we rely on a community of support. DoD and VA are the pinnacles of that community. Together you are the front end and back end of veterans' safety net. You come together seamlessly or veterans fall through the space between DoD and VA.

You have no greater mutual responsibility to those who have served and to those who serve than to ensure a complete and smooth transition from military back to civilian life. Key to that smooth transition is the transfer of the health records that document the physical and mental sacrifices of our Nation's heroes.

The Integrated Electronic Health Records initiative is critical to ushering in a more fluid process for our servicemen and women who transition into the veteran world. Ideally, instead of servicemembers hand carrying paper records with them to medical appointments, access to their records would be readily available electronically to providers and health care personnel who care for them when they take the uniform off and continue their lives as civilians.

In transforming the VA into the 21st century agency, we envision a seamless record that could benefit the men and women who have served this Nation honorably. The idea behind VA and DoD being capable of electronic communicating was not a new one. We believe that VA and DoD could accomplish this task.

For at least a decade, the two largest agencies in the government have worked this issue, often taking two steps forward and one step back. I was under the impression and, in fact, reassured as late as September of 2012 that the development of the IEHR, while challenging, was still on track of becoming the reality we intended.

So in early February when we read in the news of the decision of VA and DoD were “modifying its strategy” from the planned IEHR approach and focus, I was disappointed and disheartened.

It seems to me that we have regressed back to 2004 when the Bidirectional Health Information Exchange was the way electronic information was exchanged. I am hoping this is not the case.

There are questions that must be answered as to the future of the IEHR and plans to move forward. The original strategy, the intent of IEHR was to design, build, and implement a new single system “from scratch.”

In revising your life cycle cost estimates, you have determined that approach is too expensive. So you “modified your strategy” to use core sets of capabilities from existing EHR technologies.

But rather than selecting one system for those currently available, you modified it for each department and separately select a core system of choice.

VistA, the VA’s current system is old and by all accounts replacing VistA with an existing Commercial Off-The-Shelf package is estimated to be \$16 billion dollars, according to the September 6, 2011 letter.

VA believes that leveraging open source methodologies will increase the rate of improvement within VistA and will be much cheaper.

DoD is looking to explore commercial options for its core systems and won’t have a selection decided until March. How does this modified strategy live up to the initial intent of IEHR to be a single integrated system?

I am currently not comfortable with the direction which we seems to be heading for both agencies. I am sure everyone in here would agree that we cannot afford to continue to move forward and back on this issue.

VA was once a leader in electronic health records. Today it is one that is simply trying to keep up. This must change. You and we owe more to the Nation’s servicemembers and veterans.

I look forward to hearing the panel’s testimonies today and having an open and frank discussion as how we move forward.

So with that, Mr. Chairman, I want to thank you very much for having this hearing today. It is a very important hearing. I want to thank you once again for your leadership in this regard, and I yield back the balance of my time.

[THE PREPARED STATEMENT OF HON. MICHAUD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

And as we welcome the first panel to the table this morning, we are going to hear from the Honorable Roger Baker, Assistant Secretary for Information and Technology, and the Chief Information Officer at the Department of Veterans Affairs.

Assistant Secretary Baker is accompanied by the Honorable Robert Petzel, Under Secretary for Health at the Department of Veterans Affairs.

We will also hear on this panel from the Honorable Jonathan Woodson, Assistant Secretary of Defense for Health Affairs, and Director of TRICARE Management Activity at the Department of Defense.

He is accompanied by the Honorable Elizabeth McGrath, Deputy Chief Management Officer at the Department of Defense.

And then we are going to hear from Valerie Melvin, Director of Information Management and Technology Resources at the Government Accountability Office.

Finally, we will hear from Jacob Gadd, Deputy Director for Healthcare at The American Legion.

All of your complete written statements will be made a part of the record this morning.

Mr. Baker, you are now recognized for five minutes.

STATEMENTS OF ROGER W. BAKER, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY AND CHIEF INFORMATION OFFICER, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ROBERT A. PETZEL, UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF AFFAIRS; JONATHAN A. WOODSON, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DIRECTOR, TRICARE MANAGEMENT ACTIVITY, U.S. DEPARTMENT OF DEFENSE, ACCOMPANIED BY ELIZABETH A. MCGRATH, DEPUTY CHIEF MANAGEMENT OFFICER, U.S. DEPARTMENT OF DEFENSE; VALERIE C. MELVIN, DIRECTOR, INFORMATION MANAGEMENT AND TECHNOLOGY RESOURCES ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; JACOB B. GADD, DEPUTY DIRECTOR FOR HEALTH CARE, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

STATEMENT OF ROGER W. BAKER

Mr. BAKER. Thank you, Chairman Miller, Ranking Member Michaud, and Members of the Committee.

I appreciate the opportunity to appear before you today to discuss the VA efforts to develop a single joint electronic health record system with the Department of Defense.

And as you mentioned, accompanying me today is under secretary for Health, Dr. Robert Petzel.

I would like to assure the Members of this Committee that press reports notwithstanding, the DoD and VA remain committed to achieving the goals of the IEHR program, that is common data, common applications, and a common user interface.

We have done a poor job in communicating the changes that we are making to the program. We are looking to achieve those goals through a lower risk and lower cost path than we were on.

As my written testimony details, over the past 18 months, the IEHR program has had difficulty in making the milestones it established.

In September of 2012, the Interagency Program Office produced an updated budget estimate that doubled the estimated cost to develop the IEHR.

As a result, we, and I would say we VA and DoD together, are pursuing a different strategy to achieve the same goals by starting from an existing base of technology, what we have called a core of an EHR to build our integrated EHR upon.

The purpose of this change is to reduce risk, reduce cost, and accelerate the availability of needed functionality.

I would stress that while the IEHR program has had challenges, it has also had some successes. VA and DoD have agreed on a single data standard, the open health data dictionary, and we are moving down the path to implement it over the next year.

VA medical systems, the VistA systems that Congressman Michaud mentioned, are being moved into DISA data centers, DoD data centers so that we are collocated with DoD medical systems.

We have acquired a single enterprise services bus that will connect all the various parts of the system together. We have deployed a common graphical user interface to three locations and are expanding it to all facilities involved with polytrauma support. And we have established joint clinical requirements for the first seven of the many shared applications we plan to integrate into the IEHR.

Over the last three years, VA in our systems development area has greatly improved the results of our investments, achieving over 80 percent of the milestones we set. We do this by watching our committed dates very closely, recognizing the signs of failure early, and changing direction or even stopping a program when that is indicated.

Using those principles, VA and DoD have acted to change our approach with the IEHR to deliver on our shared goals with less cost and less risk.

Mr. Chairman, the IEHR is a complex, large, and difficult program. While we wish that we could report only successes to you and the two secretaries, as a leadership team our job is to see the problems and find solutions.

We believe we have done that in this case and we look forward to your questions. Thank you.

[THE PREPARED STATEMENT OF ROGER W. BAKER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.
Mr. Woodson.

STATEMENT OF JONATHAN A. WOODSON

Mr. WOODSON. Good morning.

Chairman Miller, Ranking Member Michaud, and Members of the Committee, thank you for providing me this opportunity to discuss our progress in the future of the Department of Defense and Veterans Administration integrated electronic health record.

In April 2009, the President charged our two departments to create a seamless system of integration. The direction was clear. When a member of the armed forces separates from the military, their electronic records, medical, personnel, and benefits will transition and remain with them forever.

Over the last three years, our departments have been working closely to deliver two functional and fundamental—on two fundamental tasks in the health care arena, one to integrate health data for an individual into a single electronic health record and, two, simultaneously modernize the department's legacy health information systems.

We have made tangible progress on a number of critical elements necessary to achieve our vision on the integrated record. The most notable efforts include the following:

The beginning to create the joint health data dictionary, ensuring that we are using the same precise language to describe health data elements and fields in our combined health record system.

Moving VA data centers to the Defense Information System Agency or DISA, an important step for efficiency in operations and creating a single repository of data.

Selecting a single DoD/VA joint single sign-on and contacts management solution that accurately identifies clients in both systems.

And implemented a joint graphical user interface or GUI that displayed information from both the Department of Defense and VA systems at the same time.

Initially rolled out in North Chicago, San Antonio, and the Hawaii health systems, this is an important interim step to make it easier for our staffs to view patient information no matter which health system the patient uses.

These are important achievements that are necessary for the seamless sharing of information regardless of other decisions we make regarding the final configuration of the integrated health record. The work that has already been accomplished is money well spent.

Now, despite these successes, we also completed an initial life cycle cost estimate for the integrated electronic health record. The cost estimate was significant. And given the increasingly constrained Federal budget environment, our secretaries directed us to reevaluate the planned approach and consider alternatives that could accelerate timelines for interoperability, reduce costs, and reduce risk.

The two departments identified specific actions we could take and on February 5th, Secretaries Panetta and Shinseki approved our recommendations that included, one, expanding our existing Blue Button capability so that VA and DoD patients can securely download their medical record using industry standard formats by May 2013, two, ensuring clinicians can see consolidated patient data through a common viewer at nine key sites by July 2013,

three, completing the mapping of VA health data to the health data dictionary by September 2013, and, four, accelerating the realtime availability of VA data by December 2013.

While our vision of an integrated electronic system remains intact, we have, however, changed the pathway to get there. Instead of building a new system from scratch, the departments will use existing core capabilities that would get us functionality to users more quickly and still allow the flexibility to add additional modules or applications that we will jointly acquire to create the modern system.

The Department of Defense's approach is to take advantage of advances in the marketplace and select existing clinical capabilities from the public and private sectors to serve as our core to build the electronic health record.

The VA has decided to use their existing system, VistA, as their core.

Circumstances require decisive action. Delaying these decisions would have only increased cost and risk. We believe the path we have chosen best serves the departments, the special populations whom we jointly are responsible for, and the American taxpayer.

I appreciate the opportunity to come before you today to provide a more comprehensive review of the future of the integrated electronic record and I look forward to your questions.

Thank you.

[THE PREPARED STATEMENT OF JONATHAN A. WOODSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Woodson.
Ms. Melvin, you are recognized for five minutes.

STATEMENT OF VALERIE C. MELVIN

Ms. MELVIN. Good morning.

Chairman Miller, Ranking Member Michaud, and Members of the Committee, thank you for the opportunity to participate in today's hearing on VA's and DoD's efforts to share electronic health records.

As you know, the departments operate two of the Nation's largest health care systems which during this fiscal year are projected to provide coverage to about 9.6 million servicemembers and their beneficiaries and to 6.3 million veterans.

VA's and DoD's systems have many common business needs for providing health care coverage to these individuals and toward this end, the two departments have an extensive history of working to achieve shared health care resources.

Our work has examined the departments' efforts over the last 15 years to share data between their individual systems and to develop interoperable electronic health record capabilities.

We have noted varying degrees of progress, but also pervasive and persistent management challenges related to their efforts.

At your request, my testimony today summarizes our work that has examined the departments' activities in this regard.

Overall, VA and DoD have relied on a patchwork of initiatives involving their separate health information systems to achieve varying degrees of electronic health record interoperability.

For example, the departments' early efforts included developing capabilities to electronically transfer separating servicemembers' health information from DoD to VA and building an interface to enable the sharing of computable data between the departments' modernized health data repositories.

Further, in response to the 2008 National Defense Authorization Act, they established objectives for meeting specific data sharing needs and an interagency program office that was to be accountable for implementing an electronic health record system.

More recently, the departments have engaged in developing a virtual lifetime electronic health record as well as information technology capabilities for the first joint Federal health care center.

While collectively these initiatives have increased data sharing in various capacities, the departments have recognized that more is needed.

However, their efforts to achieve fully interoperable electronic health record capabilities have been limited by long-standing project management and planning weaknesses, inadequate accountability, and poor oversight which often has led to changes in the departments' priorities, focus, and timeframes for completing the initiatives.

As a factor contributing to these weaknesses, the departments' interagency program office which was to be the single point of accountability for electronic health data sharing has not been positioned to fulfill its key management responsibility.

Accordingly, we have made numerous recommendations to VA and DoD aimed at addressing such challenges as the persistent absence of clearly defined and measurable goals and metrics, as well as the associated plans and timeframes for gauging progress toward achieving full interoperability.

The 2011 initiative to develop a single integrated electronic health record system had the potential to mitigate some of the challenges that have served as impediments to exchanging data in the departments' separate systems.

However, the recent decision to reverse course and continue to operate and exchange health data among these separate systems raised concerns in light of the historical challenges we have noted.

Further, while the departments have said their new approach to developing an integrated electronic health record will deliver capabilities sooner and at lower cost, long-standing institutional deficiencies in key IT management areas of strategic planning, enterprise architecture, and investment management could prevent them from jointly addressing their common health care system needs in the most efficient and effective manner.

We have ongoing work, undertaken at the request of the Senate Committee on Veterans' Affairs, to examine VA's and DoD's decisions and activities related to this latest endeavor.

Mr. Chairman, this concludes my prepared statement. I would be pleased to respond to any questions that you or other Members of the Committee may have.

[THE PREPARED STATEMENT OF VALERIE C. MELVIN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Ms. Melvin.

Mr. Gadd, you are recognized for five minutes.

STATEMENT OF JACOB B. GADD

Mr. GADD. Good morning.

I want to begin with a short story. I was personally on an American Legion site visit to Anchorage, Alaska to examine transition of care. While there, I met a veteran who was frustrated and I asked him to talk about his frustrations with transition.

And he said it was simple. It was his records. When he went to VA, they told him that they could not access his records even though it was a joint venture site. And then he had to go back over to DoD to get his records. When he went back over to DoD, the base told him to come back in two weeks because the base had run out of paper.

The fact that our government cannot handle this basic task for a veteran in transition is inexcusable.

On behalf of our national commander, James Koutz, and the 2.4 million members of The American Legion, I would like to thank you, Chairman Miller, Ranking Member Michaud, and Members of the Committee, for the chance to talk to you this morning because while all these distinguished members of the panel can tell you the impact of the electronic record for VA or DoD, we are here to tell you the impact this failure is going to have on the veteran. And, unfortunately, it will not be good.

VA and DoD have come before you today to say they are still pursuing the same goal as before. They have told us that they will get the same results and are still moving towards an integrated record.

But as we have heard on February 5th, the secretaries of DoD and VA changed their plans. They said that they are going to keep their same platforms and instead connect each other's platforms through a graphical user interface.

The American Legion finds this announcement and direction forward both troubling and unacceptable. Veterans are not getting the single system they were promised. As long as VA and DoD remain in separate camps pursuing their own individual systems, it is the veterans that will be short changed.

The American Legion supported the creation of a virtual lifetime electronic record because we have seen firsthand the difference having all of the records in front of you makes when a veteran is seeking treatment or filing a claim for a disability.

Drawing on decades of experience from veterans and service officers of our organization, we saw the need for a truly seamless record between VA and DoD.

In a resolution passed at our convention in 2011, not only did we call for this to be implemented this year, 2013, we supported the concept strongly enough to note features that should be included to make the system function better for the people that it was actually meant to serve, the veterans.

We recommended VSOs and other key stakeholders be included in the planning process so we could share our experience and speak to the benefits and the drawbacks of a joint health care record system.

However, VSOs have been left out of the majority of the planning for this record and we were not consulted about the wisdom of abandoning a single unified record for veterans. We had to find out through a newspaper article like the rest of America.

We recommended that a unified system integrate all the branches of the VA in addition to the DoD records so that VHA, VBA, and NCA could all speak the same language and clearly to each other. Such a system should also fully integrate electronic scheduling and make appointments within the health care system easier for veterans, but this is not what we are getting.

We recommended that a unified system help a servicemember injured on active duty so their records could be flagged, so years later when they left the service, that information would be readily available.

We all know about the claims backlog. A single unified record was something that could have actually made a dent in the process and deliver benefits to deserving veterans faster. The majority of the delay in claims, as we all know, is the collection of medical evidence that a single unified record could solve.

For example, The American Legion has seen when we present fully developed claims the importance of having all of the information in place and easily accessible by VA.

It takes an average claim 257 days to get a decision. Fully developed claims, when all the information is in place, are averaging just 120 days, finally reaching the number under Secretary Shinseki's goal of 125 days to complete a claim. We have even seen claims coming out of the Pittsburgh office at a little over 30 days.

Getting all of the information into one place can be the key to finally breaking the back of the backlog, but we won't have it if we do not get what veterans were promised back in 2009, a single unified record, a true seamless record between VA and DoD.

The American Legion has had a great deal of experience dealing with VA's electronic health care records over the years.

Through people like former legislative director, Warren McDonald, The American Legion was involved in the creation of VistA, picking up the work pioneered by the Public Health Service and the National Bureau of Standards in the early 1980s.

Later, Sonny Montgomery and Charles Hagel who worked for the VA helped implement it nationwide. Thirty years later, we are faced with some of the same challenges.

Do we continue to invest in paper files, patches, and stop gap measures or do we invest our efforts in building a new and world-class health care system for the future?

VA and DoD have spent four years and close to a billion dollars to develop this and we are in the same place that we were four years ago.

The American Legion understands VA and DoD are both committed to improving the transition process, but until they fulfill the promise made to veterans of a single seamless, unified record, the veterans of this country will remain skeptical of their government's ability to deliver on all of the promises made to them.

I thank you for this opportunity to bring the voice of veterans to this Committee and I am happy to answer any questions that you may have.

[THE PREPARED STATEMENT OF JACOB B. GADD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much for everybody's testimony this morning.

And as we start out, I think it would be a good idea to get some definitions down so the Committee understands the language in which you spoke this morning. We have heard several individuals talk about a common user interface.

Mr. Woodson, I think you had said something about a bus that connects them all together.

And I guess if somebody would define what that means and then which is this closer to, interoperable or integrated.

Mr. Woodson.

Mr. WOODSON. Thank you, Mr. Chairman.

Let me see if I can address very specifically your question. The electronic health record has many components to it that includes a common data store, so the information in a place where it can be verified, and then a series of applications in which it is organized and then a screen, if you will, where providers can, in fact, look at the information, interact with the information to utilize it for care or do arrangement of information, so-called computable information to improve the quality of care.

Our intent is to have clearly a common single electronic record which includes the common data stores, a single authoritative base where VA information, DoD information on patients are in the same place.

The common data centers make sure that all of the interfaces for the applications, and there will be different applications depending on whether you are a pulmonologist or an endocrinologist or you need to work with business systems, billing, et cetera, but common interfaces, this enterprise service bus which allows us to organize and transfer information and plug applications in, we have agreed to acquire common applications going forward.

The difference is that in order to accelerate time to delivery, because there are so many components, we felt it was important to see if we could use existing cores which are sets of applications that need to be tightly integrated, otherwise you produce hazards in patient safety, and this is the subtle difference in what we are talking about, but it is going to be the same graphic user interface, same data centers, same infrastructure for the electronic health record.

And then finally, I would note is that understanding that the Department of Defense and the Department of VA do have different missions. It is important to note that as part of the business process, there needs to be some fine tuning because there are other applications and other technology that they need to touch as part of their business and so it is really one single electronic health record.

Mr. BAKER. If I could just add to that a little bit, Mr. Chairman.

I think the most important thing that VA and DoD have agreed to, and there have been a lot of agreements, is that health data dictionary that says that the data produced by VA and the data produced by DoD will be represented exactly the same way in exactly the same database so that it is accessible from any facility in the VA or DoD.

Adherence to that and focusing on achieving that will provide the largest benefit of all the things that we are working on if you were to break those pieces down. So the representation of the data, the structure of the data, adherence to that representation is probably the key piece of what we are doing.

The CHAIRMAN. Anybody want to add anything?

Ms. MCGRATH. I would just reiterate the importance of the data that Mr. Baker mentioned. Without standardized the data, then you cannot achieve the interoperability that we are all after. And so that is an extremely important point.

In this particular business case DoD has established standard data across the Defense Department. Given the mobility of our active duty servicemembers, we must have the standardized data in order for us to then transition seamlessly. When the member transitions from DoD care to VA care, the data really is the key. And so I would just put a very fine point on that.

The CHAIRMAN. And I understand that the data is the key, but we are talking about two core technologies still.

Why in the world can't we get to one core technology?

Ms. MCGRATH. So, again, I will be happy to start. The path the departments were on, and you have heard multiple times, indicated that the cost estimate was just not affordable. And so the decision was made to start from some thing, again to reduce risk—

The CHAIRMAN. Can I interrupt just for a second?

Ms. MCGRATH. Oh, yes, please.

The CHAIRMAN. I appreciate the department's concern about affordability, but what is going to serve the servicemember and the veteran the best, the cheap one or the one that may cost a little more?

Ms. MCGRATH. Well, I appreciate the question, and can say that our approach is to provide service to our veterans while remaining mindful of cost.

The CHAIRMAN. That is what you just said.

Ms. MCGRATH. Well, yes, cost absolutely is a factor. Risk is also a factor. The integration that is required from building every module from scratch also increases risk to a program because more connections must be made. And so, the more things you need to connect, the higher the risk, higher the cost, higher the integration.

We asked is there an opportunity to reduce risk that would still yield the business outcome that we want to achieve, maintain schedule, and produce the integrated record at a lower cost. The determination was that if you started from some thing, some set of core capabilities focused on patient safety, as Dr. Woodson mentioned, then you had the ability to deliver the integrated record from a core set of capabilities. And so you build out from some thing as opposed to building the entire system brick by brick.

The CHAIRMAN. And I appreciate the effort, but it sounds to me like we are doing a u-turn and going back to the exact same thing again, just maybe going on a different road to get there.

And my time is expired, but, Mr. Baker, I just want to know one thing. You had met with some of the Committee staff about a week before the announcement hit the paper that you were not going to be doing the process in the way everybody thought you were going to be moving. You did not say anything to the staff at that point.

And four, five, six days later, it hits the press that you are going to go in a different direction.

Is there a reason or did somebody make that decision after you talked to staff?

Mr. BAKER. Congressman, as you know, I talk to your staff quite a bit. I have tried to be very communicative.

The CHAIRMAN. But this—

Mr. BAKER. Understand.

The CHAIRMAN. —was one specific meeting about this issue.

Mr. BAKER. At that meeting, I felt that we had not yet briefed the secretaries on the recommendation that we were making. It was pre-decisional information. It would be inappropriate for me to get ahead of the secretaries and their ability to make the decision that we were going to recommend to them.

And so at that meeting, I did not feel it would be appropriate for me to have that discussion before it had been had with the secretaries.

The CHAIRMAN. So I am to believe that in a week's time, two secretaries of the largest agencies in the Federal Government were able to come to a consensus of an entire change of direction? I find that really hard to believe.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Concerning the cost estimates, in 2011, the initial estimates of the cost to develop the integrated electronic health records was projected to be between four and six billion dollars. However, in September of 2012, the interagency program office produced a new estimate of the cost that doubled the cost of the development of the system.

My first question is, what incident or surrounding circumstances prompted a re-look at the initial projection of four to six billion dollars?

My second question would be is the driving factors of the cost increase and, thirdly, why couldn't VA and DoD settle on one system to use?

I will start with Mr. Baker and I will ask DoD to also respond.

Mr. BAKER. Thank you, Congressman.

I believe the re-look at the cost was driven by the DoD processes, the milestone A and milestone B, kind of a typical thing that a program would do operating under those processes. But I would let Ms. McGrath or Mr. Woodson address that a bit more.

The second question was what drove that. And I think the frank answer is experience. We have had 18 months to see what it was going to take to look at the requirements for some of the packages that needed to be acquired and the path forward on those.

And when the IPO looked at what they had seen and used that then to build a new estimate, that the estimate was significantly larger.

And the third piece relative to why not one core, I think the VA is quite happy with and convinced that the VistA system is the place to start. It is a good system and we own it. The DoD is not yet there from their perspective. They are going down a path and will consider VistA along with other alternatives for their selection of the core.

I think that is probably where we are at this point. I will just leave it there.

Mr. MICHAUD. Mr. Woodson, would you like to respond?

Ms. MCGRATH. The timing of the life cycle cost estimate was exactly as Mr. Baker indicated as part of the acquisition process within the Department of Defense. We do a full-blown engineering life cycle cost estimate before, what we refer to as a milestone—early in the program, early enough in the program that we can, assess cost and use it to ensure that we are on the right path.

Some of the drivers for that cost estimate were those things that I mentioned about the high level of integration, cost, and procurement required to achieve the path that we were on.

I would also just reiterate the Department of Defense is looking at VistA along with other commercial capabilities to serve as its core. And, again, when we say the core, it is a jointly defined core between the two organizations focused on delivering the standard data and creating the integrated electronic health record.

Mr. MICHAUD. Dr. Petzel, do you and the physicians in VHA believe VistA is a modern system that is effective?

Dr. PETZEL. Well, Congressman Michaud, we have had now 25 years of experience with VistA and our clinicians would say that it is the best clinical management platform that they have ever used.

You have to remember that 70 percent of our docs come from the VA system, but they rotate through hospitals all over the country and have experience with a wide variety of medical information systems.

And I am quite confident that if you were to interview them, they would say this is the best, again, clinical management platform that exists in this country right now.

Mr. MICHAUD. What's so amazing is that it is, and I have heard the same thing from not only VA employees but also the private sector, that it is the best system. So I cannot fathom why Department of Defense will not move to that particular system.

Ms. MCGRATH. We certainly are considering VistA along with commercial capabilities as we evaluate the opportunities to serve as our core.

Mr. WOODSON. So your question is excellent and certainly I have no doubt as to what Dr. Petzel's assessment is of VistA. In fact, I have used it in previous years.

There are a couple of issues for the Department of Defense is that no matter how you slice this program for the Department of Defense, this is a new acquisition. And the issue we need to understand is that as good as VistA is, it is not one system. It is a number of different systems, so we would have to choose one of those hundred plus systems to try and transfer over.

For us, because it is an acquisition program, if you buy, let's say, a commercial off-the-shelf product from a vendor, you get with that implementation support. You get people who come in and configure it. There is no infrastructure really right now for us to bring VistA into 56 hospitals and 700 clinics and be able to configure it.

The good news about VistA is that, again, it was ahead of its time and it is a good electronic health record. But the way it was developed, it does not have all of the manuals that would allow us

to bring it over easily, understand master files, and so there is some risk for the Department of Defense in trying to acquire it.

Now, having said that, the Department of Veterans Affairs is helping us analyze how we might do that and that is part of our evaluation going on right now. We have asked very specific questions relative to how, in fact, VistA can be modernized and segmented to bring over what we need as even we acquire in the future applications together.

But the issue is that it clearly is of a lower risk for the Department of Veterans Affairs because it is already functioning in their systems and reflects their business processes and their clinical processes. For the Department of Defense, it represents a new acquisition.

And then the final thing I will say is that I think it is important for this program in some sense to skate to where the puck will be. And what I mean by that is the current VistA system is a generation one plus two in terms of how we look at electronic health records.

Industry is already at a generation three and moving to a generation four. And just to give you an example of what I am talking about, as medicine has advanced and become more complicated, imbedded in the medical record is a lot more decision support.

We would need to assess what it would require for us to bring VistA over, modernize it, and what the total cost of ownership would be over time because we would have to develop an infrastructure to maintain it, to modernize it, innovate on it so that we stay at a pace with the commercial market.

So there are several factors that we need to consider in our decision.

The CHAIRMAN. Mr. Runyan.

Mr. RUNYAN. Dr. Petzel, did you have something to add to that?

Dr. PETZEL. Well, I think we just wanted to clarify the fact that there is a core VistA that is one in the same and that is the VistA that we would use and what DoD would be using. There aren't a hundred plus different kinds of the core of VistA. So that is a moot point for us.

Mr. RUNYAN. Thank you.

Mr. Baker, just kind of going back to what the Chairman was asking, if you kind of knew you were going to make the decision and you were meeting with Committee staff on this exact issue, why wouldn't you have had the brief with the secretaries to inform us so we do not have to see it come up in the paper?

Mr. BAKER. Congressman, let me first apologize for the fact that you read it in the paper. That certainly was not by my design. But I work for the secretary of Veterans Affairs and I felt that the information we were working on at that point was pre-decisional.

The two secretaries get together on a scheduled basis. We knew that meeting was coming. They had not yet been presented the recommendation or made a decision on that front.

To my view, it would have been presumptuous of me to get out in front of my boss on that topic in any briefing with any organization. And so while I apologize in the way that you learned about it, that was not certainly the way that I would have defined it.

In my view, I needed to make certain that I handled this appropriately with the secretary, with the two secretaries.

Mr. RUNYAN. Now, doing obviously one of the biggest things no matter what system at the end of the day we decide to go with, you have talked about the joint dictionary obviously being the first step.

And I know Dr. Roe probably has had some experience in medical coding, if you will, which I believe is at the gist of this.

Where are you in that process in making sure everybody is speaking the same language?

Mr. BAKER. Congressman, that is the purpose of the five quick whims that we recommended to the secretaries and that they agreed on and that is to bring the large-scale data that we hold into conformance with that health data dictionary by the end of 2013 so that the DoD database known as the CDR and the VA database known as the CDW represent data in the same—exactly the same dictionary, exactly the same fashion so that when we exchange information about medicines or lab results that we are not translating. We are specifying. It looks exactly the same. And that is what those quick whims that we announced in February relative to interoperability are.

The secretaries believed, and this specifically came from a request from Secretary Panetta, is can you give us some quick whims in the interoperability area. And the answer is yes. If we focus on making those databases conform to the HTD, we can get to that part of the system faster.

Mr. RUNYAN. And you are not creating your own vocabulary within the VA, DoD. It would be standardized to—

Mr. BAKER. Yes. It exists—

Mr. RUNYAN. —the private sector, everything else?

Mr. BAKER. It exists today. One of the things that we agreed to was that in adopting that standard, it had to be open so that anyone could use that standard. And so the vendor of the standard put it into the public domain before we made the announcement that we had agreed to that standard.

That standard is also based on the published national standards. And I will use the acronyms and then somebody in the medical side is going to have to fix them. It is LOINC, RxNorm, and SNOMED are three medical standards for data representation that are managed by the National Bureau of Standards, I believe, the National Bureau of Medical Standards.

Dr. PETZEL. And excuse me, Congressman, but just to add a little bit further, the office of the national coordinator is anticipating that our efforts to standardize this data are going to be a beacon for the rest of the country in terms of what they need to do and the standards that they need to adopt so that everybody's records will eventually be saying the same thing.

Mr. RUNYAN. Which would make this whole transition a lot easier.

Dr. PETZEL. It certainly would.

Mr. RUNYAN. I think everybody would argue that.

So I yield back, Chairman.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman, and thank all of you for coming here.

I think this last part that was being brought up is actually critical. While I am disappointed in how some of this rolled out, I also think putting it in the context of where the private sector is at on this.

And we had an opportunity, the Chairman, the Ranking Member, myself, to witness the Kaiser Permanente, the VA program out there that they are doing. It was an electronic medical record that was talking to other electronic medical records and to pharmacies and being able to recognize handwritten notes and all of the things that are really important.

What is that and is that the vision you are trying to get to?

And the private sector input into this is going to be critical because as you said, Dr. Petzel, they want this as badly as we do here and they do not have it at this point.

So is that Kaiser run what we are looking at?

Mr. BAKER. Thank you, Congressman.

The specific item you are talking about was the original pilot of the Nationwide Health Information Network.

Mr. WALZ. Right.

Mr. BAKER. And that is defined by HHS, the office of the national coordinator, a set of protocols for exchanging information between different medical record systems.

If you think about what that system does for us, it allows us, and we are now in production with that, to exchange information with private sector hospitals in Indianapolis, as you pointed out, San Diego, and a variety of health information exchanges around the country.

That is something that both DoD and VA have implemented for that exchange and we are promulgating it. That deals with all of the work that we do where people that we see are also seen in the private sector. So that is the strategy we have.

Mr. WALZ. What percentage of people is that? It is significant. Am I right?

Mr. BAKER. We let the doctors address that.

Dr. PETZEL. Well, Congressman Walz, from our perspective in VA, as many as 40 percent of our patients have some interaction with the private sector.

Mr. WALZ. So if you want a truly interoperable system, both streamlining data and protecting the patient, that is going to be a critical component too. To get the two of you talking smoothly on the same platform without the ability to reach outside the system is not the way we want to go. Is that fair to say?

Mr. WOODSON. Well, I think we have several objectives, but your objectives which you are talking to is very important in one of our objectives. It is to be able to exchange data with the private sector as well as, of course, with our Federal partner in a seamless manner.

And the key thing is just to understand that one part of the program is focused on this issue of exchanging data, standardizing data, and being able to exchange it wherever it needs to go to include blue button and all sorts of things so that the patient has control of their information as well.

And then the second part that I think has caused some of the concern is really the information system we have within our Federal agencies to just record information and provide decision and support.

What you are talking about is extraordinarily important and one of the major aims of our program.

Dr. PETZEL. And, Congressman Walz, just to highlight the differences, the National Health Information Network, the NHIN, is a black box into which Kaiser puts its data, we put our data, DoD puts their data, and then any of us can extract the other's information given the proper identities. That is what that is about.

What we are about in between DoD and VA is creating a fully integrated medical record so we do not have to do that. We do not have to put it into a black box, et cetera. It is just one seamless continuous record whether they are being seen in VA or DoD. Different concept.

Mr. WALZ. It seemed like the black box worked. That might be the difference. It seemed to me that the black box worked.

Mr. BAKER. Congressman, at the level that is happening with the Nationwide Health Information Network, VA and DoD have been exchanging at that level for years. You know, that is a set of information that the clinicians have determined as most critical when they first see a patient, allergies, prescriptions, you know, those sort of things.

The whole medical record is a much more comprehensive piece of data that is not exchanged by the Nationwide Health Information Network.

Mr. WALZ. Okay. Thank you all.

I yield back.

The CHAIRMAN. Before I recognize Dr. Roe, I would like to ask one question because we keep going back to cost and it seems that DoD is focusing a lot of their decisional record on cost.

And I just would like to know has sequestration or the Defense budget had anything to do with the decision to change the direction in which we were traveling?

Ms. MCGRATH. I think cost is always a factor in every program. Cost, schedule performance, they are standard facets of every acquisition program.

The CHAIRMAN. Did sequestration or Defense budget cuts have anything to do with the decision that has been made?

Ms. MCGRATH. We do not fully understand the impact, the full impact that sequestration—

The CHAIRMAN. It is coming Friday.

Ms. MCGRATH. Right. Yes, I understand.

The CHAIRMAN. You do not know yet the full impact?

Ms. MCGRATH. Some of it will depend on if there are additional flexibilities provided to the agencies with regard to how the cuts are taken. That will help inform—

The CHAIRMAN. That is hoping against hope.

Ms. MCGRATH. Yes.

The CHAIRMAN. We have been at this for 16 months. When I say sequestration has been the law of the land since November of 2011—

Ms. MCGRATH. So for—

The CHAIRMAN. —no agency sitting at the table today took it seriously. Now everybody—excuse me?

Ms. MCGRATH. I am sorry?

The CHAIRMAN. You kind of acted as though you had taken it seriously. Did you take sequestration seriously in January of 2011 or 2012?

Ms. MCGRATH. The department certainly has executed the proper plans within the organization to prepare for sequestration. Specific to this program, I can tell you, though, budget cuts as a result of the agreement to move this sequestration timeline from January to March resulted in a decrement to the DoD budget on this particular program in excess of \$50 million.

We are assessing every program, to include this one, to determine the full impact that the sequestration will have. Sequestration will have an impact on this program.

The CHAIRMAN. Mr. Woodson, did the \$400 billion worth of cuts that were taken by DoD over a ten year period and the opportunity of sequestration impact DoD have anything to do with the decision to change the direction that both agencies said they were heading in and then abruptly changed?

Mr. WOODSON. So, I think what it did do is it focused more acutely the need to make a more proper and accurate assessment of the costs of the program. And so, you have to look at the timelines of how things were, in fact, sort of evolving.

Yes, I mean, if you're looking down the barrel of significant budget cuts you look at all your programs and say, how can we make them more efficient? And how can you achieve the same end at reduced cost and reduced risk?

But, to be fair the issue is, the department has done planning but these are uncharted waters. We have the combination of issue of sequestration and CR, which has produced enormous budgetary pressure. So, if you are asking me, could we accurately predict how things would unfold and how we take into account every possible situation that might occur? I don't think we have because I don't know that we know what the universe of possibilities are.

The CHAIRMAN. And I appreciate the concern for sequestration and what I was driving at is, every time on the Armed Services Committee we would ask service secretaries SECDEF, you know, what were you doing to prepare? I would ask commanders in the field, have you been given any direction? The answer was, no.

And that is what is concerning those of us who are sitting here today. All of the sudden everybody is running around with their hair on fire over the last 90 days when this is not something new.

I mean, and we should have been focusing on how much this was costing back in the very beginning not just at the end either. But, it bothers me that nobody at the table is willing to fight for the best outcome. You are now fighting for the most cost-effective outcome. Mr. Woodson?

Mr. WOODSON. Yeah, I appreciate your question and your sentiment. I think we have always fought for the best outcome and to be good stewards of the taxpayer dollar, we always have to do these reassessment of costs, which is the value of what we spend the dollars on. And that is a function of good program management.

I don't think we are just going for the cheapest variety. We want full functionality. And as I said before, we want a system that will serve us into the future. We want to skate to where the puck will be, not to where it is or has been.

And the issue that I think everyone needs to appreciate is that over—we have talked about issues about what we have done over ten years. The change in technology over ten years is just dramatic. I mean, everyone in this audience probably has a cell phone. The kind of cell phone you had in the year 2000 or 1998 is radically different from the one you have today and so, we have to take into account appreciation, the change in technology and making sure we are positioned to move ahead with the pack in the future.

The CHAIRMAN. And I can appreciate that. And let me use this analogy. An X-box and a Playstation can play the same game on the same TV screen, but they don't talk together. And that is the concern that I have about the direction that we are heading. Dr. Roe?

Dr. ROE. Thank you, Chairman. And for full disclosure, an electronic medical record made me a Congressman. We instituted that in our medical practice, one of the most difficult things I did. So, I appreciate your pain of trying to make this work.

But, having said that, I know Ms. Melvin said that she and you all were committed to a vertical electronic health record. Well, I was always committed to dunking a basketball, but I could never do it. Commitment didn't mean I would actually get there.

And I think that is what concerns me now, is here we are starting in 1999—I have been on the Veterans Affairs Committee four years, this is my fifth year on here. We started having this discussion and Mr. Walz was there and the Chairman was here, the Ranking Member was here.

I asked this question about three or four years ago, I said, in ten years are we going to be still sitting here talking about something we talked about for the last ten years and spent billions of dollars and didn't do? And remember, when you are looking at this right here, you are looking at a doctor that has to sit—data is information about a patient that needs to be accessible so that that patient gets the best care.

And I think the point that was made by Mr. Gadd, this is about people, this is about patients, this is about veterans and taking care of these folks. And I think the first question I was—change is tough and I realize, I have been through the DoD, I have been to Great Lakes twice to look at that, obviously, with Mr. Baker accompanying me there and it is not easy.

Dr. Wenstrup had to leave. He had to go just a minute ago, but he has served in the military in Iraq and he stated that, yeah, you have a single sign-in, but two different entry templates, two pathways, it is difficult, it slows them down.

I have said this all along. If it takes you—when you enter your record, if it takes a doctor three minutes for the thing to ramp up and get in and you are seeing 25 people that day, you have just delayed your day two, three hours just because of technology.

First thing I would ask, if these systems can't talk to each other—and look, there are smart people sitting down there. A lot smarter than I am about electronics. I am fairly ignorant about it.

But if the VistA system was just 25 years old, is the best technology we have, this is what I am hearing, then that shouldn't be real expensive. And the first thing I would have asked is, if that is the system that quotes the best, I would argue maybe it is, maybe it isn't, but if it is, how much would it cost to put it in?

Just say, okay DoD, we are going to scrap ours. We are going to go to one system so that when he goes into the military or I go back in and I sign up, I have my virtual records, so that you don't have to worry about all that integration and all that, with one system.

And I think Mr. Michaud asked that question; how much does it cost to do it? I know it wouldn't be easy to do, but what is the cost? That is the first thing I would have asked. Because we are going to be sitting here ten years from now saying it doesn't work.

Ms. MCGRATH. Part of the analysis we are conducting with regard to the opportunity to use VistA or a commercial capability includes both cost and schedule, so right now, I don't have a cost estimate for you to say how much would it cost to implement this for the Department of Defense.

Dr. ROE. My times getting short, but I think that would be the first thing I want to know is, look, we have got to pick one or the other and we have said this on the Committee now for four years.

It looks like this integration when it happens and talking to Brad, I mean, to Congressman Wenstrup, I mean, Dr. Wenstrup, is that it is difficult and I have seen it when we were up at Great Lakes a year and a half or so ago.

I mean, just pulling up a CBC and a urinalysis report is not an integrated health care system. That is pretty simple stuff. And what you need is you need one; when that soldier goes in—when I went in 40 years ago this month, I had the same electronic record that Thomas Jefferson had, a piece of paper. And it looks like that we are having—we are almost back to that now where these two systems are not going to be able to talk—at least they can say simple sentences together, but not get all that information they need.

And it looks to me like—and Mr. Chairman, I believe we are going to be sitting here ten years from now saying the same thing. I honestly believe that.

Can anybody sit here and tell me if I am fortunate enough to get re-elected for a few more terms that I am not going to have this same conversation when I have no hair on my head.

Dr. WOODSON. I don't think we will.

Dr. ROE. Well, reassure me why, Dr. Woodson. Why won't we? Because we have been since 1999.

Dr. WOODSON. Right. And I think since—the point I was trying to make before about the advancement in technology is that we have reordered our thinking about what an electronic health record is. In fact, standards for electronic health records are being published as we speak and what the expectations of what it means to have an electronic health record has changed dramatically.

And remember most of the private sector is just getting into electronic health records. So, the good news for the Federal government is that we were in it early. The problem is we developed our own home grown systems and now we are at the place where we

need to make them talk to each other effectively and serve the men and women of the military and the veterans appropriately.

Dr. ROE. Dr. Woodson, not to interrupt you, but my time is up, so I have got a series of questions I want to submit to you all. But, I have found nothing in here today that reassures me that I am not going to be having this conversation five years from now.

Mr. CHAIRMAN. Congressman, I have to make the observation that in 1988, we had the best opportunity to do this when the DoD adopted VistA through their contractor at that point. We diverged at that point even though we started on the same technology. I emphasize—

Dr. ROE. Well, I think it is time to converge again, it sounds to me like and get on—we diverged 24 years ago, it is time to find out what does it cost? Can it be done? I mean, that ought to be fairly simple.

I mean, how much would it cost? It is an older system, it has been upgraded, I am sure, like any automobile or any other technology has and with speeds and all that. And then go to one system, because I don't see this ever working if we don't. I yield back.

Mr. CHAIRMAN. Mr. Baker, please.

Mr. BAKER. We are very clear from a VA perspective, we like the system, our clinicians like the system. It is maintainable, it is modern. As you point, if it is not the best, it is one of the best electronic health record systems out there. And it has one advantage over every other system, we already own it. We don't have to pay for it again. I think that is where the VA is in its selection of VistA.

Ms. MELVIN. Chairman Miller, if I may, I would like to offer a perspective.

The CHAIRMAN. Yes, ma'am.

Ms. MELVIN. One of the things that has been discussed today, obviously, is in terms of cost and how much will it cost to get to this. I think there are some very fundamental deficiencies or weaknesses within the approaches that have been taken over the years.

We have had a number—as I mentioned in my statement, over 15 years that this has been going on. And one of the things of concern to us is in terms of VA and DoD having a joint approach to doing this, our work has pointed, in particular, to what we see as some critical barriers to the department's—both departments' ability to really get the types of answers that you are asking for today.

The types of discussion, the information that they are relaying today is very critical. It is all very important information that does have to be discussed and considered as they consider how to go about getting to a unified electronic health record system.

The problem though is that in the work that we have conducted over the years, there has not been joint strategic planning. There has not been an architecture defined. There have not been investment management processes in place to guide the efforts that these departments are undertaking, and as a result of that you get the situation that we are in today where there are many considerations that the departments are taking, but there aren't really any answers relative to what the particular defined end state is that these departments are trying to achieve in the way of having an integrated electronic record versus an integrated electronic health

record system. And I think you have been talking about a unified system and that is what, ultimately, the goal has been to achieve.

There are many considerations that have to go into that, from planning, from the standpoint of cost, risk, all of things that they have spoken of that are very important. But there is no defined roadmap at this point for getting there. And unless the departments take a step to look at what they need to get to, what they have in place right now and how they will transition from that in a very specific and a very defined way, I am afraid we might see ourselves in this same position in the future.

The CHAIRMAN. Thank you very much for the additional information. What we as Members hear quite frequently is that nobody wants to blink between VA and DoD. And I sit on both Committees, so—I mean, I'm on HASC as well. But I hear more often than not that the agency that guards its turf the most is DoD and they don't want to give up any ground. Somebody has got to give in this process as we go through and we want to help.

I mean, it is not—I am not saying that to be accusatory, that is just what I hear. I mean, I go to combat hospitals and the doctors in those hospitals in theory tell me that they like VA's platform better.

And I just—we are fighting this fight, since 2004 we have had this discussion, we are going back to the same place. The other thing if you can think, you may have to get some information, but I understand that DoD did an RFI prior to the decision to change direction.

Okay. So, is there an RFI out? And what was the date of that request?

Ms. McGRATH. Yes, the RFI was issued on February 8th, I believe that was a Friday, and the responses are due back today.

The CHAIRMAN. Okay. Mr. O'Rourke?

Mr. O'ROURKE. Thank you. Ms. Melvin, you talked about longstanding institutional deficiencies and I think in your last statement you helped to define what those are. Do you have any specific recommendations to correct those longstanding deficiencies? You talked about lack of strategic planning and doing that planning in a joint manner. Anything more specific that we can hang a hat on, that someone could report back to, that we could chart progress against a specific goal related to those deficiencies?

Ms. MELVIN. There are specific criteria that are attached to the recommendations that we have made. We have three outstanding recommendations in those areas for VA and DoD at this point that still need to be addressed.

We can certainly work to—or provide information relative to some of the specific things that they would need to look at. But, certainly, in terms of having defined plans, having integrated schedules, having performance goals and measures, those are particular things that the departments need to work to define for themselves in terms of—related to what they are trying to achieve.

It is very difficult to tell them what that should be. They would need to look at, for example, the two systems that they are considering, all of those are options that have to be on the table. They have to look at the alternatives. They have to consider what other

variables, what are the critical milestones, the risks, everything that is involved with that.

So there are specific things that would go with having a strategic plan. There are certainly specific aspects to having a detailed architecture that would help define, you know, what their as-is state is, and what their future state is. And I think that is the critical piece, what the future state is that they are trying to get to.

We have not seen information to really ever clearly define what that target state is supposed to be from the standpoint of what they are trying to achieve. So, all of those things, collectively, would have to come into play.

Mr. O'ROURKE. You also mentioned in your opening testimony poor oversight—

Ms. MELVIN. Yes.

Mr. O'ROURKE. —as one of the factors that has led to the frustrating position that we are in today. Could you go into a little bit more detail about that? Who is accountable for that poor oversight? How do we correct that problem?

Ms. MELVIN. Well, over the 15 or so years that we have looked at the systems we have seen poor oversight in different ways. We have seen it from the standpoint of there not being a defined or identified leader to take the helm of these particular initiatives.

I think, at this point, we are looking at the integrated program office, the IPO, as the primary oversight body that is in place, to do that. When that office was put in place the intent was that it would be the point of accountability for them achieving the electronic health record. However, how accountability is defined and what mechanisms and measures they have had in place to really be accountable has been a concern to us.

We have work ongoing right now that's looking at the effectiveness of that office. But we have had concerns in the past relative to the pace at which it was able to be staffed. Who was actually making decisions there and, quite frankly, the money has always been divided between VA and DoD up to now. And so, that has always been an issue also that is on the table in terms of how effectively this office could function in terms of overseeing and really being accountable for this effort.

Mr. O'ROURKE. And Mr. Gadd, I want to thank you for your testimony. You helped to put a human face on an issue that for many people can be reduced to processes or numbers or abstractions and having just had our Veterans Town Hall Meeting in El Paso this last weekend, 200 veterans showed up and many of these terms and phrases and, frankly, excuses that we are hearing are not going to be very helpful and will not give them the hope that they need. And more importantly will not meet the obligations that we owe to these veterans.

One thing that you said that I know everyone can hang their hat on is—and it caught my attention is, you cited Pittsburgh and a 30 day turnaround. Can you talk a little bit about that? And then for the other Members of this panel, how do we get that turnaround in El Paso and in other VA systems throughout the country?

Mr. GADD. Thank you very much. And first off I would say we want one system. It is not a pie in the sky, it has been—Congress

has invested, our country has, our veterans want one system. We envision a system where any service officer that is filing a claim can put a name and a last four in and pull the record up. I mean, we are not IT guys either, but we just want to move that claim through. And part of the fully developed claims process is having all that collection of medical evidence ready to go.

In fact, I talked to a veteran this morning and he said it has taken him six months at the D.C. VA Medical Center to get his paper copies of his records.

I mean, they are the real loser in this. We can't wait ten years for the plans to change again or not have a record that truly gets them the transition and gets them into health care, moves their claims through.

So, we would add with that fully developed claims process we see what it looks like when we have those things in place.

Mr. O'ROURKE. Is that Pittsburgh?

Mr. GADD. That's Pittsburgh, correct.

Mr. O'ROURKE. Okay. Thank you. Thank you.

The CHAIRMAN. Mr. Denham?

Mr. DENHAM. Thank you, Mr. Chairman. I did not come here with a list of prepared questions today. I came here to listen and understand why decades of inaction haven't been fixed yet.

You know, I have got an interesting chart here from CRS. It starts in 1982—when I was a freshman in high school, 1982 starting with a computer system and then '88 developing the system. I can tell you in '89 when I left active duty and was handed my little yellow shot records and they said, don't ever lose these, whether you are on reserve status or whether you completely depart the military, don't ever lose these shot records.

I can tell you how disappointed I was when I had a conversation with Mr. Walz about a year and a half ago and Mr. Roe as we took a trip over to Afghanistan and I had to go search through my warehouse to find those little yellow shot records because several decades later we still don't have a system.

Now during that time not only did I spend over 16 years between active duty and reserves, but I started a company where I can track every one of my thousands of plastic containers across the United States and some in other countries.

I started a farm where I have got to know where my almonds are, you know, not only what lot or where they are sitting or where we are warehousing them, but what can they actually go in.

Now, as a private individual, if I can figure out how to take today's technology and run a business, the question is why can't we do it in a Department of Defense? And so, we have asked this question now a couple of times. I have only been in Congress just over two years, but we have already had a couple of different hearings on this. We had both secretaries agree.

So, my frustration is that not only have we let several decades go by, but you have been given directive by the President, by your agency secretaries to get this done. My belief is that you don't have the will to get it done. That we have such a big bureaucracy that everybody wants to control their own system rather than come together on one system.

And these aren't the first times we have heard these excuses. Well, cost—sure, cost is always a factor. Sequestration, we really didn't understand that was coming. We haven't had a budget in four years, so we are not really sure what the budgets are going to be.

Dammit, it is time to get over the excuses and get this fixed. We have brave men and women that are coming home at huge numbers right now. We don't want to see these backlogs of benefits continue to escalate.

We have a very succinct opportunity to fix it today. We have the systems and know-how to get it done today. What we need is you guys to work together and if it takes the VA taking the lead because they are not as severely affected by sequestration, then get it done. But we need to have the VA working within the Department of Defense before these individuals leave active duty today and making sure that we have got one set of records. So they are not carrying around for several decades that little yellow shot record.

This is inexcusable. I don't want to be sitting here next year with the same exact problem where we have got our benefits or our veterans still sitting with a larger backlog of benefits not being able to get through the system because it is taking 40 to 50 days just to research their paper records that they may have just received months prior. It is inexcusable.

So, I didn't have any questions today. I wanted to come in here and hear how the changes are happening, how the departments are working together, how we have one system that is ready to go because those that have volunteered at a time of war to serve our country, to put their lives on the line, deserve nothing less.

They come home tomorrow, they ought to be in the system tomorrow, knowing what benefits they are able to receive, knowing what level of disability they are before they leave active duty and we ought to have one system that—whether they come back 20 years from now, it doesn't take a 50 day or a five day system to decide what eligibility they have.

This is inexcusable and you need to get it right or we are going to force you to get it right. I believe that this is something that we can handle within the Federal government, that we have a duty and an obligation to get it handled within the Federal government.

But I have got to tell you, the more time that goes by, the more conversations that this group has, I continue to lean more towards the private sector because I can get it done in the private sector. Because I have to have it done in the private sector. Because I have the will to keep my business alive.

I don't always feel that same duty and obligation on behalf of those brave men and women that are willing to risk it all. This should not be a simple—it should not be a difficult task. This should be a very simple one with the technology and know-how that is out there.

And I don't believe that with the several decades that have gone by, the many budgets, the many allocations, the support of both secretaries and a President that has given a directive, that cost should be a factor in this as well.

So, I am looking for some answers and I will come up with some questions, because what we have heard today, once again, is inexcusable. I yield back.

The CHAIRMAN. Mrs. Negrete McLeod?

Mrs. MCLEOD. Thank you, Mr. Chair. I guess I would just have to ask the common sense question, what do we do now? And where do we go now? And what is going to be done? Because I belong to Kaiser in Southern California, I can go to any Kaiser in Southern California and my records are there.

The CHAIRMAN. Any comments? Ms. McGrath?

Ms. MCGRATH. I think what has been laid out this morning is our commitment, certainly, to achieving the business outcomes we set out for an integrated electronic health record and making sure that patients—our servicemembers, active duty, reserve, veterans—have access to their information and those that serve them from our clinical community also have access to the information they need at the point of care.

Mr. Baker laid out some of our focus areas that will be achieved within this calendar year, namely getting the data right. The interoperable mapping of our core data is being done so that by the end of the year we can communicate in a very seamless way.

Now, we have also identified the approach to the systems modernization and we would certainly be happy to keep this Committee informed on our progress as we move toward that decision, again, with the outcome of achieving jointly an integrated electronic health record.

I think the departments really have worked very closely together, certainly since I have been a part of this for the last two years. Everything we do is joint, from the business process conversations with our clinical communities, we have joint clinical integrated product teams. We have a joint architecture review board. We have a joint portfolio management approach. We have a joint oversight of the program, involving Mr. Baker, myself, Dr. Woodson and Dr. Petzel and the Deputy Secretary, Under Secretary of Defense for Personnel and Readiness. Everything is done together and I would say the overall commitment of our organizations to get this done is strong.

Mr. MICHAUD. Congressman Michaud. I would just add that as with Kaiser, you can go to any VA hospital around the country and your inpatient/outpatient complete and total medical record is available.

Ms. MELVIN. If I may, I would just reiterate the comments that I made earlier about the need—I agree that there are a lot of joint things that are happening. One thing though that I think it is important to have joint is the strategic planning in place, which involves really taking a close look at having a defined strategy going forward.

I think it is important also that they take lessons learned from places like Kaiser or other entities that have done this to really build that into what they are doing and I know they are working with Kaiser as part of some of their initiatives. But, I think that is important to continue to do, to look at that more deliberately relative to an overall strategic plan and an approach for actually getting to the future state.

Mr. GADD. And too, I would like to add that what we would like to see is for them to go back to doing the single unified record and moving that process forward, looking at Vista, looking at the ZOD platform and ways that they can modernize it to meet the needs of our veterans coming back in the 21st century.

We need a system that is efficient, that is fast, that our veteran service officers can access to help these veterans coming back during their time of transition, to getting into health care and getting into claims. And it is unclear with this new direction that they are taken through this graphical user interface how that actually is going to happen.

The CHAIRMAN. I think what is interesting is we talk about the jointness between the two and I can appreciate that, but in 2008 in the NDAA, and this is really for the Committee's information, we mandated an inter-agency program office, which was supposed to be the central clearing house for all of this information and I've only heard a cursory mention of the IPO even sitting at the table this morning and so, it is interesting to me that, you know, this is an agency that has been out there that really hasn't produced anything, but its supposed to have been. Mr. Huelskamp?

Mr. HUELSKAMP. Thank you, Mr. Chairman. I do find it interesting that—and I would like to hear from the IPO office about this issue. That would be, perhaps, very instructive.

But, like my colleague, I didn't come with any prepared questions, but many have developed. First of all, I want to clarify some data. When the President stated his goal in April 2009, at that time, zero percent of all veterans had the ability to have electronic health records transferred from the DoD to the VA. What is the percent today? Is it still zero percent?

Mr. WOODSON. Congressman, no. My understanding is that today all electronic information from the DoD kept in their medical record is transferred to the VA for use if the individual comes to the VA for service.

Mr. HUELSKAMP. So, the—I guess I am confused. Mr. Gadd gave us an antidote of the paper that had to be transferred over. What percentage of the records are not electronic?

Mr. PETZEL. Congressman, the vast majority of the DoD records that we need for medical care are electronic and we can get them through what we call the bidirectional information exchange. It is not realtime, but we do have access to those records.

I think that what Mr. Gadd was talking about had to do with the benefits process, which is a different issue than the medical care process and in that process they need to get everything that is available including, in some cases, some written records.

Mr. HUELSKAMP. So, the President's goal; what percentage of that goal has been met?

Dr. PETZEL. From the medical perspective, it is nearly 100 percent.

Mr. WOODSON. So, just to clarify, to do proper adjudication of benefits you need medical records, personnel records and benefits information. What Dr. Petzel has just referred to is the ability to exchange medical records or health information. There is much work to be done on exchanging benefits and personnel information.

The CHAIRMAN. Mr. Gadd?

Mr. GADD. If I can add to that. The DoD and VA do a great job through the military treatment facilities, for example, if someone is severely injured, you know, they have got care coordination there. But for the veteran coming back that is a combat veteran or a veteran, they still need in some cases—as I said this morning, I talked to a veteran who went to the D.C. VA. He asked for his records from them and they said that they had to get them for him and he waited six months to go to his mailbox and find those records.

So, if it is really, you know, they are really able to do it instantaneously, he wouldn't have had to wait six months. So, I simply have to disagree with the panel.

Mr. HUELSKAMP. Thank you, Mr. Gadd. Yes, I'm a little confused by that. So the President set out a goal and apparently the timeline has moved—well, actually, I don't know if the timeline has moved, according to the statements from DoD that said, "We will achieve the President's goal far sooner and at a lower cost." So, when exactly is the timeline going to achieve that goal? When can we come in here and expect that achievement?

Ms. MCGRATH. The full interoperability that we are talking about, using the standard data, the health data dictionary that has been mentioned many times today, all of the facets associated with that, will be done by the end of this calendar year. So, by the end of 2013.

What is also—

Mr. HUELSKAMP. Excuse me. I must be a little confused. So, the President's goal will be completely achieved by the end of this year?

Ms. MCGRATH. For the interoperability, the standardization of the data between the core data base in VA and the core data in the Department of Defense, yes. This will yield full interoperability between our two organizations.

I think what also has been discussed here is the nationwide health information network utilization by the Federal space, us, and the private sector.

Mr. HUELSKAMP. Well, we must be talking past each other, because I thought we had a major problem and you are telling me it will be done at the end of the year.

Dr. PETZEL. If I could clarify. I think the difference to your point is that there are a lot of records that are on paper and those aren't—they have to be requested by the benefits folks and they have to be transferred over if they are going to happen. The electronic information is transferring.

But the electronic information relative to the service treatment record is to my understanding not a large part of the entire service treatment record. I don't want to get too far into that area, but thinking about it from the benefits perspective, I know that one of the main things our benefits folks have to do is request that paper service treatment record in order to do the benefits that folks are looking for and that can take awhile to get.

Mr. HUELSKAMP. Well, I am sorry, I am about out of time. I think you are talking past my question. If you could provide the timeline? I don't have it in any of the data we have been provided for the Committee, but the full timeline of achieving that entire

goal. As well as, you said the cost would be reduced, how much is the cost going to be reduced from originally projected?

Ms. MCGRATH. To have an apples to apples comparison we would do the same type of cost estimate and we expect that cost estimate to be done in the summer.

Mr. HUELSKAMP. Well, ma'am, just quickly. You said, "We will achieve the President's goal far sooner and at a lower cost." So, you are telling me the President's goal is going to be achieved at the end of the year, I think, that is, obviously, not true, you are missing my question. But what is the lower cost estimate? That was from your testimony. Do you know what that lower cost estimate is, the savings?

Ms. MCGRATH. We anticipate that the cost will be lower. I don't have a specific dollar value to give you today until I do the same level of engineering cost estimate that was done.

Mr. HUELSKAMP. Thank you. I yield back.

The CHAIRMAN. How can we assume that it would be lower if you don't have the cost estimate now?

Ms. MCGRATH. As was identified earlier, the life cycle cost estimate when it was done was an engineering level estimate. By starting from a core set of capabilities that are already integrated, there will be integration costs that would have existed in sort of the previous way that will not exist in the proposed way forward. And so, by the nature of the design, I will have less integration to do if I start with a bundled core set of capabilities than if I did not. So that is what is the main driver, of the statement that it will be a lower cost, because I will be doing less integration.

The CHAIRMAN. And tell us, again, why you won't use VistA?

Ms. MCGRATH. We plan to evaluate VistA along with—

The CHAIRMAN. How long has VistA existed?

Ms. MCGRATH. I am not sure.

The CHAIRMAN. And have you not had time to evaluate it?

Ms. MCGRATH. We did an evaluation in 2010 of VistA actually, it was 2009, as it existed at the time. When the Department was going on its own path toward modernization prior to Secretary Gates and Secretary Shinseki deciding to, not use either of the Department's legacy systems and—

The CHAIRMAN. That is three secretaries ago, right?

Ms. MCGRATH. Yes. The Department made the commitment to go joint back in—actually, I believe it was March of 2011 and we did evaluate VistA when DoD was going on its own path. The decision was made to go joint. We have not assessed VistA in that interim timeframe.

The CHAIRMAN. Why wouldn't you assess, I mean, that is—it is there. It works. People like it and you—DoD won't look at it.

Ms. MCGRATH. The two secretaries agreed that we weren't going to use either of our legacy environments. AHLTA is the name of the DoD legacy system. VistA is the name of the VA's system.

We decided not to use either of our legacy systems back in that timeframe and to take a joint path forward. We have been operating and moving down that path for the last two years.

The decision was made again recently to adopt a core set of capabilities and build from a core. The VA decided to use VistA as their core. We are not as familiar with the system. We do not use it

every day. The documentation—there’s a lot of things that we would—to Dr. Woodson’s point earlier, we would want to assess it so that we could understand the cost, the risk, the—

The CHAIRMAN. I apologize. This is very interesting to me because I have an article in Fed Talks that it says, “In an unprecedented move, the Department of Veterans Affairs posted a draft response to a Department of Defense request for information, which is the RFI, for an integrated electronic health platform. And in the draft posted by a senior advisor, the VA makes a case for deploying the Veterans Health Information System and Technology architecture.” But, you are—

Ms. MCGRATH. We posted the RFI, and asked for responses no later than today. This is one of those responses. We are evaluating that response, along with the others that we have received and will receive by close of business today and are absolutely doing the analysis on all the responses we receive.

The CHAIRMAN. But the secretaries agreed not to use the Legacy platforms.

Ms. MCGRATH. Back in 2011.

The CHAIRMAN. So, now we are back to using the legacy platform again.

Ms. MCGRATH. Well, the VA has decided to use a legacy platform.

The CHAIRMAN. Okay. Mr. Takano? Mr. Brownley? Mr. Kaufman?

Mr. KAUFMAN. Thank you, Mr. Chairman. Assistant Secretary Baker, in May of 2011 the VA stated that, “The improvement rate of VistA can be increased without increasing current spending by better involving the private sector and true private sectors practices in both the governance and the development of the VistA system.” Is this true? Can you explain why the Information Technology Acquisition Advisory Council, a 501C3 with a participation of transformation minded senior leaders from government, academia, industry and public interest has not been allowed to participate?

Mr. BAKER. I’m sorry, which organization? VistA is an open source. Anybody who wants to participate can participate. So, I would have to go back to the open source foundation to ask that question about, you know, why would anyone be excluded. But as an open source organization, I believe the definition in the bylaws is that anybody can participate.

Mr. KAUFMAN. Well, the allegation is that there were organizations that were excluded. I wonder if you can get back to the Committee on that on record?

Mr. BAKER. I would be happy to do that. That absolutely should not be happening.

Mr. KAUFMAN. This question is for Assistant Secretary Woodson and Assistant Secretary Baker. In May 2011, VA stated that, “Based on industry examples, VA’s expectation is that leveraging an open source community will increase the rate of improvement and innovation within VistA by drawing on new talent and new ideas from the commercial and public sectors.” Has this proven to be a true statement, given the current state of this system?

Mr. BAKER. So, thank you, Congressman. We believe that is true and I can give you a very specific example. We have recently gone out for using the open source with a prize approach to delivering a scheduling package for VistA. Now, scheduling in VistA has a long history and it is not a good one, relative to the VA inside government trying to develop that.

What we have done through the open source, making all of that code available to anyone who has a scheduling package, to integrate their scheduling package with VistA and provide us an example of that working with the open source. The big point there is, it is a tremendous risk reduction for us. When we do an acquisition of a scheduling package we will know that we can buy one that already works with VistA.

So, just down that path, we have gone out and eliminated the possibility of what we did in the past, which was spend \$127 million and get nothing. So, getting out of the typical governmental way of moving VistA forward and into a joint with the private sector—not with private sector as contractors, but with the private sector as full contributors to, how can you move this forward?

Just one point I would make. There are over 100 non-VA hospitals that have picked up VistA outside the VA and implemented it. There are private sector partners with us in this open source. So, I view VistA as an ecosystem of an electronic health record that is nationally and internationally used.

We are looking for that entire participation. The vendors that serve that community, the hospitals that use that and the VA, to work together to move VistA forward, not just the government.

Mr. KAUFMAN. Assistant Secretary Woodson?

Mr. WOODSON. Thank you very much for that question. And as part of our evaluation of VistA, which is ongoing and should be complete by the end of March, we are considering this information about the accelerated rate of modernization and the issues of cost for modernization.

We are also considering the issue, again, of total cost of ownership and evaluating these other issues of how we would transfer it over, because as I mentioned before, the evaluation of which system to choose is an acquisition decision no matter if we accept VistA or if we were to look in other commercial venues.

So, we are evaluating—and that is exactly why we are taking another look at this time is because the situation may have changed since the previous evaluations were done, the analysis of alternatives back in 2009 and other reports that came out of the private sector that were commissioned by the VA, which called into question the ability to modernize VistA at that time. So, we are re-evaluating that.

The final thing I would say is that, you know, I think it is due diligence to look at the VistA system against the commercial market because it is about the rate of innovation. It is about the fact that technology advances rapidly and we have got to not only be able to acquire it, but we have got to understand what resources we will need to commit to constantly modernizing it.

And all of the discussion this morning, including the GAO comments, have suggested that historically we have not done very well about how to modernize our system.

So, Alta is a worldwide database and we can share records across the world, MTFs and alike, but we are not very good at modernizing. So we are looking at this at this time.

Mr. KAUFMAN. Not very well is an understatement. Mr. Chairman, I yield back. Thank you.

The CHAIRMAN. Thank you very much. Mr. Michaud?

Mr. MICHAUD. I have one last question for the Department of Defense. When has DoD formally designate IEHR as a program of record?

Ms. MCGRATH. The Department included the IEHR in its—I would like to get back to you to be certain, but I believe it was the 2010 budget.

Mr. MICHAUD. So, you already have designated as a program of record?

Ms. MCGRATH. Yes. I believe it was in the 2010, but again, I would like to go back and verify.

Mr. MICHAUD. Okay. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Thank you, Members, for being here today. I would like to thank the panel. Please know that the frustration that the Committee shares is not with you individually, it is with the bureaucracy that exists. We have to work together to try to solve this problem that is out there today. We serve one mission and that is those that wear the uniform and become a veteran. It is a person and that is who we are serving.

So, I would ask unanimous consent that all Members would have five legislative days to revise and extend and add any extraneous material without objection.

With that, the panel is excused and this hearing is adjourned.

(Whereupon, at 11:04 a.m., the Committee was adjourned)

A P P E N D I X

Prepared Statement of Hon. Jeff Miller, Chairman

Good morning.

I would like to welcome everyone to today's hearing titled "Electronic Health Record U-Turn: Are VA and DoD Headed in the Wrong Direction?"

Today's hearing is prompted by the recent announcement by the Departments of Defense and Veterans Affairs that they would no longer be developing a single, integrated electronic health record, or "iEHR." The announcement earlier this month was surprising to this Committee and the Congress given the number of previous statements that the health record was coming along as planned, even on an accelerated timeline.

The other surprise about VA and DoD's announcement was that this Committee first heard about it from news reports instead of directly from VA itself. While that's not the first time this has happened, it is equally disappointing given the number of times that this Committee has voiced its willingness to work with the departments in support of making the iEHR a reality.

In late 2010, both departments co-announced an integrated Electronic Health Record as "a single solution to our common requirements."

In June 2012, the two departments set an expected timeline of a 2017 rollout for the iEHR.

In July 2012, both Secretaries testified to this Committee and the Armed Services Committee, reinforcing that a single integrated record was the way forward and that their respective departments would achieve that goal together.

This past December, it was stated that VA and DoD could roll out the health record even faster, without much supporting detail.

The latest news, a mere two months later, has us asking whether even the original 2017 timeline is realistic, and whether the end product will deliver that same level of integration for transitioning servicemembers.

"Interoperable" is not the same as "integrated." While I understand that information can still be shared, VA and DoD must better explain to this Committee, the Congress, and, most importantly, to servicemembers how this new way forward is going to deliver what has been mandated, is badly needed, and has been talked about for over a decade.

I am concerned that this new approach is a step backwards toward the model that had been previously tried and failed, namely, maintaining two different systems between two departments and wishfully thinking that the two systems will eventually talk to one another. I am further concerned about the stewardship of taxpayer dollars over the past several years. I find it hard to think of another description than "down the drain" for funding that may have produced little result- the same funding that could have gone toward taking care of active and former servicemembers.

Assistant Secretary Baker, I understand you are leaving VA in the very near future and therefore won't directly oversee the joint electronic health record's development much longer. While I wish more progress had been made during your tenure, I can only hope that your successor doubles down on his or her efforts to make this a reality.

The need for a seamless record hasn't been discussed for over a decade with the mere expectation that we'll just continue to discuss it. The time for action is long past, and each time the objective changes or the goalposts move, it is servicemembers and veterans who lose the most. That is unacceptable to this Committee, and should be to VA and DoD as well. I look forward to hearing more today about how, when, and in what form VA and DoD will finally bring about a joint electronic health record.

Prepared Statement of Hon. Michael Michaud, Ranking Minority Member

Thank you, Mr. Chairman.

We, as a Nation, have a “sacred trust” to care for those who have served and sacrificed. To do this, we rely on a “community of support.”

DoD and VA are the pinnacle of that community. Together you are the front-end and the back-end of the veteran safety-net. You must come together seamlessly or veterans fall through the space between you.

You have no greater mutual responsibility to those who have served you, and to those you serve, than to ensure a complete and smooth transition from the military back to civilian life.

Key to that smooth transition is the transfer of the health records that document the physical and mental sacrifices of our Nation’s heroes.

The Integrated Electronic Health Record (iEHR) initiative is critical to ushering in a more fluid process for our servicemen and women who transition into the veteran world.

Ideally, instead of servicemembers hand carrying paper records with them to medical appointments, access to their records would be readily available, electronically, to the providers and health care personnel who care for them when they take the uniform off and continue their lives as civilians.

In transforming the VA into a 21st century agency, we envisioned a seamless record that could benefit the men and women who have served this country honorably.

The idea of VA and DoD being capable of electronic communication was not a new one. We believed that VA and DoD could accomplish this task.

For at least a decade the two largest agencies in the government have worked this issue – often taking two steps forward and one step back.

I was under the impression, and in fact reassured, as late as September 2012 that the development of the iEHR, while challenging, was still on track to becoming the reality we intended.

So, in early February when we read in the news of the decision that VA and DoD were “modifying its strategy” from the planned iEHR approach and focus, I was disappointed and disheartened.

It seems to me that we have regressed back to 2004 when the Bidirectional Health Information Exchange was the way electronic information was exchanged. I am hoping this is not the case.

There are questions that must be answered as to the future of the iEHR and plans to move forward.

The original strategy – the intent of iEHR – was to design, build and implement a new, single system “from scratch.” In revising your life cycle cost estimates, you have determined that approach is too expensive.

So, you “modified your strategy” to use a core set of capabilities from existing EHR technologies. But rather than selecting one system from those currently available, your modified strategy is for each Department to separately select a core system of choice.

VistA, the VA’s current system is old and by all accounts replacing VistA with an existing Commercial Off The Shelf package is estimated to be \$16 billion dollars, according to a September 6, 2011 letter.

VA believes that leveraging open source methodologies will increase the rate of improvement within VistA and will be much cheaper.

DoD is looking to explore commercial options for its core system and won’t have a selection decision until March.

How does this modified strategy live up to the initial intent of iEHR to be a single, integrated system?

I am currently not comfortable with the direction we seem to be heading.

I am sure everyone in here would agree that we cannot afford to continue moving forward and back on this issue. VA was once a leader in electronic health record-keeping – today, it is one that is simply trying to keep up.

This must change. You – we - owe more to the Nation’s servicemembers and veterans.

I look forward to the testimony today and a frank, open discussion on the way ahead.

Prepared Statement of Hon. Roger W. Baker and Dr. Robert Petzel

Good morning Chairman Miller, Ranking Member Michaud, and Members of the committee. We appreciate the opportunity to appear before you today to discuss the Department of Veterans Affairs' (VA) efforts to develop an integrated Electronic Health Record (iEHR) with the Department of Defense (DoD). Our testimony will address the current and future state of iEHR. We will also address the decision to utilize the Veterans Health Information Systems and Technology Architecture (VistA) as VA's core for iEHR.

First, we would like to dispel any notion that VA and DoD are moving away from a single, joint, electronic health record—both Secretary Shinseki and Secretary Panetta reaffirmed our commitment to this in public statements on February 5th. What has changed is the strategy that we will use to accomplish that goal.

Initiation of the iEHR

In April of 2009, President Obama charged the Departments of Defense and Veterans Affairs to make Servicemember and Veteran health record information seamlessly available so that all information about a Servicemember or Veteran is available when they seek service from VA or DoD. In May of 2009, as VA and DoD established the Virtual Lifetime Electronic Record (VLER) program to provide portability and accessibility of health, benefits, and administrative data for every Servicemember and Veteran, regardless of status, for the remainder of their lives, addressing the challenges many Veterans experience transitioning to VA service.

In addition to the exchange of information facilitated by VLER, in March of 2011, Secretaries Shinseki and Gates agreed that VA and DoD would work together to establish a joint plan to create a single, joint electronic health record (iEHR). Key to the decision to work together was the fact that both VA and DoD were pursuing paths to modernize their existing EHR platforms. DoD was planning to replace its current EHR, the Armed Forces Health Longitudinal Technology Application (AHLTA), with a new electronic health record, and VA was planning to improve VistA by establishing an Open Source consortium and gradually replacing parts of the system with packages acquired from private sector developers. In June of 2011, the Secretaries accepted the plan put forth by the Departments, which included the fundamental architecture, governance, and approach that would deliver an iEHR.

iEHR Governance

To address the challenges in achieving a large-scale, joint DoD–VA initiative, the iEHR program established a governance structure designed to support interagency decision-making. The Interagency Program Office (IPO), established under PL 110–181, serves as the single point of accountability for the joint development and implementation of iEHR. The IPO receives direction, supervision, and control from the Department Secretaries and guidance from the IPO Advisory Board and Joint Executive Committee (JEC). The IPO receives requirements from and collaborates with DoD / VA Health and Benefits Executive Councils (HEC and BEC) and the JEC reviews the implementation of iEHR activities.

The governance structure was established to ensure decisions are made and executed at the appropriate level in the organization. The IPO Advisory Board co-chairs are the DoD Deputy Chief Management Officer (DCMO) and the VA Assistant Secretary for Information and Technology. In 2013, an Executive Committee of the IPO Advisory Board was established to oversee the execution of the iEHR program and the IPO. In the event the Executive Committee cannot reach a consensus, issues are addressed by the JEC, and then to the two Secretaries, if necessary.

iEHR Cost Estimates

The IPO has approximately 135 federal employees, several hundred contractor employees, and approximately \$758 million in planned spending for FY 2013. Despite these resources, the IPO has been challenged to meet its program deadlines. The initial estimate of the cost for the iEHR presented to the Secretaries in 2011 projected the cost to develop the iEHR at between \$4 and \$6 billion. VA and DoD agreed to split the costs of iEHR development equally, and a cost sharing memorandum of understanding was completed in 2012. In September of 2012, the IPO produced a new estimate of the cost of the iEHR that doubled the estimated cost of development of the system. While no missed milestone has yet caused a change in the “critical path” toward Initial Operating Capability (IOC) in 2014, the program has met very few of the milestones it has set.

Revised iEHR Plan

In December of 2012, when presented with the revised cost and schedule information, the Secretaries directed that the Interagency Program Office (IPO) Advisory Board Co-Chairs and the Health Executive Committee (HEC) Co-Chairs prepare and provide a report within 30 days that would assess the current program strategy, provide “quick win” recommendations to accelerate interoperability and recommend changes to the governance structure and budget impacts. As a result, the IPO Advisory Board Co-Chairs and HEC Co-Chairs provided a plan which the Secretaries approved that included:

- *Program Strategy:* Adjusted the iEHR acquisition business rules agreed to in March 2011 from “buy” commercially available solutions for joint use, “adopt” a Department-developed application if a modular commercial solution is not available and one Department has a solution, “create” a joint application on a case by case basis if neither a modular commercial or Department-developed solution are available, to “adopt, buy, create” to leverage existing capabilities for joint use. The Departments will also define a “core” set of iEHR capabilities that would allow us to evaluate the selection of existing EHR products to reduce program risks and costs while accelerating implementation.
- *Quick Wins:* Accelerate the federation of VA and DoD clinical health data, to include VA’s mapping of the Health Data Dictionary (HDD) to their Corporate Data Warehouse (CDW) and update the CDW to provide near real-time patient data access. This data interoperability work will be completed by January 2014. The VA will also rapidly adopt the common DoD–VA identity management solution and create the VA–DoD Medical Community of Interest network and security infrastructure. VA and DoD will continue to expand and accelerate patient access to data through the “Blue Button” initiatives.
- *Governance:* Established an Executive Committee of the IPO Advisory board consisting of the DoD Deputy Chief Management Officer, the DoD Assistant Secretary for Health Affairs, the VA Under Secretary for Health, and the VA Assistant Secretary for Information and Technology.

Additionally the Secretaries approved deployment of the JANUS Graphical User Interface (GUI) to five VA polytrauma rehabilitation centers and two associated Military Treatment Facilities.

Under this plan, VA has committed to use the “core” technology of VistA, while DoD will evaluate available alternatives in order to make a “core” technology selection that will best fit its needs. In order to achieve the desired data interoperability between both Departments, both “cores” will conform to an agreed-upon set of standards that enable the secure and interoperable exchange of information.

While the immediate focus is on accelerating data interoperability between the two Departments, our end goal remains the same – to make certain that we are creating a single, joint electronic health record for each Servicemember and Veteran.

VA Selection of VistA

VA chose the “core” technology of VistA to reduce the costs and risks associated with the selection and implementation of a different technology. Most importantly, while we are engaged in continuously improving VistA, it is still one of the best EHR systems available worldwide. And, because the source code to VistA is available via Open Source, we know that we will always be able to achieve competitive pricing for any changes we need to make.

VistA’s current Graphic User Interface known as the Computerized Patient Record System (CPRS), allows providers to update a patient’s medical history, place a variety of orders, and review test results and drug prescriptions. Its tabbed chart interface organizes problem lists, pharmacy data, orders, lab results, progress notes, vital signs, radiology results, transcribed documents, and reports from various studies such as echocardiograms in a clinically relevant manner. CPRS enables clinicians to enter, review, and continuously update all order-related information connected with any patient. With CPRS, a clinician can order lab tests, medications, diets, radiology tests and procedures, record a patient’s allergies or adverse reactions to medications, request and track consults, and enter progress notes, diagnoses, and treatments for each encounter, and enter discharge summaries. Close integration with the Clinical Reminders and Text Integration packages allows better record keeping and compliance with Clinical Guidelines and medical record requirements.

The system has been implemented at all VA medical centers and at VA outpatient clinics, long-term care facilities, and domiciliaries – 1,300 sites of care throughout the Veterans Health Administration. VA is the largest installation of VistA, with over 250,000 daily users at 152 of the nation’s largest hospitals and over 800 com-

munity-based outpatient clinics nationwide. VA serves over 6 million unique Veterans each year, and every visit is tracked and supported through the VistA EHR. The largest individual VistA “sites” each have more than 80 million orders in their individual databases and each of these sites creates and handles an average of 22–28 thousand new orders per weekday.

VistA consists of approximately 160 applications (modules) which cover all aspects of health care and health care delivery (i.e. hospital operations). More than half are clinically focused; the rest are supportive/administrative applications that are integral to delivering efficient, comprehensive, and safe patient care for the largest medical system in the US. VistA functionality reaches far beyond the general hospital/health care EHR requirements. Highly complex, government-specific regulations related to health care coordination, reporting, compliance, billing, and countless other functions. VistA represents a deep and comprehensive integration of services.

In 2012, the VA health care system was honored to have 16 of its health care entities named to the 2012 “Most Wired” hospitals list. The list that is released by Hospitals & Health Networks annually, in partnership with McKesson, the College of Healthcare Information Management Executives (CHIME), and the American Hospital Association (AHA), is a result of a national assessment aimed at ranking hospitals which are leveraging health information technology in new and innovative ways.

Conclusion

Mr. Chairman, the iEHR has proven to be a very challenging program, but both DoD and VA are committed to achieving the President’s goal of making Servicemember and Veteran information seamlessly available across the two Departments. As part of our efforts to make rapid progress on data interoperability, we are pleased to announce that in the coming months VA will be deploying the Janus Graphic User Interface to five VA polytrauma rehabilitation centers and two associated Military Treatment Facilities; standardizing health care data to facilitate interoperability; upgrading the Corporate Data Warehouse to enable the near real-time exchange of data between Departments; and enabling patients in both Departments to download and transmit their medical records using national standards in with what is known as the Blue Button.

We appreciate the opportunity to appear before you today, and we are prepared to respond to any questions you may have

Prepared Statement of The Hon. Jonathan Woodson, and Hon. Elizabeth A. McGrath

Chairman Miller, Ranking Member Michaud, and members of this distinguished Committee, thank you for extending the invitation to both the Department of Defense and Department of Veterans Affairs to testify today on our integrated Electronic Health Record (iEHR) program.

In April 2009, the President charged our two Departments to, “work together to define and build a seamless system of integration with a single goal: when a member of the Armed Forces separates from the military, he or she will no longer have to walk paperwork from a DoD duty station to a local VA health center; their electronic records will transition along with them and remain with them forever.” This goal is important not only to Service members’ continued medical care, but also to their benefits processing. Given the President’s clear direction, our Departments have been working on two very important efforts simultaneously. First, we are committed to ensuring that all health data for an individual can be brought together into a seamless electronic health record. Second, we are both committed to modernizing and replacing our legacy health information technology systems.

In March 2011, the two Departments agreed to pursue a common approach to develop and implement the next generation of EHR capabilities meeting both goals for two Departments. Specifically, we agreed to implement a common architecture, data and services, data centers, interface/exchange standards and presentation layer. The plan had been to design, build and implement this new system from the ground up and jointly purchase individual clinical applications that could “plug-in” to the common architecture.

Since that time, the following significant important work has been done to develop and pilot capabilities to facilitate the exchange of information between Departments and improve the information accessible to doctors and patients in both VA and DoD medical systems.

- The first step in creating interoperability between two computer systems is to make sure that the exchanged data means the same thing. DoD has a Health Data Dictionary to make sure that its various health IT systems can exchange information. VA is currently mapping VistA data elements to the same data dictionary, ensuring that we have data interoperability between the two Departments.
- By locating both Departments' health data in the same place, we improve our ability to access and distribute the data. VA is migrating its health data to the DoD Defense Information Systems Agency (DISA) data centers;
- Currently, to upgrade a single component of our current systems requires considerable work at great expense. Our joint service oriented architecture approach and purchase of a shared enterprise service bus allows greater flexibility in designing and upgrading software applications for each Department and promotes agility and flexibility with regards to communication and interaction between applications
- We have selected a single DoD-VA joint Single Sign On/Context Management (SSO / CM) solution and are in the process of installing it across the DoD. Medical Single Sign-On allows users to log in once to the health care systems and move from application to application without having to reenter passwords. Health care providers can focus on documenting patient care instead of remembering their multiple passwords. Patient Context Management allows users to choose a patient in one application and have the patient context follow to other participating clinical applications once they are launched.
- When clinicians are treating patients who receive health care from both Departments, it is useful to have patient information presented to the clinician in a single view. We have implemented a joint Graphical User Interface (GUI) pilot at North Chicago, Tripler, and San Antonio that displays information from both DoD and VA systems to allow providers from both Departments a single common view for patient information.
- As we look to purchase clinical applications for joint use, our medical providers must identify the requirements or functionality that each application should provide. We are well on our way to jointly completing business process mapping for initial clinical capabilities.

During this time, we also completed an initial Life Cycle Cost estimate for the program and identified various development plans, which included an option to accelerate functionality, and to reduce costs and technical risks to the program.

We discovered that there were specific actions that we could take together to accelerate availability of seamless information across the two Departments. These "quick wins" were approved by Secretaries Panetta and Shinseki on February 5, 2013, and include:

1. Expanding our "Blue Button" capability so that VA and DoD patients can securely download and transmit their medical records to the destinations of their choice, using national standards, via the internet in industry standard formats by May 2013;
2. Accelerating a common display or viewer that will allow clinicians to see a virtual consolidation of patient data at nine key sites, including our VA's five polytrauma rehabilitation centers by July 2013;
3. Completing the mapping of VA health data to the Health Data Dictionary by September 2013; and
4. Accelerating the "real-time" availability of VA health data by December 2013 so that providers have access to the most recent and best data to care for patients

In addition to these efforts to accelerate availability of seamless information, both Departments are also working to modernize or replace our underlying information technology systems. To reduce cost and technical risk, the two Departments agreed to modify the strategy. Instead of designing, building, and implementing a new system "from scratch", we would use a "core" set of applications from existing EHR technology, to which could be added additional modules or applications, as could be added. DoD is reviewing available commercial and governmental options, and anticipates a decision on this issue by the end of March. VA has decided to use its current system, VistA, as its core.

Some have interpreted this shift in strategy as backing away from our commitment to achieve an integrated electronic health record. Nothing could be further from the truth. The two Departments intend to create an integrated electronic health record and remain committed to shared, standard data, shared applications,

and a shared common user interface. By focusing on a number of quick wins to accelerate availability of seamless information across the two Departments this year we will achieve the President's goal far sooner, and at a lower cost.

Going forward, we look to leverage existing government and commercial EHR technology as a way to reduce risks and overall costs of modernizing our health information technology systems, while accelerating the delivery of new capabilities.

By establishing exchange and increased functionality across our two systems by 2014, we will create a "Virtual Lifetime Electronic Record" for each Service Member and Veteran, thus achieving the President's vision of every separating Service member having his or her information available for a smooth transition to Veteran status, whether it is to coordinate the delivery of health care or achieve rapid adjudication of benefits. The voluntary service of our Service members is indispensable to the freedoms we enjoy as a nation. Our Service Members, Veterans, retirees, and eligible family members deserve nothing less than the best possible care and service our Departments can provide. We will maintain our focus and momentum and will continue to provide you updates on our progress and achievements.

We look forward to your questions.

Prepared Statement of Valerie C. Melvin

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

Thank you for the opportunity to participate in today's hearing on efforts of the Department of Veterans Affairs (VA) to share electronic health records with the Department of Defense (DOD). As you know, VA and DOD operate two of the nation's largest health care systems, which, in fiscal year 2013, are projected to provide coverage to approximately 6.3 million veterans and 9.6 million active duty service members and their beneficiaries at estimated costs of about \$53 billion and \$49 billion, respectively.

Both VA and DOD have long recognized the importance of advancing the use of shared health information systems and capabilities to make patient information more readily available to their health care providers, reduce medical errors, and streamline administrative functions. Toward this end, the two departments have an extensive history of working to achieve shared health care resources, dating back to the 1980s.¹ Our work has examined the departments' efforts over the past 15 years in undertaking a variety of initiatives to share data between their individual health information systems and to develop interoperable health record capabilities. In this regard, reports that we issued between 2001 and 2012 have noted various degrees of progress by the departments; however, we have also highlighted, and recommended that VA and DOD address, pervasive and persistent management challenges that have impeded their ability to achieve fully interoperable electronic health record capabilities.² My testimony today (1) summarizes VA's and DOD's efforts, and challenges faced, in electronically sharing health information and (2) describes the departments' recent change in their approach to developing an integrated electronic health record.

In developing this testimony, we relied on our previous work. We also obtained and reviewed information on the departments' actions in response to our previous recommendations. We conducted our work in support of this testimony during February 2013. All work on which this testimony is based was performed in accordance with generally accepted government auditing standards. Those standards require

¹Since the 1980s, VA and DOD have entered into many types of collaborations to provide health care services—including emergency, specialty, inpatient, and outpatient care—to VA and DOD beneficiaries, reimbursing each other for the services provided. These collaborations vary in scope, ranging from agreements to jointly provide a single type of service to more coordinated "joint ventures," which encompass multiple health care services and facilities and focus on mutual benefit, shared risk, and joint operations in specific clinical areas.

²See for example, Computer-Based Patient Records: Better Planning and Oversight by VA, DOD, and IHS Would Enhance Health Data Sharing, GAO-01-459 (Washington, D.C.: Apr. 30, 2001); Electronic Health Records: DOD and VA Have Increased Their Sharing of Health Information, but More Work Remains, GAO-08-954 (Washington, D.C.: July 28, 2008); Electronic Health Records: DOD's and VA's Sharing of Information Could Benefit from Improved Management, GAO-09-268 (Washington, D.C.: Jan. 28, 2009); Electronic Health Records: DOD and VA Efforts to Achieve Full Interoperability Are Ongoing; Program Office Management Needs Improvement, GAO-09-775 (Washington, D.C.: July 28, 2009); Electronic Health Records: DOD and VA Interoperability Efforts Are Ongoing; Program Office Needs to Implement Recommended Improvements, GAO-10-332 (Washington, D.C.: Jan. 28, 2010); and Electronic Health Records: DOD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs, GAO-11-265 (Washington, D.C.: Feb. 2, 2011).

that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The use of information technology (IT) to electronically collect, store, retrieve, and transfer clinical, administrative, and financial health information has great potential to help improve the quality and efficiency of health care. Historically, patient health information has been scattered across paper records kept by many different caregivers in many different locations, making it difficult for a clinician to access all of a patient's health information at the time of care. Lacking access to these critical data, a clinician may be challenged to make the most informed decisions on treatment options, potentially putting the patient's health at greater risk. The use of electronic health records can help provide this access and improve clinical decisions.

Electronic health records are particularly crucial for optimizing the health care provided to military personnel and veterans. While in military status and later as veterans, many VA and DOD patients tend to be highly mobile and may have health records residing at multiple medical facilities within and outside the United States. Making such records electronic can help ensure that complete health care information is available for most military service members and veterans at the time and place of care, no matter where it originates.

Although they have identified many common health care business needs, both departments have spent large sums of money to develop and operate separate electronic health record systems that they rely on to create and manage patient health information. VA uses its integrated medical information system—the Veterans Health Information Systems and Technology Architecture (VistA)—which was developed in-house by VA clinicians and IT personnel. The system consists of 104 separate computer applications, including 56 health provider applications; 19 management and financial applications; 8 registration, enrollment, and eligibility applications; 5 health data applications; and 3 information and education applications. Besides being numerous, these applications have been customized at all 128 VA sites.³ According to the department, this customization increases the cost of maintaining the system, as it requires that maintenance also be customized.

In 2001, the Veterans Health Administration undertook an initiative to modernize VistA by standardizing patient data and modernizing the health information software applications. In doing so, its goal was to move from the hospital-centric environment that had long characterized the department's health care operations to a veteran-centric environment built on an open, robust systems architecture that would more efficiently provide both the same functions and benefits of the existing system and enhanced functions based on computable data. VA planned to take an incremental approach to the initiative, based on six phases (referred to as "blocks") that were to be completed in 2018. Under this strategy, the department planned to replace the 104 VistA applications that are currently in use with 67 applications, 3 databases, and 10 common services. VA reported spending almost \$600 million from 2001 to 2007 on eight projects, including an effort that resulted in a repository containing selected standardized health data, as part of the effort to modernize VistA. In April 2008, the department estimated an \$11 billion total cost to complete, by 2018, the modernization that was planned at that time. However, according to VA officials, the modernization effort was terminated in August 2010.

For its part, DOD relies on its Armed Forces Health Longitudinal Technology Application (AHLTA), which comprises multiple legacy medical information systems that the department developed from commercial software products that were customized for specific uses. For example, the Composite Health Care System (CHCS), which was formerly DOD's primary health information system, is still in use to capture information related to pharmacy, radiology, and laboratory order management. In addition, the department uses Essentris (also called the Clinical Information System), a commercial health information system customized to support inpatient treatment at military medical facilities. DOD obligated approximately \$2 billion for AHLTA between 1997 and 2010.

A key goal for sharing health information among providers, such as between VA's and DOD's health care systems, is achieving interoperability. Interoperability enables different information systems or components to exchange information and to use the information that has been exchanged. This capability allows patients' elec-

³ A site includes one or more facilities—medical centers, hospitals, or outpatient clinics—that store their electronic health data in a single database.

tronic health information to move with them from provider to provider, regardless of where the information originated. If electronic health records conform to interoperability standards, they can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization, thus providing patients and their caregivers the necessary information required for optimal care. (Paper-based health records—if available—also provide necessary information, but unlike electronic health records, do not provide decision support capabilities, such as automatic alerts about a particular patient’s health, or other advantages of automation.)

Interoperability can be achieved at different levels. At the highest level, electronic data are computable (that is, in a format that a computer can understand and act on to, for example, provide alerts to clinicians on drug allergies). At a lower level, electronic data are structured and viewable, but not computable. The value of data at this level is that they are structured so that data of interest to users are easier to find. At a still lower level, electronic data are unstructured and viewable, but not computable. With unstructured electronic data, a user would have to find needed or relevant information by searching uncategorized data. Beyond these, paper records can also be considered interoperable (at the lowest level) because they allow data to be shared, read, and interpreted by human beings.

VA and DOD Have Pursued Various Efforts over Many Years but Have Been Challenged in Achieving Fully Interoperable Electronic Health Records

Since 1998, VA and DOD have relied on a patchwork of initiatives involving their health information systems to achieve electronic health record interoperability. These have included efforts to: share viewable data in existing (legacy) systems; link and share computable data between the departments’ modernized health data repositories; establish interoperability objectives to meet specific data-sharing needs; develop a virtual lifetime electronic health record to track patients through active service and veteran status; and implement IT capabilities for the first joint federal health care center. While, collectively, these initiatives have yielded increased data-sharing in various capacities, a number of them have nonetheless been plagued by persistent management challenges, which have created barriers to achieving the fully interoperable electronic health record capabilities long sought.

Early Efforts to Share Information in Legacy Systems Suffered from Project Planning and Management Weaknesses

Among the departments’ earliest efforts to achieve interoperability was the Government Computer-Based Patient Record (GCPR) initiative, which was begun in 1998 with the intent of providing an electronic interface that would allow physicians and other authorized users of VA’s and DOD’s health facilities to access data from either of the other agency’s health facilities.⁴ The interface was expected to compile requested patient health information in a temporary, “virtual” record that could be displayed on a user’s computer screen. However, in reporting on this initiative in April 2001, we found that accountability for GCPR was blurred across several management entities and that basic principles of sound IT project planning, development, and oversight had not been followed, thus, creating barriers to progress.⁵ For example, clear goals and objectives had not been set; detailed plans for the design, implementation, and testing of the interface had not been developed; and critical decisions were not binding on all partners. While both departments concurred with our recommendations that they, among other things, create comprehensive and coordinated plans for the effort, progress on the initiative continued to be disappointing. The department subsequently revised the strategy for GCPR and, in May 2002, narrowed the scope of the initiative to focus on enabling DOD to electronically transfer service members’ electronic health information to VA upon their separation from active duty. The initiative—renamed the Federal Health Information Exchange (FHIE)—was completed in 2004.

Building on the architecture and framework of FHIE, VA and DOD also established the Bidirectional Health Information Exchange (BHIE) in 2004, which was aimed at allowing clinicians at both departments viewable access to records on shared patients (that is, those who receive care from both departments, such as veterans who receive outpatient care from VA clinicians and then are hospitalized at

⁴ Initially, the Indian Health Service (IHS) was also part of this initiative, having been included because of its population-based research expertise and its long-standing relationship with VA. However, IHS was not included in a later revised strategy for electronically sharing patient health information.

⁵ GAO-01-459.

a military treatment facility). The interface also enabled DOD sites to see previously inaccessible data at other DOD sites.

Further, in March 2004, the departments began an effort to develop an interface linking VA's Health Data Repository and DOD's Clinical Data Repository, as part of a long-term initiative to achieve the two-way exchange of health information between the departments' modernized systems—known as CHDR. The departments had planned to be able to exchange selected health information through CHDR by October 2005. However, in June 2004, we reported that the efforts of VA and DOD in this area demonstrated a number of management weaknesses.⁶ Among these were the lack of a well-defined architecture for describing the interface for a common health information exchange; an established project management lead entity and structure to guide the investment in the interface and its implementation; and a project management plan defining the technical and managerial processes necessary to satisfy project requirements. Accordingly, we recommended that the departments address these weaknesses and they agreed to do so.

In September 2005, we testified that the departments had improved the management of the CHDR program, but that this program continued to face significant challenges—in particular, with developing a project management plan of sufficient specificity to be an effective guide for the program.⁷ In a subsequent testimony, in June 2006, we noted that the project did not meet a previously established milestone: to be able to exchange outpatient pharmacy data, laboratory results, allergy information, and patient demographic information on a limited basis by October 2005.⁸ By September 2006, the departments had taken actions which ensured that the CHDR interface linked the departments' separate repositories of standardized data to enable a two-way exchange of computable outpatient pharmacy and medication allergy information. Nonetheless, we noted that the success of CHDR would depend on the departments' instituting a highly disciplined approach to the project's management.

Efforts to Comply with 2008 Mandate to Achieve Fully Interoperable Health Records Capabilities Lacked Project Plans and Measures of Effectiveness

To increase the exchange of electronic health information between the two departments, the National Defense Authorization Act (NDAA) for Fiscal Year 2008 included provisions directing VA and DOD to jointly develop and implement, by September 30, 2009, fully interoperable electronic health record systems or capabilities.⁹ To facilitate compliance with the act, the departments' Interagency Clinical Informatics Board, made up of senior clinical leaders who represent the user community, began establishing priorities for interoperable health data between VA and DOD. In this regard, the board was responsible for determining clinical priorities for electronic data sharing between the departments, as well as what data should be viewable and what data should be computable. Based on its work, the board established six interoperability objectives for meeting the departments' data-sharing needs:

- **Refine social history data:** DOD was to begin sharing with VA the social history data that are currently captured in the DOD electronic health record. Such data describe, for example, patients' involvement in hazardous activities and tobacco and alcohol use.
- **Share physical exam data:** DOD was to provide an initial capability to share with VA its electronic health record information that supports the physical exam process when a service member separates from active military duty.
- **Demonstrate initial network gateway operation:** VA and DOD were to demonstrate the operation of secure network gateways to support joint VA–DOD health information sharing.
- **Expand questionnaires and self-assessment tools:** DOD was to provide all periodic health assessment data stored in its electronic health record to VA such that questionnaire responses are viewable with the questions that elicited them.
- **Expand Essentris in DOD:** DOD was to expand its inpatient medical records system (CliniComp's Essentris product suite) to at least one additional site in

⁶GAO, Computer-Based Patient Records: VA and DOD Efforts to Exchange Health Data Could Benefit from Improved Planning and Project Management, GAO-04-687 (Washington, D.C.: June 7, 2004).

⁷GAO, Computer-Based Patient Records: VA and DOD Made Progress, but Much Work Remains to Fully Share Medical Information, GAO-05-1051T (Washington, D.C.: Sept. 28, 2005).

⁸GAO, Information Technology: VA and DOD Face Challenges in Completing Key Efforts, GAO-06-905T (Washington, D.C.: June 22, 2006).

⁹Pub. L. No. 110-181, § 1635, 122 Stat. 3, 460-463 (2008).

each military medical department (one Army, one Air Force, and one Navy, for a total of three sites).

- **Demonstrate initial document scanning:** DOD was to demonstrate an initial capability for scanning service members' medical documents into its electronic health record and sharing the documents electronically with VA.

The departments asserted that they took actions that met the six objectives and, in conjunction with capabilities previously achieved (e.g., FHIE, BHIE, and CHDR), had met the September 30, 2009, deadline for achieving full interoperability as required by the act. Nonetheless, the departments planned additional work to further increase their interoperable capabilities, stating that these actions reflected the departments' recognition that clinicians' needs for interoperable electronic health records are not static. In this regard, the departments focused on additional efforts to meet clinicians' evolving needs for interoperable capabilities in the areas of social history and physical exam data, expanding implementation of Essentris, and additional testing of document scanning capabilities.

Even with these actions, however, we identified a number of challenges the departments faced in managing their efforts in response to the 2008 NDAA. Specifically, we identified challenges with respect to performance measurement, project scheduling, and planning. For example, in a January 2009 report, we noted that the departments' key plans did not identify results-oriented (i.e., objective, quantifiable, and measurable) performance goals and measures that are characteristic of effective planning and can be used as a basis to track and assess progress toward the delivery of new interoperable capabilities.¹⁰ We pointed out that without establishing results-oriented goals and reporting progress using measures relative to the established goals, the departments and their stakeholders would not have the comprehensive picture that they need to effectively manage their progress toward achieving increased interoperability. Accordingly, we recommended that DOD and VA take action to develop such goals and performance measures to be used as a basis for providing meaningful information on the status of the departments' interoperability initiatives. In response, the departments stated that such goals and measures would be included in the next version of the VA/DOD Joint Executive Council Joint Strategic Plan (known as the joint strategic plan). However, that plan was not approved until April 2010, 7 months after the departments asserted they had met the deadline for achieving full interoperability.

In addition to its provisions directing VA and DOD to jointly develop fully interoperable electronic health records, the 2008 NDAA called for the departments to set up an Interagency Program Office (IPO) to be accountable for their efforts to implement these capabilities by the September deadline. Accordingly, in January 2009, the office completed its charter, articulating, among other things, its mission and functions with respect to attaining interoperable electronic health data. The charter further identified the office's responsibilities in carrying out its mission in areas such as oversight and management, stakeholder communication, and decision making. Among the specific responsibilities identified in the charter was the development of a plan, schedule, and performance measures to guide the departments' electronic health record interoperability efforts.

In July 2009, we reported that the IPO had not fulfilled key management responsibilities identified in its charter, such as the development of an integrated master schedule and a project plan for the department's efforts to achieve full interoperability.¹¹ Without these important tools, the office was limited in its ability to effectively manage and provide meaningful progress reporting on the delivery of interoperable capabilities. We recommended that the IPO establish a project plan and a complete and detailed integrated master schedule. In response to our recommendation, the office began to develop an integrated master schedule and project plan that included information about its ongoing interoperability activities.

It is important to note, however, that in testifying before this committee in July 2011, the office's former Director stated that the IPO charter established a modest role for the office, which did not allow the office to be the single point of accountability for the development and implementation of interoperable electronic health records.¹² Instead, the office served the role of coordination and oversight for the

¹⁰ GAO-09-268.

¹¹ GAO-09-775.

¹² Legislative Hearing on H.R. 2383, H.R. 2243, H.R. 2388 and H.R. 2470, Before the Subcommittee on Oversight and Investigations of the Committee on Veterans' Affairs, U.S. House of Representatives, 112th Cong., First Session (July 20, 2011) (statement of Debra M. Filippi, Former Director, U.S. Department of Defense/U.S. Department of Veterans Affairs Interagency Program Office), February 25, 2012, <http://veterans.house.gov/prepared-statement/prepared-statement-debra-m-filippi-former-director-us-department-defenseus>.

departments' efforts. Additionally, as pointed out by this official, control of the budget, contracts, and technical development remained with VA and DOD. As a result, each department had continued to pursue separate strategies and implementation paths, rather than coming together to build a unified, interoperable approach.

Virtual Lifetime Electronic Record Initiative Lacked Comprehensive Planning

In another attempt at furthering efforts to increase electronic health record interoperability, in April 2009, the President announced that VA and DOD would work together to define and build the Virtual Lifetime Electronic Record (VLER) to streamline the transition of electronic medical, benefits, and administrative information between the two departments. VLER is intended to enable access to all electronic records for service members as they transition from military to veteran status, and throughout their lives. Further, the initiative is to expand the departments' health information sharing capabilities by enabling access to private sector health data.

Shortly after the April 2009 announcement, VA, DOD, and the IPO began working to define and plan for the initiative. In June 2009, the departments adopted a phased implementation strategy consisting of a series of 6-month pilot projects to deploy a set of health data exchange capabilities between existing electronic health record systems at local sites around the country. Each VLER pilot project was intended to build upon the technical capabilities of its predecessor, resulting in a set of baseline capabilities to inform project planning and guide the implementation of VLER nationwide.

The first pilot, which started in August 2009, in San Diego, California, resulted in VA, DOD, and Kaiser Permanente being able to share a limited set of test patient data. Subsequently, between March 2010 and January 2011, VA and DOD conducted another pilot in the Tidewater area of southeastern Virginia, which focused on sharing the same data as the San Diego pilot plus additional laboratory data. The departments planned additional pilots, with the goal of deploying VLER nationwide at or before the end of 2012.

In June 2010, DOD informed us that it planned to spend \$33.6 million in fiscal year 2010, and \$61.9 million in fiscal year 2011 on the initiative. Similarly, VA stated that it planned to spend \$23.5 million in fiscal year 2010, and had requested \$52 million for fiscal year 2011.

However, in a February 2011 report on the departments' efforts to address their common health IT needs, we noted that although VA and DOD identified a high-level approach for implementing VLER and designated the IPO as the single point of accountability for the effort, they had not developed a comprehensive plan identifying the target set of capabilities that they intended to demonstrate in the pilot projects and then implement on a nationwide basis at all domestic VA and DOD sites by the end of 2012.¹³ Moreover, the departments conducted VLER pilot projects without attending to key planning activities that are necessary to guide the initiative. For example, as of February 2011, the IPO had not developed an approved integrated master schedule, master program plan, or performance metrics for the VLER initiative, as outlined in the office's charter. We noted that if the departments did not address these issues, their ability to effectively deliver capabilities to support their joint health IT needs would be uncertain. We recommended that the Secretaries of VA and DOD strengthen their ongoing efforts to establish VLER by developing plans that include scope definition, cost and schedule estimation, and project plan documentation and approval. Officials from both departments agreed with the recommendation, and we are monitoring their actions toward implementing them. Nevertheless, the departments were not successful in meeting their goal of implementing VLER nationwide by the end of 2012.

Poor Project Planning Contributed to Information Technology Delays at the Joint Federal Health Care Center

VA and DOD also continued their efforts to share health information and resources in 2010 following congressional authorization of a 5-year demonstration project to more fully integrate the two departments' facilities that were located in proximity to one another in the North Chicago, Illinois, area. As authorized by the National Defense Authorization Act for fiscal year 2010,¹⁴ VA and DOD facilities in and around North Chicago were integrated into a first-of-its-kind system known as the Captain James A. Lovell Federal Health Care Center (FHCC). The FHCC is unique in that it is to be the first fully integrated federal health care center for use

¹³ GAO-11-265.

¹⁴ Pub. L. No. 111-84, div. A, title XVII, 123 Stat. 2190, 2567-2574 (2009).

by both VA and DOD beneficiaries, with an integrated workforce, a joint funding source, and a single line of governance.

In April 2010, the Secretaries of VA and DOD signed an Executive Agreement that established the FHCC and defined the relationship between the two departments for operating the new, integrated facility, in accordance with the 2010 NDAA. Among other things,¹⁵ the Executive Agreement specified three key IT capabilities that VA and DOD were required to have in place by the FHCC's opening day, in October 2010, to facilitate interoperability of their electronic health record systems:

- **medical single sign-on**, which would allow staff to use one screen to access both the VA and DOD electronic health record systems;
- **single patient registration**, which would allow staff to register patients in both systems simultaneously; and
- **orders portability**, which would allow VA and DOD clinicians to place, manage, and update clinical orders from either department's electronic health records systems for radiology, laboratory, consults (specialty referrals), and pharmacy services.

However, in a February 2011 report that identified improvements the departments' could make to the FHCC effort, we noted that project planning for the center's IT capabilities was incomplete.¹⁶ We specifically noted that the departments had not defined the project scope in a manner that identified all detailed activities. Consequently, they were not positioned to reliably estimate the project cost or establish a baseline schedule that could be used to track project performance. Based on these findings, we expressed concern that VA and DOD had jeopardized their ability to fully and expeditiously provide the FHCC's needed IT system capabilities. We recommended that the Secretaries of VA and DOD strengthen their efforts to establish the joint IT system capabilities for the FHCC by developing plans that included scope definition, cost and schedule estimation, and project plan documentation and approval. Although officials from both departments stated agreement with our recommendation, the departments' actions were not sufficient to preclude delays in delivering the FHCC's IT system capabilities, as we subsequently described in July 2011 and June 2012.

Specifically, our 2011 report noted that none of the three IT capabilities had been implemented by the time of the FHCC's opening, as required by the Executive Agreement;¹⁷ however, FHCC officials reported that the medical single sign-on and single patient registration capabilities subsequently became operational in December 2010.

In June 2012, we again reported on the departments' efforts to implement the FHCC's required IT capabilities, and found that portions of the orders portability capability—related to the pharmacy and consults components—remained delayed.¹⁸ VA and DOD officials described workarounds that the departments had implemented as a result of the delays, but did not have a timeline for completion of the pharmacy component, and estimated completion of the consults component by March 2013.

The officials reported that as of March 2012, the departments had spent about \$122 million on developing and implementing IT capabilities at the FHCC. However, they were unable to quantify the total cost for all the workarounds resulting from delayed IT capabilities.

VA and DOD Recently Changed Their Approach to Developing an Integrated Electronic Health Record

Beyond the aforementioned initiatives, in March 2011 the Secretaries of VA and DOD committed the two departments to developing a new common integrated electronic health record (iEHR), and in May 2012 announced their goal of implementing it across the departments by 2017. According to the departments, the decision to pursue iEHR would enable VA and DOD to align resources and investments with common business needs and programs, resulting in a platform that would replace the two departments' electronic health record systems with a common system. In addition, because it would involve both departments using the same system, this ap-

¹⁵The Executive Agreement identified 12 areas of integration for the FHCC, one of which is information technology.

¹⁶GAO-11-265.

¹⁷GAO, VA and DOD Health Care: First Federal HealthCare Center Established, but Implementation Concerns Need to Be Addressed, GAO-11-570 (Washington, D.C.: July 19, 2011).

¹⁸GAO, VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Evaluation Plan Lacking, GAO-12-669 (Washington, D.C.: June 26, 2012). In this report, we noted that orders portability for radiology had become operational in June 2011 and for laboratory in March 2012.

proach would largely sidestep the challenges they have encountered in trying to achieve interoperability between separate systems.

To oversee this new effort, in October 2011, the IPO was re-chartered and given authority to expand its staffing level and provided with new authorities under the charter, including control over the budget. According to IPO officials, the office was expected to have a staff of 236 personnel—more than 7 times the number of staff originally allotted to the office by VA and DOD—when hiring under the charter was completed.

However, IPO officials told us that, as of January 2013, the office was staffed at approximately 62 percent and that hiring additional staff remained one of its biggest challenges.

Earlier this month, the Secretaries of VA and DOD announced that instead of developing a new common integrated electronic health record system, the departments would now focus on integrating health records from separate VA and DOD systems, while working to modernize their existing electronic health record systems. VA has stated that it will continue to modernize VistA while pursuing the integration of health data, while DOD has stated that it plans to evaluate whether it will adopt VistA or purchase a commercial off-the-shelf product. The Secretaries offered several reasons for this new direction, including cutting costs, simplifying the problem of integrating VA and DOD health data, and meeting the needs of veterans and service members sooner rather than later.

The numerous challenges that the departments have faced in past efforts to achieve full interoperability between their existing health information systems heighten longstanding concerns about whether this latest initiative will be successful. We have ongoing work—undertaken at the request of the Chairman and Ranking Member of the Senate Committee on Veterans Affairs—to examine VA's and DOD's decisions and activities related to this endeavor.

Barriers Exist to Jointly Addressing VA's and DOD's Health Care System Needs

VA's and DOD's revised approach to developing iEHR highlights the need for the departments to address barriers they have faced in key IT management areas. Specifically, in a February 2011 report, we highlighted barriers that the departments faced to jointly addressing their common health care system needs in the areas of strategic planning, enterprise architecture, and investment management.¹⁹ In particular, the departments had not articulated explicit plans, goals, and time frames for jointly addressing the health IT requirements common to both departments' electronic health record systems, and their joint strategic plan did not discuss how or when they propose to identify and develop joint solutions to address their common health IT needs. In addition, although DOD and VA had taken steps toward developing and maintaining artifacts related to a joint health architecture (i.e., a description of business processes and supporting technologies), the architecture was not sufficiently mature to guide the departments' joint health IT modernization efforts. Further, the departments had not established a joint process for selecting IT investments based on criteria that consider cost, benefit, schedule, and risk elements, limiting their ability to pursue joint health IT solutions that both meet their needs and provide better value and benefits to the government as a whole. We noted that without having these key IT management capabilities in place, the departments would continue to face barriers to identifying and implementing IT solutions that addressed their common needs.

In our report, we identified several actions that the Secretaries of Defense and Veterans Affairs could take to overcome these barriers, including the following:

- Revise the departments' joint strategic plan to include information discussing their electronic health record system modernization efforts and how those efforts will address the departments' common health care business needs.
- Further develop the departments' joint health architecture to include their planned future state and transition plan from their current state to the next generation of electronic health record capabilities.
- Define and implement a process, including criteria that consider costs, benefits, schedule, and risks, for identifying and selecting joint IT investments to meet the departments' common health care business needs.

Officials from both VA and DOD agreed with these recommendations, and we have been monitoring their actions toward implementing them. Nonetheless, important work remains, and it takes on increased urgency in light of the departments' revised approach to developing the iEHR. For example, with respect to planning, the departments' joint strategic plan does not describe the new approach to how the de-

¹⁹GAO-11-265.

partments will address their common health care business needs. Regarding architecture, in February 2012, the departments established the Health Architecture Review Board to provide architecture oversight, approval, and decision support for joint VA and DOD health information technology programs. While the board has generally met monthly since May 2012 and has been working to establish mechanisms for overseeing architecture activities, the extent to which the departments' revised approach to iEHR is guided by a joint health architecture remains to be seen. With regard to defining a process for identifying and selecting joint investments, the departments have established such a governance structure, but the effectiveness of this structure has not yet been demonstrated. In particular, the departments have not yet demonstrated the extent to which criteria that consider costs, benefits, schedule, and risks have been or will be used to identify and select planned investments.

In summary, while VA and DOD have made progress in increasing interoperability between their health information systems over the past 15 years, these efforts have faced longstanding challenges. In large part, these have been the result of inadequate program management and accountability. In particular, there has been a persistent absence of clearly defined, measurable goals and metrics, together with associated plans and time frames, that would enable the departments to report progress in achieving full interoperability. Moreover, the Integrated Program Office has not functioned as it was intended—as a single point of accountability for efforts to implement fully interoperable electronic health record systems or capabilities. The 2011 decision to develop a single, integrated electronic health record system to be used across both departments could have avoided or mitigated some of these challenges. However, the more recent decision to reverse course and continue to operate separate systems and develop additional interoperable capabilities raises concern in light of historical challenges. Further, although the departments have asserted that their now planned approach will deliver capabilities sooner and at lower cost, deficiencies in key IT management areas of strategic planning, enterprise architecture, and investment management could continue to stand in the way of VA's and DOD's attempts to jointly address their common health care system needs in the most efficient and effective manner.

Chairman Miller, Ranking Member Michaud, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions that you may have.

GAO Contact and Staff Acknowledgments

If you have any questions concerning this statement, please contact Valerie C. Melvin, Director, Information Management and Technology Resources Issues, at (202) 512-6304 or melvinv@gao.gov. Other individuals who made key contributions include Mark T. Bird, Assistant Director; Heather A. Collins; Kelly R. Dodson; Lee A. McCracken; Umesh Thakkar; and Eric L. Trout.

GAO Highlights of GAO-13-413T

ELECTRONIC HEALTH RECORDS

Long History of Management Challenges Raises Concerns about VA's and DOD's New Approach to Sharing Health Information

Why GAO Did This Study

VA and DOD operate two of the nation's largest health care systems—systems that serve populations of veterans and active service members and their dependents. To better serve these populations, VA and DOD have been collaborating for about 15 years on a variety of initiatives to share data among the departments' health information systems. The use of IT to electronically collect, store, retrieve, and transfer such data has the potential to improve the quality and efficiency of health care. Particularly important in this regard is developing electronic health records that can be accessed throughout a patient's military and veteran status. Making such information electronic can ensure greater availability of health care information for service members and veterans at the time and place of care. Although they share many common business needs, both VA and DOD have spent large sums of money to develop and maintain separate electronic health record systems that they use to create and manage patient health information.

GAO was asked to testify on (1) the departments' efforts, and challenges faced, in electronically sharing health information and (2) the recent change in their approach to developing an integrated electronic health record. In preparing this statement, GAO relied primarily on previously published work in this area.

What GAO Recommends

Since 2001, GAO has made numerous recommendations to improve VA's and DOD's management of their efforts to share health information.

What GAO Found

The Departments of Veterans Affairs (VA) and Defense (DOD) have undertaken a number of patchwork efforts over the past 15 years to achieve interoperability (i.e., the ability to share data) of records between their information systems, however, these efforts have faced persistent challenges. The departments' early efforts to achieve interoperability included enabling DOD to electronically transfer service members' electronic health information to VA; allowing clinicians at both departments viewable access to records on shared patients; and developing an interface linking the departments' health data repositories. As GAO reported, however, several of these efforts were plagued by project planning and management weaknesses, inadequate accountability, and poor oversight, limiting their ability to realize full interoperability.

To further expedite data sharing, the National Defense Authorization Act of 2008 directed VA and DOD to jointly develop and implement fully interoperable electronic health record capabilities by September 30, 2009. The departments asserted that they met this goal, though they planned additional work to address clinicians' evolving needs. GAO identified weaknesses in the departments' management of these initiatives, such as a lack of defined performance goals and measures that would provide a comprehensive picture for managing progress. In addition, the departments' Interagency Program Office, which was established to be a single point of accountability for electronic health data sharing, had not fulfilled key management responsibilities.

In 2009, the departments began work on the Virtual Lifetime Electronic Record initiative to enable access to all electronic records for service members transitioning from military to veteran status, and throughout their lives. To carry this out, the departments initiated several pilot programs but had not defined a comprehensive plan that defined the full scope of the effort or its projected cost and schedule. Further, in 2010, VA and DOD established a joint medical facility that was, among other things, to have certain information technology (IT) capabilities to facilitate interoperability of the departments' electronic health record systems. Deployment of these capabilities was delayed, however, and some have yet to be implemented.

In 2011, the VA and DOD Secretaries committed to developing a new common integrated electronic health record system, with a goal of implementing it across the departments by 2017. This approach would largely sidestep the challenges in trying to achieve interoperability between separate systems. However, in February 2013, the Secretaries announced that the departments would focus on modernizing their existing systems, rather than developing a single system. They cited cost savings and meeting needs sooner rather than later as reasons for this decision. Given the long history of challenges in achieving interoperability, this reversal of course raises concerns about the departments' ability to successfully collaborate to share electronic health information. Moreover, GAO has identified barriers to the departments' jointly addressing their common needs arising from deficiencies in key IT management areas, which could continue to jeopardize their pursuits. GAO is monitoring the departments' progress in overcoming these barriers and has additional ongoing work to evaluate their activities to develop integrated electronic health record capabilities.

Prepared Statement of Jacob B. Gadd

"I'm asking the Department of Defense and the Department of Veterans Affairs to work together to define and build a seamless system of integration with a simple goal: when a member of the Armed Forces separates from the military, he or she will no longer have to walk paperwork from a DoD duty station to a local VA health center; their electronic records will transition along with them and remain with them forever." - President Barack Obama April 9, 2009

It began as a simple goal, something seemingly well within the grasp of a modern, twenty-first century nation – create a seamless, single health record for veterans. Sadly, four years and a billion dollars later, veterans are left with the feeling their government is throwing in the towel. Veterans are left with the feeling that the two great agencies they have served in and been served by, the Department of Defense (DOD) and the Department of Veterans Affairs (VA), have been unable to come to a simple compromise that would have provided a single, unified record. According

to a February 5, 2013 press conference involving both Secretary Panetta of DOD and Secretary Shinseki of VA, a stop gap measure to access both record systems will be put in place and both VA and DOD will continue to maintain and use their legacy systems. This is not what the veterans of America were promised.

Chairman Miller, Ranking Member Michaud and distinguished Members of the Committee:

The American Legion is grateful for the opportunity to come before you today and represent the views of our 2.4 million members on this topic. This is a decision that will have a lasting impact on the entire veterans' community, as well as on active duty service members serving today and the men and women of the future who have yet to answer the call to serve.

The American Legion supported the creation and implementation of a Virtual Lifetime Electronic Record (VLER). The veterans and service officers of our organization saw firsthand the vital need for seamless communication between VA and DOD. In a resolution passed at our National Convention in Milwaukee, WI in the summer of 2011, not only did our members call for implementation of this record as soon as 2013, we also supported the concept strongly enough to note features such a record should include to be of best use to veterans.

The American Legion recommended Veterans Service Organizations (VSOs) and other key stake holders be included in the planning process so we could share our vital experience in the implementation of VLER. Yet VSOs have been left out of the majority of planning. We called for a single system to improve communication between VA, DOD and elements of VA such as the Veterans Benefits Administration (VBA), Veterans Health Administration (VHA) and National Cemetery Administration (NCA) yet this does not appear to be any part of the integrated plan moving forward. The American Legion supported innovation within this system to improve scheduling for veterans' appointments with their healthcare system, yet VHA still struggles with timely appointments for veterans.

The American Legion recommended specific ways in which VLER could help veterans with receive the benefits they earned with their service and sacrifice. With a truly integrated record, when a service member was injured or took ill on active duty, their record could be flagged automatically. Years later, following discharge from service, when VA went back to look at the single, unified record, those flags would stand out and make service connection for those disabilities, a benefit earned by the veteran, far easier and less time consuming. Because VA and DOD steadfastly cling to their previous legacy system, it seems likely this will be impossible and the true benefit of technology cannot be implemented on behalf of the veteran.

Veterans' healthcare records are hurting the disability claims process. This is happening at every level, from currently transitioning veterans to veterans who have been out of service for come time. Improving the healthcare records will help the claims process and will aid VA in their goal to break the back of the backlog. Most importantly, it will help veterans get the benefits they deserve in the timely fashion they deserve.

Current service members transitioning out of the military for medical reasons are experiencing lengthy delays in the Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) process. The average number of days pending for an MEB/PEB case is 374 days. Much of the delay time involves medical records and scheduling appointments. These are service members who have not even left service yet, and the delays with records are impacting their claims.

When they go to transition, even greater problems arise. During an American Legion visit to a DOD/VA Joint Venture site Legion staff had the opportunity to interview veterans about the transition process. One veteran expressed that the transition process had actually worked very well, "except for my records." The veteran explained "I enrolled in VA and they asked me for my DOD treatment records [because they did not have access to them]. I walked over to DOD and they told me the base had run out of paper to print the record and to come back in a few weeks." That our government could not handle this extremely basic task during the transition period for a veteran should be a source of national embarrassment.

The American Legion's work on the Fully Developed Claims (FDC) pilot project has shown what an impact having quick, easy access to records can have. These claims require getting all of the information together up front to expedite the process for veterans, something that would be improved for all veterans if there was a single, unified electronic record. While the average days pending for regular claims in the system is 257 days, in the FDC program, claims are averaging 120 days, which is under Secretary Shinseki's stated goal of 125 days for a veteran's claim. Furthermore, in some locations, such as Pittsburgh, The American Legion has been seeing claims decided accurately in 30-35 days. This is the impact of having all the

useful information available right up front for VA. This can be the key towards breaking the backlog.

The American Legion recognizes that some benefit has come from the collaboration. There has been some improvement in communication between VA and DOD over the past four years, although there is certainly room for much more. The collaboration on this project has led to some beneficial results for veterans in the form of eBenefits Portal, the "Blue Button" which allows for the download of healthcare information and some improvement to transition. However, in the end, the veterans are still not receiving what they were promised – a single, integrated system to track their health from the moment they volunteer to serve to the time their families must access their earned benefits from the National Cemetery Administration.

While VA and DOD may still be pursuing improved communications, they have abandoned the Integrated Electronic Health Record (iEHR) and that should justly raise an alarm amongst the veterans' community. This may save money now, but it wastes a portion of the billion dollars already spent. Furthermore, as illustrated by the impact of having readily accessible records in the claims process, it's an abandonment of technological solutions to the difficult problems the claims system faces.

Veterans should be able to expect 21st century technological solutions that are forward looking, not a retreat to the legacy of the past where VA and DOD maintain their own separate camps. The men and women who serve chose to serve one government, so one government should be able to deliver one healthcare record to them. This technology should not be out of our grasp.

I thank you on behalf of The American Legion for the opportunity to provide our viewpoint on this critical matter.

Executive Summary

The Department of Defense (DOD) and the Department of Veterans Affairs (VA) may still be moving forward with some stop gap measure to allow for access to veterans' health records, but it breaks the promise of a single record from the start of their military career throughout their life. This is important because a single unified record will help streamline the benefits process and allow for improved treatment and health care as they access the VA and DOD systems.

- Having all of the records up front drastically reduces processing time for claims and will help slash the claims backlog. The American Legion has seen this first hand through our work on the Fully Developed Claims program.
- By abandoning a single, unified record, key functionality, such as the ability to "flag" a file when a veteran is injured or takes ill on active duty, will hurt the claims process and the ability for any caregiver accessing the file to have a full disability picture of the veteran and render the best possible care.
- Ultimately, this is not what veterans were promised, and furthermore to abandon this project after a billion dollars worth of development with little to show for it is a breach of trust.
- The American Legion recognizes VA and DOD are still working to some kind of solution, and applauds them for the progress made on some components, such as the eBenefits portal, however we urge them to keep their promise to veterans and deliver the single record the veterans deserve.

Questions For The Record

Letter and Questions From: Hon. Jeff Miller, Chairman, To: Hon. Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs

March 15, 2013

The Honorable Eric K. Shinseki
 Secretary
 U.S. Department of Veterans Affairs
 810 Vermont Avenue, NW
 Washington, DC 20420

Dear Mr. Secretary:

I request your response to the enclosed questions for the record I am submitting in reference to the House Veterans' Affairs Committee hearing entitled "Electronic Health Record U-Turn: Are VA and DoD Headed in the Wrong Direction?" that took

place on February 27, 2013. I would appreciate if you could answer the enclosed hearing questions by the close of business on April 26, 2013.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Ms. Bernadine Dotson at Bernadine.dotson@mail.house.gov. If you have any questions, please call Mr. Eric Hannel, Majority Staff Director of the Oversight & Investigations Subcommittee, at 202-225-3527.

Sincerely,
JEFF MILLER
 Chairman
 JM/eg

Questions for the record:

1. Now that the Department of Veterans Affairs (VA) and the Department of Defense (DoD) have decided against one longitudinal electronic health record (EHR) for all the military personnel, how will interoperability between the two systems be achieved? Will you competitively bid for a system that guarantees the exchange of patient information where the data is treated with the utmost security? How will you test the systems in advance and ensure that software upgrades to continuous interoperability will be included in the price? What will the penalties be for failure to deliver and maintain a system that above all provides patient safety through a comprehensive patient record?

2. What effect has the organizational culture had on VA's inability to continue developing the iEHR as it was originally portrayed?

3. Please provide a full accounting of the staffing levels at the Interagency Program Office (IPO), including how many VA employees are there as of February 27, 2013, how many DoD employees are there as of February 27, 2013, and what the total number of employees from both departments are expected to be at the IPO.

4. If DoD goes with a commercial-off-the-shelf (COTS) product for the health record, what measures are in place to ensure this will integrate with VistA and the development efforts to date on a joint electronic health record?

5. Please provide VA's criteria for halting or terminating a major IT project.

6. A study released in 2009 by Kaiser Permanente showed that implementation of a comprehensive, integrated EHR system for 225,000 ambulatory care patients decreased the "total office visit rate decreased 26.2 percent, the adjusted primary care office visit rate decreased 25.3 percent, and the adjusted specialty care office visit rate decreased 21.5 percent." It also increased "Scheduled telephone visits increased more than eightfold, and secure e-mail messaging, which began in late 2005, increased nearly sixfold by 2007." Kaiser Permanente concluded that, "Introducing an EHR creates operational efficiencies by offering nontraditional, patient-centered ways of providing care. EHRs can help achieve more-efficient contacts between patients and providers, while maintaining quality and satisfaction." Given the high number of veterans who are elderly and/or living in rural areas, have DoD and VA considered how an integrated, rather than interoperable, system could lessen the travel burden while maintaining care for those veteran populations?

7. According to the Institute of Medicine, "the success of any health-care system rests not only on its physical infrastructure and care providers but on how it collects, maintains, transfers, and processes health information, especially patient records." In your opinions would an integrated electronic health record system enable better care than making multiple systems interoperable?

8. How does your plan of interoperability differ from that of the joint DoD-VA hospital at Lovell Health Care Center, which attempted interoperability that the Institute of Medicine found to "raise the specter of patient injury because of negative drug ...or allergy interactions ..." and posed "an unacceptable threat to patient safety"?

9. Do you believe an integrated DoD-VA electronic health record system would decrease the amount of time veterans have to wait to see a physician?

10. What has prevented VA and DoD from establishing a comprehensive electronic health record system? Why did the IPO's cost estimates of \$4–6 billion for integrated electronic health record development double from 2011 to 2012?

11. What effect do you think an integrated electronic health record system would have on delivery of mental health care?

12. Do you believe a comprehensive integrated health record system between DoD and VA is achievable? What is your current timeline for achieving this if so?

Responses From: Department of Veterans Affairs, To: Hon. Jeff Miller, Chairman

1. Question: Now that the Department of Veterans Affairs (VA) and the Department of Defense (DoD) have decided against one longitudinal electronic health record (EHR) for all military personnel, how will interoperability between the two systems be achieved? Will you competitively bid for a system that guarantees the exchange of patient information where the data is treated with the utmost security? How will you test the systems in advance and ensure that software upgrades to continual interoperability will be included in that price? What will the penalties be for failure to deliver and maintain a system that above all provides safety through a comprehensive patient record?

VA Response: The Department of Veteran Affairs (VA) and the Department of Defense (DoD) have two distinct goals and are committed to doing both in the most efficient and effective way possible:

1. Create a seamless health record integrating VA and DoD data
2. Modernize the software supporting DoD and VA clinicians

The first goal targets the President's vision of having one longitudinal electronic health record for all military personnel. The two Departments are taking aggressive actions in 2013 to create a seamless health record, meaning that:

- VA and DoD doctors will be able to see and act on the same integrated patient information.
- Service members and Veterans will be able to go from one care facility to another and their records will follow them.
- Service members and Veterans will be able to securely download and share their medical records with others—creating health record portability for patients.

Lots of information is exchanged across the DoD and the VA today. However most of the information we share today is not standardized or available in real time to support urgent clinical decisions. As an example, different names for “blood glucose” in the DoD and VA systems make it impossible to integrate and track blood sugar levels for diabetics across the two systems. Once these data are mapped to standard codes it will be possible to chart and track the blood sugar levels across time and across DoD and VA records.

So our number one task is taking key clinical information in DoD and VA health records and making it standardized, integrated and immediately available for clinicians so they have the information they need to make critical medical decisions.

2. Question: What effect has the organizational culture had on VA's ability to continue developing the iEHR as it was originally portrayed?

VA Response: VA and DoD are bound by different constraints when it comes to information technology (IT) delivery. VA is bound by the Program Management Accountability System (PMAS), which requires delivery every 6 months or less and uses agile methodology. DoD is bound by DoD 5000, among other things, which is different than the PMAS management process. DoD funds executed for iEHR must be compliant with appropriate governing statutes and regulations, and this can present challenges when trying to execute projects using agile and incremental delivery as required by VA's PMAS process.

Working within these constraints we are taking immediate steps to deliver seamless, integrated health information on an accelerated basis:

We are creating a Data Management Service that will give DoD and VA clinicians access to integrated patient health record information. The service will retrieve data from across DoD and VA for a given patient for seven critical clinical areas—medications, problems, allergies, lab results, vitals, immunizations, note titles—representing the vast majority of most patients' clinical information.

The data will be mapped to open national standards—the same as those being adopted by the private sector—making the data computable and supporting health information sharing not only across the DoD and the VA, but also with private sector providers. The data will be available in near real-time, so clinicians can rely on it for urgent clinical decisions. The standardized, integrated data will fuel a variety of apps, tools and views supporting clinicians. The Data Management Service will be developed and deployed by the beginning of CY 2014. At the beginning of CY 2014, nine high priority sites will have access to these data through a single integrated view. DoD and VA intend to make standardized, integrated clinical record data broadly available to clinicians across the DoD and VA later in CY 2014.

We are also enhancing “Blue Button” functionality, giving patients the ability to download and share their own electronic medical record information (in structured and coded format), helping them take control of their own health.

3. Question: Please provide a full accounting of staffing levels at the Interagency Program Office (IPO), including how many VA employees are there as of February 27, 2013, how many DoD employees are there as of February 27, 2013, and what the total number of employees from both departments are expected to be at the IPO.

VA Response: As the chart below illustrates, DoD and VA remain committed to providing appropriate staffing resources to the DoD/VA Interagency Program Office (IPO). As of February 27, 2013, IPO employed 86 DoD employees and 86 VA employees. Total employment as of February 27, 2013, was 172. Including staff detailed to IPO, IPO was staffed to 72.9 percent as of February 27, 2013. IPO is authorized for a total of 236 full-time equivalent positions.

Staffing Status by Division and Agency Includes 15 DoD Details & 19 VA Details (as of 2/27/2013)								
Division	Agency	Assigned	Detailed	Total Staffed	Total Vacant	Authorized Positions w/o Details	Percent Staffed Permanent End Strength	On-Hand End Strength with Details
Bus Ops	DoD	12	2	14	4			
	VA	5	1	6	7			
Bus Ops Total		17	3	20	11	28	60.7%	71.4%
CIRD	DoD	9	2	11	6			
	VA	4	2	6	8			
CIRD Total		13	4	17	14	27	48.1%	63.0%
Exec Sec	DoD	2	0	2	1			
	VA	2	0	2	0			
Exec Sec Total		4	0	4	1	5	80.0%	80.0%
iEHR	DoD	23	4	27	7			
	VA	17	6	23	14			
iEHR Total		40	10	50	21	61	65.6%	82.0%
IPO HQ	DoD	1	1	2	0			
	VA	3	1	4	1			
IPO HQ Total		4	2	6	1	5	80.0%	120.0%
Tech Div	DoD	23	6	29	24			
	VA	21	7	28	21			
Tech Div Total		44	13	57	45	89	49.4%	64.0%
VLER	DoD	1	0	1	3			
	VA	15	2	17	2			
VLER Total		16	2	18	5	21	76.2%	85.7%
Grand Total		138	34	172	98	236	58.5%	72.9%

Details include: 15 DoD on loan + 19 VA = 34 : Total 172 Total Staffed
*Includes 1 SES Position Pending from Detailed to Assigned

4. Question: If DoD goes with a commercial-off-the-shelf (COTS) product for the health record, what measures are in place to ensure that will integrate with VistA and the development efforts to date on a joint electronic health record?

VA Response: Both DoD and VA intend to leverage open standards, open architecture and open published APIs, ensuring the best-value solution for their future clinical software. This approach will avoid vendor lock-in and will foster a thriving, competitive marketplace.

DoD and VA will each deploy a “core” set of capabilities as early as possible; this “core” set of capabilities will provide the initial base around which a modernized EHR system will be assembled.

VA decided earlier this year to deploy an iEHR “core” based on VistA. DoD will pursue a competitive process to select its “core,” selecting from the vibrant EHR marketplace, to include VistA-derived alternatives, to deliver a best-value solution. Each agency will expand its “core” capabilities to deliver a full suite of modernized clinical support to patients and medical personnel.

5. Question: Please provide VA’s criteria for halting or terminating a major IT project?

VA Response: All major IT projects within VA are managed through PMAS. Projects are made up of increments. An increment is the segment of the project that produces an agreed-to portion of a functional business capability. A project increment has the following characteristics:

- Is a body of work that delivers capability directly related to a project;
- Has a defined start and end date, which does not exceed 6 months;
- Has a defined budget; and
- Requires Business Sponsor acceptance of the delivered capability or capabilities, also known as the incremental deliverable.

The PMAS Guide offers guidance on how to evaluate VA IT projects and increments under varying circumstances if the need to halt or terminate a project arises. PMAS offers means to inform VA leadership of changes and/or risks that may impact project cost, schedule, scope, and quality, known as Yellow and Red Flags. In addition, two PMAS states provide opportunities for halting or terminating projects, the Paused State and the Closed State.

Increments enter the Paused State when it is determined that the increment needs to perform additional planning activities before continuing in the Active State. Increments only enter the Paused-Planning State from the Active State. An increment may enter the Paused-Unfunded State from any PMAS State other than the Closed State. This decision is made by the office of responsibility, or through a TechStat meeting. A project will be Paused after missing three increment deliverables. If, during an early TechStat (fewer than three missed dates) it is determined that the increment is off track, an increment will be placed in the Paused State. In addition, an increment may be placed into the Paused State if the increment loses funding, but still has a valid business need.

There are two types of Paused States:

- Paused-Planning: Projects that are placed in the Paused State to complete additional planning activities after missing three increment deliverables or as determined in an early TechStat as described above. A project or increment may enter the Paused-Planning State only from the Active State.
- Paused-Unfunded: Increments that have lost funding. An increment may enter the Paused-Unfunded State from any PMAS State other than the Closed State.

The Assistant Secretary for Information and Technology or designee can enter an increment into Closed-Stopped State if an increment needs to be halted or terminated. An increment enters or is placed in the Closed State for a variety of reasons. These reasons include, but are not limited to, the following:

- Business priorities have changed; and
- Poor performance.

A project that is stopped will not have the opportunity to restart unless the Business Sponsor indicates that the need for the project still exists and a new project is initiated to accomplish the business need.

6. Question: A study released in 2009 by Kaiser Permanente showed that implementation of a comprehensive, integrated EHR system for 225,000 ambulatory care patients decreased the “total office visit rate decreased by 26.2 percent, the adjusted primary care office visit rate decreases 25.3 percent, and the adjusted specialty care office visit rate decreased 21.5 percent.” It also increased “Scheduled telephone visits increased more than eightfold, and secure e-mail messaging, which began in late 2005, increased nearly sixfold by 2007.” Kaiser Permanente concluded that, “Introducing an EHR creates operational efficiencies by offering nontraditional, patient-centered ways of providing care. EHRs can help achieve more-efficient contacts between patients and providers, while maintaining quality and satisfaction.” Given the high number of veterans who are elderly and/or living in rural areas, have DoD and VA considered how an integrated, rather than interoperable, system could lessen the travel burden while maintaining care for those veteran populations?

VA Response: This specific study cites impacts of implementing a comprehensive electronic medical record (EMR) system using an integrated health care delivery system. It is important to note that this is not to be confused with attempts to integrate two disparate health care systems across organizational boundaries. It is also important to note that this study was done in a health system that had only limited prior experience with an EMR. Only a third of Kaiser's facilities had used a fully functional EMR for approximately 2 years; the others used a read only EMR in parallel with paper records. An integrated health care delivery system is one which integrates an organization's EHR across inpatient and outpatient care settings, clinical decision support, and real-time connectivity to laboratory, pharmacy, radiology, and other ancillary systems. DoD and VA both have extensively implemented EMRs in both inpatient and outpatient settings for many years, but independently within each Department. As such, the Departments have already realized many of the efficiencies noted in this article within their respective health care systems.

The challenge is to extend those efficiencies across Departmental boundaries to make care in effect seamless for those who transition from one system to the other. The Departments are taking steps to coordinate workflow, availability of data for decision-making and clinical decision support across the two Departments.

7. Question: According to the Institute of Medicine, "the success of any health-care system rests not only on its physical infrastructure and care providers but on how it collects, maintains, transfers, and processes health information, especially patient records." In your opinions would an integrated electronic health record system enable better care than making multiple systems interoperable?

VA Response: We agree that this is a top priority. The key issue is to make key patient data—whether from the private sector, the DOD or VA—seamlessly available for clinical decisions. This does not require that the two Departments use the same software systems.

For example, two different email systems can send email to each other, because email records are easily exchangeable and sharable. Private sector experience shows, using the same system does not guarantee that information can be shared. The important thing is that both systems use national standards to express the content and format of the information. Since these are the same standards being used in private sector systems, DoD and VA clinicians will be able to exchange information with each other as well as with private providers.

8. Question: How does your plan of interoperability differ from that of the joint DoD-VA hospital at Lovell Health Care Center, which attempted interoperability that the Institute of Medicine found to "raise the specter of patient injury because of negative drug ... or allergy interactions ..." and posed "an unacceptable threat to patient safety"?

VA Response: As noted in the Institute of Medicine (IOM) report, the two independent systems currently in place at the James A. Lovell Federal Health Care Center (JALFHCC) have limited ability to share patient information, which significantly reduces clinical efficiency. The lack of ability to share patient data results in time-consuming workarounds, including manual checking of important drug interactions. By providing a seamless flow of health care data, quality, safety, and efficiency gains can be realized at JALFHCC. As we indicated previously, our number one task is taking key clinical information in DoD and VA health records and making it standardized, integrated and immediately available for clinicians so they have the information they need to make critical medical decisions.

9. Question: Do you believe an integrated DoD-VA electronic health record system would decrease the amount of time veterans have to wait to see a physician?

VA Response: Our accelerated actions in 2013 to make available a seamless health record that integrates DOD and VA information for clinicians is likely to increase productivity in the health care delivery system, resulting in decreased appointment waiting time. This is separate and distinct from our plans to modernize the software supporting DoD and VA clinicians.

10. Question: What has prevented VA and DoD from establishing a comprehensive electronic health record system? Why did the IPO's cost estimates of \$4-6 billion for integrated electronic health record development double from 2011 to 2012?

VA Response: The original budget estimate in 2011 projected a development and deployment budget of \$4-\$6 billion, this estimate was conducted using analogous

work based on the requirements and architecture known at that early stage. IPO recently developed a bottom-up life cycle cost estimate (LCCE) in September 2012. This LCCE was nearly double the budget estimate that was made when the program was just beginning. The development of LCCE was required as part of the Milestone B approval process, a part of DoD's acquisition process and the process adopted across the broader iEHR Program. While VA agrees with the methodology used to develop the new LCCE, VA is still working with IPO to adjust the LCCE to reflect the lesser costs seen by VA as a result of fully embracing PMAS.

However, the recent decision to accelerate data interoperability capabilities and shift the strategy to select a minimal core set of capabilities from an existing EHR system is likely to drive costs down.

11. Question: What effect do you think an integrated electronic health record system would have on delivery of mental health care?

VA Response: The work of both Departments to create a seamless health record that integrates data from both systems will improve care coordination and accelerate selection of effective treatments or identification of treatments that have been tried and proven ineffective for an individual. Having seamless, integrated information available longitudinally will also help in the identification of best practices in treatment of mental health conditions. Longitudinal health records for individuals receiving mental health care will also help identify potential risk factors and improve care delivery for both departments.

12. Question: Do you believe a comprehensive integrated health record system between DoD and VA is achievable. What is your current timeline for achieving this if so?

VA Response: DoD, VA, and the DoD/VA IPO believe that taking key clinical information in DoD and VA health records and making it standardized, integrated and immediately available for clinicians so they have the information they need to make critical medical decisions. These seamless, integrated data will be available in certain sites in 2013, and broadly available to DoD and VA clinicians in 2014. In addition, we also expect that DoD and VA patients will be able to download and transmit their health records via Blue Button in the industry standard formats published by the Department of Health and Human Services no later than May 31, 2013.

Letter and Questions From: Hon. Michael Michaud, Ranking Minority Member, To: Hon. Chuck Hagel, Secretary of Defense

March 5, 2013

The Honorable Chuck Hagel
Secretary of Defense
1000 Defense Pentagon
Washington, DC 20301-1000

Dear Mr. Secretary:

In reference to our Full Committee hearing entitled, "Electronic Health Record U-Turn: Are VA and DoD Headed In The Right Direction?" that took place on February 27, 2013, I would appreciate it if you could answer the enclosed hearing questions by the close of business on April 15, 2013.

Committee practice permits the hearing record to remain open to permit Members to submit additional questions to the witnesses. Attached are additional questions directed to you.

In preparing your answers to these questions, please provide your answers consecutively and single-spaced and include the full text of the question you are addressing in bold font. To facilitate the printing of the hearing record, please e-mail your response in a Word document, to Carol Murray at Carol.Murray@mail.house.gov by the close of business on April 15, 2013. If you have any questions please contact her at 202-225-9756.

Sincerely,

MICHAEL H. MICHAUD
Ranking Member

CW:cm

Questions Submitted by Ranking Member Michaud

1. When was iEHR designated a Program of Record? What acquisition type and category is it, and what acquisition activities and milestones have been accomplished since designation?

2. Please provide the Committee with the budgetary resources provided to the IPO since its inception and the anticipated resource requirements for FY 2014 through FY 2017.

3. Please provide the Committee with all previous milestones announced by the IPO and whether or not these milestones have been reached. If a milestone has been reached has it been reached by the projected date?

4. In your testimony you state that “[t]o reduce cost and technical risk, the two Departments agreed to modify the strategy.” Please provide the Committee with supporting materials to support the conclusion that the revised strategy will indeed “reduce cost and technical risk”, including alternatives considered

Question #1 From: Hon. Michael Michaud, Ranking Minority Member, To: DCMO McGrath

Question: When was iEHR designated a Program of Record? What acquisition type and category is it, and what acquisition activities and milestones have been accomplished since designation?

Answer: Following the decision between the Secretaries of Defense and Veterans Affairs on March 17, 2011 and the subsequent re-chartering of the Interagency Program Office in October 2011, iEHR was identified in the DoD FY2013 budget submission in February 2012.

The Deputy Chief Management Officer as Milestone Decision Authority (MDA) signed an Acquisition Decision Memorandum on April 18, 2012 to define the iEHR acquisition program based on prior agreements reached by the Secretaries of Defense and Veterans Affairs. iEHR is a Major Automated Information System.

The MDA approved iEHR Increment 1 Milestone B and Increment 2 Milestone A on December 4, 2012 and approved the Increment 1 Acquisition Program Baseline on February 13, 2013. Currently, Increment 1 functionality testing continues in a laboratory environment, and operational testing is scheduled to begin in May 2013.

Other related acquisition activities and milestones include:

- Implemented Single Sign-On and Context Management capabilities at site in San Antonio.
- Achieved Development and Test Center / Development and Test Environment Initial Operational Capability.
- Conducted Increment 1 Test Readiness Review.
- Conducted Increment 2 Initial Design Review.
- Awarded Service-Oriented Architecture/Enterprise Service Bus contract.
- Released Technical Specifications Request for Information (RFI).
- Released RFI for Pharmacy capability and update.
- Released RFI for Immunization capability.

The Department is exercising close oversight of this program to limit government liability and expenditure of funds to specific increments, deliverables and outcomes.

Question #2 From: Hon. Michael Michaud, Ranking Minority Member, To: DCMO McGrath

Question: Please provide the Committee with the budgetary resources provided to the IPO since its inception and the anticipated resource requirements for FY2014 through FY2017.

Answer: The IPO was re-chartered in October 2011 to serve as the joint program office for the new DoD/VA iEHR mission. Below, you will find a table summarizing the FY2012 and FY2013 funds that were appropriated to DoD for iEHR, as well as the funding proposed in the President's FY2014 Budget Submission for FY2014 – FY2017. Please note that many of the FY2012 and FY2013 funds are multi-year appropriations and that DoD has spent \$185.43M of these budgeted funds to date.

\$M	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
DoD iEHR	\$449.795	\$331.016	\$344.101	\$216.022	\$217.100	\$218.094

Question #3 From: Hon. Michael Michaud, Ranking Minority Member, To: DCMO McGrath

Question: Please provide the Committee with all previous milestones announced by the IPO and whether or not these milestones have been reached. If a milestone has been reached has it been reached by the projected date?

Answer: The following are key deliverables identified by the IPO in support of iEHR. While you will notice that some of these milestones have been delayed, significant progress has been made, and we believe, in conjunction with our new revised strategy, the iEHR initiative remains on a path to deliver on the President's vision.

Lifecycle Cost Estimate

Milestone	Planned Date	Completion Date	Comment
Deliver Life Cycle Cost Estimate (LCCE) for iEHR Increments 1 through 6	8/29/12	8/29/12	

Single Sign On / Context Management (SSO/CM) with Virtualization Platform (AVHE) Capability Deliveries

“Single Sign-On” enables a user to access multiple applications after logging in only once. “Context Management” allow clinicians to choose a patient once during an encounter and have all required applications are able to present information on the patient being treated. This capability has been successfully deployed to the Development Test Center (DTC) for testing.

Milestone	Planned Date	Completion Date	Comment
Select single SSO/CM solution for use by both Departments	5/17/11	5/17/11	
Complete installation at San Antonio	10/31/12	11/2/12	
Complete installation at Portsmouth, Tripler, and Landstuhl	12/31/12, 2/28/13, 3/29/13		Product implementation challenges identified in SATX resulted in decision to delay additional site installations

Janus Graphical User Interface (GUI) Pilot Capability Deliveries

Janus Joint Legacy Viewer (JLV) is a key enabler for the iEHR User Experience (UX), providing an integrated read-only view of the longitudinal patient record from DoD and VA sources. This deliverable tracks the implementation of the first delivery of an early UX pilot application focusing on the ability to “read” information contained in the iEHR system. Future deliveries will include the ability to write new information to the health record.

Milestone	Planned Date	Completion Date	Comment
Implement Janus JLV at the James A. Lovell Federal Health Care Center	12/1/11	12/1/11	
Implement Janus JLV at Audie Murphy VAMC and Brooke Army Medical Center in San Antonio (3rd Site)	9/30/12	11/28/12	

Development and Test Center (DTC)

The DTC provides a testing configuration that mimics the operational healthcare environment and infrastructure.

Milestone	Planned Date	Completion Date	Comment
Install hardware	3/30/12	6/15/12	
Receive Authority to Operate	1/15/12	6/19/12	
Install infrastructure	12/30/12		Delays primarily due to manpower availability caused by competing operational capability priorities and external organization dependencies
Install legacy clinical applications	12/30/12		

Establish Service Oriented Architecture (SOA) Suite / Test Environment

The SOA Suite and Enterprise Service Bus (ESB) are the heart of the infrastructure that supports clinical applications. These two component parts allow the communications between the data, services and applications that will comprise iEHR. The first deliverable stands up the SOA Suite and ESB in a test environment.

Milestone	Planned Date	Completion Date	Comment
Award contract	9/30/2011	3/20/2012	Initial award voided due to vendor protest. Contract re-awarded.
Install SOA/ESB in contractor sandbox	4/19/12	4/19/12	
Install SOA/ESB in government sandbox	7/26/12	7/26/12	
Conduct SOA Suite demonstration and evaluation	9/19/12	9/17/12	
Install SOA/ESB in DTC	11/19/12	11/19/12	
Receive SOA/ESB Authority to Operate	1/18/13	2/27/13	
Install SOA/ESB in San Antonio and Hampton Roads DoD Sites	3/15/13	3/15/13	

Health Data Dictionary Made Openly Available and VA Legacy Data Mapping

The 3M Health Data Dictionary (HDD) is the common data model used by all DoD medical treatment facilities. A key tenet of the iEHR initiative is VA's agreement to adopt this data model, which is based on national standards and will ensure integrated common data for all patient information across DoD and VA.

Milestone	Planned Date	Completion Date	Comment
Sign license agreement to make HDD publicly available	7/31/11	5/23/12	Protracted license negotiations with VA
Award contract for VA legacy data mapping	8/6/12	8/6/12	
Issue final report on data mapping	12/15/12	1/31/13	
Release core HDD content	9/21/12	9/21/12	

Milestone	Planned Date	Completion Date	Comment
Issue collaboration specifications	2/4/13	2/4/13	

Integrated Program Level Requirements Approved by the Health Executive Council (HEC)

With the active participation of clinical staff from both Departments, the iEHR program will harmonize healthcare delivery processes. The DoD/VA Interagency Clinical Informatics Board (ICIB) and the IPO have jointly prioritized clinical capabilities and grouped them into planning increments based on functional priority, technical feasibility, and financial viability. The ICIB has provided the integrated Program Level Requirements (iPLR), which detail the functional requirements for the defined joint capabilities and serve as the foundation of the iEHR program. Definition of iEHR functional requirements is overseen by the ICIB with approval by the DoD/VA HEC.

Milestone	Planned Date	Completion Date	Comment
Approve Integrated Program-Level Requirements	5/1/12	7/27/12	ICIB and HEC approval delays
Approve Lab and Access Control Business Justification Packages (BJPs)	8/30/12	10/17/12	ICIB and HEC approval delays
Approve Immunization BJP	6/18/12	11/30/12	ICIB and HEC approval delays
Approve Identity Management BJP	8/14/12	10/17/12	ICIB and HEC approval delays
Approve Pharmacy BJP	11/30/12	11/30/12	

Make iEHR Architecture Artifacts Available to Potential Vendors and Complete Initial Technical Design

The Technical Specifications Package (TSP) contains technical documents including architecture artifacts that provide high-level technical and business requirements that define the needs for a standardized and interoperable DoD/VA iEHR solution. These artifacts have been uploaded to <http://www.tricare.mil/tma/ipo/vendor.aspx> and have been updated since then.

Milestone	Planned Date	Completion Date	Comment
Publish Technical Specification Package	5/11/12	5/11/12	
Conduct iEHR Initial Design Review	10/12/12	11/28/12	

Acquire Clinical Capabilities

Milestone	Planned Date	Completion Date	Comment
Issue Pharmacy RFI	5/31/12	5/31/12	
Issue Laboratory RFI	6/12/12	6/12/12	
Issue Immunization RFI	8/6/12	8/6/12	

Question #4 From: Hon. Michael Michaud, Ranking Minority Member, To: DCMO McGrath

Question: In your testimony you state that “[t]o reduce cost and technical risk, the two Departments agreed to modify the strategy.” Please provide the Committee with supporting materials to support the conclusion that the revised strategy will indeed “reduce cost and technical risk”, including alternatives considered.

Answer: Our revised strategy provides a number of advantages as DoD and VA work toward our joint goals of ensuring that all health data for an individual can be brought together into a seamless electronic health record and modernizing or replacing our legacy health information technology systems. Broadly, the new strategy accelerates the delivery of important data interoperability and other benefits and ensures that those benefits are not dependent on the delivery of a new system. It also simplifies an extremely complex program by using a core set of applications from existing EHR technology, to which additional modules or applications could be added as necessary, thereby also reducing cost.

First, for the rest of this year, our efforts are focused on completing the data interoperability work that will create a single health record for all personnel, regardless of whether they are treated at a DoD or VA hospital. This work can be done without replacing the underlying health information technology systems for either Department. By quickly delivering on a key component of the President’s commitment to our veterans, this work significantly reduces the overall risk of the program.

Second, in December 2012, a group of clinical and technical experts from DoD and VA came together to evaluate the concept of a tightly integrated set of Core iEHR capabilities, provided by a single vendor, as a foundation for facilitating Clinical Transformation while maximizing patient safety and optimal functionality. A number of benefits result from acquiring a core set of clinical applications, including:

1. Allowing the government to consider the use of commercially available existing Generation 3 electronic health record systems, which are already deployed and proven. This would allow for the system to evolve with industry, reducing the risk of needing to modify or modernize the system in the near future.
2. Ensuring that the clinical capabilities which must be tightly integrated to ensure patient safety are already integrated when implemented. Reducing the number of interfaces between key capabilities and storing and retrieving patient data in a single database minimizes the likelihood of error or degradation in collecting, transmitting, computing or interacting with patient data, thereby improving patient safety.
3. Reducing the amount of government integration and interfacing required. Rather than the government bearing the cost, time, and risk of integrating as many as 50 clinical applications one-by-one, a core set of a dozen or more clinical applications will be delivered at one time.
4. Reducing reliance on legacy systems by accelerating the timeline for implementation and migration of business processes into the new system.
5. Ensuring that Clinical Capabilities fulfill a series of key care scenarios, rather than just conforming to a list of individual, disparate functional requirements.

Question #5 From: Hon. Beto O’Rourke, To: Hon. Jonathan A. Woodson

Question: Former Army Surgeon General Schoomaker and several other military leaders testified in 2009 that the DoD needs to replace their current clinical system, AHLTA, in order to improve quality of care, patient engagement, provider satisfaction, and efficiency. The VA’s clinical system VistA needs significant modernization. I understand that the DoD was well into planning for commercial clinical system acquisition when those plans were halted in order to coordinate with the VA. Isn’t it true that after two years of planning among the DoD and VA, the proposed combined system would force the DoD to wait until 2017 to replace core clinical systems (8 years after General Schoomaker’s testimony)?

Answer: No, it is not correct that the proposed combined system would force the DoD to wait until 2017. Access to the Armed Forces Health Longitudinal Technology Application (AHLTA) will be turned off as each hospital gets the complete set of integrated electronic health record (iEHR) capabilities.

The original iEHR plan proposed by the Department of Defense (DoD)/Department of Veterans Affairs (VA) Interagency Program Office (IPO) planned for the de-

velopment of six increments over a five year period ending 2017. Each increment will be deployed after it is developed. Early increments will take about two years to deploy across the entire enterprise because we also have to develop and deploy the new infrastructure that support the increments. Later increments will deploy much faster because they will be installed in the then-existing regional data centers allowing the later increments to be 'turned on' for each hospital in the region. As the increments are deployed to each hospital, and when that particular hospital acquires enough of the new capabilities that replace AHLTA, then access to AHLTA from that hospital would be turned off. AHLTA will be finally turned off with the deployment of the iEHR to that last hospital. This plan meets the requirement of providing global access to Service member's healthcare record under both the legacy electronic health record system (EHRS) and new iEHR as we transition. There is a very similar plan under development to support a decision for an iEHR core by DoD- no matter which core DoD chooses.

Question #6 From: Hon. Beto O'Rourke, To: Hon. Jonathan A. Woodson

Question: The plans announced by the Secretaries earlier this month would allow the DoD to rapidly replace their failing system with a commercial system. Why shouldn't we let the DoD adopt a commercially available system that can meet their patient care and safety needs today even if it's not the same as the VA's system?

Answer: The Department of Defense's (DoD) is currently doing an analysis in support of selecting a core from an electronic healthcare record system (EHRS). This analysis includes an assessment of the Department of Veterans Affairs' (VA) VistA system EHRS as well as what is available from the commercial EHRS market, as part of the effort to accelerate the development and deployment of the integrated electronic health record (iEHR) with reduced risk, in less time, with more capabilities, and less cost. A decision by DoD should be announced soon where DoD will select either VistA or decide to execute an acquisition plan for a commercial EHRS core. If DoD decides to acquire a commercial EHRS core, it will fully support healthcare data interoperability between DoD and VA.

A critical requirement of the EHRS solution is to ensure that healthcare data are shared and interoperable between DoD and VA. This will be achieved through the use of healthcare data standards as well as the use of a common data model supported by the Health Data Dictionary (HDD). All healthcare data will be stored using these standard formats. This ensures that clinicians can capture, retrieve, and view the healthcare data from either a DoD or VA EHRS.

Question #7 From: Hon. Beto O'Rourke, To: Hon. Jonathan A. Woodson

Question: Members of this committee have fairly voiced their concerns about the Secretaries' recent decision and whether the DoD and VA will be able to share patient information if they are on separate systems, as this has been challenging to do with their current government-developed systems. Commercial systems can use standard methods to exchange patient information. Couldn't the DoD use these methods to share patient information with the VA if they adopted a commercial system? I also understand that the DoD and VA share as many if not more patients with commercial healthcare organizations as they do among the two agencies. If they used commercial systems, wouldn't the DoD and VA be able to exchange information with the commercial healthcare neighbors that are providing care to their members?

Answer: Yes, the Department of Defense (DoD) could use standard methods to share patient information with the Department of Veterans Affairs (VA) if DoD adopted a commercial system. If DoD and VA used commercial systems, they would be able to exchange information with the commercial healthcare neighbors. The exchange of healthcare data, and standardized healthcare data interoperability, is built into the integrated electronic health record (iEHR) solution. By using a common information infrastructure framework (CIIF), common shared federated data repositories, the Enterprise Service Bus / Service Oriented Architecture (ESB/SOA), common healthcare data standards, and the Health Data Dictionary (HDD), the Departments will be able to exchange regardless of whether either Department uses commercial system components.

It is this focus on exchange of standardized data that will also enable exchange with private sector providers.

Question #8 From: Hon. Beto O'Rourke, To: Hon. Jonathan A. Woodson

Question: Our nation's healthcare leaders have switched from self-developing complex clinical systems to purchasing commercially available systems. These groups include Johns Hopkins Medicine, Partners HealthCare, and Kaiser Permanente. They report that commercial systems lower operating costs, increase efficiency, and improve care. George Halverson, the CEO of Kaiser Permanente, has said that they transformed their care delivery, improved their patients' outcomes, and are saving \$5 billion per year as a result of their electronic systems. Why shouldn't the DoD follow the same path?

Answer: It is possible that the Department of Defense (DoD) could follow the same path as the major healthcare delivery organizations (HDOs) in the nation have followed in moving away from self-developed electronic health record systems (EHRs) and towards a commercially available EHR. DoD is performing an analysis in support of selecting an EHR core. This analysis will assess the Department of Veterans Affairs' (VA) VistA EHR along with offerings from the commercial EHR market leading to an EHR solution that has a lower risk, lower cost, with more capacities, and in a shorter time, as contrasted to a government-integrated solution. DoD will likely assess a number of factors including risk, safety, schedule, capabilities, and costs. The DoD decision is imminent.

Regardless of the direction DoD goes in selecting its EHR core, commercially available software capabilities are very much a part of the integrated electronic health record (iEHR) plan. The DoD/VA Interagency Program Office (IPO) has identified a number of joint capabilities that will be shared between the Departments, married to a shared infrastructure that will be acquired using an adopt/buy/create process. This means that IPO will first seek the adoption of viable Government Off The Shelf (GOTS) or open source (OS) software, then consider buying Commercial Off The Shelf (COTS) software, before it creates EHR software itself. The government has learned many times that the adoption or purchase of existing software results in a far lower total cost of ownership as contrasted to the development of in-house software. Nevertheless, there are some cases where these adopt/buy alternatives don't exist so that IPO will have to develop solutions. Every effort will be made to keep the 'create' approach to a minimum.

Question #9 From: Hon. Beto O'Rourke, To: Hon. Jonathan A. Woodson

Question: Why should we ask our service member and families to wait for a newly-developed system when there are commercially available systems running our nation's top ranked hospitals and clinics?

Answer: We do not intend to make our service members and their families wait for a newly developed system. Today, the DoD's electronic health record system allows for world-class care to be provided at all DoD medical facilities, and we have empowered our beneficiaries to actively engage in their own care by reviewing and downloading their personal health information. In addition, DoD and the Department of Veterans Affairs (VA) currently share more health information than any two organizations in the nation.

As we move forward to continue to enhance our care of service members and their families, we have been working on two important tasks: the replacement of our aging legacy electronic health record system while simultaneously establishing full data interoperability with VA (i.e., creation of a single integrated electronic health record). First, by achieving interoperability of health care data, patients will be able to download/transmit their health records and doctors will be able to get the data they need to inform clinical decisions, regardless of where the user sits and where care is provided. The second area of emphasis has been the replacement of our current underlying health information technology (IT) systems. If we accomplish the first objective, we will achieve the President's goal. The second objective is eventually necessary for both DoD and the VA, but does not have to be done to achieve data interoperability. In addition, the replacement of our legacy health IT system will be done in a way that is transparent to the patients that we serve.

We agree that there are viable commercially available health IT systems, and so we are currently evaluating the full range of options for DoD's "core" system, to include best commercial solutions. We believe that this approach of beginning with a core set of capabilities will reduce the cost and time required to replace our legacy system.

Question #10 From: Hon. Beto O'Rourke, To: Hon. Jonathan A. Woodson

Question: By waiting for a new system to be developed, what opportunities could the DoD and VA be missing to improve health outcomes that commercial healthcare organizations are already achieving today through the use of their commercial system?

Answer: Our goal is to continue to improve health outcomes and take advantage of advances in the commercial marketplace as quickly as possible. As we move forward to continue to enhance our care of service members and their families, we are currently evaluating the full range of options for DoD's "core" system, to include best commercial solutions. We intend to make a decision on how we will proceed within 30 days and then will move as rapidly as possible to acquire the best possible solution.

Letter From: Hon. Michael Michaud, Ranking Minority Member, To: Hon. Gene L. Dodaro, Comptroller General of the United States, Government Accountability Office

May 2, 2013

The Honorable Gene L. Dodaro
Comptroller General of the United States
Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Dodaro:

In reference to our Full Committee hearing entitled, "Electronic Health Record U-Turn: Are VA and DoD Headed In The Right Direction?" that took place on February 27, 2013, I would appreciate it if you could answer the enclosed hearing questions by the close of business on June 2, 2013.

Committee practice permits the hearing record to remain open to permit Members to submit additional questions to the witnesses. Attached are additional questions directed to you.

In preparing your answers to these questions, please provide your answers consecutively and single-spaced and include the full text of the question you are addressing in bold font. To facilitate the printing of the hearing record, please e-mail your response in a Word document, to Carol Murray at Carol.Murray@mail.house.gov by the close of business on June 2, 2013. If you have any questions please contact her at 202-225-9756.

Sincerely,

MICHAEL H. MICHAUD
Ranking Member

CW:cm:jz

Question From: Hon. Beto O'Rourke, To: Ms. Valerie C. Melvin, Director, Information Management and Technology Resources Issues, U.S. Government Accountability Office

Ms. Valerie Melvin

1. The same 2011 GAO report states that we have already invested \$600 million in VistA modernization over 6 years and \$2 billion on AHLTA over 13 years. Can we justify spending ongoing tax payer dollars to support these expensive systems while an entirely different system is being developed? Couldn't we begin immediately replacing these expensive systems if the DoD and VA purchased commercial systems?

Letter From: Ms. Valerie C. Melvin, Director, Information Management and Technology Resources Issues, U.S. Government Accountability Office, To: Hon. Michael Michaud, Ranking Minority Member

June 14, 2013

The Honorable Michael H. Michaud

Ranking Member
Committee on Veterans' Affairs
House of Representatives

Subject: *Department of Veterans Affairs and Department of Defense Electronic Health Records: Response to Post-Hearing Questions for the Record*

Dear Mr. Michaud:

This letter responds to your May 2, 2013, request that we address questions submitted for the record by Representative Beto O'Rourke, related to our statement at the February 27, 2013, hearing on the direction of the Department of Veterans Affairs (VA) and Department of Defense (DOD) Integrated Electronic Health Record (iEHR).¹ At the hearing, we discussed, among other things, the two departments' efforts over the past 15 years to achieve interoperable electronic health records and the persistent challenges that they have faced as a result of project planning and management weaknesses, inadequate accountability, and poor oversight. The enclosure provides Representative O'Rourke's questions and our responses, which are based on our previously issued products.

If you have questions regarding the responses, please contact me at (202) 512-6304 or melvin@gao.gov.

Sincerely yours,

Valerie C. Melvin
Director, Information Management and Technology Resources Issues

Enclosure-1

Questions Submitted by Representative Beto O'Rourke

1. The same 2011 GAO report states that we have already invested \$600 million in VistA modernization over 6 years and \$2 billion on AHLTA over 13 years. Can we justify spending ongoing tax payer dollars to support these expensive systems while an entirely different system is being developed? Couldn't we begin immediately replacing these expensive systems if the DOD and VA purchased commercial systems?

Regardless of the direction of the departments' plans, DOD and VA will need to operate and sustain their existing health information systems until new or modernized systems are ready for operation. As you have noted, both departments have invested significant time and resources on health system modernizations; however, the departments have not yet been successful in these efforts. Consequently, at this time, they will need to rely on their existing electronic health information systems to collect, store, and retrieve patient health information in order to provide care for military personnel and veterans.²

The purchase of commercial systems could potentially represent an effective approach to modernizing or replacing the departments' existing electronic health information systems. However, as we have reported, the effective acquisition of commercial information technology (IT) systems is a complex undertaking that should incorporate activities to ensure that (1) commercial product modification is effectively controlled, (2) relationships among commercial products are understood before acquisition decisions are made, and (3) the organizational impact of using new system functionality is proactively managed.³ Both DOD and VA have struggled to successfully manage their respective major IT acquisitions. Specifically, we reported in 2010 that six of nine DOD implementations of commercial enterprise resource planning systems had experienced schedule delays ranging from 2 to 12 years, and five had incurred cost increases ranging from \$530 million to \$2.4 billion.⁴ Further, in March 2013, we issued a report on cost, schedule, and performance of DOD's major automated information systems and found that 11 selected programs were either costing more than planned, taking longer than planned to deliver, and/or had not

¹ GAO, *Electronic Health Records: Long History of Management Challenges Raises Concerns about VA's and DOD's New Approach to Sharing Health Information*, GAO-13-413T (Washington, D.C.: February 27, 2013).

² GAO-13-413T and GAO, *Electronic Health Records: DOD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs*, GAO-11-265 (Washington, D.C.: Feb. 2, 2011).

³ GAO, *Information Technology: DOD's Acquisition Policies and Guidance Need to Incorporate Additional Best Practices and Controls*, GAO-04-722 (Washington, D.C.: July 30, 2004).

⁴ GAO, *DOD Business Transformation: Improved Management Oversight of Business System Modernization Efforts Needed*, GAO-11-53 (Washington, D.C.: Oct. 7, 2010) and *High-Risk Series: An Update*, GAO-13-283 (Washington, D.C.: Feb. 14, 2013).

performed as intended.⁵ Similarly, VA has been challenged in successfully managing its major IT acquisitions. For example, we reported in May 2010 that VA's effort to replace its outpatient scheduling system was hindered by ineffective oversight and weaknesses in key project management areas, including acquisition planning, requirements development, and risk management.⁶ Until these project management weaknesses are addressed, the two departments will continue to jeopardize their ability to achieve modernized health information systems—whether through their own development or commercial acquisitions.

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⁵ GAO, Major Automated Information Systems: Selected Defense Programs Need to Implement Key Acquisition Practices, GAO-13-311 (Washington, D.C.: Mar. 28, 2013).

⁶ GAO, Information Technology: Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System, GAO-10-579 (Washington, D.C.: May 27, 2010).