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EXAMINING THE PROGRESS OF ELECTRONIC HEALTH RECORD INTEROPERABILITY BETWEEN THE U.S. DEPARTMENT OF VETERANS AFFAIRS AND U.S. DEPARTMENT OF DEFENSE

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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EXAMINING THE PROGRESS OF ELECTRONIC HEALTH RECORD INTEROPERABILITY BETWEEN THE U.S. DEPARTMENT OF VETERANS AFFAIRS AND U.S. DEPARTMENT OF DEFENSE

TUESDAY, JULY 14, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Space, Walz, Adler, Hall, Roe, and Bilbray.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Good morning. This meeting is July 14th, 2009 and this hearing will come to order. Welcome to the Subcommittee on Oversight and Investigations. This is a hearing on the Interagency Program Office (IPO) examining the progress of the electronic health record interoperability between the U.S. Department of Veterans Affairs (VA) and U.S. Department of Defense (DoD).

I would like to thank everyone for attending today's Oversight and Investigations Subcommittee hearing entitled the Interagency Program Office examining the progress of electronic health record interoperability between the VA and DoD.

Thank you especially to our witnesses for testifying today.

We are here today to examine the progress being made by the DoD and the VA to achieve electronic health record interoperability.

Currently there is no single VA/DoD electronic record that captures all the information needed for delivery of health care and benefits to servicemembers, veterans, and their beneficiaries.

As many of you know, on April 9th, 2009, President Obama, along with Secretary of Veterans Affairs Eric Shinseki and Secretary of Defense Robert Gates, announced that the VA and DoD would create a joint lifetime electronic record that would contain information from the day the individual enters military service through their careers and for the remainder of their lives as veterans if they enter the VA system.

Mandated by the "National Defense Authorization Act (NDAA) of 2008," the Interagency Program Office was established to act as the single point of accountability for DoD/VA electronic health record interoperability.

As the September 30th deadline for electronic health record interoperability approaches, it is imperative to ensure that both the DoD and VA are organized and working together to deliver a comprehensive system that will modernize and simplify record sharing between Departments.

In 1982, under the VA and DoD "Health Resources Sharing and Emergency Operations Act," both DoD and VA were first encouraged to find common ground to create a more efficient health care system that would be worthy of the sacrifices our men and women make every day.

Since then, although there have been significant improvements in sharing patient record information, both the DoD and VA have yet to find the common ground to achieve full electronic health care interoperability.

The U.S. Government Accountability Office's (GAO's) report on the state of DoD and VA's health record sharing initiatives is not due until the end of July, but I am grateful that they are here today to update us on the progress these two Departments have made in meeting the statute's requirement.

As a growing number of men and women are returning from the battlefields in Iraq and Afghanistan with more complicated and more severe wounds, it is time to make their care and treatment easier. It is time for us to improve upon a system that will ensure the best and most complete care, efficient benefit delivery, and a seamless transition back into civilian life.

Under the leadership of Director Rear Admiral Gregory Timberlake and Deputy Director Cliff Freeman of the Interagency Program Office, both here today, I am hopeful, I am expectant that we will see headway toward the vision Congress and the President have established for a VA of the 21st century.

[The prepared statement of Chairman Mitchell appears on p. 40.]

Mr. MITCHELL. Before I recognize the Ranking Republican Member for his remarks, I would like to swear in our witnesses. If all witnesses from both panels would please stand and raise their right hand.

[Witnesses sworn.]

Mr. MITCHELL. Thank you.

I would now like to recognize Dr. Roe for opening his remarks.

OPENING STATEMENT OF HON. DAVID P. ROE

Mr. ROE. Mr. Chairman, thank you for holding this hearing.

The issues of seamless transition and the interoperability of the transfer of medical records between the Department of Defense and Department of Veterans Affairs is one that Congress has been working on for a number of years.

During the 109th Congress alone, the Committee on Veterans' Affairs held a total of ten hearings on the issue of seamless transition. Again last Congress, this Subcommittee held a hearing on March 8, 2007, on seamless transition; on May 8, 2007, VA and

DoD data sharing; on October 24, 2007, on the status of sharing electronic medical records; and on June 24, 2008, VA and DoD cooperation in reintegrating the Guards and Reserves.

Time and time again, the issue of interoperability and data sharing of critical medical information between the DoD and VA has been discussed, studied, and demoed, and the degree of progress is dismally glacial.

This is one of the reasons that section 1635 was included in the "2008 National Defense Authorization Act." This section revealed a plan of action for the two Departments to create a schedule and set a deadline of September 30, 2009, and issue requirements for, (1) establishment of the Interagency Program Office (IPO); (2) establishment of the requirements for electronic health records (EHR) systems or capabilities, including coordination with the Office of the National Coordinator for Health Information Technology (IT); (3) any acquisition and testing required in the implementation of electronic health record systems or capabilities that allow for full interoperability; and, (4) implementation of electronic health record systems or capabilities.

I am interested in learning the progress that DoD and VA are making and moving forward with the interoperability transfer of medical data between the two Departments.

In the past, this information has been held in what several Members have called independently stovepiped electronic medical record systems that had difficulty transferring data between the two departments.

This issue is of great concern to me as well as other Members of this Committee. I hope that measurable progress has been made toward better communication and cooperation between the two Departments.

The care of our Nation's servicemembers and veterans is of primary importance to everyone at this hearing today. They have served our country valiantly in the face of battle and should not have to be worried about whether or not their health providers have the tools and information they need to provide care that is timely, medically appropriate, and necessary.

Mr. Chairman, I look forward to hearing from our witnesses today and yield back the balance of my time.

[The prepared statement of Congressman Roe appears on p. 40.]

Mr. MITCHELL. I ask unanimous consent that all Members have 5 legislative days to submit a statement for the record. Hearing no objection, so ordered.

At this time, I would like to welcome Panel One to the witness table. Joining us on our first panel is Valerie Melvin, Director for Information Management and Human Capital Issues at the U.S. Government Accountability Office.

I ask that all witnesses stay within 5 minutes for their opening remarks. Your complete statements will be made part of the record.

Thank you very much, Ms. Melvin.

STATEMENT OF VALERIE C. MELVIN, DIRECTOR, INFORMATION MANAGEMENT AND HUMAN CAPITAL ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. MELVIN. Thank you, Mr. Chairman, Ranking Member Roe, and Members of the Subcommittee. I am pleased to be here today to discuss the VA/DoD Interagency Program Office and efforts toward achieving interoperable electronic health records.

As you know, the Departments have been working for over a decade to share data between their health information systems. Yet, while they have made progress on a number of fronts, questions have persisted concerning when and to what extent the intended sharing capabilities of the two Departments will be fully achieved.

As you have stated, to expedite their efforts, the "National Defense Authorization Act" for fiscal year 2008 directed VA and DoD to jointly develop and implement by September 30th fully interoperable electronic health record systems or capabilities and it established an Interagency Program Office to be a single point of accountability for the departments' efforts.

Also, the Act directed GAO to semiannually report on the Departments' actions toward achieving interoperability. Accordingly, we have previously issued two reports, in July 2008 and January 2009. We plan to issue a third report near the end of this month, a draft of which is currently being reviewed by the Departments.

At your request, my testimony today summarizes findings from the draft report focusing on the Departments' progress in setting up the Interagency Program Office and actions taken to achieve fully interoperable capabilities.

Regarding the Interagency Program Office, VA and DoD have taken important steps to make it operational by, for example, recruiting and hiring staff for government and contractor positions within the office.

Further, the Office has established a charter to articulate its mission and functions with respect to attaining interoperable electronic health data and it has developed standard operating procedures in such areas as strategic communication.

Nevertheless, key leadership positions for the Director and Deputy Director continue to be filled on an interim basis as the Departments attempt to hire permanent officials.

In addition, the Office has not yet performed key tasks that are fundamental to effective IT management and that would be essential to effectively functioning as the point of accountability.

In particular, the Office has not implemented our earlier recommendation that it establish results-oriented goals and performance measures for the objectives identified to meet the Departments' data sharing needs and fulfill interoperability requirements.

However, early development and use of results-oriented metrics is essential to providing a meaningful baseline against which to measure the progress of the program and the outcomes associated with its implementation.

Further, while the Office has begun to develop an integrated master schedule as required by its charter, the version provided for our review lacked critical information that would be vital to managing these complex efforts, such as detailed project tasks and

associated start and completion dates, as well as relationships between tasks.

Similarly, a project management plan is essential, but the Office has not yet developed one. As we have noted in prior work, without a plan that describes the project's scope, resources, and key milestones, VA and DoD lack a key tool needed to successfully guide their efforts.

With regard to their ongoing efforts, the Departments have achieved plan capabilities for three of the six interoperability objectives that they identified to meet their data sharing needs, related to sharing social history and physical exam data and the operation of secure network gateways.

For three other objectives, related to sharing data from health assessment questionnaires and self-assessment tools, expanding DoD's inpatient medical record system, and demonstrating initial document scanning, the Departments have partially achieved plan capabilities with additional work needed to fully meet clinicians' needs for health information.

To improve the management and the success of VA's and DoD's efforts to achieve full interoperability, our draft report recommends the Interagency Program Office's establishment of a project plan and a complete and detailed integrated master schedule. This is in addition to establishing performance metrics as we have previously recommended.

Without these critical tools, the Office's ability to effectively provide oversight and management, including meaningful assessment of the progress and delivery of interoperable capabilities, is jeopardized.

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

[The prepared statement of Ms. Melvin appears on p. 41.]

Mr. MITCHELL. Thank you very much.

At this time, before we get to the questions, I would like to defer to Mr. Space and then Mr. Hall.

OPENING STATEMENT OF HON. ZACHARY T. SPACE

Mr. SPACE. Thank you, Mr. Chairman.

And I hope you will accept my apologies for arriving late and my advance apologies for having to leave. I have a very important 10:30 meeting that I have to attend to regarding my Energy and Commerce Committee assignment. But I do appreciate the opportunity to deliver a brief statement.

I would like to thank you, Chairman Mitchell, for calling this hearing and for giving me the opportunity to say a few words about this important issue.

The interoperability of medical records between the VA and the DoD is not a technical problem or a coordination problem. Access to medical records is a quality of life problem for our veterans.

And I did not have the benefit of hearing your statement, Mr. Chairman, but I suspect you may have referenced Specialist Travis Fugate. Okay. You will recall that Travis testified at a Committee hearing earlier. Like so many other veterans of the conflicts in Iraq and Afghanistan, he suffered a combat injury that left him with

severely impaired vision. His doctor at the VA was unable to perform the necessary surgery because of the complicated reconstruction his facial nerves had undergone in prior operations under DoD care.

I believe that the U.S. Government failed Mr. Fugate by effectively losing the records of his prior surgeries, leaving him completely blind. This is just an example of the significant quality of life issues faced by veterans because we have not yet met this goal of fully sharing medical records.

I am frustrated at the lack of progress over the past decade and even more frustrated that no law or directive seems to have any impact on the speed of implementation.

I understand that there are significant financial, technological, and logistical barriers to progress into the completion of an entirely interoperable electronic medical record. I also understand that there are multiple levels of interoperability and that the office must balance competing demands for both quality record sharing and faster implementation.

However, I feel compelled to remind those responsible for this project that every day that we do not overcome the challenges to implementing this system is a day that we pass on the hardship to our veterans. Their sacrifices and their challenges are much greater and much more personal and heart breaking than our challenges in establishing this system.

I look forward to hearing from the witnesses here today and I hope that their testimony will illuminate a clear and achievable path to success on this initiative.

And I yield back. Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

Mr. Hall.

OPENING STATEMENT OF HON. JOHN J. HALL

Mr. HALL. Thank you, Mr. Chairman and Ranking Member Roe, for holding this hearing.

Ms. Melvin, Admiral Timberlake, and Assistant Secretary Baker, thank you for being here today to testify.

One of the largest impediments facing the VA and the veterans it serves is the handoff from DoD. In my conversations with veterans, I have heard stories that simply astound me. Veterans walking paper files from one office to another banded together with rubber bands and covered in sticky notes.

It is hard to believe that in 2009 veterans must still shlep their materials from a DoD doctor to a VA doctor as paper files, costing time, money, and meaning that, as was mentioned by Mr. Space, the quality of care is not what it should be.

I have been working on trying to fix this issue as have many of us on the full Committee and the Subcommittee since I was first elected to Congress and last year sponsored legislation to require the VA to convert to electronic records and modern information technology. I was proud to see it signed into law, a good first step toward bringing the VA into the 21st century.

For more than a decade, Congress, the VA, and the DoD have been trying to move this interoperability initiative forward. We

have finally made some progress on this common-sense, good government initiative.

In January of last year, for instance, Congress established the Interagency Program Office to allow the DoD and the Department of Veterans Affairs to fully share personal health information between the two agencies. It seems like the VA and the DoD are making progress, but, unfortunately, things are not moving as quickly as they should.

We laid down a deadline of September 30th, 2009, which is less than 80 days away. And I hope that in the course of this hearing, we will hear some good news about the progress being made, learn about ways we can help to fix any problems that have arisen, and work together to take steps to move the process along.

I thank you and I yield back.

Mr. MITCHELL. Thank you.

Ms. Melvin, I have a couple questions. In your testimony, you state that though DoD and VA have generally made progress toward making the IPO operational, the absence of performance metrics and absence of a complete integrated master schedule and an absence of a project plan limits the IPO's ability to effectively report on the delivery of interoperability capabilities.

Since the IPO was created, what actual and tangible benefits has the Office brought to improve the quality of life to our Nation's veterans?

Ms. MELVIN. I would start by saying that it appears that setting up and bringing the Office into operation has been the main accomplishment of the Office thus far. It is important to note that they have been recruiting staff for that Office. They have been hiring staff and they have developed standard operating procedures and an initial version of their master schedule.

However, what we have seen beyond that has been primarily, I think, focused on reporting to Congress in terms of meeting the requirements of the Act for reporting out on what the Office is doing.

We have not yet seen the evidence of any real linkage between what they are doing and how this is really translating into measurable progress as well as in terms of improvements in quality of health.

I think it is important to note that in looking at improvements in quality of health, that is probably something that will require a while to get to because you have to have the means in place to really start serving the clients in terms of what they are giving them in capabilities.

However, it is important that they establish their milestones and measures to make sure that they can look forward to specifically what they are providing and serving the clinicians' needs as well as the patients' needs and in terms of the capabilities that they are offering to them.

So we have not seen the quality of care improvements yet.

Mr. MITCHELL. Maybe this second question is not appropriate then. According to your testimony, since the IPO has yet to fully meet clinicians' needs for health information, has the limited accomplishments, that is DoD and VA mainly meeting three of the six interoperability objectives, given clinicians everything they need to provide complete health care to our Nation's veterans?

Ms. MELVIN. I think it is important to point to and ask VA and DoD relative to the clinicians' needs. They have been relying on the Interagency Clinical Informatics Board to define the patients' needs and, as I understand it, that is still an ongoing process.

However, they have put some capabilities in place and VA and DoD do maintain that relative to the capabilities that they are providing to meet the interoperability objectives that they have defined for September 2009, coupled with the initiatives that they have put in place, the Federal Health Information Exchange (FHIE), the Bidirectional Health Information Exchange (BHIE), that, in fact, those will give them the capabilities that they are looking to have in place by September 2009.

However, from our perspective, we cannot really tell whether, in fact, that will truly meet their needs because we have not seen the mechanisms in place yet for them to truly measure performance against these particular goals.

It is only with understanding specifically what it is that they are trying to achieve quantitatively and measurably will we be able to assess that.

I would add, however, that both VA and DoD have acknowledged that there is additional work that will need to be undertaken after September 2009 to continue to provide additional capabilities.

And across our work, we have seen instances or indications that there are significant areas of work needed. For example, the Essentris System, while that is one place that they, in fact, did establish a measurable goal, they have also indicated that a significant portion of that goal will have to be accomplished after 2009, specifically, I think we include in our testimony, 92 percent of the inpatient beds served by September 2010.

Beyond that, we also know that a laboratory data sharing capability that was supposed to be a computable capability by, shortly after September 2009, it is our understanding that that also has been pushed out to a later date.

So while they are making incremental increases in their sharing of data, as far as how that collectively will meet clinicians' needs, that is still in our view a bit uncertain.

Mr. MITCHELL. Thank you.

I will defer to Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

A couple things. This interoperability is not going to happen by September 30th obviously. And let me just make a couple of quick points.

Of the three things that you said you could get now, as a physician, if I walk in to see a patient, I can pull up their allergies. I can do that in 2 seconds. Are you allergic to anything?

Number two, your social history. Do you smoke, drink? Do you take prescription drugs? I can do that in 5 seconds.

And how much money have we spent? And what else can I find when I pull this up because as a physician, when I see a patient, and a very good point was made by Mr. Space, there are some critical bits of information that you do need.

When I am in there and someone else has had three or four previous surgeries or whatever that they may have had, that is very critical to know what was done during those surgeries. It is very

critical to know their lab data, to know their X-rays, those types of things. That is very critical.

Is that available when you walk in to see a patient? When you walk in, I walk in as a doctor, sit down to talk to a patient, some of these things you mentioned, I can get the history in literally less than 15 seconds? I do not need a record for that.

Ms. MELVIN. I do not want to paint the picture that they do not have any sharing capabilities. As I mentioned earlier, they have had a number of initiatives that they put in place over time, their Bidirectional Health Information Exchange, their Federal Health Information Exchange, which allows information from DoD to go to VA when a servicemember separates. They do have a number of capabilities.

We have reported previously on, for example, them having pharmacy and drug allergy, computable data which is what is considered the highest level of interoperability. There are a number of capabilities that they currently have in place.

One of the difficulties that we have, however, is in terms of finding a place that we can truly look across both VA and DoD and see how all of these various efforts are being put together to work toward this——

Mr. ROE. Not to interrupt, but when a patient comes to see me, if they bring a stack this big, at least I have something to look at.

Ms. MELVIN. Yes.

Mr. ROE. And when a patient gets out of the military and they are severely injured as we have seen, all of us here have seen the terrible injuries a lot of these soldiers have seen, that information, I do not see how it can be all that hard to get that information from Walter Reed if somebody ETSs (expiration term of service) from the military to the VA at Mountain Home in Johnson City, Tennessee.

How can it be that hard?

Ms. MELVIN. It is hard if you have not established specifically how you are going to go about doing that from the standpoint of having specific plans for how the interoperability will be achieved. We do know that they have some sharing capability, as I was saying earlier.

You are right. We do understand that some patients come into, for example, Walter Reed with their paper folders attached to them. And VA and DoD have been working toward some scanning capabilities to try to make that information electronically available, but there is not a comprehensive record at this point.

Mr. ROE. Well, here is the problem I have with this. And I put an electronic medical record system into operation, our group had done it for 70 providers. And I realize this is a huge system. I understand, believe me, the stumbles and bumbles that you go through in implementing. This is an incredibly complex system.

But it really all comes down to taking care of a patient. So when a soldier leaves, I do not know—I cannot understand up here yet after all this. I have read all this testimony. I still cannot understand when a soldier leaves the military why that soldier could not leave with a memory stick or a DVD or whatever and have all that information right there. You can walk in my office. I can plug a

DVD in, a memory stick or whatever you want to and you can walk out with your complete medical record in your hand.

Now, why can we not do that?

Ms. MELVIN. Mr. Roe, that is a very good question. I think it is one that has to be directed to VA and DoD.

Again, I would go back to they have not set the basic mechanisms in place to make sure that they have a program that looks across all of the different initiatives that they have and that builds them collectively to make sure that they have the capability that you are asking for.

They have made steps in that direction. But, again, we have not seen the progress that we feel is necessary for them to really have one collective record across VA and DoD to accomplish just what you are saying.

Mr. ROE. I think, and I will not take much more time, but I think in Great Lakes Naval and VA venture had a joint venture in 2002.

Are they are able to do that where there was a joint venture?

Ms. MELVIN. We have not looked specifically at them, but I do understand that they are taking some initiatives toward creating that type of capability.

However, within the documentation that we have reviewed so far, we have not seen specifically how they are doing that. We have not seen the evidence of how that is being achieved or what they have actually accomplished.

It is my understanding that a lot of the milestones that are necessary for accomplishing that are still due sometime maybe next year.

So we understand that maybe they have done some project initiation and some business requirements, but I am not certain at this point as to exactly what they have achieved in that capability and it is not specified in the documents that we have seen thus far.

Mr. ROE. Thank you.

Mr. Chairman, I will need to leave early to go to another meeting and I ask unanimous consent in absence of a Member of the Minority Party, Counsel be permitted to ask questions of the witnesses.

Mr. MITCHELL. Mr. Space.

Mr. SPACE. Thank you, Mr. Chairman.

The goal in creating the IPO was to create this single point of accountability for achieving the interoperable health care data. And it strikes me as a bit ironic that with that as its main goal, to this date as of right now, there are still some serious concerns about its leadership and management.

And I cannot help but be stricken by the fact that if this were a private company, and I know it is not and I know its intents and purposes are much different, but if this were a large corporation and 10 years ago their IT Director were dispatched to achieve interoperability, I am wondering how many IT directors in that 10-year period would have been fired for failing to get this job done.

To this day, it is my understanding that the IPO does not have a Director and it does not have a Deputy Director.

Ms. MELVIN. That is correct, sir.

Mr. SPACE. Can you give us, and I know your report touches on it, but can you give us some idea as to why they have waited so

long to engage in this process of assigning permanent leadership as opposed to interim directors, number one?

And, number two, what kind of time table we can expect for the appointment of a Director and a Deputy Director under the IPO?

Ms. MELVIN. It is our understanding that there were a couple of factors in play. I would actually go back to about December, which is December of 2008, which is when we understand that the office finally got an approved delegation of authority to be able to operationalize itself. So I would say that that is one factor.

We do understand that they have been trying to hire. And in speaking with them, what we understand is that they have had a number of candidates come across and it seems that in some cases, they have withdrawn their nomination, at least in one instance that I know of.

It is my understanding that currently, however, they do have a candidate whose name has been sent forward and an application has been sent forward to OPM and that they are awaiting a decision from the Office of Personnel Management (OPM) on that.

In the interim, they have an interim Director whose appointment has been extended through at least the time of hiring or September 30th. I am not sure whether it is one or the other, but at least at that point.

With regard to the Deputy Director, it is our understanding from VA that they are also in the process of selecting someone for that position. And we have been told that they intend to have someone in place by the end of July.

However, I have no more specifics relative to whether that is going to actually occur as intended at this point.

Mr. SPACE. Do you believe that they are exercising proper diligence in the creation of a leadership team and a management team in this process or have they been lax or failed to properly prioritize this issue?

Ms. MELVIN. It appears that they have given priority to it. However, I would say that it has been a very slow process in terms of what they have done and the appointments that they have tried to make to the positions so far.

If you separate it from the staff positions, they have put those positions in place, the hires for those positions or at least selected them, but for the leadership positions, I would say that we do question how long it is taking them to get them in place. I do not think that it has been a particularly expeditious process.

Mr. SPACE. Right. I think that is pretty obvious from the face of things.

And has the VA or the DoD given you any specific reasons as to why they have failed to appoint permanent leadership at the very top of this program that is supposed to achieve interoperability within 80 days? It just seems to me to be a complete lack of responsibility and prioritization.

Ms. MELVIN. No other than indicating that they were trying to hire individuals, that they had selected individuals who subsequently withdrew their application and that they had to go back out through the recruiting and rehiring process subsequently to find a person for that position.

Mr. SPACE. Thank you.

Ms. MELVIN. You are welcome.

Mr. SPACE. I yield back the balance of my time.

Mr. MITCHELL. Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman.

Since 1992, the Departments had latitude to be able to address this issue. How long have you been working on this project?

Ms. MELVIN. We have been looking at VA——

Mr. BILBRAY. You personally.

Ms. MELVIN. How long have I personally? Since about 2001, I think.

Mr. BILBRAY. Two thousand one?

Ms. MELVIN. Yes.

Mr. BILBRAY. How long has the Department been into it?

Ms. MELVIN. Since 1998, they have been working on electronic sharing capabilities.

Mr. BILBRAY. And are we going to reach our September 30th goal?

Ms. MELVIN. It depends on how that is defined. We have concerns about the clarity of the definition for fully interoperable and what it means at September 30th to say that they have full interoperability.

They will achieve something. It will likely be perhaps a measure more than what they have had in the past relative to incremental increases in sharing in terms of increased scanning, for example, increased sharing of social history data, and the like.

What we have not been able to get from VA and DoD to date has been a clear quantitative and measurable definition of what it is that they will have at that point.

If you look at the interoperability objectives that are in place right now, they talk about establishing an initial scanning capability or expanding a capability. For us, that does not convey in terms of what you will actually have as far as a measurable capability.

Mr. BILBRAY. Now, you are talking about over the Internet, not this issue that the client has to bring in a package, basically the ability to access a system over the Internet no matter where you are and be able to access this?

Ms. MELVIN. They have varying initiatives. We have not seen yet that big picture relative to how all of these projects are going to come together to create that one——

Mr. BILBRAY. Well, before we go on, let me just really lay down a marker. If you do not have this data available on the Internet to where anybody anywhere basically if they have the right access systems can access this because, frankly, I just think that, you know, I would love to talk about details, things like the biometrics. Any patient comes in, you know, and we can biometrically read them. We can get to their CO. We can find out if they want to be a donor, this, this, and this.

Ms. MELVIN. Yes.

Mr. BILBRAY. Those are all issues. What scares me is that we are not even getting around to that modem. Is this a technical problem or is this a bureaucratic problem to reaching our goals?

Ms. MELVIN. I think it is largely a bureaucratic problem from the standpoint of managing the overall initiatives. They have a number

of initiatives that allow them to share data. Again, I do not want to paint the impression that they are not sharing. They are sharing data. But from the standpoint of having one longitudinal, if you will, electronic health record across these two Departments, that does not currently exist in the form that I believe perhaps was intended or was thought about in terms of the legislation.

Underlying all of that is the fact that the Departments do not have the necessary planning in place to explain how they will take all of the multiple projects that they have that allow them to share capabilities on some level at this point, bring them all together into one package that enables them to share in the way that you are describing.

Mr. BILBRAY. Ms. Melvin, do you understand that, though, for 20 years, Congress has been looking for this, the new President, this is one of his top priorities he talks about. When he talks about all this other, with health care, he starts off with this. And, you know, this is the vanguard for the national data system.

If we cannot make it work here, how in the world is the new President going to make it work with 350 million people?

Ms. MELVIN. I understand exactly where you are coming from in terms of that. At this point, though, I do not believe that they will be able to produce the type of system that is intended unless they have done more in terms of looking across what they have and they have established more of a convincing approach to how they are going to bring all of these initiatives together.

Mr. BILBRAY. Do we have a prototype that we see over the horizon? We see somebody that seems to have a system that will work. Do we have a prototype that we can build our assumptions around?

Ms. MELVIN. There are systems. VA actually has a great system in terms of what it provides. The difficulty is in terms of looking for examples of interoperability from the standpoint of bringing together different systems and making them work and deciding how you are going to do that from a technical standpoint. And that is the part that VA and DoD have not done.

I cannot point to a specific example of one that has worked successfully, but I do not believe that technically—technology is the problem with their ability to do this. I do believe that it is a management problem.

Mr. BILBRAY. Thank you.

Let me just say to my colleagues as we design the system, you know, I operated a supervised health care system for 3 million people, and if I can leave you with one thing, if we do not have a system that allows a veteran to go into an emergency room and for us to biometrically be able to pull up his files, be able to know what their health is, know little things like do they want to be a donor, all those things need to be in the system. If you do not have a system to where you can automatically, a physician in an emergency can pull up these files, then the system is deficient.

And I just ask you to keep an eye on that as we come and go as policymakers, but this is one of the goals, sort of a minimum goal. We want to make sure that every veteran, thus in the long run every citizen, will be able to have their files drawn up by a physician in an emergency room just because they are able to pull

the biometrics and pull those files. And I hope that we keep that as a goal.

Thank you very much, Mr. Chairman.

Mr. MITCHELL. Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman.

And thank you, Ms. Melvin.

And I would just comment on Mr. Bilbray's remarks. I agree.

And, you know, my family who are and friends who are in TRICARE because they are either in service or working still for DoD are quite happy with the care they receive there and the ability, in fact, to go to any DoD medical facility and have their record pulled up.

And as you said, Ms. Melvin, once they are in the Veterans Health Administration (VHA) system and have their veterans' health card can go to any VA facility in the country and have their electronic record pulled up. The problem as I see it is the handoff from DoD to VA.

And, you know, I have the honor of chairing a Subcommittee on Disability Assistance and Memorial Affairs as well as the honor of serving on this Committee. And one of the things that we are most concerned about is this interoperability and the electronic handoff because it is the beginning of being able to establish whether there should be a claim granted or not, especially with our new veterans.

Our Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) vets who are emerging now into civilian or VA world and leaving active duty, they really need, especially facing the injuries that the Chairman referred to, you know, some severe injuries, they need to be able to have hopefully at the speed of light their electronic medical record transferred to the VA so that we can go ahead and process their claims expeditiously.

In your testimony, you stated that the Interoperability Office still has not established quantifiable and measurable goals and performance measures and that the office has cited a number of different reasons for the delay.

As of today, less than 80 days from the deadline, there are still 4 vacant positions. That means it has taken more than a year and a half for the Office to get staffed up. This does run back into the previous Administration and when the "Claims Modernization Act" was passed as part of our veterans omnibus bill in the last term.

So, in fact, it seems that the Office is likely not to be fully staffed up until after September 30th.

So my question, I guess, to you is, the unemployment rate in this country is teetering close to 10 percent. I have personally spoken to dozens of veterans who are looking for work, including some who are quite qualified in engineering, computer technology, et cetera.

Can we not find qualified people, even qualified veterans to fill these jobs? And what do you believe is causing the delay in hiring staff? Is there something we in Congress can do to speed up that process?

Ms. MELVIN. One of the points I would like to make about hiring the staff, it is very important that they get those in place, and you are right that it has taken a while to do that.

I think it is important, though, to also recognize that as they put staff in place and define what exactly it is that they are going to

do, it is important for them to have put the other basics in place as far as what this office is going to be doing relative to achieving interoperability.

Right now without having the basics relative to a project plan to really define their resource needs, the timelines, their financial needs, it is very difficult to say whether they are choosing the right people for the right jobs. So there is probably a need for an element of caution in what they are doing.

Having said that, since they have moved ahead, it does appear that there has been an effort on their part to try to be careful about who they are hiring. However, it is not very clear yet as to why they really—it is not clear to us as to why they have not been able to secure all the positions. I believe it is four positions within the government type positions that they have.

It is our understanding they have all of the contractor positions. But, again, I would ask the question more importantly do they know what these individuals are going to be doing that they are putting in place.

Mr. HALL. Last year, VA commissioned a study by IBM to look into the electronic handoff and the compatibility of different systems. Apparently they were dissatisfied with that and toward the end of last year, before our new Secretary was sworn in, I believe, contracted with Booz Allen Hamilton to do another study of how the systems should be structured.

Have you seen that study? Are you aware of it? I think it was commissioned by Veterans Benefits Administration (VBA), but it has a bearing on VHA as well.

Ms. MELVIN. I am vaguely familiar, but I do not feel that I am informed enough today about the details on it to speak to it very effectively.

Mr. HALL. We are waiting to see it and hopefully will soon. And it is, I understand, an attempt to come up with the correct or the most expeditious approach to this compatibility problem.

Any more suggestions you can make to speed the process along? In terms of hiring, for instance, you said a number of candidates have withdrawn. Is that because of issues that they did not want aired in confirmation or is it because of other factors? Do you know what the reasons are?

Ms. MELVIN. I do not know the reasons for that. I would say, however, that it is very important that the leadership be put in place for this Office. The tone from the top is all important for setting the stage for how effective any organization is going to operate.

I think it is very important that the IPO, the Interagency Program Office, be not just another layer in the process of what they have already had, but that it be an effective office and that it have an established and defined definition of what it really is going to be as far as achieving interoperability and its role from an accountability standpoint.

Mr. HALL. Thank you very much.

Thank you, Mr. Chairman.

Mr. MITCHELL. Mr. Walz.

Mr. WALZ. Well, thank you, Mr. Chairman, again for a long line of very pertinent and important oversight responsibilities here.

And, Ms. Melvin, thank you again. In my short time here, I found your reports to be very helpful, very informative, and helping us move us in the right direction. So thank you for that.

I do want to note that on the positive side of things today, we have both VA and DoD setting in the same room. That is positive for around here. But you do not see Members of the Armed Services Committee here with us.

So this issue of seamless transition for many of us, and I see many folks setting out there, have worked on this thing for decades. There is a cynicism that pervades this issue because we all know that the fundamental reason for wanting to get seamless transition is better care for our veterans, more accountability over the system, and cost savings in the long run. So it is in everybody's best interest to get there.

So I do want to make note that under the Chairman's leadership and Chairman Filner and the Ranking Member, I think you are right. We are making some progress.

I wanted to note one thing. You did talk about in here we are starting to share on allergy data that is going back and forth. The one thing I did note, though, is you said between June 2008 and January 2009, we got 9,000 more patients on that.

Ms. MELVIN. Yes.

Mr. WALZ. At that rate, the current military will be enrolled in 78 years.

Ms. MELVIN. My understanding is that they are at about 33,000 or 34,000 now. It is a slow process, yes.

Mr. WALZ. That might be an understatement. The point of that hearing is, is that the best we can do is where I am trying to get at. If that is the best we can do, when I think of the President's declaration in April of this year when he talked about the virtual lifetime electronic record (VLER) that many of us see as the holy grail of fixing the backlog in claims that Mr. Hall's Subcommittee deals with on a daily basis, the care that veterans get, the timely delivery of not only medical services but medals that were deserved and all of that, was he just making a pie-in-the-sky suggestion or the way I am treating it is, is this was a Presidential Directive that needs to be done? And are we moving toward that in a fashion that is attainable?

Ms. MELVIN. I think that obviously there are a lot of questions about where they are going to be by any particular date and especially the September 30th date.

VA and DoD have a lot of experience. I mean, we talked earlier about the fact that, you know, they have been at this data sharing, since about 1998. And from that standpoint, there should be a lot of lessons and experiences learned that they can bring to bear in terms of how they move forward.

Having said that, I think again it is important that you have the necessary foundation in place to guide your efforts. And until the two Departments really can come together very convincingly to show how they are working together differently and better than they did on previous initiatives to achieve this, advance achieving the interoperability, the questions will remain in terms of——

Mr. WALZ. And I think both organizations know the skepticism that is out there amongst the veteran's community. As you said,

you have been tracking progress on this yourself for 8 years. You will do this long enough to retire and the next person will track progress.

And at the point right now I think many of us are saying we are willing to draw the line in the sand.

I do have a question. The staff, we were just discussing this, the interesting part of this. Mr. Space brought up a good part about the staffing and staffing up. We do not have all of the staff positions filled. We do not have all the government positions filled.

All 16 private contractors already hired, what are they doing if we do not even have the vision?

Ms. MELVIN. That is the question and that is a concern for us in terms of who they have brought in to work right now and really not having the overall project planning in place to really guide that effort.

It is a very valid question. It is a question of concern relative to how you use these individuals effectively to accomplish the goal that you have and that you do so in a cost-efficient way.

Mr. WALZ. Okay. I am old schoolteacher, so that is called a preparatory set for the next panel.

Ms. MELVIN. Okay.

Mr. WALZ. So thank you.

Ms. MELVIN. You are welcome.

Mr. MITCHELL. Thank you.

And thank you, Ms. Melvin, for your work and we appreciate very much your testimony.

Mr. BILBRAY. Mr. Chairman.

Ms. MELVIN. Thank you very much.

Mr. MITCHELL. Yes.

Mr. BILBRAY. Can I just ask one last question, one statement?

Mr. MITCHELL. Yes.

Mr. BILBRAY. How many times have you testified before this Committee, ma'am?

Ms. MELVIN. You know, I have to provide you a number for the record, but it has been numerous.

Mr. BILBRAY. Is that numerous or countless?

Ms. MELVIN. No, I would not say countless.

Mr. BILBRAY. Okay. Close to it, though, huh? Thank you.

Ms. MELVIN. But a number of times, yeah.

Mr. MITCHELL. Thank you very much.

Ms. MELVIN. You are welcome.

Mr. BILBRAY. Thank you, Mr. Chairman.

Mr. MITCHELL. At this time, I would like to welcome Panel Two to the witness table.

For our second panel, we will hear from Rear Admiral Gregory Timberlake, Acting Director of the Interagency Program Office. Rear Admiral Timberlake is accompanied by Cliff Freeman, Deputy Director of the Interagency Program Office.

Also joining us is Mary Ann Rockey, Deputy Chief Information Officer, Military Health System, U.S. Department of Defense. She is accompanied by Captain Michael Weiner, Chief Medical Officer, Defense Health Information Management System.

Also with us is the Honorable Roger Baker, Assistant Secretary for Information and Technology, U.S. Department of Veterans

Affairs. Assistant Secretary Baker is accompanied by Dr. Paul Tibbits, Deputy Chief Information Officer, Office of Enterprise Development; Scott Cragg, Executive Director and Program Manager for the Virtual Lifetime Electronic Record Program, U.S. Department of Veterans Affairs; Dr. Douglas Rosendale, Enterprise System Manager for Joint Interoperability Ventures in the Office of Health Information, Veterans Health Administration; and Dr. Ross Fletcher, Chief of Staff of the Washington, DC, VA Medical Center.

Please be seated.

At this time, I would like to recognize Admiral Timberlake, Ms. Rockey, and Assistant Secretary Baker for up to 5 minutes each. And I just want you to know that your testimony will be as submitted in the record.

Thank you.

STATEMENTS OF REAR ADMIRAL GREGORY A. TIMBERLAKE, SHCE, USN, ACTING DIRECTOR, U.S. DEPARTMENT OF DEFENSE/U.S. DEPARTMENT OF VETERANS AFFAIRS INTERAGENCY PROGRAM OFFICE; ACCOMPANIED BY CLIFF FREEMAN, DEPUTY DIRECTOR, U.S. DEPARTMENT OF DEFENSE/U.S. DEPARTMENT OF VETERANS AFFAIRS INTERAGENCY PROGRAM OFFICE; MARY ANN ROCKEY, PROGRAM EXECUTIVE OFFICER/DEPUTY CHIEF INFORMATION OFFICER (ACQUISITION), MILITARY HEALTH SYSTEM, U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY CAPTAIN (SELECT) MICHAEL WEINER, MC, USN, CHIEF MEDICAL OFFICER, DEFENSE HEALTH INFORMATION MANAGEMENT SYSTEM, U.S. DEPARTMENT OF DEFENSE; HON. ROGER W. BAKER, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY, OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PAUL A. TIBBITS, M.D., DEPUTY CHIEF INFORMATION, OFFICE OF ENTERPRISE DEVELOPMENT, OFFICE OF INFORMATION AND TECHNOLOGY, U.S. DEPARTMENT OF VETERANS AFFAIRS; SCOTT CRAGG, EXECUTIVE DIRECTOR AND PROGRAM MANAGER, VIRTUAL LIFETIME ELECTRONIC RECORD PROGRAM, U.S. DEPARTMENT OF VETERANS AFFAIRS; DOUGLAS E. ROSENDALE, DO, FACOS, ENTERPRISE SYSTEM MANAGER FOR JOINT INTEROPERABILITY VENTURES, OFFFICE OF HEALTH INFORMATION, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND ROSS D. FLETCHER, M.D., CHIEF OF STAFF, WASHINGTON, DC, VETERANS AFFAIRS MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF REAR ADMIRAL GREGORY A. TIMBERLAKE, SHCE, USN

Admiral TIMBERLAKE. Thank you very much, Chairman Mitchell, Ranking Member Roe, and distinguished Members of the Subcommittee. I appreciate this opportunity to discuss the role of the IPO in the ongoing data sharing activities of the Department of Defense and the Department of Veteran Affairs.

As has been previously mentioned in recent months, the IPO has been focused on two central areas, first facilitating the efforts of the two Departments to develop capabilities that will allow for full

interoperability of their electronic health records by the end of September of this year and, two, working with the Departments to develop an effective governance and management model for the new virtual lifetime electronic record project announced by the President. These two areas will be the focus of my testimony today.

Let me begin by providing you with a very brief overview of the DoD/VA Interagency Program Office or the IPO. Since its inception in 2008, the main objective of the IPO has been to provide management oversight of joint DoD/VA information sharing efforts.

Specifically the IPO works with the DoD and VA to ensure that by September of this year, as previously mentioned, electronic health record systems or capabilities have been developed that allow for full interoperability of personal health care information between the Departments.

DoD and VA began laying the foundation for this full interoperability in 2001 when the first patient health information was shared electronically using the Federal Health Information Exchange or FHIE.

Since that time, both Departments have continued to enhance and expand the types of information that is shared as well as the manner in which it is shared. By building upon the prior accomplishments of the Departments to develop interoperable, bidirectional electronic health records, the IPO and the Departments have been successful in formulating a plan to meet the requirements of section 1635 of the FY 2008 "National Defense Authorization Act."

As part of this plan, VA's and DoD's ability to utilize well-known interoperability capabilities like the FHIE and the Bidirectional Health Information Exchange have been greatly expanded. At the same time, new capabilities like the clinical data repository, health data repository or CHDR have been added, allowing even more medical data to be transferred between DoD and VA. These systems are enabling unprecedented amounts of medical data to be transferred between DoD and VA.

My colleagues on the panel have included detailed information about these and other interoperability capabilities in their written testimony.

Today I am pleased to report that we are on target to achieve the capabilities that allow for full interoperability of personal health care information for the delivery of clinical care by September 2009 as defined by our DoD/VA Interagency Clinical Informatics Board.

The future promises even greater possibilities for data sharing as we work to fulfill the President's vision to develop a virtual lifetime electronic record or VLER. The VLER will serve as a single source of health care, benefits, and personnel information on the servicemember and veteran from the time of accession through the entire military career and the veteran continuum up to and including burial.

The effort to create a VLER is a monumental undertaking representing one of the largest projects that any two Federal departments have collaborated on in recent years. As with any undertaking of this magnitude, proper planning and governance is absolutely critical to success.

To begin, new IT conceptual frameworks must be established to provide health and benefits data sharing architecture to which both Departments can connect their electronic health record.

To date, discussions between the Departments have focused on leveraging common services architecture framework to support modernized tools. The strategy for VLER implementation has been agreed upon by DoD and VA at a Joint Executive Council meeting on the 26th of June. This plan will allow expansion beyond the current level of interoperability to bring it in line with the President's direction in his speech of April 9th.

In addition to discussions on the scope of VLER, the IPO also plays an active role in efforts to reach interdepartmental consensus on broad technical requirements issues. In this area, progress is being made on the Departments' efforts to agree to use a nationally recognized set of uniform and open standards for information exchange.

This approach would enable DoD and VA to create an architectural framework capable of interconnecting systems from both the private sector and the government.

Thank you very much for the opportunity to address the Committee and to provide you with an update on the important work that is being done by both Departments to advance electronic data sharing between the DoD and VA. I look forward to answering any questions you may have.

[The prepared statement of Admiral Timberlake appears on p. 48.]

Mr. MITCHELL. Thank you.

Ms. Rockey.

STATEMENT OF MARY ANN ROCKEY

Ms. ROCKEY. Thank you, Chairman Mitchell, Ranking Member Roe, and Members of the distinguished Subcommittee. Thank you for inviting me to discuss the substantial progress made to date with VA/DoD electronic health record interoperability. I am pleased to join my dedicated colleagues from the VA and IPO.

Our electronic data sharing efforts have gained undeniable momentum since we first began sharing data in 2001. The scope of these efforts has increased steadily, improving the delivery of health care and administration of benefits to our Nation's servicemembers and veterans.

Right now electronic health data is accessible to VA for more than 4.8 million separated servicemembers. Each day, health care providers and benefits specialists access electronic data on patients as they deliver care and resolve claims.

We also share real-time data on 3.3 million shared patients and made it possible for DoD and VA providers to view real-time electronic data from each Department's electronic health record system.

Sharing data on care delivered in deployed settings is critical to improve continuity of care for our wounded, ill, and injured servicemembers.

Since 2007, we have shared data for care delivered in Iraq, Afghanistan, and Kuwait. This theater outpatient and inpatient data is accessed using the Departments' existing EHRs. Today more

than 2.4 million theater outpatient clinical encounters are available to DoD and VA providers who treat these servicemembers and veterans.

We have also made great strides in sharing servicemembers' inpatient care records. As the Committee knows, Landstuhl Regional Medical Center is the first stop for many wounded, ill, and injured servicemembers. Interagency access to inpatient discharge summaries from Landstuhl and other large hospitals is a tremendous aid to the continuity of care. Records are available from 21 military sites that account for 55 percent of our inpatient beds. We expect to share inpatient records for 90 percent of our inpatient beds by 2010.

Today the Bidirectional Health Information Exchange provides two-way, on-demand, viewable data exchanged between all DoD and VA facilities in real time. This live data flow became available enterprise-wide in July 2007 and includes data from 1989 forward.

The data exchange includes allergy information, outpatient pharmacy data, demographic data, inpatient and outpatient lab results and radiology reports, procedures, vital sign data, patient histories, questionnaires, and theater clinical data.

We are also transferring health data on separating servicemembers to the VA through the Federal Health Information Exchange. This comprehensive data flow began in 2002 and includes data from 1989 forward.

The transferred data includes inpatient and outpatient lab and radiology results, outpatient pharmacy data, allergy information, discharge summaries, admission disposition and transfer information, consultation reports and pre- and post-deployment health assessments and health reassessments (PDHRA).

In September 2006, the Department established interoperability between the data repositories used by the respective EHR systems. This DoD/VA interface enables the exchange of interoperable and computable outpatient pharmacy and medication allergy data between the Departments on patients who receive care from both health care systems. Information is included from DoD pharmacies, retail pharmacies, and mail order pharmacies. This functionality is available to all DoD facilities enabling drug-drug interaction checking and drug allergy checking using data from both Departments.

To ensure continuity of care for our polytrauma patients, we are also exchanging radiology images and digital and scanned medical records between Walter Reed Army Medical Center, National Naval Medical Center, and Brooke Army Medical Center to the four VA polytrauma centers. This capability began in March 2007.

We are moving swiftly and surely toward full health care information interoperability to support the provision of clinical care by 30 September 2009. With the two Departments, we look to a group of clinicians called the Interagency Clinical Informatics Boards to identify specific mutual data needs supporting care, continuity, and health-related benefits administration.

Moving forward, we will build on this foundation to enhance future electronic health care information sharing. We will collaborate with the U.S. Department of Health and Human Services (HHS) on national standards. These standards are necessary for broader exchange of health information to realize the President's vision of the

virtual lifetime electronic record and the Nationwide Health Information Network.

Clearly we have made much progress in enhancing and expanding VA/DoD sharing and plan to continue these efforts. Our interagency collaboration continues to support the provision of the highest quality care for our Nation's heroes, past, present, and future.

Thank you again for inviting me today. I am accompanied by my Chief Medical Information Officer, Dr. Michael Weiner, who is here to show you how our clinicians can access theater and BA data within our EHR system. I will be happy to answer any questions. Thank you.

[The prepared statement of Ms. Rockey appears on p. 52.]

Mr. MITCHELL. Thank you.

Assistant Secretary Baker.

STATEMENT OF HON. ROGER W. BAKER

Mr. BAKER. Thank you, Mr. Chairman. Thank you for the opportunity to update you on the status of our efforts to exchange electronic medical information with our partners at the Department of Defense.

This Committee has always been supportive of our efforts and I look forward to providing you the information you need. And I would note that as this is the first time that I have appeared before the Committee, I appreciate the opportunity to come and testify and I look forward to seeing the Committee numerous more times in my tenure. So thank you.

As you noted, I am accompanied by Dr. Paul Tibbits, Mr. Scott Cragg, and Dr. Doug Rosendale, senior members of the team working on this. And I would note that after my remarks, Dr. Ross Fletcher, who is one of the fathers of the VistA system, will demonstrate how DoD information is accessed and used by a clinician from within VistA.

VA and DoD have made great progress in the exchange of information necessary to provide services to our Nation's veterans. For servicemembers who separate from the service, electronic medical records are delivered to VA and incorporated into VistA via a one-way transmission.

For servicemembers who are being seen at both DoD and VA facilities, a bidirectional system makes their information available to both services. And for our most seriously wounded warriors, an exchange of information directly between the polytrauma care facilities ensures that all necessary information is available at the point of care.

As impressive as this interoperability is, our work cannot stop. First, the current systems have shortfalls. VA clinicians need further training to ensure they know when DoD information is available and how to access it.

Second, performance for BHIE, the Bidirectional Health Information Exchange, which is the system that accomplishes the two-way transmissions, can be very slow and is sensitive to how local computers are configured or how they are set up.

Some information that is available today in a viewable form could also be made searchable and we recognize the need to do that from our clinicians.

And while we are able to exchange information in electronic forms, information that is not currently made electronic is substantially less efficient for clinicians even if made available later via scanning.

An example of further progress being made is our joint work on the Captain James A. Lovell Federal health care Center.

The BHIE system that I mentioned earlier was designed to share data collected between episodes of care for patients receiving care in both VA and DoD systems. But a patient in the collocated environment of North Chicago may see either or both a DoD and VA clinician during a single episode of care.

We have determined that additional functionality is required to ensure that data is exchanged seamlessly, including a single patient registration for both VistA and Armed Forces Health Longitudinal Technology Application (AHLTA), a single sign-on to both systems for our clinician, and the ability to easily move orders between the two systems.

VA and DoD information interoperability successes to date have focused on applications that facilitate exchanging patient information between the departments to individual electronic medical record systems.

On April 9, 2009, the President along with Secretary Shinseki and Secretary Gates announced that VA and DoD would create a joint virtual lifetime electronic record or VLER. The VLER will permit information vital to health care and other benefits and services to be available seamlessly to both Departments from the moment a servicemember enters the military. I would say, gentlemen, I believe that means getting beyond interoperability and into common use.

The potential benefits of the VLER are many and planning and creating and implementing the VLER will be a challenging endeavor. VA and DoD are working jointly together on an overall strategy to achieve the President's vision and developing an effective governance model to implement that strategy.

In closing, I would like to thank you again for your continued support and the opportunity to testify before the Subcommittee on the accomplishments and the important future work of VA and DoD to improve medical record sharing between us. I look forward to your questions. Thank you.

[The prepared statement of Mr. Baker appears on p. 60.]

Mr. MITCHELL. Thank you.

The questions I have first are for both DoD and VA. For both Departments, what obstacles or difficulties have you encountered while working to increase electronic health care interoperability? And what actions have the Departments taken to address these obstacles? Again, what are the difficulties or obstacles you face, and obviously you have some, and what have you done to address them?

Admiral TIMBERLAKE. Sir, I may start just from my observations. I was asked to come back on active duty in January to be the interim Director and so I have had some observations.

Some of them are just simply due to the fact that we are trying to work between two separate Departments and those Departments have different budgeting cycles and processes. They have different

contracting processes. They have different ways by which they develop and define their requirements.

And in my personal opinion, some of the difficulty has been in trying to find the ways to move smoothly when you have rules and regulations set up for two different Departments, but you are trying to bring them together.

I will now turn to my counterparts and see if they have specific issues that they wish to share.

Mr. BAKER. Certainly I would look to some of the experts that came with me on this, but two things that I would observe for you.

These are two huge, separately developed medical systems that we are looking to bring together. And a key issue is that representations of information in one system are not necessarily the same as they are in the other system.

And so the Departments have created information exchange systems to pull information out of one, translate it, and put it into the other. What that means is while the maintenance and development of the two main missions go forward, we also now have the responsibility for bringing along those interchange systems in between them.

It is not an easy process. Technically it is not simple and requires an awful lot of work to bring forward. And as you look at the individual types of information that need to come forward, whether it be pharmacy records, whether it be viewable information or computable information, determining what the data standards are and how those will be represented as they are exchanged from system A to system B is fairly complex.

And while I agree that the main issues facing us may well be on the, you know, how do we continue to get along and define things, you know, from a cooperative standpoint, technically this is also a very challenging problem. And I do not think we can lose sight of the fact that it is not an easy question that is being asked here.

Mr. MITCHELL. You suggested there are two large bureaucratic organizations, two systems, but I think instead of trying to defend and protect the particular base, if they look at the ultimate goal, which should be the case, and that is looking after the veteran, you should be able to overcome the difference in cultures, the difference in systems, the different things that have happened over time. And I would hope that that would happen.

One other question for both DoD and the VA. Why have the Departments not addressed the GAO's recommendations from the January 2009 report to develop results-oriented performance goals and measures for the achievement of full interoperability?

Ms. ROCKEY. Currently we have an information interoperability plan and a joint strategic plan. And the Interagency Clinical Informatics Board (ICIB) sets the priorities for the items in the IIP and JSP and those, the ICIB requirements, I believe in the updates for the Information Interoperability Plan (IIP) and Joint Strategic Plan (JSP), and Rear Admiral Timberlake can confirm this for me, the updates of those plans will have those measures in them for the next version.

Admiral TIMBERLAKE. Yes. The JSP is actually a product of the Joint Executive Council and it is the projects that have been agreed upon between the two departments. And with the revision

that is going on now, we will have measurable goals, all the things that were talked about by the GAO in their report going forward.

And the IIP is actually, if you will, almost a look ahead, the strategic goal. It is what we should be asking the ICIB or the other work groups to I come up with next to be done by the Departments. And obviously as those then roll, if and when they roll into the JSP, they will be assigned measurable outcomes and program guidance will occur. Yes, sir.

Sir, could I ask might it be appropriate at this time to have the demonstration of what information we can share?

Mr. MITCHELL. Sure.

Admiral TIMBERLAKE. Captain Weiner, if you would go first, please.

Captain WEINER. Chairman Mitchell, Ranking Member Roe, and Members of the distinguished Committee, thank you for allowing us the opportunity to demonstrate the military health system electronic health system.

What I would like to just spend 1 second is sort of showing you what our clinicians see throughout our enterprise and then the shared information in context for today that we are able to view from our VA colleagues.

So we have been able to select a patient, a real-time patient back in April that was ultimately seen in theater. That data was captured back in Kuwait. He was then medevacked, air evacked up into Balad in Iraq and then moved to Landstuhl where he received further care. He came back to the States and then was ultimately seen by the VA in Palo Alto.

[Slide.]

Captain WEINER. This first view is the view that a clinician when they log on to our system and pull up a particular patient, this is what they see. So just to sort of orient everyone, up on the left is tabular bars and icons that help navigate throughout the system.

Up on the top, we have selected previous encounters and you can either select it on the left or up on the top for ease. And it is a chronological order of care that has been delivered to this patient in an outpatient setting.

You will see some other tabs up above, allergy, meds, DoD, VA, theater which we will discuss in a bit.

And the other thing I would like to point out is just for this particular patient, there is a T up in the upper right-hand corner and then there are also Ts next to two different encounters of care, demonstrating that this patient was seen in a theater setting, so automatically letting the clinician, if he is coming to see us, if we take a second and think that we are seeing him, we are logging on, and he is coming to us for follow on care, what previous care has he seen.

And then just as a separate note, you can see up here, there is a little nose that demonstrates he has allergies and then there is a little red flag that demonstrates he has command interest and meaning that he is a wounded warrior and that we want to ensure that we are able to review his entire record.

So this particular gentleman, a 40-year-old, was seen in Kuwait. You see in the big frame down below is actually the care that was documented and the incident that was documented.

Looking up just a little above where we saw the T, the theater notes, we also see that he was ultimately seen at Landstuhl Regional Medical Center. He had an ophthalmology appointment for some follow-up care and that care is all documented down in the large pane.

But as we see this patient, he describes to us that he was also air evacked. He was also seen by the VA. And we know by the theater encounter that there is more data that can be seen.

So we click over to DoD/VA theater history, which is also above and on the left. And you cannot really see right—well, right there, the pointer, this entire column on the right helps us demonstrate the chronologic order that the patient was seen in.

So up at the top, if we slide this to the top, we are at current care. This is care that was delivered back in April. So we know that he was seen on April 24th and then we realize that there is a discharge summary done on April 27th, but there are also some ICU nursing notes from when he was seen. There is an operative note and then there is his surgical note.

So all care that was seen and documented in theater is here; we can click here to view note details of his discharge summary. And what we see is the record, the discharge summary. And, again, we are seeing him now as an outpatient, say at Bethesda Naval Hospital, and we want a summary of what care occurred in theater while he was an inpatient. And we see that he was seen at Balad Air Base and we see what his admission diagnosis is and we see what his discharge diagnosis is.

He also lets us know that he was seen just a few weeks ago by our colleagues at the VA at Palo Alto. So we slide our bar all the way up and in chronologic order with the top being the most recent, we see he was seen at the prosthetics clinic. He was seen by the speech pathology clinic and then also some physical rehabilitation.

But we are interested in his neuropsychiatric assessment. We click on to view details and here we see the entire assessment conducted in the VA at Palo Alto.

So prior to leaving, though, we like to discuss with him some new medications for the cause of his follow-up visit. We can go up above and we can click medications and we want to ensure that there will be no drug-drug interaction of any medications that we give and to also know what current medications he is taking.

And prior to closing out, we also want to make sure he does not have any allergies with any of the medications that he has been given or as we see down in other any medications he has received in civilian pharmacies. So we click on the allergy tab and as a final, we are able to see allergies that were collected in both the DoD and in the VA.

And with that, we are able to get a full view from the time, the point of injury from Kuwait to each movement throughout the system to his final appointment within the VA.

Thank you for your time and we will be happy to entertain any questions.

Mr. MITCHELL. Thank you.

My understanding is the VA also has a presentation?

Admiral TIMBERLAKE. Yes. Dr. Fletcher would show you the VistA system. Minor technical adjustment here.

Dr. FLETCHER. It is my pleasure to be here to show the system that we are using at the current moment. We obviously are covering a lot of VA hospitals at one time, but also are increasingly able to see a good deal of the information coming over from DoD.

You have already been told about the FHIE, the BHIE, the bidirectional view, the computable data, and the sharing of data for severely wounded warriors, so I will not go into that except to show you how it works in actual patients.

[Slide.]

Dr. FLETCHER. The first patient is a dual user for VA and DoD. He served in Bosnia, Iraq, and Afghanistan. It actually says he was exposed to blasts at least 11 times, the last one in Afghanistan, rupturing his tympanic membrane and probably causing some TBI.

When he comes to our institution, the cover sheet looks like this. If I click on remote data available, I will see that there is Defense Department data as well as Baltimore data. And simply clicking on that and I get a look-up of that information. It will start out with new and then become done, at which point I can click on the discharge summary and see that.

If I click on other pieces of information, I will see the progress notes. And you can see in this instance that the progress note comes from the field hospital. As described earlier, this is a note from Afghanistan at the time that he had a shrapnel wound to his head which also caused the tympanic membrane to be ruptured as we saw later. Even at this time, he could still hear a whisper, however. But the exact details of what was done is in this format.

If I clicked on viewable information, I could see it in a Web-based site that was talked about earlier. We do have a Web-based site that will show us all the information of the patient, whether he has been seen in any other VA sites, but also wherever there is a cruciform with the arrow, this information is available for the DoD as well and this is the DoD note you just saw pulled up in this Web-based viewable form.

I can click on the pharmacy outpatient and, again, it will be new for a while, but then as it is done I can see the whole medication list from Bethesda, Walter Reed, and many other sites if I go down the list. These are very important because at the time we were seeing him, even after he left the service, we were having to follow him on a daily basis with his medications largely being given to him from Bethesda Navy. So we needed to know exactly what he was on when we would see him in our hospital. But simply using this Bidirectional Health Information Exchange, we could see that updated real time whenever we are seeing the patient.

Notice that if I go into older areas of his medication, we see that I can view what was given to him in Landstuhl, Germany, Walter Reed, Eisenhower, Camp Shelby, and even CVS Pharmacy. So the TRICARE information that is coming over is seen by us as well all in one site.

This is a different patient, but it also shows information from the TRICARE health clinic, DeLorenzo Health Clinic at the Pentagon. I like to show this because while I was in the Army, I served in that health care clinic under Dr. DeLorenzo. It was not called that

at that time. He was well known in this city because he had accompanied many people through the Bataan Death March and helped a lot of people out at that time.

If we look at the laboratory data, we can simply by clicking flag isolate all the abnormal lab data, so we do not have to look at the whole list. We can look at the combined data from the DoD sites and VA at the same time.

Second patient is a severely wounded warrior who went to DoD polytrauma and then to our polytrauma sites and then to the VA. This particular patient had an improvised explosive device (IED) blast and suffered a fractured spine and had traumatic brain injury as well.

When I go to remote data and find out if it is available, I can initialize the Defense Department data and click on allergies. The patient had not been seen in Washington, so it was not assessed. But as the information became more available, penicillin allergy was seen at every DoD site the patient was seen, so Brooke, Martin, Bethesda, Navy all had that allergy listed.

And as a matter of fact, if I tried to give penicillin to the patient, which I simulate here, it would tell me that we had not assessed the allergy as he walks in the emergency room but that he has had adverse reactions to penicillin reported over from the DoD sites. So this is computable data allowing me to cancel that order and move on.

This is the same patient whose image has been shipped over in the severely Wounded Warrior Program. All the images and all the files in a PDF format have been sent over to the polytrauma sites. The beauty of that is that in the VA, if it is in the imaging system, I in Washington can easily see the records that have been sent to Richmond or sent to Tampa. They are all interchangeable and whenever I pick up images, all of these images are available to me.

If I click on the zoom feature, you can see that in this instance, he has screws into his spine. And at this point, there is a fracture of the spine. The screws are not at that level, but they are above and below that level. And this is very helpful for me to see the image as well as the description of the image.

I also can pull a PDF document up. In this instance, it was about 1,600 pages, but it was well indexed and I can search through that and see all the information that was available not only at Walter Reed but all the sites prior to that, in Landstuhl, Germany, as well.

If I go to the third patient, this is one that was dual care initially, now with the VA. The patient was hit by a truck, had severe traumatic brain injury and that the patient was in coma when she came to our hospital. And we thought she might well not live much less achieve any reasonable activity in the future.

This is the way the record appears. And, again, I can pick up the remote data and see that she has chemistries listed. These are Palo Alto, Bethesda Navy, Richmond. I can also pull up the consults which are seen in both places. And I can see the discharge summaries. Again clicked on the discharge summaries to see the discharge summaries from the DoD as well as VA.

Here is a radiology report. Radiology reports have been shared on the bidirectional health information system for quite some time,

but more recently the actual X-rays are now being shared between our place and Walter Reed and between our place and Beaumont and the North Chicago. We can see them so that if this comes up, I can simply click on the image and now I can see these two images.

This is the first one. These are some months apart. This one is in March and the follow-up is in October of the same year. Notice they are very different. And I can cycle through these in a comparison mode. I see very large vacuous holes inside the brain, which are the ventricles, which are quite swollen, not swollen at the same level several months later.

I can go through them together and notice how much bigger these are and how much the brain has been pushed up against the skull. And the fact that she was not able to wake up was easily judged by this problem.

Mr. MITCHELL. Dr. Fletcher, can we wind this up?

Dr. FLETCHER. Yes, I will.

Mr. MITCHELL. I think we get the gist of this.

Dr. FLETCHER. I will.

Mr. MITCHELL. We are way over time.

Dr. FLETCHER. Yes, I will.

We put a catheter inside the ventricle and decompress that. And now you can see that she can wake up.

This is another example of sharing of the X-rays which I will quickly click through and summarize by saying that I have shown you some examples of the Federal Health Information Exchange, the Bidirectional Health Information Exchange, the CHDR Program which is computable data, the Wounded Warrior Program, and the VIX Image Sharing Program.

Thank you very much.

Mr. MITCHELL. Thank you.

Admiral TIMBERLAKE. Mr. Chairman, thank you very much for your indulgence in allowing us to demonstrate this because one thing I noticed when I came to the office was that there was a lot more sharing going on than I had ever as a veteran before I came back on active service ever understood.

I am not going to stand here and tell you it is perfect and there is not more to do and this is not VLER, but certainly I think there is more going on than many of us out in my veterans' community ever understood.

Thank you.

Mr. MITCHELL. Thank you.

Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman.

You know, I want to just open up for discussion and I just got to tell you looking at the task in front of us, I do not see any way we are going to reach the threshold mandated in 2010. In fact, we have a new joint facility opening up in 2010.

Is that facility going to be able to share data files from the two agencies, two Departments?

Mr. BAKER. Sir, that facility will utilize the Bidirectional Health Information Exchange, what we have right now, and several new features that pull AHLTA and VistA more closely together to allow

exchange of orders, allow single sign-on for doctors, and a single registration for patients.

So enhance interoperability at the facility from what we currently have right now between AHLTA and VistA.

Mr. BILBRAY. Well, the question is enhanced from what we have now seems to be short of what we hope to have or thought we were going to have as dictated by Congress.

Let me just tell DoD up front that if I was the manager and I looked at this issue, I have to figure that not only is the client going to be with the VA 20 to 30 years where you are maybe 5 to 10, but that because Veterans is going to inherit the client, any good manager would reverse engineer it from where the files are going and then modify the source to reflect that long term.

I just got to say right up front, and I want DoD to defend yourself on this issue, a reasonable manager would say the lead agency should be VA because they are the recipient and they are going to be the custodians longer than DoD.

DoD, what is your argument to defend your turf here over the fact that VA ought to be setting the standards and only if you can show where it is not compatible with your active duty should you be able to modify it?

Ms. ROCKEY. The Interagency Clinical Informatics Board sets the priorities for sharing, on what information we are going to share and that is based on clinical priorities. We are making changes in our architecture to enable sharing not just with VA but sharing also with private sector, which is a big component of the lifetime electronic record that we discussed earlier.

I think it is critical the sharing not just with VA but that we are able to use standards so that we can connect to the Nationwide Health Information Network and be able to share information with the private sector as well.

Between VA and DoD, over 50 percent of our care is in the private sector and it is critical that we are able to share information and get information from the private sector as well as between VA and DoD.

Mr. BILBRAY. When we right now have problems with Bethesda talking to Walter Reed, I mean, it pretty well tells me that we need some adult supervision here and that we need to set a standard, somebody needs to set a standard. And right now you are talking about the Committee setting a standard that everybody lives with without one agency having the lead and the other one basically being a support system.

You have a major problem with the Veterans Affairs Department being the lead agency with this data system?

Ms. ROCKEY. The requirements for interagency sharing are set by the Clinical Informatics Board, which has VA and DoD on the Board. The IIP and the Joint Strategic Plan are developed by both DoD and VA.

Mr. BILBRAY. Ma'am, in all fairness, the system may sound good on paper, but the results that we are seeing is not a result that, you know, I do not think this Committee wants to accept and I do not think the public will accept. The fact is everybody seems to be basically passing around the process but not getting to an outcome that reflects reality. And the issue is somebody needs to be in com-

mand here to dictate it and at least then set a standard that everybody else can work around or ask for modification, a mainframe to build around.

You are saying the Committee is doing that. I have not seen and I do not think this Committee has seen that as being an outcome that is timely and appropriate.

Ms. ROCKEY. I think the establishment of the IPO in April of 2008 is a big step forward and putting the leadership in place at the IPO as was discussed with the GAO testimony is a critical next step for moving that forward. But I think the IPO will provide that leadership and is providing that leadership now under the interim guidance of Admiral Timberlake.

And I see us continuing to move forward on interoperability and, again, not just with VA, which is critical for our servicemembers, but also with the private sector as the private sector begins the sharing process and moves forward with the sharing process as well.

Mr. BILBRAY. Thank you very much.

And, Admiral, thank you for coming back. I mean, what a thankless job. And hopefully we will when your successor will be a permanent appointment, at least in the foreseeable future.

I yield back, Mr. Chairman.

Mr. MITCHELL. Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman.

Admiral, am I correct in surmising that the samples that we just looked at of different servicemembers' records were selected from the many others which may or may not be as complete or be as interconnected? And, if so, what percentage of those who have been separated from service in the last year had this degree of interoperability and depth so that the physician from VA or DoD or private sector, but especially VA, can access all that information going back to when the injury may have occurred?

Admiral TIMBERLAKE. I will take for the record the percentage. But what I wanted to say was, you know, going back, and it was mentioned earlier about Specialist Fugate, we have, we, these two Departments have worked madly over the last few years to be sure that more and more of the patient encounters are recorded electronically. And the electronic patient encounters that are recorded are now available between the two Departments.

[The DoD subsequently provided the following information:]

For recently separating servicemembers, with the exception of shared images, the samples shown are representative of the electronic health data available to VA. Servicemembers who separated several years ago may still have a significant portion of their medical data that were not captured electronically. While we are unable to provide a percentage of separated servicemembers that would have the degree of interoperability demonstrated, we can say the majority of servicemembers separating in the last few years will have a significant amount of health data available to VA.

Not all prior servicemembers will have Theater data available electronically to VA. The ability for VA to access Theater data became operational in October 2007. VA would not be able to access Theater data on individuals in Theater prior to October 2007. Likewise, not all former servicemembers would have digital radiology images available to VA at this time, since that capability is operational at a limited number of pilot sites.

VA has access to electronic health information on more than 4.8 million individuals. The earliest data, starting with ancillary data, are from 1989.

Since 2001, more and more data have been made available electronically. At this time, electronic health data are not available to private physicians.

In general, VA has access to:

- Since 2001, for *separated servicemembers*, DoD has provided VA with one-way historic information through the Federal Health Information Exchange. On a monthly basis, DoD sends laboratory results; radiology reports; outpatient pharmacy data; allergy data; discharge summaries; consult reports; admission, discharge, transfer information; standard ambulatory data records; demographic data; Pre- and Post-deployment Health Assessments; and Post-deployment Health Reassessments.
- For *shared patients* being treated by both DoD and VA, the Departments continue to maintain the jointly developed Bidirectional Health Information Exchange (BHIE) system, which was implemented in 2004. Using BHIE, DoD and VA clinicians are able to access each other's health data in real-time, including the following types of information: allergy; outpatient pharmacy; inpatient and outpatient laboratory and radiology reports; demographic data; diagnoses; vital signs; family history, social history, other history; questionnaires; and Theater clinical data, including inpatient notes, outpatient encounters, and ancillary clinical data such as pharmacy data, allergies, laboratory results and radiology reports.

Admiral TIMBERLAKE. Now, having said that, you know, I personally, this is my 36th year of Naval service, active and Reserve, I think I have 8 years of electronic data, so I have about 28 years of carrying around a big, thick record.

But if we are talking about what we are doing now, you know, then I think in most instances, I am not going to tell you it is a hundred percent because somebody is always going to find the, you know, the——

Mr. HALL. Exception.

Admiral TIMBERLAKE. Yeah, that proves the thing. But if it is entered electronically, then they can see it between. Now, you know, there are some issues. I think it was brought up earlier by Mr. Baker. Sometimes you go to a facility and somebody does not understand how to do it.

DoD had an issue where if you do not get the functionals, the business community, the physicians to tell you what, really tell you what the requirements are, you know, they had a thing for a while where the DoD people could not get to the VA data because instead of a button that would be—you know, they just said build us a button, so they built a button that said BHIE.

Well, techies did that. That is what the IT people are supposed to do. But the functionals did not then teach the clinicians that that is what that button meant. And so for a long time you could go to somewhere like Walter Reed and a lot of physicians would not know how to see the data. It was available to exchange, but they did not understand how to do it.

And let me turn to Mary Ann or——

Ms. ROCKEY. I do want to point out that that button is no longer labeled BHIE, that that was what you saw in the demonstration. It is VA information and theater information is what it is labeled, now which is a better descriptor.

Also, a little different architecture for our electronic health record system in which we have a central data repository. So the capabilities you saw are accessible across the DoD.

Mr. HALL. I do not want to minimize the progress that you have shown us because this is the first time in my recollection that we

have seen this kind of electronically accessible record for a servicemember, that is accessible from both Departments.

But I just wonder if anybody here at the table can tell me what percentage, let us just say today, what percentage of servicemembers leaving active duty today and being separated and joining the Veterans Corps have records that look like that and that have that degree of detail and accessibility and interoperability?

Admiral TIMBERLAKE. You know, my understanding, sir, is that when the serviceman separates, every bit of DoD electronic information is transferred via the BHIE to the Veterans Administration.

Now, the Veterans Administration does not access that until a member comes in for care or treatment because of privacy issues and Health Insurance Portability and Accountability Act (HIPAA) and all, but it is transferred.

Mr. BAKER. Sir, I think we would agree with that. Maybe a statistic for you. May help or may not. The statistic I have is that in April of 2009, there were 295,000 accesses of the BHIE, of the bidirectional system.

The other statistic is that there are about 4.8 million unique patients that have been transferred from the DoD to the VA via the FHIE, the Federal Health Information Exchange.

I do not have the percentages for that. I just have the statistics. We can certainly, I believe, come back to you with what we believe the actual percentage is of DoD patients. We believe it is a hundred percent, but we would like to make certain that we do a little bit of analysis from the folks here at the table and come back to you with the actual answer.

But of the people leaving service today, if they have any electronic records from the DoD being seen, that information is transferred into the VA.

Mr. HALL. Thank you very much.

Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

First of all, I would like to thank every one of you for your service. I think all too often we get into the heart of these and we forget the incredible work you are doing, the incredible selfless service to the public sector, when all of you could be in the private sector. I understand that.

And, Admiral, you came back out of that. So I think we want to be very clear and also to be very clear that we are absolute partners with you in this endeavor because you can be certain when we go home, we set on the other side of the table and our veterans set up here and grill us on everything that is there. And that is the way a system is supposed to work.

But I do want to be very clear that we are all in this together. It is absolutely understood that everyone in this room wants the quality care for our veterans, timely manner, do it in the most efficient and cost-effective manner. So I know sometimes we lose that and we get lost in a little bit what goes on.

A couple of question on this and I am impressed that we are making progress on that. I think Mr. Hall asked some good questions.

I as a 24-year veteran that retired in 2006, if I went to the VA, what would my record look like?

Mr. BAKER. Gentlemen, somebody who knows VistA——

Mr. WALZ. Where would they get it? How would I find out about it? I went in there. I was a 24-year artilleryman. I cannot hear very well. What is going to happen?

Mr. BAKER. I would ask Dr. Fletcher to address that one.

Dr. FLETCHER. You would see a button that says remote data. They would see a button and it is labeled remote data. And if they clicked on that or went in VistA Web, it would automatically come up if you had been seen in DoD and VA. And all of that data in terms of radiology reports, all the labs, all the medicines, most of the electronic notes would be available to the doctor.

Mr. WALZ. And I say this, I just have to say when we deployed in 2006, I will be damned if I did not have to get every shot again. No record, nothing. Nine of them. Oh, First Sergeant, you do not have any records. How can I not have any records?

So my question is still, and I know it has been maybe—maybe 3 years ago is a lifetime, but I still just know from personal experience that that 201 file that is this thick that is in the safe in the bottom of my house, I am convinced that is the only one at this point. And that makes me a little nervous.

And I say this because I am passing on, yes, maybe anecdotal from I see Vietnam veterans out there, I see Iraq veterans out there. Our question is, is that I absolutely, I am trying to get to where we are going and where this is happening.

I want to come back to where the GAO was on this. And they came to a different conclusion than I am hearing from you.

Now, the one thing was, as many of you—do not think I do not underestimate the technical side of this. It is massive. And I agree with, I think, Admiral, you said this or maybe it was Mr. Baker, you are shooting for a hundred percent. And I think, you know, we have to. This is a zero sum game. I do not know if we will ever get there. The Secretary says that, but anything less than that attempt is probably not right for our veterans.

What I am trying to figure out is, is that they were very clear. They stated three things. They think it is taking you too long to hire staff. They think we forced you to come up here and testify here where you should all be out doing your job right now basically is what it said, and that you are trying to align yourself with a time table.

And I agree, Admiral. You said our time tables are different, our funding is different, and it would be easier if we could just get those into alignment. Our job is to try and help you get there.

So I want to see if maybe, Admiral, this might be for you to respond first. The GAO wrong about that on why we are not getting there?

Admiral TIMBERLAKE. I think that many of the things that they have said are absolutely right on. Let me address your first issue.

I tried to be specific that we can only transfer electronic information that we have. If you are like me, you know, there is a lot of your information that is on paper.

Mr. WALZ. That is right.

Admiral TIMBERLAKE. We cannot transfer paper electronically. That is a whole other discussion, but it is outside of the electronic health record.

So your information may be limited depending upon how long you were in the service after we started the transfer.

Mr. WALZ. Right.

Admiral TIMBERLAKE. As far as the other, yes, it is taking both Departments a long time in my opinion to bring personnel on board. I am not sure why.

On the DoD side, part of it was that although the office was stood up, and I would almost call it a virtual office, in April with a couple of—Cliff was one and another, and a DoD person that tried to start getting some of the program descriptions written and the people hired. And they had a couple of loaned military officers for a few months.

But on the DoD, they could not begin to officially hire until this delegation of authority memo was signed which was not done until December 30th. Once that happened, then the DoD position descriptions could go out and we could start the process of trying to hire. And we are continuing to do that.

The VA, they went out earlier, but with the change of Administration relooking at what their—because each Department hires the people and then gives them to me or my hopefully successor soon. They had to look at their priorities.

And I might let—do you have something, Cliff? Let me let Cliff——

Mr. FREEMAN. Yeah. It is not for lack of effort. The position descriptions were written for the, what used to eight positions, were written in May of 2008. That was a month after we stood up the office. And then the seventh position was written the next month when the Senior Oversight Committee (SOC) decided that we would also oversee benefits and personnel.

It has been a challenging experience and very frustrating. We have had certs that came back with only one name on them. Very nice people, but they were not the skill set that we needed. We have offered jobs to people and they have turned them down, either stay in the private sector or take other government jobs. So I do not think it is for lack of effort.

And the one thing I would like to say is that although all the positions have not been filled, what we have done is we have borrowed very qualified folks from the two Departments to come in and make sure that those skill sets we needed did not go unfilled.

So DoD brought on people in uniform to help us. The VA provided folks, some project managers and folks to help fill those specific spots.

So I do not want to leave the Committee with the impression that the work went undone because we did not fill the permanent positions.

Mr. WALZ. No. And I very much appreciate that.

And I would say, if the Chairman indulges me for an extra minute, to just let you know these hearings are meant to be bidirectional also. Our job is if these are things we can cut through, and I am absolutely committed to this seamless transition, we are starting to send out overtures and it is difficult here to try and get

Armed Services to work with VA, but we are making that attempt and talking to members over there of ways that we can make this happen.

So these are the things that need to be brought to our attention, to the staff's attention if there are things that we can help speed that up because I think any of us who have worked in this environment know that what you are saying is absolutely true. We just cannot allow those hurdles to get in the way of making this happen, if there is anything we can do to break them down.

I yield back. Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you.

Just indulge me, if the Committee would for just a second.

I heard Mr. Walz say that when he went back to be deployed that there is no record of any of his shots. And I was just talking to our counsel here. When he was first deployed in 1991, he had 25 shots. When he was redeployed in 2002 through 2004, there was no record of them again.

The problem with this, of course, is when a veteran tries to apply for benefits, and I think that I heard, Ms. Rockey say that every electronic record that DoD has is transferred to the VA, but it looks to me like a lot of the problem is that DoD does not have all this stuff on electronic records.

Our counsel here says that he had to carry them around with a rubber band around them and he carried them around himself. The real problem then occurs when they try to apply for benefits. So it is just an observation.

If the Committee will indulge me, I want to ask two quick questions of the Admiral.

First, will the Interagency Program Office meet its statutory deadline on September 30th, 2009, to have an interoperable electronic health record system?

Admiral TIMBERLAKE. Thank you, sir. I will take the first crack at perhaps answering that.

My understanding in reading of H.R. 4986, the "NDAA 2008," Public Law 110–181, section 1635 required, and I quote, "By no later than September 30th, 2009, electronic health record systems or capabilities that allow for full interoperability of personal health care information between the Department of Defense and the Department of Veterans Affairs."

The two Departments and then again the IPO when it was subsequently set up turned to that expert working group we have mentioned in the Health Executive Council called the Joint Clinical Informatics Board at that time, subsequently called ICIB, to define what these capabilities should be.

Those members examined the information sharing capabilities currently extant between the Departments of Defense and Veterans Affairs and identified a path toward reaching the next level of integration, which they said would support this interoperability for the provision of clinical care.

They used five criteria established by the Institute of Medicine (IOM) that defined the core functionalities of an EHR. The five criteria from the Institute of Medicine are improve patient safety, support the delivery of effective patient care, facilitate manage-

ment of chronic conditions, improve efficiency and feasibility of implementation.

Using the IOM model and prioritizing provider access to clinically relevant information, the JSP now called ICIB members made the determination that the sharing of this additional set of capabilities, which have been talked about between the VA and DoD in addition to currently shared information would provide a level of clinical care sufficient to reach the desired level of interoperability.

Adding these new capabilities to the already robust information sharing occurring between the two Departments provides a level of integration that far surpasses the level generally observed between health care systems and the private sector.

It should be noted that the Departments were looking at and the ICIB were looking at interoperability from a functional perspective. In other words, what is needed for the provision of clinical care. They had not and I believe still have not spent a lot of time and energy trying to define the term interoperability from an academic perspective. As to whether something is fully interoperable depends on the use case or what the functional business community or medical community says it needs to do with the data.

So the Departments considered the provision of clinical care to be their first priority since that is in essence the use case at a high level. And that is the priority they are addressing now. And, thus, in addition to the current and ongoing information exchange, they identified six additional capabilities that they believed needed to be developed by September 30, 2009, to meet the requirement for EHRs or additional capabilities.

And those six by expansion of Essentris or provision of an inpatient record component to AHLTA, demonstration of trusted gateways so you can share the information, the social history refined, as we talked about, demonstrate a capability to do document scanning and expansion of the questionnaires that were already mentioned and then showing the separation physical exams are going back and forth.

As of today, three of those objectives have been met and the other three appear to be en route to being achieved by September 30th. So it is my opinion that we will meet that deadline based upon these definitions which the departments have come up with working together.

Mr. MITCHELL. So the answer is yes?

Admiral TIMBERLAKE. My answer is at this time, it seems to me we will.

Mr. MITCHELL. I understand about the six interoperability objectives. I thought the GAO said there was only one that was met. You say there is three?

Admiral TIMBERLAKE. According to my most recent update which is right here, we have three that seemed to have been met and there are three that are still in process, but I believe will be met.

Ms. ROCKEY. I can confirm it is the three. Social history, separation physical exams, and the expanded gateways have been completed.

Mr. MITCHELL. One last question, if the Subcommittee will indulge me.

According to the GAO, in early July, DoD and VA reported they had selected 10 of 14 government positions. However, all 16, and this kind of goes back to what Mr. Walz said, all 16 designated contractor positions have been filled.

If there has not been established results-oriented goals and performance measures for all six objectives yet, how does the IPO measure whether the contractors are meeting their requirements? What is the scope of work of the contractors and what positions do they fill?

Admiral TIMBERLAKE. The contractors range from support staff such as secretaries to specialists in program management who work with our program manager to begin to gather the data that was talked about.

Now, I will be the first to admit we are not fully where we want to be. But, for example, in looking at and following the status of the Essentris implementation, which is just one of the six which is not complete, we were following what was the contract, was the contract let, and then what were the outcomes that the Departments had agreed upon would define success.

In that case, success was defined by selecting an inpatient module, which ended up being Essentris, having the contract let, and then deploying that contract, that capability at three additional sites in DoD facilities, one from each service.

As of today, I believe two Army? I will ask Ms. Rockey.

Ms. ROCKEY. Yes, that is correct. We have two Army sites complete and we are on track for at least one Air Force and one Navy site by September.

Admiral TIMBERLAKE. And so at that level and that sort of a rudimentary level of program management, I would be the first to admit we have goals, we have objectives, and we are tracking to see that the DoD and VA are meeting them.

Mr. MITCHELL. Mr. Wu.

Mr. WU. Thank you for your indulgence, Chairman Mitchell. A couple questions.

Admiral Timberlake or the collective group, as a staff member and as a Staff Director, it has been painful to listen to this testimony.

The NDAA requirement on interoperable systems in our opinion was not to identify the six objectives. It was to have the system in place.

In looking back in former PowerPoint presentations, this thing was supposed to have been in effect 2005. And if you will indulge me, I will read you the quote from the press release when this agreement came in place.

"In October of 2002, this joint initiative marks the beginning of an era of renewed and I believe unprecedented collaboration between the health care resources of VA and DoD. This partnership is critical to our ability to continue to deliver high quality care in our respective beneficiaries across the country," quote, unquote.

Now it is 7 years later and we are just beginning to identify what those objectives are to get there.

When you opened the doors in October of 2010 and you are seeing DoD beneficiaries and veterans affairs' beneficiaries, what are you going to be able to do?

I understand. I heard the testimonies saying you will have joint sign-off. You will have this sharing. I personally do not believe that you will be able to see the patients in the seamless manner that the NDAA 2008, the spirit of what you were supposed to do and where you are at right now. I hear a lot of excuses. I do not think that is right.

I see in the NDAA language that the House Armed Services Committee (HASC) put out after the joint hearing that they recommended that all the money from DoD and from MHS be stripped because there was no adult supervision.

Would you like to comment on that because we have not moved forward in the manner that I think was in the spirit of what the Members of Congress wanted?

Admiral TIMBERLAKE. I am going to allow my two colleagues to comment on that because I think you have switched over to talking about the North Chicago Federal Health Care——

Mr. WU. Well, I think North Chicago has been touted to be the poster child of interoperability and I see that it is silent in the testimony of VA and DoD. Not silent. One line in the testimony. And this was supposed to be the joint venture, the demonstration of interoperability. I do not see that happening.

Ms. ROCKEY. For North Chicago, the requirements for the six baseline functional requirements for opening day, and this is in addition to the current sharing we are already doing, of that, we have completed one so far. We have the requirements defined for the other five in detail. Those were delivered in June.

We have a Joint Incentive Fund (JIF) package that we have pending to work on single patient registration process, single sign-on, phase one of single order entry, address rapid dental, and work on outpatient appointment scheduling as well. Those are the items that were identified as baseline functional requirements for North Chicago and those are the ones we are targeting for completion by October 2010.

Mr. WU. Thank you, Chairman Mitchell, but I understand that that JIF money is going to be VA money, not DoD money. That is my last question. Thank you very much, Chairman Mitchell.

Mr. MITCHELL. Thank you.

I want to thank all of you for appearing today. And I think you realize how seriously we take this. And we understand you are trying to work for this. It is very vital because many people's lives and quality of life are dependent on these records.

So, again, thank you very much, and this concludes the hearing. It is adjourned.

[Whereupon, at 11:57 a.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Harry E. Mitchell, Chairman, Subcommittee on Oversight and Investigations

I would like to thank everyone for attending today's Oversight and Investigations Subcommittee hearing entitled, the *Interagency Program Office: Examining the Progress of Electronic Health Record Interoperability Between VA and DoD*. Thank you especially to our witnesses for testifying today.

We are here today to examine the progress being made by the Department of Defense and Department of Veterans Affairs to achieve electronic health record interoperability. Currently, there is no single VA/DoD electronic record that captures all information needed for delivery of health care and benefits to servicemembers, veterans and their beneficiaries. As many of you know, on April 9, 2009, President Obama, along with Secretary of Veterans Affairs Eric Shinseki and Secretary of Defense Robert Gates, announced that the VA and DoD would create a Joint Lifetime Electronic Record that would contain information from the day individuals enter military service, through their careers, and for the remainder of their lives as veterans if they enter the VA system.

Mandated by the National Defense Authorization Act of 2008, the Interagency Program Office was established to act as the "single point of accountability" for DoD/VA electronic health record interoperability. As the September 30 deadline for electronic health record interoperability approaches, it is imperative to ensure that both the DoD and VA are organized and working together to deliver a comprehensive system that will modernize and simplify record sharing between Departments.

In 1982, under the VA and DoD Health Resources Sharing and Emergency Operations Act, both DoD and VA were first encouraged to find common ground to create a more efficient health care system that would be worthy of the sacrifices our men and women make every day. Since then, although they have made significant improvements in sharing patient record information, both the DoD and VA have yet to find the common ground to achieve full electronic health record interoperability. The GAO's report on the state of DoD and VA's health record sharing initiatives is not due until the end of July, but I'm grateful that they are here today to update us on the progress these two Departments have made in meeting the statute's requirements.

As a growing number of men and women return from the battlefields in Iraq and Afghanistan with more complicated and more severe wounds, it is time to make their care and treatment easier. It is time for us to improve upon a system that will ensure the best and most complete care, efficient benefits delivery, and a seamless transition back into civilian life. Under the leadership of Director Rear Admiral Gregory Timberlake and Deputy Director Cliff Freeman of the Interagency Program Office, both here today, I am hopeful—I am *expectant*—that we will see headway toward the vision Congress and the President have established for a VA of the 21st century.

Prepared Statement of Hon. David P. Roe, Ranking Republican Member, Subcommittee on Oversight and Investigations

Mr. Chairman, thank you for holding this hearing.

The issue of Seamless Transition and the interoperability of the transfer of medical records between the Department of Defense and the Department of Veterans Affairs is one that Congress has been working on for a number of years. During the 109th Congress alone, the Committee on Veterans Affairs held a total of 10 hearings on the issue of Seamless Transition. Again, last Congress, this Subcommittee held a hearing on March 8, 2007 on Seamless Transition, on May 8, 2007 on VA/DoD Data Sharing, on October 24, 2007 on the status of sharing electronic medical

records and on June 24, 2008 on VA and DoD Cooperation in Reintegrating the Guards and Reserves.

Time and again, the issue of interoperability and data sharing of critical medical information between the DoD and the VA is discussed, studied and demo'ed and the degree of progress is dismally glacial. This is one of the reasons that section 1635(e) was included in the 2008 National Defense Authorization Act.

This section revealed a plan of action for the two departments to create a schedule and set a deadline of September 30, 2009, and issued requirements for (1) the establishment of the Interagency Program Office (IPO); (2) the establishment of the requirements for electronic health records (EHR) systems or capabilities, including coordination with the Office of the National Coordinator for Health Information Technology; (3) any acquisition and testing required in the implementation of electronic health record systems or capabilities that allow for full interoperability; and (4) the implementation of electronic health record systems or capabilities.

I am interested in learning the progress that DoD and VA are making in moving forward with the interoperable transfer of medical data between the two departments. In the past, this information has been held in what several members have called "independently stove-piped electronic medical records systems" that had difficulty transferring data between the two departments. This issue is of great concern to me as well as other members of the Committee. I hope that measurable progress has been made toward better communication and cooperation between the two departments.

The care of our Nation's servicemembers and veterans is of primary importance to everyone at this hearing today. They have served our country valiantly in the face of battle, and should not have to be worried about whether or not their health care providers have the tools and information they need to provide care that is timely, medically appropriate, and necessary.

Mr. Chairman, I look forward to hearing from our witnesses today, and yield back the balance of my time.

Prepared Statement of Valerie C. Melvin, Director, Information Management and Human Capital Issues, U.S. Government Accountability Office

ELECTRONIC HEALTH RECORDS

Program Office Improvements Needed to Strengthen Management of VA and DoD Efforts to Achieve Full Interoperability

GAO Highlights

Why GAO Did This Study

For over a decade, the Department of Veterans Affairs (VA) and the Department of Defense (DoD) have been working on initiatives to share electronic health information. To expedite their efforts, Congress mandated in the National Defense Authorization Act for Fiscal Year 2008 that VA and DoD establish a joint interagency program office to act as a single point of accountability in the development of electronic health records systems or capabilities that allow for full interoperability (generally, the ability of systems to exchange data) by September 30, 2009.

In this statement, GAO summarizes findings from its upcoming report, focusing on progress in setting up the interagency program office and the departments' actions to achieve fully interoperable capabilities by September 30, 2009. To do so, GAO analyzed agency documentation on project status and conducted interviews with agency officials.

What GAO Recommends

GAO's draft report recommends that the Secretaries of Defense and Veterans Affairs emphasize the interagency program office's establishment of a project plan and integrated master schedule to guide their interoperability activities.

What GAO Found

VA and DoD have made progress in setting up the interagency program office; however, the office is not yet effectively positioned to be accountable for the departments' efforts to achieve fully interoperable electronic health record systems or capabilities. The departments have taken the important steps of completing personnel descriptions and hiring necessary staff to perform the office's functions, but key leadership positions (for the Director and Deputy Director) continue to be filled on

an interim basis. In addition, the office has established a charter and begun to demonstrate responsibilities outlined within this document. Nonetheless, the office is not yet fulfilling key information technology management responsibilities in the areas of performance measurement, project planning, and scheduling—all of which are essential to establishing the office as a single point of accountability for the departments' interoperability efforts.

VA and DoD continue to take steps toward achieving full interoperability by the September deadline. In this regard, the departments have achieved planned capabilities for three of six interoperability objectives (see table) that they identified to meet their data sharing needs—refine social history data, share physical exam data, and demonstrate initial network gateway operation. For the remaining three objectives—expand questionnaires and self assessment tools, expand DoD inpatient medical records system, and demonstrate initial document scanning—the departments have partially achieved planned capabilities, with additional work needed to fully meet clinicians' needs for health information.

Description of VA and DoD Interoperability Objectives

Objective	Description
Refine social history data	DoD will begin sharing with VA social history data 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 will provide an initial capability to share with VA its electronic health record information that supports the physical exam process when a servicemember separates from active military duty.
Demonstrate initial network gateway operation	DoD and VA will demonstrate the operation of secure network gateways that provide expanded bandwidth to support information sharing between DoD and VA health care facilities.
Expand questionnaires and self assessment tools	DoD will provide all periodic health assessment data stored in its electronic health record to the VA such that questionnaire responses are viewable with the questions that elicited them.
Expand DoD inpatient medical records system	DoD will expand its inpatient medical records system to at least one additional site in each military medical department (one Army, one Air Force, and one Navy for a total of three sites).
Demonstrate initial document scanning	DoD will demonstrate an initial capability for scanning servicemembers' medical documents into its electronic health record and sharing the documents electronically with the VA.

Source: GAO based on VA and DoD data.

View GAO–09–895T or key components. For more information, contact Valerie Melvin at (202) 512–6304 or melvinv@gao.gov.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Departments of Veterans Affairs' (VA) and Defense's (DoD) interagency program office and efforts toward advancing the use of health information technology to achieve interoperable electronic health records. As you know, VA and DoD have been working for over a decade on initiatives to share data between their health information systems; yet, while they have made progress in a number of areas, questions have persisted concerning when and to what extent the intended electronic sharing capabilities of the two departments will be fully achieved. To expedite their efforts, the National Defense Authorization Act for Fiscal Year 2008[1] included provisions directing VA and DoD to jointly develop and implement, by September 30, 2009, fully interoperable electronic health record systems or capabilities that are compliant with applicable Federal interoper-

[1] Pub. L. No. 110–181, § 1635 (2008).

ability[2] standards. It further established an interagency program office to be a single point of accountability for the departments' efforts.

Also, the act directed us to report semiannually on VA's and DoD's progress in implementing their electronic health record systems. In this regard, we have previously issued two reports (in July 2008 and January 2009). We plan to issue a third report near the end of this month—a draft of which is currently with the departments for their review and comments. At your request, my testimony today summarizes findings from this latest draft report, focusing on the departments' progress in setting up the interagency program office as a point of accountability for the implementation of interoperable electronic health records, and actions being taken to achieve these capabilities by September 30, 2009.

In developing this testimony, we relied on our previous work supporting the draft report. We conducted our work from April 2009 through July 2009, in the Washington, D.C. metropolitan area. All work on which this testimony is based was performed in accordance with generally accepted government auditing standards. Those standards require 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 and is important to improving the performance of the U.S. health care system. 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.[3]

Key to making health care information electronically available is interoperability—that is, the ability to share data among health care providers. Interoperability enables different information systems or components to exchange information and to use the information that has been exchanged. This capability is important because it allows patients' electronic 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. In the health IT field, standards may govern areas ranging from technical issues, such as file types and interchange systems, to content issues, such as medical terminology. Unlike paper-based documents, electronic health records can also provide automatic alerts about a particular patient's health, or other advantages of automation.

In prior reports, we have discussed the different levels of interoperability that agencies can achieve.[4] 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. At still a 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 also can be considered interoperable (at the lowest level) because they allow data to be shared, read, and interpreted by human beings. According to VA and DoD officials, not all data require the same level of interoperability, nor is interoperability at the highest level achievable in all

[2] Interoperability is the ability of two or more systems or components to exchange information and to use the information that has been exchanged. Further discussion of levels of interoperability is provided later in this testimony.

[3] An electronic health record is a collection of information about the health of an individual or the care provided, including patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports.

[4] These levels were identified by the Center for Information Technology Leadership, which was chartered in 2002 as a research organization to help guide the health care community in making more informed strategic IT investment decisions. According to VA and DoD, the different levels of interoperability have been accepted for use by the Office of the National Coordinator for Health Information Technology.

cases. For example, unstructured, viewable data may be sufficient for such narrative information as clinical notes.

VA and DoD Are Required by Law to Establish an Interagency Program Office and Achieve Full Interoperability

As previously noted, the National Defense Authorization Act for Fiscal Year 2008[5] called for VA and DoD to jointly develop and implement fully interoperable electronic health record systems or capabilities by September 30, 2009, and established an interagency program office to be accountable for the departments' efforts in this regard. The departments have been working to set up this office since April 2008. 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.

Further, to help meet the intent of the act, the Interagency Clinical Informatics Board,[6] made up of senior clinical leaders from both departments who represent the user community, began establishing priorities for health data sharing between VA and DoD. The board subsequently identified six interoperability objectives for meeting the departments' data sharing needs, as reflected in table 1.

Table 1: Description of VA and DoD Interoperability Objectives

Objective	Description	Associated interoperability level
Refine social history data	DoD will begin sharing with VA the social history data that is currently captured in the DoD electronic health record. Such data describe, for example, patients' involvement in hazardous activities and tobacco and alcohol use.	Structured, viewable electronic data
Share physical exam data	DoD will provide an initial capability to share with VA its electronic health record information that supports the physical exam process when a servicemember separates from active military duty.	Structured, viewable electronic data
Demonstrate initial network gateway operation	VA and DoD will demonstrate the operation of the secure network gateways[a] to support joint DoD–VA health information sharing.	There is no interoperability level associated with this objective.
Expand questionnaires and self assessment tools	DoD will provide all periodic health assessment data stored in its electronic health record to the VA in such a fashion that questionnaire responses are viewable with the questions that elicited them.	Structured, viewable electronic data
Expand DoD inpatient medical records system	DoD will expand its inpatient medical records system (CliniComp's Essentris[b] product suite), also called the clinical information system, to at least one additional site in each military medical department (one Army, one Air Force, and one Navy for a total of three sites).	Unstructured, viewable electronic data
Demonstrate initial document scanning	DoD will demonstrate an initial capability for scanning servicemembers' medical documents into its electronic health record and sharing the documents electronically with the VA.	Unstructured, viewable electronic data

Source: GAO Analysis of VA and DoD data.

[a] Secure network gateways provide expanded bandwidth to support information sharing and ensure secure and reliable data communications between VA and DoD health care facilities.

[b] Essentris is a commercial health information system customized to support inpatient treatment at military medical facilities.

According to the former acting director of the interagency program office, VA and DoD consider achievement of these six objectives, in conjunction with data sharing capabilities previously achieved (e.g., the Federal Health Information Exchange

[5] Pub. L. No. 110–181, § 1635 (2008).

[6] This board was originally named the Joint Clinical Information Board.

(FHIE),[7] the Bidirectional Health Information Exchange (BHIE),[8] and the interface between DoD's Clinical Data Repository (CDR) and VA's Health Data Repository (HDR), known as CHDR),[9] to be sufficient to satisfy the requirement for full interoperability by September 2009.

DoD/VA Interagency Program Office Has Made Progress in Becoming Operational, but Is Not Fully Functioning as a Single Point of Accountability

As our report later this month will note, VA and DoD have taken important steps to make the interagency program office operational. However, more work is needed to solidify its leadership and management capabilities if the office is to effectively function as a single point of accountability for achieving interoperable electronic health data.

In particular, the departments have completed personnel descriptions and recruited and hired staff for government positions and obtained necessary contractor staff to perform the office's functions. As of early July, the departments reported that they had selected staff members for 10 of 14 government positions and that recruitment efforts were underway to fill the remaining 4 positions by late September 2009. Further, all of the 16 designated contractor positions had been filled.

Nonetheless, VA and DoD continue to fill the office's key leadership positions—that of director and deputy director—on an interim basis. To their credit, the departments have taken steps to hire a full-time permanent director and a deputy director to lead the office. Earlier this month, DoD selected a candidate for the director position, VA concurred with the selection, and the candidate's application was sent to the Office of Personnel Management for approval. In the meantime, the departments requested and received an extension of the interim director's appointment until September 30, 2009, or until a permanent official is hired. Further, as of late June, interagency program officials stated that actions were underway to fill the deputy director position and that VA was interviewing candidates for this position. The interim director stated that the departments anticipate making a selection for the deputy director position by the end of this month.

Beyond the need to appoint these key permanent leaders, the office needs to fulfill a number of responsibilities identified in its January 2009 charter that are critical to its effectiveness. To this end, the office has taken several steps. For example, it submitted its first annual report to Congress that summarized the departments' efforts toward achieving full interoperability and the status of key activities completed to set up the office. Further, the office developed 11 standard operating procedures in areas such as program management oversight, strategic communications, and process improvement.

However, the office has not yet carried out other key responsibilities identified in its charter that are fundamental to effective IT program management and that would be essential to effectively serving as the single point of accountability. For example, the office has not yet established results-oriented (i.e., objective, quantifiable, and measurable) goals and performance measures for all six of the interoperability objectives discussed previously.

In particular, early development and use of results-oriented metrics is an important IT program management activity. Performance goals and measures, if effectively implemented, can provide a meaningful baseline against which to measure the progress of a program and the outcomes associated with its implementation. VA and DoD agreed with our previous recommendation calling for the development of

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[7] FHIE, enhanced through its completion in 2004, provides a one-way transfer of data that enables DoD to electronically transfer servicemembers' electronic health information to VA when the members leave active duty.

[8] BHIE, established in 2004, was aimed at allowing clinicians at both departments viewable access to records on shared patients—that is, those who receive care from both departments. For example, veterans may receive outpatient care from VA clinicians and be hospitalized at a military treatment facility. To create BHIE, the departments drew on the architecture and framework of the information transfer system established by the FHIE project. Unlike FHIE, BHIE is a two-way interface that allows clinicians in both departments to view, in real time, limited health data (in text form) from the departments' existing health information systems. The interface also allows DoD sites to see previously inaccessible data at other DoD sites.

[9] Combining the names of the two repositories, the Clinical Data Repository/Health Data Repository (CHDR) interface, pronounced "cheddar," implemented in September 2006, linked the department's separate repositories of standardized data to enable a two-way exchange of computable health information. These repositories are a part of the modernized health information systems that the departments have been developing—DoD's AHLTA and VA's Health*e*Vet.

such goals and measures.[10] Further, the interagency program office charter identified the development of metrics to monitor the departments' performance against interoperability objectives as a responsibility of the office. Nevertheless, the office has developed performance goals for only one of the six identified interoperability objectives—the expansion of DoD's medical records system (Essentris) to share inpatient discharge summaries with VA. Department officials have stated that results-oriented goals and measures for the other five interoperability objectives will be included in the next version of the DoD/VA Joint Executive Council Joint Strategic Plan, expected to be completed by December 2009. To the extent that the departments establish and effectively use results-oriented goals and measures for their interoperability objectives, they will be better positioned to gauge their progress toward achieving fully interoperable capabilities and improving veterans' health care.

Further, development of an integrated master schedule is a key IT program management activity, especially given the magnitude and complexity of the departments' efforts to achieve full interoperability. According to DoD guidance,[11] an integrated master schedule should identify detailed project tasks and the associated start, completion, and interim milestone dates; resource needs; and relationships (e.g., sequence and dependencies) between tasks.

While the program office has begun to develop an integrated master schedule as required by its charter, the current version does not include the attributes of an effective schedule. For example, the schedule included limited information—only the name of the objective and a completion date of September 30, 2009—for three of the six interoperability objectives (i.e., refine social history data, share physical exam data, and expand questionnaires and self assessment tools). The schedule did not include information on tasks to be performed to meet the objectives, nor start dates, resource needs, or relationships between tasks for any of the six objectives. Without a complete and detailed integrated master schedule, the departments are devoid of critical information that could be vital to their ability to appropriately respond to project needs and guide project efforts.

Similarly, development of a project plan is an important activity for IT program management. Industry best practices and IT program management principles stress the importance of sound planning for any project. Inherent in such planning is the development and use of a project management plan that describes, among other things, the project's scope, resource needs, and key milestones. The interagency program office charter identified the need to develop a project plan but, as of late June, the office had not yet done so. As we have noted in our prior work,[12] without a project plan, the departments lack a key tool that could be used to guide their efforts in achieving full interoperability.

In discussing these activities, the interagency program office's interim director and former acting director cited three reasons for why performance measurement, scheduling, and project planning responsibilities had not been accomplished. First, they stated that because it has taken longer than anticipated to hire staff, the office has not been able to perform all of its responsibilities. Second, the office's interim leadership and staff have focused their efforts on providing interested parties (e.g., Federal agencies and military organizations) with briefings, presentations, and status information on activities the office is undertaking to achieve interoperability, in addition to participating in efforts to develop a strategy for implementation of the Virtual Lifetime Electronic Record, which the President announced in April 2009. Finally, according to the officials, the office waited until June to begin the process of developing performance metrics so that it could do so in conjunction with the departments' annual update to the Joint Strategic Plan that is scheduled for completion in December 2009.

In the absence of sufficient metrics to monitor progress, a complete integrated master schedule, and a project plan, the interagency program office's ability to effectively provide oversight and management, including meaningful reporting on the progress and delivery of interoperable capabilities, is jeopardized. As importantly, the absence of these critical management tools calls into question the effectiveness of this office in functioning as the single point of accountability for achieving full interoperability, and the departments' overall success in meeting this goal.

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[10] GAO, *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).

[11] DoD Integrated Master Plan and Integrated Master Schedule Preparation and Use Guide, Version 0.9, October 21, 2005.

[12] GAO, *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).

VA and DoD Are Taking Steps To Meet Their Objectives, but Activities To Meet Clinicians' Needs Are Expected To Remain After the Deadline for Achieving Full Interoperability

VA and DoD continue to take steps toward achieving full interoperability by September 30, 2009. In this regard, the departments have achieved planned capabilities for three of the objectives—refine social history data, share physical exam data, and demonstrate initial network gateway operation. Specifically, with regard to these objectives, the departments have accomplished the following capabilities:

- The sharing of viewable social history data captured in DoD's electronic health record, thus providing VA with additional clinical information on shared patients that clinicians could not previously view. These data describe, for example, patients' involvement in hazardous activities and tobacco and alcohol use.
- The sharing of physical exam data, allowing VA to view DoD's medical exam data through the BHIE interface, which supports the physical exam process when a servicemember separates from active military duty. VA clinicians are able to view outpatient treatment records, pre- and post-deployment health assessments, and post-deployment health reassessments.
- The operation of secure network gateways to support health information sharing between the departments, thus facilitating future growth in data sharing. As of early July, the departments reported that five network gateways were operational and that data migration to two of the operational gateways had begun.[13] The departments believed these five gateways satisfy the intent of the objective and will provide sufficient capacity to support health information sharing between VA and DoD as of September 2009.

For the remaining three objectives—expand questionnaires and self assessment tools, expand Essentris in DoD, and demonstrate initial document scanning—the departments have partially achieved planned capabilities, with additional work needed to fully meet clinicians' needs.

Specifically, for the objective to expand questionnaires and self assessment tools, the departments intend to provide all periodic health assessment data stored in the DoD electronic health record to VA in a format that associates questions with responses. Health assessment data is collected from two sources: questionnaires administered at military treatment facilities and a DoD health assessment reporting tool that enables patients to answer questions about their health upon entry into the military. Questions relate to a wide range of personal health information, such as dietary habits, physical exercise, and tobacco and alcohol use. While the departments have established the capability for VA to view questions and answers from the questionnaires collected by DoD at military treatment facilities, they have not yet established the additional capability for VA to view information from DoD's health assessment reporting tool. Department officials stated that they intend to provide this capability by September 2009.

However, the other two objectives—expand Essentris in DoD and demonstrate initial document scanning—are expected to require substantial additional work beyond September to meet clinicians' needs. By September 30, DoD intends to expand its Essentris system to at least one additional site for each military medical service and to increase the percentage of inpatient discharge summaries that it shares electronically with VA to 70 percent. According to the interim director of the interagency program office, as of late June 2009, the departments had expanded the system to two Army sites (but not yet to an Air Force or Navy site) and were sharing 58 percent of inpatient discharge summaries. The interim director stated that the departments expect to share 70 percent of inpatient discharge summaries and expand the system to an Air Force and a Navy site by the September deadline. Nevertheless, the official added that to better meet clinicians' needs, DoD will need to further expand the inpatient medical records system. In this regard, the department has established a future goal of making the inpatient system operational for 92 percent of DoD's inpatient beds by September 2010.

The departments also expect to demonstrate an initial capability to scan servicemembers' medical documents into the DoD electronic health record and share the documents electronically with VA by September 2009. According to the program office interim director, the departments were in the process of setting up an interagency test environment to test the initial capability to query medical documents associated with specific patients as of late June 2009. He stated that the departments expect to begin user testing at up to nine sites by September 2009. According

[13] The five operational gateways are located in Dallas, Texas; Reston, Virginia; Kansas City, Missouri; North Chicago, Illinois; and Santa Clara, California.

to this official, these activities are expected to demonstrate an initial document scanning capability. However, after September 2009, the departments anticipate needing to perform additional work to expand their initial document scanning capability (e.g., completion of user testing and establishment of the scanning capability at all DoD sites).

In conclusion, VA and DoD have continued to increase electronic health information interoperability, and have taken steps to meet the six objectives that they identified as necessary to achieve full interoperability by September 30, 2009. However, for two of the six interoperability objectives, the departments subsequently plan to perform significant additional activities that are necessary to meet clinicians' needs. Further, the departments' lack of progress in establishing fundamental IT management capabilities that are the specific responsibilities of the interagency program office contributes to uncertainty about the extent to which they will achieve full interoperability by the deadline. Although the departments have generally made progress toward making the program office operational, the absence of performance metrics, and a complete integrated master schedule and a project plan, limits the office's ability to effectively manage and provide meaningful progress reporting on the delivery of interoperable capabilities that are deemed critical to improving the quality of health care for our Nation's veterans.

To better improve the management of VA's and DoD's efforts to achieve fully interoperable electronic health record systems, our draft report recommends that the Secretaries of Defense and Veterans Affairs emphasize the interagency program office's establishment of a project plan and a complete and detailed integrated master schedule.

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

Contact and Acknowledgments

If you have any questions on matters discussed in this testimony, please contact Valerie C. Melvin, Director, Information Management and Human Capital Issues, at (202) 512–6304 or *melvinv@gao.gov*. Other individuals who made key contributions to this testimony are Mark Bird, Assistant Director; Rebecca Eyler; Michael Redfern; J. Michael Resser; Kelly Shaw; Eric Trout; and Merry Woo.

Prepared Statement of Rear Admiral Gregory A. Timberlake, SHCE, USN, Acting Director, U.S. Department of Defense/U.S. Department of Veterans Affairs Interagency Program Office

INTRODUCTION

Chairman Mitchell and distinguished Members of the Committee, thank you for the opportunity to discuss the role of the DoD/VA Interagency Program Office (IPO) in the ongoing data-sharing activities of the Department of Defense (DoD) and the Department of Veterans Affairs (VA). Collaboration between the two Departments on information technology issues has grown exponentially in recent years, enabling the Departments to explore ways in which they may benefit jointly from data-sharing innovations in the private sector, as well as helping to foster bold new government-driven information-sharing capabilities, like the development of a "Virtual Lifetime Electronic Record" (VLER) for servicemembers and veterans. Working on behalf of the DoD/VA Joint Executive Council, the IPO plays a key role in facilitating these efforts, and in providing oversight of various data-sharing initiatives between the Departments. In recent months, the IPO has been focused on two central areas: (1) facilitating the efforts of the two Departments to achieve full interoperability of their electronic health records by September of this year, as defined by the VA and DoD clinicians that rely on this data to treat patients, and (2) working with the Departments to develop an effective governance and management model for VLER. These two areas will be the focus of my testimony today.

IPO BACKGROUND

In April 2008, DoD and VA formed the "DoD/VA Interagency Program Office" (IPO) in response to section 1635 of the National Defense Authorization Act for fiscal year 2008, which required the creation of an entity to serve as a single point of accountability for the rapid development and implementation of electronic health record (EHR) systems or capabilities between the Departments. Section 1635 further mandated that full interoperability of personal health care information between the DoD and VA be achieved by September 2009. Since its inception, the IPO has

worked diligently to achieve this mandate, providing the Departments with reliable, effective management oversight of potential risks involving the identification, coordination, and review of information sharing requirements, and informing stakeholders about the impact these processes may have on DoD/VA information sharing progress.

The responsibility for developing requirements and executing technical information technology solutions remains with the respective DoD and VA organizations, using the Departments' established statutory and regulatory processes for acquisition, funding, management control, information assurance, and other execution actions. The differences between the Departments in these areas can pose challenges to effective collaboration on joint DoD/VA information sharing projects. In order to overcome such challenges, the IPO has worked closely with the existing leadership of the Joint Executive Council to provide focused assistance and oversight to ensure the Departments achieve their goals. Our work includes facilitating discussions between DoD and VA functional business communities on areas such as supporting the definition of DoD/VA data-sharing requirements, promoting effective synchronization of DoD/VA schedules for the technical execution of joint data-sharing initiatives, assisting in the coordination of funding considerations, and assisting in obtaining the input and concurrence of stakeholders.

The nature of the IPO's work requires a professional staff that possesses a wide scope of varied, but complementary, skills and knowledge. The initial staff of the IPO consisted of an Acting Director from the DoD, an Acting Deputy Director from the VA, and four military personnel that were briefly detailed to the IPO as a final assignment before retirement. In the early stages of the IPO's formal existence, this small staff focused most of their energies on acquiring office space and equipment, determining permanent staffing requirements and an office governance structure, advertising for and recruiting permanent staff, drafting the IPO charter, writing the first IPO report to Congress, and setting in place procedures to gather information that would enable the IPO to provide informed oversight of the interoperability efforts of the two Departments.

The staffing model that the IPO developed consists of two Senior Executive Service positions, fourteen DoD and VA civilian government positions, and a small contingent of contracted employees (up to sixteen). Filling these positions with the most highly qualified personnel possible has been challenging and time-consuming, because all of the government employees had to go through an extensive formal hiring process. This process includes the development of detailed position descriptions; advertising the positions on USA Jobs; processing applications based on relevant knowledge, skills, and abilities; selection of candidates for interviews; formal job offers; and security clearance vetting. The hiring process was the same for all job applicants regardless of whether the applicant was already a Federal employee or was hired from the private sector. Approximately half of the candidates that were selected came from the private sector; the remaining candidates were already Federal employees, but not all of them were executive branch Federal employees.

The hiring process is now nearing completion. The current status of our staffing posture is as follows: Ten of the fourteen government positions are now hired and on staff. This includes the Chief of Staff, two Audit Analysts (DoD & VA), one Senior Program Analyst for Health (DoD), a Configuration Management expert (VA), a Public Affairs Specialist (DoD), a Budget Analyst (VA), a Portfolio Analyst (DoD), and two Senior Financial Program Analysts (DoD & VA). In addition, three civilian government positions have accepted job offers, but are not yet on staff. These include a Senior Program Analyst for Benefits (DoD), a Senior Program Analyst for Health (VA), and a Senior Management Analyst (VA). The only position that remains unfilled is a Senior Program Analyst for Benefits (VA). The IPO is currently evaluating candidates for this position. The anticipated target date for filling this position is late summer of this year.

Advertising for the Senior Executive Service (SES) Director position closed on March 17, 2009. The SES screening board convened on April 16, 2009, to rank the candidates and select those to be interviewed. The process for selection is on-going.

The SES Deputy Director's position announcement closed April 17, 2009. Initial interviews have occurred, with additional interviews of the top one or two candidates to follow. After a selection is made, the candidate will be referred to DoD for concurrence. Upon concurrence from DoD, a formal offer will be made, contingent on a security background check. The anticipated start date for the new Deputy Director is late summer 2009.

HEALTH DATA SHARING AND INTEROPERABILITY

The Departments began laying the foundation for interoperability in 2001, when the first patient health information was transferred electronically from DoD to VA using the Federal Health Information Exchange (FHIE). Since that time, both Departments have continued to expand the types of information that is shared, as well as the manner in which information is shared. By leveraging the prior accomplishments of VA and DoD, the IPO and the Departments have been successful in formulating a plan to achieve full interoperability for the provision of clinical care by the September 2009 target date. This plan centers on meeting the data-sharing requirements of treating clinicians in the two Departments as defined by the DoD/VA Interagency Clinical Informatics Board (ICIB).

From an early point in the planning process, the IPO and the Departments agreed to turn to the ICIB to assist in the prioritization of DoD/VA health data interoperability initiatives. The ICIB is an organization comprised of clinicians from both DoD and VA. The Deputy Assistant Secretary of Defense for Clinical and Program Policy and the Chief Patient Care Services Officer, Veterans Health Administration, serve as its lead functional proponents. Through the ICIB, we enabled the clinical community to define the items that must be shared by September 2009 in order to achieve full interoperability. Once the ICIB identified and prioritized its needs for electronic data-sharing, their recommendations were forwarded to the Health Executive Committee (HEC) for review and approval. Upon approval by the HEC, the list of priorities was handed off to requirements and definition teams, and then to our information technology teams to develop applications and tools to put them into operation.

Detailed information about the Departments' ongoing data-sharing initiatives appears in the prepared testimony of Mr. Charles "Chuck" Campbell, Chief Information Officer, Military Health System (MHS) and Mr. Roger Baker, VA Assistant Secretary for Information and Technology. As a general overview, however, VA and DoD have continued to improve upon the successes of existing data exchange initiatives like the Federal Health Information Exchange (FIDE) and the Bidirectional Health Information Exchange (BHIE), and have expanded the type of data that is available through the Clinical Data Repository/Health Data Repository (CHDR interface). To add further capability, new pilot programs such as the BHIE Imaging Pilot have been developed. This pilot is now deployed and operational at several major military and VA medical centers across the country.

While much progress has been made toward our current interoperability goals, some challenges still remain. The key challenges include the following:

- Developing, adopting, and maturing standards at the national level to ensure efficient operational use.
- Updating capabilities, systems, infrastructure, and technology consistent with emerging standards.
- Identifying and prioritizing information requirements for sequential upgrade to new technologies and common services, as defined by the business process owners and the functional community.

In addition to this list of challenges, the Departments must continually work together to overcome difficulties created by different acquisition and funding cycles, different contracting processes, and differences in information assurance certification processes. The Departments and the IPO continue to engage in collaborative efforts to ensure that any impediment that may arise from these differences is resolved in an efficient manner. In spite of these challenges, the IPO and the two Departments are on track to achieve full interoperability for the provision of clinical care by September 30, 2009, as defined by the Interagency Clinical Informatics Board.

THE VIRTUAL LIFETIME ELECTRONIC RECORD: THE VISION AND THE BROAD CONCEPTUAL CHALLENGES

On April 9, 2009, the President, along with Secretary Gates and Secretary Shinseki, announced that DoD and VA have taken the first step in creating a joint Virtual Lifetime Electronic Record (VLER). President Obama pointed out the largest challenge that the two Departments face in their continuing efforts to modernize their electronic health and benefits records systems, declaring that "there is no comprehensive system in place that allows for a streamlined transition of health care records between DoD and the VA." Creating such a capability would mark a departure from data-sharing efforts in the past, which have centered on developing an ever-proliferating array of information-sharing programs that allow one Department to access patient data captured in the electronic health record system of the other

Department. While this strategy has allowed DoD and VA to share unprecedented amounts of patient health care data, the adoption of new technologies can provide even more efficiencies in the collection, retrieval, and use of patient health care data across the Departments. Recognizing this, the President directed the two Departments 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." These activities will be carried out in coordination with the health IT implementation going on nationwide and headed by the Department of Health and Human Services.

In a press release that was issued shortly after the President's speech, the White House highlighted the importance of creating a comprehensive virtual lifetime electronic records capability between DoD and VA, and noted some of the advantages that would likely result from the establishment of a VLER: "Access to electronic records is essential to modern health care delivery and the paperless administration of benefits. It provides a framework to ensure that all health care providers have all the information they need to deliver high-quality health care while reducing medical errors. The creation of this joint Virtual Lifetime Electronic Record by the two organizations would take the next leap to delivering seamless, high-quality care, and serve as a model for the Nation."

As the White House pointed out, the potential benefits of a VLER are indeed monumental, but so is the effort required in order to plan, create, and implement a VLER. This effort represents one of the largest projects that any two Federal Departments have made in recent years, and there are a number of challenges that must be overcome to achieve the President's vision. To begin, new IT conceptual frameworks must be established to provide a health and benefits data-sharing architecture to which both Departments can connect their electronic records systems. To date, discussions between the Departments have been focused on leveraging a common services architecture framework to support modernized tools and technologies on both sides.

In addition to the over-arching conceptual issues on the technical side, the Departments must establish an effective governance model and collaborative strategy for the VLER. Each Department has unique processes for funding, management, and oversight for information technology projects. These processes must be brought into alignment in key areas in order for successful planning and development to occur on the VLER initiative.

The IPO also plays an active role in efforts to reach inter-Departmental consensus on broad technical requirements issues. Progress is being made on the Departments' efforts to agree to use a nationally recognized set of uniform and open standards for information exchange, such as those being implemented by the Department of Health and Human Services' Nationwide Health Information Network. This approach will enable DoD and VA to create an architectural framework that is capable of sharing electronic health data from both the private sector and the government. Ultimately, such an information-sharing architecture may serve as a model for national electronic records data sharing.

CONCLUSION

The IPO and the Departments are engaged in many efforts to ensure that full interoperability for the provision of clinical care is achieved by September of this year. We recognize that interoperability does not have a discrete end point, as technologies and standards continue to evolve. Our efforts in the future will continue to build upon our past successes, allowing the Departments' to maintain their standard of providing the highest quality care for our servicemembers, veterans and their beneficiaries.

That future is beginning to come into focus as we make progress on joint efforts to plan the Virtual Lifetime Electronic Record. Creating and implementing the VLER will require an unprecedented amount of effort, coordination, and interagency cooperation. The IPO is committed to this work, and looks forward to continuing to facilitate the efforts of the Departments on the VLER. When operational, the VLER will provide our servicemembers, veterans, and service providers with the health and benefits data they need, when and where they need it, thereby ultimately improving the quality of both health care and benefits services.

Thank you for the opportunity to address the Committee, and to provide you with an update on the important work that we are doing to advance electronic data-sharing between the DoD and VA. I look forward to keeping you apprised of our progress

toward our shared goal of improving the quality of services for our servicemembers, veterans and their families.

Prepared Statement of Mary Ann Rockey, Program Executive Officer/Deputy Chief Information Officer (Acquisition), Military Health System, U.S. Department of Defense

INTRODUCTION

Chairman Mitchell, Ranking Member Roe, and Members of this distinguished Committee, thank you for the opportunity to discuss with you the progress that is being made toward creating an interoperable electronic health record (EHR) for the provision of clinical care between the Department of Defense (DoD) and Department of Veterans Affairs (VA).

Great strides forward have been made in electronic data sharing between the Departments during the past few years. The Departments currently experience a level of interoperability unsurpassed by other health care delivery partners. This shared information supports the delivery of high-quality health care and the administration of benefits to our Nation's servicemembers and Veterans. The EHR interoperability achieved by the Departments is a showcase and a precursor for U.S. electronic health data sharing and interoperability initiatives such as the Nationwide Health Information Network (NHIN). This network of networks is being developed to provide a secure, nationwide, interoperable health information infrastructure that will connect providers, consumers, and others involved in supporting health and health care. Like our DoD/VA sharing solutions, the NHIN will enable health information to follow the patient, ensuring it is available for clinical decision-making, and supporting appropriate use of health care information beyond direct patient care.

The Departments are committed to evolving and expanding the appropriate sharing of health information to enhance care delivery and continuity of care for our patients. Efforts are underway to deliver full interoperability, as defined by DoD and VA clinicians who rely on data to treat patients, for the provision of clinical care by September 2009, and to provide expanded interoperability capabilities beyond September 2009. As with any large information technology initiative, the Departments have met and resolved challenges and will continue to do so in the future.

Today, I will discuss our joint efforts, highlighting the level of data sharing achieved through the data sharing solutions that form the foundation for EHR interoperability.

OVERVIEW—ELECTRONIC DATA SHARING

DoD and VA began laying the foundation for interoperability in 2001 when our Departments first shared health care information electronically. Since that time, we have enhanced and expanded the types of information we share, as well as the ways in which we share; created increased organizational transparency; and formed oversight and governing bodies to ensure our sharing efforts progress at a pace meeting or exceeding the needs and expectations of our stakeholders.

The foundation of current and future health care information sharing includes data sharing initiatives that have enhanced continuity of care for separated servicemembers and shared patients; enabled our providers to view health care information originating in the other Department's EHR; and alerted providers to the potential for severe allergic reactions or drug interactions before an electronic prescription was issued.

Continuity of Care for Separated Servicemembers (Potential VA Patients). Since 2001, DoD has transferred electronic health information on separated servicemembers to a jointly developed data repository known as the Federal Health Information Exchange (FHIE). VA providers and benefits specialists access the data in FHIE daily for use in the delivery of health care and resolution of claims.

As of May 2009, DoD has transferred health information for over 4.8 million patients to the FHIE data repository. Of these 4.8 million patients, approximately 3.3 million patients have presented to VA for care, treatment, or claim determination. The amount of data available to VA continues to grow as health information on recently separated servicemembers is extracted and transferred to VA. Transfer of data to VA is executed in a manner that is compliant with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

The transferred data includes: inpatient and outpatient laboratory results and radiology reports; outpatient pharmacy data from military treatment facilities (MTFs), retail network pharmacies, and DoD mail-order pharmacy; allergy information; dis-

charge summaries; admission, disposition, and transfer information; consultation reports; standard ambulatory data record information such as diagnostic codes, primary care physician, treating physician; patient demographic information; and Pre/Post-Deployment Health Assessment (PPDHA) and Post-Deployment Health Reassessment (PDHRA) forms. As of May 2009, over 2.5 million PPDHA and PDHRA forms on more than 1.0 million individuals have been sent from DoD to VA.

DoD also transfers data to FHIE for VA patients treated in DoD facilities under local sharing agreements, making that data accessible to VA providers. As of May 2009, over 4 million cumulative patient messages containing laboratory, radiology, pharmacy, and consult information have been transmitted on VA patients treated in DoD facilities.

Continuity of Care for Shared Patients. For shared patients being treated by both DoD and VA, the Departments continue to use the Bidirectional Health Information Exchange (BHIE) which enables real-time bidirectional sharing of allergy information; outpatient pharmacy data; demographic data; inpatient and outpatient laboratory results and radiology reports; ambulatory encounters/clinical notes; procedures; vital sign data; patient histories; questionnaires; and theater clinical data including inpatient notes, outpatient encounters, and ancillary clinical data, such as pharmacy data, allergies, laboratory results, and radiology reports.

AHLTA, the DoD's EHR, serves as the enterprise foundation for information interoperability with VA. Access to BHIE data is available through AHLTA and through VistA, VA's EHR, for patients treated by both Departments. As of May 2009, information on more than 3.3 million shared patients, including over 117,980 theater patients, is available through BHIE.

To increase the availability of clinical information on a shared patient population, VA and DoD leveraged BHIE functionality to allow bidirectional access to inpatient documentation from DoD's inpatient documentation system. This capability is operational at some of DoD's largest inpatient facilities, representing more than 55 percent of total DoD inpatient beds. By the end of Fiscal Year (FY) 2010, this capability will be operational for approximately 90 percent of total DoD inpatient beds.

In addition to sharing viewable text data, VA and DoD are leveraging the BHIE infrastructure to support the exchange of digital radiology images to support continuity of care. The Departments will continue to monitor and evaluate this capability.

For our most seriously wounded, ill, and injured servicemembers transferring to VA Polytrauma Rehabilitation Centers (PRCs) for care, the Departments continue to send radiology images and scanned medical records electronically from three major DoD trauma centers at Walter Reed Army Medical Center, Brooke Army Medical Center, and Bethesda National Naval Medical Center to VA PRCs located in Tampa, Florida, Richmond, Virginia, Minneapolis, Minnesota, and Palo Alto, California. To date, scanned medical records for 230 patients and digital images for 167 patients have been sent.

Computable Data for Shared Patients. In September 2006, the Departments established interoperability between AHLTA's Clinical Data Repository (CDR) and VA's Health Data Repository (HDR). The DoD/VA Clinical Data Repository/Health Data Repository (CHDR) interface enables the first exchange of interoperable and computable outpatient pharmacy and medication allergy data between the Departments on patients who receive care from both health care systems. DoD's outpatient pharmacy data exchange includes information from MTF pharmacies, retail pharmacies, and mail order pharmacies. This functionality is available to all DoD facilities.

For patients with pharmacy and allergy data exchanged through CHDR, DoD providers view a combined medication and allergy list without having to access a separate application or making any changes to how they typically view medication or allergy data within AHLTA. The exchange of computable outpatient pharmacy and medication allergy data enables drug-drug interaction checking and drug allergy checking using data from both Departments. In FY 2008 alone, DoD providers were presented with more than 19,600 Level 1 and Level 2 drug-drug alerts; these are the most severe potential drug alerts provided to clinicians for decision support. This capability significantly enhances patient safety and quality of care.

Clinicians are actively using CHDR and we are currently exchanging outpatient pharmacy and medication allergy data on more than 34,000 patients who receive health care from both DoD and VA. These patients are referred to as Active Dual Consumers (ADCs). In September 2008, DoD implemented a process to automatically identify patients being treated in both Departments and began setting the ADC flag on approximately 50 patients per day. When the ADC flag is activated, medication and drug allergy data is exchanged between the repositories. Subsequently, when a new medication or drug allergy is recorded by a provider in either

Department, the new data is sent to the other Department's repository. This capability is being implemented in a phased approach to enable the Departments to monitor the impact on system performance and perform capacity planning.

Virtual Lifetime Electronic Record. On April 9, 2009, the President, along with Secretary Shinseki and Secretary Gates, announced that VA and DoD have taken steps toward creating a joint Virtual Lifetime Electronic Record (VLER). VA and DoD are working together on an overall strategy to achieve the President's VLER vision and jointly developing an effective governance model. The VLER will permit information vital to health care, benefits, and services, to be available seamlessly to both Departments from the moment a servicemember enters into the military until the servicemember's or Veteran's death. The testimony by the Acting Director of the Interagency Program Office will address the Departments' collaborative work on this important interagency effort.

It is important to note that the DoD EHR "way ahead" dovetails with the plans being discussed for the virtual lifetime electronic record, which will leverage the investments made in the Departments' existing electronic record systems. DoD is making a number of improvements to our EHR to enhance its performance, reliability, and usability. Those improvements include an improved flexible graphical user interface and architecture that uses a common services approach.

MEETING THE INTEROPERABILITY DEADLINE

The Departments expect to achieve by no later than September 30, 2009, electronic health record systems or capabilities that allow for full interoperability of personal health care information between the Department of Defense and the Department of Veterans Affairs to support the provision of clinical care. The DoD/VA Interagency Clinical Informatics Board (ICIB) has played a critical role in defining the priorities for the Departments in meeting the September 2009 interoperability deadline and will guide our continued progress in electronic data sharing after the initial interoperability goals are achieved.

DoD Coordination with the Interagency Program Office. Achieving our electronic data sharing goals requires increased agency transparency. To increase DoD's organizational transparency, the DoD/VA Interagency Program Office is involved in internal DoD and cross-organizational DoD/VA meetings hosted by the Military Health System Office of the Chief Information Officer (CIO) focused on DoD/VA electronic data sharing initiatives. This level of involvement and access to DoD information ensures the Interagency Program Office is able to provide management oversight of potential risks involving the identification, coordination, and execution of information sharing requirements.

Further, to ensure open lines of communication are maintained, I have designated an Interagency Program Office liaison within the Office of the CIO. This knowledgeable senior staff member has access to the Department resources necessary to ensure the Interagency Program Office receives timely responses to requests for information and assistance.

DoD/VA ICIB. To ensure clinically relevant information is shared electronically between the Departments, the ICIB was formed. The ICIB is an organization comprised of clinicians from both DoD and VA. Through the ICIB, we enabled the clinical community to define the items that must be shared by September 2009 in order to achieve full interoperability. The Deputy Assistant Secretary of Defense for Clinical and Program Policy and the Chief Patient Care Services Officer, Veterans Health Administration, serve as the lead functional proponents. The ICIB guides clinical priorities for what electronic health care information the Departments should share next and reviews planned clinical information system solutions for DoD/VA sharing to ensure alignment to clinical sharing priorities as defined by the ICIB.

To support efforts to meet the September 2009 deadline, the ICIB submitted clinical priorities to the Interagency Program Office and DoD/VA Health Executive Council. For future years, the ICIB will prioritize additional health related sharing requirements to continually advance DoD/VA interoperability in a manner that supports clinicians in health care delivery.

As the Departments work together to enhance data sharing by September 2009 and to achieve the vision for the virtual lifetime electronic record agreed to by the Secretaries, there will be key interoperability challenges, including:

1. Developing and adopting standards at the national level and the maturing of those standards for operational use;
2. Updating systems, infrastructure, and technology consistent with emerging standards;
3. Identifying and prioritizing information sharing requirements; and

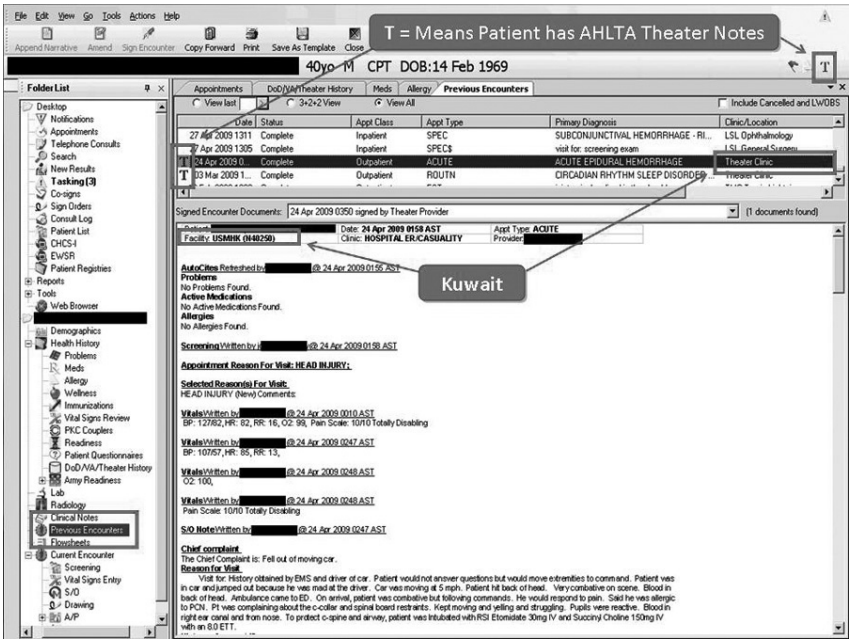
4. Making the business process changes necessary to support increased electronic data sharing.

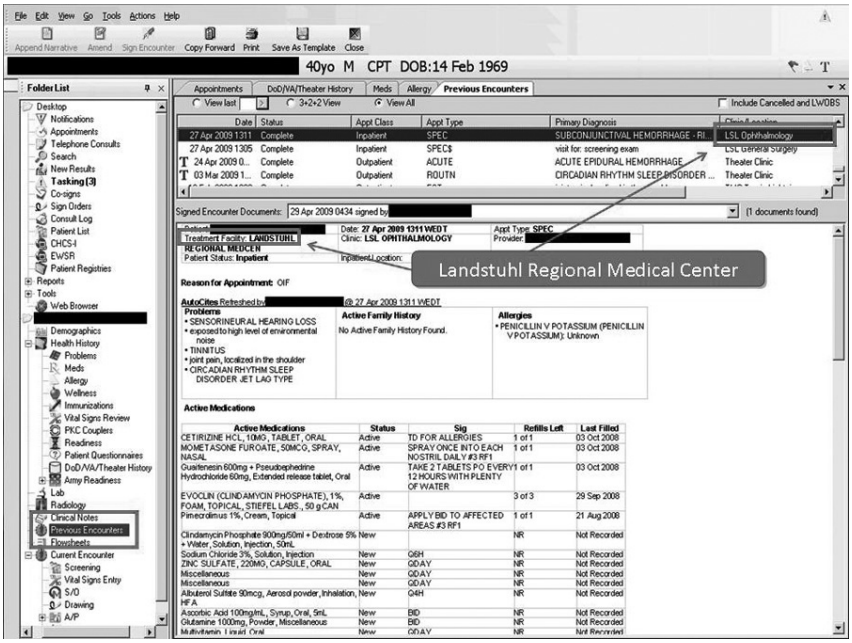
The Departments and the Interagency Program Office will continue to collaborate with the Department of Health and Human Services, and others, on the development and adoption of the national standards required to enable health information to follow the patient regardless of the point of care. Our beneficiaries receive health care from the private sector so the ability to exchange health information between the public and private sectors is critical to both Departments. In addition, fulfillment of our goal of the virtual lifetime electronic record requires that it include complete administrative and medical information from all points of care. We look forward to future opportunities to present this Committee with our progress toward increased health data sharing and interoperability.

CONCLUSION

Mr. Chairman and distinguished Members of the Committee, the efforts of DoD and VA to share health care information have gained undeniable momentum. We continue to build on this momentum, leveraging our EHR and our solid foundation of electronic data sharing initiatives as we move toward this September and the goal of full interoperability for the provision of clinical care and beyond. Further, our EHR way ahead will rapidly increase our data sharing capabilities with VA as well as our private sector care delivery partners through both the virtual lifetime electronic record and NHIN.

I value your insight, recommendations, and guidance. We are all working toward the same end—to provide the highest quality care for our Nation's heroes, past and present—and we must continue to work together to achieve our goals as efficiently and effectively as possible. Thank you again for the opportunity to discuss the significant progress achieved toward DoD/VA interoperable electronic health record.


T = Means Patient has AHLTA Theater Notes
40yo M CPT DOB:14 Feb 1969
Kuwait


40yo M CPT DOB:14 Feb 1969
Landstuhl Regional Medical Center

File Edit View Go Tools Actions Help

Close

[redacted] 40yo M CPT DOB:14 Feb 1969

Folder List

Appointments | DoD/VA/Theater History | Meds | Allergy | Previous Encounters

Note Title: ICU Nursing Note
Note Date: 27Apr09 Provider: [redacted]
Click here to view note details

Note Title: ICU Nursing Note
Note Date: 27Apr09 Provider: [redacted]
Click here to view note details

Note Title: Discharge Summary
Note Date: 27Apr09 Provider: [redacted]
Click here to view note details

Note Title: Operative Note
Note Date: 26Apr09 Provider: [redacted]
Click here to view note details

Note Title: ICU Nursing Note
Note Date: 26Apr09 Provider: [redacted]
Click here to view note details

Note Title: ICU Provider Note
Note Date: 26Apr09 Provider: [redacted]
Click here to view note details

Note Title: SURGICAL NOTE
Note Date: 26Apr09 Provider: [redacted]

File Edit View Go Tools Actions Help

Close

[redacted] 40yo M CPT DOB:14 Feb 1969

Folder List

Appointments | DoD/VA/Theater History | Meds | Allergy | Previous Encounters

BHIE Data Viewer Module

Patient Data

Allergy
Clinical Notes
Encounters
Histories
Laboratory
Problems
Outpatient Medications
Questionnaires
Radiology Reports
Vitals

Patient Summary

Data Sources

Clinical Note Details
Note Title: Discharge Summary
Note Date: 27Apr09 Provider: [redacted]

Note Type: Progress Note Location Name: 332ND EXPEDITIONARY MED GROUP

Balad Air Base Iraq

Complete Note:
332nd AFTH TRANSFER/ DISCHARGE SUMMARY

FULL NAME/RANK
[redacted] / Captain, USA

SSN/MR#:
[redacted]

DATE OF ADMISSION:
24 APR 2009

DATE OF DISCHARGE: 27 Apr 2009

ADMISSION DIAGNOSIS:
Temporal bone basilar skull fracture
Epidural hematoma
Brain Contusion
Aspiration pneumonitis/pneumonia

DISCHARGE DIAGNOSIS:
Same

BRIEF HPI:
40 y/o USA [redacted] who either fell or jumped from a moving vehicle at low speed. Per EMS and vehicle driver, pt struck the back of his head. Presenting GCS was 14, but pt reportedly intubated for combativeness. CT scan revealed R occipital epidural hematoma, R temporal bone fracture, and shift of structures to the left and effacement of basilar cisterns. Decision was made to transfer pt to Balad for neurosurgical consultation. Transfer was delayed because of weather. Pt received 2 doses of manitol and

File Edit View Go Tools Actions Help

Close

[redacted] 40yo M CPT DOB:14 Feb 1969

Folder List

Appointments | DoD/VA/Theater History | Meds | Allergy | Previous Encounters

Note Date: 19Jun09 Provider: [redacted]

Click here to view note details

Note Title: PROSTHETICS CLINIC 14073
Note Date: 19Jun09 Provider: [redacted]

Click here to view note details

Note Title: SPEECH PATHOLOGY DISCHARGE SUMMARY 12574
Note Date: 19Jun09 Provider: [redacted]
CCC-SLP

Click here to view note details

Note Title: NEUROPSYCH ASSESSMENT FINAL 12701
Note Date: 19Jun09 Provider: [redacted]

Click here to view note details

Note Title: REHAB NURSING SHIFT ASSESSMENT
Note Date: 18Jun09 Provider: [redacted]

Click here to view note details

Note Title: PM&R INPT 14833
Note Date: 18Jun09 Provider: [redacted]

Click here to view note details

Note Title: PT DISCHARGE 11112
Note Date: 18Jun09 Provider: [redacted]

File Edit View Go Tools Actions Help

Close

[redacted] 40yo M CPT DOB:14 Feb 1969

Folder List

Appointments | DoD/VA/Theater History | Meds | Allergy | Previous Encounters

BHIE Data Viewer Module

Patient Data

Allergy
Clinical Notes
Encounters
Histories
Laboratory
Problems
Outpatient Medications
Questionnaires
Radiology Reports
Vitals

Patient Summary

Data Sources

Clinical Note Details

Note Title: NEUROPSYCH ASSESSMENT FINAL 12701
Note Date: 19Jun09 Provider: [redacted]

Note Type: 999-9 Location Name: PALO ALTO HCS

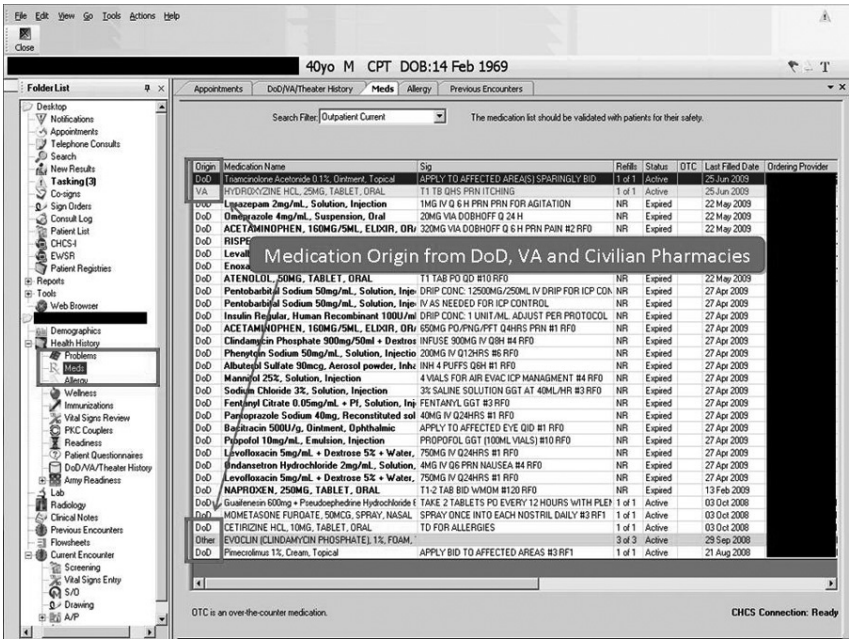
Palo Alto VA

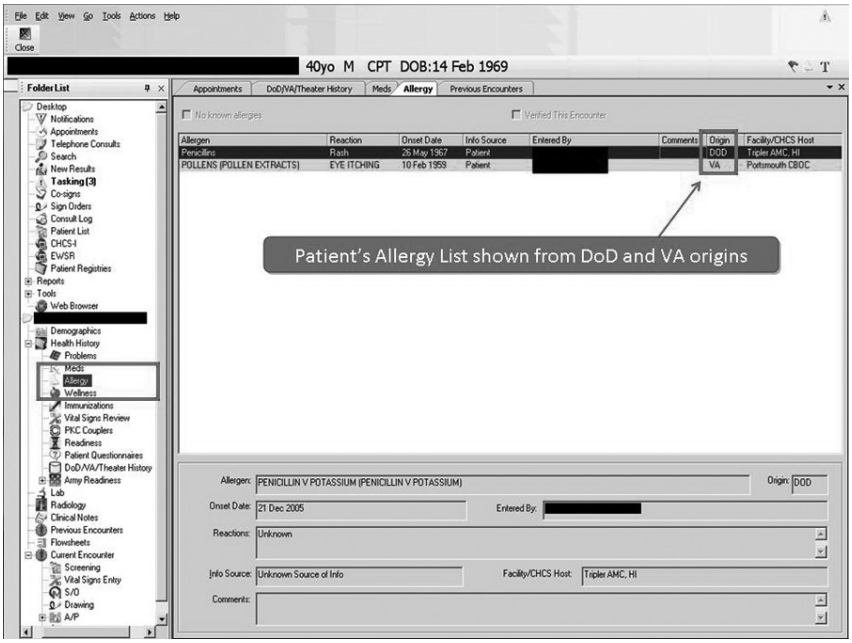
Complete Note:
PALO ALTO HCS;640
14517097
06/19/2009 18:20
NEUROPSYCH ASSESSMENT FINAL 12701
[redacted]
LOCAL TITLE: NEUROPSYCH ASSESSMENT FINAL 12701
STANDARD TITLE: NEUROPSYCHOLOGY NOTE
DATE OF NOTE: JUN 19, 2009@18:20 ENTRY DATE: JUN 24, 2009@18:21:14
AUTHOR: [redacted] EXP COSIGNER:
URGENCY: STATUS: COMPLETED

IDENTIFYING INFORMATION
Patient Name: [redacted]
Age (DOB): 40 (02/14/1969)
Ethnicity: Asian-American
Gender: Male
Marital Status: married
Education: 19 years
Handedness: Right
Military Branch: [redacted]
Rank: Captain

REASON FOR REFERRAL
[redacted] was referred for a neuropsychological evaluation to assess general cognitive and emotional functioning to inform treatment recommendations.

HISTORY OF PRESENTING PROBLEM
[redacted] is a 40-year-old, [redacted], Army Captain who was serving in Kuwait when he fell off a slow moving vehicle and struck the back of his head per witnesses on 4/23/09. He sustained a right temporal bone fracture,


40yo M CPT DOB:14 Feb 1969
Appointments
DoD/VA/Theater History
Meds
Allergy
Previous Encounters
Search Filter: Outpatient Current
The medication list should be validated with patients for their safety.
Origin | Medication Name | Sig | Refills | Status | OTC | Last Filled Date | Ordering Provider
Medication Origin from DoD, VA and Civilian Pharmacies
OTC is an over-the-counter medication.
CHCS Connection: Ready


40yo M CPT DOB:14 Feb 1969
Appointments
DoD/VA/Theater History
Meds
Allergy
Previous Encounters
No known allergies
Verified This Encounter
Allergen | Reaction | Onset Date | Info Source | Entered By | Comments | Origin | Facility/CHCS Host
Penicillins | Rash | 26 May 1967 | Patient | DOD | Tripler AMC, HI
POLLENS (POLLEN EXTRACTS) | EYE ITCHING | 10 Feb 1959 | Patient | VA | Portsmouth CBOC
Patient's Allergy List shown from DoD and VA origins
Allergen: PENICILLIN V POTASSIUM (PENICILLIN V POTASSIUM)
Origin: DOD
Onset Date: 21 Dec 2005
Entered By:
Reactions: Unknown
Info Source: Unknown Source of Info
Facility/CHCS Host: Tripler AMC, HI
Comments:

Prepared Statement of Hon. Roger W. Baker,
Assistant Secretary for Information and Technology,
Office of Information and Technology, U.S. Department of Veterans Affairs

Mr. Chairman, thank you for the opportunity to update you on the status of our efforts to exchange electronic medical information with our partners at the Department of Defense (DoD). This Committee has always been supportive of our efforts and I look forward to providing you the information you need. Accompanying me today are Dr. Paul Tibbits and Mr. Scott Cragg.

VA and DoD continue to work toward improving the exchange of medical information to best serve our active duty servicemembers and Veterans who come to us for medical care. Today, we are sharing more information than ever before. Although our data exchanges are unprecedented in the scope and amount of data we share, we realize there is more work to be done and are taking the steps necessary to meet our goals and comply with section 1635 of the National Defense Authorization Act (NDAA). I will address some of our recent successes, as well as some of the issues facing VA, as we work with DoD to expand our access to shared electronic medical information.

I think you will agree that the current level of data sharing between VA facilities and between VA and DoD facilities is without equal anywhere else in the country. VA's award-winning electronic medical record system, VistA, is recognized worldwide as a model for integrated health information technology systems. Developed by VA from a clinical perspective, VistA is successfully deployed and used by administrative and clinical staff working in more than 1,200 VA medical centers, clinics, and nursing homes across the country. VA hospitals using VistA are one of only three hospital systems that have achieved the qualifications for the Healthcare Information and Management Systems Society (HIMSS) stage 7, the highest level of electronic health record integration, while a non-VA hospital using VistA—the Midland Memorial Hospital in Midland, TX—is one of only 42 U.S. hospitals that have achieved HIMSS stage 6. VistA was awarded the prestigious *Innovations in American Government Award* by Harvard University's Ash Institute for its estimated annual efficiency improvement rate of 6 percent. One of the key modules facilitating VistA's information availability,

My Health*e*Vet, is the recipient of numerous government and industry accolades, including the CIO 100 award and first place in the 2009 TEPR (Toward the Electronic Patient Record) personal health record competition. Open-source versions of VistA are widely deployed in private health systems, public hospitals, and medical offices in the U.S. and overseas.

The NDAA mandates that both Departments achieve full interoperability of electronic health record capabilities and systems by September 2009. The NDAA also includes the requirement to establish the DoD/VA Interagency Program Office (IPO), which today provides vital coordinating linkages as envisioned by the NDAA legislation.

Information Interoperability Plan

The DoD/VA information interoperability plan (IIP) continues to serve as our interoperability roadmap. The IIP describes the current state of electronic data sharing between the Departments and identifies the gaps that must be addressed to achieve the level of information interoperability necessary to support the clinical and benefits needs of our Veterans and members of the Armed Forces. The IIP provides the strategic organizing framework for current and future work and establishes the scope and milestones necessary to measure progress toward intermediate and long term goals.

The IIP also emphasizes leveraging our existing data exchanges through which we already share almost all essential health information in viewable format. By September 2009 we will enhance the existing data exchanges to share those additional types of information identified and prioritized by the Interagency Clinical Information Board (ICIB). The ICIB comprises clinicians from both DoD and VA. It is responsible for identifying and prioritizing the types and format of electronic medical information that needs to be shared by DoD and VA, to care for our patients. This group ensures that our data sharing is focused on needs identified and prioritized by clinicians for clinicians. Thus, we have used our clinician community to define for us those high priority items that must be shared by September 2009.

I will now discuss the specific types of data sharing occurring in more detail.

Exchange of electronic medical information

VA and DoD are successfully sharing electronic medical information on separated servicemembers and shared patients, who come to both VA and DoD for care and benefits. Since 2001, the Federal Health Information Exchange (FHIE) has accom-

plished the one-way transfer of all clinically pertinent electronic information on more than 4.8 million separated individuals—approximately 3.3 million of these individuals have come to VA for health care or benefits as Veterans. In addition to FHIE, VA and DoD clinicians are using the Bidirectional Health Information Exchange (BHIE) to view current medical data on shared patients, including Veterans, active duty personnel, and their dependents from every VA and DoD facility. Today, VA and DoD continue to share bidirectional viewable outpatient pharmacy data, allergy information, inpatient and outpatient laboratory results (including chemistry, hematology, microbiology, surgical pathology, and cytology), inpatient and outpatient radiology reports, ambulatory progress notes, procedures, and problem lists.

Our most recent enhancements in bidirectional exchange added vital sign data (including blood pressure, heart rate, respiratory rate, temperature, height, weight, oxygen saturation, pain severity, and head circumference) from all VA and DoD facilities, DoD Theater clinical data (including inpatient notes, outpatient encounters, and ancillary clinical data such as pharmacy data, allergies, laboratory results, and radiology reports), and inpatient discharge summaries from DoD's largest military treatment facilities, representing more than 55 percent of total DoD inpatient beds.

DoD and VA continue to improve our efficiency in transferring digital radiological images and scanned inpatient information for every patient being transferred from Walter Reed and Brooke Army Medical Centers and Bethesda National Naval Medical Center, to one of our four polytrauma centers in Richmond, Tampa, Palo Alto, and Minneapolis. Our polytrauma doctors find this information invaluable for treating our most seriously injured patients.

In addition to the viewable text and scanned information we receive and share with DoD, VA and DoD are sharing computable allergy and pharmacy information on patients who use both health care systems. The benefit of sharing computable data is that each system can use information from the other system to conduct automatic checks for drug interactions and allergies. In VA, we have implemented this capability at seven of our most active locations where patients simultaneously receive care from both VA and DoD facilities. Once a patient is "turned on" with this capability, his or her pharmacy and allergy information is computable enterprise-wide in DoD and VA and available for this automatic clinical decision support.

Our social workers, transition patient advocates, and other military liaison staff continue to successfully use the Veterans Tracking Application (VTA) to improve the coordination of care for patients transitioning from DoD to VA. VTA provides our staff with key patient tracking and patient coordination information on a near real-time basis.

Finally, VA and DoD are dedicated to ensuring that transitioning servicemembers receive the benefits they have earned in a timely manner. The information critical to the provision of benefits is obtained through the One VA/DoD data sharing initiative, which consolidates the transfer of data between DoD and VA and will eventually eliminate the need for paper copies of DD–214s. The Defense Enrollment Eligibility Reporting System (DEERS) supports that transfer, and the VA Defense Information Repository (VADIR), serves as the secure and authoritative database for a servicemember's demographic, personal identity information, and military history. This longitudinal electronic eligibility record can be used by all VA entities to administer benefits and care for a transitioning servicemember.

Details of the DoD/VA Information Interoperability Plan (IIP)

The DoD/VA IIP provides a roadmap to guide our Departments' information technology investment decisions and establish a shared understanding of interoperability principles, practices, enablers, and barriers.

The IIP is a living document whose ultimate purpose is to identify and address the information needed by the Departments to improve continuity of care and benefits administration for our Nation's servicemembers, Veterans, and their beneficiaries. To that end, the plan aligns our goals with 22 specific initiatives that make up the pathway to information interoperability.

In addition to identifying those actions necessary to achieve inter-Departmental interoperability, the IIP also identifies the barriers to success that need to be overcome. These barriers include concerns about data standardization and quality, information privacy and confidentiality, the investment cost to implement the initiatives, and the investment cost to upgrade legacy systems and infrastructure.

Interoperability by September 30, 2009

VA is working closely with our DoD partners to implement the provisions of the NDAA requiring interoperability by September 2009. Our main commitment is to ensure doctors and health care staff from both Departments have the information they need from each other to treat our common patients. This is not to say all elec-

tronic medical data will be shared; only to emphasize that everything deemed essential by our clinicians will be shared.

With respect to the September 2009 target, the ICIB plays a key role by determining, from a clinical perspective, the categories and priorities of clinical information that must be shared to most effectively treat our beneficiaries and meet the NDAA requirements. The ICIB recommends to the DoD/VA Health Executive Council (HEC) the types and format of health information that is necessary to provide top quality, effective care to shared patients, wounded warriors coming to us for treatment and rehabilitation, and Veterans transitioning to VA for care and benefits. The HEC approves or disapproves the ICIB recommendations.

To attain the interoperability of electronic health record capabilities and systems recommended by the ICIB by September 2009, the HEC approved six ICIB recommendations. Working collaboratively with DoD, three of these recommendations are already complete (share refined social history data, expand sharing of questionnaires/self assessment tools, and share information to support separation physical exams). A fourth recommendation to establish trusted network gateways is well underway. DoD and VA have approved implementing four enterprise gateways and up to five Federal health care center (FHCC) gateways. The focus of these gateways is to support VA/DoD general purpose health data traffic (i.e., CHDR, LDSI, FHIE/BHIE, imaging). All four enterprise gateways are operational, as is the FHCC gateway supporting the Captain James A. Lovell FHCC (North Chicago).

A fifth recommendation, document scanning, is also well underway. DoD has piloted the capability to scan paper documents and associate them with a specific patient so that providers are aware that the documents are available. Interagency testing of this pilot capability is on schedule for September 2009. The sixth initiative focuses on DoD's expansion of their inpatient electronic medical record system.

Under the purview of the Senior Oversight Committee (SOC) and in conjunction with the ongoing efforts of the DoD/VA Joint Executive Council (JEC), we are continuing our efforts to meet the immediate needs of seriously injured servicemembers transitioning to VA as a result of the current operations in theater settings. All transitioning servicemembers will benefit from this work. Toward this end, VA and DoD, working with the IPO, are continuing to define information and technology requirements to support disability evaluation, assessment, and documentation of traumatic brain injury and Post-traumatic stress disorders, case management tools, and automated solutions for reserve component records. Additionally, work continues on development of the eBenefits portal that will support unified and secure Web access to benefits and services that support wounded warriors. The SOC has been instrumental in defining requirements and implementing acquisition activities to support these key critical business needs.

Despite these accomplishments, we realize our work is not done and continue to expand the types of electronic medical data we share. For example, we are now sharing digital radiology images bidirectionally beyond the initial test site in El Paso, Texas. This capability is now available at several sites, including the Washington, DC, VA Medical Center, Walter Reed Army Medical Center, and National Naval Medical Center, where VA providers now use DoD radiology images to conduct service disability rating examinations.

Another example of our ongoing efforts is the enhancement of our ability to share computable health information. The capability enabling the exchange of computable outpatient pharmacy and medication allergy data for shared patients was made available to all DoD sites in December 2007.

VA and DoD will enhance this capability by adding computable laboratory (chemistry and hematology) results in the summer of 2010.

The Path to Information Interoperability in the Future

To date, VA and DoD information interoperability successes have focused on developing a suite of applications that facilitate exchanging patient information between the two Department's individual electronic medical record systems. However, on April 9, 2009, the President, along with Secretary Shinseki and Secretary Gates, announced that VA and DoD have taken steps toward creating a joint Virtual Lifetime Electronic Record (VLER). The VLER will permit information vital to health care, benefits, and services, to be available seamlessly to both Departments from the moment a servicemember enters into the military until the servicemember's or Veteran's death. The potential benefits of the VLER are many and planning, creating, and implementing the VLER will be a challenging endeavor. VA and DoD are working together on an overall strategy to achieve the President's VLER vision and jointly developing an effective governance model.

Concurrent with the VLER effort, VA continues to develop Health*e*Vet as our foundational tool, to deliver top quality health care to our patients and share impor-

tant medical information with DoD and eventually, other health care partners that treat our Veterans. VA appreciates this Committee's past support of this project and its continued funding, which is vital to our success.

In closing, I would like to thank you again for your continued support and the opportunity to testify before this Subcommittee on the important work we are undertaking to improve medical record sharing between the VA and DoD. I would now like to address any questions you might have.

Statement of Hon. Cliff Stearns,
a Representative in Congress from the State of Florida

Thank you, Mr. Chairman.

Thank you for holding this very important hearing. As a Representative from the State of Florida, which is home to the second largest veterans population in the country, this is an issue I have been particularly concerned about, and I am glad to be here this morning to receive the latest updates from the VA and DoD on their efforts to achieve full interoperability of their electronic health records.

September 30, 2009, as we all know, is the deadline set for VA and DoD to achieve interoperability of personal health care information. Achieving this interoperability is essential to ensuring our returning servicemen and women receive the care they need and the seamless transition they deserve.

Many of my own constituents have had to suffer through the frenetic and often frustrating transition from DoD to VA, and I commend the progress that has been made thus far to achieve interoperability. However, we are just three short months away and we are not at a point where all electronic health information is being shared, and it appears that we won't have full and complete interoperability by the September 30th deadline.

One important component of achieving interoperability is the ability of DoD to scan medical documents of servicemembers into its Electronic Health Record (EHR) and then share these important documents electronically with the VA. This document scanning and sharing initiative is reported to be "on schedule" and I sincerely hope this component of interoperability is deliverable by the deadline.

Additionally, I am concerned about reports of incomplete staffing at the Interagency Program Office for key information technology management positions and the management challenges reported by the GAO. Any potential problems must be identified and addressed immediately. Our veterans have waited long enough, we can't afford significant delays—our veterans' quality of life depends upon it.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigation
Washington, DC.
August 12, 2009

Honorable Gene L. Dodaro
Acting Comptroller General
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Comptroller General Dodaro:

Thank you for the testimony of Valerie C. Melvin, Director of Information Management and Human Capital Issues, U.S. Government Accountability Office at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations hearing that took place on July 14, 2009 on "Examining the Progress of Electronic Health Record Interoperability Between the U.S. Department of Veterans Affairs and U.S. Department of Defense."

Please provide answers to the following questions by COB on Wednesday, September 16, 2009 to Todd Chambers, Legislative Assistant to the Subcommittee on Oversight and Investigations.

1. How would the GAO grade the efforts of both the Department of Defense (DoD) and the Department of Veterans Affairs (VA) on their efforts toward interoperability of systems?
2. VA and DoD have been meeting for decades on interoperability and resource sharing. The law permitting them to address this issue goes as far back as 1982. Why are we just now seeing a description of VA and DoD interoperability objectives? Is this a technology or a bureaucratic cultural issue?
3. In your testimony, you state the progress is being made, but do you feel that under the circumstances, IPO, VA and DoD are maximizing their time and effort in moving forward as expeditiously as possible? If not, how do you propose they make changes to fulfill the intent of the NDAA and maximize production?
4. What plans do DoD and VA have for continuity as key leadership positions are permanently filled? What challenges to do you foresee?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers. If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Majority Staff Director, Martin Herbert, at (202) 225–3569 or the Subcommittee Minority Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

Harry E. Mitchell
Chairman

David P. Roe
Ranking Republican Member

MH/tc

U.S. Government Accountability Office
Washington, DC.
October 13, 2009

The Honorable Harry Mitchell
Chairman
Subcommittee on Oversight and Investigations
House Veterans' Affairs Committee
335 Cannon House Office Building
Washington, D.C. 20515

The Honorable David Roe
Ranking Member
Subcommittee on Oversight and Investigations
House Veterans' Affairs Committee
335 Cannon House Office Building
Washington, D.C. 20515

Subject: Program Office Improvements Needed to Strengthen Management of VA and DoD Efforts to Achieve Fully Interoperable Electronic Health Records: Responses to Post-Hearing Questions

This letter responds to your August 12, 2009, request that we answer questions relating to our testimony on July 14, 2009.[1] During that hearing, we discussed the Departments of Veterans Affairs' (VA) and Defense's (DoD) interagency program office and efforts toward achieving fully interoperable electronic health record capabilities. Your questions, along with our responses, follow.

1. **How would the GAO grade the efforts of both the Department of Defense (DoD) and the Department of Veterans Affairs (VA) on their efforts toward interoperability of systems?**

Based on their accomplishments as of late July 2009,[2] we would grade the departments' efforts toward achieving fully interoperable electronic health record systems as incomplete. As noted in the testimony, DoD and VA identified six objectives for achieving full interoperability in compliance with applicable standards by September 30, 2009. When we last reported on their efforts in late July, the departments had achieved planned capabilities for three of the objectives—refine social history data, share physical exam data, and demonstrate initial network gateway operation. For the remaining three objectives, the departments had partially achieved planned capabilities, with additional work needed to fully meet the objectives. Regarding an objective to expand questionnaires and self-assessment tools to provide VA all periodic health assessment data stored in DoD's electronic health record, department officials stated that they intended to complete the additional work by September 2009. The officials stated that they also intended to meet objectives to expand DoD's inpatient medical records system for each military medical service and to demonstrate an initial capability to scan servicemembers' medical documents; however, they noted that additional work related to these objectives would be required beyond September to achieve the fully interoperable capabilities necessary to meet clinicians' needs for health information.

Further, we reported in late July that the DoD/VA Interagency Program Office had not yet been effectively positioned to serve as the single point of accountability for the implementation of fully interoperable electronic health records. While the departments had made progress in setting up the office by recruiting and hiring staff to fill government and contractor positions, they lacked full-time permanent leadership for the office and had not fulfilled key information technology management responsibilities in the areas of performance measurement, project planning, and scheduling. Thus, the office was limited in its ability to effectively manage and provide meaningful progress reporting on the delivery of interoperable capabilities that are intended to improve the quality of health care provided to our Nation's veterans.

2. **VA and DoD have been meeting for decades on interoperability and resource sharing. The law permitting them to address this issue goes as far back as 1982. Why are we just now seeing a description of VA and DoD interoperability objectives? Is this a technology or a bureaucratic cultural issue?**

While VA and DoD have been working to exchange patient health information electronically since 1998, the departments undertook key steps to define their interoperability objectives only within the last 2 years. Specifically, it was not until

[1] GAO, *Electronic Health Records: Program Office Improvements Needed to Strengthen Management of VA and DoD Efforts to Achieve Full Interoperability*, GAO–09–895T (Washington, D.C.: July 14, 2009).

[2] GAO, *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).

December 2007 that the departments established the Interagency Clinical Informatics Board[3] (made up of senior clinical leaders from both departments who represent the user community) to be responsible for determining clinical priorities for electronic data sharing between VA and DoD. The departments included the six interoperability objectives identified by the board in the September 2008 DoD/VA Information Interoperability Plan (Version 1.0), which was developed to address the requirements for interoperable electronic health records set forth in the National Defense Authorization Act for Fiscal Year 2008 (NDAA). The departments produced a draft of the plan in March 2008, completed their reviews of the plan approximately 6 months later, and issued the plan in September 2008.

Our reviews of VA's and DoD's efforts to electronically share health data have generally identified managerial, rather than technical, deficiencies as a key factor hindering the departments' progress toward achieving interoperability. For example, in reporting on the departments' initial efforts to "share clinical information via a comprehensive, lifelong medical record" in 2001, we noted that accountability for the initiative[4] was blurred across several management entities, and that basic principles of sound information technology (IT) project planning, development, and oversight had not been followed, creating barriers to progress. In June 2004, we reported that the two departments lacked an established project management structure and a lead entity with final decision-making authority to guide the investment in and implementation of this capability, and a project management plan that defined the technical and managerial processes necessary to satisfy project requirements.[5] Also, in June 2006, we noted that although VA and DoD had developed an interagency project management plan, this plan had not specified the authority and responsibility of organizational units for particular tasks, and the work breakdown structure was at a high level and lacked detail on specific tasks and time frames.[6] Further, with regard to their more recent efforts to meet the NDAA's requirement for full interoperability, we reported in July 2008 that the departments lacked a fully established program office and a finalized implementation plan with milestones for setting up the office and for carrying out activities, such as validating and establishing requirements for interoperable health capabilities.[7] In January 2009, we reported that the departments had not established results-oriented (i.e., objective, quantifiable, and measurable) performance goals and measures to be used as a basis for reporting interoperability progress.[8] In July of this year, we noted that the departments' lack of progress in establishing fundamental IT management capabilities that are specific responsibilities of the interagency program office had contributed to uncertainty about the extent to which the departments would progress toward achieving full interoperability.[9] We recommended actions to address these deficiencies and improve the departments' efforts to electronically share health data.

3. **In your testimony, you state that progress is being made, but do you feel that under the circumstances, IPO, VA, and DoD are maximizing their time and effort in moving forward as expeditiously as possible? If not, how do you propose they make changes to fulfill the intent of the NDAA and maximize production?**

Our studies suggest that neither VA and DoD, nor the interagency program office have effectively maximized their time and effort to expeditiously achieve interoperable electronic health records. Although we have noted progress in the departments' sharing of patient health data, we have also pointed out their need to address important weaknesses in their data sharing efforts. This need is highlighted in the history of management weaknesses (previously discussed) that have persisted since our earliest reporting on the departments' efforts in 2001.

The reports that we have issued in response to the NDAA have included recommendations to VA and DoD that are relevant to fulfilling the intent of the act.

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[3] This board was originally named the Joint Clinical Information Board.

[4] This initiative was called the Government Computer-Based Patient Record. See GAO, *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).

[5] GAO, *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).

[6] GAO, *Information Technology: VA and DoD Face Challenges in Completing Key Efforts*, GAO–06–905T (Washington, D.C.: June 22, 2006).

[7] GAO, *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).

[8] GAO, *Electronic Health Records: DoD's and VA's Sharing of Information Could Benefit from Improved Management*, GAO–09–268 (Washington, D.C.: January 28, 2009).

[9] GAO–09–775.

For example, in our reports since July 2008, we have recommended that the departments expedite efforts to put in place permanent leadership, staff, and facilities for the interagency program office. We have also recommended that they develop results-oriented goals and associated performance measures for their interoperability objectives, document these goals and measures in the department's interoperability plans, and use the goals and measures as the basis for future assessments and reporting of interoperability progress. Similarly, we have recommended that the departments direct the interagency program office to establish a project plan and a complete and detailed integrated master schedule to guide their efforts to achieve fully interoperable electronic health record systems. In the absence of these important mechanisms, VA, DoD, and the interagency program office are limited in their ability to effectively manage and successfully deliver the intended interoperable capabilities.

4. **What plans do DoD and VA have for continuity as key leadership positions are permanently filled? What challenges do you foresee?**

At the time of our studies, VA and DoD planned to have acting officials serve in key leadership positions (i.e., as director and deputy director) until permanent officials could be hired. In this regard, the departments had taken action toward hiring a full-time permanent director and a deputy director to lead the office. However, our July testimony and report noted that these positions continued to be filled on an interim basis.[10] As of early July, DoD had selected a candidate for the director position, VA had concurred with the selection, and the candidate's application had been sent to the Office of Personnel Management for approval. In the meantime, the departments requested and received an extension of the current acting director's appointment until September 30, 2009, or until a permanent official was hired. Additionally, the acting director had stated that the departments anticipated making a selection for the deputy director position. As we have previously noted, until the departments appoint these key permanent leaders, the interagency program office will be challenged to fulfill all of the responsibilities that are fundamental to effective program management and that are essential to effectively serving as the single point of accountability for achieving fully interoperable capabilities.

In responding to these questions, we relied on previously reported information that was compiled in support of our July 14, 2009, testimony and our July 28, 2009, report. Our work in support of those products was performed in accordance with generally accepted government auditing standards. Should you or your staffs have any questions on matters discussed in this letter, please contact me at (202) 512–6304 or melvinv@gao.gov.

Valerie C. Melvin
Director, Information Management and Human Capital Issues

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigation
Washington, DC.
August 31, 2009

Honorable Robert M. Gates
Secretary of Defense
U.S. Department of Defense
1000 Defense Pentagon
Washington, D.C. 20301

Dear Secretary Gates:

Thank you for the testimony of Rear Admiral Gregory Timberlake, SCHE, USN, Acting Director of the Interagency Program Office and Mary Ann Rockey, Deputy Chief Information Officer, Military Health System, U.S. Department of Defense at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations hearing that took place on July 14, 2009 on "Examining the Progress of Electronic Health Record Interoperability Between the U.S. Department of Veterans Affairs and U.S. Department of Defense."

[10] GAO–09–895T and GAO–09–775.

Please provide answers to the following questions by COB on Tuesday, October 29, 2009 to Todd Chambers, Legislative Assistant to the Subcommittee on Oversight and Investigations.

1. Who is the reporting authority for Admiral Timberlake? How long has Admiral Timberlake been Acting Director of the IPO program?
2. When was the IPO charter finally approved by the Department of Defense?
3. Should the Great Lakes Naval/North Chicago VA joint venture, scheduled for opening in 2010 be considered the poster child for VA/DoD interoperability?
4. Though only 10 out of 14 government positions have been filled, how much have the 16 contractors cost the U.S. taxpayers? Since there is no meaningful baseline to measure performance, how can you tell whether the contractors are adding any value to the IPO?
5. What are DoD's plans, including a schedule, for expanding the capability for scanning DoD documents into AHLTA?
6. What percentage of DoD's medical records is still in paper format? What are the department's plans, including a schedule, for transitioning medical records from paper to an electronic form?
7. What is the plan and timeline for DoD to expand Essentris to 100 percent of its sites and account for every inpatient bed in the DoD system? What challenges does this create for clinicians and medical providers between both DoD and VA medical systems?
8. Are we correct in surmising that the samples that the Committee viewed during the hearing of different servicemembers' records were selected from the many others in which may or may not be as complete or be as interconnected? If so, what percentage of those who have been separated from service in the last year had this degree of interoperability and depth so that the physician from VA or DoD or private sector, but especially VA, can access all that information going back to when the injury may have occurred.

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers. If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Majority Staff Director, Martin Herbert, at (202) 225–3569 or the Subcommittee Minority Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

Harry E. Mitchell
Chairman

David P. Roe
Ranking Republican Member

MH/tc

Questions for the Record
The Honorable Harry Mitchell, Chairman
Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs
July 14, 2009

Question #1: Who is the reporting authority for Admiral Timberlake? How long has Admiral Timberlake been Acting Director of the IPO program?

Answer: For purposes of executing the IPO mission, the IPO Director is subject to the authority, direction and control of the Under Secretary of Defense (Personnel and Readiness)(USD(P&R)) in the USD(P&R)'s dual position as the Director, Defense Human Resources Activity.

In performing IPO's oversight role, the IPO Director reports to the Department of Veterans Affairs/Department of Defense Joint Executive Council cochairs; namely, the USD(P&R) and Deputy Secretary of Veterans Affairs.

Due to RADM Timberlake's active military status, his official reporting chain follows Navy policy and includes the Chief of Naval Operations.

RADM Timberlake's initial set of orders covered January 5, through July 2, and the second set cover July 3, through August 29. We anticipate orders will need to be extended through September 30.

Question #2: When was the IPO charter finally approved by the Department of Defense?

Answer: The IPO charter was executed on January 16, by Deputy Secretary of Veterans Affairs (VA), Gordon H. Mansfield, and Under Secretary of Defense for Personnel and Readiness, Dr. David S. C. Chu. On June 26, the VA/DoD Joint Executive Council directed IPO to revise the statement of responsibilities and authority in its charter. A revised and restated IPO charter is anticipated by September 30, subject to review and approval by Deputy Secretary of VA, W. Scott Gould, and Deputy Secretary of Defense, William J. Lynn III.

Question #3: Should the Great Lakes Naval/North Chicago VA joint venture, scheduled for opening in 2010 be considered the poster child for VA/DoD interoperability?

Answer: Member of Congress, VA, and DoD sought to address the need to replace Naval Hospital Great Lakes (NHGL) and utilize excess patient care capacity at nearby North Chicago Veterans Affairs Medical Center (NCVAMC). In 2002, the decision was reached to create the first Federal Health Care Center (FHCC), a fully integrated partnership between NHGL and NCVAMC. Developing the first FHCC is a major initiative. A single chain of command will manage inpatient and outpatient medical and dental care at the new Captain James A. Lovell Federal Health Care Center (JALFHCC); the new Federal ambulatory care clinic co-located on the JALFHCC campus; DoD clinics at recruit and student training centers; and VA Community-Based Outpatient Clinics. The Departments expect to realize benefits in the simultaneous, non-duplicative provision of accessible, high-quality health care for recruit, Active Duty, dependent, retiree, and Veteran beneficiary populations.

JALFHCC has many unique business needs that require alternate technology solutions. Future FHCCs also will have unique business needs, which may or may not require development of alternate technology solutions. For example, beneficiary population and catchment area, local facility organizational structure, resources, funding, networks, and specific Service requirements may all influence DoD/VA business needs. Using a common services approach with service oriented architecture establishes an environment in which functions can be standardized and used across systems and processes, enabling the Departments to develop common business and data services to utilize across the DoD/VA continuum of care. Enterprise solutions developed for JALFHCC will be exported to other joint ventures, whenever appropriate.

By October 2010, the Departments seek to achieve the following key capabilities at JALFHCC:

- building a single patient registration process that unifies patient registration, so that registering a patient in either system will begin the registration process in both systems;
- creating a clinical single sign-on capability that enables a clinical user to log securely into multiple clinical applications with a single user name and password, and maintains the patient context across applications;
- developing the first phase of orders management/order portability for:
  - laboratory
  - radiology
  - pharmacy and
  - consultations/referrals; and,
- beginning the development of applications to support Navy operational readiness requirements, such as mass rapid dental exams.

The Departments will also gather requirements and work flow data for financial, quality, performance, and workload metrics processes, and, explore cross agency outpatient appointment scheduling.

Question #4: Though only 10 out of 14 government positions have been filled, how much have the 16 contractors cost the United States taxpayers? Since there is no meaningful baseline to measure performance, how can you tell whether the contractors are adding any value to the Interagency Program Office (IPO)?

Answer: The IPO has filled 10 of 14 government positions with personnel on staff. The status of the four remaining positions follows:

- Senior Program Analyst—Benefits (DoD): Selection made; anticipate security clearance process to be completed in August 2009; anticipate report date to be September 28, 2009

- Program Analyst (VA): Selection made; anticipate report date to be August 20, 2009
- Senior Program Analyst—Health (VA): Anticipate internal and external advertisement to close by the end of Fiscal Year 2009
- Senior Program Analyst—Benefits (VA): Anticipate candidate selection by the end of Fiscal Year 2009

The work of the IPO spans a variety of skill sets and functional areas, and relies on a team-like atmosphere to accomplish its mission. Contractors provide critical support in each functional area. Contractors at the IPO bring skill sets that augment work done by government personnel. Skills provided by contractors at the IPO include:

Subject Matter Expertise in Service Oriented Architecture

This contract support role has specific application to the VA/DoD and Nationwide Health Information Network data sharing environments, which have been described in documentation related to the Virtual Lifetime Electronic Record (VLER). In this role, contractors at the IPO provide experience and expertise that is scarce in both Departments. The contractors also contribute to IPO with their understanding of common services architecture, business users, client users, and use cases, as applicable, in VA or DoD.

Quality Assurance and Risk Management

This role ensures an effective program operations management process exists at the IPO. The purpose of such a process is to adequately and quantitatively evaluate and identify risk. The contractors also provide support to ensure that quality assurance programs at the IPO are adequate. This is fundamental, foundational work needed to build and implement standards specifications for VLER. The work of this subject matter expert, coordinating with subject matter experts from each Department, is critical.

Congressional Relations

The IPO is frequently asked to provide information about data interoperability and the progress being made toward VLER. Contract support staff in this role provide advice to IPO leadership and government leads regarding audit and external oversight activities. This position requires superior written and oral communications skills, as well as knowledge of information technology and health program delivery that contract staff is able to provide.

These positions, as well as other contract support at the IPO, bridge gaps in existing resources to complete the IPO team quickly and effectively. As of July 14, 2009, about $2.0 million has been spent on 16 contract support staff. The value of the contract for IPO contract support is $4.9 million.

Question #5: What are DoD's plans, including a schedule, for expanding the capability for scanning DoD documents into AHLTA?

Answer: The DoD Healthcare Artifact and Image Management Solution (HAIMS) will enable DoD users to scan or import documents and artifacts, associate those documents and artifacts with a patient's record, and make them globally accessible to authorized DoD and Department of Veterans Affairs users.

The initial evaluation of HAIMS, in a test environment, will be completed by the end of September 2009. The first phase of HAIMS implementation activities will begin at the end of Fiscal Year (FY) 2009 and will involve software systems integration testing and deploying capabilities for limited user testing. Nine sites (three Navy, three Army, and three Air Force) will be selected for limited user testing, which is planned to run from December 2009 through March 2010. Based on the results of the limited user testing, enterprise-wide deployment of HAIMS is anticipated to begin in FY 2010.

Question #6: What percentage of DoD's medical records is still in paper format? What are the department's plans, including a schedule, for transitioning medical records from paper to an electronic form?

Answer: In accordance with Strategy 3.5 of the VA/DoD Joint Strategic Plan, signed January 2009, a Medical Records Working Group (MRWG) has been established under the Benefits Executive Council. The MRWG is involved in the systematic examination of all phases of the Military paper service treatment record (STR) lifecycle management process, with an emphasis on promptly providing accurate and complete STR related information for all Servicemembers in all components and veterans to DoD and VA designated benefits determination decision-makers.

Analysis of the entire STR lifecycle conducted by the MRWG this year generated more than 50 recommendations. Next steps include implementing low cost/high impact recommendations and developing business cases for other recommendations. Key recommendations included interim means of eliminating costly and problematic paper-based business processes associated with STR maintenance and transfer until the Virtual Lifetime Electronic Record (VLER) is developed and implemented. The interim solution must bridge the gap until VLER is in place by leveraging existing records management system capabilities to support the scanning of paper-generated documentation into a repository that would either exist parallel to the AHLTA record or enable scanning directly into the AHLTA record. DoD would then expand the use of its Defense Personnel Records Information System to provide Veterans Benefits Administration regional offices with ready access to this medical documentation on a Servicemember.

It is important to consider, while DoD has achieved an increase in the number of outpatient clinical encounters being documented in AHLTA in recent years, some care continues to be documented on paper. Additionally, even if today we capture 100 percent of data electronically, for those personnel who were in the military prior to full implementation of AHLTA, at least a portion of their records will be paper-based. Further, at the time of a Servicemember's separation or release from Active Duty, a hard copy of the STR (which includes the outpatient medical record) must be sent to the VA Records Management Center in St. Louis. This process involves manually printing any encounters that were captured in AHLTA and reconciling them with the hard copy outpatient medical records folder.

Question #7: What is the plan and timeline for DoD to expand Essentris to 100 percent of its sites and account for every inpatient bed in the DoD system? What challenges does this create for clinicians and medical providers between both DoD and VA medical systems?

Answer: The DoD Military Health System continues to expand its use of Essentris, an inpatient clinical documentation product. On March 26, DoD awarded a contract for centrally funded implementation and sustainment of Essentris to vendor, CliniComp International. DoD anticipates that by the end of Fiscal Year 2009, DoD will be sharing discharge summaries with VA from 24 Essentris sites which cover 59 percent of DoD's total inpatient beds. DoD plans to deploy Essentris to cover more than 90 percent of its total inpatient beds by January 2011.

To realize the full value of Essentris, DoD and VA clinicians and medical providers must be aware that information exists, must know how to access it, and must actually access it. To facilitate access to Essentris data, the DoD desktop icon through which DoD clinicians and providers access the data has been relabeled to read VA information and Theater information to be more intuitive.

Question #8: Are we correct in surmising that the samples that the Committee viewed during the hearing of different servicemembers' records were selected from the many others in which may or may not be as complete or be as interconnected? If so, what percentage of those who have been separated from service in the last year had this degree of interoperability and depth so that the physician from VA or DoD or private sector, but especially VA, can access all that information going back to when the injury may have occurred.

Answer: VA has access to electronic health information on more than 4.8 million individuals. The earliest data, starting with ancillary data, are from 1989. Since 2001, increasingly more data have been made available electronically.

Not all prior Servicemembers will have Theater data available electronically to VA. The ability for VA to access Theater data became operational in October 2007. VA would not be able to access Theater data on individuals in Theater prior to October 2007. Likewise, not all former Servicemembers would have digital radiology images available to VA at this time, since that capability is operational at a limited number of pilot sites.

Additionally, VA and DoD are working to upgrade and enhance the technical framework that supports data sharing and improve the framework's capability to handle increasing amounts of shared data. Contract awards for beginning these upgrades and enhancements are expected in the next 2 months.

In general, VA has access to:

- Since 2001, for *separated Servicemembers*, DoD has provided VA with one-way historic information through the Federal Health Information Exchange. On a monthly basis DoD sends laboratory results; radiology reports; outpatient pharmacy data; allergy data; discharge summaries; consult reports; admission, dis-

charge, transfer information; standard ambulatory data records; demographic data; pre- and post-deployment health assessments; and post-deployment health reassessments.

For *shared patients* being treated by both DoD and VA, DoD continues to maintain the jointly developed Bidirectional Health Information Exchange (BHIE) system, which was implemented in 2004. Using BHIE, DoD and VA clinicians are able to access each other's health data in real-time, including the following types of information: allergy; outpatient pharmacy; inpatient and outpatient laboratory and radiology reports; demographic data; diagnoses; vital signs; family history, social history, other history; questionnaires; and Theater clinical data, including inpatient notes, outpatient encounters, and ancillary clinical data such as pharmacy data, allergies, laboratory results and radiology reports.

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigation
Washington, DC.
August 12, 2009

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

Dear Secretary Shinseki:

Thank you for the testimony of the Honorable Roger W. Baker, Assistant Secretary for Information Technology, U.S. Department of Veterans Affairs, accompanied by Paul Tibbits, M.D., Deputy Chief Information Officer, Office of Enterprise and Development, U.S. Department of Veterans Affairs, Scott Cragg, Executive Director and Program Manager, Virtual Lifetime Electronic Record Program, U.S. Department of Veterans Affairs, Douglas E. Rosendale, DO, FACOS, Enterprise System Manager for Joint Interoperability Ventures, Office of Health Information, Veterans Health Administration, U.S. Department of Veterans Affairs, and Ross D. Fletcher, M.D., Chief of Staff, Washington, DC Veterans Affairs Medical Center, Veterans Health Administration, U.S. Department of Veterans Affairs at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations hearing that took place on July 14, 2009 on "Examining the Progress of Electronic Health Record Interoperability Between the U.S. Department of Veterans Affairs and U.S. Department of Defense."

Please provide answers to the following questions by COB on Wednesday, September 16, 2009 to Todd Chambers, Legislative Assistant to the Subcommittee on Oversight and Investigations.

1. You stated that DoD and VA have come a long way in sharing electronic medical records to serve our veterans, but please discuss the challenges you see with fee-basis documents, test results, imaging, etc. for our veterans that are referred out to civilian physicians. How does this affect our Reserve/Guard forces, as well as our rural veterans in need of medical care?
2. Please tell us how many patients get transferred to a polytrauma center each year and what is the percentage of those patients that are referred with their digital radiological images and scanned inpatient information? Are any being transferred without these electronic medical records at this point in time?
3. It is stated in testimony that the DoD and VA Information Interoperability Plan (IIP) is a living document and that it has 22 initiatives that make up the pathway to information interoperability. Would you define this document as fluid or certain? What challenges exist with working on this "living" document? If the IIP is always evolving, do you believe that you will ever reach a fully interoperable state?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers. If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Majority

Staff Director, Martin Herbert, at (202) 225–3569 or the Subcommittee Minority Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

Harry E. Mitchell
Chairman

David P. Roe
Ranking Republican Member

MH/tc

Questions for the Record
The Honorable Harry Mitchell, Chairman
Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs
July 14, 2009

Examining the Progress of Electronic Health Record Interoperability Between the U.S. Department of Veterans Affairs and U.S. Department of Defense

Question 1: You stated that DoD and VA have come a long way in sharing electronic medical records to serve our veterans, but please discuss the challenges you see with fee-basis documents, test results, imaging, etc. for our veterans that are referred out to civilian physicians. How does this affect our Reserve/Guard forces, as well as our rural veterans in need of medical care?

Response: Using the bidirectional health information exchange (BHIE), the Department of Veterans Affairs (VA) and the Department of Defense (DoD) currently share almost all pertinent clinical information that is available electronically on shared patients. This includes Veterans residing in rural areas since BHIE is available at every VA medical center. Patient clinical test results, such as laboratory and radiology reports, are included in this information and are available in readable text format. Additionally, VA and DoD have made some progress sharing images at select locations, and are working on the capability to support image sharing enterprise-wide. Patients for whom records are shared between VA and DoD include those Reserve and National Guard forces who are serving on active duty and have military health data available in DoD systems. It also includes those who are fully separated or demobilized from service and who are referred to VA for care or treatment.

With respect to sharing fee basis documents, test results and images with private civilian clinicians, VA is working with DoD and other civilian participants at a national level to develop the Nationwide Health Information Network (NHIN) sponsored by the Department of Health and Human Services (HHS). NHIN will leverage recognized interoperability standards to support information sharing among both government and private health care organizations. Within the context of NHIN, VA and DoD will apply lessons learned from its data sharing efforts to ensure that information is available to support Veteran care where and when it is needed. The data sharing capabilities using NHIN will be contingent on whether private sector providers choose to use NHIN. When VA and DoD exchange data through NHIN it will include all Veterans and servicemembers, including those in rural areas.

Question 2: Please tell us how many patients get transferred to a polytrauma center each year and what is the percentage of those patients that are referred with their digital radiological images and scanned inpatient information? Are any being transferred without these electronic medical records at this point in time?

Response: On average, 100–125 active duty patients are referred annually to a VA polytrauma rehabilitation center (PRC) from military treatment facilities. From April 2008 to present, 103 active duty patients were referred to a PRC from National Naval Medical Center (NNMC), Walter Reed Army Medical Center (WRAMC) and Brooke Army Medical Center (BAMC). All 97 of the patients referred from NNMC and WRAMC were sent with both digital radiological images and scanned patient information. The six patients referred from BAMC during this period provided only digital radiological images (not scanned patient information).

Additionally, for fiscal 2008 through June 30, 2009, 92 active duty patients were referred to a PRC from other DoD military treatment facilities and warrior transi-

tion units which are not yet sending digital radiological images or scanned patient information.

Question 3: It is stated in testimony that the DoD and VA Information Interoperability Plan (IIP) is a living document and that it has 22 initiatives that make up the pathway to information interoperability. Would you define this document as fluid or certain? What challenges exist with working on this "living" document? If the IIP is always evolving, do you believe that you will ever reach a fully interoperable state?

Response: The information interoperability plan (IIP) is a fluid living document intended to guide the interoperability efforts between VA and DoD. The IIP does not represent "funded" or "programmed" projects but provides a necessary strategic blueprint VA and DoD can work toward. VA and DoD define "interoperability" based on the business needs to share information. For example, health data interoperability is determined by the clinical priorities established by VA and DoD clinicians on the Interagency Clinical Informatics Board (ICIB). With respect to challenges, VA and DoD must work to achieve interoperability while facing disparate funding cycles for information technology development. The Departments are also faced with fulfilling shared business requirements for information while simultaneously meeting the unique mission needs of each organization (i.e., support for DoD warriors and support for VA long term care facilities). Additionally, achieving interoperability depends not only on technical progress made by the Departments, but also on the availability of data standards to support information exchange. The Departments must remain aligned with national standards identification and development efforts led by HHS while at the same time making progress to share data between VA and DoD. To address challenges related to standards, VA and DoD continue to participate on national standards development organizations and have closely partnered with HHS and industry leaders for health technology.

While the IIP evolves, so does the availability of data standards and modern technologies that will continue to improve data sharing between the Departments. In this regard, the Departments anticipate that the level of interoperability will continue to evolve. The focus of sharing information is on supporting the level of interoperability that meets the information requirements identified by those who need the information, such as clinicians treating Veterans and staff adjudicating claims benefits. In this regard, VA and DoD believe the goals of the IIP will be met.

○